PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTHCARE SECTOR IN SWITZERLAND, AUSTRIA AND ITALY

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Ort, Datum

Unterschrift
DEDICATION

This thesis is dedicated to Regina Puthenpurayil and Mikhail Korotaev.

Regina accompanied me during the Bachelor study in Vienna. We met first in 2008, in our very first class and we also graduated nearly on the same day in 2012. Four years between world dominion, big dreams, tears, severe disappointments, nice travels, and a hopefully ever-lasting friendship. Thank you, for your great support!

Mikhail was studying with me in three different countries during the Master study. For this reason, lessons in Russian culture were a point on the daily agenda. He reminded me, in a particular way that money, success and business are not always the most important things in life. Let us hope we will still discuss in 20 years, if not missing the moment's opportunities or long term strategic planning is the key to happiness.
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ABSTRACT

This paper is aimed at the analysis of PPPs in the healthcare sector in Switzerland, Austria and Italy. New Public Management and Austrian Economics is the theoretical base. A description of all three healthcare sectors can be found. The primary data consist of 18 expert interviews that were evaluated with the summarizing content analysis according to Mayring. In Switzerland no PPPs exist in the healthcare sector. The main reason is the intact public finances. In Austria PPPs can be found in areas such as facility management and maintenance. But, there are also other examples such as the hospital in Oberndorf. Italy is a large market for PPPs in the healthcare sector, because private partner are needed to finance. Hospitals are a difficult market for competition. The participation of private investors and companies changes the healthcare sector, a competition for patients is one result.
Introduction
Public-private partnerships (PPPs) are gaining, in spite of mixed findings, importance in the European Union. PPPs are welcomed by politicians, for example in Austria (Greiling & Häusler, 2011). Further, PPPs could be an opportunity for private companies to invest in the healthcare sector in many different countries.

According to Greiling & Häusler (2011), there was less research done on PPPs in the health care sector than on PPPs in other areas of public infrastructure (e. g. bridges, ports, and roads). The two authors refer to literature such as Barretta & Ruggiero, 2008; English, 2005; Grimsey & Lewis, 2004; Chung, 2009; Shaoul et al., 2008; Barros & Martinez-Giralt, 2009 or Ludwig et al., 2010. When the health care sector was analysed, there was a focus on the most important countries in New Public Management, e. g. Australia or United Kingdom (Greiling & Häusler, 2011). In this paper, PPPs in the health care sector in Switzerland, Austria and Italy were investigated. Those are countries where there is a lack of research. Additionally, the situation in Switzerland, Austria and Italy was also compared, not only assayed.

Jochheim (2011, p. 48) explains that England can be seen as the motherland of PPPs in Europe. Cutbacks in the public spending were caused by the oil crisis, this is seen as a turning point. M. Thatcher and her conservative party won the elections in 1979, she tried to improve the public budgets with privatizations. From 1986 privatization got more criticized, for this reason, the public-private partnership was created in 1992/93 (Maikisch, 2007, Slide 3). When T. Blair and the Labour-Party came to power, the concept of PPP was made the first time ready to use (Jochheim, 2011, p. 48). PPPs were established as the so-called „Third Way“, a middle path between only governmental service provision and privatization (Ivansits & Filipic, 2007, p. 92f).

According to The British Government (2013), the UK is the world leader in healthcare PPPs. 22 years of experience, over 130 healthcare PPP projects and £12 billion of capital value speaks for the very well - established PPP sector. The project range is very different. The St. Bartholomew’s and Royal London Hospitals project was the largest PPP project in the healthcare/hospital sector. The contract was £ 1.1 billion. But, there is also a residential care home costing £2.8m that was built with a PPP-contract.
Some important milestones are (The British Government, 2013):

- 1991: PPPs were introduced in the UK
- 1996: First contract was signed to finance, design, build, and operate a 1000-bed hospital in Norwich
- 2006: The largest PPP contract in the UK was signed (St Bartholomew’s and Royal London project)
- 2012: More than 130 PPP projects in healthcare schemes have been completed, underway or approved since the year 2001
- 2016 (planned): St Bartholomew’s and Royal London project should be completed

The following research questions are answered in this paper:

1. Do healthcare PPPs exist in Switzerland, Austria and Italy?
   In this paper, it should be investigated, if PPPs in the hospital sector can be found in those three countries.

2. What are the main differences and similarities between healthcare PPPs in Switzerland, Austria and Italy?
   One of the aims of this paper is to show the differences of PPPs in the healthcare sector between three countries with a different history, political system, economic situation, culture and law system. The reason why PPPs are in action, for what task they are used, geographical phenomena and future perspectives are to be analysed.

3. What is the connection between public debt and healthcare PPPs?
   Switzerland, Austria and Italy face different budgetary situations. In this paper, the research was done testifying if there is a connection between public debt and PPPs.

4. What are the advantages and disadvantages of market mechanisms in the healthcare sector?
The pros and cons of different market mechanisms in the healthcare sector, such as competition or the pursuit of profit are to be analysed.

The theoretical part of the paper starts with a definition, which declares what is meant by “public-private partnership”. In this chapter, also different models of PPPs will be explained. After, the theoretical background is declared, a summary of the most relevant philosophic ideas can be found. Because it is very difficult to understand processes related to PPPs in the healthcare sector, without some basic information about each healthcare sector, an overview of the healthcare sectors of all three countries is the content of the next chapter. The empirical part begins with an explanation why a qualitative method was used. On the following pages the method of collecting the primary data is presented. Afterwards, the technique how the data was evaluated is explained. All relevant results, which could be gained during primary data research, can be found on the subsequent pages. The paper finishes with a summary, a discussion of results and a conclusion.
I. THEORETICAL FRAMEWORK

1. Definition: Public-Private Partnerships

There is no definition of PPPs that is widely accepted, an increasing amount of countries tailor the definition of PPPs to their laws, legal and institutional structure (PPPIRC, 2015). PPP is a superordinate for different forms of cooperation between the public and the private sector (Vornholz, 2005, p. 34). In scientific literature, the many different forms of cooperation, which are called public-private partnership, make the term very heterogeneous and it is difficult to understand what exactly each author is talking. The use of the term “PPP” can be even called excessive and random (Wiesinger, 2009). For those reasons, no exact definition can be given.

Typically, PPPs are medium- or long-term agreements between the government and a private partner (Girmscheid & Dreyer, 2006; OECD, 2011; PPPIRC, 2015). The private partner serves obligations that were before obligations of the public sector (World Bank, 2015). PPPs combine the alignments of governments with the profit aims to the private partners. The government dictates the quantity and quality of the services that are required from the private partner (OECD, 2011).

Girmscheid & Dreyer (2006) and the OECD (2011) explain that design, management, construction and financing of a capital asset may be the tasks the private partner has to fulfil. The OECD (2011) declares further that the asset should be delivered to the government or to the public that is using that asset.

The risk in PPPs is usually shared by the public and the private partner (Girmscheid & Dreyer, 2006; OECD, 2011; PPPIRC, 2015). If a PPP is effective depends on the appropriate and sufficient transfer of risk to the private partner (OECD, 2011).

PPPs are typically undertaken as a special purpose vehicle, which is mostly a consortium for the most important activities in the PPP (OECD, 2011). The key argument for PPPs is that the design and the operation of an asset become more efficient, i.e. more “value for money” is possible than with the traditional forms of procurement and production (OECD, 2011). It can be said that PPPs have strong economic aims. A higher efficiency should be created by a specific allocation of tasks (life-cycle and process-orientation and a share of
risk) between the two partners. A transfer of know-how and resources should be reached to relieve pressure on public budgets (Girmscheid & Dreyer, 2006). Wiesinger (2009) explains that in a PPP both parties keep their identity and do not change their roles.

It should be mentioned that defining what is meant by PPP is very difficult, has further reasons. Within the category of PPPs a rather wide range of different models exist, which may be different from country to country. This is also a point, which raises the number of different definitions. These different models are not only influenced by the responsibilities the private partner has to fulfil, but also by conceptualisation of the asset and the ownership (OECD, 2011).

1.1. PPP-models
According to PPPIRC (2015) PPPs have a wide range of various models. These models differ, e. g. in the involvement and risk the private sector takes. All terms are fixed in a contract. The figure 1 below gives a rough overview.

Figure 1: PPP models (own illustration) (PPPIRC, 2015a)

1.1.1. Build, Operate, Transfer (BOT)
According to PPPIRC (2015b) BOT is rather used to create a discrete asset rather than an entire network. Further, the asset is typically entirely new. The private partner gains its revenues through a fee that the project company charges the government. Tariffs, which are directly charged to costumers, are not common.

1.1.2. Design, Build, Operate (DBO)
PPPIRC (2015b) states that in this model the government owns and finances the construction of the facility. Private partners design, build and operate, certain agreed
inputs should be met. A turnkey contract is not included, what makes the financial documentation simpler to a BOT model. The financial risk, which is taken by the private partner, is rather small.

1.1.3. Joint Venture

PPPIRC (2015c) states that a joint venture, in a PPP, arises when the government requires and equity stake in the project company, or when the government sells a stake of a public owned utility.
2. Theoretical background

2.1. New public management

According to Miklós (2011), the main goal of New Public Management is the transformation of the traditional public administration into a more effective institution. The supporters of New Public Management believe that a higher quality of public standards can be achieved by competition, strengthening of market coordination and use of private management techniques. Rolling back bureaucratic coordination and accepting primacy of market signals a link to L. von Mises and F. A. von Hayek\(^1\), two of the most important advocates of the New Austrian school of economics, and various new right thinker – the representatives of the public choice theory: Betton, Buchanan, Niskanen and Tullock (Dunleavy, 1986, p. 15; Miklós, 2011).

The movement was set off during the period with M. Thatcher in power in Great Britain and R. Reagan in the United State, therefore the first steps of these movements can be linked to neoliberal, conservative economic movements (Deakin & Walsh, 1996; Mascarenhas, 1993; Pollitt 1993).

Alonso et al. (2011) states that Great Britain was the starting point (Vickers & Yarrow, 1988) where a radical different approach about the role of the government within the economy was set off, and spread afterwards over the other countries in Europe. Deep reforms of the public sectors begun and triggered huge reforms in the public sectors as deficit and public spending needed to be reduced (Clifton et al., 2003; 2006). Deregulation programs, liberalization and privatization were included in this reform. Because, privatization was not possible everywhere, new ideas were developed how to change the management within the public sector. Management methods of the private sector should be implemented and used, this was the birth of “New Public Management” (Alonso et al., 2011). This trend continued in the 1980s, the supporters of New Public Management put a focus on reducing and downsizing the size of the public sector (Pollitt & Bouckaert, 2003, p. 21; Van de Walle & Hammerschid, 2011, p. 24).

\(^{1}\) Hayek was, according The Economist (2013), “Mrs Thatcher’s favourite intellectual guru”. Further, the University of Freiburg (2016) writes that Hayek received a Nobel Prize in 1974.
After two, or in some cases three, decades New Public management is associated with a lower number of people who work for the government and reduced public spending (Alonso et al., 2011).

2.2. Austrian economics – A theory of capitalism and market

Austrian economics is used as a theoretical background for this paper for several more reasons: As mentioned in chapter 2.1. New Public Management has its roots in conservative neo-liberal economics. Additionally, during the expert interview the question if private investors/companies or the government is the better manager of public infrastructure had a central role. The experts where, in many cases, discussing which role the government in the healthcare sector has and why neoliberal ideas are needed or not needed. In most cases neoliberal ideas were more in the centre than the exact implementation in hospitals, which are owned and managed by the government.

But, New Public Management it’s not the only theory that plays an important role when PPPs are discussed. When „public choice“ is defined according to Mueller (1989, p. 1) as „the economic study of nonmarket decision making, or simply the application of economics to political science“, affinities in methodology can be found between the approaches of public choice and market process approaches, because of these affinities market process theorists can use public choice analysis to conduct research about politics, and scholars of public choice should be free to make use of market process analysis in economics (Boettke & López, 2002). Public choice theory studies political processes with the economic way of thinking, and which in turn deals with exchanges of relationships in different social settings and individual decision-making processes. Hayek was the first theorist who unified social science by creating a common rational choice model and was one of the forerunners of the political economics, by publishing „The Road to Serfdom“ in 1945 and „The Constitution of Liberty“ in 1960 (Boettke & López, 2002). According to Gawel (2011), Public Choice Theory can be used to analyse the chances of success PPPs have in the existing decision-making structures and in what way the influence of politics is brought into this. Furthermore, it helps to consider the political aspect. Gawel further states that political influence can be an obstacle to efficient PPPs and can decrease efficiency either.
According to Taylor (1980, pp. 7 - 11), the Austrian School of Economics began with C. Menger, a professor of political economy. Menger's theory dispelled that the value of goods is objective. The subjective theory of value was the basic foundation of the Austrian school of thought, two important theorists were Mises and Hayek. Mises got wide attention in the 1920s from other economists, because of his theory that socialism is totally impossible in a modern economy because of a lack of market prices. Market prices are essential for a rational resource allocation. Mises and Hayek contributed to making the Austrian theory to an integrated theory. Hayek focused on the problem of „knowledge in society“ and that coordinating actions of interacting market participants gives and important insight in economics. Austrian economics have a special methodological position: Empiricism has little place in Austrian economics and mathematical grounds are opposed, conceptual understanding should be used instead of qualitative relations. Further, these phenomena in economics can be described by individual actions rather than by entities that are over standardised like „society“. This is called methodological individualism.

„What distinguishes the Austrian School and will lend it immortal fame is precisely the fact that it created a theory of economic action and not of economic equilibrium or non-action."

- L. von Mises -

Huerta de Soto (2009, p. 35) explains that the entrepreneurship is the focus of the Austrian theory. The entrepreneur is always in disequilibrium. For this reason, the entrepreneur cannot play a central role in neoclassical economics. Entrepreneurship is, according to the Austrian scholars, creating and discovering of new information that did not exist before, on the contrary, neoclassical economics is based on expected costs and benefits.

This paper is based on a qualitative research method (see chapter 5.1.), and also Austrian economics is qualitative (Benink et al., 2010). So, also the methodological background of Austrian economics and the way research in this paper have a harmony.

“The development of economics as a science which is always based on human beings, the creative actors and protagonists in all social processes and events (the subjectivist conception), is undoubtedly the most significant and characteristic contribution made by the Austrian School of economics, founded by Carl Menger.”

- J. Huerta de Soto -
2.2.1. Efficiency

According to Huerta de Soto (2009, p. 4), the influence of mechanical physics eradicated the idea in economic efficiency from its very basics. Everything that remains was a reduced static aspect, which tries exclusively to reduce the misspending. F. W. Taylor also supported static efficiency\(^2\). Taylor writes about an establishment of a „productive efficiency“ department in all industries that supervises workers and measures time, which people spend at work and to avoid waste of any kind. This abstract concept became an idol that commanded everything, that it even spread into political ideology (Huerta de Soto, 2009, p. 5).

Huerta de Soto (2009, pp. 11 & 12) explains that I. M. Kirzner, a theorist who follows the footsteps of Mises and Hayek, developed a new idea of dynamic efficiency by analysing entrepreneurship. Kirzner defines dynamic efficiency as the ability to encourage entrepreneurial acts as extraordinarily coordinating and social coordination, not in a Paretian or static way, but in a dynamic one which is the „process during which market participants become aware of mutually beneficial opportunities for trade and, in grasping these opportunities, move to correct the earlier errors“ (Kirzner, 1997, p. 67). The author additionally pointed out that the dynamic-efficiency criterion defined by him, which has its basics in entrepreneurial coordination and creativity is free from all value judgement – totally „wertfrei“ (Kirzner, 1998, pp. 187 - 200).

2.2.2. Pursuit of profit

“The profit of the one is the profit of the other.”

- F. Bastiat -

O’Driscoll & Rizzo (2014, p. 38) explain that profit is a pure entrepreneurial gain, which is caused by superior knowledge. Profit is a residual of all costs for all factors of production. Profit must be attributed a creative spark (Kirzner, 1973, p. 35). There is market inconsistency when price of the same good differs among competitors and cannot be

explained by individual profit margins (Kirzner, 1979, pp. 157 & 158). This can happen when the price of two apple juices, with the same apple quality, differ more than by the transportation costs or when the prices of output are not exhausted by the costs of inputs (O'Driscoll & Rizzo, 2014, p. 38). In this case, the entrepreneur with its coordinating function can have the role of an arbitrager (Kirzner, 1973, p. 46).

According to O'Driscoll & Rizzo (2014, p. 38) eliminates the existence of superior information inefficacies. The reason why the price for the production of information does not absorb pure profits and leaves normal returns only is because the seller of those goods often underestimates the value. It is not easy to evaluate the value of knowledge that has just been produced. The value of such resources can only be predicted when production is exactly known what will be produced (Arrow, 1971, p. 148). So, the knowledge from emergence of losses and profits is that the knowledge of knowledge is imperfect (Kirzner, 1979a, pp. 137 - 153).
3. Public-Private Partnerships in the healthcare sector

Unece et al. (2012) state that because of the rising number of people with chronic diseases, extremely fast changing technology and ageing populations the cost of providing healthcare is increasing exponentially. Governments are looking forward to PPPs to improve health outcomes, contain costs and to meet critical goals in health policies. The study further explains that experiences with PPPs in the health sector are rather recent.

According to the European Commission (2013, p. 5), a high amount of literature is quite positive on PPPs, the reason this is written mostly by promoters of partnerships. Mostly, literature on PPPs is provided by the government and hardly ever by the private partners, this leads to a view, which is one-sided. Although, PPP hospitals are operating in Portugal since 200, only few project evaluations are available. In the UK PPPs exist even longer than a decade. Also in this case, there are only a few independent evaluation studies existing.

The European Commission (2013, pp. 239 & 240) explains that countries with high tax burdens prefer PPPs to the traditional public services. The value for money should be higher and the risk allocation should be more efficient. Another reason why governments enter PPP contracts is spreading payments over a longer period, the whole contract life. During the economic crisis higher amount of risk within PPP contracts was transferred to the public partner, this is especially not optimal when the sub-sovereign rating is under stress and when the government is already overleveraged. But, the risk of construction, operation and maintenance is hardly ever valued in public budgets in the traditional procurements. PPPs reduce the stress on short-term budget constraints and reduce fiscal liabilities by transferring risk to the private partner. Private borrowings are more costly than government’s ones but when government debt reaches a particular level rating agencies downgrade governments and increase the overall costs for government’s debt. The connection between governmental borrowings and PPPs is one of the focuses of this paper.
3.1. Private-public partnerships in the hospital sector around the world

The European Commission (2013, pp. 239 & 240) further explains that the distribution of PPPs between different countries is diverse. From 2005 to 2007, 40% of all healthcare investments in Great Britain were PPP projects. In comparison, in many other countries, PPP projects amounted to less than 1% of healthcare investments.

According to PwC (2010, p. 8) in Europe during the first half of the year 2010, four billion dollars were invested in PPP hospitals. The largest deal was done in Stockholm, the 700-bed Karolinska is also the largest PPP hospital in the world. Another project is, a new 1,465-bed hospital in Spain. Ontario, British Columbia, and Quebec invested ten billion dollars in healthcare PPPs between 2005 and 2010. McGill University Hospital in Montreal, worth 1,3 billion dollars is North America’s largest PPP hospital. The Chris Hani Baragwanath Hospital, in South Africa, is the biggest PPP hospital in Africa. On this point, it has to be mentioned that PPPs deliver not only buildings. PwC further explains that PPPs deliver primary care services in Spain, cancer treatment in Germany and malaria vaccines in Africa.

3.2. Risks for public-private partnerships in the healthcare sector

PwC (2010, p. 7) states that PPPs were also criticized. Failures of PPPs, e. g. in Australia, Italy or Japan, allowed doubting and opened up a discussion about „privatising“ healthcare. This ideological debate will also be a subject of discussion in the empirical part in this paper.

According to European Commission (2013, p. 240), healthcare PPPs are mainly financed by banks and local sponsors, so negative feedback loops can be created between public debt and banks.

PwC (2010, p. 13) explains that the workforce cost is between 50% and 75% of health spending. Healthcare is labour-intensive and often heavily unionised with sticky structures of compensation. In many countries, benefits are higher in the public sector than in the private sector, in others it is the opposite. Labour laws, which have to be addressed from both sides, and unions, have to become more flexible to support the growth of healthcare PPPs. In Austria labour costs are between 50% and 75% of total costs. People who work in healthcare are civil servants that have a lifetime job, this makes the implementation of
PPPs difficult. The Psychosomatic Centre in Eggenburg was an expectation, because it is standing outside of government’s healthcare plan.

The health care sector is highly technologized, innovations can appear so quickly that it is difficult to estimate the costs in the future. Service-based PPPs force the private sector to provide the same level of technology during the entire time the contract is valid. The latest technology is demanded by patients and physicians alike, but it is also a major cost driver (PwC, 2010, p. 14).
4. Country characteristics

4.1. Switzerland

4.1.1. Country-specific information

4.1.1.1. Geography
According to the CIA/Switzerland (2016), the area of Switzerland counts 41,277 km$^2$. Austria, Liechtenstein, Germany, Italy, and France border Switzerland. Germany, Italian, French, and Romanian are all official languages. De Pietro et al. (2015) explains that 27% of Switzerland’s population was born abroad. This makes Switzerland, after Luxembourg, the country with the second highest amount of foreign-born inhabitants in Europe (OECD, 2015). Switzerland’s immigrant population is characterized by a high amount of people who have a tertiary school education, and of which 65% to 85% of persons emigrate from another OECD country (Dumont & Lemaître, 2005). These highly skilled immigrants show the need, in the past, for qualified workers in many different sectors, the healthcare sector is an example (De Pietro et al., 2015).

4.1.1.2. Economic context
The CIA/Switzerland (2016) explains some economic key parameters: Switzerland has a modern and prosperous market economy. 34% of GDP was the public debt in 2015. The working force is (as mentioned in chapter 4.1.1.1) highly skilled and the GDP per person is within the highest worldwide. Switzerland’s economy shows a highly developed service sector, e.g. financial services, and an on high-technology based manufacturing industry with a production that is strongly knowledge based. Further, the Swiss economy is one of the most competitive in the world, because of political and economic stability, highly developed capital markets, low cooperate taxes and a notable infrastructure. Table 1 shows the development of the GDP in Switzerland between 1980 and 2013.
4.1.1.3. Political context

According to De Pietro et al. (2015) Switzerland is special for its political system, e.g. the municipalities and cantons have a very high autonomy. The Federal Constitution created the cantons in the responsibility of the Confederation. In comparison to many other countries, the population is much stronger involved in political decision-making. Nearly every important municipal, cantonal or federal decision has to be decided by the population directly. According to The Swiss Confederation, there are 26 cantons. In some cases only 23 cantons are counted, because six cantons are counted as half-cantons for historical reasons. However, all half-cantons have the same autonomy as all other cantons. Further, Switzerland counts 2352 municipalities that also have a high autonomy.

Table 1: GDP in Switzerland (De Pietro et al., 2015 quotes the World Bank 2014, 2015)

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<td>GDP (in billion current US$)</td>
<td>112.5</td>
<td>244.0</td>
<td>324.0</td>
<td>256.0</td>
<td>384.8</td>
<td>549.1</td>
<td>658.9</td>
<td>631.2</td>
<td>650.4</td>
</tr>
<tr>
<td>GDP, PPP (in billion current international $)</td>
<td>90.1</td>
<td>169.8</td>
<td>192.9</td>
<td>233.5</td>
<td>274.9</td>
<td>381.2</td>
<td>405.3</td>
<td>417.0</td>
<td>433.7</td>
</tr>
<tr>
<td>GDP per capita (in thousand current US$)</td>
<td>17.8</td>
<td>36.3</td>
<td>46.0</td>
<td>35.6</td>
<td>51.7</td>
<td>70.6</td>
<td>83.3</td>
<td>78.9</td>
<td>80.5</td>
</tr>
<tr>
<td>GDP per capita, PPP (in thousand current international $)</td>
<td>14.2</td>
<td>25.3</td>
<td>27.4</td>
<td>32.5</td>
<td>37.0</td>
<td>48.7</td>
<td>51.2</td>
<td>52.1</td>
<td>53.7</td>
</tr>
<tr>
<td>GDP annual growth rate (%)</td>
<td>4.60</td>
<td>3.67</td>
<td>0.48</td>
<td>3.67</td>
<td>2.99</td>
<td>2.95</td>
<td>1.79</td>
<td>1.05</td>
<td>1.93</td>
</tr>
<tr>
<td>General government final consumption expenditure (% of GDP)</td>
<td>9.8</td>
<td>11.3</td>
<td>11.8</td>
<td>11.1</td>
<td>11.6</td>
<td>11.0</td>
<td>11.0</td>
<td>11.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Cash surplus/deficit (% of GDP)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>-0.53</td>
<td>0.02</td>
<td>0.56</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tax revenue (% of GDP)</td>
<td>n/a</td>
<td>n/a</td>
<td>8.5</td>
<td>n/a</td>
<td>9.9</td>
<td>9.6</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Public (central government) debt, total (% of GDP)</td>
<td>n/a</td>
<td>n/a</td>
<td>21.4</td>
<td>n/a</td>
<td>40.5</td>
<td>23.8</td>
<td>24.3</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Value added in industry (% of GDP)</td>
<td>34.5</td>
<td>31.3</td>
<td>29.6</td>
<td>26.5</td>
<td>26.4</td>
<td>26.3</td>
<td>26.9</td>
<td>26.8</td>
<td>26.4</td>
</tr>
<tr>
<td>Value added in agriculture (% of GDP)</td>
<td>n/a</td>
<td>2.5</td>
<td>2.1</td>
<td>1.3</td>
<td>0.99</td>
<td>0.8</td>
<td>0.8</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Value added in services (% of GDP)</td>
<td>n/a</td>
<td>66.2</td>
<td>67.6</td>
<td>72.2</td>
<td>72.6</td>
<td>72.9</td>
<td>72.3</td>
<td>72.5</td>
<td>72.8</td>
</tr>
<tr>
<td>Labour force (in million people, total)</td>
<td>n/a</td>
<td>3.8</td>
<td>3.9</td>
<td>4.0</td>
<td>4.2</td>
<td>4.5</td>
<td>4.6</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Unemployment, total (% of labour force)</td>
<td>n/a</td>
<td>2.1</td>
<td>3.3</td>
<td>2.7</td>
<td>4.4</td>
<td>4.5</td>
<td>4.0</td>
<td>4.2</td>
<td>4.4</td>
</tr>
<tr>
<td>Real interest rate</td>
<td>n/a</td>
<td>2.7</td>
<td>4.7</td>
<td>2.7</td>
<td>2.9</td>
<td>2.4</td>
<td>2.3</td>
<td>2.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Official exchange rate (Sw.fr./US$)</td>
<td>1.7</td>
<td>1.4</td>
<td>1.2</td>
<td>1.7</td>
<td>1.2</td>
<td>1.0</td>
<td>0.9</td>
<td>0.9</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Sources: World Bank, 2014; World Bank, 2015.
The high autonomy of the cantons has a significant influence on PPPs in the healthcare sector, this topic will be discussed in the empirical part.

4.1.1.4. Demography

According to Enderli et al. (2015), Switzerland is, along with Italy (chapter 4.3.1.3.), with 82.2 years among the countries with the highest life expectancy worldwide. Since the beginning of the century, the life expectancy of a new-born increased steadily. High-quality healthcare and improved hygiene are reasons for this high quality of living.

In figure 2 can be seen that the largest part of the population in Switzerland is between 45 and 54. The amount of people between zero and ten years old is rather small.

![Figure 2: Demography of the Swiss population (CIA/Switzerland, 2016)](image)

De Pietro (2015) explains that the population in Switzerland is aging, as in many other countries in Europe. The percentage of people who are older than 65 was in 2013 4% higher than in 1980. During the same time, the amount of people between 0 and 14 fell by 5%.
4.1.2. The Swiss healthcare system

4.1.2.1. Role of government

According to Avik (2011), healthcare insurances that are run by the government or sponsored by the employer do not exist in Switzerland, the citizens have to buy them themselves. Therefore, prices for insurance are transparent. A minimum benefits package is defined by the government, which has to be offered to each inhabitant by the insurance companies. Health care is subsidized for people with lower income, so people do not have to spend more than 10% of their income. 99.5% of the citizen in Switzerland have an insurance. The insurance companies have to compete on service and price, because more than 100 different private companies exist. Patients can choose completely freely their doctors and waiting time for an appointment is nearly as low as in the one of the world leader, the U.S.

Enderli et al. (2015) explain that there is a high degree of satisfaction with the Swiss healthcare system. 82% of the people in Switzerland have a very or fairly positive impression of their system. This shows also that there is no ground for huge reforms. High-quality services and free choice are the two main characteristics with which the electorates describe their health system. Further, there is a high stake of people who require a largely market-oriented system.

Figure 3: Satisfaction with the Swiss health care system (Enderli et al., 2015 quotes Health Monitor 2015)
### 4.1.2.2. Centralisation and Decentralisation

De Pietro et al. (2015) states that by international standards the Swiss healthcare system remains strongly decentralized. In 1848, the first Federal Constitution only mentioned sanitary measures when epidemics appear. The cantons were responsible for all other health care regulation and legislation. After, greater coordination was required, almost all healthcare reforms were assigned to the federal level. So, the federal level plays an important role, and according to several proposals, centralization is likely to continue. However, the Swiss healthcare system continues to be highly decentralized, in comparison to many other countries. This fact can be shown by some examples. Cantons are still important in ambulatory and inpatient care. The corporatist tradition supports decentralized decision making in healthcare. Additionally, it is necessary for a regulatory model that manages competition to involve private actors, e. g. companies or patients. To summarize, decisions are taken on different levels and various models co-exist, e. g. traditional healthcare provision and management care.

According to Enderli et al. (2015) most hospitals in Switzerland are controlled and owned by the municipalities and cantons. As a result, emergency care, hospital planning,
licensing monitoring, financing the training of doctors and rescue services are in the hands of the cantons.

4.1.2.3. Financing and Financial challenges

4.1.2.3.a Sources of Financing
Enderli et al. (2015) write that the total health care costs are 68 billion Swiss Franks. Those costs are covered through different channels. In 2012, more than 60% of the total health care costs were financed by private households, of which the largest part was paid directly into the insurance system. Approximately a fifth was used to pay for particular services directly, which the insurance does not cover (out-of-pocket payments) (see also chapter 4.1.2.3.c). The public purse (municipal, cantonal and federal) financed more than 32% of health care costs.

4.1.2.3.b Health Expenditure
According to De Pietro (2015), Switzerland has one of the highest shares of healthcare spending in Europe. In 2013, Switzerland spent 11.5% of GDP on healthcare, the Netherlands and France are the only countries that spent more. At this point, it should be also mentioned that Switzerland has a very high GDP and a well working economic system (see chapter 4.1.1.2.). Figure 5 shows the development of the health expenditure of Switzerland and is compared with other countries examined in this paper.
Enderli et al. (2015) explains that the Swiss healthcare system is expensive, but it’s outcomes are of very high quality. Between 2011 and 2012 the costs increased by 5.3%, the average growth in the years before was 4.3%.

4.1.2.3.c Out-of-pocket payments

Out-of-pocket spending is high in Switzerland, compared to other countries in Europe. In 2014, patients had to pay 26.8% out-of-pocket payments in Switzerland. In other countries, the shares are smaller, what the households directly have to finance (see table III).
Table 2: Out-of-pocket payment 2014, Switzerland compared to other Europe countries (OECD Health Data, 2016)

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>19.4%</td>
</tr>
<tr>
<td>Germany</td>
<td>13.5%</td>
</tr>
<tr>
<td>Italy</td>
<td>22.1%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5.2%</td>
</tr>
<tr>
<td>Portugal</td>
<td>27.7%</td>
</tr>
<tr>
<td>Slovenia</td>
<td>12.7%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>26.8%</td>
</tr>
</tbody>
</table>

4.2. Austria

4.2.1. Country-specific information

4.2.1.1. Geography
Austria has an area of 83,879 km² (WKO, 2015) and consists of 9 regions. Italy, Switzerland, Lichtenstein, Germany, Czech Republic, Slovakia, Hungary, and Slovenia border Austria. According to the World Bank/Austria (2016), Austria counts 8.5 million inhabitants in 2014.

4.2.1.2. Economic context
The CIA/Austria (2016) explains that Austria is economically closely tied to other EU economies. It can be called a well-developed market economy with skilled labour and a high standard of living. The Austrian economy is structured in a large service sector, a moderate industrial sector and a highly developed, but small, agricultural sector. The unemployment rate is, in comparison to other European countries, low but for Austrian terms historically high. Generous early retirement and expensive vocal training are reasons that caused this low unemployment rate. Even after 2012, public finances are not stable. The public debt reached in 2014 a historical level of 83.4% of GDP.

4.2.1.3. Demography
OECD Better Life (2016) explains that life expectancy in Austria is 81 years, which is one year more than the OECD average. Women have a life expectancy of 84 years and men
of 78 years. Further, Austria performs better in measures of well-being than most other countries in the Better Life Index of the OECD. Austria is ranked above the average in subjective well-being, health status, jobs and earnings, environmental quality, personal security, but below the average in work-life balance.

The age pyramid below shows that the largest part of the Austrian population is between 45 and 49 old. Comparably few people are between 0 and 10 years old.

![Age Pyramid of Austrian Population](image)

*Figure 6: Demography of the Austrian population (CIA/Austria, 2016)*

### 4.2.2. The Austrian healthcare system

#### 4.2.2.1. Role of government

According to the BMG (2013, p. 11 & 12) the base of health care is the social insurance model, which guarantees all Austrian inhabitants equal access to services on a high quality irrespective of age, sex, social status, income or origin. The health insurance protects 99.9% of the population. The social insurance in Austria is compulsory. Law regulates the access to all services. The General Social Insurance Act (ASVG) is the most
important legislative basis. All people who are insured have access to a broad variety of different services: Primary health care services, inpatient and outpatient care, psychotherapy, physiotherapy, speech therapy, dental services, curative massage, home and mobile care, rehabilitation, ergo therapy, ambulance services, health technology, prescription medicines, wheelchairs, preventive health services, and special care for people with disabilities.

The BMG (2013) further explains that patients are free to choose their family physician. Family physicians have, in many cases, a contract with the social health insurance funds. Those physicians have, in comparison to many other countries, no function as gatekeepers. As a result, patients can access directly outpatient care in hospitals. The Austrian social health insurance funds include the Federal government and its provinces, local governments or other social security institutions, who are also suppliers of health care.

4.2.2.2. Centralisation and Decentralisation

Hofmarcher & Quentin (2013, pp. 40 - 42) explain the centralisation and decentralisation of the Austrian healthcare sector. There are practically no provisions on a regional basis taking place that are carried out by federal authorities. Certain tasks are transferred to the Länder by the constitution. For this reason, it can be said that regionalization/devolution is taking place in Austria. Except in Vienna, all Länder have sourced out hospital operating bodies. This can be called, a kind of organizational privatization. Public and private non-profit-making hospitals, e.g. Vinzenz Hospitals Group, are included. The institutional and regulatory structure is decentralized and based on contract relations. Further, the institution for financing and responsibility is not the same. This separation is seen as inefficient (Fuentes et al., 2006; Handler, 2007), and makes consolidation more difficult (IMF, 2011).

4.2.2.3. Financing and Financial challenges

4.2.2.3.a Sources of Financing and health expenditure

The BMG (2013, pp. 19 – 22) states that the Austrian healthcare system represents a particular combination. The combination consists of mandatory income-based social
insurance contributions, private payments in the form of direct and indirect co-payments, and public income generated through taxes. The social insurance is the most relevant source, by gaining 45% (€ 14 billion) of the health expenditure in 2011. Whereas in-patient care is shared between the social insurance and the public sector, social health insurance funds finance outpatient’s care almost entirely. Taxes mostly finance long-term care services. Social health insurance funds, the federal government, local and provincial governments generate account for 76% of the total health expenditure. Households, private non-profit organisations and companies gain 24% via private health expenditure, e.g. expenditure of private health insurance companies, out-of-pocket payments. 76% of all health spending is done by the public body is slightly above the average of the OECD (OECD Health Statistics/Austria, 2015).

![Figure 7: Public and private health expenditure in Austria (OECD Health Statistics/Austria, 2015)](image)

According to OECD Health Statistics/Austria (2015), the health spending in share in terms of GDP was 10.1% in 2013, while the average of the OECD average was 8.9%. This level was the same in 2012, which also matches the level of healthcare spending in 2009. Austria spent 3453 USD per capita in 2013, this is also above the average of the OECD with USD 3453 USD. The growth per capita dropped in 2013 by 0.3% in real terms. This was the first drop since 1981.

1 Preliminary estimate.
2 Data refer to 2012.
In the next years, the expenditures, as a per cent of GDP, will slightly increase (The Economist Intelligence Unit, 2014). In the 2018 it is estimated to be 11.4%.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>11.2</td>
<td>11.1</td>
<td>10.9</td>
<td>11.1</td>
<td>11.1</td>
<td>11.2</td>
<td>11.2</td>
<td>11.3</td>
<td>11.3</td>
<td>11.4</td>
</tr>
<tr>
<td>US</td>
<td>17.1</td>
<td>17.0</td>
<td>17.0</td>
<td>16.9</td>
<td>16.9</td>
<td>17.0</td>
<td>17.0</td>
<td>17.1</td>
<td>17.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Japan</td>
<td>9.5</td>
<td>9.6</td>
<td>10.1</td>
<td>10.3</td>
<td>10.4</td>
<td>10.4</td>
<td>10.5</td>
<td>10.5</td>
<td>10.6</td>
<td>10.6</td>
</tr>
<tr>
<td>China</td>
<td>5.2</td>
<td>5.0</td>
<td>5.2</td>
<td>5.3</td>
<td>5.4</td>
<td>5.6</td>
<td>5.7</td>
<td>5.9</td>
<td>5.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Germany</td>
<td>11.8</td>
<td>11.6</td>
<td>11.3</td>
<td>11.3</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
<td>11.6</td>
<td>11.7</td>
<td></td>
</tr>
</tbody>
</table>

* A Actual, b Economist Intelligence Unit estimates, c Economist Intelligence Unit forecasts.

**Table 3:** An international comparison of healthcare spending (in % of GDP) (The Economist Intelligence Unit, 2014)

4.2.2.3.b Out-of-pocket payments

According to BMG (2013, pp. 12 & 13) certain health care services follow special conditions, this means for special types of illnesses or some age face cost sharing as a consequence. When Austrian inhabitants use health services that are not part of their health catalogue provided by the health insurance fund (e. g. OTC medicine), they are confronted with out of the pocket payments. Those payments can be partially refunded. Furthermore, it should be mentioned that people with chronic illnesses or disabled people do not have to pay co-payments, and there are also many other expectations.

OECD Health Statistics/Austria (2015) states that in 2013 out-of-pocket spending was 17% and was slightly falling over the last decade. These 17% is below the average of the OECD of 19%. However, when compared to other Western European countries such as United Kingdom (10%), France (7%), and Germany (14%) out-of-pocket spending in Austria was rather high.

4.3. Italy

4.3.1. Country-specific information

4.3.1.1. Geography

According to Lo Scalzo et al. (2009), Italy’s territory is 301,316 km² and consists of 20 regions and two autonomous provinces. Austria, Slovenia, France and Switzerland border

4.3.1.2. Economic context
The CIA/Italy (2015) lists the following numbers. Italy is the third largest economy in the Euro Zone. The public debt is, with 132% in 2014, on a comparatively high level. So, there is a high pressure from different investors and the European partners to make reforms. The GDP is 10% below the pre-crisis level. In 2014, the GDP was $2.128 trillion. So, it is on place 13 among the highest GDPs worldwide. The GDP per capita was $ 35,500, in 2014. This means Italy is on place 49 compared to the rest of the world. The GDP growth was -0.4% which is place 202 compared to all other countries.

Lo Scalzo et al. (2009) explain another important characteristic of Italy that should be mentioned here. This is characteristic of Italy’s dual economy. 75% of the total GDP was produced in the North and Centre of Italy. One region in the North, the Lombardy, has even accounted for 20% of the total amount of GDP. This proportion did not change over two decades.

4.3.1.3. Demography
The structure of the population has significantly changed since 1970. The standard of living in Italy is high and the health status of the single individuals has changed over the last two decades. The rates of fertility dropped between 1970 and 2006 from 2.42 to 1.35, which is below the level of replacement – this rate is even among the lowest worldwide (Lo Scalzo et al., 2009). In additionally, the life expectancy is among the highest in the world (Eurostat, 2015).
In the data of the CIA/Italy (2015) can be seen that the biggest group in Italy are the people between 35 and 64. The group of people over 60 is rather large.
ISTAT (2011) predicted that the age average will grow from 43.5 in 2011 to a maximum of 49.8 in 2059. In 2013 21.8% of all Italian inhabitants were over 65 years, in 2043 32% will be over 65.

4.3.2. The Italian healthcare system

4.3.2.1. Role of government

According to Genteli (2009), the right to health care is granted by Article 32 of the Italian Constitution. This right led to the establishment of the SSN (Servizio Sanitario Nazionale\(^3\)). The Constitutional Court reaffirmed that based on Article 32 it is obligatory to always provide a minimum of health care, even in difficult economic times. Lo Scalzo et al. (2009) explains that the minimum of statutory benefits is defined by the central governments and is valid for all residents in every region. This was named the essential levels of care (LEA).

\(^3\) Engl.: National Health Service
The LEA sets a common framework among all regions and should set a minimum level of treatment for all citizens.

Mossialos et al. (2015) states that the SSN covers all citizens and foreigners who live legally in Italy. The coverage of the insurance is automatically and universal. Since 1998 also, illegal immigrant can access urgent services. By paying the treatments from the own pocket also temporary visitors can receive health care. A substantive insurance does not exist, because the SSN does not allow members refusing their service and seek only private care. Supplementary and complementary private insurances are available. Approximately 15% of the Italian population have a private insurance.

### 4.3.2.2. Centralisation and Decentralisation

Mossialos et al. (2015) explain that the SSN is decentralized, it is organized on local, regional and national levels. The Italian constitution divides healthcare within all regions, autonomous provinces, and the national government. The regions and provinces are mandated with the organization and delivery of all healthcare services. Further, they have a significant autonomy to create and change the macro structure of their particular healthcare system. Hospital care, public health care, outpatient specialist care, primary care, specialist care, social care, and public healthcare are transferred to local units. Regional managers supervise over the general managers of those units.

Di Novi et al. (2015) explains that independent reviewers (e.g. Bloomberg, 2014) ranked Italy on place three, out of 50 countries, on the efficiency of health care system. Life expectancy is high (see also chapter 4.3.1.3.) and child mortality is low (infant mortality rate in 2011, U.S vs. Italy: 6.1 vs. 2.9 out of 1,000 live births). Further, Italy spends 9% of GDP yearly on healthcare. In comparison, the health care spending of the United States is 17% of GDP per year. Unfortunately, the rather large differences between the Italian regions are hidden in this. Di Novi et al. (2015) write that according to the ISTAT-Health for All data, infant mortality rate (2009 is the most recent data) was 1.5 in Aosta Valley and 4.9 in Sicily (out of 1,000 live births). In addition, healthcare spending varies across regions, it amounts 5% of GDP in the North and 10% in the South.
4.3.2.3. Financing and Financial challenges

4.3.2.3.a Sources of Financing

Ferré et al. (2014) explain that the SSN is mainly financed by national and regional taxes. Further, cost sharing for pharmaceuticals products and outpatient care exist in Italy. The WHO (2014) explains that in 2012 the total health expenditure was accounted for 9.2% of the Italian GDP. This means it is slight below the average of the EU, which is 9.6%.

The distribution of the main sources of financing are summarized in the following table:

<table>
<thead>
<tr>
<th>Sources of financing</th>
<th>% of total financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRAP and additional IRPEF</td>
<td>35</td>
</tr>
<tr>
<td>VAT and other excise taxes (Decree Law n. 56/2000)</td>
<td>47</td>
</tr>
<tr>
<td>Other transfers from public and private organizations</td>
<td>9</td>
</tr>
<tr>
<td>Health organizations’ revenue and other income</td>
<td>3</td>
</tr>
<tr>
<td>National Health Fund and Restricted National Funds</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4: The main sources of financing, 2012 (Armeni & Ferrè, 2013)

Thomson et al. 2013 state that the IRAP (l’imposta regionale sulle attività produttive) is a tax paid by the salaries of public sectors employees and the value added tax of companies. It is nationally pooled and further allocated back to the different regions (e.g. the spread between the operating revenue and costs before interest and expense). In particular certain industries, the tax could be raised by 0.92% The IRPEF (L’imposta sul reddito delle persone fisiche) is a surcharge, which is managed by the regions, and the basic rate was 1.23% in 2012. Also, this tax can be raised (Ferré et al., 2014).

According to Ferré et al. (2014) the reason why some regions have increased their IRAP and IRPEF rates is that they are responsible for their deficits in health care themselves and set rates that sustain the costs. Molise, Calabria and Campania have the highest rates, so these are examples of regions, which did not meet the expenditure goals and plans.
Thomson et al. (2013) write that the VAT (base rate: 38.5%) is used for regions, which did not gain enough resources to provide their inhabitants the core of LEA. The national government collects the VAT. It is a fixed amount of the revenue of the valued-added tax.

All other resources used to finance the health care system are unrestricted and gained by private and public organizations (Ferré et al., 2014).

Also, the distribution of per capita deficit is regionally very different, a North-South divide can be seen:

![Figure 11: Healthcare deficits by per capita and by region in Italy, 2001 – 2012 (Armeni & Ferré, 2013)](image)

**4.3.2.3.b Health Expenditure**

According to Armeni & Ferré (2013) health expenditure increased between 1990 and 2012, most other OECD countries performed similarly. For this reason, this topic is an important issue for all the affected governments.
Table 5 shows that the expenditure had not changed between 2010 and 2012, the change was only 1.1% per year. Stricter controls for different regions are a reason that the expenditure did not enlarge, which started after particular regions had high deficits. A formal „financial recovery plan“ (Piani di Rientro) was introduced for Italian regions that had overspendings. As a result, the overspendings decreased. Between 2009 and 2012 the health care expenditure grew by 0.9% annually. In comparison, from 2000 to 2009 the growth rate was 4.7%.

The WHO (2014) compares a range of different countries. The spending of Italy was among the lowest. The expenditure declines in Spain, Great Britain and Italy and becomes more equal to the average of the EU. But, also the GDP in Italy grew less than in other European countries (Armeni & Ferré, 2013).
Figure 12: A European comparison of healthcare spending (in % of GDP) (WHO, 2014)

Also, at this point, regional differences should be further discussed. Figure 12 shows the differences among the regions. But, also, according to Ferré et al. (2014), a convergence between the different regions’ spending can be seen. Generally, it is shown that regions in the North and the Centre are above the average of the nation and regions of the South below. Among other things, this can be explained by a different age structure. Usually, elderly people create higher health care costs. Concluding, it can be said that regions with a lower economic development tend to have a smaller expenditure than higher developed ones, even if the spread is shrinking.
Table 6: Per capital health expenditure in the different Italian regions, 1990 - 2012 (Armeni & Ferrè, 2013)

<table>
<thead>
<tr>
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<tbody>
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<td></td>
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<tr>
<td>Piedmont</td>
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<td>1893</td>
<td>1907</td>
<td>1893</td>
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<td>758</td>
<td>997</td>
<td>1392</td>
<td>1629</td>
<td>2076</td>
<td>2170</td>
<td>2236</td>
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<td>1185</td>
<td>1573</td>
<td>1766</td>
<td>1813</td>
<td>1872</td>
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<td>A.P. Bolzano</td>
<td>722</td>
<td>995</td>
<td>1589</td>
<td>2059</td>
<td>2134</td>
<td>2183</td>
<td>2284</td>
</tr>
<tr>
<td>A.P. Trento</td>
<td>731</td>
<td>907</td>
<td>1318</td>
<td>1722</td>
<td>2044</td>
<td>2088</td>
<td>2290</td>
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<tr>
<td>Veneto</td>
<td>746</td>
<td>861</td>
<td>1249</td>
<td>1609</td>
<td>1769</td>
<td>1788</td>
<td>1732</td>
</tr>
<tr>
<td>Friuli Venezia Giulia</td>
<td>730</td>
<td>968</td>
<td>1234</td>
<td>1650</td>
<td>1958</td>
<td>1979</td>
<td>2076</td>
</tr>
<tr>
<td>Liguria</td>
<td>841</td>
<td>957</td>
<td>1342</td>
<td>1837</td>
<td>2026</td>
<td>2006</td>
<td>2043</td>
</tr>
<tr>
<td>Emilia R</td>
<td>856</td>
<td>975</td>
<td>1282</td>
<td>1699</td>
<td>1906</td>
<td>1920</td>
<td>1926</td>
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<tr>
<td>Centre</td>
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<tr>
<td>Tuscany</td>
<td>788</td>
<td>931</td>
<td>1240</td>
<td>1647</td>
<td>1919</td>
<td>1899</td>
<td>1914</td>
</tr>
<tr>
<td>Umbria</td>
<td>766</td>
<td>865</td>
<td>1251</td>
<td>1629</td>
<td>1807</td>
<td>1806</td>
<td>1841</td>
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<tr>
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<td>834</td>
<td>986</td>
<td>1237</td>
<td>1544</td>
<td>1744</td>
<td>1795</td>
<td>1793</td>
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<tr>
<td>Lazio</td>
<td>788</td>
<td>931</td>
<td>1283</td>
<td>1919</td>
<td>2011</td>
<td>1995</td>
<td>1965</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abruzzo</td>
<td>724</td>
<td>761</td>
<td>1281</td>
<td>1729</td>
<td>1757</td>
<td>1743</td>
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<tr>
<td>Molise</td>
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<td>776</td>
<td>1145</td>
<td>2033</td>
<td>2072</td>
<td>2070</td>
<td>2037</td>
</tr>
<tr>
<td>Campania</td>
<td>692</td>
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<td>1150</td>
<td>1670</td>
<td>1747</td>
<td>1719</td>
<td>1710</td>
</tr>
<tr>
<td>Puglia</td>
<td>671</td>
<td>783</td>
<td>1109</td>
<td>1515</td>
<td>1751</td>
<td>1772</td>
<td>1731</td>
</tr>
<tr>
<td>Basilicata</td>
<td>603</td>
<td>707</td>
<td>1071</td>
<td>1505</td>
<td>1753</td>
<td>1796</td>
<td>1818</td>
</tr>
<tr>
<td>Calabria</td>
<td>586</td>
<td>721</td>
<td>1130</td>
<td>1423</td>
<td>1741</td>
<td>1719</td>
<td>1697</td>
</tr>
<tr>
<td>Sicily</td>
<td>700</td>
<td>747</td>
<td>1054</td>
<td>1559</td>
<td>1666</td>
<td>1698</td>
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</tr>
<tr>
<td>Sardinia</td>
<td>695</td>
<td>860</td>
<td>1163</td>
<td>1632</td>
<td>1826</td>
<td>1674</td>
<td>1932</td>
</tr>
<tr>
<td>ITALY</td>
<td>730</td>
<td>940</td>
<td>1208</td>
<td>1648</td>
<td>1825</td>
<td>1836</td>
<td>1850</td>
</tr>
</tbody>
</table>

**4.3.2.3.c Public and out-of-pocket payments**

Mossialos et al. (2015) explain that primary care and inpatient care are free to used. There are different lists of such services, positive and negative ones, which decide based on, e. g., appropriateness, human dignity, or medical necessity. This means e. g. outpatient optometrist visits are covered, but laser eye surgeries are not. All regions can decide if they include particular services that are not involved in the list, but those services have to be financed by the respective regions themselves.

In 2012, 78.2% of all health care spending was covered by public finances, and 21.8% was privately financed with OOP (out-of-pocket) payments (Ferré, F. et al. 2014). Mostly, OOP payments consist of outpatient’s care, dental services, pharmaceuticals products,
and voluntary health insurance coverage. This is just slightly above the EU average (78.8%) (WHO, 2014).
II. EMPIRICISM

The research questions, which are presented in the introduction, will be answered with a qualitative research in this part. The research questions are:

1. Do healthcare PPPs exist in Switzerland, Austria and Italy?
2. What are the main differences and similarities between healthcare PPPs in Switzerland, Austria and Italy?
3. What is the connection between public debt and healthcare PPPs?
4. What are the advantages and disadvantages of market mechanisms in the healthcare sector?

5. Method

5.1. Methodical challenges

5.1.1. Qualitative vs. quantitative methods

To enable a comparison between the different situation of PPPs in Switzerland, Austria, and Italy the summarising content analysis based on Mayring (2015) is used. This method is a qualitative approach. As discussed in the theoretical part many parameters differ between Switzerland, Austria and Italy, such as budgetary deficit, geography (e.g. size of the country), current problems and challenges, financing of the healthcare system, regional differences…

Expert interviews are used to describe the PPPs. Between five and nine experts have been conducted for each country. All expert opinions will be analysed and compared. There is no large database that is used. Additionally, PPPs will be explained and not analysed on numeric variables. For all these reasons, a qualitative research is more reasonable than a quantitative.

Klieber (2005, p. 9) states that qualitative methods are more efficient to explain social reality. Additionally, it tries to look inside the living environment and explains it according to the reality (Flick et al. 2000, p. 14).
According to Flick et al. (2000, pp. 14-17) qualitative research methods work well with questions that are not very well investigated. For this work, countries are used where discussions about PPPs are not very common (see introduction), which makes comparing expert opinions about PPPs in the health care sector rather a new idea. Qualitative research is very open to the research area, which should be analysed (Kuckartz et al., 2008, pp. 11-14).

Diekmann (2007, p. 531) explains that qualitative research methods are focused on the analysis of the subjective perspective of the interviewee. For this work the subjective perspective of PPPs will be analysed and compared with other experts’ views of the same country and also with opinions of how PPPs work in other countries.

5.2. Method of collecting primary data

5.2.1.1. Guided expert interviews
For this paper guided expert interviews were used. To analyse the situation of PPPs in the health care sector, specific knowledge is needed. First, it is necessary to have a deep and broad knowledge about the healthcare system in the different countries. Second, there are only a few people who have personal experience with PPPs by working in the hospital sector or doing research in this field. Expert interviews are a possibility to gain specific and concentrated knowledge from well-selected persons (University of Trier, 2002). Further, it is possible to develop hypotheses with a guided expert interview (Jocher, 2009, p. 64). The guided interview is a tool that systemizes and condenses pre-scientific knowledge (Atteslander et al., 2003, p. 157).

According to the University of Frankfurt, the guided expert interview has particular differences to other interview forms. Guided expert interviews are used when there is no possibility to get a large sample, when the topic and the answers are very complex and when the research should be explorative. Expert interviews can be helpful to operate hypotheses generating, but it is also possible to work deductive – it is possible to test one or more hypothesis.

According to Mieg & Näf (2005), the expert interview is an approach in which experts can answer rather freely to the given questions. This is advantageous because in many cases,
experts can add important and interesting information to the given questions. What is rather clear but should be mentioned here is that the goal is not to define response categories in advance. The guideline helps the interviewer and the interviewee to stick to the questions.

Mief and Näf (2005) mention that the number of interviews is very small, in some cases there is only one expert who gives an interview. Because, of this open questions and the small number of interviews which are held, experts interviews is categorized as a qualitative method.

5.2.1.2. The interview guideline
The interview guideline was developed after it was decided which focus areas should be analysed. The whole guideline consists of open questions, so there are no answer options given (Peters, 2010, pp. 35 & 36). The order of the questions can vary from interview to interview, because the expert can decide him- or herself in which sequence the questions should be answered. Questions can be skipped, if the interviewee does not know the answers, a question was already answered before when another question was asked or if an expert does not want to give an answer.

All experts conducted were specialized in a particular field. For this reason, two different interview guidelines were created. One guideline gave the interviewee the possibility to discuss only the management of hospitals, the second guideline was focused on the construction of hospitals. The topics and content of both questionnaires were the same. Further, the questionnaire was nearly equal for all countries to guarantee a fair comparison.

Question one and two are skill questions, for statistical data is asked (Peters, 2005, pp. 35 & 36). The purpose of these questions was to prepare the expert for the level of complexity and to go in the topic. These two questions should make it very clear that the goal of the questionnaire is not to analyse the health care system, the guideline aims the analyses of PPPs in the health sector in a particular country. Atteslander (2003, p. 129) advises to start with introductory question(s) and not with the most important one.
Questions three to nine are the main body of the questionnaire, the goal is to analyse the topic and subtopics (Peters 2005, pp. 35 & 36). In those questions, also sub-questions can be found to become more precise. These questions should motivate the expert to tell his or her opinion and make estimations (University of Trier, 2002). The main body of the questionnaire is also focused on answering the research questions (Peters 2005, pp. 35 & 36).

Question three was created to compare the importance of PPPs within different countries. The expert should do a short market analysis, when he or she gives the answer on question four. The next question, question five, was created to get know the ideological viewpoint of the interviewee. The costs of PPPs are focused in question six. The link between the involvement of private companies and modernisation is the focus of question seven. Questions eight analyses, if PPPs are concentrated in particular areas. The last question of the main body, question nine, discusses in which areas of the health sector the most profit can be gained.

The last question is to summarize all thoughts and to make a forecast for the future. This question should not only analyse if PPP will play a more important role, the question goes further. It is asked if more private companies will play a more important role in the health care system in a particular country.

All questionnaires can be found in Appendix. As an illustration, the questionnaire, which was sent out in Switzerland for building hospitals is used. Further, the questionnaire for managing hospitals in Italy can be found in this chapter. Question eight is slightly different in Italy than in all other countries.

In Austria, all questionnaires were sent in German to all experts. Further, all voice-interviews were in German. In Switzerland all experts, who replied and were prepared to give an interview, were German-speakers, for this reasons the interviews are all in German. In Italy, the experts had the choice if they want to answer in English or in Italian. All interviews were sent out in both languages. All Italian experts who gave written interviews, answered in Italian. The voice interview was in English.
5.2.1.2.a Questionnaire: PPPs in hospital construction in Switzerland

1. Which form of PPP (BOT, DBO ...) is, in the healthcare sector in Switzerland, the most common?

2. At which time PPPs play the most important role when hospitals are built?

3. Do you think PPPs play a more important role in Switzerland than in other countries? Why do you think this is the case?

4. Which are the most powerful companies that operate in the sector of building hospitals?

5. In Austria there are a lot of “critical” articles about private companies that operate in the healthcare sector. Do you think there is a threat that healthcare cannot be provided for everyone when too many companies are getting involved? Do you think they push only their own interests and not the interests of the clients of the hospitals?

6. Do you think that the involvement of private companies make the building of hospitals cheaper? What is your opinion about the cost of competition of different companies/companies and the government in this sector?

7. Do PPPs, in the health care sector, modernize the process of building hospitals? So, do you think the cooperation between a public and a private partner makes it more dynamic?

8. In Italy there is a strong concentration of PPPs in particular regions (big difference between the North and the South). Is there such a phenomenon also in Switzerland?

9. Which areas are the most profitable for private companies in the healthcare sector in Switzerland?
10. Which trend do you see for the future? Do you think private companies will play a more important role in the healthcare sector?

5.2.1.2.b Questionnaire: PPPs in hospital management in Italy

1. Which form of PPP (BOT, leasing…) is in the healthcare sector in Italy the most common?

2. In which services in hospitals you can find the most PPPs?

3. Do you think PPPs play a more important role in Italy than in other countries? Why do you think this is the case?

4. Which are the most powerful companies that operate in the sector of administrating hospitals?

5. In Austria there are a lot of “critical” articles about private companies that operate in the healthcare sector. Do you think there is a threat that healthcare cannot be provided for everyone when too many companies are getting involved? Do you think they push only their own interests and not the interests of the clients of the hospitals?

6. Do you think that the involvement of private companies make the services of hospitals cheaper? What is your opinion about the cost of competition of different companies/companies and the government in this sector?

7. Do PPPs in the health care sector modernize the administration? So, do you think the cooperation between a public and a private partner makes it more dynamic?

8. In Italy the healthcare system is strongly decentralized. What do you think is the effect on PPPs of this decentralization?
9. Which areas are the most profitable for private companies in the healthcare sector in Italy?

10. Which trend do you see for the future? Do you think private companies will play a more important role in the healthcare sector?

5.2.1.3. What is meant by experts

Mieg & Näf (2005) explain that no exact definition of the term “expert” exists. Many terms that have the same meaning (consultant, evaluator…) are used synonymous and the word is often transported from everyday language. The two authors further write that in sociology there are two possibilities to become an expert, these are a particular education (e.g. a university degree) or a particular position in an institution (company, authority, research institute…) that empowers to take part in decision-making processes. This approach was used for the present work.

The selection of experts has been done as per advice the University of Trier (2002) is advising it. Experts usually represent and have specific knowledge about particular organizations or institutions. To analyse the PPPs the experts have to work for a particular organization with a high reputation, the expert has to have a high reputation him- or herself and the expert has to have possibilities to take part in decision making processes. This gives the possibility to analyse different views from an important organization.

5.2.1.4. Carrying out the expert interviews

Before the interview, the experts were contacted personally or via E-Mail. In a short E-Mail the idea of the master thesis was explained. No details were hidden, all experts received all information that was known at this moment and all question were sent in advance. Further, all experts were informed why they were chosen for an interview. In general, the experts could choose between personal interview, an interview on the telephone and to fill out the questionnaire and send it via E-Mail.
5.2.1.4.a Interviews held personally or on the telephone
All interviews, which are held on the telephone or personally, were recorded with a Mac
Book and an iPhone or with two iPhones. All interviewees were informed before that the
interview will be recorded, they could decide when the recording starts. In some cases, it
was arranged beforehand which questions will be skipped. Some experts wanted to skip
the first question, but were answering other questions more in detail. Because, the experts
read the guideline before the interview some were answering more questions when the
third or the fourth was asked.

5.2.1.4.b Interviews answered via E-Mail
As, many experts have a full appointment calendar, it is a simplification measure to fill out
the questionnaire in Word and send it via E-Mail (Mieg & Näf, 2005). Further, it should be
said that the number of interviews, 18, is rather high. The answers of the experts are less
detailed when they answered written. So, interviews sent via E-Mail reduce the complexity
and the amount of information, the experts only answer strongly focusing on what is
asked.

5.2.1.5. Obtained data
The total amount of primary data for this paper is, as mentioned, 18 interviews. Five
interviews are spoken and 14 are written. The allocation between spoken and written
interviews is similar among the different countries.

To describe the PPPs in the Swiss health care system two spoken interviews are used.
One interviewee is an expert for the management of hospitals and the second is an expert
in the construction of hospitals. Four interview-partners gave written interviews about
hospital construction and one expert answered questions about managing hospitals.

For Austria, the obtained data is similar to Switzerland. One spoken interview for hospital
management and one the construction of hospitals is used to describe PPPs in Austria.
Four written interviews about the management of hospitals and one interview for
construction builds were used as primary data.
A one hour and 24 minutes long exhaustive spoken Interview dedicated to hospital management, one interview focused on hospital construction and four interviews for hospital management are all interviews used to investigate the PPPs in Italy.

5.2.1.6. Processing Data

These points are only important for the voice-interviews: The interviews that were sent via E-Mail can be evaluated directly. All interviews, which were recorded, were transcript. This was necessary, because for the summarising content analysis, which is used to evaluate the data, a written text is needed (Mayring 2015, p. 55). As, only the content of the interviews should be investigated, standard language is used and dialects were left out as far as possible (Kowal & O’Connell 2000, p. 441). All interviews are anonymised, which means no name of interview partners or institutions they belong to can be found in the paper. The transcription is done word-by-word and not summarized. Words that were not understood are marked with “(unint.)” for unintelligible. This system was used when the word was not understood acoustically and also when the content was not clear. If a word was not fully understood but it was rather clear what was meant, the word gets marked with a “?”.

In the transcript the Interviewer was marked with and “I” and the interviewee with a “B” (Kuckartz 2010, p. 44). The interviews were transcript in German, if they were held in German.

5.2.1.6.a Summarizing content analysis

To evaluate the primary data a summarizing content analysis was used. The interview transcripts should be reduced to an understandable short text. Further, the most important information in the written interviews should be filtered out. The texts should be short enough that they can be compared. The different options and mentioned facts of all experts should be compared and confronted with each other.

For this paper, all technical steps are equal to the explanations in Mayring (2015). This book was used during the whole evaluation as the basics to learn the technique. In pages 71 and 72 it is explained that the material, which should be analysed, has to be defined beforehand. Further, the question that should be answered by the material should be clear. Figure 12 explains step by step the modus operandi of the summarizing content analysis.
Paraphrasing (Mayring, 2015, p. 72; 2014, p. 66)

All text components, which are not content bearing, should be erased (e.g. explanatory expressions or beautifying phrases). After, the content-bearing parts of the text should be transformed to the same stylistic level. Further, all content bearing parts should be written in a form that is grammatically abbreviated.
Generalization to create the appropriate level of abstraction (Mayring, 2015, p. 72; 2014, p. 66)

A generalisation on the new level of abstraction has to be done, all old referents should be included in the new reformulated ones. Predicates should be generalized in the same way. Paraphrases that are already above the required level of abstraction should be undertaken as they are. Theoretical presuppositions should be used if some cases are not clear.

First reduction (Mayring, 2015, p. 72; 2014, p. 66)

All identical paraphrases should be erased. Further, paraphrases should be eliminated which are not contentment bearing anymore after bringing them on the new level of abstraction. All paraphrases are taken over that are essentially content bearing. Also during this step, theoretical presuppositions should be used if some cases are not clear.

Second reduction (Mayring, 2015, p. 72; 2014, p. 66)

Identical and similar statements should be merged to one paraphrase - Binding. The next steps are construction/integration. During this steps paraphrases with more statements about the same referent should be combined. In addition, paraphrases with differencing statements about the same referent should be combined. Theoretical presuppositions should be used if some cases are not clear.
For a deeper understanding an example for the first reduction is given:

<table>
<thead>
<tr>
<th>Case</th>
<th>page</th>
<th>Paraphrase</th>
<th>Generalization</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>125</td>
<td>P1: No psychological strain experienced through practice shock</td>
<td>No practice shock experienced as very enjoyable because</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P2: On the contrary, was very keen on teaching practice</td>
<td>Tended to look forward to teaching practice</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P3: University = purely academic course, little to do with teaching</td>
<td>At university teaching experience not part of course</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P4: Was able, however, to gather teaching experience beforehand</td>
<td>Prior experience of teaching</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P5: Practice was very enjoyable</td>
<td>Practice enjoyable</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P6: As far as subject matter was concerned, teaching was simple and fascinating for the students</td>
<td>Easily teachable subject matter as a condition</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P7: Had been waiting to begin teaching with some impatience</td>
<td>Had looked forward to starting to teach</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>125</td>
<td>P8: But there are some disappointments about pupils not being what one thinks they should be</td>
<td>Disappointments too</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>126</td>
<td>P9: Certainly not a practice shock</td>
<td>No practice shock</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>126</td>
<td>P10: Workload not so heavy (at most in a branch of a school)</td>
<td>Low workload</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>126</td>
<td>P11: Frustration of teacher at inner city school with possible discipline problems among students possible</td>
<td>Frustration of teacher at inner city school</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>126</td>
<td>P12: Own efforts compensated for by enjoyment of teaching</td>
<td>Found the work enjoyable</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>126</td>
<td>P13: Students still like me there</td>
<td>Had good relations to students</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>127</td>
<td>P14: Am too realistic to have had wrong ideas about teaching</td>
<td>No unrealistic expectations</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>127</td>
<td>P15: With 35 students and the amount of subject matter involved opportunity for educational work in any case low</td>
<td>Possibilities for educational work only low</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>127</td>
<td></td>
<td>K3: No practice shock, owing to flexibility, realistic attitude, adaptability and conversations with open colleagues</td>
<td></td>
</tr>
</tbody>
</table>

Table 7: The first reduction of the content analysis (Mayring, 2014, p. 70; 2015, p. 74 & 75)
Figure 14 charts the goal of the summarizing content analysis. The rectangle’s breadth represents the volume of material that should be analyses.

For all spoken interviews also a second reduction was used. The written interviews were investigated with one reduction.

![Diagram of the content analysis process]

**Figure 14:** Charted goal of the content analysis (Mayring, 2014, p. 78; 2015, p. 85)

In this paper the inductive category formation was used. The categories were created step by step from the primary data (Mayring, 2015, p. 85).

The following categories were built:

- Category A – Where are PPPs used the most often and in which form and
- Category B – Importance of PPPs in Switzerland/Austria/Italy
- Category C – Ideology
- Category D – Competition and modernisation
- Category E – Decentralisation
- Category F – Profitability
- Category G – Trends for the future
5.3. Analysis of primary data

All interviews will be presented firstly expert by expert, after all expert interviews are summarized. For all single-case analysis quotes of the transcripts are used, all quotes are in italics (Wachman 2010, p. 88).

Because, the same questionnaire was used for all countries the same categories could be built. The categories grant a fair comparison.

5.3.1. Public-private partnerships in Switzerland

Switzerland was the only country were category A and B was pooled. The reason is that the answers on all questions that category “A” contains cannot be understood by not giving the answer on category “B” beforehand.

5.3.1.1. Hospital construction

5.3.1.1.a Expert I Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Switzerland

By now, no PPPs exist in Switzerland in the healthcare sector. High transaction costs, the small project size (which causes a high autonomy) and the difficulty to merger hospitals to create larger project-sizes are reasons why no PPP-project was realized. The intact public budget is, according to Expert I Switzerland, the most important point.

Expert I Switzerland explains that rentals models, such as sale-and-leaseback-models\(^4\), are the most likely to be realized. The early phases of the SIA are the most important when a PPP should be started.

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\(^4\) An asset is sold to a finance company. Afterwards, this asset is immediately leased back. So, the seller and the lessee is the same party factually and nominally (usually two parties are involved in such a contract) (Statistics Finland).
Es gibt in der Schweiz diese SIA das ist eine Norm 112, das sind die Phasen von Projekten definiert. (...) die Anbahnung von PPPs spielt vor allem in der Phase eins und zwei, eben in der strategischen Planung, und in der Vorstudienphase sicherlich die größte Rolle. (...) Wenn man sich dann für PPP entscheidet eben dann spielt PPP über den gesamten Lebenszyklus dann eine Rolle: Baubetrieb, Planung, Erhaltung.»

Expert I Switzerland (2015, p. 1)

(ii) Category D – Competition and modernisation

The advantages of private companies that operate in sector of construction are individual regulations for each project instead of norms. The construction time could be cut.

“(…) die Bauzeiten sind fast um 50% reduziert geworden weil wir als Private natürlich ein Interesse daran gehabt haben das die Autobahn so schnell wie möglich in vollem Betrieb ist. Weil wir natürlich an der Verkehrsmenge partizipiert haben.”

Expert I Switzerland (2015, p. 5)

The costs for contract initiation are not higher than in conventional contracting. The costs of competition are not important, the crucial point is if the synergy gains are higher than the cost of financing.

“(…) die Kosten für den Wettbewerb, (...) nicht das die höher sind, weil da müsste wenn man die Kosten des Wettbewerbs vergleicht, zwischen PPP und der Standardvergabe, müsste man die Kosten für diese einmalige Vertragsanbahnung vom PPP nehmen, die natürlich zugegeben sehr sehr hoch sind, und dann vergleichen mit der Summe aller Vertragsanbahnungskosten dem konventionellen Gegenüberstehen für den Zeitraum der 30 Jahre sprich: Jede Ausschreibung für Reinigung, jede Ausschreibung für Erhaltungsmaßnahmen, die klassische Bauausschreibung

Engl.: In Switzerland the SIA exists, it is a norm 112, where phases of projects are defined. (...) for the initiation of PPPs phase one and two (strategic planning and preliminary studies) play the most important role. (...) After, it was decided that a PPP-project is realized, PPP play a role over the whole life cycle: building operation, planning and preservation (own translation).

Engl.: The construction time was reduced by nearly 50%, because we as a the private had interest to put the motorway as fast as possible in operation. The reason was that we were profiting from a high traffic volume (own translation).
(...) wenn man diese Summe nimmt glaube ich dass die Transaktionskosten der Konventionellen höher sind. Was allerdings sicher so ist, dass die Finanzierungskosten bei PPPs viel höher sind als bei der konventionellen Vergabe und da liebt dann aus meiner Sicht der Knackpunkt ob die Synergievorteile um so viel höher sind dass man die höheren Finanzierungskosten (...)"7

Expert I Switzerland (2015, p. 5)

Because, a backlog of innovation is caught up when the private participate in construction of infrastructure, a process of modernization takes place.

(iii) Category E – Decentralisation

The autonomy in Switzerland is very high. Also the social insurance system is strongly decentralized. Also, private insurance is operated in this field to a large extent. But, there are particular regulations.

(iv) Category G – Trends for the future

PPPs will be more likely in larger cantons that already have gained experience in PPP projects. In the future, more privately financed medium and long-term life cycle orientated project will be realized in Switzerland. Pension funds that are financed by foundations are strongly interested in infrastructure projects, because government bonds achieve a negative return – this is a chance for the hospital sector. Further, a Swiss PPP model will be created.

7 Engl.: (...) the cost of competition, (...) are not higher, because the cost of competition would have been compared between PPP and standard contracting, the costs of contract initiation of the PPP, which are admittedly very high, have to be taken into account and then compared with the total amount of all contract initiation costs of standard contracting over 30 years: All tenders for cleaning, all tenders for maintenance, the classical tender for building (...), when all these costs are summed up then the transaction costs of standard contracting are higher. But, what is clear is that the financing costs for PPPs are higher than for standard contracting, and here is the core issue if the synergy gains are higher than the financing costs (own translation).
5.3.1.1.b Expert II Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Switzerland

There are no PPPs in the hospitals sector in Switzerland. The direct democracy is one reason why PPPs are difficult to realize. Because of the LCC\(^8\)-notion, which is the basic of PPPs, PPPs have to be born in mind during the planning phase.

(ii) Category D – Competition and modernisation

There is a high cost pressure in the healthcare sector, but the cost pressure is in other countries is similar. The flat-rate payments are often not enough. The potential for a higher efficiency is higher with the “right” partner. Prequalification and evaluation criteria (weighting included) are very important in competition to find the “right” partner. But, the government also has a high potential for efficiency itself with the right management. In this case, the external view is often missing to use this potential.

“Bei einer guten internen Organisation, auf den Betrieb abgestimmten Bauweise sowie auf die Bedürfnisse des Patienten und Mitarbeiters (interne und extern Nutzer) abgestimmten Prozesse lassen sich die Effizienzpotentiale nat, auch ohne externen Partner erreichen.”\(^9\)

Expert II Switzerland (2015, p. 2)

(iii) Category G – Trends for the future

The development of PPP in Switzerland will be slow, because the direct democracy will also create additional barriers in the future. Many PPP-projects are not realized because of this problem.

\(^8\) LCC = Life Cycle Costing (Günther)

\(^9\) With a good internal organization, an appropriate construction style and processes that are adapted to patients and employees (internal and external users) efficiency potentials can also be gained without and external partner (own translation).
5.3.1.1.c Expert III Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Switzerland

There are no PPPs, and PPPs will also not become a trend. The refinancing is based on a system of financial and fiscal federalism. For this reason, barely available funding does not play a role. PPPs are registered in the bookkeeping of the government as financial leasing. So, PPPs compete with other financial leasing-models.

(ii) Category D – Competition and modernisation

Besides a healthcare system on a high level, also private suppliers exist. Private players increase efficiency in two different ways. Indications exist that private suppliers work more efficiently. Further, also the government tries to improve its efficiency because of growing competition and financial pressure. Additionally, the main driver of modernization is the competition for patients.

"Es gibt Hinweise darauf, das [sic] private Anbieter effizienter sind. Allerdings führt der wachsende Wettbewerb und der Druck auf die öffentlichen Finanzen auch im öffentlichen Bereich zu einer Effizienzsteigerung."\(^\text{10}\)

Expert III (2015, p. 4)

(iii) Category G – Trends for the future

The direct democracy audits the efficiency gains of PPPs. The government has experience in doing infrastructure projects.

\(^{10}\) Engl.: There is evidence that private suppliers work more efficient. But, the growing competition and the pressure on public finance also causes efficiency gains (own translation).
5.3.1.1.d Expert IV Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Switzerland

There are no PPPs in the hospital sector, not even investment projects (private engagement in financing without operations). When hospitals are built various realization methods are seldom checked in the early phases.

(ii) Category C – Ideology

PPPs are only about technical and operational performance, so the expert has the ideological view. The situation would be very different when the core service of a hospital would be privatized.

(iii) Category D – Competition and modernisation

According to Expert IV Switzerland, many studies show PPPs can increase efficiency. PPPs also cause high transaction costs. Feasibility studies prove if the potential for efficiency exceed the transaction costs significantly.

(iv) Category G – Trends for the future

The methodology and values of PPP (life cycle approach, systematic implementation, variant comparison, sharing of risks with the private sector, feasibility studies, and private engagement) will continue to develop and mix with the development of "classical" approaches in construction and facility management.

Few, PPPs according to the international approach, are going to exist in the future. But, pragmatic PPP attempts will appear further in various areas.
5.3.1.2. Hospital management

5.3.1.2.a Expert V Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Switzerland

There are no PPPs in the healthcare sector in Switzerland. Eventually, medical technology and real estate could be a topic for PPPs. According to Expert V Switzerland, the intact public finance, the fact that the government views PPPs as an act of desperation and a good access to gain new credits are important points why no healthcare PPPs were realized.

“Also, ja in der Schweiz werden PPP-Modelle von der öffentlichen Seite her, ich sag mal, als Verzweiflungstaten angeschaut. Und dann wenn man wirklich kein Geld mehr hat, oder wirklich nicht mehr weiter weiß, (...), dann wird man sich ein PPP noch überlegen sonst keines Falls, (...) dass Macht verloren geht und die Ausübung von Macht spielt im öffentlichen Sektor eine sehr große Rolle (...) und wir haben im Moment nicht so schwierige Finanzierungsverhältnisse, dass dieses Problem schon so groß wäre, dass es nötig wäre Macht abzugeben.”

Expert V Switzerland (2015, p. 10)

(ii) Category D – Competition and modernisation

In Switzerland a sharp distinction between the public and the private can be found. Hirslanden and Genolier are the biggest players in the private sector. Inpatient treatment is paid by the health insurance in both private and public hospitals.

11 Engl.: In Switzerland PPP-models are seen as an act of desperation by the government. Only when there is really no money left or when no other solution can be found, then PPPs are taken into account. (...) that power gets lost and exercise plays a huge role in the public sector (...) and at the moment the financial situation is not so difficult that it would be necessary to pass over power (own translation).
“(…) wir haben eigentlich bei uns eine ziemlich scharfe Trennung zwischen öffentlichen Spitälern und privaten Spitälern. Es gibt (…) kein öffentlich finanziertes Spital, das von einem Privaten gemanagt wird.”\(^{12}\)

Expert V Switzerland (2015, p. 11)

“(…) gut ein Drittel der gesamten stationären und ambulanten Leistungen, (…), wird von Privaten erbracht (…)”\(^{13}\)

Expert V Switzerland (2015, p. 11)

The expert also describes the Austrian and German system: The budgeting of the government is based on costs, so efficiency does not get rewarded. Competition does not cause costs. But, regulation is expensive and highly regulated systems do not work profitable. Because, the healthcare system is highly regulated the participation of private players is not visible.

“(…) insofern ich das österreichische System verstanden habe (…) man kann gar nicht von Markt oder Wettbewerb oder solchen Dingen sprechen. Das ist ja alles brutal zureguliert. (…) Viele Kalkulationen basieren darauf wie viele Kosten haben Sie, und bei höherer Effizienz gehen ja die Kosten runter und man muss da immer mitrechnen dass nicht Ihre Marge steigt, sondern dass die Vergütung revidiert wird.”\(^{14}\)

Expert V Switzerland (2015, p. 12)

80% of all hospitals in Switzerland are “more than modern”, e. g. Switzerland has an overstock of real estate. Private players were not necessary for this development. There could be small hospitals that could experience some modernization, if more private players would participate.

\(^{12}\) Engl.: (...) we have a strict separation between private and public hospitals. There is (...) no publicly financed hospital that is managed by a private player (own translation).

\(^{13}\) Engl.: (...) around on third of all inpatient and outpatient services (…), are provided by private players (…) (own translation).

\(^{14}\) Engl.: (...) as far as I understood, in the Austrian system (...) it is not possible to talk about market or competition or such kind of things. There is everything extremely overregulated (...) Many calculations are based on the costs, and if the efficiency is higher than the costs decline, here it always has to be considered that not the margin is raising, but the compensation is reduced (own translation).
(iii) Category F - Profitability
The most profitable areas for the healthcare sector are delivery (pharmaceuticals and medical technology), private psychiatric hospitals and rehabilitation.

(iv) Category G – Trends for the future
No forecast can be done, in which areas of Switzerland are more likely to be realized. There are many projects that are named “PPP”, which are not PPPs. In the West of Switzerland the people believe more strongly in the government than in the East. The financial situation is in the West better then in the East, but this is compensated yearly by the fiscal equalization scheme.

There are no PPPs in prospect!

5.3.1.2.b Expert VI Switzerland

(i) Category A – Where are PPPs used the most often and in which form and Category B – Importance of PPPs in Italy
99% of all hospitals are legally independent institutions. Further, Expert VI Switzerland stated that 70% of all hospitals are owned by the cantons and 30% are privately owned. The expert does not know any hospital with an outsourced management, hospitals manage themselves. But, support services, such as laboratory, radiology and cleaning, are outsourced in public and private hospitals.

(ii) Category C – Ideology
All public and private players, which are part of the social insurance, cannot refuse any patients, otherwise they lose the permission for their business. There is also a discussion that private hospitals prefer patients with a private insurance. There are no problems with queuing time, especially not in case of emergencies.
(iii) Category D – Competition and modernisation
There is a competition for patients between private and public hospitals, because every patient can choose the hospital freely. Competition has a positive effect on modernization. The largest private suppliers of private healthcare are Hirslanden and Galonier.

“Es gibt in der Schweiz keine Krankenhausmanagement-Gesellschaften.”
Expert VI Switzerland (2015, p. 200)

(iv) Category F – Profitability
The expert explains that orthopaedics, cardiology, radiologic investigations and ophthalmology are profitable areas. But, the remuneration system changes annually.

(v) Category G – Trends for the future
The structure of supply, between public and private players, is not going to change on a large scale. Public and private hospitals are investing and have an intact financial standing.

5.3.2. Public-private partnerships in Austria

5.3.2.1. Hospital construction

5.3.2.1.a Expert I Austria

(i) Category A – Where are PPPs used the most often and in which form
The expert mentioned that the hospitals “Wien Nord” was planned as a PPP, but was never realized as a partnership. Design, build and operate are integrated in the tendering process, this is important for an inexpensive provision.

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15 There are no hospital management companies in Switzerland.
(ii) Category D – Competition and modernisation

In Austria there is a lack of competition in the area of design, build and operate. VAMED is dominant in PPPs in Austria in the health care sector. Hospitals are in general a complicated field for competition. This is an important point, because only competition and not monopoly can create higher efficiency.

The construction of a hospital is beneficial for a private company, because a lead in knowledge is created. For this reason, it is easier to outsource the management as well.

When authorities are properly controlled, they could also work more efficiently. But, according to Expert I Austria, this does not take place in Austria. Reformations would be necessary for improvement, but for example unions are a problem.

The authorities in Austria do not set incentives for a high performance.

“(...) weil die im Wettbewerb miteinander stehen, (...), und effizient sein müssen, (...), und die Behörden das nicht sind.”16

Expert I Austria (2015, p. 21)

“(...), es ist natürlich auch möglich dass Behörden effizienter arbeiten, wenn man die entsprechend kontrolliert, nur das habe ich in Österreich bisher noch nicht gefunden, dass das gemacht wird. Es reicht nicht, dass der Rechnungshof mal ab und zu schaut ob die richtig Buchhaltung machen, es recht nicht den Staatsbetrieben einen Gewinnerzielungsauftrag zu geben. Das ist keine richtig verstandene Kontrolle von Staatsbetrieben.”17

Expert I Austria (2015, p. 21 & 22)

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16 Engl.: (...) because they compete with each other, (...) and have to efficient (...), this is what authorities are not (own translation).

17 Engl.: It is also possible that authorities work more efficient, if they get controlled appropriately, but this is not the case in Austria. It is not enough that the Court of Auditors checks they way they do book-keeping, it is not enough to give authorities an order to make profit. This is not appropriate form of monitoring from public companies (own translation).
Very high liabilities are also an important topic, because they have to be paid by the government. The costs of PPPs are very high and for this reason PPPs a particular project size is needed. Further, a lot of particular knowledge is needed as well.

(iii) **Category G – Trends for the future**
No big driving forces can be seen for PPPs in the next five to ten years, one reason is that private players do not show a very high interest.

5.3.2.1.b  **Expert II Austria**

(i) **Category D – Competition and modernisation**
PPPs make the public projects more expensive, but there is a “trick”. PPPs support the government to keep the it`s debt on the same level, because the private partner finances the project. The government rents the facility then back for an infinite time.

The participation of private partner increases efficiency, but does not boost modernisation. Possibly, also the government could work more efficiently.

The costs of competition are very high. Those costs increase the overall costs.

(ii) **Category G – Trends for the future**
Optimistic approach: Democratic processes strengthen and the disadvantages of PPP models are shown more openly.

Pessimistic approach: Capital continues to grow.

18 Engl.: (...) I don’t know any union in the public sector that is fighting for a performance-related payment, the remuneration of innovation etc..
“Der optimistische Ansatz wäre, dass sich demokratische Prozesse verstärken und somit die Nachteile von PPP-Modelle offener dargestellt werden, wodurch letztlich die öffentliche Hand wieder öffentliche Funktionen übernehmen wird müssen statt sich immer weiter zurückzuziehen (Gesundheitswesen, Wasser-, Energieversorgung,...). Der pessimistische Ansatz: Das „Kapital“ wächst weiter und bestimmt die Medien- und Politiklandschaft...”

Expert II (2015, p. 12)

5.3.2.2. Hospital Management

5.3.2.2.a Expert II Austria

(i) Category A – Where are PPPs used the most often and in which form

The frequency of particular PPP-models is determined by nomenclature. The most common “PPP”-models in Austria are evolved leasing models (classic contract models in basic hospitals). Leasing, which is not very different from PPPs, is known in the Austrian health care sector since the 70s. There are system partnerships, which are PPPs. In those partnerships the private partner provides personnel and equipment.

“(…) Systempartnerschaftsmodelle, (…), bildgebende, (…), Geräte oder auch im Labour von den entsprechenden Firmen hineingestellt werden, und dass sozusagen auch das Personal zu der privaten Firma gehört, und auch im Krankenhaus sozusagen physisch anwesend (…) wie es in einem Krankenhaus oft eine Trafik oder Ankerfiliale unten gibt, ist es klar dass bei der Anker Filiale die Brotbackmaschine und die Angestellten zu der Firma Anker gehören.”

Expert III Austria (2015, p. 244)

\[19\] Engl.: The optimistic approach would be that democratic processes strengthen and that disadvantages of PPPs are shown more openly, which would show that the government has to perceive tasks, (health, water, energy...), instead of retreat further.

The pessimistic approach: The "capital" continues to grow and determines the media and political landscape... (own translation).

\[20\] Engl.: (...) system partnerships-models, (…), imaging, (…), devices or services for the laboratory are provided by private companies, also the personnel belong to the private company and is physically present (…) like there is a tobacconist or an “Anker”- branch in the hospital in the ground floor, there it is clear that the bread oven and the personnel belongs to Anker (own translation).
For the hospital of Oberndorf a form of PPP, which goes far beyond a classical PPP was used.

„Etwas anders und kompliziert zu erklären ist die Situation im Krankenhaus Oberndorf, wo die VAMED ein Gemeindespital, (…), sozusagen quasi irgendwie mitorganisiert, (…). Das ist sozusagen so ein Deal wo Akutversorgung und Anschlussrehabilitation auf einem Gelände stattfinden, und wo zum Teil auch niedergelassene Ärzte im Konzept drinnen sind. “

[Expert III Austria (2015, p. 244)]

In Austria, PPPs can be found often in facility management and maintenance. In these areas, PPPs are used since the 70s. PPPs are not used in acute care, because Austria does not have experience with PPPs in this field, and experience plays a huge role. Further, all areas except of acute care are plan- and calculable, which is very important for private companies.

PPPs are more often used in Austria for rehabilitation facilities than for hospitals.

All areas, except of inpatient care, offer possibility for private players, but there is a high competition. Additionally, the Medical Association opposes because it does not advocate the pursuit of profit in the health care sector.

(ii) Category C – Ideology

PPPs and a public system with a supply mandate are not a contradiction. For this reason, the penetration rate will not change because of PPPs, even if there are discussions about disease that gain more and less profit.

The ideological view about private players in the healthcare system can be different. It is possible to maintain that the pursuit of profit cannot be combined with healthcare. But, it can also be argued that the private companies work more economic and private companies can teach the government a lot about personnel management.

[21 Eng.: Something different and difficult to explain is the situation in Oberndorf, where VAMED participates in the organisation of a local hospital, (…). This is a deal where acute care and follow-up rehabilitation is taking place on the same site, and also established doctors are included in the concept (own translation).]
Ideological debates are done with great passion and little evidence. But, at the moment we have no results about the value for money of PPPs, because the projects are not over.

"Diese Evidenz fehlt derzeit."22

Expert III Austria

(iii) Category D – Competition and modernisation

PPPs support the government to bypass new public debt, but the participation of private companies causes an upward cost drift. The expert explains why:

„PPP-Modelle sind aber von der Konzeption her sehr teuer man braucht Rechtsanwälte, man braucht Finanzexperten (...) was dazu geführt hat dass viele Klein- und Mittelunternehmen die in England angetreten sind bei PPP-Ausschreibungen quasi in den Konkurs getrieben worden sind, durch die extremen Vorlaufkosten, und da sind mittlerweile nur mehr wenige Große um derartige Aufträge bewerben im Vereinigten Königreich, was dazu führt dass aus einem schillernden bunten Markt wo viele potentielle Anbieter sich tummeln, erm, quasi ein Oligopol oder fast ein Monopol geworden ist. (...) Deshalb war eine Zeit lang die Idee dass man denen die anbieten eine Entschädigung zahlt, auch wenn sie den Zuschlag nicht bekommen. (...), das bedeutet aber man hat es mit erheblichen Kosten zu tun, wenn man auch Entschädigungszahlungen hat. (...), wenn man Monopole oder Oligopole zulässt, dann ist klar dass die irgendwann den Preis diktieren können."23

Expert III Austria (2015, pp. 250 & 251)

22 Engl.: This evidence is currently missing (own translation).

23 Engl.: The conception of PPPs is very expensive lawyers, financial experts are needed (...) this was the reason why many small and medium enterprises in England went into bankruptcy, because of taking part in a PPP- tendering process. Because of the high preproduction costs only large companies applied. As a result, a monopoly or an oligopoly was created instead of a colourful market. (...) For some time, there was the idea that all companies who did not get the PPP-contract receive compensation. But, this means PPPs are correlated with very high costs when the government also has to compensate. (...) If the creation of monopolies and oligopolies is allowed it is clear that they will start to dictate the price (own translation).
The costs of competition are difficult to determine. With the right contracts PPPs can be highly innovative and can enable modernisation. Further, quality advantages can be gained.

An important point is also the problem when companies go bankrupt.

“(…) das ist am Ende aller Konflikte immer das riesen Problem. (…), weil Firmen können in Konkurs gehen und können verschwinden von der Bildfläche und Staaten verschwinden nicht so einfach von der Bildfläche. Das heißt was wir häufig in den Verträgen findet ist, dass, (…), große Firmen, (…), in diese PPP-Modelle quasi Tochterfirmen hineinschicken. Das ist die berühmte GesmbH und Co KG Lösung, (…), dass die Mutter für die Tochter haftet die sie hineinschickt, aber wenn dann die Mutter finanziell ins Schwanken kommt, dann hilft aller nix mehr, dann ist wieder der Steuerzahler dran.”

Expert III Austria (2015, pp. 250 & 251)

(iv) Category E – Decentralisation

There is no geographic concentration of PPPs in Austria. So the frequency of appearance of PPPs is not connected to geographic issues, but to carriers. Social security institutions, which are close to the People’s Party (ÖVP), more frequently tend to implement more PPPs than social security institutions, which are close to the Social Democratic Party (SPÖ). But, such decisions depend also on particular people, a city councillor that belongs to the Social Democratic Party created the plans for “Wien Nord”.

(v) Category F – Profitability

Expert III Austria explains that the highest profit can be gained with activities outside of the area of public utility and where the financing structures are lucrative, which is the reason why e. g. private oncological facilities or long-term care of psychiatric patients are rare. Further, areas with a higher standardization are more profitable, such as knees and hips care.

24 Engl.: This is at the end always a big issue. (…) Because, companies can go bankrupt and can disappear, government do not disappear so easily. This is what we often find in contracts that, (…), large companies, (…), send subsidiaries in PPP-models. This is the famous GesmbH & Co KG solution, (…) the mother company bears the liabilities for the subsidiary, but when also the mother company has serious financial problems, then the taxpayer has to bear these liabilities (own translation).
(vi) Category G – Trends for the future
In the future PPPs will disguise, because of their bad image. Further, companies, such as Siemens Healthcare and General Electrics, do not only provide equipment, but also operational services. In this way, those companies will penetrate to the core area of the Austrian healthcare system. IBM also provides process optimization, only offering hard-and software is not enough. So, a trend in the future can be that companies also provide equipment, software, personnel, so, in a nutshell, an overall process optimization.

5.3.2.2.b Expert IV Austria

(i) Category A – Where are PPPs used the most often and in which form
The best chances for PPPs are in areas that can be overhanded easily, but the government wants to keep influence.

(ii) Category B – Importance of PPPs in Italy
Other EU-countries, such as Spain and England use more PPPs, especially in the construction of hospitals.

(iii) Category D – Competition and modernisation
The efficiency rises when private companies participate. The cost of competition is not an agenda.

(iv) Category E – Decentralisation
In Austria there is no concentration of PPPs in particular areas.

(v) Category F – Profitability
The fields where the highest profit can be gained are those, which do not belong to the core areas, such as cleaning, laundry and sterilisation.

(vi) Category G – Trends for the future
There will be a slight increase in PPPs in the future.
(i) Category A – Where are PPPs used the most often and in which form
The Kooperationsmodell\(^{25}\) is used the most often, because not much power has to be passed over to the private partner. The most PPP-models can be found in service areas, so the government can focus on the core area.

(ii) Category B – Importance of PPPs in Italy
PPPs are more important in Austria than in other countries, because the public debt of Austria is very high.

(iii) Category C – Ideology
Private companies are focused on maximising of their profit, but they also work more economic. The alternative to privatization is the foundation of legal entities such as GmbH or AG. An example is GESPAG that put managers of private companies in decision-making functions.

(iv) Category D – Competition and modernisation and Category E – Decentralisation
Competition is positive, it is not possible that the cost of competition are very high. The consumer/patient saves money because of competition. Further, competition optimizes the structure of organisation, makes ranges of service shorter and decision-making processes faster.

In Austria phenomena of concentration cannot be found. All federal provinces gained experience in doing PPPs or work on starting PPPs. Each year the federal states have to deal with losses. The federal provinces determine business policy for hospitals and they do not want to privatize hospitals. Because of dropping financial possibilities, a modern

\(^{25}\) Schrefel & Hajsan (2005, p. 11) explain that when this model is used a co-operation vehicle is built for a particular project. This company has public and private owners (the principal owner is usually the government) and this company is usually responsible for financing, planning and construction of the facility. Operation and maintained is done usually by another utility company.
infrastructure cannot be hold up without the participation of private players. Private companies and investors secure the quality in Austrian hospitals. Next to PPPs, privatization is the best other alternative.

„(...), weil das österreichische Krankenhauswesen, wie in allen anderen Ländern auch, stark defizitär ist. (...). Gleichzeitig ist aber dieser Bereich der einzige, in dem die Landeshauptleute noch das fast uneingeschränkte „Sagen“ haben, das sie auch nicht aufgeben wollen! – Deshalb halten sie an Ihren Kliniken fest und Privatisieren nicht in dem Maße, wie es vergleichsweise oft in Deutschland der Fall ist. “26

Expert V (2015, p. 195)

(v) Category F – Profitability
The highest profitability can be achieved with medical service features.

(vi) Category G – Trends for the future
Growing health care costs, inaction, perhaps even helplessness of politicians and the dependent managers in hospitals, coupled with constant change in policy and the following power games are chances for PPPs to grow. Changes in the healthcare sector have to be adapted for over 30 years to be successful.

5.3.2.2.d Expert VI

(i) Category A – Where are PPPs used the most often and in which form
According to Expert V PPPs can be found the most often in planning, financing, construction of hospitals, particular services, kitchen, laundries and laboratory activities.

26 Eng.: (…) because the Austrian hospital sector, such as all other countries, is heavily in deficit. (...). At the same time, the hospital sector is the only area in which the governors determine quasi alone the business policy, and they want to keep this power! For this reason, hospitals are not getting privatized to the same extent as in Germany (own translation).
(ii) Category B – Importance of PPPs in Italy

PPPs are in Austria less important than in other countries because of the financing structure. There is a rather clear separation between public and private hospitals, PPPs create only little overlap and can be found more often in spa and rehabilitation centres.

(iii) Category C – Ideology

The health and hospital sector is a public duty, so privatization trends should be rejected. Only a public system guarantees healthcare for all citizens. Even if private companies work more efficient a public system should be preferred. The main goal should be to improve quality and the patient/human should be in the main focus.

There are sensitive ethical issues when it comes to discussions about expensive drugs and machines.

In the further development of the health system people have their needs and not costs should be in the focus.

“Bei der Weiterentwicklung des Gesundheitssystems muss der Mensch mit seinen Bedürfnissen und nicht als Kostenfaktor im Mittelpunkt stehen.”27

Expert VI Austria (2015, p. 197)

(iv) Category D – Competition and modernisation

Efficiency should not be equalized with the highest profit for private companies and investors, it should aim to guarantee economical healthcare treatment for all social classes. The financial and personal resources should be provided by the public sector, all social classes should participate to gain the financial resources.

“In diesem Zusammenhang ist (...) die solidarische Finanzierung des Systems nur durch eine gleichmäßige Beteiligung aller Bevölkerungsgruppen zu gewährleisten.”28

27 Engl.: For further development in the health system, the human being with its need, and not with it’s costs, should be in the center (own translation).

28 Engl.: In this context, (...) a solidarity-based funding system can only be granted when all section of the population participate equally (own translation).
In the healthcare sector 60-70% of all costs are personnel costs, for this reason a higher efficiency can mean a higher pressure on wages.

The competition between government and private companies has negative effects. There are financial losses for health insurances and hospitals, and higher out of the pocket payments for patients when the governments hands over duties to private players.

There are no PPPs needed to use new technologies in hospitals.

5.3.2.2.e Expert VII Austria

(i) Category A – Where are PPPs used the most often and in which form
There are few PPPs, but subsidiaries, outsourcing and leasing can be found more often. PPPs play the most important role in sterile cleaning services and meals.

(ii) Category B – Importance of PPPs in Austria
There is a large distrust to external partners. So, PPPs are not very important in Austria.

„Nein! Grosses Misstrauen gegenüber externen Partnern“

Expert VII Austria (2015, p. 199)

(iii) Category D – Competition and modernisation
Competition and private incentives can gain funds, which would be otherwise used elsewhere. The expert believes in the regulated market and also does not see high costs of competition. Further, the expert stated that the cooperation between government and private enterprises pushes modernisation.

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29 Engl.: No! Large distrust towards external partners (own translation).
(iv) Category E – Decentralisation
According to the experts feeling, there could be a concentration of PPPs in Vorarlberg, there are well-functioning projects since a long time.

(v) Category F – Profitability
Hospitals that provide long-term commitments, because of a high demand (demographic change…), and ensure an appropriate interest gain the highest profit for private hospitals.

(vi) Category G – Trends for the future
There will be a rising interest in PPPs in the healthcare sector in the next years, reasons are the increasing challenges of pension funds and life insurers. Capital providers and suppliers of infrastructure will secure their markets with PPPs.

5.3.3. Public-private partnerships in Italy

5.3.3.1. Hospital construction

5.3.3.1.a Expert I Italy

(i) Category A – Where are PPPs used the most often and in which form
Expert I Italy explains that the PPP-model, which is the most often used in the hospital sector is D.B.O.S.L.T\(^{30}\).

PPPs play the most important role in three processes:
- Design (provided by private promoters)
- Construction (by the construction company)
- Management of additional services (by companies who participate in the PPP)

\(^{30}\)D.B.O.S.L.T = Design - Build - Operate - Subsidize - Lease – Transfer
Vrontis et al (2014, p. 110) explain that the project is realised and managed by the government. A periodic fee is paid to the dealer.
(ii) Category B – Importance of PPPs in Italy

PPPs were growing fast in Italy, lately. Firstly, a late start enables a fast growth. Secondly, the infrastructure is rare and out-dated. Thirdly, the public debt is very high, for this reason, there is a shortage of resources for investments.

“In questi anni, in Italia, le PPP, soprattutto nel settore sanitario, sono cresciute molto rispetto ad altri paesi.”\(^{31}\)

Expert I, Italy (2015, p 23)

(iii) Category D – Competition and modernisation

A lack of competition is the main problem, only 1.5 firms contribute to the tendering process, this worsens quality, service and diversity. The construction of hospitals is getting more expensive when PPPs are used and a lack of competition is a factor.

“Il PPP, in Italia, anche grazie alla scarsa concorrenza, ha fatto lievitare i costi di realizzazione.”\(^{32}\)

Expert I, Italy (2015, p 24)

The competition is not taking part between private and public players, but between the different steps of the PPP.

PPPs have a positive effect on modernization, the root of this effect is the shared risk.

(iv) Category E – Decentralisation

The PPP-sector is strongly decentralized. Regulation, feasibility studies and discussions are taking place on a regional level. For this reason, the success of PPPs is not equal in the different regions.

\(^{31}\) Engl.: In these years, PPPs, in Italy, especially in the healthcare sector, grew fast in comparison to other countries (own translation).

\(^{32}\) Engl.: PPPs, in Italy, created higher costs of implementation, also because of a lack of competition (own translation).
According to Expert I Italy, non-core services, such as laundry, maintenance, heat management and canteen. The revenues, which are added on the profit margins, are stable and there are no obvious risks.

(vi) Category G – Trends for the future

PPPs will grow in the healthcare sector, in construction and in management. Modernisation, development and the need for investments are important factors that will demand PPPs especially in information services, energy services and heat management.

5.3.3.2. Hospital management

5.3.3.2.a Expert II Italy

(i) Category A – Where are PPPs used the most often and in which form

BOT is the most common form of PPP for infrastructure. Leasing can be often found for expensive technology. There are cases where the technology is provided for free, but the material has to be bought for a long time from the same company, so the cost of the material covers the cost of the technology.

Sperimentazioni gestionali, which was used first in Lombardy, is another type of PPP: Italy counts 80 PPPs of this type. In Italy there is a law that hospitals which are smaller than 120 beds, have to be closed, sperimentazioni gestionali hinder the closing of small hospitals.

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33 Engl.: For this reason, PPPs work better, in every case, in regions that work more efficient and more flexible with payment deadlines, more contents and particular rules (own translation).
“(…) there is another type of partnership (…) sperimentazioni gestionali is the name in Italian. (…) a public hospital gives to a private institution, a private cooperation, (…), a piece of the hospital. (…) in Italy the hospital is made out of more hospital. (…) it has seven hospital and they give one hospital, mostly the more little one, to a private cooperation and they, (…), transform this hospital from a generalist to something like a rehabilitation centre (…) Or to a diagnostic centre. (…) in Italy there is a law: When a hospital has less than 120, (…), beds you have to close this hospital, but it is not so easy to close, because the person who live in this area, do not want that this hospital closes. Because, they have to go in another area to have some care. So, the hospital that is public give [sic] this to a private cooperation. So, that the private cooperation has (…) The responsibility to turn to change the hospital, not to close the hospital… (…) all the problems with the community is [sic] managed by the private cooperation.”

Expert II Italy (2015, pp. 40 & 41)

Further, PPPs can be found in services, such as canteen, laundry, and cleaning. Those services can be organised as PPP or as outsourcing.

Expert II Italy also explains that it is possible that a private company reconstructs a particular area within a healthcare facility, after the area is still owned by the government. This is also a form of PPP.

“This is more like an outsourcing, yes. But, sometimes it is also something like a partnership. This is the case of the mensa [sic]. You give this part of the hospital to a private company. This company will restructure the place and will buy all [sic] what you need to have lunch: Table, oven – all [sic] what you need. You use this form of a convention to restructure. The place remains to the government.”

Expert II Italy (2015, p. 43)

The areas in which PPPs are the most common are building, transforming hospitals in a rehabilitation centre or a diagnostic centre and buying expensive technology

(ii) Category B – Importance of PPPs in Italy

In Italy the second most PPPs (in all areas) can be found in Europe. PPPs found money for investments.
“Yes, generally it is the second one. I think PPPs are often used, because the public cannot fund money to do investments. In the last year, we (...) had a sort of crisis. So, there is not a lot of money to do new investments in healthcare. Public hospitals do not have the money to buy expensive technology, they do not have the money to build new hospitals. So, we used a lot of PPPs to gain money to do this investment. I think this is the most important reason why we do PPPs.”

Expert II Italy (2015, p. 45)

(iii) Category D – Competition and modernisation

For private players it is easier to fire and displace workers and to require a higher productivity, so the management of workers is more flexible. Expert II Italy thinks that sperimentazioni gestionali where mainly created to manage workers.

If PPPs would be not needed, it would be cheaper. PPPs are used for very difficult operations, such as conversing hospitals. The public is very lame and not able to manage financial returns.

“Yes, it would be cheaper. But, I think another reason why PPP is done, is because some of this operations are very critical. Like the one, which [sic] I told you before, the conversion of a hospital. In this way they can, (...), remain out of something which is difficult to manage. For the workers, (...), it is the same, if they have to transform a hospital. Now it is a worker of a private institution to tell them to go home or to / they have to change their habits. They must be more productive, this is easier for a private cooperation than for a public one. It is very difficult for the government to tell someone to work in another hospital or to do something different... (...) And so, I think that the sperimentazioni gestionali are [sic] used even for this region to facilitate/ to manage the workers. (...) another reason why PPP is used in Italy, is because of the long time to build or to transform a hospital, if you are public. You need a lot of time, because the public is

Expert II Italy (2015, p. 46)

Because of private companies that interact in the healthcare sector, the government has to be more efficient, but public and private hospitals are included in the National Health Service.
“20 years ago we did not have so many private hospitals. The majority of the hospitals was [sic] public. When the system decides to enter in the National Health Service and the competition began. The public tried to transform the hospital and tried to be more efficient, more productive. They tried to be more competitive. I think this is good. It is also good for the person who can choose between different hospitals.”

Expert II Italy (2015, pp. 48 & 49)

We have a sort of a law, public and private are all in the National Health Service. Not all the private ones, but almost all. You have private private too, you can go there only if you pay yourself. But, all the hospital I mentioned to you. You can go there and not pay, because the government pays for you. This is possible only if you have an emergency. Because, if you do not have this you are not in the National Health Service. You can be a little hospital and only do what you want. When you are integrated in the National Health Service you must have an emergency. Because, if you arrive at emergency you do not select patients. This is limiting [sic] private companies to do only what you want.

Expert II Italy (2015, p. 49)

Critical cases go in Italy to public hospitals. Critical cases are more expensive for the system and less profitable for the hospital. So, private hospitals could be free of critical cases and private hospitals could concentrate on all patients with whom you can make profit. But, taxes should be paid to give people the opportunity to get healthcare and not private companies to earn. The selection of patients is not a problem. The financial system needs to be reformed, because critical cases create losses for the hospitals.

“If you are really ill public is better.”

Expert II Italy (2015, p. 55)

There are hospitals who buy expensive technology and there are hospitals who don’t and both get the same reimburse. The system needs to be regulated, but not in the sense if it is public or private. The reimburse system changed when private companies entered the market. Private companies can buy the most convenient product, public hospitals have a special procedure. Patients choose because of the quality and not because of the costs.
(iv) Category E – Decentralisation
The costs for treatments, e.g. heart attacks, is not everywhere the same. The costs are defined by the regions, private companies make services cheaper. The costs for the government remain the same.

There is a strong decentralisation when it comes to PPPs. In the Lombardy PPPs are very common and Emilia Romagna is not using PPPs at all.

“...so we can say that as we have a decentralized system, every region do as she want. So Lombardy is surely one of the region that use much more often than other regions the PPP. (...) Other regions like Emiglia Romani, (...), do not want to do PPPs. (...) So, in media we have, in Italy, 30% private services and 70% is managed by public. I think it is something around this. (...) In the Lombardy there is more than 30% private and less than 70% in public hospital. [sic] In Emilia you have 95% public and 5% private. So, you can see that Lombardy is different, but Lombardy is not the only region who has a lot of private hospitals. This is region which is strongly simulated to have PPP. So, you have a high number of PPPs. If you go to Emiglia Romania you have very little PPPs. I think this is the only different. The sperimentazioni gestionali was born in the Lombardy.”

Expert II Italy (2015, pp. 41 & 42)

(v) Category G – Trends for the future
Also in the future this largest part of the health care system will be public, at least 70%. There will be no big change.

5.3.3.2.b Expert III Italy

(i) Category A – Where are PPPs used the most often and in which form
BOT and concessions are the most common forms in hospital construction. Imaging equipment leasing is the most popular. For instruments that need costly disposable

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34 In general, PPPs were used in the Lombardy first, not only sperimentazioni gestionali (Expert II, p. 272).

35 This type of contracts gives the concessionaire a right in the long-term to use the utility assets. The concessionaire also has to take the responsibility for some investments and the operation. The owner is the
material (e. g. laboratory reagents), rental contracts, which are free of charge, are made available for the instruments, so only the material has to be paid.

There are 80 sperimentazioni gestionali in Italy. Sperimentazioni gestionali are used for the management of ownership fractions, small hospitals, ambulatory treatments or intermediate care.

In Italy PPPs are the most common in building hospitals, reconstruction of large hospitals, large diagnostic tools, sperimentazioni gestionali, construction of new kitchens and car parks.

(ii) Category B – Importance of PPPs in Italy
Within the European Union, PPPs are second most common in Italy after the UK, reasons for this phenomena are for gaining resources for infrastructure investments or technology without increasing public debt, unpopular transformations of small hospitals, and making the time for realising shorter.

„Fino ad oggi le PPP hanno dato buoni risultati in termini di capacità di costruzione rapida di nuove facility e in termini di gestione sanitaria.“
Expert III Italy (2015, p 27)

(iii) Category C - Ideology
Tendentially, private companies are focusing on therapeutic areas and the government treats the critical cases. This situation could be changed by a different financing system.
(iv) Category D – Competition and modernisation
There is a trend that non-core services are outsourced by hospitals, e.g. laundry, cleaning, cooking or facility management. Further, it should be mentioned that private players in the health care sector are able to manage personnel better.

(v) Category E – Decentralisation
The frequency of PPPs is different among the different regions. The gap is growing. According to Expert II Italy, a larger diversity in this case is not negative.

„Le PPP sono molto usate da alcune regioni (Lombardia, Toscana) e rifiutate da alter (Emilia-romagna)...“37
Expert III Italy (2015, p 28)

(vi) Category F – Profitability
The profitability is the highest in acute care, rehabilitation, diagnosis, and facility management. 38

(vii) Category G – Trends for the future
Private companies are supposed doing non-core services, core-services will be split in 30% private and 70% public. Private firms will work in areas with a higher value creation and a lower specification (intermediate care, rehabilitation or preventive and social healthcare). The government will work in areas such as transplantation or heart surgery.

37 PPPs are widely spread in particular regions (Lombardy, Tuscany), other regions refuse PPPs (Emilia-Romagna) (own translation).

38 Expert II Italy mentioned also socio-health structures. This point was erased, because of being not specific enough.
“I servizi no core continueranno ad essere erogati da imprese private. Per i servizi core mi aspetto tra qualche anno un bilanciamento di 30% gestito da aziende private e 70% da aziende pubbliche.”

Expert III Italy (2015, p 28)

5.3.3.2.c Expert IV Italy

(i) Category A – Where are PPPs used the most often and in which form
The most common are corporate enterprises with public and private participation (e.g. spa, srl…). In highly specialized areas, e.g. transplantation, orthopaedics or rehabilitation, PPPs can be found the most often in Italy.

(ii) Category D – Competition and modernisation
Surveillance is very important when public and private actors participate in facilities.

“Credo di sì in quanto la dinamicità di un modello privato, il Know how, la capacità manageriale del privato spinge verso un efficientamento delle risorse dovendo rispondere ad un investitore privato senza però trascurare la qualità del servizio e la garanzia dell’erogazione al cittadino”

Expert IV Italy (2015, p 220)

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39 Private companies will provide non-core services. Core-services will be offered 70% by the government and 30% by private companies (own translation).

40 Question asked to the expert: „Do you think that the involvement of private companies make the services of hospitals cheaper? What is your opinion about the cost of competition of different companies/companies and the government in this sector?”

41 Engl.: Yes, I believe in the dynamic of the private model. The know-how and leadership competence creates higher resource efficiency. The participation of private players does not downgrade the service and penetration rate of its citizens (own translation).
“(Assolutamente si)”\textsuperscript{42,43}
Expert IV Italy (2015, p 220)

(iii) Category E – Decentralisation
There is a confusion how laws about PPPs should be enacted. No specials laws exist in terms of decentralization.

(iv) Category G – Trends for the future
Expert IV Italy things that the importance of private companies will grow in the health care sector.

5.3.3.2.d Expert V Italy

(i) Category A – Where are PPPs used the most often and in which form
The most common form of PPP in Italy is contracts for the constructions of hospitals and add-ons, such as parking spaces, with the agreement that the private partner manages the facility for 20-30 years.

(ii) Category D – Competition and modernisation
The participation of private player needs stricter and more transparent rules. Private companies use resources in a more efficient way and the management of workers is more flexible. An appropriate leadership is very important. PPPs modernize the administration. Competition is positive when it is regulated.

\textsuperscript{42} Question asked to the expert: „Do PPPs in the health care sector modernize the administration? So, do you think the cooperation between a public and a private partner makes it more dynamic?“

\textsuperscript{43} Engl: Absolutely (own translation)!
(iii) Category E – Decentralisation
The administration and surveillance is strongly decentralized between the 19 regions and 2 provinces.

(iv) Category F – Profitability
The highest profits can be gained in Diagnostic Imaging/Laboratory, Surgery, and Obstetrics/Gynaecology.

(v) Category G – Trends for the future
Private enterprises will play a more important role in the future.

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44 Question asked to the expert: "Do PPPs in the health care sector modernize the administration? So, do you think the cooperation between a public and a private partner makes it more dynamic?"

45 Practically, yes (own translation).
6. Summary and overview

In this chapter all research questions will be answered. Further, the most important points of the interview should be summarized.

6.1. Research question one: “Do healthcare PPPs exist in Switzerland, Austria and Italy?”

There are no PPPs in the healthcare sector in Switzerland. Further, there is no hospital that outsources its management. Outsourcing is only popular in fields such as support services, laboratory, cleaning, or radiology. Such services are outsourced in private and public hospitals. Reasons why no PPPs in the healthcare sector in Switzerland exist are the small project size, high transaction costs, the direct democracy, PPPs are in competition with other financial leasing models, the government views PPPs as an act of desperation, and, what is the most important point, the good financial situation (an intact public budget and a good access to credits). Rental models are the most likely to be realized in Switzerland. Medical technology and real estate could be potential areas for PPPs. When a new facility is built, the early phases, such as strategic planning, play the most important role.

PPPs can be found in Austria, but are more common in Spain and England PPPs. An example that even goes far beyond a “normal” PPP is the hospital in Oberndorf. The frequency of the different models is determined by the nomenclature. But, it can be said that evolved leasing models and the “Kooperationmodell” are the most common form of PPP in Austria. Further, system partnerships are common. PPPs can be found in facility management and maintained – these are the areas in which they are already very popular since the 70s. Because of a lack of experience PPPs are not used in acute care.

Also in Italy PPPs are used, they are more common than in Austria. The experts disagree on the fact whether Italy is the second largest market for PPPs in general or in the hospital sector. However, PPPs play an important role in Italy. Further, PPPs also grow fast in Italy, a reason for this is the scare and out-dated infrastructure. Common models for hospital construction are D.B.O.S.L, concessions and BOT. Further, there are 80 Sperimentazioni gestionali in Italy and corporate enterprises with public and private participation (e. g. spa, srl…) were also mentioned to be highly popular. Free rental contracts, but the material has to be paid are also common. Canteen, laundry, the
construction of car parks and cleaning are often organized with PPPs. Highly specialized areas, e. g. transplantation, orthopaedics or rehabilitation are also very common fields.

6.2. Research question two: “What are the main differences and similarities between healthcare PPPs in Switzerland, Austria and Italy?”

In Switzerland the autonomy of the cantons is very high. The social insurance is strongly decentralised and many private insurances exist. In the future the larger cantons are more likely to do PPPs. Further, more privately financed medium and long-term life cycle orientated project will be started. A Swiss PPP model will be created. The methodological values, such as life cycle approach will also be developed in the future. However, in general it is difficult to make an estimation, because no PPPs exist at the moment in the healthcare sector. The direct democracy will create barriers for PPPs. Many PPPs are not realised because of this fact. Further, the government is experienced in creating infrastructure.

PPPs in Austria are usually used in fields where the government has experience. There is no geographic concentration of PPPs in Austria. The frequency depends on carriers. In Vorarlberg are some well-functioning projects. In Austria no big driving forces for PPPs can be seen in the future. Companies that provide entire processes can be successful. Unsuccessful policies of the government are a chance for PPPs.

In Italy the PPP sector is strongly decentralized. The success of PPPs is different among the regions. PPPs will grow in the healthcare sector in different areas in the future in management and construction. PPPs are very common in the Lombardy and they are not used at all in Emilia Romagna. In the future the largest part (70%) of the healthcare system is estimated to remain public. Private companies will focus on non-core services and the government - on core services. No expert said that the trend for PPPs will decrease.
6.3. Research question three: “What is the connection between public debt and healthcare PPPs?”

The low debt, in comparison to other countries, and the good access for credits is the most important reason why no PPPs exist in Switzerland and why they will also not become a trend. On this point, all five experts agreed.

PPPs are used in Austria to keep the public debt on the same level, because the private partner finances the project and the government rents the facility back for an infinite time. The central role of the public debt was emphasised more often during the different interviews. But, PPPs usually cause a cost drift upwards.

In Italy PPPs are very popular because the public debt is very high. For this reason, there is a shortage of resources and private partners who finance the projects are needed. If PPPs would not be needed the project would be less expensive.

6.4. Research question four: What are the advantages and disadvantages of market mechanisms in the health care sector?

The government in Switzerland would be able to work more efficiently with the right management. The participation of private players in the healthcare sector raises efficiency in two ways: Private suppliers work more efficiently, and further the government tries to work more efficiently as well because of the rising financial pressure. But, the main driver for efficiency is the competition for patients. Further, the competition for patients also stimulates modernisation. PPPs higher efficiency when the potential for it exceeds the transactions costs significantly.

In Austria there is a lack of competition in the healthcare sector. Authorities could also work more efficiently, if they get controlled properly. However, this control is not taking place in Austria, unions are part of the problem. Personnel management (60-70% are personnel costs) is an important topic where the involvement of private companies can have advantages. Competition optimizes also structures of organization and makes decision-making processes faster. PPPs can be highly innovative and a quality advantages can be gained. The cost of competition was in general not seen as a problem.
But, it was mentioned that the human being with its needs should be the focus and not the costs a human being is creating.

Also in Italy there is a lack of competition, only 1.5% of companies take part in the tendering process – the costs for the construction of a hospital raise there is not enough competition. For a private company it is easier to fire and displace workers, for the creation of sperimentazioni gestionali personnel management plays a huge role. PPPs are used for very difficult operations. Also in Italy the efficiency was raising because of private players in the healthcare sector – people could choose between hospitals and the government had worked more efficiently. Further, the management plays a very important role. The time of realization for a new facility gets shorter. The participation of private companies boosts modernisation.

7. Discussion
The primary data does not contain interviews, which are held with a representative of companies who work within PPPs hand in hand with the government. Most interviewees either work in universities or in consultanciesy. As a consequence, the point of view of the government is discussed, but the paper lacks the view of the private player. This is also a problem in most other literature about PPPs (see chapter 3). In addition, three experts who gave interviews about PPPs in Italy belong to the same organization. The situation in Switzerland is similar.

Further, this paper does not discuss an overall view of statements such as if PPPs make the healthcare projects more expensive. In this case, only the costs of the project are considered, but not that private players change the healthcare sector in general.

The definition, what is meant by a PPP, differs among the analysed countries. In Italy, the differentiation is less strict, e. g. also leasing are discussed when experts were asked about PPPs

8. Conclusion
In Switzerland no PPPs exist in the healthcare sector. In the future, no PPPs according to international standards will develop. The main reason is the good financial situation of Switzerland. But, also the direct democracy plays a significant role. In Austria PPPs can
be found in facility management and maintenance. But, also other examples can be found such as the hospital in Oberndorf. Italy has a large PPP-market in the hospital sector, but regional differences exist. In Italy PPPs are needed, because the government cannot provide sufficient resources for projects in the healthcare sector. For this reason, private partners who finance projects are needed.

Competition has a positive effect on efficiency, so implementing market mechanisms in the healthcare sector is positive. However, the hospital sector is a difficult field for competition. When PPPs are done Austria and Italy face the problem that the number of companies, which take part in the tendering process, is small. This problem was experienced in Great Britain before. PPPs cause a cost drift upwards in healthcare projects.

The participation of private companies in the healthcare sector raises efficiency in two different ways. Private companies work more efficiently and the pressure on the government rises, because patients can choose between different hospitals. In addition, private enterprises have a strong interest in operating in profitable areas.
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