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Austria

Health system review

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European Observatory on Health Systems and Policies

Health Systems in Transition

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies. HiTs seek to provide relevant comparative information to support policy-makers and analysts in the development of health systems in Europe.

The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health reform programmes; to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data sources, quantitative data on health services are based on a number of different Sources,

including the Health for All database, Organisation for Economic Co-operation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to info@obs.euro.who.int. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's web site at www.euro.who.int/observatory.

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The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the Health Systems in Transition profiles is led by Josep Figueras, Director, and Elias Mossialos, Co-Director, and by Reinhard Busse, Martin McKee and Richard Saltman, Heads of the Research Hubs. Technical coordination is led by Susanne Grosse-Tebbe.

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The HiT refers to reforms and data available as at February 2006.

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List of abbreviations and glossary

Abbreviation	Austrian term	English term
AAGR	Durchschnittliche jährliche Wachstumsrate	Average annual growth rate
AGES	Agentur für Gesundheit und Ernährungssicherheit	Agency for Health and Food Safety
AIDS	Erworbenes Immunschwächesyndrom	Acquired immune deficiency syndrome
ASVG	Allgemeines Sozialversicherungsgesetz	General Social Security Act
BGBl	Bundesgesetzblatt	Federal Law Gazette
B-KAG	Bundeskrankenanstaltengesetz	Federal Hospitals Act
B-KUVG	Beamten-Kranken- und Unfallversicherungsgesetz	Act on Civil Servants' Health and Accident Insurance
BMBWK	Bundesministerium für Bildung, Wissenschaft und Kultur	Federal Ministry of Education, Science and Culture
BMF	Bundesministerium für Finanzen	Federal Ministry of Finance
BMGF	Bundesministerium für Gesundheit und Frauen	Federal Ministry of Health and Women
BMSG	Bundesministerium für Soziale Sicherung Generationen und Konsumentenschutz	Federal Ministry of Social Security, Generations and Consumer Protection
BMWA	Bundesministerium für Wirtschaft und Arbeit	Federal Ministry of Economics and Labour
BR	Bundesrat	Federal Council (Upper House of Parliament)
BSVG	Bauern-Sozialversicherungsgesetz	Act on Social Insurance for Farmers
B-VG	Bundesverfassungsgesetz	Austrian Federal Constitution
BZÖ	Bündnis Zukunft Österreich	Alliance Future Austria
CINDI	Landesweite Integrierte Interventionsprogramme für Nicht-übertragbare Erkrankungen	Countrywide Integrated Noncommunicable Disease Intervention Programme
CT	Computertomografie	Computed tomography
Dept.	Abteilung	Department

DIMDI	Deutsches Institut für Medizinische Dokumentation und Information	German Institute for Medical Documentation and Information
DMFT Index	Index geschädigter, fehlender oder gefüllter Zähne	Decayed Missing and Filled Teeth Index
DRG	Diagnose-orientierte (Fall-)Gruppe	Diagnosis-related group
EEA	Europäische Wirtschaftsregion	European Economic Area
ELGA	Elektronische Gesundheitsakte	Electronic health file
ESA	Europäisches System (Integrierter) Nationaler Volkswirtschaftlicher Gesamtrechnungen	European System of (Integrated) National Accounts
EU	Europäische Union	European Union
Fig.	Abbildung	Figure
FOPI	Forum der Forschenden Pharmazeutischen Industrie	Forum of the Researching Pharmaceutical Industry
FPÖ	Freiheitliche Partei Österreichs	Freedom Party of Austria
GDP	Bruttoinlandsprodukt	Gross domestic product
GGP	Großgeräteplan	Austrian Major Equipment Plan
GSVG	Gewerbliches Sozialversicherungsgesetz	Act on Social Insurance for the Self-employed
GuKG	Gesundheits- und Krankenpflegegesetz	Nursing Act
HDG	Hauptdiagnosengruppe	Main diagnosis group
HEK	Heilmittel-Evaluierungskommission	Medicines Evaluation Commission
HiT	Gesundheitssysteme im Wandel Profil	Health Systems in Transition Profile
HTA	Gesundheitstechnologiebewertung	Health technology assessment
HVSV	Hauptverband der österreichen Sozialversicherungsträger	Federation of Austrian Social Insurance Institutions
ICD	Internationale Klassifikation der Krankheiten	International Classification of Diseases
IHS	Institut für Höhere Studien	Institute for Advanced Studies
ITA	Institut für Technologiefolgen-Abschätzung	Institute for Technology Impact Assessment
IVF	In-vitro-Fertilisation	In vitro fertilization
KAKuG	Bundeskrankenanstaltengesetz	Federal Hospitals Act
KFA	Krankenfürsorgeanstalten	health welfare institutions
KRAZAF	Krankenanstalten-Zusammenarbeitsfonds	Hospitals Cooperation Fund
LDF	leistungsorientierte Diagnosefallgruppe	Performance-orientated (procedure or diagnosis orientated) case group
LKAG	Landes-Krankenanstaltengesetz	Land Hospitals Act
LKF	Leistungsorientiertes Krankenanstalten-Finanzierungssystem	Performance-orientated hospital financing system (Austrian DRG model)
LP	Legislaturperiode	Legislative period
MBDS	Basisdatensatz	Minimum Basic Data Set
MEL	Medizinische Einzelleistung	Single medical procedure
MRI	Magnetresonanztomografie	Magnetic resonance imaging

No.	Nummer	Number
NR	Nationalrat	National Council (Lower House of Parliament)
ÖAW	Österreichische Akademie der Wissenschaften	Austrian Academy of Sciences
ÖBIG	Österreichisches Bundesinstitut für Gesundheit	Austrian Federal Institute for Health
OECD	Organisation für Wirtschaftliche Zusammenarbeit und Entwicklung	Organisation for Economic Co-operation and Development
OEGV	Österreichischer Generikaverband	Generic Drugs Association
ÖGD	Öffentlicher Gesundheitsdienst	Public health service
ÖKAP	Österreichischer Krankenanstaltenplan	Austrian hospitals plan
ÖSG	Österreichischer Strukturplan Gesundheit	Austrian Structural Plan for Health
ÖVP	Österreichische Volkspartei	Austrian People's Party
PHARMIG	Vereinigung Pharmazeutischer Unternehmen	Austrian Association of Pharmaceutical Companies
PPG	Peering Point Gesellschaft	Peering Point Association
PRIKRAF	Privatkrankenanstalten-Finanzierungs-Fonds	Private Hospitals Financing Fund
SDR	(Alters)standardisierte Sterberate	(Age-)standardized death rate
SIGIS	Service- und Informationsstelle für Gesundheitsinitiativen und Selbsthilfegruppen	Service and Information Centre for Health Initiatives and Self-help Groups
SPÖ	Sozialdemokratische Partei Österreichs	Social Democratic Party of Austria
TBC	Tuberkulose	Tuberculosis
THE	gesamte Gesundheitsausgaben	Total health expenditure
UHK	Unabhängige Heilmittelkommission	Independent Medicines Commission
VVO	Verband der Versicherungsunternehmen	Association of Austrian Insurance Companies
WHO	Weltgesundheitsorganisation	World Health Organization

Executive summary

Introductory overview

Austria is a democratic republic and a federal state which is composed of nine Länder. The Länder have their legislative competencies and also participate in legislation at a federal level in the Bundesrat (upper house of parliament). They are divided into political districts, which in turn are made up of local communities or boroughs. Since 1990, almost all the indicators of the health status of the population have improved significantly. Life expectancy at birth of Austrians rose from an average of 76.0–79.5 years (2004) and was thus above the average of the countries which were EU Member States before May 2004 and all EU Member States. Since the nationwide introduction of mandatory social health and accident insurance in 1887/1888, the proportion of those covered by health insurance has been continuously extended and now includes 98% of the 8.1 million inhabitants.

Organizational structure and management

The Austrian health care system is characterized by the federalist structure of the country, the delegation of competencies to self-governing stakeholders in the social insurance system as well as by cross-stakeholder structures at federal and Länder level which possess competencies in cooperative planning, coordination and financing. According to the Federal Constitution, almost all areas of the health care system are primarily the regulatory responsibility of the federal government. The most important exception is the hospital sector. In this area, the federal government is only responsible for enacting basic law; legislation on implementation and enforcement is the responsibility of the nine Länder. In the outpatient sector, but also in the rehabilitation sector and in the field of medicines, health care is organized by negotiations between

the 21 health insurance funds and the Federation of Austrian Social Insurance Institutions on the one hand and the chambers of physicians and pharmacists (which are organized as public-law bodies) and the statutory professional associations of midwives or other health professions on the other. The various sectors of the health care system have traditionally 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.

Since 2002, all the Länder (except Vienna) as well as some of the private non-profit owners have privatized their hospitals, mainly in the form of organizational privatizations. The various private operating companies have one thing in common: they are responsible for the management of hospitals, whereas the Länder or local authorities as (majority) owners usually act as a guarantor. The Austrian health care system has developed almost completely into a model which is mainly based on decentralized contracts with all service providers.

Health care financing and expenditure

The financing of the health care system is pluralistic in accordance with the 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 expenditure in 2004. Mandatory insurance is based on membership of an occupational group or place of residence; thus there is no competition between health insurance funds. In 2004, the health insurance funds together had a deficit of €253 million.

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 legal framework of the specified range of benefits. There is a wide range of benefits. Alongside statutory obligatory benefits, the health insurance funds also provide various levels of voluntary benefits according to their statutes, such as in the field of prevention, for example, but particularly in relation to exemption from co-payments.

25% of total health care expenditure is financed by the federal government, the Länder and local authorities. 10% of this share was accounted for by tax financed long-term care cash benefits. The latter have been paid out to people in need of long-term care since 1993.

In 2004, around 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 organizations and 0.2% by employers (for the services of company physicians). 53% of indirect cost-sharing was accounted for by hospitals (mainly as private health insurance) and 30% by dental treatment. Direct cost sharing was 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 due 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 around 900 000 persons or about 12% of the Austrian population is exempted from direct cost-sharing.

In 2004, Austria spent around €23 billion on health care. This corresponded to 9.6% of its gross domestic product. Without taking the expenditure for long-term care into consideration, which accounts for around 10% of total health care expenditure, the proportion was 8.7%. The current revised data shows significantly higher health care expenditure than with the previous method of calculation, which for 2003 had only indicated a level of 7.5% of GDP and US$ 2257 per capita in purchasing power parities (versus US$ 2951). Seen from this perspective, Austrian health care expenditure no longer appears under-average in comparison with the EU Member States before May 2004, but over-average. Austria ranks in the lower third of EU countries when viewing the public share of total health care expenditure, with a figure of around 70% (68% according to the old health expenditure calculation method).

Health care delivery system

The public health service is the responsibility of the Länder, which delegate most of the relevant tasks to district administrative or local authorities. The public health service is particularly responsible for health reporting, protection against infection, the supervisory activities of health inspectors, environmental medicine, the mother and child preventive programme and the school physicians' service. Preventive check-ups for young people and adults are financed by the social health insurance system. In 1998, the Healthy Austria Fund was introduced, which finances health promotion initiatives from VAT revenue. Since 2005, health promotion and prevention are also defined as a subtask of the health platforms which manage the Länder health funds and which are intended to steer health care provision and financing across sectors.

Those covered by health insurance can freely choose between service providers in the outpatient sector, of whom the majority work in individual practices. In addition, outpatient clinics and hospital outpatient departments offer outpatient care. In 2003, only 43% of the 19 209 self-employed physicians in private practice had a contractual relationship with one or more health insurance funds. Around 58% worked as non-contracted physicians. Insured persons who consult non-contracted physicians are reimbursed with four fifths of the fee which the health insurance funds would pay to contracted physicians.

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 and dentists (0.5 in 2003) has risen at an over-average rate, with the figures for both professions actually doubling. There is a considerable variation in the density of physicians between the Länder. The number of nursing staff also doubled between 1980 and 2003 to 6 per 1000 inhabitants. However, it was still clearly below (by 17%) the EU average of 7.3 in 2003.

Hospitals which are listed in the hospitals plan of a Land are subject to public law ("fund hospitals") and have a statutory requirement to provide care and to admit patients. They are entitled to legally prescribed subsidies from public sources for investments, maintenance and running costs. In 2003, the ratio of beds to inhabitants of 6.0 beds per 1000 persons was clearly above the EU average of 4.2 per 1000 inhabitants. In addition, Austria had by far the highest admission rate: 28.4 per 100 inhabitants. The average length of stay in 2003 was shorter than that of the EU average (6.4 days compared to 6.9 days); the utilization of bed capacity at 76.2% was marginally below (77.5%)

With the passing of the 1993 Federal Long-Term Care Act, Austria reacted comparatively early to the approaching demographic challenges. Long-term care provision in Austria is financed almost exclusively from the federal government's budget and is paid to individuals as a money transfer in seven stages depending on their needs. Like acute inpatient care, long-term care too is a sector where federal cooperation instruments are used, specifically to ensure the uniformity of entitlement criteria and quality standards of long-term care institutions.

Since 2006, pharmaceuticals are licensed by the PharmMed Austria division of the Federal Office for Safety in Health Care in the Austrian Agency for Health and Food Safety. The Federation of Austrian Social Insurance Institutions decides on the reimbursement of the costs of licensed medicines by social health insurance funds. It receives advice on this issue from the Medicines Evaluation Commission. Since 2004, decision-making on pharmaceutical reimbursement is performed according to a box system.

Financial resource allocation

There are a multitude of financing flows and forms of financing in the Austrian health care system, reflecting the plurality of financing and service provision. Public and non-profit hospitals, which are licensed to provide acute inpatient care in the hospitals plan of the respective Land ("fund hospitals"), have a mandate to provide care to all inhabitants. In return, they have a right to subsidies to the reimbursement of operating costs. The expenditure on these hospitals reached around €8.5 billion in 2004. Of this, 40% was financed by social health insurance funds, 7.4% by private insurance (for "special class" accommodation), and 3% by private households by means of co-payments and out-of-pocket payments. The total costs were also financed by budgeted funding from the federal government (7.1%), the Länder (1.9%) and local authorities (1.3%). In addition, 40% was borne by the owners of public hospitals, i.e. from the Länder governments or private non-profit organizations. The reimbursement of inpatient services in public hospitals has been carried out on the basis of the performance-orientated hospital financing (LKF) since 1997. This consists of a core component of nationally uniform diagnosis related case groups (LDFs) and a fund control area which takes the special characteristics of hospitals into account and differs according to the Land in question.

Outpatient physician treatment is financed by (mandatory) insurance contributions, the premiums from private supplementary insurance and co-payments of private households. The payment of physicians in private practice is, in principle, set so that operating costs and investments for the practice can be amortized. The physicians' chambers at Länder level negotiate annual general agreements with the Federation of Austrian Social Insurance Institutions on the provision of contracted physician services. This has to be approved by the individual health insurance funds. The general agreements particularly include payment regulations, agreements on service volumes, and a capacity plan ("location plan"). On this basis, individual contracts are awarded to part of the physicians in private practice in accordance with the location plan. Contracted physicians receive a mixture of per capita payments for basic services and fee for service payment for services which go beyond the scope of basic services. The distribution of these payment elements varies according to specialty, Land and partly due to the type of health insurance fund. In part, agreements on volume limitations for physicians' services are combined with degressive payment scales. In principle, the utilization of resources in the outpatient sector is subject to monitoring by the supervisory physicians ("head physicians") employed by the health insurance funds.

Health reforms

Health reforms have primarily dealt with cost containment (by exploiting potential for more efficiency and raising cost sharing) and with structural reforms to improve the planning of capacities, the cooperation of stakeholders and the coordination of financing flows.

In the acute hospital care sector organizational privatizations were performed which was essentially completed by 2002. The reimbursement of services and medicines by social health insurance has been more strongly linked to health technology assessment, but only a small number of benefits have been excluded. At the same time, new benefits have been introduced, such as federal long-term care benefit, psychotherapy, preventive services, and new structures for community-based long-term care.

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.

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 a comprehensive benefit catalogue, in spite of considerable increases in expenditure and continuing cost containment measures.

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. However, the supply structure 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 in the past 15 years. The level of satisfaction of the population with the health care system continues to be high in an international comparison.

Sectoral fragmentation, which also creates the bias towards hospital care, is a long standing weakness of the Austrian health care system. In spite of numerous efforts, it has until now not been possible – in the sense of allocative efficiency – to allow funding to follow the services provided across sectoral borders. Nor has it been possible to structure the supply chain in a more needs-orientated way across these administrative and financial barriers at the sectoral borders, especially between outpatient and inpatient care or acute and long-term care.

The planning, structures and funds introduced since 2005 permit for the first time the cross-sectoral steering of capacities and financing flows. They also provide for incentives for improved interface management and integrated forms of care. However, the degree to which these measures have been implemented is still unclear.

Future reforms should pursue the following priorities: firstly, to ensure a financial basis in order to be able to continue to guarantee the provision of health care based on the principle of need and to finance it according to individuals' ability to pay. Secondly, the productivity of the employees and facilities in the health system should be increased. Thirdly, it should be ensured that increases in funding really lead 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.

1 Introduction and historical background

1.1 Introductory overview

Austria is a federal republic in central Europe (Fig. 1.1). Since 1995, Austria has been a member of the European Union (EU) and subsequently became a member of the European Monetary Union (eurozone). The euro has been legal tender in Austria since 1 January 2001, and since 1 January 2002 euro banknotes and coins have been in circulation.

Austria is a democratic republic and a federal state which is composed of the autonomous *Länder* (states) of: Burgenland, Carinthia, Lower Austria, Upper Austria, Salzburg, Styria, Tyrol, Vienna and Vorarlberg. Each *Land* (except Vienna) is divided into political districts (administrative units), which in turn are made up of local communities or boroughs. The federal capital and the seat of the Federal Government's supreme bodies is Vienna. At Länder level, federal laws are implemented by the state governor (indirect federal administration) unless there are separate federal agencies responsible for this task (direct federal administration). In indirect federal administration matters the state governor is bound by the instructions issued by the Federal Government as well as individual ministers.

Political background

Federal legislative power is in the hands of the *Nationalrat* (National Council, lower house of Parliament) and the *Bundesrat* (Federal Council, upper house of Parliament). The seat of the Nationalrat is the federal capital Vienna. The Nationalrat has 183 members and is elected for a 4-year period. The Bundesrat is the chamber of the nine Länder for federal legislation. Its members are elected by the individual parliaments of the Länder for the duration of the respective

Fig. 1.1 Map of Austria

Source: The World Factbook, 2005.

state parliament's legislative period, whereby the number of members delegated per state is based on the ratio of its inhabitants to the number of inhabitants of the most populated state. Each state, however, is entitled to be represented by at least three members. The Bundesrat therefore does not have a fixed number of members that remains the same over time. Like the members of the Nationalrat, the members of the Bundesrat have a free mandate.

The legislative power of the Länder is exercised by the Länder parliaments. The election procedures, standing orders and the status of the members in the Länder parliaments are similar to those in the Nationalrat. The Federal Government is entitled to appeal against the decisions of the Länder parliaments if it considers that federal interests are endangered. However, if the state parliament repeats its original resolution unchanged (*Beharrungsbeschluss)*, the appeal cannot hinder the passing of the resolution.

According to the Federal Constitution, the local communities are regional authorities which have a right to autonomy. That means that they carry out their financial affairs independently and have their own sphere of activity.

The legislative period of the Nationalrat is 4 years. It can, however, be shortened if the parliament votes for its own dissolution before the legislative period ends, or if the Federal President orders it on the basis of a proposal by the Federal Government, or when a demand by the Nationalrat for the Federal President's dismissal is rejected in a referendum.

For the preparation of and detailed consultations on issues, committees are appointed whose members are elected from among the members of the Nationalrat. The following have to be appointed:

- a central committee (through this body, the Nationalrat takes part in the executive role of the);
- a permanent subcommittee to be elected by the central committee (this is responsible among other things for giving its approval to the enactment of emergency decrees by the Federal President);
- an immunity committee (this advises on requests by authorities to lift the immunity of members of the Nationalrat for the purpose of prosecution);
- a committee for consultations on the reports of the Audit Office.

In addition, there are a number of special committees of the Nationalrat, such as Federationas the constitutional committee, the finance and budget committee, the justice committee, the health committee, the social committee, the education committee and others, which are established as permanent committees for the duration of the legislative period.

At the beginning of each legislative period, the Nationalrat is obliged to appoint permanent committees with fixed areas of responsibility.

With the exception of government bills, which are mostly directly assigned to a committee, the plenary session of the Nationalrat receives an insight into the bill which has been introduced in a "first reading". If a resolution is passed to proceed with the bill, it is then assigned to the committee which is entrusted with this subject matter. This then presents the results of its consultations to the plenary session in a "second reading", and a resolution on the final text can subsequently be adopted. Within the framework of the "third reading", an agreement is finally reached on the rejection or approval of the bill.

The Bundesrat can appeal (giving its reasons) against laws adopted by the Nationalrat. If the Nationalrat then sustains its original resolution, the appeal can no longer hinder the passing of the law and it is carried through.

The economic and social partnership is an informal body where employers and employees cooperate in the preparation and implementation of economic and social policy measures. The most important instrument of the economic and social partnership is the Parity Commission for wage and price issues, which was created on the basis of a voluntary agreement and is not based on

statutory regulations. The Parity Commission's members are: the Austrian Trade Union Federation, the Federal Chamber of Labour, the Austrian Economic Chamber, the conference of the presidents of the chambers of agriculture and representatives from the relevant ministries. It is chaired by the Federal Chancellor. The social partnership plays a leading role in the design of social policy. Membership in the chambers is mandatory. The chambers are financed through membership fees, and their executives are elected by the members. All the interest groups involved usually try to reach a consensus on controversial policy issues. At the level of government social policy, the social partners are involved in all decisions. Their representatives take part in political negotiations and hold important positions within the Public Employment Service and/or in the social insurance sector. The social partners provide expert opinions on all draft legislation.

Articles 10 to 15 of the Austrian Federal Constitution define the responsibility of the Federal Government and/or the Länder to issue legislation and implement laws. Within this system of distribution of responsibility, four main groups can be differentiated.

- Matters for which legislation and implementation are the responsibility of the Federal Government, that is to say, only the Federal Government can adopt legislation in the respective field and implement these regulations. Among these issues are federal government finances, the monetary, credit, stock exchange and banking systems, the civil and criminal law systems, motor vehicles, issues involving commerce and industry, military issues, the social insurance system and the health care systems (without hospitals). The area of responsibility covered by the "health care system" includes all medical health professions but also, for instance, the Epidemics Act or measures to combat the spread of acquired immune deficiency syndrome (AIDS Act).
- Matters in which the Federal Government is responsible for legislation, and the Länder for implementation. These include citizenship issues, the housing sector, redevelopment and traffic police.
- Matters in which the Federal Government is responsible for principal legislation, but where the Länder enact laws for their implementation. This type of competency arrangement is applied among others to the social assistance scheme and land reform, to welfare for mothers, infants and youths, sanatoriums and long-term care institutions and the health spa system.
- Matters in which the Länder are independently responsible for both legislation and its implementation. This includes issues regarding civil and structural engineering, tourism, the ambulance service, cinemas and other

event organizers, nursery schools and day homes, fire prevention authorities and funeral services.

The Constitutional Law on Finance of 1948 and the Financial Equalization Act which was adopted on the basis of the former are also of particular significance for the assignment of responsibility. They set out whether a certain tax, fee or contribution may be levied by the Federal Government or by the Länder (local communities), and which of these regional authorities receives – in part or in full – the yield from the relevant tax (income tax, trade tax, land tax, wealth tax, value-added tax and others).

At both legislative and executive levels, Austrian federalism can be characterized as an extreme variation of interlocking federalism *(2).* Within this system there is a clear hierarchy in which the Federal Government takes precedence over the Länder. From this perspective, the Austrian federal state rather resembles a centralized state with elements of decentralization. The institutional and organizational interlacing of the levels of the Federal Government and the Länder demands a high degree of cooperation, which is observed with the aid of formal instruments. The development of the health care system and health reforms after 1945 are thus the result of negotiations between the regional authorities with the aid of these instruments (see Section 1.2 on historical background).

Economic development

Economic growth in Austria has been weak since the start of the new millennium. In 2001, annual real growth in Austria (0.8%) was clearly below the average for the 12 countries of the eurozone (1.7%). In the two subsequent years, however, there was a stronger increase in gross domestic product (GDP) than in the eurozone, particularly in 2003. After an increase of 2.4% in 2004 and a decrease in 2005, real economic growth will only accelerate again in 2006 to a rate of 2.3% (Table 1.1). The economic growth forecast in Austria for 2005 and 2006 is slightly above that of the eurozone. Economic growth is estimated at 2.2% for 2007 in Austria as well as the eurozone. In comparison to the United States, however, Europe is clearly lagging behind in economic terms (Table 1.2).

After total employment exceeded 3 million people in Austria for the first time in 1999, a further increase in the number of employees is expected until 2007 after a temporary fall in 2001–2002. The unemployment rate (EUROSTAT calculations), at around 5%, is the third lowest in the EU[1] behind Ireland and

[1] In this document, "EU countries" are the 25 countries which were EU Member States after 1 May 2004. They comprise the 15 countries that were already EU Member States before May 2004 and the 10 countries which joined the EU on 1 May 2004.

Table 1.1 Economic indicators, 2000–2007

	2000	2001	2002	2003	2004	2005[a]	2006[a]	2007[a]
Real gross domestic product (at 2000 prices), € billion	210.4	212.1	214.2	217.2	222.5	226.8	232.0	237.0
– Change in %	–	0.8	1.0	1.4	2.4	1.9	2.3	2.2
Nominal gross domestic product, at market prices, € billion	210.4	215.9	220.7	227.0	237.0	246.1	256.2	265.7
– Change in %	–	2.6	2.2	2.8	4.4	3.8	4.1	3.7
Consumer price index (basis: 1986=100)	138	141	144	146	149	152	155	157
– Change in %	–	2.7	1.8	1.3	2.1	2.3	1.8	1.6
Dependent active employees in 1000	3 054	3 067	3 052	3 057	3 079	3 110	3 138	3 160
– Change in %	–	0.4	-0.5	0.2	0.7	1.0	0.9	0.7
Wages and salaries according to national accounts, at current prices, € billion	107.2	109.3	111.2	113.7	116.6	120.5	125.1	129.4
– Change in %	–	1.9	1.8	2.2	2.5	3.4	3.8	3.4
Wages and salaries per active employee in 1000	35.1	35.6	36.5	37.2	37.9	38.7	39.9	40.9
– Change in %	–	1.5	2.3	2.0	1.8	2.3	2.9	2.7
Unemployment rate (national definition), in %	5.8	6.1	6.9	7.0	7.1	7.3	7.2	7.3
– Absolute differentials	–	0.2	0.8	0.1	0.1	0.2	-0.1	0.1
Unemployment rate (EUROSTAT definition), in %	3.7	3.6	4.2	4.3	4.8	5.2	5.3	5.3
– Absolute differentials	–	-0.1	0.6	0.1	0.5	0.4	0.1	0.0
Labour productivity per employee	6.9	6.9	7.0	7.1	7.2	7.3	7.4	7.5
– Change in %	–	0.4	1.5	1.2	1.7	0.9	1.4	1.4

Source: Institute for Advanced Studies, 2005 *(3)*.

Note: [a] Forecast values.

Luxembourg, but is rising continuously. An improvement of the situation in the Austrian employment market can only be expected after 2006. An increase of 1.4% is forecast in labour productivity for the coming years. As the most important sources of funding for the health care system, wages and salaries are expected to rise by over 3% from 2005 onwards, a higher increase than in the previous years. However, this increase is smaller when related to individual workers, as the forecasts are based on further growth in employment levels.

Table 1.2 Forecast development of real GDP, annual percentage change, 2005–2007

	2005	2006	2007
Austria	1.9	2.3	2.2
Eurozone[a]	1.4	2.1	2.2
United States	3.6	3.5	3.3

Sources: Eurozone and USA: OECD, 2005 *(4)*; Austria: Institute for Advanced Studies, 2005 *(3)*.
Note: [a] 12 Member States of the European Monetary Union.

In order to ensure participation in the European Economic and Monetary Union, Austria's fiscal deficit (net financial requirement) was reduced to slightly below 2% (1997) of GDP with the aid of budget consolidation measures adopted in 1996 and 1997 – these mainly affected the public health and welfare system (see Chapter 6 on health care reforms). After a budget surplus of 0.3% in 2001, the fiscal deficit again rose above 1% in 2003 and will rise to 2% in 2005 according to forecasts at the time of writing *(5)*.

The development of the health care system is strongly dependent on the development of the economy as a whole. The health sector is growing faster than GDP, not only in Austria, but in almost all developed countries. Table 1.3 shows the development of the individual components of GDP in the last four decades. This enables us to examine how growth in health expenditure has developed in comparison to GDP (without the health care sector). The highest

Table 1.3 Development of health care expenditure[a] in the period 1960–2000

	1960	1970	1980	1990	2000
Per capita GDP at 1995 prices	7 025	11 557	16 295	20 139	24 589
– Growth in %	–	64.5	41.0	23.6	22.1
Per capita health care expenditure at 1995 prices	300	610	1 242	1 431	1 903
– Growth in %	–	103.3	103.6	15.2	33.0
Per capita GDP minus health care expenditure at 1995 prices	6 725	10 947	15 053	18 708	22 687
– Growth in %	–	62.8	37.5	24.3	21.3
Health expenditure as % of GDP	4.3	5.3	7.6	7.1	7.7
– Growth in health care expenditure as % of GDP growth	–	6.8	13.3	4.9	10.6

Sources: OECD Health Data, 2005 *(7)*; Statistics Austria *(8)*; Hofmarcher et al., 2004 *(6)*.

Notes: GDP: Gross domestic product; [a] health care expenditure according to the European System of National Accounts 1995.

increases in health expenditure can be observed in the 1960s and 1970s: per-capita spending on health doubled in each decade. In the 1980s, which were characterized by economic crises and spending cuts, expenditure rose by only a moderate 15% before growth doubled again in the 1990s.

Very little of the GDP growth obtained between 1960 and 1970 (6.8%) and between 1970 and 1980 (4.9%) was used for the health care system (Table 1.3). Between 1990 and 2000, however, growth in health expenditure as a proportion of GDP growth was higher and amounted to more than double that of the 1980s (*6*). This was partially due to the slowing down of economic growth.

Population and health status

Table 1.4 shows some basic (aggregate) population figures and indicators about the aggregate health status of Austrians. In 2003, the Austrian population was 8.11 million, of whom 65.8% lived in urban areas in 2002. The population growth rate in Austria is above the EU average (3.1%) at a rate of 5.0% since 1990. In 2003, the total fertility rate (1.42) in Austria was just below the EU average of 1.45. The proportion of the population over 65 rose by 0.8% to 15.7% in the period 1990–2004, whereby a particular increase in the proportion of the male population over 65 can be observed. The dependency ratio[2] was 47.4% in 2002 and is forecast to rise to 69.4% by 2030.

Since the mid-1990s, the health behaviour of Austrians has improved in almost all areas. Not only dental health has developed favourably; the amounts of vegetables and fruit eaten has also increased. However, the consumption of fats has also risen slightly. In addition, the proportion of smokers has increased by 1.5 percentage points from 27.5% (1990) to 29.0% (2000). Total cigarette consumption, however, is falling.

The incidence of work-related diseases almost halved between 1990 and 2004; the prevalence of work accidents and mortality due to accidents at work is also significantly lower in the period observed. This is also the case for the prevalence of traffic accidents and mortality due to transport accidents, which in 2004 were only about half of the level reached in 1990 (Table 1.5).

Table 1.6 shows the most significant causes of death in Austria, ranked according to the frequency of (age-standardized) mortality of the international classification of diseases (ICD-10) main diagnoses in 2003. Diseases of the circulatory system (particularly ischaemic heart diseases and cerebrovascular diseases such as strokes and cerebral thrombosis) were still among the leading

[2] The dependency ratio used by the United Nations relates the number of those aged under 15, plus the number of those aged 65 and older, to the number of those aged between 15 and 65.

Table 1.4 Population and health status, 1990 and 2004

	1990			2004			Index 1990=100		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Population, in 1 000	7 729	3 711	4 018	8 175	3 939	4 205	105	106	104
% under 15 years	17.4	18.7	16.3	16.2	17.1	15.4	93	91	94
% over 65 years	14.9	10.8	18.8	15.7	12.7	18.6	105	118	99
Birth rate (live births per 1 000 inhabitants)	11.7	12.5	10.9	9.7	10.2	9.1	83	82	83
Total fertility rate (children per woman)	–	–	1.5	–	–	1.4	–	–	97
Average fertility age (in years)	–	–	27.2	–	–	28.8[a]	–	–	106
Infant mortality per 1 000 live births	7.8	–	–	4.5	–	–	57	–	–
Crude death rate per 100 000 inhabitants	10.7	10.3	11.1	9.1	8.7	9.4	85	84	85
Age-standardized death rate per 1 000 inhabitants	8.1	10.7	6.4	6.2	7.9	4.9	77	74	76
Life expectancy at birth	76.0	72.5	79.1	79.5	76.5	82.2	105	106	104

Source: European Health for All database, January 2006 *(9)*.

Note: [a] 2003.

Table 1.5 Selected indicators of morbidity, mortality and lifestyle, 1990 and 2004

	1990	2004	Index 1990=100
Decayed, missing or filled teeth at the age of 12 (DMFT-12 Index)	4.2	1.0[a]	24
Consumption of fat per person per day (in grams)	155	158[a]	102
Average amount of fruit and vegetables consumed per person and day (in kg)	207	225[a]	109
% of regular daily smokers, above the age of 15	27.5[c]	29.0[b]	105
Number of cigarettes smoked per person per year	1 788	1 260[b]	70
– SDR, selected smoking-related causes, per 100 000	315	222	70
Consumption of pure alcohol, litres per capita	11.8	10.5[d]	89
– SDR, selected alcohol-related causes, per 100 000	123	70	57
Persons killed or injured in road traffic accidents, per 100 000	803	712[d]	89
– SDR, transport accidents, per 100 000	18	10	56
New cases of occupational diseases, per 100 000	43	26	60
Persons injured due to work-related accidents, per 100 000	2 680	1 668	62
Deaths due to work-related accidents, per 100 000	2.6	1.3[d]	63

Source: European Health for All database, January 2006 *(9)*.

Notes: SDR: Age-Standardized death rate; [a] 2002; [b] 2000; [c] 1991; [d] 2003.

causes of death in Austria. It is worth pointing out, however, that the age-standardized mortality figure of this group of diseases has more than halved in the last three decades. A similarly marked decrease in mortality can also be established in the case of external causes of morbidity and mortality (particularly traffic accidents and self-inflicted injury), diseases of the respiratory tract and diseases of the digestive system. An even greater reduction (around two thirds) can be observed in the group of illnesses of the urogenital system and of certain infectious and parasitic diseases. The highest rise in mortality between 1970 and 2003 can be observed in mental illnesses and behavioural disorders, diseases of the nervous system and of the eyes and the eye appendix. These illnesses have primarily begun to have an impact since the start of the 1990s. The only other principal diagnosis group which shows an increasing mortality rate is that of endocrine and metabolic diseases and nutritional disorders. This group is dominated (84%) by diabetes mellitus, for which the mortality rate has doubled since 1970 (though this figure is higher partly due to changes in documentation).

Between 1980 and 2004, the fall in age-standardized mortality was higher in Austria (by 39%) than the average for the EU (28%). The difference in the decrease of age-standardized mortality due to cancer was particularly noticeable. Whereas the number of cancer deaths in Austria between 1980 and 2004 fell by 20% from 213 to 170 per 100 000 inhabitants, the EU average decreased significantly less (by 8%) *(9)*.

Self-assessed health varies by gender and level of education. A special survey on self-reported health was performed as part of the Austrian microcensus on two occasions, in 1991 and 1999. The participants of the survey assessed their health on a five-point scale. Men and women with university degrees felt significantly better than people with a lower level of education: with regard to women, the proportion of those who considered their health to be very good was (age-standardized)[3] almost 8% higher for university graduates than for those who had only completed mandatory schooling or an apprenticeship. In the case of men, the difference was over 10% (Fig. 1.2).

In the time period observed (1991 and 1999), the difference between the educational-level groups seemed to decrease a little, although the feeling of well-being increases in total: there are comparatively more healthy people who have completed mandatory schooling, an apprenticeship or attended vocational secondary schools, but little change in the number of very healthy graduates or those who have passed the school-leaving examination. Fewer people with a low level of education indicated that they feel very unhealthy or unhealthy,

[3] In order to avoid distortion due to different education levels and age structures, all figures were standardized on the basis of the age structure of the Austrian population in 1999.

Table 1.6 Leading causes of death (ICD-10), age-standardized[a] per 100 000 inhabitants, 1970–2004

	1970	1980	1990	2000	2001	2002	2003	2004	1970 = 100
Diseases of the circulatory system (I00–I99)	559.2	515.2	389.5	315.3	297.8	289.1	270.7	248.3	44
– Ischaemic heart diseases (I20–I25)	206.5	152.9	153.4	132.2	125.2	130.8	124.0	115.8	56
– Cerebrovascular diseases (I60–I69)	176.2	150.3	98.9	67.8	61.9	62.3	56.2	42.8	24
Malignant neoplasms (C00–C97)	228.3	213.1	199.9	174.2	169.1	170.8	172.7	170.8	75
– of the trachea, bronchi, lungs (C33–C34)	34.6	35.6	34.5	32.7	31.5	33.4	31.9	32.2	93
– of the breast (C50)	26.5	29.3	32.4	27.6	25.9	26.0	26.2	24.6	93
– of the cervix (C53)	6.6	6.4	4.1	2.5	2.3	3.3	2.9	2.9	44
External causes (V00–Y99)	103.5	85.7	63.6	47.6	44.9	46.1	44.5	42.5	41
– Suicide and self-inflicted injury (X60–X84)	24.8	25.1	21.7	17.5	16.3	17.0	15.8	15.2	61
– Transport accidents (V01–V99)	–	25.3	18.4	11.0	10.9	11.0	11.0	9.8	39
– Motor vehicle accidents (V02–V04, V09, V12–V14, V20–V79, V82–V87, V89)	33.3	23.6	16.7	10.0	9.7	10.1	10.2	9.1	27
Diseases of the respiratory system (J00–J99)	99.0	50.4	38.6	32.9	30.9	32.5	40.3	34.7	35
– Bronchitis, emphysema, asthma (J40–J46)	28.8	17.7	18.5	9.3	8.5	20.9	25.5	21.7	75
Diseases of the digestive system (K00–K93)	69.5	61.0	44.3	33.3	31.9	33.9	33.9	30.8	44
– Chronic liver diseases and cirrhosis (K70,K73,K74,K76)	27.7	29.2	26.0	19.7	18.9	17.7	18.3	17.8	64
Endocrine and metabolic diseases, nutritional disorders, disorders involving immune mechanisms (E00–E90)	20.0	13.8	21.0	12.8	13.0	20.3	29.9	36.5	183
– Diabetes mellitus (E10–E14)	16.7	12.1	18.7	11.4	11.6	16.8	25.0	29.7	178
Mental and behavioural disorders, diseases of the nervous system and the sensory organs, diseases of the eyes and the eye appendix (F00–H95)	16.4	13.2	15.8	14.3	15.1	23.2	26.4	22.4	137
Diseases of the genitourinary system (N00–N99)	26.1	16.0	8.9	6.8	7.6	8.0	8.5	9.1	35
Certain infectious and parasitic diseases (A00–A99, B00–B99)	14.8	7.2	3.6	2.5	2.3	4.7	5.5	5.1	34
All causes of death	**1 206.2**	**1 015.7**	**810.5**	**658.5**	**632.6**	**649.6**	**652.3**	**620.1**	**51**

Sources: European Health for All database, January 2006 *(9)*; IHS HealthEcon calculations, 2006 (http://www.ihs.ac.at).

Note: [a] Age-standardized mortality reflects the crude death rate in Austria, adjusted for the age structure of the population of the European Union.

while the proportion of those who feel very unhealthy or unhealthy in individual groups with higher levels of education increases somewhat. In view of the very high levels of participation in education, this still signifies that the number of the very healthy, for example graduates, has risen, but the "elite effect" of education on health has not further increased. The average perceived well-being of the population across all educational groups is therefore rising. Irrespective of the level of education, for example, an almost equally high proportion of men indicated a very good state of health in both years (1991: 24.9% compared to 1999: 25.2%), but a markedly lower proportion indicated a very poor or a poor state of health (1991: 6.1% compared to 1999: 5.2%). On average, women who assessed their health as very good increased while those whose assessment was that their health was (very) poor decreased (Fig. 1.3). In summary, the gap between the – self-assessed – better health of men and poorer health of women has decreased *(10).*

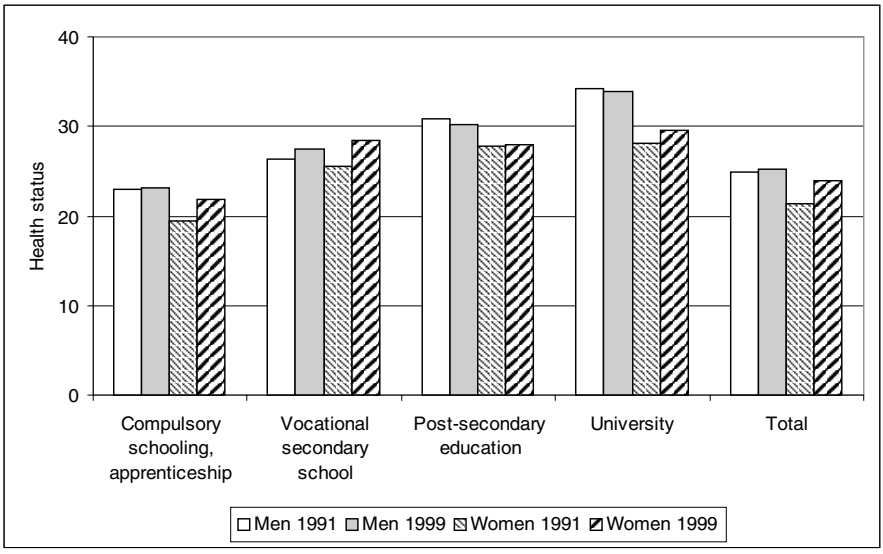
Viewed in an international context, these findings are very positive for Austria: there is evidence that the health gap between socioeconomic groups has actually increased in some European countries in the last decades *(11,12).*

1.2 Historical background

Social security before the introduction of social insurance

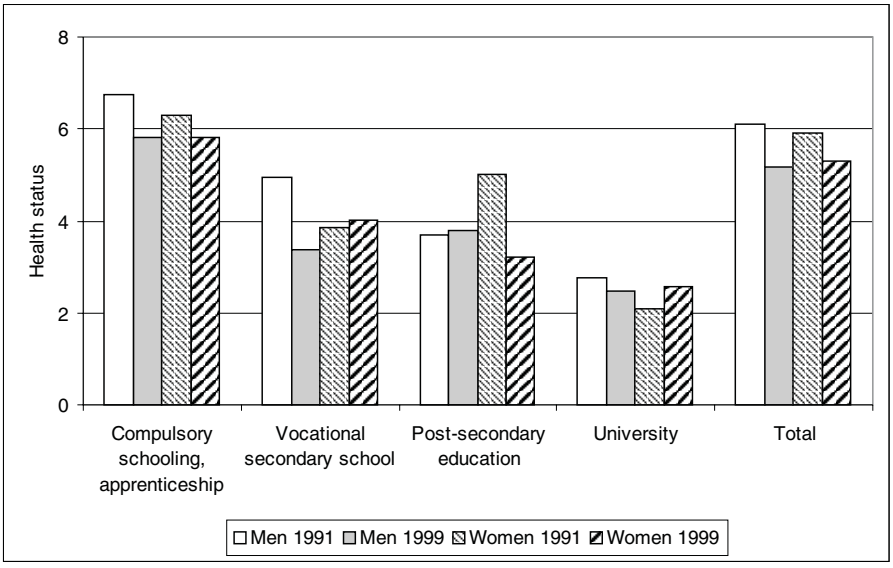
Since the late middle ages the so-called *Ausgedinge*, a flat rate income paid when they retired and transferred ownership of their holdings, had been the most important form of security for free farmers in rural areas against the risk of inability to work. For skilled tradesmen in the towns, however, there was no Ausgedinge. Skilled urban tradesmen had the choice of either carrying out their trades for the whole of their lives or moving into one of the numerous houses for the poor or hospitals in the towns. Those who had money could buy themselves into a citizens' hospital (*Bürgerspital*), for example via a life annuity contract *(15)*. A further possibility was to pay into a guild shop maintained by master craftsmen and qualified workers. After guild-based organizations had almost completely collapsed, savings banks and private insurance associations developed, as well as a number of private welfare and charity associations. Various occupational groups had their own pension and insurance institutions; in Vienna there was a special "action and catering institution". The savings bank system had its origin in the idea of the formation of financial reserves for

Fig. 1.2 Self-assessed health status ("very good") according to levels of education and gender, 1991 and 1999, in %, age-standardized



Sources: Statistics Austria, 1991 *(13)*; Statistics Austria, 1999 *(14)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Fig. 1.3 Self-assessed health status ("poor and very poor") according to levels of education and gender, 1991 and 1999, in %, age-standardized



Sources: Statistics Austria, 1991 *(13)*; Statistics Austria, 1999 *(14)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

times of hardship, having free access to the deposits made, and the fact that the concept had universal appeal *(16)*.

The mining law cooperatives are the oldest form of welfare organization and appeared from the late middle ages onwards as welfare associations for miners (miners' health insurance and pension scheme). State legislation then stipulated that risk sharing pools were to be based on joint contributions by employers and employees. Nevertheless, payments by employers tended to be seen as welfare rather than partnership. The General Mining Act of 23 May 1854 brought a reform of the miners associations' insurance funds (*Bruderladen*) which had run into considerable difficulties, but there was still no legal obligation for employers to make contributions. In 1885, employers' contribution payments only amounted to an average of around 26% of the total assets of the Bruderladen. The Trade Regulation of 1859 brought about the creation of factory and cooperative funds. For self-employed tradesmen, master craftsmen's health insurance funds were introduced in the second half of the 19th century, without mandatory membership.

The development of the health care system in Austria is closely connected to the establishment of a welfare state within the territory of the Austro-Hungarian Monarchy from 1867 onwards. The 1867 Associations Act facilitated the formation of association-based funds. In this way, the general workers' health and invalidity relief fund was founded in 1868. In 1873, the association of the general workers' health and invalidity relief funds was founded *(17)*. As early as 1872, at the Berlin Conference on workers' issues, the Prussian and Austrian bureaucrats present voiced their support for mandatory health and examination funds financed by contributions from employees and employers. However, Bismarck's social reforms were rejected by liberals and Austrian employers, but also by left-wing liberal social policy experts and social democrats *(17)*. A high point in workers' protection regulations at the time was the amendment to trade regulations in 1885. The most important provisions were: the introduction of a standard eleven-hour working day, regulations regarding breaks, free Sundays and holidays as well as additional regulations governing youth labour and women. Workers' protection was viewed as a necessary and even a priority element of social policy.

The Association of Austro-Hungarian Workers, Health and Invalidity Relief Organizations, formed in 1876, was one of the first associations of health insurance funds. Its founding members were 16 funds from Atzgersdorf, Gloggnitz, Graz, Hainburg, Inzersdorf, Klagenfurt, Linz, Mauthausen, Neunkirchen, Steyr, Ternitz, Wels, Vienna, Brno, Reichenberg (Silesia) and Budapest (only by agreement). This development was based on mutual agreements between the workers' insurance funds (membership periods in other funds were mutually recognized), which made it easier for workers to

move between individual companies. Without this, entitlements would have been lost, or waiting periods would have had to be accepted when taking on new employment *(18)*.

Imperial Sanitary Act and Supreme Health Board

The legal roots of the Austrian public health service (see Section 4.1 on public health services) lie in the Imperial Sanitary Act of 1870 *(19)*, which is still valid today and established the essential tasks to be fulfilled in the fields of sanitary supervision and epidemic hygiene. As early as the time of Empress Maria Theresia (1740–1780) there was a supreme health authority (Court Sanitary Delegation), in which all the members had equal voting rights and which was directly answerable to the Empress. In the crown countries there were Sanitary Commissions which were subordinate to the health authorities. In the course of the development of Austria into a constitutional state, which began in 1848, ministries led by answerable ministers took the place of the former central authorities with their system of decisions based on equal voting rights. The tasks of the Court Sanitary Delegation were integrated into the Ministry for the Interior while the Sanitary Commissions were placed under the control of the Länder governments. A resolution passed in 1852 established District Offices as the lowest sovereign authorities. The Local Communities Act of 1862 declared that the deployment of the sanitary police was the responsibility of the local communities. The three-pillared structure of state administration which still exists today was thus created *(20)*.

The introduction of the Federal Constitution of 1929 in the year 1945 altered the distribution of powers which had been set out for the public health service by the Imperial Sanitary Act. Through the division of the state's sphere of activity into two parts, the implementation of federal government agendas was limited and, with the exception of purely local matters, delegated to the Länder *(20)*. Legislation and its implementation in the health care system was from then on the responsibility of the Federal Government, with the exception of mortuaries and funerals, municipal public health services and the ambulance service, for which the legislation and its implementation became the responsibility of the Länder (see the introductory overview, Section 1.1*)*. In the hospitals sector, the competency of the Federal Government is restricted to basic legislation and to sanitary supervision. The Imperial Sanitary Act stipulates that authorities should make their decisions only after consultations with experts. This is the material basis for the establishment of the Länder health boards and the Supreme Health Board.

The founding of the Supreme Health Board (see Section 2.1 on organizational structure of the health care system) dates back to the Imperial Sanitary Act

of 1870. In spring 1869, a working meeting of 40 specialists from the crown countries of the monarchy was called. It was made up of scientists, experts on hospitals, medical journalists, specialists in forensic medicine and Länder sanitary experts. It was chaired by Karl von Rokitansky, who is considered to be the founding father of the Supreme Health Board. The aim of the meeting was to organize the public health service and to prepare fundamental legal provisions *(19)*. The basis for the discussions was a questionnaire which was distributed throughout the monarchy and provided information about the provision of medical care in the local communities, districts and Länder. The committee, which was composed of experts from various fields of medical science, had the task of advising the responsible minister on issues relating to the health of the population.

The introduction of social insurance

In 1887/1888, the industrial accident and health insurance scheme for workers was introduced following the model of Bismarck's social policy programme. The scheme would become the foundation of today's social security system. These measures were first considered as early as 1882 and led to a new, previously unknown path being taken in Austrian legislation: the introduction of statutory mandatory insurance. Social health insurance provided for free medical treatment, medicines and appropriate sick pay, while work accident insurance provided for injured persons' and survivors' benefits. Workers themselves funded two thirds of the costs of the system (mandatory insurance), while the other third was financed by employers. The social and health insurance scheme was administered by self-governing bodies, and did not receive any government subsidies. In 1889, a law on miners' associations (Bruderladen) was adopted which established health insurance and pension insurance schemes for workers in the mining industry. This law also fulfilled the demand for the separate management of the financial accounting of the two insurance branches. A further measure ensured that members were allowed to have their shares of the reserves of the previous fund transferred to the new fund when moving from one miners' association to another one *(21)*.

One of the reasons for the introduction and the necessity of social insurance was the poor state of health of conscripts and the social situation of wage earners *(17: 344)*. The 1887 Workers' Accident Insurance Act (Imperial Law Gazette 1/1888) created for the first time a statutory insurance institution. This insurance institution was structured territorially and was run by a board of management under state supervision. In spite of the recognition in principle of the institution's autonomy, the state's bureaucracy continued to exercise considerable influence *(15: footnote 75)*. In the same year, the Workers' Health Insurance Act of 30

March 1888 was proclaimed. The organization of health insurance funds was in accordance with German law until the end of the First World War.

Until the First World War, these achievements were largely maintained and indeed were extended by the introduction of work accident insurance for railway workers. The Active Service Act, which was valid during the First World War, suspended employee protection provisions, but some progress was achieved in the field of social insurance (an increase in sick pay and the extension of sickness benefit, as well as the abolition of workers' contributions to work accident insurance).

In the second half of the 19th century, private white-collar workers (private officials) – owing to the increasing number of large companies with bureaucratic organizations – started to constitute a separate social group. In two petitions to the Imperial Parliament, the introduction of mandatory pension, invalidity and surviving dependant's insurance was demanded, and in 1906 the Act regarding Pension Insurance for Private White-collar Workers and some Public Employees received the Emperor's official approval. It did not include either a payment guarantee on the part of the state or government subsidies. Notable aspects of this law are the principles of mandatory insurance and unlimited independent registration. Those liable for mandatory insurance were divided into six salary groups, and contributions were paid as fixed premiums of varying amounts according to the salary groups. In the lower four salary groups, the liability to pay contributions was divided between employer and employee in a ratio of two thirds to one third; in groups 5 and 6 it was halved.

The 1906 Pension Insurance for White-collar Workers Act was subject to numerous challenges. The lack of clarity of the term "white-collar worker" was particularly criticized owing to the fact that there was no clear listing of job features, and also because of the insufficient level of the minimum pensions. In the 1914 amendment to the Pension Insurance Act for White-collar Workers, the principle of independent registration was largely abandoned. In addition, a demonstrative list of job features was adopted to establish or liability for mandatory insurance or to exclude it.

In 1918 there were a total of more than 600 health, pension and work accident insurance institutions in the territory of modern Austria alone. Hundreds of these were health insurance funds for blue-collar workers, white-collar workers, and workers in agriculture, commerce and trade, etc. This fragmentation was also reflected in a range of umbrella organizations which were organized according to professions, regions or other criteria (language groups, political persuasion). In comparison to today's organizations, they only assumed a small number of common tasks *(18).*

Social insurance and the First Republic, 1918–1933

The collapse of the Austro-Hungarian Monarchy and the rise of the social democratic movement led to an extension of the social security system. This included the introduction of unemployment insurance in 1920, and the extension of health insurance to all people with employment contracts, service contracts or waged work, and the inclusion of family members. Following the example of (workers') insurance provisions, the 1920 Unemployment Insurance Act stipulated that contributions would be divided into three parts, with the employer, the employee and the state each paying a third. In addition, unlike earlier unemployment welfare, this law limited the normal duration of support to 12 (or a maximum of 20 or 30) weeks. The 1926 White-collar Workers Insurance Act regulated health, work accident and pension insurance for white-collar workers in the private sector. This law introduced the concept of division according to professions: the previous special laws for individual insurance branches were replaced by a structure arranged according to professions, with the simultaneous integration of all insurance branches. Insurance law for white-collar workers thus took the pioneering step towards occupational social insurance (for skilled workers this was only enacted by the 9th amendment to the General Social Security Act (ASVG) of 1962).

A year later, the Blue-collar Workers Insurance Act was revised (regarding health, industrial accident and accident invalidity insurance), and the Farm Labourers Insurance Act (1928) was passed. Mandatory insurance as defined by the Blue-collar Workers Insurance Act extended to all employees, with the exception of those in agriculture and forestry and private and public white-collar workers. In addition, unemployment insurance was entirely excluded from this law. However, owing to the difficult economic situation, the Blue-collar Workers Insurance Act could not come into effect immediately. Its enactment was left to a decree which was to be issued when: (a) the number of those receiving unemployment benefit or emergency assistance fell below a yearly average of 100 000; and (b) when there was a recognizable improvement of the general economic situation, so that the additional burden on the economy and public administration caused by the implementation of the Blue-collar Workers Insurance Act would be compensated for. Owing to the worsening economic situation, the fulfilment of this so-called "prosperity proviso" soon seemed improbable, and in 1929 the enactment of the Blue-collar Workers Insurance Act was linked to an easing of the burden on the economy through reforms in the public tax system; owing to the financial plight of the Länder and the Federal Government, this also proved unviable. In the longer term, only the section on "elderly welfare pensions" (long-term receipt of pensions for people over 60, at around two thirds of the level of unemployment benefit) remained the only

practical improvement in connection with the Blue-collar Workers Insurance Act. Whereas only 7% of the population had health insurance in 1907, this figure had risen to 60% in 1930 (*17*: 351).

In 1925, there were still 186 health insurance institutions – apart from the agricultural health insurance institutions and the health insurance departments of the miners' welfare associations – of which 14 did not issue (or no longer issued) formal insurance certificates. The statistics of the Ministry of Social Affairs recorded 172 health insurance institutions at the time (*22*) (Table 1.7).

Table 1.7 Number of health insurance funds, 1925

	District health insurance funds		Company health insurance funds		Cooperative health insurance funds		Association-based health insurance funds		All health insurance funds	
	Active	Existing	Active	Existing	Active	Existing	Active	Existing	Active	Existing
Vienna	2	2	3	8	34	34	9	9	48	53
Lower Austria	16	18	11	11	8	9	1	1	36	39
Upper Austria	3	3	1	2	2	2	4	4	10	11
Salzburg	1	1	1	3	1	1	1	1	4	6
Styria	18	18	10	10	1	1	4	4	33	33
Carinthia	10	10	3	3	1	1	1	1	15	15
Tyrol	10	11	2	3	2	2	7	8	21	24
Vorarlberg	4	4	–	–	–	–	–	–	4	4
Burgenland	1	1	–	–	–	–	–	–	1	1
Austria	**65**	**68**	**31**	**40**	**49**	**50**	**27**	**28**	**172**	**186**

Source: Federation of Austrian Social Insurance Institutions *(18)*.

Social insurance and the corporative state ("Ständestaat")

After the end of the First World War, laws were created for the respective occupational groups for all categories of insurance, including unemployment insurance. The self-employed were not included, or only to a marginal degree. The influence of the social-corporative principle became evident for the first time in the 1920s, with the creation of a health insurance institution for state and federal employees *(23)*. Until 1933, the election of insurance representatives had taken place by direct vote. The corporative state abolished these elections and from that time on the appointment of insurance representatives was carried out by the statutory representative bodies *(17: 23ff)*. The self-governmental administration of the social insurance institutions continued as before. In 1933, the miners' welfare associations were dissolved and their insurance reserves were transferred to the Miners' Insurance Fund established at the Workers' Accident Insurance Institution in Graz.

The effects of the world economic crisis reached their peak in the years 1932/1933. Owing to high unemployment and falls in real wage levels, the collapse in economic performance had a severe effect on the revenue of the social insurance system. An attempt to solve the financing problems was made by introducing the Social Insurance for the Self-employed Act (GVSG), and also via the introduction of mandatory health insurance contributions for the recipients of pensions. Furthermore, there were massive cuts in expenditure. This included the reduction of sick pay and the limitation of family insurance. In addition, the possibility to provide voluntary benefits was brought to an end and the salaries of the social insurance institutions' employees were reduced. The aim was to contain increases in spending via administrative measures and benefit cuts *(17: 270).*

In 1935, the GSVG was introduced. This law effectively marked the completion of the development of the social insurance system *(14).* At an organizational level, numerous drastic measures were taken, such as combining the white- and blue-collar workers' health insurance funds into an Imperial Association (Section 3 of the GSVG) and joint ventures (Section 4 of the GSVG). The joint ventures were an organizational novelty. Their task was to ensure the availability of nursing care, medical treatment and the provision of medicines and medical aids *(17: 269)*. The territorial work accident insurance institutions were abolished. The Blue-collar Workers' Insurance Institution assumed responsibility for welfare for elderly blue-collar workers. Together with various special insurance institutions, the White-collar Workers' Insurance Institution retained responsibility for the entire white-collar workers' insurance system *(24).*

Social insurance and National Socialism

On 1 January 1939, the following German laws came into force in Austria: the Imperial Insurance Regulations of 1911, the White-collar Workers Insurance Act of 1924, the Imperial Miners' Act of 1926 and the Employment Agency Act of 1927. It was expressly declared that mandatory health insurance for pensioners from the white-collar workers' and the miners' insurance schemes, which did not exist in German imperial law, was to be continued. A decree established that the blue-collar workers' pension insurance scheme in Austria should be applied in accordance with the principles of imperial law. The organization of health insurance according to occupational groups was abolished during national socialism, and the white- and blue-collar workers' (regional) health insurance funds were merged *(25).* Their self-governing structures were

abolished. According to the "leadership principle", a leader was appointed for each body; he was supported by an advisory council and bore sole responsibility for management *(17)*. Basically, only the organizational structure of the health insurance institutions remained intact *(15)*. In health insurance, some provisions (which went beyond those of the imperial insurance regulations) on benefits and on insurance coverage were maintained. For example, a longer period of entitlement to sick pay was provided for in the legislation. Equal sharing of the raising of funding was also maintained. Austrian health policy was pervaded by a desire to avoid hereditary disorders. This was expressed in laws which facilitated sterilization for "the prevention of sick offspring" and provided for a ban on marriage in the case of certain diseases *(17: 293)*.

War policy initially had no negative effect on social insurance. For example, the reduction of pensions and child benefits introduced by an emergency decree in 1932 were reversed, and health insurance was introduced in the invalidity and pension insurance schemes *(17: 293)*. Conversely, Austrian work accident legislation influenced German legislature, which led to mandatory work accident insurance being taken on in Germany in 1942. Legal protection for expectant and nursing mothers was also extended in Austria. Both the group of individuals included in social insurance and the level of benefits were maintained, or extended in the case of health insurance for pensioners. These improvements were characterized as "bribery policy" *(18: 297)*, which is confirmed by current historical research that has identified them as measures to integrate national socialism into domestic policy *(26)*.

In spite of the efforts to pick up the thread of the achievements of the First Republic, the social policy developments between 1933 and 1945 did have effects on social policy in the Second Republic. This primarily includes the consensus that "social policy developments are dependent on economic possibilities at the respective time. This 'policy of objectivity' is a part of the social policy positions of all stakeholders who play a role in decision-making in the second republic" *(17: 304)*.

After the end of the Second World War, German legislation remained dominant until the coming into effect of the ASVG in 1956. However, the Social Insurance Transition Act of 1947 (Federal Law Gazette No. 142/1947) constituted an important step on the way to "making social insurance law Austrian again" and to restoring its self-governmental structure (*15*). The holding of direct elections was not reintroduced. The most important piece of post-war legislation in Austrian social insurance was the General Social Security Act of 9 September 1955 (Federal Law Gazette No. 189/1955).

Social Insurance Transition Act 1947

After the end of the Second World War and the restoration of the Republic of Austria, the Social Insurance Transition Act of 12 June 1947 laid a new organizational basis for social insurance. The most important measure was the reintroduction of self-governance as well as the establishment of the Federation of Austrian Social Security Institutions (HVSV) *(15),* which united health insurance, work accident insurance and pension insurance under one roof. The aim was the establishment of a "people's insurance". Whereas around two thirds of the population were insured in 1946, this figure had risen to 96% in 1980 *(17).* This increased coverage was, for example, achieved by the introduction of the Act on Health Insurance for Farmers in 1965 and the Civil Servants' Health Insurance Act in 1967. Unrestricted access to hospital care, preventive check-ups, examinations for young people and rehabilitation were introduced as new services.

The General Social Security Act 1956

The ASVG, which came into force on 1 January 1956, replaced the previously valid laws in the field of social security. It integrated health, work accident and pension insurance for blue- and white-collar workers in industry, mining, commerce and trade, transport, agriculture and forestry, and also regulated health insurance for pensioners. For some special areas of insurance, social insurance laws outside the scope of the ASVG continued to be valid (Table 1.8).

Contrary to the originally planned, staged introduction of the ASVG, the Federal Ministry of Social Administration had decided to present a draft bill which would regulate the entire field of social insurance legislation. This was approached on the basis of the following principles *(27).*

- The regulation of general social insurance for blue- and white collar workers and groups of self-employed individuals who had the same status in social insurance law. Not included in the scope of the ASVG are health insurance for public employees, master craftsmen's insurance, insurance for notaries public, health insurance for recipients of unemployment benefit and unemployment assistance, and health insurance for war widows and orphans.
- The new social insurance law should be clearly described and adapted to Austrian circumstances. The number of individual terms should thus be significantly reduced in comparison to the present status.
- The group of insured people should be uniformly defined for all branches of insurance.

- The harmonization of the extent of benefits of old-age, invalidity and surviving dependants' insurance schemes to that of public servants' pension law through the introduction of an equalization supplement for pensions which do not reach a certain minimum amount.
- The plurality of fund raising in pension insurance through the appropriate setting of contribution rates, a revision of the Federal Government's contribution as well as calling on the social insurance institutions to bear the costs of the equalization supplements for pensioners.
- The maintenance of arbitral jurisdiction, but with the creation of a higher authority to ensure the consistency of judgements.
- Regulation has to be limited to a codification of current law.

The ASVG is divided into 10 sections. The draft bill originally contained 600 paragraphs. Table 1.8 provides an outline summary of the contents of the law from 1955. The 1955 ASVG was the culmination of the efforts made after 1945 to revise and standardize social insurance legislation for blue- and white-collar workers while eliminating the provisions remaining from imperial law.

In the field of health insurance, the draft bill was intended to maintain the existing levels of benefits and to carry out standardization. The ASVG is the "basic law" of social insurance for employees in the Second Republic, upon which further developments in social insurance legislation were based. It is viewed as a "guideline law" for the development of social insurance for the self-employed. With the exception of unemployment insurance, the law contains regulations on health, work accident and pension insurance for all employees except federal employees and notaries public. In addition, it regulates the organization, the administrative structure and the financing of the social insurance system. In the health care sector, the social insurance law regulating benefits (*Leistungsrecht*) is one of the main items. In the meantime, the law has been amended 65 times and numerous adjustments have been carried out.

The agreement on this draft was achieved on the basis of negotiations among the coalition partners with the involvement of experts from the Ministry of Social Affairs, the HVSV and interest groups. In the appraisal phase, the discourse between the players involved extended to the demand from employers' representatives for parity in the allocation of posts in the self-governing body and to fears of additional burdens. Physicians rejected the draft proposal, because on the one hand the contract terms were not satisfactory for them, and on the other hand there was a lack of protection against the competition from outpatient clinics owned by social health insurance funds. They underlined their opposition by calling a strike. In the end, the introduction of the ASVG took place as part of a package including the introduction of capital market laws *(17: 346).*

Table 1.8 The General Social Security Act (ASVG), 1955

Section	Title of the section	Material covered	Notes
First part:	**General regulations**		
Section I	Area of validity	Compulsory insurance, affiliation to an insurance group, voluntary insurance, tasks, competencies, benefit-in-kind principle	
Section II	Extent of insurance		
Section III	Insurance funds and their competencies; Federation of Austrian Social Insurance Institutions		
Section IV	Registration and duty to disclose information		
Section V	Funding of social insurance	Contributions, contribution basis, ceiling on insurable earnings, etc.	Establishment of contributions in the funds according to their statutes; standardization of contribution rates for blue- and white-collar workers is discussed but rejected[a]
Section VI	Benefit entitlements	How benefit entitlements arise	
Section VII	Exemption from contributions		
Section VIII	Penal provisions		
Second part:	**Health insurance benefits**		
Section I	Joint provisions		Ensuring the same level as previous benefits; establishment of statutory minimum benefits and the additional benefits according to the statutes; benefits in kind and cash benefits; free choice of physicians and unlimited entitlement to benefits for the insured; prescription fee
Section II	Individual benefits	Treatment of disease (in kind); sickness benefit for at least 26 weeks, extendable to a maximum of one year according to the fund's statutes (cash); institutional care becomes an obligatory benefit of social health insurance (in kind); family benefit (Familiengeld) (cash); conservative dental treatment and dental replacement; extended health welfare; prevention of disease; antenatal care and maternity benefits; funeral allowance	

Table 1.8 (cont.)

Section	Title of the section	Material covered	Notes
Third part:	**Accident insurance**		
Section I	Joint provisions		
Section II	Accident prevention, provisions for first aid		
Section III	Benefits		
Fourth part:	**Pension insurance**		
Fifth part:	**Relations of the insurance institutions (and their associations) to each other and compensation benefits. Liability of the employer in case of work accidents.**		
Sixth part:	**Relations of the social insurance institutions and their associations to physicians, dentists, midwives, pharmacists, hospitals and other contracting parties.**		
Section I	Joint provisions		
Section II	Relations of the social insurance institutions and their associations to physicians		
Section III	Relations of the social insurance institutions and their associations to other contracting parties		
Seventh part:	**Procedures**		
Eighth part:	**Administrative structure:** regulates the structures of the administrative bodies of the institutions and their federation, the supervisory function of the federal government and the management of assets.		
Ninth part:	**Special provisions:** regulates the insurance provisions of Austrian Federal Railways and for special insurance institutions; defines restitution rights.		
Tenth part:	**Transitional and final provisions**		

Sources: No. 599 of the supplements to the shorthand records of the Nationalrat 7th legislation period, explanatory comments on the General Social Security Act of 9 September 1955 (ASVG), Government Bill of 19 July 1955 *(27)*; IHS HealthEcon, 2005 (http://www.ihs.ac.at).

Notes: [a] "The contribution rate of 7% of the contribution basis for blue-collar workers and over 4.5% for white-collar workers shall in future only be permitted with the agreement of the Nationalrat, and only when it is necessary to cover the requirements of the institution" (quotation from explanatory comments on the ASVG, 27–28).

Developments since 1955

Table 1.9 provides an overview of the major reforms in health insurance and other branches of social insurance since the introduction of social health and work accident insurance in 1889, and also includes reforms from after the ASVG in 1955 until 2003. After 1945 there was an increase in the number of the insured from 63% of the population in 1948 to 70% in 1955. From 1955 to 1980, the proportion of those with health insurance increased further by almost 30% and reached around 99% in 1980.

From 1980 onwards, major financing problems arose for the Austrian social insurance model, owing to an economic recession. The health care system has been characterized since then by rapidly increasing expenditure, whereby the costs for hospitals in particular have risen disproportionately compared to those for outpatient care or medicines. The main reason for this is the ongoing extension of the services offered, but also the fact that the Federal Government and the Länder share competencies in health issues, which has made health policy decisions difficult to reach to this day.

Since the end of the 1970s, developments in the health care system – and control of the hospitals sector in particular – have been determined by the application of the agreements according to Federal Constitution Article 15a, the Fiscal Administration Act and planning activities, the introduction and function of which is explained in the following section. Further developments and reforms are described in Chapter 6 on health care reforms.

Agreements on the coordination of federal and Länder competencies

The close institutional links between the Federal Government and the Länder both at legislative level and at the executive level (see the introductory overview, Section 1.1) require a large amount of coordination; however, they are at the same time instruments of coordination and cooperation in themselves *(2).*

Part of the by now well-established formal instruments of the cooperative federal state are the agreements according to Federal Constitution Article 15a which can be concluded between the Federal Government and all the Länder (or individual Länder only), or between all the Länder (or between individual Länder). This instrument was further developed by the 1974 amendment to the Federal Constitution. It seeks to coordinate the respective legislative competencies.

The Fiscal Administration Act provides a general framework for the financial relations between the Federal Government, the Länder and the local

communities. It establishes that each regional authority principally has to bear its own expenses. It assigns the regulation of the distribution of taxation rights to the Federal Government and authorizes it to provide subsidies to the Länder and local communities, and it stipulates that the capacity of the regional authorities has to be taken into consideration in the financial adjustment process.

The structure of the financial constitution is described as cooperative, but at the same time hierarchical, and is characteristic of the Austrian federal state *(2).* It stipulates that the majority of taxes are to be legally regulated and also levied by the Federal Government; the revenue is then divided between the Federal Government, the Länder and the local communities according to the Financial Adjustment Act. The Financial Adjustment Act is a federal law which is limited in time and which contains detailed regulations about the financial relations between the regional authorities. It deals with the division of revenue from taxes and duties among the regional authorities and it regulates the subsidies provided by the Federal Government to the Länder and local communities.

Federal cooperation in the hospital sector

In the hospital system and the long-term care sector, health care is a "cross-sectional issue". On the basis of agreements ("state treaties"), the Federal Government and the Länder mutually undertake to ensure health care provision within the framework of their responsibilities (agreement according to Federal Constitution Article 15a) *(28).*

Since 1978, the Federal Government and the nine Länder have been concluding limited-period agreements on hospital financing in Austria. As part of this process, the Hospitals Cooperation Fund (KRAZAF) was created, which existed until 1997. The Fund was funded by all of the regional authorities involved in hospital financing, and mainly by the social insurance institutions. Alongside the distribution of funding, nationwide planning and control was the main task of the Hospitals Cooperation Fund. The establishment of this fund took place simultaneously with the aim of reforming Austrian hospital financing (see Chapter 6 on health care reforms).

Planning activities of the Federal Government

The Federal Government mainly uses planning in order to control the provision of services, particularly in the inpatient sector. In order to implement planning, it is supported by the Austrian Federal Institute for Health (ÖBIG)The Institute for Health was founded in 1973 and as a scientific service company it has the task of informing health policy-makers about the health status of the population

Table 1.9 Development of social insurance, 1889–2005

Year[a]	Legislation	Comments
1889	Blue-collar Workers Health Insurance Act Blue-collar Workers Work Accident Insurance Act	
1909	White-collar Workers Pension Insurance Act	
1920	Unemployment Insurance Act Civil Servants' Health Insurance Act	
1926	White-collar Workers Insurance Act: health insurance, work accident insurance and pension insurance for white-collar workers in the private sector Notaries Public Insurance Act: pension insurance for notaries public and notary public candidates	
1927	Blue-collar Workers Insurance Act: health insurance, work accident insurance and pension insurance for blue-collar workers in trade and commerce	Pension insurance did not come into effect.
1928	Agricultural Workers Insurance Act: health insurance, work accident insurance and pension insurance for agricultural workers	Pension insurance did not come into effect.
1935	Act on Social Insurance for the Self-employed in Trade, Industry and Commerce: Unification of the entire social insurance system for employees	Without federal employees, railway workers, agricultural and forestry workers.
1939	Introduction of German social insurance law: pension insurance for blue-collar workers through the insurance regulations of the German Reich (*Reichsversicherungsordnung*)	Health insurance is introduced for recipients of invalidity and pension insurance.
1939–1945	Adoption of the legal provisions of the German Reich Implementation of wartime industrial law	
1947	Social Insurance Transition Act and reintroduction of self-governmental structures	
1948	Founding of the Federation of Austrian Social Insurance Institutions	
1953	Chamber of Commerce Old Age Support Act: Old-age pension scheme for entrepreneurs	
1956	General Social Security Act (ASVG)	Replacement of German Reich legal provisions, summary and revision of social insurance for employees
1958	Act on Pension Insurance for the Self-employed Act on Agricultural Pension Subsidies Act on Social Insurance for Artists	
1961	Foreign Pensions Transfer Act	
1965	Act on Health Insurance for Farmers Pension Adjustment Act	To ensure the maintenance of the value of pensions
1966	Act on Health Insurance for the Self-employed	

Table 1.9 (cont.)

Year[a]	Legislation	Comments
1967	Civil Servants' Health and Work Accident Insurance Act	
1970/71	Act on Pension Insurance for Farmers	
1972	Notary Insurance Act 1972	
1973	Special Assistance Act	
1974	Continued Pay Act (for ill blue-collar workers)	
1977	Unemployment Insurance Act	
1979	Act on Social Insurance for the Self-employed in Commerce, Trade and Industry Act on Social Insurance for Farmers Act on Social Insurance for Self-employed Freelancers	
1981	Protection measures for night-shift labourers	
1987	Employment and Social Security Tribunal Act	
1993	Federal Long-term Care Benefit Act	The introduction of a seven-stage long-term care cash benefit
1994	Labour Market Policy Financing Act	
1996	Social Insurance Amendment Act	
1997	Parental Leave Act	
1999	In Vitro Fertilization Fund Act	
2000	Support for New Establishments Act	Pension system reform 2000
2001	Act on Contribution Support for Artists' Social Insurance Social Insurance Currency Changeover Accompanying Act	
2002	Child Care Allowance Act	
2003	Pension system reform 2003	
2005	Harmonization of the different pension systems Introduction of the services cheque (being implemented)	

Source: Federation of Austrian Social Insurance Institutions, 2005 *(18,32)*.

Note: [a] of coming into force.

and planning the organization of health care (see Section 2.1 on organizational structure of the health care system and Section 4.9 on health technology assessment and eHealth).

The government policy statement of January 1990 listed as one of its aims "the drawing up of an Austrian-wide health plan together with the Länder and with the involvement of the social insurance institutions. This should particularly include a hospitals plan and a major equipment plan". Nationwide health planning is an instrument to ensure structural quality and aims to optimize interfaces in the health care system. In the course of recent years, planning was

refined and is now leading to a needs-orientated range of services plan which is to include all levels of care provision. The extent to which this can be put into practice was defined in more detail towards the end of 2005 (see Chapter 6 on health care reforms).

2 Organizational structure and management

The Austrian political system provides for a division of decision-making competencies between the Federal Government, the Länder and authorized civil society organizations in the health care sector. In social insurance countries such as Austria, the state traditionally delegates competencies to membership-based insurance associations and service providers which operate in the form of self-governmental organizations. The Federation of Social Insurance Institutions (HVSV) and the health professionals' associations play an important role in statutory social insurance (mandatory insurance)and form a supply network which is organized in a corporative manner. Within the legally defined framework, health care delivery and its financing are ensured via this cooperation. The organization of mandatory social insurance is legitimated by democratically elected self-governmental structures. It possesses decentralized sovereignty over the revenue from member contributions and negotiates contracts with service providers.

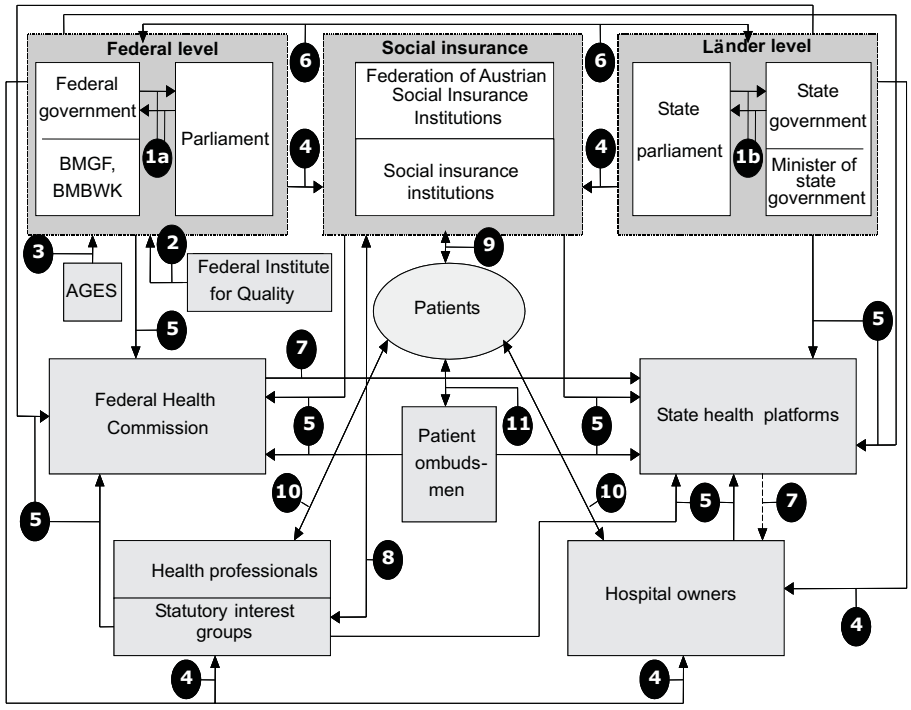
In the hospitals system and in the long-term care sector, Austrian health care is a "cross-sectional issue". On the basis of agreements ("state treaties"), the federal government and the Länder mutually undertake to ensure health care provision within the framework of their responsibilities (agreement according to Article 15a Federal Constitution) (see Section 1.2 on historical background). According to the Federal Constitution, almost all areas of the health care system are the responsibility of the Federal Government. The most important exception is the hospitals sector. In this area, the Federal Government is only responsible for enacting basic law; legislation on implementation and enforcement is the responsibility of the nine Länder. Sanitary supervision of hospitals is, however, the responsibility of the Federal Government (see Section 2.2 on planning, regulation and management).

Providing health care services to the population and controlling the health care system are considered to be a predominantly public task in Austria. More than two thirds of the financing for the health care system stems from contributions and from tax revenue. Around a third is provided directly by private households. Health services themselves are provided by public, private non-profit-making and private profit-making organizations or individuals.

2.1 Organizational structure of the health care system

The organizational structure of the Austrian health care system is defined by the interaction of public, private non-profit-making and private profit-making players. This section examines the organizational structure and the lines of accountability in the health care system, as illustrated in Fig.2.1. The functions and the significance of the individual players are described in more detail later.

Fig. 2.1 Organizational structure and lines of accountability in the health care system, 2005



Source: Federal Ministry of Health and Women, departments IV/A/4 and IV/A/5, 2005.

Notes: BMGF: Federal Ministry of Health and Women; BMBWK: Federal Ministry of Education, Science and Culture; AGES: Agency for Health and Food Safety.

(1) a) Bills proposed by the federal government (minister) to parliament or by the state government (member of the state government) to the state parliament; b) Adoption of federal laws by parliament and of Länder laws by the state parliament.
(2) The Federal Institute for Quality in the Health Care System (full name) support of the Federal Ministry of Health and Women (BMGF).
(3) Support of the BMGF within the framework of the licensing of medicines.
(4) Health care administration a) at federal government level (for example sanitary inspectors, sanitary supervision of hospitals, supervision of social insurance institutions and statutory representative bodies); b) at Länder level (for example in the field of hospital construction and operation permits, implementation of planning in the Land, investment financing; supervision of the social insurance institutions).
(5) Appointment of members to the Federal Health Commission and to the Health Platforms at Länder level.
(6) Consultation mechanism between the federal government and the Länder and/or local communities with regard to legislative activities (laws, decrees) which cause additional expenditure.
(7) a) Sanctioning mechanism: the Federal Health Agency (Federal Health Commission) can withhold funding for the respective State Health Fund (Health Platform) in the case of infringements against binding planning and instructions with regard to quality and documentation; b) State Health Funds (Health Platforms) can provide for a corresponding sanctioning mechanism against hospitals.
(8) Negotiations on market entry, services and rates (general agreement and individual contracts).
(9) Mandatory membership in social insurance institutions (compulsory insurance).
(10) a) Principal freedom of choice for patients regarding hospitals and health professionals in private practice; b) Hospitals (both public and non-profit) and health professionals in private practice with health fund contracts are obliged to treat patients.
(11) Statutory patients' representation in each Land.

Federal level

The main players at federal level are the Nationalrat and the Bundesrat (Lower and Upper Houses of Parliament), the Federal Ministry of Health and Women (BMGF) and the social insurance institutions. In the Nationalrat and the Bundesrat, bills on the extension, development and reform of the health care and social systems are debated and voted upon.

Bills are usually submitted by the BMGF. Since May 2003, the BMGF, as the legal successor of the Federal Ministry of Social Security and Generations (BMSG) (in which a State Secretariat for Health had been located since the year 2000), has been responsible for the tasks set out in the new Federal Ministries Act. The tasks of the Federal Government are largely delegated to the Länder within the framework of indirect federal administration and/or to the self-governing social insurance institutions. However, the Federal Government retains an important role in policy-making and as a supervisory authority for

the enforcement of the laws on health care provision. It also has important competencies in the training of health professionals.

As a supervisory authority, the BMGF monitors adherence to the laws which are implemented by the social insurance institutions and the professional organizations of service providers in order to ensure the provision of health care. Since reorganization, which was carried out in 2003, the BMGF has been responsible for the following areas *(29)*:

- I A: Staff Unit Coordination of Health Policy and Central Organization
- I B: Staff Unit Legislation on Health, Health Insurance and Work Accident Insurance.

Activities within the staff units extend to internal and EU coordination of health policy, to international coordination of health policy and collaboration with the World Health Organization (WHO), to health professions and general legal issues affecting physicians, psychologists, psychotherapists, medicines, hospitals, contagious diseases, and health and accident insurance including auditing and the submission of accounts of the health and work accident insurance institutions.

- II: Women's Issues and Gender Equality Division
- III: Health Care System Division

This division is responsible for quality assurance and infection epidemiology, for medical products, health promotion and prevention, safety of blood and tissue, licensing and monitoring of medicines, economic aspects of pharmaceuticals, radiation protection, drugs and addictive substances, and for health professions other than physicians.

- IV: Structural Policy and Consumer Health Division

Within this division, hospital financing, structural policy, planning and documentation are further developed. It deals with quality management, interface management and health economics issues as well as questions related to health telematics. In addition, it handles issues regarding the veterinary sector, food technology and biotechnology and genetic engineering.

The Gender Equality Ombudsperson's Office, the Gender Equality Commission for the Private Sector and the Agency for Health and Food Safety (AGES) are assigned to the BMGF.

The Ministry is supported by partly subordinate institutions and committees, which are not only active in licensing issues and legal responsibility, but also with regard to public health services (partly illustrated in Fig.2.1).

The **Supreme Health Board** acts as an advisory and expert body for the Minister of Health (see Section 1.2 on historical background). The Supreme Health Board was reorganized in May 2005. It now has 39 members (previously 19),

who are selected and appointed for three years by the responsible minister from among representatives of the various specialist areas of medical science. However, the members also include experts in health planning and financing, nursing care, quality assurance, psychotherapy and alternative medicine. The Supreme Health Board is a medico-scientific consultative committee, whose particular significance is that it is entitled to decide whether certain activities are to be regarded as medical activities, and also to decide what should be deemed "state-of-the-art" medical science. Its members receive no payment for this work and are obliged to maintain confidentiality unless the minister explicitly agrees to make points of discussion public. However, the recommendations of the Supreme Health Board are only proposals and are not binding for health policy decisions. The Supreme Health Board holds a plenary meeting two to three times a year. It is divided into subcommittees which deal with the topics of vaccinations, AIDS, the mother-child pass and dental care and prevention.[4] The newly founded Public Health Commission particularly deals with health in the workplace and illnesses related to modern civilization.

The work of the **Healthy Austria Fund** is based on the Health Promotion Act which came into effect in 1998. Its tasks range from setting-orientated health promotion (increasing resources) to primary behavioural and circumstantial prevention and health information and education. The fund is financed by a proportion of the revenue from value-added tax according to the respective Financial Adjustment Act (see Section 4.1 on public health services).

The **Federal Health Agency** was established at the beginning of 2005 as a fund under public law which is a separate legal entity. Its executive body, the Federal Health Commission, was convened in April 2005. The Structural Fund is to be replaced by the Federal Health Agency in accordance with the agreement in Federal Constitution Article 15a on the restructuring of the health care system and hospital financing. The most important task of the Federal Health Agency is to further develop the performance-related reimbursement systems in all sectors of the health care system, and to develop and implement planning and quality specifications (see Section 2.2 on planning, regulation and management). A **Federal Health Conference** in which the most important players in the health sector are represented has been established in order to advise the Federal Health Agency.

The **Private Hospitals Financing Fund** (PRIKRAF) was founded in 2002 and has the task of financing the inpatient services of 45 private hospitals that offer services which effectively contribute to health care provision. Its

[4] State Health Boards exist at Länder level. If hospitals are to be restructured, outpatient departments established, or new clinical directors appointed, the respective health board has to be consulted.

supervisory authority is the BMGF. The fund is solely financed by the social insurance institutions, and finances hospitals on a performance-orientated basis according to the valid financing principles for public hospitals (Austrian DRG model).[5] Hospitals which are reimbursed via the Private Hospitals Financing Fund are subject to nationwide documentation and quality specifications (see Section 2.2 on planning, regulation and management).

The **Independent Medicines Commission** (UHK) examines on application decisions of the HVSV on the inclusion of medicines in the reimbursement codex (see Section 2.2 on planning, regulation and management).

The **Austrian Federal Institute for Health** (ÖBIG) plans and draws up orientation aids for the organization of medical and inpatient care, preventive and social medicine. Worthy of mention here are, among other things, the work on the Austrian Hospitals and Major Equipment Plan (ÖKAP/GGP), which is being further developed into a service provision plan and will be converted into the Austrian Structural Plan for Health (ÖSG) 2006 from 1 January 2006. The Austrian Structural Plan for Health 2006 forms the basis for integrated planning in the Austrian health care system and provides the framework for detailed planning at regional level. The Austrian Federal Institute for Health keeps a register of people who have expressed a wish not to have their organs transplanted; the in vitro fertilization register according to the In Vitro Fertilization Act (this provides for the assumption of the costs of in vitro fertilization, the establishment of a fund for its financing, and the maintenance of a register); the Austrian blood vigilance register (a monitoring system which includes the entire transfusion chain from the donor, via processing and transport, through to the administering of blood and blood products to patients); as well as the medical products register, which has to be kept in accordance with the regulations of the Austrian Medicinal Products Act and the European Directive on Medicinal Products and In Vitro Diagnosis. The Austrian Federal Institute for Health supports the Price Commission based at the BMGF with information on medicines prices in the European Union (see Section 4.8 on pharmaceuticals).

The federal law which established a fund for the financing of in vitro fertilization (**IVF Fund)** guarantees entitlement to the payment of costs for couples who have not been able to have children. If the relevant conditions are fulfilled, the fund bears 70% of the costs for in vitro fertilization treatment for a maximum of four IVF attempts (see Section 4.9 on health technology assessment and eHealth).

[5] Public hospitals as defined in this report are the so-called "funds hospitals" which comprise hospitals owned by Länder and municipalities as well as non-profit-making hospitals with public law status.

The **Austrian Agency for Health and Food Safety** (AGES), carries out work in the field of food safety. It tests and examines foods according to the Austrian Food Purity Act, carries out veterinary examinations and is active in combating and preventing infectious diseases in humans. As of 1 June 2002, 18 federal institutions and federal offices in the fields of food testing, bacteriology and serology, veterinary medicine and agriculture were brought together in the newly founded agency.

The **Federal Office for Safety in the Health Care System** and the **Federal Office for Food Safety** are, like the AGES, authorities which report to the BMGF and will take up their work in 2006. The Federal Office for Safety in the Health Care System replaces the Federal Offices for Medicinal Products and its priorities will be the enforcement of the Medicines Act, the Importation of Medicinal Products Act, the Safety of Blood Products Act and the Medicinal Products Act. In an organizational sense, the two new federal offices will work within the Austrian Agency for Health and Food Safety.

The **Genetic Engineering Commission** was founded in 1995 and advises on principal questions related to the applications of genetic engineering. One of its main focuses is the field of gene diagnosis in humans. In addition, this committee deals with the creation of guidelines for genetic advice and with the medical applications of genetic engineering. The area of gene diagnosis in humans became the main focus of this scientific committee in the period between 2001 and 2004. The Genetic Engineering Commission is also responsible for making decisions on proposed sections of the Genetic Engineering Book, which documents the current status of science and technology in all the legally permitted areas of application of genetic engineering in Austria *(30).*

The **Announcements of the Health Administration Authorities** is an official publication about the public health service, periodically issued by the BMGF, and is a source of information for all those who work in the health care system. Articles from fields which are relevant to the public health service are published in the Announcements of the Health Administration Authorities, information is offered about topical national and international health issues, current publications from the health care sector are announced, and reports are offered about the activities, programmes and publications of WHO which are of interest to a broader public readership.

Alongside the BMGF, the Federal Ministry of Social Security, Generations and Consumer Protection, the Federal Ministry of Education, Science and Culture, the Federal Ministry of Finance, the Federal Ministry of Defence and the Federal Ministry of Justice are all involved in providing health care and social security. The office of the Bioethics Commission is based in the Federal Chancellery.

The **Federal Ministry of Social Security, Generations and Consumer Protection** (BMSG) is responsible for the supervision of statutory pension insurance, the , the provision of long-term care, social assistance, and issues affecting people with disabilities (see Section 4.5 on outpatient and inpatient long-term care). The Federal Social Welfare Office and its nine Länder branches are assigned to this ministry.

The **Federal Ministry of Education, Science and Culture** (BMBWK) is responsible for university medical training for physicians. When the University Act 2002 (Federal Law Gazette I No. 120/2002) came into full effect in its currently valid form in July 2005, it established the medical universities of Vienna, Graz and Innsbruck as public law entities and legal successors of the medical faculties of the universities of Vienna, Graz and Innsbruck (see Section 4.7 on human resources and training). The medical universities are federal institutions and can now – with due consideration for the agreement on services with the Federal Government – agree on the sharing of costs for the establishment, equipping and operation of university teaching hospitals with the hospital owners (see Table 5.1).

The **Federal Ministry of Finance** (BMF) is directly and indirectly involved in the area of financial adjustment between the Federal Government and the Länder and thus in hospital budgets, but also in the Healthy Austria Fund. It is also the supervisory authority for the HVSV (pension insurance institutions).

The **Financial Market Authority** is the supervisory authority of the Federal Government for the business activities of private health insurance providers. The Insurance Contract Act, which was amended by the Federal Ministry of Justice in 1994 to align it with EU requirements, provides the framework for the activities of domestic and foreign private health insurers.

The **Federal Ministry of Justice** and the **Federal Ministry of Defence** are owners of individual hospital departments and/or hospitals (for example military hospitals).

In 2001, a Bioethics Commission was established in the **Federal Chancellery**. It advises the Chancellor on the ethical aspects of social, scientific and legal issues which arise in the fields of human medicine and human biology. Particular issues include: information and promotion of the debate in society on important findings in human medicine and biology and the related ethical questions; making practical recommendations; making proposals on necessary legislative measures; and producing reports on specific issues. The Bioethics Commission is currently made up of 19 members. They include experts from the fields of medicine, molecular biology and genetics, law, sociology, philosophy and theology. The Bioethics Commission produces an annual report *(31).* It can set up working groups to prepare information on

specific subjects. According to the task at hand, the Bioethics Commission works alongside ministries involved in the subject matter (for example with the BMGF, the Federal Ministry of Social Security, Generations and Consumer Protection and the Federal Ministry of Education, Science and Cutlure). It also maintains contacts to disabled associations and self-help organizations and to the Genetic Engineering Commission. In future, the Bioethics Commission will also deal with issues regarding the allocation of funding in the areas of health and research.

Länder and local communities

The Länder and municipalities play an important role in establishing, implementing and monitoring the various aspects of the public health service (see Section 4.1 on public health services). Legislation at Länder level is made by the Länder parliaments, whose members are elected by proportional representation (see the introductory overview, Section 1.1). The state government is the supreme health authority of the Land. It is supported by the office of the state government and by the state health board. There is thus a separate department for health in each state government, which is led by a physician with civil servant status, the State Health Director. The office of each state government has a state health board at its disposal for advisory purposes.

The state administrations have established departments to combat notifiable infectious diseases. There are also vaccination centres and various advice centres, including centres providing advice on health promotion, as well as institutions which keep health statistics for the respective Land. Furthermore, the job market in the public health service along with adherence to the training regulations for medical personnel other than physicians are monitored.

In addition, each district administration has a health department (health office), which is headed by a district medical officer. The tasks of the district medical officers are also carried out by advice centres and counselling centres (antenatal clinics, vaccination centres, AIDS help centres, etc.).

Some matters, such as health inspections at local level, are the responsibility of the local governments. Some local communities have also set up joint health districts (*Sanitätsdistrikte*). In the local communities, the municipal medical officers (*Gemeindeärzte*) or the district medical officers (*Sprengel- oder Kreisärzte*) act as experts for consultation purposes.

The supervisory authorities at this level are general state administrative authorities such as the district administrative authorities, the state governor in the case of delegated federal responsibilities, and the state government in the case of delegated Länder responsibilities.

The Federal Hospitals Act (KAKuG) stipulates that each Land is obliged to ensure the availability of inpatient care for people who require it. The Länder establish the structure of inpatient acute care in quantitative and qualitative terms according to the specifications set out in health planning. Until December 2005, the Länder hospital plans had to adhere to the specifications of the ÖKAP/GGP. Since 2006, the Austrian Structural Plan for Health is in effect (see Section 2.2 on planning, regulation and management). Negotiations have not yet been finalized. In case no agreements can be achieved, the ÖKAP/GGP will remain binding. It sets out the framework for detailed planning specific to the relevant Land (see Chapter 6 on health care reforms).

According to valid agreements between the Federal Government and the Länder (agreement according to Federal Constitution Article 15a), the Länder will be supported in the provision of health care by State Health Funds at Länder level. In addition, hospital operation companies have been established in almost all the Länder; most of which have private law status.

The **State Health Funds** are public law funds and separate legal entities. Each Land has to establish such a fund. If an agreement is reached between the respective Länder, it is also possible to set up a joint health fund for several Länder. In accordance with the agreement according to Federal Constitution Article 15a on the restructuring of the health care system and hospital financing (Federal Law Gazette I No. 60/2002), the former state funds will be discontinued and replaced by the State Health Funds. The highest body of the State Health Fund is the Health Platform (see Section 2.2 on planning, regulation and management).

The management of public hospitals in all the Länder has been outsourced to **hospital operation companies** organized according to private law, with the exception of Vienna. The organizational structures of these companies differ, but one thing they have in common is that as representatives of the owners they implement the mandate of the Länder to provide health care and make strategic decisions on behalf of the Länder (see Section 2.2 on planning, regulation and management).

Social assistance (welfare) is also the responsibility of the Länder and the local communities. It is organized strictly according to the subsidiarity principle. A legal entitlement exists when neither employment nor benefits from social insurance, other institutions or family assets can provide sufficient material and social security. Social assistance benefits include cash benefits, sickness benefits, long-term care benefits and a place in a residential home or an institution. There are differing reference rates for cash benefits in the individual Länder. In addition, the Länder have a relatively large degree of scope when deciding whether the conditions for entitlement have been fulfilled.

In the long-term care sector, the Länder are also responsible for cash benefits and in-kind benefits. In order to ensure nationwide uniformity for the long-term care sector, the Federal Government and the Länder have made an agreement in the form of a state treaty. Among other things, the Länder have undertaken to establish and extend a decentralized and comprehensive network of long-term care services in outpatient care, institutional care as well as day care or night care. All long-term care institutions are required to fulfil minimum standards (see Section 4.5 on outpatient and inpatient long-term care).

The self-governmental level (social insurance and service providers)

Apart from the hospitals sector, health care provision for the Austrian population is organized by negotiations between the social insurance institutions and the professional or statutory representatives of the service providers. Whereas public bodies which exercise sovereign powers have obligatory membership (Physicians' Chambers, Pharmacists' Chambers), statutory representative bodies have no mandatory membership, except for active midwives. However, the latter are still able to conclude collective agreements in some cases.

Social insurance

The social insurance system constitutes an independent area of competence in which legislation and implementation are the responsibility of the Federal Government. The Federal Government has, however, delegated implementation to the social insurance institutions, which are managed as self-governing bodies. The Austrian social insurance system has been administered in this way since its establishment, except for the period of 1939–1947. Self-government means that the state (Federal Government and Länder governments) allows certain areas to be administered by those groups of individuals who have a direct interest in them. Through self-governance, insured people, recipients of services and those who pay contributions participate directly in social insurance. The social insurance system consists of the areas of social health insurance, social pension insurance and social work accident insurance.[6]

The most important features of self-governance are:

- organization takes the form of public bodies;
- mandatory membership and mandatory contributions according to statutory regulations;

[6] Unemployment insurance is organized separately and is administered by the Public Employment Service.

- authority to issue generally binding norms;
- the right of enforcement towards the members of the association (right to make rulings);
- appointment of its own executive bodies from among the association members (the interest groups send representatives to the administrative bodies);
- independence from directives issued by state authorities;
- the right of supervision is held by state administrative authorities.

Social health insurance is organized as mandatory insurance. The legal basis for health insurance is provided by the ASVG and the concept of illness it defines, as well as its amendments and the GSVG, the Act on Social Insurance for Farmers (BSVG) and the Civil Servants' Health and Work Accident Insurance Act (B-KUVG).

As a mandatory insurance system, the social insurance institutions cover almost all the working population and pensioners. In 2004, 97.6% of the population were covered by social (statutory) health insurance (2003: 98%) *(32,33,34)*. Since the year 2000, physicians, pharmacists, lawyers, architects, accountants, veterinary surgeons and notaries public can opt for mandatory insurance (opting out in accordance with Section 5 of the GSVG). However, if they opt out, their health insurance cover must be otherwise provided with at least almost equal services, either via arrangements with their professional bodies (particularly taking out private health insurance in a group insurance contract), or through voluntary insurance according to the ASVG or the GSVG. Multiple insurance is possible in principle. Social assistance claimants and prisoners are not usually covered by social health insurance, but they receive health services from the regional authorities *(33)*. Access to voluntary insurance is largely unrestricted. Voluntary health insurance is the most common type of voluntary insurance.

All the statutory social insurance institutions are united in the **Federation of Austrian Social Insurance Institutions**, which was founded in 1948. The HVSV is responsible for safeguarding the general and economic interests of the social insurance system, providing central services for the social insurance funds, and the coordination of the administrative activities of individual insurance funds. It has the task of drawing up binding guidelines, policy proposals, reports and statements, and concludes general agreements (*Gesamtverträge*) with interest groups. The Federation plays an important role in the further development of social insurance law and of the Austrian public health care system in general. In addition, it administers insurance data and draws up statistics.

The tasks of the HVSV include:

- safeguarding the general and economic interests of the Austrian social insurance system;
- representing the social insurance institutions in matters of common interest;
- representing the Austrian social insurance system in contacts with institutions from other countries;
- the possibility to grant legal protection in disputes which are of joint interest to the social insurance institutions;
- drawing up guidelines so that the actions of the self-governmental social insurance institutions are as concerted as possible;
- concluding agreements with the statutory representative bodies for physicians, dentists, etc.;
- the possibility to grant legal validity to certain decisions made by the social insurance institutions;
- the involvement in the balancing and division of funding in the social insurance system;
- sending of representatives to various domestic commissions;
- the publication of the specialist magazine *Soziale Sicherheit*;
- the provision of services for the Austrian social insurance institutions (issuing of insurance numbers, training of social insurance funds' staff, e-cards (new electronically readable cards for health insurance services), etc.).

The organization of the HVSV and its specific tasks have been restructured several times in the last few years in view of continuing discussions about the optimal structure of administration in the social insurance system. With the 52nd amendment to the ASVG, which came into effect in January 1994, and the corresponding amendment of the other social insurance laws, a package of laws on organizational reform in the social insurance system was adopted which aimed to streamline its structures and increase efficiency while maintaining the principle of self-governance. After the elections in the year 2000 and the formation of a centre-right government, the HVSV was again subjected to organizational reform in 2001. However, this was examined by the Constitutional Court and declared unconstitutional. The verdict mainly referred to its role as the self-governing authority of the social insurance institutions, which provides for an appropriate level of involvement of the insurance funds in its (the HVSV's) decision-making executive bodies, and in which the democratic legitimation of these bodies, which are responsible for important decisions, has to be ensured. Since January 2005, two administrative bodies have been established with decision-making competencies: the Conference of the Social Insurance Institutions and the Federation Board.

The **Conference of the Social Insurance Institutions** is composed of the chairpersons and deputy chairpersons of all the funds with the exception of company health insurance funds, from which only the fund with the largest number of members is represented, as well as three representatives of senior citizens. The conference elects a chairperson and two deputies from among its participants. The tasks of the conference include monitoring the financial management of the HVSV (statements of accounts, etc.) and decision-making on legislative activities of the Federation (guidelines, model statutes of health insurance funds (*Mustersatzungen*), model regulations for health service utilization (*Musterkrankenordnung*), etc.). The conference also approves general agreements.

The **Federation Board** consists of 12 members appointed by the Conference of the Social Insurance Institutions. Half of the members are from the employers' group and half from the employees' group. They have to be representatives of one of the funds. They are appointed on the basis of proposals from the interest groups of the employers and the employees (five members each), from the president's conference of the Austrian Chamber of Agriculture and the Public Employees' Union (one member each).

The Federation Board is responsible for the entire management of the HVSV (with the exception of the tasks which are expressly assigned to the funds' conference) and for representing it in external matters. It can set up committees and can, notwithstanding its responsibility, delegate individual tasks to them; ongoing issues can be delegated to the management of the Federation. In addition, it has to set up advisory committees for the areas of health insurance and prevention, provision for old age, work accident insurance and information technology.

Instead of the previous managing director, the Federation Board is now assisted by a management team which consists of an executive and a maximum of three deputies. The management team is subject to directives from the Federation Board.

The HVSV is supported by the following advisory bodies.

- The **Social and Health Forum** established in April 2005 consists of 44 experts from the fields of social and health policy. The committee was set up as an advisory organ on social and health policy issues for the Ministers of Social Affairs and Health and the HVSV. The Social and Health Forum draws up medium and long-term proposals for Austrian health and social policy which go beyond the scope of everyday politics. The chairperson and his/her deputies were elected from the Economic Chamber and the Chamber of Workers and Salary Earners.

- The **Controlling Group** monitors the administrative activities of the social insurance institutions and is responsible for reporting to the funds' conference and to the supervisory authorities. The Controlling Group, like the Social and Health Forum, is not a self-governmental body.
- The **Medicines Evaluation Commission** (HEK) was set up in 2004 in the course of the reorganization of the reimbursement scheme (*Erstattungskodex*) and is an advisory body for the admission of medicines to the reimbursement scheme (see Section 4.8 on pharmaceuticals). The Medicines Evaluation Commission has to give a written recommendation to the HVSV. It meets on a monthly basis and consists of 20 members, who include representatives of the HVSV, the social partners and scientists. The members are appointed for five years; in their work in the Commission they are not subject to directives and have to maintain confidentiality. Applications for the authorization of medicines are subject to pharmacological, medico-therapeutic and health economics evaluations.

The initiative **Medicines&Reason** was set up as a joint project by the social insurance institutions and the pharmaceuticals industry. In 2003, the Austrian Physicians' Chamber and the Austrian Pharmacists' Association, which had already supported the project until that time, were won over as full project members. The new concept for Medicines&Reason projects aims to establish a binding, structured, evidence-based set of guidelines for the rational prescribing, dispensing and utilization of medicines.

Service providers

The **Austrian Physicians' Chamber** is the professional representative organization of physicians in Austria. It is organized like a holding company whose members are nine physicians' chambers in the nine Länder. The main tasks of the physicians' chambers are sharing in decisions on medical education, contracting with the social health insurance funds and upkeeping the register of physicians (physicians listed in the register are entitled to engage in private practice). Membership is mandatory for every physician. Physicians practising independently can be freely chosen by patients. If they are contracting parties of the social insurance institutions, they have rights and duties in accordance with the provisions of the ASVG and the Physicians' Act as well as in accordance with their contracts. As contracting parties of the social insurance institutions, physicians are thus obliged to accept patients for treatment. Negotiations are periodically held, at least once a year, between the statutory representatives of physicians and the social insurance institutions. These cover the issues of market entry, services and fees (see Section 2.2 on planning, regulation and management

and Section 4.7 on human resources and training). In addition, patients can also choose to visit physicians without health insurance fund contracts.

The **Austrian Pharmacists' Association** is the statutory representative body of pharmacists, whether they work in public pharmacies or in hospitals. As a public body, the Pharmacists' Association is self-governmental and at the same time takes on sovereign tasks (see Section 2.2 on planning, regulation and. management and Section 4.8 on pharmaceuticals).

The statutory interest group of midwives is the **Austrian Midwives' Committee**, to which all midwives who practise their profession in Austria belong. Other health professions (psychotherapists, psychologists, medical-technical staff, physiotherapists, biomedical analysts, radiographers, dieticians, occupational therapists, speech therapists and orthoptists – as well as members of health care and nursing care professions and masseurs) are organized in professional associations with voluntary membership (see Section 4.7 on human resources and training). These are partly entitled to negotiate collective agreements. The significance of legally recognized representation is that the volume of services and rates of pay are negotiated and established in general agreements. Professional associations elect board members and nominate other people to conduct negotiations with the relevant health insurance funds or with the HVSV. Membership of the associations is not mandatory. However, the rates of payment and services which are negotiated are then applicable for all those practising the profession. The "market price" which is thus determined is then paid by the health insurance funds. Any sums exceeding these rates have to be paid by the patients themselves (see Section 3.3 on complementary sources of finance).

The **companies operating public hospitals** are also contracting parties of the social insurance institutions. The financing of their services is ensured by agreements between the Federal Government and the Länder, which contain provisions about the relations between the social insurance institutions, hospital owners and the State Health Funds (see Section 2.2 on planning, regulation and management).

Contracts can also be used to regulate the relations between the social insurance institutions and private hospitals offering services which effectively contribute to health care provision. Most private hospitals are, however, reimbursed exclusively by the Private Hospitals Financing Fund, which is funded by social insurance. More detailed regulations affecting the reimbursement of inpatient services are set out in the Private Hospitals Financing Fund Act (see Section 2.2 on planning, regulation and management).

Other stakeholders

Welfare organizations and a multitude of social service providers and self-help groups offer services for socially disadvantaged or fringe groups. Alongside public owners such as Länder or local communities, a large number of smaller organizations and 20 larger organizations – some of which operate nationwide – currently offer social services (including nursing care at home). Five organizations in the field of health and social services have joined together in the **Federal Working Group Free Welfare**. These include Caritas Austria (a catholic welfare organization), Diakonie Austria (a protestant welfare organization), the Hilfswerk Austria, Volkshilfe Austria and the Austrian Red Cross.

The most important organization in the field of emergency services is the Austrian Red Cross, which has the highest market share in the ambulance services sector. In addition, the Red Cross is the most important provider of blood products. Social services and mobile nursing care are also business areas of the Red Cross. Like most of the major welfare organizations, the Red Cross has a federalist organizational structure. It consists of a parent organization and nine associations at Länder level which are made up of district and local centres. The significance of the Red Cross partly lies in its ability to mobilize volunteers to provide services, which is also the case in other non-profit-making organizations. The financial basis of the welfare associations is provided by the fees for various services which are raised by the health insurance funds, general tax revenue, donations and cost-sharing.

The **Service and Information Centre for Health Initiatives and Self-help Groups** (SIGIS) was founded in 1993 and is now based within the Healthy Austria Fund (see Section 4.1 on public health services). SIGIS has the task of networking the individual parent organizations and contact centres and creating a climate in Austria which is conducive to self-help. There are currently well over 1000 self-help groups in the health and social sectors in Austria. Many have developed semi-professional structures over the years (nationwide associations with Länder offices and regional groups). Others work autonomously at regional level and concentrate on directly supporting patients and those affected by means of psychosocial encounter groups and by passing on information. In recent years, numerous databases and contact centres have been set up in Austria. The ArGe Selbsthilfe Österreich is a voluntary union of self-help support organizations. It is independent, which means it is not connected to a political party or a religious organization, and its work extends throughout the country. Its tasks are primarily to facilitate access to the corresponding decision-making bodies for the concerns and interests of self-help groups and organizations in the social and health sector.

The **Austrian Association of Pharmaceutical Companies** (PHARMIG) was established in 1954 as a voluntary interest group of the Austrian pharmaceuticals industry. It has 109 members. In November 2000, the Austrian Generic Drugs Association (OEGV) was founded. The Austrian Generics Association is an organization formed by several generics producers which represent around 70% of the Austrian market for these drugs *(34)*. The Forum of the Researching Pharmaceutical Industry (FOPI), is an organization formed by research-orientated international pharmaceutical companies in Austria.

Private health insurance is mainly a voluntary form of supplementary private insurance. There are seven private health insurance providers operating in Austria, which are members of the **Association of Austrian Insurance Companies** (VVO). The insurance companies UNIQUA AG and Wiener Städtische AG together have a market share of around 70%. In 2004, 82% of services were in the inpatient sector, particularly for the costs of providing a higher level of comfort in the "special class" rooms of (public) hospitals, and also for financing the services of physicians who do not have health insurance fund contracts (10%) *(35)* (see Section 3.3 on complementary sources of finance).

Around a third of the population has private (additional) health insurance *(36)*. Although the significance of private health insurance has decreased over the years, its share in the financing of public hospitals is considerable. Private health insurance in Austria finances around 7% of the costs of public hospitals (see Table 5.1 as well as Section 5.2 on payment of hospitals and Section 5.3 on payment of physicians).

2.2 Planning, regulation and management

Federal level

At federal level, social insurance law and the agreements on financial adjustment between the Federal Government and the Länder form the framework for the provision and financing of social and health services. Social insurance contributions are nationally uniform and are set by Parliament. The extent of social protection and the fairness of its distribution are thus regulated at federal government level. The subject matter covered by social insurance laws are the responsibility of several ministries. These regulations form the legal basis for the social insurance institutions' obligation to provide services. The ASVG, which covers almost 80% of people with health insurance, consists of 10 parts including the regulations on the administrative structure of the social insurance institutions (see Section 1.2 on historical background). It contains rights and

obligations for the insured and regulates the relations between the insurance funds and service providers. Apart from the task of policy-making and its functions as a supervisory authority, the Federal Government is responsible for planning and regulation in almost all areas of health care provision, and controls the mechanisms of financial adjustment between the ASVG and the Länder, particularly in the hospitals sector.

Hospitals

The regulatory framework for hospitals is provided by the Federal Constitution and by binding agreements (see the introductory overview, Section 1.1). The negotiations for the agreement, for the years 2005–2008 (agreement according to Federal Constitution Article 15a on the organization and financing of the health care system 2005–2008, Federal Law Gazette I No. 73/2005), were held within the framework of the financial adjustment negotiations which take place every four years (a legislative period), and essentially carry on from old agreements. The currently valid agreement contains for the first time a provision allowing for the complete responsibility for the health care system of the regional authorities and the social insurance institutions. A Federal Health Agency with Federal Health Commission, along with the State Health Funds with Health Platforms at Länder level, are to be established in 2005 for the planning, control and coordinated financing of the entire health care system (within and outside the hospitals sector) (see Chapter 6 on health care reforms). In this agreement, the Federal Government's competency for planning and regulation is 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 regulatory framework has the objective of creating incentives for strengthening the supply chain while at the same time ensuring or improving quality. This is to be achieved by using better documentation and the use of information and communications technology.

The role of the Federal Health Agency is primarily to create a regulatory framework and to provide specifications and guidelines for documentation and for the implementation of planning, which had to be negotiated until the end of 2005 in accordance with agreements with the Länder. In order to achieve this, important stakeholders in the Austrian health care system were appointed to the Federal Health Commission, which is the executive body of the Federal Health Agency. The Federal Government holds a majority in the Federal Health Commission. As was the case in the previously valid agreement, the Federal Government has the option of withholding funding for hospitals, particularly if the Länder do not implement the required planning and quality specifications.

This amount corresponds to around 2% of the total costs of public hospitals. Until now, this sanctioning mechanism has not been used.

The Federal Health Agency also draws up guidelines for the area of cooperation between inpatient care, day care, and outpatient care provision ("reform pool"). This is also an organizational innovation, which has the aim of implementing a compensation mechanism ensuring that additional funding is available in the case of a change in the pattern of services. This should help to achieve an extension of outpatient care, but also the further development of day clinics and outpatient facilities in the inpatient sector. It is planned to bring 1%, and by 2008, 2% of total public health expenditure into the "reform pools", which are set up at Länder level. Most of the funding for the Federal Health Agency stems from value-added tax revenue. It is divided up among the Länder according to fixed quotas.

Austrian Structural Plan for Health

The binding basis for the integrated planning of the structure of Austrian health care provision is set out in the Austrian Structural Plan for Health. It lays down the framework planning for detailed plans at regional level in the inpatient, outpatient and rehabilitation sectors, as well at the interfaces to the long-term care sector. The Structural Plan for Health is a further development of the Hospitals and Major Equipment Plan (ÖKAP/GGP). It includes planning of the range of services offered in acute inpatient care with a planning horizon until 2010. Furthermore, it provides a description of the current structure of care provision in the non-acute inpatient sector, in the outpatient sector and in the rehabilitation sector, as well as at the interfaces to the long-term care sector. Binding structural quality criteria constitute an integrating part of the planning statements within the framework of service provision planning. It is contractually specified that negotiations on the implementation of these plans had to be concluded by the end of 2005. Until then, the ÖKAP/GGP of 2003 was still in force. If no agreement is reached between the contract parties with regard to the Austrian Structural Plan for Health, the 2003 ÖKAP/GGP will continue to remain valid as the common and binding basis for planning.

Quality programmes

In addition, the Federal Government has supported and financed a multitude of quality-related projects in recent years, including the themes of interface management, quality reporting, patient orientation, antibiotics strategies, structural quality criteria, optimizing the use of blood components, hygiene, quality assurance in microbiological diagnosis, outcome quality, patient safety

and the avoidance of adverse events. In the form of the Health Reform Act 2005, a comprehensive federal law on quality in health care services was adopted. This created the legal framework for pursuing a targeted quality strategy and focusing activities in the field of quality assurance, which had become fragmented in recent years.

The basic principles of this law are patient orientation, transparency, efficiency, efficacy and patient safety. The law provides for the development and implementation of nationwide standardized specifications for health services. It affects all sectors, such as public and private hospitals and outpatient care, as well as all health professions including physicians, nurses, medical-technical staff, etc. The Federal Government has a particular coordinating role in this context. The new law stipulates that regular quality reporting will be developed, as a part of which reports will be written on all sectors and professions according to nationwide uniform methods. This instrument is designed to ensure transparency for the public and at the same time introduce a method of systematically improving quality work. The law provides for the creation of promotion measures and incentive mechanisms in order to improve and ensure quality work in the public health service.

In addition, the establishment of a **Federal Institute for Quality in the Health Care System** is stipulated; this is to support the BMGF in the development of quality specifications and nationwide coordination. At the same time, the topics of quality and interface management were elaborated on in separate articles of the agreement according to Federal Constitution Article 15a on the organization and financing of the health care system. Furthermore, work on quality and interface management were established as explicit tasks of the Federal Health Agency as well as the Health Platforms at Länder level.

Medicines

Reforms also resulted in changes to the role of the Federal Government in the field of medicines. As part of the implementation of the Good Clinical Practice Directive (2001/20/EG), since 2004 the Medicines Act has, alongside the codification of licensing deadlines, contained amendments on the carrying out of clinical tests. These include provisions on the establishment of Ethical Guidelines Commissions, which have to be consulted in multi-centre studies. The BMGF has appointed seven Ethical Guidelines Commissions for this purpose. The BMGF is supported in the authorization procedure for medicines by the Federal Medicines Institute, which examines the documents submitted and the evidence required by the Medicines Act proving quality, efficacy and safety. From 2006, these activities will be taken over by the business area PharmMedAustria of the Agency for Health and Food Safety. Whereas the

authorization of medicines and the fixing of price margins for pharmacies and wholesalers are federal government responsibilities and relate to the entire market, the social insurance institutions are responsible for negotiating whether medicines will be reimbursed for those with social health insurance.

The Independent Medicines Commission has been established as a second point at which to examine the decisions of the HVSV on the inclusion of medicines in the register of medicines. It is based within the BMGF. Applicants have the option of lodging a complaint against the decision of the Federation with the Independent Medicines Commission which has eight members and meets on a monthly basis. Additionally, the BMGF establishes the average EU price for refundable medicines. The basis for this is the Prices Act; the procedure is carried out via the office of the Price Commission with the consultation of experts from the Austrian Federal Institute for Health.

The pharmacy system is the responsibility of the Federal Government. The population of Austria is currently supplied with medicines by a total of 2221 public pharmacies, which require a licence. In order to ensure a balanced supply of medicines, around 1000 physicians in private practice also run small pharmacies in their surgeries; these are subject to official permits. There are additionally more than 50 hospital pharmacies providing a supply of medicines in hospitals. The examination procedure to determine whether new pharmacies are necessary was relaxed in 1988 in accordance with a decision of the Constitutional Court. Pharmacies are only permitted to sell those medicines to consumers which have been authorized by the BMGF. Pharmaceutical wholesalers obtain medicines from manufacturers and pass them on to public pharmacies or to hospital pharmacies. They are not allowed to sell to end users or to practising physicians, as the distribution of medicines to the consumer is largely reserved for pharmacists. The wholesale trade of drugs and pharmaceuticals requires an official licence. There are a large number of legal provisions which apply to wholesalers, which either directly affect their operations (for example trade regulations, Medicines Act) or have an indirect effect on their finances (the Prices Act, for example).

Standards for medical and nursing care

University training has also been recently reformed. The medical universities were outsourced and university fees were introduced. The issuing of degree course syllabuses is now no longer the direct responsibility of the Federal Ministry of Education, Science and Culture. The Ministry of Health is responsible for enacting regulations for the training of health professionals with the exception of physicians. Matters referring to postgraduate training are regulated by the Physicians' Act and in the physicians' training regulations.

When the University Act 2002 (Federal Law Gazette I No. 120/2002) came into full effect in its currently valid form on 1 January 2004, the medical universities of Vienna, Graz and Innsbruck were established as the legal successors of the medical faculties of the universities Vienna, Graz and Innsbruck. Medical universities thus acquired full legal capacity, enabling them as self-governing institutions to enter into legal transactions.

The University Studies Act of August 1997 had already fundamentally changed the legal framework for the overall conditions for study at Austrian universities. In the course of a maximum of five years, the individual universities had to autonomously draw up new degree course syllabuses, which have formed the legal basis for the respective courses since coming into force. Following international developments, the structure of the new syllabuses is in line with the guidelines for subject integration, problem orientation, the calculation of education and training capacities as well as evaluation and quality control. As an integral component, the syllabuses contain a qualification profile for medical graduates which describes the intellectual, practical and attitude-related abilities which the graduate has to have in order to begin postgraduate training. Since the University Act came into effect in 2002, the responsibility for changes to degree course syllabuses has been held exclusively by the individual universities.

Membership of the EU has brought about a number of new regulations in the field of medical training. The harmonization of training and mutual recognition represent the main aspects of these new regulations. Access to postgraduate training in Austria is also open to citizens from the European Economic Area (EEA) if the applicant has completed an appropriate degree.

The newly created syllabus for degrees in dental medicine came into effect at the medical faculties of the universities of Vienna, Graz and Innsbruck in the academic year 1998/1999. This degree, with a duration of 12 semesters, includes a period of practical training lasting 72 weeks. In order to practise as a dentist, graduates of this course require no further postgraduate training.

In order to make allowances for the future significance of nursing and long-term care services in the health care system, a new law on health care and long-term care was adopted. For the first time, the independent work of qualified nurses was specified in law, and the aspect of health care was introduced on a statutory basis. EU membership also brought changes for the training of midwives and for the exercise of their profession. The main points of the new law were the extension of training to three years and its raising to a post-secondary school training level, the extension of midwives' area of activity to providing comprehensive care in the areas of pregnancy, birth and immediate postnatal care, the lifting of the state's training monopoly and the abolition of the previous division of the profession into three parts.

For the academic year 2004/2005, the Medical University of Graz in cooperation with the University of Graz introduced a syllabus for the degree course Nursing Care Sciences (bachelor's degree). At the University of Vienna, a separate Nursing Care Sciences degree is also being offered. As of July 2005, it has been possible to complete training for higher medical-technical services staff and for midwives within the framework of bachelor's degree courses at polytechnics (*Fachhochschulen*). In order to ensure uniform quality standards for training, minimum requirements have been defined in a decree, particularly for practical training. This training decree was adopted in 2005 (Federal Act on the Change of the Medical-Technical Services Act and the Midwives' Act, Federal Law Gazette I No. 70/2005, July 2005).

Since the academic year 2001/2002, both domestic students and those from EU countries and EEA countries have had to pay course fees of €363.36 per semester. Students from non-EU/non-EEA countries have to pay course fees of twice this amount. For health professions apart from physicians, access is limited depending on the subject; this limitation takes the form of entrance examinations and available capacity. Indirect market barriers for physicians are also created by the waiting list for specialist training places, but also with regard to the award of contracts with the health insurance funds.

Owing to a verdict of the European Court of Justice of 7 July 2005 (Federal Law Gazette I No. 77/2005), universities were authorized to restrict access to selected degree courses (including medicine) to cope with the increasing demand of students from Germany where admission to these courses has been limited based on country-wide minimum requirements for students' results in the school-leaving examination (*Numerus clausus*). The access restriction at Austrian universities may take the form of an admission procedure or the selection of students during a period of a maximum of two semesters after admission. This arrangement is initially valid from the winter semester 2005/2006 until and including the winter semester 2007/2008. The medical universities can now decide autonomously on their respective admission procedures.

In 1997, the Hospitals Working Hours Act was passed for physicians and other medical personnel in order to ensure compliance with EU provisions. Matters referring to this law are dealt with by the Federal Ministry of Economics and Labour (BMWA). Their implementation is the responsibility of the Länder.

Health promotion and prevention

In the form of the Healthy Austria Fund, the Federal Government has an institution which initiates and supports focused health promotion activities. Furthermore, the Federal Government also participates in international health

promotion networks, including the European network "health-promoting schools" the network "healthy cities", Mégapoles (involving capital cities of the EU Member States, a transnational network), the international network "health-promoting hospitals", the network to promote health in companies and the European network of national institutes for health promotion. As part of the Health Reform 2005, the BMGF additionally launched a new preventive care and early detection programme, and initiated the drawing up of health passes for different sections of the population (see Section 4.1 on public health services).

Länder level and local level

The Länder and local communities are responsible for the provision of hospitals and for maintaining their infrastructure. They are obliged to adhere to the framework legislation of the Federal Government and thus to nationwide planning and specifications. In addition, they regulate matters concerning the public health care system, which they mostly delegate to the local communities. They are also responsible for social assistance and partly for the award of long-term care benefit and for the financing and monitoring of training institutions for health professionals apart from physicians. They fulfil the role of supervisory authority for the physicians' chambers and for health insurance funds operating at federal level which do not exceed a certain number of insured people.

Their competencies with regard to the regulation of health care have been both increased and decreased by the introduction of the Health Reform Act 2005. They have been increased because organizational conditions have been created which allow them to play an important role in the structuring of regional health care provision. They could, however, be weakened by the comprehensive nationwide planning and quality specifications. The detailed plans for the Austrian Structural Plan for Health are still, however, being negotiated with the Länder. So final statements about the degree of regulatory powers held by the Länder can only be given at a later date.

State Health Funds and Health Platforms

The most important regulatory innovation at Länder level since 2005 deals with the establishment of Health Platforms as executive bodies of the respective State Health Funds (see Chapter 6 on health care reforms). The State Health Funds are to replace the Länder Funds, which have existed since 1997. They may relate to one Land but may also be established across several Länder.

Within the framework of the State Health Funds, the main task of the Health Platforms is to take part in the implementation and the monitoring of adherence to the planning and quality specifications for the provision of services in all sectors of the health care system. A priority here is the involvement in drawing up detailed plans for all the sectors of the regional health care system. In addition, payment flows should be made transparent by means of a description of the budget framework for public expenditure in both the inpatient and outpatient sectors.

In the Health Platform at Länder level, the Länder government and the social insurance institutions are equally represented, as is the Federal Government. In addition, other stakeholders are also members of the Health Platforms, such as representatives of the physicians' chambers, town/city councils, local communities and patients' representatives. Alongside the institutions mentioned, the owners of hospitals which are financed by the respective State Health Fund are also represented on the Health Platforms. The structure of the Health Platforms should improve the cooperation between the social insurance institutions and the Länder in providing health care. This requires agreement between these players in the designated areas of cooperation. In matters for which only the Länder are responsible, they have the majority. For issues concerning outpatient care, the social insurance institutions have the majority since they are responsible for securing care in this sector. A cooperation area (reform pool) is being established to provide financial support for shifts in services between inpatient care and outpatient care. This will account for 1–2% of the total funding for the hospital and outpatient sectors. The fixed budget which has been valid since 1997 and is mainly funded by health insurance contributions, covers around half of the costs of the public hospitals, which are mostly owned by the Länder. The regulations on the performance-related distribution of this funding differ considerably between the Länder. Differences relate not only to the allocation within the budget (see Table 5.6), but also to the regulations concerning the financing provided by the Länder (*Betriebsabgang*), which lacks transparency.

Hospitals

As hospital operating companies have by now been established in almost all the Länder, the management of public hospitals has been largely privatized. However, privatization has taken the form of formal or organizational privatizations and not of material privatizations. The hospital holding companies are organized in different ways, and are now hospital service providers, with the State Health Funds as their clients. In most cases, the Land is the majority owner. In this way, the separation of the previously integrated areas of service

provision and payment has been largely implemented. In addition, private non-profit-making and other private hospital owners have also increasingly formed operating companies, some of which are organized on a nationwide basis.

The sanitary supervision of hospitals is regulated by the Federal Hospitals Act. Within the framework of indirect federal administration, this activity is therefore the responsibility of the district administration and is carried out by district medical officers. The district administration has to take action on its own initiative, without having to be urged to do so by a higher authority such as the Land or the Federal Government. Supervision normally has to be carried out in all approved institutions, and without special grounds for doing so. This means not only general hospitals and special hospitals, but also convalescent homes, long-term care institutions, maternity hospitals and clinics, sanatoriums, all private hospitals and all institutions which are licensed as independent outpatient clinics (such as physiotherapy institutions, computer tomography/magnetic resonance imaging institutions, day clinics, outpatient clinics of health insurance funds, medico-diagnostic laboratories, institutes for reproductive medicine etc.). It is at the discretion of the district administration to decide in which intervals and with which intensity sanitary supervision is to take place. The BMGF has drawn up nationally valid check lists, which include the inspection of hospital hygiene, the inspection of nursing care in hospitals and recommendations for the inspection of quality work in hospitals. If deficiencies are established, the district administration has to report this to the state governor and demand their elimination.

Internal management in hospitals is usually carried out by a committee (with equal voting rights of the members). It consists of representatives of physicians, nurses and the management. According to the level of care provided, a representative of the technical staff is usually involved in this management committee. According to the KAKuG, the management committees also have to implement quality assurance measures. All decisions which affect ongoing operations have to be made on a cooperative basis. Management posts are advertised and filled either by the hospital operating companies or by the competent authorities.

The self-governmental level

Although the Länder governments, the Nationalrat and the Bundesrat have increasingly determined the direction of legislation involving the health care system since the end of the 1970s, and have initiated and implemented reforms, the outpatient care sector in Austria is characterized by a strong, decentralized and largely autonomous development of objectives. This autonomy, legitimized via self-governance, is also taken into consideration in the Health Reform

Act 2005. The social insurance institutions in cooperation with professional associations and statutory representative bodies intervene in the planning and regulation of health care provision by awarding contracts with health insurance funds and by paying physicians and other health service providers.

Social insurance

The obligation of the social insurance institutions to provide benefits and services arises from the provisions of social insurance law. In the Austrian health care system, there are three forms of relations between the health insurance funds and service providers.

- *Integrated*. A full integration of offers and payment can be found in the area of the health insurance funds' own outpatient clinics. In addition, social insurance institutions also operate hospitals with casualty departments, and cure and rehabilitation institutions.
- *Lump-sum payments*. In the area of inpatient care provision, the social insurance institutions make payments on the basis of agreements between the Länder and the Federal Government. These are annually adjusted according to the extent of the increase in contributions revenue. This affects both public hospitals and those private hospitals which effectively contribute to health care provision.
- *Provision of benefits in kind*. In outpatient care, general agreements are concluded between the health insurance funds and the representatives of professional associations. Services and fees are determined through negotiations. The health insurance funds and/or the HVSV have a collective monopoly of demand, while the professional associations have a collective monopoly of supply.

The management of the individual social insurance institutions is carried out via self-governing bodies which are composed of representatives of the social partners (see the introductory overview, Section 1.1). They are financed by health insurance contributions. These bodies have a considerable degree of autonomy within their legislative framework. In addition, legal provisions allow the institutions to play an active role in health policy.

In the search for cost-containment strategies, repeated attempts have been made in recent years to reform the organizational structures of the social insurance institutions. This was often accompanied – as can be observed throughout the EU – by proposals to weaken the self-governing bodies or the HVSV.

The relations between the health insurance funds and self-employed physicians are governed by general agreements. These are concluded for the

health insurance funds by the HVSV together with the regional physicians' chambers and require the agreement of the relevant fund. The involvement of the HVSV has the goal of structuring contracts for the entire statutory social health insurance system – as far as possible – according to uniform principles.

For the physicians, the locally responsible physicians' associations are the contracting parties for the general agreements. There is a Physicians' Chamber in each Land. The physicians' chambers are statutory interest groups. Every medical doctor who is authorized to practice in accordance with the Physicians' Act is automatically a member of this chamber. Important elements of these general agreements are the rights and duties of contracted physicians, who conclude individual contracts with the health insurance funds on the basis of these general agreements. Further contents are the regulations on fees, which contain detailed provisions on physicians' services and their payment. The general agreements also include the so-called location plan, which regulates the number and local distribution of contracted physicians.

There are also general agreements with physicians on the regulations governing preventive check-ups with physicians in private practice and for special services such as those in the field of occupational medicine. Clinical-psychological diagnosis services are regulated in a general agreement with the Association of Austrian Psychologists.

The provision of medicines is also ensured via a general agreement. This has to be concluded between the Austrian Pharmacists' Association and the HVSV (again with the agreement of the health insurance funds).

Social insurance law also provides for the conclusion of general agreements with "other contracting parties" (opticians, orthopaedic technicians, suppliers of medical devices and equipment, orthopaedic shoemakers, etc.). In practice, such general agreements are concluded between the HVSV and the competent guild of the Federal Economic Chamber. Alongside prices, it also regulates the delivery terms and the quality requirements for the respective therapeutic aids.

Contracts are negotiated directly between public and private hospitals and health insurance funds. The contents of these contracts are governed by the ASVG, the Federal Hospitals Act and the various hospital acts of the Länder (LKAG). Owing to the regulation of competencies in the Federal Constitution, the Länder have a mandate to provide care in the hospitals sector. This has to be fulfilled either by their own hospitals or by concluding contracts with the owners of other hospitals. The costs of investment and maintenance as well as part of the operating costs are paid by the Länder, the Federal Government and the owners. The basis for services are the health plans of the Federal Government (ÖKAP/GGP and the Austrian Structural Plan for Health) and the Länder plans.

Hospital services are reimbursed via the procedure and diagnosis orientated reimbursement system (Austrian DRG model) using lump sums of case groups, which are based on principal diagnoses and (single) medical service items (see Section 5.2 on payment of hospitals).

The Private Hospitals Financing Fund finances the services of private, profit-orientated hospitals according to nationwide performance-orientated principles. There are 45 hospitals which belong to this fund. The legal basis of the Private Hospitals Financing Fund is provided on the one hand by the ASVG and the Private Hospitals Financing Fund Law, and on the other hand by a general agreement between the Economic Chamber and the HVSV as well as a contract between the latter and the Private Hospitals Financing Fund. The Fund receives a total of around €72.67 million per year from the health insurance funds. With this payment, all services in the inpatient and day clinic sectors including services resulting from medical progress are reimbursed. The distribution of the raising of funding among the individual health insurance funds is provisionally carried out according to a ratio formula which is based on the expenditure which was made on the respective hospitals in 1999. From 2005, the Private Hospitals Financing Fund will receive an amount of €76.32 million. This amount will be increased in the following years according to the increase of social health insurance revenues from contributions.

Direct supervision of the individual insurance funds is the responsibility of the relevant state governor if the area of activity of the insurance fund does not extend over more than one Land (in the case of health insurance funds only if they have more than 400 000 insured individuals). For all other insurance funds and the HVSV, the BMSG and the BMGF are the highest supervisory authorities. The highest supervisory authority for pension insurance institutions is the BMSG. The Minister of Finance can send a representative to the meetings of the administrative body of the pension insurance funds and the HVSV in order to safeguard the financial interests of the Federal Government. The supervisory authorities have the task of monitoring the financial management of the insurance institutions (and the HVSV). They can extend their supervision to issues of expediency and in exercising their right of supervision they can reverse decisions made by the administrative body. The HVSV thus has three supervisory authorities.

Service providers

Treatment by physicians within the framework of the social insurance system is predominantly carried out by "contracted physicians". Around three quarters of all physicians in private practice have a contractual relationship with social insurance institutions. General agreements which are concluded between the

HVSV and the Austrian Physicians' Chamber form the basis for the provision and the payment of physicians' services by the social insurance system. Individual contracts are concluded between individual physicians and the social insurance institutions; however, their contents are largely determined by the general agreements.

In order to monitor the provision of outpatient services, the organizational structure of the health insurance funds provides for the function of "head physicians" (supervising physicians). All services whose utilization is not or not yet contractually established are subject to the authorization of a head physician. They can be authorized by the head physician if appropriate and necessary on medical grounds (*medical indication*) and if they are among the legally specified range of services. In addition, head physicians have the function of monitoring the prescribing habits of contracted physicians, and arranging for audits if they deviate a great deal from the norm. The use of resources in the outpatient sector is thus subject to monitoring by the health insurance funds.

Fund contracts with physicians are awarded according to a "staffing plan" agreed between the regional health insurance fund and the Physicians' Chamber at Länder level. Alongside the number and local distribution of contracted physicians, the staffing plan also regulates their specialties. In the meantime, there are group practices in line with legislation on physicians, and there are legal provisions on the conclusion of contracts with group practices. While the staffing plan is drawn up on the basis of the existing medical care in hospitals in the catchment area, sociodemographic factors are also taken into consideration. The selective award of contracts together with fee negotiations leads to an overall control of the use of resources in the outpatient sector.

In cooperation with its associations at Länder level, the Austrian Physicians' Chamber administers the applications of physicians to exercise their profession and maintains a list of authorized physicians. A physician may only start working after registering on this list. Every physician who is authorized to carry out his/her profession can open a practice (freedom of establishment). The number of inhabitants per medical doctor varies considerably depending on the area of Austria in question (see Section 4.3 on outpatient health care). These variations are, however, significantly smaller in the field of care provision by contracted physicians. Practices in remote rural areas occasionally remain vacant, even though health insurance fund contracts would be available. In addition, there are considerable differences in the fees paid in different Länder. Whereas in Vorarlberg, for example, the distribution of funding for care provided by general practitioners and specialists has largely been delegated to the physician chambers, service providers in other Länder are reimbursed directly by the health insurance funds (see Section 5.3 on payment of physicians).

In 2004, the Austrian Physicians' Chamber established a quality assurance company (Quality Assurance & Quality Management in Medicine GmbH) on the basis of an amendment to the Physicians' Act. This company is currently working on the development of a decree on quality standards for physicians and dentists in private practice. The Austrian Physicians' Chamber will make these standards binding for five years at a time via a decree which requires the approval of the BMGF.

The main tasks of the Pharmacists' Association are training and further training, monitoring the fulfilment of professional obligations (disciplinary law), providing advice on all legal matters, issues regarding hospital pharmacies, combating unfair competition, and the regulations concerning night and on-call services.

The level of regulation in the Austrian pharmacy market is very high compared to other EU countries *(37).* In 1998, the licensing process for pharmacies was relaxed in line with EU regulations. This means that the licences of surgery pharmacies run by physicians will expire if a public pharmacy is opened in the same region. There was strong opposition to these regulations on the part of the Physicians' Chamber, and an interim solution was reached which led to a 10-year transitional arrangement for physicians who already had a surgery pharmacy before 1998. A verdict of the Constitutional Court quashed this arrangement as unconstitutional. In 2001, the Physicians' Chamber and the Pharmacists' Association reached a compromise: in-surgery pharmacies could be continued for a period of three years. A new public pharmacy could be opened if it was located not less than 4 km from the in-surgery pharmacy, and if not less than 5500 people would be supplied by it. If there was no in-surgery pharmacy in a certain region, a public pharmacy could be opened at any time.

The Pharmaceutical Salary Fund for Austria based in Vienna is a public body established as a nationwide social and economic institution for Austrian pharmacists. It was legally established in 1921 and forms an administrative unit together with the Austrian Pharmacists' Association. The membership of all of its committees is equally divided among representatives of employed and self-employed pharmacists. The joint administration with the Austrian Pharmacists' Association is revealed (among other things) by the fact that the delegates' meeting as the highest committee of the Pharmaceutical Salary Fund is made up of the same people as the delegates' meeting of the Austrian Pharmacists' Association.

The statutory responsibilities of the Pharmaceutical Salary Fund cover three main focuses. First, the Pharmaceutical Salary Fund is responsible for the calculation and payment of the salaries of all pharmacists who work in a public pharmacy or a hospital pharmacy on the basis of a contract of employment.

The second important task of the Pharmaceutical Salary Fund is the settlement of health insurance fund prescriptions between pharmacists and the social insurance institutions. It acts as a statutory clearing house in order to save pharmacies the trouble of having to separately invoice such a large number of cost units. Its third main task extends from acting as an employment agency via various support services to the provision of an additional old-age pension scheme; the financial aspects of all of which are settled via the Welfare and Support Fund. This is funded from membership fees of both employed and self-employed pharmacists. The bulk of the benefits of the fund (70% of total expenditure), however, are accounted for by subsidies towards the statutory pensions of former employed pharmacists *(38).*

Patients' rights

Patients' rights were first addressed in Austrian law in 1993 in an amendment to the Federal Hospitals Act (KAKuG). However, patients' rights are also established in numerous laws for various health professions (Physicians' Act, Nursing Act (GuKG), Midwives' Act, etc.) as professional obligations, as well as in the different administrative laws such as the Federal Hospitals Act, Medicines Act, Medicinal Products Act, etc. Patients' rights were summarized in a Patients' Charter in 1991 (Federal Law Gazette I 1999/195).

The generally valid and recognized patients' rights were divided into six main groups.

1. The right to health care and equal access to treatment and nursing care:
   - the right to equal access to medical treatment and qualified nursing care.
2. The right of patients to consideration for their dignity and to freedom from bodily harm:
   - the right to dignified and careful treatment and nursing care
   - the right to privacy
   - the right to medical confidentiality, discretion and secrecy.
3. The right to self-determination:
   - the right to agree to or refuse treatment
   - the right to freely choose physicians
   - the right to participation
   - the right to a dignified death
   - the right to alternative medical treatment.

4. The right to sufficient information from physicians and other medical information:
   - the right to medical explanations, physicians' duty to inform patients of possible risks of treatment;
   - the patients' right to view their medical records and obtain a copy of them.
5. The right to appropriate medical treatment:
   - the right to proper treatment
   - the right to follow-up treatment
6. The right to support for the patient from an independent patients' representative who is not subject to directives.

This charter is an agreement which was concluded between the Federal Government and the Länder (similar agreements have been concluded with all the Länder, until now except Vienna and Salzburg; the ratification process with Vienna is being conducted). However, patients' ombudsmen's offices have been established in law in all the Länder. Patients' ombudsmen are not subject to directives; they have to pursue complaints about deficiencies and are obliged to provide information and advice.

2.3 Decentralization of the health care system

The regulatory framework of the Austrian health care system consists largely of regionalization as part of the federalist structure and a delegation of competencies to statutorily legitimized actors of civil society. The fulfilment of tasks by regionally active federal authorities is practically non-existent in the Austrian health care system. Certain tasks are delegated to the Länder according to constitutional law (devolution, regionalization). Social insurance law delegates certain functions to the social insurance institutions and service provider organizations which are also organized at regional level. In the last few years there have also increasingly been privatizations, mainly in the form of the privatization of organizational tasks in the hospitals sector.

The health care system in Austria, which until recently showed strong characteristics of integrated care provision, particularly in the hospitals sector, has now developed almost completely into a supply model which is mainly based on decentralized contracts with all service providers. In the outpatient sector, these contract relationships are almost exclusively shaped by the health insurance funds and private service providers. In the inpatient sector, on the other hand, the scope of services and financing is regulated in the form of agreements

according to Federal Constitution Article 15a and the laws implementing this agreement.

In the following subsections, the decision-making competencies and responsibilities in the financing of the public health care system as well as the blend of public and private financing of service provision are described in more detail.

Decision-making and financing competencies

The Federal Constitution provides for the implementation of federal issues in the Länder either via the Federal Government's own authorities (direct federal administration) or via the state governor and the Länder authorities under his or her control (indirect federal administration). Within the framework of indirect federal administration, the Federal Government delegates the tasks of administering the health system to the Länder. In direct federal administration, the public health service carries out tasks under public law including the related investigative activities such as sanitary and hygienic supervision. The financial adjustment between the Federal Government, the Länder and local government has great significance in this context. The basis for the sharing of tax sovereignty is the Constitutional Law on Finance of 1948. Characteristic for financial adjustment in Austria is the management of tax revenue, which means that the most important taxes are established and collected by the Federal Government, but the revenue is divided up among all the regional bodies according to a different ratio formula. The specific division of tax revenue is carried out according to the Financial Adjustment Act, which establishes its distribution for several years at a time (see Section 1.2 on historical background).

Legislation and its implementation in the social insurance system are the responsibility of the Federal Government. The enforcement of social insurance laws is delegated to the social insurance institutions. There is a marked regionalization within the social insurance system. Here, the HVSV has the role of safeguarding uniform national structures. In addition, regional and structural differences are balanced via an equalization fund (see Section 3.1 on main system of financing and coverage). Although income is set at federal government level, the individual health insurance funds possess sovereignty with regard to revenue from contributions.

In the hospitals sector, a basic law is set by the Federal Government; the implementation legislation and enforcement is carried out by the Länder, which finance around half of the costs of hospitals from tax revenue, including capital costs (see Section 5.2 on payment of hospitals). The fragmentation of competencies – particularly in the hospital sector – and the resulting "dual"

financing have long been considered the most important structural problem in the Austrian health care system. In this context, a centralization of competencies has often been demanded, which is also reflected in the discussions at the Austrian Constitutional Conference *(39)*. The creation of the State Health Funds to deal with hospital financing, which accompanied the 1997 Health Reform, was, however, a further step towards decentralization in the sense of a delegation of tasks.

The Health Reform 2005 follows up this development (see Chapter 6 on health care reforms). If it is implemented as planned, however, the room for manoeuvre of the regional bodies with regard to the vertically defined extent and quality of care provision will become smaller. However, the Länder gain more horizontal autonomy, because organizational conditions have been created in the form of the Health Platforms which make it possible both to coordinate the supply chain within a region as well as to enter into supraregional cooperation schemes.

The privatization of hospital operations carried out in almost all the Länder can also contribute to this, because the hospital operating companies will, within the framework of their contractual tasks, look for possibilities to not only implement the Länders' mandate to provide health care, but to also realize specializations and to look out for cost-containing supraregional cooperation opportunities.

There is a delegation of tasks in the area of emergency care provision and social services. The responsible Länder authorities generally delegate the provision of social services to welfare associations.

Table 2.1 summarizes the decision-making competencies and differentiates them according to the most important sectors of the health care system. This portrayal is based on a well-established system in EU countries, which alongside ensuring access to services and benefits also guarantees the quality of care and financing of the health sector in a sustainable way (*40*). In order to illustrate the decision-making competencies in the Austrian health care system concisely, these targets were modified and extended to include the aspect of the reimbursement of services. As access to health care and the choice of provider is basically unrestricted from the patients' perspective, decision-making competence with regard to provision of services is relevant.

In the outpatient sector, but also in rehabilitation and in the medicines sector, decision-making competencies on financing and the provision of services (being integrated in some cases) have been delegated to the social insurance system. Leaving aside the training tasks of the regional authorities, decision-making and regulatory competencies in the outpatient sector are most distinct in the case of the social insurance institutions. This is also true for the medicines

sector, although the regulatory competencies of the Federal Government are considerable in this sector.

In the inpatient sector, the regional authorities are very influential in both planning and regulatory matters, whereby the Länder competencies are laid down by the Federal Constitution. In direct federal administration, the levels of review normally proceed from the district administration (chief officer of local government) to the state governor.

Since the negotiations on per diem payments between health insurance funds and hospital owners for recurring expenditures were dropped, and since the funding of the health insurance funds is budgeted, the planning and regulatory powers of the social insurance institutions – which were relatively limited anyway – have become marginal in the hospital sector. The Health Reform 2005 seeks to tackle this deficit in connection with the cost-containment efforts in the inpatient sector by creating the organizational conditions to encourage cooperation at the interface between the hospital sector and the outpatient sector.

In the areas of health promotion and prevention, tasks are divided and partly delegated to the social insurance institutions. With a few exceptions, health promotion and prevention are not mandatory services for the social insurance institutions. Public health service activities are delegated to the Länder, which in turn devolved these tasks to the local authorities.

The payment of money transfers to needy people is the responsibility of the Federal Government, but legal provisions in this area also stipulate that the tasks which are delegated to the Länder are fulfilled within the framework of the specifications of federal law. Like public health services, these tasks are financed by tax revenue, although in contrast to public health services the funding for federal long-term care benefit is not from value-added tax or the financial adjustment, but from the federal government budget.

Public–private mix of financing and delivery

As in almost all social insurance countries, the Austrian health care system is characterized by a mixture of public and private financing and services/benefits provision. Table 2.2 illustrates this for the year 2003. Hospital care is publicly financed and provided by hospitals essentially owned by public authorities,[7] which accounts for 48.6% of the (expenditure on) services, whereby this also includes outpatient services in hospital outpatient departments and outpatient clinics. A fifth of the expenditure on services comes from private sources,

[7] Hospital operating companies are viewed here as representatives of the public financing body.

Table 2.1 Decision-making competencies and public financing according to service areas in the health care system, 2005

Public financing	in % of public health expenditure[a]	Service areas	Provision	Quality assurance	Reimbursement
Contributions to social health insurance	19.3	*General practitioners in private practice and specialists, dentists* *Other health professions, outpatient clinics*	Regionalized[e] and delegated to the health insurance funds; scope for voluntary benefits from health insurance; partly integrated care provision.	Federal legislation, professional associations with the involvement of health insurance funds.	Delegated to health insurance funds, general agreements determine individual contracts.
	11.0	*(Medicines) therapeutic aids*	Regionalized and delegated to the health insurance funds for medicines with obligatory cost reimbursement	Federal legislation, federal competencies in the licensing of medicines and pharmaco-vigilance; prescription controls delegated to social insurance institutions.[d]	Delegated to health insurance funds: reimbursement; price negotiations carried out centrally by the Federation of Social Insurance Institutions; establishment of the average EU prices (price upper limit): federal government competence.
	1.2[b]	*Rehabilitation*	Delegated to the social insurance institutions; partly integrated care provision	Federal legislation	Delegated to health insurance funds
Contributions: 40% Tax revenue: 60%	41.1	*Hospitals including outpatient departments*	Regionalized; Länder responsible based on the Federal Constitution and KAKAuG; delegated to the social insurance institutions for work accidents and integrated care provision.	Specifications in federal and Länder laws; sanitary supervision through the federal government; licensing of hospitals by Länder.	Ongoing operations: regionalized and delegated to regionally organized funds; decentralized mechanisms for dividing up funding to hospitals (lump sums of a case group); subsidies and investments: regionalized; Länder and/or funds responsible.
	0.9	*Health promotion, prevention*	Federal and Länder competencies; partly delegated to social insurance institutions.	Federal legislation; Healthy Austria Fund; partly devolved to Länder and delegated to social insurance institutions.[d]	Partly delegated to the regional health insurance funds; general agreements.

Table 2.1 (cont.)

Public financing	in % of public health expenditure	Service areas	Provision	Quality assurance	Reimbursement
Tax revenue	18.3[c]	*Public health service (for example medical officer service, social services, environmental medicine)*	Federal, Länder and local competencies.	Federal and Länder legislation; largely delegated to the Länder with regard to organization; further devolved to local authorities.	Devolved to the Länder; further delegated to municipalities (municipal public health service).
	8.3	*Long-term care*	Länder competency; private-sector providers; family members (informal care).	Länder legislation for nursing homes,	Decentralized award of nationally uniform, means-tested cash transfers (long-term care benefit) via the pension insurance institutions.

Source: IHS HealthEcon 2005 (http://www.ihs.ac.at).

Notes: KAKAuG: Federal Hospitals Act; [a] including federal long-term care (cash) benefits (data for 2003); [b] only medical rehabilitation in health insurance; [c] including the expenditure of the Länder for health promotion; [d] health promotion and prevention strategy of the Austrian social insurance institutions 2005–2010; [e] regional: at Länder level.

but is provided in public institutions (21%); the provision of medical care by physicians without fund contracts also forms part of this share. A proportion of around 9% is privately financed and privately provided; this mainly covers services which are not included in the catalogue of publicly provided health services. On the other hand, most services of general practitioners and specialists are publicly financed but privately provided; this accounts for around 22% of the expenditure on health services.

Table 2.2 Public–private mix of financing and delivery, in % of total health expenditure, 2003

		by sources of finance		
		public	**private**	**total**
by type of provider	public	48.6	20.7	69.4
	private	21.5	9.2	30.6
	Total	**70.1**	**29.9**	**100.0**

Sources: Federal Ministry of Health and Women, 2005; Federation of Austrian Social Insurance Institutions, 2004 *(41)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

3 Health care financing and expenditure

In accordance with the tasks defined by the constitutional and social insurance laws, the financing of health care expenditure is pluralistic. Social health insurance, which covers the risk of illness of around 98% of the population, is the most important source of financing. It financed 45% of health care expenditure in 2004. Including the expenditure for long-term care (7.7%), 25% was financed from general tax revenue. Including the expenditure on private health insurance, private households financed 25% of health expenditure (Table 3.1).

Investments are mainly financed by public bodies, but have largely been subsumed under private investments from 1997: the majority of investments are made in public hospitals whose operation has been increasingly handed over to private hospital operating companies. Since 2001 all public hospitals are regarded as "private" regardless of operator status.

Private expenditure particularly includes all direct and indirect cost-sharing (see Table 3.1). Payments by private households for inpatient services, which account for the majority of indirect cost-sharing (53%), amounted to €1.6 million in 2004. Of this, around three quarters is payments for "special class" services, the remainder is accounted for by hospital cost contributions (see Table 5.1 and Section 5.3 on payment of physicians).

The proportion of health expenditure which is financed via general tax revenue increased most between 1995 and 2004, by 3.5 percentage points from 21.5% to 25.1%. This increasing trend is primarily due to the contradictory "budget discipline" in hospital financing. Whereas the budget for public hospitals (which alongside funding from social health insurance is financed by value-added tax revenue) has hardly increased in recent years, the expenditure

Table 3.1 Financing sources as a percentage of total health expenditure,[a] 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Taxes	21.5	21.3	22.5	23.3	22.4	22.3	23.8	24.3	24.7	25.1
– for long-term care	9.7	9.0	8.7	8.4	8.4	8.3	8.2	8.1	8.0	7.7
Social health insurance	44.7	43.6	45.3	44.4	45.4	45.6	45.3	45.8	45.3	45.3
Public	**66.2**	**64.9**	**67.8**	**67.6**	**67.8**	**67.8**	**69.1**	**70.1**	**70.0**	**70.4**
Private health insurance	3.6	3.6	3.3	3.9	3.7	3.9	2.8	2.3	2.3	2.4
Indirect cost-sharing[b]	14.6	14.5	14.7	14.5	14.1	14.1	13.8	13.7	13.6	13.5
Direct cost-sharing[c]	6.5	6.5	6.8	6.9	7.1	7.3	7.7	7.7	7.9	7.6
Private non-profit organizations[d]	3.9	3.9	1.4	1.3	1.3	1.4	1.4	1.4	1.4	1.4
Employers[e]	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
Private	**28.8**	**28.7**	**26.3**	**26.8**	**26.4**	**26.8**	**25.9**	**25.4**	**25.4**	**25.0**
Investments	**5.0**	**6.4**	**5.9**	**5.5**	**5.7**	**5.3**	**5.0**	**4.6**	**4.6**	**4.6**
Total health expenditure[a]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Sources: Statistics Austria, February 2006; Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon calculations, 2006 (http://www.ihs.ac.at).

Notes: [a] OECD System of Health Accounts; [b] defined as out-of-pocket payments of private households (here: including private insurance benefits in the inpatient sector). [c] defined as co-payments of private households for benefits covered by social health insurance; [d] expenditure of private non-profit hospitals, paramedical ambulance services and other non-profit organizations; [e] for occupational health services.

of the hospital owners has risen significantly (see Table 5.1). The financing of hospital expenditure by the Länder and local authorities is carried out with general tax revenue, which is distributed according to the logic of the financial adjustment between the Federal Government and the Länder (see Section 5.1 on third-party budget setting and the allocation of resources).

The share of financing of social health insurance has also increased slightly (0.6 percentage points). However, this increase only makes a small contribution to the growth of the proportion of public expenditure (+4.2 points). The total proportion which private households contribute to financing fell between 1995 and 2004 (-3.8 points), however, the amount which was raised by direct cost-sharing increased (1.1 percentage points).

3.1 Main system of finance and coverage

There are a total of 24 social insurance institutions in Austria, of which 21 are health insurance funds. With a few exceptions, membership of a health insurance fund is mandatory and is based on belonging to an occupational group. The social insurance institutions are structured either regionally or according to occupational groups (miners, the self-employed, farmers, railway workers, civil servants) or groups of individuals (wage earners and salary earners, farmers, civil servants, etc.). The largest funds are the pension insurance institution for wage and salary earners, the nine State Health Funds in the individual Länder (for employees except civil servants) and the General Work Accident Insurance Institute as the central institution for work accident insurance (for the self-employed, schoolchildren and students and employees (without civil servants)).

Apart from these there are two social insurance institutions for the self-employed (for trade, commerce and industry, and for farmers). Health and work accident insurance for most civil servants is also administered by a separate insurance institution. Furthermore, there are eight company health insurance funds (merger of Donawitz and Kindberg as of 1 January 2006) and the Insurance Institute for Railways and Mining. Every recipient of benefits from unemployment insurance is also automatically covered by health insurance and is fully entitled to benefits in kind and cash benefits.

77.0% are insured according to the ASVG, 8.5% in the civil servants' health and work accident insurance scheme, 6.8% in the scheme for the self-employed and 4.6% in the farmers' social insurance institution (Table 3.2). Each recipient of unemployment benefits automatically has social health insurance and has all rights of acess to in-kind benefits and cash benefits.

The insurance contributions for health insurance funds amount to between 7.1% and 9.1% of the contribution base, whereby there is a ceiling on insurable earnings (Table 3.3). Besides differences in the risk structure of their insured individuals, these variations are mostly due to differences in the catalogues of benefits and services of the individual insurance funds, which have their roots in the beginnings of the social insurance system (see Section 1.2 on historical background). In the case of employees, half of the contributions are paid by the employees and half by the employer. In the insurance institution for public employees, for every two people paying contributions there is one co-insured person; the total contribution ratio is 70%.

Health insurance funds collect revenue-related contributions and are responsible for the settlement of health care services including the payment of service providers in the primary and partly in the tertiary sectors. In the health

Table 3.2 Social health insurance funds and their membership, 2003

	Health insurance funds	Proportion of people with health insurance (as % of all insured)		
	Number	Entitled insured	Contributors	Persons aged 65+
Regional health insurance funds	9	75.9	77.3	67.1
Company health insurance funds	8	0.8	0.8	1.6
Insurance institution for public sector employees	1	8.5	7.6	9.7
Insurance institution for railways and mining	1	3.4	3.2	6.5
Insurance institution for the self-employed	1	6.8	6.7	6.6
Insurance institution for farmers	1	4.6	4.5	8.6
Total	**21**	**100.0**	**100.0**	**100.0**

Sources: Federation of Austrian Social Insurance Institutions, 2004 *(41)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

insurance sector, benefits in kind are mostly provided, and in most cases a payment has been established with the service providers on a contract basis.

The utilization and the extent of health services provided by the social health insurance system are basically independent of contributions. Alongside benefits in kind there are also cash benefits. Insurance cover becomes effective for those directly insured, their family members and children, either as a result of illness, owing to inability to work because of illness, as a result of motherhood and when preventive care services are used. On average, there are two insured people for every co-insured person (Table 3.2).

The basis for granting comprehensive insurance cover is the concept of illness as defined in the legal provisions for social insurance. This is orientated towards a scientific and curative approach to medicine. It states that a person's "health, ability to work and to meet essential personal needs should be restored, consolidated or improved if possible". The concept of illness is similarly defined in the private insurance sector. Any person who feels ill is entitled to medical care, without there necessarily having to be any visible signs. The offer of preventive check-ups is explicitly addressed towards those who are not ill. In addition, benefits in kind and cash benefits are granted for the treatment of work accidents and occupational diseases.

There is no competition between the health insurance funds, because insurance is entered into through the legally defined principle of mandatory insurance.

The funds therefore cannot choose their members via risk selection, nor can the members choose between different funds; however, certain occupational groups can opt out. The individual institutions have a fair degree of autonomy regarding their administrative procedures. There are differences between the individual funds with regard to innovative health management including the proactive information procurement on consumption and regular documentation of consumption on the part of both patients as well as contracting parties.

Against payment of the monthly, mandatory health insurance contribution, insured indiciduals receive a legal right to treatments stipulated in the current version of the general social insurance laws. This is based on the concept of illness defined in the ASVG. Contributions are regulated by law and thus cannot be freely set by the health insurance funds. Changes to the contribution rates are the responsibility of national health policy-makers. The contributions are collected and administered by the health insurance funds themselves.

Health insurance coverage

Coverage according to the General Social Security Act

The General Social Security Act (ASVG) is applicable to around 80% of the Austrian population. This group is essentially made up of wage and salary earners (Table 3.3). Outpatient care is largely provided according to the benefits-in-kind principle. Direct cost-sharing applies for a range of services (see Section 3.3 on complementary sources of finance). Employees in so-called marginal part-time work (with a monthly income below a certain ceiling) can choose to opt in, that is to pay voluntary social insurance contributions (see Chapter 2 on organizational structure and management).

As contributions are tied to income levels, contribution amounts paid are progressive up to the ceiling on insurable earnings. In 2005, the ceiling on insurable earnings was between €3630 and €4235, differing according to the respective fund. In social health insurance for employees, which is based on the ASVG, half of the contributions are paid by the employees themselves, and half by their employers (Table 3.3).

Civil servants

Health insurance for civil servants is also based on the benefits-in-kind principle; in outpatient physician care, this also includes a 20% co-payment for services. In the case of lower incomes, the co-payments can be waived upon application. The charging of co-payments can also be waived in the case of infectious diseases and in the event of catastrophes.

Table 3.3 Contribution rates in the social insurance system, 2005

	Contribution rates				Insured	
	Total in % of gross income[a]	**Employer's share in %[b]**	**Employee's share in %[c]**	**Ceiling on monthly insurable earnings (€)**	**in % of all insured**	**Benefit coverage regulations**
Wage earners	7.50	3.55	3.95	3 630	36.3	Benefits in kind, cost-sharing
Salary earners	7.50	3.75	3.75	3 630	44.2	Benefits in kind, cost-sharing
Free service contracts (quasi freelancers) (ASVG)	7.10	3.50	3.60	3 630[e] 4 235[f]		Benefits in kind, cost-sharing
Active civil servants	7.70	3.60	4.10	3 630	7.8	Benefits in kind, cost-sharing 20% co-payment per billed physician service
Farmers	7.50	3.70	3.80	3 630[e]	3.7	according to ASVG since 1998
Self-employed	9.10			4 235[f]	8.0	Benefits in kind, cost-sharing 20% co-payment per billed physician service
Voluntarily insured students	7.40	half paid by federal government funding		571	–	
Other voluntarily insured	7.40	n.a.	n.a.	4 095	–	
Apprentices/ trainees[d]	7.50	3.55	3.95	n.a.	–	

Sources: Federation of Austrian Social Insurance Institutions *(42)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: n.a.: not applicable; ASVG: General Social Security Act; [a] Including 0.5% supplementary health insurance contribution, half of which is paid by the employer and half by the employee; [b] Salary earners: including 0.1% supplementary contribution from the employer to finance health insurance for apprentices/trainees; civil servants: including 0.4% supplementary payment from the employer for extended treatment; [c] including 0.1% supplementary contribution by the employer to finance work accident-related services in health insurance; [d] except apprentices/ trainees in agriculture, forestry and hunting; [e] special payments agreed; [f] no special payments agreed.

Farmers

A government resolution in 1997 stipulated that the relevant fee schedules of the regional health insurance funds (ASVG) should also be applied to farmers. People insured with the social insurance institution for farmers are entitled to medical treatment as a benefit in kind as of July 1998. This ended the previous situation where farmers were required to pay for treatment in advance and then apply for reimbursement. Not only the fee schedules, but also the general agreements of the regional health insurance funds apply to those insured with the farmer's health insurance fund, so that the benefits-in-kind system which applies to regional health insurance fund members is now valid for farmers.

The self-employed

Social health insurance for the self-employed in trade, industry and commerce is based on the principle of benefits in kind and provides for co-payments of 20% per service. If a certain income level is exceeded, the insured individuals are also entitled to cash benefits. In addition, the law provides the insurance funds with room for manoeuvre in that they can plan various options into their statutes, ranging from entitlement to benefits in kind to cash benefits; accordingly, the insured can – against payment of an additional amount stipulated in the statutes – receive entitlement to cash benefits for all services or only for care in institutions, or they can, as individuals entitled to cash benefits, claim benefits in kind.

Asylum seekers

Asylum seekers who have been admitted to the federal care system are included in social health insurance if they are resident in Austria and are not already subject to mandatory insurance according to other legal provisions in the health insurance system. The federal care system has now been replaced by the "basic care system for foreigners in need of assistance and protection" based on an agreement according to Federal Constitution Article 15a between the Federal Government and the Länder. The contributions for the year 2005 were €60.69 per month and were to be paid by the Federal Government or by the Land providing the care.

Insured people in health welfare institutions

Health and work accident insurance for employees in public bodies is governed by the Act on Civil Servants' Health Insurance and Work Accident Insurance

(B-KUVG). Its legal provisions include a list of exceptions from mandatory insurance in health and accident insurance. Accordingly, the body which provides health insurance to civil servants can also be closely related to the authority employing them, which leads to the fact that alongside the insurance institute for public servants there are 17 other health welfare institutions (KFAs) (and work accident welfare institutions) for civil servants at Länder and local authority level (Table 3.4). These KFAs are not social insurance institutions, do not belong to the HVSV and are not subject to federal government supervision.

According to a survey from 1999, the 17 KFAs provided insurance cover for 204 003 people *(43)*. 120 130 of these people are main insured individuals who pay contributions to the fund of their health welfare institution. The remaining 83 873 individuals are family members who pay no contributions but are fully covered. The largest KFA with 112 509 people (around 55%) is the health welfare institute for employees of the City of Vienna. The health welfare institution of civil servants in the municipality of Hallein has the smallest number of insured individuals. The only KFA which also owns a hospital (the Hera Sanatorium) with an outpatient department is the KFA Vienna. In addition, the health welfare institution of the employees of the City of Vienna also operates three outpatient clinics and two convalescent homes. According to estimates, the expenditure of the KFAs in 1999 amounted to €300 million. Around 90% of expenditure was covered by contributions from insured individuals. Around 3% of revenue is accounted for by co-payments and prescription fees, approximately 1% by income by assets and approximately 5% by other types of income.

Risk structure compensation

Membership of an occupational group or belonging to a certain region leads to different contents of the benefits catalogues of the health insurance funds and thus to varying contribution rates and cost-sharing. The risk structures and age structures of health insurance funds also differ considerably. Whereas regional health authorities cover the smallest proportion of family members including children, there is one dependant for every two insured people in the insurance institution for public employees. This proportion is similar in the insurance institution for railway workers and mining (see Table 3.2).

As a proportion of total social insurance contributions,[8] health insurance contributions account for around 27%.[9] Whereas social insurance contributions in 2003 were around five times higher than in 1976, the expenditure of the social

[8] Employees' and employers' contributions.
[9] Statistics Austria: tax revenue in Austria according to ESNA 95 actual social security contributions.

Table 3.4 Health welfare institutions for civil servants by Land, 2005

Land	Number	Name
Burgenland	–	–
Carinthia	1	Civil Servants' Health Welfare Institution of the City of Villach
Lower Austria	1	Civil Servants' Health Welfare Institution of the Municipality of Baden
Upper Austria	6	Civil Servants' Health Welfare Institution of the Land's capital Linz
		Upper Austrian Local Civil Servants' Health Welfare
		Upper Austrian Land's Civil Servants' Health Welfare
		Upper Austrian Teachers' Health and Work Accident Institution
		Civil Servants' Health Welfare Institution of the City Council of Steyr
		Civil Servants' Health Welfare Institution of the City of Wels
Salzburg	2	Health Welfare Institution of City Council Civil Servants of the Land's capital Salzburg
		Civil Servants' Health Welfare Institution of the Municipality of Hallein
Styria	1	Civil Servants' Health Welfare Institution of the Land's capital Graz
Tyrol	4	Civil Servants' Health Welfare Institution of the Land's capital Innsbruck
		Tyrolean Land's Teachers' Health Welfare Institution
		Tyrolean Land's Civil Servants' Health Welfare Institution
		Tyrolean Local Civil Servants' Health Welfare Institution
Vorarlberg	1	Civil Servants' Health Welfare Institution of the Land's capital of Bregenz
Vienna	1	Health Welfare Institution of Employees of the City of Vienna
Austria	**17**	

Source: Federation of Austrian Social Insurance Institutions, 2005 *(44)*.

health insurance funds was six times the level of 1976. In the mid-1980s at the latest, a discrepancy started to appear between social insurance contributions and the expenditure of the health insurance funds. In 2004, the health insurance funds had a deficit of €253 million *(44)*. According to the insurance institution, the figures varied between a deficit of 6.6% and a surplus of 0.4%. The nationally active health insurance funds usually have positive balance sheet results.

In recent years, continuous measures have been taken to balance the deficits of the funds. In 2003, the contribution rates for wage and salary earners, which had been higher for wage earners since the beginnings of the social insurance scheme *(45)*, were aligned (see Section 1.2 on historical background). In addition, leisure time insurance was introduced and the contribution rates for pensioners were increased. The Health Reform 2005 was again accompanied by an increase in contribution rates (see Chapter 6 on health care reforms).

In order to ensure balanced finances in the health insurance funds, an equalization fund has been established at the HVSV which is financed by contributions from the funds themselves and by federal government subsidies *(46)*. The 1968 amendment to the ASVG provided for the granting of "subsidies" from the equalization fund, which would be due to the mandatory health insurance funds if the average contribution revenue per contribution-paying member did not reach the average value of all mandatory health insurance funds. In the course of further changes to the relevant legislation, the criterion of "sufficient liquidity" was also legally established for funds. The health insurance funds could additionally be granted "loans" from the reserves of the equalization fund. Since the mid-1970s, the contribution to the equalization fund has been continuously increased and by 2002 it amounted to 2% of the revenue from contributions per fund. From this annual revenue, reserves are formed (10% of income), which can be invested in securities. Once a year, the book-keeping and the annual accounts have to be presented to the supervisory authorities.

The 60th amendment of the ASVG (Federal Law Gazette I No. 140/2002) led to the inclusion of the insurance institute of the Austrian railways and the insurance institute for public employees in the equalization fund. Since 2003, the equalization fund has been financed by the contributions of the health insurance funds (2% of their revenue) and by the increased revenue from tobacco tax in 2002, which was the result of price rises between 1 July 2002 and 31 December 2002, and also by other income. The objective of this revision was to reduce the forecasted deficits from the expenditure of the social health insurance system, to provide the health insurance funds with sufficient funding for structural balancing and to reward the reaching of economic targets *(47)*. To this end, the contribution rate which the funds had to pay to the equalization fund for the years 2003 and 2004 was raised from 2% to 4% of the revenue from contributions (€340 million). The insurance institutions of the Austrian railways and public employees were also obliged to contribute. Added to this were interest-bearing loans (around €175 million), which had to be granted to the fund by insurance institutions holding reserves (among these were the regional health insurance funds of Lower Austria, Salzburg, Vorarlberg and Upper Austria).

The aim of these measures was to compensate for the structural disadvantages of the insurance funds. The criteria are, amongst others, the contribution revenue per insured person, the expenditure on family members and pensioners, the "major city factor" and the location of the health insurance fund. Subsidies are not considered due if there is sufficient liquid funding available (cash, securities, etc.). Furthermore, the funds receive subsidies which are based on the targets agreed (target achievement reserves) with the HVSV. On the basis of its monitoring activities, the Federation has to agree on health and social policy

targets for the financial management of the insurance institutions and set a plan for these targets in the medium term. A proportion of 45% of the equalization fund's revenues are used to compensate for structural disadvantages, 55% are used for subsidies.

Some of the funds (insurance institutions of Austrian railways and public employees and the Vorarlberg regional health insurance fund) appealed against this reorganization at the Constitutional Court, which judged that individual funds were disadvantaged by this arrangement. It declared that the increase of the contribution rate to the equalization fund was unconstitutional and against the principle of equality and thus revoked it. For the years 2003 and 2004 a transitional model was in place. Longer-term regulations are being negotiated.

3.2 Health care benefits and rationing

For all individuals covered by social health insurance, the receipt of services which qualify as social health insurance benefits is unlimited and independent of their personal income. Social health insurance has a redistributing effect owing to the income-related nature of contributions and through the guarantee of being able to claim benefits according to needs. Solidarity in the health insurance system includes the concept that, first, people pay tax according to their ability to pay, and thus make contributions (vertical fairness), and second, that all those who have a certain need for care should be treated equally in accordance with their family and economic situation (horizontal fairness). Claiming benefits is usually accompanied by co-payments, although there exceptions for social reasons (for example the exemption from the prescription fee) (see Section 3.3 on complementary sources of finance). Basically, the provision of medical treatment has to be sufficient and suitable, but may not exceed that which is necessary.

Range of benefits

As the main source of finance in the Austrian health care system, social health insurance provides the following services:

- medical care by general practitioners and specialists in the outpatient sector, including physiotherapeutic care, occupational therapy, speech therapy as well as psychotherapy, the diagnostic services of clinical psychologists and services by masseurs;
- medicines, therapeutic aids;

- dental treatment, dental prostheses;
- hospital care;
- medical nursing care at home;
- sickness benefits;
- maternity benefits;
- medical rehabilitation;
- health protection and the prevention of illness (spa treatment);
- early detection of illness and health promotion;
- travel expenses and transport costs.

Table 3.5 illustrates the activities of the social health insurance system on the basis of the use of funding for the individual service areas. Compared to the figures for 1970, total nominal expenditure has increased almost thirteen-fold. The absolute increases were most obvious in the three main areas of expenditure: hospital care (€2.9 billion), outpatient physician care (€2.5 billion) and medicines (€2.2 billion). Around 91% of services are benefits in kind. For medical nursing care and psychotherapy from health professionals other than physicians, there has been a statutory obligation to provide services since the beginning of the 1990s (50th amendment to the ASVG). Sickness benefits and maternity benefits, but also travel expenses, are all cash benefits. Sickness benefit becomes due after the expiry of the period of continued payment provided by companies (six weeks in the case of illness, eight weeks for work accidents) and amounts to an average of €26 per day.

In addition, health insurance funds provide voluntary benefits and services. These are benefits to which there is no legal entitlement, and they partly include preventive care services which are offered voluntarily according to the capacity of the health insurance funds. Differences in benefits and services between the ASVG funds are mainly to be found in the conditions for exemption from cost-sharing.

Contracts with service providers allow the insured to take advantage of their right to treatment. With regard to outpatient physician care, these are the general agreements between the social insurance institutions and the physicians' chambers, an essential part of which is the fee schedule. The latter contains the services which are to be provided on the basis of the respective individual contract and their payment, whereby the fee schedules can include mixed systems of individual and lump-sum billing (see Section 5.3 on payment of physicians). Both the extent of benefits and services as well as the fee structures can differ between the nationally active funds and the regional health insurance funds, and also within the regional health insurance funds. Care provided by personnel other than physicians in the outpatient sector is also organized via

Table 3.5 Expenditure of social health insurance, nominal in million €, 1970–2003

	1970	1980	1990	2000	2003	AAGR 1970–2003 in %	AAGR 1970–1990 in %	AAGR 1990–2003 in %	% of total 1970	% of total 2003
Insurance benefits	**806**	**2 663**	**4 988**	**9 484**	**10 415**	**8.1**	**9.5**	**5.8**	**93.3**	**94.1**
Outpatient physician care and similar services	218	729	1 390	2 474	2 730	8.0	9.5	5.3	25.2	24.7
Medicines	143	405	716	1 980	2 341	8.8	9.7	9.5	16.6	21.1
Therapeutic aids	12	52	129	204	228	9.4	8.4	4.5	1.3	2.1
Dental treatment and prostheses	61	243	432	685	694	7.6	12.8	3.7	7.1	6.3
Inpatient care in hospitals or other institutions[a]	189	760	1 588	2 778	3 039	8.8	10.3	5.1	21.8	27.4
Medical nursing care at home	0	1	2	9	10	21.2	11.2	12.2	0.0	0.1
Sickness benefits[b]	95	181	239	417	376	4.2	27.4	3.5	11.0	3.4
Maternity benefits	48	151	275	419	445	7.0	4.7	3.8	5.6	4.0
Medical rehabilitation	–	–	–	172	198	–	9.1	–	–	1.8
Health promotion and consolidation, prevention, early detection of illness[c]	15	55	118	139	143	7.1	–	1.5	1.7	1.3
Funeral allowance[d]	14	42	9	0	0	-19.7	10.8	-40.6	1.6	0.0
Travel expenses and transport costs	11	43	91	151	157	8.4	-2.4	4.3	1.3	1.4
Other services	–	–	–	55	55	–	11.1	–	–	0.5
Administration and billing expenditure	**42**	**130**	**221**	**366**	**327**	**6.4**	**8.7**	**3.1**	**4.9**	**3.0**
Other expenditure	**15**	**137**	**125**	**230**	**329**	**9.7**	**11.0**	**7.7**	**1.8**	**3.0**
Total expenditure	**863**	**2 930**	**5 334**	**10 081**	**11 072**	**8.0**	**9.5**	**5.8**	**100.0**	**100.0**

Sources: Federation of Austrian Social Insurance Institutions, 1970–2004 *(41)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: AAGR: average annual growth rate; [a] 1970: only care in hospitals and institutions, 1980 and 1990: care in hospitals and institutions as well as transfer of money to the special fund in accordance with Section 447f ASVG; 2000 and 2003: catering costs and other services as well as transfer of money to the equalization fund for hospital financing; [b] 1970–1990: sickness benefit, family allowance and daily allowance; 2000 and 2003: sickness benefit; [c] 1970: extended health welfare and prevention of illness; 1980 and 1990: health promotion, prevention of illness, youth check-ups and preventive check-ups; [d] 1970: funeral allowance.

(general) contracts, which are either concluded with statutory interest groups (midwives) or with professional organizations which are partly allowed to negotiate collective agreements.

In spite of the fact that there has been a relevant legal provision since the early 1990s, there is still no general agreement for psychotherapeutic treatment. At the start of 1991, the Psychotherapy Act came into effect (Federal Law Gazette No. 361/ 1990), and the treatment of sick individuals by psychotherapy was admitted to the benefits catalogue of statutory social health insurance. A new group of service providers was thus admitted – psychotherapists – and their services were put on an equal footing with those of medical treatment by physicians. The obligation to provide services is based on the condition that a physician's examination has taken place (ASVG Section 135, paragraph 1, line 3). This innovation was accompanied by an increase in contributions and the statutory arrangement provides for a treatment contribution of 20% of the respective contract fee by the insured party. However, there is also an additional condition: the existence of a general agreement. Even before this 50th amendment to the ASVG, treatment at the funds' expense was possible, offered for example by contracted physicians or in the health insurance funds' own institutions, but with the coming into force of the amendment the legal conditions were created to ensure psychotherapeutic treatment according to nationally uniform access criteria ("Psychotherapy on a health insurance fund voucher") *(48).* Until now, no contractual agreement has been reached between the HVSV and the Austrian Association for Psychotherapy *(49).*

As the failure of the negotiations on a general agreement became foreseeable, the social insurance institutions began to ensure the direct provision of psychotherapy services by means of contracts with (care provision) associations. The de facto provision of social insurance-funded psychotherapy is now characterized in all the Länder by a (differently weighted) combination of the three forms of direct settlement, cost reimbursement and subsidies towards costs. Psychotherapy with direct settlement, which is a benefit in kind, is provided by psychotherapists who have organized themselves in care provision associations, and also in the funds' own institutions. Medical psychotherapy is offered by contracted physicians and by (non-contracted) physicians of the patients' choice with cost reimbursement. If psychotherapy is provided by therapists who are not organized in associations (with contracts), the client receives subsidies towards his/her costs from health insurance funds *(50).*

Priority-setting and rationing

Decisions on the social health insurance funds' obligation to provide services are prepared in the discussions of the Supreme Health Board and the health officers of the Länder. Recommendations are, however, not binding for political decision-makers. In addition, there are a range of institutionalized committees within the social insurance system which deal with the setting of priorities.

Within the framework of the statutory mandate to provide sufficient and suitable treatment which does not exceed that which is necessary, a team in the HVSV prepares information for evidence-based decisions and technology assessment. This provides support for the services of head physicians, and also for contract negotiators, economists and patient counsellors. The newly established HEK also addresses issues of priority-setting (see Section 2.2 on planning, regulation and management and Section 4.8 on pharmaceuticals). Furthermore, the HVSV has dealt with the scientific determination of qualitative and quantitative objectives *(51)*.

The Health Reform 2005 also provides for three qualitative health objectives. These include the reduction of the cardiovascular morbidity rate by 40% until 2020 (for the age group over 65), the reduction of the prevalence of cancer by 15%, and of diabetes by 30%. In addition, following the initiative of health insurance funds, some Länder have formulated evidence-based health objectives which are basically compatible with national objectives, but which reflect regional priorities. Hospital operating companies have also increasingly adopted initiatives to orientate the use of funding in hospitals towards evidence-based criteria *(52)*.

According to surveys, there is a high level of awareness in the Austrian population for the fact that health services are costly: a surgery fee of €10 per quarter would be acceptable for 53% of the population *(53)*; if there were such a co-payment, 90% state that they would go to see the physician no less often as previously. However, the majority (58%) prefer a financing system for the health insurance funds which is based on solidarity and therefore an increase in health insurance contributions, rather than the introduction of higher cost-sharing levels. The proportion of the supporters of both options increased from 2002 to 2004 (cost-sharing option by 7%, increase of contributions by 6%). This corresponds to the increasing interest of the population in this issue.

The level of satisfaction of the Austrian population with their health care system continues to be high. According to surveys, almost two thirds of the population rate the current state of the Austrian health care system as "good" or "very good" *(14,54,55)*. In a European comparison, Austria thus ranks fourth behind Belgium, Luxembourg and Finland. A little over 10% of the population consider the state of the health care system to be "very poor" or "poor". As in other social insurance countries, it is also true for Austria that satisfaction with the health care system corresponds to the state of health of the population, and almost 80% consider their health to be "good" or "very good" *(56)*. However, the closure of hospitals and the restriction of health care provision belong to the "new" worries about the future held by Austrians. The concern that the health care system might break down ranks as number one according to a survey

(82%), ahead of fears about the spread of international crime and continuing high unemployment *(57).*

Public discussions about waiting times for medical treatment are not very common in Austria. This may reflect the fact that waiting times for most procedures – as in some other social insurance countries – can be considered fairly short in an international comparison. Official statements claim that waiting times for treatment in Austria are so short as to be not worth mentioning *(58).* Specific details are not available about the actual – short or long – waiting times with which this assumption could be examined. This may be related to the fact that waiting lists are only kept for transplants.

Publicly accessible investigations about the possible lack of (or excess of) services are rare in Austria. The density of care provision by general practitioners and specialists in Austria shows considerable regional variations; however, this does not necessarily imply that there is an excess or lack of physicians. In Vienna in 2002 there were, for example, 72% more practising physicians per capita than in Austria as a whole. At the level of contracted physicians, the surplus amounts to 47% and is thus significantly lower. The higher density of physicians in the cities cannot be explained purely by the fact that they are also serving the surrounding areas. In Vienna and its surroundings (Lower Austria and Burgenland) there are 30% more practising physicians per capita and 22% more contracted physicians than in the rest of Austria. Vienna also has twice as many specialists per capita as Austria as a whole, and the higher density of specialists in comparison to the figures for Austria is reflected in practically all the specialties. In spite of the surplus compared to Austria as a whole, Vienna has a lower density of physicians than Hamburg or Berlin, for example *(59)*. This shows that Austria's rural areas have significantly less physicians with social health insurance fund contracts than rural areas in Germany, and illustrates the effect created by the fact that the health insurance funds in Austria can award contracts selectively according to a location plan agreed upon with the physicians' chambers (see Section 4.3 on outpatient health care).

The Physicians' Act of 1998 created the necessary basis in professional law and in social insurance law for the establishment of group practices. This was also accompanied by the idea that regional disparities in care provision could thus be reduced. Even before the implementation of the law on group practices, it had actually been possible to establish them. The first joint practices were founded as early as the start of the 1980s *(60).* In the general agreement concluded in 2002 between the Austrian Physicians' Chamber and the HVSV, principles were recommended which should be observed on the part of the health insurance funds when concluding general agreements with group practices. These principles include the "needs-orientated" award of contracts for group

practices, more flexible opening hours, the maintenance of the principle of the free choice of physicians, access for people with disabilities and barrier-free access in general. With regard to the principle of needs-related contract awards, explicit reference is made to geographical dispersion and the availability of choice for patients. Contracts with group practices should also be concluded accordingly, for those areas in which there is insufficient provision of outpatient physician care *(61)*.

The planning principles of the Austrian Structural Plan for Health are orientated towards the reduction of disparities in the distribution of care provision, and in making it more patient-centred (see.Section 2.2 on planning, regulation and management and Section 4.9 on health technology assessment and eHealth). If the planned details can be successfully implemented, this will help to reduce imbalances in care provision in inpatient care in the medium term, and also in the primary and tertiary sectors. This will be supported by the implementation of the Quality Act 2005 (see Chapter 6 on health care reforms).

3.3 Complementary sources of finance

Besides social insurance contributions, taxes, direct and indirect cost-sharing as well as private health insurance premiums are the major further sources of health care financing (see Table 3.1). The latter contribute in particular to financing inpatient care. Expenditure on long-term care is also financed from taxes (see Section 4.5 on outpatient and inpatient long-term care).

Taxes

Including the expenditure for long-term care, around 25% of heath care expenditure is financed by funding from taxes, which mainly stems from general tax revenue (see Table 3.1). The share of taxes in financing health care has increased substantially since 1995.

Tax revenue is particularly used in inpatient care in public hospitals. The financing of acute hospital care is partially budgeted and is carried out according to performance-related criteria within the framework of this budget. The Länder, as owners of the hospitals, are not only responsible for investment and maintenance costs, but also contribute towards the running costs of the hospitals in accordance with federal and Länder legislation on hospitals (see Section 5.2 on payment of hospitals).

The owners of university teaching hospitals receive a lump sum (referred to as the "additional costs for teaching hospitals") every year from the Federal Government to finance their additional operational costs due to university research and teaching (see Table 5.1). According to Section 55 of the Federal Hospitals and Cure Institutions Act, the Federal Government has to reimburse the additional costs which result from training requirements. Payments for construction measures and investments are made on the basis of specific agreements between the Federal Government and the respective hospital owners. The Universities Act 2002 now obliges the medical universities to use business management criteria to document and evaluate the necessary data and information on the requirements of research and teaching for the determination and calculation of the additional costs for teaching hospitals. From 2007, the medical universities will have to base their figures for the payment of cost reimbursement on the calculations they have made, or alternatively they will have to come to another arrangement on reciprocal services and their evaluation in the cooperation agreement which has to be concluded with the hospital owners. In addition, medical universities can access "third-party funding" by taking on commissions for scientific research.

The proportion of tax revenue used to finance the health care system has increased considerably since 1995 (Table 3.1). As mentioned above, this funding is mainly used in the inpatient sector.

Co-payments and out-of-pocket payments

Private sources finance around 25% of total health care expenditure (see Table 3.1). Private expenditure comprises direct[10] and indirect[11] cost-sharing of private households, private health insurance expenditure, spending of non-profit-making organizations and employers (for occupational care) (see Table 3.1) *(62)*.

In 2004, direct and indirect cost-sharing amounted to €5.3 billion including expenditure on private health insurance, which can be divided up into 58% on indirect cost-sharing and 32% on direct cost-sharing payments (Table 3.1).

Payments to hospitals represent the highest proportion of indirect cost-sharing (53%), followed by physicians' services (30%) (Table 3.7). Private payments for inpatient care not only include hospital co-payments; they mainly

[10] Direct cost-sharing is direct revenue for social health insurance and includes percentage-based co-payments (for civil servants, the self-employed, employees of Austrian Railways) or fixed amount deductibles or fees per service provided (prescription fee, health voucher fee).

[11] Indirect cost-sharing mainly includes expenditure on services and/or products which are not (yet) in the benefits catalogues of the health insurance funds or whose use leads to private payments. Examples for indirect cost-sharing in Austria are expenditure on medicines for which there is no obligatory reimbursement, per diem fees for private hospital inpatient stays, or the expenditure of a private household on fixed dentures.

consist of expenditure by private households for "special class" accommodation in hospitals (around three quarters) and for long-term care in nursing homes. This proportion has increased by four percentage points since 1995. For pharmaceutical products which do not require a prescription, the proportion constituted 12% and has been falling since 1995. The proportion of expenditure accounted for by private households on other pharmaceutical products, which partly include alternative medical products, rose by 1.4 percentage points in the period under observation, and amounted to around 5% in 2003. Expenditure on dentists' services as a percentage of total indirect cost-sharing fell by 2.6%. This corresponds to the relatively strong growth in expenditure by private health insurance for dentists' services (see Table 3.11).

The largest proportion of direct cost-sharing is accounted for by medical treatment by physicians at 47%, which particularly includes the services of non-contracted physicians (see Section 4.3 on outpatient health care). This is followed by prescription fees (19%) and co-payments for therapeutic products (18%) (Table 3.8).

Whereas indirect cost-sharing grew by 2.4% per year since 1995, the average annual growth rate for direct cost-sharing was almost twice as high and amounted to 5.1%. Expenditure by private health insurance amounted to 10% of total direct and indirect cost-sharing in 2004 and had thus fallen by 4.6 percentage points since 1995 (Table 3.1). Between 1995 and 2004, private expenditure increased by 2.7% per year on average; a lower rise than that of public expenditure, which rose by 3.5% per year on average.

Whereas the level of real indirect cost-sharing is markedly higher than that of direct cost-sharing, Fig. 3.1 shows that the growth in direct cost-sharing is stronger. The rise of real per-capita expenditure on direct cost-sharing was, at an annual average rate of 3.6% between 1995 and 2004, not only clearly above that of indirect cost-sharing (1%), but was also clearly above that of real GDP growth (2%).

Fees and co-payments are the most important forms of direct cost-sharing. The outpatient department fee introduced in 2001 was withdrawn again owing to strong resistance and because of the complexity of the regulations on exceptions (*63*). In the case of health voucher fees, these are collected via the employer and there are numerous rules governing exceptions, whereby in general a minimum income level is applied *(64).* However, the reimbursement of costs also plays an important role, as some of the general practitioners and specialists providing care do not have health insurance fund contracts. Table 3.9 provides an overview of indirect cost-sharing, listed according to the date of their introduction, and Table 3.10 gives a summary of the most important forms of direct cost-sharing.

Table 3.6 Structure of nominal private health expenditure in million € and as a percentage of private health expenditure, 1995–2004

	Indirect cost-sharing	Direct cost-sharing	Direct and indirect cost-sharing	Private health insurance	Total
1995	2 490 (59.1%)	1 102 (26.2%)	3 592 (85.3%)	618 (14.7%)	4 210
1996	2 554 (58.7%)	1 154 (26.6%)	3 708 (85.3%)	639 (14.7%)	4 347
1997	2 540 (59.1%)	1 178 (27.4%)	3 718 (86.6%)	577 (13.4%)	4 295
1998	2 674 (57.2%)	1 276 (27.3%)	3 950 (84.5%)	725 (15.5%)	4 675
1999	2 700 (56.6%)	1 359 (28.5%)	4 059 (85.0%)	714 (15.0%)	4 773
2000	2 793 (55.7%)	1 451 (28.9%)	4 244 (84.7%)	769 (15.3%)	5 013
2001	2 846 (56.8%)	1 589 (31.7%)	4 435 (88.5%)	577 (11.5%)	5 012
2002	2 892 (57.8%)	1 623 (32.4%)	4 515 (90.2%)	491 (9.8%)	5 006
2003	2 960 (57.0%)	1 729 (33.3%)	4 689 (90.3%)	504 (9.7%)	5 193
2004	3 077 (57.6%)	1 722 (32.3%)	4 799 (89.9%)	540 (10.1%)	5 339
Percentage change 1995–2004	-1.5	6.1	4.6	-4.6	–
Nominal AAGR 1995–2004	2.4	5.1	3.3	-1.5	2.7

Sources: Statistics Austria, 2005; Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: AAGR: average annual growth rate; [a] except for expenditure from non-profit organizations and employers (see Table 3.1 and Table 3.12).

Possibilities for patients to be exempted from cost-sharing can be found in both legal provisions and in the guidelines of the respective social insurance institutions. Alongside the options offered by legal provisions, all health insurance funds offer the option of applying for exemption due to a "need for social protection" (this includes the income situation of the patient and/or high expenditure on outpatient physician care). In spite of the differing and complex regulations of individual health insurance funds, the reasons upon which exemptions can be based are largely similar. They include contagious and notifiable diseases, dialysis treatment and preventive check-ups. Those entitled to exemption include pensioners receiving an equalization supplement (minimum pension), co-insured children, those carrying out community service work as an alternative to military service and – on application – "people in need of social protection". The social insurance laws lay down guidelines for the "need for social protection" for exemption from the prescription fee. This includes income limits which are at the same time reference rates for the granting of an equalization supplement to pensioners. When an exemption has been granted, it is automatically valid for all entitled family members of the insured person.

Table 3.7 Indirect cost-sharing according to service areas, 1995–2004

	Indirect cost-sharing as % of total indirect cost-sharing				
	Pharma-ceutical products	Other medical products	Dentists' services	Inpatient stays (hospitals, spa and health resorts, nursing homes)	Total, nominal, in million €
1995	15.2	3.6	32.4	48.8	2 490
1996	14.7	3.7	32.5	49.1	2 554
1997	15.0	3.9	32.7	48.4	2 540
1998	17.8	3.8	30.8	47.5	2 674
1999	15.9	4.7	31.0	48.3	2 700
2000	13.7	4.7	30.8	50.8	2 793
2001	11.7	4.4	30.6	53.3	2 846
2002	12.4	4.6	29.6	53.5	2 892
2003	12.0	4.8	29.4	53.8	2 960
2004	12.4	4.9	29.8	52.8	3 077
Percentage change 1995–2004	-2.8	1.4	-2.6	4.0	–

Sources: Statistics Austria, 2005; Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Exemption from the prescription fee constitutes a benchmark for a range of exemptions from other fees. According to estimates by the HVSV, around 900 000 people are exempted from the prescription fee *(66)*. People living alone whose monthly net income for 2005 did not exceed €662.99 (for married couples €1030.23) were exempted from the fee. For people who are chronically ill and can provide evidence of related over-average expenditure, these limits are increased to €762.44 for people living alone and €1184.76 for married couples. All of these limits are raised by €70.56 for each dependent child in the household. If there are individuals with their own income living in the same household as the applicant, this income is taken into account on a pro rata basis.

Outpatient sector

General co-payments for medical treatment have to be made in the health insurance funds for civil servants, the self-employed and also in the insurance institution for railways and mining. Since 1997, those insured according to the ASVG, principally wage and salary earners (except children, pensioners and

Table 3.8 Direct cost-sharing according to services areas, 1995–2004

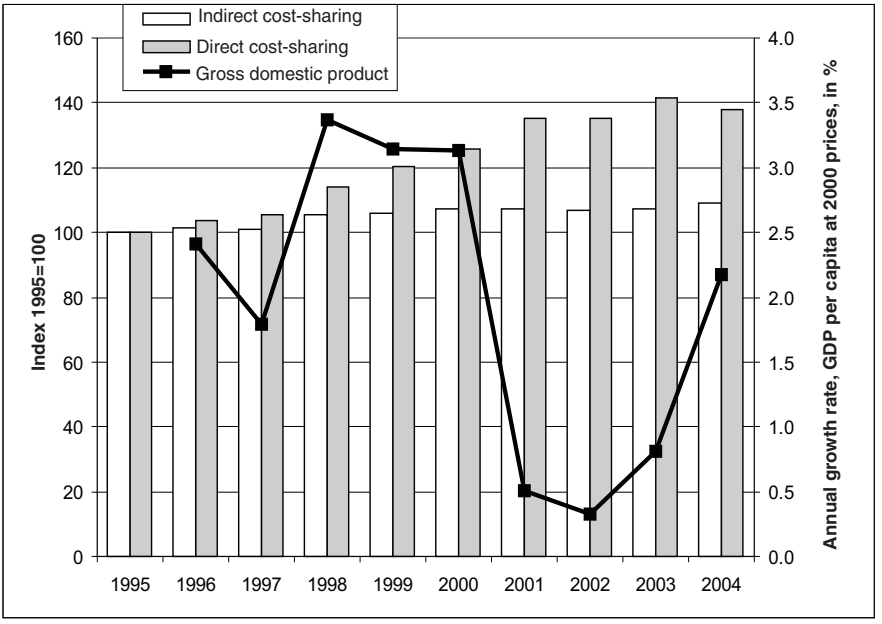
	Direct cost-sharing as % of total direct cost-sharing							Total, nominal, in million €
	Therapeutic products	Medical services by physicians	Services of health professionals other than physicians	Prescription fee	Cost-sharing for the social insurance institutions of the self-employed, railway employees, miners and public employees	Health voucher fee	Outpatient clinics fee	
1995	18.5	53.0	4.1	17.0	7.4	–	–	1 102
1996	18.5	52.5	4.2	17.4	7.5	–	–	1 154
1997	17.7	48.3	4.1	18.4	7.7	3.9	–	1 178
1998	19.8	46.2	4.5	18.3	7.5	3.7	–	1 276
1999	21.3	44.5	4.6	18.7	7.4	3.5	–	1 359
2000	20.3	46.4	4.3	18.7	7.1	3.3	–	1 451
2001	20.2	43.4	4.5	19.4	7.6	3.0	1.9	1 589
2002	19.8	44.8	4.7	19.2	8.1	2.9	0.4	1 623
2003	18.7	47.4	4.7	19.0	7.5	2.7	0.0	1 729
2004	18.0	47.5	4.8	19.5	7.6	2.7	0.0	1 722
Percentage change 1995–2004	-0.5	-5.6	0.7	2.5	0.2	-1.2	–-	–

Sources: Statistics Austria, 2005; Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

insured people who have to make other co-payments, and individuals who are suffering from a notifiable illness or are in need of social protection) pay a fee – which is valid for a quarter – of €3.63 for each health voucher; farmers pay a fee of €7.30. From 2006 onwards, this fee will be replaced by an annual fee (€10) for an "electronic health voucher" – the new e-card (Table 3.10).

In addition, cost-sharing is applied for various dental and dental prosthetic services as well as services provided by private non-contracted physicians of the patients' choice (including the services of physicians, therapists such as psychotherapists, physiotherapists, occupational therapists, speech therapists and others who do not have health insurance fund contracts).

Fig. 3.1 Development of direct cost-sharing, in € per capita at GDP prices in 2000, 1995–2004



Sources: Statistics Austria, February 2006; IHS HealthEcon calculations, 2006 (http://www.ihs.ac.at).

Table 3.9 Introduction and withdrawal of direct cost-sharing measures, 1956–2006

Co-payment	Introduction	Withdrawal
Prescription fee	1956	–
Co-payment (20% for the self-employed)	1966	–
Co-payment (20% for civil servants)	1967	–
Co-payment (railway and mining employees: 14%)	1971	–
Health voucher fee (general practitioners, specialists)	1997	2005[a]
Health voucher fee (dentists)	1997	2005[a]
Outpatient department fee	2001	2003
Service fee (e-card)[a]	2006	–

Source: Hofmarcher and Röhrling, 2003 *(65).*

Note: [a] Since 2006 an annual service fee for the e-card succeeded the health vouchers for outpatient care.

Inpatient sector

Hospitalized patients in standard class accommodation pay a fee of around €8 per day for a maximum of 28 days per year (Table 3.10). In the course of the Health Reform 2005, the option of increasing this fee to a maximum of

€10 was delegated to the Länder. In Vienna for instance, the contribution to hospital costs has been €10 per day since 2005. This fee is collected directly by hospitals. Here again, individuals who already pay a deductible as well as those in need of social protection are exempted from this regulation. The co-payment for dependants of those insured according to the ASVG is 10% of a fictitious "daily rate", for a maximum of 28 days per year (ASVG Section 447f(7)). This payment is not applied to hospitalized patients in relation to certain insurance cases (for example maternity, organ donations, dialysis treatment, etc.).

In 1996, general cost-sharing was also introduced for stays at spa resorts and rehabilitation centres. In that year, co-payments of €6 to €16 per day were charged for spa resort stays, and €6 for rehabilitation stays.

Medicines

For each pack of prescribed medicines paid for by the health insurance funds, a prescription fee of €4.45 is charged (Table 3.10). People for whom a particular level of social neediness has already been established are exempted from the prescription fee. This includes pensioners receiving an equalization supplement, patients with notifiable diseases and those carrying out community service, and entitled family members of all these groups. In addition, exemption is possible on application if certain income limits are not exceeded (for example reference rates in the case of an increased need for drugs). Exemption from the prescription fee partly has an effect on exemption in other areas too, such as therapeutic aids.

Therapeutic aids

Depending on the insurance institution, a co-payment of between 10% and 20% (currently a minimum of €24.20) has to be paid for therapeutic aids (Table 3.10). The minimum co-payment does not apply to people who constantly require such aids. In the case of medical aids which an insured person needs due to mutilation, disfigurement and disabilities, the costs are assumed by the health insurance fund up to a limit set in its statutes. As in the case of therapeutic aids, the insured person has to contribute to costs, and the above-mentioned minimum co-payment also applies. If the medical aids are provided as part of medical rehabilitation measures, the health insurance fund bears the entire costs. For children who have not yet reached the age of fifteen (or for whom increased family allowance may be claimed), and for individuals who are exempted from the prescription fee owing to a need for social protection, there is no obligation to share the costs of therapeutic aids. In 2005, deductibles for glasses and contact lenses increased to €72.60.

Table 3.10 Regulations for direct cost-sharing according to sector, 2005

	Fees	Co-payment	Deductible	Reimbursement of costs
Outpatient sector	Health voucher per quarter (no additional fee in the case of referrals): ASVG-insurees: €3.63 Farmers: €7.30	Treatment contribution per service: civil servants and self-employed in commerce, trade and industry: 20%; insurance institutes for public employees, railways and mining: 14%		Fee for non-contracted physicians of the patient's choice:[a] 80% of the amount which would be due for the consultation of contracted physicians is reimbursed
Inpatient sector	Länder laws: different rates, around €8 per day (maximum 28 days per calendar year)	Social insurance law: family members: 10% of the care fees valid in 1996, maximum four weeks per year		
Medicines	Prescription fee: €4.45 per pack			
Medical rehabilitation	€6.33 per day of care			
Medical preventive care measures (for example stays at spa resorts)	€6.33–16.11 per day, depending on income			
Therapeutic aids			In general: 10% of the costs, minimum €24.20; glasses and contact lenses: minimum of €72.60	
Psychotherapy				Reimbursement of costs: 80% of the amount due for the consultation of contracted physicians is reimbursed; subsidies towards costs are made for psychotherapists who are not physicians: €21 per session

Source: IHS HealthEcon, 2005 (http://www.ihs.ac.at).

Notes: ASVG: General Social Security Act; [a] Non-contracted physicians freely chosen by patients.

Psychotherapy

The level of private cost-sharing for psychotherapy differs between the Länder owing to the varying structure of services offered. In the western Länder (Vorarlberg, Tyrol, Salzburg), but also in Carinthia and Burgenland, psychotherapeutic treatment provided by contracted physicians or non-contracted physicians freely chosen by the patient has a comparatively high market share in relation to the remaining Länder *(50).* In accordance with these differences, cost-sharing takes varying forms.

The regulations for cost-sharing and exemptions differ according to health insurance funds, although the ASVG with its amendments is the reference law in many cases. However, there are also differences within the ASVG. The HVSV publishes a set of model statutes for all funds, but there is room for manoeuvre, especially with regard to exemptions from cost-sharing and thus in their interpretation of a need for social protection.

Voluntary private health insurance

Owing to the high proportion of people with social insurance coverage in the Austrian population, the motives for taking out private insurance are mainly to cover the costs of better accommodation in hospitals or the costs of treatment by a (non-contracted) physician of their choice and to shorten the waiting times for examinations (supplementary insurance). Around a third of the Austrian population has private (additional) health insurance. Approximately half of all those with private supplementary health insurance belong to self-employed households and 40% are civil servant and salary-earning households (*66*). The number of people with supplementary private insurance has been – after an increase in the 1980s – falling since the start of the 1990s. Private supplementary health insurance finances around 7% of the costs of public hospitals (see Table 5.1).

The most important product lines in voluntary health insurance in Austria are hospital costs insurance (supplementary insurance for superior accommodation) and hospital per diem (cash) benefit insurance. Around 80% of payments were accounted for by these two products, whereby hospital costs insurance constituted around 77% (Table 3.11). The significance of hospital per diem insurance has fallen in recent years, particularly as the insurance sums are rather small for a considerable number of people.

As well as having national rates, the majority of private health insurers also calculate a minimum rate per Land – this is adapted to the services of the respective social health insurance funds in the contract hospitals of the Land. This results in considerable differences in prices in the individual Länder. In

Table 3.11 Benefits from private health insurance, 2004

Benefits	Expenditure on benefits		
	in €	Proportion in %	Change 2003/2004 in %
Reimbursement of hospital costs	699 240	72.1	- 0.6
Hospital allowance (including replacement daily allowance and home births lump sum)	99 985	10.3	2.5
Physicians' services	44 251	4.6	2.9
Dental treatment	48 106	5.0	20.5
Health resort services	25 075	2.6	8.3
Special examinations, treatments and therapeutic aids	33 395	3.4	12.6
Travel insurance for foreign countries	4 528	0.5	-19.0
Medicines	10 774	1.1	13.2
Sickness benefit	3 016	0.3	-16.7
Costs for an accompanying person	774	0.1	- 2.9
Funeral allowance	116	0.0	- 0.9
Total	**969 260**	**100.0**	**1.4**

Source: Fried and Wendt, 2005 *(67).*

2005, for example, a monthly premium for a family with two children under the age of 18 in Burgenland amounted to €153 per month, whereas in Vienna it was €270 *(67).*

Insurance for outpatient medical treatment, in which surgery fees and visiting fees as well as the cost of medicines, therapeutic aids, etc. are reimbursed, is a further product offered by private health insurance companies. Expenditure on dental treatment increased most rapidly between 2003 and 2004 by 20%. Fixed dentures are not part of obligatory services in social health insurance, which explains this trend to some extent. Special insurance offers to cover the costs of complementary medical treatment are becoming increasingly significant. These appear in the category "Special examinations, treatment and therapeutic aids".

3.4 Health care expenditure

Table 3.12 illustrates the development of health care expenditure as it was calculated by Statistics Austria and reported to the OECD. From 1995 onwards, the figures on health care expenditure in the following section are based on data which were recalculated by Statistics Austria on the basis of the System

of Health Accounts of the OECD and published in February 2006 (see also Table 3.1). This has increased the level of comparability with many European countries.

Between 1970 and 2004, nominal health expenditure rose by an annual average of 8.4%, the real increase (at 2000 prices) was 4.6% (Table 3.12). The economy grew in the same period by 6.5% or 2.7% per year in real terms. Health care expenditure as a proportion of GDP in Austria thus grew by more than four percentage points: from 5.3% in 1970 to 9.6% in 2004. Public expenditure as a proportion of GDP in 2004 was more than twice as high as in 1970; private expenditure as a proportion of GDP rose by almost one percentage point from 2.0% in 1970 to 2.8% in 2004.

In both real and nominal terms, public health expenditure increased by around 1% more than private expenditure (Table 3.12). However, the growth of both expenditure items exceeded the real annual growth of GDP (2.7% per year). Compared to GDP growth, very little of the economic growth in the 1960s and 1980s was spent on the health care system. This changed in the 1990s: at almost the same GDP growth, the increase in expenditure on health doubled in comparison to the previous decade *(6)* (see Table 1.3).

Since 2001, investments for public hospitals are classified as private since they are operated by private hospital operator companies, though they are mainly owned by public bodies. This results in a shifting from public to private health expenditure of about 3–4%.

Health care expenditure comparisons are difficult, given that the standards used for calculations vary from country to country. 13 out of 30 OECD countries (of which six are EU countries, including Austria) have implemented health care expenditure calculations according to the international OECD Standard System of Health Accounts as a supplement to their other calculations. The calculation of health care expenditure has not been fully harmonized, however, even in the EU. Italy and the United Kingdom, for example, have not yet introduced calculations according to OECD specifications. Due to this revision, Austrian health care expenditure is now calculated as being significantly higher, because financing of public hospitals is taken into account more extensively and public and private expenditure on long-term care are now subsumed under health expenditure, as are other expenditure items including ambulance services (emergencies and transport), prisons, health services provided by company physicians and private non-profit-making organizations.

In 2004, Austria spent around €23 billion or 9.6% of its GDP on the health care sector. Without taking the expenditure for long-term care into consideration, which accounts for around 10% of total health care expenditure, the proportion was 8.7% (see Table 5.2). Austria's proportion of health expenditure ranked

Table 3.12 Development of health expenditure, 1970–2004

	1970	1980	1990	2000	2001	2002	2003	2004
Public health expenditure								
– Nominal, in million €	937	3 921	6 978	13 822	14 287	14 853	15 330	16 091
– GDP prices, 2000, in million €	2 955	6 648	8 370	13 822	14 049	14 407	14 642	15 135
– As a percentage of GDP	3.3	5.5	5.2	6.6	6.6	6.7	6.8	6.8
– As a percentage of total health expenditure	63.0	68.8	73.5	69.9	69.5	70.5	70.3	70.7
Private health expenditure								
– Nominal, in million €	550	1 776	2 514	5 963	6 271	6 204	6 472	6 679
– GDP prices, 2000, in million €	1 735	3 011	3 015	5 963	6 166	6 017	6 181	6 282
– As a percentage of GDP	2.0	2.4	1.9	2.8	2.9	2.8	2.9	2.8
– As a percentage of total health expenditure	37.0	31.2	26.5	30.1	30.5	29.5	29.7	29.3
Total health expenditure								
– Nominal, in million €	1 488	5 697	9 491	19 786	20 559	21 057	21 802	22 770
– GDP prices, 2000, in million €	4 691	9 659	11 386	19 786	20 215	20 424	20 823	21 417
– As a percentage of GDP	5.3	7.6	7.1	9.4	9.5	9.5	9.6	9.6
Memorandum								
GDP, nominal, in million €	28.2	74.7	133.6	210.4	215.9	220.7	227.0	237.0
GDP prices, 2000, in million €	91.4	130.3	163.5	210.4	212.3	214.1	216.8	223.0
Public expenditure, nominal, in million €	–	38.3	70.9	108.2	109.7	111.8	114.8	118.3
Public expenditure, GDP prices, 2000, in million €	–	64.9	85.0	108.2	107.8	108.5	109.6	111.2

Sources: OECD Health Data, 2005 *(7)*; Health care expenditure 2000–2004: IHS HealthEcon calculations, 2006 (http://www.ihs.ac.at); Statistics Austria, February 2006.

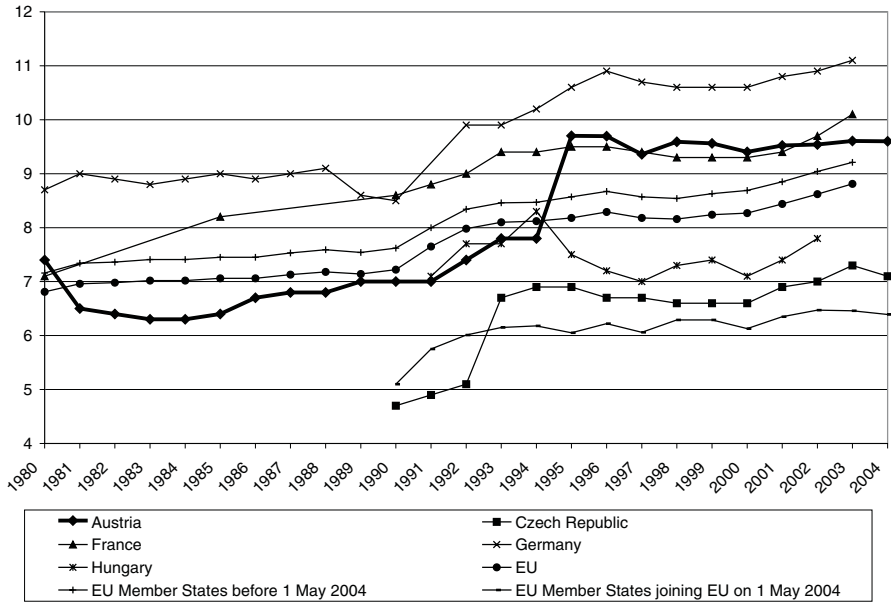
Note: GDP: gross domestic product.

above the average of the Member States belonging to the EU before May 2004 (9.3%).

Also, per-capita expenditure on health was above the average of the Member States belonging to the EU before May 2004; adjusted for differences in purchasing power it amounted to US$ 2951 (in 2003) (Fig. 3.4).

With respect to the public share of total health care expenditure, Austria ranks in the lower third of EU countries, with a figure of 71% (68% according to the old health expenditure calculation method) (Fig. 3.5). If investments

Fig. 3.2 The development of health care expenditure as a percentage of GDP in Austria, selected countries and EU averages, 1980–2004

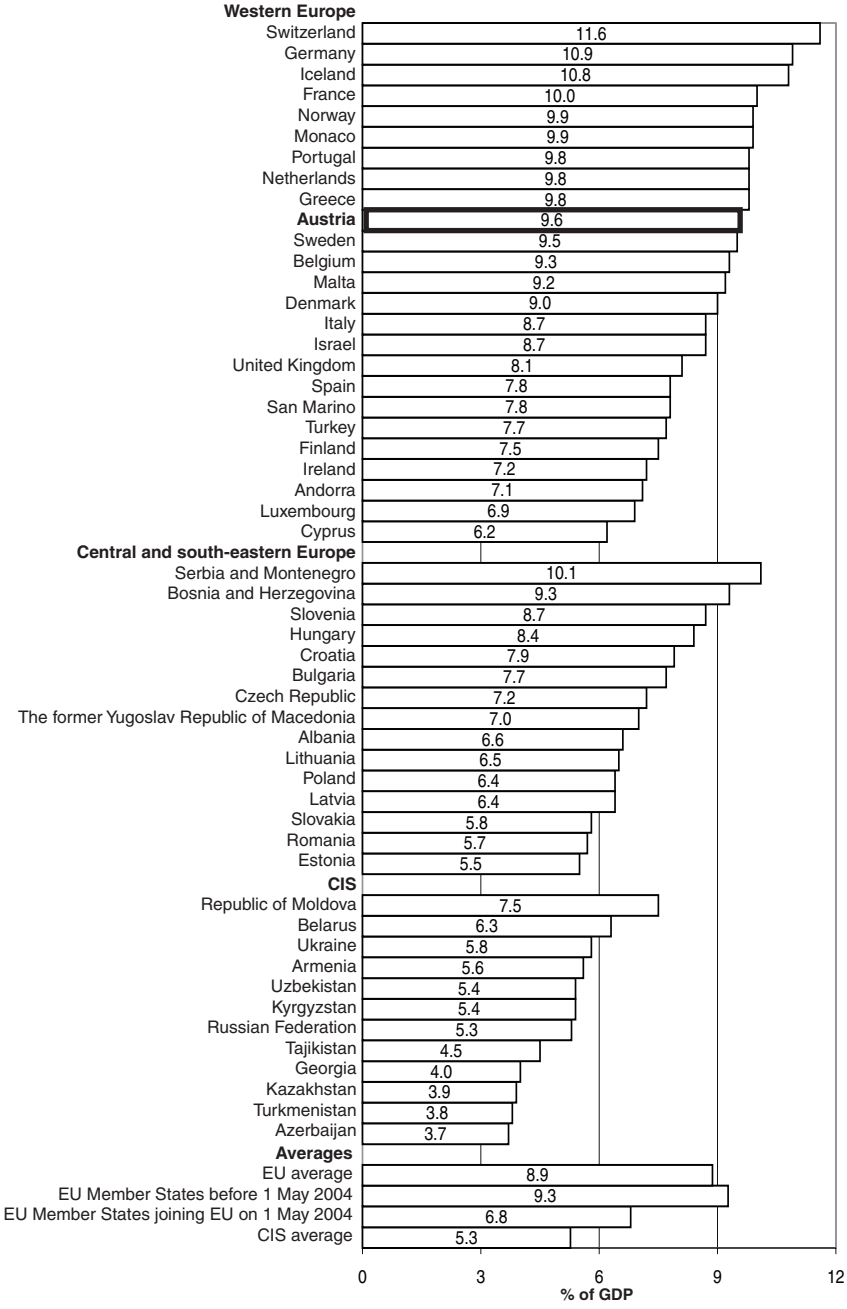


Sources: European Health for All database, January 2006 *(9)*, 1998–2002: WHO estimates; Austria 1995–2004: Statistics Austria, February 2006.

in publicly owned and privately operated hospitals were accounted as public investments, the public share of health expenditure was at around 73% (see Table 3.13.1).

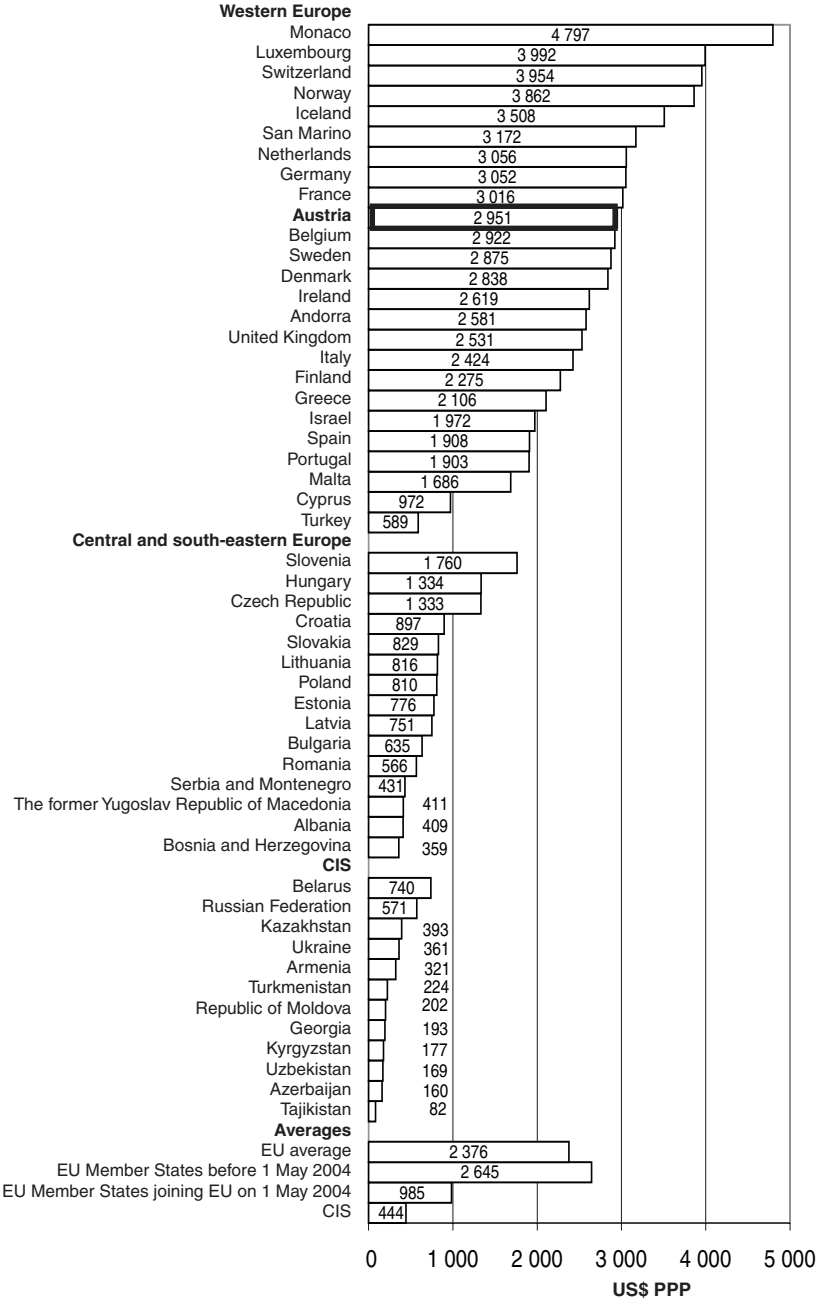
The European averages shown in Figures 3.2 to 3.5 do not yet reflect the increase in Austrian health expenditure. However, the revision of Austrian data has only little impact on these averages (less than 0.1% of GDP and a few euros in purchasing power parities), since these averages are population weighted and Austrians account for 2.1% of the population in Member States belonging to the EU before May 2004 and 1.8% of all EU inhabitants.

Fig. 3.3 Total expenditure on health as a % of GDP in the WHO European Region, 2004, WHO estimates



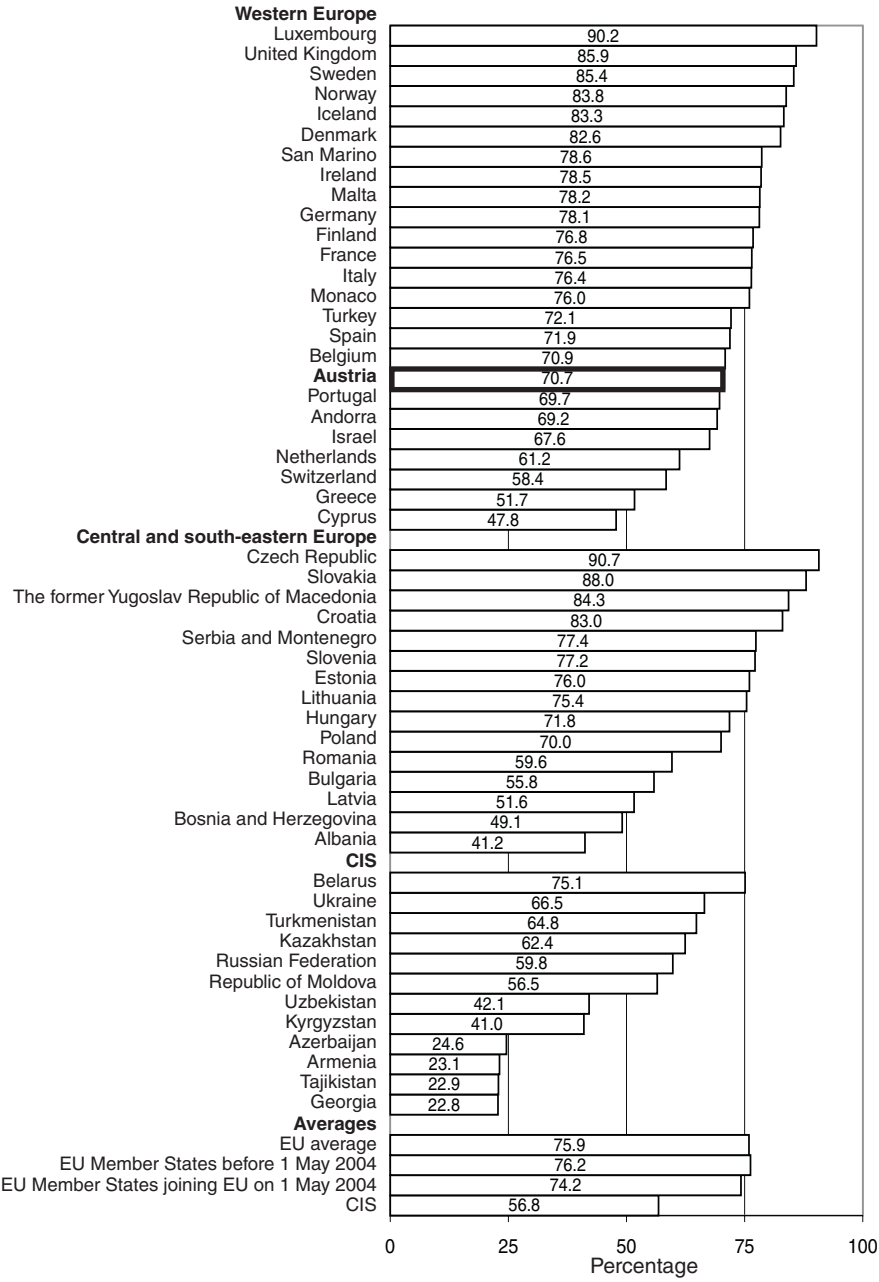
Sources: European Health for All database, June 2006 *(9);* Austria (data for 2004): Statistics Austria, February 2006.
Note: CIS: Commonwealth of Independent States; EU: European Union.

Fig. 3.4 Health care expenditure in US$ PPP per capita in the WHO European Region, 2004, WHO estimates



Sources: European Health for All database, June 2006 *(9);* Austria (data for 2003): Statistics Austria, February 2006.
Note: CIS: Commonwealth of Independent States; EU: European Union.

Fig. 3.5 Health care expenditure from public sources as a percentage of total health care expenditure in the WHO European Region, 2004, WHO estimates



Sources5: European Health for All database, June 2006 *(9);* Austria (data for 2004): Statistics Austria, February 2006.

Note: CIS: Commonwealth of Independent States; EU: European Union.

Structure of health care expenditure

Inpatient care consumes almost 40% of total health care expenditure. The proportion of expenditure used for this sector has increased by 2.4 percentage points since 1995. However, expenditure in hospital outpatient departments is also included in this item. Around 12% of the costs of public hospitals are accounted for by services provided in hospital outpatient departments. Expenditure on outpatient services amounted to 23.3% of total spending in 2004 and increased by three percentage points compared to 1975. Compared to 1995,[12] however, this proportion fell by 1.6 percentage points. Alongside the expenditure for the services of general practitioners and specialists, these items include payments to providers who are treated as the equals of physicians, such as psychotherapists. In addition, flat-rate payments by the health insurance funds for treatment in hospital outpatient departments are also included. Between 1995 and 2004, the proportion of expenditure on medical goods (spent in outpatient care) increased by four percentage points (Table 3.13). The expenditure structure of the social health insurance system is illustrated in Table 3.5.

Expenditure on long-term care as a proportion of total expenditure is decreasing, as is the proportion of spending on the outpatient sector, and was around 10% in 2004 and thus around 1% lower than in 1995. The development of expenditure shares reflects the fact the health care system is biased towards hospitals in acute care (Table 4.10), and shows the price developments in the

Table 3.13 Structure of health care expenditure as a percentage of total health expenditure, 1995–2004

	1995	2000	2001	2002	2003	2004
Inpatient care	36.5	36.9	38.4	38.8	38.6	38.9
Outpatient services	24.9	23.4	23.4	23.3	23.2	23.3
Expenditure on medical goods	13.0	16.9	16.6	17.1	17.3	17.1
– Medicines	9.8	13.2	13.1	13.6	13.9	13.8
– Therapeutic aids	2.0	2.5	2.6	2.6	2.5	2.4
Long-term care[a]	11.1	10.2	10.3	10.2	10.2	9.9

Sources: Statistics Austria, February 2006; Federal Ministry of Health and Women, 2005; Federation of Austrian Social Insurance Institutions *(41,44)*; Hofmarcher, 2005 *(87)*.

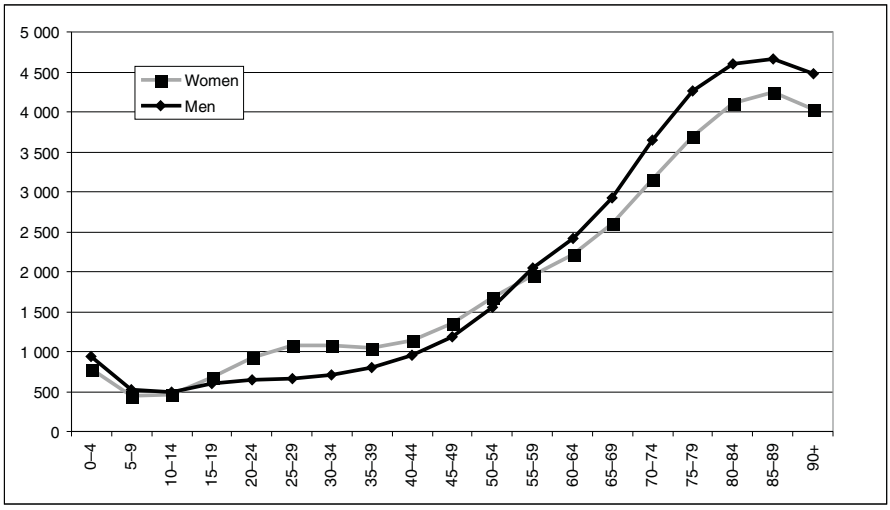
Note: [a] Federal and Länder long-term care benefit as well as private expenditure on inpatient services in nursing homes

[12] The changeover to the OECD System of Health Accounts method of calculating health expenditure carried out by Statistics Austria took place for the years 1995–2004. 1995 can thus be considered a reliable basis year.

pharmaceuticals market (Table 4.17 and Table 4.18). This is also reflected in the priorities set by the reforms since the early 1990s, in which hospital care and expenditure on medicines have been central issues (see Chapter 6 on health care reforms).

The pattern of expenditure according to age groups in Austria does not show any serious divergences compared to that of other EU countries (*68*). In Austria too, public health care expenditure rises with increasing age. Per-capita expenditure in the age group of 85 to 89-year-olds is, for example, around five times as high as that for those aged between 35 and 39. The inpatient sector dominates the age versus expenditure curve and the increase is particularly marked when people have reached retirement age. From this period onwards, men cause more expenditure than women. The age–expenditure curve for medical treatment is almost linear, but that for spending on medicines is steeper than in the inpatient and medical treatment sectors (Fig.3.6). According to calculations of the Department of Health Economics/Health Policy of the Institute for Advanced Studies (IHS HealthEcon), the future relationship between age and health expenditure in Austria will also be characterized by the development of inpatient care, although the dynamically growing medicines sector promises to result in structural shifts *(69)*.

Fig. 3.6 Public health care expenditure according to age groups, in € per capita, 2003



Sources: Federation of Austrian Social Insurance Institutions, 2003 *(41)*; Federal Ministry of Health and Women, 2005; IHS HealthEcon calculations, 2005; Hofmarcher *(87)*.

4 Health care delivery system

Services in the health care system are provided by the public health service, in outpatient care and in inpatient care in hospitals. Services are also publicly financed and partially publicly provided in the tertiary sector, which includes nursing care and rehabilitation. Outpatient care is provided to patients by mostly self-employed physicians in private practice, outpatient clinics and hospital outpatient departments. Hospital services are publicly financed, and provided in public, private non-profit-making and private hospitals. Long-term care in Austria is offered in outpatient and inpatient forms. In this chapter, the provision of services at different levels is described in detail. In addition, employment in the health care sector is compared and the training provided for health professionals briefly described. Finally, the provision of medicines and current developments in the assessment of technology in the health care system are explained in detail.

4.1 Public health services

The public health service is the part of the health care system which is provided directly or indirectly by state administration bodies or by institutions which have been established or are owned by the state. Within the public health care system, the public health service is the part which is responsible for fulfilling public and statutory tasks and interests in the health care system, including the related supervisory activities. This definition of the public health service makes it clear that this is a third sector of the health care system – alongside the hospitals and outpatient sectors – which has independent tasks to fulfil.

The work of the public health service is mainly carried out by district medical officers. The number of district medical officers has remained relatively

unchanged for years now, at around 300. This corresponds to around 1% of all practising physicians. Most district medical officers work for the district administrations, town and city councils and Länder authorities. Only a small number work for the Federal Government. The organs of the public health service are not only district medical officers, but also technicians, chemists, legal experts, biologists, psychologists, food safety authorities, sanitary auditors, disinfection assistants, social workers, speech therapists, etc.

On average, the medical officers who work in the district administrations are responsible for between 30 000 and 60 000 inhabitants. They are usually supported at the level of the district administrative authorities by one or two non-academic specialists (in most cases health attendants or disinfection officers). For special problems (disinfection, the issue of legionnaires' disease, X-ray examinations) they receive support from non-academic specialists from the Länder. For special tasks (appraisals in hospitals, residential homes for the elderly and homes for long-term care), highly qualified nurses are available as non-official experts. District medical officers are trained by means of a two-semester course in Public Health, which in some Länder is a university course leading to a postgraduate degree at a medical university. The course covers general hygiene, forensic psychiatry, forensic medicine, sanitary legislation, epidemic hygiene, social hygiene and epidemiology, toxicology and veterinary inspection regulations including animal epidemiology.

On the part of the Federal Government, further training events which take place once a year have been held since the start of the 1990s for physicians in the public health service. Guidance and instruction are provided on drawing up reports, and guidelines are also drawn up for harmonizing the classification of long-term care benefit claimants (see Section 4.5 on outpatient and inpatient long-term care). In addition, communications training and epidemiology for district medical officers are offered.

The area of responsibility of district medical officers includes all measures which serve the health of the population and consists of the following fields:

- preventive health care: vaccinations;
- the prevention and combating of epidemics, protection against infections including tuberculosis precautions;
- monitoring and supervisory activities of health inspectors;
- health reporting, health statistics, health planning;
- environmental medicine including toxicology;
- psychosocial services;
- social services and counselling centres;
- reports and work as expert witnesses;

- school physicians' service;
- preventive check-ups and advice;
- (participation in) health promotion.

Vaccinations and infection protection

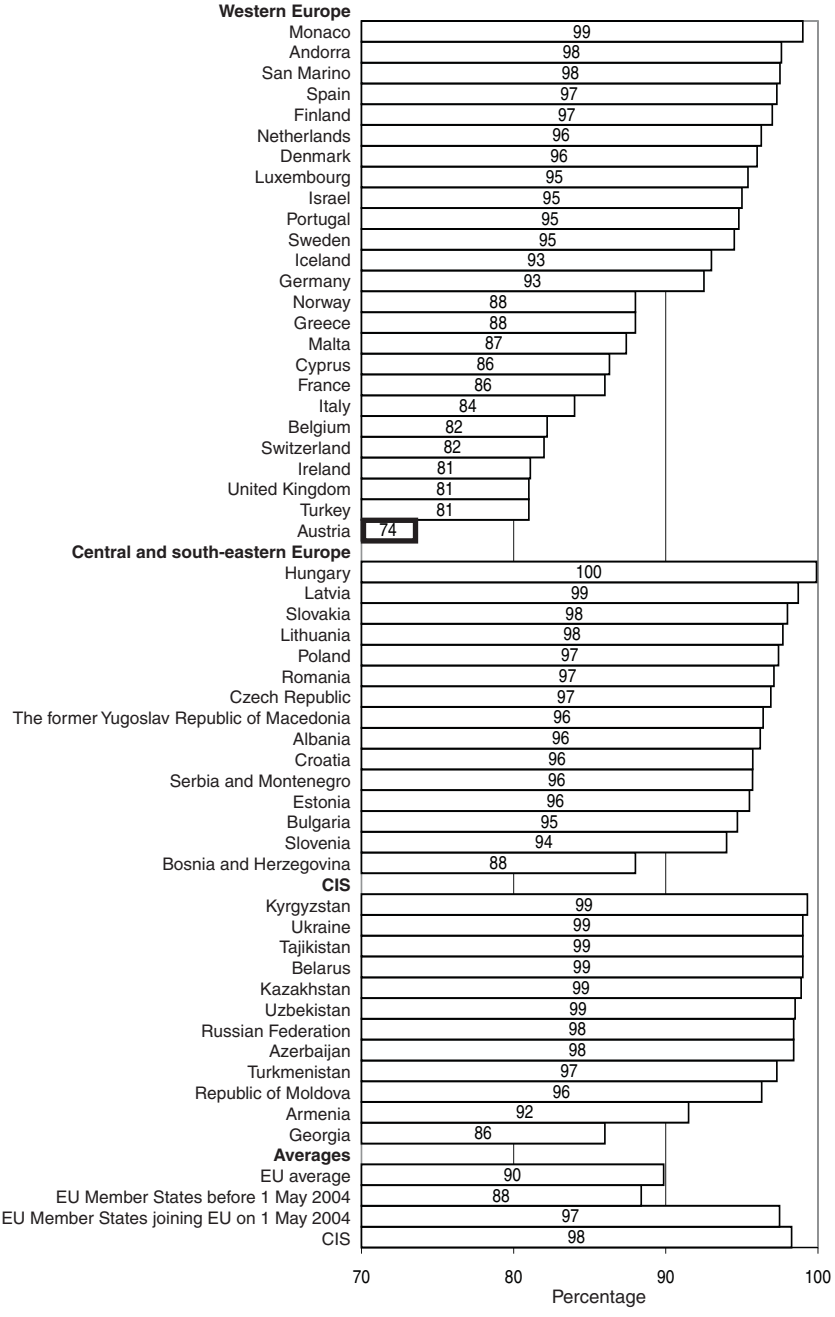
One of the areas of responsibility of the public health service in preventive health care is vaccinations. Since the implementation of the 1998 vaccination concept, the vaccinations recommended by the Supreme Health Board for children up to the age of 15 are provided free of charge. In 2005, the general vaccination plan for infants and small children up to the age of two included vaccinations against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, haemophilus, hepatitis B, measles, mumps, German measles and a conjugated multiple vaccination against pneumococci. The latter is only provided free of charge to risk groups. In addition, if indicated, vaccinations against the following are recommended: meningococci C, varicella (chickenpox) and an influenza vaccination, as well as a basic immunization against tick-borne encephalitis and hepatitis A *(70).*

Four sixths of the costs of the vaccines are borne by the Federal Government, and a sixth are paid each by the Länder and the social insurance institutions. For 2004, the vaccine costs amounted to €13.9 million. The costs of administration, distribution, administering the vaccinations and related physicians' fees are paid by the public health services of the Länder.

Within the EU, Austria has, at 73.5%, one of the lowest immunization rates against measles among infants (Fig. 4.1). It is also noticeable that in many of the countries joining the EU on 1 May 2004 the level of immunization is significantly higher and that the intervals are even shorter than in EU Member states belonging to the EU before May 2004.

The prevention and monitoring of infectious diseases is also the responsibility of the public health service. The monitoring of tuberculosis (TBC), for example, is based on a TBC control programme. The highest priority in TBC management is the overall monitoring of therapy and checking the progress of therapy in individual TBC cases. In cooperation with the district administration authorities, pulmonary centres and pulmologists in private practice, the therapy of each tuberculosis patient is monitored and the course of their progress over five years is observed. Patients with an increased risk, such as a malign basic illness, alcoholism, homelessness, imprisonment, immunosuppression, multiresistant TBC and recurrent TBC also remain within the care of the TBC prevention programme of the Länder after 5 years.

Fig. 4.1 Immunization rates for measles in the WHO European Region, 2004 (or latest available year)



Source: European Health for All database, June 2006 *(9)*.
Note: CIS: Commonwealth of Independent States; EU: European Union.

Health reporting

The public health service has been responsible for health reporting since the coming into effect of the Imperial Sanitary Act of 1870; reports originally appeared in the sanitary reports of the Länder and the Federal Government. Other fields of health reporting concern publications such as population surveys.

Environmental medicine

One of the main tasks in this field is the work of the public health service as a source of expert advice for the authorities in various administrative procedures. In proceedings according to, for example, trade regulations, the Waste Management Act or the Environmental Impact Assessment Act, the district medical officer has to judge – according to state-of-the-art medical science and based on technical reports – whether the health of people living near a plant is endangered. In addition, the extent of any possible nuisance caused to normally sensitive adults and normally sensitive children has to be assessed. This is done by evaluating the environmental medical impact of factors such as air quality, airborne noise, structure-borne sound, drinking water, bathing water, food and light, etc.

The environmental medical aspects of water quality and hygiene in swimming pools and other bodies of water are assessed according to the provisions of the Bathing Hygiene Act, whereas the environmental medical aspects of drinking water hygiene, on the other hand, are examined within the framework of the Water Rights Act. This relates, for example, to the stipulations for protected areas, the selection of materials, purification, the evaluation of the quality of drinking water, the extent of sampling and the intervals at which it is carried out.

Psychosocial services and counselling centres

The public health service offers social, psychosocial and social-psychiatric services, the provision of which is safeguarded by target agreements and service agreements with various welfare associations.

4.2 Prevention and health promotion

The field of prevention and health promotion is a “cross-sectional issue” (see the introductory overview, Section 1.1). Traditionally, the provisions of social

insurance law were strongly orientated towards a curative approach, whereas the tasks of the public health service were essentially limited to sanitary supervision and providing specialist advice to authorities, or linked to individual preventive programmes. The resulting vacuum with regard to modern concepts for health promotion and prevention was countered with the aid of a series of legislative initiatives (see Chapter 6 on health care reforms).

Preventive check-ups, advice and health passes

The objective of prevention is to improve the health of the population and the early detection of diseases. The work of the public health service is closely connected to the offer of preventive medical services. Public preventive medical care in Austria spans the entire life-cycle of a person. The measures taken by the public health service range from the mother–child medical card programme, care provided by school physicians and check-ups for young people to preventive check-ups for adults. Check-ups for young people and preventive check-ups are obligatory services for the social health insurance system. As part of the Health Reform 2004/2005, a new course was set by broadening the framework of preventive check-ups and by introducing health passes.

Mother–child medical card

The mother–child medical card was introduced at the start of the 1970s. The comparatively high infant mortality rate at that time has since been continuously reduced, also as a result of increasing levels of affluence. Between 1970 and 2003, it fell by more than 80%, from around 26 deaths per 1000 live births in 1970 to 4.5 deaths in 2003. The Austrian figure is thus below the EU average (2003: 4.9) and clearly below the average for the Member States joining the EU on 1 May 2004 (6.9). Maternal mortality has also decreased considerably, from 2.6 deaths per 10 000 live births in 2003.

The mother–child medical card ensures the provision of preventive health care for pregnant women and infants. The examinations which are provided within the framework of the mother–child medical card programme offer an opportunity for early detection and the timely treatment of illnesses, as well as for monitoring the development of the child. For the mother, the programme consists of five gynaecological examinations (including two laboratory tests and one internal examination of the mother-to-be) and two ultrasound examinations during pregnancy. For the child, five post-natal examinations of the child up to the age of 14 months (including an orthopaedic examination, an ear, nose and throat examination and an eye examination) have to be carried out. In addition, two pelvic ultrasound examinations of the child are included and four

supplementary examinations of the child can be taken advantage of between the ages of 22 months and five years.

The examinations are carried out by general practitioners and the respective specialists, are free of charge and can be claimed regardless of the person's health insurance status. The mother–child medical card examinations are, however, a prerequisite for claiming full child care allowance. The five gynaecological examinations have to be carried out during pregnancy, and the five examinations of the child by the time it is 18 months old. If proof that these examinations have been carried out is not forthcoming, only half of the child care allowance is paid after the child has reached the age of 21 months *(70,71)*.

School physician service and health pass for young people

Alongside the sanitary supervision of school facilities, the main task of the school physician service is to regularly examine schoolchildren to ensure that their state of health is adequate to take part in lessons. National school physicians' examinations were introduced in 1964. This programme is de facto a preventive check-up, which is carried out once every school year and the main aim of which is to examine the pupils' vision and hearing ability and confirm their ability to take part in sports lessons.

After a pilot phase in 2004 and a subsequent evaluation, 95 000 health passes were distributed in the 2005 summer semester by school physicians to all pupils in the eighth school year (calculated from the start of primary school) in Austria. Together with the health pass, the young people receive a vaccination pass and a health information brochure. The brochure contains information and web site references on the subjects of nutrition, exercise, dealing and coping with other people and oneself, safety, accident prevention and first aid, dental care, vaccinations, the sun as the source of life and its dangers, addictions, love and sex, contraception and protection against illness.

The young persons' examination is a service of the social health insurance system and is offered to young people in employment up to the age of 18. Young people receive a written invitation from the health insurance funds to come to the preventive check-up, and their employer is obliged to give them leave to attend and to pay them for this day. The examinations are carried out according to a uniform basic programme (physical examination, urine test and health counselling), whereby strain and stress at work is given particular emphasis. The number of young people's examinations has continually decreased, and fell by an average of 5% per year between 1990 and 2003. In 2003, 70.7% of all young people in the age group of 15–17 years took advantage of the examinations. This was, however, the highest participation rate in the period observed; in particular, a marked increase compared to the year 2002 was noticeable (6.5%).

The health pass for young persons project was initiated by the BMGF in cooperation with the Ministry of Education, Science and Culture. Around 170 experts (representatives of specialist medical organizations, school physicians and scientists) were involved in its conception. The objective of the young persons' health pass is to create a scheme for young people which informs them about their own health data and which makes dealing with the existing health care system easier. It should promote the sense of responsibility of young people over the age of 14 for their own well-being. The health pass is not only issued to pupils; it should also be used by school physicians and other physicians providing treatment. Its integration into the school physicians' examination is planned. The contents of the examination section consist of personal information from the young person (self-reflection, self-assessment and own entries), results of the annual school physician's examination and suggested examination modules which have to take place outside school if there are any abnormalities.

Preventive check-ups for adults and health passes

Preventive check-ups for adults have been offered since the start of the 1970s, the costs of which are borne by the social health insurance system. All people over the age of 19 (the insured, family members, individuals who are resident in Austria and also those without insurance) can undergo an examination once a year. For people without health insurance, the Federal Government reimburses the costs incurred by the health insurance funds. Preventive check-ups are a screening programme and target the early detection of illnesses and the reduction of suffering from disease. People for whom risk factors have been detected should receive primary preventive care (assistance and support in the reduction of the risk). In addition, diseases should be treated at an early stage. After completion of the examinations, the examinee is informed about the results and provided with additional advice in an interview with the physician. For women, a gynaecological examination is also included.

Compared to 1990, the number of preventive check-ups carried out has more than doubled, so that in 2003 just under 900 000 people or 14.3% of the Austrian population over the age of 19 took advantage of this disease prevention offer. The growth in the number of preventive check-ups for men was more dynamic (7.1% in the period of observation) than that of women (5.1%); although viewed proportionally, markedly more women (15.8%) attended examinations than men (12.5%) (Table 4.1).

As a result of the Health Reform 2004/2005, the "NEW preventive check-up" was introduced, which extended the previous range of services by adding new examinations and procedures for adults, and particularly for senior citizens. In

Table 4.1 Preventive check-ups, 1990–2003

	Preventive check-ups						Young persons' examinations	
	Absolute			in % of the population over 19 years			Absolute	in % of 15–19-year-olds
	Men	Women	Total	Men	Women	Total	Total	Total
1990	155 229	272 388	427 617	5.6	8.8	7.3	139 001	67.4
1995	226 403	364 815	591 218	7.7	11.3	9.6	91 272	60.9
2000	302 860	460 363	763 223	10.1	14.1	12.2	86 377	63.0
2001	330 518	487 921	818 439	10.9	14.8	13.0	81 430	64.2
2002	350 851	505 959	856 810	11.8	15.5	13.7	79 339	64.2
2003	376 902	521 761	898 663	12.5	15.8	14.3	70 936	70.7
AAGR 1990–2003	7.1	5.1	5.9	–	–	–	-5.0	–

Sources: Statistics Austria, 2003 *(8)*; Federation of Austrian Social Insurance Institutions, 1990–2003 *(41)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Note: AAGR: average annual growth rate.

the field of the prevention of bowel cancer, for example, colonoscopies were introduced as a new examination. For people over the age of 65, increased emphasis is laid on the functioning of hearing and eyesight, and increased targeted advice is to be provided on health-promoting changes of lifestyle in the areas of exercise, nutrition and smoking. In addition, a personal risk profile is drawn up for every person examined, and in future there will be an invitation system for preventive check-ups in order to reach more people *(72)*.

The health pass for adults as well as the health pass for senior citizens are orientated towards the "NEW preventive check-up". The values and results determined by this examination are to be documented in the passes to provide better comparability. All health passes will be distributed along with information brochures designed for the respective age groups and an international vaccination pass. The "60 plus" pass has been available since autumn 2005; health passes for people under and over 40 years old have been available from the start of 2006.

Health promotion

Since 1992, health promotion has partly been an obligatory task of the health insurance system. In this way, more emphasis is given to the role of health insurance funds in the field of prevention as well as to their significance as part of a modern health care policy. Health promotion is carried out at both

Länder level and federal government level. Health promotion in the Länder is essentially based on public subsidies which are awarded according to certain criteria (the criteria vary depending on the Land in question). On the other hand, it also rests upon initiatives by institutions and associations which set up health promotion projects and apply for relevant grants. The Health Promotion Act (Federal Law Gazette I No. 51/1998) was the first federal law solely dedicated to health promotion and which made explicit commitments in this regard. The implementation of health promotion measures and initiatives as defined by this law was delegated to the non-profit-making Healthy Austria Fund. Owing to the change in the law brought about by the Health Reform 2005, part of the revenue from tobacco tax was also transferred to the social insurance system. Legislation provides for the establishment of a fund within the HVSV which is to coordinate the use of this financing. The law also stipulates that revenue from tobacco tax has to be used for preventive check-ups as well as for health promotion measures. The Health Reform Act 2005 also established that health reforms and prevention have to be implemented at Länder level by the Health Platforms. The fulfilment of the specifications issued by the Federal Health Agency has thus been delegated to the Länder and their partners for the period 2005–2008 (see Section 2.2 on planning, regulation and management).

Healthy Austria Fund

The work of the Healthy Austria Fund is based on the Federal Act on Measures and Initiatives for Health Promotion, Health Education and Health Information (Health Promotion Act), which came into effect in 1998 and is orientated towards the 1986 Ottawa Charter of WHO. The tasks of the fund in the three-year programme (2003–2005) included the main focuses of project promotion, supporting the development of structures for health promotion, investments in further education and training and intensifying the networking of those involved in health promotion and primary prevention, as well as information, education and accompanying publicity activities. In the field of the promotion of projects, support was provided for studies on health promotion which are aimed at healthier lifestyles, practically orientated primary prevention projects with a comprehensive concept of health (bio-psychosocial well-being) and application-orientated research projects for the further development of health promotion and primary prevention. The fund partly finances the costs of projects and activities. The projects are limited in time, but can also continue over several years; long-term financing of projects is, however, not taken on.

The Healthy Austria Fund is not responsible for measures, projects and activities which fall under the responsibility of the statutory social insurance scheme or are carried out on the basis of other legislative provisions. In addition,

the Healthy Austria Fund does not assume the costs of measures, initiatives and projects which are clearly assigned to the area of responsibility of the BMSG or other ministries. Biomedical primary prevention, secondary preventive care (treatment, therapy) and tertiary prevention are also not tasks of the Healthy Austria Fund.

The Healthy Austria Fund is financed through value-added tax revenue and has annual funding of €7.25 million at its disposal. The executive bodies of the Healthy Austria Fund are the board of trustees (whose tasks include, among other things, making decisions on applications for support entailing sums of over €72 000, and establishing the content of the fund's work), the project advisory board (specialist assessment of project applications and advising the organs of the fund on the spheres of activity and the purpose of the fund) and the office (dealing with everyday business on the instructions of the board of trustees) *(73)*.

Austrian Network of Health-Promoting Hospitals

The Austrian Network of Health-Promoting Hospitals (ÖNGK) was founded at national level in 1996 with the support of the BMGF. The scientific principles of the concept of health-promoting hospitals are based on the Budapest Declaration on Health-Promoting Hospitals (World Health Organization 1991) and the Vienna Recommendations for Health-Promoting Hospitals (World Health Organization 1997). The implementation strategies of the concept of health-promoting hospitals mainly concentrate on the areas of patient orientation, staff orientation, organizational development and orientation towards the environment. Specifically, annual ÖNGK conferences are held by the Ludwig Boltzmann Institute of Medical and Health Sociology in cooperation with the BMGF, an ÖNGK project database is continuously updated and further developed, recognition procedures are carried out for new partner hospitals, and ÖNGK partners receive ongoing support.

Austrian Network for the Promotion of Health at Work

The European Network for the Promotion of Health at Work has been in existence since 1996. Its Austrian office is located within the Upper Austrian Regional Health Insurance Fund. The Austrian Network for the Promotion of Health at Work was founded at the start of the year 2000 in order to also disseminate the strategy of health promotion at regional level. Regional offices in all the Länder and the social partners have made it their task to develop joint offers and to offer concrete support to companies in their Länder.

In order to be able to implement the promotion of health at work as an appropriate company strategy, a three-staged incentive system has been developed, which is designed to also have an effect outside the company. The Promotion of Health at Work Charter has been developed, which can be signed by any company in Austria that wishes to publicly declare its commitment to this cause. In a second stage, a seal of quality is awarded to companies which carry out measures and projects to promote health at work according to the quality criteria of the network. In the third stage, companies can apply for the award of the Health Promotion Oscar, which is presented every two years to selected companies with outstanding measures and strategies for health promotion.

4.3 Outpatient health care

Outpatient health care provision in Austria is provided by self-employed physicians who predominantly work in individual practices.[13] In addition, there is direct access to outpatient clinics which are run by both the social health insurance scheme and by private individuals. Hospital outpatient departments are also providers of outpatient health care. In an organizational sense, outpatient health care is mostly based on contractual relationships between individual enterpreneurs and the health insurance funds. However, owing to the relatively high significance of hospital outpatient departments in outpatient care, which has increased even more in recent years, there is a distinct mixture of private and public service provision.

Physicians in private practice

In 2003 there were 37 447 physicians working in Austria, including specialists, dentists and physicians who were still undergoing training (see Table 4.14), of whom just over half (51.3% or 19 209) were self-employed. Between 1970 and 2003, the level of care provided by practising physicians rose by 60%. Whereas there were 546 people per physician in 1970, this ratio had changed to 218:1 in 2003. The density of provision by practising physicians is subject to considerable variations across the country. Rural regions such as the Land of Burgenland in the east (321 physicians per 100 000 inhabitants), Vorarlberg (345 per 100 000) or Upper Austria (362 per 100 000) have the lowest density

[13] Other forms of services provided by physicians include groups which share equipment, joint practices and outpatient clinics. The legislative basis for operating group practices (pilot schemes with internal medicine specialists and radiologists) was created by the amendment to the Physicians' Act 1998 (Federal Law Gazette I No.110/2001).

ratios. In contrast to this, Vienna, the federal capital and the largest city by far, has 700 practising physicians available per 100 000 inhabitants and thus more than twice as many as the above-mentioned largely rural areas.

The number of practising specialists in Austria has almost doubled since 1990 and reached the figure of 16 178 in 2003. The specialties with the highest rates of increase compared to 1990 include plastic surgery, physical medicine, neurosurgery, anaesthesiology and psychiatry. The largest proportion of practising specialists in 2003 were working in internal medicine (17.5%), anaesthesiology (10.8%) and gynaecology and obstetrics (8.7%) (Table 4.2).

In 2003, a little more than 40% (8293) of self-employed physicians in private practice (without dentists), had a contractual relationship with one or more health insurance funds. Just over half of them were general practitioners, the remainder were specialists. Contracted physicians are generally the first contact a patient makes in the health care system.

In a "location plan" which is drawn up by the health insurance funds and the physicians' chambers, the number and the regional distribution of self-employed physicians is specified. The aim of this regulatory measure is to avoid imbalances in the provision of health care. In total, there were around 1881 inhabitants per general practitioner with a health insurance contract in 2003, and 2071 inhabitants per contracted specialist. The regional variations in the density of provision between the Länder is much more distinct in the case of contracted specialists than in that of general practitioners with health insurance fund contracts. In the case of general practitioners, the difference between the Länder with the lowest and the highest densities of provision is 17 individuals per 100 000 inhabitants (ranging from 44 in Vorarlberg and 61 in Styria); for specialists it is 55 people per 100 000 inhabitants (ranging from 33 in Upper Austria to 87 in Vienna). Patients are free to choose from among contracted physicians and can select a physician of their choice without geographical restrictions.

For those insured according to the ASVG (79.1% of all directly insured individuals) and their family members, employers have issued certificates of entitlement to services to employees (known as *Krankenscheine* or health vouchers) upon demand since 1997, and continued to do so until mid-2005. For each accounting period, the patient can choose between a health voucher for general practitioners or one for specialists. During the accounting period (three months), the patient may only change from one contract physician to another with the agreement of the health insurance fund. If a patient wishes to use the services of a contract physician, he/she has to prove entitlement with a health voucher. A direct deductible of €3.63 has to be paid for the issue of a health voucher (see Section 3.3 on complementary sources of finance).

Table 4.2 Practising specialists according to specialty groups, 1990 and 2003

	1990	2003	Proportions 1990 in %	Proportions 2003 in %	Change 1990–2003 Index 1990=100
Anaesthesiology	741	1 752	8.4	10.8	236
Occupational and company medicine	–	75	–	0.5	–
Ophthalmology	458	666	5.2	4.1	145
Surgery	793	1 258	9.0	7.8	159
Gynaecology and obstetrics	823	1 357	9.4	8.4	165
Ear, nose and throat illnesses	355	522	4.0	3.2	147
Skin diseases and sexually transmitted diseases	305	562	3.5	3.5	184
Internal medicine	1 660	2 834	18.9	17.5	171
Paediatrics	649	999	7.4	6.2	154
Paediatric surgery	–	23	–	0.1	–
Pulmonary diseases	223	336	2.5	2.1	151
Diagnostic radiology	–	221	–	1.4	–
Medical and chemical laboratory diagnosis	–	232	–	1.4	–
Mouth, jaw and facial surgery	–	56	–	0.3	–
Neurosurgery	56	136	0.6	0.8	243
Neurology	344	650	3.9	4.0	189
Orthopaedics and orthopaedic surgery	305	626	3.5	3.9	205
Psychiatry	406	943	4.6	5.8	232
Physical medicine	74	208	0.8	1.3	281
Plastic surgery	22	102	0.3	0.6	464
Radiology	511	702	5.8	4.3	137
Radiotherapy-radiooncology	–	79	–	0.5	–
Accident surgery	388	802	4.4	5.0	207
Urology	272	420	3.1	2.6	154
Other clinical and nonclinical specialties	410	617	4.7	3.8	150
Total	**8 795**	**16 178**	**100.0**	**100.0**	**184**

Sources: Statistics Austria, 1990 and 2003 *(8)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Around 57% of physicians in private practice do not have a contract with a health insurance fund, and taking advantage of their services thus does not require a health voucher. If these physicians are consulted, four fifths of the fee which the health insurance funds would pay for the same service by a contract physician are reimbursed. The fees for contracted physicians are mostly considerably lower than those of private physicians.

To some extent, contracted physicians have a "gatekeeper" function, as they can control patient flows by referrals. This is the case when several specialists are consulted in one accounting period or when hospital stays and/or treatment in hospital outpatient departments is required.

Table 4.3 shows the parameters of outpatient care provision. The number of directly insured people rose by 60% between 1970 and 2003, and the volume of cases in the outpatient sector increased by 93%. In comparison, there was a rise in inpatient cases (hospital cases) of 188% (Table 4.5). This development reveals that the health care system in Austria is very hospital-centred.

The frequency of cases per insured person increased between 1970 and 2003 by just under 30% to 6.7 contacts per insured person. As the number of cases increased to a much larger extent than the number of contracted physicians, there were an average of 4718 cases per contract physician in 2003 (this is equivalent to a rise of just under 50% compared to 1970) (Table 4.3). This shows that productivity in the provision of care by general practitioners and specialists has increased significantly. This does not of course provide any final verdict about the cost-efficacy of care provision in this setting, although the improvement of the state of health of the Austrian population offers some hints in this regard (see Tables 1.4, 1.5 and 1.6).

Table 4.3 Development of some key figures in outpatient care provision, 1970–2004

	All health insurance funds		ASVG health insurance funds					
	Insured		Contracted physicians		Cases at contracted physicians[a]		Outpatient cases per insured person[b]	Outpatient cases per contract doctor[b]
	Number (millions)	Index	Number	Index	Number (millions)	Index	Number	Number
1970	4.375	100	5 350	100	18.556	100	5.2	3 468
1980	4.799	110	5 787	108	21.584	116	5.4	3 730
1990	5.091	116	6 327	118	25.158	136	5.9	3 976
2000	5.696	130	6 941	130	31.839	172	6.7	4 587
2001	5.773	132	6 979	130	32.314	174	6.7	4 630
2002	5.853	134	7 004	131	32.738	176	6.7	4 674
2003	5.930	136	7 030	131	33.157	179	6.7	4 717
2004	6.019	138	7 023	131	33.360	180	6.7	4 750

Sources: Federation of Austrian Social Insurance Institutions, 1970–2004 *(41)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: ASVG health insurance funds: regional and company health insurance funds, the insurance institution of the Austrian mining industry and the farmers' social insurance institution; [a] contacts with non-contracted physicians not included; [b] includes cases in contract physician care for which the insured claimed reimbursement from his/her health insurance fund.

With 6.7 cases per person per year in 2001, Austria was around average in comparison with other EU countries, whose average was 6.6 outpatient contacts with physicians (Fig. 4.2). In comparison with the average of the EU Member States joining on 1 May 2004 (8.4 outpatient contacts), Austria's contact frequency was below average. Contacts with non-contracted physicians are taken into account provided that they were settled with the patient's health insurance fund. However, these contact frequencies do not include any contacts with outpatient clinics or hospital outpatient departments. In international databases the frequency of outpatient contacts with physicians is thus underestimated.

Dental services

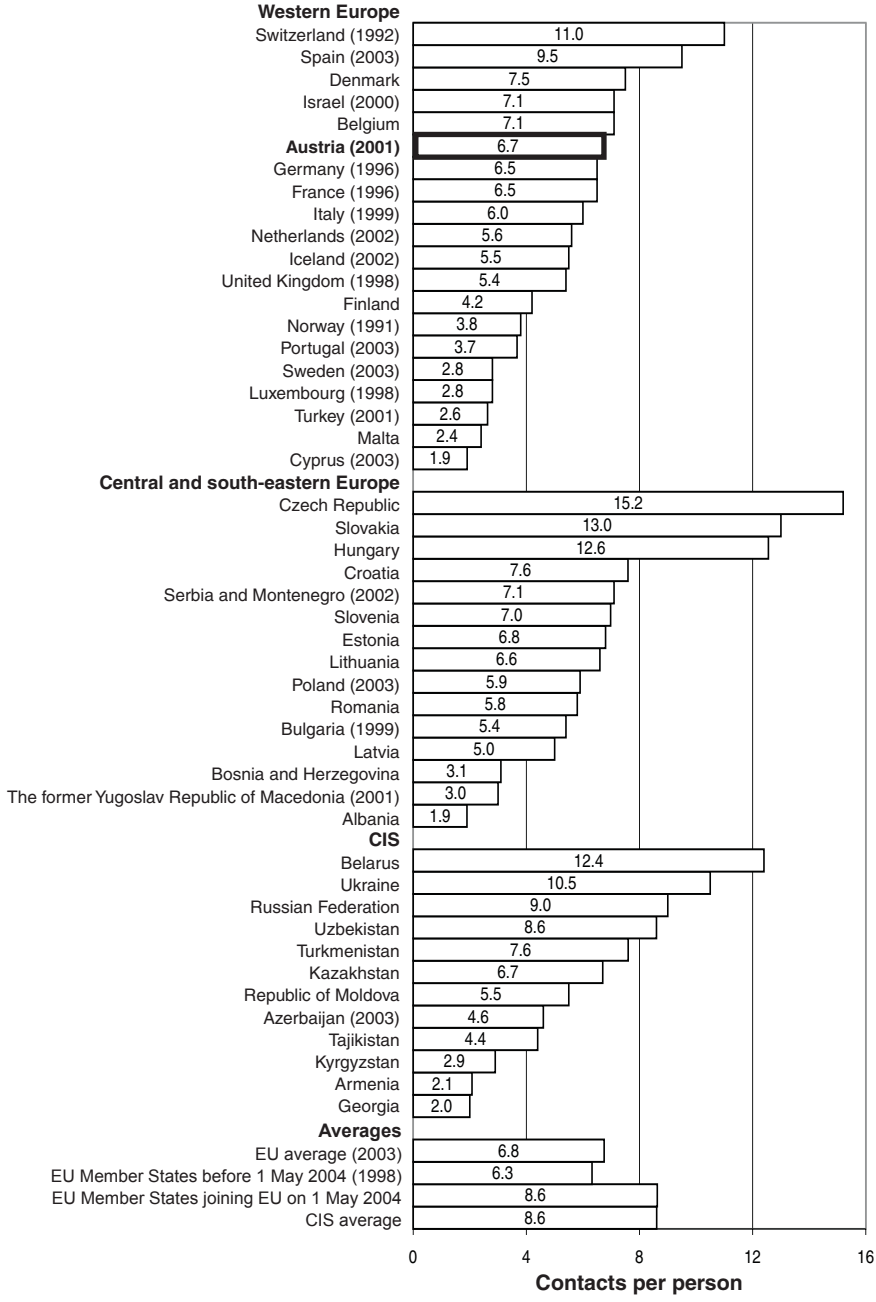
Around 11% (4037) of all practising physicians are dentists, whereby 2903 of them (71.9%) had a contractual relationship with one or more health insurance funds in 2003. A quarter of all physicians with health insurance fund contracts (physicians plus dentists) thus work in the specialist field of dentistry. In 2003 there was one contracted dentist for every 2796 inhabitants. The density of provision (dentists per inhabitant) varies considerably between the different Länder. The density of provision is highest in Vienna with 5 contracted dentists per 10 000 inhabitants; in Burgenland, Upper Austria and Tyrol it is lowest at around 2.8.

Dental treatment is basically a benefit in kind in social health insurance, which in 2003 spent 6.3% of its total budget (social health insurance expenditure) on dental treatment and dental prostheses (see Table 3.5). The cost of fixed dentures is only reimbursed by the health insurance funds in exceptional cases; the relevant costs normally have to be paid by the insured individuals (see Table 3.9). Since 1999, services for fixed dentures have also been offered by dental outpatient clinics operated by the health insurance funds, but they also have to be paid for by the insured.

Psychotherapeutic care

In 2002, around 5400 people were entitled to practise as psychotherapists according to a list kept by the Ministry of Health; i.e. there were 6.5 psychotherapists for every 10 000 inhabitants. Compared to 1992, there were almost five times as many trained psychotherapists offering their services to the population in 2002. In spite of the strong increase in the number of those entitled to practise as psychotherapists, the long-term regional imbalance in their distribution has remained unchanged. There are still differences in the density of psychotherapists between the Länder as well as between urban and rural areas. Vienna has the highest density, with seven times more psychotherapists than

Fig. 4.2 Outpatient contacts per person in the WHO European Region, 2004 or latest available year (in parentheses)



Source: European Health for All database, June 2006 *(9)*.
Notes: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.

Burgenland and five times more than Lower Austria, which are at the bottom of the ranking list. In addition, there are around 3300 clinical psychologists and around 3300 health psychologists available for the provision of psychological health care services *(74)*.

A general agreement between the Austrian Federal Association for Psychotherapy and the HVSV has not been concluded until now (see Section 3.2 on health care benefits and rationing). The provision of social insurance-funded psychotherapy is now characterized in all the Länder by a (differently weighted) combination of the three forms of direct settlement, cost reimbursement and subsidies towards costs. Psychotherapy services paid for directly by social health insurance are provided by psychotherapists in associations and in the funds' own institutions. Medical psychotherapy is offered by contracted physicians and by (non-contracted) physicians of the patients' choice with cost reimbursement. If psychotherapy is provided by therapists who are not organized in associations (with contracts), the client receives subsidies towards his/her costs. Expenditure on medical psychotherapy provided by both contracted and non-contracted physicians in 2003 constituted 28% (a sum of €12 million) of the total expenditure on psychotherapy services. The expenditure of the funds on psychotherapy which was not provided by physicians (psychotherapy via associations, with subsidies towards costs, or in fund institutions) came to €31 million in 2003 *(50)*.

Outpatient clinics

The activities of independent outpatient clinics (*Ambulatorien*) are regulated in the Federal Hospitals Act. Independent outpatient clinics are operated by various owners ranging from private individuals (for example physicians) to social insurance institutions. The fields of activity of independent outpatient clinics are basically comparable to those of practising physicians. They provide examinations and treatment for individuals who do not require inpatient treatment in hospitals. A permit from the relevant state government is required to establish and operate an independent outpatient clinic.

In 2002 there were a total of 836 independent outpatient clinics. The largest proportion of independent outpatient clinics was to be found in the Land of Vienna with 29% (243). A third of independent outpatient clinics were active in the field of physical medicine. Around 12% could be assigned to the each of the fields of dentistry and diagnostic imaging, and 5% worked in each of the areas of gynaecology and psychiatry.

The number of people employed in the 836 independent outpatient clinics amounted to a total of 9074 in 2002. Of these, 2338 were physicians (25.8%),

of whom around half were specialists; around 30% were general practitioners; a fifth were dentists and 28 were interns. In just under a third of outpatient clinics, care was provided by one physician, whereas in 17.5% of outpatient clinics more than four physicians were employed. There were clinical psychologists working in four out of ten psychiatric institutions, while there were also psychotherapists working in one in three psychiatric institutions. Health professionals with advanced training accounted for 35.1% of employees in Austrian outpatient clinics in 2002, of whom the majority of just under 70% were medical-technical staff. A further third of total employees consisted of ancillary staff *(75)*.

In 2002, the Austrian social insurance institutions operated a total of 131, or 16%, of the independent outpatient clinics, which were predominantly dental clinics (64%) and general clinics (35%).

The outpatient clinics can create considerable competition for physicians in private practice, owing to the cooperation of general practitioners and specialists within these clinics and their relatively good equipment. At the end of the 1970s, this led to the so-called "outpatient clinic debate" and to a verdict of the Constitutional Court which stipulated that before a permit could be granted for the establishment of an outpatient clinic, agreement must be reached between the physicians' professional representatives and the HVSV. If an agreement could not be reached, the state government would examine whether the clinic was required. However, these appraisals were then cut back in 1993.

Hospital outpatient departments

Hospital outpatient departments (*Spitalsambulanzen*) are an important interface in the Austrian health care system. Patients can attend directly, without a referral, upon presentation of a health voucher. Outpatient departments are available for emergency services and for acute specialist care, as well as for after-care and preventive medical check-ups. Some are open around the clock. This area of outpatient services has become increasingly extensive during recent years.

The number of cases in the outpatient departments of public hospitals reached around 5.5 million in 2003. In comparison to 1995 this corresponded to an increase of 17% (Table 4.4). The change of 9.1% between 1997 and 1999 was the most dramatic compared to the other two-year periods. The costs per outpatient case increased (15%) in hospital outpatient departments in a similar way to the number of cases; costs per case showed the greatest rise after 1999 (12%), whereas the number of cases increased most in the period from 1995 to 1999 (13%).

While the services which are offered in hospital outpatient departments can provide competition for physicians in private practice in some fields, the role

of hospital outpatient departments is more differentiated. The services offered by hospital outpatient departments do not only sometimes replace those of physicians in private practice, they often complement them. Hospital outpatient departments are particularly important in the area of primary emergency care. The scope of their services has until now been largely excluded from planning activities as well as from financing according to diagnosis-related groups (DRGs), which has given rise to cost shifts. For services provided in hospital outpatient departments, hospitals currently receive an amount per case (see Table 5.6) which is significantly below the costs per case (Table 4.4).

Table 4.4 Parameters of outpatient and inpatient care, 2003

	2003	1995=100	1997=100
Inpatient admissions (including cases of less than a day) in millions	2.538	127	118
Cases in hospital outpatient departments in millions	5.457	117	113
– Costs per hospital outpatient case in €	186.0	115	116
ASVG cases (technical specialties) in millions	5.198	149	135
ASVG cases (specialists) in millions	10.343	122	119
ASVG cases (general practitioners) in millions	15.754	103	107
Total outpatient care cases[a] in millions	**31.295**	**115**	**115**
– Fee per case (outpatient care) in €	44.9	114	110

Sources: Federal Ministry of Health and Women, 2005 *(76)*; Federation of Austrian Social Insurance Institutions *(77)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: ASVG funds: regional and company funds, Austrian miners' social insurance institution and farmers' social insurance institution; [a] only includes settled cases, whereas the Federation of Austrian Social Security Institutions' manual *(41)* also includes cases which have not been settled.

4.4 Inpatient health care

Inpatient care in Austria is predominantly publicly organized or organized with the aid of private non-profit-making owners who sometimes also operate according to public law. A hospital which is subject to public law is obliged to admit and provide services to all patients, whereas private, profit-orientated owners also have the option of refusing to admit patients. Hospitals subject to public law are also entitled to receive legally prescribed state subsidies for their day-to-day operations.

The hospitals sector has changed in recent years, as all of the Länder, except Vienna, now have companies which are organized according to private law

operating their public hospitals. The organizational forms of these companies vary; however, something which they do have in common is that their owners, the regional authorities, usually act as a guarantor. Private non-profit-making hospitals, which are partly subject to public law, have also increasingly taken on the organizational form of operating companies. The operation of specified private profit-orientated hospitals – following the system used for public hospitals – is financed according to performance-orientated principles (see Section 5.2 on payment of hospitals). Inpatient health services are thus provided by mainly privately managed public hospitals, by private non-profit-making hospitals which are partly subject to public law, and by private profit-orientated hospitals.

This section describes the provision of inpatient health care services to the population. Beginning with an overview in which the entire hospitals market is illustrated, a detailed description follows on the provision of acute care hospitals, so-called fund hospitals,[14] which provide the major part of capacities. This is then put in an international context. In Section 5.2 on payment of hospitals, the costs of acute care hospitals are described; in the introductory overview (Section 1.1), Section 2.2 on planning, regulation and management and Chapter 6 on health care reforms the legal bases, regulatory measures and reforms in the hospitals sector are described in detail.

Morbidity in hospitals

Table 4.5 shows the morbidity rates in Austrian hospitals. In 2002, a total of around 2.5 million cases were admitted to hospitals. Compared to 1970 this constituted a doubling of stays; the increase in relation to 1990 amounted to 42%. The number of stays per 100 000 inhabitants who are hospitalized due to musculoskeletal and connective tissue diseases rose seven-fold in the observation period, which was the highest rate of increase. A similarly strong rise in patient numbers was also established for malignant neoplasms (more than a five-fold increase). Inpatient stays related to pregnancy, birth and puerperium decreased by more than 50%.

For men, diseases of the circulatory system (14.7%), neoplasms (13.6%, of which 11.7% were malignant) and injuries, poisoning and miscellaneous causes (12.1%) were the most common reasons for hospital treatment in 2002. In the case of women, these were neoplasms (12.7%, of which 10.1% were malignant), diseases of the circulatory system (11.9%) and of the musculoskeletal system and

[14] Alongside fund hospitals there are also other acute hospitals, such as the accident and emergency hospitals of the General Work Accident Insurance Institution.

connective tissue (11.1%). In total, diseases of the circulatory system (13.1%) were the most common cause of hospital stays in 2002. Neoplasms followed in second place and third place was taken by diseases of the musculoskeletal system and of connective tissue. Injuries and poisoning were in fourth place.

The considerable increase and the high number of hospital stays is also partly due to more precise documentation and accounting. Day-clinic treatment for example, and also a part of outpatient treatment (for example outpatient operations) are assigned to the inpatient sector for accounting reasons. Patients are thus readmitted and discharged for all follow-up and subsequent treatment (for example in the case of chemotherapy) and are thus recorded as "new" stays or cases.

Hospital care in Austria

Table 4.6 shows the development of some key figures on hospital care in Austria. From 1980 to 2003, the number of hospitals in Austria decreased. A similar reduction also took place on average in the EU (-19%). The bed capacity in 2003 was 26% below the initial level in 1980; on average in the EU it was 32% lower (in 2002).

Table 4.7 summarizes the number of hospitals and beds actually provided[15] for 2002, differentiated according to ownership structure and hospital type. In 2003, there were a total of 67 708 beds available in 272 hospitals. The ratio of inhabitants to beds was 119 inhabitants for each bed actually provided; the bed-to-population rate was 8.3 beds per 1000 inhabitants (see also Table 4.6).

Looking at all hospitals, most beds were provided in 2003 by the Länder and Länder operating companies (52.3%). Hospitals owned by religious orders and religious communities (16.1%) were among the second largest providers of beds. Although 17% of hospitals were operated by private individuals in 2003, their share of total capacity only constituted 6.3%. Only around 3% of hospitals were owned by health insurance funds and welfare associations; these offered 1.6% of bed capacity.

42.6% of all hospitals are general hospitals, which are predominantly operated by the Länder and which provide 63.2% of beds. The proportion of specialist hospitals is only 8% lower; however, their share of bed capacity amounts to a little over a third of the proportion of beds in general hospitals. A total of 5.5% of all hospitals are long-term care institutions for the chronically ill, in which 3.8% of bed capacity is provided. In comparison to the bed capacity

[15] The actual number of beds provided is usually higher than the standardized number, owing to fluctuations in demand.

Table 4.5 Inpatient stays per 100 000 inhabitants according to main diagnoses, 1970–2003

ICD-10 classification	1970	1980	1990	2000	2001	2002	2003	2003 in %	Index 1970 =100
I. Certain infectious and parasitic diseases (A00–B99)	418	277	514	701	687	702	712	2.3	170
II: Neoplasms (C00–D48)	–	–	–	–	3 805	4 028	4 079	13.2	–
of which malignant neoplasms (C00–C97)	607	997	1 788	2 983	3 139	3 333	3 367	10.9	555
III: Diseases of the blood and blood-forming organs (D50–D89)	79	86	110	209	203	190	204	0.7	258
IV: Endocrine and metabolic diseases, nutritional disorders (E00–E90)	397	603	776	987	923	846	818	2.7	206
V. Mental and behavioural disorders (F00–F99)	–	–	–	–	1 514	1 836	1 479	4.8	–
VI. Diseases of the circulatory system (G00–G99)[a]	933	1 372	1 287	2 132	1 118	1 221	1 254	4.1	134
VII. Diseases of the eyes and the eye appendix (H00–H59)	–	–	–	–	1 089	1 143	1 187	3.9	–
VIII. Diseases of the ear and the mastoid (H60–H95)	–	–	–	–	351	378	366	1.2	–
IX. Diseases of the circulatory system (I00–I99)	1 392	2 028	3 220	4 073	3 895	4 051	4 009	13.0	288
X. Diseases of the respiratory system (J00–J99)	1 711	1 655	1 696	2 050	1 919	1 924	1 915	6.2	112
XI. Diseases of the digestive system (K00–K93)	2 359	2 476	2 164	2 300	2 452	2 696	2 756	9.0	117
XII. Diseases of the skin and subcutaneous tissue (L00–L99)	385	411	448	433	454	477	477	1.5	124
XIII. Diseases of the musculoskeletal system and the connective tissue (M00–M99)	478	964	1 854	2 849	3 010	3 170	3 296	10.7	689
XIV. Diseases of the urogenital system (N00–N99)	1 349	2 176	1 688	1 731	1 820	1 895	1 871	6.1	139
XV. Pregnancy, birth and puerperium (O00–O99)	3 220	3 296	3 362	2 928	1 470	1 527	1 469	4.8	46
XVI. Conditions originating in the perinatal period (P00–P96)	129	162	171	146	145	149	141	0.5	109
XVII. Congenital deformities and chromosome abnormalities (Q00–Q99)	78	80	172	196	219	239	240	0.8	307
XVIII. Symptoms and abnormal clinical and laboratory findings which are not classified elsewhere (R00–R99)	590	1 065	639	939	1 023	1 099	1 119	3.6	190
XIX. Injuries, poisonings and certain other consequences of external causes (S00–T98)	2 292	2 658	2 771	2 996	3 055	3 086	3 229	10.5	141
XX. Factors which influence the state of health and lead to the use of the health care system (Z00–Z99)	–	–	–	–	157	167	167	0.5	–
All diagnoses	**16 417**	**20 306**	**22 660**	**27 653**	**29 312**	**30 824**	**30 788**	**100.0**	**188**

Sources: 1970–2000: OECD Health Data, 2004 *(7)*; 2001–2002: Statistics Austria, 2002 and 2003 *(8)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Note: [a] Before 2001: G00–H95.

Table 4.6 Hospital care, 1980–2003

	1980	1985	1990	1995	2000	2001	2002	2003	Index 1980 =100	Index 1990 =100	Index 2000 =100
Total hospitals											
Hospitals per 100 000 inhabitants	4.3	4.4	4.2	4.1	3.9	3.9	3.5	3.4	78	79	87
Beds per 100 000 inhabitants	11.2	10.9	10.1	9.3	8.6	8.5	8.4	8.3	74	83	97
– Psychiatric beds per 100 000 inhabitants[a]	1.3	1.1	1.0	0.8	0.6	0.7	0.7	0.6	46	60	100
– Beds in long-term care and old people's homes per 100 000 inhabitants	–	1.4	1.2	1.2	1.1	1.1	0.9	0.9	–	75	81
Cases per 100 inhabitants	19.5	21.6	23.4	24.7	29.2	29.7	31.2	31.2	160	133	107
Average length of stay in days	17.9	14.1	13.0	10.9	8.8	8.4	8.1	8.0	45	61	90
Acute hospitals											
Acute hospitals per 100 000 inhabitants	–	–	2.6	2.5	2.3	2.3	2.3	2.2	–	85	96
Acute beds per 1000 inhabitants	–	7.4	7.0	6.6	6.2	6.1	6.1	6.0	–	86	97
Acute inpatient cases per 100 inhabitants	–	19.0	21.7	23.1	27.2	27.5	28.6	28.8	–	133	106
Average length of acute inpatient stays, in days	14.5	12.7	9.3	7.9	7.0	6.7	6.5	6.4	44	69	91
Acute inpatient occupancy rate in %	80.8	81.4	78.1	75.9	75.5	75.6	76.4	76.2	94	98	101

Sources: European Health for All database, January 2006 *(9)*.

Note: [a] Beds in hospitals in which the proportion of psychiatric (or neurological) beds is over 50%. Psychiatric beds in other hospitals, particularly acute hospitals, are assigned to the category of acute beds. The decrease in the number of beds between 1985 and 1990 is partly due to a changeover in statistics from a departmental to an institutional level.

in long-term care institutions, the bed capacity in sanatoriums is more than 50% lower with an average of 81 beds.

139 hospitals or 51% of all hospitals are public hospitals, which essentially include public and private non-profit-making acute hospitals (without emergency hospitals), and are financed by public money via State Health Funds. The bed capacity of public hospitals amounted to 49 292 beds actually provided, at the end of 2003, which corresponded to 72.8% of total Austrian bed capacity. More than 83.8% of total hospital personnel is concentrated in public hospitals, which cared for around 2.3 million hospitalized patients in 2003. The hospitalization rate for the public hospitals sector was around 28 cases per 100 inhabitants. The ratio of inhabitants to beds was 6.1 beds per 1000 inhabitants or 165 inhabitants per bed. The average length of stay of patients admitted to public hospitals for between 1 and 28 days was 5.97 days in 2003 (Table 4.8).

At the end of 2003, around 60% of hospitals together only provided around 26% of beds. This 60% of hospitals had fewer than 200 beds each. Around 75 hospitals which together had around 32% of the overall stock of beds had between 200 and 500 beds (Table 4.8). A further 23% of Austrian hospital beds

Table 4.7 Ownership and types of hospitals and beds, 2003

Distribution of hospitals and beds	Number of hospitals	As a percentage of total hospitals	Number of beds actually provided	As a percentage of total beds
According to ownership status				
Federal government	10	3.7	566	0.8
Länder, Länder operating companies	89	32.7	35 404	52.3
Municipal/local authority joint health associations	9	3.3	2 536	3.7
Local authorities and local authority operating companies	25	9.2	7 308	10.8
Health insurance funds and their welfare associations	7	2.6	1 100	1.6
Work accident and pension insurance institutions	33	12.1	4 644	6.9
Religious orders and religious communities and their companies	42	15.4	10 873	16.1
Associations, foundations	10	3.7	990	1.5
Private individuals and companies	47	17.3	4 287	6.3
Total	**272**	**100.0**	**67 708**	**100.0**
According to public law/type of hospital				
General hospitals	116	42.6	42 765	63.2
Specialist hospitals, total	94	34.6	14 545	21.5
Convalescent homes	3	1.1	243	0.4
Long-term care homes for the chronically ill	15	5.5	2 596	3.8
Sanatoriums	34	12.5	2 769	4.1
Total hospitals	262	96.3	62 918	92.9
Hospital departments in long-term care homes of the City of Vienna	10	3.7	4 790	7.1
Total	**272**	**100.0**	**67 708**	**100.0**

Sources: Statistics Austria, 2003 *(8)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

were to be found in 21 hospitals with between 500 and 1000 beds. Including university teaching hospitals, there were nine hospitals at the end of 2003 which had more than 1000 beds and together thus held 19% of the total stock of hospital beds. In the university teaching hospitals of Graz, Innsbruck and Vienna, there were a total of 5000 beds in 2003.

Almost 90% of non-public hospitals are small hospitals with less than 200 beds. This is also shown by the fact that almost half (49%) of all hospitals in Austria are not public hospitals, but that they only provide 27% of all beds (Table 4.8).

Table 4.8 Number of hospital beds by hospital type, 2003

	Number of hospitals			Proportion in %		
	Fund[a]	Non-fund	Total	Fund[a]	Non-fund	Total
Hospitals						
< 200 beds	52	115	167	37.4	86.5	61.4
200–499 beds	61	14	75	43.9	10.5	27.6
500–999 beds	18	3	21	12.9	2.3	7.7
1 000+ beds	8	1	9	5.8	0.8	3.3
Total	**139**	**133**	**272**	**100.0**	**100.0**	**100.0**
Beds actually provided						
< 200 beds	6 981	10 799	17 780	14.2	58.6	26.3
200–499 beds	18 002	3 475	21 477	36.5	18.9	31.7
500–999 beds	13 354	1 999	15 353	27.1	10.9	22.7
1 000+ beds	10 955	2 143	13 098	22.2	11.6	19.3
Total	**49 292**	**18 416**	**67 708**	**100.0**	**100.0**	**100.0**

Sources: Federal Ministry of Health and Women, 2005; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Note: [a] Public hospitals which are financed via State Health Funds.

In comparison to 1990, there were 48 fewer hospitals in Austria in 2003, which constitutes a decrease of 15% (Table 4.9). The reduction of hospitals in the public and non-profit-making hospital sectors was particularly marked. In the period observed, around 5700 beds were cut, whereby more than three quarters of all those removed had been in public hospitals. The reduction in beds in private non-profit-making hospitals was much more pronounced than in the public sector. In contrast to all the other ownership categories, there were more beds in private hospitals in 2003 than in 1990 (+30% or 979 beds).

Acute hospitals

Acute inpatient care is predominantly provided by general hospitals (63% of all hospitals, Table 4.7); in addition, a proportion of specialist hospitals are also assigned to the category of acute care. The WHO Health for All database takes all beds in acute hospitals into account, including military hospitals and prisons as well as hospitals whose proportion of psychiatric beds is lower than 50%. According to this method of calculation, 72% of hospital beds in Austria provide acute care (Table 4.6).

The number of acute hospitals was gradually reduced from 2.6 to 2.2 per 100 000 inhabitants between 1990 and 2003; at the same time, the number of acute beds was cut from 7.4 to 6 per 1000 inhabitants. Admissions for acute inpatient treatment rose from 21.7 per 100 inhabitants in 1990 to 23.2 in 1995,

Table 4.9 Development of the number of hospitals and beds, 1990–2003

	1990		2003		Change	
	Absolute	Proportion (%)	Absolute	Proportion (%)	Absolute	Relative (in %)
Hospitals						
Public	163	50.9	133	48.9	-30	-18.4
Social 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	50 153	68.3	45 814	67.7	-4 339	-8.7
Social insurance	6 138	8.4	5 744	8.5	-394	-6.4
Non-profit	13 780	18.8	11 863	17.5	-1 917	-13.9
Private	3 308	4.5	4 287	6.3	979	29.6
Total	**73 379**	**100.0**	**67 708**	**100.0**	**-5 671**	**-7.7**

Sources: Statistics Austria, 1990 and 2003 *(8)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

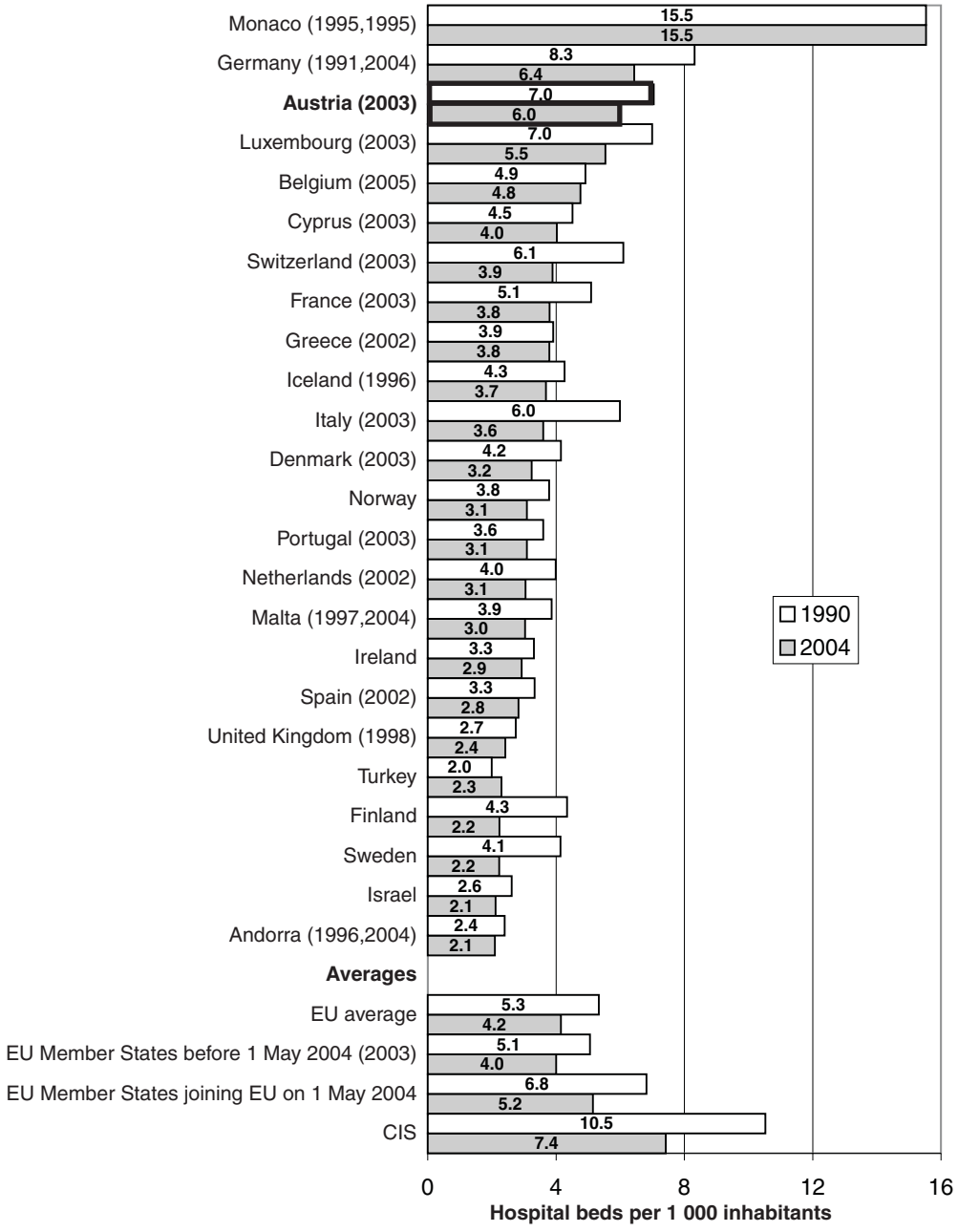
to 27.2 in 2000 and to 28.8 in 2003. The average length of stay fell during the same period from 9.3 days to 7.9 days, and then further to 7.0 days and 6.4 days. At the same time, the occupancy rate fell from 78.1% to 76.9% and 75.5% and increased slightly again to 76.2% by 2003.

In 2003, the ratio of inhabitants to beds in Austria of 6 beds per 1000 people was clearly above the EU average of 4.2 per 1000 inhabitants. In comparison to other EEA countries, the ratio of acute beds to inhabitants in Austria was the second highest after Germany, followed by Belgium, Luxembourg and Switzerland (Table 4.10). The discrepancy between the EU average and Austria in 2003 was 1.9 acute beds per 1000 inhabitants or 44%. Compared to 1990 (1.7 beds) this gap has increased: between 1990 and 2003, the ratio of acute beds per inhabitant fell by 22% on average in the EU; in Austria it only fell by 15% *(9)*.

Within the entire WHO European Region, Austria has by far the highest admission rate for acute hospitals (28.4% in 2003). In 1980, the admission rate in Austria was 24% above the comparable EU figure, and increased significantly more strongly (by 55%) than on average in the EU, so that the gap between Austria and the EU average grew to 65% in 2003 (Table 4.10).

The average length of stay was shorter than that of the EU average (6.4 days compared to 6.9 days). The occupancy rate of 76.2% in 2003 was slightly below the EU average of 77.5%. Whereas the average occupancy in the EU remained approximately constant in comparison to 1980, it fell by 4.6% to 76.2% in Austria in 2003 (Table 4.10) – an indicator that there is overcapacity in the hospitals sector.

Fig. 4.3 Hospital beds per 1000 inhabitants in acute hospitals in western Europe, 1990 and 2004 or latest available year (in parentheses)



Source: European Health for All database, June 2006 *(9)*.
Notes: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.

Table 4.10 Inpatient utilization and performance in acute hospitals in the WHO European Region, 2004 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Andorra	2.1	10.0	6.7[e]	70.0[e]
Austria	6.0[a]	28.8[a]	6.4[a]	76.2[a]
Belgium	4.8	16.9[e]	8.3[a]	65.9[a]
Cyprus	4.0[a]	8.1[a]	5.5[a]	72.8[a]
Denmark	3.2[a]	17.8[c]	3.6[a]	84.0[c]
Finland	2.2	19.9	4.2	74.0[j]
France	3.8[a]	16.6[d]	6.1[a]	84.0[a]
Germany	6.4	20.4	8.7	75.5
Greece	3.8[g]	14.5[f]	6.4[f]	66.6[f]
Iceland	3.7[h]	14.7[a]	3.6[a]	–
Ireland	2.9	14.1	6.5	85.4
Israel	2.1	17.3	4.2	98.0
Italy	3.6[a]	15.2[b]	6.8[b]	76.9[b]
Luxembourg	5.5[a]	18.4[j]	7.7[f]	74.3[j]
Malta	3.0	10.7	4.6	85.4
Monaco	15.5[i]	–	–	–
Netherlands	3.1[b]	8.8[c]	7.4[c]	58.4[c]
Norway	3.1	17.3	5.2	86.4
Portugal	3.1[a]	11.2[e]	8.2[e]	85.2[a]
Spain	2.8[b]	11.7[b]	7.0[b]	78.2[b]
Sweden	2.2	15.1	6.1	77.5[h]
Switzerland	3.9[a]	16.3[f]	9.0[a]	85.2[a]
Turkey	2.3	8.1[a]	5.6[a]	64.9
United Kingdom	2.4[f]	21.4[h]	5.0[h]	80.8[f]
Central and south-eastern Europe				
Albania	2.7	–	–	–
Bosnia and Herzegovina	3.3[f]	7.2[f]	9.8[f]	62.6[e]
Bulgaria	7.6[h]	14.8[h]	10.7[h]	64.1[h]
Croatia	3.6	14.6	8.2	89.9
Czech Republic	6.2	20.8	8.2	74.8
Estonia	4.3	17.2	6.2	68.4
Hungary	5.9	23.5	6.5	76.6
Latvia	5.4	18.8	–	–
Lithuania	6.1	21.9	7.9	77.4
Poland	4.7[b]	–	–	–
Romania	4.4	–	–	–
Serbia and Montenegro	–	–	9.7[b]	69.0[b]
Slovakia	6.1	17.8	8.4	68.6
Slovenia	3.9	16.6	6.2	73.2
The former Yugoslav Republic of Macedonia	3.4[c]	8.2[c]	8.0[c]	53.7[c]
CIS				
Armenia	3.9	7.0	8.5	41.8
Azerbaijan	7.6[a]	4.8[a]	15.8[a]	26.1[a]
Belarus	–	–	–	88.7[j]
Georgia	3.7	5.4	6.7	99.3
Kazakhstan	6.2	17.4	10.0	95.6
Kyrgyzstan	4.1	12.3[a]	10.3	90.0
Republic of Moldova	5.2	15.4	7.8	62.9
Russian Federation	8.2	21.3	12.2	87.3
Tajikistan	5.7	10.2	12.0	58.1
Turkmenistan	3.8	13.3	7.9	81.8
Ukraine	7.1	20.0	11.9	91.2
Uzbekistan	4.5	14.2	–	86.5
EU average	4.2	17.5[a]	6.9[a]	77.5[a]
EU Member States before 1 May 2004	4.0[a]	18.0[c]	6.9[a]	77.0[c]
EU Member States joining EU on 1 May 2004	5.2	20.6	7.4	73.8
CIS average	7.4	19.5	11.6	87.1

Source: European Health for All database, January 2006 *(9).*

Notes: [a] 2003; [b] 2002; [c] 2001; [d] 2000; [e] 1999; [f] 1998; [g] 1997; [h] 1996; [i] 1995; [j] 1994; CIS: Commonwealth of Independent States; EU: European Union.

4.5 Outpatient and inpatient long-term care

Outpatient and inpatient long-term care in Austria includes the sectors of psychiatry, rehabilitation and nursing care. Services and facilities for people in need of care include mobile services, day facilities (day centres) and inpatient facilities. Outpatient and inpatient long-term care is also characterized by heterogeneity with regard to responsibilities and decision-making competencies. Whereas, for example, acute psychiatry is included in the regulatory measures of the Federal Government, rehabilitation falls within the field of competency of the social insurance institutions (see Section 2.2 on planning, regulation and management). Long-term care provision, on the other hand, has been nationally coordinated between the regional authorities since 1993 with the aid of federal instruments (see the introductory overview (Section 1.1) and Section 1.2 on historical background).

Psychiatry

Since the end of the 1970s, reforms in psychosocial care provision have been carried out with the objective of converting traditional institution-based psychiatry into care which is closer to the homes and lives of the patients. Psychosocial care in Austria is supplied by a mixed system of different providers in the health and social sectors. A binding national psychiatry concept was adopted for the first time with the inclusion of the psychiatric care sector in the Austrian Hospitals Plan in 1999. The number of beds needed in specific acute hospital locations was determined based on the principles of needs-orientation, proximity to communities and integration, outpatient rather than inpatient treatment, regionalization, networking and coverage obligations, integration into the outpatient health care system, quality assurance and participation. The basis for the recommendations regarding locations and numbers of beds are provided by the bed indices for this specialist sector.

Since the 1980s, a constant reduction of beds in the inpatient sector and a significant decrease in the average length of stay have been achieved. Whereas the average length of stay in 1980 was still 95 days, in 2003 it had fallen to only 18 days. The number of acute beds decreased in this period by more than half, and amounted to 4584 actually provided in 2003. For every 10 000 inhabitants there are thus 5.6 psychiatric beds available (Table 4.6). The number of locations nationwide was to have been increased from 22 to 42 by 2005, while at the same time reducing the number of psychiatric beds to 4360.

Outpatient psychiatric care (not including hospitals) consists of physicians specializing in psychiatry, psychosocial and social-psychiatric services as well

as complementary facilities and services in the fields of housing, employment and day structure (day facilities). The development of outpatient psychiatric services and facilities is the responsibility of the Länder. For a decade now, there has been a continuous increase in psychosocial services and complementary facilities. In spite of this rise, however, the level of care currently provided is still not sufficient to fulfil requirements (too few offers and regional differences).

In order to achieve the objective of more outpatient and less inpatient care, it has been agreed that each Land should define regions for the organization of care for the mentally ill and mentally disabled in coordination with the Federal Government. The development of the above-mentioned day, outpatient and complementary facilities and services is to be intensified.

Rehabilitation

The general goal of rehabilitation is to enable patients to lead an independent life again, if possible without outside assistance, to reintegrate themselves into working life, or to complete training. Retirement due to disabilities and the need for long-term care should be prevented or at least postponed.

In the social insurance laws, varying concepts of rehabilitation with different responsibilities, objectives and tasks are defined according to the respective branch of insurance (health insurance, pension insurance or work accident insurance). Whereas social health insurance law specifies a comprehensive obligation to enable reintegration into society, the benefits and services of pension insurance are directed towards avoiding early retirement due to disability (an obligatory task) and avoiding the need for long-term care arising (a voluntary benefit within the framework of preventive health care). Benefits and services provided by work accident insurance are addressed towards the restoration of health and ability to work after work accidents and occupational diseases. To attain these objectives, the following measures are set out in the social insurance laws: medical rehabilitation measures (in health insurance, pension insurance and work accident insurance); measures to consolidate patients' health (in health insurance); preventive health care measures (in pension insurance); and employment and social measures (in pension and work accident insurance).

Medical rehabilitation includes, among other things, stays in institutions which "are primarily for rehabilitation purposes" – rehabilitation centres (which are specialist hospitals as defined by Section 2, paragraph 1, line 2 of the Federal Hospitals Act) – as well as the provision of therapeutic aids which are necessary to compensate for disabilities. Preventive health care measures are not subject to any restrictions regarding the type and equipment of the

facilities which might be used for therapy. Measures to consolidate patients' health, however, are restricted to stays in convalescent and rest homes as well as in institutions in health resorts *(44)*.

In 2004, the Austrian social insurance institutions provided rehabilitation therapy in 29 specialist hospitals (rehabilitation centres) with 3916 beds, in 12 institutions in health resorts with 1056 beds, and in five convalescent and rest homes with 510 beds *(78)*.

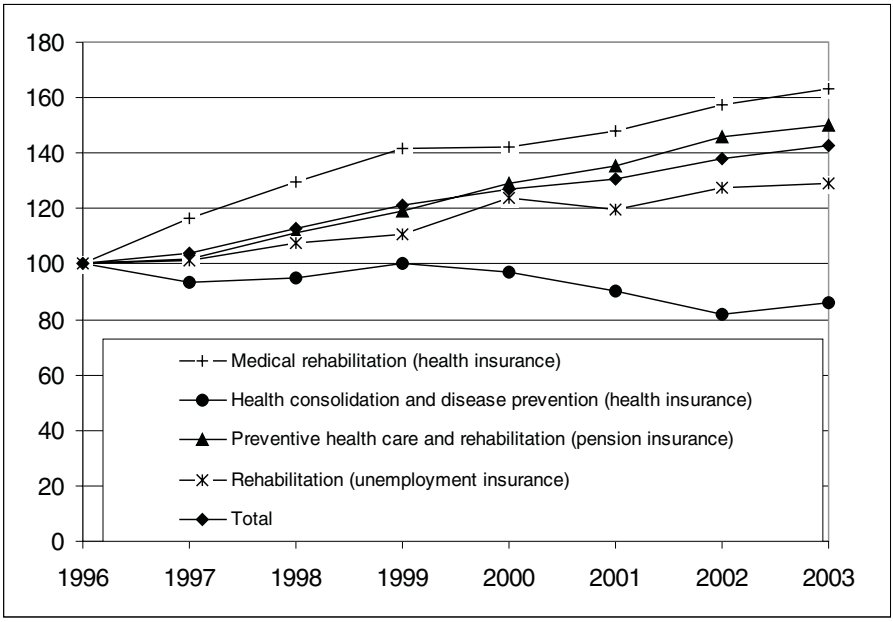
The social insurance system (health, pension and work accident insurance) spent around €720 million on rehabilitation measures in 2003. More than half of this (55.7%) was spent on preventive health care and rehabilitation via the pension insurance institutions, and around 36% was expenditure through the health insurance funds for medical rehabilitation, consolidation of health and the prevention of illness. A share of 8.7% was spent on rehabilitation by the General Work Accident Insurance Institution. The expenditure of the health insurance institutions on medical rehabilitation increased most, with a rise of over 60% since 1996. A decrease in spending in the period observed can only be noted in the expenditure of the health insurance funds on health consolidation and the prevention of illness (Fig. 4.4).

There are currently no explicit regulations on outpatient rehabilitation in social insurance legislation. They can, however, be deduced from the sections in the law that deal with "medical treatment" (in health insurance) and "preventive health care" (in pension insurance). Outpatient services related to rehabilitation are primarily provided in hospital outpatient departments, in independent outpatient clinics as well as by physicians and therapists in private practice. In addition, outpatient rehabilitation services are offered in two institutions operated by the social insurance system, one of which is dedicated to this purpose.

Long-term care

In 1993, the Federal Long-Term Care Benefit Act was passed, with the aim of standardizing long-term care provision. The Federal Long-Term Care Benefit Act and the nine largely identical Länder long-term care benefit acts introduced staged, needs-orientated long-term care benefit, to which there is a legally enforceable entitlement independent of the claimant's income and assets and the reason for their need for care. Long-term care benefit can be claimed when the need for care will presumably last for at least six months, and it is granted (also for babies) in seven stages, twelve times a year. In 2005, the levels of the benefit ranged from €148.30 to €1562.10 (Table 4.11). Long-term care benefit, which is paid from general tax revenue, was increased on 1 January 2005 by 2% for every stage.

Fig. 4.4 Expenditure of the social insurance system on rehabilitation, 1996–2003, index 1996=100



Sources: Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Table 4.11 Rates of long-term care benefit, 2005

	Rates of long-term care benefit, in € per month	Average care requirement per month in hours
Stage 1	148.30	>50
Stage 2	273.40	>75
Stage 3	421.80	>120
Stage 4	632.70	>160
Stage 5	859.30	>180 and if there is an exceptionally high need for care
Stage 6	1 171.70	>180 and if care measures are required which cannot be planned for in advance and which regularly have to be provided during the day and the night or if the constant presence of a carer is required during the day and the night
Stage 7	1 562.10	>180 and if no goal-directed movements of the person's four extremities with functional implementation are possible

Sources: Federation of Austrian Social Insurance Institutions, 2005 *(78)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

The reorganization of long-term care provision in Austria has the objective of making it possible for people requiring care to lead independent lives orientated towards their needs in spite of the restrictions they face. The system of long-term care provision, which includes elderly people and people with disabilities, provides for a combination of cash benefits and benefits in kind. This is based on an agreement on joint measures between the Federal Government and the Länder (according to Federal Constitution Article 15a). For this purpose, a benefits catalogue and quality standards for the outpatient and inpatient sectors were drawn up. On the basis of the agreement and the needs and development plans of the Länder, the following guiding principles can be identified: self-determination and needs-orientation; integration and normalization; remaining in one's own social environment; care which is in accordance with people's needs and whose supply is assured; quality assurance and professionalism; economy; freedom of choice and the support of informal care *(79).*

Table 4.12 shows that in 2003 a total of 362 252 individuals (4.5% of the Austrian population) received long-term care benefit, of whom 85% received the benefit from the Federal Government. The predominant proportion of federal long-term care benefit was distributed via the pension insurance institutions; 0.5% of federal long-term care benefit recipients claimed the benefit via work accident insurance and 9.4% via other federal bodies (Austrian railways, the federal pensions office, the post office and the Federal Social Welfare Office). As a percentage of the population, significantly more women (6.2%) receive long-term care benefit than men (2.8%) (including figures from the Federal Government and the Länder, without the victims' welfare scheme and Länder teachers). Around three quarters (72.6%) of long-term care benefit recipients can be assigned to care stages 1–3, of whom the majority belong to care stage 2 (35%).

Since 1995, the number of long-term care benefit recipients has increased by 14%, whereby there were increases in every stage except stage 2. The decrease of stage 2 recipients was exclusively due to federal long-term care benefit recipients. The number of long-term care benefit recipients in stage 1 more than doubled and thus showed the greatest increase. The number of people in long-term care benefit stages 4 and 7 almost doubled. The decisive factor here was the reduction of the average care requirement in stage 4 from more than 180 hours to more than 160 hours per month as a result of the amendment to the Federal Long-Term Care Benefit Act which came into effect on 1 January 1999. The result of this development was that the proportion of long-term care benefit recipients in stage 1 in particular increased markedly (+10.5%).

Almost half of all long-term care benefit recipients in 2003 were over 81 years. A particularly high proportion of long-term care benefit recipients aged

Table 4.12 Number and care stages of federal long-term care benefit recipients, 1995–2003

	1995				2003				1995–2003		
	Number			in %	Number			in %	Index 1995=1 000		
	Federal level	Länder	Total	Total	Federal level	Länder	Total	Total	Federal level	Länder	Total
Stage 1	22 151	8 359	30 510	9.6	62 172	10 709	72 881	20.1	281	128	239
Stage 2	148 467	14 017	162 484	51.1	109 944	16 968	126 912	35.0	74	121	78
Stage 3	51 681	10 248	61 929	19.5	52 507	10 517	63 024	17.4	102	103	102
Stage 4	23 544	4 212	27 756	8.7	46 365	6 918	53 283	14.7	197	164	192
Stage 5	19 494	4 526	24 020	7.6	25 085	4 476	29 561	8.2	129	99	123
Stage 6	4 372	2 877	7 249	2.3	7 090	2 981	10 071	2.8	162	104	139
Stage 7	2 633	1 192	3 825	1.2	4 836	1 684	6 520	1.8	184	141	170
Total	**272 342**	**45 431**	**317 773**	**100.0**	**307 999**	**54 253**	**362 252**	**100.0**	**113**	**119**	**114**

Sources: Federal Ministry of Social Security, Generations and Consumer Protection, 2003 *(80)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

under 40 could be observed in the two highest stages, with 24% and 22% (Fig. 4.5).

The expenditure on long-term care benefit by the Federal Government (including administrative costs) has risen by 6.6% since 1995 and amounted to around €1.5 billion in 2003. The expenditure of the Länder for long-term care benefit recipients according to the Länder long-term care benefit laws amounted to €277 million in 2003. In comparison to 1995, this corresponded to an increase of 8.6%. Projections by the IHS show that if the current demographic developments merely continued and were not intensified, the expenditure on long-term care benefit would increase by around 50% by the year 2025 *(80)*.

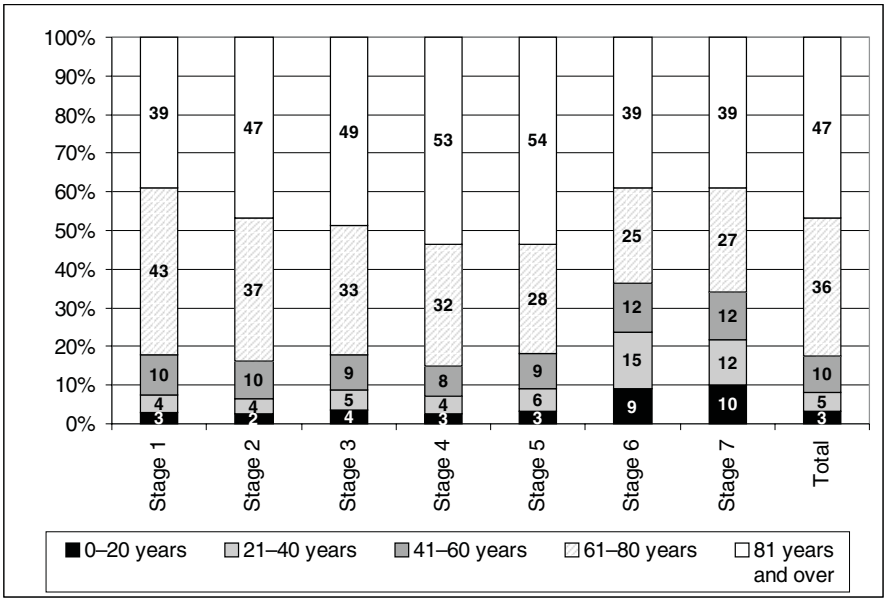
Mobile services

At the end of 2002, 7810 care providers (full-time equivalents) were employed in Austria. The density of care provision for the country as a whole is 13.4 people per 1000 inhabitants over the age of 75. At present, there are around 1800 employees (full-time equivalents) more in the mobile services sector than there were 5 to 6 years ago (figures without Vienna). This corresponds to an increase in personnel of 51%. Based on the current situation, by the year 2010 an additional 2191 full-time equivalents are planned nationwide compared to 2002 (without Salzburg, Vorarlberg and Vienna).

Day care

At the end of 2002, a total of around 1070 places in day care facilities (mostly geriatric day centres) were offered in Austria (without Burgenland). These type

Fig. 4.5 Age distribution of federal and Länder long-term care benefit recipients, 2003[a]



Sources: Federal Ministry of Social Security, Generations and Consumer Protection, 2003 *(80)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Note: [a] Without the victims' welfare scheme and Länder teachers.

of services are not very common outside Vienna, as they tend to be dependent on urban structures owing to the required geographical accessibility.

Inpatient care

At the end of 2002, there were around 67 600 places in homes, which translates into 116 places for every 1000 inhabitants aged 75 and older. Of these, around 53 000 places (78% of places in homes) were long-term care places. Since the survey of the actual situations in 1995/1996/1997, there has been an increase in the number of places in homes by 4.3% or 2800 places. In total, there was a massive reduction of residential places in favour of a considerable extension of long-term care places. The actual situation in Austria in 2002 almost reached the figures for places in homes calculated in the needs and development plans for the year 2010: only another 433 places would have been needed to complete the target figure for 2010. There are around 21 250 full-time equivalent employees in old people's homes and long-term care homes. The actual number of people employed is considerably higher than the full-time

equivalents figure, as a proportion of the personnel work on a part-time or hourly basis. In the period between 1995/1996/1997 and 2002, the personnel levels in all old people's and long-term care homes increased by around 60% or 7760 full-time equivalents.

For people with mental and multiple disabilities, there are currently around 13 550 places (17 places per 10 000 inhabitants) available in day centres in Austria, which translates into around a third more places than in the mid-1990s. The number of places required as calculated for five Länder in the year 2010 has thus already been fulfilled. The number of fully and partially supervised residential places has increased by just under 70% since the mid-1990s. Nationwide there are around 8400 places, whereby the proportion of partially supervised residential places has increased significantly *(80).*

4.6 The integration of service provision

Services are provided on four levels in the Austrian health care system. The public health service is provided by the state's administrative bodies, which also have certain responsibilities for health promotion and prevention. The structures created for this date back to the Imperial Sanitary Act of 1870 (see Section 1.2 on historical background). In the course of recent decades, prevention and health promotion have increasingly become one of the tasks of the social health insurance system, which in addition plans, coordinates and finances the provision of services in the outpatient sector.

Rehabilitation services are also provided by the social insurance system. The provision of acute inpatient care, on the other hand, mainly belongs to the duties of the Länder and its financing is divided up between the social insurance system and the regional authorities. Supplying inpatient long-term care is also essentially the responsibility of the Länder. All the care levels are interlinked with regard to the content of their tasks (see Table 2.1). However, the plurality of financing sources and of the bodies providing care in the Austrian health system lead to breaks in the supply chain. This situation is further exacerbated by differences in the structures between the Länder (see, for example, Table 5.6). The supply levels are therefore not only characterized by plurality with regard to responsibilities and flows of financing; this is also supplemented by differences between the Länder and also by differences in individual service sectors of the social health insurance system (see Section 3.2 on health care benefits and rationing).

The procedure and diagnosis orientated reimbursement system of acute inpatient care services (Austrian DRG model) (see Section 5.2 on payment

of hospitals) in connection with budgeted funding from the social health insurance system for inpatient care provision (see Table 5.1) has led to an increase in the level of technical efficiency in this sector, particularly in recent years *(81).* However, there is a considerable incentive for hospitals to admit as many patients as possible (and these as often as possible). The reasons for this are: first, hospital outpatient departments are not integrated into this method of financing (see Table 5.6); second, budgets are set for the funding from the social health insurance system for hospitals; and third, service provision in the outpatient sector is controlled via the selective award of contracts. The admission rate has been significantly higher than that of comparable industrial countries for many years now (see Table 4.10). In addition, the currently valid "special class regulations" create a further incentive for hospitals to keep bed capacities high (see Section 5.3 on payment of physicians). The increase in productivity at the given, relatively high capacity level in this service sector was, and still is, therefore also being achieved by "avoidable" hospital stays.

These developments have further intensified the problems in providing an integrated and balanced care supply (inefficiency of allocation), because not all patients are cared for in those service sectors where their requirement for medical and nursing care encounters suitable resources. In spite of numerous efforts to improve the integration of care provision in the light of increased patient orientation, efforts to close administration-related gaps between outpatient and inpatient care and between acute inpatient care and long-term care (and outpatient and long-term care) have been unsuccessful until now (see Chapter 6 on health care reforms).

There are indications that hospital (and hospital outpatient department) interventions are increasingly being substituted by services in the outpatient sector (see Table 4.4). However, reforms since the 1990s show that hospitals were the centrepiece of care provision (see ral budget consolidation goals.

The outpatient sector, which is characterized by a mixture of public and private financing and service provision (see Table 2.2) and has thus developed its own "supply culture", has remained largely untouched since the start of the 1990s and has thus reacted only to a limited extent to the changes in flows of patients and outpatient/day-clinic care provision. Furthermore, there is insufficient data compared to the hospitals sector. There is neither systematic information on the frequency of referrals nor is it currently possible to evaluate the extent of a possible substitution process taking place between outpatient treatment (including hospital outpatient departments) and inpatient treatment. For this it would be necessary to know the fixed costs and the severity of cases in the different settings. The provision of care in hospitals is, in addition, more integrated, which apart from the comfort factor obviously also increases patients' trust, given that more than 5 million patients utilize hospital

outpatient departments every year (see Table 4.4). Since 1995, the proportion of expenditure on inpatient care, which also includes the spending on hospital outpatient departments, has increased by 2.4 percentage points and amounted to just under 39% of total health expenditure in 2004; the share of expenditure on outpatient care, on the other hand, has fallen by 1.6 percentage points and amounted to 23.3% in 2004 (see Table 3.13).

Although the frequency of health reforms has increased and the depth of their contents have been extended in the last thirty years (see Chapter 6 on health care reforms), all of the measures taken were embedded in existing constitutional law and social insurance service provision legislation, and thus within a historically established framework (see Section 1.2 on historical background). Also, the current method of financing in the hospitals sector, in connection with budget-setting by social insurance system funds, "fossilizes" the structures of care supply, particularly in the outpatient sector. This structurally conservative health policy, which has been set out on the basis of a political consensus, may also be responsible for the fact that the public health service in Austria, the roots of which date back to legislation from 1870, is not very attractive for physicians and other health professionals – particularly in comparison to the inpatient sector.

Thus, the Austrian health care sector has continuously been "hospital biased". This can be ascribed to the administrative separation between the supply levels and the correspondingly modest professional development opportunities for health care personnel in the outpatient sector and the public health service.

4.7 Human resources and training

Employees in the health care system

The total number of employees increased by 3.6% between 1995 and 2004 (Table 4.13). The services sector overall grew at a rate of 9.5%, while the health, veterinary and social sector reached a rate of 32%. The heath care sector thus grew more than twice as rapidly as the services sector, and employment levels rose around eight times more than those in the economy overall. In 2004, 171 972 people or 5.6% of total employees worked in this sector. The figures for the health, veterinary and social sector do not include employees who work in public health administration or in the social insurance institutions. In this way, the proportion of employees in health care is underestimated.

The health care and social sector makes the second highest contribution to the growth of employment in the EU after the provision of business-related

services *(82)*. The workforce survey reveals that – when all employees are included – the proportion of those employed in the health care system in Austria (8.2%) is below the EU average of 9.7%. Between 1995 and 2004, the number of actively employed individuals in Austria experienced a total annual growth of 0.4%; in the same period, the number of those working in the health care and social sector increased by 3% on average. This trend will presumably continue in the future: according to estimates by the IHS, the difference in growth rates will be maintained, and by 2007 around 4500 additional individuals per year will find employment in the health care sector. This translates into an increase of 5.8% in the total number of those employed (2007).

Of the approximately 4500 employees who will join this sector by 2007, at least two thirds will be women. This underlines the fact that the health care and social sector is an important employment market for women. More than

Table 4.13 Employees[a] in the health care system and in the economy as a whole, 1995–2004

	Employees,[a] in millions						Women as a proportion of total employees	
	Health, veterinary medicine and social services			Overall economy			Health, veterinary medicine and social services	Overall economy
	Men	Women	Total	Men	Women	Total		
1995	28 275	101 977	130 252	1.74	1.23	2.97	78.3	41.3
1996	29 126	106 108	135 234	1.73	1.23	2.96	78.5	41.6
1997	29 415	106 890	136 305	1.73	1.24	2.97	78.4	41.8
1998	29 321	108 431	137 753	1.73	1.27	3.00	78.7	42.2
1999	30 641	112 490	143 131	1.74	1.29	3.04	78.6	42.6
2000	31 344	116 605	147 949	1.75	1.32	3.07	78.8	43.1
2001	36 184	119 862	156 046	1.74	1.34	3.08	76.8	43.6
2002	37 279	122 419	159 698	1.72	1.35	3.06	76.7	43.9
2003	39 212	126 545	165 757	1.72	1.35	3.07	76.3	44.0
2004	40 198	131 774	171 972	1.72	1.36	3.08	76.6	44.2
Index 1995=100	142	129	132	99	111	104	99	107
GR 1995–2000	2.1	2.7	2.6	0.0	1.4	0.6	–	–
GR 2000–2004	6.4	3.1	3.8	-0.4	0.8	0.1	–	–
GR 1995–2004	4.0	2.9	3.1	-0.2	1.1	0.4	–	–

Sources: Federation of Austrian Social Insurance Institutions *(41,44)*; IHS HealthEcon, 2005 (http://www.ihs.ac.at).

Notes: GR: growth rate; [a] actively employed persons, without recipients of child care allowance and those completing military service.

three quarters of those employed in the health care sector are women, whereas in the economy as a whole only two of out five employees are women. In other words, for every 100 male employees in the health care, veterinary and social sector in 2004, there were 328 female employees. On the other hand, the ratio for all employees is 100 men to 79 women.

In 2003, the total number of people in selected occupational groups in the health care sector was 113 608 (69% of total employees in the health care, veterinary and social sector) (Table 4.14). Compared to 1970, the number of employees in this occupational sector increased by 193%. In 2003, 33% of the employees included here were physicians and 51.5% were nurses. The total number of physicians employed increased by 174% between 1970 and 2003, while the number of those employed in hospitals rose by 138%. Of the different groups of practising physicians, the highest increases were recorded among specialists. The number of employees in hospitals in 2003 was almost four times higher than in 1970. In 2003, 20.1% of hospital personnel were physicians, while just over 60% were nurses. The highest increase rates among those people employed in hospitals during the period of observation were for specialized medical-technical staff (a seven-fold increase).

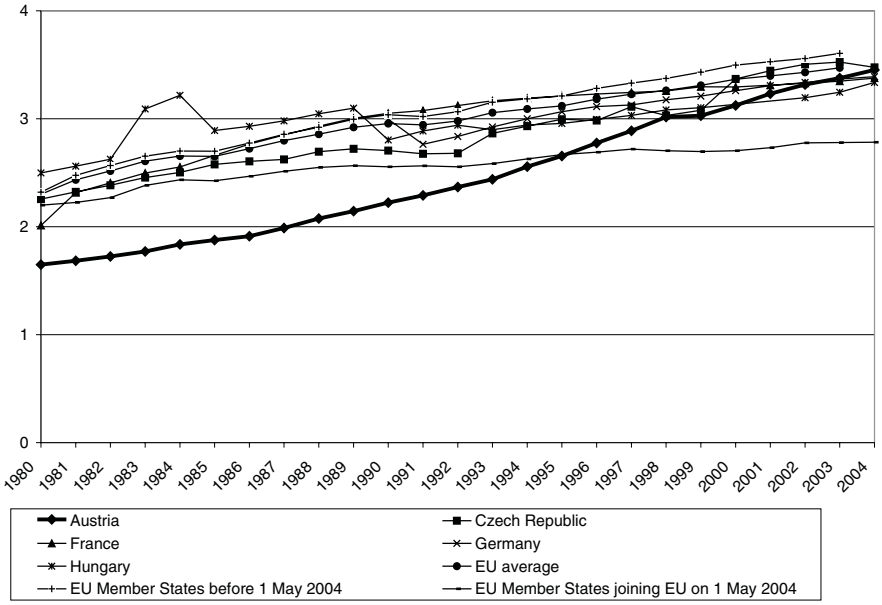
Table 4.14 Selected occupational groups in the health care system, 1970–2003 (head count)

	1970	1980	1990	2000	2001	2002	2003	in %	in %	Index 1970=100
Practising physicians	**13 682**	**18 888**	**26 033**	**34 639**	**35 812**	**36 531**	**37 447**	**100.0**	**33.0**	**274**
General practitioners	5 388	5 735	8 394	10 796	11 081	11 335	11 488	30.7	–	213
Specialists	4 765	6 639	8 795	14 536	15 205	15 376	15 925	42.5	–	334
Dentists	1 395	1 950	2 795	3 580	3 688	3 956	4 037	10.8	–	289
Physicians undergoing training[a]	2 134	4 564	6 049	5 727	5 838	5 864	5 997	16.0	–	281
Employed in hospitals	**25 062**	**48 521**	**68 424**	**92 046**	**93 000**	**93 331**	**95 264**	**100.0**	**–**	**380**
Physicians	–	8 040	12 622	17 445	18 052	18 409	19 103	20.1	–	238
Health care and nursing staff	14 682	22 186	30 842	46 219	46 669	46 796	47 687	50.1	42.0	325
Care assistants[b]	–	–	–	11 148	11 281	10 786	10 824	11.4	9.5	97[c]
Medical-technical staff with advanced training	2 014	3 445	5 896	8 893	9 084	9 267	9 534	10.0	8.4	473
Medical-technical specialist services	258	910	1 260	1 920	1 952	1 895	1 839	1.9	1.6	713
Paramedical services[b]	7 467	13 114	17 003	5 348	4 864	5 046	5 143	5.4	4.5	69
Midwives	641	826	801	1 073	1 098	1 132	1 134	1.2	1.0	106[c]
Total	**38 744**	**59 369**	**81 835**	**109 240**	**110 760**	**111 453**	**113 608**		**100.0**	**293**
Mobile services (nursing staff and other carers)							7 810[d]			

Sources: Statistics Austria *(8)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: [a] Without foreign physicians who are in Austria for study purposes; [b] Care assistants can only be shown separately from 1998 onwards (previously included in paramedical services); [c] Index 2000=100; [d] In 2003, the number of persons in mobile nursing and care services was recorded as 7810 (in full-time equivalents).

Fig. 4.6 Number of physicians per 1000 people in Austria, selected countries and EU averages, 1980–2004



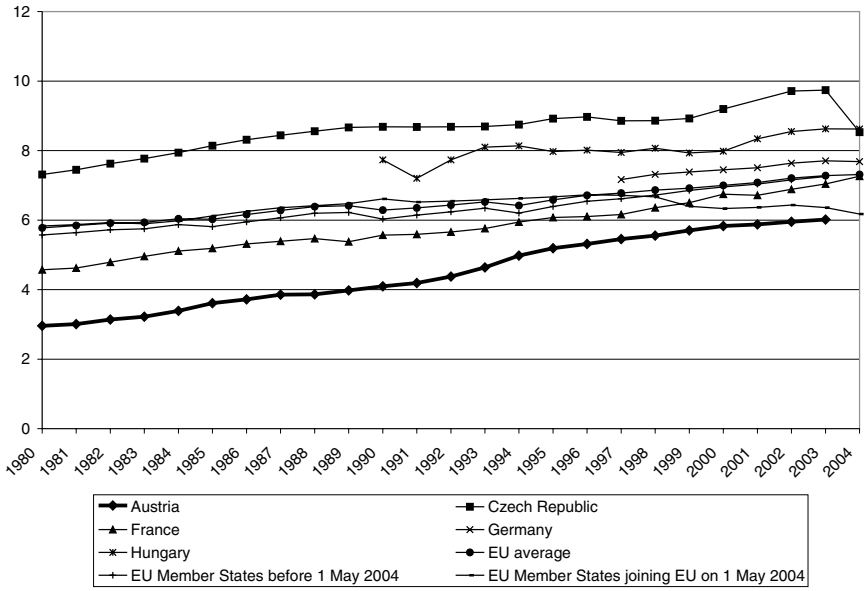
Source: European Health for All database, January 2006 *(9)*.

The number of physicians in Austria in 2004 was the same as the average for the EU at 3.5 physicians per 1000 inhabitants. In 1980 and 1990 Austria had still been around 25% below the average value for Europe with ratios of 2.3 and 3.0 physicians per 1000 inhabitants respectively. Among the countries selected in Fig. 4.6, growth in Austria was especially marked. A doubling of the physician-to-inhabitants ratio can be observed compared to 1980.

There was also a doubling of nurses in the period of observation. However, in contrast to physicians, the number of nurses in 2003 (6.0 per 1000 inhabitants) was, at 22%, still clearly below the average EU figure (7.3) (Fig.4.7).

If a high ratio of physicians to inhabitants is accompanied by a low ratio of nursing personnel, it can be concluded that, in general, physicians relatively often carry out tasks which have already been taken over by nurses in other countries. The numbers of personnel in the health care system listed in Fig.4.8 and Table 4.15 show no correlation between high (or low) ratios of physicians per inhabitants and low (or high) ratios of nurses. On this basis, no statements can therefore be made about substitution effects or about whether inputs are being employed efficiently.

Fig. 4.7 Number of nurses per 1000 people in Austria, selected countries and EU averages, 1980–2004

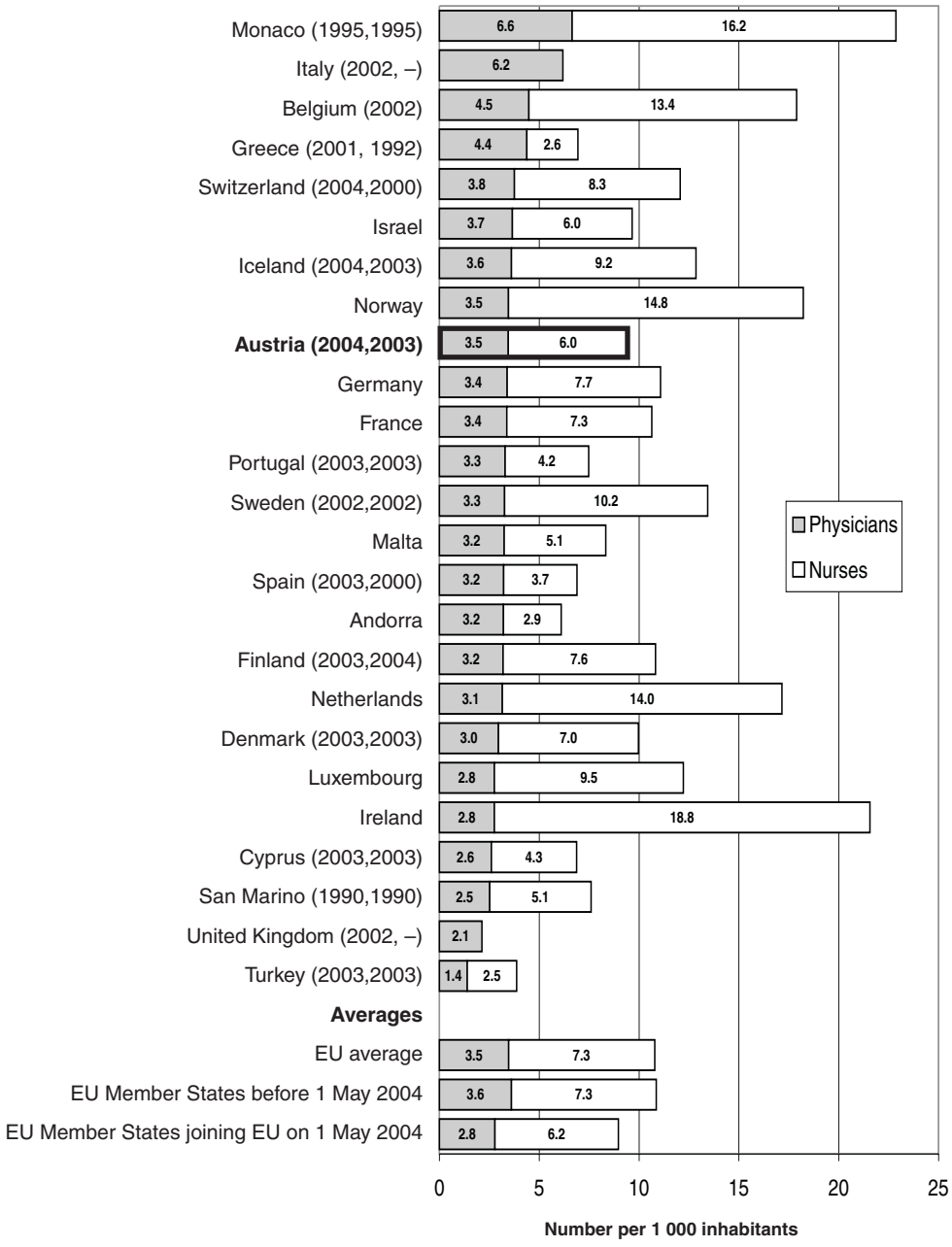


Source: European Health for All database, January 2006 *(9)*.

The average ratio of physicians to inhabitants in the EU in 2003 was 3.5 physicians per 1000, while that of nurses reached the figure of 7.3. The dispersion of the nurses-to-inhabitants ratio is four times higher than that of the physicians-to-inhabitants ratio. Coverage by physicians was around the average level for the EU in 2003. However, in all the other figures illustrated in Table 4.15, Austria is more than 20% below the EU average.

The other health professions also show significant dispersion within the EU. In general it can be stated that the methods of documentation used for health professionals other than physicians vary considerably from country to country, which makes comparisons problematic. In addition, the numbers of people given in the employment figures are usually distorted because part-time employment is particularly common in jobs mainly held by women.

Fig. 4.8 Number of physicians and nurses per 1000 inhabitants in western Europe, 2004 or latest available year (in parentheses)



Source: European Health for All database, January 2006 *(9).*
Note: EU: European Union.

Table 4.15 Number of health care professionals[a] in the European Union per 1000 inhabitants, 2004 or latest available year (personnel including those still in training)

	Physicians		Dentists		Nurses		Pharmacists		Midwives	
	Per 1 000 inhabitants	Index EU= 100	Per 1 000 inhabitants	Index EU= 100	Per 1 000 inhabitants	Index EU= 100	Per 1 000 inhabitants	Index EU= 100	Per 1 000 inhabitants	Index EU= 100
Austria	**3.52**	**102**	**0.50**	**78**	**6.32**	**78**	**0.62**	**77**	**0.21**	**72**
Belgium	4.59	133	0.83	130	11.30	140	1.49	184	0.67	226
Denmark	3.08	89	0.85	133	7.57	94	0.52	64	0.24	80
Germany	3.45	100	0.80	125	9.95	123	0.60	74	0.10	35
Estonia	3.28	95	0.82	129	6.74	84	0.60	74	0.32	108
Finland	3.28	95	0.89	140	21.96	273	1.65	203	0.77	259
France	3.41	99	0.69	108	7.33	91	1.10	136	0.27	91
Greece	4.67	135	1.20	188	2.64	33	–	–	0.21	69
Ireland	2.73	79	0.56	88	18.89	234	0.87	107	–	–
Italy	6.31	183	0.65	102	–	–	1.18	145	–	–
Latvia	3.03	88	0.57	89	5.37	67	–	–	0.21	72
Lithuania	4.04	117	0.71	112	7.78	97	0.71	88	0.33	110
Luxembourg	2.68	78	0.70	110	9.47	117	0.82	102	0.27	92
Malta	3.24	94	0.45	71	5.93	74	2.07	255	0.31	105
Netherlands	3.25	94	0.49	77	14.07	175	0.21	26	0.13	42
Poland	2.40	70	0.31	49	4.86	60	0.66	81	0.57	191
Portugal	3.31	96	0.53	83	4.47	55	0.88	109	–	–
Sweden	3.35	97	1.54	241	10.55	131	0.62	76	0.71	240
Slovakia	3.28	95	0.45	70	7.18	89	0.55	67	0.29	96
Slovenia	2.32	67	0.62	97	7.39	92	0.45	55	0.35	116
Spain	3.12	90	0.50	78	3.89	48	1.02	126	–	–
Czech Republic	3.61	105	0.67	105	10.21	127	0.58	71	0.48	160
Hungary	3.34	97	0.55	86	9.07	113	0.53	66	0.20	67
United Kingdom	2.13	62	0.45	71	–	–	0.60	74	–	–
Cyprus	2.63	76	0.92	144	4.22	52	0.20	25	–	–
EU Member States before May 2004	3.58	104	0.67	106	8.43	105	0.85	105	0.25	85
EU Member States joining EU on 1 May 2004	2.88	83	0.45	71	6.80	84	0.62	76	0.46	153
EU	**3.45**	**100**	**0.64**	**100**	**8.06**	**100**	**0.81**	**100**	**0.30**	**100**

Source: European Health for All database, July 2005. The database January 2006 *(9)* partly revised figures, indicating for example a lower number of nurses for Finland and Germany.
Note: [a] Figures are arrived at by adding the most recent personnel figures plus graduates as a low estimate of personnel still undergoing training.

Training

Physicians

Medical training in Austria is characterized by a dual system. Degree courses in medicine, which have a minimum duration of at least six years for all medical professions, can be taken at three medical universities (Vienna, Innsbruck and

Graz). Since the Federal Act on the Accreditation of Educational Institutions as Private Universities (University Accreditation Act) (Federal Law Gazette I No. 168/1999) came into force, the operation of private universities has been allowed after accreditation, which must be applied for to the Accreditation Council. In the health care sector, four accredited private universities (a third of all accredited private universities in Austria) offer courses. Accreditation is valid for five years at a time; a first extension of up to five years can then be applied for. After 10 years have passed, accreditation for a further 10 years at a time can take place. Private universities are not financed by the Federal Government. The required evidence showing that personnel, premises and equipment are in accordance with international standards has to be provided together with the application.

In the academic year 2002/2003, 2072 individuals started first degree courses in medicine in Austria. Approximately 18% came from abroad. In total, there were 19 950 students in 2002/2003, of whom just under 60% were women. The proportions of women and men among medical students in Austria have been reversed in the last 30 years: in 1970/1971 there were 307 male students for every 100 female students; by 1990/1991 the number of male students had fallen to 106, and in the academic year 2002/2003 there were only 71. In comparison to the academic year 1970/1971, there were almost three times as many students of medicine.

The University Act 2002, as well as the degree course syllabuses of the individual universities which were subsequently adopted, form the essential legal basis for degree courses in medicine. After graduation, a further postgraduate specialist training course (of varying durations) has to be completed as an intern before the profession can be practised independently. This postgraduate training is regulated by the Physicians' Act of 1998 as well as by the Training Regulations for Physicians in the version of the Federal Law Gazette I No. 169/1998, which is a decree equivalent to a law and implements the legal provisions in detail.

To work as a general practitioner, practical training lasting at least three years is required. This has to be completed in hospitals which are recognized as training institutions by the Austrian Physicians' Chamber. Parts of training can be completed in a recognized surgery run by a self-employed general practitioner, or in a group practice or outpatient department which provides training. Agreement has to be reached with the Minister of Education, Science and Culture for the recognition of university teaching hospitals, clinical institutes and other organizational units including subunits of medical universities. Training centres are recognized as such upon application, provided that the facilities, the services provided and the volume of patients ensure that the training objectives can be attained. In general hospitals and in specialist hospitals

which are recognized as training centres for general medical practice, the number of interns in training for general medical practice who can be employed is determined by the number of systematized beds.

In 2003, 5997 Austrian citizens were working as interns, of whom around 54% were actually able to complete their training in hospitals in 2003. In comparison to 1970 this corresponded to an increase of 181% (Table 4.14).

A particular requirement of training for specialists is a minimum of six years' training in the respective specialty and the relevant subsidiary subjects. According to the currently valid regulations for medical training, there are 44 specialties (for example surgery, internal medicine, psychiatry) and 22 additional subjects (for example vascular surgery, cardiology, neuropsychiatry for children and young people) whose practice requires special training.

In order to efficiently evaluate the training of interns and to ensure its quality, special reports are written throughout training. In these reports, the individual training stages are listed on the basis of the minimum training catalogue, and each sub-stage of training completed is confirmed with the date and signature of the medical doctor responsible for the training course.

The 2001 amendment to the Physicians' Act introduced important changes in training and further training. The task of the Physicians' Chamber in carrying out inspections is worth emphasizing: training centres for trainee physicians are now inspected by a team of selected physicians – this is a quality assurance method which follows a tried and tested procedure used in other countries. General practitioners and specialists now have to complete an examination which is a prerequisite for engaging in independent medical practice. Transitional arrangements for this have been put in place. Examinations for general medical practice and specialists' examinations are already being carried out, and on 31 December 2004 the last interim deadlines expired; since this time physicians can no longer be licensed for independent medical practice without first completing the examination. Obligations for physicians to take part in further training have also been defined in more detail (*83*: 178).

Further important changes brought about by the amendment to the Physicians' Act (Federal Gazette I No. 110/2001) were: the creation of a basis in occupational law for group practices; changes with regard to the employment of foreign and foreign-trained physicians (physicians from the EU Member States joining on 1 May 2004 are permitted to practise in Austria as long as they have the necessary recognized qualifications); improvements in quality assurance regarding emergency physicians (a mandatory course including a final theoretical and practical examination); improvements in the field of patients' rights (see Section 2.2 on planning, regulation and management); changes in the area of welfare funds and physicians' chamber regulations; a revision of

physicians' obligations to report certain illnesses; physicians' obligations with regard to documentation after taking up the profession and changes referring to the physicians' register *(83: 61).*

Qualified health care and nursing professionals

Training lasts three years for general nurses, children's nurses and psychiatric nurses. Training in the areas of children's nursing and psychiatric nursing can also be completed within the framework of a one-year special course following training in general health and nursing care. Nursing schools may only be established in connection with hospitals which possess the specialist departments or other organizational units which are required for practical training.

Training for nursing assistants lasts one year (full-time course) or correspondingly longer in the case of in-service training, but must include at least 1600 hours of training. It takes place as part of a nursing assistant course at, or in connection with, general hospitals, hospitals for the chronically ill, homes for long-term care or regional authority institutions which offer nursing care at home, and can be completed as part of employment. The course is jointly managed by a specialist leader, an organizational course leader and a medico-scientific leader; the course participants are trained in practical aspects of the work by qualified nursing professionals.

In the academic year 2002/2003, a total of 62 schools were available for training in general nursing, 8 for training in children's nursing and 10 for the training of psychiatric nurses. Thirty schools offered nursing assistant courses in 2002/2003. In 2002, 86% of the 7203 students in schools for general and children's nursing were female. In schools for psychiatric nursing, 78% of the 520 students were female, and on the nursing assistants' courses the figure was 84% (of a total of 1204 students).

In June 1997, a new law governing health care and nursing was adopted by the Nationalrat which acknowledged nursing as an activity in its own right and defined areas in which nurses have sole or joint responsibility, interdisciplinary areas of work, and numerous special tasks. In order to be able to work in a further-reaching field of nursing (special tasks as well as teaching or management tasks), qualified nursing professionals have to complete a mandatory special training course. Draft regulations drawn up by provider organizations for the development of special training and further training for qualified heath care and nurses are currently being considered.

Health care and nursing training have become issues of major public interest again owing to demographic developments, the health policy guideline of

"outpatient before inpatient", the needs and development plans of the Länder, the existing shortages of care personnel (predominantly in homes for long-term care and in the outpatient care sector), as well the falling numbers of applicants for Austria's health care and nursing schools. Although the federal law regulating these professions is only six years old and has already been amended, there is a need for action in order to be able to fulfil the mandate to provide care and to cover requirements in the care sector in the future *(83)*.

There are around 15 courses at polytechnics (*Fachhochschulen:* new universities offering shorter, more practically orientated degree courses) and university courses in the health care and nursing management sectors in Austria. Applications by the polytechnics to establish courses at their institutions for qualified nursing and health care personnel have been received by the *Fachhochschulrat*, the council responsible for course accreditation.

In the winter semester 2004, a three-year bachelor's degree course in nursing sciences was offered for the first time by the University of Graz. At the University of Vienna, students can enrol for a four-year degree in care sciences. In the Land of Tyrol, the private University for Health Sciences, Medical Informatics and Technology offers both bachelor's degree courses in business management in the health care system, biomedical information technology and care sciences, and master's degree courses for health sciences, biomedical information technology, information management in medicine, tourism and leisure medicine and nursing sciences. In addition, a doctorate course is available in the subjects of health sciences, biomedical information technology and care sciences. The bachelor's and master's degrees can be taken either as full-time courses or on "block release", thus alongside employment. The doctorate courses are available in both forms *(84)*.

Midwives

Midwives accounted for around 1% of hospital personnel in 2003 (Table 4.14). Training for midwives is currently provided at seven midwives' academies and is based on the Midwives Act of 1994. Training is open to students who fulfil the entrance requirements for universities. Upon completion of the three-year training course, students receive a diploma and are entitled to practise their profession either as employees or in private practice. Access to the profession is open to both men and women; however, all of the 152 students on the course in the year 2002/2003 were women. The Federal Government's monopoly of training which had existed until 1994 has been lifted and measures to oblige midwives to attend further training were established.

In some institutions, a pilot system has already been successfully introduced in which midwives working in hospitals are involved in follow-up care for new

mothers and their babies, and where expectant mothers can take their own midwives into hospitals.

Since July 2005, training can be completed either at a post-secondary school level academy (similarly to training for medical-technical staff) or within the framework of a bachelor's degree course at a polytechnic. The first bachelor's degree courses for midwives at polytechnics is expected to begin in 2006 *(85)*.

Medical-technical services

The profession of medical-technical services staff was regulated in 1992 in the Medical-Technical Services Act. Staff who belong to the field of higher medical-technical services include physiotherapists, biomedical analysts, radiology technicians, dieticians, occupational therapists, speech therapists and orthoptists.

Training is currently open to students who fulfil the entrance requirements for universities and takes place at academies following completion of secondary education. Upon completion of the three-year training course, students receive a diploma and are entitled to practise their profession according to physicians' instructions either as employees or independently in private practice. According to figures from the Länder health authorities, there were 59 academies as at December 2004. On 1 October 2003 there were a total of 2411 students enrolled at these academies.

In July 2005 the legal basis was created permitting the completion of training either at an academy or with a relevant bachelor's degree course at a polytechnic (Federal Law Gazette I No. 70/2005). The first polytechnic students are expected to take up their courses in autumn 2006. Future graduates from polytechnics will be on an equal footing with graduates from the academies. Both types of course have a duration of 3 years.

Alongside higher medical-technical services, it is also possible to train in specialized medical-technical services in Austria. The training course lasts three years and entitles graduates to carry out simpler activities in the medical-technical sector in the field of radiography and in physiotherapy under a physician's supervision. There are five schools for specialized medical-technical services, which as at 1 October 2003 were attended by a total of 269 students.

Training for cardiotechnical services is an in-service course which can be pursued alongside existing employment. The entry requirement is a diploma in medical-technical laboratory services, in radiological services or in the qualified health care and nursing sector with relevant special training or evidence of experience. The course is attended by only two to three people per year *(85)*.

Medical masseurs and massage therapists

The Medical Masseurs and Massage Therapists Act of 2002 raised the status of the formerly ancillary occupation of "therapeutic pool attendant and massage therapist" and also created a new career opportunity for commercial masseurs after appropriate additional training.

The training course is made up of modules. Training for medical masseurs consists of two modules (A and B) with a total of 1690 hours and entitles the masseur to exercise the profession according to a doctor's instructions and under the supervision of physicians and physiotherapists. After an additional module for massage therapists consisting of 800 hours, it is possible to work in private practice. In December 2004, the Länder health authorities recorded 23 training institutions for medical masseurs and 32 establishments for massage therapists. On 1 October 2003, a total of 138 people were attending training courses to become medical masseurs, and 72 people were training to become massage therapists *(85).*

Paramedics

Paramedics can carry out the tasks regulated by the First-Aiders and Paramedics Act of 2002 either voluntarily or as a profession, by working as a soldier in the Austrian Army or as a public employee. Ambulance first-aid staff complete 260 hours of training, and emergency paramedics an additional 480 hours. For those training as ambulance first-aid staff, there are various possibilities to gain credits for related work experience. On 1 October 2003, a total of 2225 people were attending training courses to become ambulance first-aid staff, and 357 people were training to become emergency paramedics *(85).*

Paramedical services

In 2003, 5143 people worked in the field of paramedical services. This field includes nine occupations, of which the job of surgical assistant accounts for the largest proportion of personnel with 46%. Training for paramedical services personnel normally consists of a course encompassing 135 hours. These courses are offered in hospitals, academies for adult education in the field of health, or in training centres operated by nongovernmental organizations. The relevant work may already be taken up before the training course has been completed, though in this case successful completion of the course has to be proven within two years of starting work.

4.8 Pharmaceuticals

The pharmaceuticals market

According to figures from the industry's interest group, there are around 160 pharmaceutical companies active in Austria. This figure also includes companies which only trade in pharmaceuticals. According to Statistics Austria, there are 24 manufacturing companies working in Austria *(86)*.

Pharmaceutical companies are predominantly small and medium-sized companies. The larger pharmaceutical companies are mostly subsidiaries of international groups of companies. Austrian pharmaceuticals companies produced products worth around €1344 million in 2002 (Table 4.16). This is equivalent to around 1.5% of the value of production in the Member States belonging to the EU before May 2004, which was generated by around 9200 employees *(87)*. Imports by pharmaceuticals producers in Austria amount to around €3091 million and exports are worth €3041 million.

In the consumption of medicines, Austria is somewhat below average in the European Union with 21.8 packs per inhabitant (*88*). Between 1996 and 2001, the turnover in the self-medication market rose by 25%. This accounted for around 8% of the total turnover in 2003. The volume of turnover in the market for over-the-counter medicines was around 9% of total turnover. Member States belonging to the EU before May 2004 spent an average of 1.9% of their GDP on research and development in 2000; the figure for research in Austria was 1.83% *(87)*.

Medicines are largely supplied via public pharmacies and physicians' surgery pharmacies, the latter of which ensure the provision of medicines in rural areas.

Table 4.16 Pharmaceuticals market, 1998–2003

Pharmaceuticals market	Year	Change
Production (in million €)	**2002**	**1998–2002**
Pharmaceuticals production	1 344	5.5%
Turnover (in million €)	**2003**	**2000–2003**
Total medicines[a]	3 347	23.4%
Over-the-counter medicines	311	15.4%
Self-medication	274	14.4%
Consumption	**2003**	**1998–2003**
Packs of medicines per inhabitant	21.8	9.5%

Sources: Association of the European Self-Medication Industry, 2004 *(89)*; European Federation of Pharmaceutical Industries and Associations (EFPIA), 2004 *(90)*; Austrian Association of Pharmaceutical Companies (PHARMIG), 2003 *(91)*; Austrian Pharmacists' Association, 2005 *(94)*; Austrian Federal Institute for Health *(92,93)*.

Note: [a] Including non-prescription medicines, homeopathic products and the hospitals market, at public pharmacy prices.

In 2003, there were 2221 pharmacies in Austria, of which more than half (52%) were public pharmacies, 45% were physicians' surgery pharmacies, 2% were hospital pharmacies and 1% were branch pharmacies. Compared to 1999, the number of public pharmacies has increased (+7%), as has that of branch pharmacies (+5%), whereas a decrease could be observed in the number of surgery and hospital pharmacies (-2%).

There were a total of 12 831 people employed in public pharmacies in Austria in 2003. Of these, 4623 (26%) were pharmacists. The percentage of women among pharmacists is 76%. Two thirds of all pharmacists work on a part-time basis (*94*). Pharmacists have the tasks of supplying medicines and of advising patients on taking them. Pharmacists are not permitted to substitute medicines prescribed by physicians with similar products.

The Austrian pharmaceuticals sector has been characterized by substantial increases in expenditure since the beginning of the 1990s (Table 4.17). The

Table 4.17 Expenditure on medicines by sources of financing, 1990–2003

Year	Total medicines expenditure (ME)[a]		Health insurance[b]			Private households				
		Index		Index		Cost-sharing[c]		Other expenditure[d]		Proportion of ME
	in million €	1990 =100	in million €	1990 =100	in %[f]	in million €	1990 =100	in million €	1990 =100	in %[g]
1990	1 054	100	589	100	55.9	127	100	338	100	44.1
1991	1 148	108	650	110	56.6	137	108	361	107	43.4
1992	1 271	121	729	124	57.4	148	117	394	116	42.6
1993	1 391	132	802	136	57.7	162	128	427	126	42.3
1994	1 494	142	870	148	58.2	174	137	450	133	41.8
1995	1 580	150	912	155	57.8	187	147	481	142	42.2
1996	1 668	158	966	164	57.9	201	159	501	148	42.1
1997	1 737	165	994	169	57.2	216	171	527	156	42.8
1998	1 932	183	1 139	194	59.0	233	184	560	165	41.0
1999	2 150	204	1 298	221	60.4	255	201	597	177	39.6
2000	2 267	215	1 373	233	60.6	271	214	623	184	39.4
2001	2 391	227	1 414	240	59.1	308	243	670	198	40.9
2002	2 550	242	1 525	259	59.8	311	245	714	211	40.2
2003	2 724	259	1 622	276	59.5	329	259	774	229	40.5
Average annual rate of increase in %										
1990–1995	8.4		9.2			8.1		7.3		
1995–2000	7.5		8.5			7.7		5.3		
2000–2003	6.3		5.7			6.6		7.5		

Sources: Federation of Austrian Social Insurance Institutions 10/1991 to 10/2003; Austrian Federal Institute for Health, 2005 *(95)*.

Notes: ME: medicines expenditures; [a] Without the hospitals market; [b] Data from medicines statistics of the Federation of Austrian Social Insurance Institutions, without value-added tax and minus prescription fees; [c] Prescription fees; [d] Expenditure on self-medication, medicines subject to the prescription fee and spending on medicines by private health insurance companies (this item also includes pharmacies' turnovers, with food supplements and cosmetics amounting to around 20% of private turnover). [e] Without prescription fees; [f] Proportion of health insurance expenditure as a percentage of total expenditure on medicines; [g] Proportion of spending by private households as a percentage of total medicines expenditure.

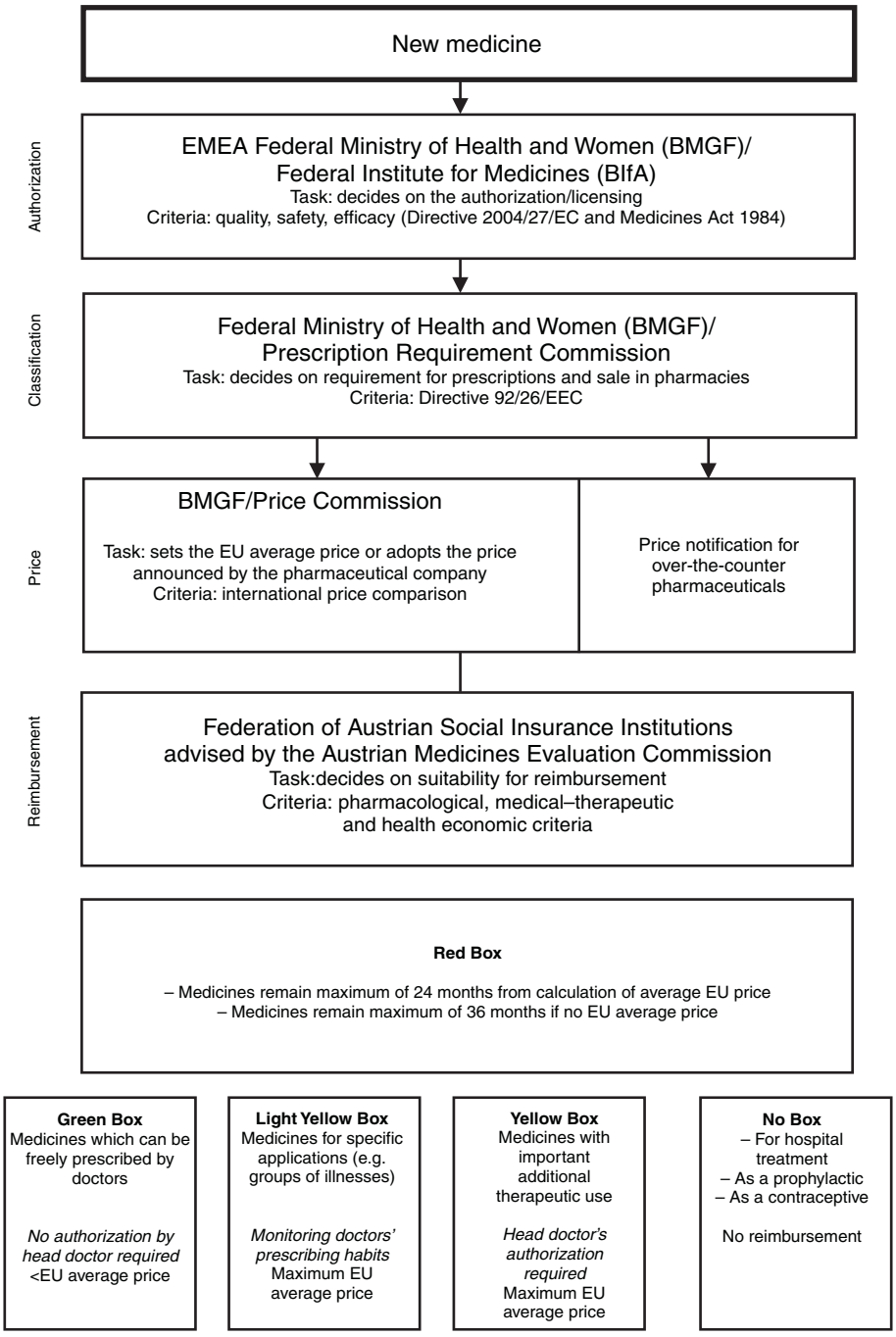
reasons for this are demographic developments and the related factor of medical progress. Structural problems, including strong market regulation, probably also play an important role. In an international comparison, the proportion of generic drugs on the Austrian pharmaceuticals market is very low (below 10%). Furthermore, more than 60% of cost increases are accounted for by medicines which require the authorization of "head physicians".

Authorization and reimbursement of medicines

Alongside the annual adjustments of the prescription fee, there has been increased regulation of prices and amounts in the pharmaceuticals market since the mid-1990s and to some extent before then *(96)* (see Chapter 6 on health care reforms). In 2003, negotiations were initiated by the BMGF with various interest groups (pharmaceuticals industry, wholesalers, pharmacists and physicians) with the aim of agreeing on a new package of reforms in the medicines sector. The focus was on a structural reform of the pharmaceutical sector and cost-containment measures. The main result was the presentation towards the end of 2003 of a new reimbursement codex for the social insurance system to overcome structural defects in the distribution and market access of innovations and generic drugs. The new reimbursement codex is characterized by a box system (Fig. 4.9).

- The red box contains (for a limited period of time) all new medicines; the financial reference point is the average EU price, which cannot always be calculated immediately according to the criteria published by the BMGF. For the physicians prescribing them, these medicines are subject to a new form of medical approval (authorization by "head physicians", see Section 4.3 on outpatient health care). Quantity controls refer to the medical requirements of patient groups, special indications and stages of illness as well as to the incidence and prevalence of the condition.
- The yellow box contains all medicines with an essential additional therapeutic benefit, which are available for specific medical indications and thus for specific patient groups. Price-fixing mechanisms, such as quantity discounts and price grades, will be introduced. As in the case of the medicines in the red box, the products in the yellow box are subject to medical authorization and quantity controls by the social health insurance system. The light-yellow box contains medicines for specific uses, for groups of illnesses for example. These are not subject to approval by head physicians.
- The green box lists those medicines which can be freely prescribed by contracted physicians. The regulation of prices after the expiry of the patent on a pharmaceutical product stipulates that the price of the original product

Fig. 4.9 Market and price regulation of medicines, 2005



Source: Austrian Federal Institute for Health, 2005.

is then reduced by 30%, and the price of the first generic is 25% below the price of the original product. The second generic has to be reduced by 15% below the price of the original product; the third generic by 10%. There are no price regulations for further generics which enter the market. If there is no generic drug on the market, the HVSV can put the active substance of the product out to tender.

- Medicines used for treatment in hospitals, as a prophylactic or contraceptive are not assigned to any of the boxes ("no box"); for these pharmaceuticals reimbursement is only offered in exceptional cases.

The new reimbursement codex leads to a reduction in the price levels to the EU average for medicines which require the authorization of a "head physician" (red box). It also provides for a time-limited and transparent admission procedure of pharmaceuticals to the yellow and green boxes, and it ensures that patients are guaranteed a regular supply of important therapeutic innovations (yellow box). The reduction of prices after the expiry of patents has the effect of opening up the market for generics. This is designed to increase prescribing of these products from currently under 10% to over 20%.

The most recent revision of the head physicians' authorization rule came into force on 1 January 2005. In contrast to the previous regulation, patients no longer have to obtain the authorization of a head physician at the health insurance fund for prescription of a drug; this now has to be arranged by the prescribing medical doctor. Physicians may not transfer this obligation to their patients. In future, it is planned that authorization from head physicians can be obtained by physicians via the e-card (see Section 4.9 on health technology assessment and eHealth). Until the full introduction of the e-card, varying special arrangements apply between individual health insurance funds and the physicians' chambers.

The establishment of the 20-member HEK (including representatives of the social insurance institutions, scientists and chambers (Chamber of Labour, Economic Chamber, etc.)) has replaced the former special advisory council. The main task of the commission is to make recommendations to the management of the HVSV as to which box a medicine should be assigned to, and which active substance or group of active substances can be put out for tender after the expiry of the patent.

A further consequence of the new medicines package was the discontinuation of the Register of Medicines at the end of 2004. All medicines which were listed in the Register of Medicines until the end of 2004 have been listed in the green area of the reimbursement codex since January 2005, while all specialist medicines which were in the special list of medicines of the Register of Medicines until the end of 2004 are now in the yellow area of the reimbursement

codex. Substances used by pharmacists to produce medicines themselves according to physicians' prescriptions which were listed in the Register of Medicines until the end of 2004 are in the yellow area of the reimbursement codex as of 2005. The latest edition of the reimbursement codex was published on 1 October 2004.

Prescribing medicines

Physicians who prescribe medicines at the expense of health insurance funds have to adhere to the guidelines on the economic prescription of medicines and therapeutic aids. The issuing of these guidelines is set out in the ASVG. Physicians have to ensure that from among several medicines which are suitable for therapeutic purposes the most reasonably priced one is selected. Adherence to these guidelines has to be monitored by the health insurance funds. If a medical doctor consistently exceeds the average sums of colleagues in the same specialty, he or she can be ordered to reimburse the difference in costs.

First results show that the target corridor of an annual cost increase of between 3% and 4% has been achieved. In 2004, the cost increase amounted to around 3%, while the forecast for 2005 is 2.8% *(97)*.

The number of prescriptions at the expense of the social health insurance funds has increased by an annual 1.2% since 1993 to around 102 million

Table 4.18 Prescriptions at the expense of health insurance funds, 1993–2003

Year	Number of prescriptions		Expenditure per prescription
	absolute (in millions)	related to inhabitants	in €
1993	90.4	11.4	10.8
1994	92.4	11.6	11.5
1995	94.5	11.9	12.1
1996	93.2	11.7	12.8
1997	91.9	11.5	13.1
1998	96.4	12.1	14.1
1999	101.4	12.7	15.3
2000	101.4	12.7	16.2
2001	98.5	12.3	17.5
2002	99.1	12.3	18.5
2003	102.0	12.6	19.1
Average annual rate of increase in %			
1993–2003	1.2	1.0	5.9
1993–1998	1.5	1.2	6.6
1998–2003	1.1	0.8	6.2

Sources: Federation of Austrian Social Insurance Institutions, 1995–2004 *(41)*; Austrian Federal Institute for Health *(92,93,95)*.

prescriptions. In 1993, around 11 prescriptions were recorded per inhabitant and in 2003 the figure was around 13. The expenditure per prescription almost doubled in the period of observation and reached a level of €19.10 in 2003 (Table 4.18).

Medical products

Medical products is the product group in the health care sector which is most extensive and largest in terms of numbers. The legislative framework for the production, distribution and use of medical products is the Austrian Medicinal Products Act (Federal Law Gazette No. 657/1996), which regulates the quality, safety and efficacy of medical products. Before products can be offered for sale, a European licensing procedure has to be carried out. In addition, the Medicinal Products Act regulates practically the entire life-cycle of medical products, including clinical testing, maintenance and preparation in health facilities. However, it does not regulate remuneration for these products.

The Austrian market for medical products is characterized by a very high dependence on imports. A large majority of the medical products required for the health care sector are obtained from abroad, predominantly from within Europe. AUSTROMED is the association of medical product companies in Austria. Its member companies employ 5000 people. Around 75% of the medical products market is supplied by companies whose annual turnovers amount to less than €5 million. Approximately 53% of these companies are Austrian-owned, while the remainder work as subsidiaries or at least have foreign divisions.

4.9 Health technology assessment and eHealth

Alongside the direct assessment of technology as it is applied in the Austrian health care system, this section reports on measures which have generally gained in importance owing to developments in technology. These developments are summarized in the subsection on eHealth. The recently institutionalized regulations for in vitro fertilization and for the tasks of the coordination office for transplants also constitute technology assessment measures in a broader sense, as do planning activities with regard to major items of equipment.

Health technology assessment

Since the mid-1990s, the Institute for Technology Impact Assessment (ITA) has been investigating methods of health technology assessment (HTA). The

objective of HTAs is to determine the medical and economical usefulness of medical interventions. Rationalization of the use of available resources (the reduction of ineffective and inefficient applications) is to be given preference over the rationing of services. The most important components of a systematic HTA process include:

- the identification and prioritizing of the medical interventions which are to be evaluated;
- carrying out data collection and analysis from a multitude of primary studies from various disciplines (such as clinical research/medicine, health care systems research and health economics);
- synthesizing this information, processing it in a national context and drawing clear conclusions;
- the dissemination of this information, verdicts and recommendations to national decision-makers at different levels of the health care system;
- ideally, evaluating the influence of HTA on the actual provision of medical care.

For Austria, only the ITA has taken part in the respective EU cooperation programmes *(98)*. Apart from the ITA, the Austrian Federal Institute for Health also carries out technology assessments. At institutions of the Austrian Academy of Sciences (ÖAW), research is also carried out in the fields of molecular medicine, biomedical age research, molecular biotechnology, biophysics and X-ray structure.

Furthermore, a department for evidence-based medicine is being established in the HVSV which deals with this subject matter and is developing expert knowledge in the field. These activities integrate the best possible external evidence from systematic research, clinical expertise from the experience of individual physicians, and the interests and needs of patients *(99)*.

Major medical equipment

The Major Equipment Plan, which has been integrated into the Austrian Hospitals Plan since 1997, is an area of health technology assessment in the broadest sense. The plans are more needs-orientated than cost–benefit orientated. The quality of structures and fair provision are at the forefront of planning principles. Economic efficiency is also taken into account, in so far as the recommendations for locations also take the provision of major equipment by physicians in private practice into consideration. In addition, the plan is to be continuously updated and adjusted.

In comparison with other OECD states, the Austrian population benefits from greater than average provision of major medical equipment in the fields of magnetic resonance technology, computer tomography devices and radiotherapy units (*100*). The ÖKAP/GGP (see Section 2.2 on planning, regulation and management) provides a definition of such devices. Table 4.19 shows the major equipment which was available in the hospitals sector in 1998 and 2003, including that in rehabilitation centres and in the outpatient sector. In 2003 there were 102 more devices than in 1998, which translates into an increase of 18.4%. It should be emphasized that the number of magnetic resonance scanners almost doubled in the period of observation.

Table 4.19 Major medical equipment, 1998 and 2003

	1998			2003			Change 1998–2003, absolute		
	Acute hospitals	Rehabilitation and outpatient facilities	Total	Acute hospitals	Rehabilitation and outpatient facilities	Total	Acute hospitals	Rehabilitation and outpatient facilities	Total
Computer tomography scanners	126	82	208	155	80	235	29	-2	27
Magnetic resonance scanners	38	30	68	76	55	131	38	25	63
Digital subtraction angiography units	69	3	72	70	1	70	1	-3	-2
Coronary angiography units	26	4	30	38	4	41	12	-1	11
Shockwave lithotripters	12	1	13	13	0	13	1	-1	0
Supervoltage radiotherapy units	33	0	33	44	0	44	11	0	11
Emission computed tomography scanners	105	22	127	80	21	101	-26	-1	-27
Positron emission tomography scanners	3	0	3	21	1	22	18	1	19
Total[a]	**412**	**142**	**554**	**495**	**161**	**656**	**83**	**19**	**102**

Source: Austrian Hospitals and Major Equipment Plan, 1999 and 2003.

Note: [a] Can contain errors from rounding up figures.

In Vitro Fertilization Fund Act

Since 1 January 2000, the federal law for the establishment of a fund to finance in vitro fertilization (IVF Fund Act, Federal Law Gazette I No. 180/1999) has been in force. This law governs the assumption of the costs for in vitro fertilization by the Federal Government. For this purpose, a fund was established at the BMGF to jointly finance in vitro fertilization. This fund covers 70% of the costs of in vitro fertilization; the remaining 30% have to be borne by the patients themselves. Per couple and attempted pregnancy there is an entitlement to reimbursement of costs for a maximum of four attempts in the case of tubal sterility in the woman or in the case of the man's sterility, provided that at the beginning of an attempt the woman has not yet reached the age of 40 and the man is not yet 50.

Hospitals which carry out in vitro fertilization for which the costs are assumed by the IVF Fund require a licence in accordance with Section 5, paragraph 2 of the Reproductive Medicine Act, a legally valid contract with the IVF Fund and a contract of treatment with the patient. In addition, quality criteria have to be fulfilled every year. On the one hand, 50 attempts have to be carried out annually per contract institution, on the other hand there has to be proof of a pregnancy rate of 18% per follicular puncture. The Austrian Federal Institute for Health keeps a register in which anonymous data on treatment are stored. Its evaluations of this data also form a part of quality assurance and monitoring and are drawn up for each contract hospital *(101).*

Transplantation Coordination Office

The main task of the transplantation coordination office, known as ÖBIG-Transplant, which was established in 1991 at the Austrian Federal Institute for Health (ÖBIG), is the nationwide promotion of the transplant system. It promotes the finding and management of organs and tissue, supports the exchange of information and data in cooperation with the Eurotransplant International Foundation and carries out the documentation of transplants in Austria. In addition, it draws up analyses and carries out planning work, promotes transparency and safety in the organ donation and transplant system and does public relations work. The executive bodies of the coordination office consist of the management of the Austrian Federal Institute for Health including its project manager, and the transplantation advisory council. This interdisciplinary committee consists of experts and interest groups from the field of transplantation and the health care system in general. The transplantation advisory committee is mainly responsible for drawing up and deciding on the

operative working programme as well as providing the expert support needed for the implementation of the working programme.

The working programme 2004, for example, included the implementation of a programme to promote organ and stem cell donations, the organization and holding of communication seminars ("Organ Donation – Interviewing the Family Members") and further work regarding international cooperation with central European states in the field of transplantations. Its regular issuing of transplantation reports to Austrian hospitals is intended to disseminate the internationally agreed "allocation rules" for organs. In addition, an initiative was put in place to nominate a person in each relevant hospital in order to represent the hospital's interests in the field of transplant medicine. Workshops are held for these nominees *(102).*

eHealth

Promoting the deployment of new information and communications technology in the health care system is the explicit aim of a series of international and national strategies in Austria, the majority of which are related to the eEurope Initiatives and the eHealth Action Plan of the European Union *(103).*

e-card

From 2006 onwards, paper health vouchers will be replaced by the e-card. The e-card is a smart card with which the insured and their family members can take advantage of medical services. Unlike health vouchers, which were only used by those insured in accordance with the ASVG and their family members, insurees of other insurance funds have also received the e-card (GSVG, Act on Civil Servants' Health Insurance and Work Accident Insurance, insurees of health welfare institutions), as have people in marginal part-time employment, although they are not subject to statutory social health insurance.

The card was issued in stages to all insurees and their entitled family members during 2005, and can be used at every contracted physician's surgery (dentists, specialists or general practitioners), every contracted facility and in the social insurance institutions' own facilities, as well as for preventive health check-ups and examinations within the framework of the mother–child medical card. In the first phase of the e-card, its use in hospitals (inpatient and outpatient) is not yet possible. Legislation provides for the payment of a service fee of €10 per calendar year for the e-card (ASVG Article 135, paragraph 3) which is collected by employers. The first service fees were collected on 15 November 2005 for the year 2006.

Health information network and peering point

The health information network facilitates all variations of data exchange with the aid of new technologies; it was conceived as a "closed network" with "open architecture". A closed network means that it is only accessible for a precisely defined group of users. Open architecture means that in principle every further task and service can be added to the medical information highway. The exchange of examination findings or the drawing up and sending of electronic prescriptions (ePrescription) to pharmacists via the health information network are planned.

These services are not related to the e-card and are processed via a separate pathway. Authorization to use this pathway is issued by the so-called peering point (network hub). This electronic distributor on the Internet has the function of a gatekeeper. The connection from physicians' practices to the peering point is only accessible for authorized physicians. In future, the health information network is also to be used for financial settlement between physicians and health insurance funds. In addition, physicians in private practice will receive the opportunity to gain electronic access to current scientific literature, international conference databases or the current data held by physicians' chambers.

For the operation and management of the peering point, the HVSV and the Austrian Physicians' Chamber have jointly founded a limited company, of which each partner holds 50% (Peering Point Association, PPG).

Electronic health file and e-prescription

In the agreement according to Federal Constitution Article 15a, the contract parties agreed on the priority of conceiving and introducing an electronic health file (ELGA) and electronic prescriptions. In a first stage, the content plus the legal, technological and socioeconomic issues involved are being clarified in a feasibility study, from which the structure and concrete implementation measures will be derived.

A broad-based discussion process is to be initiated with regard to data protection law. The efforts of the BMGF are directed towards the conception of a service-orientated technological and organizational infrastructure which is in accordance with the available standards and adapted to the requirements of the Austrian health care system. In order to facilitate the medium- and long-term planning of the detailed measures required, and to ensure financial feasibility, a model is being developed which has to be harmonized with the national eHealth strategy currently being conceived.

Increased efficiency and qualitative improvements for the benefit of patients are expected from the ePrescription. These can stem from the linking of

databases on medicines and their effects and the resulting extended basis for advice. In a first stage, implementation options are being drawn up which will then be evaluated from an economic perspective, thus broadening the basis for decisions on the specific design of the structure.

In connection with activities at European level, against which the progress of technological development in the health care system is measured, the ministry intends to establish an information management system which essentially includes the following elements within the health care system:

- the establishment of an infrastructure reporting system
- the economic evaluation of technology projects
- an evaluation of the social effects of the use of technology.

In an initial stage, the establishment of the infrastructure reporting system will be tackled. The BMGF has set up a platform in cooperation with a private organization which is designed to facilitate discussions and the exchange of views, but also the drawing up of recommendations for concrete activities. It is accessible for all stakeholders in the health care system and also for companies operating in this sector. The primary objective of this eHealth initiative is to focus previously isolated knowledge and to lay down the basic conditions, demands and contents of a national eHealth strategy as defined by the eHealth Action Plan.

5 Financial resource allocation

Funding for the health care system predominantly stems from contributions and taxes (around 70%). Private households finance around 30%. Fig. 5.1 summarizes the flows of funding and explains the origin of financing and its uses. The structure of the raising of funding in the health care system is illustrated in Table 3.1.

The raising of funding and the mechanism for its redistribution between the health insurance funds is described in Table 3.3 in Section 3.1 on main system of finance and coverage. The development of the use of funding is illustrated in Table 3.13 in Chapter 3 on health care financing and expenditure. In the following sections, the setting of budgets in the hospitals sector and the remuneration of hospitals and physicians in private practice are described in more detail.

5.1 Third-party budget-setting and the allocation of resources

Public health expenditure in Austria is mainly financed by the social health insurance system. These finances are raised and used in a decentralized manner and are not subject to any budget-setting process in a narrower sense, but are the result of the health insurance funds' obligation to ensure that services are in accordance with the current provisions of social insurance law (see Section 3.1 on main system of finance and coverage). For the treatment of insured people in hospitals, the health insurance system contributes a flat rate amount to a (partly) overall budget (Table 5.1). The social health insurance system finances around 40% of the total costs for public hospitals. The financing of

public hospitals can thus be described as a pluralistic system. However, there is also a mixture of tax and contributions financing in the fields of preventive care and health promotion (see Table 2.1). The following section deals with budget-setting in the hospitals sector.

In the estimate for the Federal Government's budget for 2005, the health sector accounted for €836 million, from which €395 million or 4.6% of the costs for public hospitals are provided. With the inclusion of the funding for the additional costs for teaching hospitals, this share of financing is increased to 7% (Table 5.1). Around 5% of the total identified financing volume of the health care system is thus within the Federal Government's budget. With this funding, the Federal Government attempts to exercise a controlling influence on the health care system, and on the hospitals sector in particular. Together with the social insurance institutions, the Federal Government forms one side of the equation in the budgeting process for the hospitals sector; on the other side are the Länder, local authorities and private owners. Owing to the distribution of competencies in the Federal Constitution, however, the Federal Government's responsibility in the hospitals system is restricted to carrying out a regulatory role (see the introductory overview, Section 1.1).

The budget-setting process in the hospitals sector

Regular financial adjustments are carried out between the Federal Government and the Länder (see the introductory overview, Section 1.1). The total budget for hospitals, which is raised by the health insurance funds, by the Länder and local communities and by the Federal Government, is a part of the financial adjustment negotiations and is the subject of a separate agreement between the Federal Government and the Länder (Federal Constitution Article 15a on the Reform of the Health Care System and Hospital Financing), which in its latest version is valid for the years from 2005 to 2008.

Since 1997, the hospital sector has been subject to (partial) overall budget control, into which all the providers of funding in the health care system are integrated. The Federal Hospitals and Cure Institutions Act contains a mandate for the Länder to provide hospital care. According to the Constitutional Law on Finance of 1948, the Länder are principally obliged to bear the costs of the construction and maintenance of suitable hospitals. This task is closely linked to the health insurance system's obligation to render services. The legal structures thus reflect the raising of funding, as Table 5.1 shows in the case of public hospitals.

The costs of public hospitals amounted to €8.5 billion in 2004, of which hospital outpatient departments accounted for around 12%. Of these costs, the

social health insurance system financed 40%, the Federal Government 7.1%, the Länder 1.9% and local communities 1.3%. Whereas the funding from the social health insurance system increased (+27%) between 1997 and 2004, as did that of the Länder (0.949% of value-added tax revenue) and local communities (0.642% of value-added tax revenue), federal government funding (1.416% of value-added tax revenue) was around a third lower in 2004 than in 1997. This is in line with general stability objectives (see Chapter 6 on helath care reforms), as is illustrated by the reduction in the proportion of the total budgeted funding for the financing of public hospitals (1997: 56.5%, 2004: 50.2%).

This "budget discipline" was accompanied by an increase of 67% between 1997 and 2004 in the funding which is raised by the hospital owners. This is also reflected in the increasing proportion of financing which they provide: whereas hospital owners (essentially the Länder, but also private non-profit-making organizations) financed around 31% of the costs of public hospitals in 1997,

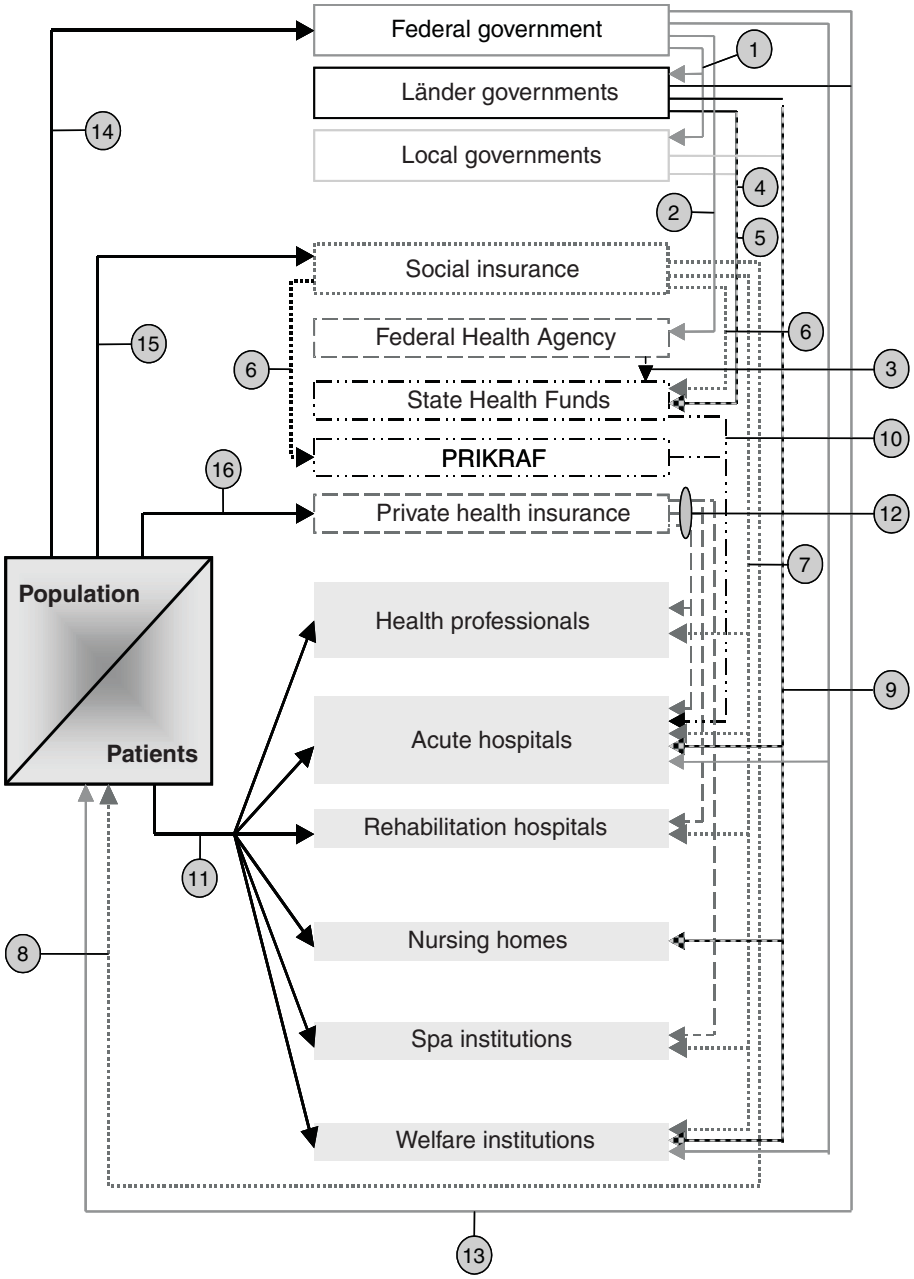
Table 5.1 Public hospitals by source of funding, 1997–2004

	Sources of funding	1997	2001	2002	2003	2004	Change 1997–2004		
		in % of the total costs of public hospitals					in % 1997–2004	in % per year (nominal)	nominal 1997 =100
Budgeted funding	Social insurance[a]	41.5	41.2	40.8	40.2	40.0	-1.5	–	127
	Federal government	6.9	5.1	5.0	4.6	4.6	-2.3	–	89
	Federal government: additional expenditure for teaching hospitals	4.7	3.7	3.6	3.4	2.5	-2.2	–	69
	Länder	2.1	2.0	2.0	1.8	1.9	-0.2	–	117
	Local communities	1.4	1.4	1.4	1.2	1.3	-0.2	–	116
Other funding	Owners[b]	31.4	35.4	36.4	38.0	39.7	8.3	–	167
	Private health insurance[c]	9.6	8.3	8.0	7.9	7.4	-2.2	–	101
	Private households including cost-sharing	2.4	2.9	3.0	2.9	2.7	0.4	–	–
	Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**–**	**–**	**–**
Memorandum		in million € (nominal)							
	Cost of public hospitals	6 461	7 548	7 762	8 045	8 523	–	4.0	132
	– Budgeted funding	3 659	4 036	4 092	4 123	4 281	–	2.3	117
	– Owners[b]	2 027	2 668	2 823	3 055	3 380	–	7.6	167
	– Private health insurance[c]	621	624	617	633	629	–	0.2	101
	– Private households including cost-sharing	154	220	230	234	233	–	6.1	151
	Total funds raised	**6 461**	**7 548**	**7 762**	**8 045**	**8 523**	**–**	**4.0**	**132**

Source: Federal Ministry of Health and Women, 2005; Statistics Austria *(8)*; the Association of Insurance Companies *(104)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: [a] Including cost-sharing (1997: €31 million, 2004: €36 million) and from 2002 including PRIKRAF expenditure (€73 million); [b] Länder, local communities, religious orders and other private non-profit enterprises, etc.; [c] 90% of expenditure of private households for inpatient health services according to national accounts.

Fig. 5.1 The flow of funds in the health care system, 2005



Source: Federal Ministry of Health and Women, Departments IV/A/4 and IV/A/5, 2005.

Notes: PRIKRAF: Private Hospitals Financing Fund;
(1) Financial adjustment between the federal government and the Länder;
(2) Budget funding from the federal government for the Federal Health Agency: a) fixed funding, b) 1.416% of value-added tax revenue in the respective year;
(3) Funding from the Federal Health Agency for the State Health Funds;
(4) Funding from Länder governments for the State Health Funds: a) 0.949% of value-added tax revenue in the respective year, b) the shares of the Länder in covering operational deficits also flow into the majority of the State Health Funds;
(5) Funding from local authorities to the State Health Funds: a) 0.642% of value-added tax revenue in the respective year, b) the shares of the local authorities also flow into covering operational deficits in the majority of the State Health Funds;
(6) Funding from the social insurance institutions to: a) the State Health Funds; adjustment analogous to the change in contribution revenue, b) the PRIKRAF; adjustment analogous to the contribution revenue;
(7) Funding from the social insurance institutions which goes directly to hospitals (acute rehabilitation), to members of the health professions, care institutions and welfare institutions;
(8) Funding from the social insurance institutions which goes directly to patients;
(9) Funding from the Länder and/or local authorities, which goes directly to hospitals, nursing homes and welfare institutions;
(10) Funding from the State Health Funds to public and private non-profit acute hospitals and from PRIKRAF to private non-profit acute hospitals;
(11) Cost-sharing and co-payments by patients;
(12) Payments from private health insurance companies to service providers;
(13) Federal or Länder long-term care benefit to recipients;
(14) Taxes;
(15) Contributions to social health insurance;
(16) Contributions to private health insurance.

their contribution had risen to almost 40% in 2004. The proportion of financing provided by private health insurance decreased by 2% and amounted to 7.4% in 2004 (see Section 3.3 on complementary sources of finance and Section 5.3 on payment of physicians). Cost-sharing by patients and those who paid privately financed around 3% of the costs of public hospitals.

At a total of 4%, the annual average growth in the costs of public hospitals was above growth in GDP in this period (Table 5.2). At the same time, the funding raised by the owners of hospitals between 1997 and 2004 increased most, at an annual average of 7.6%, followed by the funding from private households (6.1%), budgeted funding (2.3%) and private insurance (0.2%).

Budgeted funding for the remuneration of the State Health Funds amounted to €4.07 billion in 2004. The additional expenditure for teaching hospitals is a contribution from the Federal Government for the construction and expansion of those public hospitals which at the same time act as training centres of the medical university faculties in Vienna, Graz and Innsbruck. This results in a total sum of €4.28 billion. After the deduction of a number of lump sums amounting to around €20 million (funding to support the transplantation system, to promote

nationally significant preventive care programmes and treatment measures as well as funding for the financing of projects and planning), the budgeted (value-added) tax revenue (Federal Government, Länder, local communities) and the funding from the social insurance system are divided up among the State Health Funds according to defined ratios (see Section 6.2 on content of health reforms). The ratios for the different Länder are determined according to their population, based on a formula using data from the latest census, and/or are orientated towards previous budgets. They do not reflect any differences in the requirements or in the risk structure of the population. How the budgeted funding is distributed among hospitals varies according to the Land in question (Table 5.6).

The financing of private hospitals, which are not financed through State Health Agencies, but which to a certain extent make an effective contribution to public health care provision, takes place via the Private Hospitals Financing Fund (see Section 2.2 on planning, regulation and management). These hospitals received a budget of €72.67 million in 2004, which was raised by the social insurance institutions. This amount has also been fixed as a prospective payment since 2002.

In total, the hospitals sector accounts for around 40% of health care expenditure in Austria (Table 3.13 and Table 5.2).

Table 5.2 illustrates the cost trends in the hospitals sector and in the health care sector as a whole. The growth of costs in public hospitals in the period between 1997 and 2004 was, at 4%, exactly the same as the growth of total health care expenditure. Between 2000 and 2004, the growth of costs in public hospitals (4.2% per year) was significantly above the increase in health care expenditure (3.7%) and even more significantly above average annual GDP growth (3.0%).

More than half (2003: 52.0%) of the (primary) costs[16] in public hospitals are for personnel, 13.9% for medical consumer goods, 10.9% for fees, taxes and other costs, 8.6% for nonmedical external services, 2.3% for nonmedical consumer goods, 1.4% for energy costs and 1.3% for external medical services. Around 10% of costs are accounted for by imputed depreciation and interest.

[16] The primary costs are calculated from the sum of the cost type groups 1–8 (personnel costs, costs for medical durables and consumer goods, costs for nonmedical durables and consumer goods, costs for external medical services, costs for nonmedical external servcies, energy costs, taxes/contributions/fees, imputed investment costs).

Table 5.2 Development of final costs[a] in public hospitals (nominal), 1997–2004

	Final costs[a]	AAGR	THE[b]	AAGR	(GDP)	AAGR	Final costs[a]		THE[b]
	million €	in %	million €	in %	million €	in %	as a % of THE	as a % of GDP	as a % of GDP
1997	6 461	–	15 541	–	185 141	–	41.6	3.5	8.4
1998	6 662	3.1	16 610	6.9	192 384	3.9	40.1	3.5	8.6
1999	6 935	4.1	17 209	3.6	200 025	4.0	40.3	3.5	8.6
2000	7 239	4.4	17 768	3.3	210 392	5.2	40.7	3.4	8.4
2001	7 548	4.3	18 446	3.8	215 878	2.6	40.9	3.5	8.5
2002	7 762	2.8	18 906	2.5	220 688	2.2	41.1	3.5	8.6
2003	8 045	3.6	19 587	3.6	226 968	2.8	41.1	3.5	8.6
2004	8 523	5.9	20 514	4.7	237 039	4.4	41.5	3.6	8.7
AAGR 1997–2000	3.9	–	4.6	–	4.4	–	–	–	–
AAGR 2000–2004	4.2	–	3.7	–	3.0	–	–	–	–
AAGR 1997–2004	4.0	–	4.0	–	3.6	–	–	–	–

Sources: Ministry of Health and Women, 2005; Statistics Austria *(8)*, IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: THE: total health expenditure; AAGR: average annual growth rate; GDP: gross domestic product; [a] Including imputed investment capital costs (imputed depreciation, interest and rents); final costs are cost adusted for revenues hospitals might receive from selling services and products, for example "meals on wheels". [b] Total health expenditure according to the OECD System of Health Accounts without expenditure on long-term care and private expenditure on nursing homes.

5.2 Payment of hospitals

Since 1997, payment of half of the ongoing operating costs of hospitals has been on a prospective performance-orientated basis by modified diagnosis-related groups (DRG). The units of calculation used are points. Points values are arrived at retrospectively and are determined by Land at the end of the accounting period by dividing the fixed budget (see Table 5.1) by the points gained. Although there is uniformity in the calculation of DRGs, the financing of recurrent costs of hospitals in Austria is highly fragmented and is subject to very different arrangements (see Table 5.6), with regard to both the distribution of budgeted funding to the institutions and the funding which is raised by the owners. Moreover, these arrangements are not very transparent. The costs incurred by hospitals for investments and upkeep are mainly borne by the owners/operators.

Performance-orientated hospital payment (Austrian DRG model)

The performance-orientated hospital financing system (*Leistungsorientiertes Krankenanstalten-Finanzierungssystem*, LKF) is a case fee payment system based on modified diagnosis-related groups (Austrian DRG system) and allows billing on the basis of actual services rendered in public hospitals (see Section 4.4 on inpatient health care). The currently valid reimbursement system in the inpatient sector differentiates between two financing areas: the nationally uniform DRG core area, and the DRG fund control area, which can be varied by the individual Länder.

In the core area of the Austrian DRG model, the basis for the awarding of points for an inpatient stay are procedure- and diagnosis-orientated case groups (*Leistungsorientierte Diagnosefallgruppen*, LDF), including all special scoring rules. A nationally uniform number of points is allocated for stays in intensive care units, for acute neurological aftercare, for geriatric care and for services in the psychiatric day care sector. Special rules apply for lengths of stay above the upper bound or below the lower bound.

The core area has been continuously further developed since 1997, updated and subjected to annual revisions. In the years 1999 and 2000, the DRG flat rates were recalculated together with selected reference hospitals, and the results were included in the model for 2002. Since then the Austrian DRG model has remained basically unchanged in the core area – apart from some minor changes which were required from a medical or economic perspective. For the Austrian DRG models 1997–2001, the number of points for the DRG flat rates was determined on the basis of around 500 000 inpatient stays and costs calculated in 20 reference hospitals. This scoring system was updated as part of the project "DRG recalculation" and has been in use since the 2002 Austrian DRG model.

The fund control area of the Austrian DRG model can be modified by individual Länder and enables them to also take structural criteria into account (Table 5.3). By means of appropriate modification of the fund control area, different levels of hospital personnel and equipment of individual Länder (resulting, for example, from varying mandates to secure care) can be considered in the performance-orientated distribution of funding from State Health Funds.

From 2006 onwards, however, only functions related to the provision of care may be taken into account in the organization of the fund control area. This relates to hospitals providing highly specialized central and focused care, hospitals with certain specialist care mandates and hospitals with special regional care functions.

Table 5.3 Characteristics of the performance-orientated hospital financing system, 2005

Performance-orientated hospital financing system (LKF)	
Core area Nationally uniform	Points are allocated to inpatient stays on the basis of performance-orientated diagnosis-related case groups (LDF), including also all specific regulations for point allocation.
Fund control area Adjustable by the Länder	In addition, the following criteria may be considered in the LKF, taking into account Länder-specific requirements: Hospital type Personnel Equipment State of hospital buildings Utilization of capacities Quality of accommodation

Source: Federal Ministry of Health and Women, 2005 *(105).*

Nationally uniform core area

For the formation of the individual procedure- and diagnosis-orientated groups, a tree algorithm was used in which medical, economic and statistical criteria were included. This algorithm differentiates between three stages.

In stage 1, all patient cases from the reference hospitals were divided up on the basis of selected (existing) single medical service items into a group of cases based on single medical procedures (*MEL-Gruppen*) and a group of cases based on main diagnoses (*HDG-Gruppen*). To determine the case group based on single medical procedures, the surgical interventions listed in the benefits catalogue and a small number of nonsurgical services were used.

In stage 2, consideration was given to the homogeneity of services and the medical categories of the procedures or main diagnoses, as well as to the homogeneity of costs within statistically significant groups. From the single medical service items, 209 single medical procedure groups were formed, and from the diagnoses 230 main diagnosis groups were formed.

In stage 3 of the algorithm, 407 procedure- and/or diagnosis-orientated case groups (DRGs) were formed on the basis of structural characteristics in the single medical procedure groups, and 476 DRGs were formed based on the main diagnosis groups.

In 2005, a total of 883 DRGs based on either procedure- or diagnosis-orientated case groups were thus available. The points per case group establish the DRG flat rate, which represents the median of the costs calculated for all the patients within a given DRG and this is shown in euros. In the course of

recalculations, there has been a shift among the financing units from main diagnosis groups towards single medical procedure groups. Whereas 38% of the DRG flat rates were based on single medical procedures in 1998, their proportion had increased to 46% in 2003 (Table 5.4).

Every DRG flat rate consists of a performance component and a day component. For intensive care units, separate intensive care cost surcharges are determined per day. The performance component is based on the costs, calculated in the reference hospitals, which are directly assigned to patients as single medical services; these can be personnel costs for an operating team, for example, or the costs for medical consumer goods. Costs which are not directly assigned to individual services are – with the exception of the costs of intensive care units – combined into the day component, which is dependent on length of stay. For each DRG, upper and lower bounds of length of stay have been defined using data from the year 1999.

For the 2005 model, the length of stay values were evaluated on the basis of the 2003 data, and appropriate changes were carried out in the case of significant deviations. These bounds for length of stay were determined for the single medical procedure groups from the patients within an 80% interval of all patients, and for the main diagnosis groups within a 60% interval. A 30% interval was applied for the main diagnosis groups in the psychiatric sector. In this way, length of stay outliers can be identified earlier in the case of patients not receiving surgical treatment, who have more widely spread lengths of stay than surgery patients. As further criteria, it was determined that the upper and lower bounds for length of stay may only deviate by a maximum of 50% from the median length of stay. For patients whose length of stay is shorter than the lower length of stay bound of their case group, a reduced flat rate per case is calculated according to the actual length of stay. For patients whose length of

Table 5.4 Medical service item groups and principal diagnosis-related groups as a basis of performance-orientated flat rates per case, 1998, 2000 and 2005

Number of LDF, based on	1998		2000		2005	
	Number	Proportion	Number	Proportion	Number	Proportion
Medical service item (MEL) groups	324	38%	346	40%	407	46%
Principal diagnosis-related (HDG) groups	524	62%	521	60%	476	54%
Total number of LDF	**848**	**100%**	**867**	**100%**	**883**	**100%**

Source: Federal Ministry of Health and Women, 2005 *(105)*.

Notes: LDF: performance-orientated diagnosis-related case groups. The points allocated to a LDF establish the LDF flat rate.

stay is above the upper bound, supplementary points are calculated for each additional day on a declining scale.

In the latest version of the Austrian DRG model (2004/2005), adjustments were made to the length of stay values for 55 DRG flat rates per case. In the course of the evaluation of the single medical procedure case group "chemotherapy", the service components were recalculated resulting in shifts of individual items within the groups. The new benefits catalogue was streamlined by deleting irrelevant services, adding nine new services and making the catalogue text more precise. There was also an extension of services in the day-clinic model. In addition, two new DRG flat rates were included in the benefits catalogue (in the fields of orthopaedic surgery and oncological therapy) and changes were made to two further DRG flat rates (in the fields of cardiac surgery and neurology).

Documentation and data quality

Since 1989, all Austrian hospitals have been obliged to record patients' diagnoses on the basis of the version of the WHO's ICD published by the competent Austrian ministry. From January 2005, hospitals can use both the recording of diagnoses according to the BMSG ICD-10 2001 (based on the version ICD-10-1.3 published by the German Institute for Medical Documentation, DIMDI) and the recording of services according to the BMGF's 2005 benefits catalogue in its current version.

The legislative basis for the recording of diagnoses and services is the 1996 Federal Act on Documentation in the Health Care System in its 2003 version, and the 2003 decree on the recording of diagnoses and services in the inpatient sector. In order to ensure nationwide uniform documentation, the BMGF has published guidelines in the form of manuals. As a basis for performance-related reimbursement, public hospitals have to present monthly diagnoses and services reports to the Länder government and/or State Health Fund in accordance with Länder legal provisions (Table 5.5).

The minimum basic data set (MBDS) ascertained per inpatient hospital stay supplies the necessary data basis for the reimbursement of hospital services according to the Austrian DRG system. In addition, this data forms an information basis for the description (actual state), analysis and planning of the services provided in the health care sector. Through the introduction of nationwide uniform diagnoses and services documentation, a common database was created which facilitates the national and international comparability of the range of diagnoses and services of hospitals. The data set is additionally used internally in order to obtain information on the respective range of diagnoses and services in individual hospitals or departments.

Table 5.5 Data in diagnoses and services reports

Administrative data	Data related to the patient's stay	Patient-related data
	Hospital number	Date of birth
	Admission number and date of admission	Sex
	Type of admission	Citizenship
	Department admitting patient, transfers	Main place of residence
	Date of discharge and type of discharge	Bearer of costs
Medical data	Main diagnosis (according to ICD-10 BMSG 2001, four-figure) Additional diagnoses (according to ICD-10 BMSG 2001, four-figure) Selected medical service items (according to the benefit catalogue, BMGF 2005)	

Source: Federal Ministry of Health and Women, 2005 *(105)*.

In order to ensure data quality, the data should fulfil the criteria of being complete, detailed, verifiable and understandable. The Austrian DRG model 2005 has been extended by the inclusion of plausibility checks with regard to the exclusion of combinations of single medical procedures with the same service date. The references to inadmissible service combinations included in the previous circular letters on medical documentation were integrated in the form of "warnings".

The structure of hospital financing in the Länder

There are substantial differences between the Länder concerning criteria for the allocation of resources to hospitals (Table 5.6), the density of beds and the amount of investments (see Table 5.7), as well as the costs of acute inpatient care (see Table 5.8).

Different reimbursement models have developed over time with the aid of the fund control area, which can be modified by the individual Länder. A closer look at the individual Länder models does not reveal any serious changes in comparison to the respective initial model from 1997 *(106),* but does show shifts in individual aspects. In Carinthia, Styria and Vienna, there is still no fixed proportion of financing assigned to the core areas and the fund control areas; the control aspect is achieved by a weighting of DRG points, which varies from Land to Land. However, these weighting factors have been changed in some of the Länder. In Styria, the university teaching hospital now has a higher weighting (1.3) than in the initial phase (1.15), and, with two exceptions, the weighting factor of 1.0 is now applied to all the other hospitals. In this way, the university hospital has been significantly upgraded in a financial sense compared to the former arrangement. A change in the same direction – a higher weighting factor only for the university teaching hospital – was also introduced in Tyrol. This

is an indication of increased specialization. In addition, the weighting factors appear to have become more economically based. For example, the weighting factor "personnel" was supplemented by the factor "utilization" in Vienna. The activities of hospital outpatient departments are still only integrated into the DRG flat rate per-case system in one Land: Lower Austria. In Tyrol, financing is carried out via outpatient department points.

Reduction of beds and investment costs

In 1997, a binding Austrian Hospitals Plan was agreed on, including a Major Equipment Plan (ÖKAP/GGP) (see Section 4.9 on health technology assessment and eHealth) and has since been continuously adapted (see Section 1.2 on historical background and Chapter 6 on health care reforms). The ÖKAP

Table 5.6 Distribution of budgeted funding according to individual Länder, 2004

	Distribution between core and fund control areas	Weighting criteria	Reimbursement of hospital outpatient departments
Vienna	No separation between core and fund control areas Weighting according to personnel levels and utilization		Flat rate
Lower Austria	100:0	Weighting according to the type of hospital	Performance-related[a]
Burgenland	70:30	Fixed percentage per institution	No special reimbursement for outpatient services
Upper Austria	100:0	not applicable	Flat rate
Styria	No separation between core and fund control areas Weighting according to the type of hospital		Flat rate[a]
Carinthia	No separation between core and fund control areas Weighting according to the type of hospital		Flat rate[a]
Salzburg	No proportional separation between core and fund control areas	Not applicable	Flat rate
Tyrol	70:30	Weighting according to the type of hospital	In accordance with the funds' outpatient points
Vorarlberg	85:15	Weighting according to the personnel factor	Flat rate

Sources: Audit, accounting and activity reports of the respective hospital financing funds *(107)*; IHS HealthEcon, 2005 (http://www.ihs.ac.at).

Note: [a] Arrangement according to accounting report 2000.

specifies the locations of hospitals, the range of specialties offered and the total number of beds per hospital.

A maximum number of beds per specialty is also specified for each Land. The regulations set out in the ÖKAP are binding. If these specifications are not adhered to, the Federal Government can withhold the payment of funding for the financing of hospitals in the Länder (see Section 2.2 on planning, regulation and management).

In 2003, the ratio of acute beds to inhabitants amounted to 6.1 beds per 1000 inhabitants and had fallen by 12% compared to 1993. In comparison to the national average ratio of acute beds to inhabitants in 1993, Vienna and Carinthia had increased their stock of beds by 2003, whereas Styria and Tyrol had reduced theirs. The reduction of beds thus took place more slowly in Carinthia and Vienna than in other Länder (Table 5.7). The ratio of acute beds to inhabitants is markedly higher in Austria than the EU average (see Table 4.10).

Investments are mainly made by the owners and/or hospital operators. This activity is recorded in the cost type group "imputed investment capital costs". The investment capital costs per bed fluctuated between €7700 in Vorarlberg and €28 500 in Vienna; the national figure in 2003 was €17 406 per bed. Investment costs in Vienna and Tyrol are clearly above the national average, whereas those in Vorarlberg are markedly below average and those in Burgenland are just under half of the national average (Table 5.7). Vienna and Innsbruck (in the Land of Tyrol) possess large university teaching hospitals. In addition, these areas provide care for bordering regions. Graz, the capital of Styria, also has a university teaching hospital. However, the investment costs per bed in this region were below the national average.

Development of hospital costs in the Länder

A total of 3.6% of GDP or €8 billion was spent on acute care hospitals in 2003 (see Table 5.2). Translated into beds, each bed cost €163 219 on a national average. Compared to 1993 this constituted an increase of 65% or an average annual increase of 5% per bed. Vienna has the highest costs per bed and is 41% above the national average. Tyrol and Styria are just under average. Average annual costs per bed increased most in Styria; the increase was comparably small in Vorarlberg, but also in Vienna. In general, there is a weak but positive correlation between the level of costs per bed and growth rates: in Länder which had a high cost level in 2003, the growth rate of costs is lower. This indicates that the development of costs in the individual Länder is becoming more unified.

In 2003, inpatient stays cost a national average of €3525, with those in Vienna costing around 40% more, and those in Styria 6% more. The average

Table 5.7 Investments and ratio of beds to inhabitants according to Länder, 1993 and 2003

	Beds					Imputed investment capital costs	
	per 1000 inhabitants		Index Austria=100		Change in %	per bed in €	Index Austria =100
	1993	2003	1993	2003	1993–2003	2003	2003
Burgenland	5.1	4.5	73	74	-10.7	9 084	52
Carinthia	7.6	7.0	110	115	-8.4	15 299	88
Lower Austria	5.9	5.1	85	84	-13.7	9 481	54
Upper Austria	7.2	6.3	104	104	-12.5	15 722	90
Salzburg	7.4	6.5	107	107	-12.2	13 326	77
Styria	7.2	5.9	104	97	-18.2	16 327	94
Tyrol	6.9	6.0	100	98	-13.6	21 122	121
Vorarlberg	6.3	5.7	91	93	-10.1	7 703	44
Vienna	7.5	6.9	109	114	-8.6	28 539	164
Austria	**6.9**	**6.1**	**100**	**100**	**-12.4**	**17 406**	**100**

Sources: Federal Ministry of Health and Women, 2005; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

national costs per bed day increased significantly more (+65%) than the costs per employee (+35%) between 1993 and 2003 (Table 5.8). This development shows that the intensity of services and "technology costs" are generally rising strongly and more dynamically than personnel costs. In addition, we can assume that productivity in hospitals has risen markedly in the last few years, which has also been confirmed by more recent studies *(108, 108A)*.

Table 5.8 Development of costs in acute inpatient care according to Länder, 1993 and 2003

	Per actually provided bed				Per inpatient stay				Per bed day				Per employee (full-time equivalents)			
	2003	A =100	1993 =100	AAGR	2003	A =100	1993 =100	AAGR	2003	A =100	1993 =100	AAGR	2003	A =100	1993 =100	AAGR
Burgenland	123 406	76	176	5.8	2 506	71	132	2.8	386	88	176	5.8	71 834	96	141	3.5
Carinthia	143 004	88	163	5.0	3 048	86	101	0.1	416	95	150	4.2	76 249	102	141	3.5
Lower Austria	136 144	83	171	5.5	2 971	84	115	1.4	400	91	175	5.8	72 282	97	131	2.8
Upper Austria	139 842	86	171	5.5	2 982	85	117	1.5	399	91	172	5.6	71 566	96	136	3.1
Salzburg	144 186	88	172	5.6	3 377	96	126	2.4	439	100	172	5.6	75 902	102	138	3.3
Styria	156 227	96	191	6.7	3 724	106	134	3.0	401	91	191	6.7	70 374	94	137	3.2
Tyrol	160 847	99	178	6.0	2 913	83	105	0.5	430	98	172	5.6	70 555	94	141	3.5
Vorarlberg	134 644	82	153	4.4	2 898	82	105	0.5	400	91	153	4.3	77 306	103	138	3.3
Vienna	229 719	141	146	3.8	4 979	141	98	-0.2	545	124	149	4.0	80 397	108	132	2.8
Austria	**163 219**	**100**	**165**	**5.2**	**3 525**	**100**	**111**	**1.1**	**439**	**100**	**166**	**5.2**	**74 748**	**100**	**135**	**3.0**

Sources: Federal Ministry of Health and Women, 2005; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Notes: AAGR: average annual growth rate (in %); A: Austria.

The introduction of the Austrian DRG model system in 1997 was intended to optimize the allocation of funding between outpatient and inpatient treatment. There have only been limited indications until now that patients have been increasingly treated in the outpatient sector since 1997. Whereas the number of cases in hospital outpatient departments increased by 13% between 1997 and 2003, the number of cases treated by general practitioners rose by 7%. The number of cases treated by specialists rose by 19%, and those in technical-diagnostic specialties by 35% (see Table 4.4). This can be seen as an indication that diagnostic preliminary examinations, for example, are being increasingly outsourced. The development of aggregate expenditure proportions also does not indicate that there has been a substitution effect between outpatient and inpatient care. Since 1995, the proportion of expenditure on inpatient care has increased by 2.4 percentage points and amounted to just under 39% of total health expenditure in 2004; the share of expenditure on outpatient care, on the other hand, fell by 1.6 percentage points and amounted to 23.3% in 2004 (see Table 3.6). However, it cannot be ruled out that the severity of cases and thus the costs in hospital outpatient departments have risen more than those in the outpatient sector.

5.3 Payment of physicians

Physicians and other health professionals who work in hospitals, nursing homes or rehabilitation institutions (see Table 4.14) are mainly paid according to payment schemes based on public services or private law. In addition, many pay regulations provide for a range of bonuses depending on the Land in question, so that income comparisons are difficult, not only between groups of employees, but also between the Länder. A proportion of the employees in the public health care system are civil servants, for whom there are separate payment regulations. Work in private practice alongside an employment contract is also possible for health professionals other than physicians. In addition, physicians have the opportunity to earn additional income by treating private patients in public hospitals. According to estimates made by the Austrian Physicians' Chamber, gross initial pay for physicians amounts to around €50 000 per year; after 10 years' experience it can reach €75 000.

Additional insurance is also an important source of supplementary income for physicians who work in public hospitals (see Section 3.3 on complementary sources of finance). As payment levels in the public sector are relatively low, this is commonly viewed as an incentive to keep physicians in the public sector. Or, expressed another way, salaries in the public sector can be kept

comparatively low, as the fees from "special class" patients form an essential part of physicians' income. In the case of senior physicians, they can amount to several times their regular salary. In the appendix to its 1997 report, the National Audit Office criticized the fact that income from fees, in connection with surcharges for special class accommodation in hospitals, creates incentives to increase inpatient care *(109).* Of the approximately €630 million paid for supplementary insurance policies in voluntary health insurance in 1996, around 60% was accounted for by fees, whereby there are differing arrangements in the Länder with regard to the handing over of part of the fees to the hospital owners. The proportion of fees per case in 2004, for example, amounted to 70% in Tyrol, and almost 50% of the hospital costs per case in Styria. In addition, there are different arrangements relating to the sharing of fees between senior physicians and other medical personnel according to the Land in question.

The level of additional income for physicians depends on the number of special class beds in a department. The number of special class beds is, in turn, dependent on the total number of beds in a department. This may not, however, exceed 25% of the total bed capacity (Article 16, paragraphs 1 and 2 of the Hospitals and Cure Institutions Act). The linking of the number of special class beds to the number of beds in the standard class contains an incentive to keep bed capacities high. The National Audit Office also noted that special class patients also exhibit longer lengths of stay in some areas, thus creating a greater requirement for beds. This incentive has probably been significantly mitigated since the introduction of the ÖKAP/GGP in 1997, though it does still continue to exist, since the financial penalties imposed by the Federal Government for non-adherence to the bed reduction plans are comparatively low. According to the current agreement on hospital financing, the Federal Government can withhold a total of €127 million (divided up according to Länder ratios) if bed reduction is not implemented. This translates into around 1.5% of the total costs of public hospitals. Until now, the Federal Government has not applied this penalty to any of the Länder, although it has threatened to do so in two cases.

Incomes in the health care and social sector of the economy (see Table 4.13) are 12% below the median monthly income and approximately at the level of the below-average incomes in trade and commerce. In the textiles sector, incomes are a quarter lower than the Austrian median income, and they are 30% lower in the tourism industry *(110).*

Payment of physicians in private practice

The social health insurance system spent €2.7 billion on outpatient physicians' services and other comparable services in 2003. According to legislation, the following have equal status to treatment by physicians: physiotherapeutic

treatment, speech therapy, phoniatric and audiological treatment, occupational therapy treatment, the services of massage therapists and psychotherapists and the diagnostic services of clinical psychologists. This expenditure figure additionally includes the lump-sum payments from health insurance funds for hospital outpatient departments and health insurance spending on non-contracted physicians. If patients wish to visit non-physician health professionals in outpatient care, their services first have to be prescribed by a physician. Between 1990 and 2003, expenditure on the outpatient care sector grew at an average of 5.3% per year, and thus at around the same rate as the total expenditure of the social health insurance system (see Table 3.5). In 2003, the expenditure on physicians' and equivalent services represented 24.7% of the total budget of the social health insurance system.

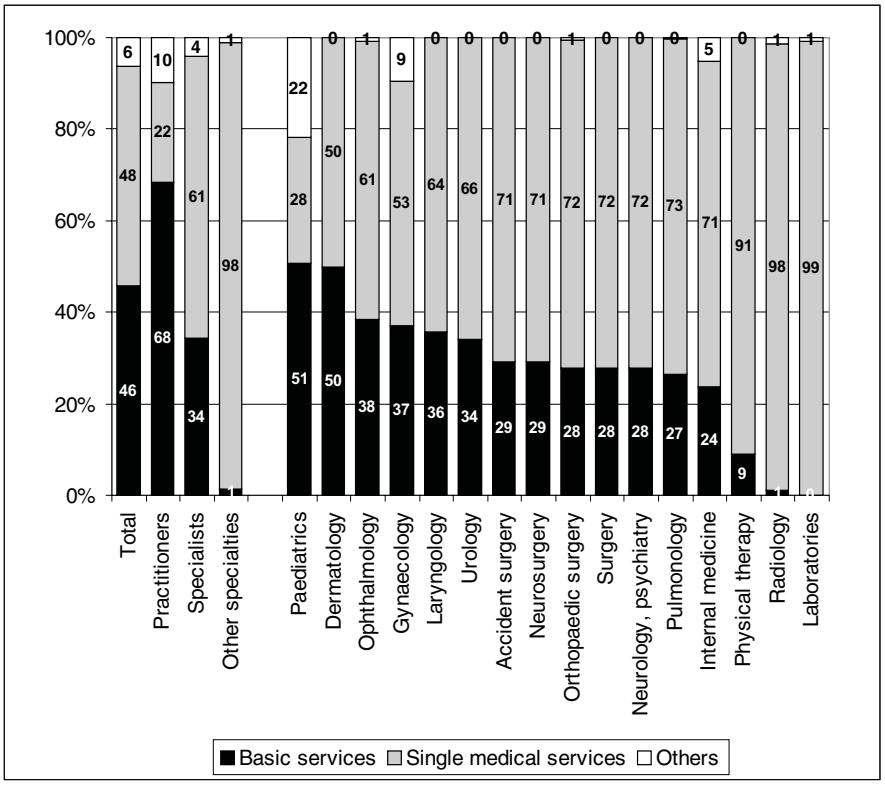
Most of the health insurance funds reimburse the services which are provided for insured individuals according to a mixed fee system, in which lump-sum reimbursement (payment for basic services) and fee-for-service reimbursement exist side by side. The fees which are billed by contracted physicians are settled with the ASVG funds (these are the nine regional health insurance funds, the company health insurance funds, the farmers' social insurance institution and the social insurance institution for the self-employed) on a quarterly basis. All of the other health insurance funds settle their accounts on a monthly basis, whereby there are varying limits on what can be charged depending on the Land in question.

The ASVG contains a section which stipulates that the reimbursement of contracted physicians principally has to be carried out on a fee-for-service basis. In practice, the proportion of the fee which is settled on a fee-for-service basis as defined by the fee regulations varies considerably depending on the specialty (Fig. 5.2). The extreme values at the upper end of this range are accounted for by the technical specialties; physicians specializing in radiology and laboratories work almost exclusively on a fee-for-service basis. In the case of general practitioners, on the other hand, single services only account for a fifth of the total. For the category of so-called general specialists (not including the specialties of physical medicine, radiology and laboratories), an average of 61% of total turnover is settled on a fee-for-service basis. The average for all contracted physicians is 48%.

In the case of general practitioners, flat rates per case, basic practice allowances, and fees for home visits account for the lion's share of billed fees. In the case of general specialists, only a third of all invoiced amounts are accounted for by these services.

The flat rate for basic services is paid for the vast majority of insured people for a period of three months, independently of how often services are utilized.

Fig. 5.2 Structure of fees for contracted physicians in private practice according to specialties (ASVG funds), 2003



Sources: Federation of Austrian Social Insurance Institutions, 2005 *(111)*; IHS HealthEcon calculations, 2005 (http://www.ihs.ac.at).

Note: ASVG funds: regional and company health insurance funds, the insurance institution of the Austrian mining industry and the farmers' social insurance institution.

The level of the flat rate varies according to specialty and Land. The fee per health voucher for general practitioners in the ASVG funds came to an average of €40.75 in 2003. This fee per health voucher consists of several items. In the case of general practitioners, around 21% stems from flat rates per case, 28% from basic practice allowances, 22% from fees-for-services and 12% from home visits. The remainder is accounted for by flat rates for on-call duty, travel allowances, costs for locums, mother–child medical card examinations, home care services and carrying out preventive health check-ups. The average fee per case for general specialists was between €35.10 (dermatology) and €86.20 (internal medicine) (Table 5.9).

The level of the amount paid for basic services fees is based on a declining scale in some Länder, and is dependent on the number of health vouchers invoiced per physician and per accounting period. This measure is intended to ensure fairer distribution among physicians given the constraints of the budget. Some individual health insurance funds reimburse physicians exclusively on a fee-for-service basis at monthly intervals.

Fee rates are set in regular negotiations between the health insurance funds and the physicians' chambers. Both the health insurance funds and the physicians' chambers calculate the costs of new services and subsequently negotiate the level of adjustments which may be necessary. The most common grounds for disagreements in the negotiations are the time charged for each consultation and the utilization of equipment. If no agreement can be reached, the respective region can be faced by a situation in which there are no valid contracts. Courts of arbitration are called upon to resolve disputes about the application and interpretation of contracts. In general, there has been a trend towards fee-for-service reimbursement for physicians in private practice in recent years.

Development and distribution of fees

The level of turnover per case for general specialists was 17% above overall turnover figures in 2003. General practitioners attain a level of 90% of the total turnover per case, other specialists reach a level of 95%. Compared to 1995, turnovers per case increased by 21% in total, and by 23% for general specialists. The development of turnovers per case in the technical specialties was comparatively moderate, and reached 81% of the 1995 level in 2003. The number of cases in the technical specialties showed the highest growth rates, and were almost 50% above the level of 1995 (Table 5.9).

A problem that is often mentioned in relation to the existing payment system is quality assurance, particularly the monitoring of process and outcome quality. A common subject of debate with regard to ensuring structural quality is the accessibility of physicians' practices. In 2004, a quality assurance company was established which developed standards for physicians' care which were subsequently made obligatory by the Physicians' Chamber (see Section 2.2 on planning, regulation and management).

People insured on the basis of the ASVG receive benefits in kind, whereby there are differing forms of cost-sharing depending on the fund in question. Those in nationwide funds make co-payments in the form of percentages (see Table 3.9). Settlement is carried out between the physician and the health insurance fund. Patient reimbursement is the method of settlement applied when

Table 5.9 Structure and development of the turnovers of general practitioners and specialists (ASVG funds), 2003

	2003			Index 1995=100			Proportions 2003 (in %)		2003 (total=100)
	Turnover in million €	Cases in millions	Turnover per case in €	Turnover	Cases	Turnover per case	Turnover	Cases	Turnover per case
General practitioners	**642.0**	**15.8**	**40.8**	**123**	**103**	**120**	**45.4**	**50.3**	**90**
General specialists	**547.0**	**10.3**	**52.9**	**150**	**122**	**123**	**38.7**	**33.0**	**117**
Pulmonology	30.9	0.4	73.2	165	139	119	2.2	1.3	162
Ophthalmology	76.7	1.9	40.5	161	128	125	5.4	6.1	90
Surgery	17.2	0.2	81.8	182	130	140	1.2	0.7	181
Dermatology	43.1	1.2	35.1	147	120	123	3.1	3.9	78
Gynaecology	74.0	1.8	41.4	119	102	117	5.2	5.7	92
Internal medicine	90.4	1.0	86.2	154	122	126	6.4	3.4	191
Paediatrics	46.2	1.0	44.9	133	119	112	3.3	3.3	99
Laryngology	39.8	0.8	48.3	157	127	124	2.8	2.6	107
Neurology, psychiatry	39.3	0.5	79.7	183	152	120	2.8	1.6	177
Neurosurgery	0.3	0.0	80.7	143	82	175	0.0	0.0	179
Orthopaedic surgery	56.0	0.8	68.4	153	124	123	4.0	2.6	151
Urology	32.0	0.6	56.3	172	158	109	2.3	1.8	125
Accident surgery	1.3	0.0	75.8	156	159	98	0.1	0.1	168
Other specialists	**223.6**	**5.2**	**43.0**	**121**	**149**	**81**	**15.8**	**16.6**	**95**
Radiology	140.1	2.0	70.9	126	132	96	9.9	6.3	157
Physical therapy	11.6	0.1	157.1	139	134	104	0.8	0.2	348
Laboratories	71.8	3.1	22.8	110	162	68	5.1	10.1	51
Total	**1 412.6**	**31.3**	**45.1**	**139**	**115**	**121**	**100.0**	**100.0**	**100**

Source: Federation of Austrian Social Insurance Institutions, 1995 and 2003 *(77)*.

Notes: ASVG funds: regional and company health insurance funds, the insurance institution of the Austrian mining industry and the farmers' social insurance institution.

a person covered by social insurance visits a physician without a social insurance contract (non-contracted physicians). Until 1996, the cost of consulting a non-contracted physician was fully reimbursed in accordance with the fees agreement with contracted physicians. The reimbursement received by patients now amounts to 80% of the rates agreed upon with contracted physicians.

Patient-related cost reimbursement is also valid for privately insured individuals. Patients have to apply for reimbursement of the fee rates set out in the contracts after consulting a physician.

General specialists achieved an average annual turnover of €198 995 in 2003, whereas for general practitioners the figure was €160 696. In comparison to 1999, this corresponded to increases of 13% and 7% respectively (Table 5.10). Technical specialists achieved an increase of 15%. However, compared to the growth in the number of cases, the development in technical specialists' turnover

Table 5.10 Development of the turnovers of general practitioners and specialists (ASVG funds)

	Turnover in € per doctor			Cases per doctor		
	1999	2003	Index 1999=100	1999	2003	Index 1999=100
General practitioners	150 611	160 696	107	3 968	3 943	99
General specialists[a]	175 504	198 995	113	3 617	3 762	104
Other specialists[b]	653 234	752 815	115	14 379	17 503	122
Total	**182 173**	**200 626**	**110**	**4 289**	**4 445**	**104**

Source: Federation of Austrian Social Insurance Institutions, 1999 and 2003 *(77).*

Notes: ASVG funds: regional and company health insurance funds, the insurance institution of the Austrian mining industry and the farmers' social insurance institution; [a] Pulmonology, ophthalmology, dermatology, gynaecology, internal medicine, paediatrics, laryngology, neurology, psychiatry, neurosurgery, orthopaedic surgery, urology, accident surgery; [b] Radiology, physical therapy, laboratories.

was lower (-6%). The highest increases were experienced by general specialists, whose fee income went up by 9% in relation to the number of cases.

However, fees should not be equated with income in the case of physicians in private practice, as costs resulting from the operation of the practice (rent, electricity, etc.) and the salaries of employees (receptionists, etc.) have to be paid from these. The level of overheads for physicians' practices depends on the specialty and amounts to around 50% on average.[17]

The income report provides indications of the level of physicians' incomes (*112*). Male specialists earn €178 652 per year in the third income quartile ("highlighted annual earnings from self-employment"). This income is around three times as high as the average earnings of all self-employed people, and is 41% above that of male lawyers in a comparable income category. Compared to the average income of employed individuals of €23 196 per year (2000), the average income of self-employed physicians in the third income quartile amounted to €141 051 per year (1999). Female self-employed physicians earn significantly less and some do not even earn 50% of the income of their male colleagues. The relationship between the average employees and physicians' incomes is thus similar to that in the United States: according to OECD data, United States physicians earn 5.5 times as much as average employees. Physicians earn 3.2 times as much as employees in the United Kingdom, and only 1.4 times as much in Canada *(113).*

[17] Information from personal communication with the Federation of Austrian Social Security Institutions and the Austrian Physicians' Chamber.

A cross-sectional comparison of incomes does not, however, offer a complete picture of the income situation of physicians. It does not take into account that physicians begin their careers relatively late in comparison to other professions owing to the long duration of education and training. Only comparisons of lifetime earnings levels between individual occupational groups would provide conclusive statements about differences in incomes.

6 Health care reforms

On the issue of health reforms, the responsible stakeholders are always faced by the question of which cost increases are affordable in the public health care system. The "affordability" of the health care sector is strongly linked to overall economic development. Not only that – the health sector is also growing faster than GDP, not only in Austria, but in almost all developed countries. Reforms in the health care system in Austria – as in all welfare states – are based on the principle of maintaining the current levels of quality in health care provision for everyone. In order to achieve this, a package of objectives is usually pursued within a delicate balance between efficiency and fairness of distribution. In Austria, this takes place against the background of a political consensus that a market-based provision of health care services is incompatible with the aims of the welfare state. The financing and provision of services in Austria are particularly guided by supply-side regulations which are designed to plan care provision.

Since the early 1990s there have been a series of reforms in the Austrian health care system. However, in spite of numerous changes and amendments to laws, the organizational and financing structures set out by the Federal Constitution of 1925 and the social and care provision legislation of the ASVG have been adhered to in all legislative periods (see the introductory overview (Section 1.1) and Section 1.2 on historical background). The objective of developing and extending social protection and thus also health care provision has also been upheld in all legislative periods. In 1994, a guideline referring to a "more efficient structuring of the health care system" was formulated for the first time, whereas the government policy statement of 1990 had still referred to the necessity of safeguarding that which had been achieved and access to the provision of care for all *(114,115)*. Accompanied by increases in contributions, this led to changes in the legislation on care provision and to an extension of

the obligatory benefits provided by health insurance funds. Health promotion and preventive care have also been increasingly emphasized from the mid-1990s onwards. In addition, the promotion of patients' rights was, alongside the reform of training for health professionals, at the centre of health policy activities at the end of the 1990s.

The legislative separation of organizational and financial structures in the Austrian health care system, in connection with the increasing availability of services and rising demand, have necessitated increased cooperation between all stakeholders in all legislative periods. Since the end of the 1970s, cooperative instruments of the federal state (agreements according to Federal Constitution Article 15a) have been employed which enable the Federal Government to exert a controlling influence, particularly in the inpatient care sector. In spite of its comparatively marginal share of financing (see Table 5.1), the Federal Government has begun to oversee care provision more closely and to initiate measures for the further development of the health care system. Since 1997 at the latest, it has taken on the role of a central coordinator for structural policy measures which develops standards for inpatient care and prescribes them in agreement with the Länder. It can also impose sanctions if stakeholders do not adhere to agreements. In this process, the planning of general inpatient services and state-of-the-art medical care and the resulting guidelines for hospitals have been particularly important elements until recently. The Federal Government's increasing desire to regulate has come at the price of a gain in autonomy for the Länder, and has fostered decentralization (see Section 2.2 on planning, regulation and management).

Table 6.1 illustrates the main focuses in health reforms since 1977; the objectives of reforms since then are explained in the following section. Section 6.2 refers to the content of health reforms from 1997. An overview of reforms before 1997 is provided by Section 1.2 on historical background. A more detailed description of health reforms in the 1990s is offered by the earlier version of the Health Care Systems in Transition Profile: Austria 2001 *(1)*.

Table 6.1 is orientated towards whether the reforms led to an improvement in the access to provision, and in its quality and efficacy, or whether they were designed to ensure the sustainability of its financing. This differentiation employs the EU's objectives for the development of public health care systems (*40*). The criteria "sustainable financing" refers to the financial position of the health insurance funds. The financing of benefits and services through taxes should therefore be interpreted as an easing of the burden on health insurance funds in this context. However, it results in an increasing orientation of the health care sector towards overall economic stability targets. This is compatible with the health policy objectives of ensuring a mixed system of financing from contributions and general tax revenue. In recent years, comprehensive reforms

were invariably related to the financial position of the social health insurance system (see Section 3.1 on main system of finance and coverage) and to general budget consolidation goals.

6.1 Aims and objectives

The targets set by the health care reforms in the 1990s, and in particular the goal of ensuring the financial sustainability of the public health care system, are embedded in the overall economic goal of budget consolidation. When it joined the European Economic and Monetary Union in 1998, Austria also took on the obligation to try to reduce its structural budget deficit as far as possible in accordance with the Pact for Stability and Growth. This led in 2001 to the adoption of the Austrian Stability Pact, which was renewed in 2005 and is also implemented via an agreement pursuant to Article 15a of the Federal Constitution *(116)*. According to this, the financial equalization process between the Federal Government and the Länder and the stability pact provide the framework for target-setting in the health care sector. Budget discipline and structural reforms, both of which are budget consolidation goals, have thus been determining factors for reforms in the health care sector since the mid-1990s, a fact which is reflected by the legislative measures taken.

Budget consolidation and cost-containment

The initial cooperation between the Federal Government, the Länder and the social insurance institutions in 1978 pursued the objective of linking the expenditure of the health insurance funds to developments in revenue (revenue-orientated expenditure policy). This goal was pursued on a more or less continuous basis in all of the subsequent agreements, and was accompanied by budget consolidation efforts and ongoing adjustments to contribution levels.

Since the mid-1990s, ensuring the financial feasibility of the health care system has been increasingly and more explicitly formulated as a key objective. In the 1990s, reforms in industrial countries were concentrated on securing long-term financial sustainability *(117)*. To this end, cost-sharing, performance-related forms of payment and budgets were employed (*118*). Austrian reform efforts were thus in line with international trends. This led to a stabilization of expenditure growth rates, particularly in inpatient care, as could also be observed at international level (see Table 3.5 and Table 5.2).

Cost-containment measures in the inpatient sector were accompanied by a series of regulations designed to stabilize the growth of expenditure on

Table 6.1 Main focuses of health care reforms, 1977–2005

Political background	Year of adoption	Main objectives	Target areas			Federal cooperation instruments
			Access	Quality and efficacy	Sustainable financing	
1975–1983 SPÖ majority	1977	Increasing transparency			Introduction of cost-centre and cost-type accounting in hospitals	
	1978	Cost–containment			First 15a Federal Constitution agreement: "Revenue-orientated expenditure policy". Start of systematic planning activities by the Federal Government and carrying out of controlling tasks	
1983–1986 coalition between SPÖ and FPÖ	1985	Improvements in combating epidemics		HIV/AIDS Act, health education and information, safe tests	Financing via tax revenue	Regular 15a Federal Constitution agreements between Federal Government, Länder, and social insurance institutions, continuation of the "revenue-orientated expenditure policy", development of performance-orientated financing and of the Hospitals and Major Equipment Plan
1986–2000: coalition governments between SPÖ and ÖVP	1989	Cost–containment, transparency		Documentation for hospitals	Direct cost-sharing for inpatient stays	
	1992	Extension of care provision, budget consolidation	Benefits mandatorily covered by social health insurance: psychotherapy, rehabilitation, preventive health care, medical nursing care at home		Contribution increases	
	1993	Extension of care provision	Improved access to long-term care and harmonization	Specific 15a Federal Constitution agreement, specification of standards for nursing homes, establishment of patients' rights, Commission for Quality Assurance, hospital hygiene	Tax financing, needs-orientated money transfers from the federal budget (federal long-term care benefit)	
	1997	Budget consolidation, cost–containment		Documentation, quality specifications for hospitals	Sixth 15a Federal Constitution agreement: Introduction of performance-orientated hospital financing, partial budget-setting, obligatory capacity plan, health voucher fee	
	1998	Extension of vaccination protection	Improved access to vaccinations		Mainly tax-financed	Regular 15a Federal Constitution agreements between the Federal Government and the Länder, further development of the performance-orientated hospital financing system (LKF) and of the Hospitals and Major Equipment Plan into service provision planning
	1998	Promotion of healthy lifestyles		Health Promotion Act Healthy Austria Fund	Financing via tax revenue	
	1998	Promotion of quality of health professionals	Group practices become possible	Training of physicians and other health professionals is brought into line with EU guidelines		
	1998	Extension of care provision	Access to social insurance cover for marginal part-time workers			

Table 6.1 (cont.)

Political background	Year of adoption	Main objectives	Target areas			Federal cooperation instruments
			Access	Quality and efficacy	Sustainable financing	
1986–2000: coalition governments	1999	Promotion of patients' rights	Definition of six principles: access, dignity, self-determination, information and suitable medical treatment			
2000 – coalition government between ÖVP and FPÖ/ later BZÖ (splinter group of FPÖ)	2000	Extension of care provision	Access to reproductive services		Partly financed from tax revenue	Regular 15a Federal Constitution agreements between the Federal Government and the Länder, further development of the performance-orientated hospital financing system (LKF) and of the Hospitals and Major Equipment Plan into service provision planning
	2000	Budget consolidation			Reimbursement of share of turnover increases in pharmacies to health insurance, renewed cuts in margins for wholesalers (1995, 1997), renewed extraordinary increase of the prescription fee (1996)	
	2001	Budget consolidation			Outpatient clinics fee introduced, abolished 2003	
	2002	Cost–containment, budget consolidation			Setting of budgets in health insurance funding for private profit-orientated hospitals, revision of the Equalization Fund (lifting of this ruling by the Constitutional Court)	
	2003	Budget consolidation			Standardization of contribution rates of wage and salary earners, leisure-time accident insurance, raising of the contribution rates for pensioners' "medicines packages"	
	2005	Budget consolidation, quality assurance, cost–containment		Eighth 15a Federal Constitution agreement: "reform pool", specifications for obligatory planning of services, increase of health insurance contributions, renewed increase of the ceiling on insurable earnings, increases in tobacco tax and cost-sharing Quality Act: nationwide quality specifications; development and extension of day-clinic treatment, further reduction of beds; Health Telematics Act		

Source: IHS HealthEcon, 2005 (http://www.ihs.ac.at).

Notes: SPÖ: Social Democratic Party Austria; ÖVP: Austrian People's Party; FPÖ: Freedom Party Austria; BZÖ: Alliance Future Austria.

medicines (see the subsection on medicines, within Section 2.2 on planning, regulation and management). Apart from the annual adjustments of prescription fees (see the subsection on co-payments and out-of pocket payments within Section 3.3 on complementary sources of finance), from 1995 there was an extension of the declining-scale margins for wholesalers, extraordinary increases in the prescription fee, a gradual opening of the market for medicines in the reimbursement codex, a reduction in prices and mark-ups, and in the year 2000 a type of public private partnership was introduced, with pharmacies in which 13% of turnover increases are refunded to the health insurance funds (*96*). In addition, the project "Medicines&Reason" was established in 1996 (see Section 2.2 on planning, regulation and management). In 2003 a new "medicines package" came into effect which, based on regulations for price formation, is designed to sustainably control the very dynamic developments in prices and quantities (see the subsection on medicines, within Section 2.2 on planning, regulation and management, as well as Table 3.5, Table 4.17 and Table 5.2).

The Health Reform 2005 is also orientated towards safeguarding the financial feasibility of the Austrian health care system via measures to contain costs, increase efficiency and exercise a controlling function (see Section 6.2 on content of health reforms).

The context for these objectives within the EU is the budget discipline demanded by membership of the eurozone and the Lisbon Strategy. In March 2000, the EU heads of state and government leaders adopted a plan to make the EU "the most competitive and dynamic knowledge-based economic area in the world". Among the contents of the strategy is the modernization of the "European social model – investing in people and combating social exclusion" *(119).* In addition, in a communication from the European Commission in 1999, it was agreed that one of the main objectives of increased cooperation of the Member States should be to ensure health care provision which fulfils high-quality criteria and is financially viable in the long term. This was to be achieved via "a concerted strategy to modernize social protection". The initiative was approved by the European Council in March 2000 in Lisbon. In a report presented by the Commission in 2001, it was established that the health care and long-term care systems in the EU are faced by the challenge of realizing three objectives at the same time: full access to benefits and services, high quality and financial sustainability *(120).* These activities are the basis of the method of open coordination in policy areas such as the health care system which are not the responsibility of the Community.

Structural reforms

With the agreement pursuant to Federal Constitution Article 15a on the reform of the health care system and hospital financing for the years 1997 to 2000, the existing hospital financing fund (see Section 1.2 on historical background) was replaced by the structural fund at federal government level and by nine Länder funds *(121)*. The establishment of the financing funds as new legal entities was accompanied by the reorganization of financing and decision-making flows for the largest sector of the health care system. The Structural Commission and the Länder commissions were established as the respective executive bodies of the structural fund and the Länder funds.

The new institutional structures were accompanied by hopes that it would prove possible to increase the integration of the inpatient and outpatient sectors. The aim was to free up efficiency reserves and improve the ease of movement between structures for patients by developing interface management. In spite of continuing efforts and repeated political commitments to improve the integration of the supply chain, no major advances have yet been made in this field.

However, it has at least proved possible to establish – for the first time – a binding Hospitals and Major Equipment Plan as a structural policy instrument. Furthermore, for the first time the objective was formulated of drawing up an Austrian health plan which would include all areas of care provision. In 1997, the objective of implementing a performance-orientated hospital financing system based on procedure and diagnosis orientated groups throughout Austria was finally achieved. This goal had been targeted for many years in agreements between the Federal Government and the Länder.

However, this did not lead to the lifting of the strict separation between the individual sectors of the health care system. The Health Reform 2005 is thus again designed to achieve improved coordination in the planning, control and financing of the entire health care system with further changes to institutional structures and more specific targets. In this context, measures were agreed upon to speed up shifts in services between the hospitals and the outpatient sector (see Section 6.2 on content of health reforms).

Other objectives

Since the mid-1990s, health policy has concentrated on the development of concepts for health promotion and prevention, alongside various activities designed to develop a quality assurance strategy (see Section 2.2 on planning, regulation and management). Health policy-makers have tried to orientate themselves towards the concept of "new public health policy" – the main focus of which is to provide the services which correspond to the current health status

of the population as a whole, to facilitate access to these services, and thus to optimize the health of the country's inhabitants. In 1998, the Health Promotion Act was passed and the Healthy Austria Fund established. The adoption of the "NEW Preventive Check-up" in 2005 was an attempt to focus the fragmented competencies in this field and to offer evidence-based preventive measures (see Section 4.1 on public health services). In addition, the Health Reform 2005 aimed to promote the utilization of information and communications technology, which is decisive for the health care system, and to intensify the application of health economics approaches.

"Health for All" targets of the World Health Organization

As in other countries, Austrian health care policy is orientated towards the "Health for All" framework developed by the WHO Regional Office for Europe. However, specific WHO health objectives have not been adopted nationally.

Austria can point to the following initiatives in its implementation of the World Health Organization's Ottawa Charter.

- The Land of Vorarlberg has participated since 1985 in the CINDI programme (Countrywide Integrated Noncommunicable Disease Intervention Programme) for cooperation in jointly combating diseases prevalent in industrialized countries such as heart attacks, strokes, cancer and mental disorders.
- As a WHO Collaborating Centre, the Ludwig Boltzmann Institute for Medical and Health Sociology provides the impetus for health promotion in this field.
- In addition, Austria participates in the projects "Health-promoting schools", "Healthy cities", "Health and work" and "Health in prisons".
- Austria cooperates in projects concerning smoking, alcohol, drugs and infectious diseases including HIV/AIDS. Measures at national level are taken in accordance with World Health Organization objectives (for example Alcohol Action Plan, Tobacco Action Plan).

6.2 Content of health reforms

1997–2000

Budget consolidation and cost-containment

The most important budget consolidation measure in this legislation was the introduction of the Austrian DRG system of hospital financing, which had already been prepared by the Hospitals Cooperation Fund. This was accompanied by the setting of budgets for the health insurance institutions' funding of hospital financing. Payments from the social insurance institutions to hospitals are now linked to increases in the revenue of the health insurance funds (revenue-orientated expenditure policy). In this way it was also possible to take into account the objective of contribution rate stability as a part of general budget consolidation efforts to achieve the goals for participation in monetary union. This was accompanied by the establishment of budgets for minimum contributions of the regional authorities towards hospital financing.

In order to overcome the financial consequences of structural changes and to regulate the changes in services offered in the inpatient, day care, day-clinic, outpatient and private practice sectors, a consultation mechanism was established between the social insurance institutions and the Länder. In addition, sanction mechanisms were defined which offer the Federal Government the opportunity to withhold from the Länder a share of federal funding in the case of important infringements of jointly agreed plans until the State Health Fund or the Land has initiated appropriate measures for the restoration of compliance with the plans for hospitals. This sanctioning mechanism has never been used.

In addition, a hospital fee was introduced in 1997 (see Section 3.3 on complementary sources of finance) and measures were taken in the pharmaceuticals market. For instance, there was an unplanned increase of the prescription fee.

Structural reforms

With regard to structural changes, the agreement according to Federal Constitution Article 15a on the Reform of Health Care and Hospital Financing included the replacement of the Hospitals Cooperation Fund and the establishment of a structural fund and nine Länder funds as well as a Structural Commission of the Federal Government and nine Länder commissions (*121*). The Structural Commission consisted of representatives of the Federal Government, the Länder commissions, representative bodies of the towns/cities and local communities, and a representative from the hospitals run by religious orders. The Federal Government's representatives held a majority.

The Länder commissions consisted of representatives of the respective Land, representative bodies of the towns/cities and local communities, the legal entities operating hospitals, the social insurance institutions and the Federal Government. The Länder held a majority of votes in the Länder commissions.

The main content of the agreement was the establishment of the binding Austrian Hospitals and Major Equipment Plan (ÖKAP/GGP) which also included a hospital outpatient departments plan, a location plan for fund-contracted physicians, a long-term care sector plan and a rehabilitation plan.

The ÖKAP/GGP specifies the locations of hospitals, the specialties offered and the total number of beds per hospital. The maximum number of beds per speciality and Land is also stipulated. For a number of specific medical-technical large appliances (for example computer tomography, magnetic resonance imaging scanners), the plan also specifies the respective numbers which can be installed in hospitals and in the outpatient sector (as long as they are to have health insurance fund contracts and are thus relevant for public health care provision). Included in the basis for planning are also demographic factors, developments in medical science, lengths of stay in hospitals, geographical structures as well as the functions of hospitals as providers of services. Experts from the medical sector, from the state governments, the hospital operators and the physicians' chambers are involved in the planning process. Agreement on the plans is reached between the Federal Government and the Länder. The regulations set out in the ÖKAP are binding. If they are not adhered to, the Federal Government (represented by the structural fund) can withhold the payment of financing to the Länder. Part of the planning process at federal level is the continuing adjustment, evaluation and further development of the ÖKAP/GGP (see Section 2.2 on planning, regulation and management).

In January 1999, the ÖKAP/GGP was revised and extended. The reference point for this revision was the change in the age structure of the population and the related changes of the range of diseases encountered in acute medical care. For the first time, the sectors of acute geriatrics/remobilization were included in the plan, an initial concept for comprehensive coverage with palliative care was defined and the first national psychiatry plan was integrated into the ÖKAP/GGP. In addition, the 1999 ÖKAP/GGP included minimum standards for intensive care units for the first time. The agreements made in the ÖKAP/GGP were to be implemented by the Länder themselves in the Länder hospitals plans.

Other contents

In the agreement reached between the Federal Government and the Länder, quality assurance in the health care system was expressly set out as one of

the tasks of the above-mentioned Structural Commission (see Section 2.2 on planning, regulation and management).

2000–2004

Budget consolidation

The government programme 2003 provided for a harmonization of the contribution rates of the different groups of the insured *(122).* In view of the cash shortfalls in the funds, this was then implemented and raised a total of around €300 million. The health insurance contributions of salary earners were raised to the same level as those of wage earners, and "equal treatment" of wage and salary earners was thus achieved for the first time in the history of the Second Republic (see Section 1.2 on historical background). In addition, the contribution rates for all the insured were increased in order to cover the risk of leisure-time accidents. The health insurance contributions of pensioners are to be increased annually by a quarter of a percent until they have reached a level of 4.75% of the respective pension.

Structural reforms

The ÖKAP/GGP was updated and gradually extended in the years 2001 and 2003. Alongside the establishment of hospital locations, maximum numbers of beds per hospital and the maximum number of beds per specialty and Land, the ÖKAP/GGP also contained agreements on structural changes corresponding to demographic and medical developments. This work intensified efforts to reduce the imbalances in the provision of health care. A further measure in this period was the first psychiatric services plan to be integrated into the ÖKAP/GGP, which included the decentralization of psychiatric care, bringing it closer to people's homes, and integrating it into general care provision. Plans for nationwide psychosomatic services were also drawn up for the first time.

Other contents

One of the most important issues in this agreement between the Federal Government and the Länder is quality work. Quality goals at federal level, necessary activities and specific projects were defined. Nationwide quality projects were then implemented, including, among others, the topics of patient orientation, interface management, quality reporting, optimization of the use of antibiotics, and optimization of the use of blood components. Special emphasis was placed on involving important stakeholders and occupational groups in

the implementation of the projects, in order to ensure as much acceptance and practical relevance as possible for the project results.

Reforms in 2005 with planning until 2008

Following on from the reforms of 1997, a range of measures have been implemented in this legislative period which both further develop organizational and decision-making structures, and change planning activities and create the conditions for a more flexible use of funding in the public health care system. Furthermore, the legislation focuses on both quality assurance and information and communications technology.

Budget consolidation and cost-containment

The increase in contribution rates, the rise in the ceiling on insurable earnings, and the increases in cost-sharing and tobacco tax have, along with the lifting of health insurance contributions for pensioners already adopted in 2003, raised an additional €425 million per year for the health care system. This is accompanied by a package of cost-containment measures. In the financial adjustment for 2005–2008, it was stipulated that €300 million worth of measures are to be taken to contain costs and raise efficiency and the level of control in the health care system. These measures refer in particular to increasing day care treatment with a corresponding reduction in beds, avoiding parallel services and implementing measures to lower costs in areas of hospitals which do not directly affect patients. The extent to which these measures have been fulfilled are to be evaluated after two years.

Hospital financing. The Austrian DRG system of hospital financing will be continued and is to be subjected to further development by 2007. The main focuses of further development are to include the promotion of day care services and the updating of the model through calculations using a revised calculation guide based on updated hospital cost accounting. Furthermore, integrated supply concepts and the reduction of the burden on inpatient care are to be promoted by the development of a points model for medical follow-up care, transfers between departments and hospitals, and readmissions. The coordination of the Austrian DRG model with the services supplied in hospital outpatient departments and private practice is to be achieved through the harmonization of documentation and the separation of the contents and the scoring of flat rates per case from other areas of care provision. In addition, a performance-orientated financing concept is to be developed for the outpatient sector which is coordinated with the inpatient sector.

The creation of a new instrument of cooperation designed to provide motivation for cooperation between financing bodies is closely linked to the structure of raising funding for hospital financing (see Table 5.1). Important impulses for cost-containment will result from this cooperation if the stakeholders involved interact in a constructive manner.

Cooperation area (reform pool). In order to provide support for agreed structural changes or for projects which result in shifts in services between the inpatient and the outpatient sectors at Länder level, financing can be made available from the State Health Funds (reform pool). For the year 2006, funding amounting to at least 1% of the total financing for the inpatient and outpatient sectors (approximately €150 million) is to be used. For the years 2007 and 2008, funding amounting to at least 2% of the total financing for the inpatient and outpatient sectors (approximately €300 million) is to be reserved.

A prerequisite for supporting these shifts in services is that the respective Land and the social insurance institutions reach an advance agreement on the content of these measures and that both the Land and the social insurance institutions benefit from these shifts. A further condition for the award of funding is appropriate documentation of the status quo and the changes in the services provided in the inpatient and outpatient sectors by the respective financing partners. For the first time, this newly created reform pool makes it possible for money to follow services at the interface of outpatient and inpatient health care. In this way, the efficacy of funding could be significantly increased.

Structural reforms

Federal Health Agency and Federal Health Commission. The Federal Health Agency was established as a fund under public law and as a separate legal entity. Its main tasks are:

- drawing up quality specifications for the provision of health services;
- involvement in the creation of guidelines for the transparent representation of the use of funding and the accounting of hospitals and hospital trusts, along with the creation of guidelines for the transparent representation of estimates and the accounting of the social insurance institutions for the outpatient sector;
- service provision planning as the framework for the provision of health services in all sectors, whereby quality guidelines should be taken into account, and the development of suitable forms of cooperation between service providers;

- the development and further development of performance-orientated reimbursement systems (outcome-orientated, flat rate and capped) including all health care sectors;
- drawing up guidelines for nationwide documentation including all sectors of the health care system as well as the further development of a documentation and information system for analyses to observe the developments in the Austrian health care system, whereby particular attention should be paid to gender-specific differentiation;
- basic guidelines for interface management between the various sectors of the health care system;
- cooperation in the health telematics sector and the electronic health file;
- drawing up guidelines for the cooperation sector (reform pool).

The executive body of the Federal Health Agency is the Federal Health Commission. This is composed of representatives of the Federal Government, the social insurance institutions, the Länder, towns and cities and local communities, hospitals run by religious organizations, patients' ombudsmen's offices and the Austrian Physicians' Chamber. The Federal Government holds a majority of votes in the Federal Health Commission; however, agreement has to be reached with the Länder and the social insurance institutions on all important matters. In the case of infringements against resolutions of the Federal Health Commission, the Federal Health Agency has to withhold the parts of the funding which it transfers to the State Health Funds until compliance with the resolution has been restored. The Federal Health Agency replaces the structural fund, the Federal Health Commission and the Structural Commission.

State Health Funds and Health Platforms. The State Health Funds were also established as funds under public law and as separate legal entities. The Länder had until the end of 2005 to establish State Health Funds. The highest executive body of a State Health Fund is the Health Platform at Länder level. It is responsible for the following tasks:

- cooperation in implementing and monitoring adherence to quality guidelines for the provision of health services;
- representation of the budget framework for public expenditure in the inpatient and outpatient sectors;
- cooperation in drawing up specific plans for the provision of services in all sectors of the health care system, taking quality guidelines into account;
- the implementation of performance-orientated reimbursement systems (outcome-orientated, flat rate and capped) including all health care sectors on the basis of appropriate documentation systems;

- carrying out analyses to observe the developments in the Austrian health care system, whereby particular attention should be paid to gender-specific differentiation;
- interface management between the various sectors of the health care system;
- cooperation in the health telematics sector, in market monitoring and price information;
- the development of projects for health promotion and the development and implementation of specific measures to improve structures including documentation of shifts in services between the health care sectors;
- the realization of joint pilot schemes for the integrated planning, implementation and financing of specialist medical care in the hospital outpatient department sector and the private practice sector (the development of new cooperation models, medical centres, etc.) and the coordination of the planning of resources between the health care system and the nursing care sector.

In addition, the Länder can delegate further tasks from their area of responsibility to the Länder Health Platforms. The respective Land and the social insurance institutions are equally represented in the Länder Health Platforms, and the Federal Government is also represented. Further members are representatives of the local communities and local authorities, the patients' ombudsman's office, the legal entities operating the hospitals reimbursed via the State Health Funds, and the Physicians' Chamber. The following stipulations apply for the passing of resolutions at a Länder level.

- In matters which are the responsibility of both the Land and the social insurance institutions (cooperation area), agreement between the two parties is required.
- In matters in which either the Land (inpatient sector) or the social insurance institutions (outpatient sector) are solely responsible, the Land or the social insurance institutions hold a respective majority.
- In the case of resolutions which infringe against decisions adopted by the Federal Health Agency, the Federal Government has the right of veto.

Austrian Structural Plan for Health. In accordance with the basic intention of the new agreement to intensify the integration of the public health service, the Austrian Structural Plan for Health will be developed into an instrument of integrated health planning for the entire field of health care provision, involving inpatient and outpatient care, and acute and long-term care, including rehabilitation as well as the interfaces between the different care sectors and levels. The methodical approach to this is service provision planning, which

will replace the traditional planning of locations, the specialties offered and bed supply. The amount of medical services required (based on more than 400 diagnoses and services) until the planning horizon of 2010 is estimated on the basis of regionally highly divergent age- and gender-specific population forecasts and epidemiological and medical developments which also take regional particularities into account.

The required provision of services is linked to binding criteria (such as staffing levels, available infrastructure and minimum patient numbers to ensure sufficient practice) in order to guarantee an equally high quality of services throughout Austria. The establishment of accessibility criteria is designed to ensure the continued existence of a regionally balanced care provision structure in the future. When these criteria are fulfilled, the provision of services is basically independent with regard to location, but also in respect of the type of institution, that is to say it can be inpatient, day care or outpatient (in hospital outpatient departments or in the private practice sector), and in the public or private sectors. An initial Structural Plan for Health was to have been drawn up by the end of 2005; the relevant negotiations, however, have not yet been completed.

For the time being, the Austrian Structural Plan for Health will contain a service provision plan for the acute inpatient sector and – in this first stage – will describe the actual status of further care provision sectors and levels (outpatient medical treatment, rehabilitation, care of the elderly and long-term care) as far as this is permitted by the currently available data. In this way, comprehensive and comparable information about the existing health care structures in all Austrian regions will be made available for the first time. A total of 32 health care regions were determined for planning within the framework of the Austrian Structural Plan for Health. These are orientated towards the regions as defined by the European Commission's EU-level statistics classification system (NUTS III regions). The health care regions are assigned to four health care zones (west, north, east and south).

Other contents

Legislation in the Health Reform 2005 provides for changes in the field of quality policy. In addition, it includes measures which open the way for the increased application of technology in health care.

Quality Act: one of the most important measures in the Health Reform 2005 is the Quality Act. With this law, the Federal Government has created a legal framework which enables it to further develop the numerous quality issues tackled in recent years in a structured way, and to thus pursue a targeted quality strategy.

The basic principles of this law are patient orientation, transparency, efficiency, efficacy and patient safety. It has created the opportunity to develop and implement nationally standardized specifications which cover all the sectors of the health care system. The act affects all the sectors: public and private hospitals and outpatient clinics, physicians and all other health professionals, such as medical-technical staff, midwives and nursing personnel – in short, all providers of health care services.

The nationwide specifications are to be jointly developed with all those affected in the health care system. The particular role of the Federal Government in this process is that of a coordinator. The main contents of the law refer to the specifications for quality in the provision of health care services and the related development of standards for structures, processes and results. These three concepts are viewed as aspects of quality work and of an overall Austrian quality system. In this context, structures refer to the equipment and facilities of a health care institution and the qualifications of the health care personnel. With regard to processes, there will be framework guidelines as to how a service should be provided. Outcome orientation is an area which has not yet been dealt with to any great extent in Austria, and for which intensive development and educational work needs to be carried out.

In addition, the new law stipulates that regular quality reporting has to be developed, as a part of which standardized reports have to be drawn up on all sectors and all professions. On the one hand, this instrument is designed to ensure transparency for the public, but at the same time it also introduces a method for the systematic improvement of quality work. As improvement is not achieved by either voluntary activities or compulsion alone, it was important that the law should stipulate the creation of promotional measures and incentive mechanisms to improve and ensure quality work in the health care system. In order to be able to manage all the work arising in the future, a quality institute will be established to support the Minister of Health and Women in dealing with the tasks which emerge in relation to the new act. The regulations which are enacted on the basis of this law will apply to all health care service providers in future, and penalties can be imposed if they are not adhered to.

Federal Institute for Quality in the Health Care System. The Federal Institute for Quality in the Health Care System should develop think tanks while at the same time integrating already existing meaningful quality activities. In this way, it will be able to use as much knowledge and experience as possible in its work, and ensure the necessary level of acceptance. The systematic involvement of patients is also planned.

The tasks of the Federal Institute for Quality include:

- participation in drawing up general specifications and principles for the development of standards in the fields of structural, process and outcome quality, and the analysis of improvement including a priority concept and a recognition procedure for the documentation on quality reporting and for quality reporting itself, for contributory measures, incentive mechanisms and supervision;
- monitoring, recommendation and drawing up obligatory quality standards to be issued by the Minister of Health and Women (federal quality directives) or recommended as an orientation aid (federal quality guidelines);
- compilation of an annual quality report;
- the implementation of and/or participation in promotional measures and introducing incentive measures;
- the implementation of, or participation in, monitoring compliance with the regulations of this law and the regulations or other guidelines issued on the basis of this law.

The establishment of this institute is planned for the year 2006.

Promotion of preventive care programmes. In order to promote preventive care programmes and treatment measures of nationwide significance, an annual sum of €3.5 million is provided within the framework of the Federal Health Agency. These projects are measures which are to be financed via one body for the whole of Austria, depending on the necessity for national coordination or the specific nature of the measure. The use of this funding requires prior agreement between the Federal Government, the social insurance institutions and the Länder.

Documentation in the health care system. Whereas standardized documentation has been implemented in the inpatient sector for many years, there is a lack of comparable data from hospital outpatient departments and physicians in private practice. The number of inpatient admissions and the related expenditure are thus known, but no reliable information can be given about the total expenditure on treatment. There is also no incentive to avoid unnecessary inpatient admissions.

The objective is therefore the creation of a common database using the standardized documentation of diagnoses according to the ICD-10 and the preparation of standardized documentation of services in a similar way to the inpatient sector. This is to be initiated on 1 January 2007. On the basis of this supplementary documentation, the foundations for an integrated care provision concept are to be created, as well as better cooperation between the individual sectors of the health care system and thus increased efficiency of the overall system, for example by avoiding parallel and multiple services. Comparable

documentation of diagnoses and services is an essential precondition for the coordination of financing in the inpatient and outpatient sectors and thus the support of outpatient health care.

Promotion of the transplantation system. The Federal Health Agency can employ an annual sum of €2.9 million to promote the transplantation system in Austria. This is intended to ensure the continuity of organ donations and to achieve an increase in the number of organ donors to around 30 per million inhabitants. In the field of stem cell transplantation, it is important to ensure that donors are adequately registered and available in sufficient numbers.

Health telematics including health records and ePrescription. The Health Telematics Act specifies supplementary data security requirements which – in view of the particular sensitivity of legally collected health data – have to be followed during electronic transmission. The definitions contain a clear list of types of data which are to be considered health data when transmitted electronically. The authority for, and legitimacy of, the collection and use of health data are solely to be judged in accordance with the 2000 Data Protection Act or other relevant laws; the application of these laws or the rights which they guarantee to those affected are neither restricted nor changed by the Health Telematics Act.

The Health Telematics Act is addressed to providers. These are people or institutions which regularly use health data as part of their employment (including self-employment), their business or operational purpose (for example hospitals), or within the framework of their service offer (data processing service companies).

Furthermore, as part of information management, structural information about the application of technology in the health care system is to be made available. This will, for instance, also include a register of health professionals who are integrated into the electronic exchange of data.

7 Conclusions

In spite of numerous measures to influence the dynamics of growth in the Austrian health care system, the development of care provision since the early 1990s has clearly been defined by the health policy priority of extending insurance cover and maintaining access to health care services for the entire population. This objective was also a determining factor behind the reforms carried out since the mid-1990s, although from an overall perspective – and under the influence of economic stability targets – a great deal of emphasis was placed on budget consolidation, cost-containment and structural reforms.

A clear improvement in the health status of the Austrian population can be observed since 1970 (see Table 1.6). The higher reduction of the mortality rate compared to other EU countries has been accompanied by a change of lifestyle in favour of more health-conscious behaviour (see Table 1.5). These "health gains" in connection with relatively unrestricted access to service providers and institutions and combined with freedom of choice may be responsible for the fact that the satisfaction of the Austrian population with health care provision is lasting and comparatively high. Until now, the Austrian population has been confronted by neither formal waiting lists nor by explicit rationing, although reliable studies on these topics are rare. The high level of satisfaction and high life expectancy in combination with a relatively high level of fairness in distribution has ensured a place for Austria among the top 10 in a comparison of the performance of the health care system with other European Region countries *(123).*

The regulatory framework in the Austrian health care system consists of a mixture of the delegation of sovereign tasks and regionalization. The fulfilment of tasks by regionally active federal authorities is practically non-existent in the Austrian health care system. The delegation of tasks as provided for by the Federal Constitution and the regionalization of care provision set out in social

insurance legislation have been supplemented in recent years by privatization, mainly in the form of organizational privatization (hospital operating companies, for example).

The health care system in Austria, which until recently showed strong characteristics of integrated care provision, particularly in the hospitals sector, has thus now developed almost completely into a supply model which is mainly based on decentrally organized contracts with all service providers. In the outpatient sector, these contract relationships are almost exclusively shaped by the health insurance funds and private service providers. In the inpatient sector, on the other hand, the scope of services and financing are regulated by federal cooperation instruments and the laws which implement these agreements. Since 1997 at the latest, the Federal Government has enhanced its role as a regulatory authority, which pushes ahead agreements on standards for inpatient care and can impose sanctions if stakeholders do not adhere to them. In this process, the Federal Government places particular emphasis on the planning of inpatient and state-of-the-art medical care and the resulting guidelines for hospitals. The Federal Government's increased desire to regulate came at the price of a gain in autonomy for the Länder, and fostered decentralization. This decentralization naturally leads to a stronger desire for regulation on the part of the Federal Government, which is reflected in the measures targeted in the Health Reform 2005.

Seen from an overall perspective, Austrian health policy is guided by a lasting consensus which transcends party politics. This states that the health care sector essentially has to be subjected to supply-side regulation by means of plans and service amounts, and not on the basis of (price-) regulated competition between the health insurance funds. The introduction of competition between health insurance funds was discussed, but unlike in Germany, the Netherlands and Switzerland, control via mandatory membership in health insurance funds, state planning and cooperation in bodies made up of a cross-section of stakeholders were preferred *(124)*.

The following subsections describe some of the challenges facing the Austrian health care system. However, not all are mentioned and no priorities are suggested.

Ensuring the revenue base

The estimated amount of economic growth which will probably be consumed by the Austrian health care sector in the near future is already clearly above that of earlier decades. Compared to GDP growth, very little of the economic growth achieved between 1960 and 1970 and between 1970 and 1980 was used

for the health care system. This changed in the 1990s: with almost the same GDP growth, the increase in expenditure on health doubled in comparison to the previous decade (see Table 1.3). This trend will presumably continue: average annual public health expenditure (at GDP prices for 2000) increased significantly more than real GDP between 2000 and 2004 (see Table 3.12).

In spite of the fact that almost all sectors of the population are obliged to participate in the financing of social health insurance, expenditure has grown faster than revenue since the mid-1980s, notwithstanding the increase in the employment rate – although unemployment has also risen at the same time. Unemployment and marginal part-time employment contracts in particular weaken the income base of the social health insurance system. The relatively low growth of total wages in connection with the rapid availability of medical-technical innovations for all people have led to repeated increases in contribution rates in recent years, but also to a significant extension of patient cost-sharing. Between 1995 and 2003, the payroll basis decreased by almost four percentage points from 73.4% to 69.5% of economic output. The regular above-average increases in the ceiling on insurable earnings have avoided a severe erosion of the contribution basis; nevertheless, this has lagged behind the development of GDP *(125).* Given the moderate growth expectations for the Austrian economy, the financing of the health insurance system will continue to remain on the health policy agenda.

Currently, however, no specific proposals or models are being publicly debated. Whereas the Social Democrats and the Greens are basically in favour of an extension of the contribution base or a lifting or increase of the ceiling on insurable earnings, the centre-right coalition has refrained from making specific proposals. Although the efficiency of administration in the social health insurance system has significantly increased over time (see Table 3.5), there have been considerable party political differences in recent years with regard to the position of the self-governing bodies in the health care system, including the HVSV, and also with regard to risk compensation between the health insurance funds. With increasing fiscal pressure, administrative reforms will also continue to be on the health policy agenda in the future.

The stabilization of expenditure growth and the noticeable decrease in budgeted funding for hospitals (see Table 5.1) are indicators for adherence to overall economic budget discipline. However, owing to the dual financing scheme (particularly in the hospitals sector), this increases the pressure on the social insurance system and also on hospital owners. In order to compensate for the increasing financial strain on hospital owners, half of the additionally available funding from contribution increases will go to hospitals from 2005. Overall, expenditure on hospitals as a proportion of total health expenditure has

increased considerably since 1995, whereas the spending which is earmarked for outpatient care has fallen (see Table 3.13). This can be seen as an indication of errors in allocation. Until now, structural reforms have only stimulated the development and extension of outpatient and day care sectors to a minor extent. In order to achieve this, it will be necessary to finance hospitals from a single source in the medium term. In its latest country report, the OECD proposes the transfer of tax revenue in hospital financing to the social insurance institutions, which would then coordinate the provision of care in the regions via contracts with the aid of nationwide requirements plans. In this way, potential for greater economic efficiency in the hospitals sector could be utilized and the efficiency of allocation increased *(126).*

Although many indicators suggest that there is considerable potential for increased efficiency in the hospitals sector, neither cost-containment measures in this service segment nor administrative reform will solve the long-term financing problems in the Austrian health care system. Ensuring the long-term sustainability of public revenue will – all other things being equal – depend on the structure of payroll financing and the regular adjustment of the ceiling on insurable earnings, if the aim of guaranteeing the equity and equality of the health care system is to be achieved or upheld. This applies all the more as the replacement of payroll financing by financing through general tax revenue cannot be expected to take place in the medium term.

The mixed system of financing which the legislative situation has created in Austria, particularly in the inpatient sector, has long been considered the most significant structural problem. To a certain extent, this problem is intensified by the stability pact and by financial adjustments between the Federal Government and the Länder. The incentive for cost shifts and irrational target-setting which is inherent in the dual financing mechanism will continue to demand structural reforms in the future. As a change in the currently valid mechanism would require an amendment of the Federal Constitution, it is highly probable that the mixture of payroll and tax financing will continue to be a feature of the Austrian health care system in the short and medium term. This is all the more likely because there is presently a political consensus that market reforms such as competition between health insurance funds, which were introduced by other European social insurance countries in the 1990s, will not be pursued.

However, the relatively large proportion of tax financing in the Austrian health care system has the advantage that the burden on wage costs created by contribution payments is kept comparatively moderate, which has a positive effect on the Austrian economy. This advantage is of course balanced by the disadvantage that the cost and effort required for the improved coordination of service providers at the interface between outpatient and inpatient care is high and increasing.

Interface management and allocation efficiency

The 1997 reform was accompanied by a reorganization of financing flows and decision-making flows. One of its goals was to increase the integration of service provision in the inpatient and outpatient sectors at regional level, and to boost efficiency and enhance the movement between structures for patients by improving interface management. In spite of continuing efforts and repeated political commitments to improve the integration of the supply chain, no major advances have yet been made in this field.

Through the development of decentralized cooperation areas ("reform pools") and via the Quality Act, the Health Reform 2005 has for the first time created the organizational prerequisites for an interface between outpatient and inpatient care provision. If it is implemented as planned, however, the room for manoeuvre of the regional bodies with regard to the vertically defined extent and the quality of care provision will become smaller. On the other hand, the Länder will gain more horizontal autonomy, because organizational conditions have been created in the form of the Health Platforms which make it possible to coordinate the supply chain within a region as well as to enter into supraregional cooperation schemes. The privatization of hospital operations carried out in almost all the Länder can also contribute to this, because the hospital operating companies will, within the framework of their contractual tasks, look for possibilities to not only implement the Länders' mandate to provide health care, but also to realize specialties and take advantage of cost-containing supraregional cooperation opportunities if they arise.

The increasing integration of care provision was one of main objectives of the Health Reform 2005. The Austrian Structural Plan for Health is designed to help achieve this. The methodological approach to this is service provision planning. This represents a further step in the implementation of specifications for service amounts (at all supply levels) in order to provide fair access to care, but also to ensure the provision of services. However, the specific details are still being negotiated with the regional authorities in their role as the owners of hospitals. Implementation would imply that overprovision or shortages of supply and thus inefficiency of allocation would be mitigated and eliminated in the medium term.

The cooperation instrument "reform pool" is designed to promote efficient allocation – the use of funding – where it is most useful, and provides stakeholders with the opportunity to compensate for shifts in services which arise, for example because of the reduction of inpatient capacities. How and whether cooperation between the providers of financing within the Health Platforms will take place cannot yet be determined, but will be evaluated in two years in accordance with the valid agreement.

Cost-containment and reimbursement

Owing to the combination of budget-setting and performance-related reimbursement, expenditure on inpatient treatment has increased at around the same pace as GDP since 1997 (see Table 5.2). As all hospital owners, regional authorities and the health insurance funds are involved because of the possibility that consultation and sanctioning mechanisms may be applied, the hospitals sector in each Land is partly subject to overall budget control.

Owing to Länder legislation, however, the Länder are able to use their discretion when financing the funds. Except for the budgeted funding for hospital financing, the remaining money in the funds is not earmarked. In this way, different reimbursement systems emerge in individual Länder (see Table 5.6). In addition, there is little transparency in the way that hospital owners deal with the hospitals outside the "budget". However, it is noticeable that there has been a convergence in the expenditure patterns of the Länder in recent years (see Table 5.8), which may indicate that the provision of care is becoming more balanced. Since 1997, hospital owners have financed an increasing share of the costs of hospitals (see Table 5.1). The pressure on Länder budgets which is thus created had to lead to increased efforts to reduce overcapacity – at least in the medium term – in case the reimbursement of hospitals is standardized and/or no additional funding flows into this sector.

Not only the reimbursement of hospitals, but also the remuneration of outpatient service providers varies according to the regional health insurance fund (and thus also essentially according to the Land in question), although the HVSV takes care to ensure the uniformity of contracts. There will also be great challenges in this area in future, given that more flexible working hours and fee structures for general practitioners and specialists in private practice will be necessary in order to create incentives for the introduction of new types of practices (such as group practices) and new practice opening hours, in order to promote weekend services and home visits, and to develop structures which can react flexibly to future demand.

Age structure and increasing demand

The future demand for care depends on the availability of medical and nursing services, which are not least affected by the changes in the age structure of the population. The pattern of expenditure according to age groups in Austria does not show any serious divergences from that of other EU countries. In Austria too, public health care expenditure rises with increasing age. The per-capita expenditure in the group of people aged 85–89 is, for example, around five times as high as that for those aged between 35 and 39. The inpatient sector

dominates the age versus expenditure curve, and the increase is particularly marked when people reach retirement age. The age–expenditure curve for medical treatment is almost linear, but that for spending on medicines is steeper than in the inpatient and medical treatment sectors. The expenditure on federal long-term care benefit is even more strongly focused on the older age groups (see Fig. 3.6).

In relation to the future development of the age structure, the ratio of public health expenditure to GDP is expected to rise by around 30% by 2050; the expenditure on long-term care (long-term care benefit as a percentage of GDP) will more than double by 2050. Expressed in simplified terms and related to public health expenditure, the average contributions for health insurance as a percentage of gross wages will rise from the current level of 7.5% to around 10% by 2050 purely as a result of the change in the age structure of the population. However, in the meantime a number of indicators suggest that it is not increasing life expectancy per se which leads to the increasing cost of health care provision. It is rather the proximity to death which causes comparatively high costs. It is indeed probable that the state of health of elderly people will improve, which has already been observed in the past in Austria.

Austria reacted comparatively early to the approaching demographic challenges with the passing of the 1993 Federal Long-Term Care Act. Long-term care provision is financed almost exclusively from the Federal Government's budget in Austria (see Table 2.1 and Table 4.12) and is paid to individuals as a money transfer depending on their needs. Federal cooperation instruments designed to ensure the uniformity of entitlement criteria and quality standards for institutions are also used for this service sector.

The dividing line between acute and long-term care in the inpatient sector has been vague until now and is not always accompanied in practice by a justifiable differentiation between the contents of acute care and nursing care. The dividing line between the two care sectors will also continue to remain unclear to a certain extent in the future. The development and extension of long-term care institutions began to take shape only recently, after the development of acute care provision had been at the forefront of discussion in recent decades owing to advances in medical science. The overlap between acute and long-term care will continue to lead to a certain degree of "unjustified occupation of beds". The establishment of "acute geriatric" departments in Austria, for example, is an indicator for this. Since the year 2000, it has been possible to charge a flat rate per case for "geriatric medicine" in Austrian acute hospitals. A clear separation between acute and long-term care will not be possible in the future either, given that research is being carried out which will lead to new forms of treatment, particularly in the field of the typically age-related diseases such as Alzheimer's and Parkinson's. Typically age-related diseases are in themselves

sources of medical-technical innovations which, once they are broadly applied, lead to increasing demand and utilization of health care services, not only in acute care but also in long-term care.

Employment and productivity

Employment in the health care system is closely linked to changes in the age structure of the population and to rising demand. After the provision of business-related services, the health care and social sector makes the second highest contribution to the growth of employment in the EU. Austria is no exception to this rule. Between 1995 and 2004, the number of actively employed people in Austria experienced a total average annual growth of 0.4%; in the same period, the number of those working in the health care and social sector increased by 3% on average (see Table 4.13). This trend will presumably continue in the future: according to estimates by the IHS, the difference in growth rates will be maintained, and by 2007 around 4500 additional people per year will find employment in the health care sector. Of these, at least two thirds will be women. This underlines the fact that the health care and social sector is an important employment market for women. More than three quarters of those employed in the health care sector are women, whereas in the economy as a whole only two of out five employees are women.

In addition, we can assume with a fair degree of certainty that the productivity of service providers in hospitals has risen markedly in the last few years, which has been confirmed by more recent studies. In addition, the average national costs per bed day increased significantly more between 1993 and 2003 than the costs per employee (see Table 5.8) and the number of employees per bed. This development shows that the intensity of services and "technology costs" are generally rising strongly and more dynamically than personnel costs.

The availability of medical services and new technologies is desirable and necessary if Austria wishes to remain one of the countries which has a health care system that functions well. However, it will be necessary to ensure that the efficiency of the additional funding used for these purposes is guaranteed.

Future reforms will thus have to contain the following priorities: first, the financing base will have to be ensured, in order to guarantee the continuation of the utilization of health care services according to needs and to the individual's ability to pay (solidarity principle); second, the productivity of employees in the health care system will have to continue to rise; and third, it will need to be ensured that increased funding really has an effect on the health of the population. This is generally the case given the rapid advances in medical science, but it can only be guaranteed if quality assurance plays a defining role

in medical practice, and when investment decisions are guided by improved methods of technology assessment. As Austria has a great deal of catching up to do in this sector, future reforms will have to devote more attention to this area.

8 Health care legislation

8.1 Ongoing amendments, 1978–2005

- Current agreements according to Federal Constitution Article 15a on hospital financing
- Current amendments to the General Social Security Act (ASVG)
- Current amendments to the Act on Social Insurance for the Self-employed
- Current amendments to the Act on Social Insurance for Farmers
- Current amendments to the Civil Servants' Health and Work Accident Insurance Act
- Current amendments to the Act on Social Insurance for Freelance Professionals

8.2 Laws and amendments, 1978–2005

Year	Laws
1978	BGBl No. 453/1978 First agreement according to Federal Constitution Article 15a between the Federal Government and the nine Länder (establishment of the Hospitals Cooperation Fund, KRAZAF) (NR: LP XIV GB 948 AB 960 p. 98. BR: AB 1880 p. 378) Further agreements on the establishment of the KRAZAF in the years 1983, 1995, 1988, 1991 and 1995
	BGBl No. 454/1978 Federal law: Establishment of the KRAZAF (NR: LP XIV IA 38/A and 102/A AB 969 p. 98. BR: AB 1818 p. 378) Further federal laws on the establishment of a Hospitals Cooperation Fund: 1983, 1985, 1988, 1991 and 1995
	BGBl No. 456/1978 Federal law: Amendment to the Hospitals Act (original version BGBl No. 1/1957) Amendment to the Hospitals Act, BGBl No. 1/1957, in the version of the federal laws BGBl No. 27/1958, BGBl No. 281/1974, BGBl No. 659/1977 Further amendments to the Hospitals Act in the years 1979, 1982, 1983, 1985, 1988, 1990, 1991, 1993, 1995, 1996, 1998, 2000, 2001, 2002, 2004; current designation of this federal law: Hospitals and Cure Institutions Act
1983	BGBl No. 119/1983 Federal law: Establishment of the KRAZAF (NR: LP XV IA 219/A AB 1333 p. 139. BR: AB 2618 p. 430) Further federal laws on the establishment of a Hospitals Cooperation Fund: 1983, 1985, 1988, 1991 and 1995
	BGBl No. 121/1983 Federal law: Financial participation of the social health insurance institutions in the KRAZAF (NR: LP XV AB 1335 p. 139. BR: AB 2620 p. 430)
	BGBl No. 185/1983 Federal law: Medicines Act (NR: LP XV IA 1060 AB 1480 p. 148. BR: AB 2696 p. 433) Amendments to the 1983 Medicines Act in the years 1988, 1994, 1996, 1997, 1998, 2001, 2002, 2004, 2005
	BGBl No. 660/1983 Federal law: Amendment to the Physicians' Act Amendment to the Physicians' Act, BGBl No. 92/1949, in the version of the federal laws BGBl No. 129/1951, BGBl No. 119/1952, BGBl No. 169/1952, BGBl No. 17/1955, BGBl No. 189/1955, BGBl No. 50/1964, BGBl No. 229/1969, BGBl No. 460/1974, BGBl No. 425/1975 and BGBl No. 140/1983 (NR: LP XV IA 62/A AB 162 p. 28. BR: AB 2787 p. 441) Further amendments to the 1984 Physicians' Act: 1987, 1989, 1992, 1994, 1997, 1998; replaced by 1998 Physicians' Act

	BGBl No. 165/1983 Federal law: amendment to the Federal Act on Degree Courses in Medicine Amendment to the Federal Act on Degree Courses in Medicine No. 123/1973, in the version of the federal laws BGBl No. 224/1980 and 129/1981 (NR: LP XV IA 1291 AB 1482 p. 148. BR: AB 2712 p. 430) Further federal laws to amend the Federal Act on Degree Courses in Medicine: 1984 and 1988
	BGBl No. 182/1983 Decree: amendment to the Physicians' Training Regulations Amendment to the Physicians' Training Regulations, BGBl No. 36/1974, in the versions of the decrees BGBl No. 529/1975, BGBl No. 661/1976 and BGBl No. 357/1981 Further amendments 1986, 1988, 1989, 1994 and 1998; replaced by further Physicians' Training Regulations (original version BGBl No. 152/1994, amendment 1998)
1986	BGBl No. 293/1986 Federal law: Measures against the spread of acquired immunodeficiency syndrome (AIDS Act) (NR: LP XVI IA 184/A AB 952 p. 142. BR: AB 3127 p. 476) Amendments to the AIDS Act 1989, 1993, 1997, 1998 and 1999; replaced by the AIDS Act 1993 (original version BGBl No. 728/1993, amendments: 1997, 1998, 1999, 2001)
	BGBl No. 633/1986 Decree: Establishment of the extent of variable values and some fixed amounts from the General Social Security Act, the Act on Social Insurance for the Self-employed, the Act on Social Insurance for Farmers and the Civil Servants' Health and Work Accident Insurance Act for the calendar year 1987
1987	BGBl No. 314/1987 Federal law: Amendment to the Physicians' Act 1984, the General Social Security Act and the Federal Act on the Regulation of Specialist Nursing Services, Medical-Technical Services and Paramedical Services (NR: LP XVII GB 137 AB 208 p. 25 BR: 3276 AB 3305 p. 490)
1988	BGBl No. 283/1988 Federal law: Amendment of the following social insurance acts: ASVG (general), GSVG (self-employed), BSVG (farmers), B-KUVG (civil servants), NVG (notaries public) 1972, the Federal Budget Act (BHG), the Continued Pay Act (EFZG) and the Unemployment Insurance Act (AlVG) 1977, as well as the regulation of the financial participation of the social health insurance institutions in the KRAZAF (45th amendment to the ASVG, 14th amendment to the GSVG, 12th amendment to the BSVG, 17th amendment to the B-KUVG, 6th amendment to the NVG 1972, 3rd amendment to the BHG, 5th amendment to the EFZG and amendment to the AlVG 1977) (NR: LP XVII GB 544 AB 592 p. 64. BR: 3479 AB 3485 p. 502)
	BGBl No. 682/1988 Decree: Recording of diagnoses in hospitals Amendment of the decree on the recording of diagnoses in hospitals of 1990, repealed in 1994
1990	BGBl No. 157/1990 Federal law: Adaptation of the Hospitals Act to the Accommodation Act (NR: LP XVII AB 1204 p. 132. BR: 3817 AB 3822 p. 526)

	BGBl No. 449/1990 ST0180 Federal law: Amendment to the Federal Act on the Regulation of Specialist Nursing Services, Medical-Technical Services and Paramedical Services (NR: LP XVII IA 401/A AB 1392 p. 149. BR: AB 3970 p. 533)
	BGBl No. 361/1990 Federal law: Psychotherapy Act (NR: LP XVII GB 1256 AB 1389 p. 146. BR: AB 3896) Amendment: 2001
1991	BGBl No. 175/1991 Decree: Nursing Assistants' Regulations
	BGBl No. 702/1991 Federal law: Regulation of the financial participation of the social health insurance institutions in the KRAZAF (NR: LP XVIII GB 332 AB 346 p. 53. BR: AB 4187 p. 548)
1992	BGBl No. 460/1992 Federal law: Regulation on higher medical-technical staff (MTD Act) (NR: LP XVIII GB 202 AB 615 p. 78. BR: AB 4332 p. 557) Amendments to the MTD Act: 1993, 1996, 1996, 2001, 2002, 2004, 2005
1993	BGBl No. 110/1993 Federal law: Federal Long-Term Care Act and amendment to the General Social Security Act, the Act on Social Insurance for the Self-employed, the Act on Social Insurance for Farmers, the 1972 Act on Insurance for Notaries Public, the Civil Servants' Health and Work Accident Insurance Act, the Execution of Sentences Act, the 1965 Pensions Act, the Earnings Act, the 1967 Salt Works Pension Regulations, the 1967 Post Office and Telegraph Pension Act, the Federal Act of 1 July 1967 on the pension entitlements of the civil employees of the former Imperial and Royal Military Administration and their surviving dependants, the War Victims Welfare Act of 1957, the Army Welfare Act, the Victims' Welfare Act, the Victims of Crime Act and the Employment Law and Social Security Tribunal Act (NR: LP XVIII GB 776 AB 908 p. 100. BR: AB 4442 p. 564) Amendments of the Federal Long-Term Care Benefit Act in the years 1993, 1994, 1995, 1996, 1998, 2001, 2002, 2003, 2004 and 2005
	BGBl No. (866/1993) Agreement between the Federal Government and the Länder according to Federal Constitution Article 15a on joint measures of the Federal Government and the Länder for people in need of care (including appendices) (NR: LP XVIII GB 1069 AB 1331 p. 136. BR: AB 4660 p. 576)
	BGBl No. 398/1993 Decree: health insurance contribution rate for public employees of the Vienna Municipal Utilities and Transport Services for those persons insured according to ASVG Section 479a, paragraph 1, line 5
	BGBl No. 310/1994 Federal law: Midwives Act (NR: LP XVIII GB 1461 AB 1542 p. 157. BR: 4773 AB 4770 p. 583) Amendments: 1994, 1997, 1999, 2002, 2005
1996	BGBl No. 745/1996 Federal law: Documentation in the health care system (NR: LP XVII GB 380 AB 430 p. 49. BR: AB 5325 p. 619)
	BGBl No. 783/1996 Decree: Diagnosis and services documentation in the inpatient sector Amendments in the years 1998, 2000 and 2002

	BGBl No. 784/1996 Decree: Documentation of data on costs in hospitals whose owners are financed on the basis of the agreement according to Federal Constitution Article 15a on the reform of the health care system and hospital financing for the years 1997 to 2000 (cost accounting regulations for public hospitals)
	BGBl No. 785/1996 Decree: Documentation of statistical data in hospitals whose owners are financed on the basis of the agreement according to Federal Constitution Article 15a on the reform of the health care system and hospital financing for the years 1997 to 2000 (statistics regulation for public hospitals)
	BGBl No. 786/1996 Decree: Documentation of statistical data in hospitals, whose owners are not financed on the basis of the agreement according to Federal Constitution Article 15a on the reform of the health care system and hospital financing for the years 1997 to 2000 (statistics regulation for non-public hospitals)
	BGBl No. 657/1996 Federal law: Medicinal Products Act (NR: LP XX GB 313 AB 389 p. 43. BR: AB 5286 p. 618) Amendments of the Medicinal Products Act in the years 1998, 1999, 2001, 2002, 2003 and 2005
	BGBl No. 746/1996 Federal law: Health and Social Sector Allowances Act and amendment of the Financial Adjustment Act 1997 and the Catastrophe Fund Act 1996 (federal law, with which allowances in the health and social sector are regulated (Health and Social Sector Allowances Act) and amendments are made to the Financial Adjustment Act 1997 and the Catastrophe Fund Act 1996) (NR: LP XX GB 395 AB 476 p. 47. BR: AB 5318 p. 619) Further amendments of the Health and Social Sector Allowances Act: 1997, 1998, 2003
1997	BGBl I No. 111/1977 Agreement according to Federal Constitution Article 15a on the reform of the health care system and hospital financing for the years 1997 to 2000 (NR: LP XX GB 382 AB 432 p. 49. BR: AB 5327 p. 619)
	BGBl I No. 8/1997 Federal law: Hospital Working Hours Act and amendment to the Working Hours Act. Federal law with which a Working Hours Act for health professionals in hospitals, nursing institutions and similar facilities was created (Hospital Working Hours Act) and the Working Hours Act was amended (NR: LP XX GB 386 AB 537 p. 53. BR: AB 5359 p. 620) Further amendments to the Hospital Working Hours Act in the years 1998, 1999, 2001, 2002, 2003
	BGBl I No. 108/1997 Federal law: Health and Nursing Care Act as well as amendments to the Nursing Care Act, the Training Proviso Act and the 1984 Physicians' Act Federal law, with which the Federal Act on Health Care and Nursing Professions (Health Care and Nursing Care Act) was enacted, and with which the Nursing Care Act, the Training Provision Act and the 1984 Physicians' Act were amended (NR: LP XX GB 709 AB 777 p. 82. BR: 5494 AB 5515 p. 629) Amendments to the Health Care and Nursing Care Act: 1998, 1999, 2002, 2004, 2005

1998	BGBl I No. 169/1998 Federal law: Physicians' Act 1998 and amendment to the Training Proviso Act (NR: LP XX GB 1386 AB 1400 p. 142. BR: AB 5785 p. 645) Amendment to the 1998 Physicians' Act: 2000, 2001, 2002, 2003, 2004
	BGBl I No. 52/1998 Federal law: Amendment to the federal law on public vaccinations against contagious polio (NR: LP XX GB 947 AB 956 p. 109. BR: AB 5644 p. 637)
	BGBl I No. 51/1998 Federal law: Health Promotion Act Federal law on measures and initiatives for health promotion, education and information (Health Promotion Act) (NR: LP XX GB 1043 AB 1072 p. 109. BR: AB 5643 p. 637)
	BGBl I No. 96/1998 Federal law: Cardiac Technicians' Act and amendments to the Training Proviso Act and the Hospital Working Hours Act (NR: LP XX GB 1166 AB 1272 p. 128. BR: AB 5708 p. 642) Amendment to the Cardiac Technicians' Act: 2001
1999	BGBl I No. 195/1999 Agreement on safeguarding patients' rights (Patients' Charter) (NR: LP XX GB 1824 AB 1984 p. 174. BR: AB 5985 p. 656) Further agreements on safeguarding patients' rights (Patients' Charter) in the years 2001, 2002, 2003
	BGBl I No. 180/1999 Federal law: Establishment of a fund to finance in vitro fertilization (IVF Fund Act) (NR: LP XVII AB 2010 p. 182. BR: AB 6058 p. 657) Amendment: 2004
	BGBl II No. 59/2000 Decree: Amendment to the EEA Physicians' Proof of Qualifications Regulation – EEA Physicians' Regulation
2001	BGBl II No. 120/2001 Decree: Exemptions from the charging of the outpatient clinic treatment fee
	BGBl I No. 111/2001 Federal law: Pharmacists' Association Act 2001 (NR: LP XX GB 628 AB 692 p. 76. BR: AB 6444 p. 679) Amendment: 2004
2002	BGBl I No. 30/2002 Federal law: Enactment of a federal law on the training, work and the profession of first-aiders (First-aiders' Act) and amendment to the Federal Law on the Regulation of Specialized Medical-Technical Services and Paramedical Services, the Training Proviso Act and the Hospital Working Hours Act (NR: LP XX GB 872 AB 930 p. 89. BR: AB 6563 p. 683)
	BGBl I No. 33/2002 Federal law: Amendment to the Medicines Act, the Prescription Requirement Act, the Pharmacists' Act, the Medicinal Products Act and the Pharmacopoeia Act (NR: LP XX GB 777 AB 934 p. 89. BR: 6541 AB 6566 p. 683)
	BGBl I No. 42/2002 Federal law: Private Hospitals Financing Act (PRIKRAF Act) (NR: LP XX GB 578/A AB 980 p. 91. BR: 6569 AB 6572 p. 684) Additional PRIKRAF Act in 2004 (BGBl I No. 165/2004)

	BGBl II No. 145/2002 Decree: Private hospitals financing fund (PRIKRAF), the executive bodies of the fund and its tasks, appropriate sanctions and supervision of the fund (PRIKRAF decree)
	BGBl I No. 60/2002 Agreement according to Federal Constitution Article 15a including appendices on the reorganization of the health care system and hospital financing (NR: LP XX GB 395 AB 410 p. 52. BR: AB 6287 p. 671)
	BGBl I No. 65/2002 Federal law: Administrative Reform Act 2001 (NR: LP XX GB 772 AB 885 p. 83. BR: 6488 AB 6496 p. 682)
	BGBl I No. 169/2002 Federal law: Medical Masseurs and Massage Therapists Act (MMHmG) and amendment to the Federal Law on the Regulation of Specialized Medical-Technical Services and Paramedical Services, the Training Proviso Act and the Hospital Working Hours Act, the MTD Act, the Educational Documentation Act, the ASVG, the Act on Social Insurance for the Self-employed, the Act on Social Insurance for Farmers and the Civil Servants' Health and Work Accident Insurance Act (NR: LP XX GB 1140 AB 1262 p. 111. BR: AB 6755 p. 690) Amendments to the MMHmG: 2003, 2004
	BGBl I No. 140/2002 Federal law: 60th amendment to the ASVG (NR: LP XX GB 1183 AB 1193 p. 111. BR: 6698 AB 6747 p. 690) Reorganization of the Equalization Fund
2003	BGBl II No. 420/2003 Decree: Training for first-aiders – First-aiders' training decree
	BGBl II No. 589/2003 Decree: Regulation on the documentation of diagnoses and services
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	BGBl II No. 277/2003 Decree: Amendment of the regulation on occupational medicine training for physicians
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	BGBl II No. 473/2004 Regulation on licensing and the control of medicines
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2005	BGBl I No. 73/2005 Agreement according to Federal Constitution Article 15a on the organization and financing of the health care system (NR: LP XXII GB 692 AB 708 p. 90. BR: AB 7174 p. 717)
	BGBl I No. 107/2005 Amendments to the Health and Food Safety Act, the Food Safety Act, the Medicinal Products Act, the 2002 Import of Medicines Act, the 1999 Blood Safety Act and the Authorities' Transitory Act
	BGBl I No. 126/2005 Federal Act: Dentists' Act (NR: LP XXII GB 1087 AB 1133 p. 125. BR: AB 7402 p. 727)
	BGBl II No. 295/2005 Decree: Amendment to the health voucher presentation regulation

Notes: BGBl: Federal Law Gazette; NR: Nationalrat (Lower House of Parliament); BR: Bundesrat (Upper House of Parliament); LP: legislative period; GB: government bill; see also list of abbreviations and glossary.

9 Appendices

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9.2 HiT methodology and production process

The Health Systems in Transition (HiT) profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources, and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/observatory/Hits/20020525_1.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents, and published literature. Furthermore, international data sources may be incorporated, such as those of the Organisation for Economic Co-operation and Development (OECD) and the World Bank. OECD Health Data contain over 1200 indicators for the 30 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All (HFA) database. The HFA database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health for All policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard HFA data have been officially approved by national

governments. With its summer 2004 edition, the HFA database started to take account of the enlarged European Union (EU) of 25 Member States.

HiT authors are encouraged to discuss the data in the text in detail, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of 10 chapters:

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organizational structure: provides an overview of how the health system in a country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.
3. Financing: provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.
4. Planning and regulation: addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of health technology assessment and research and development.
5. Physical and human resources: deals with the planning and distribution of infrastructure and capital stock; the context in which information technology (IT) systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
6. Provision of services: concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.
7. Principal health care reforms: reviews reforms, policies and organizational changes that have had a substantial impact on health care.

8. Assessment of the health system: provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.
9. Conclusions: highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.
10. Appendices: includes references, useful web sites, legislation.

Producing a HiT is a complex process. It involves:

- writing and editing the report, often in multiple iterations;
- external review by (inter)national experts and the country's Ministry of Health – the authors are supposed to consider comments provided by the Ministry of Health, but not necessarily include them in the final version;
- external review by the editors and an international multidisciplinary editorial board;
- finalizing the profile, including the stages of copy-editing and typesetting;
- dissemination (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

The Health Systems in Transition profiles

A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country profiles provide an analytical description of each health care system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the European Region and beyond. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health care services;
- to describe accurately the process, content and implementation of health care reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

How to obtain a HiT

All HiT profiles are available in PDF format on ***www.euro.who.int/observatory***, where you can also join our listserve for monthly updates of the activities of the European Observatory on Health Systems and Policies, including new HiTs, books in our co-published series with Open University Press, policy briefs, the ***EuroObserver*** newsletter and the ***Eurohealth*** journal. If you would like to order a paper copy of a HiT, please write to:

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Austria (2001[e], 2006[e])
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Uzbekistan (2001[g])

Key

All HiTs are available in English. When noted, they are also available in other languages:

[a] Albanian
[b] Bulgarian
[c] French
[d] Georgian
[e] German
[f] Romanian
[g] Russian
[h] Spanish
[i] Turkish
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HiTs are in-depth profiles of health systems and policies, produced and maintained by the Observatory using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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