Efficiency Review of Austria's Social Insurance and Healthcare System

Volume 1 – International Comparisons and Policy Options

London School of Economics and Political Science (LSE Health) ▪ August 2017 ▪

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Table of Contents

Tables

Figures

Authors and acknowledgments

In 2016, the London School of Economics and Political Science (LSE Health) was engaged by the Austrian Ministry of Labour, Social Affairs and Consumer Protection to undertake a review of the country's social insurance system. Additional partners involved in the study include the Institute for Advanced Studies (Vienna), the University of Salzburg and Contrast Ernst&Young Management Consulting GmbH, and two leading healthcare experts from France and the Netherlands. Outlined below are key authors from each of these institutions.

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In addition to the primary authors outlined above, Volume 1 of this review also drew upon research and analysis completed by the following academics and policy experts.

Institution	Name and role	Contribution
Austrian Ministry of Health and Women's Affairs	Various	Provided relevant information throughout the review.
University of Vienna	Anna Theresa-Renner, Assistant Professor	Collection and analysis of data examining utilisation of inpatient healthcare services in Austria, including regional variations.

Institution	Name and role	Contribution
London School of Economics and Political Science (LSE Health)	Martin Wenzl, Research Officer	National and international analysis of case management approaches and best practice principles.
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London School of Economics and Political Science (LSE Health)	Professor Panos Kanavos, Programme Director of the Medical Technology Research Group (LSE Health)	Assistance with information regarding international and national Health Technology Assessments arrangements
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National Institute of Health and Disability Insurance (Belgium)	Mr Thomas Rousseau	Provision of information related to the Belgium health insurance system.
Bocconi University	Professor Giovanni Fattore, Chairman of the Department of Policy Analysis and Public Management	Information regarding Italy's taxation system
Imperial College London	Martina Orlović, Research ASociate	Research assistance

Disclaimer: Please note, although information provided by the above authors was used to develop policy options, final policy options were defined by LSE.

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Executive Summary

Review brief

In 2016, the London School of Economics and Political Science (LSE Health) was engaged by the Austrian Ministry of Labour, Social Affairs and Consumer Protection to undertake an efficiency review of the country's social insurance system. The review was specifically targeted at health competencies within the social insurance system; for this reason, other forms of care covered by Federal and Länder governments, were only examined where directly applicable.

The review can be broken into four interconnected components, each led by a separate organisation. Further details on each of these components and their aligning report are provided in the table below.

Volume number and report	Objective	Lead organisation
1 – International Comparisons and Policy Options	Compare the Austrian system to international experiences, and using this information, define a range of policy options to improve efficiency within the system.	London School of Economics and Political Science (LSE Health), including a team of international experts, and the Institute for Advanced Studies (Health Economics), Vienna
2 – Legal Analysis	Analysis of relevant legal considerations within the social insurance system.	University of Salzburg
3 – Stakeholder Submissions	Compilation of formal submissions provided by key stakeholders within the Austrian social insurance system.	Compiled by LSE Health
4 – Situational Analysis	Map out current healthcare arrangements within the Austrian social health insurance system.	Contrast Ernst&Young Management Consulting GmbH

This report represents *Volume 1 - International Comparisons and Policy Options*. The report drew upon information collected in volumes 2 to 4, as well as further analysis of reports completed by Austrian organisations and experts, and international experiences. Using this information, a range of policy options designed to improve efficiency within the Austrian social insurance system were developed.

Overview

Our analysis of the Austrian social health insurance system revealed that the system is both complex, as a result of its multi-level governance structure, and fragmented, given the dual nature of financing. Specifically, outpatient care is financed by social health insurance, whereas inpatient care falls under the joint responsibility of federal and Länder governments. Such an arrangement fosters various inefficiencies including cost-shifting, and discourages continuity of care, which leads to higher overall costs.

This finding is not new, and has been highlighted by various research institutions, as well as policy-makers, as a key barrier to improving healthcare system efficiency. As a result, in recent years, many efforts have been made to improve coordination and align incentives.

Ultimately, the problem of dual financing can only be overcome either with major constitutional reform or with joint budgets across the spectrum of care. However, we recognise the extreme legal difficulty implementation of joint budgets presents, given a two-thirds majority within Parliament is required. In response, the policy options within this report present pragmatic approaches to enhance coordination and improve efficiency within the current system.

Another key issue that has been raised, is that concerning the number of social health insurance carriers. Multiple purchasers of healthcare is not uncommon, for this reason, the total number of carriers, in our opinion, is not viewed as the most important barrier to achieving efficiency. Rather, it is how Austria differs in terms of the types of services procured by purchasers, and secondly, by the allocation of funds to purchasers which represent key challenges. In regard to the former challenge, Austria is unique in that healthcare purchasers operate in silos (i.e. insurance carriers versus Länder), that is, purchasing care for a portion, as opposed to all healthcare services. Concerning the latter challenge, only a small proportion of health insurance carrier funds are risk-adjusted, which results in inequities. This is also the case with other resource allocation mechanisms in Austria (i.e. federal government to the Länder or from social health insurance to the Länder), which are mostly based on political negotiations and historical allocation patterns.

Limited risk-adjustment has meant that, despite mostly uniform contribution rates, differences in benefits for specific services may occur. Such an arrangement is inequitable and goes against international trends. However, it is worth highlighting that self-reported unmet medical need in Austria is one of the lowest in Europe.

Ensuring high-quality care has also been a key agenda for policy-makers in recent years. Despite this, the types of quality indicators measured, in addition to the uses of information collected in Austria, could be enhanced. More robust information on quality within the system will ultimately improve patient outcomes via the development of evidence-based policies.

Finally, it is evident that Austrian policy-makers have recognised primary care and public health as a key area for enhancement, for example, with the development of the diabetes disease management program. Nevertheless, discussions with stakeholders, in addition to findings within the policy and academic literature, reveal that relative to other advanced European countries, Austria's primary care and public health sectors could be significantly improved. This is evidenced by, for example, low rates of vaccinations and lower than average life-expectancy projections, as well as high inpatient admissions rates. Such findings reiterate the need for further investment in primary care and public health, while being cognisant that, in the short-term, cost-savings are unlikely, given the presence of fixed hospitals costs.

Summary of policy options

Based on the findings outlined above, a range of policy options to improve efficiency within Austria's social health insurance system have been proposed. Policy options have not been ranked given, ultimately, it is the responsibility of Austrian policy makers and stakeholders to make decisions regarding the direction of the healthcare system.

In reviewing these policies, we offer policy-makers and stakeholders the following recommendations: first, to view policy options outlined in this report, as well those by various Austrian research institutions and organisations (including stakeholder submissions – Volume 3 of this review); second, to ensure future discussions and implementation of policy options be done in a transparent and inclusive manner so that key stakeholders do not view change as a 'zero-sum game'; and third, to keep in mind that no healthcare system is perfect, and that any future efforts should build upon current successes, which in the case of Austria, include high-levels of population satisfaction as a result of ease of access to healthcare services, and low levels of unmet need.

It is important to highlight that the remit of this review was limited, given it was restricted to the social insurance system. However, as previously outlined, given the complex nature of the healthcare system, where directly applicable, consideration was given to healthcare under the jurisdiction of federal and Länder governments.

Policy options: Structure of the social insurance system

Four alternative models have been proposed to improve efficiency and equity within the system. Models 1-3 involve structural change to the social insurance system through an amalgamation of carriers. Amalgamation, in the short-run, can lead to cost increases given expenses associated with structural change and implementation. However, in the medium- to long-term, if implemented correctly, these models could lead to efficiency gains, for example, through economies of scale and scope, and enhanced knowledge transfers. It is important to note that sub-options for models 1-3 have also been developed, however, they have not been included in this summary. Model 4 would increase efficiency and equity by extending risk-adjustment and enhancing coordination within the current structural model.

- **Model 1 (partial amalgamation):** one national accident insurance carrier, one national pension insurance carrier, one employed health insurance carrier (GKKs, BVA, VAEB, BKKs and KFAs) and one self-employed health insurance carrier (i.e. SVA and SVB).
- **Model 2 (limited amalgamation):** one national pension insurance carrier, one self-employed health insurance carrier, one employed health insurance carrier (excluding civil servants, i.e. BVA, VAEB and KFAs), one accident insurance carrier (excluding civil servants), and one joint accident and health insurance carrier for civil servants.
- **Model 3 (health and accident amalgamation):** one national pension insurance carrier, one health and accident insurance carrier divided by each of the nine states.
- **Model 4 (insurance coordination):** model 4 aims to improve the current social insurance system by enhancing risk-adjustment between health insurance carriers, as well as improving coordination between carriers through Joint Specialists Centres. Joint Specialist Centre 'themes' would be defined by a joint Working Group (including HVSV, and both the Ministry of Health and Women's Affairs, and the Ministry of Labour, Social Affairs and Consumer Protection), however, it will be the responsibility of carriers who takes on each theme. Although not compulsory, carriers will be incentivised to actively participate in the scheme to minimise duplication.

Policy options: Risk-adjustment

Given model 4, as outlined above, is introduced, the following five risk-adjustment options have been proposed to improve equity and efficiency within the system. RA1 and RA2 are considered the most comprehensive and thus mutually exclusive, RA3-5, however, could be implemented in unison.

- **RA1:** All funds received by social health insurance carriers to be risk-adjusted through a central agency (i.e. HVSV). Alternatively, a step-wise approach could also be considered, whereby the proportion of funds risk-adjusted are increased over time until it is felt there is an equitable distribution of funds.
- **RA2**: This option would involve a simultaneous reduction to contribution rates and the implementation of an earmarked levy dedicated to risk-adjustment across social health insurance carriers.
- **RA3**: RA3 would amalgamate existing risk-equalisation schemes into one pool of funds to be used for risk-adjustment purposes. Using the most recent data, risk-equalisation schemes amount to €3 billion annually (including the Hebesätze, or €1.4 billion, excluding the Hebesätze).
- **RA4**: Under this option, social health insurance carriers would subsume responsibility for hospital outpatient departments using an appropriate level of funds from State Health Funds. A central agency (i.e. HVSV) would be responsible for redistributing funds to carriers based on a range of risk-adjustment factors. Funds could be used, for example, to enhance primary care and hospital outpatient departments.
- **RA5**: Finally, RA5 would pool a proportion of contributions into a central fund (managed by the HVSV), which would then be used to reimburse GPs on a capitated risk-adjusted basis. Given the significant cultural change associated with this policy (i.e. by registering with one GP), this policy is should only be considered in the long-term.

Policy options: Collection of contributions

The following policy options relating to the collection of contributions are provided below:

Collection of contributions

- **Base SVB contributions on actual income**: a shift in taxation base towards actual income promotes an alignment between BSVG and ASVG funds in regards to the collection mechanism of contributions, and improves equity in the financing system.

- **Introduction of a proportional fiscal system with maximum contributions in the SVB**: a shift from the regressive to a more proportional fiscal system in conjunction with the introduction of a maximum contribution amount could promote a more equitable collection of contributions, which can be rendered fiscally neutral.
- **Aligning the BVA contribution base with that of regional carriers**: lower BVA's employee contributions, whilst raising employer contributions to harmonise the collection of contributions across funds, which could be rendered fiscally neutral. Gradually lower user charges for BVA insured to the regional fund level (GKK) to foster equity in the collection of contributions across funds.

Multiple insured persons in Austria

- **Single collection of contributions without a choice of carrier***:* introduce a single location for the collection of contributions, in addition to keeping maximum contribution bases in place. This can either be in the form of an independent entity or by nominating regional funds to collect contributions on behalf of all funds, in order to simplify the administration process. As such, the refund for excess contributions could be automatically calculated through an official channel, without the need for manual applications. An absolute hierarchy, or a hierarchy based on the main income source of an individual could be introduced to determine the carrier membership of an individual. Further studies on the financial impact on carriers need to be conducted prior to application of this option.
- **Single collection of contributions with a choice of carrier***: similar to the option presented above,* with the main difference that insured persons could choose their carrier of preference, based on their professions. While this option does not entirely eliminate inequity in the system, it may reduce the former, as insured could only switch carriers on an, for example, yearly basis, rather than intermittently charging different carriers.
- **Multiple collections of contributions without a choice of carrier**: insured individuals continue to pay to multiple carriers, however, the insured would be automatically assigned to a default carrier. This constitutes the carrier for which the insured pays the largest share of contributions and the insured is only entitled to benefits of the default carrier. All carriers receiving contributions for the insured would re-direct these contributions to the respective default carrier. In addition, the refund process for excess contributions could be automated, in order to reduce the administrative burden of manual applications and to eliminate inconveniences to the insured.

- **Multiple collections of contributions with a choice of carrier**: similar rationale to the option presented above, with the main difference that individuals have the option to choose a default fund to access services from, while the second carrier will conduct transfers of funds to the former. However, this would only lead to partial improvements in equity.
- **Retrospective payments between carriers**: one of the carriers conducts retrospective payments to the second insurance carrier, which was predominantly used by the insured person to access services. This system constitutes a modification of the current mechanism in that it adds a compensatory mechanism to ensure the financial stability of funds. However, it must be noted that this option may be more difficult to implement and does not render the system more equitable.

Policy options: Defining and harmonising benefits

The following the policy options to define benefits within the healthcare system are proposed.

- **Outpatient drugs**: disclosure of outpatient drug assessments would render the current process more transparent.
- **Inpatient drugs:** enhance and strengthen coordination and procurement policies across regions and introduction of a transparent decision-making process for inpatient pharmaceuticals.
- **Establishment of an independent, arm's length HTA body**: transition into an independent, arm's length HTA body that undertakes HTA for different types of technology and provides advice to relevant decision-makers in order to increase transparency.
- **Promote a full HTA for a subset of technologies**, particularly those that have important resource implications (high cost/high volume). Formal evaluations should be introduced across costly technologies and a threshold for this purpose should be established.
- **Establish clear parameters regarding the conduct of HTA**, such as type of evidence requirements and the types of evidence that can be admitted into assessment and appraisal.
- **Provide guidance on** methods of assessment and criteria (beyond costs and effects); the role of stakeholder involvement; the appeals process and associated timelines; timelines for assessment and re-assessment for rapid reviews, full HTAs and multiple HTAs; and, the monitoring and implementation of decisions.
- **Provide information on** the structure and composition of the relevant committee (technology Appraisal Committee – TAC), which needs to reflect the stakeholder complexity in the context of

each technology type and the national-regional-local trade-offs that exist in different circumstances.

The following the policy options to harmonise benefits within the healthcare system are proposed.

- **Estimated cost of harmonising a specific set of benefits**: initial costs of a harmonisation for specific goods and services (i.e. medical aids and therapeutic devices; dentures; health care services including psychotherapy, physiotherapy and logopedics) were estimated by increasing the per capita expenditure levels of those funds that are (1) below the average per capita expenditures across all funds and (2) below 70% of the highest per capita expenditure across all funds. **Total additional costs per year of harmonising specific benefits across all funds**:
    - (1) €171.075.130 (Risk-adjustment (age and gender) for medical aids and therapeutic devices: €176.988.291). Percentage change in expenditure of SHI for these benefits: ↑19.4% (↑20.1).
    - (2) €390.177.440 (Risk-adjustment (age and gender) for medical aids and therapeutic devices: €394.090.543). ↑42.8% (↑43.6).
- While this study provides initial cost calculations, the harmonisation of benefits is a political decision to be taken by the government and stakeholders. Even though a harmonisation of benefits is central to ensuring equity, it is noteworthy that Austria has one of the lowest levels of unmet need in Europe.
- **Data collection**: a unified collection of high-quality data that is comparable across funds is of central importance to supporting the harmonisation of benefits. Further efforts are required to ensure uniform data storage and structure.
- **Financing options** in the case of a political decision to harmonise benefits:
    - (1) Partial funding could ensue through a risk-adjustment scheme, or enhanced risk-adjustment scheme
    - (2) Alternatively, or in addition, government funds could be directed to insurance carriers that offer a slightly less comprehensive benefits package compared to other funds.
    - (3) Further funds could be directed to the project by improving efficiency in the system. For instance, a reduction in hospitalisations could lead to significant savings. However, significant investments in outpatient and primary care are required in the first instance to maintain high-quality care, whilst simultaneously reducing hospital admissions, meaning that savings to be used for a harmonisation could be generated in the mid- to long-term.

- (4) In addition, better coordination and consolidation could also lead to efficiency gains, which could be directed in the form of savings to increase coverage of benefits in Austria.

Policy options: User charges

The following policy options to enhance efficiency and equity via user charges have been proposed. Please note, none of the policy options recommend an increase in user charges, rather a change in their composition to maximise efficiency within the system.

- **Pharmaceutical cap:** under this option, the universal 2% net income pharmaceutical cap would be replaced by a three-tiered cap, with insurees being allocated to caps according to their total income. Those in the lowest income band would be subject to a lower cap (i.e. 1.5%), middle income earners would see no change in their cap (i.e. remain at 2%), while high-income earners would see their cap increase to 2.5%. Depending on the success of the cap, consideration could be given to expanding the cap to all inpatient and outpatient healthcare services.
- **Value-based user charges**: once a robust HTA system is in place, it is advised that rates of user charges be linked to HTA findings, with insurees paying less (or nothing) the more effective a product/service is. Ideally user charges would take into account individual circumstances, however, this is associated with high-levels of administrative burden. Therefore, it is recommended that value-based user charges be linked to the effectiveness of products/medical devices/services (i.e. inverse relationship between effectiveness and co-insurance/payment rate). In the interim, policy-makers could encourage 'softer' value-based user charges, following the lead of the SVA and VAEB.
- **Convergence of user charges to the lowest level:** finally, it is recommended that current trends continue by encouraging convergence of user charges across health insurance carriers to improve equity within the system.

Policy options: Investment in healthcare services

Three policy options to enhance investments in healthcare services are proposed. These relate to accounting practices, reserves, and whether carriers should make or buy healthcare services.

- **Accounting**: to improve clarity, it is recommended that carriers only term liquid assets as 'reserves', that is, monies which can be used for investment purposes.
- **Enhance use of reserves:** to improve access to healthcare services for all, it is advised that the use of reserves be enhanced, for example by: a) pooling all or a part of a carrier's contributions into

one fund for investment purposes (e.g. to enhance primary healthcare), b) encourage joint investment across carriers (without pooling reserves), or c) encouraging carriers to open up their facilities to all individuals, not just their insured population.

- **Make or buy**: before investing in healthcare services, carriers should be encouraged to undertake a comprehensive analysis before investing, to determine whether it is most appropriate to make or buy (or concurrently source). However, to improve capacity within each health insurance carrier, it is encouraged that carriers invest, at least partly, in their own healthcare services.

Policy options: Broadening the social welfare base

Austria is a strong economic performer, with a relatively high level of employment and GDP per capita. Economic growth is expected to grow over the next few years, however, consideration should be given to current and future challenges facing the economy including an ageing population, and a rise in self-employment, digitalisation and automation. Based on these challenges, the following policy options have been developed to ensure sustainability of the social insurance system.

- **Education and skills**: Align education with future skills required within the workforce, and encourage lifelong learning.
- **Retirement policies**: encourage further efforts to increase the actual retirement age (i.e. encourage people to stay in the workforce for longer).
- **Workforce participation**: continue efforts to increase the proportion of women working within the formal economy.
- **Taxation policies**: after 'softer' policy options, as those outlined above, have been introduced, consider changes to the tax system if further funds are required. Specifically, by using total income as opposed to earned income as the basis for contributions, raising company contributions, and/or introducing additional earmarked health taxes.

Policy options: Contractual agreements

To improve efficiency within the healthcare system via a change to contractual agreements, the following policy options are recommended. These policy options have been broken down according to broad timelines, which reflect their relative importance.

Short-term:

- **Arbitration:** to ensure a level playing field during contractual negotiations, the following option is proposed; allow the Federal Arbitration Committee to postpone the termination of contracts from three to six months, after six months an external arbiter would be introduced to facilitate negotiations. Given no agreement is reached, the Ministry of Health and Women's Affairs would set the contractual agreement based on feedback from the external arbiter.
- **Selective contracts:** If certain items cannot be agreed upon in the general contract, allow social health insurance carriers to selectively contract (e.g. to fill physician vacancies).
- **Structural plans:** if current regional structural plans fail to achieve their desired objective, it is advised that an independent committee be developed to provide recommendations on the number and locations of physicians. Recommendations would form the basis of contractual negotiations, with a requirement to justify any deviations to the Ministry of Health and Women's Affairs.
- **Harmonisation among specialists:** Harmonise naming of services/items across outpatient specialists to improve transparency.
- **Primary and outpatient care:** given the high number of hospital admissions, it is clear that primary care within the healthcare system requires improvement. Multiple policies could be introduced to achieve this, for example, by encouraging group practices, primary healthcare units, and extending hospital outpatient departments and disease management programs. It is important to note that efficiency gains from enhancing primary care are only realisable in the medium- to long-term given fixed supply-side costs within the inpatient sector (e.g. buildings, labour).

Medium-term:

- **Bundled payments:** to enhance coordination and continuity of care, social health insurance and Länder could implement joint budgets for chronically ill patients who frequently access healthcare services. Such an approach would avoid patients 'wandering' the system and ensure that appropriate care is provided.
- **Rural and remote GP remuneration**: to increase the number of physicians working in rural and remote areas, it is recommended that GPs in these areas be paid on a risk-adjusted capitated budgets, which takes into account the unique circumstances of working in these areas. To further incentivise physicians, flat rate payments could be introduced to complement capitated budgets, such payments should be linked to actions/services that promote overall improvement in healthcare quality (e.g. smoking cessation programs).

Long-term:

- **GP remuneration**: if the capitated system amongst rural and remote GPs is successful, consideration could be given to extending the scheme to urban GPs, who would also receive additional flat rate payments.
- **Role of GPs**: it is recommended that the role of GPs in the healthcare system be enhanced to relieve the burden placed on inpatient care, specifically, by encouraging individuals to register with a single GP who would take responsibility for the individual's overall healthcare plan. Such a system would be voluntary, and only realisable once appropriate structures and processes have been put in place (e.g. more advanced GP training, greater number of GPs).

Policy options: Healthcare quality

Policy options to improve healthcare quality within the system have been grouped into three categories. First, changes to the role ÖQMed, second, changes to data availability and quality indicators, and third, changes to hospital admissions, readmissions and discharge management.

In regard to the **role of ÖQMed:**

- Retain ÖQMed and create an additional independent quality committee responsible for monitoring the quality of care among contracted and non-contracted physicians.
- Relocate ÖQMed to the Ministry of Health and Women's Affairs, and give the organisation control over monitoring the quality of care among contracted and non-contracted physicians.
- Maximise the value of data collected through quality indicators through, for example, providing physician feedback and sharing best practice principles.

In regard to **data availability and quality indicators**:

- Develop a coding system for outpatient diagnosis, this would allow outcome indicators to be implemented.
- Increase focus on outcome indicators, and where possible link them to aligning process indicators.
- Link quality indicators across all levels of care to develop patient pathways.
- Allocate responsibility for developing and implementating indicators to the relevant professional group within the Ständiger Koordinierungsausschuss. However, any new indicators should be developed in consultation with the medical community.

In regard to **hospital admissions, readmissions and discharge management:**

- Research is needed to investigate the causes, as well as clinical and policy implications, of high rates of hospital discharge and readmission in Austria (outside remit of this review).
- In order to outbalance political benefits and costs, federal government funds to Länder should be based on objective criteria that reflect the needs of the population.
- Apply additional pressure from the financial targets within the *Zielsteuerung Gesundheit* and the stability pact (i.e. using real values instead of nominal values).
- Austrian Structural Health Plan to base its forecasts on epidemiological data and best practice of service provision, rather than using current demand as a proxy for need
- Further integrate secondary care units in the outpatient sector with primary and hospital care
- In regard to payment of care, for hospitals, the LKF system could be linked to quality of care, while in the first instance, a DRG system within the outpatient sector is advised, given this would improve information on patient pathways. Finally, and as previously mentioned under 'medium term' contractual agreements, bundled payments using funds from a joint budget (between Länder and social insurance) could be introduced, with pilots first being run for multi-morbid, high cost patients.

Policy options: Demand and supply of physicians

Policy options to increase the availability of physicians include:

- **Improving work-life balance** for both male and female physicians, especially in regard to child and elderly care (with a specific focus on those working in rural and remote areas).
- **Reducing incentives for physicians to emigrate**, for example, by providing clarity over future work conditions, ensuring working conditions are compatible with those abroad in regard to hours worked and reimbursement.
- **Reducing the 'brain drain'** occurring during the transition phase between medical school and professional training, for example, by improving training programs and ensuring these programs are allocated sufficient time.
- **Checking if working time directive compliance necessitates prolongation of training periods**, especially for specialists who need also dexterity, not only knowledge.

Policy options to increase the productivity of physicians include:

- **Improving the reputation of physicians working in primary care**, for example, via additional GP training requirements to fulfill their responsibilities within newly established primary healthcare units.
- **Delineating physician roles** within primary healthcare units and those performed within a hospital outpatient department**.**
- **Free-up time of physicians** by allocating relatively 'low-skilled' tasks to other healthcare professionals (such an approach may require additional education training for other health care professionals).
- **Training and motivating existing professionals to adjust to re-allocations of tasks and responsibilities** given the number of physicians nearing retirement age.

Policy options: Monitoring and information needs

The following policy options relating to e-health are provided below:

- **Synergy potentials in data storage**: identify synergy potentials between data storage sites, while avoiding the construction of new sites, in order to make efficient use of existing capacity.
- **E-prescribing and recall system**: introduce automated electronic prescribing and a recall system for medical adherence to reduce prescribing-related errors, while concurrently improving control of prescriptions, reducing time spent on prescription queries and promoting continuity of care.
- **E-vaccination**: implement an e-vaccination application with a recall system in order to create an optimised overview of immunisation status and vaccination schedule, whilst preventing duplicate immunisations and possible adverse events from drug-to-drug interactions. A national electronic immunisation data collection system could further improve the monitoring and evaluation of immunisation rates in Austria.
- **Digital imaging in ELGA**: expand the database for digital images from different medical devices to improve site- and time-independent information sharing between medical professionals and health care enterprises to enhance operational efficiency and to prevent unnecessary repeat examinations.
- **Standardisation of the diagnosis classification system**: inclusion of outpatient diagnoses may constitute a better representation of a patient's medical history and interoperability could be improved by standardising the diagnosis classification system.

- **Evaluation and monitoring of a patient's medical history**: a tracking system with a search function to monitor the development of specific parameters, such as blood pressure, may further enhance patient treatment. Further efforts should be undertaken to implement a patient summary.
- **Expansion of data collection**: a more extensive patient record, which, for example, includes information from the yearly medical check-up, could further improve patient-centred care, provided an insured person has expressed interest in the service.
- **Immediate sharing of information on health care use**: providing information on health care costs in addition to the utilisation of services through ELGA's online portal could enable year-round access to necessary information for patients and prevent billing errors.
- **Dissemination of information on ELGA to health care providers:** develop ELGA showcases that could be presented to health care providers, such as pharmacies, to facilitate and support the roll out of ELGA across as many health care providers as possible.

Policy options: Pharmaceutical expenditure and procurement

The following three policies are recommended in regard to pharmaceutical expenditure:

- **Enhance international relationships** to gain a better understanding of drug transaction prices within the outpatient market. Currently, external reference pricing, which draws upon list prices, is used, which doesn't necessarily reflect actual prices paid for drugs.
- Austria should consider **modifying domestic regulations on statutory prescription drug price cuts** so that they are linked to patent expiration rather than generic drug entry.
- **Limit the risk faced by payers and promote efficient use of resources** by introducing managed entry agreements.

To enhance the use of generics, the following policies are suggested:

- Given the increasing demand for healthcare services, we recommend **increasing the role of pharmacists** within the healthcare system, which would enhance efficiency and reduce the burden placed on physicians.
- **Incentivise physicians to prescribe more generics,** where appropriate**.**

Finally, to enhance procurement policies:

- Effort should be directed at **improving interface management between inpatient and outpatient pharmaceutical sectors** to limit cost-shifting and improve coordination of patient treatment. For

example, by developing a joint budget for all pharmaceuticals, enhancing the role of the Medikamentenkommission, and /or enhancing ELGA so that information regarding a patient's drug treatment (in both inpatient and outpatient settings) is easily understood by prescribers.

Policy options: Health literacy, disease prevention, health promotion

The following policy options relating to health literacy and disease prevention are provided below:

Health literacy

- **Improving health communication between patients and doctors**: Clear health communication between patients and doctors could be further improved by specifying specific criteria pertaining to the communication process (e.g. 'teach back'; avoiding jargon) in the Chamber of Physician's quality evaluation criteria of physician practices or in contracts.
- **Expand the dissemination of health information**: the national self-information portal could offer a number of additional language settings, other than German, in order to increase use of the site. A child-friendly, interactive information site could be developed as well.
- **Increase role of different stakeholders**: the role of various stakeholders in promoting health literacy should be increased. For instance, a point of contact for patients with limited health literacy levels should be defined to offer training and support, such as patient ombudsperson offices, while physicians could direct the respective patients to these contact points. Pharmacists could be further trained to identify and manage patients with lower literacy levels.
- **Module on health literacy**: a module on health literacy in the education setting (e.g. primary or secondary education) could be introduced to establish a solid and uniform health literacy knowledge basis across population groups.

Disease prevention

Immunisation

- **Inclusion of vaccinations in the mother-child passport**: create awareness and incentivize immunisation of children to increase low childhood immunisation rates.
- **Coverage of cost-effective vaccines for adults**: an additional coverage of adult vaccinations, where cost-effective, could potentially increase adult immunisation rates of a number of important vaccine-preventable diseases.

- **Walk-in vaccination and injection services at pharmacies**: by introducing walk in vaccination and injection services at community pharmacies, following a prescription by a physician, the immunisation process could be rendered more flexible, time-saving and convenient to patients.
- **E-vaccination to improve monitoring and re-calling of-, as well as data collection on vaccinations**: implement an e-vaccination application with a recall system in order to create an optimised overview of immunisation status and vaccination schedule, whilst preventing duplicate immunisations and possible adverse events from drug-to-drug interactions. A national electronic immunisation data collection system could further improve the monitoring and evaluation of immunisation rates in Austria.

Diabetes

- **Expansion of the diabetes disease-management-programme (DMP)**: in order to improve the equity and quality of diabetes treatment in Austria, it is suggested to further strengthen efforts in the disease management programme, which should be gradually expanded over time.
- **Remuneration of DMP-physicians**: the financial compensation of DMP-physicians should be assessed in order to ensure appropriate rewards in line with the time taken to manage diabetes patients, and to incentivise more physicians to enter the programme.
- **Training of physicians**: inclusion of diabetes specific-tasks in the grid certificate may further expose physicians to additional training and as such improve the management of patients with diabetes. Another option is to render further training more binding by defining explicit follow-up measures in the case that physicians fail to follow the training.
- **Training of DMP-physicians**: the introduction of a voluntary training and a confidential supervision by experiences diabetes specialists may increase physician participation in the DMP programme.
- **Establishment of a national diabetes registry**: By extending data collection efforts, a national diabetes registry could be implemented in order to improve the collection of data to monitor and evaluate trends in diabetes.

Cardiovascular diseases

- **Comprehensive study:** Undertake a comprehensive study into the underlying factors of the high CVD disease burden and mortality in Austria. Based on the findings, appropriate measures could be introduced to reduce CVD-related morbidity and mortality.

Policy options: Case and care management

A total of eight policy options to enhance case and care management within Austria have been proposed:

- Target case management and other types of coordinated care based on need
- Pilot new models, evaluate pilots rigorously and scale up successful ones
- Increase organisational and financial integration of providers
- Ensure comprehensiveness of the range of services covered by case management
- Include inter-disciplinary cooperation in education and training programs of professionals
- Continue strengthening the role of primary care and embed case management in primary care
- Provide workplace and return-to-work interventions early
- Embed case management in broad return-to-work interventions.

Policy options: Administration costs

The following policy option relating to administration costs is provided below:

- **Administration caps:** link caps to potential economies of scale arising from more streamlined activities, as opposed to historical allocations. Alternatively, require health insurance carriers to justify higher administration costs, given such costs are often required to improve equality (e.g. performance measurement).

Policy options: Healthcare fraud

Healthcare fraud leads to a significant amount of waste in healthcare systems. To combat healthcare fraud and limit waste within the system, the following two policy options are recommended:

- **Comprehensive study:** Jointly undertake a comprehensive study into the types of healthcare fraud within the system (including associated costs). Based on these findings, implement appropriate policies to create an environment that limits the opportunity for fraud to occur.
- **Digitalisation:** enhance the sophistication of ELGA to enable health insurance carriers to better identify instances of healthcare fraud

1 Introduction

1.1 Review brief

In 2016, the London School of Economics and Political Science (LSE Health) was engaged by the Austrian Ministry of Labour, Social Affairs and Consumer Protection to undertake an efficiency review of the country's social insurance system (see Appendix A for the original Concept Note). The review was specifically targeted at health competencies within the social insurance system; for this reason, consideration of accident and pension insurance, as well as other forms of care covered by Federal and Länder governments, were only examined where directly applicable.

The review can be broken into four interconnected components, each led by a separate organisation. In the first instance, a legal analysis by professors at the University of Salzburg undertook a review of relevant provisions within the law, with findings summarised in *Volume 2- Legal Analysis*. Concurrently, an exercise to map out existing arrangements within the Austrian social health insurance system was completed by Contrast Ernst&Young. Primary and secondary data were used to collect relevant information with findings provided in *Volume 4 – Situational Analysis*. To ensure all relevant stakeholder opinions were collected and analysed, stakeholders, in addition to roundtable discussions (held in February and May 2017), were encouraged to submit a formal statement. *Volume 3* of this report – *Stakeholder Submissions* – combines these statements (see Appendix B for an overview of the invitation provided to stakeholders). Finally, drawing upon information collected in volumes 2-4, as well as further analysis of reports completed by Austrian organisations and experts, and international experiences, a range of policy options have been recommended to improve efficiency within the system (*Volume 1 – International Comparisons and Policy Options*) (see Table 1 for an outline of the review's components).

Table 1: Overview of the efficiency review into Austria's social insurance system

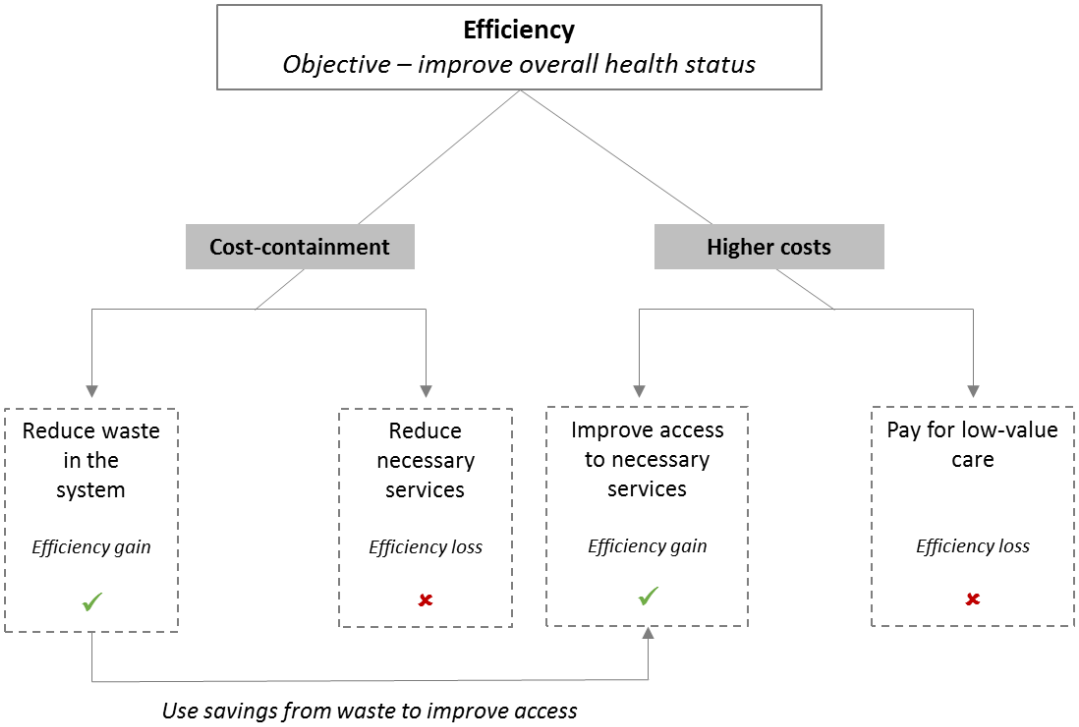
Volume number and report	Objective	Lead organisation
1 – International Comparisons and Policy Options	Compare the Austrian system to international experiences, and using this information, define a range of policy options to improve efficiency within the system.	LSE Health, including a team of international experts, and Institute of Advanced Studies

Volume number and report	Objective	Lead organisation
2 – Legal Analysis	Analysis of relevant legal considerations within the social insurance system	University of Salzburg
3 – Stakeholder Submissions	Compilation of formal submissions provided by key stakeholders within the Austrian social insurance system.	Compiled by LSE Health
4 – Situational Analysis	Map out current arrangements within the Austrian social health insurance system.	Contrast Ernst&Young Management Consulting GmbH

It is important to highlight that efficiency should not be equated with cost-containment, rather the overall objective of efficiency improvements is to enhance overall health status. Using this definition, efficiency gains can be achieved by either:

- Containing costs through a reduction in waste, or a reduction in necessary services (e.g. non-targeted user charges). If the latter, cost-savings will only be realised in the short-term, given patient healthcare costs are likely to increase in the long-term
- Improving access to necessary and beneficial services, through higher expenditure, or using savings from reducing waste (see figure below).

Figure 1: Conceptual framework to improve efficiency within healthcare systems



Source: Framework developed by author.

1.2 Structure of Volume 1 of the review

The following outlines the structure of the remainder of Volume 1, which is based on the Concept Note developed by the Ministry of Labour, Social Affairs and Consumer Protection (see Appendix A). Please note, a description of the Austrian situation for each component of the review has been provided within this report, however, for a more detailed description of arrangements within the Austrian social insurance system, please see *Volume 4 – Situational Analysis*. Legal considerations for each of the policy options has also been provided, in brief, in this report. Similarly, for further information, see *Volume 2 – Legal Analysis.*

- **Chapter 2** provides an overview of the Austrian health care system, including current strengths and challenges
- **Chapter 3** compares key health care indicators in Austria against those in European and OECD countries
- **Chapter 4** outlines the current social security system and provides policy options for how the system could be re-structured to improve efficiency

- **Chapter 5** examines financing mechanisms within the social insurance system including contributions and aligning benefits, user charges, investment activities and the social welfare base
- **Chapter 6** relates to contracts and purchasing arrangements, which covers provider reimbursement, contractual agreements, healthcare quality, the workforce (physicians, specifically), monitoring and information needs, and procurement of pharmaceuticals
- **Chapter 7** relates to public health and disease management, specifically ill-health prevention, health promotion and literacy, and case management
- **Chapter 8** explored additional efficiency potentials arising from administration, healthcare fraud and business IT processes
- **Chapter 9** provides an overview of the review, including all policy options recommended.

1.3 Overview

Our analysis of the Austrian social health insurance system revealed that the system is both complex, as a result of its multi-level governance structure, and fragmented given the dual nature of financing. Specifically, outpatient care (i.e. GPs, outpatient specialists and pharmaceuticals) is financed by social health insurance, whereas inpatient care (including pharmaceuticals) falls under the joint responsibility of federal and Länder (state) governments. Such an arrangement fosters various inefficiencies including cost-shifting, and discourages continuity of care, which leads to higher overall costs (e.g. high level of unnecessary hospitalisations).

This finding is not new, and has been highlighted by various research institutions, as well as policy-makers, as a key barrier to improving healthcare system efficiency. As a result, in recent years, many efforts have been made to improve coordination and align incentives. For example, under the 2005 Healthcare Reform, State Health Funds were introduced to improve coordination between the intra- and extra-mural sectors (e.g. Reform Pool initiative). Further, under the most recent reform (2013), the concept for primary healthcare units (PHUs) was introduced; today two units are in operation with plans for 75 PHUs by 2020.

Ultimately, the problem of dual financing can only be overcome either with major constitutional reform or with joint budgets across the spectrum of care (i.e. primary, outpatient, inpatient, long-term and social care). However, we recognise the extreme legal difficulty implementation of joint budgets presents, given a two-thirds majority within Parliament is required. In response, the policy options within this report present pragmatic approaches to enhance coordination and improve efficiency.

Another key issue that has been raised, is that concerning the number of social health insurance carriers. Multiple purchasers of healthcare is not uncommon, for example, in England, responsibility for purchasing services is devolved to over 200 Clinical Commissioning Groups. Further, in Sweden, provision of healthcare falls under the remit of 21 county councils and regions. For this reason, the total number of carriers, in our opinion, is not viewed as the most important barrier to achieving efficiency. Nevertheless, options to enhance efficiency by amalgamating carriers and encouraging coordination have been proposed.

In our opinion, the two pressing challenges facing Austria refer to the types of services procured by purchasers, and secondly, by the allocation of funds to purchasers. In regard to the former challenge, Austria is unique in that healthcare purchasers operate in silos (i.e. insurance carriers versus Länder), that is, purchasing care for a portion, as opposed to all healthcare services. Concerning the latter, only a small proportion of health insurance carrier funds are risk-adjusted, which results in inequities. This is also the case with other resource allocation mechanisms in Austria (i.e. federal government to the Länder or from social health insurance to the Länder), which are mostly based on political negotiations and historical allocation patterns.

Limited risk-adjustment has meant that, despite uniform contribution rates (with the exception of the BVA, which only differs by 0.015%, and the farmers (SVB)), differences in benefits for specific services may occur. Such an arrangement is inequitable and goes against international trends. However, it is worth highlighting that self-reported unmet need (healthcare) in Austria is one of the lowest in Europe (see Figure 2, which outlines the three dimensions of universal health coverage).

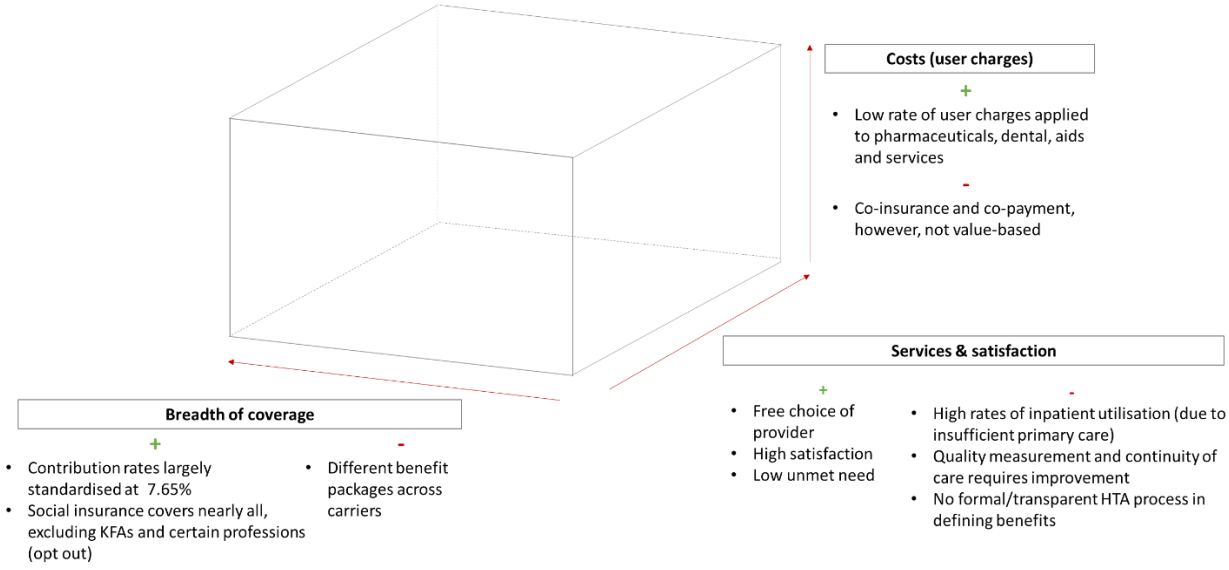
Ensuring high-quality care has also been a key agenda for policy-makers over recent years. For example, with the introduction of the Federal Institute for Quality in Healthcare Systems (including the Austrian Society for Quality Assurance and Quality Management in Medicine), as well as quality indicators for inpatient (Austrian inpatient quality indicators, A-IQI) and outpatient care (Austrian outpatient quality indicators, A-OQI). Despite this, the types of quality indicators measured, in addition to the uses of information collected in Austria, could be enhanced. More robust information on quality within the system will ultimately improve patient outcomes via the development of evidence-based policies (see Figure 2).

Finally, it is evident that more recently Austrian policy-makers have recognised public health as a key area for enhancement, for example, with the development of the diabetes disease management program. Nevertheless, through discussions with stakeholders, in addition to findings within the policy and

academic literature, it is clear that relative to other advanced European countries, Austria's primary care and public health sectors could be significantly improved. This is evidenced by, for example, low rates of vaccinations and lower than average life-expectancy projections, as well as high inpatient admissions rates, including those for ambulatory care sensitive conditions (e.g. diabetes and asthma). Such findings reiterate the need for further investment in primary care and public health, while being cognisant that, in the short-term, cost-savings are unlikely, given the presence of fixed hospitals costs (e.g. labour and maintenance) (see Figure 2).

Key findings, as described above, have been summarised in the following figure outlining the three key dimensions within universal healthcare systems. The dimension 'breadth of coverage' outlines who is covered by pooled funds, 'services and satisfaction' refers to what services are covered, while 'costs (user charges)' explains what proportion of costs for services are covered. Key findings within the Austrian system have been categorised as either positive, or requiring improvement (1).

Figure 2: Dimensions of universal health coverage



1.4 Summary

Based on the findings outlined above, a number of policy options to improve efficiency within Austria's social health insurance system have been proposed. In reviewing this policies, we offer policy-makers and stakeholders the following recommendations: firstly, to view policy options outlined in this report, as well those by various Austrian research institutions and organisations (including stakeholder submissions – Volume 3 of this review); secondly, to ensure future discussions and implementation of policy options be done in a transparent and inclusive manner so that key stakeholders do not view change as a 'zero-sum game'; and thirdly, to keep in mind that no healthcare system is perfect, and that any future efforts should build upon current successes, which in the case of Austria, include high-levels of population satisfaction as a result of ease of access to healthcare services, and low levels of unmet need.

2 Overview of the Austrian social security and healthcare system

Chapter 2 provides an overview of the Austrian healthcare system including major stakeholders and their function. Following on from this description, an overview of key strengths and challenges facing the system are explored. Given the overall report is focused on improving efficiency, significant emphasis has been placed on 'challenges' as findings were used to identify efficiently potentials

2.1 Organisation of the health system

Austria is a federal state made up of nine states (Länder), who in turn are comprised of municipalities, with the exception of Vienna (2,3). Both federal and state governments are vested with legislative and executive powers. Municipalities, on the other hand, are not granted legislative powers, instead, they issue ordinances to fulfil federal state administrative tasks.

In international terms, Austria's healthcare system can be classified as a social health insurance system, given, primarily, employers, employees and the self-employed pay contributions in return for access to a package of healthcare services (2,3). The healthcare system is characterised by its dual nature, whereby competencies, and thus financing arrangements, are split between federal and state governments, and social health insurance (3,4). Specifically, outpatient care (i.e. GPs, outpatient specialists and outpatient pharmaceuticals) is financed by social health insurance, whereas inpatient care (including pharmaceuticals) falls under the joint responsibility of federal and Länder governments. As a result, the system has often been referred to as both complex and fragmented (3). For example, although most major healthcare forms fall under the legislative competency of the federal government (Article 10, 12 B-VG), they require approval from the states (Bundesländer). Therefore, provision of hospital care often dominates the political debate (at the expense of other forms of care) (3).

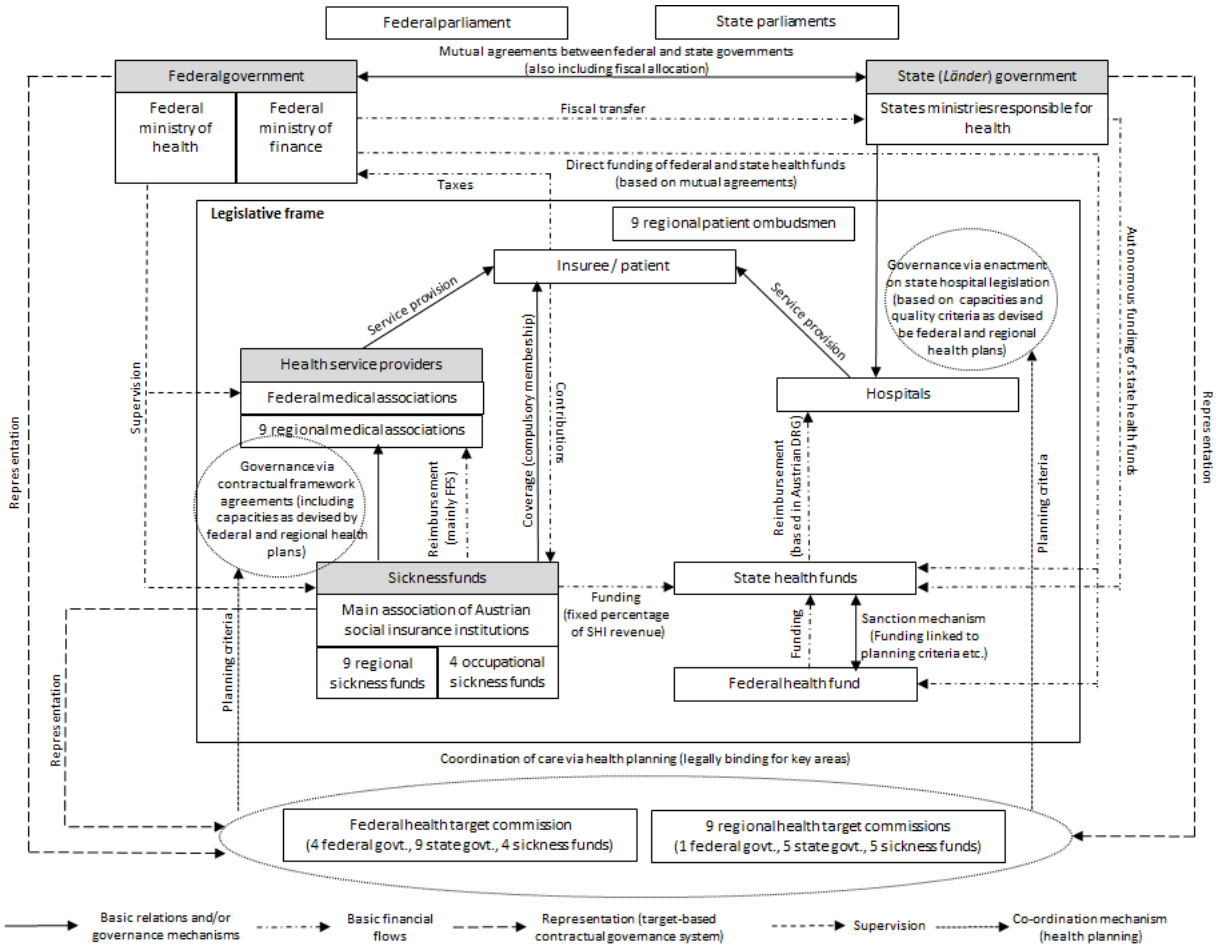
Various actors are involved in organising the Austrian health system. Each actor differs in terms of their political legitimation and inner governance mechanisms. Social health insurance carriers, as well as the professional bodies, are established on the basis of occupational and/or regional membership and operate as self-governing bodies (however, the Federal Government is responsible for social insurance legislation) (3). As a result, social insurance carriers enjoy autonomy from government intervention, for example, by appointing their own supervisory boards (3). Federal and state governments, on the other hand, are directly legitimised by the electorate.

As stipulated by constitutional law, the federal government is primarily in charge of regulating healthcare. Within social health insurance, carriers are subject to different laws, specifically the ASVG applies to GKKs (regional health insurance carriers, Gebietskrankenkasse), BKKs (corporate health insurance carriers) Betriebskrankenkasse) and the VAEB (railways and mining insurance carrier, Versicherungsanstalt für Eisenbahnen und Bergbau), the GSVG for the SVA (self-employed insurance carrier, Sozialversicherungsanstalt der gewerblichen Wirtschaft), the BSVG for the SVB (farming insurance carrier, Sozialversicherungsanstalt der Bauern), and the B-KUVG for the BVA (civil servants carrier, Versicherungsanstalt öffentlicher Bediensteter). In regard to hospital care, the Federal Government is only responsible for setting the framework for regulation, with state governments delivering healthcare services in order to meet their constitutional obligation.

As shown in the figure below, the current legal framework has led to a high number of actors involved in the organisation and governance of the health system. To improve coordination between social health insurance, and federal and state governments, several initiatives have been introduced (3,5). For example, in 2005, State Health Funds were implemented for the purpose of pooling funds from social health insurance, and federal and state governments to finance public acute care hospitals (according to the country's DRG system).[1] Their role is also to improve coordination between intra- and extra-mural sectors (e.g. 'Reform pool' initiative). Further, under the 2013 Healthcare Reform, both federal and state target control commissions were established to help achieve the country's overall health target of increasing the number of healthy life years by two over the next 20 years (e.g. by enhancing population health literacy (target 3) and encouraging positive nutritional habits (target 7)).

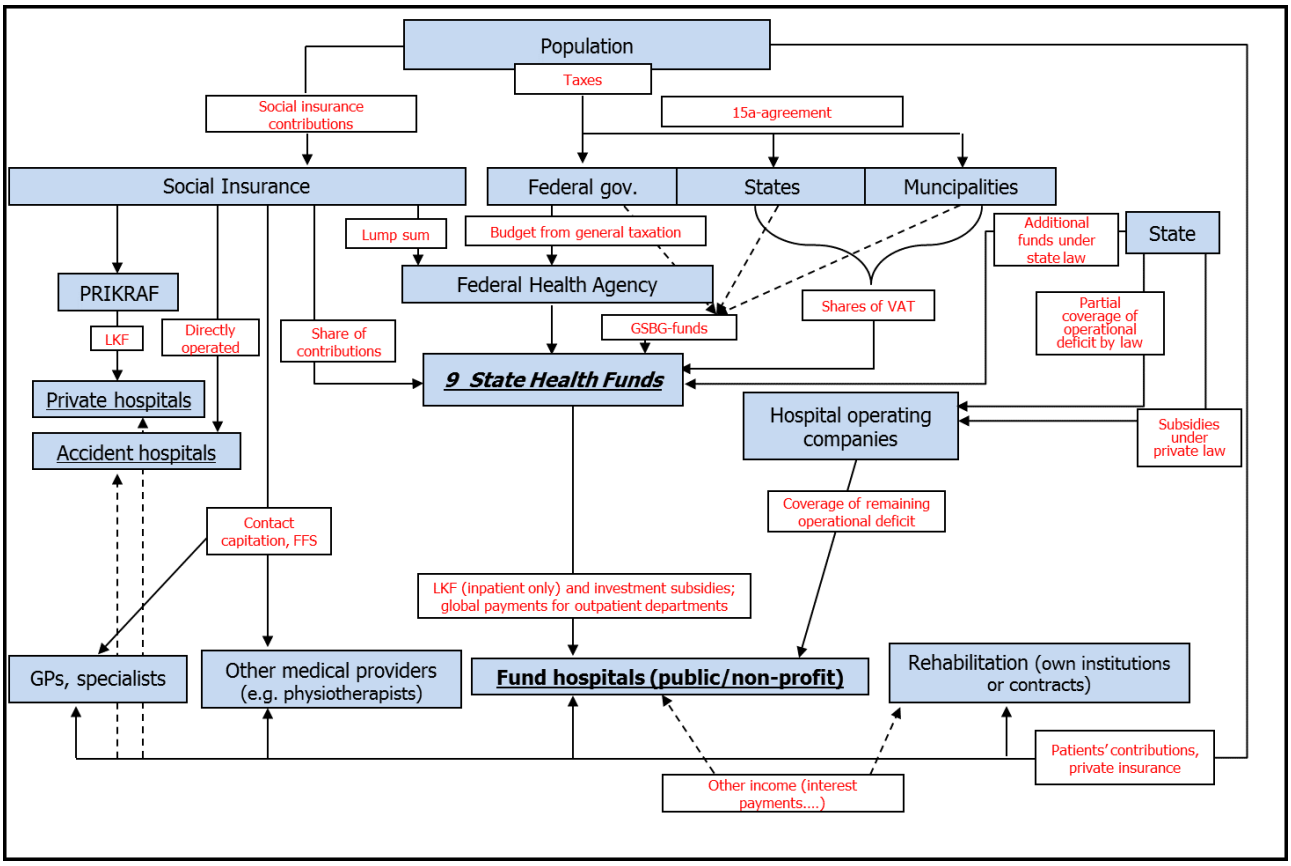
[1] State Health Funds are the primary form of financing for hospitals, however, additional funding stems from general taxes, municipalities, VAT and social insurance.

Figure 3: Organisation of the Austrian Health System, 2017



Source: Ostermann, H. 'Organisation and governance of the Austrian health system'. Working paper (unpublished) for the Austrian HiT-report (forthcoming 2018). 2017.

Figure 4: Organisation of the Austrian Health System, 2017, financial flows



Source: (6)

2.1.1 Governance

The various actors involved in the Austrian health system can best be described by their (inherent) governing structure and/or corresponding area of governmental sovereignty. The relevant categories therefore encompass the federal level, the state level, and social health insurance level.

Federal level

At federal level, the federal parliament, as the representation of legislative power, as well as the Federal Ministry of Health and Women's Affairs and, to a lesser extent, the Federal Ministry of Finance represent the key actors in health system governance.

There are various commissions in charge of advising the Ministry of Health and Women's Affairs, all of which require significant medical and/or scientific expertise. The most prominent commission, in this regard, is the Supreme Health Board (Oberster Sanitätsrat), which advises the Ministry on specific medical

queries, including 'start of the art' medical technology and services. In addition to the Supreme Health Board, various advisory boards have been established based on mutual agreements set out in Article 15a agreements of the Federal Constitution, or directly on behalf of the Ministry, according to Article 8 of the Federal Constitution.

The Ministry is also supported by subordinate agencies responsible for various consultancy tasks regarding areas such as information services, food and health safety, and technical infrastructure. For example, by the Austrian Public Health Institute (Gesundheit Österreich GmbH),[2] Austrian Agency for Food and Health Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit GmbH)[3] and the Electronic Health Record Company (ELGA GmbH)[4].

Länder (state) level

Developing the framework for legislation falls under the remit of the Federal Government, however, it is the Länder governments who implement detailed legislation (3).

At the level of the Länder (states), the state parliaments, as well as the state ministers responsible for healthcare, represent the main actors in regard to health system governance. The remit of state health ministers, in general, encompasses the following areas of responsibility:

- General issues of (public) health
- Hospital care (running their own hospital or contracting out to providers)
- Ambulatory services
- Healthcare labour
- Long-term care.

As previously outlined, the Länder are responsible for providing hospital care, specifically by ensuring the availability of adequate hospital capacity. Hospital services are either provided by public state-owned hospitals or public hospitals run by not-for-profit institutions. Regardless of ownership, hospitals are reimbursed by State Health Funds (which receive monies from federal, state and local governments). All

[2] The national public health research and planning institute, which also administers the Federal Funds for Health Promotion (Fonds Gesundes Österreich).
[3] Joint agency of the Ministry of Health and Women's Affairs and the Ministry of Agriculture, Forestry, Environment and Water management in charge of the protection of human, animal and plant health, of medical and drug safety, as well as of food security and consumer protection along the food chain.
[4] Joint institution of the Federal Government, the state governments and social health insurance carriers. The company is responsible for further development of the national e-health infrastructure as well as for the coordination of all relevant activities to roll-out electronic health records.

states, with the exception of Vienna, have established state-owned operating companies for their hospitals, most of them in the form of a public or private limited companies.

Finally, all Länder have established patient ombudsman/lawyers (Patientenanwälte) offices. Each ombudsman operates as an independent institution responsible for informing patients of their rights, as well as acting as mediators and advocates of patient interests where poor-quality care or malpractice has occurred.

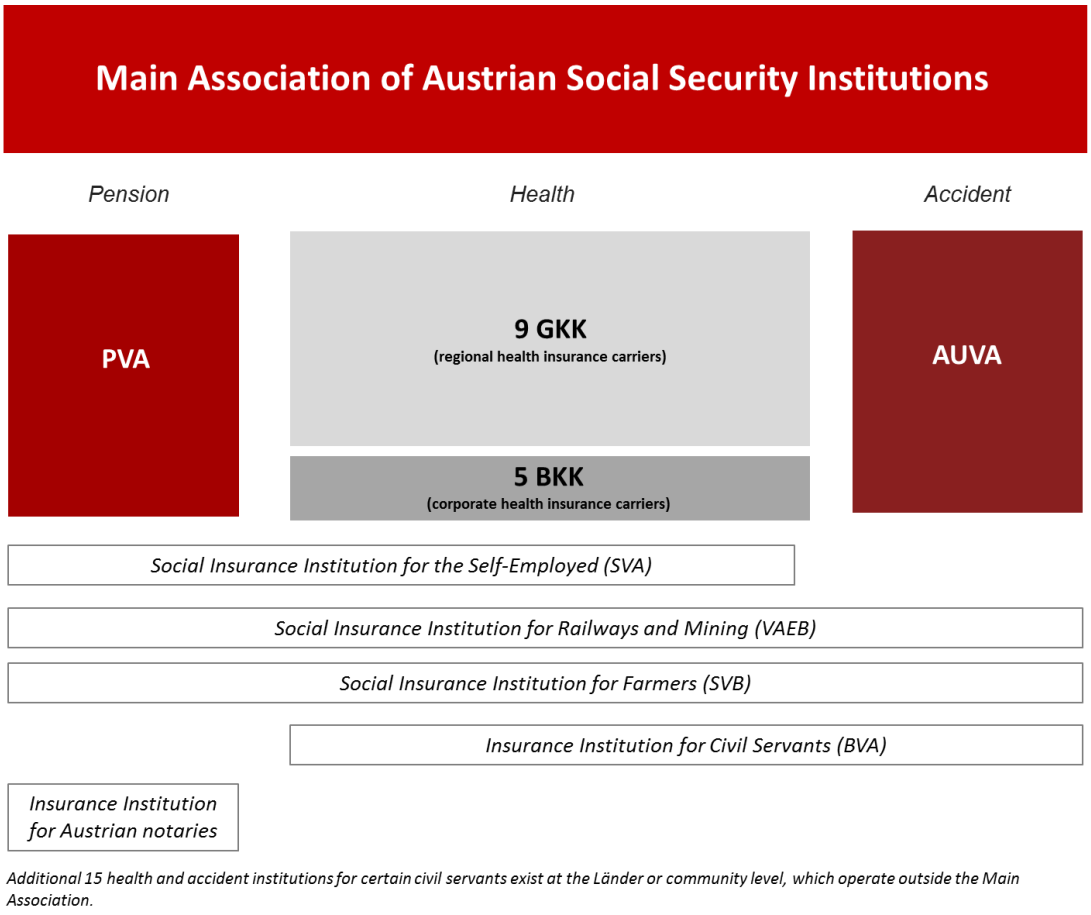
Social health insurance

The primary self-governing bodies relevant within the health care system are the social insurance carriers. In addition, there are professional bodies representing health service providers (predominantly the Chamber of Physicians), as well as voluntary professional associations (3).

The current organisational structure of the health insurance system was established in 1947 under the Social Insurance Transition Act, which established the Main Association of Austrian Social Security Institutions (Hauptverband der Österreichischen Sozialverischerungsträger, HVSV). The HVSV operates as the umbrella organisation for all insurance carriers operating within social insurance, which also covers pension and accident insurance. Theoretically, the HVSV is responsible for regulating all social insurance carriers, however, in effect, it relies upon the cooperation of its members (i.e. the carriers) (3).

The HVSV currently includes 21 social insurance carriers, 18 of which offer health insurance (see figure below). The vast majority of the population are covered by social insurance (i.e. 99%), given, by law, Austrian inhabitants are assigned to an insurance carrier based on their employment status. Specifically, *most* employees (and their dependents) are insured by a regional health insurance carrier (GKK) corresponding to the location of their employment. Employees not covered by GKKs include railway workers and miners, self-employed, farmers and civil servants. Each of these employment groups are insured with carriers specific to these groups, which in addition to health may also provide work accident and/or pension insurance. Five, relatively small, professional health insurance carriers (BKK), based on former key public industries, also offer health insurance. In addition to these social insurance carriers within the HVSV, some groups of Länder and municipal civil servants are insured with one of 15 KFAs (Krankenfürsorgeanstalten), offering health and accident insurance. The KFAs are not represented in the HVSV and their establishment under Länder law is provided for by the B-KUVG.

Figure 5: Organisation of Austrian social insurance, 2017



Additional 15 health and accident institutions for certain civil servants exist at the Länder or community level, which operate outside the Main Association.

As previously discussed, health insurance carriers are responsible for the provision of outpatient care for its insurees (3). To carry out this function, carriers must engage in negotiations with the Chamber of Physicians (with one operating in each state), to create a general contract outlining reimbursable services and associated fees. In addition, health insurance carriers may also provide care with their own institutions (3).

2.2 Strengths

2.2.1 Access

The Austrian healthcare system performs well on all dimensions of healthcare coverage as it is based on a social insurance model that guarantees all inhabitants equitable access to high quality health services – irrespective of their age, sex, origin, social status or income. Thus, access to healthcare services is high

with 99.9% of the population being covered by the social health insurance system (7). Most of the remaining 0.01% are able to opt out in favour of full private health insurance (e.g. physicians). Relatively low co-payments for services also enhance access to healthcare. Persons who are chronically ill or persons from vulnerable groups are exempt from most co-payments. Also providing for timely access to acute and emergency services is the number of most provider types and the wide availability of services for the population due to planning criteria already factoring in accessibility.

2.2.2 Equity

Equity, in regard to access to healthcare, is also high given that the social health insurance system covers vulnerable groups such as asylum seekers and needs-based minimum benefits recipients (8). In terms of services provided, very few Austrians report unmet needs in terms of medical or dental examinations due to costs, travel or waiting times according to an analysis of EU-SILC (Statistics on Income and Living Data) (7). Further, the income gradient among reported cases is low, indicating equitable access to care. All in all, this equitable access can be ascribed to the principles of the Austrian healthcare system, which are solidarity, affordability and universality and to the fact that patient rights are not only legally defined but can also be enforced by law. Patient ombudspersons in each Land ensure low level access to assistance in cases of malpractice and other types of misconduct irrespective of the individual's capability to cope with such matters.

2.2.3 Resilience

The Austrian healthcare system is very stable in terms of the ability to create revenues and to provide services. This can probably be attributed to the overall economic policy and industrial relations geared towards stability, for which the tradition of compromise among the social partners seems to be key. What is more, the system of self-governed social health insurance provides for some independence from political and subsequent budgetary changes in the federal government. As a result, during the economic crisis of 2008 and onwards, the Austrian healthcare system proved comparably resilient (9). Further, the 2013 healthcare reform established a common understanding of a vision for the Austrian healthcare system as well as instruments to find joint solutions for necessary change among SHI, Länder and federal government.

2.2.4 Satisfaction

Finally, patients seem to be satisfied with the overall quality of healthcare in Austria: According to the Eurobarometer, 96% of the population regard the system as 'good' and rate the quality of healthcare

compared to other EU Member States as 'better' (60%) or 'the same' (34%) (10). A factor which could play a part in contributing to the high satisfaction is the free choice of healthcare providers alongside their availability. This high satisfaction could also be linked with a high self-reported health status of 70%, i.e. almost three quarter of the Austrian patients classify their health status as being 'good' or 'very good' (11).

2.3 Challenges

2.3.1 Governance

Split competences

A fundamental issue in the Austrian healthcare system is the split in competencies between at the federal and Länder level, which is outlined in the constitution (3). In regard to hospital care, laws are passed at the federal level for general healthcare, which includes laws social health insurance is based upon. It is also at the federal level that responsibility for executing the law lies (art. 10 of the constitution). Concurrently, the Länder have the right to pass and execute laws on the basis of a more general federal law. The Länder, alongside municipalities, are also responsible for long-term care, however, it is the federal government who funds the long-term care allowance through pension insurance carriers. A similar overlap in competencies exists for areas of healthcare concerning people with disabilities (see Volume 2 – Legal Analysis for further details)

This fragmentation makes intergovernmental negotiations necessary. Specifically, approximately every five years such discussions lead to an agreement according to art. 15a of the constitution on the organisation and financing of healthcare. This split in competencies is frequently discussed in the literature as a major obstacle to improving health service delivery, especially for the chronically ill. Accordingly, Austria is not a top-performer in regard to rates of chronic diseases among countries in Europe (6,12–17).

Previous attempts to attribute whole areas of governmental tasks to only one level of government were not successful. Neither the 'Österreichkonvent' 2003-2005[5] nor the working group on administrative reform 2009-2011 brought about a change in this constitutional setup. The healthcare reform 2005 aimed at creating platforms on the federal (Federal Health Commission, *Bundesgesundheitskommission*) and

[5] Results of the Österreich-Konvent are presented on http://www.konvent.gv.at/

Länder level (State Health Platform, *Landesgesundheitsplattform*) to jointly plan the structures and take decisions in the Austrian healthcare system. Moreover, a common planning framework, the Austrian Structural Plan for Health (*Österreichischer Strukturplan Gesundheit, ÖSG*) was introduced, to be substantiated on the Länder level between Land and SHI as the Regional Structural Plan for Health (*Regionaler Strukturplan Gesundheit*). However, the success of the reform as a whole seems to have been limited and the Austrian Structural Plan has been criticised for its limited ability to achieve coordination of planning (18,19). Thus, the healthcare reform 2013 institutionalised a common governance instrument, the target control system for health (*Zielsteuerung Gesundheit*), alongside virtual common budgets between SHI and each Land, subject to a maximum expenditure growth path. It also instated a second body on both federal and Länder level, the Federal Target Control Commission (*Bundeszielsteuerungskommission*) and the State Target Control Commission (*Landeszielsteuerungskommssion*), responsible for planning and executing the target control instrument (Gesundheitsreformgesetz 2013). These new institutions consist only of representatives of the main payers in healthcare, the federal government, the Länder and SHI and seem to be an attempt to reduce the complexity in decision making processes. In 2017, with a new 15a-agreement for both organisation and financing as well as target control, structural planning was made more compulsory by instating the 'Gesundheits-Planungs-GmbH', a limited liability company receiving sovereign rights from both the federal and the Länder level to make parts of the structural planning mandatory by official decree (Vereinbarungsumsetzungsgesetz 2017). The Federal Target Control Commission replaced the Federal Health Commission as the governing body of the Federal Health Agency.

Fiscal and parafiscal federalism, veto players

The split of competencies within healthcare between the levels of government entails that healthcare is heavily affected by fiscal federalism (20). Over the years, negotiations resulted in numerous rules and exceptions, making the financial flows complicated and thus in-transparent (6,13,21). In addition to fiscal federalism, the same phenomenon applies to social health insurance, as every insurance carrier is self-governed and entitled to its insurees' contributions. Federal, Länder and SHI's contribution to hospital financing as well as partial equalisation between insurance funds are based on historical values instead of needs, and are incomplete. What is more, as the federal government levies taxes in the name of all levels of government, this paves the way for 'fiscal illusion': An expansion in hospital services by Länder governments might be favourable with voters, who in turn are not directly burdened by increased Länder taxes (21). While budget constraints apply and debt burden is limited by the stability pact, some Länder

were indeed creative by e.g. having the hospital operating companies taking on debts, indicating the need for a transparent way of needs-based allocation for tax money.

Federal structures can also be found in most other corporatist elements in Austria. The social partners as the main carriers of social health insurance as well as the Chamber of Physicians have federal structures as well. Together with the strong role of government levels in a Bismarckian healthcare system, Austria has to cope with an unusually high number of veto players, making the process of healthcare reform more complex (15,22).

Governance of social insurance funds

Many European countries ensure responsiveness to insurees either by the introduction of competition (either between more public funds like in Germany or Belgium or between private insurer like in the Netherlands and Switzerland) or by improving their representation (e.g. in Scandinavian countries). While competition might be beneficial in terms of improving responsiveness, it is also prone to unwanted risk-selection. Establishing effective and efficient representation, on the other hand, also proves to be a challenging task.

Austria is one of the few countries with a Bismarckian system in Western Europe that has not introduced choice and competition between insurance carriers, further the system continues to rely on compulsory profession-based insurance (23). Governing bodies are elected indirectly whenever the employers' or employees' chambers hold elections. These governing bodies send their chairpersons to form the governing body of the Main Association of Social Security Institutions (HVSV). As a result, both voice and choice for insurees are rather limited, which limits the incentive for carriers to be responsive and innovative (22). For example, one study (24) finds one of the reasons that DMPs have not been successful is that insurance carriers lack the incentive to reallocate means accordingly. Thus, introducing some elements of competition, e.g. yardstick competition while at the same time improving representation would contribute to system efficiency.

Hospital laws

With regard to the hospital sector, it is difficult to assess and compare the performance of hospitals across Austria given the current competence distribution and financing arrangements (dual financing). Through the existing competence distribution in many fields there are ten hospital laws. Currently a pattern relating to Länder laws can be seen, which shows that the Länder either take over federal legal regulations or implement them by means of own expressions with identical content. Thus, there are ten legislators,

administration departments and legal departments employed with identical topics. In this area a bundling of legislation to the federal level would have a high efficiency potential (i.e. by implementing laws in a more timely manner). The Austrian Court of Audit identified several potentials in its report 'Verwaltungsreform 2011' (Bund 2011/1), for example, the fragmented constitutional competences in health care, the deficient coordination between the intra- and extramural sector, the overload of the inpatient sector, the high location density, insufficient balance of services and collaborations, the lacking cross-carrier service offer, the service shift between intra- and extramural sector and the absent quality measurement and assurance (25). For further details regarding possibilities to re-distribute competences with respect to the hospital laws, and in accordance with the constitutional law, please see Volume 2 – Legal analysis (Chapter 6).

2.3.2 Revenue collection and pooling

Contribution base

For SHI, the contribution base is income by the employed, their employer's part of contributions and income by the self-employed. With the exception of farmers, a uniform contribution rate is then applied. There are no recent studies measuring the degree of equity in financing. However, some older studies show that the social health insurance system was more regressive than other European SHI-systems at the time of the respective studies (23,26,27). This narrow (i.e. only work-related) contribution base is somewhat mitigated by the fact that the contributions to hospital financing and some other health related activities from all levels of government are based on VAT and general taxes. Nevertheless, Austria has one of the highest tax wedges in the OECD (28).

Contributions are collected by each health insurance carrier separately. Where people have more than one source of income, this might mean that they are multiple insured. On the one hand, multiple insured must actively ask for refund if they reach the maximum contribution level with all insurance carriers combined. On the other hand, they can choose their insurer in every case of health service provision. Thus multiple insurees, for example, can avoid user charges in one case, while benefitting from high reimbursement for medical appliances in another, raising equity issues in an insurance system without competition (16).

General taxation also subsidises healthcare through the system of 'Hebesätze'. These 'Hebesätze' are a fictitious employer's contribution for pensioners, paid by the respective pension insurance. However, given the federal government subsidises pensions (with the level of subsidisation differing across carriers), the general tax payer effectively subsidises some funds more generously than others.

Pooling across risks and income

Due to the profession-based insurance system, with the regional health insurance funds as a default, risks as well as income groups are distributed unequally. Nevertheless, no internationally comparable comprehensive risk-adjustment system is in place (16). Only the regional health insurance funds take part in the equalisation fund according to §447a, redistributing 1.64% of contributions.[6] As per capita income of insurance funds varies considerably, a major mechanism to reduce the difference in per capita means are the very different tariffs for contractual partners and equalisation funds for various areas like hospital financing. Further mechanisms are in place e.g. mutually reimbursing work accident insurance and health insurance, albeit only through historically based lump sums.

As a considerable part of healthcare is funded by the federal government and the Länder, risk-equalisation is also an issue there. However, the fiscal equalisation system is mainly based on negotations rather than a risk or needs-based allocation formula.

Differences in entitlement and reimbursement

Due to historical developments as well as different incomes per recipient, entitlement to services and reimbursement vary between the insurance carriers. While some general rules are defined by law, the insurance carriers' statutes and so called 'Krankenordnungen' play a major role in defining entitlement and reimbursement. The HVSV issues a template statute and a template 'Krankenordnung' and make certain items compulsory for all insurance carriers (§455 and §456 ASVG). However, as the governing body taking the decision in the HVSV consists of the chairpersons of the insurance carriers, there are only few such mandatory clauses, which can also be seen from comparing the statutes in the SozDok[7] or HVSV (2016) (29). The KFAs, which are outside the HVSV, seem to have even more generous deviations from the average insurance fund, for example, reimbursing all costs incurred by non-contract providers (as opposed to the 80% offered by other carriers). This, however, raises equity concerns, as insurees can neither choose their fund nor have effective voice options, while paying the same contribution rates.[8]

[6] For more information on the risk-equalization fund according to §447a ASVG see SAR or SGKK(2006)
[7] SozDok ist he documentation system of social insurance law, www.sozdoc.at
[8] This is partly mitigated by the fact that some funds have higher user charges.

2.3.3 Purchasing and provision of services

Public health

As with other fields in healthcare, the tasks within public health are split between all levels of government and SHI. In its inception, SHI was aimed at providing care for the ill, and only in the last two decades was tasked with measures of prevention and health promotion (see changes to §116 ASVG). The healthcare reform of 2013 tackled some of the issues already laid out in a report of the European Observatory on Public Health in Austria, most notably to adopt the concept of health in all policies and making prevention and health promotion an explicit goal (30). Nevertheless, Austria still lags behind in some major public health areas, like tobacco control, where it takes the last rank in the tobacco control scale 2016, as well as in alcohol consumption (17,31).

The healthcare reform 2013 also introduced a system of health targets. Ten very broadly defined framework health targets (*Rahmengesundheitsziele*) were determined. These are monitored by 40 Meta-indicators (32). Each framework target has several operative targets (*Wirkungsziele*), each of which are again to be monitored by 1-2 indicators. For each operative target, several pre-existing or newly developed measures were defined, each of which is to be measured by one indicator. In addition to this, the target-control health (*Zielsteuerung Gesundheit*), mainly concerned with the healthcare system proper, is governed by 26 targets monitored by 106 indicators (33). While it is admirable that after a long time with little activity in the field of public health, considerable efforts were made to catch up, the number of targets and measures seems overambitious. International experience shows that a lower number of targets that are widely shared among the stakeholders but consequently observed on all levels is the more promising approach (34,35). Indeed, the latest federal target control agreement (*Bundeszielsteuerungsvertrag*) shows a reduction of targets at least for target control health.

Ambulatory care: structure and personnel

The ambulatory sector is split between outpatient departments in hospitals and physicians in private practice (extramural sector). Both subsectors provide a wide range of specialist services, creating an overlap and interactions that provide the opportunity for supplier-induced demand (36). There is little integration, as SHI is responsible only for services outside the hospital. Access to both subsectors is not limited or coordinated, creating the opportunity to overconsume services while at the same time hampering coordination of care. In the extramural subsector, the predominant form is single practice,

limiting its ability to cater to the needs of complex patients or cases out-of-hours, and thus, continuity of care.

In the extramural sector, the typical practice consists of the GP or specialist and their practice aid. Efficient allocation of tasks to differentiated non-physician personnel is not possible. In general, Austria performs poorly in terms of true primary health care, leading to comparably low performance in terms of avoidable hospitals admissions and outcomes in chronic diseases (37–39). This major downside is planned to be tackled by the PHC-law, allowing different groups of health professionals to work together. If a true primary care based system is to be implemented, GPs need to be able to cope with a wide variety of health and social problems that can mainly be found in GP-practices. Gathering experience with the setting before taking a post as a self-employed GP in the field, however, is difficult because postgraduate training for GPs is still primarily situated in hospitals despite a recent reform (Ärztinnen-/Ärzte-Ausbildungsordnung 2015 – ÄAO 2015).

Ambulatory care: contractual arrangements

In order to contract GPs and specialists working in practices, SHI has to engage in negotiations with the regional Chamber of Physicians for all physicians (GPs and specialities) combined. Selective contracts with only one speciality or single physicians without a general contract is not envisaged by the law. This joint negotiation therefore probably increases the veto-power of every single speciality, as only a so called general contract (*Gesamtvertrag*) with all specialities together can be concluded (14,22).

In order to ensure similar general contracts, the Main Association of Social Security Institutions in theory has to negotiate all general contracts on behalf of each sickness fund (§341 ASVG). However, this is purportedly not the case, perpetuating a great diversity in contracts as well as fee schedules. The diversity does not only pertain to the height of the tariff for one and the same service, but also the items themselves, leading to considerable differences in the number and thus the structure of the fee schedules, as can be seen in the meta fee schedule of the Main Association of Social Security Institutions that tries to match the different items to a common list. Apart from the fee schedule, the number of contract physicians per region are negotiated (§342 ASVG). The positions themselves, however, are filled through a list handled by the Chamber of Physicians, creating an individual contract between the insurance fund and the physician. Thus, the respective insurance fund cannot decide to contract a specific person on its own. The list is filled based on criteria proposed to the MoH by the Chamber (§343 (1a) ASVG), e.g. professional experience, additional qualifications, time on the waiting list etc. While SHI can only terminate an individual contract due to severe misconduct by the physician, a contract physician can

terminate at any time with a three-month notice period. In case a general contract terminates without a new general contract or the general contract is terminated by one of the parties, an arbitration committee can only extend it for a limited period (§348 ASVG). After that, all individual contracts expire, and all patients need to pay for physician services out of pocket and have to submit the invoices to their insurance fund. As this is a severe administrative burden and an inconvenience to patients, it has been argued that the current negotiation framework favours the physician side (40).It has also been argued that SHI is very limited in the way it can fulfil its task according to §338(2) to provide adequate medical care to its insurees, which, in contrast e.g. to Germany[9], it bears alone (22).

As there are in fact different general contracts for physician services, also the number of contract physician differs. Some physicians opt to only contract with some of the insurance funds, which leads to the paradox situation that smaller but more affluent funds have more physicians under contract than the §2-funds (see the following table):

Table 2: Number of contracts with different insurance funds

	§2-funds	VAEB	BVA	SVA
GPs	3.950	4.025	4.001	4.052
Specialists	3.044	3.353	3.393	3.407
General specialists	2.814	3.130	3.168	3.181

Source: Ärztekostenstatistik 2015

This system also leads to an unusual separation into the contracted GPs and specialists as opposed to a large and growing number of non-contracted self-employed physicians (explained in detail in section 6.3.7).

Ambulatory care: financing and payment

The fee schedules for contracted physicians are in general not based on costing data as it is done in relative value scales like TARMED or EBM, but rather on negotiated fees that are jointly increased no matter the underlying changes (41). TARMED and EBM are used in Switzerland and Germany, respectively. Both

[9] In Germany, SHI and the Associations of SHI-contracted physicians (Kassenärztliche Vereinigungen) carry the joint responsibility to provide adequate services (§72 SGB V).

systems are based on cost calculations for each service so that compensation reflects the actual expenses and efforts by the personnel. What is more, fees differ considerably between insurance funds, as also the law (§342(2)) states that fees should be set according to the financial power of the insurance fund. This is found to set distortionary incentives for physicians when treating patients. It is also an inefficient allocation of funds, as some physicians have their practice in areas with a population dominated by insurees whose insurance fund pays low fees. This essentially means that the low fees already have to be an acceptable source of income, whereas physicians in affluent regions in this sense thus receive economic rents.

The payment mechanism for GPs is contact capitation (approx. 70% of income) with additional fees for service (30% of income). For specialists overall, this ratio is essentially reversed. For some services, insurance funds usually apply a maximum volume, beyond which they pay only a reduced or no fee. By international comparison, the Austrian payment system seems thus to be outdated, as it neither reflects actual costs and efforts incurred nor the risk-structure of patients, nor does is incorporate quality (41,42). For primary care, the changes in the course of the PHC law is supposed to bring about a change in the payment system for GPs, as the changes to the ASVG require SHI to develop a payment system that introduces a more differentiated system of capitation, case-based payments, fee for service and probably some pay-for-performance components (see the new §342b (3) ASVG introduced by the *Gesundheitsreformumsetzungsgesetz 2017*). Nevertheless, there will still be no payment mechanisms fostering integration of primary and secondary care.

The outpatient departments in hospitals are paid by a global budget based on historical values. This sets a distortionary incentive to admit patients to inpatient care, where the hospital receives DRG-points per stay. On the other hand, SHI pays for all extramural services alone, while it contributes ca. 45% in the form of a lump sum to hospital financing. This sets the incentive for SHI to restrict services that it has to pay for in full, channelling patients to outpatient departments in hospitals. This might be an explanation why despite a lot of public debate, the integration of the extramural sector with outpatient departments (envisaged in the healthcare reform of 2005) as well as out-of-hours care in the extramural sector are not well developed. Another possible reason is that any change in this setting would create additional costs during the transition. Winding down capacity of outpatient departments leaves the hospital with fixed costs for some time, while a possible transfer of funds to the extramural sector requires payment of full costs, even if they are lower than full costs inside the hospital.

Inpatient care: structure and personnel[10]

Austria has an unusually large inpatient sector and above average inpatient stays. Several factors seem to contribute to this. One is probably the fiscal illusion already mentioned, i.e. in an ageing population, it is politically beneficial to build hospitals, even more so when for the constituency, the connection to the tax burden this entices is concealed (20). Also, the payment system favours the inpatient departments (see below). Another reason might be that even publicly funded non-profit hospitals are allowed to have a so called 'Sonderklasse'. Patients in the 'Sonderklasse' are not only entitled to improved amenities, but the treating physicians also receive additional fees from the private health insurance fund usually paying the additional amenities. In turn, the hospital management claws back some of these fees for the use of the facilities in the function of a 'private' physician[11]. In sum, there is an incentive for both the hospital management and the physicians to cater to patients in the 'Sonderklasse'. As the law (§16 KaKuG) allows for only 25% of hospital beds being 'Sonderklasse', there is an incentive to keep the overall number of beds high as well (28). In addition to this, the 'Sonderklasse' might also cause equity issues, as it can be assumed that patients creating additional income through their private insurance's payments, or being an actual private patient in the hospital physician's private practice, expect preferential treatment (43). What is more, it has been shown that patients with voluntary health insurance have shorter waiting times ceteris paribus and are in some cases offered payments order to shorten waiting times (44).

Austria also has many smaller hospitals that might not be scale efficient, while in general, there seems to be room for improvement to increase efficiency in the inpatient sector (45,46). Given this structure, more specialisation, division of tasks as well as cooperation among hospitals or between hospitals and other providers in relation to certain processes could help increase efficiency even without a fundamental structural change (47).

The personnel structure is dominated by registered nurses followed by physicians. Several professions working in hospitals in other countries do not exist, making the allocation of tasks inefficient. For example, there are no physician assistants, medical coders or phlebotomists, for which there is not even approved training (48).

[10] The analysis is restricted to the publicly funded hospitals, so called fund-hospitals (Fondsspitäler) due to being financed through the State Health Funds.
[11] Mind though that these physicians are still employees of the publicly funded hospital.

Inpatient care: contractual arrangements

While hospitals are formally a contractual partner of SHI, the latter's role is very limited, as the contractual relationship is governed by the provisions in the 15a-agreement on organisation and financing of the healthcare system. In effect, SHI pays a portion of their income to the state health funds (Landesgesundheitsfonds), forfeiting all say in hospital matters. In the state health fund, the Land has the automatic majority in all matters hospital, although paying only about 30% of total hospital costs. Although theoretically, the federal level, contributing about 12% of total hospital costs, can withhold its contribution if a Land does not comply with rules set by the Federal Health Agency (e.g. the ÖSG or the Austrian DRG-system) (art. 45 and 46 of the 15a agreement on organization and financing of the healthcare system 2017-2021), this has never happened so far, possibly due to political considerations (19). With the healthcare reform 2013, Land, SHI and federal government are obliged to work more closely, as especially Land and SHI have a shared responsibility to reach healthcare and financial targets (Gesundheitsreformgesetz 2013). However, accountability for the healthcare targets is based on the publication of the monitoring reports by GÖG, which due to the large number of targets most likely does not receive widespread public attention. The latest 15a-agreement on target control 2017-2021 introduced a sanction mechanism, which was detailed by the Gesundheitszielsteuerungsgesetz 2017. §§34-38 of this law regulate mechanisms in case targets are not reached, one of the parties is in violation of an agreement within the target control mechanism, or no agreement on target control on the Länder level is reached. In the first case, the target control commission of the Land has to submit a report to the federal target control commission as to why the targets were not reached, which is then accepted or rejected. Either way, this report is made public. If a party is in violation of the target control agreement, one of the other parties can notify the federal target control commission which then proposes a resolution. If the issue is not resolved within two months, an arbitration mechanism can be invoked. In case no agreement can be reached on the Länder level, the points of dissent are reported to the federal target control commission, which in turn publishes this report. The federal target control commission or the MoH proposes a resolution for the points of dissent.

Inpatient care: financing and payment

SHI, the federal government, the Länder and municipalities all contribute to every State Health Fund through a complicated financing arrangement that has been frequently criticized due to its intransparency and lack of needs-orientation (13,14,39). Each State Health Fund pays the hospitals within its Land, so that changes in patient flows can only be factored in whenever a new 15a-agreement is reached. The

Austrian DRG system called LKF (Leistungsorientierte Krankenanstaltenfinanzierung) is currently used for the inpatient departments only. The LKF system currently does not include quality-dependent components. It is also strictly based on the stay rather than a treatment episode (including readmissions). Through the LKF system, the State Health Fund's budget for the inpatient sector is distributed to all hospitals in the Land. However, as the federal government only requires that more than 50%[12] of costs of the hospital have to be reimbursed through LKF, every State Health Fund pays very different values per LKF-point. The remaining costs are called 'Betriebsabgang' and are thus not a true operating deficit. Each Land can, within some limits, enact different rules as to how this Betriebsabgang is covered by a block payment called 'Betriebsabgangsdeckung'. It has been argued that this mechanism creates soft budget constraints for hospitals owned by the Land while creating harder budget constraints for their private non-profit counterparts, as part of the Betriebsabgang can be attributed to the hospital owner, which is in most cases the Land again for public hospitals, but private entities, mostly religious orders, in the case of private non-profit hospitals (46). What is more, as each inpatient stay creates financial compensation, but outpatient departments are paid through a global budget, an incentive is set for the management to shift treatments to the inpatient departments, resulting in unnecessary admissions and as illustrated by the high number of cataract surgeries entailing an inpatient stay (41). In order to mitigate the problem, treatments in day clinics were incentivised, as they are paid as a full overnight stay. This measure shows some effect as the latest monitoring report shows (49), albeit with considerable differences between the Länder.

Rehabilitation

The responsibility for rehabilitation rests with all three branches of social insurance, depending on the cause for needing rehabilitation. Therefore, many social insurance carriers have rehabilitation facilities of their own. Little research has been done in the area of challenges in rehabilitation. An example is Sperl *et al.* (2011) on child rehabilitation (50). The authors stress the deficits in the area of rehabilitation of children due to a lack in appropriate facilities and show international examples on how to improve this field.

Only since 2004, there is a more detailed overview of capacities and attempts to plan those capacities in the rehabilitation plan by the HVSV and GÖG, currently in its 2016 edition. From the aims of the

[12] This requirement was included in the 15a-agreement so that hospitals belong to the private sector according to the System of National accounts, effectively removing deficits and debts in hospitals from the public sector. However, the Manual on Government Deficit and Debt laying out the rules for Maastricht conformity does no longer recognize this, so that more than 3 billion Euros had to be added to Austria's Maastricht debt in 2011.

rehabilitation plans, it becomes obvious, that Austria has far too few capacities in ambulatory rehabilitation, and inpatient rehabilitation capacities need to be adapted. Care coordination with hospitals is again hampered by split competencies.

Pharmaceuticals

In the first decade of the new millennium, pharmaceutical expenditures were a major concern for SHI, especially volume increases. Through diverse measures, most notably a reduction of VAT from twenty to ten percent, as well as introducing a system of rebates and supporting physicians to prescribe more economically, the cost increase could be curbed. However, in recent years, some expensive new drugs have again challenged SHI‘s pharmaceutical budgets. Also, SHI is only responsible for pharmaceuticals outside hospitals, while hospitals bear the costs of their own drugs, incentivising cost shifting. At least for high cost medications, this was attempted to be tackled by the healthcare reform 2013 by the introduction of the pharmaceutical commission (*Medikamentenkommission*) issuing recommendations on high-priced drugs. Improved procurement might be necessary in both the hospital and the extramural setting, as Austria does not perform as well as in previous years in terms of drug prices (51).

Integration of care

The split in competencies, the financing and payment mechanisms described above, detailed regulations for structures and contractual arrangements and limited funds for innovation reduce the ability of the Austrian healthcare system to provide integrated care. So far, only one DMP has been rolled out, with initial findings revealing a positive impact, however, participation in the program is low (24). This is a concern, as Austria’s demographics follow the general trend in most European countries of double ageing, alongside an increase in chronic and multiple chronic diseases.

Other important fields like long term care and social care are the responsibility of municipalities and Länder, and thus, not easily integrated with health care. The joint responsibility for primary health care established in the healthcare reform 2013 still has to show concrete effects in service provision, as currently, true primary healthcare units are still rare, and for integration towards secondary care only some projects exist. Also, there are some training courses for case management, but rarely defined positions in healthcare facilities.

3 International comparative analysis

This chapter provides an international comparison of Austria's healthcare system in regard to expenditure, resources, health outcomes and utilisation.

3.1 Overview

This chapter presents an introduction to the performance of Austria's healthcare system, specifically this analysis details the country's methods of healthcare financing, its physical and human resources, its health outcomes and extent of healthcare utilisation. Healthcare financing is considered with regards to the magnitude of spending on healthcare, both at a country level and an individual level, in addition to Austria's means of financing and the corresponding contributions of different financing methods to total expenditure.

The adequacy of Austria's healthcare resources is best assessed through an analysis of the distribution of labour resources as well as physical capital, for example hospital beds. However, in order to construe an informed opinion of the performance and adequacy of Austria's healthcare system it is essential to consider the overarching dimension of health outcomes. As such this report utilises indicators in the context of life expectancy, burden of illness and unmet need.

Finally, a key objective of any healthcare system is access, hence this report will discuss healthcare utilisation in Austria to determine whether this goal is achieved and to what extent inequities present themselves within the country.

Various data sources were employed in order to create this chapter including OECD Health Statistics data 2015, the Global Burden of Disease Study 2015, Eurostat database in addition to data provided directly by GÖG. A series of figures were constructed using the available data which were then utilised to inform observations regarding the Austrian healthcare system. A comparative analysis approach was adopted, therefore throughout the chapter comparisons are drawn between Austria and other OECD countries. Given Austria employs a health insurance system, more granular comparisons were made among European OECD countries also operating health insurance systems such as Germany, France, Netherlands, Switzerland, Luxembourg and Belgium.

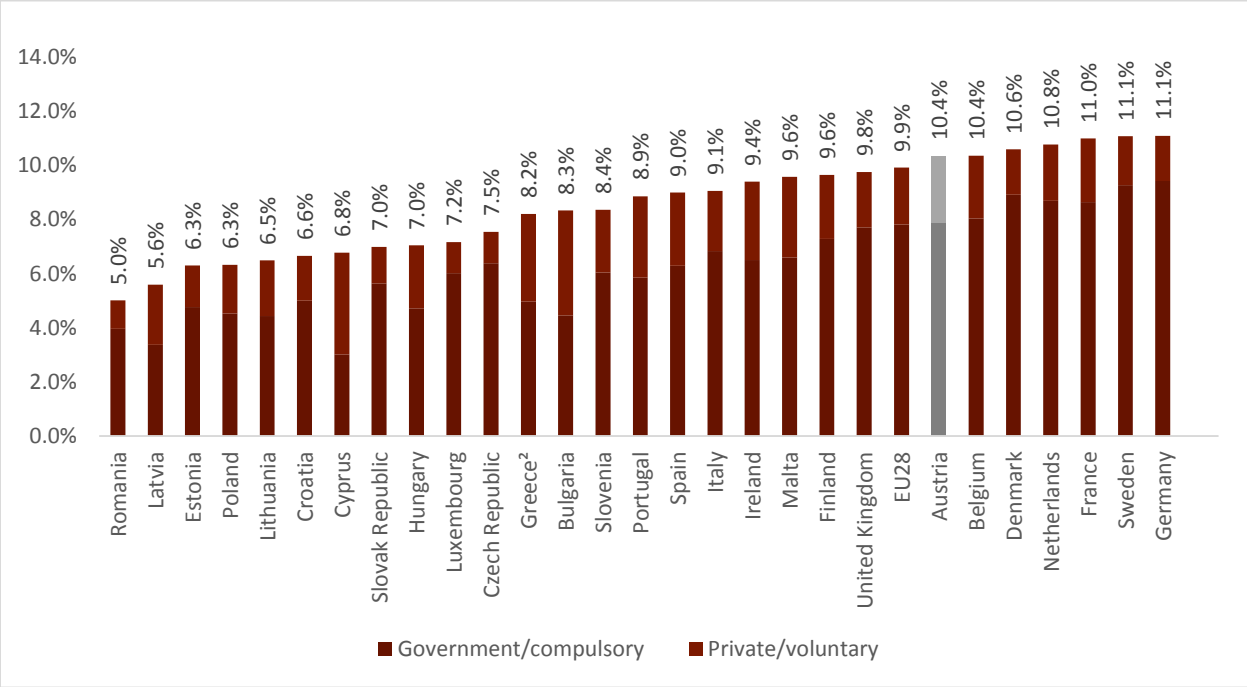
3.2 Healthcare financing

3.2.1 Health expenditure as a proportion of GDP

Compared with other European countries, Austria's health expenditure represents a relatively large proportion of GDP. Specifically, Austria spends 10.4% of its GDP on health, which is 0.5 percentage points above the EU(28) average, however, lower than in countries such as Germany (11.1%) and France (11%) (see Figure 6).

Austria's health expenditure is comprised mostly of public financing arrangements through government spending and compulsory health insurance (7.9%) and to a lesser extent, private sources and voluntary health insurance (2.5%); the larger proportion attributed to government/compulsory financing is broadly mirrored among other European countries.

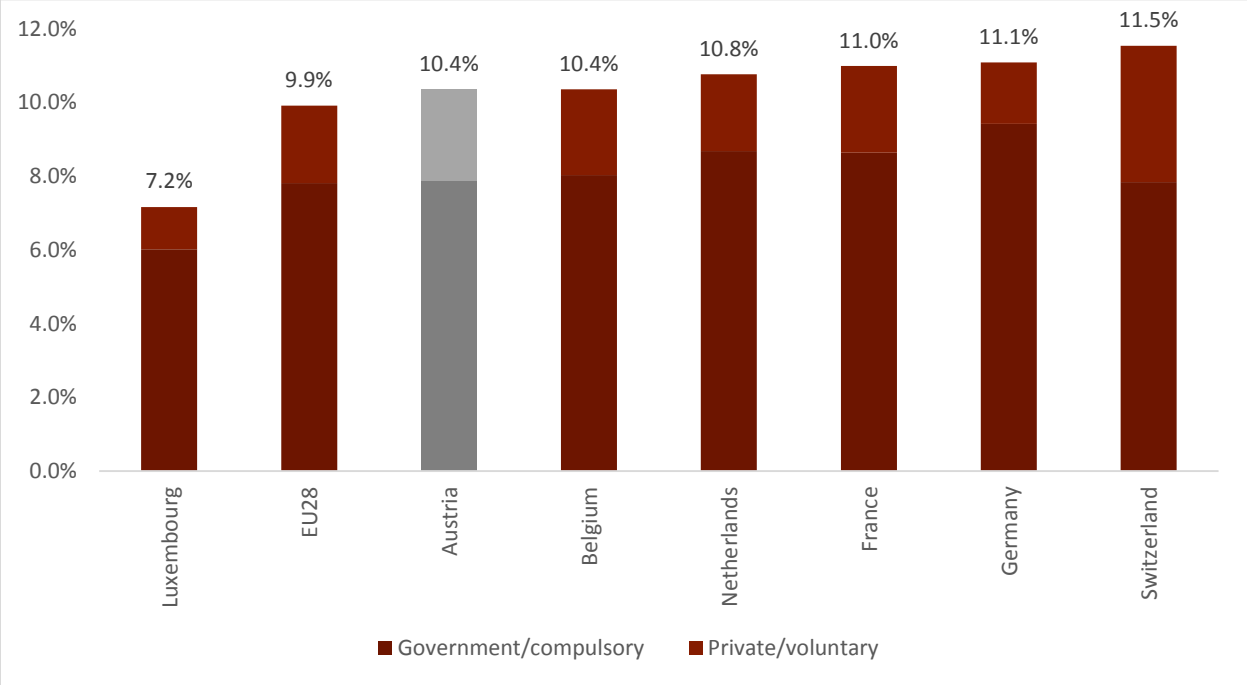
Figure 6: Health expenditure as a proportion of GDP (Europe) (2015)



Source: (52)

Regarding European countries, which are also characterised by a health insurance system, health expenditure as a proportion of GDP in Austria is comparable to other entities and is equal to that in Belgium, as depicted in the figure below. This subset of countries appear to spend a relatively higher proportion of GDP on health than other OECD countries which do not operate a social insurance system.

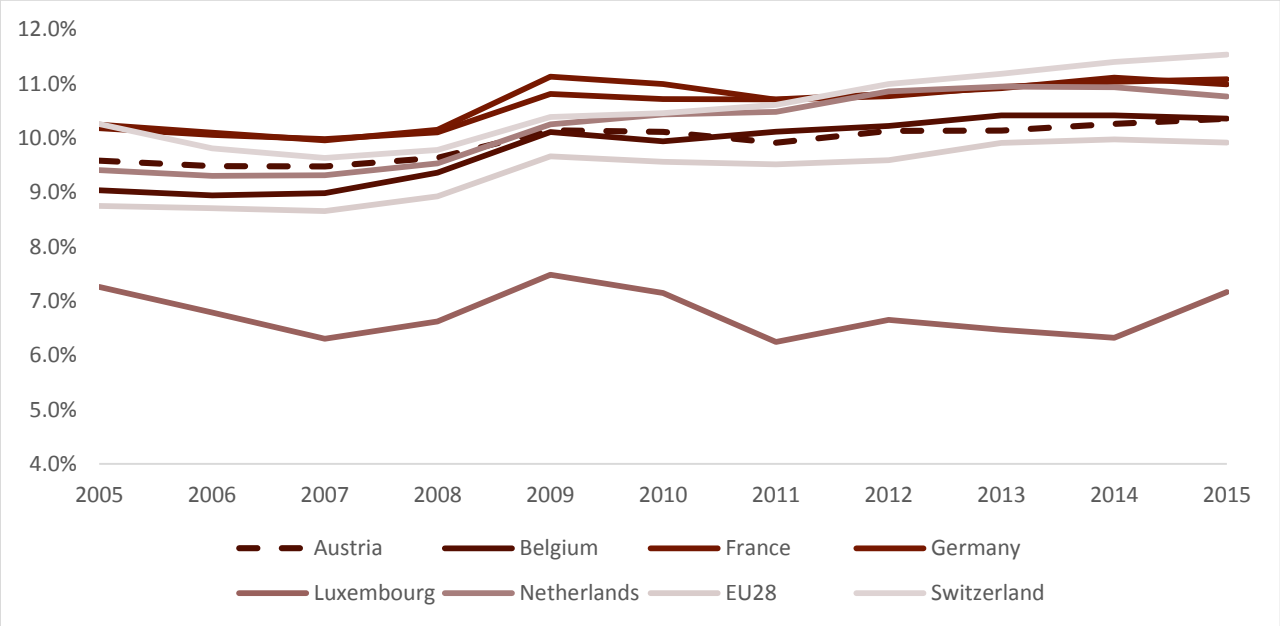
Figure 7: Health expenditure as a proportion of GDP (European social insurance systems) (2015)



Source: (52)

Health expenditure as a proportion of GDP has experienced an upward trend in Austria, albeit increases have been small. Similar to other European countries, the sharpest increase occurred between 2008 and 2009 (see Figure 8). This trend can be attributed to the fall in GDP caused by the Global Financial Crisis.

Figure 8: Trend in health expenditure as a % GDP, European social insurance systems, 2015

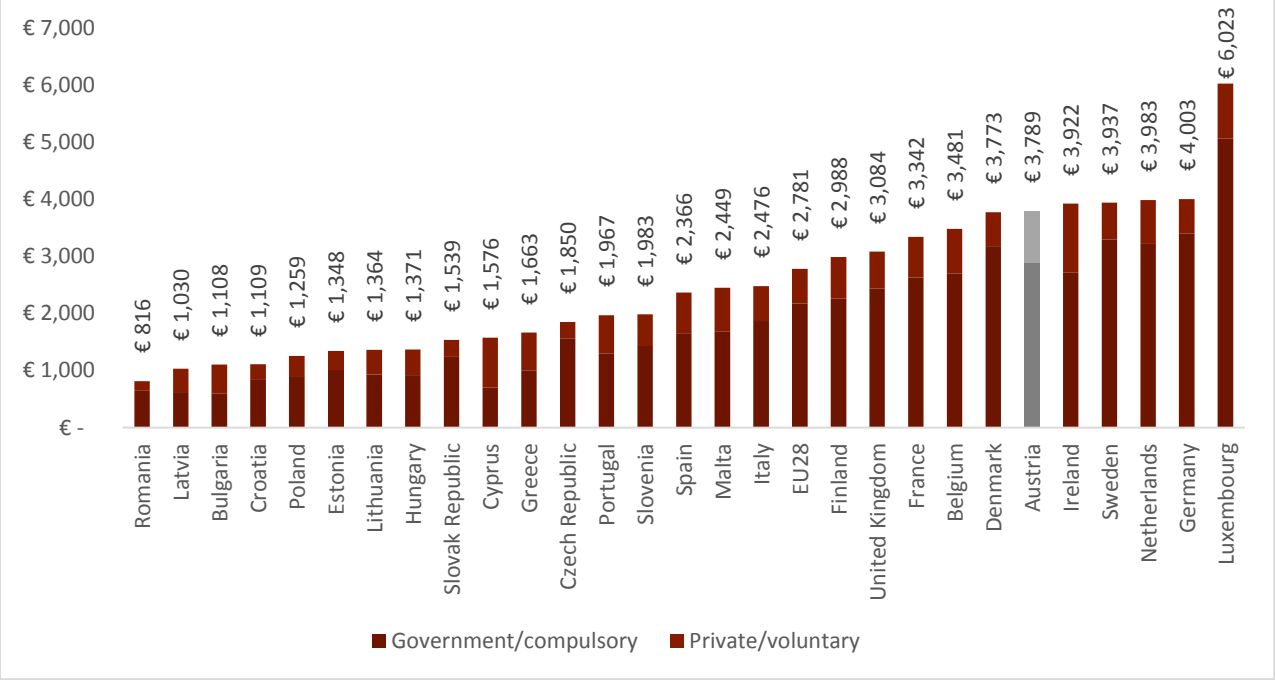


Source: (52)

3.2.2 Health expenditure per capita

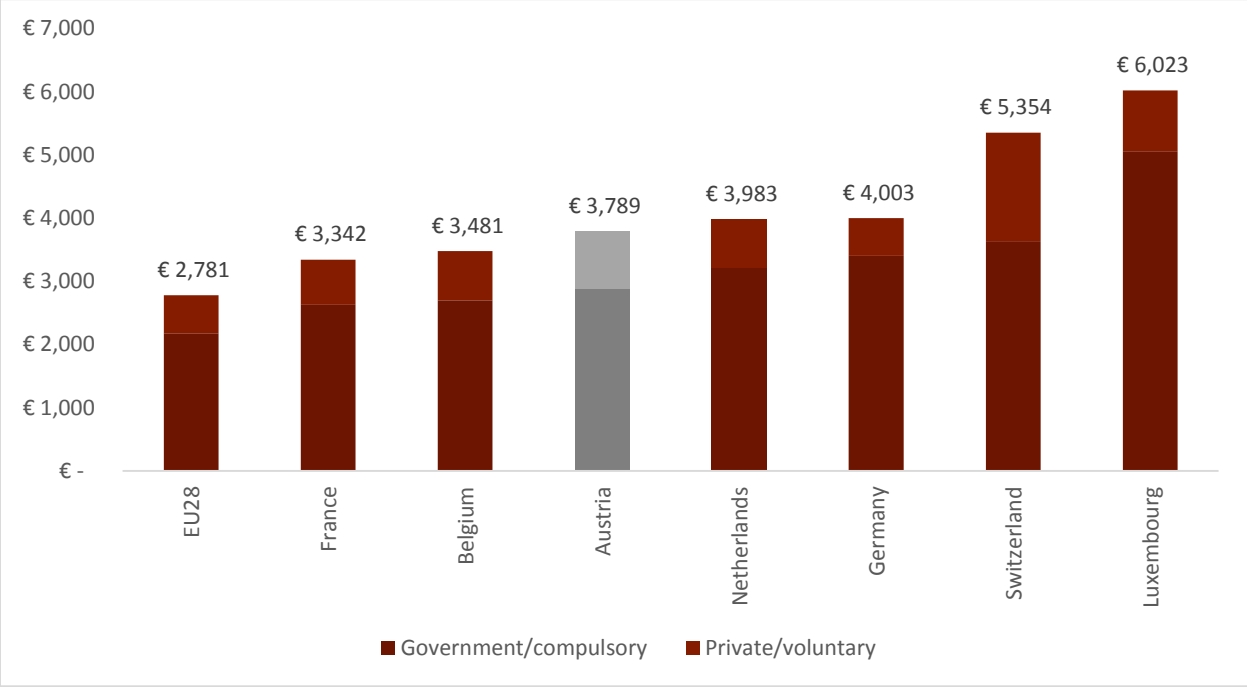
An international comparison of health expenditure per capita demonstrates that Austria performs well with respect to the extent of resources spent on healthcare. Figure 9 illustrates that Austria's health expenditure per capita of €3,789 is the 6th largest among the 28 European countries used for comparison. As discussed above, this amount is comprised largely of government/compulsory spending which amounts to €2,884 per capita and is supplemented by private/voluntary spending of €905. The mean health expenditure per capita among European countries with health insurance systems is €3,621, therefore Austria's health expenditure per capita is above average compared to the countries shown in Figure 9. However, the average is heavily influenced by Luxembourg, which has an expenditure per capita 66% above the average (i.e. €6,023).

Figure 9: Health expenditure per capita (OECD) (2015 or nearest year) (€ PPP)*



Source: (52)
Note: *PPP=purchasing power parity.

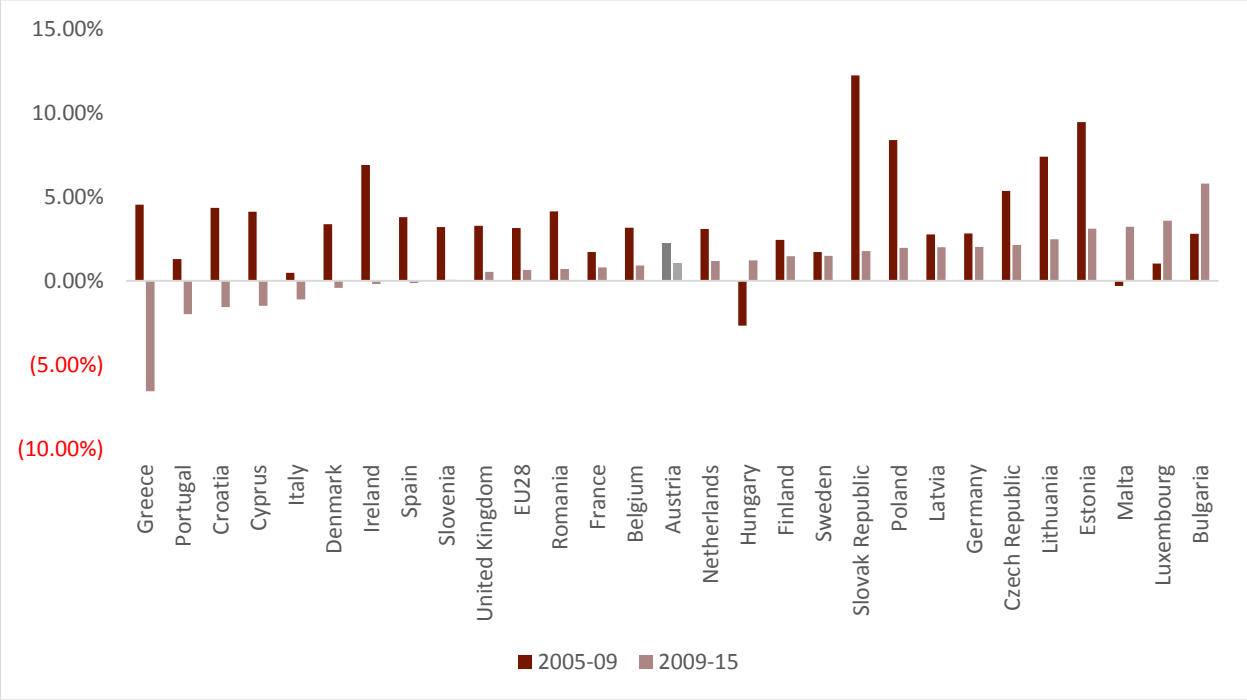
Figure 10: Health expenditure per capita (European social insurance systems) (2015 or nearest year) (€ PPP)



Source: (52)

Austria's average annual growth rate in per capita health expenditure declined from 2.23% (2005-09) to 1.06% (2009-15). This trend can be seen globally as a decline in the average annual growth rate also occurred in 24 other European countries. The difference in growth rates across the two time periods examined however was smaller than many other European countries.

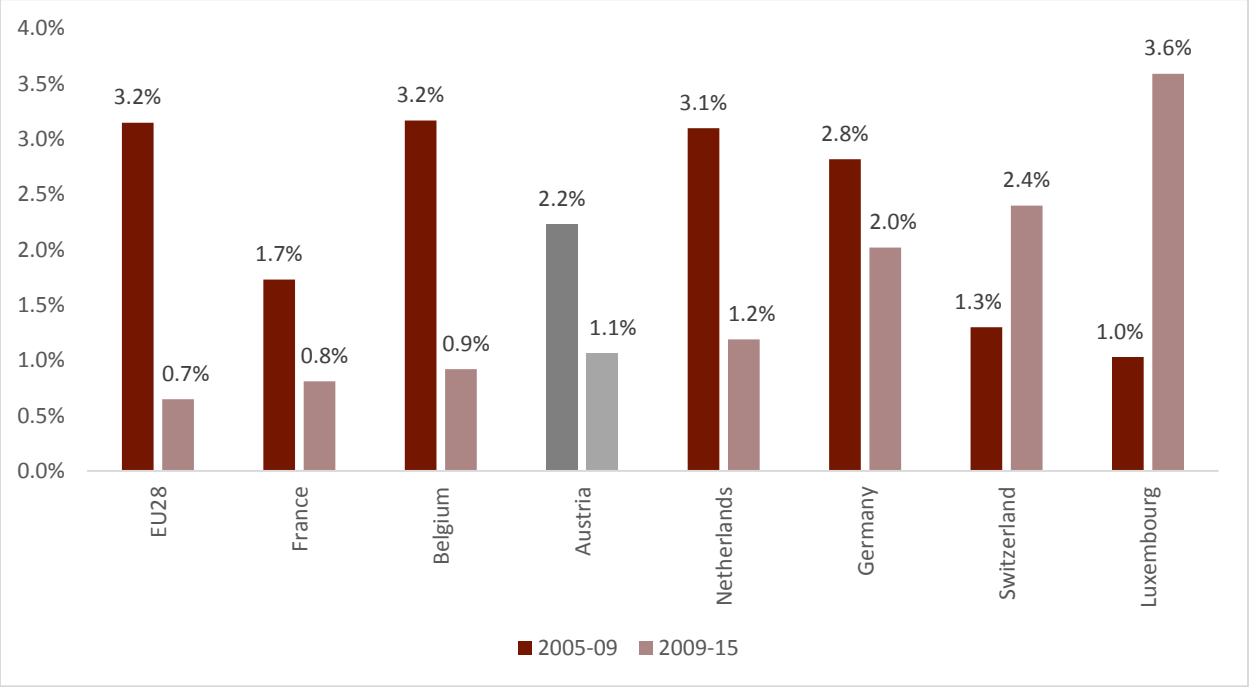
Figure 11: Average annual growth rate in per capita health expenditure (real terms) (2005-2015 or nearest year) (OECD)



Source: (52)

Austria's average annual growth rate between 2005 and 2009 (2.2%) was greater than in Luxembourg, Switzerland and France, which had growth rates of 1.0%, 1.3% and 1.7%, respectively. Conversely, its annual growth rate was significantly lower than other European countries with health insurance systems, including Belgium which grew by 3.2%. Austria's average annual growth rate was lower between 2009 and 2015 at 1.1%, which is in stark contrast to Switzerland and Luxembourg whose growth rates for that period were 2.4% and 3.6%, respectively. Austria's average annual growth rate from 2009-2015 however was still 0.4 percentage points higher than the lowest average rate for the group (i.e. EU(28) at 0.7%) (see the figure below).

Figure 12: Average annual growth rate in per capita health expenditure (real terms) (2005-2015 or nearest year) (European social insurance systems)

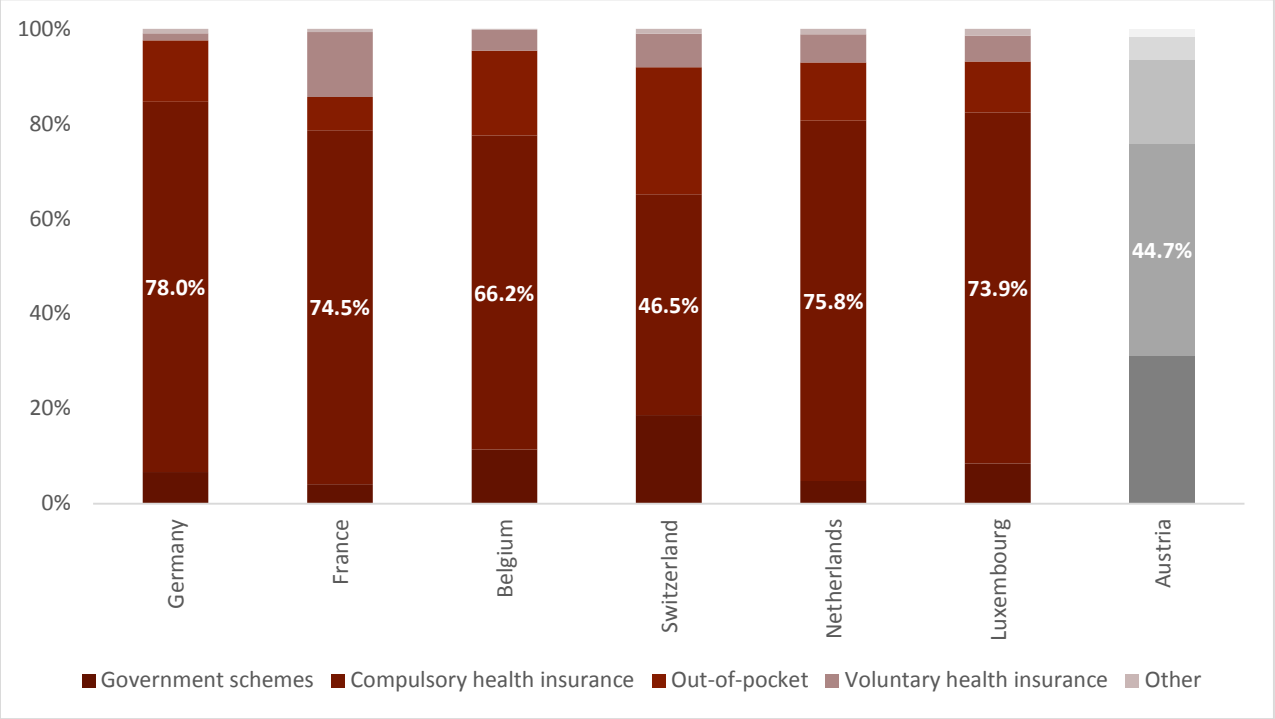


Source: (52)

3.2.3 Composition of financing

The composition of healthcare financing in Austria correlates with a general trend that the majority of expenditure in European countries with social insurance systems is comprised of compulsory health insurance (CHI) (see the figure below). Approximately 45% of health expenditure in Austria is attributed to CHI, followed by government schemes (31.1%). However, despite CHI acting as the primary source of funding, compared to other European countries operating health insurance systems, Austria funds a relatively lower proportion of its health expenditure through this mechanism. Its financing structure is most closely aligned to that of Switzerland, however, out of pocket spending in Austria is markedly less at 17.7% of health expenditure compared to 26.7% in Switzerland. This figures emphasises the importance of government schemes instead of user charges to make up funding shortfalls.

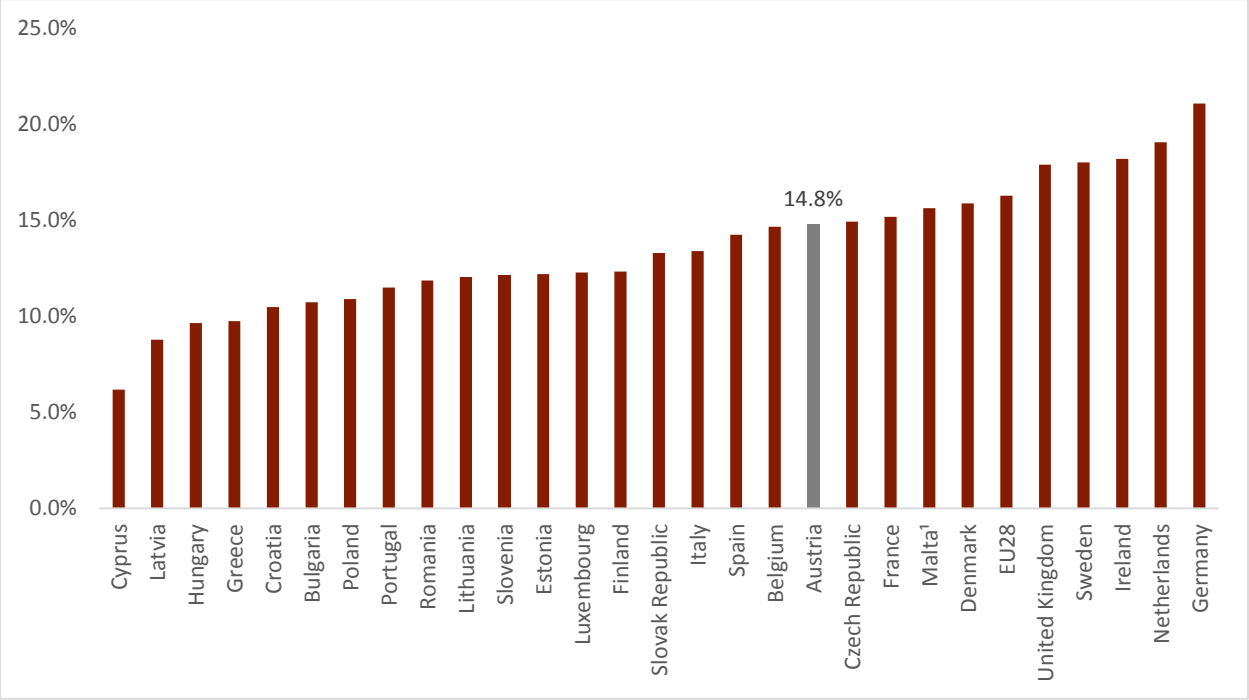
Figure 13: Current health expenditure by financing type (2014) (European social insurance systems)



Source: (52)

Government/compulsory insurance spending as a percentage of total government expenditure in Austria is 14.8%. This is 6.3 percentage points lower Germany which has the highest proportion amongst countries depicted in the figure below.

Figure 14: Government/compulsory insurance spending as % total government expenditure (European social insurance systems)



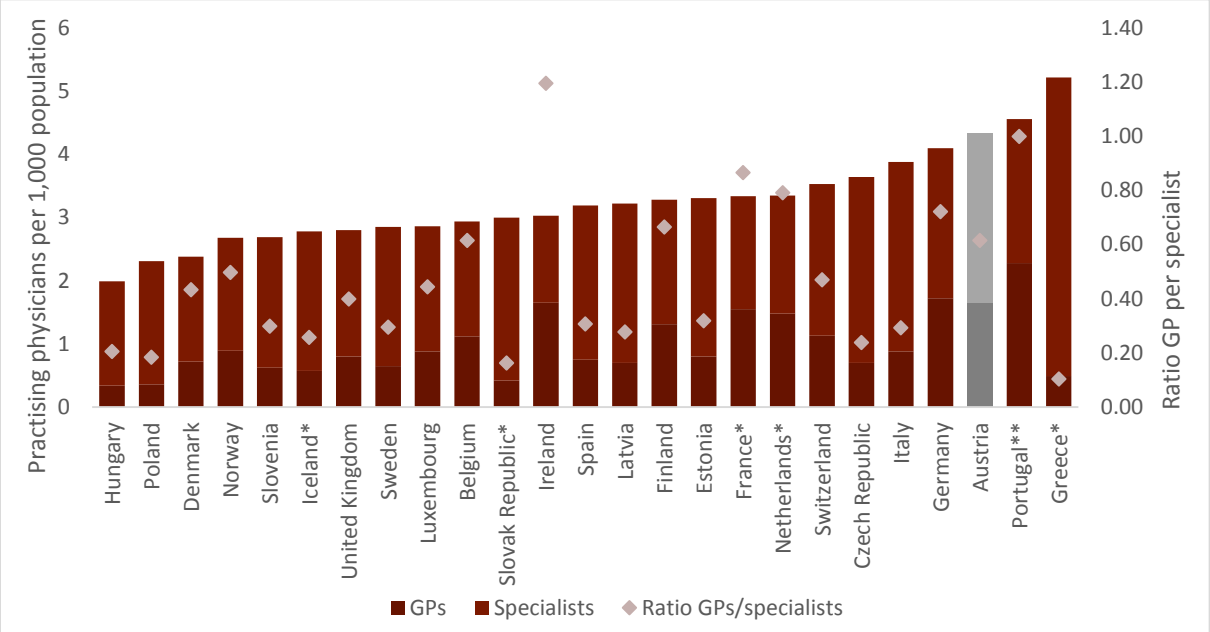
Source: (52)

3.3 Physical and human resources

3.3.1 Labour

The density of human resources in Austria varies according to the profession in question. An analysis of relevant data reveals that within hospitals, Austria is heavily reliant on physicians. Specifically, Austria has 4.33 practising physicians per 1,000 people, which is only surpassed by Portugal and Greece.

Figure 15: Practising physicians per 1,000 population in 2014 (or latest year available (a))

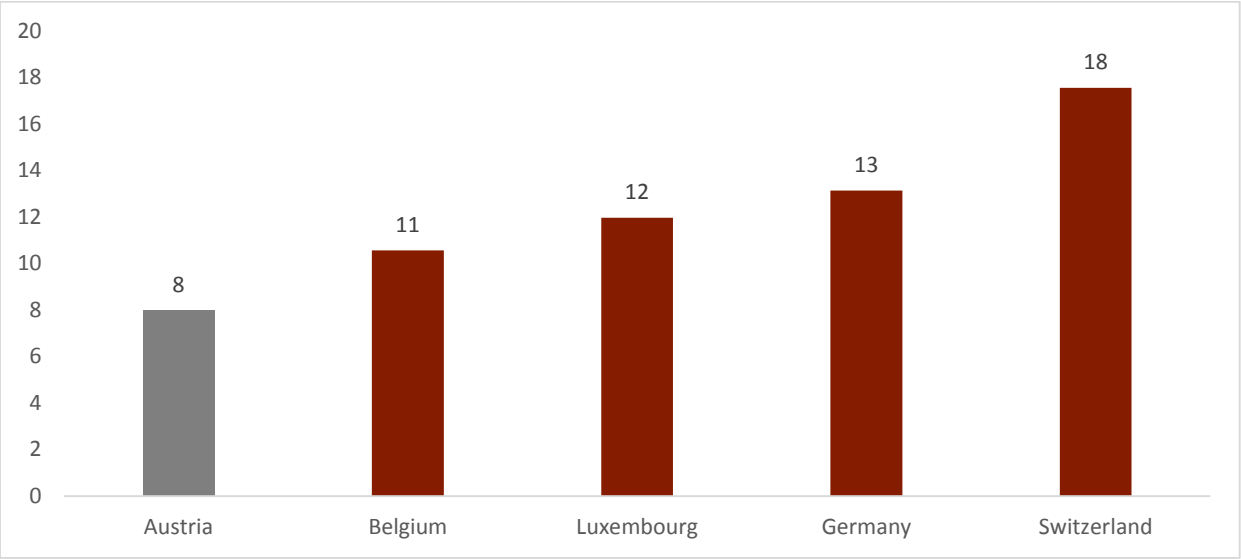


(a) Latest available year: BE: 2013, DK: 2007, SE: 2013, UK: 2013
(*) Includes physicians working as health care managers, educators, researchers, etc.
(**)Includes all physicians licensed to practice
Source: (52)

Compared to countries operated health insurance systems in Europe, it is evident that Germany, France, Belgium, Luxembourg and Switzerland all function with less practising physicians, however a noteworthy observation is the significant imbalance of labour resources evident in Austria as it also has the lowest density of practising nurses compared to the same countries (although no data was available for France). Specifically, there are only eight nurses per 1,000 people, which is significantly lower than Switzerland, the country with the highest density, which has 18 nurses per 1,000 people (see Figure 16).

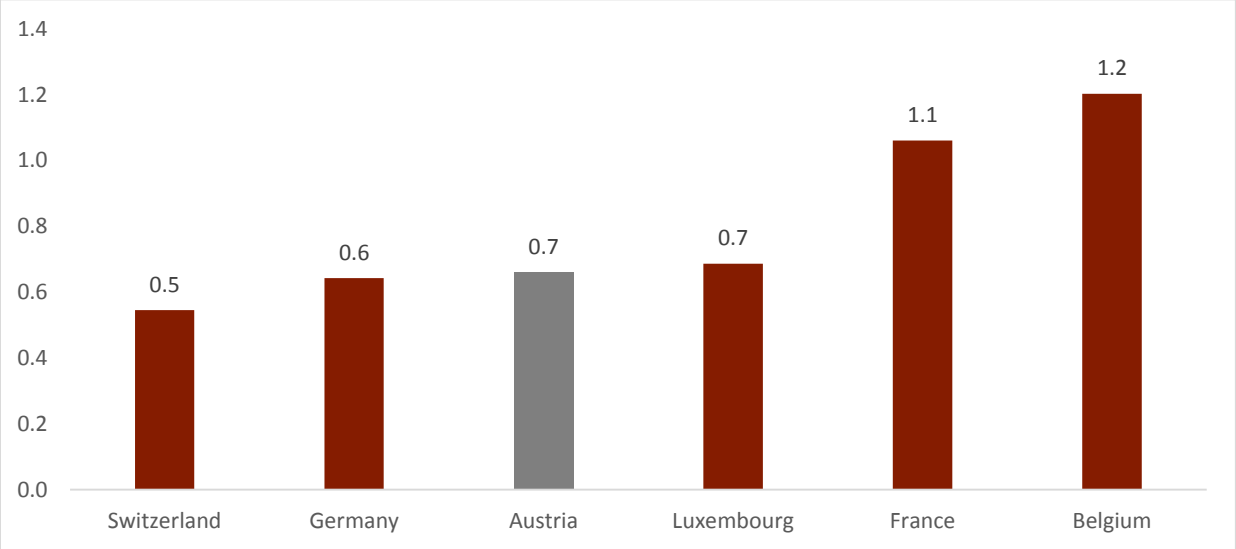
This suggests a strong dependence on physicians within the healthcare system. With respect to pharmacists, Austria has a moderate density which can be considered somewhat typical of European countries with social insurance systems. There are 0.7 dispensing pharmacists per 1,000 people in Austria which places the country just below the mean density for the basket of countries used for comparison in Figure 17.

Figure 16: Practising nurses per 1,000 people (2015 or nearest year) (European social insurance systems)



Source: *(52)*

Figure 17: Practising pharmacists per 1,000 people (2015 or nearest year) (European social insurance systems)



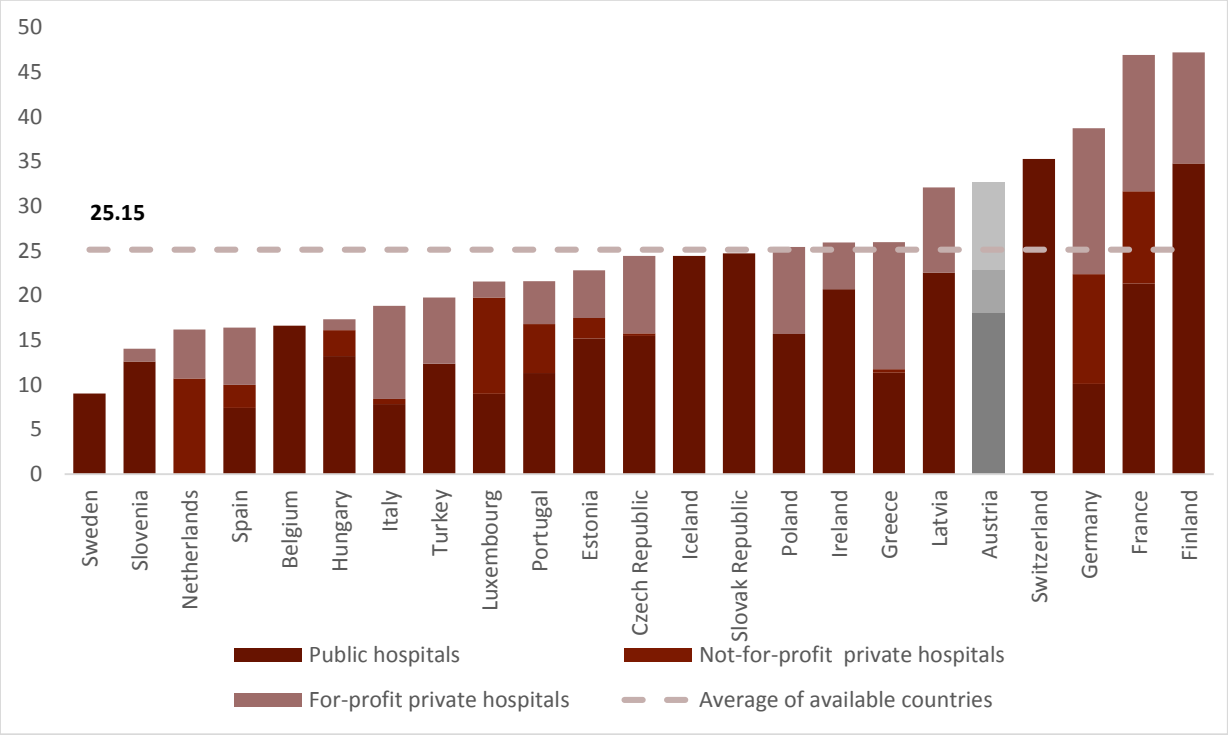
Source: (52)

3.3.2 Capital

The Austrian health care system relies heavily on secondary care, which is reflected by high resource utilisation in the hospital sector compared to other European countries. Austria has the fifth highest number of hospitals, see Figure 18, and the second highest number of hospital beds per capita in Europe (see Figure 19). In 2014, 7.59 beds were available per 1,000 Austrian inhabitants, which is almost 1.5 times

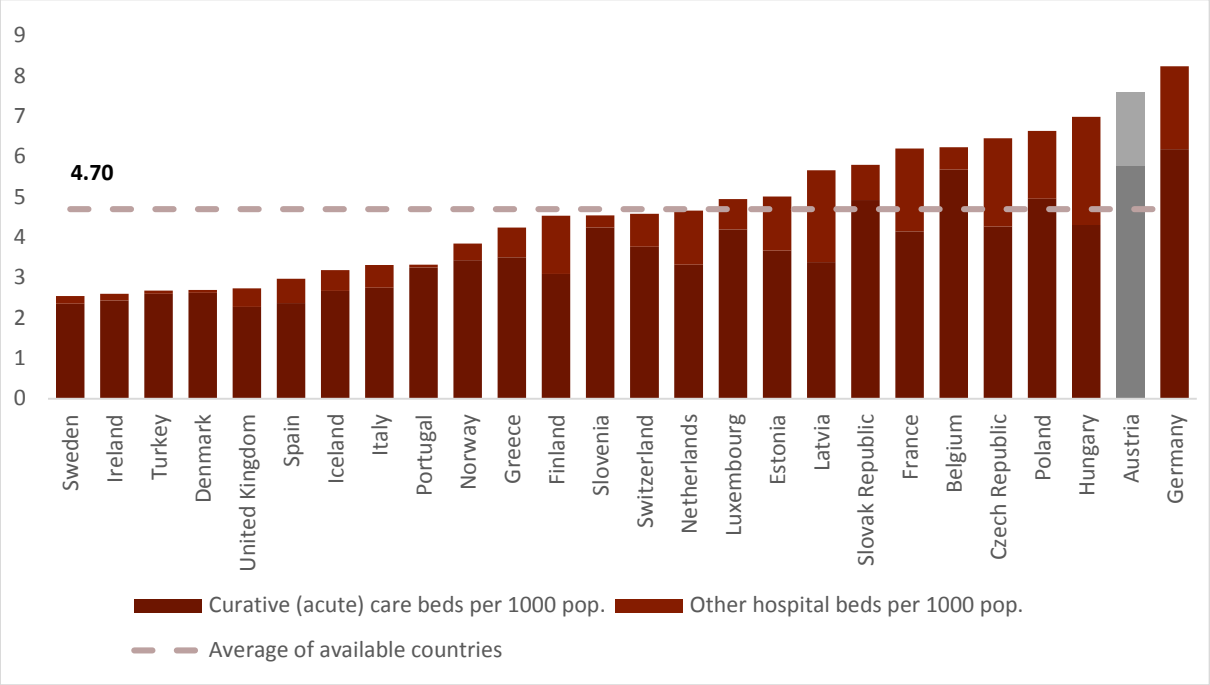
higher than the average of the 28 Member States of the European Union (EU). Over the last ten years this number has on average decreased by 12% in the EU, but only by 2% in Austria (see Figure 20).

Figure 18: Number of hospitals per million population in 2014 (or latest available year (a))



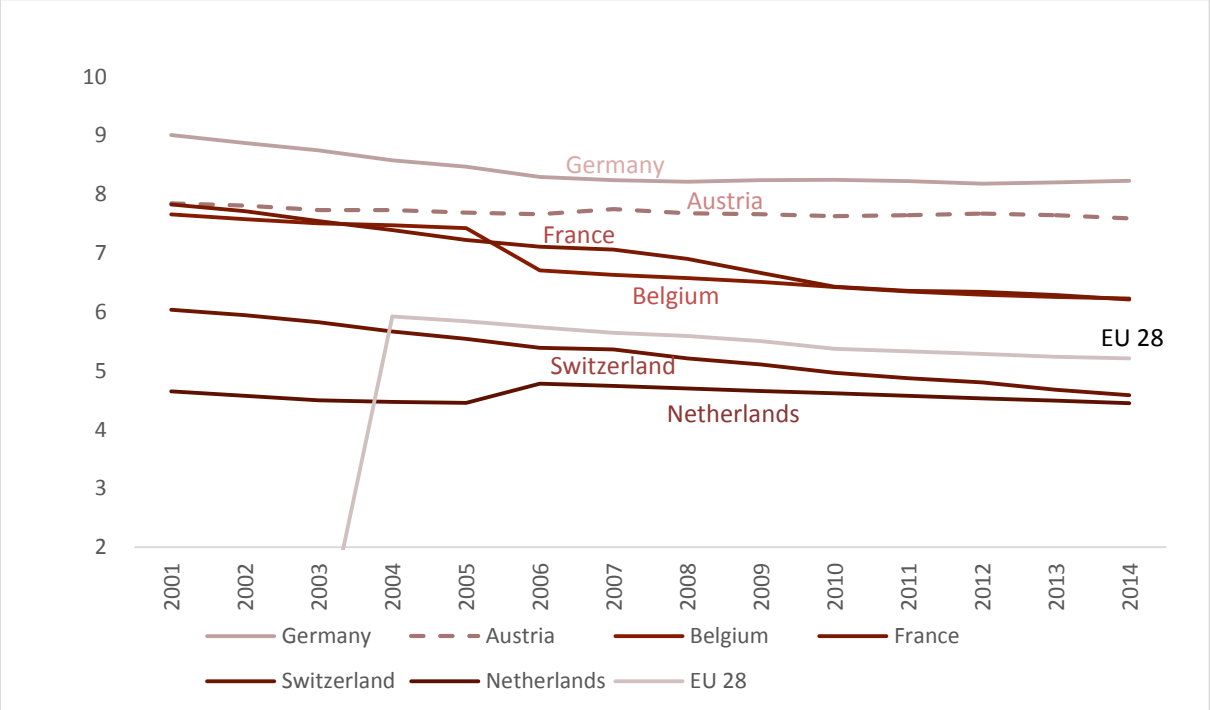
Note: (a) Latest available year: HU: 2011, IR: 2012, IT: 2013, PL: 2011, PT: estimate for 2014.
Source: (52)

Figure 19: Number of hospital beds per 1,000 population in 2014 (or latest available year (a))



(a) Latest available year: IT: 2013, NL: 2009 (2012 for curative care beds)
Source: (52)

Figure 20: Number of hospital beds per 1,000 population 2001 – 2014 for selected countries



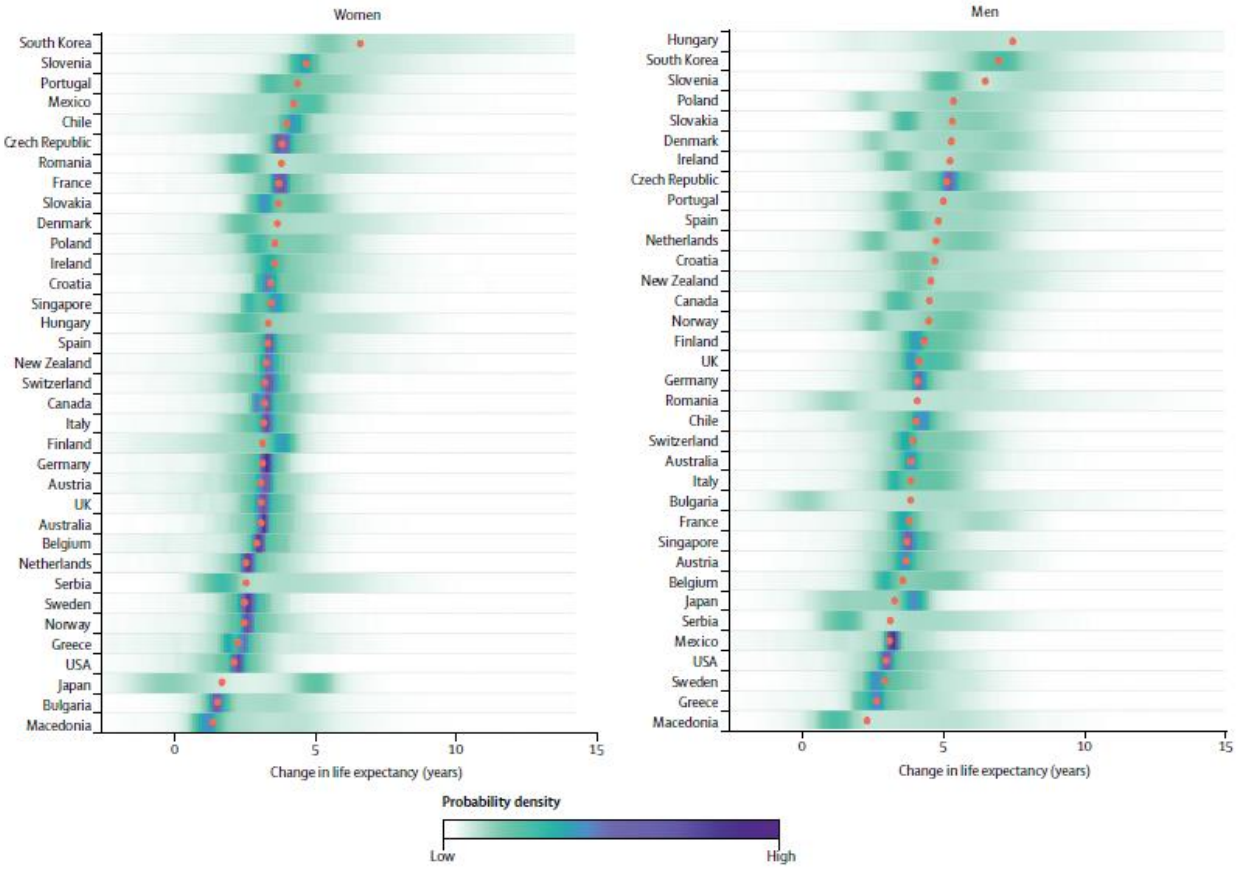
Source: (53)

3.4 Health outcomes

3.4.1 Life expectancy

The 2015 Global Burden of Disease Study identified that life expectancy for males was 78.8 years, and 83.7 years for females in Austria (see figures below). This is a marked increase from 1990 where life expectancy for males and females was 72.3 and 78.8, respectively. A study conducted by Kontis *et al*. (2017), which aimed to forecast national life expectancies, found that Austria was in the bottom half of the 35 countries[13] analysed in regard to the median projected change in life expectancy at birth from 2010 to 2030 (men and women) (54). The median projected change for women and men was 3.25 and 3.75 years, respectively (see Figure 21).

Figure 21: Projected life expectancy between 2010 and 2030 (men and women)

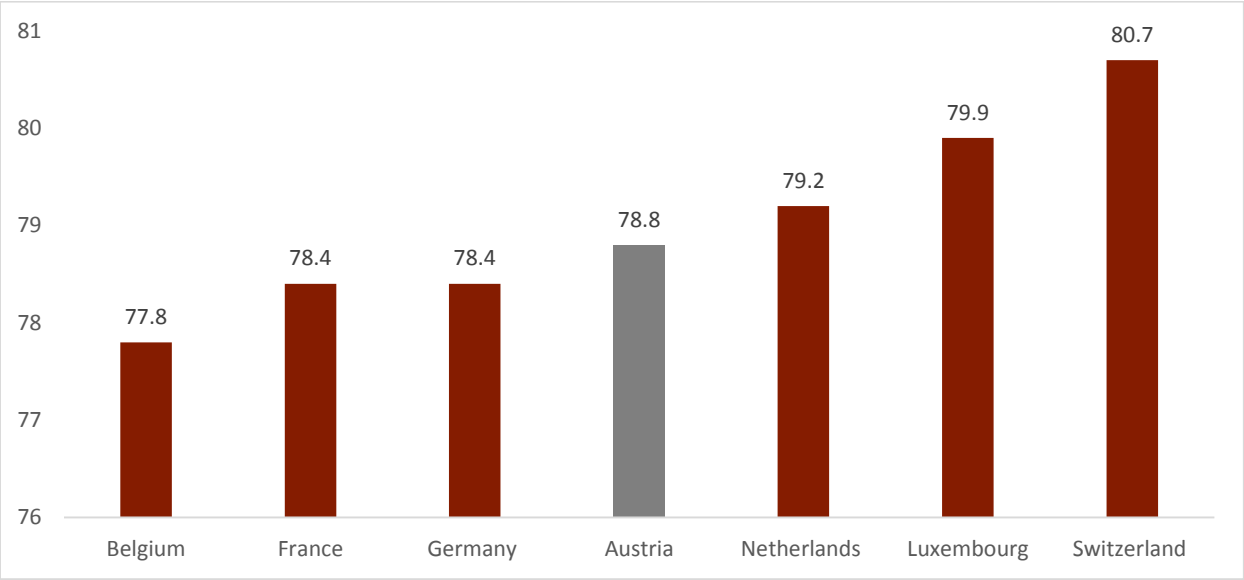


Source: Graph taken directly from (54)

[13] Including countries such as Belgium, Germany, France, Switzerland and the Netherlands.

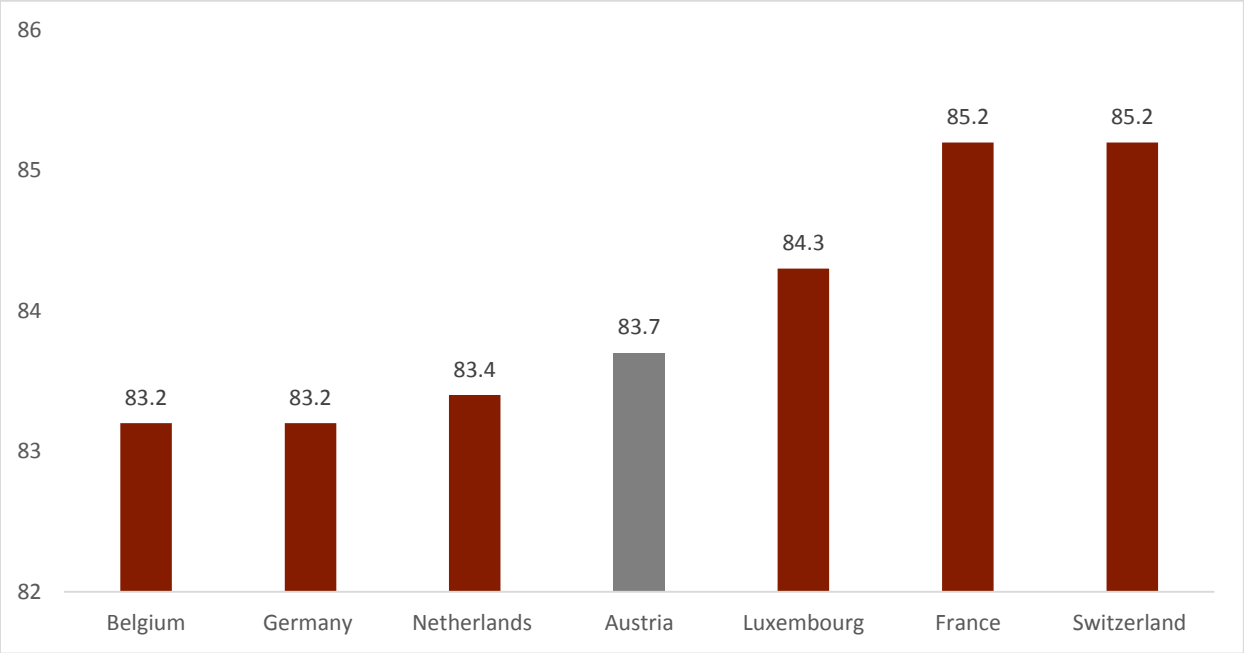
The projected female-male difference in 2030 was significantly less than that in 2010, a trend observed in almost all countries examined, indicating gender inequalities are expected to narrow. Both Kontis *et al*. (2017) and the OECD indicate that Austria lags significantly behind Switzerland and France with regards to overall life expectancy, both of which are highly comparable countries to Austria due to their health insurance systems (54). Nonetheless, the Austrian life expectancy exceeds that of Germany and Belgium, albeit only marginally. Analysing male and female life expectancies separately shows that Austria is placed in the middle of European countries with social insurance systems for both cases. For both genders Austria is bettered by Switzerland and Luxembourg.

Figure 22: Male life expectancy (European social insurance systems) (2015)



Source: (55)

Figure 23: Female life expectancy (European social insurance systems) (2015)



Source: (55)

3.4.2 Burden of illness

The top 10 causes of death in 2015 in Austria were: ischaemic heart disease, Alzheimer disease, cerebrovascular disease, lung cancer, COPD (chronic obstructive pulmonary disease), colorectal cancer, chronic kidney disease, diabetes, hypertensive heart disease and breast cancer. All of the aforementioned causes of death are non-communicable diseases, eight of which rank within the top 10 causes of premature death, in addition to self-harm and pancreatic cancer (see Figure 25). Notably, there has been a significant reduction since 2005 in the number of premature deaths caused by road injuries. The number of years of life lost (YLL) attributed to ischaemic heart disease is the highest among the top 10 causes of premature mortality in the majority of OECD countries, but is especially high in Austria as well as Germany. With respect to morbidity, low back and neck pain was ranked as the biggest cause of disability in both 2005 and 2015. The biggest risk factor which drives the most death and disability combined is diet, closely followed by high systolic blood pressure, however tobacco smoke and alcohol and drug use are also prominent. Collectively these risk factors implicate that unhealthy lifestyles play a significant role in Austria's burden of illness. The most prevalent health problem in both 2005 and 2015 was oral disorders.

Figure 24: Top 10 causes of death by rate in 2015 and percent change, 2005-2015

Disease	2005 ranking	2015 ranking	Percentage change
Ischaemic heart disease	1	1	-2.3%
Alzheimer disease	3	2	20.2%
Cerebrovascular disease	2	3	-11.5%
Lung cancer	4	4	9.1%
COPD	5	5	5.1%
Colorectal cancer	4	6	-42.8%
Chronic kidney disease	12	7	50.6%
Diabetes	7	8	-4.4%
Hypertensive heart disease	11	9	42.5%
Breast cancer	9	10	5.1%

Source: (55)

Figure 25: Leading causes of premature death (YLLs) in 2015 and percent change, 2005-2015

Disease	2005 ranking	2015 ranking	Percentage change
Ischaemic heart disease	1	1	-11.5%
Lung cancer	2	2	2.4%

Disease	2005 ranking	2015 ranking	Percentage change
Cerebrovascular disease	3	3	-19.6%
Alzheimer disease	5	4	12.7%
Self-harm	4	5	-14.5%
COPD	7	6	-0.2%
Colorectal cancer	6	7	-6.6%
Breast cancer	9	8	-2.6%
Diabetes	10	9	-14.1%
Pancreatic cancer	12	10	11.5%

Source: (55)

Compared to other OECD countries there are definite similarities in the burden of illness. In Germany, Switzerland, France, Luxembourg and Belgium, the number one cause of death and premature death in 2015 was also ischaemic heart disease. Unhealthy lifestyles contribute significantly to the burden of disease and the number of Disability Adjusted Life Years (DALYs) in the aforementioned countries. Tobacco smoke, dietary risks, alcohol and drug use and high systolic blood pressure comprise the top four risk factors in all of Austria, Luxembourg, France and Belgium. Alcohol and drug use is less of a risk factor in Germany however.

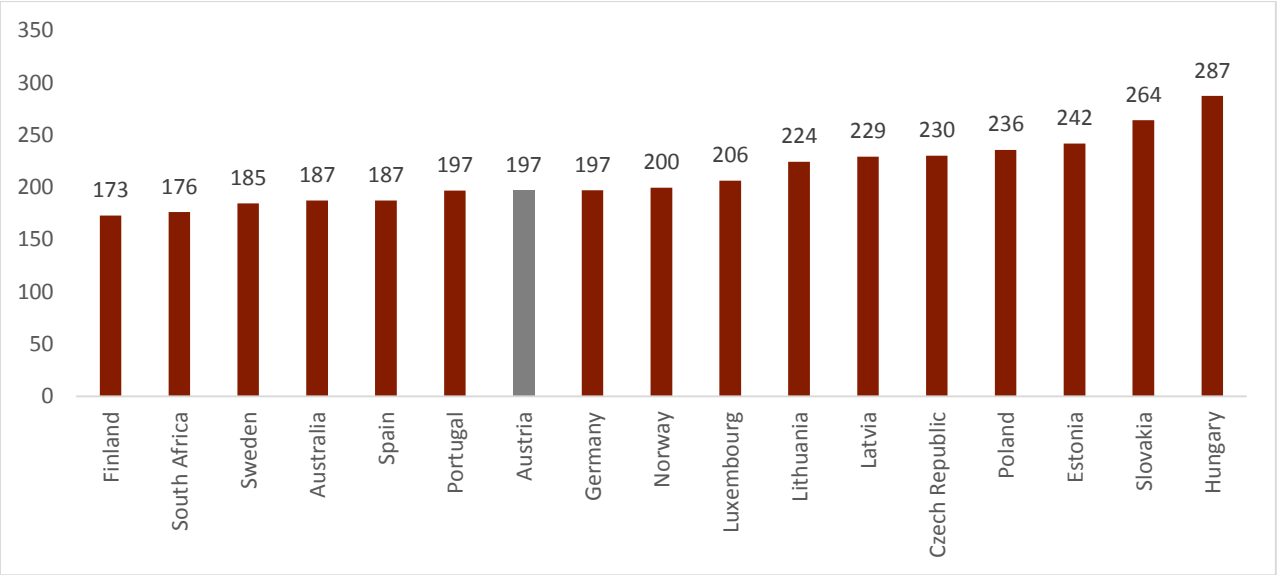
Austria performs relatively well according to the indicator of deaths from cancer per 100,000 people. Specifically, in 2015 there were 197 deaths from cancer per 100,000 people, which aligns exactly with Germany and is considerably better than the worst performer of the group in the figure below. On the other hand, it is possible to determine there is scope for improvement as several countries performed better, achieving a lower number of deaths; in particular Finland had only 173 deaths per 100,000 people.

Austria performed particularly well with regards to survival for stomach cancer, achieving a 33.1% age standardised net survival rate which was only surpassed by Belgium (33.4%) when comparing the countries included in Figure 27. Austria also has the highest age standardised net survival rate for lung

cancer, 17.9%, compared to fellow OECD countries, despite tobacco smoke being the third leading risk factor driving death and disability combined according to the Global Burden of Disease study. It is higher than the worst performer in the group, the UK, by 8.3 percentage points.

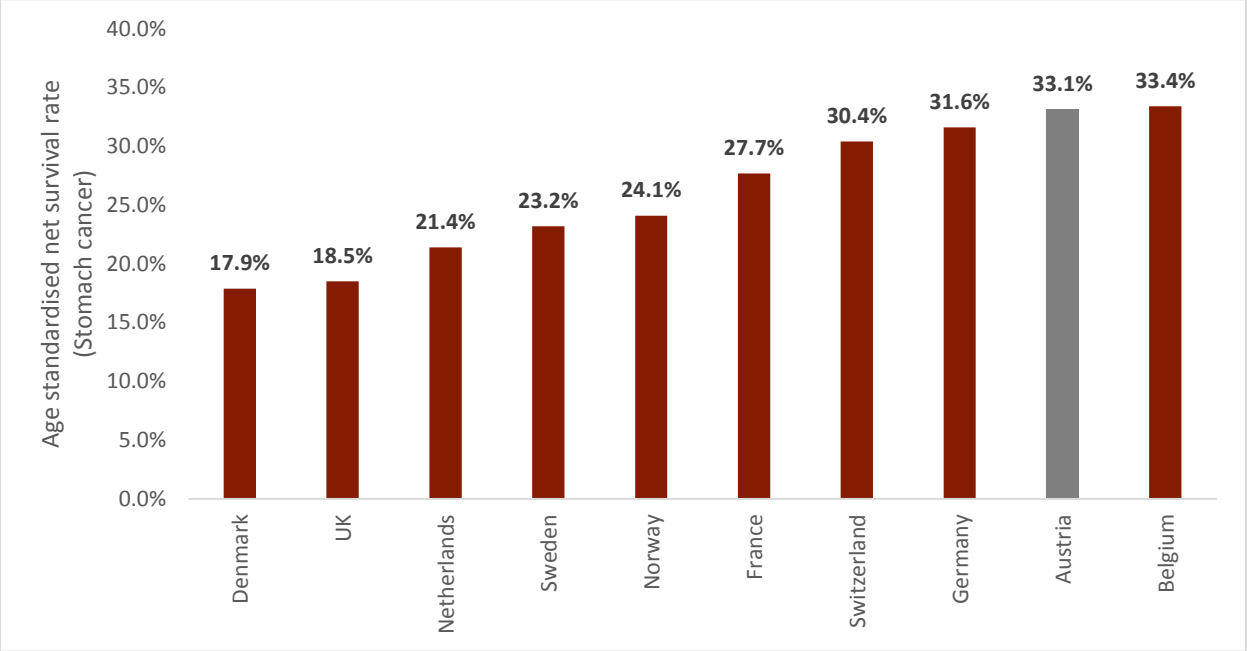
Despite generally performing well against cancer metrics which act as indicators of overall health care performance, one anomaly exists. The age standardised net survival rate for leukaemia within adults is only 45.8% which is lower than many European countries including those also operating social insurance systems such as Belgium, France, Switzerland and Germany. More than half of adults diagnosed with leukaemia in these countries survive the disease, whereas less than half survive the disease in Austria.

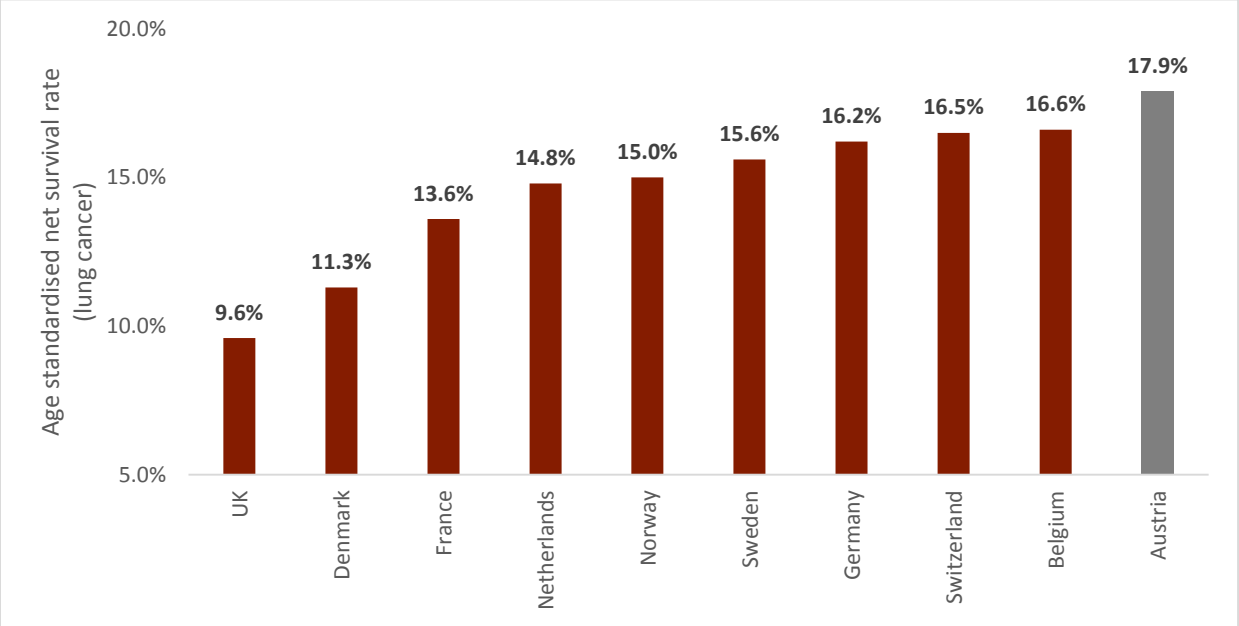
Figure 26: Deaths from cancer per 100,000 people (2015)

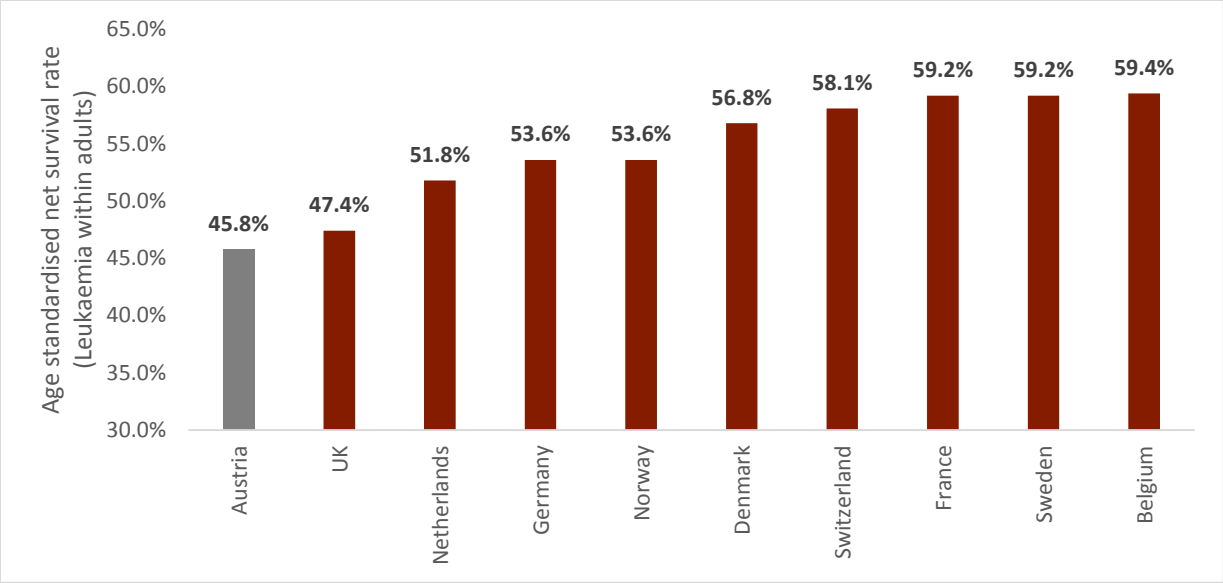


Source: (52)

Figure 27: Cancer survival rate (various types)



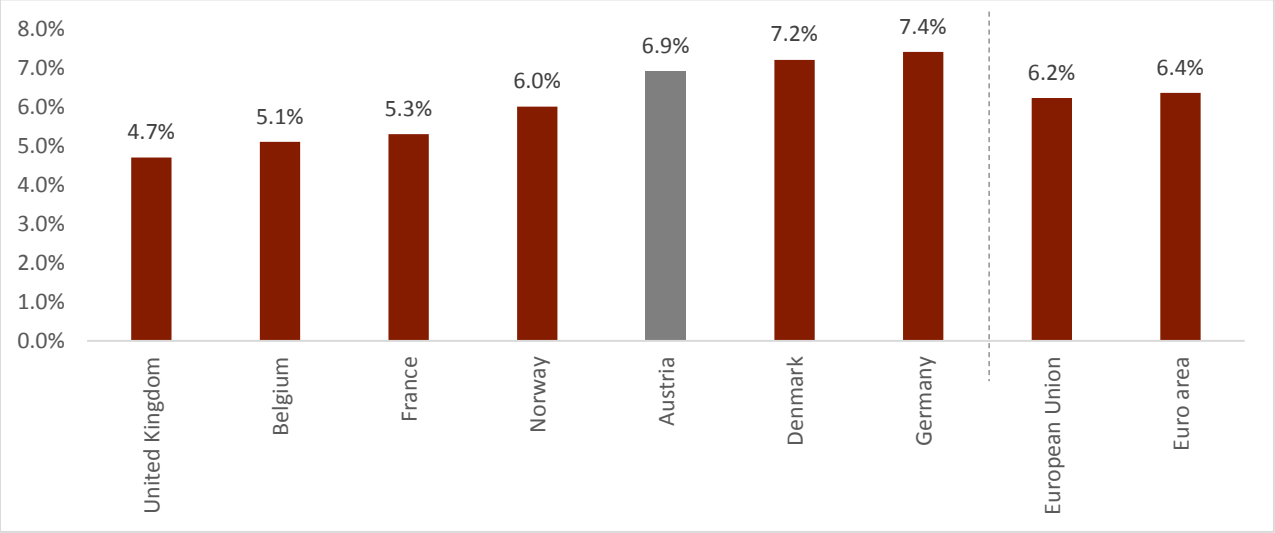




Source: (56)

The prevalence of diabetes in Austria is relatively high at 0.7 percentage points above the average for the European Union and 2.2 percentage points higher than the country with the lowest prevalence, the UK (see Figure 28). This indicates that the impact of this disease on public health in Austria is of significance. Furthermore, diabetes is associated with unhealthy lifestyles thus reiterating that population health in Austria suffers due to risk factors such as diet and high body-mass index. Primary care is important for the management and prevention of diabetes therefore the above average prevalence once again points to weaknesses within Austria's primary care system.

Figure 28: Prevalence of diabetes (20-79 years) (2015)



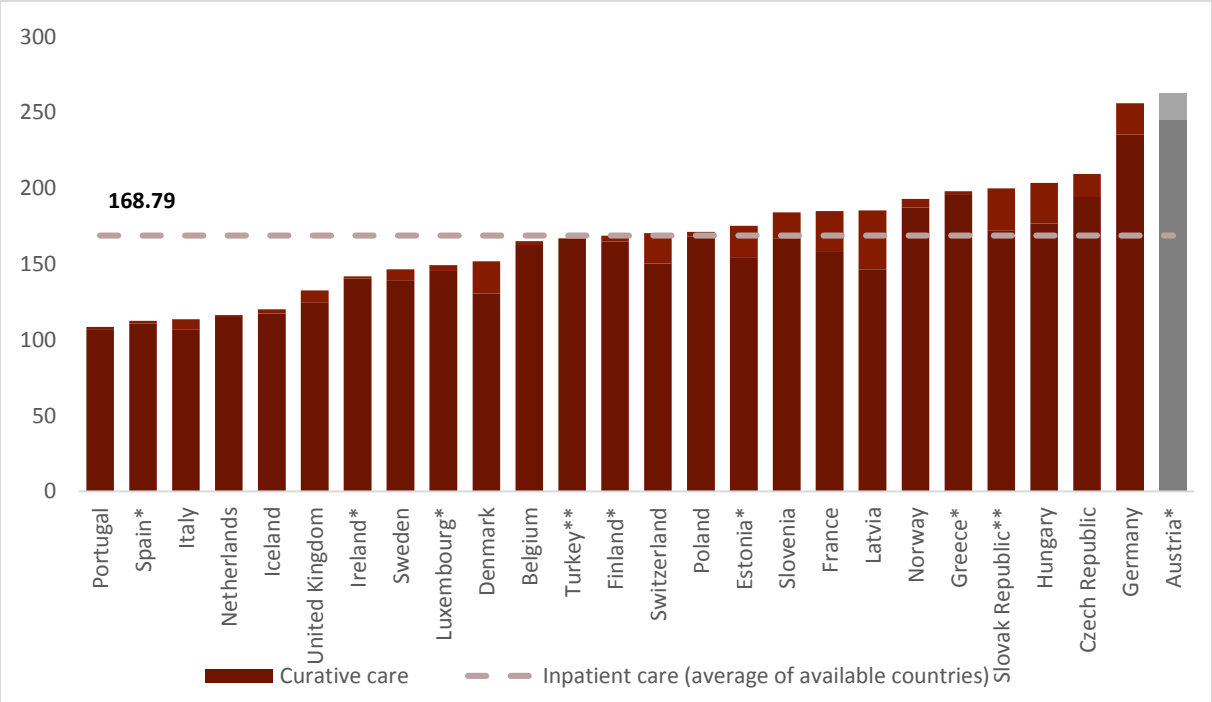
Source: (57)

3.5 Healthcare utilisation

3.5.1 Overall healthcare utilisation

The utilisation of the hospital sector can best be described by the discharge rates from inpatient hospital stays, that is, the number of patients leaving the hospital after at least one night. The rate of hospital discharges per inhabitant can be influenced by a number of demand- and supply-side factors. The former include the age structure and morbidity of the population, as well as other demographic characteristics, whereas the latter mainly refers to the capacity of the hospital sector and its substitutes in the outpatient sector. Austria displays the highest number of inpatient hospital discharges per year (2014 or latest available) with only Germany exhibiting similar values of more than 250 discharges per 1,000 inhabitants. These numbers are considerably above the average of the available European countries which was less than 170 discharges per 1,000 inhabitants (see Figure below). It should be noted that the four countries with the highest discharge rates, Austria, Germany, the Czech Republic and Hungary, are also among the countries with the highest number of hospital beds per inhabitant (see Figure 19).

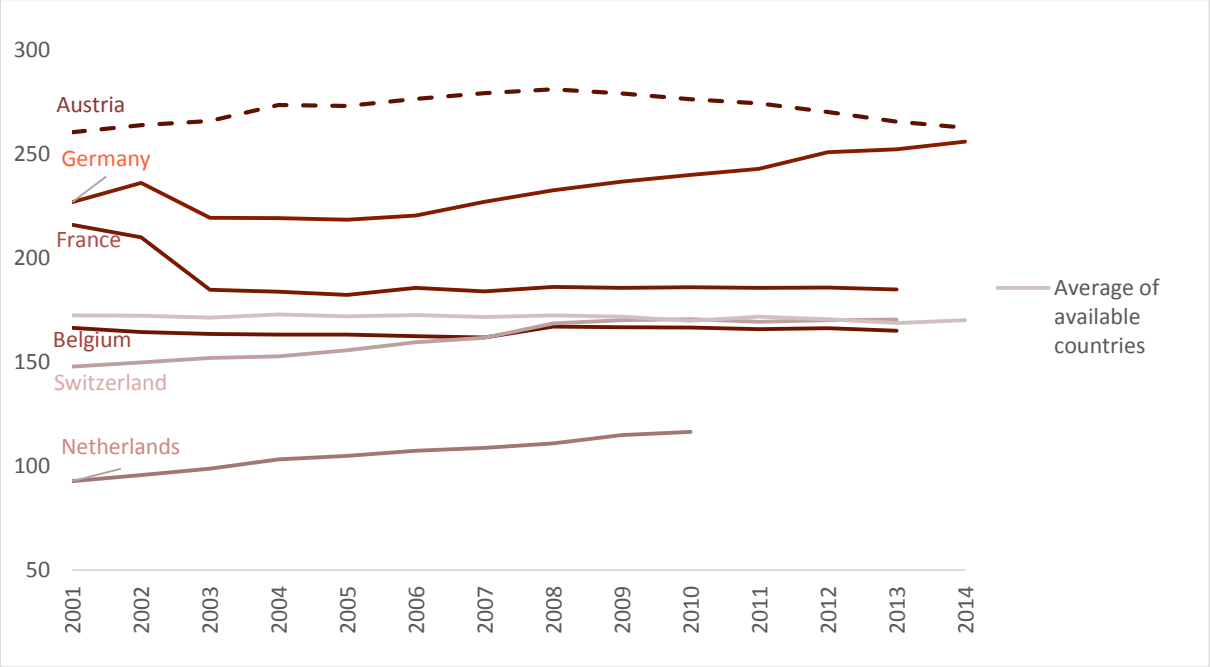
Figure 29: Number of inpatient discharges per 1,000 inhabitants (2014 or latest available year (a))



(a) Latest available year: BE: 2013, DK: 2013 (2009 for curative care), EL: 2011, FR: 2013, NL: 2010.
(*) Excludes discharges of healthy new-borns(**) Includes same-day discharges
Source: (52)

Time series data (2001 to 2014) does not reveal a noticeable trend for Austria regarding hospital discharges, as it is in line with the average trend of the available European OECD countries (see figure below). Other health insurance countries, such as Germany, the Netherlands and Switzerland, exhibit a compound annual growth rate of 0.9%, 2.3%, and 1.1%, respectively. On the contrary, France has a negative compound annual growth rate (- 1.2%).

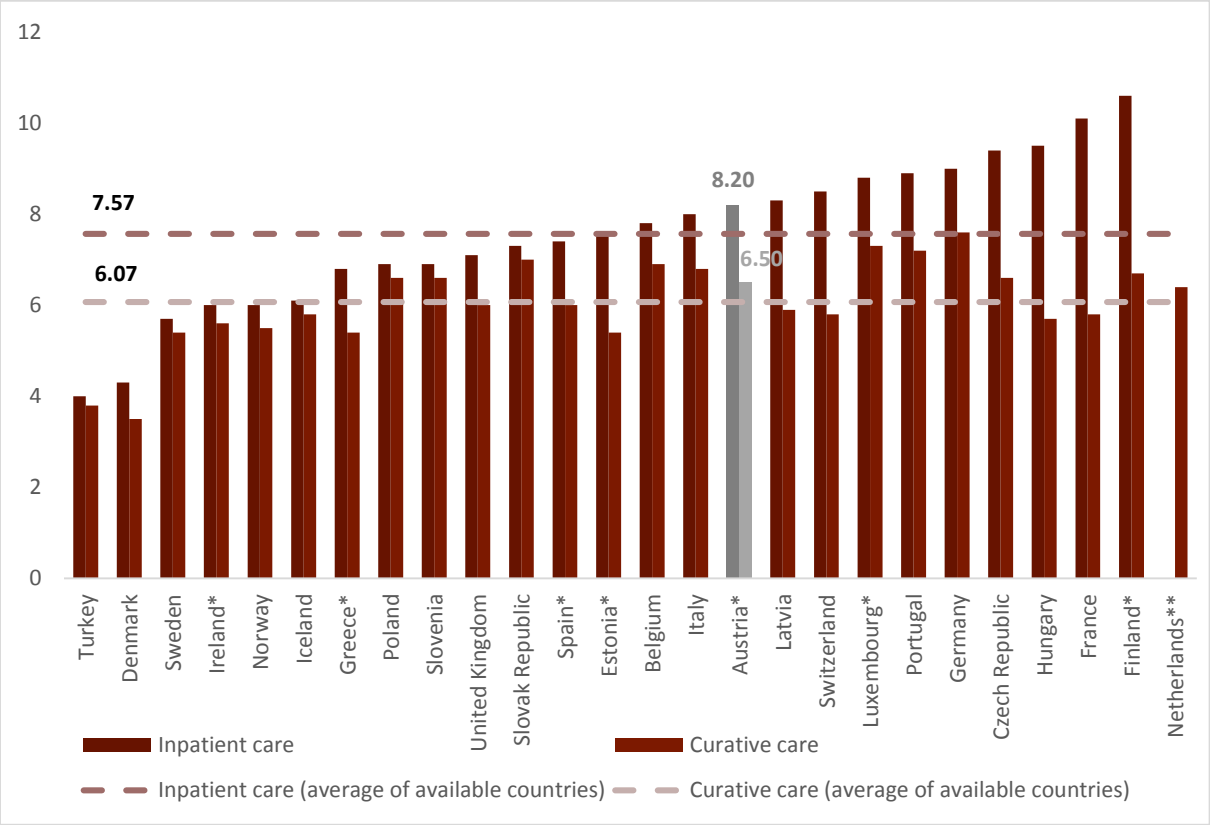
Figure 30: Inpatient hospital discharges per 1,000 inhabitants (2001-2014)



Source: (52)

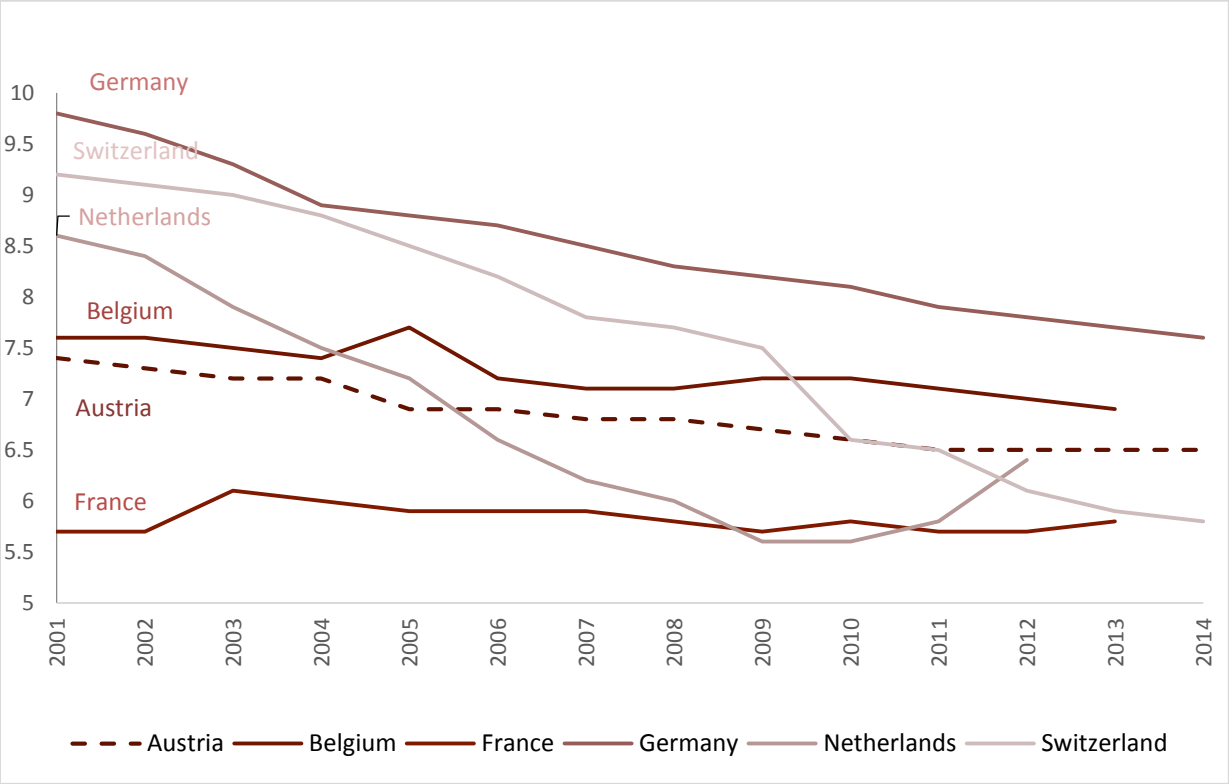
Regarding the average length of hospital stay (total number of days stayed by all inpatients divided by the number of discharges per year), which is often cited as a measure for the efficiency of the hospital sector (OECD 2015), Austria lies marginally above the average for available European countries (i.e. 7.6% vs. 8.2% for inpatient care, and 6.1% vs 6.5% for curative care). On average, the length of inpatient stays are declining in the available European OECD countries.

Figure 31: Average length of stay in days (2014 or latest available year (a))



(a) Latest available year: BE: 2013, DK: 2013 (2005 for curative care), FR: 2013, EL: 2011, NL: 2006 (2012 for curative care)
(*) Excludes discharges of healthy new-borns
(**) Includes only acute/curative care|
Source: (52)

Figure 32: Average length of hospital stay for curative care (2001 – 2014)

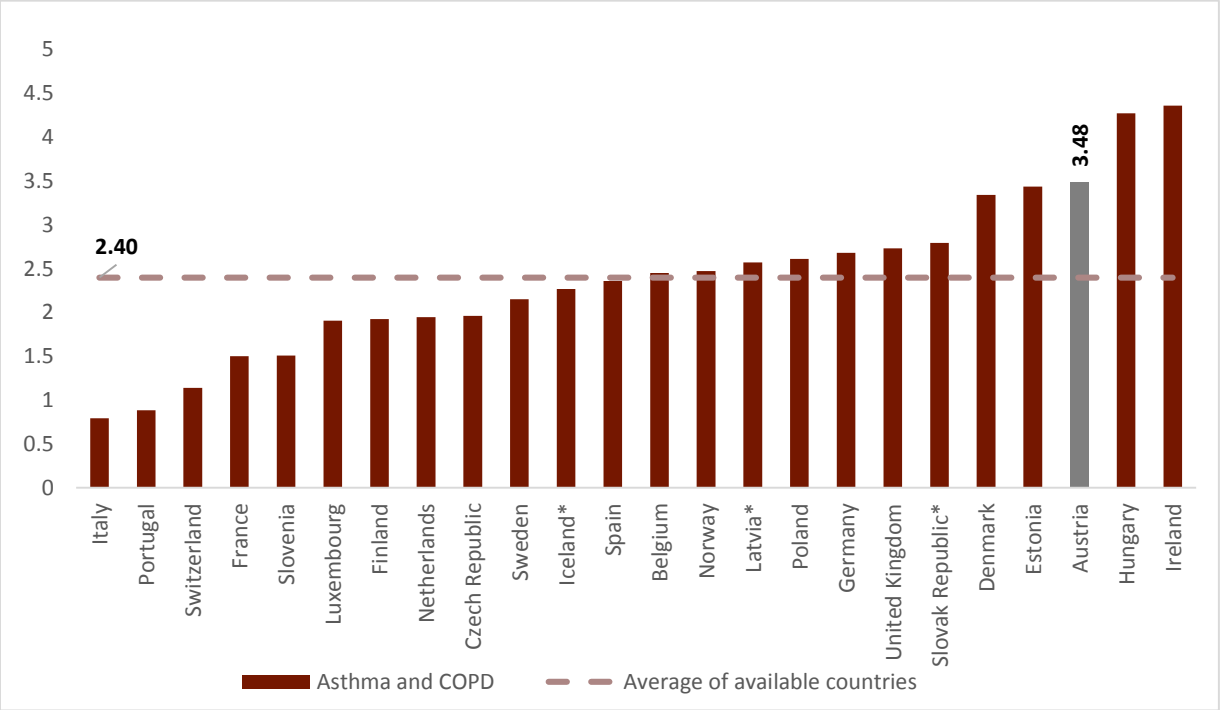


Source: (52)

To evaluate whether hospitalisations are potentially avoidable by accessible and effective primary health care, a list of so called ambulatory care sensitive conditions (ACSCs) has been proposed by various health system and policy researchers (58–61). The advantage of using ACSC as an indirect measure for primary care quality is that hospital data can be used, which is often routinely collected and therefore usually more reliable and comparable than data collected for example, through interviews. The OECD adopted the notion of ACSC, for which hospitalisations are potentially avoidable, to measure the quality of the primary care. Data on five common chronic diseases, which are part of the most used definitions of ACSCs (e.g. (58)), is available for cross-country comparisons. These conditions are asthma, COPD, diabetes, congestive heart failure (CHF) and hypertension. The data is presented as number of hospitalisations with one of the conditions, as primary diagnosis, among people aged 15 years or older, per 1,000 inhabitants. It is also age and sex standardised to the OECD population over 15 in 2010. For all conditions, reasons for variations could be not only the quality of the primary health care system, but also in differing levels of morbidity and differing coding practices between countries. Some countries were, for example, unable to fully rule out double counting of patients due to referrals (details can be found in the notes of Figure 33 to Figure 36) (17).

Asthma and COPD are analysed together given their close physiological relationship (Postma and Rabe 2015) (see Figure 33). Ireland, Hungary and Austria showed the highest hospitalisations rates for these conditions (3.48, 4.28 and 4.36. per 1,000 age-sex standardised population, respectively). The rate for Austria might be overestimated as not all transfers could be identified due to inappropriate coding and the lack of a patient identifier to correct for double-counting. The average number of hospitalisations of patients aged 15 and older per 1,000 sex-age standardised population in 2014 (or latest available year) was 2.4, which is around 30% less than the Austrian rate.

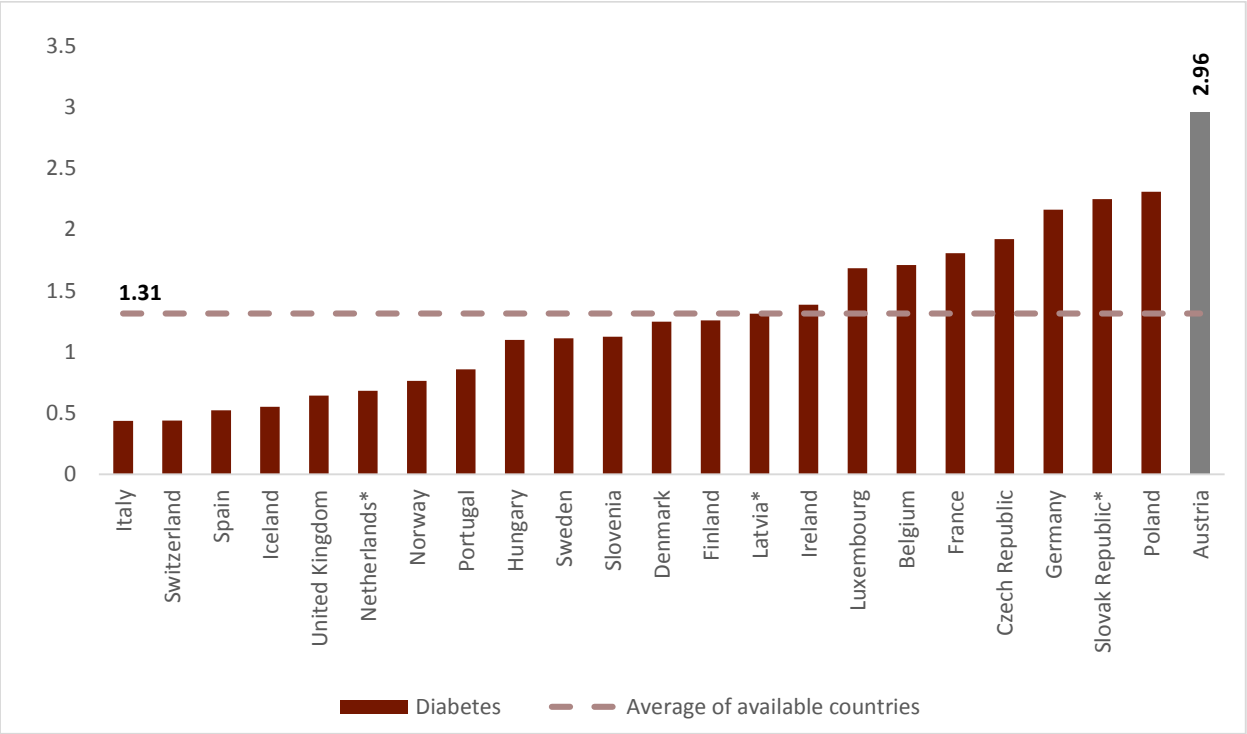
Figure 33: Hospitalisations for Asthma and COPD of population 15 years and older – age and sex standardised per 1,000 inhabitants (2013 or latest available year (a))



(a) Latest available year: BE: 2011, CH: 2012, HU: 2012, IS: 2012, LU: 2012, NL: 2011, SK: 2012
(*) **IS**: Includes cystic fibrosis and anomalies of the respiratory system. **LV**: Excludes discharges from hospitals that only provide rehabilitation services. **SK**: Includes J45, J46 for asthma and J41, J42, J43, J44, J47 besides J40 for COPD
Source: (52)

Hospitalisations for diabetes related conditions in Austria are more than twice as high as the average of the available European OECD countries (2.96 versus 1.31 per 1,000 sex-age standardised population over 15) (see Figure 34). This large difference might in part be due to double-counting of transferred patients, however, the countries with the second and third highest rate (Poland and Slovak republic) suffer from coding problems that might lead to an overestimation.

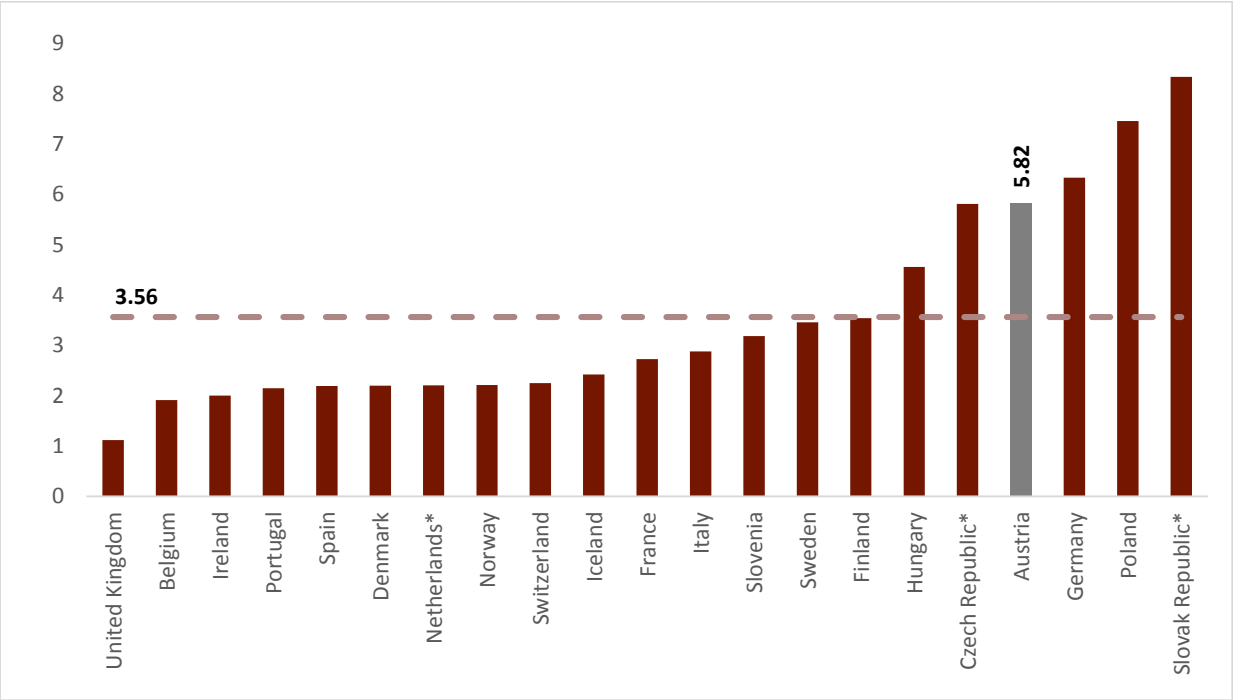
Figure 34: Hospitalisations for diabetes of population 15 years and older – age and sex standardised per 1,000 inhabitants (2013 or latest available year (a))



(a) Latest available year: BE: 2011, CH: 2012, HU: 2012, IS: 2012, LU: 2012, NL: 2011, SK: 2012
(*) **LV**: Excludes discharges from hospitals that only provide rehabilitation services. **NL**: Includes E12 to get comparable outcomes with ICD9. **SK**: Includes E10, E11, E13, and E14.
Source: (52)

Hypertension is the leading cause for congestive heart failure (Levy *et al*. 1996) and is therefore analysed together with it (see figure below) (62). Again, Austria exhibits rates above the average of the available European OECD countries (5.81 versus 3.56) for these conditions, with only Germany, Poland and the Slovak Republic having higher hospitalisations rates (6.33, 7.46 and 8.34, respectively).

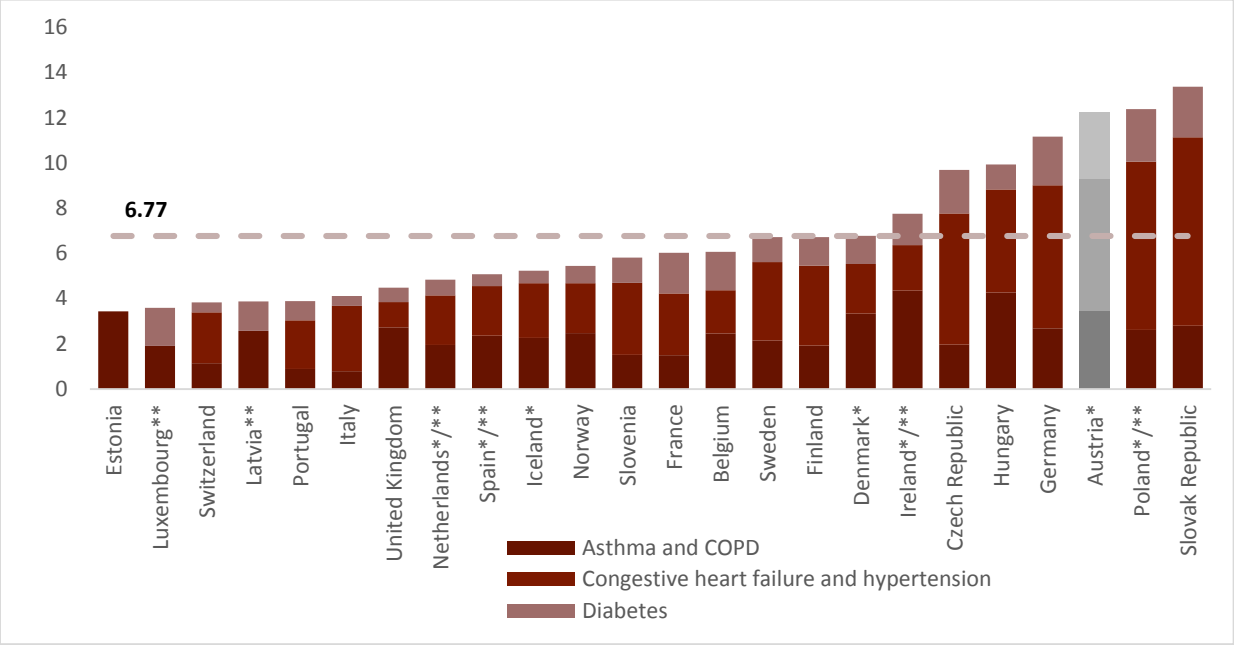
Figure 35: Hospitalisations for congestive heart failure and hypertension of population 15 years and older – age and sex standardised per 1,000 inhabitants (2013 or latest available year (a))



(a) Latest available year: BE: 2011, CH: 2012, HU: 2012, IS: 2012, LU: 2012, NL: 2011, SK: 2012
(*) **CZ**: Excludes operation diagnosis I00-I99. **LV**: Includes cases with cardiac procedures codes. **NL**: Includes 404.0, 404.1 and 404.9 instead of 404.01, .03, .11, .13, .91, .93 for CHF and excludes 403 and 404 for hypertension (ICD-9) **SK**: Includes I11 also I11.9, I13, I13.1 and I13.9, I50 for CHF and I10, I11, I11.0, I12, I12.0, I13, I13.0, I13.1 and I13.2 for hypertension and cases with cardiac procedures.
Source: (52)

The cross-country analysis of the cumulated hospitalisation rates for the five available ACSCs shows that Austria ranked third after the Slovak Republic and Poland with a total of 12.26 hospitalisations for asthma, COPD, diabetes, CHF and hypertension per 1,000 population over 15 (age and sex standardised) in 2013. The average of all available countries was 6.77, and therefore 45% below the level of Austria.

Figure 36: Hospitalisations for five ACSC conditions of population 15 years and older – age and sex standardised per 1,000 inhabitants (2013 or latest available year (a))

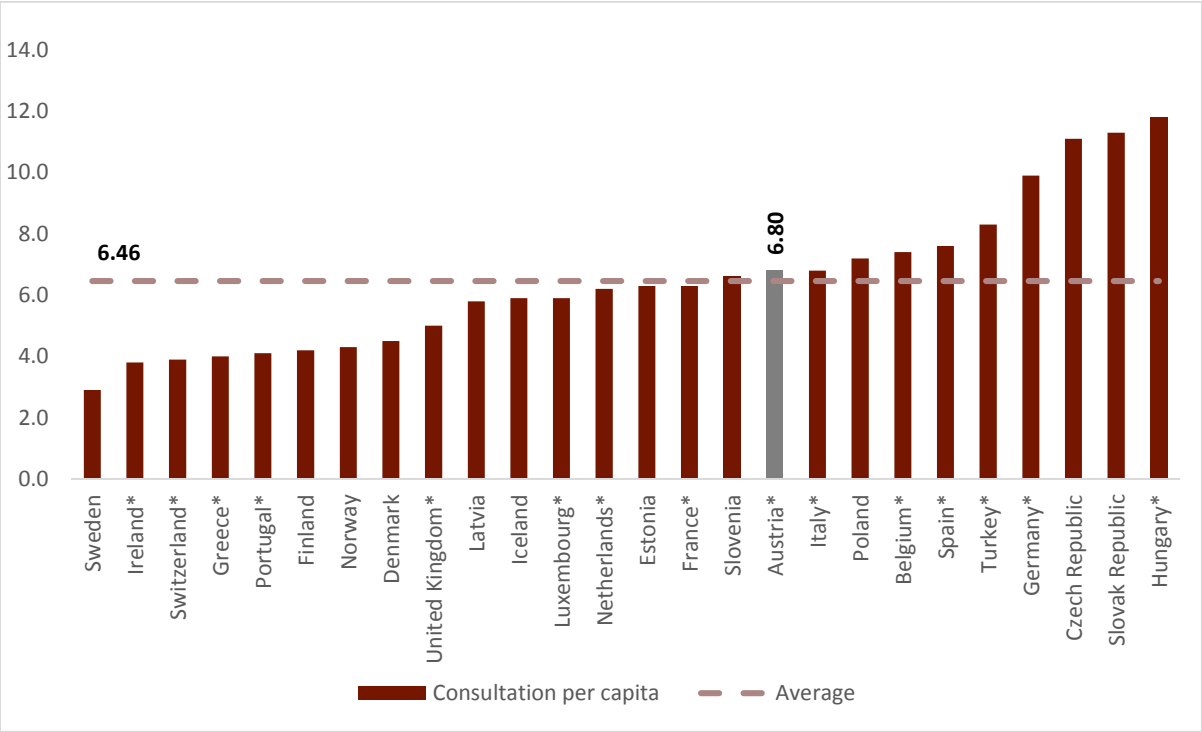


(a) Latest available year: BE: 2011, CH: 2012, HU: 2012, IS: 2012, LU: 2012, NL: 2011, SK: 2012
(*)Cases transferring from another institution were not excluded for all indicators
(**) See footnote [14]
Source: (52)

Despite these rather high numbers of general and potentially avoidable hospitalisations, the number of outpatient consultations per capita in Austria is slightly above the average of all available European OECD countries (6.8 versus 6.5) (see figure below).

[14] **IR**: Excludes data from private hospitals (underestimation of up to 15%). **LV**: Data refer to patients whose treatment expenses were covered from the state budget. **LU**: Data only cover the insured resident population. **NL**: Several hospitals stopped participating in the National Medical Registry and excludes several hospitals with incomplete data. **PL**: Completeness about 90%. **ES**: excludes data from private hospitals (underestimation of 15-20%, progressively increased since 2005).

Figure 37: Outpatient consultations per capita in 2014 (or latest available year (a)(b))



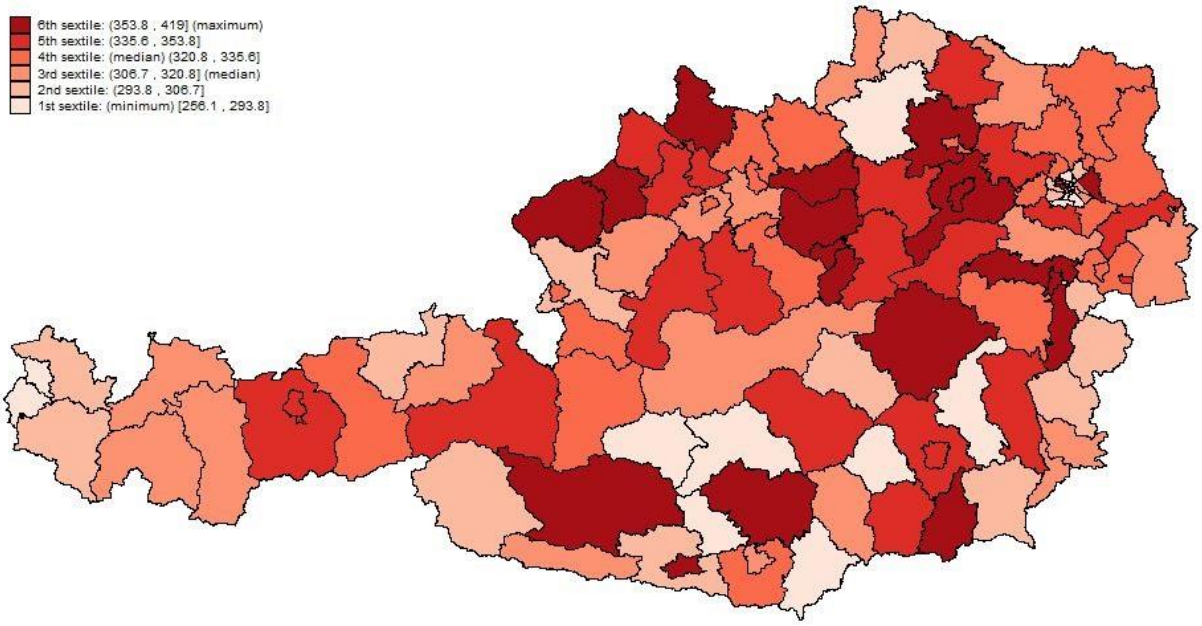
(a) Latest available year: BE: 2011, CH: 2013, CZ: 2013, EL: 2006, ES: 2013, IR: 2010, IT: 2013, NL: 2013, PT: 2012;
(b) Includes consultations/visits to both generalist and specialist medical practitioners, physician's offices, patient's home, outpatient department in hospital; and ambulatory healthcare centres.
(*) See footnote [15]
Source: (52)

3.5.2 Regional variations in healthcare utilisation

Hospitalisation rates do not only vary between countries but also within. In Austria, the all-cause hospitalisation rates in 2015 varied from 256.1 to 419.0 per 1,000 inhabitants (see Figure 38) between the 117 political districts (including city districts of Vienna). Hence, the political district with the highest rate recorded four times more hospitalisations than the region with the lowest rate.

[15] **AT**: excludes privately paid consultations. **BE**: excludes self-employed; includes medical assistance during urgent transfer to hospital. **CH**: includes only population aged 15+; excludes collective households (e.g. retirement homes). **FR**: includes external consultations with midwives. **DE**: includes only the number of cases of physicians' treatment according to reimbursement regulations (only counts first contact over a three month period). **EL**: excludes privately paid consultations. **HU**: includes consultations for diagnostic exams such as CT and MRI scans. IR: includes telephone consultations; includes only population 18+. **IT**: includes visits for prescribed laboratory tests and scheduled treatments (e.g. injections, physiotherapy). **NL**: excludes contacts for maternal and child care. **PT**: excludes visits to private practitioners. **ES**: includes only population aged 15+. **UK**: excludes consultations in independent sector and specialists outside hospital outpatient departments; includes telephone consultations.

Figure 38: Regional variations in all-cause hospitalisations per 1,000 inhabitants in 117 Austrian political districts (2015)[16]

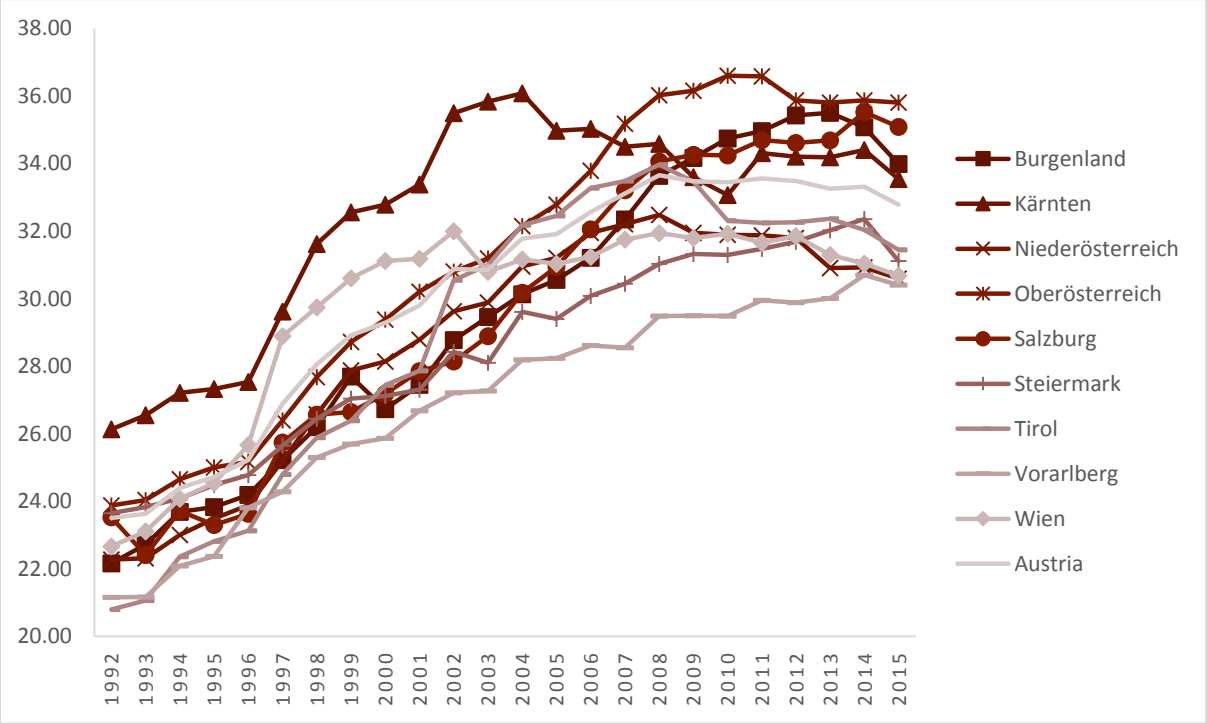


Source: Gesundheit Österreich GmbH / Austrian Ministry of Health

The long-term trend, however, seems to be following a similar pattern in all nine federal states (Bundesländer), with an increase in hospitalisations per 1,000 inhabitants of up until 2007 and a flattening of the curve since then (see Figure 39).

[16] Method for classifying the choropleth map: class breaks correspond to quantiles of the distribution of variable attribute, so that each class includes approximately the same number of polygons.

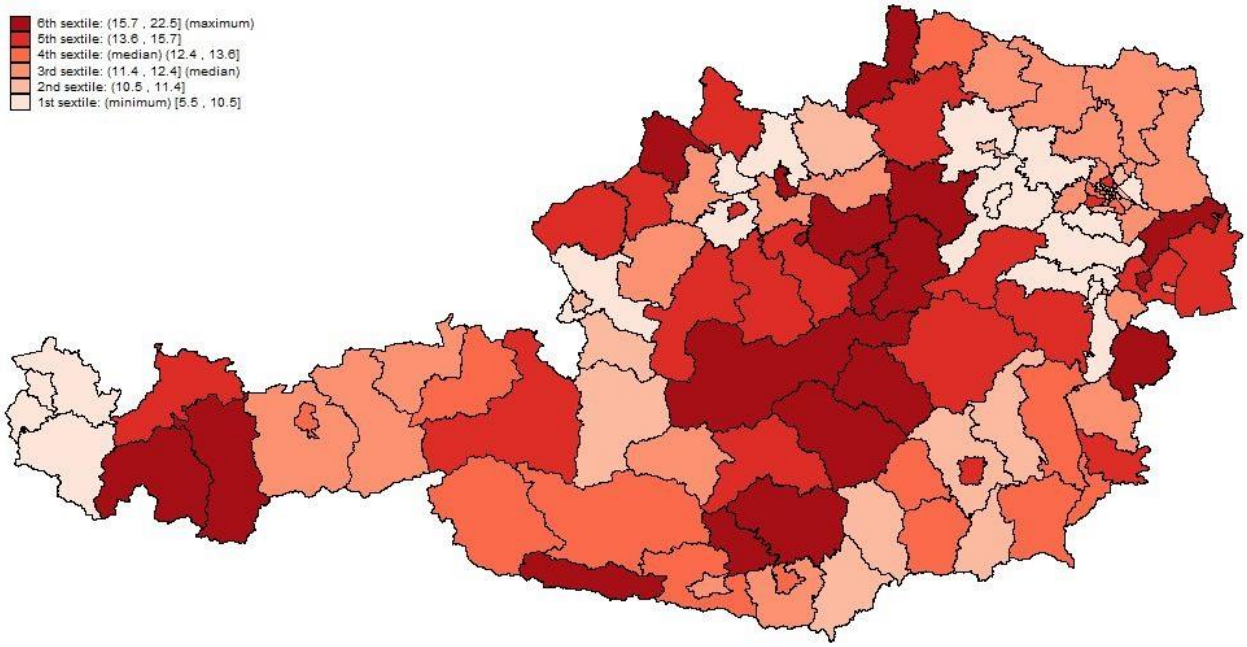
Figure 39: Time trend of all-cause hospitalisations per 1,000 inhabitants in 9 Austrian federal states (2015)



Source: Gesundheit Österreich GmbH / Austrian Ministry of Health

The district level variations in hospitalisations for selected ambulatory care sensitive conditions (ACSCs) ranges from 5.5 to 22.5 per 1,000 inhabitants; that is a variation of 4.1, indicating that the region with the highest rate of ACSC hospitalisations was 4.1 times greater than the region with the lowest recorded figures. For all-cause hospitalisations, the variation is significantly less at 1.6 (see Figure 40).

Figure 40: Regional variations in hospitalisations for asthma, COPD, congestive heart failure, hypertension and diabetes per 1,000 in 117 Austrian political districts (2013)[17]



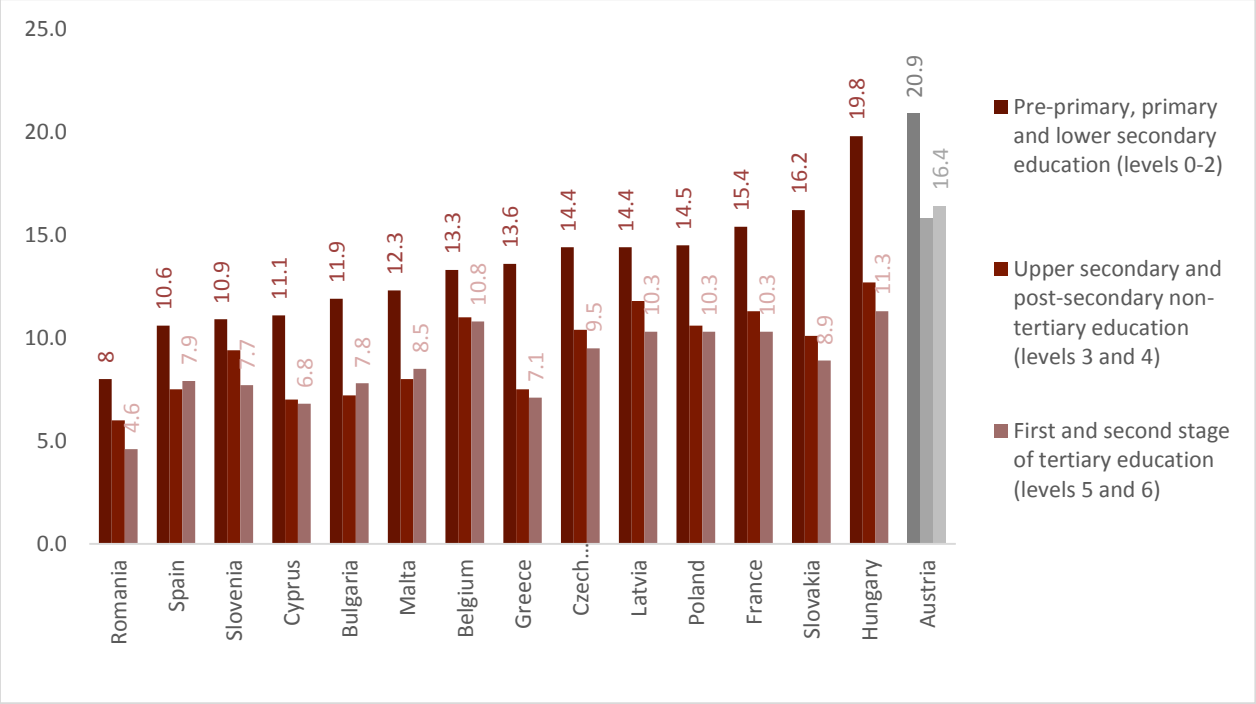
Source: Gesundheit Österreich GmbH / Austrian Ministry of Health

3.5.3 Equity of healthcare utilisation

It has been acknowledged by the WHO and most national governments that (unfair) health disparities due to socioeconomic characteristics exist and should be eliminated for social but also for economic reasons. Evidence regarding a socioeconomic gradient of health care utilisation in the EU Member States can be found in the results of the 'European Health Interview Survey' (EHIS). Data is publicly available for the first wave which was conducted between 2006 and 2009. The collected data shows that 17.3% of the Austrian population reported at least one inpatient hospitalisation during the 12 months before the interview (see Figure 41). Persons with pre-primary, primary and lower secondary education reported a higher rate of 20.9%, whereas onlh 16.4% of those with tertiary education reported inpatient stays. This means that persons with a tertiary education report 27% less inpatient stays than those with primary or lower secondary education. Compared to other European countries participating in the EHIS, this is a rather low gradient (the highest one is recorded in Greece with over 90%).

[17] Method for classifying the choropleth map: class breaks correspond to quantiles of the distribution of variable attribute, so that each class includes approximately the same number of polygons.

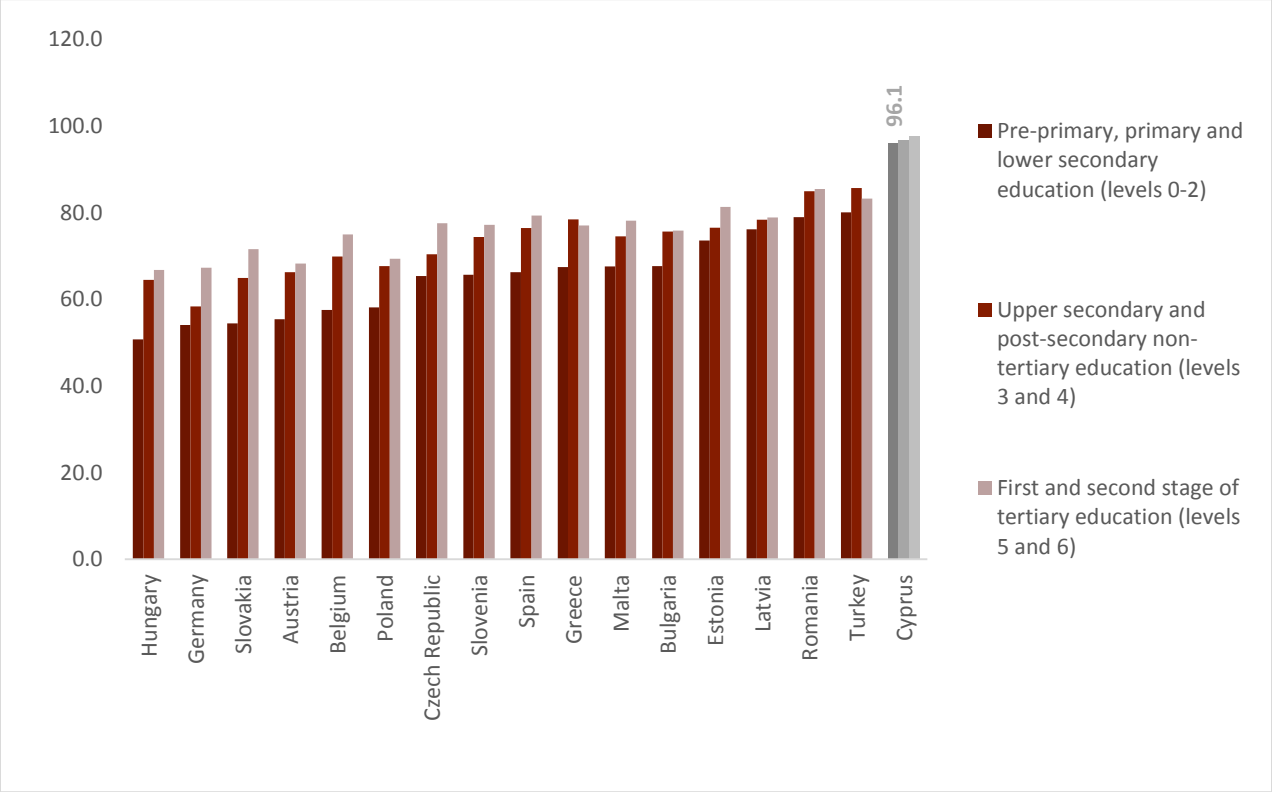
Figure 41: Percentage of population with at least one inpatient hospital admission during the last 12 months by educational attainment level (self-reported between 2006 and 2009)



Source: (63)

Regarding primary health care, 63.8% of the Austrian interviewed population stated that they had no contact with a general practitioner (GP) during the last 12 months. Of those persons whose highest educational attainment is lower secondary, only 55.4% reported that they had no GP contact which is almost 20% below the percentage reported by persons with tertiary education. Compared to the other countries in the survey, this is a rather high gradient (see Figure 42).

Figure 42: Percentage of population with no contacts with a general practitioner during the last 12 months by educational attainment level (self-reported between 2006 and 2009)



Source: (63)

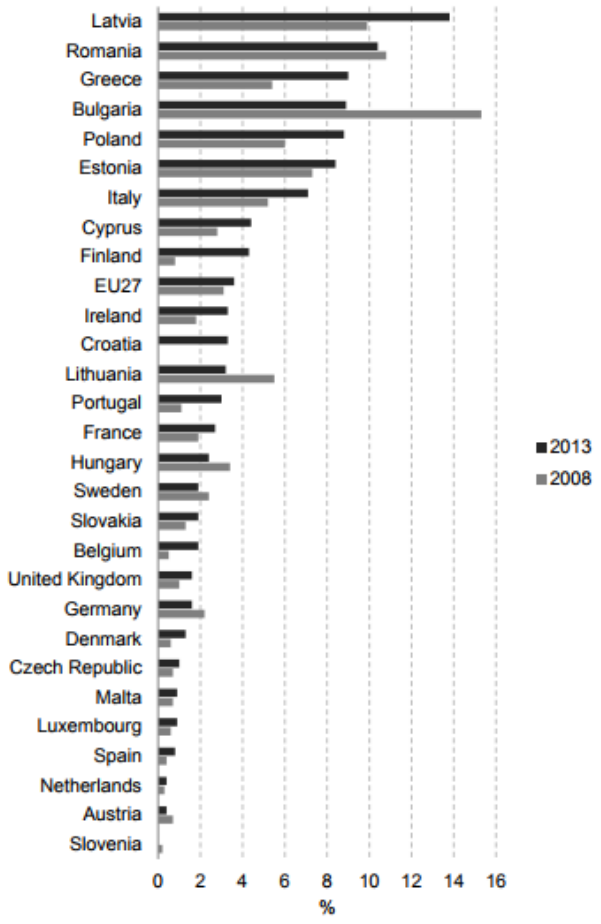
3.5.4 Unmet need

In a study conducted by Detollenaere *et al.* only a small percentage of the Austrian population reported unmet need; of the 32 countries analysed, Austria had the 7th lowest percentage of people reporting unmet healthcare needs (64). In addition, the authors showed that the gap between healthcare needs of low- and high-income groups was comparatively small, and only six countries demonstrated smaller gaps. The data therefore implies that Austria does not exhibit significantly large inequities in access to healthcare. The Netherlands, which also operates a social insurance system, had an even smaller percentage of people reporting unmet need, and interestingly, scored highly with regard to primary care strength indicators. Conversely, all of France, Belgium, Switzerland, Luxembourg and Germany presented larger percentages, the highest being France where over 5% of people reported unmet need. Austria conformed to the general trend whereby the lowest income group reported the highest unmet need.

Results from the above study are mirrored by data collected and analysed within a recent report by the European Commission (65). Based on EU-SILC (Statistics on Income and Living Conditions) data, of the 29

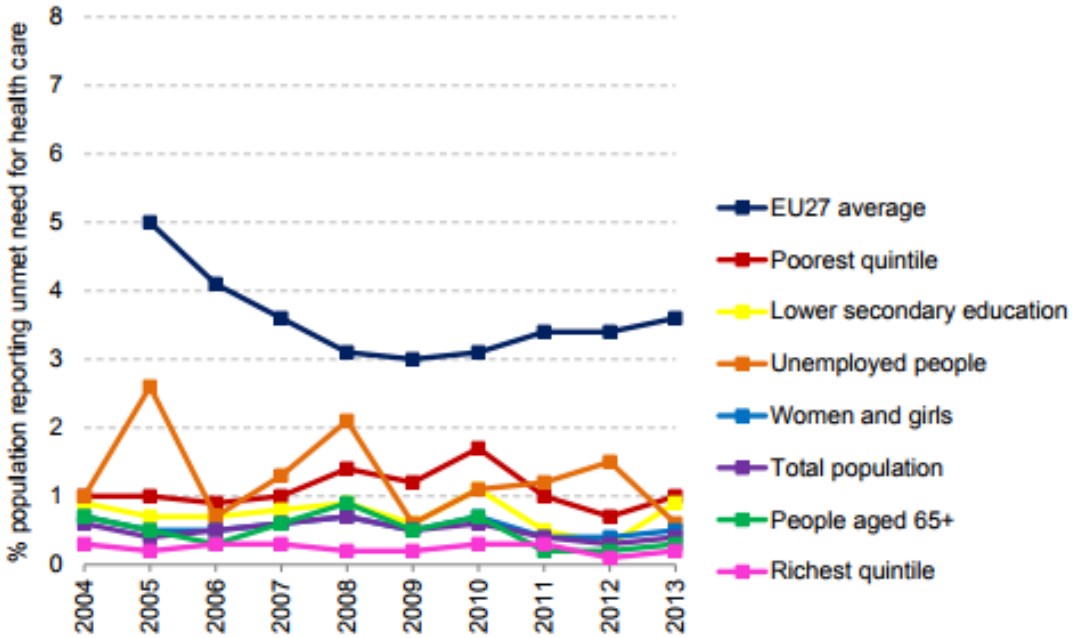
countries examined, Austria had the second lowest share or people reporting unmet healthcare needs as a result of cost, travel distance and waiting times (as of 2013) (65). Further, results from the data show that Austria has made significant progress in this area between years 2008 and 2013 (Figure 43). Using the same data, an analysis of unmet need in Austria, compared to the EU(27), was also undertaken according to range of population groups, namely: poorest quintile, lower secondary education, unemployed, female, people aged 65+ and richest quintile. Results from this analysis are promising, given even those in vulnerable groups (e.g. unemployed) recorded significantly lower levels of unmet need than the EU average (see Figure 44).

Figure 43: Share of people reporting unmet need for healthcare due to cost, travel distance and waiting time (EU(28), 2008-13)



Source: Taken directly from (65)

Figure 44: Trends in unmet need for healthcare due to cost, distance or waiting time (Austria and EU(27) average, 2004-13)



Source: Taken directly from (65)

3.6 Summary

The performance of Austria's healthcare system can be summarised using the main findings of this chapter. Compared with other European and OECD countries, Austria spends a relatively large proportion of GDP on healthcare, albeit it is more similar to those OECD countries which utilise a health insurance system. This finding is mirrored at the individual level when analysing health expenditure per capita data.

Similar to other European countries, healthcare expenditure as a proportion of GDP is rising, however by contrast, the average annual growth rate in health expenditure per capita is decreasing. Austria's main source of financing is compulsory health insurance yet it also relies quite heavily on taxation and government schemes, unlike many of its OECD social insurance country peers.

The data in this chapter provides an insight into the relative importance of different health care providers. It is evident that hospital provision is inflated compared to many other OECD countries, due to the high numbers of hospitals and hospital beds, implying insufficient provision is available at the primary care level. With regards to health care professionals, data supports the view that there is an over reliance on physicians and under reliance on other professions, in particular nurses.

Life expectancy in Austria has exhibited an upward trend, which is also reflected in comparator countries, however, current life expectancy is lower than than in several European countries with health insurance systems, suggesting Austria is underachieving in this respect. Further, relative to a number of European countries, life expectancy projections are low. Such results suggest further effort is required to enhance current public health initiatives (as outlined in chapter 7).

The indicator of deaths from cancer per 100,000 people provides a largely positive view of health outcomes in Austria, and for most types of cancer Austria performs close to the average of the countries examined, or better with regards to age standardised net survival rates. Prevalence of diabetes however is above the European Union average. Finally, the burden of disease in Austria is largely similar to that in analogous countries with the highest amount of premature death attributable to ischaemic heart disease, whilst the biggest risk factors are associated with unhealthy lifestyles.

Secondary healthcare utlisation is relatively high in Austria, compared to similar countries, and analysis of hospitalisations for ambulatory care sensitive conditions provides insight as to whether hopsitalisations in general are potentially unnecessary. Interestingly, Austria displayed above average rates for asthma and COPD, diabetes and hypertension and congestive heart failure, which provides further evidence that primary healthcare performance is less than optimal. Utilisation of healthcare differs according to educational attainment, suggesting inequities do exist, with more educated persons reporting a lower percentage of inpatient stays in hospitals. Whilst there appears to be an apparent disparity, it is important to observe that it is less extreme than those in other European countries.

Figure 45: Overview of international comparative analysis results

Financing

- Above average expenditure on health when compared to the EU average, however, lower than other countries operating social health insurance systems
- Relatively low average annual growth rate in years 2005-09, and even less between 2009-15

Physical and human resources

- Relatively high number of practising physicians per 1,000 people, with a concurrently low number of practising nurses and pharmacists
- Significant number of hospitals and hospital beds, and thus high rates of inpatient admissions relative to EU and OECD countries

Health outcomes

- Life expectancy figures for men and women mirror those found in other European social health insurance systems, however, in regard to projections, Austria performs relatively worse
- Similar to most developed countries, major areas of disease burden are non-communicable and include ischemic heart disease, COPD, and diabetes

Utilisation

- Austria has the highest number of inpatient discharges per 1,000 people when compared to European OECD countries, however, an analysis of trends reveals the number of discharges has been falling since 2008
- Hosptialisations by ACSC reveal that Austria has a relatively high number of admissions for asthma and COPD, diabetes, and congestive heart failure
- In the outpatient sector, utilisation aligns wit figures recorded across a number of OECD countries
- All-cause and ACSC hospitalisation rates differ across the nine states, with the latter experiencing significantly greater variation
- Austria experiences relatively low levels of unmet healthcare need across all groups in society, including the unemployed and those in the lowest income quintile.

4 Structure of Austria's social security system

This chapter outlines the organisation of the Austrian social security system. Based on the strengths and weakness of Austria's healthcare system, four alternative social insurance models have been proposed. The models ultimately aim to improve patient wellbeing by improving both efficiency, effectiveness and equity within the system.

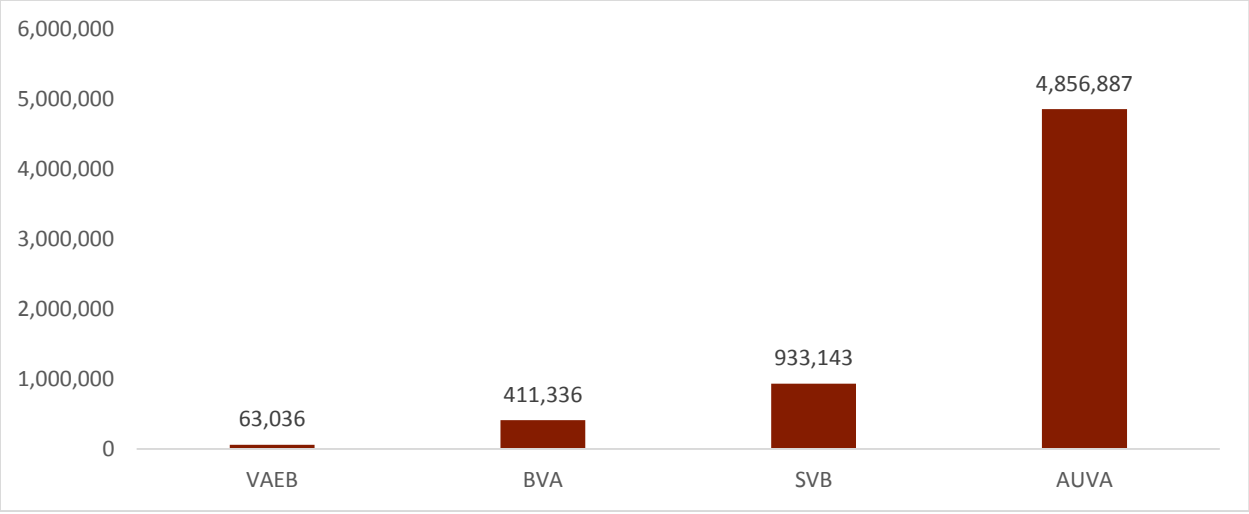
4.1 Structure of social security in Austria

4.1.1 Status quo

Austria's social security system is comprised of three pillars, namely, accident, health and pension insurance. There are a total of 21 insurance carriers within the current system who offer single or multiple types of insurance (66). As previously outlined, all 21 social security carriers are united under the HVSV.

Accident insurance covers physical damage, death or inability to work, as a result of workplace accidents or occupational disease. Accident insurance is offered by the: Austrian Workers' Compensation Board (AUVA); Insurance Institution for Railways and Mining (VAEB); Insurance Institution for Public Sector Employees (BVA); and the Insurance Institute for Farmers (SVB). AUVA is the largest provider, covering 78% of the population (67).

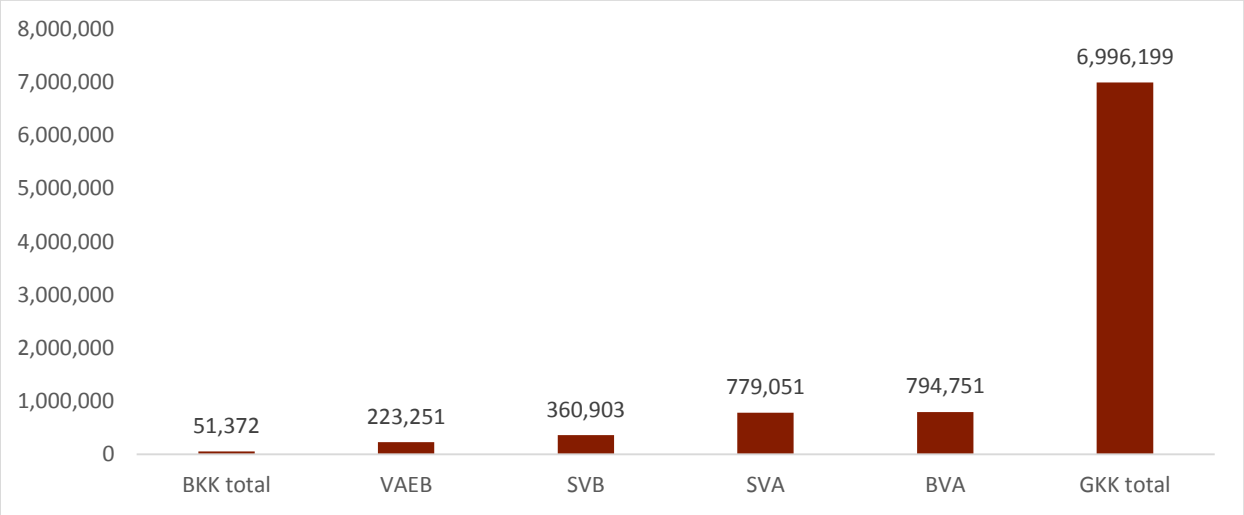
Figure 46: Number of insured persons per accident insurance carrier



Health insurance covers sickness, health check-ups, incapacity to work caused by diseases, as well as maternity costs. Most of the population are covered by one of the nine GKKs (i.e. 76%), covering each of

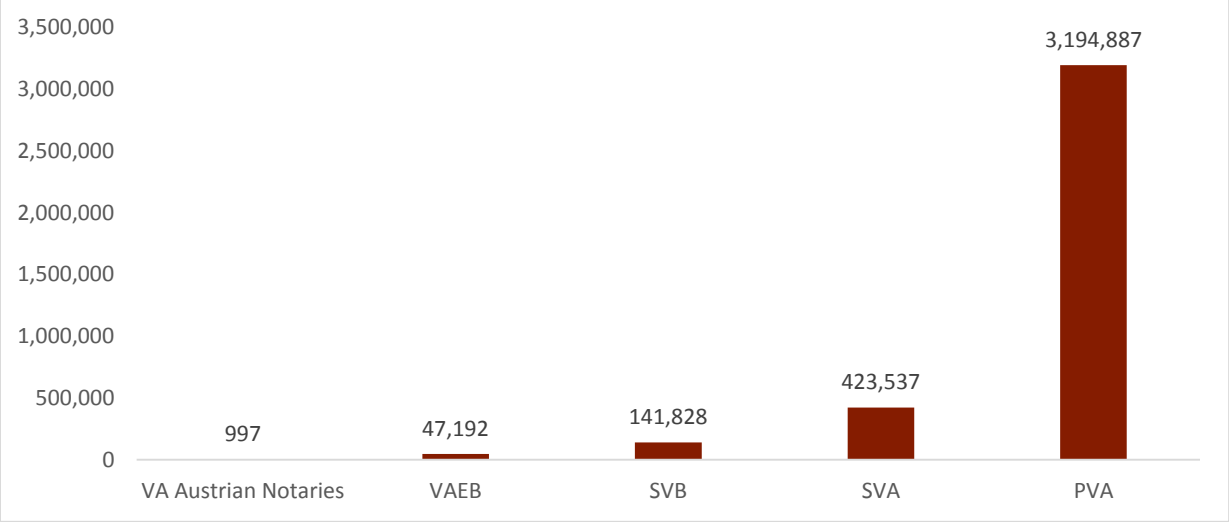
the Länder. The remaining 24% of the population are covered by either the Insurance Institution for the self-employed (SVA), the VAEB, SVB or the BVA (13).

Figure 47: Number of insured persons per health insurance carrier



Lastly, **pension insurance** covers insurance claims for those of retirement age, as well as for those who have limited working ability, and death. Pension insurance also provides rehabilitation services and healthcare. Eighty-four per cent of the market is covered by the PVA. Pension insurance is also provided by the SVA, SVB and VAEB, in addition, there is a pension insurance institution for notaries (67).

Figure 48: Number of insured persons per pension insurance carrier



Although not technically within the social insurance system, it is important to highlight health and accident insurance offered to civil servants through the Krankenfürsorgeanstalten (KFA).[18] There are currently 15 KFAs covering health and accident insurance to 200,000 people at the Länder or community level. In addition, since 2000, seven employment groups have been given the choice to 'opt out' of the statutory insurance scheme (article 5, GSVG), given their insurance is covered, for example, by voluntary health insurance under the ASVG or GSVG. These professions cover pharmacists, physicians, lawyers, architects, public accountants, veterinarians and notaries (68). For further details on the structure of Austria's social insurance system, please see Volume 4 – Situational Analysis.

4.1.2 Policy options: Social insurance structural models

The debate of merging social insurance carriers has been discussed extensively within Austria over the past decade. Advocates of amalgamating carriers point to potential benefits, namely from economies of scale and scope (as outlined below).

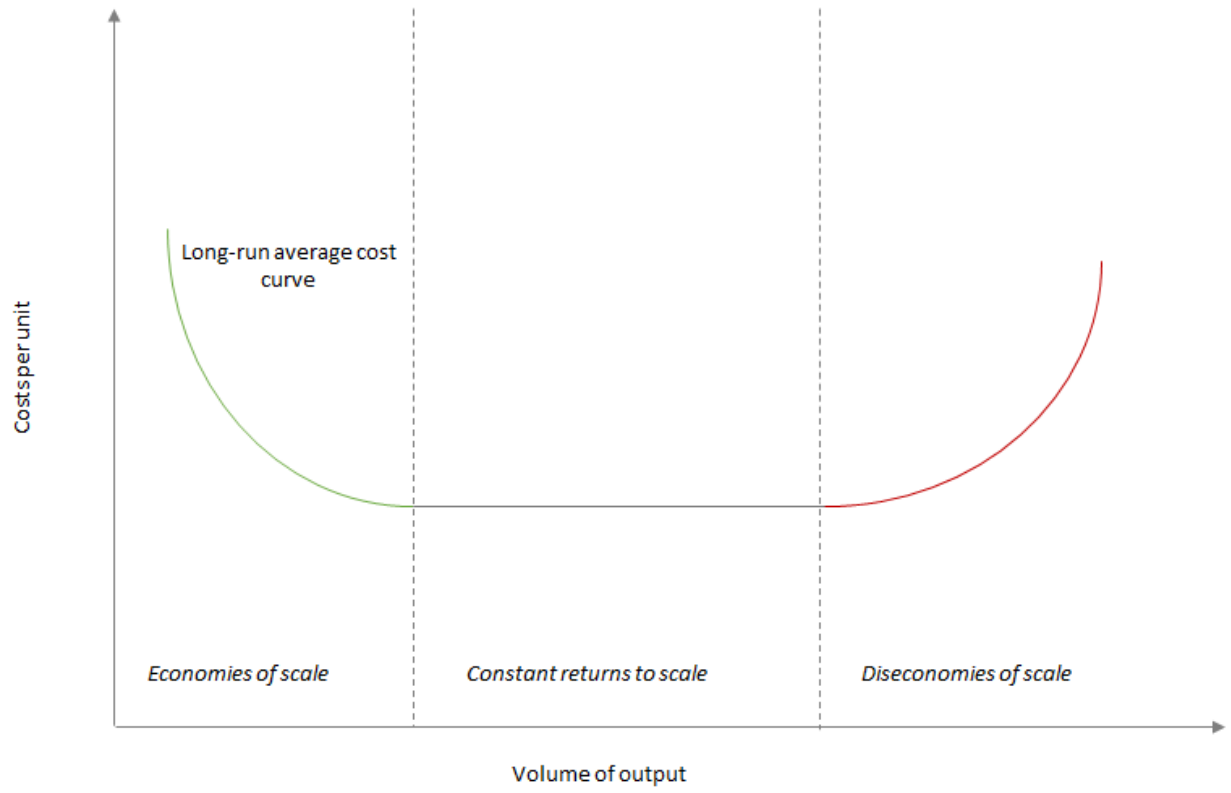
Economies of scale

In theory, firms can reduce average costs of production if they increase their level of output. This is commonly referred to in the literature as 'economies of scale' (69). For example, economies of scale may be achieved by streamlining IT processes, human resources, as well as data collection and analysis. It is important to note that, theoretically, economies of scale is not continuous, in that once a certain threshold is reached, the decline in costs per unit will stagnate and eventually rise once more (see figure below). For this reason, firms should take caution when expanding their operations given it may also lead to diseconomies of scale due to the heightened complexities associated with managing a significantly large business (70).

The specific threshold before diseconomies of scale are reached is rarely known, and is likely to differ across and within industries. Consequently, economies of scale are not necessarily achieved in practice.

[18] KFAs operate in Carinthia (n=1), Lower Austria (n=1), Upper Austria (n=6), Salzburg (n=1), Styria (n=1), Tyrol (n=2) and Vienna (n=1) (15 KFAs in total) (Source: BGBI §2 Abs. 2: Ausnahmen von der Krankenversicherung).

Figure 49: Long-run returns to scale



Economies of scope

A second driver of efficiency relates to economies of scope, whereby it is less expensive to produce a range of products together, as opposed to producing each product on its own (e.g. by reducing parallel structures, which lead to unnecessary costs) (70). Regarding economies of scope, there exist two conflicting theories, namely the 'Conglomeration Hypothesis' and 'Strategic Focus' (71). The former, states that firms can take advantage of cost and revenue scope economies by operating in several business lines or offering a multitude of different products, resulting in superior efficiency compared to specialised firms. The latter, on the other hand, argues that specialised insurers generate superior efficiency by focusing on one or a limited set of offerings from their core business, where they exhibit competitive advantages (71). According to Cummins *et al.* (2010), in terms of insurance, the Strategic Focus argument outweighs arguments made within the Conglomeration Hypothesis (71). Further Conglomeration Hypothesis within the Austrian social health insurance context is not possible given there is no opportunity to expand outside the three forms of insurance.

Additional benefits of mergers

Amalgamation of carriers may also address specific challenges facing Austria's social security system including:

- The lack of cooperation among insurance carriers (for example, during contract negotiations with the Chamber of Physicians, and in regard to investment of own institutions)
- Differences in benefit packages across carriers, with wealthier funds offering their insured population a wider range of benefits and better access to healthcare
- Structural fragmentation caused by national and regional laws governing different insurance carriers
- Limited risk-equalisation to take into account different structures across health insurance carriers.

Notwithstanding the above, amalgamation is not the only tool available for improving efficiency and coordination within the system. That is, significant improvements to efficiency and coordination can be potentially achieved within the current structural model given weaknesses within the system are addressed. Therefore, it is recommended that the net-benefits of restructuring the social insurance system be contrasted against enhanced cross-carrier cooperation.

In light of this, four alternative structural models have been developed, each offering differing levels of amalgamation across insurance carriers. For each of the four models proposed, an overview of the model, rationale, challenges and legal considerations have been provided.

It is important to note that amalgamation is unlikely to lead to cost-savings in the short-run given it takes time to adjust supply-side factors, such as office space and labour. Further, additional costs will arise from the development and implementation of new processes that are compatible with the new structural model. This is evidenced by the 2002 merger between pension insurance for workers and employees (PVArb and PVAng). Specifically, the greatest cost incurred by the merger was in 2003 (one year after the merge), which amounted to €35.2 million. This figure subsequently declined to €22.7 million in 2005, and eventually €5.6 million by 2008. Reasons for the additional short-term costs include inflexible labour and capital, as well as there being significant structural differences between the two PVA branches. Specifically, the PVA for workers was organised in a decentralised manner with four regional offices, whereas the PVA for the employees had one central head quarter overseeing nine branches.[19]

[19] The final structure largely mirrored that of the workers PVA, with the development of nine regional offices. This decentralised structure required additional staff, with associated increases in office space.

In the long-run, merger costs declined for several reasons including:

- Selling unused properties
- Standardising IT processes to fit with the general structure used within social insurance
- Bulk purchasing of standard software licenses
- Concurrent sourcing of IT personnel (i.e. hire externals on an ad-hoc basis (which led to annual savings of €1.36 million)).

Despite these savings, overall, the predicted savings of 10% were counteracted by overall costs totalling €114.8 million (as of 2007) (72).

Further evidence that mergers lead to cost increases in the short-run is found within the German context. Specifically, the German Court of Audit found administration costs rose in the first year after mergers (up to 18% for certain sickness funds). In addition, due to collective employment contracts, the level of staff cannot be adjusted, thus limiting efficiency potentials.[20]

[20] Information regarding the impact of mergers in the short-run completed by Contrast Ernst&Young.

Table 3: Proposed structural models for Austrian social security system

Model	Description	Risk-adjustment (RA)	Rationale	Challenges
Model 1* *Partial amalgamation*	- 1 accident insurance - 1 pension insurance - 1 employed health insurance - 1 self-employed health insurance	- Limited need for formal RA due to large insurance pools - Re-evaluate need for RA every five years	- Standard fees, access and benefits - Joint procurement - Economies of scale - Knowledge specialisation - Introduce KFAs into social security	- Standardisation - KFA competencies - SVB contribution base - BKK administration costs
Model 2* *Limited amalgamation*	- 1 pension insurance - 1 self-employed health insurance - 1 health insurance for employed (excluding civil servants) - 1 accident insurance for employed (excluding civil servants) - Joint health and accident insurance for civil servants	- RA between civil servants and employed health insurance	- Standard fees, access and benefits - Joint procurement - Economies of scale - Knowledge specialisation - Introduce KFAs into social security Step-wise approach to amalgamation	- Standardisation - KFA competencies - SVB contribution base - BKK administration costs Develop RA across employed health insurance carriers and funds for civil servants
Model 3* *Health and accident amalgamation*	- 1 pension insurance - 1 health and accident insurance split according to the nine states	- Limited need for formal RA due to large insurance pools - Re-evaluate need for RA every five years	- Standard fees, access and benefits - Joint procurement - Economies of scale - Knowledge specialisation	- Standardisation - KFA competencies - SVB contribution base - BKK administration costs - Splitting AUVA into regions

Model	Description	Risk-adjustment (RA)	Rationale	Challenges
			Introduce KFAs into social security	
Model 4 *Insurance coordination*	- Current structure - Enhancement of current competence centres - Enhanced risk-adjustment across all health insurance carriers	- Develop RA across all insurance carriers	- Enhance equity and efficiency - Improve coordination among health insurance carriers	- Encouraging meaningful participation in competence centres - Exclusion of KFA from social security

Note: *Various sub-models exists for models 1, 2 and 3 and have been included in the table below.

Model 1: Partial amalgamation

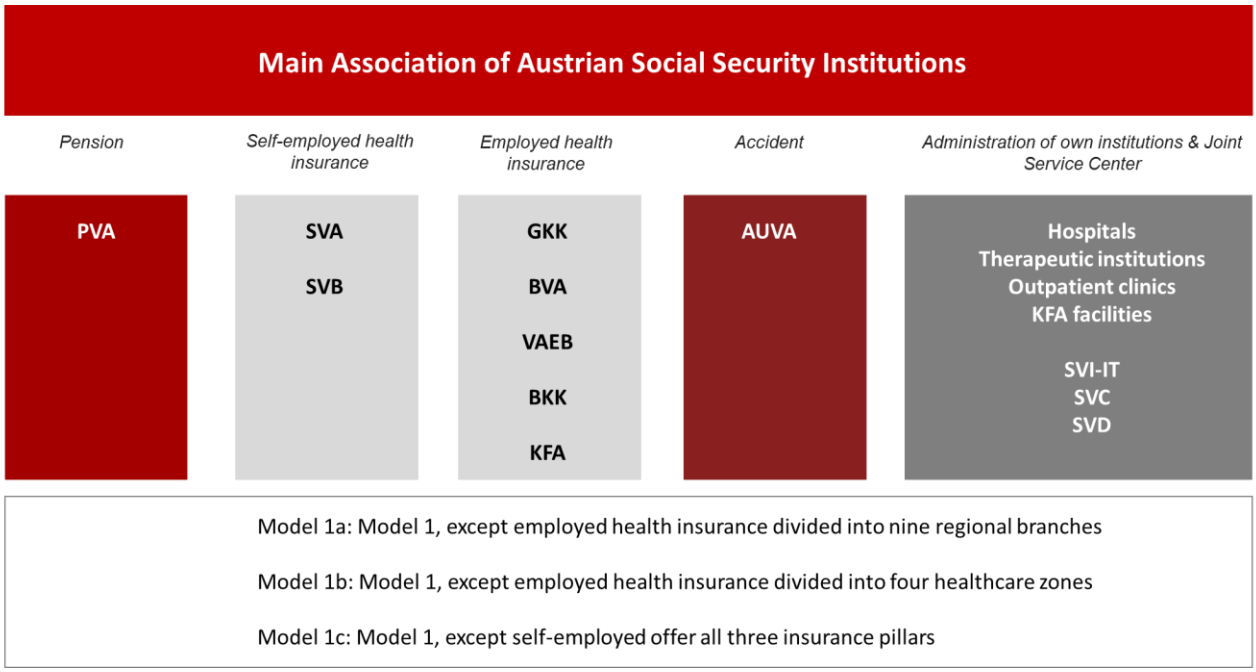
Description

Model 1 retains the three-pillared structure of the current system with separate insurance for health, accident (AUVA) and pension (PVA). Under the new system, all three insurance pillars would be nationalised with no single insurance carrier offering multiple or all types of insurance. The health insurance pillar would be split into two groups – employed and self-employed. Employed health insurance would cover all nine regional health insurance funds (GKK), the BVA, VAEB, BKKs, and KFAs, which currently operate outside the social security system. Self-employed health insurance would amalgamate the SVA and SVB. Governance principles and representation for both health insurance carriers could be based on the principle of proportionality.

In regard to national pension and accident insurance pillars, under model 1, all types of rehabilitation services would be subsumed by AUVA, with the exception of invalidity rehabilitation. This arrangement is necessary given these services are funded by pension insurance.

Health care institutions owned and run by insurance carriers (i.e. hospitals, outpatient clinics, rehabilitation centres) would be managed by one central agency, with similar arrangements applying for shared service centres. One exemption would apply, specifically, AUVA will retain control over their own hospitals.

Figure 50: Structural model 1



Rationale

Unlike the status quo, model 1 delineates each insurance pillar so that health (employed), health (self-employed), accident and pension are provided on a national level. Under this new arrangement, one health insurance carrier for the self-employed and one for the employed would be responsible for negotiating with the Chamber of Physicians on tariff levels and services. As a result, variability in fee schedules would be minimised.

The new structure would create larger risk pools, particularly within the health insurance pillar, thereby improving efficiency and equity within the system (see section 4.2 for further details on the benefits of larger risk pools).

Given the size of each of the two health insurance carriers (self-employed and employed), it is presumed that no formal risk-equalisation mechanism is needed. However, the need for a formal system of redistributing funds could be evaluated every five years.

Lastly, creating four separate insurance pillars, each with their own focus, can foster synergies and knowledge specialisation, leading to better services for the insured population.

Challenges

Despite the above benefits of consolidating insurance carriers, several challenges are associated with this form of amalgamation. Each of these challenges has been summarised in the table below, as well as an aligning strategy.

Table 4: Challenges associated with implementing model 1

Challenge	Strategy
Standardising specialist fees, user charges and benefits Currently insurance carriers offer different arrangements for accessing and paying for healthcare.	Standardisation of arrangements will be required, however, it should be phased in over a period of time (e.g. 5-10 years). This will provide the insured population and carriers' time to adjust.
KFA competencies Unlike other insurance carriers, KFAs are governed by the Länder and do not form part of the HVSV. KFAs also pay for all private expenditures, and in certain cases, pay in full for (non-contracted) physicians (Wahlärzte) (as opposed to the 80%).	KFAs under model 1 will have to form part of HVSV and operate under a similar law. Unlike the current KFA arrangement, employed health insurance will not fully reimburse patients who access non-contracted physicians.
Contribution base of SVB The contribute base for current SVB carriers differs from the SVA, with the farmers employing a non-income related base. Therefore, under the merge, the self-employed will be required to cross-subsidise.	This challenge could be addressed by either: changing the SVB contribution base so that is it fairer; or using efficiency gains from the consolidated organisation to subsidise the low contribution base from SVB insured population.
Administration cost the BKKs BKK administration costs are currently borne by companies	The administration costs of BKKs would need to be shifted to the health insurance carrier and away from companies. However, overall savings in

Challenge	Strategy
	administration through merging may counteract this additional administrative burden.

Variations

Model 1a

Model 1a mirrors model 1, with the exception that the national health insurance carrier for the employed would be split according to the Länder configuration. The branches may either sit under one national umbrella organisation, or operate as independent, autonomous carriers. Under this arrangement, risk-adjustment across the branches would need to be facilitated by one central agency for employed health insurance.

It could be argued that dividing the employed health insurance carrier into regions would strengthen cooperation within current State Health Funds, for example by extending existing coordination activities.

Model 1b

Unlike model 1a, model 1b would split the national health insurance fund for the employed into four healthcare zones (which incorporates 32 regions), as specified by the Austrian Structural Health Plan (Österreichischer Strukturplan Gesundheit, ÖSG):

- East: Northern Burgenland, Lower Austria and Vienna
- South: Styria, Carinthia and Southern Burgenland
- Noth: Upper Austria and Salzburg
- West: Tyrol and Voralberg.

By splitting carriers by healthcare zones, the planning of social health insurance would align with the Austrian Health Care Structure Plan (ÖSG). In addition, dividing insurance according to the configuration of the Länder risks increasing hospital utilisation, given the Lands are responsible for the provision of inpatient care (i.e. own, regulate and fund hospitals). Model 1b may also equalise the balance of power between social health insurance and the Länder, given one significantly large insurance carrier would negotiate with multiple Lands.

Model 1c

Model 1c differs from model 1 by jointly allowing the SVA and SVB to operate all three insurance pillars, as opposed to just health. Under the status quo, both carriers offer services beyond health insurance, with the SVA providing health and pension, while the SVB offers all three types of insurance.

Legal considerations

Model 1 and 1a

With respect to models 1 and 1a, certain legal challenges occur, however, most of these challenges can be addressed with simple legislative acts (i.e. no requirements of a two-third majority). Specifically, due to the self-governance-principle, as it is understood in the case-law by the Constitutional Court, amalgamation of employed and civil servants schemes as well as those for self-employed and farmers is possible if the system of collecting contributions is harmonised and (at least: or) separate groups ('curias') of insured persons are formed within the respective self-governance bodies (for details see below Volume 2, chapter 5).

Under such a common umbrella institution, the provision of services by physicians and other medical staff and the administration could be organised together. But as those curias (according to the self-governance-principle) must be authorised to release their own regulations (such as 'Satzungen' or Krankenordnungen') this could be contradictory to the goal of harmonization of risks and benefits.

Incorporation of the KFAs, however, would require either corresponding legislation by the regional Parliaments (Landtage) or amendments to Federal Constitution which would be subject to two-third-majorities in both chambers of the Federal Parliament (for details see below Volume 2, chapter 5.2.3.).

Model 1b

From a legal point of view, model 1b would cause constitutional problems (only) with respect to regulations for hospitals. Under the current Constitutional system, the Federal Parliament is authorised only for ruling "principles" of hospital law whilst the Regional Parliaments are competent to pass more detailed implementation regulations which are applicable, however, only to the respective Land and therefore not applicable to entities (such as these "healthcare zones") covering several Länder.

With respect to amalgamation of GKKs and BVA respective SVA and SVB and the incorporation of the KFAs the same applies as explained regarding Model 1.

Model 1c

Implementation of model 1c would require harmonisation of benefits (for details see below Volume 2 chapter 5.3), as well as harmonisation of policies regarding collections of contributions between the SVA and SVB.

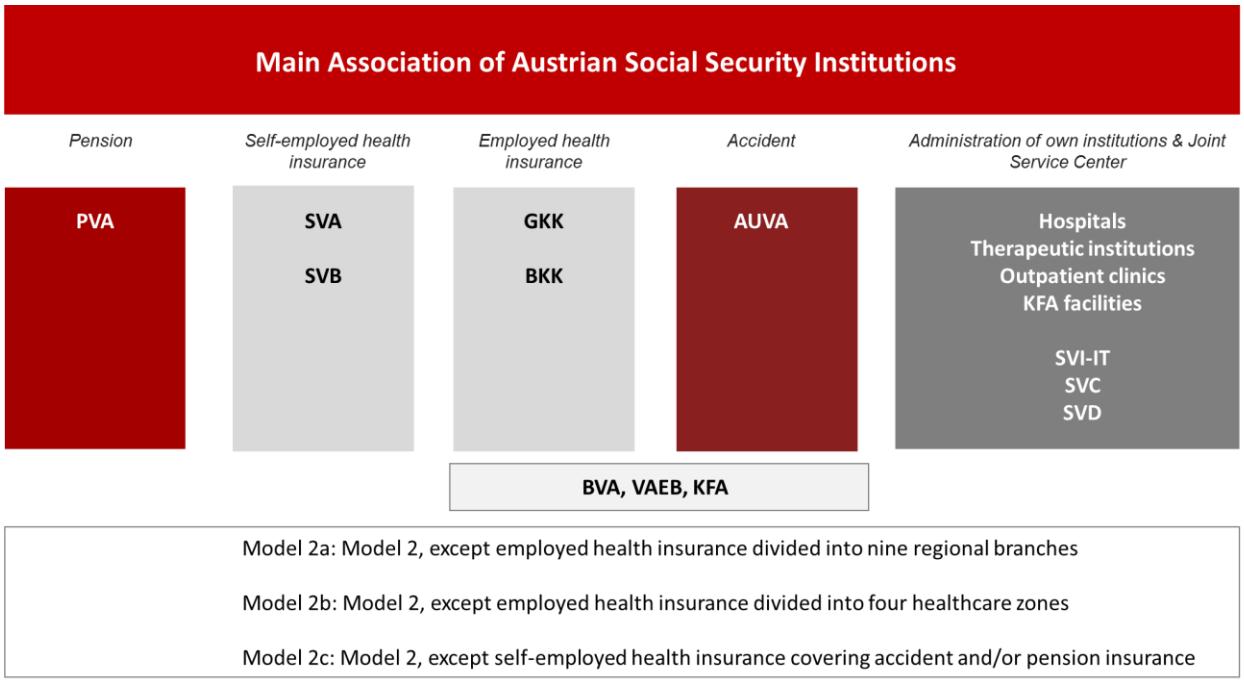
Model 2: Limited amalgamation

Description

Model 2 would create one national insurance pillar for pension and another pillar for self-employed health insurance. In addition, GKKs and BKKs would amalgamate to form a significantly sized employed health insurance carrier. Unlike model 1, model 2 would create a new health and accident insurance carrier for civil servants, that is, the BVA, VAEB (of which 53% are active civil servants (including dependents)) and KFAs. Regarding accidents, those not covered by the civil servant carrier would receive insurance from AUVA.

Lastly, similar to model 1, own institutions run by insurance carriers would be managed by one central agency to enhance efficiency and coordination.

Figure 51: Structural model 2



Rationale

The BVA, VAEB and KFAs would establish a new health and accident insurance carrier given their insurees are a relatively homogenous group. The rationale for this separation is that these carriers may, in the short-run, be more challenging to amalgamate given they currently offer extended benefits and greater access to physicians. Given civil servants have favourable risk profiles, the BVA, VAEB and KFAs would be required to participate in a risk-adjustment scheme with the employed health insurance carrier. The risk-adjustment scheme would be monitored by a central agency governing all relevant health insurance carriers (i.e. all except self-employed).

Finally, relative to the status quo, model 2 would create larger risk pools thus improving efficiency and equity, increase economies of scale, foster knowledge specialisation and promote joint procurement.

Challenges

Implementing model 2 is associated with challenges outlined under model 1. The added challenge of model 2, is to ensure a robust risk-adjustment mechanism between the employed health insurance, and the civil servants is implemented so that the employed health insurance carrier is not put at a disadvantage.

Variations

Model 2a

Similar to model 1a, under model 2a, employed health insurance (GKKs and BKKs only) would be divided according to the Länder. The branches may sit under one umbrella organisation or operate as independent, autonomous carriers. Risk-adjustment between the Lands and between the civil servant carrier would be facilitated by one central agency.

Model 2b

Unlike model 2a, model 2b would create four branches or independent employed health insurance carriers based on the healthcare zones. Risk-adjustment would be required across the healthcare zones, and between the civil servants and employed health insurance carrier.

Model 2c

Model 2c would maintain the same arrangements under model 2, however, the self-employed health insurance would also cover pension and/or accident insurance. For example, implementation could be step-wise by first offering pension and health (given this falls within current SVA and SVB remits), and later extended to accident insurance.

Legal considerations

Model 2

With respect to Model 2 the same legal issues as those posed by model 1 apply. Amalgamation of schemes for all self-employed is possible as far as the system of collecting contributions are harmonised and (at least: or) separate groups ('curias') of insured persons are formed within the respective self-governance bodies. The problem concerning incorporation of the KFAs remains.

Model 2a

From a legal point of view the same applies as explained with regards to model 1.

Model 2b

With respect to Model 2b the same problems with respect to regulations for hospitals would have to be faced as already explained regarding model 1b.

Model 2c

From a legal point of view the same applies as explained with regards to model 1c.

Model 3: Health and accident amalgamation

Description

Model 3 would create one national pension insurance carrier, and nine regional insurance carriers offering both health and accident insurance. The nine regional carriers may operate under the one umbrella organisation as branches, or as independent, autonomous carriers.

Similar to models 1 and 2, owned institutions would be managed and administered by a central agency.

Figure 52: Structural model 3

Model 3a: Model 3, except employed health and accident insurance divided into four healthcare zones

Model 3b: Model 3, except health and accident insurance is split between self-employed and employed

Model 3c: Pension and accident insurance combined into one national insurance pillar, in addition to one health insurance pillar (divided by regions, or healthcare zones)

Rationale

As is the case in models 1 and 2, model 3 enlarges the risk pool, enhances joint procurement, and fosters knowledge specialisation. For example, by combining the employed and self-employed, funds will automatically be risk-adjusted given high- and low-risk individuals are pooled into one carrier. Nevertheless, given differences across states, a formal risk-adjustment mechanism across the nine health and accident insurance carriers would be required.

Challenges

Implementing model 3 is associated with challenges outlined under model 1. In addition, there is limited synergies, in terms of services, between health and accident given health is increasingly focused on prevention, while accident insurance concerns patients who are already injured and therefore require specific healthcare and rehabilitation. Further, splitting AUVA into regions or healthcare zones may be counterintuitive and unnecessarily increase administrative costs (i.e. diseconomies of scale).

Variations

Model 3a

Model 3a would separate employed health and accident insurance into healthcare zones, which would also require a robust risk-adjustment mechanism.

Model 3b

Under model 3b, health and accident insurance would be further split according to employment status, that is, by employed and self-employed.

Model 3c

Model 3c would instead amalgamate pension and accident insurance into one national insurance pillar. This would avoid splitting national insurance into branches based on Länder configurations. Health insurance would be provided by one insurance pillar, which would be split according to regions or healthcare zones.

Legal considerations

Model 3

Amalgamation of health and accident insurance both of employed and self-employed would cause (constitutional) problems with regards of the principle of self-governance (different risks, different interests, and different representation of insurees) (for details see below Volume 2 chapter 5.2.2.).

Model 3a

With respect to Model 3a, the same problems with respect to regulations for hospitals would have to be faced previously explained under model 1b.

Model 3b and 3c

No constitutional problems have to be observed in this respect, but there are some actual concerns against 'splitting' of AUVA (see below Volume 2 chapter 10.3).

Model 4: Care coordination

Description

Model 4 maintains the current social insurance structure, including relevant legal entities, however, two additional changes are made. First, a risk-adjustment system across all carriers offering health insurance would be implemented. Second, the role of current competence centres would be enhanced and renamed as Joint Specialist Centres. A number of Joint Specialist Centres would be created, each providing a defined set of services designed to improve the efficiency of the overall social health insurance system.

A joint Working Group including representative from the HVSV, Ministry of Health and Women's Affairs, and the Ministry of Labour, Social Affairs and Consumer Protection, would be given responsibility for institutionalising Joint Specialist Centres by coordinating their development and implementation, and defining the list of 'specialties/themes' within each of the centres. To develop this list, a comprehensive mapping exercise could be undertaken to identify, a) areas of need, and b) complementary tasks/responsibilities, which could be bundled into a Joint Specialist Centre.

Once the Working Group have defined a list of specialties/themes and their associated services, individual social health insurance carriers must negotiate among themselves which carrier will take responsibility for each Joint Specialist Centre.

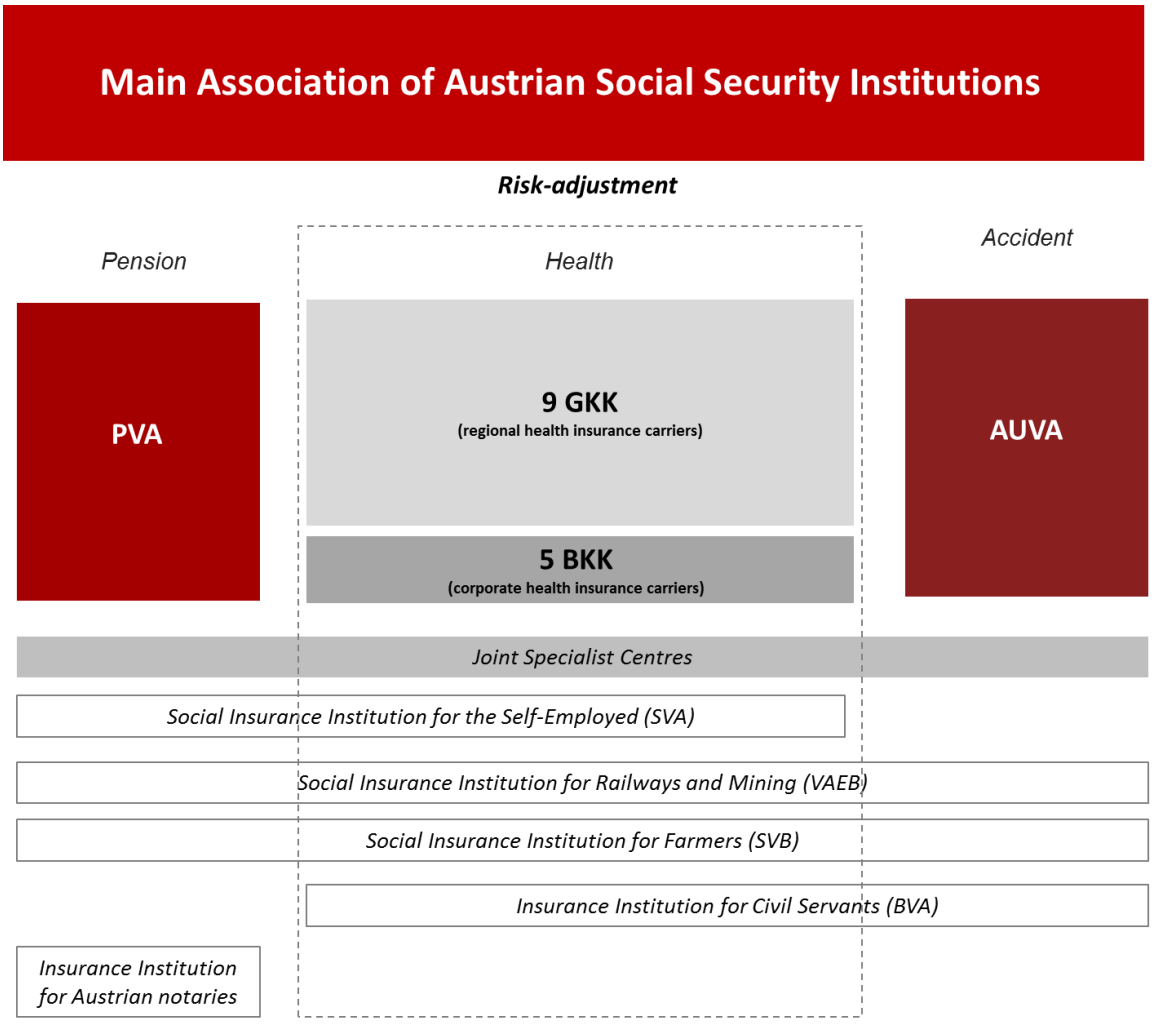
A preliminary list of specialties/themes for Joint Specialists Centre has been outlined below, and could be used as the basis for further discussions within the HVSV:

- Collection and auditing of contributions
- General legal matters
- Joint procurement
- Business management (e.g. accounting, payments)
- Performance optimisation
- Management of contractual partners (increasing bargaining power of the social insurers, and harmonising benefits)
- Specific healthcare treatment (e.g. dental health centres, rehabilitation facilities).

Under this model, it is necessary to define a proportion of costs (for example, as a proportion of contributions paid) that each carrier must dedicate to their respective centre. If this amount is not specified, it is likely that some, if not all, carriers would dedicate very little, thus minimising potential efficiency gains. The dedicated amount of cost could also fall within the remit of the Working Group.

Lastly, to incentivise participation in the scheme, take-up and subsequent participation within Joint Specialist Centres should be independently evaluated within the short-term. If results from the evaluation determine health insurance carriers were unable to derive maximum efficiency and coordination benefits associated with model 4, models 1, 2 or 3 could be considered. Alternatively, changes to the law could be introduced, which require carriers to actively participate (e.g. by specifying a minimum proportion of costs to be dedicated to Joint Specialist Centres).

Figure 53: Structural model 4



Rationale

The primary rationale for model 4 is the introduction of a comprehensive risk-adjustment mechanism across carriers offering health insurance (see section 4.2.7 for the five potential risk-adjustment options

under this model). As a result, health insurance carriers will have similar financial means and therefore be able to offer their insured populations the same benefits. Further, fostering inter-carrier cooperation can counteract inefficiencies and eliminate unnecessary costs caused by duplication.

Several advantages are associated with the proposed Joint Specialist Centres. Most importantly by:

- Enhancing and providing incentives to promote Joint Specialist Centres fosters an environment where further efficiency gains can be realised
- Giving responsibility for coordinating the development and implementation of Joint Specialist Centres to a Working Group minimises duplication within the system, thus improving overall efficiency
- Assigning social health insurance carriers with responsibility for a specific specialty/theme fosters specialisation, which again promotes efficiency within the system.

Challenges

In regard to model 4, a key challenge will be for carriers to allocate responsibility for Joint Specialist Centres, for example, powerful health insurance carriers may in fact define how all centres are allocated. As a result, carriers who have been allocated less desirable Centres may refuse to actively participate.

Although not a challenge, one significant disadvantage of model 4, relative to all other models, is the exclusion of the KFAs from the social security system.

Legal considerations

From a legal point of view, the main legal challenges arising from model 4 regards the proposed risk-adjustment mechanism. According to the case law ruled by the Constitutional Court, a mechanism aiming to compensate risks between different institutions and groups does not violate constitutional principles as long as there is a 'sufficient personal and material link' between the respective 'Versichertengemeinschaften'. A sufficient link in this respect can be assumed the more, the less differences can be identified with regards to contributions and benefits (including the framework of contractual partnership law) of the respective scheme. Without a sustainable withdrawal or even elimination of those differences (that could be achieved be simple legislation without two-third majorities, though) there is no sufficient link so far between the GKKs and the BVA, nor between GKKs and SVA or between SVA and SVB.

A risk adjustment scheme covering all carriers would meet the requirements under Constitutional Law only insofar as structural disadvantages can be proofed in an evidence-based way (and are not caused

only by regional disparities which are already compensated within national-wide carriers themselves). Otherwise a risk adjustment schemes could be implemented only by an amendment to Federal Constitution (i.e. only with a two-third majority). Nevertheless, a risk adjustment (mainly) based on taxes would be possible from a legal point of view (s below 4.2.7. and Volume 2 chapter 8.).

As long as participation in these Joint Specialist Centres is not compulsory there are no legal impediments at all. Legally binding participation, however, could cause constitutional problems with respect to the principle of self-governance. That would not be the case as far as legislation is only defining targets and that particular way of cooperation as a means to achieve these targets and as long as the carriers themselves (or their representatives in the respective bodies of the Hauptverband) decide which ones of them should run such a Centre and which ones would merely participate.

4.2 Risk-adjustment mechanisms

Enhanced risk-adjustment is a key motive for restructuring Austria's social security system, given its impact on both efficiency and equity. This section explores risk-adjustment in more detail, including case studies from a range of healthcare systems in Europe. Findings from the analysis have been used to inform policy options aimed at improving current methods of redistributing funds across health insurance carriers.

4.2.1 Resource allocation methods

There exist numerous financing mechanisms to fund healthcare systems across Europe, including general taxation, local taxation, compulsory insurance and voluntary insurance. Despite this, all systems have one thing in common, that is, to devolve responsibility of purchasing healthcare to numerous 'health care plans' (73). In England, for example, over 200 Clinical Commissioning Groups (CCGs) are responsible for purchasing care, while in social health insurance systems, responsibility lies with various sickness funds (74).

Austria, similar to other countries, has multiple healthcare purchasers, including individual social health insurance carriers. However, the country is unique in that responsibility for purchasing care is split according to the type of care being provided (i.e. social health insurers purchasing primary care, and outpatient care, including pharmaceuticals, while the Länder purchase inpatient care, social care and associated medicines). Austria also distinguishes itself from other countries in regard to risk-adjustment

for resource allocation. Specifically, the current risk-adjustment across carriers is minimal (see section 4.2.6), and does not incorporate all carriers within the system.

A decision must be made on how to allocate pooled funds to various devolved purchasers in a way that meets health system objectives, namely, efficiency and equity. Allocation of funds can generally be grouped into one of the following three categories: a) full retrospective reimbursement for healthcare expenditure; b) activity-based reimbursement based on a pre-determined fee schedule (e.g. DRGs); and/or c) via a prospective budget based on expected healthcare expenditure (73). Increasingly governments have moved towards prospective budgets, given it lowers risk by fixing their funding commitment (see Table 5 for further details) (73).

Table 5: Risk associated with different resource allocation methods

	Full retrospective reimbursement	**Activity based reimbursement**	**Prospective budget**
Pooling agency	High risk	Medium risk*	Low risk
Purchaser	Low risk	Medium risk*	High risk
Funding commitment	Uncertain	Uncertain	Fixed

Note: *Risk for agency in terms of volume, and risk for purchaser in terms of case severity.

4.2.2 Methods to redistribute funds

Pooling agencies who pay purchasers prospectively must decide on a method by which to allocate funds. As outlined by Rice and Smith (2002), there are four methods of reimbursement, all of which are outlined in Table 6, along with potential implications.

Table 6: Methods to set prospective budgets and aligning implications

Reimbursement method	**Implications**
Size of bids from purchasers	Purchasers have an incentive to inflate bids to receive greater funds.

Reimbursement method	Implications
Political negotiation	Vulnerable to political favouritism, with evidence showing this method is unsustainable in the long-term.
Historical precedent	This method is often viewed as arbitrary, further it does not encourage efficiency or take into account unmet need.
Independent method to measure need	*Increasingly scientific methods are being used to measure the level of need. Namely in the form of capitated budgets.*

Source: (73)

Scientific methods to measure the level of healthcare need are common across developed healthcare systems, primarily in the form of capitated budgets. Capitated budgets pay purchasers a prospective flat rate fee, to cover specific services for a fixed population, over a defined period (i.e. place a cost on the head of each individual covered, subject to an overall budget constraint) (73). Given healthcare needs differ significantly across groups, the amount of funds allocated to each purchaser must also differ, that is, pooling agencies must redistribute funds based on relative need (i.e. risk-adjustment) (73).

4.2.3 Risk-adjustment factors

As stated by Juhnke *et al*. (2016), the 'basic principle' of risk adjustment is to classify key healthcare risks, and compare the level of risk across different groups in order to forecast future expenditure (75). Despite the existence of various risk-adjustment models across countries, the aforementioned authors were able to identify a set of common indicators, which include, for example, age, gender, diagnosis, disease severity, disability status and employment status.

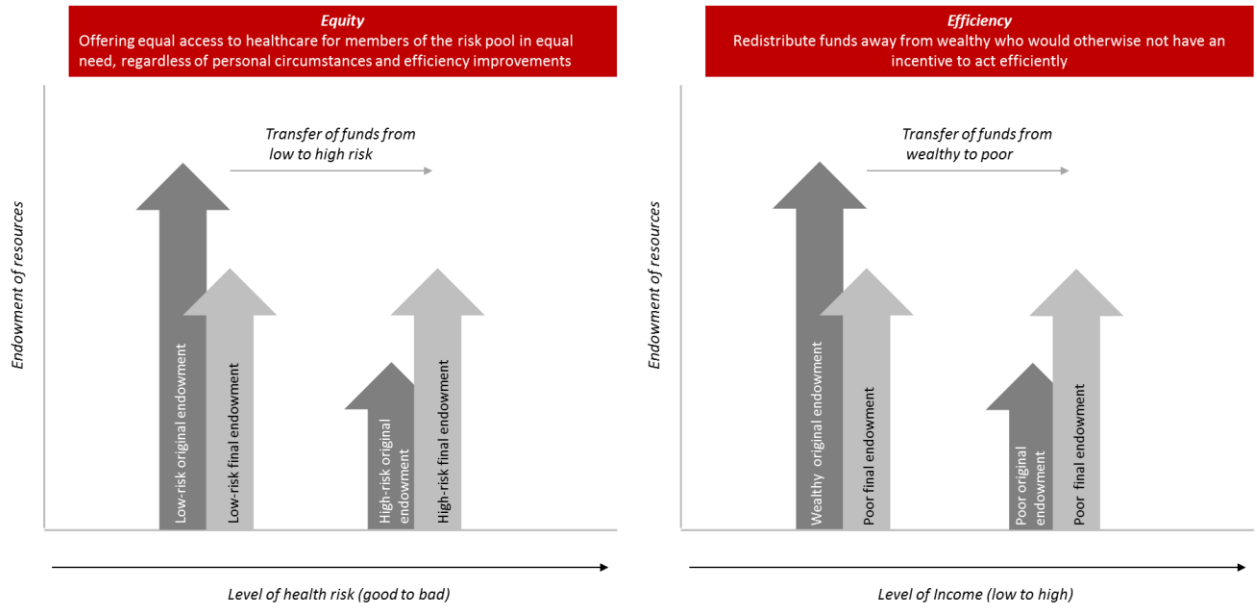
It is important to note, that although methods to risk-adjust payments have advanced, their predictive ability is still low. As will be discussed in further detail within this section (international case studies), approximately 20% of the variation in risk-adjustment factors can explain variations in individual healthcare expenditure (76). As a result, risk-adjustment mechanisms lead to systematic under and over payments to certain groups in society (76).

4.2.4 Impact of risk-adjustment on health system objectives

Equity and efficiency

Pooling, and the subsequent risk-adjusted distribution of funds, plays a key role in achieving health system objectives, namely, *equity* and *efficiency* (see figure below). Specifically, risk-adjustment can improve equity considerations by spreading the risk associated with healthcare expenditure across a diverse range of people. This allows equal access to healthcare, regardless of the individual's risk profile (76). Risk-adjustment promotes efficiency by redistributing funds held by insurance carriers with favourable risk profiles, to funds with unfavourable risk profiles. Transfers of funds between carriers fosters a 'level playing field', which can improve overall population health (76). For example, additional funding to carriers with unfavourable risk profiles will reduce the probability of insurees delaying or forgoing treatment, which lead to worse health outcomes and high long-term expenditure (76).

Figure 54: Impact of risk-adjustment on efficiency and equity



Source: Largely adapted from (76)
Note: Dark grey arrows indicate initial endowment, while light grey arrows represent endowment after risk-adjustment.

Impact of risk pooling type on equity and efficiency[21]

The ability of risk-adjustment to achieve equity and efficiency objectives, however, depends on the type of risk pooling mechanism employed. As outlined by Smith and Witter (2004), risk pooling can be broken down into the following four categories: no risk pooling, unitary risk pooling, fragmented risk pooling and integrated risk pooling

No risk pooling

No risk pooling, in which patients are responsible for all healthcare costs, is associated with the highest level of individual uncertainty. In such circumstances, vulnerable groups receive no subsidy and are excluded from treatment if they cannot afford care. Patients can choose to purchase private health insurance to reduce uncertainty, however, in the absence of community-rated premiums, the elderly and/or sick are likely to be discriminated against and pushed out of the market. Further inefficiencies from this model arise from high transaction costs, for example, from collecting and calculating user charges (76).

Unitary risk pooling

Under unitary risk pooling systems, all funds, whether they be collected through general taxation, social insurance or user charges (for example), are pooled into one central fund. The central fund is then responsible for purchasing healthcare to meet the demands of the population. Such a system overcomes many of the equity and efficiency concerns that arise from systems with no risk pooling (76).

Notwithstanding comments outlined above, unitary risk pooling is not without its faults. Specifically, there is an incentive for supplier-induced demand (SID), which may lead to differences in benefits packages, thus having a negative impact on equity principles. Further inefficiencies arise from moral hazard whereby patients consume more than is necessary, given the economic barrier of price is removed. Lastly, unitary risk pools remove individual choice which reduces competition, and prevents individuals from accessing benefits they are willing to pay for (76).

Fragmented risk pooling

Unitary risk pools, when too large, are associated with managerial control and coordination problems. Therefore, as outlined above, responsibility for purchasing healthcare is usually devolved to numerous

[21] This section was largely taken from Smith & Witter (2004). *Risk Pooling in Health Care Financing: The implications for health system performance*. HNP Discussion Paper. September 2004.

organisations. As a result, fragmented risk pools are created. Risk pools may be designated according to geographical location, employment status, personal characteristics (e.g. health or age), or may be voluntary, as is the case in competitive insurance markets. Variations will therefore exist across risk pools, however, is inversely related to the size of the risk pool. That is, a system with a large number of small risk pools is associated with high variations in spending compared to a small number of large risk pools (76).

Variation in expenditure across risk pools can negatively impact both efficiency and equity if not corrected for. For example, in competitive insurance markets, differences in risk will result in higher premiums for groups with a higher proportion of sick/elderly (76).

Integrated risk pooling

As outlined above, pure fragmentation can lead to significant differences across groups, which negatively impact efficiency and equity. In response, many systems now enforce financial transfers between risk pools to reduce or eliminate high levels of variation (76).

Two operational models for integrated risk pooling exist. First, a central agency can collect and redistribute pooled funds to risk pools based on expected healthcare expenditure. Or second, risk pools continue to collect revenues, who are then responsible for redistributing funds from low to high risk pools (76).

In regard to equity considerations, this type of pooling may allow risk pools with high levels of employment and a low number of non-earning dependents to charge relatively lower premiums. If rejected on equity grounds, another transfer will be required to take into account differences in the revenue base of risk pools (76).

Table 7: Types of risk pooling

Type	Magnitude of uncertainty	Impact on efficiency	Impact on equity
No risk pooling	Very high	Cream skimming Transaction costs	Discriminates vulnerable groups
Fragmented risk pooling	High	Competitive market breaks down without corrective action	Competitive systems can lead to variations in premiums

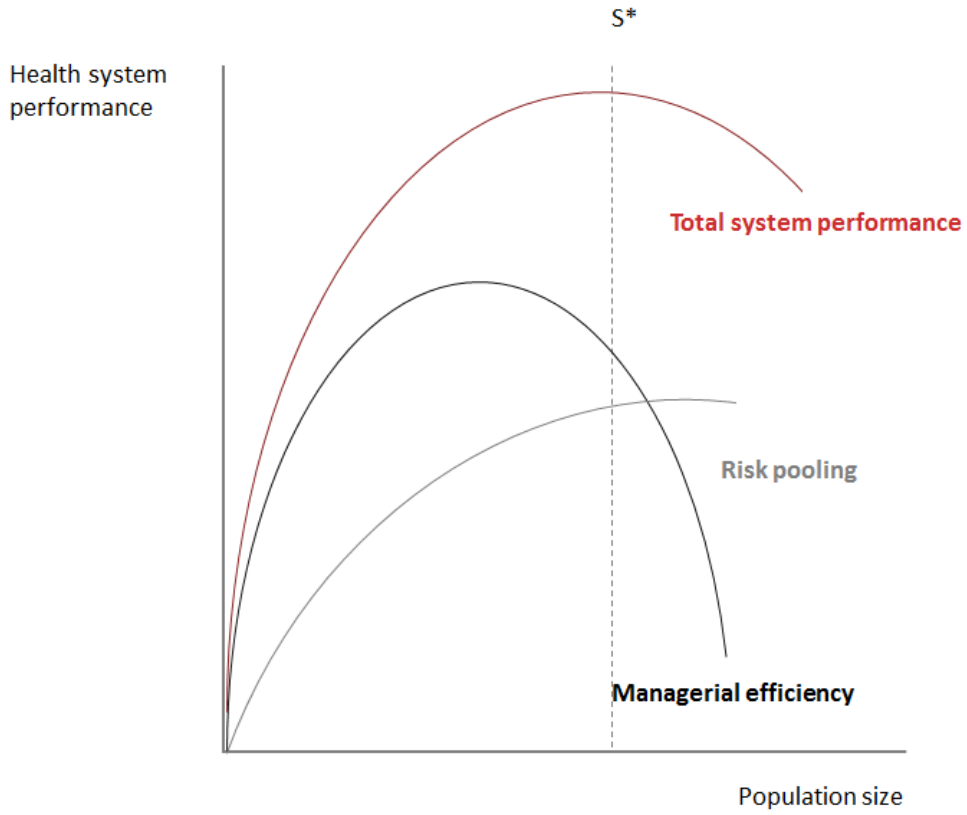
Type	Magnitude of uncertainty	Impact on efficiency	Impact on equity
Integrated risk pooling	Medium	Second set of transfers needed to account for differences in revenue base	Differences in premiums across risk pools
Unitary risk pooling	Low	Supplier induced demand Moral hazard Reduced competition Denying benefits that patients are WTP for Difficult to control and coordinate	Distributes funds form healthy/wealthy to the poor/sick Differences in benefits packages

Source: (76)

A move from no risk pooling to unitary risk pooling is associated with gains in equity. However, gains in equity must be traded against efficiency losses (see

Figure 55). For example, unitary risk pooling can redistribute funds from the sick/poor to the healthy/wealthy, however, such systems are associated with supplier-induced demand, moral hazard and problems with managerial efficiency. Ultimately, however, the optimal size of the population is dependent on country-specific circumstances and preferences (76).

Figure 55: Trade-off between equity and efficiency in risk pooled systems



Source: Taken directly from (76)

4.2.5 International case studies: Risk-adjustment

Risk-adjusted capitated budgets come in many forms across healthcare systems, however, they can largely be separated into two categories: territorial and non-territorial. In general, the former relates to instances

where national funds are distributed to geographically defined purchasers of care, while the latter, concerns redistribution of pooled funds to various insurance agencies (either in competitive or non-competitive markets) (see Table 8).

Table 8: Types of risk-adjusted capitated budgets

Type	How?	Why?	Example*
Territorial	Redistribution of nationally pooled funds to regional bodies based on assessment of need	Ensure resources are distributed in a way that secures equitable access to care	*UK* Sweden Spain Finland
Non-territorial (competitive model)	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Protect against risk segmentation and selection	*Germany* *Belgium* *Netherlands* *Switzerland*
Non-territorial (non-competitive model)	As above	Ensure resources are distributed in a way that secure equitable access to care	*Austria*

Note: *Italicized countries are described in further detail in the following section.

Territorial risk-adjustment

England

Resource allocation methods have existed in England since the 1970s in order to address disparities in funding and healthcare needs across regions (77). Starting from 2002, as a way to reduce avoidable health inequalities, a deprivation adjustment was included in a risk-adjusted formula which determined the level of funding each Primary Care Trust (up until 2013, responsible for purchasing a range of healthcare services) received (i.e. poorer areas received larger budgets). Primary Care Trusts were later replaced by Clinical Commissioning Groups, who received risk-adjusted capitated payments (77).

The structure of England's healthcare services changed significantly under the *Health and Social Care Act*. The Act, which was introduced in 2012, aimed to separate the government from the day-to-day running of the NHS (78). Specifically, under new arrangements, the Department of Health transfers a lump sum of

money (approximately £95 billion a year) to NHS England, an arm's length body that is held to account through annual mandates with the Secretary of State (78).

NHS England devolves responsibility for purchasing secondary and community care healthcare services to over 200 Clinical Commissioning Groups (CCGs) across the country (see Figure 56 for further details). Given CCGs work at the community-level and are led by healthcare professionals (namely GPs), they are seen to be in a strong position to purchase healthcare that meets the needs of their designated population (79).

Figure 56: Clinical Commissioning Groups (England)

Purpose and coverage

CCGs are responsible for purchasing healthcare services such as mental health, urgent and emergency care, elective hospital services and community care. Each CCG covers between 100,000 to 900,000 people, with an average of 250,000. Coverage is based on GP practice lists.

Leadership

CCGs are led by an elected body of GPs, and other clinicians such as nurses and lay members of the community.

Funding

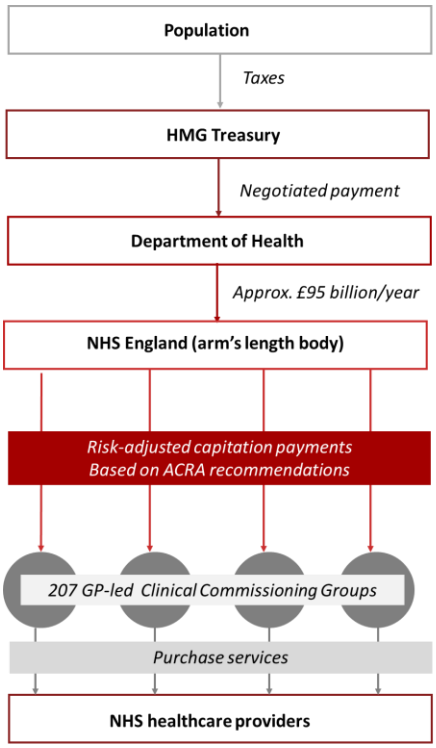
Receive risk-adjusted capitated budgets from NHS England. Funding for CCGs comprises two-thirds of the NHS budget. Budgets are set for five years, the first three of which are firm, and two which are indicative.

Number

There exist 207 CCGs as of 2017.

Source: (2)

Figure 57: Paying and purchasing healthcare in England



Source: Author's own creation

The latest funding allocation to CCGs was determined by the NHS England Board in December 2015 (2016-2021). Allocations made to each CCG are based on advice from an independent, expert technical committee (i.e. Advisory Committee on Resource Allocation, ACRA), which comprises GPs, academics, NHS managers and public health experts (80).

Once a national budget for healthcare has been determined, the following four steps are taken to calculate the amount of funds received by each CCG:

1. Determine the target allocation for a CCG based on need and unavoidable cost (explained further under 'factors')
2. Establish a baseline, which amounts to the previous year's allocation in addition to any adjustment payments
3. Calculate the difference between target and baseline figure
4. Determine how far each CCG has moved from their target allocation (point 1 above) each year (i.e. pace of change policy).

Target allocations (point 1 above) for each CCG are determined through a weighted capitation formula which is based several factors, as outlined in Table 9.

Table 9: Weighted capitation factors for England's CCGs

Risk-adjustment factor	Description
Size	Takes into account the number of individuals within the GP practice list (projections are made for future numbers).
Age and gender	Takes into account age and gender to reflect that young and old have different health needs, as do men and women.
Factors 'over and above' those relating to age and gender	Additional adjustment to take into account relative need that goes beyond age and gender.
Unmet need and health inequalities	Assesses need on current NHS services, however, this omits unmet need. Therefore, there is an additional payment based on population health (standardised mortality rate for those aged 75 years and under).
Location	Market Forces Factor to take into account that the provision of healthcare services is more expensive in certain areas (e.g. London). Also an additional payment for providing emergency ambulance services in sparsely populated areas, and operating A&E departments in remote hospitals.

Source: (80)

Non-territorial risk-adjustment

Non-territorial risk-adjustment schemes are common within European social insurance systems, including Belgium, Netherlands, Switzerland and Austria. An overview of each of these models, including proportion of insurance funds that are risk-adjusted, responsible agency, and the type of risk-pooling is provided in Table 10. Further details on each of these models is provided thereafter.

Table 10: Overview of non-territorial risk-adjustment mechanisms in European social health insurance systems

Country	Factors	Proportion of insurance funds risk-adjusted	Responsible agency	Premium rate restrictions	Type of risk pooling
Belgium	Gender, age, unemployment, mortality, invalidity, urbanisation, income, and dependent persons	30%	National Institute for Health and Disability Insurance	Yes	Integrated
Germany	Morbidity, age and gender	100% of contributions	Federal Insurance Authority	Yes	Integrated
Netherlands	Age, gender, income, region, drug consumption, socioeconomic status, mental care, and previous medical costs	50% of payments made to health insurers	National Healthcare Institute	Yes	Integrated
Switzerland	Age, gender, prior hospitalisations and pharmaceutical expenditure	100% outpatient, 50% inpatient	Common Institution	Yes	Integrated
Austria	**Age, gender, and high-cost medical expenses**	**1.64% of income from contribution (GKKs only)***	**Main Association of Austrian Social Security Institutions**	**Yes**	**Mixed of fragmented and integrated (GKKs)**

Source: See descriptions below. Note: *Main source of risk-adjustment within the system, other compensatory mechanisms also exist.

Belgium

Risk-adjustment was introduced into the Belgium healthcare system in 1995, prior to this, all sickness funds were fully reimbursed for their costs (81). Since 1995, sickness funds have been financially responsible for 25% of any discrepancy between actual spending and budget allocations, of which 30% is determined according to a risk-adjusted allocation (82).[22]

Similar to the Netherlands, Belgium has an external subsidy risk-adjustment system. Under this system, the insured population pay a small flat-rate premium directly to their desired insurer, as well as an income-dependent contribution. Unlike the flat-rate premium, income-dependent contributions are pooled by the National Institute for Health and Disability Insurance (INAMI-RIZIV) (hereafter, Central Fund), which is a government agency responsible for organising and managing healthcare insurance (83). Monies within the Central Fund are redistributed to sickness funds, and can be separated into two groups. The first type of payment is a normative, risk-adjusted payment, while the second payment is a retrospective payment based on actual expenditure (84). The weight allocated to the risk-adjusted payment was originally set at 10%, with plans to increase its value to 40%.

Factors included within Belgium's risk-adjustment model for both the employed and self-employed are outlined in the table below.

Table 11: Risk-adjustment factors in Belgium

Employed	**Self-employed**
Active population: • Gender, age, unemployment, working in the public sector, mortality, invalidity, urbanisation (density), and urbanisation (quality of housing) Invalids: • Number of dependent persons, mortality Pensioners:	Active population: • Number of dependent persons, income, mortality, urbanisation (density), urbanisation (quality of housing) Invalids: • Age, income Retired:

[22] Information sourced directly from National Institute of Health and Disability Insurance in Belgium.

Employed	Self-employed
• Number of dependent persons, mortality, urbanisation (quality of housing)	• Age, number of dependent persons, urbanisation (density)
Widowers and orphans:	Widowers and orphans:
• Age, mortality	• Age, mortality

Source: (84)

Schokkaert *et al.* estimated the predictive ability of Belgium's risk-adjustment model to determine actual expenditure by sickness funds (85). Estimation results using the risk-adjustment model since 2008 found that 40% of the variation in expenditure can be attributed to variations in the risk-adjustment factors used in the model.

Germany

Risk-adjustment was introduced into the German social health insurance system in 1994, which adjusted payments to sickness funds based on age, gender, and invalidity pension status (in total, there were 670 mutually exclusive 'risk' cells) (86,87). Three main reasons were cited for the introduction of a risk-adjustment scheme, which are: a) to ensure fair competition among sickness funds by equalising risk structures; b) to equalise price differences across sickness funds; and c) to avoid risk-selection and adverse selection (88).

The original 1994 risk-adjustment scheme did not succeed as it was not able to compensate all sickness funds, given the high proportion of healthy, affluent people switching funds (87). The latest risk-adjustment scheme was introduced in 2009 under the *Act to Strengthen Competition in Social Health Insurance* (GKV-Wettbewerbstärkungsgesetz) (2007) (87,89). Specifically, the Act introduced the Gesundheitsfonds, hereafter, the Central Health Fund (CHF), which redistributes insurance contributions based on the sickness fund's risk profile. The CHF is administered by Germany's Federal Insurance Authority (Bundesversicherungsamt) (87,89).

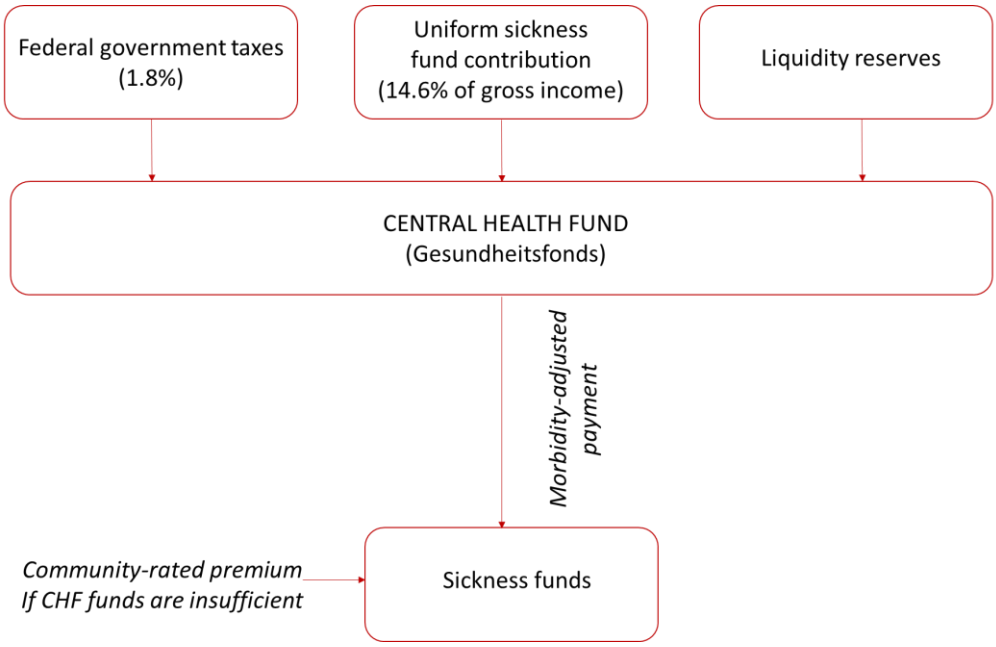
A major element of the Act to Strengthen Competition in Social Health Insurance was the change in how contribution rates are set. Specifically, the Act set, in law, a standard contribution rate (Social Code Book for Statutory Health Insurance), which is currently 14.6% of an individual's gross income (split evenly

between employers and employees) (90). Previously, sickness funds were able to set their own contribution rate (91).

Sickness funds are responsible for collecting contributions, however, these payments are immediately transferred to the CHF (i.e. same-day transaction) (89). The CHF redistributes employer/employee contributions to the sickness funds according to a morbidity-based risk adjustment scheme (morbiditätsorientierter Risikostrukturausgleich (Morbi-RSA)) (see section below for further detail). If the funds provided by the CHF are not sufficient to cover the sickness fund's expenses, funds must charge an additional flat-rate, community rated premium (i.e. a premium that is the same for all those insured, regardless of risk profile). Conversely, sickness funds can use excess handouts from the CHF to refund the insured, however, they are not legally obliged to do so (87,92). These supplementary premiums are collected directly by the sickness funds, and are thus associated with high administrative costs/effort (92).

In addition to contributions, the CHF receive payments from federal and state government taxes, specifically, 1.8% of taxes, and a liquidity reserve (89). However, these two payments are minor compared to contributions (92).[23] An overview of the German health insurance system is provided in Figure 58.

Figure 58: Overview of funding within the Germany Health Insurance System



Source: Adapted from (87)

[23] Tax subsidies and the liquidity reserves comprised approximately 12.7% of payments into the CHF as of 2011.

The payment sickness funds receive from the CHF can be broken down into four groups, which are outlined in Table 12.

Table 12: Breakdown of CHF payments to sickness funds (Germany)

Coverage	Risk-adjustment	Proportion of CHF payment
Standard benefits package	Yes	92%
Administration costs	Half of the payment is risk-adjusted (the other half is made per capita)	5.2%
Voluntary benefit package	No (flat-rate payment per capita)	Not specified
Incentive payment to participate in disease management programmes (DMPs)*	No (flat rate payment – approx. 150€)	Not specified

Source: (87)
Note: There exist DMPs for diseases such as diabetes, coronary heart disease, obstructive pulmonary diseases, breast cancer. DMPs are expected to improve the quality of healthcare received by the individual.

The CHF redistributes contributions based socio-demographic (i.e. age, gender, and invalidity of pensions) and morbidity-based criteria (Morbi-RSA) (91). To assist in developing an appropriate risk-adjustment, the government appointed a Scientific Advisory Board to assist in determining which 80 'severe' or 'costly and chronic' diseases should be included in risk-adjustment calculations (87,89,91,92). A disease was considered eligible if the diagnosis exceeded the average per capita expenditure of all insured by at least 50% (the top 80 most expensive diseases were included in the risk-adjustment calculation) (87).

Buchner *et al*. (2013) undertook a study which calculated the ability of Germany's risk-adjustment mechanism to predict expenditure by sickness funds. At the individual level, the authors conclude that the risk-adjustment scheme, introduced in 2009, had a predictive accuracy of approximately 20%. That is, 20% of the variation in factors used to risk-adjust payments (e.g. age, gender and morbidity) can explain

variations in individual level expenditure (93).[24] Specific figures on the performance of Germany's risk-adjustment model have been provided in the table below. The figures have been taken directly from Buchner *et al.* (2013).

Table 13: Performance of Germany's risk-adjustment model

	R^2 (%)	CPM (%)	MAPE (€)
Model, including sick pay	19.6	21.5	1,953
Model, excluding sick pay	20.2	22.5	1,817

Source: (87)

At the group level, the predictive power of the risk-adjustment mechanism is calculated using the ratio of the sum of CHF payments and the sum of expenditures for a group of insured people. An analysis of this ratio by the author's revealed that the scheme leads to systematic underpayments to those in higher age groups, with multiple chronic conditions, and/or living in urban areas (87).

Given the risk-adjustment mechanism is not able to fully adjusted for differences in expenditure, a number of sickness funds have charged a supplementary premium, merged with other sickness funds or closed (92).

Netherlands

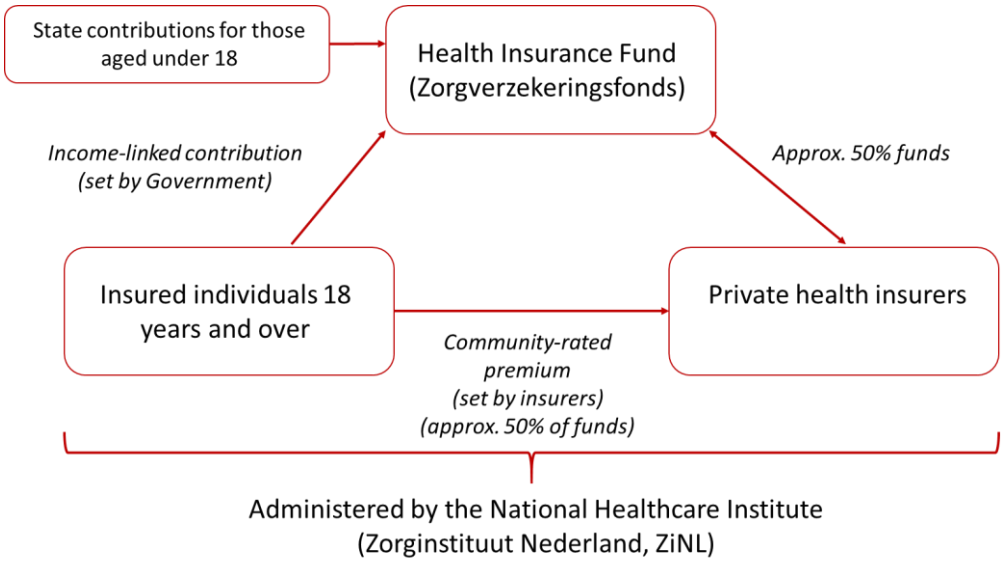
In 2006, the Dutch Government implemented the Health Insurance Act (Zorgverzekeringswet) which introduced regulated, privately managed health insurers in place of sickness insurance funds. Under new healthcare arrangements, a proportion of funds received by health insurers is risk-adjusted, to remove incentives for risk-selection (94,95).

[24] The new model had a CPM (Cumming's Prediction Measure) of approx. 22% (closer to 100% indicates a better fit). The CPM is the proportion of the sum of absolute deviations from the mean in individual costs that is explained by the risk model.

Health insurers in the Netherlands receive their funds from three forms of payments. The first payment is a flat rate premium for those aged 18 years and over (6.65% and paid by employers in a central fund), the second is a contribution from the State to compensate for those aged under 18 years, and the third, is a community-rated premium paid directly by the individual (94,95).

Contributions from employers, the self-employed ad state contributions for aged under 18 are pooled directly into the Health Insurance Fund (Zorgverzekeringsfonds).[25] The Health Insurance Fund is administered by the National Healthcare Institute (Zorginstituut Nederland - ZiNL), which is responsible for the quality, accessibility and affordability of healthcare in the Netherlands (96) (see Figure 59 for an overview of the SHI payment system in the Netherlands).

Figure 59: Overview of payment system to private health insurers (Netherlands)[26]



Source: Adapted from (94)

Contributions, which are determined by the government, are set at a level so that approximately 50% of all funds received by health insurers are risk-adjusted, with the community-rated premium accounting for the remaining 50% (94,95).

[25] For the employed, employers are responsible for pooling funds into the Health Insurance Fund, for the self-employed it is the responsibility of the Tax and Customs Authority (Source: feedback from P. Jeurissen, 2017).

[26] The two-way arrow between the Health Insurance Fund and private insurers states that enrolees with very favourable health profiles will have lower expected costs than 50% of the nominal premium. Insurers who only enrol such people will have to refund part of their nominal premium to the Health Insurance Fund as a way to avoid cream skimming. However, this does not happen in practice (Source: feedback from P. Jeurissen, 2017).

As of 2017, all risk-adjustment payments are ex-ante, and are set prior to the calendar year. This provides insurers with an incentive to fund services within its financial means (i.e. community-rated premiums and risk-adjusted payments). The ex-ante contribution from the Health Insurance Fund is based on health expenditure of the insured based on their risk profile, less the estimated income from a calculation premium (not the same as the community-rated premium, as this would incentivise insures to lower premiums) and the mandatory deductible (set at €385 per annum). The factors used to estimate expenditure costs are outlined in the section below (94,95).

Up until 1st January 2017, a second retrospective payment to health insurers was made to account for non-observable changes in the risk profile of insured population (95). The payment was introduced as a way to reduce risk-selection in the case of a suboptimal risk adjustment system, however, it was gradually phased out to further encourage efficiency among insurers (94).

Risk-adjustment factors used within the Dutch system can be grouped into eight groups, all of which are outlined in Table 14.

Table 14: Risk-adjustment factors in the Netherlands

Risk-adjustment factor	Description
Age and gender	Those of older age have higher healthcare expenditures, as do women of birth-rearing age (20-40).
Income	Nature of income such as whether the individual receives social security payments, is salaried or is self-employed.
Region	Higher compensation is provided to those living in regions with a high proportion of non-western immigrants, above-average risk of mortality and low income.

Risk-adjustment factor	Description
Consumption of pharmaceuticals	Patients who use drugs for chronic diseases in an outpatient setting are considered to be at higher risk of excessive healthcare expenditure.
Chronic conditions	Chronic conditions, treated at the inpatient level, are divided into 13 categories. Individuals with one or more of these conditions receive greater compensation. Includes expensive DRGs, and excludes pharmaceuticals.
Socioeconomic status	Socio-economic status of individuals.
Mental care	Those living in a one-person household are considered at great risk of mental health issues, and require greater compensation.
Other	Use of medical aids, and high medical costs in previous years.

Drawing upon a range of previous research, van de Ven *et al.* (2015) estimated the incentive for risk selection within the Dutch health insurance market. This was measured through the extent to which the current risk-adjustment mechanism over- or under-compensated insurers for specific groups 'for which no explicit risk-adjusters' existed (93). Results from their analysis show that insurers are systematically over (under) paid for groups with favourable (unfavourable) risk profiles. As an example, for 18.9% of the study population who reported the worst score for health,[27] the insurer was undercompensated on average by €670 per person, each year. Conversely, for 68.5% of the study population who recorded no chronic condition, the insurer was overcompensated €152 per person, per year (93). A selection of exact results taken directly from van de Ven *et al.* (2015) are provided in the table below.

[27] Based on the SF-12 Health Survey (97)

Table 15: Average under or overcompensation per person and year within the Dutch health insurance market

Selected groups (poor or good health)	Under (over) compensation (per person and year)	Predictive ratio*	Reduction in under (over) compensation due to risk-equalisation
Worst score for physical health (poor)	-€670	0.85	-75%
At least one chronic condition (poor)	-€331	0.90	-80%
No chronic condition (good)	+€152	1.16	-66%
Highest education level (good)	+€142	1.10	-61%

Source: (93)
Note: *Predictive ratio is calculated by dividing average predicted expenses over average actual expenditures. Thus, a predictive ratio less (greater) than 1 indicates under (over) compensation.

Switzerland

In general, Mandatory Health Insurance (MHI) premiums differentiate between cantons and are community-rated. Nevertheless, the old and sick have higher premiums when compared to the young and healthy. Hence, risk adjustment is needed in Switzerland to avoid the risk selection of the individuals by MHI companies.

Switzerland introduced risk-adjustment into its social health insurance system in 1993, with minor alterations made to the model in 2011 (98). Until the end of 2011, the risk-adjustment formula only considered age and gender. There were 15 different age groups and two gender categories resulted in 30 age and gender categories. The financial flows from the Common Institution to MHI companies do ensure that per insured person, within one of those categories, the available resources are the same across MHI

companies within the same canton. Unlike in the Netherlands and Germany, the risk-adjustment model in Switzerland is 'internal' in that it is not subsidised by additional government funds (98).

MHI companies in Switzerland collect the majority of their funds through community-rated premiums (i.e. premiums are the same within each MHI company, within a particular canton[28] or sub-region) (99). MHI companies that have favourable risk profiles (e.g. younger and/or wealthier) are required to transfer funds into a pool of funds, which is administered by the Common Institution (a foundation that that is predominantly financed by MHI companies, and to a lesser extent, the federal government) (99).

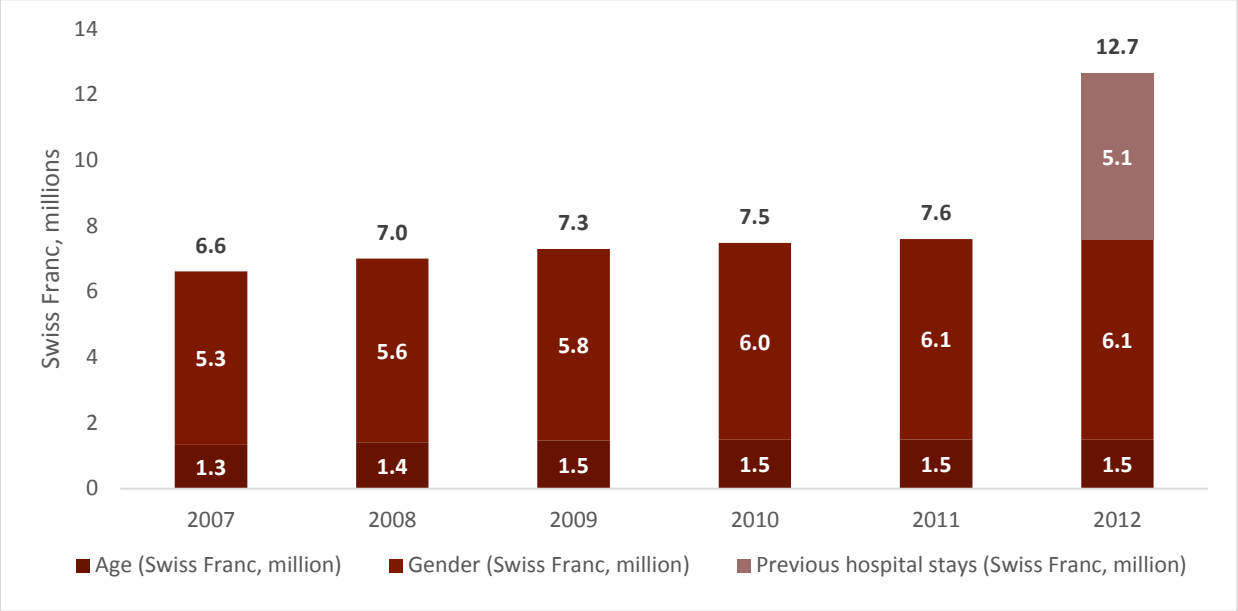
Funds within the Common Institute are then distributed to MHI companies based on a range of risk-adjustment factors (see section below). As can be seen in the graph below, the formula was revised in 2012 and took prior hospitalisation (depending on how many nights were spent consequently after each other either in a hospital or nursing home on the past year) into account. Through the amendment in the risk-adjustment formula, the gross redistribution amount increased significantly. Nevertheless, the net redistribution across MHI companies has not increased, as redistribution takes place mostly within the individual companies. Redistribution within companies is common as each insurance company has both high and low risks during the same period of time. Hence, internal risk-adjustment is required. Based on the calculation of premiums, the improved risk-adjustment formula will consequently lead to lower premiums in the insurance plans of high risk groups. The future of the risk-adjustment scheme will lead to changes in the formula and taking other factors into account (see section on 'Factors' below).

The factors used within Switzerland's risk-adjustment model have changed since its inception in 1993. Today, factors include age (since 1993), gender (since 1993), prior hospitalisations (i.e. more than three nights in a row in an acute hospital or nursing home within the year) (since 2012), and pharmaceutical expenditures exceeding 5,000 Swiss Francs (as of 2017) (99). Further risk-adjustment factors can be included by the Federal Council, the senior executive body of the federal government (99).

The figure below outlines trends in the gross redistribution of funds within Switzerland's risk adjustment mechanism, including the source of the redistribution. It is evident from the data that the majority of redistributed funds stem from differences in gender.

[28] There are 26 cantons in Switzerland, each with their own constitution, legislature, government and courts.

Figure 60: Swiss risk-adjustment trends and redistributions (2007-2012)



Source: (99)

4.2.6 Risk-adjustment mechanisms in Austria

In 1961, Austria introduced a Risk Equalisation Fund (REF), which has a primary purpose of compensating for structural differences among regional health insurance carriers (that is, differences in contribution income, insured persons, and region). Participation of social insurance carriers in the REF has changed over time with insurance carriers joining and leaving between its inception until now, where only GKKs participate (see Table 16).

Table 16: Participation of insurance carriers in the Risk Equalisation Fund

Period	Insurance carriers participating in REF
Before 2000	GKK, VA Bergbau and SVA
2001-2002	GKK, VA Bergbau, SVA and SVB
2003-2004	GKK, VA Bergbau, SVA, SVB, VAEB and BVA
2005 to current	GKK

Sources of funding

The majority of funds for the REF stem from contributions collected by GKKs. Remaining funds are sourced through various streams. An overview of each funding stream and their contribution to the REF (as of 2016) is provided in Table 17.

Table 17: Assets and Source of Funding for the Equalization Fund 2015, based on Handbuch der ÖSV, 2016

Assets of the REF, including the Source of Funding, in 2015 (in € mio)	
(1) Contributions of the GKK	€167.9
(2) Flat rate payment §1a GSBG	€91.9
(3) Contributions according to §3 DAG (employer tax)	€27.9
(4) Income according to §447f Abs. 9 ASVG	€0
(5) Other incomes	
(a) Transfers according to §447a Abs. 10 ASVG (tobacco tax)	€12.4
(b) Interest earnings	€0
Total	**€300.1**

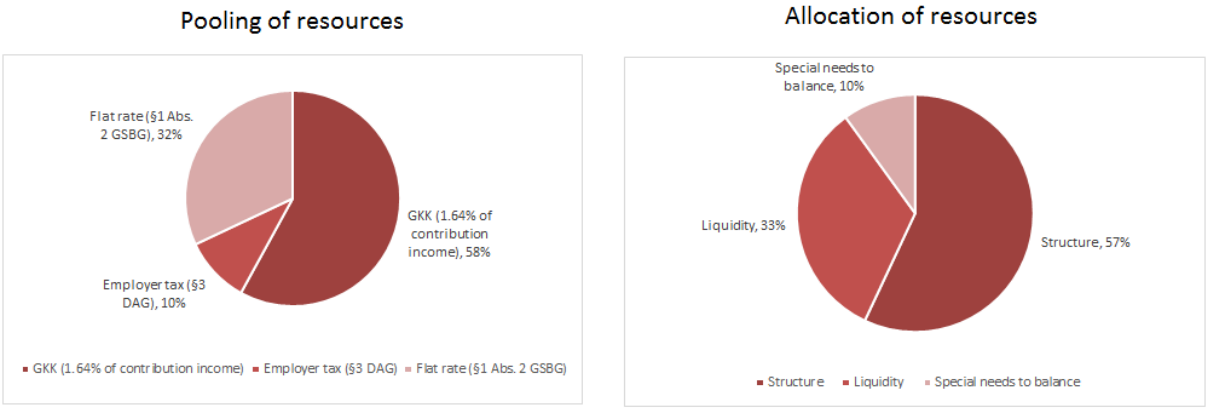
Mechanism

The allocation of REF funds is based on three criteria:

1. The equalisation of structural differences
2. The balancing of the liquidity
3. The covering in case of a special need for compensation.

Each of the above three criteria are assigned a weighting to reflect their relative importance. As of 2015, structural differences were weighted at 57%, and liquidity and special needs compensation at 33% and 10%, respectively. A visual description of the allocation of funds based on the above criteria is provided in Figure 61.

Figure 61: Pooling and Allocation of the Financial Resources of the Risk Equalisation Fund, Contrast EY illustration, based on data from HVSV.



Factors

In 2006, a scientific structural model was introduced to predict healthcare expenditure across GKK insurance carriers. The structural parameters chosen for inclusion are age, gender and cost-intensity of the insured persons. Data for these parameters are sourced from the Main Association of Austrian Social Security Institutions, who are responsible for calculating the structural equalisation model.

Further details on the REF can be found in Volume 2 of this report (Situational Analysis report).

Additional risk-adjustment mechanisms

The Risk Equalisation Fund plays the most significant role in redistributing funds across health insurance carriers. However, a range of other compensatory mechanisms also exist and have been outlined in Table 18 below.

Comparison with other European risk-adjustment models

Unlike other European social health insurance systems reviewed within this section, Austria does not have a competitive social insurance market. This, however, does not mean risk-equalisation is not necessary. Specifically, risk-adjustment is required given:

- **Regional differences:** income from contributions differs between the Länder due to differences in each region's labour market, as a result, income from contributions differs across regional carriers (i.e. GKKS)

- **Demographic differences:** dissimilar ratios between working persons versus pensioners, or differences in the age of insurance-entitled persons
- **Structural differences:** structural changes regarding the professions of the insured (for example the number of employed persons is growing, whereas the number of farmers is diminishing).

It is evident from a review of international systems that all countries take a different approach to risk-adjustment. Despite this, there are two areas where Austria differs significantly from all other countries. First, the Risk Equalisation Fund, which is the primary risk-adjustment scheme in the system, is made up of just 1.64% of GKK contributions, in other countries such as Germany and Switzerland (for outpatient care), all monies received by insurers are risk-adjusted, while in the Netherlands this figure is 50%. Second, Austria is unique in that not all insurers participate in risk-adjustment, with only the GKKs participating in the Risk Equalisation Fund. For further information, please see Volume 4 – Situational Analysis.

Table 18: Financial compensation in the Austrian social insurance system

Cause	Participants	Instrument	Budget 2016 (€ millions)
		Funds	
System of structural equalisation	All regional health funds, i.e. GKKs	Equalisation fund of GKKs (§ 447a ASVG)	311
Transfer to a) Länder health care funds b) Federal health care agency	All social security carriers (Exception: Insurance Institution for Austrian Notaries)	Equalisation funds for hospital financing (§ 447f ASVG)	a) 5.138 b) 83,6
Transfer to Länder health care funds (Health promotion funds)	All health insurance carriers	Health promotion funds according to § 19 G-ZG (§ 447g ASVG)	13
Health promotion and physical health examination	All health insurance carriers	Funds for early detection (physical health) examinations and health promotion (§ 447h ASVG)	4
Orthodontic adjustments for children and teenagers	All health insurance carriers	Funds for dental health (§ 447i ASVG)	80
		Accounting	

Cause	Participants	Instrument	Budget 2016 (€ millions)
Financing of pension insurance	All pensions insurance carriers (Exception: Insurance Institution for Austrian Notaries)	Accounting entity pension insurance	2.303
Financial support of goal-oriented regulation	All GKKs	Accounting entity funds for the insurance structure	10
Other compensatory measures: Claims for compensation and equalisation of burden			
Claims for compensation of health insurance towards accident insurance	All GKKs, BKKs and AUVA (Exception: BKK for public transport employees) Compensation by federation	Special flat rate (§ 319a ASVG)	174
Claims for compensation for support payments in case of long-lasting sickness (§ 104a GSVG)	SVA and AUVA	Reimbursement of expenses to SVA (§ 319b ASVG)	
Non-uniform burden of transfer to Länder health care funds (§ 447f ASVG)	All health insurance carriers Compensation by federation	Equalisation of burden for hospital care expenses (§ 322a ASVG)	
Maximum prescription fee 2% of net income	Health insurance carriers according to ASVG, GSVG, BSVG Compensation by federation	Equalisation of burden REGO (§ 322b ASVG)	

Source: Finanzierung – Wahlmodul – Allgemeine Fachausbildung, 2016

4.2.7 Policy options: Risk-adjustment

Risk-adjustment mechanisms

At a high-level, risk-adjustment involves an allocation of pooled funds to purchasers based on need. This does not mean that carriers with favourable risk-profiles wholly 'lose out', given they too will receive funds, rather their allocation per insuree will be relatively lower than sicker/older insurees.

Required risk-adjustment within Austria's social insurance system depends on the structure of insurance carriers. A summary of risk-adjustment requirements under the proposed structural models has been included in Table 19.

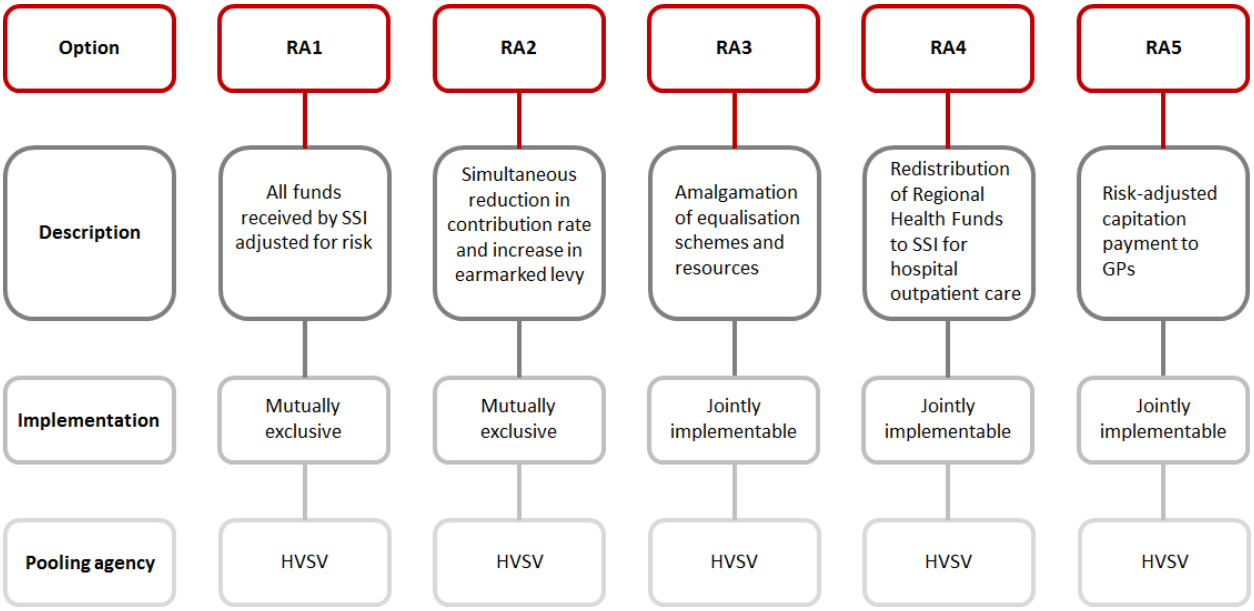
Table 19: Proposed structural models and aligning risk-adjustment requirement

Proposed structural model	**Risk-adjustment requirement**
Model 1* *National insurance carriers for accident, pension and health (split into employed and self-employed)*	Natural risk-adjustment caused by significantly large risk pools.
Model 2* *As model 1, except removal of civil servants from employed health and accident insurance*	Natural risk-adjustment for pension, accident and self-employed health insurance; formal risk-adjustment required between civil servants and employed health insurance required.
Model 3* *National pension insurance and one national health and accident insurance pillar*	Natural risk-adjustment caused by significantly large risk pools.
Model 4 *Existing structure with greater risk-adjustment across carriers, in addition to enhance Joint Specialist Centres*	Greater levels of risk-adjustment with the exact risk-adjustment mechanism and size to be specified.

Note: *For variations of these models involving regional or healthcare zone branches, risk-adjustment across regions/zones would be required.

Given the current structure is maintained, that is, model 4 is implemented, comprehensive risk-adjustment mechanism is required. This section describes five policy options which could be adapted to the structural model developed under model 4 to improve both efficiency and equity. The options are not necessarily mutually exclusive, and in certain cases, could be implemented in unison.

Figure 62: Proposed risk-adjustment policy options



Note: RA3 is broken down into RA3(a) and RA3(b) to reflect marginal differences in the sources of revenue pooled for risk-adjustment.

Risk-adjustment option 1 (RA1)

Description

An analysis of the breakdown of revenue for social health insurance carriers in Austria reveals the minor role risk-adjustment plays in the current system. Specifically, just 1.7% of health insurance revenue stems from the Risk Equalisation Fund (§ 447a), compared to 82.7% and 10% from contributions and VAT compensation (GSBG), respectively (100). Following on from international experience, RA1 proposes an expansion and extension of risk-adjustment, specifically by:

- Pooling all revenues into a central fund (operated by the HVSV) which are then redistributed according to a range of risk-adjustment factors
- Extending risk-adjustment across all health insurance carriers, not only GKKs.

Out of all the proposed options, RA1 is the most comprehensive and is therefore associated with significant efficiency and equity gains.

Due to possible constitutional constraints, the possibility of implementing this option is uncertain, therefore other proposed options should also be considered.

For the above reason, consideration could be given to implementing RA1 in a step-wise approach. That is, first introducing partial risk-adjustment, with incremental increases in the proportion of funds risk-adjusted over time.

Legal considerations

According to the case law by the Constitutional Court, a mechanism aiming to compensate risks between different institutions and groups would not violate constitutional principles given there is a 'sufficient personal and material link' between the respective health insurance carrier populations ('Versichertengemeinschaften'). The link will be more sufficient smaller the differences identified with regards to contributions and benefits (including the framework of contractual partnership law) of the respective scheme. Without a sustainable withdrawal or even elimination of those differences (that could be achieved by simple legislation without a two-thirds majority) there is no sufficient link between the GKKs and the BVA, the GKKs and SVA, nor between SVA and SVB.

RA 1 would meet the requirements under Constitutional Law only insofar as structural disadvantages can be proved in an evidence-based way (and are not caused only by regional disparities which are already compensated within national-wide carriers themselves). Otherwise a risk adjustment scheme could be implemented only by an amendment to Federal Constitution (i.e. only with a two-third majority). Nevertheless a risk adjustment (mainly) based on taxes would be possible from a legal point of view (for details see below Volume 2, chapter 8.).

Risk-adjustment option 2 (RA2)

Description

RA2 proposes a reduction in the employee contribution rate across all health insurance carriers. The reduction in the contribution rate would be matched by an equivalent increase in an earmarked levy, which would be channeled into a central fund managed by the HVSV. The HVSV would then be responsible for distributing pooled funds to health insurance carriers based on a set of pre-defined risk-adjustment factors.

The exact reduction in contributions is not defined in this report, rather it should be discussed and debated by government stakeholders. It is suggested that changes to the contribution base are not drastic, given the level of tax is outside the control of insurance carriers. Specifically, under RA2, insurance carriers will be required to give-up control over a proportion of their revenue, with this proportion now being subject to political negotiation.

If implemented, the current Risk Equalisation Fund would be abolished, given earmarked levy funds are expected to be sufficient to equalise risk.

Legal considerations

It has previously been mentioned that a system for compensating different structural risks based on taxes would meet the requirements under constitutional law. These taxes should be collected by the HVSV on behalf of the 'Bund' (or directly by a Federal authority) and should be explicitly declared as 'tax', so revenue collected from these taxes may be used for a specific purpose to the benefit of health insurance.

Risk-adjustment option 3 (RA3)

Description

RA3 proposes amalgamating funds from existing risk-equalisation schemes to be pooled into a central fund managed by the HVSV. The figure below outlines identified sources of revenue which could be used for risk-adjustment purposes. The sources of revenue are broken down by 'current sources of risk equalisation' and 'new potential sources of risk equalisation'.

Out of all proposed options, RA3 is the most feasible in the short-term given it does not require any constitutional changes, or amendments to the contribution base.

As outlined in the table below, RA3 can be broken down into two sub-options: RA3(a) includes all current and new sources of risk equalisation, including the Hebesätze, while in RA3(b), the Hebesätze would be excluded.

Table 20: Sources of revenue for risk-adjustment option 3

Source of revenue	Amount
Current sources of risk equalization	
Equalisation fund for regional health insurance (§ 447a)	Total budget of **€311 million** in 2016
Equalisation fund for the burden of REGO (§ 322b ASVG)	Total amount (as of 2015) was **€6 million**
Fund for dental health (§ 447i ASVG	Flat rate payment of **€80 million**
Health promotion fund (§447g)	Total budget of **€13 million** in 2016
Fund for preventative check-ups and health promotion (§447h)	Total budget of **€3.5 million** in 2016
Fund for offsetting burden due to 15a agreement (§332a ASVG)	Total amount (as of 2015) was **€132 million**
Special lump sum payment social health insurance – accident insurance (§319a ASVG)	Equated to **€173.96 million** in 2016
Equalisation fund for hospital financing (§447f ASVG)	Equated to **€49.64 million** in 2015
New potential sources of risk equalisation	
VAT from Ministry of Finance (currently refunded straight to insurance carriers)	In 2015, equated to **€454 million** (continue to increase with higher levels of expenditure)
Pharmaceutical claw-back (currently refunded straight to individual health insurance carriers)	in 2016 amounted to **€122 million** in (increase to €160 million in 2017, with additional increases expected in future years)

Source of revenue	Amount
Between 2012 and 2016, the government contribution rate (i.e. employer) for civil servants was reduced by 0.3%. This policy could be adopted once again with additional funds used for risk-adjustment	Given the reduction in the employer's contribution (i.e. the Government) is decreased by 0.3 percentage points, savings of **€60 million** annually could be redirected for risk-adjustment purposes.
Option RA3(b) only: Hebesätze* – pension insurance is obliged to pay the Hebesätze to health insurance (5.1% rate multiplied by the Hebesätze, which differs cross funds). Given pension insurance is funded to a considerable extent by government, the Hebesätze are indirectly funded through tax money and can therefore be used for risk-adjustment purposes.	In 2015, the PVA (GKK), VAEB, SVA and SVB paid **€1.6 billion** as Hebesätze contributions*.
TOTAL FUNDS FOR RISK-ADJUSTMENT RA3(a): €3 billion annually RA3(b): €1.4 billion annually	

Note: *There is no Hebesätze for retired civil servants as their pensions are paid directly by former employers and are financed directly out of the federal budget.

Legal considerations

There are no legal impediments to implementing RA3.

Risk-adjustment option 4 (RA4)

Description

In Austria, hospitals are largely financed through the nine State Health Funds, who are in turn funded by social insurance (46%), provinces (32%), federal states (12%) and municipalities (11%):

- The Federal Government through the Federal Health Agency (i.e. general taxes)
- Regional VAT allocation from the Länder (i.e. 0.95%)
- Share of VAT from municipalities according to the fiscal equalisation law (FAG)
- Respective Land
- GSBG-funds (Health and Social Sector Contribution Act)
- Social insurance via the Federal Health Agency (§447f ASVG) (101).[29]

Despite contributing to just under half of total hospital budgets, social insurance carriers are not entitled to participate in decision-making processes regarding healthcare within a hospital setting.

Under RA4, social insurance carriers would subsume joint responsibility for funding and operating outpatient centres in hospital settings, which currently fall under the responsibility State Health Funds. At present, the proportion of total State Health Funds dedicated to outpatient centers is approximately €661.5 million per year.[30] However, these figures are based on historical negotiations and therefore do not represent the actual costs associated with providing outpatient care. For example, in 2015, actual expenditure on outpatient departments within hospitals equated to €2.015 billion.[31]

Under RA4, social insurance, provinces, states and municipalities would continue to divert resources into State Health Funds. Once collected at the regional level, State Health Funds would be required to allocate approximately 15% of total funds to the HVSV (approximate amount of funds spent on outpatient hospital departments). Funds pooled within a joint fund will be redistributed to health insurance carriers based on several risk-adjustment factors.

Carriers will spend funds on improving primary care and outpatient departments within hospitals, thus reducing the number of hospitalisations. For example, by developing multi-professional networks within an outpatient setting. Funding will be spent collectively, therefore RA4 requires resources to be pooled under a joint fund and allocated based on need (e.g. indirect risk-adjustment). Although demand for

[29] The Federal Government is included in the list, but not in the percentages above, given it is captured in figures from the Länder and municipalities (i.e. Federal Government is responsible for collecting taxes on behalf of the Länder and municipalities).
[30] No data was provided for Burgenland. Therefore, based on population size, the figure was derived by multiplying the Voralberg figure of €44.7 million by 0.8, which equated €35.8 million.
[31] Please note that this figure may be an underestimate of the real costs given data for Burgenland was not available, further Styria does not explicitly state this figure, therefore only costs that were clearly defined as be redistributed to outpatient departments was included.

inpatient care may decline, in the short-run (i.e. transition period), funding for hospitals should cover fixed costs, such as building maintenance and employee wages.

In addition to improving efficiency and equity, RA4 has the added benefit of aligning outpatient services, which are currently offered in both hospitals and outpatient specialist clinics.

Legal considerations

Even though no constitutional obstacles can be identified regarding this option, it has to be considered that a number of amendments would be required. Amendments to ASVG and other social insurance laws may be adopted by the Federal Parliament (with a simple majority) but require amendments to several treaties between the Federal State and the Länder, according to Article 15a of the Federal Constitution including the 'Finanzausgleich' (Fiscal Equalisation Law).

Risk-adjustment option 5 (RA5)

Description

GPs in Austria are reimbursed through a mix of fee-for-service (30%) and contact capitation (70%), where GPs receive the one flat rate payment for each individual patient within a quarter (i.e. three months). Under RA5, a proportion of health insurance contributions would be pooled into a central fund, managed by the HVSV, with funds being used to pay GPs on a risk-adjusted capitated basis (i.e. all GP income would be risk-adjusted and provided in the form of a capitated payment). For this system to work, patients must be registered with a single GP for one year (as opposed to three months, which is the current arrangement), with the possibility of switching GPs every six months if unsatisfied. To encourage patients to register with the one GP, financial incentives could be introduced. For example, as is the case in France, reducing user charges for patients who visit the 'preferred GP' (i.e. the GP they are registered with) (see section 5.3 for further details on the French system).

The requirement for patients to be registered with one GP for a year represents a significant cultural shift, given the high-value placed on freedom of choice within the Austrian healthcare system. For this reason, RA5 is a longer-term solution and should only be introduced once there is increased acceptance among the population that changes to the healthcare system are required.

Legal considerations

RA5 would require several legal amendments. First, of all regulations, such as § 135 (2) ASVG stipulating that insured persons must have a choice at least between two physicians available within a reasonable period of time, would have to be changed. Second, it is likely that the collective agreements concluded

with the Chamber of Physicians would have to be changed, which is subject to the consent of the doctors' representatives. Legislative interventions in this respect might be possible, however, they must be justified under constitutional law by 'public interest', in that the intervention must be appropriate and reasonable. Any change of the tariff system must consider the constitutional principle of 'Vertrauensschutz', meaning that all individuals may trust in a legal situation (especially if it concerns a long-period of time) providing for a certain sort or level of benefits and, thus, is protected against intensive and/or sudden reductions (i.e. a smooth transition is required if physician fees are changed to their disadvantage)**.**

Risk-adjustment factors

Despite significant advancements in risk-adjustment mechanisms, their predictive ability is limited. For example, in Germany a 2013 study found that only 20% of differences in expenditure could be accounted for by changes in risk-adjustment factors (87). In the Netherlands, van de Ven *et al*. (2015) measured the systematic under and over payment of insured people at -€670 and +€152, per person per year, respectively (93).

Given the inherit difficulty of accounting for differences in healthcare expenditure, a Scientific Advisory Committee should be commissioned to identify risk-adjustment factors relevant to the Austrian context. Once a set of risk-adjustment factors has been chosen by the Scientific Advisory Committee, their decision could be enforced by the law that governs social insurance. This could be the ASVG itself as well as a specific provision in a separate legislative act.

It is suggested that members of the Scientific Advisory Committee draw upon existing forms of risk-adjustment in countries such as the Netherlands, Germany and the UK (see Table 21 for example risk-adjustment factors). However, applicability within the Austrian context needs to be considered, for example, the possibility of 'gaming' among health insurance carriers, with only those factors that cannot be manipulated being included within the system. Lastly, in addition to needs-based, demand side risk-adjustment factors (see Table 21), in the short-term, it is recommended that supply-side factors (e.g. employees) are considered, given it takes time to make significant structural changes and reallocate resources. Over time, for example 10 years, the weight or relative importance of supply-side factors should be reduced to make way for demand-side, needs-based factors.

Table 21: Commonly applied risk-adjustment factors

Risk-adjustment factor	Example countries
Age and gender	Nearly all models
Diagnosis	Germany, Netherlands
Disease severity	Germany, Netherlands
Disability status	Belgium, Netherlands
Employment status	Belgium
Prescription of drugs (indicator of chronic diseases)	Netherlands (inpatient and outpatient prescriptions) Switzerland (pharmaceutical expenditure)
Employment status	Germany, Belgium, Netherlands (income)
Sickness allowance entitlement	Germany
Unmet need and health inequalities	UK
Geography and urbanisation	UK, Belgium, the Netherlands

Source: (75,80)

Summary of risk-adjustment policy options

- **RA1** and **RA2** offer the most comprehensive forms of risk-adjustment, and are therefore mutually exclusive
- **RA3-5** are less comprehensive and may be jointly implemented with RA1 and RA2
- **RA3** would build upon existing risk-equalisation schemes, and of all the four options, is probably the most straight-forward to implement. For this reason, RA3 could be used as a first step to

enhance risk-adjustment before more comprehensive mechanisms are considered (i.e. RA1 and RA2)

- **RA4 and RA5** require reforms within the primary and hospital systems and therefore cannot be implemented unless there is a willingness among policy makers to change existing arrangements
- A Scientific Advisory Committee could be commissioned to determine appropriate risk-adjustment factors to be applied to the risk-adjustment scheme
- The Scientific Advisory Committee is advised to review relevant factors from existing, sophisticated risk-adjustment schemes; unlike many of these schemes, supply-side factors should be taken into account in the short-term
- Changes to risk-adjustment mechanisms could be extended to all layers of the Austrian healthcare system.

RA1, where all revenue received by insurance carriers are risk-adjusted, and **RA2,** which involves a simultaneous reduction in contributions and the introduction of an earmarked levy, are the most comprehensive of the proposed options. Therefore, these mutually exclusive options are expected to have the greatest impact on health system performance.

The remaining options, **RA3** (pooling of existing risk-equalisation schemes), **RA4** (redistribution of hospital outpatient funds to social insurance) and **RA5** (GP risk-adjusted capitation payment), are not as extensive as RA1 and RA2, however, from a legal and political perspective, may be easier to implement in the short-term. Further, these options are not mutually exclusive and could, in certain cases, be jointly implemented. For example, a move towards a risk-adjusted capitated payment scheme for GPs (**RA5**) would complement a system where funds from various risk-equalisation schemes are merged and re-distributed to health insurance carriers (**RA3**).

Lastly, **RA4** and **RA5** involve major structural changes within the system. As a result, either scheme should only be pursued if there is strong political motivation.

Going forward a Scientific Advisory Committee could be established to develop a range of risk-adjustment factors relevant to the Austrian context. It is suggested that the Scientific Advisory Committee draw upon existing countries with sophisticated risk-adjustment systems (e.g. UK and the Netherlands). Further, in the short-term (e.g. 10 years), risk-adjustment could take into account both demand- and supply-side factors.

Although outside the remit of this review, consideration should be given to extending risk-adjustment to all layers of the Austrian healthcare system. Namely, between the Federal Government and the Länder (State Health Funds) (where funds are currently allocate according to historical allocations), and between social insurance and the Länder.

Implementation of any of the proposed risk-adjustment options should be done in a gradual manner. This will allow time for supply-side factors to re-adjust, which is not always possible in the short-run.

It is important to highlight that even a more extensive risk-adjustment scheme won't necessarily create a level playing field, given, risk-adjustment factors explain only part of total healthcare expenditure. That is, the redistribution of funds will not wholly reflect actual needs of each carrier's insured population. As a result, carriers with favourable risk profiles are likely to continue to accumulate sufficient reserves.

Lastly, risk-adjustment should not be expected to solve all inefficiencies and inequities within the healthcare system, given that some could be considered 'acceptable'. For example, tertiary hospitals and highly specialised centres (e.g. for rare disease) should continue to be located in highly populated urban areas only. Acceptable inefficiencies include subsidies to primary healthcare units, physician networks, as well as healthcare workers in remote and rural areas in order to improve access in these locations.

5 Financing of social security

Chapter 5 explores healthcare financing systems in Austria and other social health insurance systems across Europe. The chapter has been broken into five sections covering collection of contributions, benefit packages, user charges, investment opportunities in healthcare, and concludes with an overview of potential policies to broaden the social welfare base.

5.1 Collection of contributions

Contribution systems in Austria are governed by different laws and therefore may result in varying contribution bases and rates across insurance funds. Ultimately this leads to different levels of self-funding, as well as different ratios between individual's contributions and funds provided by federal tax. Therefore, an alignment in the collection of contributions across different types of funds may render the contribution systems more equitable. This chapter provides an overview of four different contribution systems, followed by an assessment of the differences and recent policy developments, and a number of policy options to harmonise the collection of insurance contributions.

5.1.1 Workers and employees

For workers and employees the contribution is based on the due earned income during the contribution period, as specified in §44 ASVG. Following §49 ASVG, the remuneration is defined as monetary and in-kind earnings, which the compulsory insured employee is entitled to, owing to his/her employment. As such, the principle of entitlement-to-remuneration applies, rather than the inflow principle that is predominantly found in tax law. In the case of entitlement-to-remuneration, the minimum level considered for the contribution base is the civil claim for payment, as regulated by, for example, collective agreements and employment contracts. However, contributions are not based on the actual amount of payment received. Having a claim to a specific amount is sufficient to calculate and pay contributions, regardless of whether the employee has received a lower pay.

The maximum contribution for workers and employees for the year 2017 is set at €4,980 per month, which amounts to €166 per day, and the marginal amount for those with minor employment is set at €425.70. In line with the ASVG, the contribution rates apply to workers, employees, freelancers, agricultural workers and miners. The rates amount to 1.3% for the accident insurance, which is paid by the employer; 7.65% for the health insurance, of which 3.87% and 3.78% are paid by the employee and employer respectively; and 22.8% for pension insurance, which is split into 10.25 % for the employee and 12.55%

for the employer. Please see Table 22 for a detailed list of the contribution rates for workers and employees.

Table 22 Social insurance contribution rates (in percent) for workers and employees in 2017

3. Beitragssätze (in Prozent)

Bezeichnung	Arbeiter[1]			Landarbeiter			Angestellte			Freie Dienstnehmer		
	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber-anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber-anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber anteil
Krankenversicherung, § 51 ASVG	7,65	3,87	3,78	7,65	3,87	3,78	7,65	3,87	3,78	7,65	3,87	3,78
Unfallversicherung, § 51 ASVG	1,30	0,00	1,30	1,30	0,00	1,30	1,30	0,00	1,30	1,30	0,00	1,30
Pensionsversicherung, § 51 ASVG [10]	22,80	10,25	12,55	22,80	10,25	12,55	22,80	10,25	12,55	22,80	10,25	12,55
Knappschaftliche Pensionsversicherung, §§ 51,51a ASVG	28,30	10,25	18,05	-	-	-	28,30	10,25	18,05	-	-	-
Arbeitslosenversicherung (AV) [9]	6,00	3,00	3,00	6,00	3,00	3,00	6,00	3,00	3,00	6,00	3,00	3,00
IESG-Zuschlag	0,35	0,00	0,35	0,35	0,00	0,35	0,35	0,00	0,35	0,35	0,00	0,35
Arbeiterkammerumlage [2]	0,50	0,50	0,00	0,75	0,75	0,00	0,50	0,50	0,00	0,50	0,50	0,00
Wohnbauförderungsbeitrag	1,00	0,50	0,50	-	-	-	1,00	0,50	0,50	-	-	-
Schlechtwetterentschädigungsbeitrag [3]	1,40	0,70	0,70	-	-	-	-	-	-	-	-	-
Nachtschwerarbeits-Beitrag [4]	3,40	0,00	3,40	3,40	0,00	3,40	3,40	0,00	3,40	-	-	-
Dienstgeberabgabe [5]	16,40	0,00	16,40	16,40	0,00	16,40	16,40	0,00	16,40	16,40	0,00	16,40
Beitrag für Versicherte in geringfügigen Beschäftigungsverhältnissen gemäß § 53a ASVG [8]	14,12	14,12	0,00	14,12	14,12	0,00	14,12	14,12	0,00	14,12	14,12	0,00
Beitrag zur Betrieblichen Vorsorge (BV) [7]	1,53	0,00	1,53	1,53	0,00	1,53	1,53	0,00	1,53	1,53	0,00	1,53
Sozial- und Weiterbildungsfonds-Beitrag (SO)[9]	0,80	0,00	0,80	-	-	-	0,80	0,00	0,80	-	-	-

5.1.2 Self-employed persons engaged in commercial activity and insured with the SVA

The contribution paid for by self-employed persons insured with the SVA is based on the individual's income, as stated on the income tax statement. In addition, compulsory pension and health insurance contributions, which were paid in advance for the respective calendar year, are added to the income.[32] The contribution base for health insurance is restricted to a maximum of €69.720 and a minimum of €5.108,40, while the minimum base for the pension insurance amounts to €8.682. As the income tax statement is issued at the end of each year, a preliminary calculation of contributions is conducted.

In 2016, the monthly minimum contribution base for health insurance was lowered to the level of the ASVG-based marginal earnings threshold. In addition, the monthly minimum contribution base for the pension insurance will be gradually lowered in a total of 12 times to the marginal earnings threshold until 2022. The contribution rate for SVA-insured amounts to 18.5% and 7.65% for pension and health insurance respectively. If individuals are compulsory insured under the FSVG law, then the contribution

[32] (102)

rate for pension insurance is 20%. In the case of the accident insurance, insured pay a monthly fixed amount of €9.33 (in 2017), which is independent of income.

5.1.3 Farmers insured with the SVB

There are two contribution systems in the SVB and insured persons can either pay contributions based on the value of their agricultural/forestry business or opt for the contributions foundation option, which is based on the income as indicated on the income statement. If the insurance value (*Vollpauschale*) of a business is below €75,000 (or below €130,000 in the case of *Teilpauschale*), then the insured needs to opt for the first option. As a result, approximately 90% of all businesses fall into the first category. In this case, the contribution rates for health, pension and accident insurance are 7.65%, 17% and 1.9% respectively. In 2017, the minimum contribution base in the flat-rate system amounts to €785.56 for the health and accident insurance, and €425.70 for pensions insurance.

The insurance value, which serves as a basis for the contribution rates, is calculated using the tax unit value of the agricultural/forestry area and a so-called income factor, which is a fixed percentage stratified by unit value levels. However, it must be noted that the percentage decreases as unit values increase, constituting an advantage to larger businesses. For instance, the percentage of an agricultural area with a tax unit value between €5,100 and €8,700 is set at 19.17%, while that for tax unit values between €43,700 to €87,500 amounts to 3.06%. Furthermore, each unit value category is rounded up to the next €100, which may lead to an average reduction of €50 of the unit value. It must be noted that for farming businesses operated by married partners, the maximum contribution basis is reached with a unit value of €277,200, which is more than three-times higher than that for a business operated by a single operator (i.e. €87,500). Table 23 provides an overview of the unit values and fixed percentages used to determine the insurance value, which serves as a basis for the contribution rates.

Table 23: Overview of unit values for the calculation of the insurance value of an agricultural/forestry business

Unit value (Einheitswert)				Percentage considered for contribution base (fließt in BGL ein)
from	- EUR	to	5,000 EUR	19.17 %
from	5,100 EUR	to	8,700 EUR	21.30 %
from	8,800 EUR	to	10,900 EUR	17.31 %
from	11,000 EUR	to	14,500 EUR	11.98 %
from	14,600 EUR	to	21,800 EUR	9.72 %
from	21,900 EUR	to	29,000 EUR	7.19 %
from	29,100 EUR	to	36,300 EUR	5.33 %
from	36,400 EUR	to	43,600 EUR	3.99 %
from	43,700 EUR	to	87,500 EUR	3.06 %

For insured persons who opt for the contribution foundation option, the contribution is calculated on the basis of income that is indicated on the income tax statement. The method of assessment is the same as the one used under the GSVG law. In contrast to the first option, the minimum contribution bases are higher, amounting to €1,476.16 for health and accident insurance, and €785.56 for the pension insurance.

5.1.4 Civil servants and public employees

In the case of the social security of the civil service, there is a maximum contribution base for health insurance that amounts to €4,980 (in 2017), however, this does not apply to the accident insurance. When it comes to pension insurance, only new contractual civil servants are insured with the PVA, in line with the ASVG law. The new contractual civil servants are charged a 10.25% contributions rate for pension insurance and the employer pays a share of 12.55%, amounting to a total of 22.8%. A maximum contribution base is in place for contractual civil servants and university employees, however, for employees who are subject to the Pension Act there is no maximum base and the pension contribution is levied by the employer. The contribution rate for the health insurance for active civil servants is 7.635%, which is split in 4.1% for the civil servant and 3.535% for the employer. For accident insurance, the rate

amounts to 0.47%, however, as previously described, there is no maximum contribution base. The table below outlines key differences in contributions between the BVA and regional funds.

Table 24: Differences in contributions for health and accident insurance between the BVA and regional funds

	BVA	Regional insurance funds
Employee contribution for health insurance	4.1%	3.87%
Employer contribution for health insurance	3.535%	3.78%
Overall contribution rate for health insurance	**7.635%**	**7.65%**
Accident insurance	0.47%	1.3%
Overall contribution rate for health and accident insurance	**8.105%**	**8.95%**

5.1.5 Differences in the collection of contributions and recent policy developments

Although health insurance contribution rates are uniform across carriers, with a minor deviation of 0.015% in the case of the BVA, contribution bases and mechanisms vary across types of funds and therefore result in different levels of self-funding, as well as different ratios between individual's contributions and funds provided by federal tax. However, variations may be partly explained by the setting of contribution bases and differences in the cumulative contributions paid for health, accident and pension insurance.

With the aim to better align the GSVG-, BSVG- and ASVG-defined contribution mechanisms, several changes were made in recent years to unify the maximum contribution bases. Nevertheless, substantial differences in the setting of contribution bases with respect to the different social insurance laws prevail. For instance, self-employed persons are assessed on the basis of their profits, farmers are assessed against the insurance value of the agricultural/forestry business, while employed individuals are assessed in terms of their salaries. Since each system follows its own logic, the reporting and examination can be different in the carriers. In particular with respect to the self-insured persons, this leads to an increased expenditure

for the controlling and verification process pertaining to the correct calculation and payment of contributions to the social insurance.

Furthermore, under the BSVG law, farmers have the option to pay contributions based on the standard value of their agricultural/forestry business or to opt for the contributions foundation option, which is based on the income as indicated on the income statement and follows the same method as applied under GSVG law. According to the SVB annual report (2015), out of a total of 120.253 BSVG-based contribution assessments, 106.249 (i.e. 88%) were calculated in terms of the standard value; 8.972 were based on an individual contribution basis, which in particular applies to multiple insured persons in the case that differential contribution bases are set to avoid the exceedance of the specified maximum contribution; 3.400 were assessed through income statements (i.e. BGT-option); and 1.732 income-producing businesses and businesses with the 'Kleine Option', where the setting of the contribution base is not or not purely based on the standard value, were assessed in terms of their earnings as indicated on the income statement.

Differences can also be found across ASVG-, GSVG- and BSVG-defined minimum contribution bases. For example, in the case of farming businesses that are operated by married partners, the minimum contribution basis for the farmers' pension insurance is €212.85 and €392.78 for the health insurance (in 2017). In contrast, the ASVG marginal earnings threshold is set at €425.70. Moreover, the calculation and setting of the contribution bases differ significantly between the employed and self-employed. For instance, self-employed persons can control their contributions basis to a certain degree through the tax law, or in the case of farmers, via the effect of the flat rate model. In addition, there are deductions for capital and restructuring gains, as laid out in the GSVG law. By contrast, the contribution base for social contributions paid by employees and workers constitutes the paid wage (Entgelt) by the employer. However, in regards to income tax, employees and workers are allowed some deductions in the so-called Arbeitnehmerveranlagung, which is similar to the income tax return of the self-employed.

5.1.6 Policy options: Collection of contributions

Multiple contribution systems in the SVB

Contributions based on actual income

Contributions for farmers and operating managers, who opt for the contributions foundation option, are assessed on the basis of the income, as stated on the tax statement. Under this option, insured persons

would pay contributions that are based on the actual net income, i.e. taxable income. The objective of a shift in taxation base is to promote an alignment between BSVG and ASVG funds in regards to the collection mechanism of contributions, and therefore to improve equity in the financing system.

Introduction of a proportional fiscal system with maximum contributions

The largest share of contribution assessments is based on the insurance value of an agricultural/forestry business. This insurance value is calculated using the tax unit value of the agricultural/forestry area and a so-called income factor, which is a fixed percentage stratified by unit value levels. However, the percentage decreases as unit values increase, constituting an advantage to larger businesses, despite the presence of maximum contribution bases. For instance, the percentage of an agricultural area with a tax unit value between €5,100 and €8,700 is set at 19.17%, while that for tax unit values between €43,700 to €87,500 amounts to 3.06%. This option proposes a shift from the regressive to a more proportional fiscal system in conjunction with the introduction of a maximum contribution amount. The rationale is to introduce a fiscal system that promotes a more equitable collection of contributions and which can be rendered fiscally neutral.

Collection of contributions in the BVA

Aligning the BVA contribution base with that of regional funds

The difference in the health insurance contribution rate between the BVA and the regional funds amounts to 0.015%, with regional funds having a slightly higher contribution rate. However, it must be noted that the share of contributions borne by employers and employees differs. As such, BVA-insured employees pay a relatively higher share of the contributions, amounting to 4.1%, as compared to 3.87% for employees insured with a regional fund. The reverse applies to the employer's share, which is set at 3.535% for the BVA and 3.78% for the regional funds. Under this option, BVA contribution rates would be aligned with those of regional funds, meaning that employee contributions would be lowered by 0.23% to 3.87%, and employer contributions would be raised by 0.25% to 3.78%, creating a new contribution ratio between employees and employers. With a total collection of €903,013,331 in contributions in 2015, an increase in the BVA contribution rate would amount to an additional €18.43 Mio in the collection of contributions.

Following the alignment between contribution rates in the first stage of the harmonisation process, BVA contributions could be rendered fiscally neutral in the mid-term. The second part of the alignment process takes into account user charges, which are currently higher for BVA-insured than for those insured with a

regional fund. In order to foster equity in the collection of contributions across funds, user chargers for BVA insured would be gradually lowered to the regional fund level. This implies an estimated decrease of €71,195,921 in income for the BVA, which would be partially offset with the additional contributions of €18.4 Mio, resulting in €52.7 Mio costs to the employer. However, it must be noted that the accident insurance contribution rate, borne by the employer, remains 0.83% lower for BVA insured, than for workers and employees. In addition, the BVA is running excess reserves, which may be used to further mitigate the additional costs.

Legal considerations

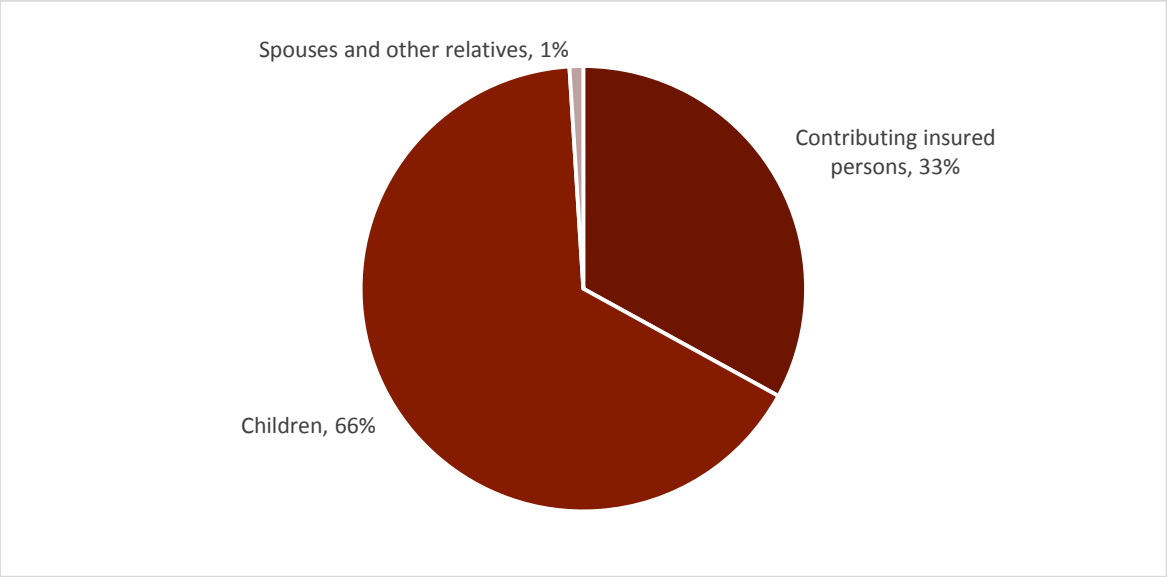
No particular constitutional (but, of course, political) impediments have to be faced in regard to the above policy options.

5.1.7 Collection of contributions of multiple insured in Austria

Number of cases and types of multiple insurances

In 2016, an annual average of 717.538 persons were covered by multiple insurances, of which two-thirds were dependents. In detail, the multiple insured comprised 66% children and 1% spouses or other relatives (i.e. partner, or civil partners). As such, only about one-third of multiple insured persons paid contributions to the social security system, i.e. were gainfully employed or pensioners. Therefore, the amount of persons who are covered by multiple insurances and also pay contributions is comparatively small.

Figure 63: Persons with multiple health insurances, annual average in 2016, based on data from HVSV



Multiple insured persons with gainful employment

In 2016, 138.587 persons[33] pursued multiple occupations (meaning two or more occupations). The number of multiple-insured working people rose slightly within the past years. However, considering that the total amount of working people has also risen, the share of persons with multiple occupations remained constant. On the 1st of July 2016, 3.5% of the Austrian workforce had more than one occupation.

Table 25: Austrian workforce with multiple occupations 2008-2016, as of 1st July 2016

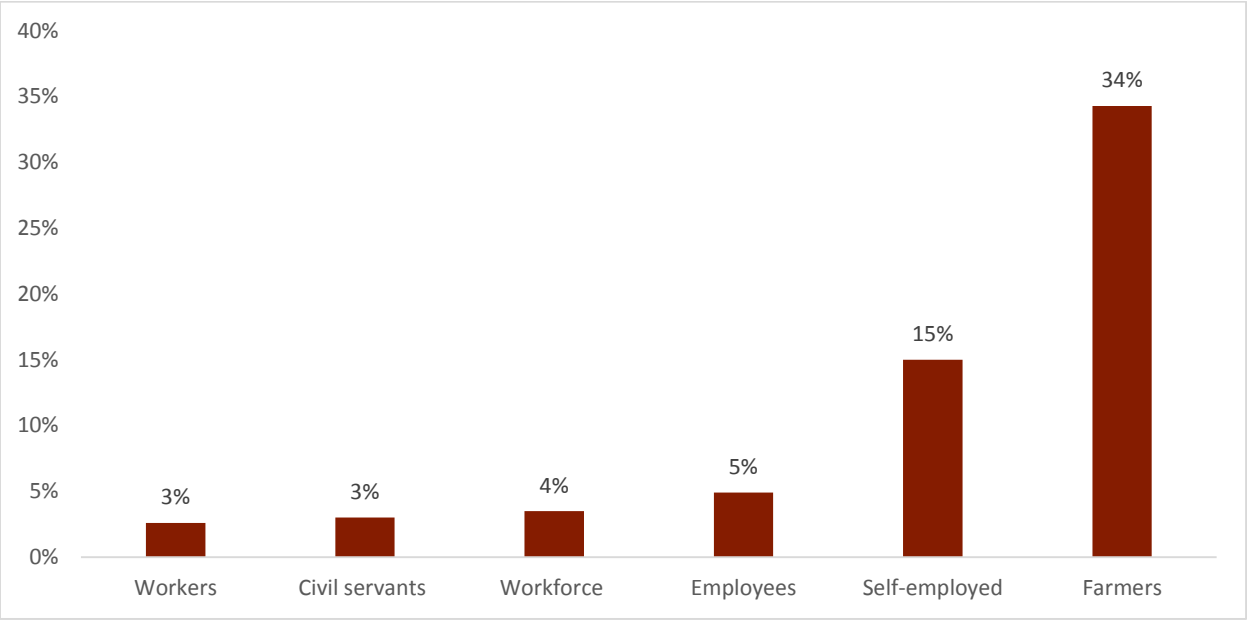
Year	Total	Number of people with one, two or multiple occupation(s)			Total number of Occupations
		One	Two	Multiple	
2016	3.951.054	3.812.467	132.987	5.600	4.095.791
2015	3.898.605	3.762.696	130.358	5.551	4.040.615
2014	3.876.062	3.741.652	128.910	5.500	4.016.490
2013	3.850.535	3.716.365	128.776	5.394	3.990.625

[33] Remark: This includes persons, who have multiple occupations, yet the same health insurance.

Year	Total	Number of people with one, two or multiple occupation(s)			Total number of Occupations
		One	Two	Multiple	
2012	3.770.318	3.637.643	127.446	5.229	3.908.699
2011	3.733.277	3.601.550	126.589	5.138	3.870.614
2010	3.667.358	3.537.436	124.893	5.029	3.802.780
2009	3.628.881	3.498.613	125.333	4.935	3.764.543
2008	3.700.450	3.567.066	128.360	5.024	3.839.320
2016	100.0%	96.49%	3.37%	0.14%	103.7%
2015	100.0%	96.51%	3.34%	0.14%	103.6%
2014	100.0%	96.53%	3.33%	0.14%	103.6%
2013	100.0%	96.52%	3.34%	0.14%	103.6%
2012	100.0%	96.48%	3.38%	0.14%	103.7%
2011	100.0%	96.47%	3.39%	0.14%	103.7%
2010	100.0%	96.46%	3.41%	0.14%	103.7%
2009	100.0%	96.41%	3.45%	0.14%	103.7%
2008	100.0%	96.40%	3.47%	0.14%	103.8%

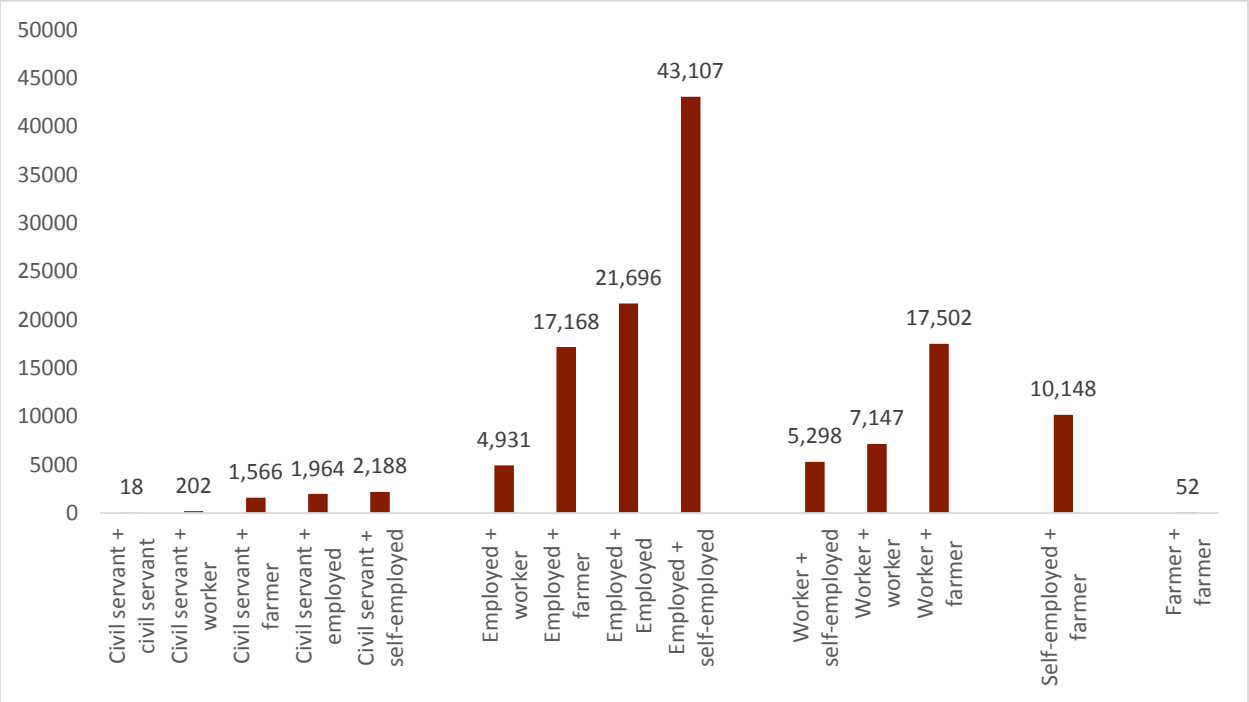
In particular, self-employed persons and farmers frequently have multiple occupations. For instance, this is the case for 15% of self-employed individuals and 34% of all farmers (please see the figure below).

Figure 64: Share of persons with multiple occupations in %, as of 2016, based on data from HVSV (men and women)



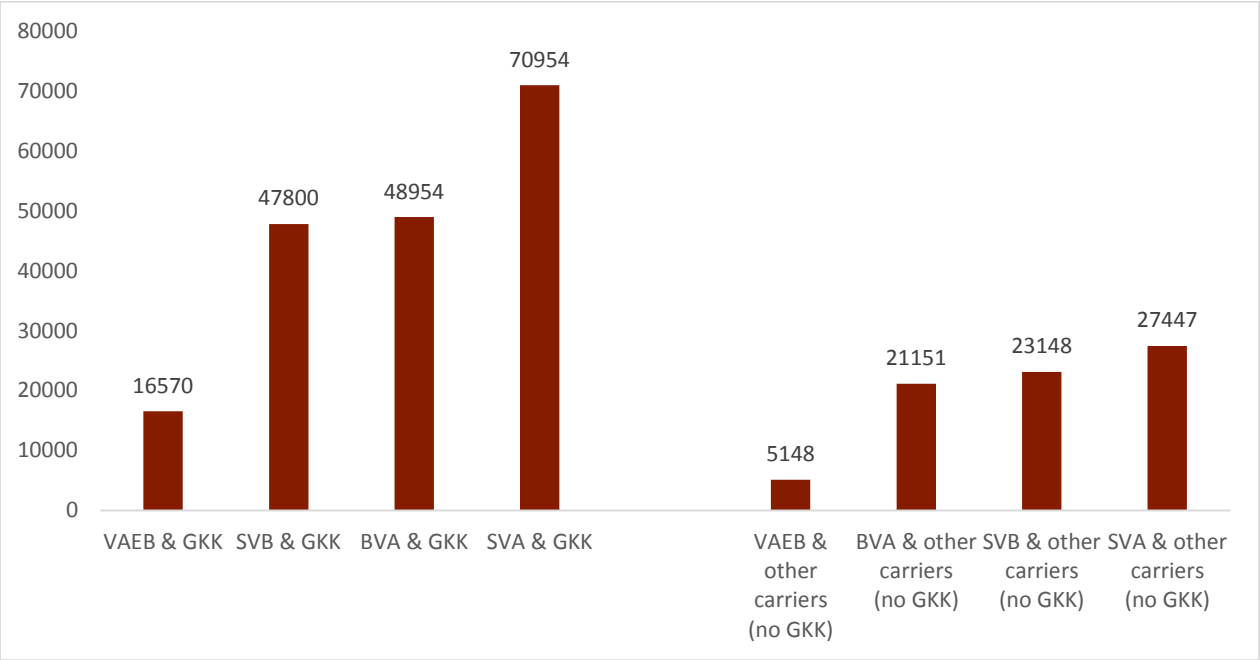
Out of 138.587 persons who had multiple occupations (meaning two or more occupations), 47% were self-employed and 35% were farmers (as of 1st July 2016). For persons with two occupations, the most common combination was being self-employed and employed, which was followed by being in twofold employment, and the combination between farmer and employee/worker (please see figure below).

Figure 65: Working persons who have two occupations, as per 1st July 2016, based on data from HVSV



With regards to the types of social security carriers, contribution-paying multiple insured persons were most commonly insured with one of the Regional Health Insurance Institutions and the Social Insurance Institution for Commerce and Industry (SVA) (for further information on combinations of insurance carriers, please see Figure 66, which also includes retired persons).

Figure 66: Contributing multiple insured and their health insurance institutions, as per 30th April 2016, based on data from HVSV



Social security legislation for multiple insured persons

The obligation to contribute exists up to a maximum contribution base.[34] If the total sum of contributions exceeds the (annual) maximum contribution base, either the differential assessment claim (ex-ante) or the refund of contributions (ex-post) can avoid payment of disproportionate amounts (i.e. above the maximum contribution base). A precondition for the refund is that the sum of all contribution bases for the compulsory insurance in the respective year exceeds the 35-fold daily amount of the maximum contribution basis for the compulsory insurance (for 2017, this results in €5,810.00 per month).[35]

In the case of health insurance, 4% of the excess amount that transcends the maximum threshold of the ASVG contribution is refunded, as this comprises the employee's as well as the employer's contribution, which equals 3.87% and 3.78% respectively[36]. In contrast, GSVG-/FSVG-/BSVG-contributions (i.e. commercially or free-lancing self-employed persons, or farmers) get refunded in full.[37]

[34] (103)
[35] Bäuerliches Beitragswesen im Überblick
[36](104)
[37] SVA Info „Mehrfachversicherung Pensionsversicherung", 2016

However, the respective applications normally have to be actively filed, which not all multiple insured persons will do. The application for refunding the health and unemployment contributions needs to be submitted to one of the insuring health insurance carriers. The application must be submitted until the end of the third calendar year, following the respective contribution year. If this application is also filed for the following contribution years, it is valid for as long as the insured person is registered for compulsory insurance with this health insurance carrier.

The occurrence of exceeding contributions may be avoided by applying for the differential assessment claim. Based on the ASVG contribution base, the GSVG-/FSVG- contribution base is set at a level that is likely to eliminate an exceeding contribution. Hence, a (partial) exemption from the GSVG obligation to contribute takes place. Furthermore, multiple insured persons secure insurance periods in every pension system of their insurances. However, in order to claim the pension, insurance months, which were acquired in parallel, can only be claimed once. This means that insurance months have to be assigned to one of the pension systems. For this purpose the hierarchy ASVG – GSVG – BSVG applies. 11.4% of the amount which was paid in surplus (above the maximum threshold) gets refunded for the ASVG, while for the GSVG/FSVG/BSVG, the full excess contribution (i.e. the employee part) is reimbursed.

To date, the so-called wage-sum-procedure has been utilised, where the employer calculates and pays the monthly contribution for all of his/her employees (including both, the employee and the employer contribution fees), without the contributions being allocated to the single person. Hence, the monthly contribution statement is adequate proof, i.e. the names of the employees do not need to be indicated, yet only the wage-sums suffice, which are broken down into contribution- and settlement-groups. Only after the end of the calendar year the pay-slips and the statement of contribution bases have to be created, which comprise the contribution basis for each insured person.

On 1st of January 2019, the monthly contribution base notification (mBGM) will replace this system, for which the legal framework is set by the reporting-obligation Act.[38] The mBGM means a complete system transformation for the employers and the social insurance carriers, enabling high quality and more timely data about monthly contributions. Consequently, in future, data will be available more promptly and not only after the end of the calendar year. More specifically, the mBGM represents a simplification of applications and a decrease in having to report redundant data. In addition, this makes changes in the

[38] (105)

insurance history more transparent, errors are avoided due to a clearing system, and the contribution groups are replaced by a new tariff-system.[39]

Multiple insured civil servants

For civil servants, the situation is slightly different. Civil servants, who simultaneously engage in a commercial activity, are also compulsory insured in the pension insurance - in accordance with the GSVG. Both, the minimum and the maximum contribution base apply, when establishing the contribution base according to the GSVG. The salary of civil servants does not influence the contribution base compliant with the GSVG.

This is differently dealt with in the health insurance: Besides the B-KUVG, the commercial activity leads to an additional compulsory insurance in line with the GVSG. Since 2006, the contribution base according to B-KUVG is credited to the GSVG minimum contribution base for health insurances. In case the contribution base (in accordance with B-KUVG and GSVG) exceeds the maximum contribution base and an applicable substantiation is available, the contribution base according to GSVG must be set temporarily at most to the difference between B-KUVG and the maximum contribution base. The same applies to the employed persons, who are insured according to ASVG and B-KUVG.

However, if based on regional law, a sickness insurance claim exists for a sickness insurance institution (Krankenfürsorgeanstalt, KFA), then neither a crediting on the minimum contribution base according to GSVG, nor a restriction of the maximum contribution base apply[40]. Therefore, for civil servants an addition of the contribution bases should be allowed within pension insurance and the KFA, in order to enable an automatic refund of contributions, exceeding the maximum contribution base.

In the work programme of the federal government for 2017/2018, which was decided in a special council of ministers on the 30th January 2017, a simplification of multiple insurances was planned, potentially taking effect from September 2017[41]: 'There exist many possible combinations of occupations. Persons who have multiple occupations that are gainful, i.e. employee and part-time farmer, pay multiple social security contributions and are multiple insured. The obligation to contribute persists up to the maximum contribution base. If the sum of the contribution bases exceeds the maximum contribution base, the exceeding contributions can be avoided by claiming differential assessment (in advance) or a refund of

[39] (106)
[40] WKO Info: „Beamte als gewerblich Selbständige"; January 2017
[41] „Für Österreich . Arbeitsprogramm der Bundesregierung 2017/2018" January , p.9

contributions (afterwards). In the future, an automatic difference assessment/refund of contributions through social security will be introduced in case of multiple occupations.

Allocation of contribution income and costs

Besides the issue of allocating contribution income among multiple insurances, another problem presents the fact that cost allocation is currently not regulated. In fact, the person with multiple insurances, may decide which insurance has to bear the costs of treatment (this may possibly be also influenced by the contractual partner, if he/she partners multiple social security institutions). Thus, distributing the contribution income in relation to the allocation of costs of the different health insurance carriers would be reasonable and fair.

Currently, if the multiple insurance is based on ASVG and GSVG, the GSVG contribution base is reduced by the differential assessment, independent of where the costs are allocated. In case of multiple insurances of multiple employments according to ASVG, employee contributions exceeding the maximum contribution base can get refunded. This happens at the carrier that receives the filed application for differential assessment.

The current situation is problematic, since numerous incentives that have to be taken into consideration exist. If left uncoordinated, these could potentially influence the cost allocation:

- Scope of service of the respective carrier
- Issue of user charges and cost sharing
- Issue of remunerating physicians providing the same service
- Amount of remuneration, since with physicians-of-choice 80% of the fees a contractual partner would charge, are refunded.

5.1.8 Policy options: Multiple insured persons in Austria

A simplification via automatic refunding for multiple insured persons and an internal cost allocation is considered a reasonable alternative to the current system of retrospective, manually filed reimbursement. The cost allocation should be based on an estimation of payment flows and not on single bills of the individual insured persons. The more services, rates and tariff models are harmonised, the easier it will be to obtain a mechanism that involves all health insurance carriers.

Single collection of contributions without a choice of fund

At present, multiple insured persons in Austria pay contributions to all funds they are compulsorily insured with. As the total contributions may exceed the maximum contribution bases, multiple insured must manually file yearly applications for reimbursement, in order to receive a refund of the excess payment. In addition, multiple insured can choose which carrier to charge for a good or service on a case-by-case basis, constituting an inequitable advantage compared to those insured with a single fund. For instance, multiple insured may avoid paying user charges that are prevalent across more "generous" funds, such as the BVA or SVA, while simultaneously making use of those funds' greater benefits when necessary (e.g. in order to reduce waiting times or to receive greater allowances for specific services). this policy introduces a single location for the collection of contributions, in addition to keeping maximum contribution bases in place. This can either be in the form of an independent entity or by nominating regional funds to collect contributions on behalf of all funds, in order to simplify the administration process. As such, the refund for excess contributions could be automatically calculated through an official channel, without the need for manual applications.

Under this option, insured persons do not have a choice of fund. Instead, a hierarchy could be introduced to determine the fund membership of an individual. This could either be an absolute hierarchy of funds or a hierarchy based on the main income source of an individual. However, it must be noted that a system based on a hierarchy is only feasible if it does not undermine the financial position of a fund. Hence, further studies on the financial impact on funds need to be conducted prior to applications of this option.

Single collection of contributions with a choice of fund (sub-option)

This sub-option follows the same model as the option above, with the main difference that insured persons could choose their fund of preference, based on their professions. While this option does not entirely eliminate inequity in the system, it may reduce the former, as insured could only switch funds on an e.g. yearly basis, rather than intermittently charging different funds.

Multiple collections of contributions without a choice of fund

Under this option insured individuals continue to pay to multiple funds, however, the insured would be automatically assigned to a default fund. This constitutes the fund for which the insured pays the largest share of contributions and the insured is only entitled to benefits of the default fund. All carriers receiving contributions for the insured would re-direct these contributions to the respective default fund. In addition, the refund process for excess contributions could be automated, in order to reduce the

administrative burden of manual applications and to eliminate inconveniences to the insured. However, such a system is only feasible if it does not undermine the financial position of a fund, such as the SVB. Hence, prior to the application of this option, a study on the financial impact on funds needs to be conducted.

Multiple collections of contributions with a choice of fund (sub-option)

This sub-option follows a similar rationale to that outlined above, with the main difference that under Option 2a individuals have the option to choose a default fund to access services from, while the second carrier will conduct transfers of funds to the former. However, as in the case of previous options discussed, there are only partial improvements in equity.

Retrospective payments between funds

For this final option, one of the funds conducts retrospective payments to the second insurance carrier, which was predominantly used by the insured person to access services. This system constitutes a modification of the current mechanism in that it adds a compensatory mechanism to ensure the financial stability of funds. However, it must be noted that this option may be more difficult to implement and does not render the system more equitable.

Legal considerations

Some of the above options may cause problems with respect to the principle of self-governance: As long as there are different 'Versichertengemeinschaften' each of them based on the type of employment of the respective insuree, it will be difficult to justify that only one of them is receiving all the contributions, most of all if that particular carrier is determined more or less 'by chance' (including a choice by the insurees themselves).

So if substantial harmonization and/or amalgamation of carriers (which should be the main options) cannot be achieved, it seems that a risk-adjusment-system taking into account also the special situation of multiple-insured persons would be a better and more equitable option.

5.2 Defining benefits

5.2.1 Overview

The move towards universal health coverage raises key policy questions, such as how to design and regulate benefits to ensure a financially sustainable coverage of services for all insured persons (107). Most countries have developed a rationale and mechanism to guide the composition of a benefits basket, which specifies the full or partial coverage of publicly financed health care services, activities and goods accessible to all residents in social and national health systems. These benefits can be defined through two approaches and often countries employ a mix of both, depending on categories of goods and services: (1) an 'open specification' with a general description of benefits outlining eligibility for these benefits, and (2) 'closed specification' with detailed (positive) listings of all benefits that are covered through public financing (108). However, approaches and the extent of regulation differ between countries, highlighting ambiguities and challenges in creating a common benefits package. The following section provides a high-level overview of the regulation of service coverage in Belgium, France, Germany, Netherlands and Switzerland, and concludes with a brief comparison to the Austrian system.

5.2.2 Regulation of health insurance benefits in Europe

Belgium

Regulated benefits

Almost the entire Belgian population is insured with one of the seven health insurance entities. These include five national associations, which can be broken down into approximately 60 local sickness funds, one public fund for individuals not wishing to join any of the five associations, and a separate fund for railway employees. All insurance funds must offer the legally defined compulsory benefits package. Thus, differences in services are only present in complementary or supplementary insurance (109).

Service coverage in Belgium is based on a closed specification system with detailed positive listing (108). As such, the content of the compulsory package is specified in the national fee schedule (*nomenclature*), which lists an identification number, the contractual fee and reimbursement rate for more than 8,000 services. Negotiations on the inclusion of new treatments and exclusion of obsolete ones between the representatives of the health insurance funds and healthcare providers take place yearly or biennially (109). In order to inform and support evidence-based coverage decisions, the Belgian Health Care Knowledge Centre (KCE) performs a number of health technology assessments. However, the KCE merely

issues non-binding recommendations and is not involved in the actual decision-making or implementation process of the benefit basket (110).

The compulsory benefits package is broad and includes services such as medical care (e.g. GPs, specialists, psychiatric care, hospital care), physiotherapy, prescription drugs, most dental care, home and nursing home care, among many others (109). Certain services, such as alternative therapies (e.g. homeopathy, acupuncture) are not covered by the basic insurance, while plastic surgery, spectacles and orthodontics may be reimbursed under specific conditions (109).

Optional benefits

In addition to the compulsory benefit package, sickness funds may offer supplementary or complementary insurance. Content and insurance policies for services, such as optic and dental care, alternative medicines and certain co-payments for hospital care, differ between providers, leaving room for competition (109).

France

Regulated benefits

Eighty-six per cent of the French population are covered by the general statutory health insurance (SHI) scheme for salaried workers in the private sector (also applicable to legal residents not covered by other funds). The remaining are members of the SHI scheme for self-employed (6%) or members of the scheme for farmers and agricultural workers (5%). The content of the compulsory benefits package is defined at the national level and applies to all SHI schemes (111). Hence, differences in services are only present in complementary or supplementary insurance.

Similar to Belgium, the service coverage in France is based on a closed specification system with a detailed positive listing of more than 8000 covered benefits (108). These positive lists are defined at the national level and apply to all regions. The Ministry of Health specifies the positive list for drugs and medical devices for both outpatient and inpatient care, while the statutory health insurance (UNCAM) is responsible for the listing of medical procedures (111). The coverage decisions are evidence-based, following a health technology assessment of the effectiveness and/or cost-effectiveness of all interventions by designated committees of the independent French National Authority for Health (HAS) (112).

Overall, the benefits package consists of outpatient- (e.g. GPs, specialists, dentists, and midwives) and inpatient care (e.g. hospital care, rehabilitation or physiotherapy), diagnostic services and therapies (e.g. physio-, speech therapy) if prescribed by doctors. Pharmaceutical products, medical appliances and

prostheses are covered if these are included in the national positive list and if prescribed by a physician. Health-care related transport is reimbursed in the case of prescription. Cosmetic surgery, spa treatments or services of uncertain effectiveness are not included in the basic package (111).

Optional benefits

While the SHI provides a broad benefit package, coverage is generally not 100% and varies between services. Therefore, insured persons can take out complementary insurance to cover all or parts of the residual costs or supplementary insurance for benefits not covered by the SHI (111).

Germany

Regulated benefits

Eighty-seven per cent of the population in Germany are insured with one of the 113 statutory health insurance funds (GKV funds), while 11% have opted for substitutive private health insurance (PKV) (113). The Contribution rates vary between sickness funds, however, 95% of GKV benefits are statutorily regulated through Social Code Book V (*SGB V*) (114). The statutory regulation of services also applies to the basic tariff, which private health insurers are obliged to offer and which encompasses compulsory benefits analogous to the benefit package covered by the GKV.

As stated in legislation (§12 SBG V), benefits can only be claimed for services that are adequate, appropriate and economical. It is the Federal Joint Committee's (FJC) task to evaluate and determine the specific medical and medico-technical examination and treatment methods for inclusion in the service catalogue (115). For instance, examination and treatment methods for the outpatient sector must be approved by the FJC for their diagnostic or therapeutic benefit, medical necessity and effectiveness. Previously approved services can be excluded from the catalogue if they no longer reflect the current state of scientific evidence. In contrast, all services performed during an inpatient stay are automatically covered, unless a specific treatment method has been explicitly precluded due to insufficient therapeutic benefit (115).

The comprehensive benefits package of the sickness funds encompasses preventive and early detection measures, essential medical treatment (i.e. outpatient and inpatient care, and rehabilitation, including surgical dressings, therapeutic appliances and medication), therapies (e.g. psycho-, physio-, speech- and ergotherapy), medically necessary transportation, dental care, and sickness benefits. Additional services include insurance coverage for stays abroad in EU member states and choice of doctors and specialists

(116). Although alternative treatments, like homeopathic products, are not part of the statutory benefits package, they are covered by a number of sickness funds.

Optional benefits

Differences in benefits across GKV insurers are due to optional tariffs (*Wahltarife*), which were introduced as a way to increase competition in 2007 (117). There are two types of optional tariffs: the mandatory and the voluntary optional tariff. The mandatory optional tariff is regulated through legislation (§53 SGB V), which means that sickness funds must offer the following four service options as part of the tariff: integrated care, structured treatment programmes for chronically ill, sickness benefits for the self-employed, and family physician care (118). Via voluntary optional tariffs, sickness funds can advertise a number of non-regulated services, such as tariffs with deductibles, contribution refunds and alternative medicines. In addition to the services offered by the statutory insurance, individuals can opt for supplementary private health insurance (118).

Netherlands

Regulated benefits

There are three types of health insurance in the Netherlands: the obligatory basic insurance for essential curative care, the obligatory national insurance for long-term and unaffordable care, and the optional supplementary insurance. All individuals must sign up with a private non-profit insurance provider to obtain the non-risk-based basic health insurance for curative care, which is harmonised across health insurers (119).

Service coverage in the Netherlands is based on an open specification system with a general description of benefits. The content of the basic benefits package is regulated by the central government, based on advice from the National Healthcare Institute (ZIN) (120). Following the main criteria, services should be essential, effective, cost-effective and unaffordable for individuals. Other factors, such as budget and political considerations may further influence the decision-making (121). However, not all treatments are evaluated or reviewed. Instead, the Healthcare Insurance Board defines a list of priorities for the benefits package agenda, which is held bi-annually (121).

In line with the Health Insurance Act 2015, the benefit package comprised, among other services, medical care (i.e. GPs, specialists, midwives, mental care and hospital care), home nursing and personal care, therapies (e.g. physio- speech-, exercise- and occupational therapy), pharmaceuticals and medical aids and devices, maternity care, transportation of sick patients, and dental care (for children until the age of

18; persons aged 18 and older are eligible for specialist dental care and a set of false teeth). Also included were quit-smoking programmes and geriatric rehabilitation care (120).

Optional benefits

Individuals may also take out supplementary coverage for additional services not included in the basic package. Supplementary insurance is offered by various competing providers and comprises health services such as dental care for adults aged 18 and over, alternative therapies and medicine, contraception, glasses and contact lenses (122).

Switzerland

Regulated benefits

All Swiss residents must take out compulsory basic insurance offered by one of approximately 60 private non-profit health insurance funds (123). Contribution rates vary between insurance providers and geographic regions, however, insurers are obliged to offer the same basic compulsory health insurance (*obligatorische Krankenpflegeversicherung*) to any person, regardless of income, age, sex, or health condition (124).

The catalogue of benefits is broadly defined by the Swiss Health Insurance Act (KGV/LAMal), which stipulates that services must be effective, appropriate and cost-effective (Art. 32 KVG/LAMal). Additionally, the federal government employs explicit positive lists and lists of medicines not eligible for reimbursement to specify certain contents of the package, such as pharmaceuticals and medical devices. However, most physician services are not formally assessed, which can lead to coverage of services with little scientific proven value (125).

The basic insurance only covers services that are provided in the resident's state. However, exemptions include emergencies and compelling medical reasons (e.g. complex interventions such as organ transplantations) (124).

In practice, the package comprises most GP, chiropractor, midwife and specialist services, inpatient care, pharmaceuticals and medical devices, laboratory tests, as well as therapies (e.g. physio- and speech-therapy, nutritional and diabetes counseling, outpatient care by nurses, occupational therapy, and psychotherapy if prescribed by a physician). Costs for transport or rescue are partially paid for, while coverage for long-term care is based on medical necessity. Dental care is covered in the case of severe illness of the masticatory system or if related to care of other diseases (e.g. leukemia). The positive list also specifies a number of prevention and examination measures (e.g. pap smears, mammography

screening and selected vaccinations) (124,125). As of 2017, the benefits package will also cover homeopathic medicines.

Optional benefits

To broaden the basic coverage, the insured can take out private supplementary or complementary insurance with any insurance provider. This type of insurance comes at an additional cost with risk-based premiums. Benefits and policies vary across funds and are difficult to compare. Generally, these benefits can be categorised into outpatient- and inpatient-related supplementary services. Supplementary outpatient coverage may include orthodontic treatment, alternative medicine, and spectacles/contact lenses. Supplementary coverage for inpatient stays may comprise stays in a private or semi-private hospital ward, and choice of doctor (e.g. senior physicians) (124,125).

5.2.3 Regulation of benefits in Austria

Status quo

About 80% of the Austrian population are insured with one of the nine regional insurance funds (GKKs), with the remainder being members of a specialist- and/or company insurance funds. The contribution rates for regional funds are uniform and insured persons are automatically assigned to a specific fund, based on the place of residence and occupational group. Although the contribution rates are the same across regional funds, the benefits are not fully harmonised and can vary for both benefits in-kind and in-cash.

The guiding rationale is that treatment must be sufficient and appropriate, however, it should not exceed the necessary. Furthermore, there is a positive list for outpatient drugs based on evidence-based technology assessments. However, there are no additional positive lists or lists of interventions not eligible for reimbursement that specify covered benefits for outpatient- or inpatient care. Instead, each insurance fund specifies a statute (*Satzung*), which lists their covered services. In addition, the Main Association of the Social Insurance Funds (Hauptverband der Sozialversicherungsträger, HVSV) is legally obliged to define a template statue (*Mustersatzung*). As such, the HVSV can render a service obligatory, however, a unanimous vote by all insurance funds is required.

Service coverage in Austria is based on an open specification system with a general description of benefits. For instance, the General Social Security Act (ASVG) defines an array of broad services that are covered by social health insurance. According to the legislation, the Social health insurance covers the following services: outpatient - (i.e. general practitioners and specialists), inpatient- and medical nursing care,

rehabilitation, therapies (psycho- and speech therapy), pharmaceuticals and therapeutic aids, maternity and sickness benefits, health promotion and illness prevention, and a number of basic dental services, among others. Generally, complementary medicine methods, such as homeopathy, are not included in the benefit basket (126).

Comparison of the regulation of health benefits plans across European countries

As outlined in the country descriptions, the six countries differ in type, approach and extent of regulation pertaining to benefits. Similar to Austria, most countries in this analysis employ a guiding principle and an open specification with a general (functional) description of benefits, which is outlined in legislation. Such open specifications may be ambiguously defined and therefore undermine to some extent the harmonisation of benefits, as is the case in Switzerland, for example. However, it must be noted that not only the benefits packages, but also the contribution rates/premiums may vary between funds in Switzerland, Netherlands and Germany. In contrast, the contribution rates for regional funds in Austria are harmonised, whilst this is not necessarily the case for benefits packages. In addition, positive lists are generally used to specify coverage for prescription drugs, although in Austria the list only comprises outpatient drugs. France and Belgium are the only countries in this sample to produce detailed positive lists of more than 8,000 outpatient and inpatient goods and services, enhancing the harmonisation of benefits across insurance providers. The table below provides an overview of the regulation of benefits across the six European countries.

Table 26: Overview of the regulation of benefits across six European countries

	Austria	Belgium	France	Germany	Netherlands	Switzerland
Regulated benefits						
Legislation						
Source	General Social Security Act (ASVG)	Law on Compulsory Health Insurance and Allowances *(Loi relative à l'assurance obligatoire soins de santé et indemnités*)	Social Security Code (*Code de la sécurité sociale*)	Social Code Book V (*Sozialgesetzbuch V, SGB V*)	Health Insurance Act (*Zorgverzekeringswet*)	Swiss Health Insurance Act (KGV, LaMal)
Coverage criteria	Treatment must be sufficient and appropriate, however, it should not exceed the necessary (§133(2) ASVG)	Medical goods and services need to be included in the positive list	Medical goods and services need to be included in the positive list	Benefits can only be claimed for services that are adequate, appropriate and economical (§12 SBG V)	Services should be essential, effective, cost-effective and unaffordable for individuals (1992/1995 Dutch Committee on Choices in Health Care (Dunning Committee*)*	Services must be effective, appropriate and cost-effective (Art. 32 KVG/LAMal)
Approach to define the benefits package	Open specification with a general (functional) description of benefits	Closed specification system with detailed positive listings	Closed specification system with detailed positive listings	Open specification with a general (functional) description of benefits	Open specification with a general (functional) description of benefits	Open specification with a general (functional) description of benefits
Mechanism to define benefits						
Outpatient services						

	Austria	Belgium	France	Germany	Netherlands	Switzerland
	Functional description of benefits; and a non-exhaustive positive list defined by each carrier	Detailed positive list	Detailed positive list	Functional description of benefits; and positive list (less detailed)	Functional description of benefits; and list of medicines not eligible for reimbursement	Functional description of benefits; and list of medicines not eligible for reimbursement
Prescription drugs	Positive list	Positive list	Positive list	Positive list	Positive list	Positive list
Regulatory body	Each insurance fund specifies a statue (*Satzung*) that lists the services covered. The HVSV is legally obliged to define a template statue (*Mustersatzung*) and can make some services obligatory. In addition, there are some HTA processes for prescription drugs.	Representatives of the sickness funds and of the health care professionals negotiate the fee schedule yearly or biennially KCE can make recommendations	Positive list defined at national level Drugs and medical devices added to list by MoH Procedures added by SHI Committees within HAS provide advice based on HTA results	Federal Joint Committee (FJC) Based on HTA results	Central government	Federal government Not all treatments evaluated/reviewed. The Healthcare Insurance Board defines a list of priorities for the package agenda, which are reviewed bi-annually
Optional benefits						
Type of optional benefit	Insured can take out supplementary private health insurance.	Sickness funds and private funds may offer supplementary or complementary insurance.	Complementary and supplementary insurance can be taken out with private insurers.	Statutory insurance: • Mandatory optional tariffs • Voluntary optional tariffs.	Private supplementary insurance is offered by various competing providers.	Private supplementary insurance can be taken out with any provider.

	Austria	Belgium	France	Germany	Netherlands	Switzerland
				Supplementary private health insurance.		

Furthermore, a comparison of eight European countries by Van der Wees *et al.* (2014) showed that a number of countries are increasingly relying on evidence-based strategies to define the benefit package and to keep it affordable (e.g. Belgium, France and Germany) (108). Regardless of the approach and type of health system, packages generally appeared similar between countries. The key differences in coverage were identified for dental care and physical therapy (108). For instance, routine dental care for adults is not covered in the Netherlands and Switzerland (see the table below for the selected comparison of services for adults covered by public financing across European countries by Van der Wees *et al.* (2016) (127)). However, the scope and extent of differences in service provision across funds within countries remains to be examined.

Table 27: Health services for adults covered by public financing. Based on Van der Wees et al. (2016)[42]

Services	Austria	Belgium	France	Germany	Netherlands	Switzerland
Primary care physician	✓	✓	✓	✓	✓	✓
Medical specialist	✓	✓	✓	✓	✓	✓
Maternal care	✓	✓	✓	✓	✓	✓
Hospital care	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓	✓
Prevention	✓[43]	✓	✓	✓	✓	✓
Dental care	✓	✓	✓	✓	×	×
Mental healthcare	✓	✓	✓	✓	✓	✓

[42] Comparisons in this table refer to adults aged 19-60 without chronic disease or low income.
[43] Partial coverage, including e.g. general preventive check ups and gynecological check ups . Immunisations and other screenings not fully covered.

Services	Austria	Belgium	France	Germany	Netherlands	Switzerland
Physical therapy	✓	✓	✓	✓	✓[44]	✓
Occupational therapy	✓	✓	✓	✓	✓	✓
Speech therapy	✓	✓	✓	✓	✓	✓
Medical devices	✓	✓	✓	✓	✓	✓
Cosmetic surgery[45]	×	×	×	×	×	×

5.2.4 The role of HTA in defining benefits in Europe and implications for Austria

Overview

The purpose of this section is to examine the Health Technology Assessment (HTA) processes in European countries with publicly funded social health insurance systems and attempt to draw some lessons for Austria. The study countries (and their respective agencies) under examination are England (National Institute for Health and Care Excellence, NICE), France (Haute Autorité de Santé, HAS), Germany (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, IQWiG), and the Netherlands (Zorginstituut Nederland, ZIN (formerly College voor zorgverzekeringen, CVZ) before trying to draw some comparisons with Austria.

With regards to the responsibilities and structure of national HTA agencies, across all study countries HTA agencies are autonomous and their role is advisory. In that capacity, they assess and appraise the value of health care interventions and make recommendations for coverage. Usually, a technical group is responsible for early assessment of evidence following which an expert committee appraises the request

[44] Physical therapy in the Netherlands is only covered for certain chronic conditions after 20 sessions.
[45] Not covered on a general basis; may be covered in some specific instances.

for coverage and produces recommendations for the ultimate decision maker. The topic selection process is generally not fully-transparent, with most agencies predominantly assessing new health care interventions that are expensive and/or with uncertain clinical benefits. In all countries, official country-specific pharmacoeconomic evaluation guidelines are in operation, mainly concerning methodological and reporting issues (128,129). Although some of the HTA agencies tend to focus on pharmaceutical products, others evaluate all types of health care interventions, therefore the term "pharmacoeconomic" might not be representative of the types of guidelines in place, in which case it might be more appropriate to be referred to as "methods for HTA".

In terms of evidence and evaluation criteria considered, generally all study countries assess the same types of evidence, however the precise information and value parameters analysed and the way they are evaluated differ across countries. Typical data sources widely used by all countries include scientific studies (e.g. clinical trials, observational studies), national statistics, clinical practice guidelines, registry data, surveys, expert opinion and evidence from pharmaceutical manufacturers (130).

In terms of methods and techniques applied and in addition to clinical benefit assessment, all countries adopt some type of economic evaluation technique (mainly Cost-utility analysis or Cost-effectiveness analysis) as an analytical method to derive the value of new technologies, besides France and Germany, both of which formally used to apply solely a comparative assessment of clinical benefit as the preferred methodology but with economic evaluation progressively becoming more important as of 2013.

All countries acknowledge that randomized controlled head-to-head clinical trials is the most reliable and preferred source of treatment effects (i.e. outcomes), with data from less-rigorous study designs being accepted in most study countries (England, France, Germany) e.g. when direct RCTs for the comparators of interest are not available (130–132). Also, most agencies require systematic literature reviews to be submitted by manufacturers as a source of data collection and carry out their own reviews. A meta-analysis of key-clinical outcomes is recommended for pooling the results together given the homogeneity of the evidence in England and Netherlands (130–132). If evidence on effectiveness is not available through clinical trial data, then France and Netherlands allow for a qualitative extrapolation based on efficacy data, with, England applying both qualitative and quantitative modelling. In both England and Netherlands, short-term clinical data are extrapolated also if data on long-term effects are absent.

In terms of resources used, and in addition to direct medical costs, France considers all relevant costs including direct non-medical and indirect costs, both for patients and carers (129,130); however, only direct costs are considered in the reference case analysis and incorporated in the ICER (133). Germany

also takes into account informal costs and productivity gains separately as a type of benefit, whereas England additionally considers cost of social services. In the Netherlands, the Health Care Insurance Board's "Manual for cost research" applies for the identification, measurement and valuation of costs; pharmacoeconomic evaluations need to include both direct and indirect costs inside and outside the healthcare system (134).

In all study countries both costs and benefits are discounted (129,131,135,136), and uncertainty arising due to variability in model assumptions is investigated usually in the form of sensitivity analysis. No explicit, transparent, or clearly defined cost-effectiveness thresholds exist in any of the countries except for England.

Finally, in terms of the decision outcomes and implementation, evaluation outcomes are primarily used to inform coverage decisions relating to the reimbursement status of the health care interventions but also pricing decisions, either directly or indirectly. Generally the time needed for the evaluation of a health technology to be completed differs from country to country. However, in line with the EU Transparency Directive, all countries must have reached a decision on pricing and reimbursement within 180 days post marketing authorization (137). In all countries the final decision report is publicly available, usually through the HTA agency's website (137,138), and the policy implication of the evaluation outcome relates to the pricing and reimbursement status of the technology: reimbursement (List), no reimbursement (Do Not List), or conditional reimbursement (List With Restrictions) (137,139). However, all countries apply access restrictions usually relating to specific indications or specific population sub-groups. Most countries employ dissemination procedures in order to support the implementation of their decisions, including prescribing guidelines and national drug formularies (140), having appeal mechanisms in place in case of dissent, revising their decisions either according to fixed time schedule or on a rolling basis (131,137).

HTA processes in Europe

England

In England, the Secretary of State for Health has indicated to NICE a number of factors that should be considered in the evaluation process: (i) the broad balance between benefits and costs (i.e. cost-effectiveness); (ii) the degree of clinical need of patients; (iii) the broad clinical priorities for the NHS; (iv) the effective use of resources and the encouragement of innovation; and (v) any guidance issued by the Secretary of State (141–143). Decisions are supposed to reflect society's values, underlined by a fundamental social value judgment (144). The degree of unmet clinical need is a formal criterion taken

into account, at least partially being reflected by the availability of alternative treatments (132,145). NICE acknowledges that rarity has a key role in the assessment of orphan medicinal products and NICE's Citizens' Council has stated that society would be willing to pay more for rare and serious diseases (146). The severity of the disease is taken into account mainly through the special status of life-extending medicines for patients with short-life expectancy as reflected through the issuing of supplementary advice of life-extending end-of-life (EOL) treatments by NICE (132,147).

All clinically relevant outcomes are accepted with final clinical outcomes (e.g. life years gained) and patient HRQoL being preferred over intermediate outcomes (e.g. events avoided) or surrogate endpoints and physiological measures (e.g. blood glucose levels) (131,148–150); particular outcomes of interest include mortality and morbidity. Safety is mainly addressed through the observation of adverse events (132). Uncertainty is addressed explicitly through quality of evidence, implicitly, through preference for RCTs and indirectly, through rejection of submissions if evidence is not scientifically robust.

The encouragement of innovation is an important consideration and by definition, the incremental therapeutic benefit as well as the innovative nature of the technology are formally taken into account as part of the product's incremental cost effectiveness ratio (ICER) (132). Although productivity costs should be excluded, cost of time spent on informal caregiving can be presented separately if this care might otherwise have been provided by the NHS or the Personal Social Services (PSS) (151).

As already reflected through NICE's working principles, the relative balance between costs and benefits (i.e. value-for-money) and the effective use of resources should be taken into account in England (e.g. through the explicit cost-effectiveness criterion) (141). Some studies also suggest that the impact of cost to the NHS in combination with budget constraints (budget impact considerations) are taken into account alongside the other clinical and cost-effectiveness evidence (139,143,152–154). Besides the notion of clinical need as reflected through NICE's principles, other equity considerations include the 'need to distribute health resources in the fairest way within society as a whole' and the aim of 'actively targeting inequalities', both of which are explicitly mentioned by NICE as principles of social value judgements (141). Equality, non-discrimination and autonomy are other explicit ethical considerations (145).

The preferred type of economic evaluation is CUA with cost per QALY gained being the favoured health outcome measure, but CEA may also be accepted if there is supporting evidence to do so (as in the case that the use of QALY for a particular case seems inappropriate) (129,130,136,141,142,150,155–157). Although evidence suggests the existence of a threshold ranging somewhere between £20,000 and £30,000 (149,155,158,159), it is evident that such a threshold range may not be strictly applied in practice,

with some products with a cost per QALY below these ranges receiving negative coverage recommendations and other products above these ranges ending up with positive recommendations (150,160,161). Indeed, several studies point towards the existence of a threshold range based on which additional evidence on several factors is required for the recommendation of technologies with an ICER of above £20,000, and even stronger evidence of benefit in combination with explicit reasoning required for the coverage of technologies with an ICER above £30,000 (132,137,142,143,158,162). Indeed, additional criteria may apply as part of NICE's deliberative process that may push the acceptable ICER beyond the acceptable range; these criteria include severity of the disease, rarity, end-of life criteria, innovativeness of the technology, and equity, particularly in the context of disadvantaged populations and paediatric use. Despite the historically accepted ICER range of £20,000-£30,000 per QALY, a recent study using data on primary care trust spending and disease-specific mortality estimated an empirical based "central" threshold of £12,936 per QALY, with a probability of 0.89 of less than £20,000 and a probability of 0.97 to be less than £30,000 (163).

Reimbursement status has no direct effects on price, but indeed price indirectly affects the reimbursement status of the pharmaceutical in question as it will have an impact on the ICER. Major and minor restrictions exist though: the former relate to cases where the technology is indicated only for second-line treatment (and beyond) or for only specific sub-population, and the latter relate to the need for specialist supervision or treatment monitoring (143); performance based agreements (or response rules) also exist, especially in regards to the use of biologics and cancer drugs, according to which a pre-specified clinical (endpoint) condition must be reached at a specific post-assessment time point for the coverage of the technology to continue (164).

The NHS in England is legally obliged to implement NICE recommendation and guidance that has been accepted by the Secretary of State for Health and fund the recommended technologies within three months from the outcome of the decision, possibly by displacing resources from the use of other technologies (132,150). However, NICE may revise technology appraisals once new evidence becomes available, with the average rate of positive recommendations (with or without restrictions) being around 90% (165).

France

In France the dominant model of technology assessment and appraisal relates to (comparative) assessment of clinical benefit, in combination with selective use of economic evaluation. Assessment of (comparative) clinical benefit is conducted through the use of two key indicators, namely, the product's

overall medical benefit (Service Médical Rendu, SMR) and the improvement of medical benefit (Amélioration du *Service Médical Rendu, ASMR)*; the former determines reimbursement, while the latter informs pricing decisions. The SMR provides a ranking of a new product's absolute benefit, regardless of existing alternatives, ranging from important to insufficient (4 categories); in principle, the higher the SMR, the higher the rate of reimbursement. The ASMR provides a ranking of the new product's comparative benefit relative to existing therapies, ranging from 'breakthrough' (ASMR I) to 'no improvement in clinical benefit' (ASMR V) for a total of 5 categories. As of October 2013, economic criteria have been introduced with the Commission for Economic Evaluation and Public Health (CEESP) evaluating the cost-effectiveness (without a cost-effectiveness threshold in place) of products assessed to have an ASMR I, II or III that are likely to impact social health insurance expenditures significantly (total budget impact greater than EUR 20 million), being used by the Economic Committee for Health Products (CEPS) in its price negotiations with manufacturers (166). Nevertheless, and under this current framework, these economic evaluations do not have the same impact on price negotiation with ASMR, which are directly linked with pricing but instead their role is limited to a consultative one. Both the severity and the existence of alternative treatments are acting as formal criteria, thus essentially defining the concept of 'need' (145). Severity is considered as part of the SMR, taking into account symptoms, possible consequences (including physical or cognitive handicap) and disease progression (in terms of mortality and morbidity) (167). The existence of alternatives is scored against a categorical 2-level scale (Yes vs. No) (133,168).

Clinical evidence (relating to therapeutic efficacy and safety) acts as the most important formal criterion of the evaluation process (137). The product's medical benefit or medical service rendered (SMR) relates to the actual clinical benefit of the drug, responding to the question of whether the drug is of sufficient interest to be covered by social health insurance. It takes into consideration the following criteria: (a) the seriousness of the condition; (b) the efficacy of the treatment; (c) side effects of the drug; (d) its place within the therapeutic strategy given other available therapies; and (e) its interest for public health (129).

Clinical novelty is considered by definition through the product's improvement of medical benefit (*ASMR) relating to the* relative added clinical value of the drug which informs the pricing negotiations. Additional innovation characteristics relating to the nature of the treatment (e.g. differentiating between symptomatic, preventive and curative) are also considered but as a second line of criteria (131,137,167,169). In terms of socioeconomic parameters, 'expected' public health benefit acts as another explicit dimension via an indicator known as public health interest ("Intérêt de Santé Publique",

ISP), which is assessed and scored separately by a distinct committee as part of the SMR evaluation but is not used often (145,167,169,170).

Until recently, cost was not acknowledged as an explicit or mandatory criterion, but budget impact, while not mandatory, has always been recommended highly (167). Although the expert committee had been reluctant to use cost-effectiveness criteria in the evaluation process (137,153), following the by-law of 2012 (which took effect in 2013) the role of economic evidence was strengthened (168). The CEESP gives an opinion on the efficiency of the drug based on the relative added clinical value (ASMR) of alternative treatments. Additional explicit parameters considered in France include the technology's place in the therapeutic strategy mainly in relation to other available treatments (i.e. first-line treatment vs. second-line treatment etc.), and the technology's conditions of use (133,167,168).

Comparative assessment of clinical benefit incorporating final endpoints as an outcome measure used to be as the single evaluation procedure in place. However, economic analysis of selected pharmaceuticals with expected significant budget impact is continuously being considered more formally, especially if its choice is justified and any methodological challenges (especially associated with the estimation of QALYs) are successfully addressed (129,130,133,135,145,168). The choice between CEA and CUA depends on the nature of the expected health effects (if expected significant impact on HRQoL then CUA, otherwise CEA).

By assessing the evidence of the product's medical benefit or medical service rendered (Service Médical Rendu, SMR), the improvement in medical benefit and added therapeutic benefit (Amélioration du Service Médical Rendu, ASMR) are derived, which determine the reimbursement status and influence the price level of the product respectively, therefore only drugs with additional therapeutic value can "obtain a higher reimbursement basis" (137). However, drug registration is subject to renewal every 5 years and a drug may also be subject to post-registration studies.

Germany

In Germany the Act to Reorganize the Pharmaceuticals Market in the Statutory Health Insurance (SHI) System [Gesetz zur Neuordnung des Arzneimittelmarktes in der gesetzlichen Krankenversicherung (AMNOG)] came into effect on 1 January 2011. Since then, all newly introduced drugs are subject to early benefit assessment. Pharmaceutical manufacturers have to submit a benefit dossier for evaluation by the Institute for Quality and Efficiency in Health Care (IQWiG). A final decision is made by the Federal Joint Committee (Gemeinsame Bundesausschuss, G-BA). Benefit for new drugs encompasses the "patient-

relevant therapeutic effect, specifically regarding the amelioration of health status, the reduction of disease duration, the extension of survival, the decrease in side effects or the improvement in quality of life" (171). Importantly, all new drugs are reimbursed upon marketing authorization and benefit assessment mainly determines price rather than reimbursement status. There are no pricing restrictions one year post-MA. Severity is considered as part of added (clinical) benefit assessment. The clinical assessment is based on "patient-relevant" outcomes, mainly relating to how the patient survives, functions or feels, essentially accounting for the dimensions of mortality, morbidity and HRQoL (172).

Similarly to France, all clinically relevant outcomes are considered and final clinically meaningful outcomes (e.g. increase in overall survival, reduction of disease duration, improvement in HRQoL) are preferred over surrogate and composite endpoints (129,130,135,148,172). HRQoL endpoints are considered if measured using validated instruments suited for application in clinical trials [24, 32]. With regards to uncertainty, the Institute ranks the results of a study according to "high certainty" (randomized study with low bias risk), "moderate" (randomized study with high bias risk), and "low certainty" (non-randomized comparative study).

The complete evidence base on value is then assessed and a conclusion is reached on the probability of the (added) benefit and harm graded on a six level scale, notably, (a) major added benefit, (b) considerable added benefit, (c) minor added benefit, (d) non-quantifiable added benefit, (e) no added benefit, and (f) lesser benefit (167,172). The quality of the evidence is assessed on a three-level scale, as follows: (a) proof, (b) indication of proof and (c) hint of proof. Following one year of free pricing the G-KV Spitzenverband either (a) puts the product in a reference group if there is no proof of evidence of significant added benefit, or (b) if there is major or significant added benefit, the price is negotiated with the outcome being a price which is between the comparator and the initial list price of the new product.

Clinical novelty is considered implicitly as part of the consideration of added therapeutic benefit for premium pricing. Ease of use and comfort (if relevant for morbidity or side effects) can be reflected indirectly through treatment satisfaction for patients which can be considered as an additional aspect, however not as an explicit factor, similarly to the nature of treatment/technology (173). Public health benefit is not explicitly considered but only partially reflected through the requirement from manufacturers to submit information on the expected number of patients and patient groups for which an added benefit exists as well as costs for the public health system (statutory health insurance) (167,173). All direct costs have to be considered, including both medical and non-medical (when applicable), whereas indirect costs are not a primary consideration but can be evaluated separately if they are substantial, with

productivity losses due to incapacity being included only on the cost side (174). In turn, productivity losses due to mortality are only considered in the outcome on the benefit side (to avoid double counting). Budget impact analysis (BIA) is mandatory and should include any one-off investments or start-up costs required in order to implement a new technology, with methodology and sources clearly outlined (129,174).

Economic evaluation is not standard practice in the evaluation but rather optional and can be initiated if no agreement is reached between sickness funds and the manufacturer on the price premium or if the manufacturer does not agree with the decision of the G-BA regarding premium pricing (added benefit); instead, BIA is mandatory (Advance-HTA, 2016). 'Cost-effectiveness' acts as one of the most important formal evaluation criteria in Sweden. Parameters having a socioeconomic impact, such as avoiding doctor visits or surgery, productivity impact, and, in general, savings on direct and indirect costs are also considered (167). Germany is the only country that does not apply any conditions of use in regards to specific sub-populations, in principle reimbursing drugs across the whole indication spectrum as listed on the marketing authorization (167).

Economic evaluations are performed within therapeutic areas and not across indications, thus an efficiency frontier approach of CBA using patient relevant outcomes is the preferred combination of analysis method-outcome measure (129,130,135,174,175). Since the introduction of the AMNOG, economic evaluations are supposed to be conducted for cases when price negotiations fail after the early benefit assessment and the arbitral verdict is challenged by the technology supplier or the statutory health insurer (174). However, no such analysis has been submitted so far and seems unlikely to ever happen because the CBA would have to be re-evaluated by IQWiG which would hardly bring any better results (167).The efficiency frontier approach is used to determine an acceptable "value for money", even though this is not involved in the process of the initial rebate negotiations.

The Netherlands

The Netherlands focuses on four priority principles when assessing medical technologies: (a) the "necessity" of a drug (severity / burden of disease) (145,176); (b) the "effectiveness" of a drug, according to the principles of Evidence-Based Medicine (EBM) (140,176); (c) the "cost-effectiveness" of a drug (158); and (d) "feasibility", that is how feasible and sustainable it is to include the intervention or care provision in the benefit package (177,178). The severity of the disease can be considered either implicitly or explicitly, more recently tending towards explicit burden of disease measures. The availability of treatments is considered by estimating the number of treatments perceived as necessary and comparing

these with the actual capacity in place, whereas the prevalence (e.g. rarity) of the disease is also considered.

Therapeutic value is the most critical criterion for reimbursement in the Netherlands as part of which patient preference data and user friendliness might also be considered (140), with surrogate and composite endpoints included in the analysis, in addition to disease-specific quality of life endpoints.

Although clinical novelty is a key innovation dimension considered, the ease of use and comfort might be used informally on an ad hoc case-by-case basis, whereas the nature of treatment or technology might only be implicitly considered. In terms of socioeconomic impact, explicit estimates might be produced to measure any public health benefit, whereas social productivity is also considered.

In the assessment process by ZIN, the cost-effectiveness criterion follows that of the therapeutic value and the cost consequence analysis. Cost-effectiveness is only considered for drugs with added therapeutic value, which are either part of a cluster and are reimbursed at most at the cluster reference price or are not reimbursed in the absence of possible clustering (140,179). The agency usually performs its own BIA, although voluntary submission from the manufacturer is also an option (140,153). The Netherlands also takes into consideration explicitly ethical criteria based on egalitarian principles, such as solidarity and affordability of the technology by individual patients (145,167,180). The preferred type of economic evaluation is CUA if the improvement in quality of life forms an important effect of the drug being assessed, or, if this is not the case, a CEA (134,181).

There is no formal threshold in place but there have been some attempts to define one. The €20,000 per life-year gained (LYG) threshold used in the 1990s to label patients with high cholesterol levels eligible for treatment with statins has been mentioned in discussions on rationing, but was never used as a formal threshold for cost-effectiveness. The same was the case with a threshold that the Council for Public health and Health Care wanted to implement based on criteria such as the gross domestic product (GDP) per capita, in line WHO recommendations, which for the Netherlands would translate into €80,000/ QALY (179). The Council also suggested that the cost per QALY may be higher for very severe conditions (a tentative maximum of €80,000) than for mild conditions (where a threshold of €20,000 or less may be applied) (178), but none of the above was ever implemented. The positive outcome of an HTA results in the inclusion of the medical technology in the positive list (140), and if the cost-effectiveness analysis for a new innovative pharmaceutical is of good quality, reimbursement will principally not be denied on the basis of cost-effectiveness, despite potentially relatively high cost-per-QALY values (179).

A system of coverage with evidence development (CED) for high cost and orphan inpatient drugs has been used extensively between 2006 and 2011. Currently, financial-based agreements and performance-based risk sharing agreements are considered as well. So far, revisions seemed to be taking place systematically after four years for in-patient drugs and on an ad hoc basis for out-patient drugs (137,176), however more recent evidence suggests that in practice, the process is irregular with providers asking the Dutch healthcare authority for a revision of reimbursement.

HTA in Austria

As stipulated in Article 15a of the Federal Constitutional law on the financing and organisation of the health care system, evidence based medicine (EBM) and health technology assessment (HTA) should be employed to inform and support policies that ensure the quality of care in Austria. Following, a national strategy for the framework and implementation of HTA was introduced in 2010. Despite efforts to consolidate HTA in Austria and its use in specifying a list of reimbursable outpatient drugs, there is no systematic assessment of technologies or interventions to inform decision-making regarding the definition of a basic benefits package, nor a defined body to assess and appraise technologies. Rather, the system consists of a number of decentralised HTA units of varying importance that carry out specialised services.

Indeed, a key challenge in the Austrian setting stems from the division of competencies between the federal states, who take care of hospitals, and the social security institutions (SSIs) that focus on the outpatient sector. As such, regions are primarily focused on how to reduce hospital LOS and SSIs focus only on patients in outpatient settings, leading to a shift of burden (e.g. SSIs do not look at LOS, because they do not want to take over the costs). The two players only reflect on the economics of their own sector.

In what concerns the current state of HTA in Austria, due consideration needs to be given to different types of technologies, specifically, (a) surgical and diagnostic interventions, (b) out-patient pharmaceuticals and (c) in-patient pharmaceuticals. The distinction between these three types of interventions highlights the differences in the use of HTA as well as the competences by different health stakeholders in the Austrian health system. The processes for the above types of technologies are discussed briefly in turn.

With regards to surgical and diagnostic interventions, all new hospital interventions that are included in the hospital benefits catalogue (excluding drugs; including surgical and diagnostic high-risk interventions

such as pacemakers), are already being assessed. Hence, no intervention can be included in the catalogue, unless an evidence analysis has been undertaken.

With regards to out-patient pharmaceuticals, all out-patient pharmaceuticals that are to be included in the list of reimbursable pharmaceuticals (*Heilmittelverzeichnis*) need to undergo a health technology assessment. These are rapid assessment and, as such, manufacturers submit their dossiers for an evaluation to the Main Association of the Social Insurance Carriers (HVSV). Following an assessment of the evidence by the EWG department within the HVSV, a recommendation is issued to the Drug Evaluation Committee (*Heilmittel-Evaluierungs-Kommission (HEK)*). This committee, which constitutes the final appraisal body, consists of 20 members: 10 representatives from social insurance, 3 independent research experts, 2 representatives from the Austrian Federal Economic Chamber, 2 representatives from the Austrian Federal Chamber of Labour, 2 representatives from the Medical Chamber, and 1 representative from the Chamber of Pharmacists. The inclusion of pharmaceuticals in the reimbursement list is governed by §351g ASVG VO-EKO, which provides a transparent overview of the goals and procedures of the pharmacological, medico-therapeutic and health economic evaluations. The latter constitutes primarily cost-effectiveness analyses that do not encompass social costs. However, the final assessment and appraisal reports are not published, rendering the decision-making process non-transparent, and manufacturers have the right to appeal in court in the case of unfavourable decisions.

With regards to in-patient pharmaceuticals, the process is different from the one outlined above for out-patient pharmaceuticals. Each hospital company (i.e. public and private limited not-for-profit hospitals[46]) within a federal state has a pharmaceutical commission (*Arzneimittelkommission*), which defines the list of drugs to be used at their respective hospital(s). Each hospital can either have their own list, or the hospital company can make the list binding for all its hospitals. The task of the pharmaceutical commission is to create and adapt the list for inpatient pharmaceuticals, as well as to develop guidelines for the procurement and use of pharmaceuticals. According to §19a (4) of the Federal Law for Hospitals and Rehabilitation Facilities (KAKuG), the development of these guidelines must take into consideration the appropriateness and cost-effectiveness of a pharmaceutical product. Specifically, of several therapeutically equivalent pharmaceuticals, one should choose the one that constitutes the greatest economic advantage (4.1). However, there is no explicit obligation to perform health technology assessments. As such, hospitals may or may not employ HTA as a tool to inform decision-making. For

[46] Vienna is the only region owning hospitals, which are therefore governed by the rules of Viennese administrative bodies.

instance, a recent survey has shown that merely 10% of the surveyed hospitals have reported the use of HTA (Czypionka et al., 2017). Hospital pharmaceuticals include costly interventions, such as oncology products; these are reviewed at a regional level and each hospital has its own list. Each region has a drug commission that creates the benefits catalogue for pharmaceuticals. As a result, treatments and pharmaceuticals differ across regions. Furthermore, there is no connection between the hospital decision-making and the 9 regional social security institutions, even though hospitals are largely financed (approx. 46%) by the social security institutions. Finally, different hospital companies and hospitals within a region may employ different HTA procedures and methods, leading to further cross- and intra-regional differences in access to inpatient drugs. Overall, and in what concerns hospital pharmaceuticals, HTA is not mandatory, assessments, where they take place are decentralized and there is no uniform and/or transparent evaluation process.

From an institutional standpoint, there are a number of (HTA) units of varying importance. Key among them is the Ludwig Boltzmann Institute (LBI), which is financed by research councils and 60% by the payers of the system: MoH (10%); Social Security Institutions (SSIs); and nine regional health funds that take care of hospitals. It conducts mostly single-technology assessments of high-tech medicines and some public health interventions. Medical devices review is also centralised through LBI. Assessments are not economic evaluations or cost-benefit analyses but only clinical benefit analyses (similar to France and Germany) and budget impact analyses. In this context, LBI assesses the benefits of new interventions to aid the benefits catalogue of hospitals for goods/services that require tariffs. Based on these assessments, LBI makes recommendations (primarily the assessment stage) and then political committees make the final decisions (i.e. appraisals). Final decisions are made publicly available. Other organisations that perform some type of HTA include Gesundheit Österreich (GÖG), Donau-Krems University (DUK), Private University for Medical Informatics and Technology (UMIT), and Medical University Graz (IAMEV) (see Figure 67 outlining the type of work they undertake).

Some institutions are very small and each has its individual specialisation (e.g. in methods) and ownership structure. Therefore, there is hardly any overlap in the work undertaken. However, there is no actual body in place to prevent duplications (e.g. in some cases GÖG performs quick assessments/rapid reviews and subsequently, the LBI institute is commissioned to perform an HTA on the same intervention, which constitutes an inefficient policy strategy). There is an informal network of Austrian HTA units, which meets once annually. The event is coordinated by the GÖG, however, the funding provided for coordination activities is limited.

Figure 67: Institutions performing HTAs in Austria

1 Hauptverband der österreichischen Sozialversicherungsträger (HVSV)

- Conducts assessments of out-patient medicines as part of reimbursement decision-making

2 Ludwig Boltzmann Institut (LBI)

- Conducts HTAs on public health interventions; high-tech medicine review (i.e. surgical and diagnostic high tech interventions) is also centralised through LBI

3 Gesundheit Österreich GmbH (GÖG)

- Small unit for assessments for the Minister of Health;
- Third party assessments for other countries, not Austria
- Coordination function for HTA, but not implemented

4 Institute of Public Health, Medical Decision-making and Health Technology der Privaten Universität für Medizinische Informatik und Technik (UMIT)

- Health economics and models
- EU Horizon Scanning

5 Department für Evidenzbasierte Medizin und Klinische Epidemiologie der Donau-Krems Universität (DUK)

- Evidence-based medicine

6 Institut für Allgemeinmedizin und evidenzbasierte Versorgungsforschung (IAMEV)

- HTA on health services research in connection with general practice

In addition to the institutions outlined in the figure above, there are a number of other institutions that have the capacity to undertake evaluations. The table below provides an overview of all institutions with evaluation capacity in Austria, including the type and main source of financing.

Table 28: Institutional evaluation capacity in Austria

Institution	Main financing source	Type of financing	Focus
Austrian Public Health Institute (GÖG)	Ministry of health; Federal Health Agency	Project-based, funding defined on annual budgets	Impact Assessments, Evaluation Studies, (small) HTA reports

Institution	Main financing source	Type of financing	Focus
Austrian Public Health Institute (GÖG) – Sub-branch for planning and research	Länder and Social health insurance institutions (as third-party funders	Project-based (third-party funding based on projects)	Evaluation studies, Impact Assessment
Ludwig-Boltzmann Institute for HTA	Ministry of health; Federal Health Agency, Social health insurance institutions	Project-based, funding defined on annual budgets	HTA reports
Division for EWG at the Main Association	Main Association of social security institutions	Project based, also funding other studies (e.g. framework arrangement with the IHS and Medical University Graz)	Various studies on Evidence and Economic Evaluations
Competence Centre for Health Promotion and Prevention	Main Association of social security institutions and Health insurance institution for railway workers and miners		Evaluation studies
IHS Health Economics and Health Policy	Various stakeholders; Research grants, EC-funding	Framework arrangement with the Main Association; other commissioned work, research grants	Health Services Research, Evaluation Studies
Medical university Graz (Institute for General	Main Association of social security	Basic funding from university, framework	Evaluation studies

Institution	Main financing source	Type of financing	Focus
Medicine and Evidence-based Health) Research	institutions (as third-party funder); research grants	arrangement with the Main Association	
University of Linz (Chair in Health Economics)	Federal Government; Christian Doppler-society	Basic funding and research grants	Various studies in health economics
Medical University Vienna (Chair in Health Economics)	Federal government; EC, LBG	Basic funding and research grants	Economic evaluations and other quantitative studies
Danube-University Krems (Department for evidence-based Medicine and clinical epidemiology)	Land Lower Austria; Austrian stakeholders; EC	Basic funding; commissioned projects research grants	Evaluation studies, EBM reviews
Evaluation commission for pharmaceuticals (HEK)	Main Association of social security institutions	Basic funding and fees for applications	Positive list for the reimbursement of pharmaceuticals
Universities of Applied Science Upper Austria, Burgenland	Länder; other stakeholders	Basic funding, commissioned projects	Various projects in health services research

Good governance principles

Currently, there are no policy reforms on HTA. There are many decentralized decision-makers and there is no effort to create and finance a national HTA institute or an HTA board in order to establish a centralized research institute. Regional decision-makers also seem to prefer to make their own decisions and are against a centralized body. Although promoting efficiency in resource allocation appears difficult

in such a fragmented environment, a number of options exist to improve the coherence, transparency and functionality of the current system and, potentially, help the transition to an independent, arm's length system. These options are examined in turn.

What HTA system for Austria?

The current approach to HTA in Austria is fragmented and, often, non-transparent. Addressing fragmentation would require consolidation or better coordination. The existence of multiple units undertaking HTA is not necessarily a negative development and, most certainly, it is a feature of some insurance-based and/or decentralized health systems. Examples include Italy and Spain in this context. However, all these institutions undertaking HTA could be brought under a formal umbrella and either be consolidated into a hierarchical structure or coordinated more effectively. Addressing non-transparency would require that assessments and appraisals are conducted in a clear, transparent and inclusive manner, whilst ensuring that recommendations are well supported by good evidence and clear reasoning. Deviation from available guidance would require clear reasoning and arguments.

If consolidation and/or more effective coordination could in principle address the issues arising from fragmentation (and potential duplication) and non-transparency, the next question is how such consolidation and effective coordination should take place. A key international trend in this context is a clear preference for independent, arm's length HTA agencies that provide advice to decision-makers. One could, therefore, imagine a transition into an independent, arm's length HTA body that undertakes HTA for different types of technology (pharmaceuticals, medical devices, surgical procedures, etc) and provides advice to the relevant decision-makers concerned. It is clear from the Austrian setting that the decision-makers vary according to the type of technology or indeed the setting in which the technology is being made available. Such coordination/ central function exists already in the context of medical devices, where LBI is taking the lead. A comparable process may need to be generated for pharmaceuticals (both out- and in-patient) and other technologies if this does not exist.

It is not uncommon for the same HTA body to be accountable to or serve different decision-makers, as reflected by the structure of the health care system. In France, for example, HAS is providing advice to health insurers on whether a new product should be reimbursed and is also advising separately the Ministry of Health and the Economic Committee on the pricing strategy based on incremental benefit.

An important set of issues arises from a likely consolidation and coordination and relates to workload and topic selection. This is also related to the HTA process and whether this is going to be a rapid assessment or a full HTA. All these involve important trade-offs. A full HTA may be time consuming and it is certainly

an in-depth assessment of wider costs and benefits from introducing a new technology; it maybe in the interests of Austrian decision-makers to promote a full HTA for a subset of technologies, particularly those that have important resource implications. Formal evaluations should be introduced across costly technologies and a threshold for this purpose should be established. Clarity is therefore needed on topic selection and the choice between rapid assessment and full HTA. International evidence can provide detailed steer on the criteria that can be used for this purpose.

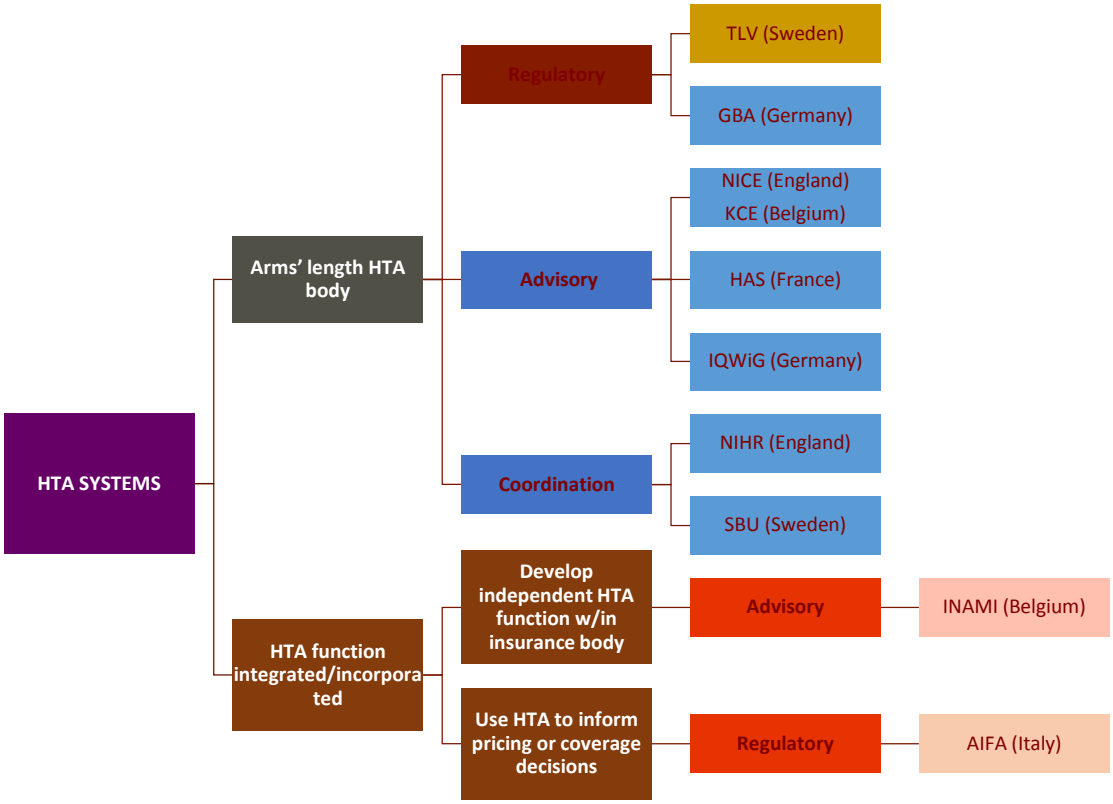
Clarity is also needed on a number of parameters regarding the conduct of HTA, such as type of evidence requirements and the types of evidence that can be admitted into assessment and appraisal; whether the HTA body will commission further evidence generation or conduct its own analysis, or whether it will rely on manufacturer submissions; guidance is needed on the comparators used in assessments; guidance is needed on the methods of assessment and the criteria – beyond costs and effects - that can be used as part of a deliberative process in the appraisal phase; the role of stakeholder involvement, particularly on issues such as scoping of assessments, consultation as part of HTA, review of draft reports, among others; the appeals process and the associated timelines; the timelines for assessment and re-assessment for rapid reviews, full HTAs and multiple HTAs (if applicable); and the monitoring and implementation of decisions.

Clarity is also required on the structure and composition of the relevant committee (Technology Appraisal Committee - TAC) that will review the evidence and make binding funding decisions. The TAC needs to reflect the stakeholder complexity in the context of each technology type, and the national-regional-local trade-offs that exist in different circumstances.

HTA in pharmaceuticals deserves particular mention since it is currently internalized and follows the integrated option in

Figure 68. If an independent, arm's length HTA body is not forthcoming, disclosure of out-patient drug assessments would make the current process more transparent. The introduction of an arm's length HTA body would enhance transparency of process, among other things, and would be a preferred option. In the case of in-patient pharmaceuticals, better coordination needs to take place across regions, including a transparent decision-making process. Again, the independent arm's length HTA body would be better placed to undertake this and coordinate across regions, stakeholders and evidence, although, arguably this may take some time to materialize and build consensus.

Figure 68: Types of HTA systems



Source: Kanavos, 2017.

5.2.5 Harmonisation of benefits in Austria

Differences in benefits

There are four different types of differences in benefits that need to be examined, namely legally defined differences in benefits, statue based differences, de facto differences, and differences in benefits due to contractual policies. The following section will focus on the legal and statute based differences in benefits.

Legally defined differences

Please refer to Volume 2 – Legal Analysis, specifically, sections 3.2.3 to 3.2.5.

Statute based differences

Each insurance fund in Austria specifies a statute (Satzung), which lists the services covered by a fund. Unless the template statue, which is defined by the Main Association of the Social Insurance Carriers, renders a service obligatory, the benefits for some categories of goods and services may differ across funds. These differences are captured in the latest report on the different statue regulations published by the Main Association and are present in the following areas:

- Medical aids
- Therapeutic appliances
- Dental care
  - Orthodontics
  - Dentures
- Sickness payment
- Special sickness payment for inpatient stays
- Public health measures (Tick-borne encephalitis vaccine)
- Cost subsidies in the case that contractual regulations are not present, more specifically lump sum payments for the reimbursement of medical costs
  - Non-medical psychotherapy
  - Ergotherapy
  - Medical home care
  - Physiotherapy
  - Logopedics
  - Freelance massage therapy
  - Medical and therapeutic aids
  - Paediatric nurses
  - Diagnosis through clinical psychologists
  - Other
- Travel (journey) costs
- Transportation costs.

The following section provides an overview of the statute-based differences in benefits across funds (please see Table 29), as well as further descriptions of the differences in benefits for goods or services with significant variations across carriers, including medical aids, therapeutic appliances, dental care, sickness pay, TBE-vaccination, travel (journey) costs, and other services such as psychotherapy,

physiotherapy, ergotherapy and logopedics. It must be noted that in line with §131b (1) ASVG, the allowance amount offered to the insured for using non-contracted services depends on the financial situation of the funds as well as the economic need of the insured, which explains some of the current differences in the size of benefits across funds.

Table 29: Statute-based differences in benefits across insurance funds

Good(s)/Service(s)	**Differences in benefits in-kind/in-cash across the insurance funds**
Medical aids	Allowances vary between the 3- and 8-fold amount of the maximum contribution base of 166 EUR, i.e. between 498 EUR and 1,328 EUR.
Therapeutic appliances	Allowances vary between the 3- and 8-fold amount of the maximum contribution base of 166 EUR, i.e. between 498 EUR and 1,328 EUR. Allowances for therapeutic aids that are suited to replace functions of missing or deficient body parts, vary between 3- and 20-fold amount of the maximum contribution base, i.e. 498 EUR and 3,320 EUR.
Dental care (orthodontics and dentures)	Orthodontics: Patient contribution ranges between 10% and 50% per year of treatment and repair - for contractually agreed tariffs. Funds may reimburse 50% to 100% per year of treatment and repair – for non-contractually agreed tariffs. Some funds, such as the VAEB, BVA, SVA and SVB may reimburse a fixed annual amount for specific treatments. Dentures: Patient contributions for acrylic resin dentures, metal framework dentures, full metal crowns on clip teeth and veneered metal-ceramic crowns for partial dentures and their repairs range from 10% to 50% of the contractually agreed tariff rates.
Sickness payment	The number of weeks covered is between 26 and 78 weeks. Generally carriers cover 52 weeks.
Special sickness payment for inpatient stays	Currently not provided by WGKK, KGKK, TGKK, BVA and BKK Zeltweg.
TBE-vaccine	Allowances range between 2 EUR and 19 EUR.

Good(s)/Service(s)	Differences in benefits in-kind/in-cash across the insurance funds
Travel (journey) costs	Not covered by WGKK, NÖGKK, BGKK, KGKK, TGKK, BKK Wiener Verkehrsbetriebe. The coverage across the remaining carriers ranges between 0.07 and 0.10 EUR per kilometre for journeys without an accompanying persons and between 0.11 and 0.24 EUR per kilometre for journeys with an accompanying person. Some funds include additional criteria for reimbursement, such as specification of the type of service for which journey costs are covered.
Transportation costs	Not all carriers cover the transportation costs and among those that do, allowances may vary. The following carriers do not provide allowances: VGKK, VAEB, BKK Mondi, and BKK Zeltweg. A number of carriers do not provide allowances, except for in specific circumstances or cover a specific percentage of the tariff cost: NÖGKK, BVA and SVA. The remaining funds offer allowances per route equal to the amount of the prescription charge. However, some funds may specify conditions, or provide allowances that are twice as high as the prescription charge.
Reimbursement of non-contracted services: Non-medical psychotherapy	E.g. allowances range between 8.72 EUR and 15 EUR for 30 min sessions. There are additional differences in contingents of benefits in kind.
Ergo therapy	E.g. allowances range between 12.72 EUR and 29 EUR for 30-minute sessions. There are additional differences in contingents of benefits in kind.
Physiotherapy	Differences in the reimbursement of single vs. group sessions and in the type of therapies, in addition to differences in allowances. There are additional differences in contingents of benefits in kind.
Logopedics	Covered by BGKK, BKK Kapfenberg, BKK voestalpine Bahnsysteme, BKK Zeltweg, and SGKK. Allowances range between 14.53 EUR and 22.09 EUR for a 30-minute session.

Good(s)/Service(s)	Differences in benefits in-kind/in-cash across the insurance funds
Medical home care	Not covered by StGKK, TGKK, BKK voestalpine Bahnsysteme, BKK Zeltweg, BKK Kapfenberg. The allowances across the remaining carriers vary between 4.36 EUR and 8.72 EUR per visit.
Freelance massage therapy	All carriers, except for the SGKK, TGKK, VGKK and the SVA, have adopted the allowance amount for freelance massage therapy, as specified in the template statute. The remaining carriers have specified different allowances and/or may cover additional services, such as lymph drainage.
Medical and therapeutic aids	Not covered by SGKK, TGKK, VGKK. Some funds cover between 75% and 80% of the billing amount, deducting the patient contribution. Other carriers define benefits on a case-by-case basis or set the amount of the allowance equal to a comparable tariff service.
Paediatric nurses	Not covered by WGKK, NÖGKK, BGKK, OÖGKK SGKK, VAEB, SVA, SVB, BKK Wiener Verkehrsbetriebe. The coverage across the remaining insurance funds ranges between 4.36 EUR and 12 EUR during the day per case and day of care.
Diagnosis through clinical psychologies	Partial coverage of 14.53 EUR only available for VGKK and BKK Wiener Verkehrsbetriebe.
Other	In addition to the above listed types of services, there are several other services, for which some of the funds offer benefits. These services include, e.g. acupuncture, midwife consultations, sonography, and CT-guided nerve root infiltration.

1. Medical aids

Medical aids are regulated through §137 ASVG and include, among others, glasses, contact lenses, orthopaedic arch support, trusses and wheelchairs. The coverage for this category of goods varies substantially between carriers, with differences in benefits being legally defined with reference to the statute. For instance, §137 (5) stipulates that insurance carriers cannot bear costs for medical aids that

exceed a ceiling amount defined in the carrier's statue. The statute can either define a uniform ceiling for all medical aids or different ceilings for specific types of medical aids, however, as stated in §108 (3), the ceiling may not exceed the 10-fold amount of the maximum contribution base (*HBG*) of 166 EUR, which amounts to 1,660.00 EUR and refers to the monthly demand.

In the case of allowances for medical aids, the template statute provides for a bandwidth that ranges between the 3- and 8-fold amount of the maximum contribution base of 166 EUR, i.e. between 498 EUR and 1,328 EUR. However, in the case of contact lenses the lower bandwidth may be decreased to e.g. the 1-fold amount of the maximum contribution base. This translates into some of the funds bearing costs that are three times the amount of the maximum contribution base, such as the WGKK, NÖGKK, StGKK, KGKK, and TGKK, while other funds, including ÖOGKK, SGKK, VGKK, VAEB, BVA, SVA and SVB cover the 8-fold amount of the maximum contribution base, amounting to a difference of up to 830 EUR per insured person (please see the table below for a detailed list).

Table 30: Differences in the coverage of costs of medical aids across insurance funds

Insurance carrier	**Ceilings for the coverage of medical costs** (based on the maximum contribution base (HBG) of 166 EUR)	**Ceilings for appropriate repairs**
WGKK NÖGKK StGKK KGKK TGKK BKK Kapfenberg	3-fold amount of the HBG	3-fold amount of the HBG
BKK Wiener Verkehrsbetriebe	4-fold amount of the HBG	4-fold amount of the HBG
BGKK	5-fold amount of the HBG	5-fold amount of the HBG
OÖGKK SGKK VGKK* VAEB BVA SVA SVB BKK Mondi BKK voestalpine Bahnsysteme BKK Zeltweg	8-fold amount of the HBG	8-fold amount of the HBG *5-fold amount of the HBG

In addition, it should be noted that the user charges differ between the fund for the self-employed (i.e. SVA), which is regulated through the GSVG, and all other funds. As such, the user charges for SVA-insured

persons amount to 20% of the medical aids costs (at least 20% of the maximum contribution base (HBG), i.e. 33.20 EUR; at least 60% of the maximum contribution base (HBG), i.e. 99.60 EUR for visual aids), while those of all other funds amount to 10% of the medical costs (at least 20% of the maximum contribution base (HBG), i.e. 33.20 EUR; at least 60% of the maximum contribution base (HBG), i.e. 99.60 EUR for visual aids).

2. Therapeutic appliances

As stipulated in §154 ASVG, allowances for therapeutic appliances in the case of mutilations, disfigurement and physical deficiency may be specified in the statue insofar as there is no claim from the statutory accident insurance or entitlement to benefits in kind as part of the medical rehabilitation measures. Both the federal states or the social insurance can be in charge of the coverage of therapeutic aids, and depending on the case, responsibility may be borne by the accident, pension or health insurance. Thus, the law does not provide for benefits in kind, except in the case of medical rehabilitation. In practice, however, there are in some cases contracts for benefits in kind that define tariff rates, although levels of patient contributions may vary across carriers.

Similarly to medical aids, the allowances for this category of goods vary substantially between carriers, with differences in benefits being legally defined with reference to the statute. The allowance comes to 90% (80% in the case of the SVA) of the medical costs, however, it cannot exceed the ceiling amount specified in the statute. Since 2016, this ceiling ranges between the 3- and 8-fold amount of the maximum contribution base of 166 EUR, i.e. between 498 EUR and 1,328 EUR. However, in the case of therapeutic aids that are suited to replace functions of missing or deficient body parts, the ceiling can vary substantially between funds, ranging between the 3- and 20-fold amount of the maximum contribution base of 166 EUR, i.e. between 498 EUR and 3,320 EUR. For instance, regional funds such as the WGKK and TGKK provide allowances of up to 498 EUR, while the NÖGKK, ÖOGKK and SGKK can provide benefits in cash of up to 3,320 EUR (please see the table below for a detailed list), amounting to a difference of up to 2,822 EUR between some funds

Table 31: Differences in the provision of allowances for general therapeutic appliances across insurance funds

Insurance carrier	**Ceilings for the provision of allowances for general therapeutic aids** (based on the maximum contribution base (HBG) of 166 EUR)
WGKK NÖGKK TGKK	3-fold amount of the HBG

Insurance carrier	Ceilings for the provision of allowances for **general therapeutic aids** (based on the maximum contribution base (HBG) of 166 EUR)
BKK Kapfenberg	
BKK Wiener Verkehrsbetriebe	4-fold amount of the HBG
StGKK	4.5-fold amount of the HBG
BGKK KGKK	5-fold amount of the HBG
OÖGKK SGKK TGKK VGKK VAEB BVA SVA SVB BKK Mondi BKK voestalpine Bahnsysteme BKK Zeltweg	8-fold amount of the HBG

Table 32: Differences in the provision of allowances for specific therapeutic aids across insurance funds

Insurance carrier	Ceilings for the provision of allowances for **therapeutic aids that are suited to replace functions of missing or deficient body parts** (based on the maximum contribution base (HBG) of 166 EUR)
WGKK TGKK BKK Kapfenberg	3-fold amount of the HBG
StGKK	4.5-fold amount of the HBG
BGKK	5-fold amount of the HBG
KGKK	7-fold amount of the HBG
SVA	8-fold amount of the HBG
NÖGKK OÖGKK SGKK VGKK VAEB BVA SVB BKK Wiener Verkehrsbetriebe BKK Mondi	20-fold amount of the HBG

Insurance carrier	Ceilings for the provision of allowances for therapeutic aids that are suited to replace functions of missing or deficient body parts (based on the maximum contribution base (HBG) of 166 EUR)
BKK voestalpine Bahnsysteme BKK Zeltweg	

3. Dental care

The statutes pertaining to dental care are for the most part harmonised across funds and there is a nationwide uniform contract and fee schedule for conservative surgical services. In addition, since 2015 all children and adolescents until the age of 18, who suffer from severe tooth displacements (=IOTN-4 and IOTN-5), are eligible for free dental braces, regardless of their fund affiliation. However, in the case of orthodontics for adults or dentures there may be significant differences in patient contributions or allowances across funds, as specified in the statutes. For instance, patient contributions for orthodontic services for insured persons over the age of 18 may range between 10% and 50% of the contractual tariff rate. In case of treatments without contractually agreed tariffs, insurance funds may reimburse 50% to 100% of the treatment or repair costs. In addition, some funds, such as the VAEB, BVA, SVA and SVB may reimburse a fixed annual amount for specific treatments. Please see the table below for further reference.

Table 33: Differences in patient contributions for orthodontic treatments (excluding repairs) with contractually agreed tariffs across insurance funds

Insurance carrier	Patient contributions as a percentage of the contractually agreed tariff rate per treatment year
WGKK NÖGKK BGKK OÖGKK StGKK KGKK SGKK TGKK SVA SVB (IOTN < 4) BKK Wiener Verkehrsbetriebe BKK Kapfenberg	50%
BKK Zeltweg	35%
VAEB	30%
VGKK*	*(max. 30%)

BKK Mondi BKK voestalpine Bahnsysteme	25%
SVB (IOTN > 4)	20%
BVA	10%

When it comes to dentures, similar differences across funds prevail. For example, patient contributions for acrylic resin dentures, metal framework dentures, full metal crowns on clip teeth and veneered metal-ceramic crowns for partial dentures and their repairs range from 10% to 50% of the contractually agreed tariff rates. Table 34 provides an overview of the differences across carriers for acrylic resin dentures as an example.

Table 34: Differences in patient contributions for acrylic resin dentures (excluding repairs) with contractually agreed tariffs across insurance funds

Insurance carrier	Patient contributions as a percentage of the contractually agreed tariff rate per treatment year
WGKK NÖGKK KGKK TGKK BKK Wiener Verkehrsbetriebe BKK Kapfenberg	50%
StGKK	40%
BKK Zeltweg	35%
VAEB	30%
BGKK OÖGKK SGKK VGKK* SVB BKK Mondi BKK voestalpine Bahnsysteme	25% *(max. 25%)
SVA	20%
BVA	10%

4. Sickness payment

In the event of illness-related incapacity to work, all insurance carriers, except for the SVA, provide sickness benefits for up to 52 weeks. In addition, the ÖOGKK, VAEB, BKK Mondi, BKK voestalpine Bahnsysteme and BKK Zeltweg allow for the possibility to extend sickness pay from 52 to 78 weeks, while the BVA offers to pay a maximum of 78 weeks of sickness benefit to all of its insured persons. In contrast,

the SVA offers a support benefit starting on the 43rd day of work absence and which is paid for a maximum of 20 weeks. This benefit amounts to 29.46 EUR per day. In addition to this support benefit, the SVA may cover up to 26 weeks of sick pay in the case of voluntary supplementary insurance. Insured persons pay a 2.5% contribution rate and can make use of the benefit once the individual has been four days absent from work. The extension of sickness benefit from 52 weeks to a maximum of 78 weeks can be achieved through a change in the statue (please see Table 35 for an overview of the differences across carriers).

Table 35: Differences in the coverage of sickness payment across insurance carriers

Insurance carrier	Maximum duration of the provision of sickness payment
SVA (*Only with supplementary insurance)	26 weeks
WGKK NÖGKK BGKK StGKK KGKK SGKK TGKK VGKK BKK Wiener Verkehrsbetriebe BKK Kapfenberg	52 weeks
OÖGKK VAEB BKK Mondi BKK voestalpine Bahnsysteme BKK Zeltweg	52 (-78) weeks
BVA	78 weeks

5. Special sickness payment for inpatient stays

In the case of necessary, inevitable inpatient stays[47] at hospitals, as well as rehabilitation centres as part of the follow-up treatment, ten of the health insurance carriers pay special sickness benefits, while five do not provide the benefit (please refer to the table below for an overview).

[47] The entitlement to special sickness benefits for inpatient stays is subject to further regulations. Please refer to §30 of the insurance fund statutes.

Table 36: Differences in the coverage of special sickness payment for inpatient stays across insurance carriers

Insurance carrier	Benefit provided for in the statute
NÖGKK BGKK OÖGKK StGKK SGKK VGKK VAEB BKK Mondi BKK voestalpine Bahnsysteme BKK Kapfenberg	Yes
WGKK KGKK TGKK BVA[48] BKK Zeltweg[49]	No

6. Public health measures: TBE-vaccine

Health insurance funds provide allowances for the insured and their dependents for the costs of tick-borne encephalitis (TBE-) vaccine, which may range between 2 EUR and 3.70 EUR across regional funds, between 3.70 EUR and 16 EUR for national funds and between 2 EUR and 19 EUR across all insurance carriers (please see the table below for an overview of the different allowances across funds).

Table 37: Differences in the allowances of TBE-vaccination across insurance carriers

Insurance carrier	Allowance in EUR for the TBE-vaccination
WGKK	2.00 EUR
NÖGKK OÖGKK TGKK VGKK BKK Wiener Verkehrsbetriebe	3.63 EUR
BGKK StGKK KGKK SGKK SVA	3.70 EUR

[48] Implementation of special sickness pay is not appropriate.
[49] Implementation of special sickness pay is planned.

Insurance carrier	Allowance in EUR for the TBE-vaccination
BKK Kapfenberg	7.30 EUR
VAEB	10.00 EUR
BKK voestalpine Bahnsysteme	12.50 EUR
BKK Zeltweg	15.00 EUR
BVA	16.00 EUR
SVB*	(*max. 80% of the actual costs)
BKK Mondi	19.00 EUR

7. Travel (journey) costs

A number of regional funds do not cover travel journey costs (please see Table 10 for a detailed overview). With the exception of SVB and BKK Zeltweg, the remaining funds offer reimbursement at 0.09 EUR per kilometre for journeys without an accompanying person and 0.14 EUR per kilometre for journeys with accompanying persons. The SVB offers 0.10 EUR per kilometre, however, this is only applicable to journeys for preventive check-ups and public health measures for ill health prevention. Furthermore, the SVB does not pay benefits in the case of journeys with an accompanying person

Table 38: Differences in the coverage of travel (journey) costs across carriers

Insurance carrier	Allowance in EUR per kilometre for journeys without an accompanying person	Allowance in EUR per kilometre for journeys with an accompanying person
WGKK NÖGKK BGKK KGKK TGKK BKK Wiener Verkehrsbetriebe	No	No
SVA	0.07 EUR	0.11 EUR
OÖGKK StGKK VGKK VAEB BVA* BKK voestalpine Bahnsysteme BKK Kapfenberg	0.09 EUR *(max. of 0.09 EUR)	0.14 EUR *(max. of 0.14 EUR)
BKK Zeltweg SVB (*only for preventive check-ups and public health measures for ill health prevention; does not pay benefits in the case of journeys with an accompanying person.)	0.10 EUR	0.15 EUR

8. Psychotherapy, physiotherapy, ergotherapy and logopedics

The statute outlines differences in benefits for psychotherapy, physiotherapy, ergotherapy and logopedics provided by non-contracted health professionals. As such differences can be found in the reimbursement of single vs. group sessions and in the type of therapies, and allowances. For instance, allowances for ergotherapy range between 12.72 EUR and 29 EUR for 30-minute sessions, and between 8.72 EUR and 15 EUR for 30-minute psychotherapy sessions (excluding psychologists). Allowances for logopedics treatments at non-contracted health professionals are currently provided by BGKK, SGKK, BKK Kapfenberg and BKK voestalpine Bahnsysteme only. However, it must be noted that allowances for non-contracted health professionals may correspond to the level of benefits-in-kind provided by the respective carriers, which depend on the number of health professionals they have contracts with. Therefore, a high allowance for non-contracted professionals may also imply lower benefits-in-kind. Hence, there are additional differences in contingents of benefits in kind, which are not captured in the statutes and which need to be examined, in order to harmonise benefits for these services.

Cost of harmonising benefits across funds

Methodology

The scope and level of per capita expenditures for the use of statute-defined benefits vary across funds and types of services. However, these differences in expenditure do not necessarily reflect cross-carrier differences in benefits, as there are number of additional factors that can influence the former, including the risk structure of the insured population, variations in tariffs, differences in entitlement to benefits, authorisation regimes, service form and quantity. As such, a higher per capita expenditure does not necessarily imply better benefits for the insured, and individual-based data may constitute a more sophisticated basis for an analysis of differences in risk structures and benefits across carriers. However, due to data limitations, this study proceeds with a comparison based on cross-carrier variations in per capita expenditures.

The following section highlights differences in the per capita expenditures across carriers for medical aids, therapeutic devices and dentures, using data from the official income statements of carriers for the year 2015 that are provided by the Main Association of the Social Insurance Carriers. Data for psychotherapy, physiotherapy and logopedics was obtained from the HVSVs *Einzelnachweisung ärztlicher Hilfe* for the year 2015 and the average per capita expenditures include both contracted and non-contracted health professionals. In order to estimate the initial costs of harmonisation for specific goods or services, unadjusted and risk-adjusted calculations were performed.

For the unadjusted calculations, we present the range and average of per capita expenditures for benefits-in-kind and in cash across funds. Following, we introduce a number of different expenditure floors and increase the per capita expenditure (PCE) of those funds, where expenditure levels are below the newly defined floor. However, if a fund's per capita expenditure is greater than that of the newly introduced floor, then the fund's expenditure levels are not lowered. These artificial per capita expenditures of a fund are then multiplied with the number of insured persons in order to obtain an estimate of the total expenditure of a carrier for a good or service when levels of benefits are raised.

Two different floors were employed for this exercise: (1) the average expenditure across all funds and (2) 70% of the highest per capita expenditure within a category of goods or services. At last, the total floor-based expenditures are aggregated across funds and compared to the present overall expenditures for specific goods or services. The difference between those two overall expenditures constitutes a basic bandwidth estimation of the cost of increasing benefit levels, which would resemble a partial or complete harmonisation of services across funds, depending on the type of artificial floor used for the calculation (please see Table 39 for results).

However, a number of limitations prevail. For instance, it must be noted that the income statement includes data on dental treatment and dentures, however, does not specify the costs of orthodontic care. Therefore, the present calculations only refer to the cost of harmonising dentures across funds. Furthermore, the cost of harmonising allowances for transportation costs were not included due to significant regional and geographical differences in proximity to health care facilities, which may undermine actual differences in per capita expenditures. In addition, recent policy developments have taken into consideration the differences in benefits for transportation costs and include the aim to harmonise patient contributions for transportations pertaining to specific treatments, including chemotherapy, radiotherapy, dialysis and emergency transport, among others.

Similarly, the costs of harmonising sickness pay were excluded, as not only the social insurance entitlements, but also the labour law entitlements vary across carriers. Hence, merely extending the duration for which insured are entitled to social insurance sickness pay would not take into account variations in labour law entitlements, which may explain differences in the duration of sick pay entitlements. In addition, some funds offer to pay allowances for a longer time period due to the low number of insured patients applying for the benefit. Last, it must me emphasised that the cost bandwidths are based on unadjusted calculations that do not take into account any of the previously mentioned influencing factors, such as risk structures and variations in tariffs. Thus, the higher expenditure floors

may over- or underestimate actual costs and are not necessarily synonymous to efficient levels of expenditure.

Therefore, where possible, a sensitivity analysis is performed in which per capita expenditures of funds are risk-adjusted for age and gender. First, the total expenditures for specific goods or services are calculated for each risk group within the respective carriers. As this information is not available in the income statements, the distribution of total expenditures across age and gender groups for medical aids and therapeutic appliances is derived from the LIVE dataset, which enables the calculation of age-and gender-adjusted per capita expenditures. The LIVE database is a product that collects information on the costs of the health insurance benefits used by the insured, who receive a yearly statement on the former. The data encompasses all carriers except for the SVA and VAEB, who run separate systems to collect data in order to inform their members about the annual use of benefits. Following, the risk-adjusted per capita expenditures are raised to one of the two artificial floors, as previously described.

However, there are limitations to this sensitivity analysis. For once, it is noteworthy that total expenditures for the same category of goods or services differ between these two datasets. For example, the income statement reports a total expenditure of 729,111,510 Mio for dental care and dentures, while 702,601,048 Mio are reported in LIVE. On the other hand, the total expenditure for medical aids and therapeutic appliances is with 494,808,415 Mio significantly higher in LIVE compared to the 191,691,415 Mio reported in the income statement, despite not even including data for the SVA and VAEB. Therefore, the LIVE distribution of expenditures across age and gender may not reflect the actual distribution corresponding to the income statement. Furthermore, LIVE data on distributions of use across risk groups are only available for medical aids and therapeutic, as the remaining categories do not apply to the previously identified statue-based differences. Last, the per capita distributions across risk groups for dental care combine both dental care and dentures in LIVE. Given that the focus lies on dentures only and that the per capita distribution for dental care is most likely to differ significantly from that of dentures, no risk-adjustment is performed.

In addition, there are a number of other population risks that may exacerbate variations in per capita expenditures and which ought to be adjusted for, such as income levels and employment status. Furthermore, there are several additional factors that should be accounted for besides the risk structure of the insured population, in order to approximate the actual costs of harmonising benefits. Therefore, a risk-adjustment that accounts for the effects of age and gender on per capita expenditures may somewhat

improve cost estimations of harmonising benefits, however, it is not sufficient to approximate actual costs.

Results

As presented in Table 39, the per capita expenditures for medical aids and therapeutic appliances, dentures, psychotherapy, physiotherapy and logopedics vary significantly between funds. However, as previously emphasised, the differences may be due to several factors that cannot be accounted for in the present calculations, such as risk structure of the insured population, variations in tariffs, differences in entitlement to benefits, authorisation regimes, service form and quantity, and therefore should be considered with caution.

Following the introduction of two artificial expenditure floors, an unadjusted cost of harmonising benefits across specific goods and services was calculated (please refer to Table 40 and Table 41 for the cost of harmonising benefits). The initial calculations, which do not account for a number of significant influencing factors, may provide an initial guidance to approximate costs of a partial harmonisation, however, the results may deviate to a significant extent from the actual costs, unless further adjustments are made. Based on the initial calculations, raising the per capita expenditure (PCE) of those regional funds whose PCE lies below the average PCE-level of all funds, would come at a cost of EUR 148.653.819 Mio, while raising the PCE of all carriers to the average PCE is estimated to cost EUR 171.075.130.

In comparison, increasing per capita expenditures to a level that equals 70% of the currently highest PCE could come at a cost that is approximately 2.2 times higher than the cost of introducing the artificial floor 1. For instance, raising the PCEs of funds that currently have an expenditure level below floor 2 is estimated at a cost of EUR 327.763.167 Mio and EUR 390.117.440 Mio, when harmonising across regional funds and across all funds respectively (please see Table 42).

Furthermore, when taking into account the age and gender risk-structures of the funds (except for SVA and VAEB, as data is not included in LIVE) for medical aids and therapeutic appliances, the estimated costs of harmonising benefits deviate from the unadjusted calculations, ranging between an additional EUR 3.9 and 6.6 Mio. Cost may further deviate if calculations are adjusted for additional risks, such as income, and for the remaining goods and services other than medical aids and therapeutic appliances. Please see Table 40 and Table 41 for an overview of the cost of a partial harmonisation.

Overall, the present total expenditure for the described goods and services is estimated to increase between 0.194% (floor 1) and 0.428% (floor 2) if benefits are harmonised across regional funds only, and

between 0.223% (floor 1) and 0.509% (floor 2) if goods and services are expanded across all health insurance carriers. However, as previously mentioned, these values need to be cautiously examined due to the presence of other influencing factors that could not be accounted for. Please see Table 43 and Table 44 for a detailed overview of the total expenditures across different floors post harmonising benefits.

Table 39: Per capita expenditures for different goods and services

Type of good/service	Medical aids and therapeutic appliances	Dental care (Dentures only)	Psychotherapy	Physiotherapy	Logopedics
Range of the per capita expenditure across all funds	16.3 – 54.4	20.8 – 60.3	1.2 – 11.3	6.9 – 44.5	0.5 – 3.3
Average per capita expenditure across all funds	30.4	33.2	4.3	20.6	1.9
Average per capita expenditure across regional insurance funds	26.6	25.8	6.1	16.2	1.8

Table 40: Estimated costs of harmonising benefits for specific goods and services across regional funds

Type of good/service	Medical and therapeutic aids	Dental care (Dentures only)	Other health care services (psychotherapy, physiotherapy, logopedics)
Floor 1: average PCE across all funds	€32.582.895	€51.750.530	€64.320.393
Risk-adjusted (age and gender)	*€38.496.056*		
Floor 2: 70% of the highest PCE across all funds	€79.855.873	€114.931.717	€132.975.577
Risk-adjusted (age and gender)	*€86.412.726*		

Table 41: Estimated costs of harmonising benefits for specific goods and services across all insurance funds

Type of good/service	Medical and therapeutic aids	Dental care (Dentures only)	Other health care services (psychotherapy, physiotherapy, logopedics)
Floor 1: average PCE across all funds	€39.190.971	€58.520.453	€73.363.706
Risk-adjusted (age and gender)	*€45.104.132*		
Floor 2: 70% of the highest PCE across all funds	€98.316.345	€130.888.706	€160.972.388
Risk-adjusted (age and gender)	*€102.229.448*		

Table 42: Estimated costs of harmonising a number of specific benefits across insurance carriers

	Total cost of harmonising benefits **across regional funds** in EUR	Total cost of harmonising benefits **across all funds** in EUR
Floor 1: average PCE across all funds	**€148.653.819**	**€171.075.130**
Risk-adjusted (age and gender)	*€154.566.980*	*€176.988.291*
Floor 2: 70% of the highest PCE across all funds	**€327.763.167**	**€390.177.440**
Risk-adjusted (age and gender)	*€334.320.020*	*€394.090.543*
Current expenditure for the specified benefits	**€765.736.932**	

Table 43: Total expenditure and change in expenditure after a harmonisation of specific benefits across regional funds only

	Total expenditure for the specified benefits post-harmonisation	Percentage change in expenditure of SHI
Floor 1: average PCE across regional funds	**€914.390.742**	**↑19.4%**
Risk-adjusted (age and gender)	*€920.303.903*	*↑20.1%*
Floor 2: 70% of the highest PCE across all funds	**€1.093.500.090**	**↑42.8%**
	€1.100.056.943	*↑43.6%*

	Total expenditure for the specified benefits post-harmonisation	Percentage change in expenditure of SHI
Risk-adjusted (age and gender)		

Table 44: Total expenditure and change in expenditure after a harmonisation of specific benefits across all funds

	Total expenditure for the specified benefits post-harmonisation	Percentage change in expenditure of SHI
Floor 1: average PCE across regional funds	**€936.812.053**	**↑22.3%**
	€942.725.214	*↑23.1%*
Risk-adjusted (age and gender)		
Floor 2: 70% of the highest PCE across all funds	**€1.155.914.363**	**↑50.9%**
	€1.159.827.466	*↑51.4%*
Risk-adjusted (age and gender)		

5.2.6 Policy options: Harmonising benefits

The aim of a harmonisation of benefits is to provide equal access to a comprehensive set of qualitative (state of the art) goods and services to all insured persons, irrespective of their association with an insurance fund. This refers in particular to the regional funds, for which contribution rates are already harmonised, as well as the care system of the federal and regional public servants and company funds. In consideration of the differences in benefits that are perceived and criticised by the insured community, a decree was issued by the Trägerkonferenz in October 2016, followed by a set-up of a working group to address the present variations in benefits across health insurance carriers. The working group has identified 23 goods and services that are to be harmonised in a gradual manner, of which the following eleven goods and services are to be addressed in the first phase: TBE-vaccine, PSA test, transportation

costs (i.e. patient contributions), endovaginal sonography, wheelchairs, absorbent incontinence products (e.g. diapers and pads), blood glucose test strip, FreeStyle Libre, orthodontic services, sickness pay (i.e. family allowances) and special sickness pay for inpatient stays.

Furthermore, a report was published as part of the Trägerkonferenz on 13 June, in which carriers have agreed to expand the provision of benefits for psychotherapeutic services by one-fourth. The aim is to extend provision of care from 65,000 patients in 2015 to more than 78,000 patients in 2019 and to grant access to multi-professional health care facilities for an additional 3,500 children and adolescents. Although each carrier specifies their own targets for psychotherapeutic services, the recent developments provide a good example of cross-carrier coordination efforts to define and aspire towards a common goal of extending and to some extent harmonising the provision of benefits to the insured.

These developments are central to improving access to and provision of goods and services, and ought to be gradually expanded across other areas, where differences persist. This chapter has described a number of such areas, including legally and statue based differences in benefits across funds that are identifiable and of relevance to the insured. For instance, significant variations exist in the coverage of costs of medical aids and therapeutic appliances, patient contributions and allowances for dentures and orthodontics, the maximum duration for which sickness pay is granted and allowances for other services such as psychotherapy, physiotherapy, ergotherapy, and logopedics.

In addition to identifying areas for harmonisation, the financial impact on insurance carriers needs to be assessed as well. This study has attempted to provide initial cost estimations by introducing a number of expenditure floors to raise and concurrently harmonise the level of benefits in form of per capita expenditures across funds, by increasing the expenditure levels of those funds that are e.g. below the average per capita expenditures. Although the estimated costs need to be considered with caution, as there are a number of influencing factors that could not be accounted for due to data limitations (e.g. variations in tariff rates), the estimated cost bandwidths may provide initial insights into the possible financial impact on insurance carriers and may guide the prioritisation of categories of goods and services that are to be harmonised in the initial stages. In addition, it is highly suggested to take into consideration and perform additional studies that account for influencing factors, such as tariff rates, population risk-factors and volume, in order to further assess and determine actual differences in benefits and to approximate the true costs of a harmonisation.

Furthermore, a unified collection of high-quality data that is comparable across funds is of central importance to supporting the harmonisation of benefits. Although there have been significant

developments in recent years to improve the quality of data, a number of limitations prevail that may undermine cross-carrier comparability. For once, billing periods, which can be monthly or quarterly, differ across funds and consequently produce incomparable data. Moreover, the relatively large number multiple insured obscures expenditure ratios. Therefore, further efforts are required to ensure uniform data storage and structure. One example would be to extend the LIVE database to the SVA and VAEB, in order to collect comprehensive and comparable information on expenditures across risk classes, such as age and gender.

The harmonisation of benefits across areas of concern to the insured is an important step forward and one that needs to be gradually continued. However, in the longer-term evidence-based mechanisms, such as health technology assessments, should be employed and fostered to define benefits packages, in order to inform reimbursement and coverage decisions that promote and extend the provision of (cost-) effective, safe and qualitative goods and services, while simultaneously ensuring the financial sustainability of the health care system.

In addition to harmonising benefits, there are other areas that need to be considered and addressed as part of the aim to improve equity and access to care. For instance, these include structural inequalities due to current contracting policies and the availability of resources.

Legal considerations

Most of the distinctions between the different branches of the Austrian health care system with respect to services and benefits in kind could be harmonised by legal acts passed by the national Parliament (even without a 2/3-majority). This would be possible as long as there is no intensive and/or sudden reduction compared with the entitlement as it was before, which would be a violation of the constitutional principle of 'Vertrauensschutz'.

Legal interventions aiming to harmonisation of benefits could be a problem, too, as far as existing collective agreements (e.g. those with the Chambers of Physicians) are concerned. Such interventions can be justified under constitutional law, however, by 'public interest', (which could be assumed basically with respect to harmonisation measures) as long as the respective intervention is appropriate

From a legal point of view the easiest way of harmonisation could be pursued by the different health insurance carriers themselves by coordinating their respective 'Satzungen' which would be possible with regards to all services and benefits that are not strictly determined by legislation.

The same applies to the 'Mustersatzung' released by the 'Hauptverband', which is authorised to declare certain (but – at present – not all) provisions of that Mustersatzung as binding. Harmonisation measures could be pursued most of all by widening the scope of those binding provisions as laid down in the Mustersatzung by covering all health insurance carriers which is subject, though, to unanimity in the 'Trägerkonferenz', and thus, requiring the consent of all carriers.

Harmonisation with respect to the 'Krankenfürsorgeanstalten' is much more difficult as they are based on regional law which is under the competencies of the Regional Parliaments ('Landtage'). So covering the KFAs, too, would require an amendment to the Federal Constitution or at least coordinated legal acts passed by each Landtag.

(For details see Volume 2 chapter 3.3.).

Summary of policy options: Harmonisation of benefits

With the aim to initiate a process of harmonisation of benefits in Austria, recent developments have focused on a select choice of 23 goods and services that are to be adjusted across insurance carriers in the coming future. Building on these developments, this study has provided an initial estimation of costs for three broad categories of goods or services, which differ in the scope and level of per capita expenditures across insurance funds. However, a main driver of these cross-carrier variations constitutes the difference in tariffs. Therefore, further studies need to be conducted that account for this influencing factor.

While this study provides initial cost calculations, the harmonisation of benefits is a political decision to be taken by the government and stakeholders. Even though a harmonisation of benefits is central to ensuring equity, it is noteworthy that Austria has one of the lowest levels of unmet need in Europe, as identified in an international analysis of trends in Chapter 3 of this report. Although some European countries have more comprehensive and uniform benefits packages, they have experienced higher levels of unmet medical need than in Austria. This is because there are a number of other important factors to equity, including access to care and the level of user charges, which are not considered major challenges within the Austrian environment.

There are a number of financing options in the case of a political decision to harmonise benefits. (1) Partial funding could ensue through a risk-adjustment scheme, or enhanced risk-adjustment scheme, as outlined in the options in section 4.2.7 (2) Alternatively, or in addition, government funds could be directed to

insurance carriers that offer a slightly less comprehensive benefits package compared to other funds. (3) Further funds could be directed to the project by improving efficiency in the system. For instance, a reduction in hospitalisations could lead to significant savings. However, significant investments in outpatient and primary care are required in the first instance to maintain high-quality care, whilst simultaneously reducing hospital admissions, meaning that savings to be used for a harmonisation could be generated in the mid- to long-term. (4) In addition, better coordination and consolidation could also lead to efficiency gains, which could be directed in the form of savings to increase coverage of benefits in Austria.

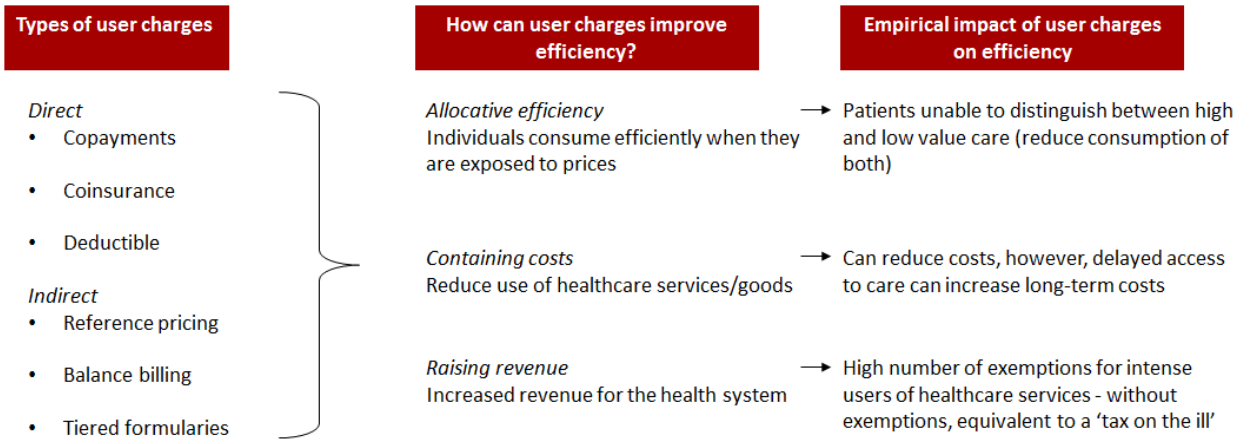
5.3 User charges

Cost-sharing, theoretically, can improve healthcare efficiency through three main channels (see Figure 69). First, by exposing the patient to price, a rational individual will only consume care that is of high-value and cost-effective. As outlined within Gemmill *et al*. (2008), any reduction in consumption of healthcare as a result of user charges is seen to contribute to allocative efficiency, irrespective of the impact on vulnerable groups and health outcomes (182). Second, a reduction in healthcare consumption due to user charges assists in containing expenditure. Third, user charges can raise revenue if they are set at a rate that does not significantly deter utilisation. This last argument is more relevant in low-income countries where public funds may not be sufficient to supply adequate levels of healthcare. In such settings, injections from private resources can improve overall health, given vulnerable groups are exempt (182).

Despite the above three arguments, there is increasing empirical evidence[50] to suggest user charges may have the opposite effect. In regard to improvements in allocative efficiency, research has shown that patients do not have the knowledge to distinguish between high- and low-value care, leading to a reduction in both necessary and unnecessary care. By delaying or forgoing necessary care, patient outcomes are likely to worsen, therefore leading to greater long-term healthcare costs. Lastly, the ability of user charges to raise revenue is limited by exemption policies, which are needed to protect vulnerable groups (e.g. elderly and/or chronically ill). Specifically, since vulnerable groups consume a disproportionally greater amount of healthcare services, user charges are unlikely to significantly impact revenue. Without exemptions, user charges would effectively act as a 'tax on the ill' (182).

[50] Evidence and aligning references included in the remainder of the report.

Figure 69: Efficiency argument for user charges



Source: Adapted from (182)

As outlined above, there is limited evidence on the positive impact user charges have on efficiency. Instead of abandoning cost-sharing, policy-makers have instead begun to link user-charges with incentives to encourage a reduction in low-value care only (i.e. value-based user charges) (183). Given the patient's lack of medical knowledge, this translates into taking the decision of what is considered high-value care away from patients and to external experts. A number of countries across Europe and the US currently employ various forms of value-based user charges, which are most common within the outpatient drug market (183).

The remainder of this section explores the types of user charges, case studies in the European context, the impact of user charges, value-based user charges, and concludes with an overview of policy options.

5.3.1 Types of user charges and incentives

User charges can be applied to patients directly, which requires a financial payment for certain health care goods or services, or indirectly through top up payments if only a fixed rate for a drug or service are reimbursed (see Table 45 and 46 below). Commonly used direct and indirect user charges have been outlined in the tables below, including associated patient incentives.

Table 45: Direct user charges and associated incentives

Type of user charge	Definition	Incentive
Co-payments	Paying a fixed fee of the medical good or service.	Patient may reduce volume of services. Regarding drugs, patients may reduce the number of prescriptions, while simultaneously increase the size of the prescription. No incentive to switch to cheaper products unless co-payment differs.
Co-insurance	Paying a fixed proportion of the cost of the medical good or service.	Patient may reduce volume of services, and there is an incentive to switch to a cheaper product.
Deductible	When an insured person is liable to pay up to a certain threshold of costs, before the insurance takes on a certain amount or proportion of the costs.	When close to the deductible, there is an incentive to increase consumption of services to reach threshold. When not close, patients have an incentive to reduce consumption and/or switch to a cheaper product.

Source: (182)

Table 46: Indirect user charges and associated incentives

Type of user charge	Definition	Incentive
Reference pricing (mostly for prescription drugs)	Users have to pay the difference of the drug price relative to the maximum the payer is willing to pay for a particular group of similar drugs.	Patient less likely to consume a product that is above the reference price. Incentive to switch to a cheaper, generic product.
Extra / balance billing	Users have to pay the difference between the amount the payer is willing to reimburse and the price charged by the provider.	Patient has an incentive to consume products/services that the health insurance will reimburse in full.
Multi-tiered formularies (prescription drugs)	Typically involve 2-3 layers which are associated with different co-payment levels (e.g. first tier usually generics with low co-payment).	Incentive for the patient to switch to generic products.

Source: (182)

5.3.2 User charges in European Social Health Insurance Systems

The share of OOP spending within total health expenditure (THE) differs significantly across countries with SHIs in Europe. Swiss citizens currently pay the greatest proportion of OOP, followed by Belgium and Austria. France and the Netherlands, have relatively low OOP expenses, at 6.4% and 5.2% of THE, respectively (184). In France, this is due to the high proportion of the population covered by private health insurance to cover additional expenses, while in the Netherlands, the figure excludes the annual €385 deductible.

Table 47: Out of pocket spending of total health expenditure (%) (2014)

Country	OOP as a % of THE
Switzerland	26.8
Belgium	17.8
Austria	**16.1**
Germany	13.2
Luxembourg	10.6
France	6.4
Netherlands*	5.2
OECD	**13.6**
High-income	**13.3**

Source: (184). Note: *Excludes the €385 deductible.

In all European countries with SHI systems, cost-sharing is applied to acute inpatient care and pharmaceutical sector. At the outpatient level, cost-sharing is employed in all countries except Austria and Germany. Deductibles are less common with only the Netherlands and Switzerland enforcing such a mechanism (185,186).

Table 48: User charges in European social health insurance systems

Country	General deductible	Acute inpatient care	Outpatient primary care	Outpatient specialists	Pharmaceuticals
Austria	×	✓	**Depends on insurer**	**Depends on insurer**	✓
Belgium	×	✓	✓	✓	✓

Country	General deductible	Acute inpatient care	Outpatient primary care	Outpatient specialists	Pharmaceuticals
France	✕	✓	✓	✓	✓
Germany	✕	✓	✕	✕	✓
Luxembourg	✕	✓	✓	✓	✓
Netherlands	✓	✓	✕	✓	✓
Switzerland	✓	✓	✓	✓	✓

Source: (185,186)

Most European SHI systems, have protection mechanisms in place to protect patients from catastrophic health care expenditures for individuals of low income and the chronically ill; these come in the form of complete exemptions, reduced user charges, a ceiling of total income spent on user charges, or absolute ceilings.

Table 49: Protection mechanisms within cost sharing systems

	Total OOP	Inpatient acute care	Outpatient care	Pharmaceutical (sum or % of income)
Austria*	Exemptions vary: minimum pension, children, civil servants and "people requiring social protection"*	Maximum days pa, exempt: "people requiring social protection"	Exempt from e-card fee: children, pensioners and "people requiring social protection"	Cap (2% of net income) Exempt: Low-income and vulnerable groups (e.g. people with infectious diseases)
Belgium	Out-of-pocket cap by income level		OMNIO: "preferential reimbursement" if income below threshold: Reduced copayments	OMNIO: "preferential reimbursement" if income is below threshold: higher reimbursement for low income

	Total OOP	Inpatient acute care	Outpatient care	Pharmaceutical (sum or % of income)
France	Exempt: chronic, disabled, pregnant**	Exempt: chronic, disabled, pregnant and low income	Deductibles capped to €50pa	Deductibles capped to €50pa
Germany	Total cap by % of income (2%) (lower for those with chronic conditions)	Maximum days pa		Total cap by (%)
Luxembourg		Maximum days pa		Exempt: drugs for chronic diseases
Netherlands	Low income receive financial support to pay user charges and premiums, i.e. "Health care allowance". Children (up to 18) do not bear any co-pays. Excludes GP consultations.			
Switzerland	Total cap (absolute sum)	Not included in cap, Exempt: children, students and maternal care	Included in general cap	Included in general cap

Source: (4)
Note: *Austria: exemptions differ by health insurances (e.g. e-card fee only relevant for GKKs). **France: low income indirectly exempt through free complementary VHI.

5.3.3 International case studies

France

Outpatient: €1 as well as between 30% to 70% of costs, depending if they are registered with a physician or specialists or not, and if they are referred to a specialist or not

Inpatient: €18 a day, and €13.50 for patients who require psychiatric facilities (if the procedure is not costly, then a 20% co-insurance rate applies, as opposed to a €18 a day fee)

Pharmaceuticals: €0.50 per drug box, in addition to a subgroup specific cost-sharing rate

France's health expenditure not covered by SHI is covered either by voluntary health insurance or by patients (187). What makes France stand out is its voluntary health insurance system which covers user charges (while contracts differ, on average they voluntary health insurance covers around 50% of charges) (187). Thus the existence of voluntary health insurance explains the relatively low OOP spending at just 6.2% of THE in 2014 (the lowest of all OECD countries) (184).

In France, cost-sharing is required for all four categories: acute inpatient care, primary care, outpatient specialists, and outpatient prescription drugs (185), as well as any type of care not included in the SHI positive list (187).[51] Co-payments are required in acute patient care in terms of payments per day as well as a catering fee. Specifically, patients are required to pay €18 a day, this figure falls to €13.50 for patients who require psychiatric facilities (185).

In primary care, a copayment of €1 is required, as well as 30% of costs if individuals are registered with a physician and 70% if they are not (185).[52] Specifically, patients who are registered with the GP are required to pay 30% of €25 (i.e. €7.50) plus an additional €1 (185).

For utilisation of outpatient specialist care, patients also pay €1 as well as 30% of costs or 70% of costs, depending if they were referred to see the specialists or not (higher co-insurance rate for those who are not referred) (185). Certain specialist areas do not require referrals, so cost sharing is always 30% for gynecologists, ophthalmologists, psychiatrists and neuropsychiatrists (185).

Outpatient prescription drugs are subject to a copayment of €0.50 per drug box, in addition to a subgroup specific cost-sharing rate (185). This is determined by the *Service Medial Rendu* (SMR), a rating determined by the severity of the pathology of the medication's primary indication and by the efficacy and tolerance of the drug (0%, 35, 70%, 85%) (lower copayment for necessary, more serious treatments) (185,187). The €0.50 or €1 payments are, despite their traditional meaning, sometimes referred to as deductibles- they are the value that is subtracted from the amount that the patient would otherwise be reimbursed (187).

Extra-billing is also prominent among specialist doctors, and to a lesser extent, GPs in private practices. At present, approximately 50% of specialists and 8% of GPs have the right to bill over the official tariff rate.

There are various protection/exemption mechanisms in place. For example, as the system is based on direct payments, that is paying now and being reimbursed later, there are exemptions in place for low income families (beneficiaries of CMU-C, ACS and AME insurance) and particularly expensive care, such that the patient is not required to pay in advance of being reimbursed (187). Such immediate third party

[51] Positive lists outline drugs that are reimbursed. Any products not in the positive list, must be paid in full by the patient.

[52] In France, since 2004 (Medicin Traitan), patients are required to sign with a physician, either a specialist or GP (depends on the patient's preference). The vast majority (approx. 99%) register with a GP.

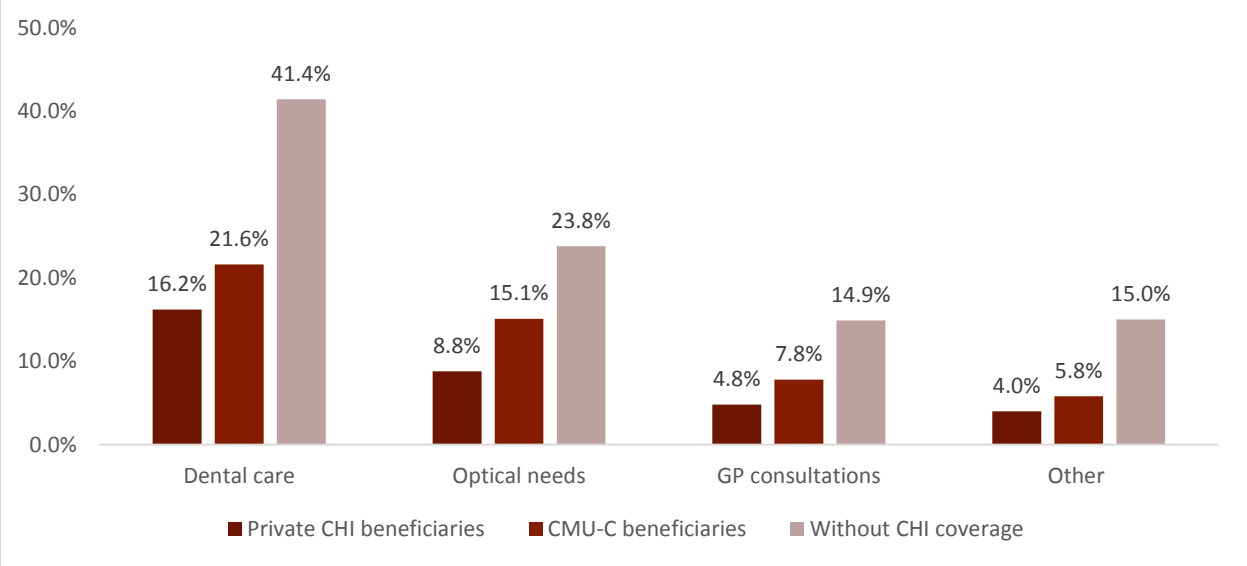
payments have recently been extended (2016) to include long-term/chronic patients as well as pregnancies, with plans to include all SHI recipients by November 2017 (187).

Subgroups of individuals, as well as other particular circumstances are exempt from co-insurance. Specifically, chronically ill individuals, some specific treatments (e.g. abortions/fertility treatments), occupational injuries, pregnant women, contraceptives until 18 years of age, organ donations and disabled dependents (187). In total, there are 30 groups of diseases which are exempt and which make up two-thirds of public expenditure on health.

While low income individuals are not exempt from all co-insurance, they are eligible for free public complementary health insurance to cover all such costs (187). Low income individuals (i.e. CMU-C and AME beneficiaries) are however exempt from inpatient cost-sharing (187). Lastly, for all individuals, the additional €1 or €0.50 payments for outpatient services and prescription charges are capped to a total of €50 per annum (187). At the inpatient level, there is a maximum co-insurance rate of 20%, however, this is not applicable for diagnostic or surgical procedures whose costs exceeds €120.

Despite the above exemption policies, unmet need due to financial barriers exists. For example, a 2012 study found that, on average, 18% of National Health Insurance beneficiaries, aged at least 18 years, reported unmet need in regard to dental care. This figure fell to 10% for optical care needs, 5% for medical consultations and 4% for other types of care (188).

Figure 70: Unmet care needs due to financial barriers by complementary health insurance coverage (2012)



Source: (188)

Germany

Outpatient: Up until 2012, flat rate quarterly payment for accessing primary care (Praxisgebuehr) (abolished) *Inpatient*: €10 per day, capped at 28 days per year *Pharmaceuticals:* 10% copayment of the pharmacy's sale price of a drug

Co-payments, as well as corresponding exemption mechanisms are central to the German health care system. At 13.2%, Germany's proportion of OOP spending within THE is close to the average of OECD or high-income countries (184), with the highest share coming from pharmaceutical payments (189). The 1989 *Health Care Reform Act* advocated cost-sharing to raise revenue, make patients liable for part of the costs, and encourage appropriate use of health care by lowering co-payments to reward positive behavior (e.g. preventative healthcare) (189). In order to reach the *Statutory Health Insurance Modernization Law* (2004) savings expectations, OOP requirements increased (189). Among these policies, was the introduction of standardised copayments for acute inpatient care, as well as the quarterly payments for first physician contact at the primary level, the *Praxisgebuehr,*[53] the latter was abolished in 2012 (189). The reason for the abolishment was the combination of a limited reduction in health care utilisation and high administrative costs, which resulted in insignificant cost savings (190–192) (see Table 50 below).

Table 50: Germany's Praxisgebuehr (primary care co-payment) (abolished)

Germany's Praxisgebuehr	
Type of user charge	Co-payment.
Amount	€10 for the first visit to an outpatient physician (GP or specialists) or dentist's office within a three-month period.
Exemption	Those aged under 18 years. Also exempt for preventative medical services (e.g. health check-ups, cancer screenings).
Duration	2004-2012.

[53] Under the policy, all adults within the statutory sickness funds had to pay 10 euros at their first physician visit within each three-month period. Vaccinations and preventative services are exempt.

Germany's Praxisgebuehr	
Impact	Limited impact on access to physicians after first year (see Table 54 for details).

Source: (193)

The German health care system has co-payments for acute health care as well as outpatient prescription drugs (185). In inpatient acute care, patients are required to pay a €10 fee per day (185). This is however capped at a total of 28 days a year (185). Regarding pharmaceutical expenditure, patients pay a 10% copayment of the pharmacy's sale price of a drug (185). There is however also a reference pricing system in place,[54] so when a patient insists on a more expensive originator drug, they must pay the difference between the originator and cheaper generic product (189).

Germany has always placed a strong emphasis on its protection mechanisms. These exemptions however do not apply for reference pricing differentials that patients are required to pay (189). Protection mechanisms in Germany come in the form of a total OOP cap of annual household income. Spending is capped to a maximum of 2% of household income for healthy individuals, and at 1% for chronically ill (189). Chronically ill is defined by either requiring long-term care, being severely disabled or providing a certificate from a doctor about the importance of continuous treatment (189). Furthermore, individuals with 'extraordinary spending' which is defined on a case-by-cases bases may be eligible to apply for an exemption from income tax (189).

Netherlands

Outpatient: €385 annual deductible, which applies to specialist outpatient care (not GP consultations), *inpatient care* and *pharmaceuticals*.
Further user charges subject to each individual's health insurance plan.

The proportion of OOP spending within THE in the Netherlands is the lowest of the European SHI systems at 5.2% (184). Since 2014, there has been an increase in the OOP spending mainly due to an increase in the mandatory deductible (194).

[54] There exists internal and external referencing price. The former uses the prices of drugs already on the national market with similar therapeutic effects to determine the cost of the new drug, while the latter looks at the cost of the same drug in other countries to determine price.

In the Netherlands, there is limited cost-sharing beyond the compulsory deductible, which is set at €385 per annum and applies to all individuals 18 years and above (194). The logic behind the deductible is to reduce moral hazard, which it seems to be doing as approximately only half the population reach the full amount of the deductible (194). This deductible applies to the use of most health care services including outpatient prescription drugs and diagnostics, but does not include GP consultations, maternity care, home nursing and integrated care in primary care settings (diabetes, chronic obstructive pulmonary disease, asthma, cardiovascular risk management), as well as care for children (194). Patients are thus not liable to pay any user charges for outpatient GP care, while outpatient specialist care, outpatient prescription drugs, as well as inpatient care are subject to deductible payments (194).

The amount of cost-sharing beyond the deductible depends on individual's health plan (194). Patients also have the choice of an additional 'voluntary deductible', the value of which they can choose themselves (between €100-€500 per year), which acts to lower their premiums (the reduction of the yearly premium is approximately 50% of the voluntary deductible amount) (194). The voluntary deductible is applied across the same care sectors as the compulsory deductible, however, only a small although growing proportion of patients opt for this option (i.e. approximately 12% of the insured population, of which 69% choose the maximum deductible amount) (194).

In-kind policies may limit reimbursement to contracted providers, while restitution policies offer free choice of provider, however, compensation for services is only made up to an amount set by the insurer (194). The majority of individuals choose an in-kind policy, while only a small minority chose a selective policy, which covers less contracted providers than a normal in-kind policy (194). Thus cost-sharing would occur if patients covered by in-kind policies choose providers which are not contracted by their insurer. Although, under Dutch law there exists freedom of choice which means that such co-payments might not form a material barrier to visit a provider of choice.

The Netherlands has also implemented certain value-based user charges schemes (explained in further detail in the next section of this chapter). For example health insurers have the option of offering a scheme where deductibles are not charged if preferred medicines are used, preventive health programs for certain diseases are followed, or contracted providers are chosen (194). Furthermore, there is a reference pricing system in place, in the sense that after the general deductible is reached, there is no cost-sharing for outpatient prescription drugs, except for the price differential between generic drugs and chosen branded drugs (185,194).

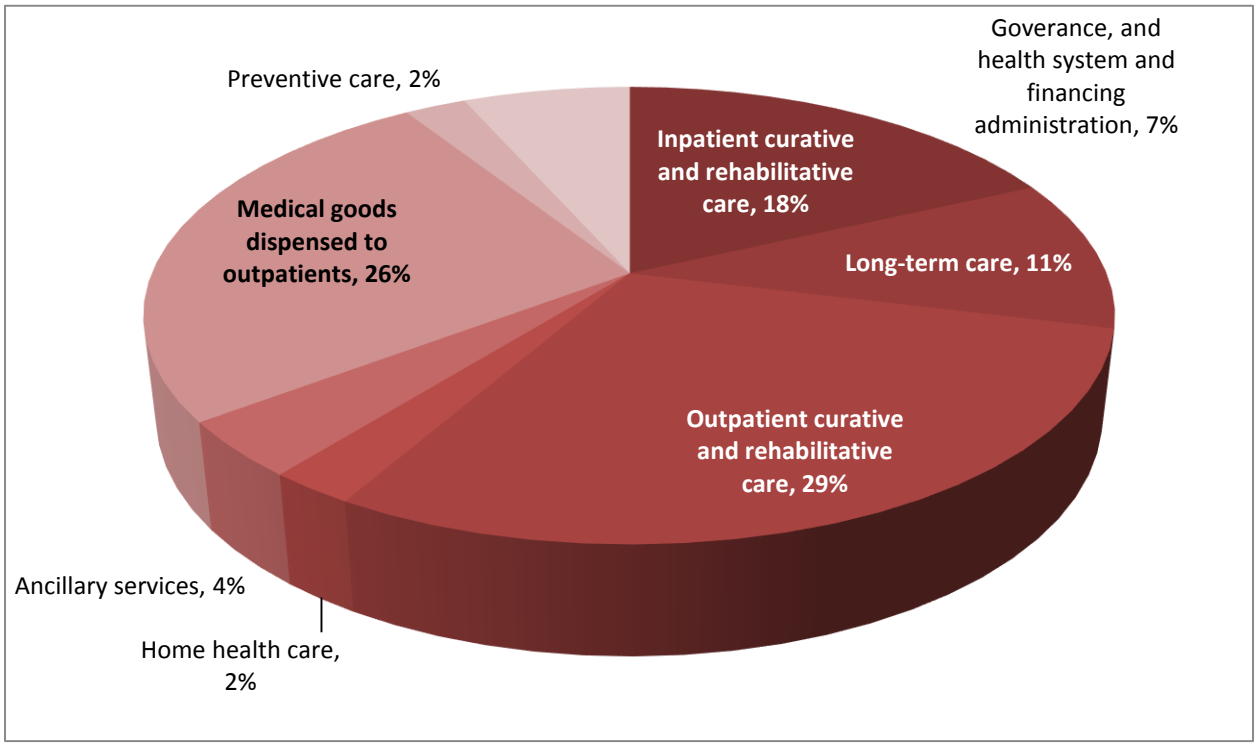
There are no exemptions to the deductible or contributing to SHI premiums (194). Low income individuals receive a 'Health Care Allowance' which is based on the average premium by insurers and the compulsory deductible (194). This is paid in advance of every month and surplus finances or deficits are balanced out on an individual level (194). Chronically ill and disabled individuals are not exempt from user charges either (194). However, low income beneficiaries were fully compensated for the substantial increase of the deductible in 2013 in their healthcare allowances. Also municipalities, are allowed to and often do, offer group plans to people on welfare that bear lower user charges (due to pre-payment of the deductible).

5.3.4 User charger policies in Austria

Out-of-pocket payments in the Austrian healthcare system

As of 2015, Austrian citizens spent €17.1 million on voluntary health care payments (€4.5 million) and household OOP payments (€12.6 million). For voluntary healthcare payments, patients typically spend their funds on inpatient curative and rehabilitative care (i.e. 48%), followed by governance and health system financing administration (25%). For household OOP payments, the largest item of expenditure relates to outpatient curative and rehabilitative care (37%), with inpatient care accounting for just 7% of overall expenditure. When combining voluntary healthcare and household OOP payments, 29% of all private expenditure is targeted at outpatient, rehabilitative care, followed by medical goods at the outpatient level (26%), and inpatient care (18%) (see Figure 71).

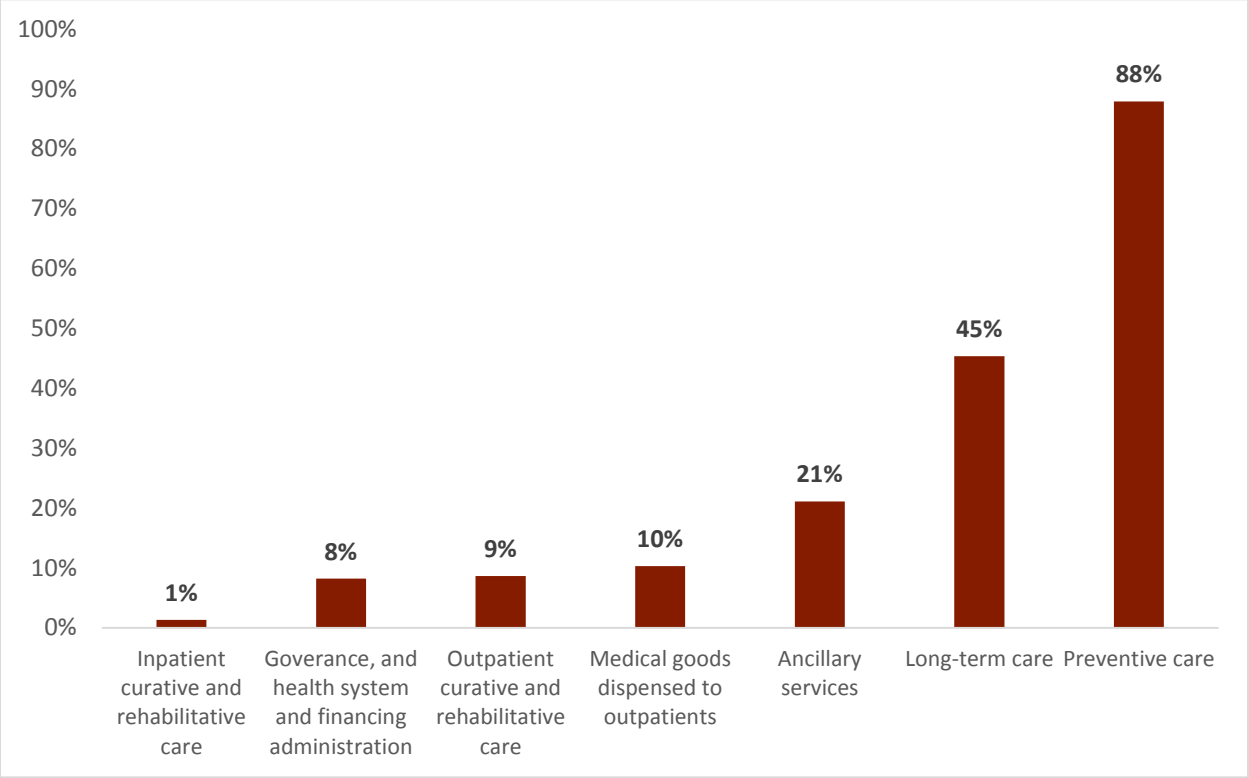
Figure 71: Share of voluntary household expenditure and household OOP by type of care (Austria, 2015)



Source: Statistics Austria (System of Health Accounts)

In terms of trends, between 2004 and 2013, private healthcare expenditure per capita (constant prices) have been increasing across all levels of care. In particular, preventative care and long-term care rose by 88% and 45%, respectively. Inpatient care, on the other hand, grew by just 1% over the specific period (see Figure 72).

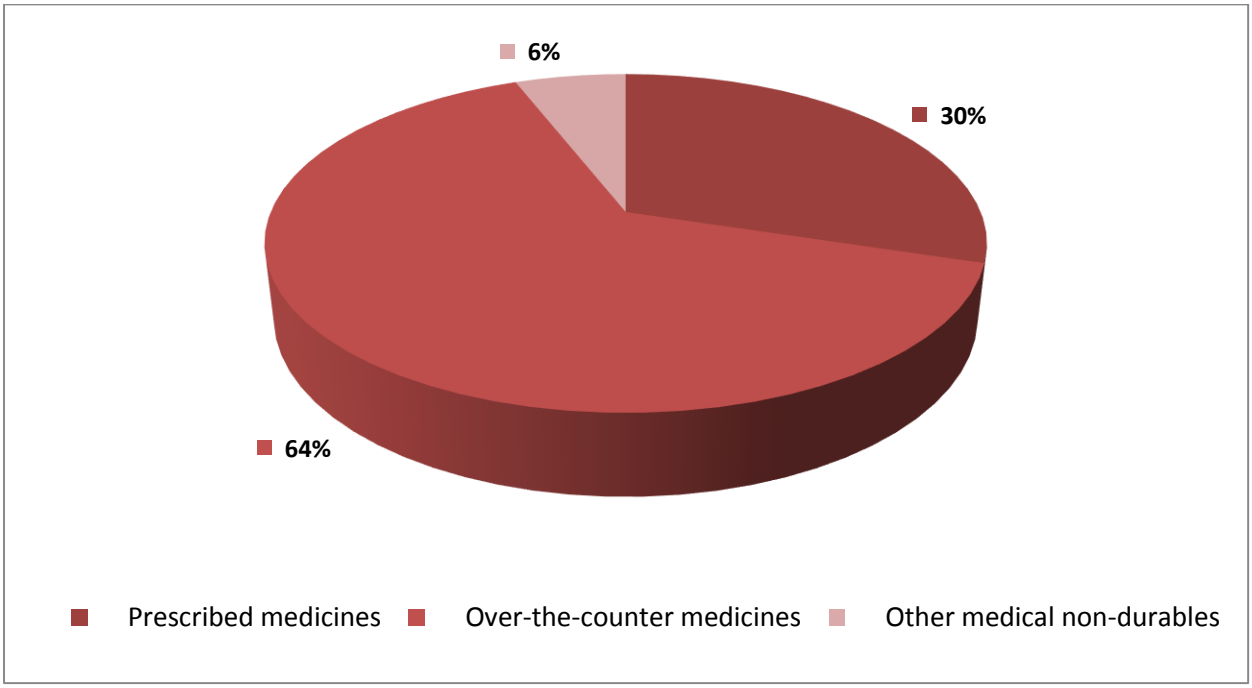
Figure 72: Percentage change in per capita private expenditure between 2004 and 2013



Source: Statistics Austria (System of Health Accounts)

In terms of pharmaceuticals, the majority (64%) of private expenditure is spent on over over-the-counter medicines. The remaining 36% of private expenditure was spent on prescribed medicines (30%) and other medical non-durables (6%) (see the figure below). The relatively low proportion of private expenditure on prescribed medicines is due to the high level of subsidisation via government schemes and social health insurance (i.e. 88% of total prescribed medicine expenditure).

Figure 73: Share of private pharmaceutical expenditure (2015)



Source: Statistics Austria (System of Health Accounts)

User charges in social health insurance

Outpatient: Depends on the insurer (varying rates of co-insurance across health insurers) *Inpatient*: Co-payment between €12-20 per day (capped at 28 days), with rates varying across regions and insurance status *Pharmaceuticals:* flat rate payment of €5.85 per packet of drugs (with an expenditure cap at 2% of the individual's net income)

An overview of user charger arrangements across all social security institutions in Austria is provided in Table 52. Social insurance carriers all offer different user charges, with the exception of copayments for pharmaceutical products. Specifically, all insurance carriers charge a flat rate payment of €5.85 per packet of drugs. If the cost is below €5.85, then the patient must pay the full amount (e.g. if the cost is €4.00, the patient must pay €4.00). To protect vulnerable groups, there exist prescription fee exemptions. Latest data show that 517,601 people received permanent exemption status.[55]

[55] Information provided directly from the Ministry of Labour, Social Affairs and Consumer Protection.

Table 51: Exemption policies for pharmaceutical prescription fee

Group	Description	Law
General exemptions	• Contagious disease • Young men in civilian service and immediate relative • Asylum seekers	Decree by the HVSV according to §31(5)16
Exemptions for social reasons (automatic)	• Those on low pensions • All insured when REGO has been reached	
Exemptions for social reasons (require application process)	• Those under a certain income threshold	

Source: (68)

In a positive move, a cap on pharmaceutical expenditure was introduced at 2% of an individuals' net income (excluding inpatient drug expenditure). Previously, those who are financially vulnerable and/or those with chronic conditions were not protected against high drug expenditure. In 2015, 400,506 people reached this threshold.[56]

For outpatient services, regional insurance carriers (GKKs) charge an €11 service fee for the e-card each year. In regard to healthcare services, patients who seek medical care from non-contracted doctors will only be reimbursed 80% of the cost charged by contracted doctors, and thus pay the remaining 20% OOP (plus an additional cost if the non-contracted doctor charges more than the contracted fee). A co-payment for medical aids is also required of GKK insurees. Lastly, relative to wealthier funds, GKKs offer less benefits, which increases the level of indirect OOP for their insured populations.

Other insurance carriers, with the exception of the SVB, employ a co-insurance rate between 14-20% on all outpatient services. The SVB, on the other hand, charge a flat-rate payment of €9.61 per quarter *if* the patient accesses medical care.

[56] Ibid.

In addition to the traditional user charges outlined above, the SVA and VAEB have experimented with value-based user charges. Specifically, the SVA reduces the co-insurance amount from 20% to 10% if the patient achieves preventative healthcare goals agreed with by their doctor (e.g. weight, physical exercise), while the VAEB repays €1 per medication package if a patient switches to a cheaper generic product (see figure below for further details).

Figure 74: Value based user charges within Austria's social insurance system

The SVA has introduced a 'Be Healthy on Your Own' program which aims to encourage people to take better care of their health. To achieve this, the SVA will reduce the co-insurance rate for medical and dental care from 20% to 10% if the patient makes improvement in one of the following five areas: weight, physical exercise, tobacco consumption, alcohol consumption, and blood pressure. Exemptions are rewarded for all areas, except alcohol and tobacco consumption (e.g. pregnant women).

The co-insurance rate is also reduced for those with Type 2 Diabetes who engage in the Diabetes Disease Management Program (Therapie Aktiv).

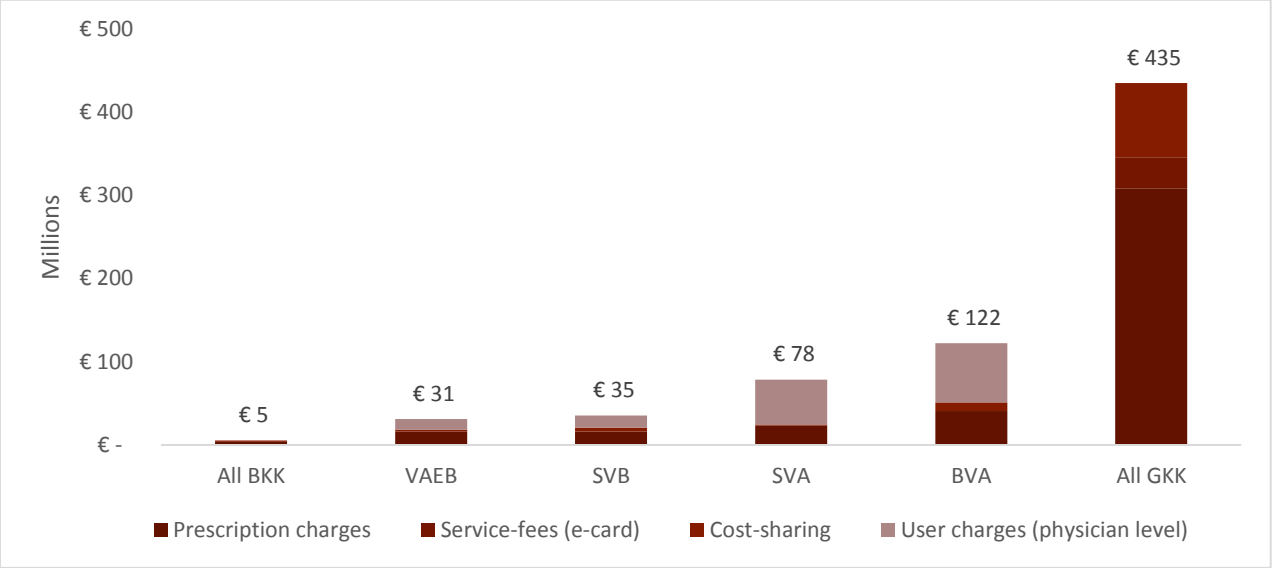
Data on participation from 2012 (latest available) revealed low participation rates across all income groups. Specifically, participation in preventative check-ups (which are required to receive the co-insurance reduction) ranged between 7.5% to 14.9% depending on the income rate at which the individual's contribution rate was set (those in the lowest income group were the least likely to participate).

The VAEB offers a simpler value-based user charger program, that is, the 'Best-Price-Euro'. Under this program, insurees are reimbursed €1 per medication package if they switch to a cheaper generic product.

Source: (195)

In 2015, patients spent €708 million on user charges within Austria's social insurance system. Drug prescriptions represented the highest share of user charges at €409 million, or 58% of all user charges. This result is not surprising given all health insurance carriers implement user charges for pharmaceuticals. The second largest component of cost-sharing in Austria relates to medical practices at €152 million, while the smallest component is made up of the e-card fee charges by regional carriers (€38 million).

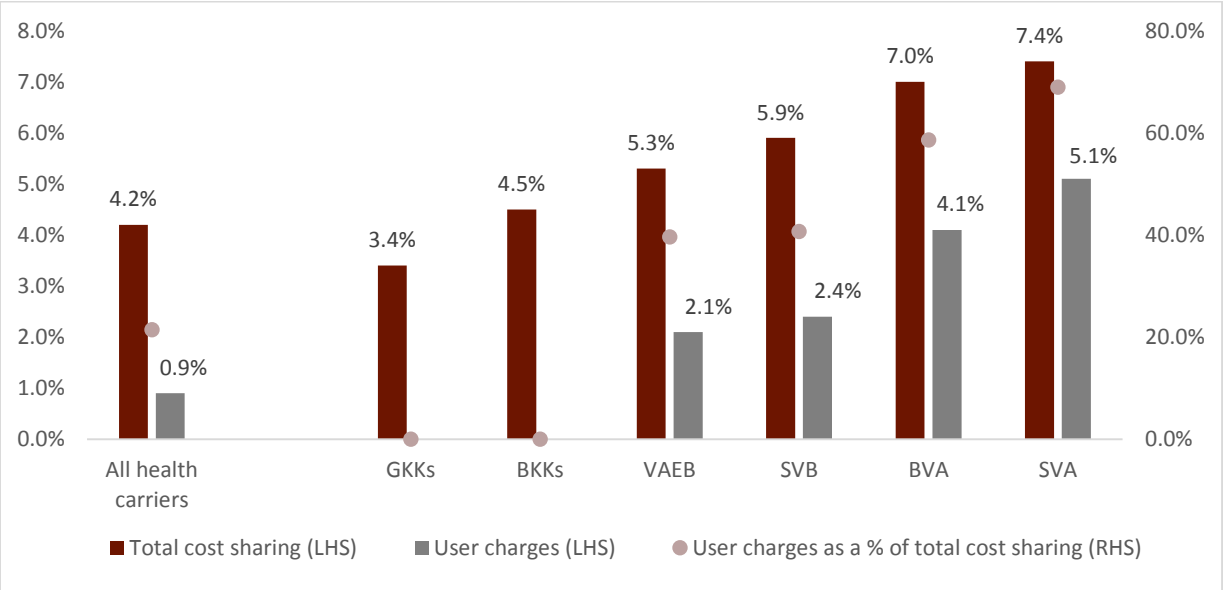
Figure 75: Revenue generated from user charges in Austria (millions) (2015)



Source: Information provided by the Ministry of Labour, Social Affairs and Consumer Protection (sourced from Finanzstatistik 2015)

Total fees (user charges and cost-sharing) as a proportion of total income differs across each health insurance carrier. Drawing upon 2013 data, user charges represented between 3.4% (all GKKs) and 7.4% (SVA) of total income. On average, 4.2% of total income is made up of revenue from cost-sharing (see Figure 76).

Figure 76: Share user charges and cost sharing in total income, 2015



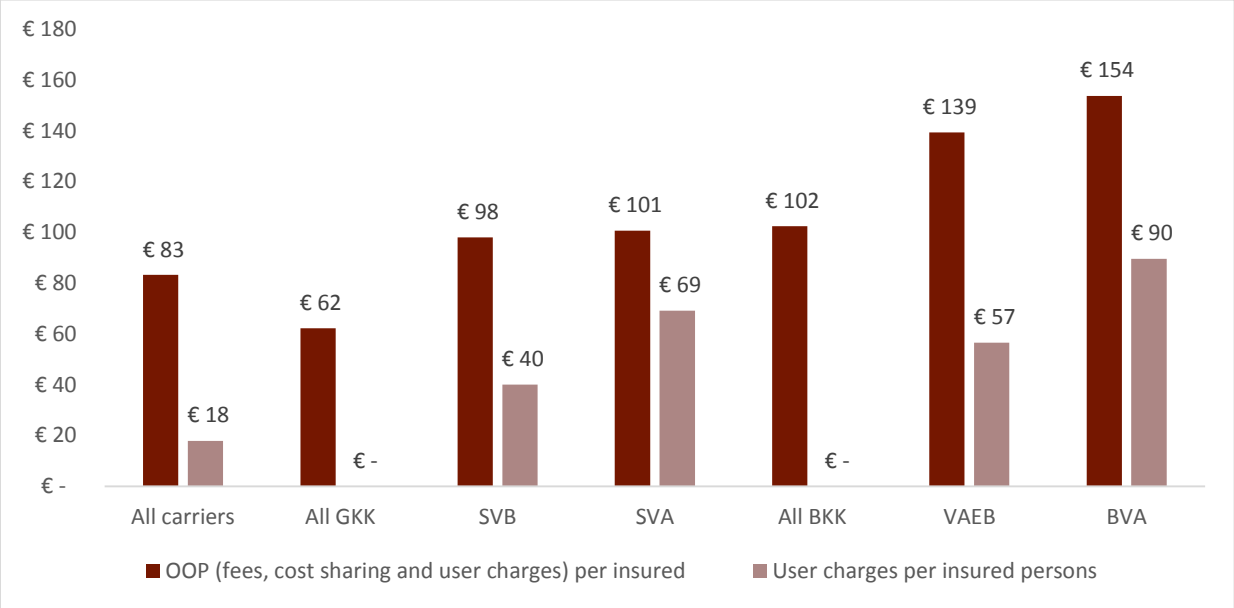
Source: Information provided by the Ministry of Labour, Social Affairs and Consumer Protection (sourced from HVSV)

The final figure within this section compares the cost per insuree between total fees, cost sharing and user charges, and only user charges. User charges for GKKs and BKKs is €0, which reflects the fact, that in technical terms, these carriers have not implemented user charges (i.e. only the €11 e-card service fee).

For all remaining carriers, the proportion of user charges within OOP varies significantly. For example, 68% of OOP within the SVA can be attributed to user charges, compared to 41% within the SVB and VAEB.

For further information, please see Volume 4 – Situational Analysis.

Figure 77: User charges per insuree across health insurance carriers (2015)



Source: Based on data from Finanzstatistik (2015)

Table 52: User chargers for services among Austrian social security institutions

Type of service	ASVG[a]	GSVG[a]	BSVG[a]	B-KUVG[a]	VAEB
Medical assistance	€11.35 services per calendar year[b]	20% (or 10%) co-insurance rate[c]	€9.61 contribution per treatment	10% of the contracting authority for certain services defined in the Articles of Incorporation	Treatment contribution of 7% of the contract rate[d]
Dental treatment: Preservative-surgically	As above	As above	As above	Co-insurance rate of 10%	Co-insurance rate of 20%
Dental treatment: Orthodontics (jaw regulation)	As above	Additional payment of 50% of the respective contract	Additional payment of 50% of the tariff costs	Co-insurance rate between 10-20%	Co-insurance rate of 30%
Children and adolescent services	-	-	-	-	-
Dentures	€11.35 services per calendar year (same charge as that specified under 'medical assistance'), plus additional payment according to Articles of Incorporation	20% of the insurer's costs 50% of contract for skeletal metal prosthesis and solid metal crowns on bracing teeth with partial denture	Additional payment of 25% for total plastic prostheses 50% for metal framework prostheses and staples	Co-insurance rate of 10%	30% co-insurance rate
Hospital care	10% for the first 4 weeks of nursing care Only for relatives[e]	-[e]	10% for the first 4 weeks of nursing care	-[e]	-[e]
Drugs			€5.85 prescription fee		

Type of service	ASVG[a]	GSVG[a]	BSVG[a]	B-KUVG[a]	VAEB
Medical aids	Co-insurance rate of 10%, minimum €33.20) (for visual aids min. 99,60 €)[f]				
Aids	Co-insurance rate of 10% (minimum €33.20)	Co-insurance rate of 20% (minimum €33.20)	Co-insurance rate of 10% (minimum €33.20)	Co-insurance rate of 10% (minimum €33.20)	Co-insurance rate of 10% (minimum €33.20)
Sick pay	-	-	-	-	-
Health insurance (nach § 139 Abs. 2a and 2b ASVG)	-	Not provided	Not provided	Not provided	-
Rehabilitation	-	Not provided	Not provided	-	-
Screening/medical check-ups of adolescents	-	-	-	-	-
Public health	Cost of the KVT				
Organ transplant (registration and registration costs)	-	-	-	-	-
Medical home care	-	-	-	-	-
Maternity benefits	-[g]	-[g]	-[g]	-[g]	-[g]

Note: [a] ASVG: GKKs, BKKs, PVA, AUVA; GSVG: SVA and AUVA; BSVG: SVB; B-KUVG: BVA. [b] Amount for the calendar year 2018; The collection will take place in November 2017. [c] Pay lower contribution rate if health goals are reached. [d] In the case of the use of medical assistance within the framework of the pilot project "diabetes mellitus health diabetes" as well as within the framework of the mobility project model region Mürztal pilot project "Movement as a drug", the treatment contribution must be 0%. [e] Cost contributions to be made on basis of national legislation, provided health insurance hasn't collected deductibles under social insurance law. [f] Cost of takeover by insurance carriers is up to a maximum amount as outlined in Articles of Association. Maximum amount differs across insurers. [g] Corresponding costs must be paid for medicinal products and medicinal aids.

5.3.5 Impact of user charges

Over the past 30 years in the EU, there has been a shift from public funding (through taxes and social health insurance) towards private funding (particularly through OOP payments) (196). As previously mentioned, the evidence around user charges has not directly aligned with what economic theory would suggest. More specifically, there have been concerns about the impact of user charges' impact on a health systems' efficiency, health outcomes and equity.

An overview of the impact of user charges on equity, demand for healthcare services, and expenditure is provided below.

Table 53: Impact of user charges

Area	Impact
Equity	Essentially a 'tax on the ill', given this group consume a relatively high proportion of healthcare services. Low-income individuals less likely to access healthcare services.
Demand for healthcare	Reduction in necessary and unnecessary healthcare services as patients unable to always distinguish between and high and low value healthcare. Impact on patient often limited by influential role of doctors in prescribing (drugs). Impact depends on level of user charge (i.e. price inelastic if user charge makes up small % of income).
Expenditure	No clear evidence on impact – can reduce expenditure in the short-term, however, long-term costs can increase due to delays in accessing care ('squeezed balloon effect'). Limited impact on expenditure if there are numerous exemptions.

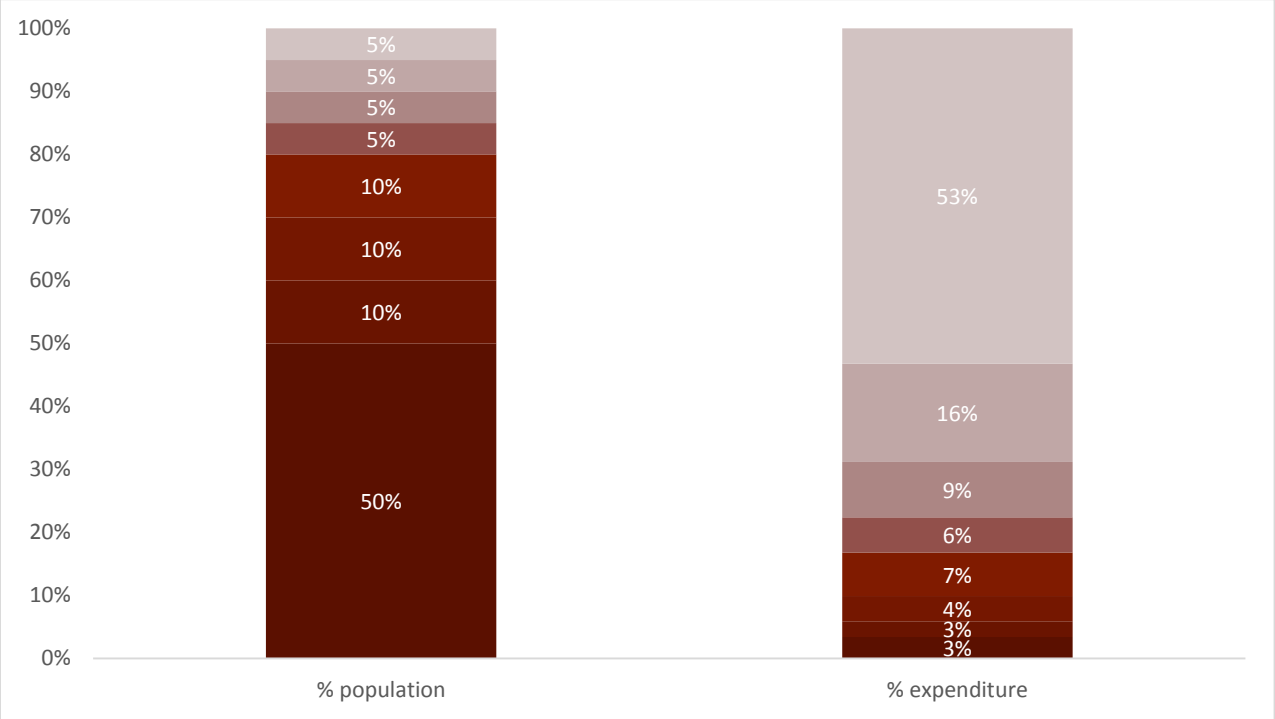
Source: See descriptions below.

Impact on equity

User charges may lead to an unequal reduction in health care utilisation and thus health. Specifically, in Western countries, such as Austria, a small proportion of the population (e.g. the elderly and/or chronically ill) contribute to a significantly higher proportion of health care expenditure. This is demonstrated in Figure 78, which shows the proportion of the German population and their aligning healthcare expenditure. Specifically, 5% of the population in Germany consume 53% of total healthcare expenditure (24% in the Netherlands), this figure increases to 79% for 10% of all patients. Similar results are found in France where 20% of the top healthcare consumers make up 60% of total user charges (i.e. average yearly user charge of €1,327 for the top 20% compared to €182 for the remaining 80%) (197).

Given most healthcare expenditure is consumed by a relatively small group of patients (i.e. the sick and/or elderly), user charges essentially act as a 'tax on the ill' (198).

Figure 78: Distribution of health expenditure for the German population



As those who are unhealthy are more likely to be from lower socio-economic backgrounds, user charges have an even greater impact on access to care for vulnerable groups. For example, as discovered within the RAND HIE (199) and confirmed through various other studies, low income individuals, and other vulnerable groups, are more likely to forego care, including essential care, in response to user charges

(see Table 54) (182,200). A recent detailed case study from the Netherlands the impact of the annual deductible on access to specialist medical care is provided in Table 55.

Table 54: Impact of user charges on equity (overview of academic studies)

Study	Country	Description
Rückert *et al.* (2008)	Germany	Germany's Praxisgebuehr (primary care flat rate payment) delayed access to care for young/healthier people. In regard to per capita income, 67.9% of those on 'very little income' delayed seeing a physician, compared to 42.6% of those on 'very high income'.
Schoen *et al.* (2010)	Various*	In all countries, except the UK, those on below average income were more likely to have experienced 'at least one access barrier due to cost' (e.g. in Germany, 27% vs 17%, and in the Netherlands, 13% vs 3%).
Chandra *et al.* (2010)	US	Retirees in poor health had greater reductions in spending on physician visits and prescription drugs than those in good health (3% and 8% reduction in physician visits and drugs, respectively, for health retirees compared to 15% and 27% for unhealthy retirees).
Chernew *et al.* (2008)	US	Patients from low-income backgrounds are more sensitive to drug co-payments than middle- to high-income patients (i.e. low-income patients less likely to adhere to medications, particularly for Statins).

Source: (193,200–204)
Note: *Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, US and UK.

Table 55: Case study - Impact of the Dutch compulsory deductible on specialist referrals

Setting

In the Netherlands, patients are charged a €385 deductible per year. At the outpatient level, the deductible is charged to outpatient specialists, but not GP consultations. The deductible is charged if the patient follows the GP referral to a medical specialist.

Objective

To determine the impact of the deductible on non-compliance with medical specialists care (i.e. patients not following up with GP referrals to specialist).

Results

Between 2008 and 2013, the annual deductible increased from €150 to €385 per year, over the same period, the non-compliance rate grew by 7 percentage points (i.e. from 20% to 27%).

Non-compliance rates were higher for:

- younger patients (i.e. 31% for those aged 25-39 years, 26-27% for older patients, and 25% for children)
- those with multiple chronic diseases (i.e. 28-29% for those with at least 1 chronic condition, compared to 26% for those without a chronic condition)
- those living in urban deprived areas (i.e. 28% for those living in urban deprived areas, compared to 27% for those in other areas).

Source

Van Esch *et al.* (2017). Increased cost sharing and changes in noncompliance with specialty referrals in The Netherlands. *Health Policy*, 121, pp.180-188.

Source: (205)

Impact on demand for healthcare

One of the main aims of user charges is to shift financial responsibility to the patient to reduce unnecessary health care utilisation. A systematic review of recent evidence confirms that the vast majority

of studies show that user charges reduce the use of emergency department, outpatient prescription drugs, general practitioners and specialists (206).

Evidence, both from the RAND HIE (207), as well as recent literature reviews have confirmed that individuals do respond to the existence or to increases in user charges by reducing their health care use (182,200,206,206,208). However, the argument that user charges increase efficiency relies on the assumption that patients have the information and knowledge to make rational judgements and decisions over the necessity of particular health care interventions. Evidence has shown that this assumption does not hold for the majority of patients. Both the RAND HIE (199,207), as well as various reviews and studies have confirmed the inability of most patients to distinguish between high and low value care. As a result, user charges often lead to a reduction in both essential and nonessential care (182,183,200).

With regards to outpatient care, a systematic review of the literature found that user charges do reduce utilisation, however a few outliers saw no effect (206). Evidence on the impact of the German Praxisgebuehr does show a slight reduction in outpatient physician visits, but not significant enough to generate cost savings (191,192). Further, the impact of the co-payment on demand was only apparent during the transitory year in 2004, after which demand for physician visits remained the same (191).

The impact of user charges on utilisation differs by the amount of the user charge, as well as the population subgroup. In regards to the user charge amount, in Sweden, where user charges make up a relatively low proportion of income, their increase over time had a minor impact on health care utilisation (i.e. patients are price inelastic when user charges are low) (209). The impact of user charges on healthcare utilisation also depends on the relative power of other stakeholders. For example Gemmill *et al*. explain the limited response to prescription drug charges, due to the influential role of doctors in prescribing, which means patients' drug demand is relatively price inelastic (182). Moreover, healthy patients are more likely to reduce health care use in response to higher OOP than chronic patients as their health care use is generally not as essential to their immediate health (182). However, the difference in reduction in health care use between high and low income individuals, due to OOP payments representing different shares of their income, leads to equity concerns.

Impact on health expenditure

Pharmaceutical spending: Gemmill *et al*. confirmed in their review of OECD countries, that the impact of user charges on total prescription drug expenditure and drug prices are unlikely long term (182)**.** Most included studies find that increased cost-sharing resulted in a slight reduction in total pharmaceutical

expenditure and a shift of cost burden to patients, however the magnitude of the impact on total cost depends on the amount the user charge increases costs, as well as the types of drugs or which segment of the population it targets (182).

There is limited evidence of the impact reference pricing has on long term pharmaceutical expenditure. Gemmill *et al*. suggest that it is unlikely that such user charges can give long term pharmaceutical cost control, rather this mechanisms simply shifts costs towards patients (182). Their review does find evidence of drug prices dropping in response to reference pricing, however findings suggest that changes in drug prices are likely to cancel out - i.e. while some drug prices drop, others increase to meet the reference price (182). Thus, the introduction of reference pricing is unlikely to lead to a decrease of pharmaceutical expenditure at a given level of consumption.

Total health expenditure: The impact of user charges on total health care spending is not unanimous with studies finding both a positive and negative impact on long term expenditure. The RAND HIE brought the expectation that total spending may decrease in response to increased cost-sharing (199). However, reviews of the literature ever since conclude that the effect of cost-sharing on total health care expenditure is more likely to be an increase (182,200). The potential for a so-called 'squeezed balloon' effect as well as increasingly expensive new technologies are considered potential barriers to a reduction in spending (183,200). The squeezed balloon effect refers to the shift in costs from preventative/maintenance health care to more acute health care (183,200). The RAND HIE, as well as reviews of studies ever since, have confirmed the possibility of such an increase in total health costs (199,200). Gemmill *et al*.'s literature review finds that prescription drug charges are likely to lead to an increase in costs due to increased usage of alternative services such as in-patient care, long-term care, as well emergency department admissions (182).

Outpatient specific studies suggest similar results. In addition to the German Praxisgebuehr not generating sufficient cost saving due to limited response from patients (191–193) , the policy resulted in high amounts of administrative costs, which caused its abolishment (190). Moreover, supporting the squeezed balloon hypothesis, decreased preventative care utilisation may also result in increased intensive/acute care costs in the long run. For example, a Danish study found that high risk individuals were almost twice as likely to attend a heart disease screening if it was provided free of charge rather than if they had to pay a fee OOP (210).

The distribution of health spending across populations is highly skewed given the majority of services are used by a narrow segment of the population (e.g. elderly, those with chronic conditions) (see Figure 78).

Since increased cost-sharing has a greater effect on healthier patients, it is likely to skew the spending distribution further (i.e. healthy will consume even less) (200). Chronically or acutely sick people are unlikely to be as affected by an increase in cost sharing, given their lack of control after initiating treatment (200), as well as treatment being essential for many chronically ill patients.

Lastly, the impact of user charges on controlling health care expenditure is limited given the existence of numerous exemption policies to protect vulnerable patients.

5.3.6 Protection mechanisms

The above-mentioned impact on equity highlight the importance of protection mechanisms for vulnerable groups. Such protection mechanisms come in forms of capping total OOP spending, reduced fees, as well as exemptions. All the considered European SHI Systems have some form of protection mechanism in place (see Table 49). Such mechanisms have the potential to improve health care efficiency and equity.

Analysis of the variation of equity in health by type of health insurance finds that annual caps or exemptions reduce the likelihood that those on low incomes and/or chronically ill will avoid treatment due to costs (203). A recent Swedish analysing access to healthcare by education level over time found that among people of poor health, those who are less educated have lower access to care (209). However, they do find that the increase in user charges over time, only had a marginal impact on the extent of the inequality in access to care, which they attribute to both relatively low levels of user-charges as well as Sweden's extensive protection mechanisms, such as their payment cap to protect the chronically ill (209).

5.3.7 Value-based cost sharing

The negative impact of user charges on equity, access and healthcare expenditure has led to an increase in the employment of value-based cost sharing. Value-based cost-sharing entails nudging individuals towards more essential or more valuable care, in order to decrease the likelihood of patients limiting their access to essential care. The intended goal is minimise waste and spending on health and thus maximise efficiency.

Cost-sharing can target health care utilisation towards high value-care, both through rules/mandates, as well as through incentivising patient or provider behaviour (211). Mandating a reduction in low-value care use can be, for example, an automatic switch from a branded product to a generic if available (i.e. generic substitution) (211). It has been shown that value-based user charges have the ability to increase use of high-value services and drugs, however they may bring with them high administrative costs, as well as equity concerns (211).

Across European SHI systems, value-based approaches have been applied to encourage utilisation of preferred providers, more effective outpatient prescription drugs, generic utilisation, as well as use of preventative services or behaviour (see Table 56).

Table 56: Value-based approaches across providers, outpatient prescription drugs and prevention

Policy area	Policy	Country
Outpatient drugs (therapeutic value)	Differential cost sharing by level of clinical effectiveness (less cost-sharing for more effective)	France
Outpatient drugs (clinical indication)	Level of cost-sharing dependent on severity of disease to treat	Belgium, Finland, France, Norway
Outpatient drugs (clinical indication)	Patients must meet clinical conditions to determine effectiveness	Finland
Outpatient drugs (relative price)	Lower cost-sharing for cheaper drugs vs higher cost-sharing for drugs with a generic alternative	Belgium, Denmark, Finland, France, Germany, Netherlands
Prevention	Preventative behaviour incentivised through bonus schemes, or different co-payments	Belgium, Germany
Use of preferred providers	Cost-sharing determined by whether the provider is preferred or not	Netherlands (limited – insurers can offer this, but are not obliged to)

Source: (211)

Value-based cost-sharing: prescription drugs

Value-based cost sharing is most commonly applied to outpatient prescription drugs. Within this context, value, can refer to a range of factors such as economic or therapeutic value, clinical indication/therapy area/patient need, or relative prices to substitutable drugs (211). Majority of the literature on value-based cost-sharing revolves around reference pricing. Reference pricing is expected to both switch

patients' demand to cheaper generic drugs, but also to reduce prices of pharmaceuticals subject to reference pricing regimes, and reduce total pharmaceutical expenditure.

Various systematic reviews have shown that reference pricing can in fact effectively shift prescription drug use to cheaper drugs (212,213). However, there is evidence of contrary results, for example, Swartz in her review argues that this may be due to a lack of patients' understanding of the interchangeability of branded and generic drugs (200). Regarding impact on pharmaceutical expenditure, reference pricing can decrease prices of some products, while cheaper generics may raise their price to meet the reference threshold, this cancelling out any cost savings (182,211) (182). Thus, reviews have found that reference pricing is unlikely to generate overall long term pharmaceutical cost control, and instead simply shifts costs towards patients (182).

Figure 79: Case study - Impact of value-based user charges for prescription drugs

Setting

Claims data from two US employ-sponsored health plans was analysed to determine whether more aggressive multi-tiered formularies policies had a greater impact on utilisation on three drugs (i.e. ACE inhibitors, proton-pump inhibitors, and statins).

Results

Those enrolled in the more aggressive health insurance plan experienced a slower growth in the probability of using a drug, further, there was a greater shift from the plan to the enrollee. Those in the aggressive healthcare plan were more likely to switch from tier-3 statins (most expensive tier) to either tier-1 or tier-2 medications (49% vs 17%). Similar results were found for ACE inhibitors and proton-pump inhibitors.

Source

Huskamp *et al*. (2003). The effect of incentive-based formularies on prescription-drug utilisation and spending. The *New England Journal of Medicine*. Vol 349, pp. 2224-2232.

Source: (214)

Value-based cost-sharing: preventive services

Exempting preventive health care services from user charges or incentivising healthy/preventative behaviour is another type of value-based cost-sharing.

In some SHI systems with user charges in place for outpatient primary care (185), the decision to exempt preventative care from user charges acts to direct patients to valuable care. As Danish studies have shown, individuals are almost twice as likely to attend preventative and screening procedures if they are provided free of charge, in the latter case even for individuals at particularly high risk of poor health (210,215).

Similarly, in the Netherlands, Belgium and Germany, bonus schemes have been introduced to encourage patients to partake in prevention schemes (i.e. supporting healthy behaviour and early detection of chronic diseases) (211).

Figure 80: Case study - Impact of value-based user charges for preventative services

Setting

Systematic review of differential user charges between primary and secondary care across eight studies covering six countries.

Results

Five studies examining the impact of greater secondary care user charges found that most (n=4) saw a decrease in secondary care utilisation, and three showing an increase in primary care utilisation. One study evaluating the impact of a reduction in primary care user fees saw an increase in primary care utilisation. The introduction of a fee for those who access secondary care without a referral led to a reduction in primary are utilisation (one study). Lastly, one study found that higher secondary care user charges led to higher utilisation of primary and secondary care. The authors noted that caution should be taken when interpreting results given quality of studies examined.

Source

Hone *et al.* (2017). Does charging different user fees for primary and secondary care affect first-contacts with primary healthcare? A systematic review. *Health Policy and Planning*. Vol 32(5), pp. 723-731.

Source: (216)

Limitations of value-based cost-sharing

Although value-based cost-sharing addresses certain issues associated with user charges, it does have limitations of its own.

The first limitation concerns efficiency. Specifically, developing and up-keeping value-based user charges come with a high administrative burden which has led several countries to cancel value-based schemes,

for example, Denmark, Norway and Sweden (211). Due to these additional costs, the impact of user charges on efficiency are often not felt until the long-term.

Secondly, information asymmetry and the role of physicians' in administering healthcare limit the patients' ability to respond to user charges (211). Moreover, in order for value-based cost-sharing to achieve its intended effect, it is important to have a robust information system that is transparent to providers and patients (211).

Lastly, the specific example of France highlights the importance of careful policy design to accompany value-based approaches. In France the existence of additional insurance covering OOP payments, has limited the impact of reference pricing on patients (211).

5.3.8 Policy options: User charges

User charges could act as a signal to consumers to reduce consumption of unnecessary, low-value care, while simultaneously raising revenue. For this reason, they are a popular tool among health policy-makers. However, for the following reasons, caution should be taken when implementing non-targeted user charges. First, user charges reduce consumption of both high- and low-value care as often patients are unable to differentiate between the two. A delay in consumption of necessary, high-value care may lead to worsening health conditions and thus greater long-term health expenditure. Second, those who are relatively sicker and poorer, consume a disproportionate amount of healthcare services. User charges therefore act as a 'tax on ill', which limits their revenue raising potential, given exemptions usually apply to such patients.

For reasons outlined above, we have proposed policy options which advocate user charges that are fairer, more equitable, and linked to value. It is important to note that we do not recommend an increase in user charges, rather change in the composition of user charges to maximise efficiency, for example, by linking payment to the value of care provided.

Fairer, more equitable pharmaceutical expenditure caps

Out-of-pocket expenditure for pharmaceuticals is capped at 2% of net income for all insured people. Although a positive initiative, given the capped amount is independent of an individual's income, the exemption policy fails to reflect insurees ability to pay. We propose a fairer more equitable system by dividing the pharmaceutical expenditure cap into three levels. The first level applies to low-income earners who would see their pharmaceutical expenditure cap reduced from 2% to 1.5%. The second level, comprising middle-income earners, would experience no change in their pharmaceutical expenditure cap

given it would remain at 2%. Lastly, the cap for third-level, high-income earners would increase to 2.5% (see Table 57).

Table 57: Proposed changes to the pharmaceutical expenditure cap

Income-level	Proposed pharmaceutical expenditure cap on net income
Low	1.5%
Medium	2.0%
High	2.5%

To ensure insurees are allocated to the appropriate level, which reflects their true ability to pay, the individual's total income could be taken into account (i.e. income from primary form of employment, as well as income derived from property ownership or other types of economic activity). Social health insurers do not have access to information on total income due to privacy reasons. To overcome this barrier, it is proposed that the relevant tax office provide social health insurers with a brief statement on which co-insurance rate should be applied to individuals, without reporting the actual overall income of the individual.

The exact income brackets for each of the three-levels has not been laid as this should be discussed and debated within government. To the extent possible, the chosen brackets should ensure fiscal neutrality. However, if this cannot be ensured, consideration should be given to government compensation within the short-term (e.g. five years), to allow social health insurers time to re-adjust to a reduced revenue stream.

The impact of the policy should be evaluated within the short-term. If the policy generates a positive impact on patients and insurers, the cap could be extended to all inpatient and outpatient healthcare services.

Lastly, the proposal outlined above will benefit those on lower incomes, this does not mean, however, that changes should be made to existing exemption policies for vulnerable groups.

Legal considerations

There are no specific legal observations or concerns in this respect. Implementation could be done as well on legislative level as on level of 'directives' (Richtlinien) released by the HVSV (which is currently the case, § 31 Abs 5 Z 16 ASVG).

Value-based user charges

Value-based user charges are limited in Austrian social health insurance, with only the SVA and VAEB experimenting with such policies (see Figure 74). A reason for this may be the limited use of health technology assessments, which inform policy-makers about the clinical- and cost-effectiveness of a drug/service/device. Therefore, as a first step, an improvement in HTA processes in Austria is required (e.g. enhance transparency, improve coordination) (see section 5.2.4). Hereafter, it is recommended that social health insurers draw upon findings from HTAs to determine co-insurance rates across products/services (i.e. reducing user charges for high-value care).

The development of robust HTA systems is likely to take time. Therefore, in the meantime, social health insurance carriers could draw upon experiences and findings from the SVA and VAEB to implement other forms of value-based user charges. For example, by linking user charges to engagement with preventive care and/or consumption of generics (see Figure 74 for further details). However, such policies are behavioural-based, which for reasons outlined below, are associated with implementation issues.

Ideally value-based user charges would consider individual circumstances. However, such policies are complex (e.g. various exemption policies), which in turn increase administrative costs. Therefore, user charges should be linked to the effectiveness of a product/medical device/service, as determined by a robust HTA. This approach is adopted by various countries (e.g. reduced or no co-payments for generic products).

Legal considerations

There are no specific legal observations or concerns in this respect. Implementation could be done as well on legislative level as on level of 'directives' (Richtlinien) released by the Hauptverband (which is currently the case, § 31 Abs 5 Z 16 ASVG).

Convergence of user charges

As outlined in Table 52, differential user charges are applied across health insurance carriers. This creates inequalities across insured populations, and may restrict certain individuals from accessing appropriate healthcare services. For this reason, it is recommended that wealthier funds (such as the SVA) reduce their co-insurance rate, for example, from 20% to 10% or less for ambulatory care so as to align with rates set by the BVA (10%) and VAEB (7% by 2018). It is important to note that this is already occurring as evidenced by the drop in revenue from user charges, specifically from €152.2 million in 2015 to €128.7 million in 2016 (217).

Naturally, user charges will converge if carriers are amalgamated, as proposed under structural models 1, 2 or 3 (see Table 3). In this instance, user chargers must be revised to ensure all insurees have the same or better access to healthcare. However, harmonisation of user charges should be slowly phased in to take into account affordability, given revenues will be reduced.

Legal considerations

There are no specific legal observations or concerns in this respect, either. It should be considered, however, that user charges for all employed insurees would cause quite huge additional administrative costs if they were collected by the funds themselves.

Summary of policy options for user charges

In summary, user chargers should be implemented with caution given, if they are not targeted, are likely to disproportionally impact sicker/poorer populations. Further, blunt user chargers will reduce access to both valuable and non-valuable services, which may lead to higher expenditure in the long-term. For these reasons, we have developed policy options that aim to improve equity and efficiency in the system. Regarding the former, we propose a three-tiered pharmaceutical expenditure cap based on a patient's financial means, with those from lower socioeconomic backgrounds paying less. To improve efficiency, all social health insurers should consider implementing value-based user charges drawing upon findings form robust HTAs.

5.4 Investment in healthcare services

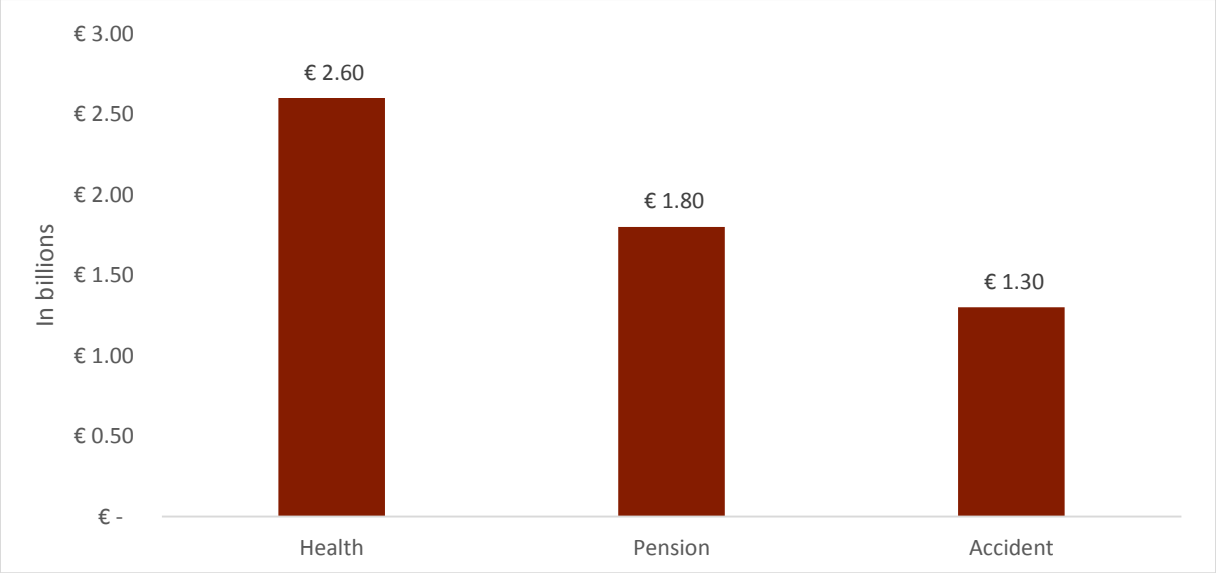
To improve access to high-quality care, social insurance carriers invest heavily into service provision. Funds for investment are derived from a portion of reserves (i.e. assets less liabilities), which can be used to 'make' (developed and owned by the insurer) or 'buy' (purchased from a provider) healthcare services. Alternatively, insurers may enter into an arrangement which combines the two funding models.

Section 5.4 first outlines the level of reserves within the social insurance system, with a specific focus on health insurance carriers. Second, an overview of how to efficiently invest reserves is provided. Specifically, when to make or buy healthcare services, and ways to coordinate investment.

5.4.1 Reserves within the social insurance system

Reserves within the social insurance system represent the sum of assets less liabilities. At the end of 2015, the sum of reserves across all three insurance pillars equated to €5.7 billion. Of this amount, 47% was attributed to health insurance, compared to 31% and 22% for pension and accident insurance, respectively (see the figure below). It is important to note that reserves are not necessarily liquid as they may also include items such as real estate and owed contributions.

Figure 81: Level of reserves by insurance pillar, in billions (2015)

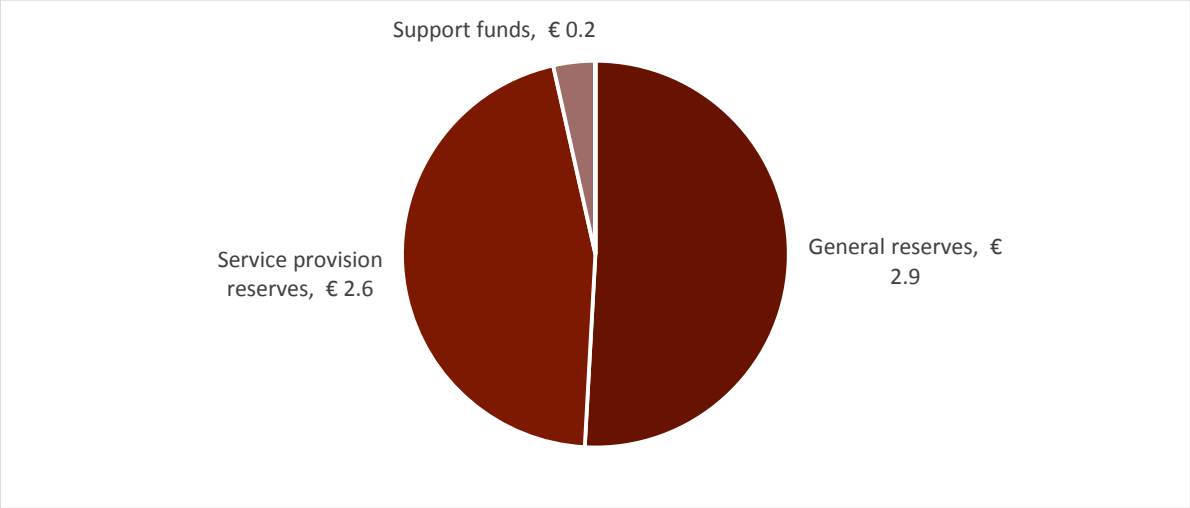


Source: (218)

Reserves can be broken into three exclusive groups, namely, general reserves, service provision reserves, and smaller special reserves (i.e. support funds and replacement procurement reserves). In regard to service provision reserves, health insurance carriers are required to build up reserves totaling 1/12 of total

service expenditures to cover fluctuations in contribution income and benefit payments. A breakdown of reserves by each of the three categories is outlined in the figure below, which shows that just over half of reserves are considered 'general reserves'.

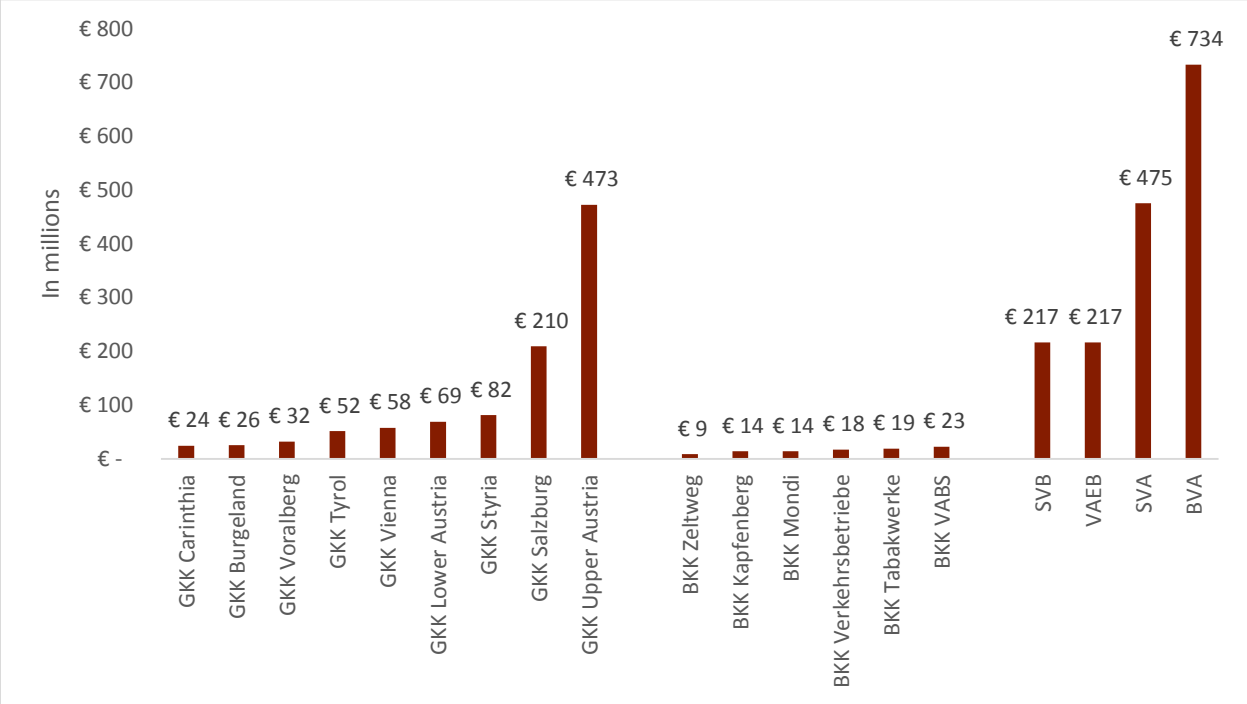
Figure 82: Net asset structure of social insurance carriers, in billions (2015)



Source: (218)

Reserves at the individual health insurance carrier level are provided in Figure 83 figure below. Results from the data reveal significant differences, with reserves ranging from €9 million (BKK Zeltweg) to €734 million (BVA). As a generalisation, reserves are greatest among carriers offering more than one insurance pillar, followed by GKKs and finally, BKKs.

Figure 83: Net assets of individual health insurance carriers, in millions (2015)



Source: (218)

As previously outlined, reserves comprise more than just liquid assets. Three significant forms of assets, in addition to cash, include real estate, contribution claims, and securities, loans and deposits. As shown in Table 58, there is no clear pattern in regard to the division of assets.

Table 58: Breakdown of assets as a proportion of total assets by health insurance carrier (2015)

Insurance carrier	**Share of total assets**		
	Real estate	*Contribution claims*	*Securities, loans and deposits*
GKK total	4%	59%	29%
BKK total	3%	18%	74%
VAEB	5%	15%	64%
BVA	7%	0%	80%
SVA	4%	56%	30%

Insurance carrier	Share of total assets		
	Real estate	*Contribution claims*	*Securities, loans and deposits*
SVB	0%	27%	49%

Source: (218)

5.4.2 Make, buy and concurrent sourcing of healthcare services

Make or buy

In a purely competitive market with numerous competitors, homogenous products, limited barriers to entry, and perfect consumer knowledge, it is often presumed that there will be an optimal allocation of resources. The healthcare market, however, is not 'perfect' for a number of reasons including information asymmetry, moral hazard, adverse selection, and imperfect information (219). For these reasons, provision of healthcare is not solely left to the private market, with payers of health care (e.g. social health insurers) employing a mix of in-house (make) and outsourced services (buy).

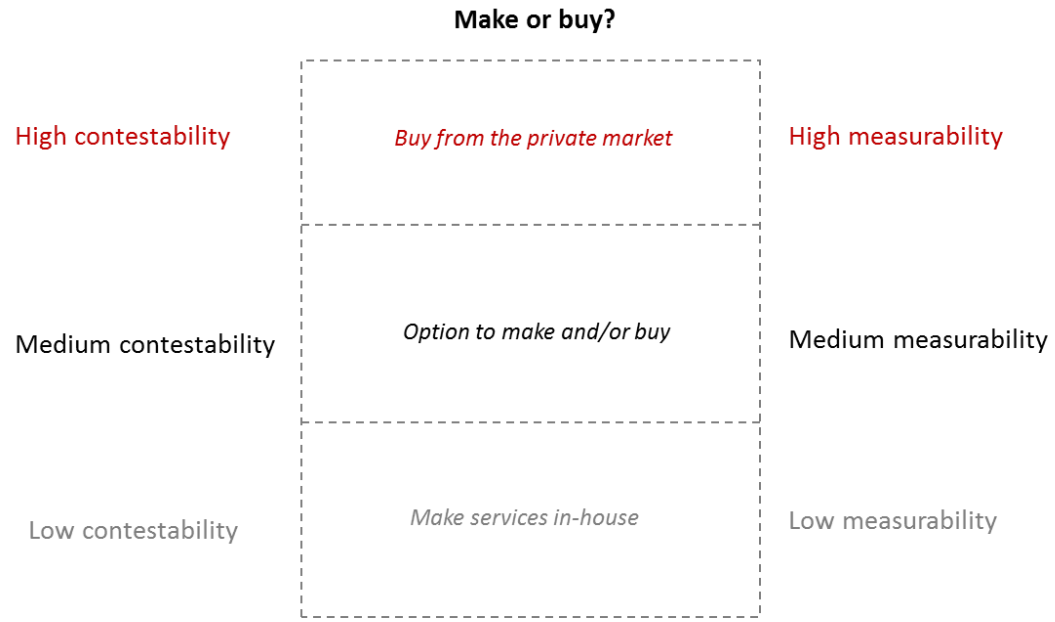
Despite ample literature on the topic, there is no consensus on whether to solely make or buy services. What is frequently reported, are the conditions which influence such decisions. In regard to the healthcare market, two salient factors determine whether services should be made or bought, *contestability* and *measurability* (220):

- Contestability: A market is contestable if the service operates in a market where there are low barriers to entry and exit. For example, expertise and reputation increase barriers to entry, which reduce contestability.
- Measurability: Ability to measure the inputs, processes, outputs and outcomes of a particular service. High measurability implies tasks can be easily defined and evaluated and therefore suitable for purchasing. For example, volume and prices of drugs and equipment are relatively easy to measure (220–222).

Each healthcare service, as specified by the World Health Organisation, can be placed along a continuum matrix, which ranges from high measurability and contestability, to low measurability and contestability (220,221). The 'make or buy decision grid' states that if a healthcare service operates within a highly competitive market and can be easily measured, then it should be contracted out to a private provider.

On the other hand, if there is a limited number of competitors (e.g. monopoly provider) and information cannot be easily collected and analysed, services should be provided in-house (see figure below).

Figure 84: Make or buy decision grid



Source: Adapted from (220)

When examining the broader literature on make and buy (i.e. outside the healthcare market), several additional factors were identified. These factors, including their impact on make or by decision making, have been outlined in Table 59.

Table 59: Additional factors impact make or buy decisions

Factor	Description	Impact on decision-making
Centrality of task	Whether the task is considered central or core to the organisation's overall objective.	Tasks that are not considered critical are more likely to be outsourced (e.g. cleaning, catering). By outsourcing such tasks, more effort can be directed at fulfilling core competencies.
Asset specificity	Level of asset specificity used within production. This factor is closely	Idiosyncratic, nuanced assets are more likely to be produced in-house.

Factor	Description	Impact on decision-making
	related to contestability as high levels of specificity restrict market access.	
Irregular demand	Irregular or cyclical demand which is outside the control of the organisation.	If demand is irregular, organisations will be more likely to outsource relevant services as capital and labour may otherwise sit idle during downturns.
Labour expertise	Highly skilled staff often demand higher wages, which are generally provided in the private sector. Thus it can be difficult for the public sector to employ those with the required skill set.	Training staff to a specific level of expertise can be costly, especially if staff turnover is high. In this instance, it is preferable for organisations to contract highly-skilled workers on an ad-hoc basis.
Intellectual property	For example, patient records.	If an organisation's IP is highly sensitive, then services are more likely to be provided in-house.
Synergies	Complementary services across the organisation's supply chain.	Providing services in-house builds up internal capacity. In certain instances, improved capacity and knowledge in one area may enhance tangential components of the supply-chain, thus improving overall service provision. (see below)
Market failures	The healthcare market is often associated with market failures; that is, where the free market fails to provide an adequate level of service. This frequently occurs in rural and remote areas where demand is low, thus leading to inequitable access.	Where market failures occur, health insurance carriers should consider making their own services. Proper analysis is required to determine whether the market has in fact failed.

Source: (221–223)

Concurrent sourcing

Despite various factors outlined above, in practice, the decision to either make or buy is not straightforward. As a result, organisations are increasingly turning to mix methods of sourcing, which incorporate both aspects of make and buy (i.e. concurrent sourcing) (223).

Specific environments in which concurrent sourcing is supported by empirical evidence are provided in Parmigiani (2007) (223). These include where:

- There is technological uncertainty
- The organisation and supplier have complementary areas of expertise
- Economies of scope exist.

Relative to purely making or buying services, concurrent sourcing enhances an organisation's knowledge by fostering information sharing (i.e. learning from the provider). Information sharing is particularly pertinent during times of rapid unpredictable technological development, given it enhances the organiation's likelihood of adopting relevant, successful strategies. Therefore, in times of technological uncertainty, organisations should concurrently source (223).

The level of internalisation, that is, in-house production, falls on a continuum related to the organisation's level of expertise (i.e. there is a positive relationship between expertise and producing services in-house). In general, the organisation will have a high-level of expertise, but with certain knowledge gaps. Therefore, the organisation will be motivated to partner with the supplier to combine complementary areas of expertise (223).

Concurrent sourcing can improve efficiency as, where possible, services will be produced simultaneously as opposed to in silos (i.e. economics of scope). Specifically, simultaneous production leads to a 'fuller utilisation' of production inputs (between the organisation and supplier), which reduces average costs compared to when services are produced independently (223).

5.4.3 Policy options: Investment in healthcare services

Reserves and investment coordination

In addition to liquid assets, reserves among social insurance carriers also include items such as claims on contributions and real estate. Current financial reporting requirements delineate reserves according to the categories outlined above, yet all are termed as 'reserves'. This terminology is misleading given not

all reserves are liquid and in certain cases are required to fund essential services. For this reason, we recommend the following two policy options. First, only report assets that are liquid and not required to fund required services as reserves, to make it explicit that these assets can be used for investment purposes. Remaining items would then be classified as 'non-liquid assets'. And secondly, enhance the use of reserves via the following three options:

1. **Pooling all or a part of each carrier's reserves into a joint central fund**, administered by the HVSV. To encourage social insurance carriers to pool liquid reserves, the make-up of total reserves as a proportion of each carrier's contribution should be made clear. These proportions would then be used to allocate investment returns across the social insurance system (i.e. those who contribute more to the pool of reserves would receive greater financial returns from investments).
2. **Encourage joint investment without pooling reserves,** with contributions to investment based on each carrier's level of reserves.
3. Encouraging carriers who invest in healthcare services to **open up their facilities to all individuals, not just their insured population.**

Enhanced coordination of investment activities is associated with many benefits including: a) avoiding duplication of effort; b) improving allocative efficiency, thus improving insuree access to relevant services; and c) promoting specialisation and efficiency by assisting services to suitable carriers.

In regard to options 1 and 2 above, the following six high-level complementary recommendations regarding investment coordination have been provided:

1. Develop an overarching investment strategy for social health insurance, with all future investments being reported to a central agency
2. Require all future investments to align with the aforementioned investment strategy
3. Social health insurance carriers to jointly invest in facilities/programs that improve primary and public health (e.g. primary healthcare units, disease management programs, case management, dental clinics, and other joint competence centres[57]); as outlined in option 3 above, these could be made open to all individuals, not just insured populations of carriers who have made investments.

[57] At present, only three joint competence centres exist - Integrated Care (Integrierte Versorgung), Therapeutic Products and Aids (Heilbehelfe und Hilfsmittel, HBI), and Transportation (Transportwesen, TW). See Volume 2- Situational Analysis for further details.

4. Use liquid reserves to invest in 'bricks and mortar' capital, which would be rented out to providers. Under this arrangement, insurers would not lose their reserves as they would earn rental income.
5. Utilise the target control mechanisms and joint virtual budgets at the Länder level to better coordinate investment in facilities (e.g. if the Länder have excess capacity in outpatient department, health insurance carriers could use this capacity for setting up PHUs or other outpatient clinics).
6. Formalise investment coordination between Federal States and health insurance carriers, which in turn would improve services across the spectrum of care.

Legal considerations

There are no legal impediments with respect to an enhanced financial reporting.

The 'pooling' of already allocated reserves, however, could be a problem with respect to the principle of self-governance as pooling of reserves would lead to a (partial) transfer between different groups of insurees ('Versichertengemeinschaften'). According to the case law by the Constitutional Court, such transfers are lawful only insofar as there is a 'sufficient personal and material link' between the respective groups. As long as all insurance carriers benefit proportionally from such a central fund this has not be considered as an unlawful transfer, of course (for details see below Volume 2 chapter 11).

Make, buy or concurrent sourcing

As outlined in section 5.4.2, there is no clear rule as to whether insurance carriers should make or buy, given both sourcing options are associated with a range of advantages and disadvantages. Based on a review of the relevant literature, we recommend that prior to each investment decision, social insurers undertake a mapping exercise against each of the factors outlined in Figure 84 and Table 59. In particular, insurers should focus on aspects related to contestability in the market, and measurability of tasks and performance.

Notwithstanding the above, for the following reasons it is recommended that health insurance carrier invest partly in developing their own healthcare services:

- To improve knowledge and capacity, which could enhance their ability to negotiate more favourable contractual agreements

- To improve flexibility by offering a 'fallback' option should contractual agreements break down (i.e. as is the case now, carriers could employ additional physicians, who are not contracted, to provide services within their own healthcare institutions)

Legal considerations

There are some legal impediments with respect to providing services within the carriers' own institutions such as § 339 ASVG (an agreement with the Chamber of Physicians is requested for establishment or enhancement of an 'Ambulatorium') or under the KAKuG (requring a public assessment of needs). So this option would be subject to amendments by (of course, only simple) legislation.

Summary of policy options for healthcare investment

Reserves across the social insurance system, and specifically within health insurance, differ across carriers. However, gross value of reserves can be misleading and therefore difficult to compare. Specifically, reserves do not wholly reflect 'leftover' funds for investment purposes given figures also include non-liquid assets such as real estate and contributions owed. For this reason, it is recommended that only liquid assets be termed as 'reserves' within the remaining grouped as 'non-liquid assets'. Liquid reserves could then be pooled into a central investment fund, with returns to carriers proportional to the level of investment made.

Using reserves, health insurance carriers have the option to make, buy or concurrently source healthcare services. No option is superior, therefore, decisions made by carriers should consider circumstances within the market, in particular, how contestable the market is and how well the service can be measured. Nevertheless, to improve the capacity and flexibility, it is recommended that carriers partially invest in producing their own services.

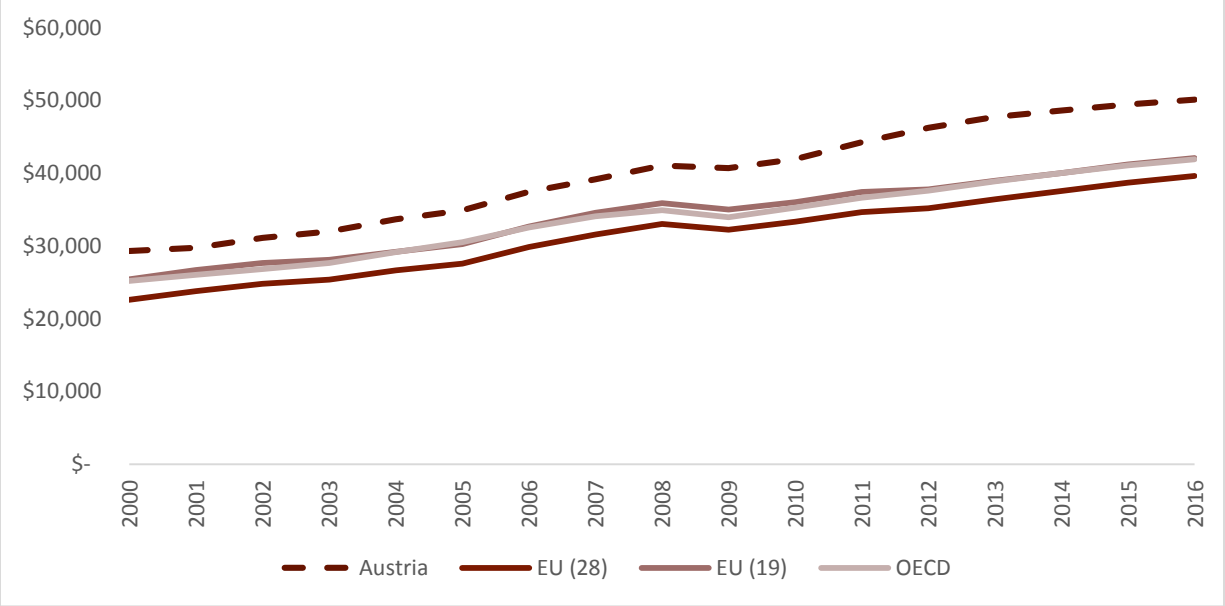
As previously outlined, liquid reserves could be pooled into a central fund to improve overall healthcare provision. To ensure monies within the fund are maximised, an overarching strategy, which all carriers would abide by, is recommended. For example, the strategy could outline appropriate competence centres to invest in.

5.5 Broadening the social welfare base

5.5.1 Historical economic performance

Within Europe, Austria is a strong economic performer, with a relatively high level of employment and GDP per capita. For example, since year 2000, Austria has recorded a higher GDP per capita (total, and in terms of per hour worked) than the average of the Euro Zone (19), European Union (28), and the OECD (see Figure 85).

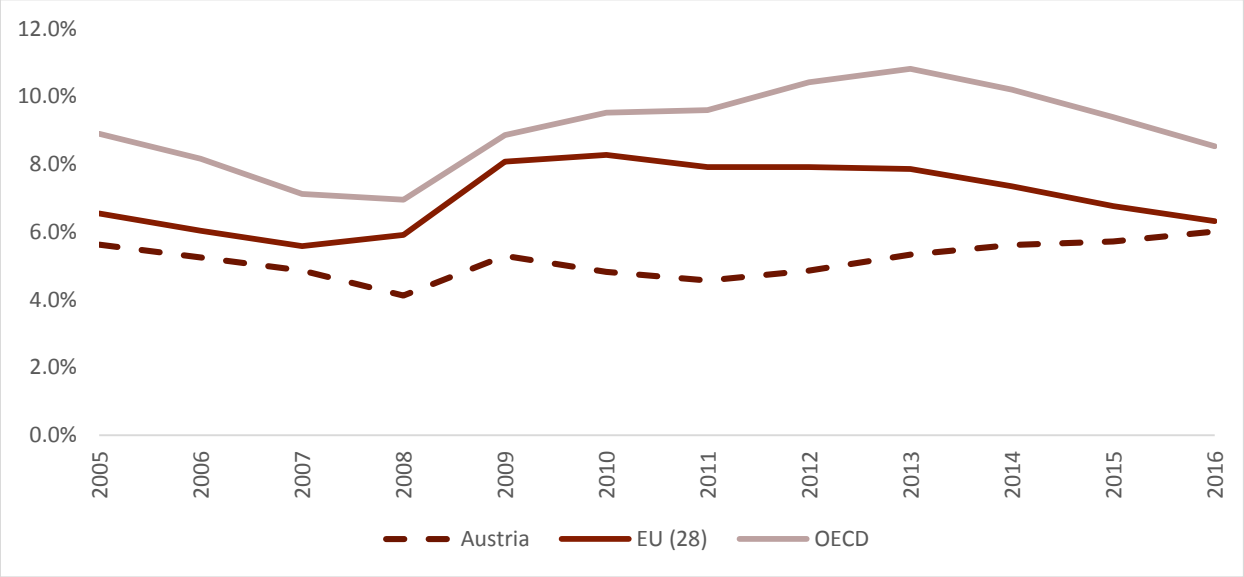
Figure 85: GDP per capita in Austria, EU and OECD (2000-2016)



Source: (224)

In regard to employment, historically (i.e. between 2005 and 2014), Austria's unemployment level has fallen below both the OECD and EU. However, since 2014, unemployment in Austria, unlike international trends, has been increasing (see Figure 86).

Figure 86: Unemployment rate for Austria, EU and OECD (2005-2016)



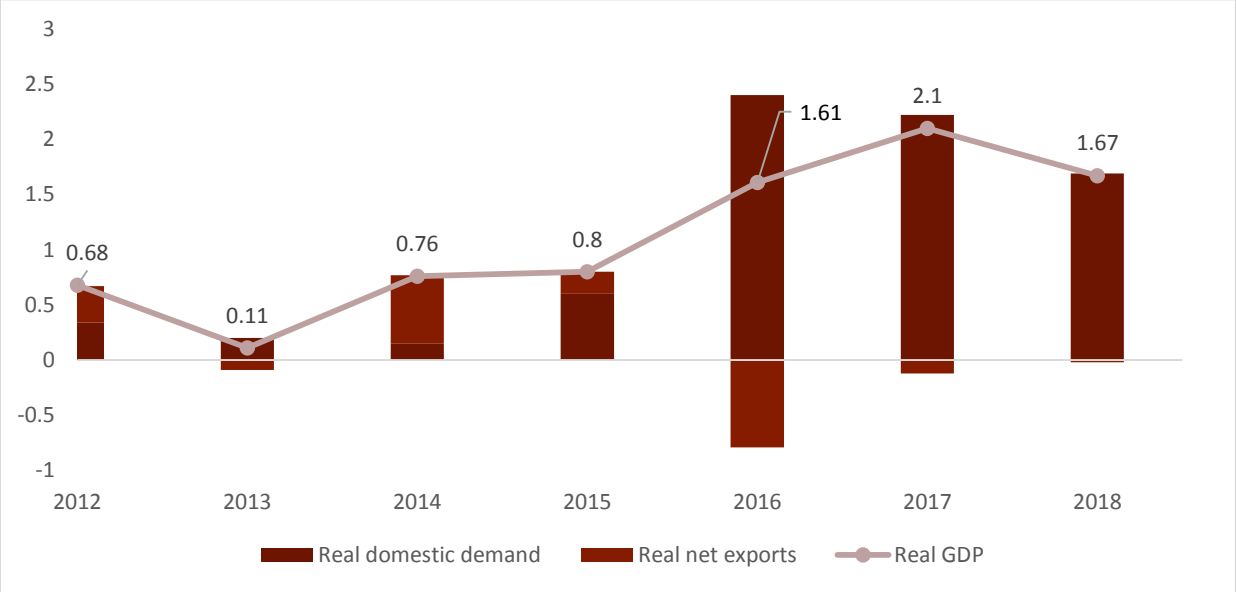
Source: (225)

5.5.2 Future economic performance and challenges facing social health insurance

Economic forecasts

According to the Austrian Institute of Economic Research (WIFO) and the OECD, Austria's economic outlook looks strong (226,227). In the short-term, the Austrian economy is expected to grow by 2% and 1.8% (real terms) in years 2017 and 2018, respectively (226). From 2018-2021, the growth rate is predicted to decline marginally to 1.5% in real terms, or 1.7% in actual terms (226). The relatively high level of economic growth will stem from strong domestic demand, caused by the 2015-16 tax reform, which boosted disposable income levels (see figure below) (227).

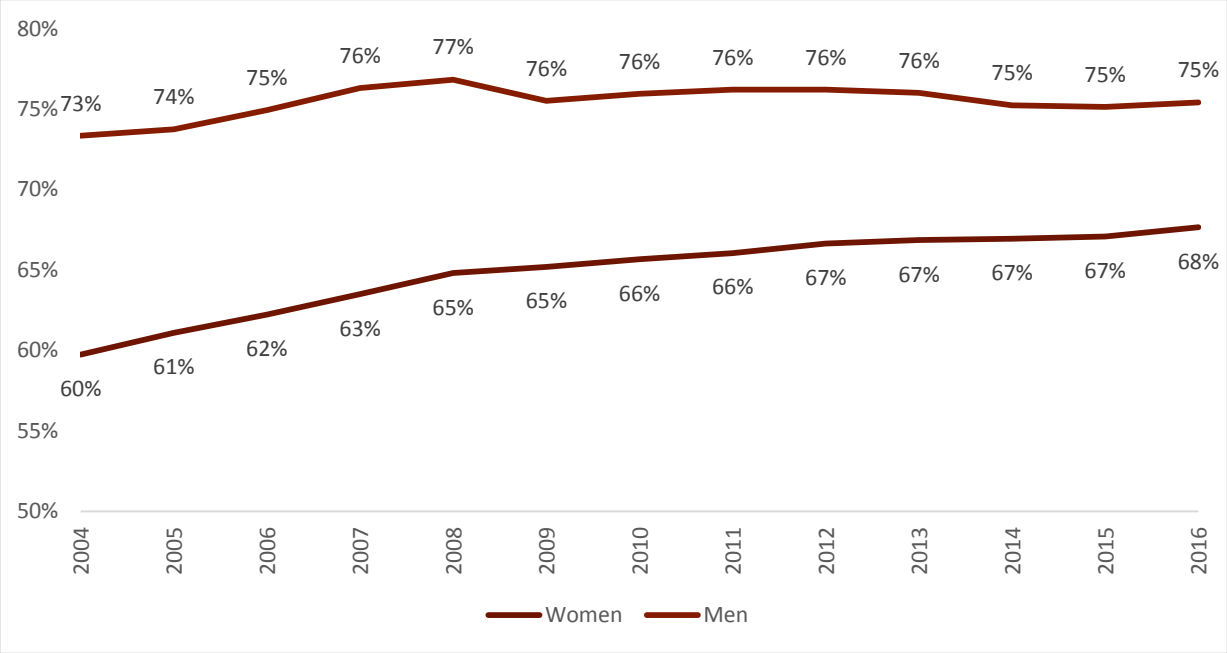
Figure 87: Change in real GDP growth, historical and projected (2012-2018)



Source: (227)

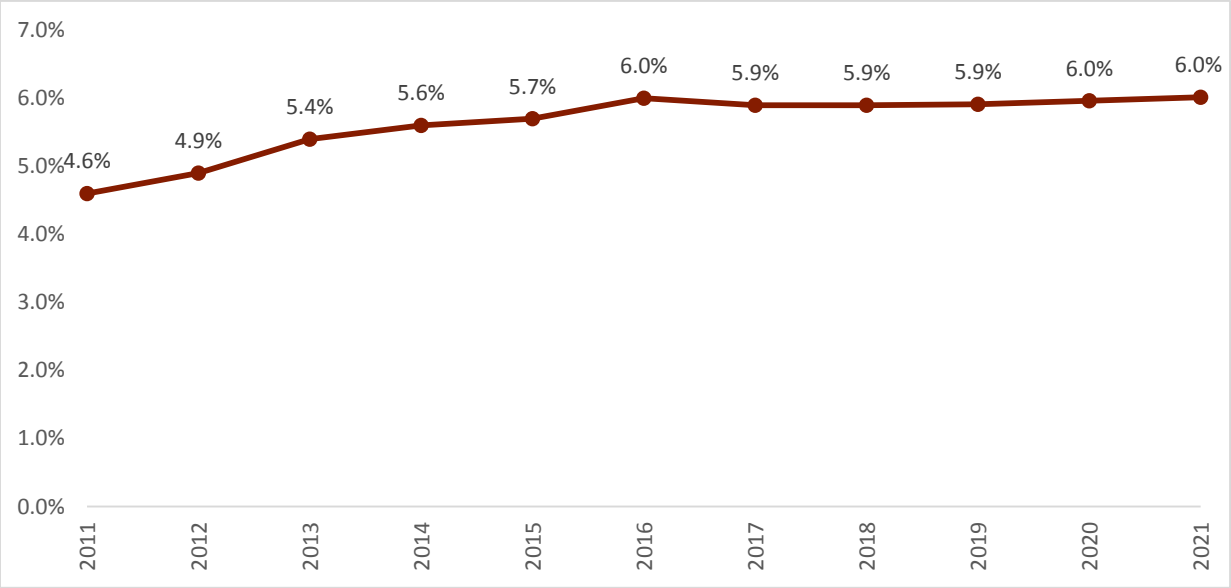
In terms of the labour market, levels of employment will continue to rise as a result of immigration, an increase in the actual retirement age and higher participation by women in the workforce, which, as of 2016, was 7 percentage points below that of men (an improvement from the 13-percentage point difference in 2004). Strong projected economic growth will likely absorb changes to the labour market, as a result, unemployment should stabilise at approximately 6% (see Figure 89).

Figure 88: Participation rate by gender for working age population (2004-2016)*



Source: Data provided by the Ministry of Labour, Social Affairs and Consumer Protection.
*Note: *Those aged 15-64 years.*

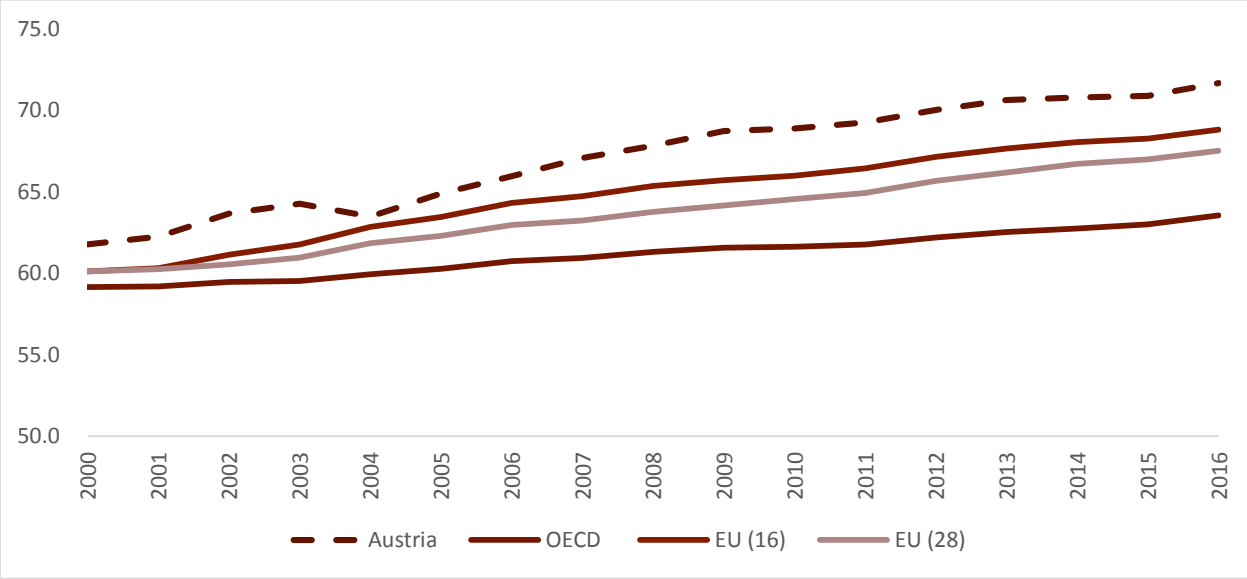
Figure 89: Unemployment rate, historical and future projections (2011-2021)



Source: Medium - term forecast of WIFO March 2017 (provided by the Ministry of Labour, Social Affairs and Consumer Protections)

Although Austria's female participation rate is lower than men, when compared to other developed countries, Austria performs strongly in this regard. For example, since 2000, the female participation rate in Austria has outperformed countries within the OECD, Eurozone and EU (see Figure 90).

Figure 90: Female participation rate with Austria, Eurozone (16), EU (28), and OECD (2000-16)

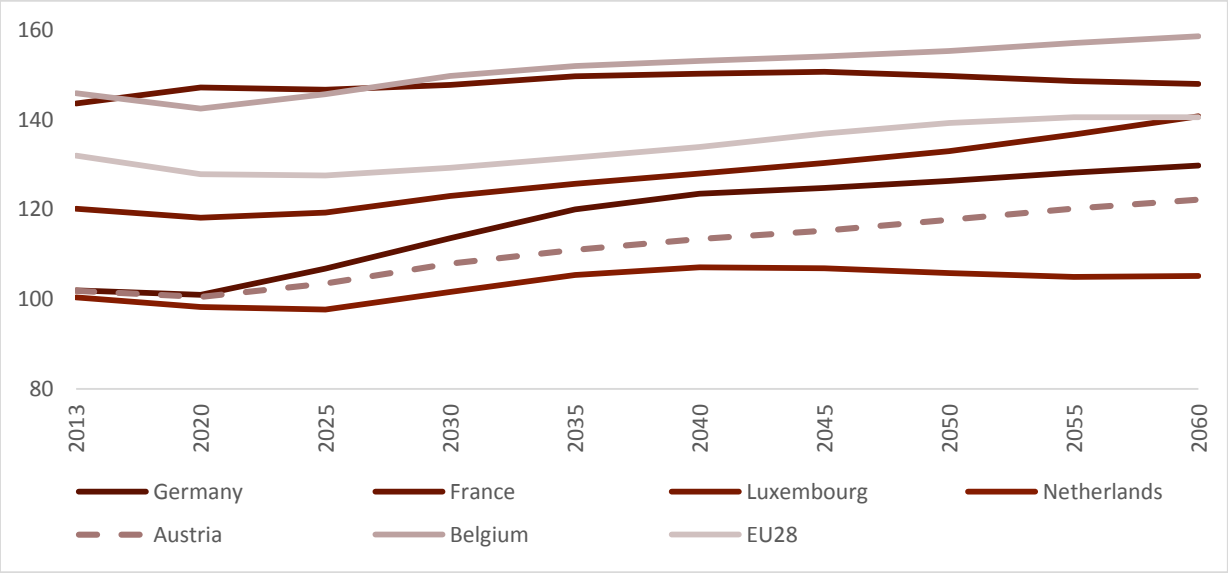


Source: (228)

Despite positive economic projections, future challenges impacting social health insurance finances need to be considered. In particular, Austria's population is ageing, meaning the proportion of the working age population will decline, while simultaneously those in retirement will rise. This will negatively impact the financial capacity of health insurers as contribution revenue will decrease, while the number of health services accessed will increase (given older people access healthcare services more frequently). For example, the *EU-Commission Ageing Report* (2015) estimated that the total economic dependency ratio[58] for Austria will increase from 101.9 in 2013 to 122.2 in 2060 (see Figure 91) (229).

[58] Ratio of dependent people, both young aged below 20 and elderly aged 65 or above, relative to the working-age population (20-64))

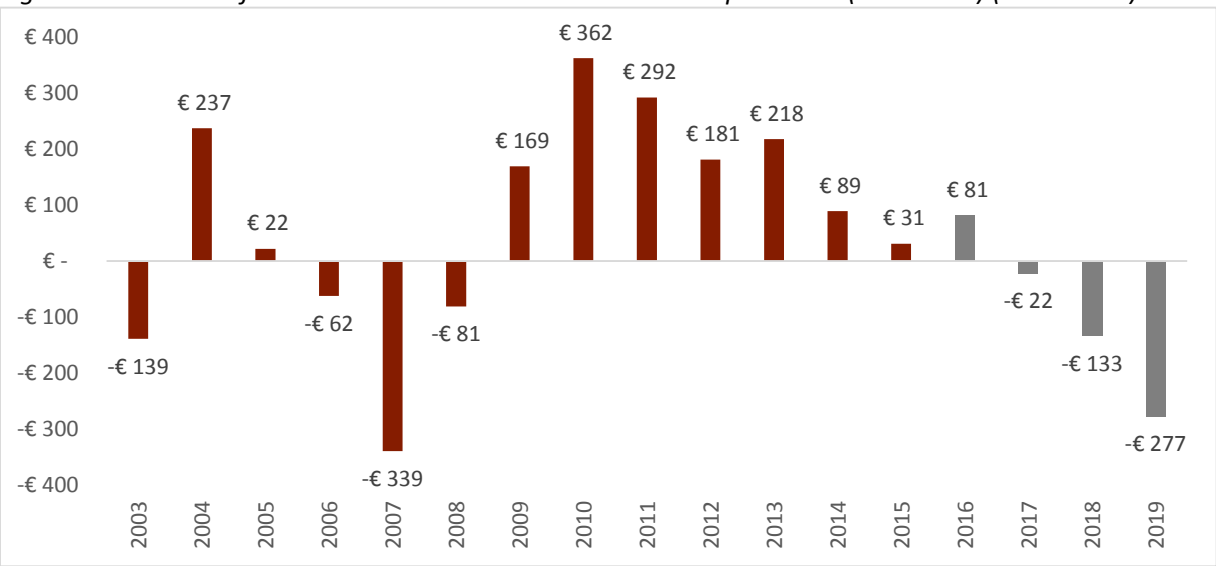
Figure 91: Total economic dependency ratio projections for Austria (2020-2060)



Source: (229)

Taking into account demographic and economic predictions, changes to social health insurance contribution revenue have been estimated. For example, the HVSV (2017) forecasted the balance of social health insurance revenues and expenditures up until 2019. Results from their research reveal that from 2017 onwards, social health insurance, on average, will operate in deficit, which in 2019 will amount to €277 million.

Figure 92: Balance of social health insurance revenues and expenditure (in millions) (2003-2019)



Source: Main Association of Austrian Social Security Institutions. IHS. 2017.
Note: Red columns = actual figures, Grey columns = projected figures.

Future labour market challenges

In addition to an ageing population, social health insurers will face challenges arising from changes to the labour market, namely digitalisation, self-employment, and most importantly, the sophistication and proliferation of artificial intelligence (AI) (see Table 60) (230–232).

Table 60: Labour market challenges facing social insurance systems

Challenge	Description	Challenge to financing
Digitilisation	Advances in technology have increased the size of the online economy.	Three main tax challenges caused from digitalisation are: lack of physical presence in a country, valuing personal data, and characterising payments.
Self-employment	The digital economy has led to an increase in the number of non-standard workers, including those who are self-employed.	Tax avoidance.
AI and automation	Advances in AI and automation are increasingly rendering certain forms of human capital obsolete.	Potential for mass unemployment leading to lower tax revenues.

Source: See descriptions below.

Digitalisation

The proliferation of the Internet across all age groups and economies has led to significant growth in the online marketplace (233). As outlined by a recent OECD report (2016), internet companies are no longer dominated by service providers, or soft- or hard-ware companies, but rather platform operators (e.g. Apple, Google, Facebook and Airbnb) (233).

The proportion of the population who engage with online platforms is significant and continues to grow. A recent study found that 17% of Europeans use services within a collaborative online platform (e.g. Uber, Airbnb), of these people, just under a third (32%) provide the service (234,235). A recent report (2016)

estimated the size of the European collaborative digital economy at €4 billion in terms of revenue in 2015, which generated €28 billion worth of transactions (236).

The digital economy offers consumers better, smarter products and services, and therefore plays a significant role in economic growth (237). However, it also represents a key challenge for governments in terms of tax collection. The OECD has categorised these tax challenges into the following three categories:

1. **Nexus:** Unlike traditional 'brick and mortar' businesses, digital businesses are highly mobile, therefore digital companies often operate in countries without a physical or legal presence.
2. **Data:** Personal data is highly profitable for digital companies such as Google and Facebook, who use it for advertising purposes. A key challenge is how to attribute value to this data and how to classify it for tax purposes.
3. **Characterisation:** It has become increasingly difficult to characterise payments in new digital business models, given there is no intermediary (238,239).

Other indirect tax challenges resulting from digitilisation involve VAT in terms of cross-border trades in good, services and intangibles (i.e. results in minimal to no levels of VAT being applied) (239).

Governments across the OECD recognise the important challenge digitilisation represents to their economies. In response, the OECD has created a Task Force on the Digital Economy (TFDE) which evaluated several policy options to address tax challenges posed by digitalisation. The TFDE concluded that exceptions to permanent establishment (PE) should be modified so that core activities performed by a company in a specific country are taxed accordingly. Secondly, they recommend that countries apply international VAT/GST guidelines, which outline global standards on the allocation of VAT/GST taxing rights on cross-border transactions (239). An overview of policy options explored by the TFDE, including those outlined above, are provided in Figure 93.

Figure 93: Policy options to tackle tax challenges caused by the digital economy

The OECD TFDE analysed several policy options to tackle the tax challenges caused by the digital economy. The options included:

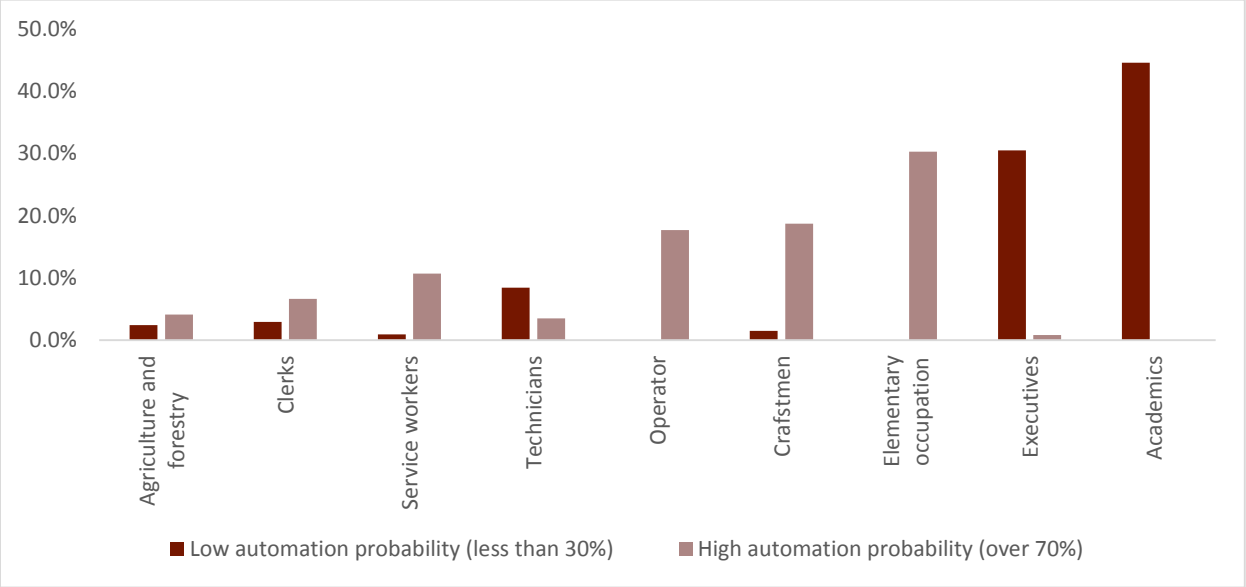
- **Changes to the exceptions of Permanent Establishment (PE) status, that is, whether preparatory of auxiliary activities should remain exempt***
- Alternative to the current PE threshold

- Introduction of a withholding tax on payments by country residents for goods and services purchased online from non-resident providers
- Introduction of an equalisation levy to ensure equal treatment between foreign and domestic suppliers (essentially it is a way to tax non-resident companies who have significant economic presence in a country)
- Collection of VAT on imports of low-valued goods
- **Collection of VAT on cross-border business-to-consume supplies of services and intangibles***

Source: (239)
Note: *Dot points which are bolded reflect policies that were eventually supported by the TFDE. The remaining policies were not supported.

As in all countries, automation probability differs significantly across professions. A recent report by Nagl *et al*. (2017), examined automation probability across nine professions in Austria. Their findings show that across the professions, low automation probability ranges from 0% to 44.6%, and between 0% and 30.3% for high automation probability (see the figure below) (240). Further, Austria has recently introduced a digitalisation strategy called 'School 4.0', which includes training to enhance IT competencies amongst school-aged children.

Figure 94: Low and high automation probability by profession (Austria)



Source: *(240)*

Self-employment

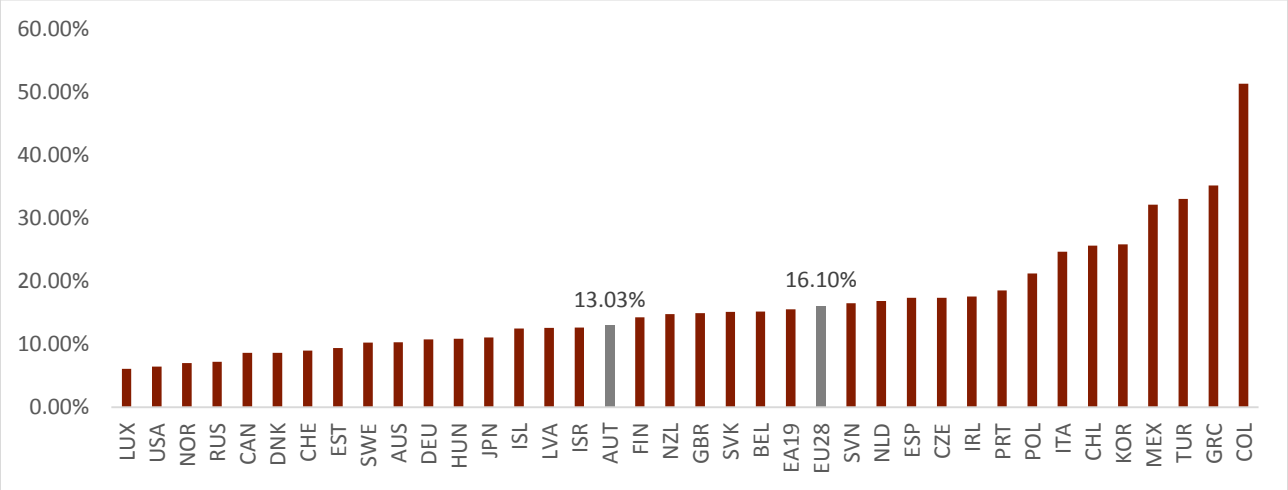
The digital economy has led to a growth in non-standard work (NSW), which is defined by what it is not: 'full-time dependent employment with a contract of indefinite duration' (233). NSW is often irregular (e.g. part-time or temporary) and the individual is often self-employed.

Self-employment is challenging the traditional labour market, particularly within occupations such as management, technicians and associate professionals (see figures below) (241). Workers who classify themselves as self-employed are more likely to work multiple jobs, have numerous income sources, and in many cases, can work from anywhere in the world. Despite drastic changes to the labour market, standard working hours, minimum wages, insurance, taxes and benefits have remained unchanged or have only been marginally adapted (241).

Self-employment is often viewed positively as it allows workers greater flexibility, requires entrepreneurship and innovative ideas thus boosting overall economic growth. On the other hand, it can be seen as exploitative as many workers are not awarded basic employment rights, and are more exposed to financial insecurity (242).

In terms of public financing, self-employment represents a challenge to governments as it is associated with lower tax rates, lower incomes and higher rates of tax evasion (242). In Austria, for example, there is an increasing number of 'bogus' self-employed individuals who do so to avoid tax or social security contributions (243).

Figure 95: Self-employment as a % of total employment for a selection of countries (2015)



Source: (244)

AI and automation

The developed world is facing a new industrial revolution caused by advances in AI which make certain forms of manual routine labour increasingly obsolete (e.g. bank tellers, cashiers, car assembly) (230,231). To date, job losses caused by automation have largely been felt by the middle-class and those with lower levels of education, thus widening the income equality gap (245). For example, the OECD (2016) estimate that 40% of workers who have a lower secondary education degree are employed in jobs with a risk of automation, compared to 5% for those with a tertiary degree or above (241). However, development in AI will increasingly place highly-skilled jobs under risk. Prominent examples already present within the economy are outlined below:

- Law firms are turning to E-Discovery software to sift through large volumes of documents, which is replacing the work undertaken by human clerks or paralegals
- Enlitic has developed deep learning technology to assist healthcare providers in clinical decision making (e.g. Enlitic software can compare multiple lung CT scans to identify blood vessels, harmless imaging artefacts or malignant lung nodules) (246).

For decades' economists have predicted rising rates of unemployment caused by advances in technology. The debate continues today with a number of researchers predicting growing unemployment attributable to the rise in computer controlled equipment (see Figure 96). For example, the OECD have predicted that AI will lead to a loss of 5.1 million jobs across numerous countries between 2015 and 2020. At a country-specific level, researchers within the US have estimated that each additional robot will replace between 180 to 340 workers.

Figure 96: Impact of automation on unemployment: Brief review of recent research papers and policy reports

Frey & Osborne (2017). ***The future of employment: How susceptible are jobs to computerization.***

- The authors looked at 702 occupations in the US and estimated that over the next two decades, 47% of workers in the country could be automated.

Acemoglu & Restrepo (2017). ***Robots and jobs: Evidence from US Labor Markets.***

- Research showed that one additional robot per 1,000 workers is associated with a reduction in the employment to population ratio by 0.18-0.34 percentage points (i.e. one additional robot could replace 180 to 340 workers).

OECD. (2016). ***Automation and independent work in a digital economy.***

- Based on results from the Survey on Adult Skills, 9% of jobs across the OECD are at high-risk of being automated*
- For a further 25% of jobs, it is expected that 50% of their tasks will change significantly due to automation.

World Economic Forum. (2016). ***The Future of Jobs.***

- Predicted that between 2015-2020 there would be a total of 7,165,000 job losses across 20** different countries due to automation and AI, largely in office and administration, and manufacturing and production.
- Over the same period, AI and automation is expected to create an additional 2,021,000 jobs within the areas such as business and financial operation, and management.
- Net impact of 5,144,000 job losses between 2015 and 2020. However, the combined population of all countries used in the study is well over 2 billion, therefore 5.1 million jobs could be considered relatively small.

Source: (230–232,241,247)
Note: *OECD figures are markedly below that of other studies given their methodological approach. Specifically, the OECD report looks at task content of individual jobs in each occupation, as opposed to occupations as a whole. ** Australia, Brazil, China, France, Germany, the Gulf Cooperation Council (GCC), India, Italy, Japan, Mexico, South Africa, Turkey, the United Kingdom and the United States.

The impact of AI on employment should not thwart its development given technological developments lead to significant improvements in everyday lives. Further, other industries may 'soak up' workers who have been made redundant in highly-automated industries (e.g. demand for labour in the health and long-term care sector which will continue to grow as people get older and sicker). Lastly, productivity gains may in fact expand employment opportunities within affected areas thus boosting overall employment (230). For example, one study found that for each job created in a high-tech industry, an additional five complementary jobs are also added (see the figure below for an overview of the impact of AI and automation on the economy) (241).

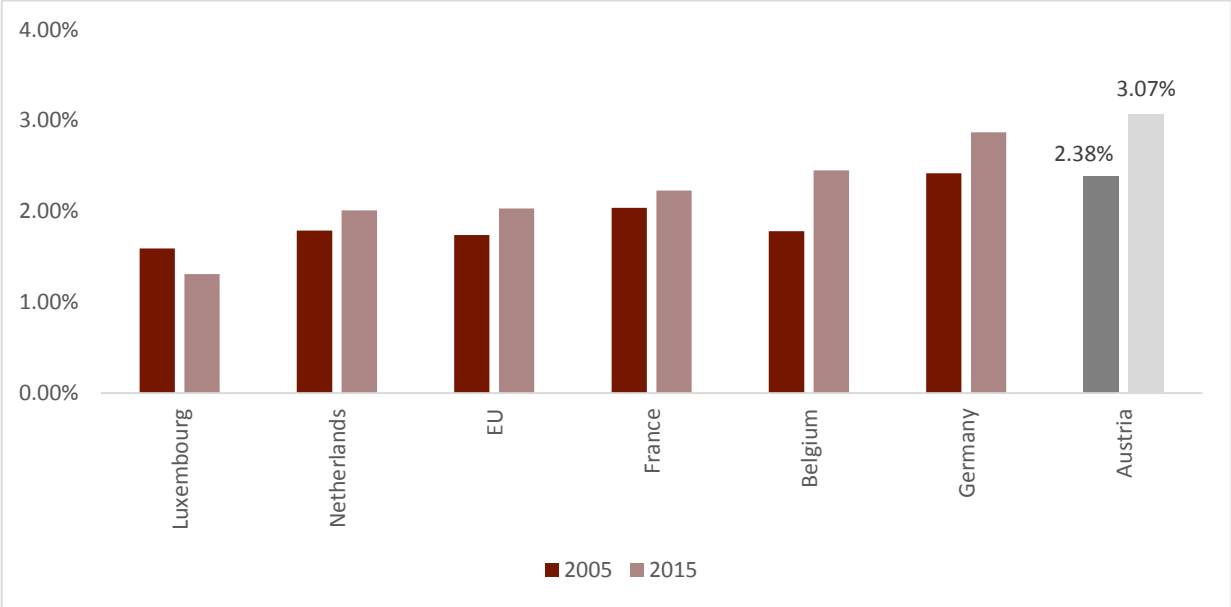
Figure 97: Impact of artificial intelligence and automation

- Improved quality of life
- Productivity gains
- Creation of new jobs

- Workforce displacement
- Unemployment
- Income inequality

Although automation and AI is unlikely to lead to high levels of unemployment, and in certain cases, may increase overall employment, governments still need to act swiftly to fully capitalise on the benefits of technological advances, and to avoid short-term employment displacement. Policies within Austria are already showing promise in terms of adapting to changing labour markets. For example, relative to other European countries, Austria spends a relatively high amount on R&D, most of which stems from the private sector (see Figure 98) (248).

Figure 98: R&D expenditure as a % GDP for a selection of EU countries (2005 and 2015)



Source: (248)

5.5.3 Current international policy responses

Social insurance systems, in the past, have relied upon a mix of policy options to broaden the social welfare base. Typically, governments rely on changes to taxation policy to raise healthcare funds, for example, through the introduction of new taxes, or via changes to the taxation base. Examples of prominent taxation policies targeted at widening the financial welfare based are outlined in this section and include changes to the French taxation base, earmarked health taxes and the Financial Transactions Tax.

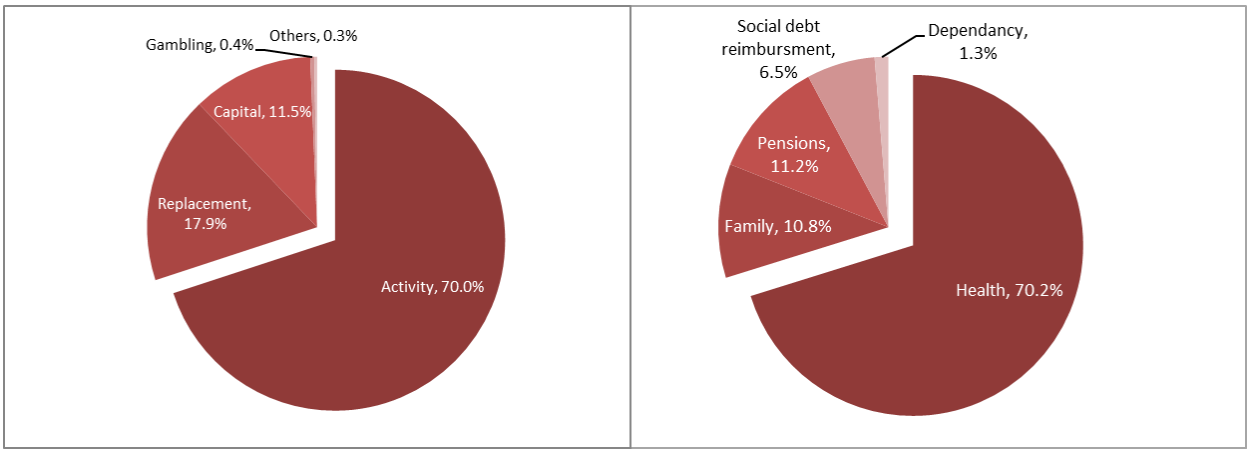
Changes to the French taxation base

During the 1990s, France was faced with slow economic growth and high rates of unemployment. Consequently, the country experienced high budget deficits, which were largely attributed to the healthcare sector. In an effort to improve the sustainability of the healthcare system, in 1995, the then President called for reform within the social insurance system, including ways to widen the revenue base (249,250).

In 1997, the French Government proposed a bill on social security funding, outlining a significant increase in the general social contribution tax (contribution sociale généralisée (CSG)) (i.e. from 3.4% to 7.5% (5.3% earmarked for health)), along with a simultaneous reduction in employee sickness insurance contributions (5.5% to 0.75%) (249,250).

By increasing the CSG, the French Government increased the social welfare base given, unlike sickness contributions, the CSG also takes into account income derived from unemployment and disability benefits, gambling, pensions and financial assets (see figure below for a breakdown of CSG funds). Today, 70.2% of CSG funds are allocated to the country's healthcare sector(249,250).

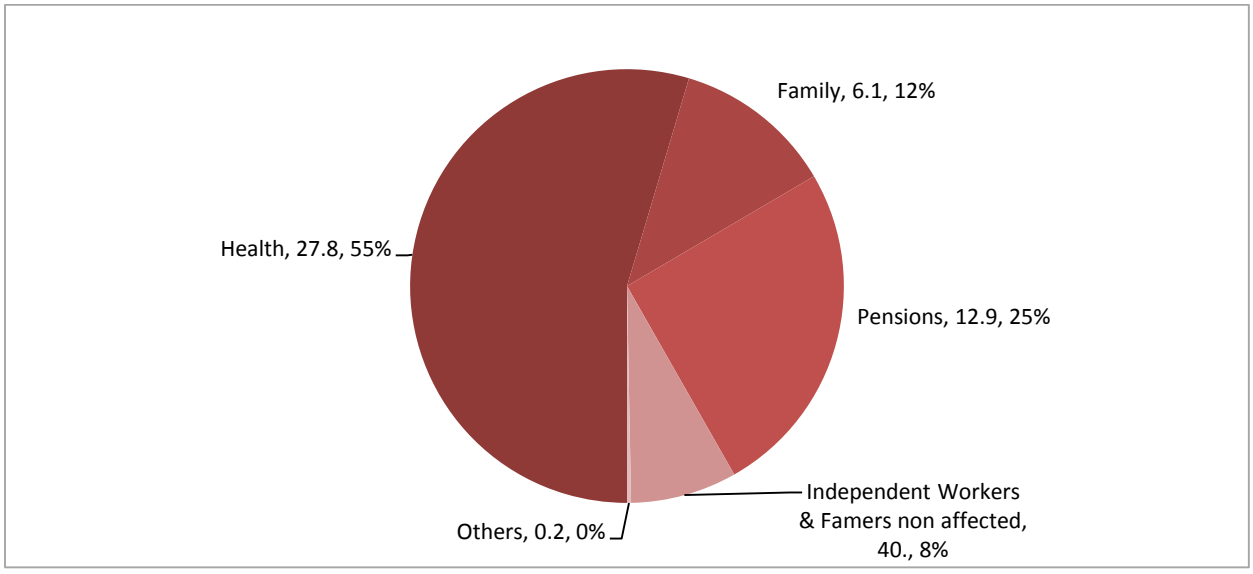
Figure 99: Origins and allocation of CSG revenues (2012)



Source: (250)

The CSG represents the government's greatest effort to diversify funds for healthcare. Over the past 10 years, the government has generated a 'third pillar' of revenue for social security through the form of additional taxes (Impôts et Taxes Affectés), which includes over 20 types of earmarked taxes. In 2012, these taxes raised €51 billion, with just over half (55%) of these funds being dedicated to health (249,250).

Figure 100: Distribution of earmarked taxes for social security (% and billion EUR) (2012)



Source: (250)

A timeline demonstrating the source of funds for social security in France has been provided in Figure 101. The figure shows that France has made significant progress in diversifying the financial base for healthcare, and is therefore less reliant on the labour market.

Figure 101: Distribution of CNAMTS resources (1968-2013)

Source: (250)

It is important to note that various exemptions within the CSG, most prominently the 'Livret A', where interest from savings (up to €15,000) are exempted from the CSG (and also from income tax) (covers 75% of French households). The same exemptions also apply to: Livret Juene (savings accounts for people aged 12-25) (15% of hosueholds), Livret de Développement Durable (savings accounts for sustainable development) (37% of households), and Livret d'épargne Populaire (popular savings accounts) (20% of households).

Earmarked 'sin' taxes

In response to rising rates of obesity, tobacco and alcohol consumptions, a number of countries have introduced 'sin taxes' on items that are deemed unhealthy (251). In many cases, these taxes are earmarked with all or a portion of revenue being used to fund areas within healthcare, such as health prevention and promotion, and health insurance (252). Thus, the objective of earmarked sin taxes is two-fold: firstly, to discourage unhealthy consumption, which may reduce future demand for healthcare, and secondly, to raise revenue for underfunded areas within the healthcare sector (252).

Several countries in America, Europe and Asia have implemented one or several forms of sin taxes in recent years. For example:

- The UK announced the introduction of a sugar tax within the Government's 2016 budget. The tax is expected to raise £400 million a year.
- Denmark introduced a levy of €2.41 per kilogram of saturated fat used in a food product (2011). This policy was not considered successful and subsequently abandoned in 2012.
- As of 2017, France's tax on sweetened drinks totaled €7.53 per hectolitre (i.e. 100 litres). In 2016, the tax raised €313 million. Further, taxes on tobacco and alcohol account for around €8 billion and €1 billion in revenue each year, respectively.
- Several US states have sugar drink taxes in place, a 2009 report estimated that a national tax of 1 cent per ounce on sugar-sweetened beverages would generate US$14.9 billion annually (250).

By linking additional tax revenue to specific health projects, public support is more likely, which may outweigh industry opposition (251).

Italy's IRAP (imposta regional sulle attività)

Tax in Italy is collected at the federal, regional and local level. At the regional level, governments tax companies, including foreign companies with branches in Italy, on their productive activities (i.e. the imposta regional sulle attività (IRAP)). The IRAP is generally set at 3.9%, however, for banks and financial entities, and insurance corporations this rate is higher at 4.2% and 5.9%, respectively (253,254). The IRAP represents one of the primary forms of funding for Italy's National Health System (i.e. 35% of total financing) (254). Key features of the IRAP are outlined in Figure 102.

Figure 102: Italy's imposta regional sulle attività (IRAP)

- IRAP is an earmarked corporate tax levied on the net added value of production
- The IRAP is applied at the regional level by resident companies and by foreign companies with permanent establishment (PE) status
- IRAP is not levied on foreign income
- IRAP is pooled at the national level, and later allocated back to the regions
- Each region has the flexibility to increase or decrease the IRAP by 0.92%, meaning that different levels of IRAP tax are applied across the country

Source: (253,254)

Financial Transactions Tax

The Financial Transactions Tax (FTT) has been proposed as a uniform tax on share, bond and currency transactions. The objective of the tax is to increase contributions from the financial sector to widen the revenue base. The original suggested tax rate was 0.5%, however, economists suggest a figure ranging between 0.1-1% (255–257).

FTTs are designed to increased funds for governments to offer greater stability within the economy. On the other hand, such a tax may lead to a reduction in financial transaction, leading to job losses in the financial sector. Further, banks are likely to pass on the costs to consumers, therefore lowering returns for pensioners and those with savings (255–257).

Several Asian countries have implemented an FTT including Hong Kong, India (Mumbai), South Korea (Seoul), and Taiwan (Taipei). In Europe, in 2011, the European Commission proposed a FTT for the entire EU. By 2012, a unanimous agreement on the tax could not be reached, however, several member states were keen to go ahead with implementing an FTT. To date, an FTT in Europe has not been introduced (255–257).

5.5.4 Policy options: Broadening the social welfare base

Based on international experiences and new challenges facing labour markets across the world, including Austria, a number of policy options have been developed to broaden the country's social welfare base. These have been grouped into the following policy categories: taxation, education and skills, retirement, and workforce participation.

Education and skills[59]

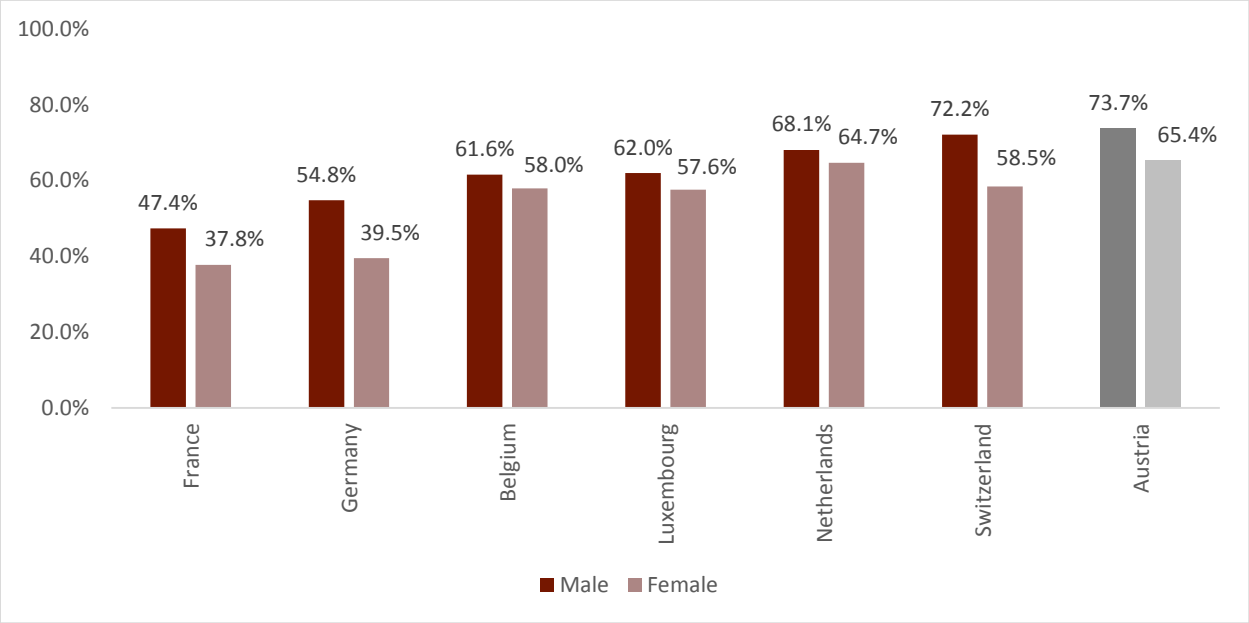
Education systems

It is advised that governments and industry leaders fully cooperate to ensure that academic institutions teach students skills that meet future demands. This may entail increased investment in vocational training, and programs which promote re-training and lifelong learning (as described in further detail below). It is important to note that Austria already performs well in this area, with a relatively high

[59] These policies have been based on options derived by the World Economic Forum (2016) and the US Government (247,258).

proportion of students within upper secondary education engaged in vocational education and training (see Figure 103).

Figure 103: Share of upper-secondary students in vocational programs (2014)



Source: (259)

Lifelong learning

People are living and working longer today than in the past. Longer lives partnered with a rapidly changing economy mean that an increasing number of older people find themselves out of work and without the relevant skills to fill upcoming positions. The Austrian Government could enhance its effort to collaborate with business to encourage ongoing retraining and upskilling to ensure employee skills set are up to date. The Government may also offer tax breaks or other financial incentives to businesses on expenditure related to retraining/upskilling.

Such initiatives have already been undertaken in this area. For example, in January 2017, the Austrian Government created an additional 30,000 training positions. Of these positions, half are dedicated to young professionals (i.e. under the age of 25), with the remaining half falling under the 'Second chance in the Labour Market' concept. For example, under this concept, 6,500 positions are awarded to those who wish to re-orientate their career.

Further education

Automation and AI will reduce demand for highly-routine manual labour. The focus should therefore be on providing the younger population with higher education which will allow them to transition into jobs requiring strong cognitive skills.

Governments could assist this process by offering incentives for individuals wishing to seek higher education. Governments could also run education campaigns during high-school years to encourage children to go on to further education.

Legal considerations

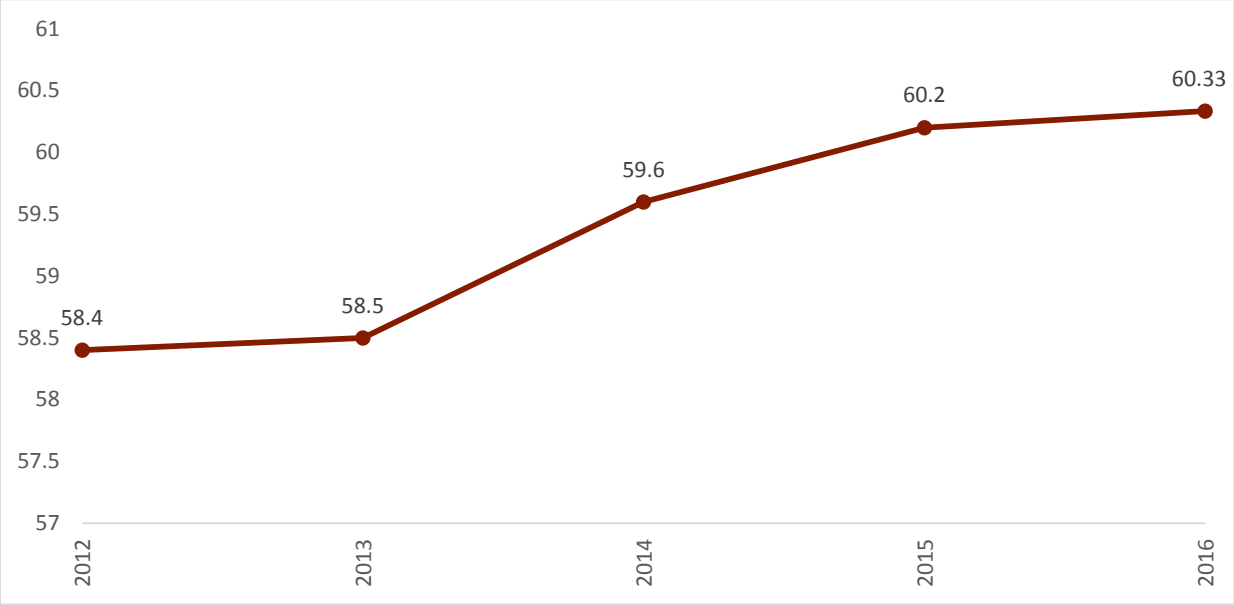
No particular legal impediments exist for the above policy options.

Retirement policies

The legal retirement age in Austria is 65 years for men and 60 years for women, with an expectation that the latter figure will converge to the male age by 2033 (260).[60] Despite the legal retirement age being set between 60-65 years, the actual retirement age in Austria is approximately 60 years. To address this issue, the Ministry of Labour, Social Affairs and Consumer Protection have put in place several pension reform measures, which have already seen positive returns (for example, abolishment of early retirement options). Specifically, between 2012 and 2016, the real retirement age increased from 58.4 to 60.33 (see Figure 104) (8,261).

[60] There are provisions in place for early retirement. Specifically, men can retire at 62 years if they had been employed for 45 years, for women, an equivalent policy has been suspended until their legal retirement age has been harmonised.

Figure 104: Trend in the real retirement age (2012-16)



Source: Data provided by the Ministry of Labour, Social Affairs and Consumer Protection

It is recommended that the Ministry of Labour, Social Affairs and Consumer Protection continue its effort to raise the actual retirement age in coming years. Policy-makers should also continue their effort in the area of health prevention and promotion to avoid early retirement where possible.

Legal considerations

An increase of the actual retirement age is a salient issue in public discussion as well as for policymakers. The main legal impediment that has to be faced in this respect is the principle of 'Vertrauensschutz', meaning that all individuals may trust in a legal situation (especially if it is applicable already for a long-period of time) and, thus, are protected against intensive and/or sudden reductions. Therefore, 'smooth transition provisions' are required for any amendments aiming to increase retirement age.

Workforce participation

The participation rate of women aged 15-64 years is significantly below that of men at 68%. Although this figure represents a significant increase from 60% in 2004, additional policies to encourage women to enter or re-enter the workforce should be implemented. For example:

- Improve affordability and quality of child care
- Encourage businesses to offer flexible working time arrangements

- Encourage fathers to be more involvement in child-rearing responsibilities, for example, through changes to parental leave arrangements.

Increasing the number of women in the formal workforce will improve the financial strength of social health insurers, as well as reduce the need to increase taxes to fund healthcare.

Legal considerations

Even though a wide range of measures would be necessary for implementing these policy options, no particular legal impediments have to be faced in this respect.

Taxation policies

At present, 80% of revenue for social health insurers is sourced from employee/employer contributions. The reliance on contributions may be problematic given labour market volatility, which is expected to worsen given rising rates of self-employment, digitalisation, ageing of the population, and AI and automation. To address this challenge, social health insurers could:

- Alter the contribution base to consider total income, including income from benefits and properties, for example. If this approach is taken, the maximum income threshold should be upwardly revised to fully realise the financial benefits of widening the contribution base (explored further in the section regarding 'collection of contributions').
- Alter the contribution base stemming from employers, for example by taxing profits. However, caution should be taken when considering this approach as although it may lead to short-term gains, in the long-run, Austrian companies may be less competitive on a global scale and less likely to hire, thus reducing overall contributions (see Italy's IRAP, Figure 102, for further details).
- Diversify revenue sources by increasing the level of earmarked health taxes, beyond the current tobacco tax (§ 447a Abs. 10 ASVG), which currently contributes to the Risk Equalisation Fund (2/3 of tax revenue) and the Health Prevention and Promotion Fund (1/3). For example, additional taxes could be levied on alcohol, and products with high levels of sugar and saturated fat. Before such taxes are introduced, it is important to clearly specify whether the main objective of the tax is to change health behaviours or raise revenue. If the former, the literature suggests that taxes should be set 20% or above (specifically, for sugar-sweetened beverages).

Legal considerations

Whilst increasing taxes dedicated to a specific health purpose would not cause particular legal impediments, widening of the basis for social insurance contributions by including income which is not gained from (self-)employment would lead to problems with respect to the fundamental concept of social insurance, which is closely linked to (self-)employement and, thus, to the income gained from that source. Moreover a problem with respect to the principle of self-governance has to be faced, too, as persons living on properties are not part of any 'Versichertengemeinschaft': So why should they pay contributions and why should (self-)employed persons share their risks with landlords etc? (for details see Volume 2 chapter 5.2.2.)

International studies

In addition to the policy options outlined above, it is advised that the Austrian Government keep up-to-date with research being undertaken in this area by international institutions, namely the OECD. For example, this year, the OECD have commissioned a *Future of Work* project to advise governments on how to address challenges caused by changes to the traditional labour workforce (see Figure 105).

Figure 105: OECD Future of Work project

The OECD initiative on the *Future of Work* will look at how demographic change, globalisation and technological progress are affecting the quantity and quality of jobs, as well as labour market inclusiveness, and what this means for the labour market, skills and social policy. As part of this project, the OECD will look at which schemes or models providing social protection to non-standard workers are already in place across the OECD, how well they work, and what implementation problems exist.

Summary of policy options for broadening the social welfare base

First and foremost, to ensure the financial sustainability of the social insurance, policy-makers should implement appropriate policies to improve efficiencies within the system. Only then should further efforts to widen the social welfare base be considered.

Within section 5.5.3, a description of the FTT was provided, however, it has not been included within our proposed policy options given there is disagreement about the policy's implementation across Europe.

Specifically, this option is not recommended given the adverse impact an FTT would likely have on financial markets if implemented by a single country.

It is advised that the government intensify its effort to prepare the labour market for changing industry demands. Specifically, by investing in relevant education programs that span across an individual's working life. By ensuring skills match demand, the possibility of rising unemployment as a result of AI and automation will be minismised. A continuation of policies to boost the actual retirement age and participation of women in the workforce is also highly recommended in the short-term.

Changes to the tax system, through a broadening of the contribution base, should only be considered if 'soft' measures (as outlined above) are unable to raise sufficient funds. This approach is recommended for various reasons. First, there is no political consensus or motivation to pursue this policy. Second, Austria already draws upon both direct and indirect taxes to subsidy healthcare. And thirdly, an increase in taxes is inconsistent with recent policies to reduce the overall tax burden for citizens.

Lastly, in regard to earmarked sin taxes, we advise that the Austrian Government commission a study to evaluate the impact such taxes have on changing individual behaviour and raising additional revenue. Based on findings from the review, the Government could consider extending sin taxes beyond the current tobacco tax (§ 447a Abs. 10 ASVG).

6 Contracts and purchasing

Chapter 6 relates to contracts and the purchasing of services within healthcare systems. The chapter is focused on the negotiation process between providers (i.e. physicians) and payers (i.e. health insurance), for example, by covering topics such as reimbursement and quality of care. Issues regarding IT and procurement of medicines (including expenditure) are also discussed.

6.1 Framework for primary and outpatient care

Policy-makers are increasingly interested in strengthening primary and outpatient care given its role in promoting coordinated, appropriate health services. Primary and outpatient care therefore plays a salient part in improving healthcare efficiency by minimising unnecessary, costly services delivered within an inpatient setting. A pivot towards primary and outpatient care is evident in Austria, where, in recent years, two primary healthcare units have been established, in addition to financial incentives for establishing group ambulatory care centres (further details provided in section 6.3.8).

Dimensions of primary and outpatient care can be broken down into 10 elements, which are further grouped into the following three indicators: structure, process and outcomes (262). Many of these dimensions are influenced by contractual negotiations, therefore the agreement reached between social health insurance and the Chamber of Physicians is of significant importance for improving primary and outpatient care.

Further details regarding contractual negotiations, including elements within the primary and outpatient care conceptual framework, are discussed in sections 6.2 and 6.3.

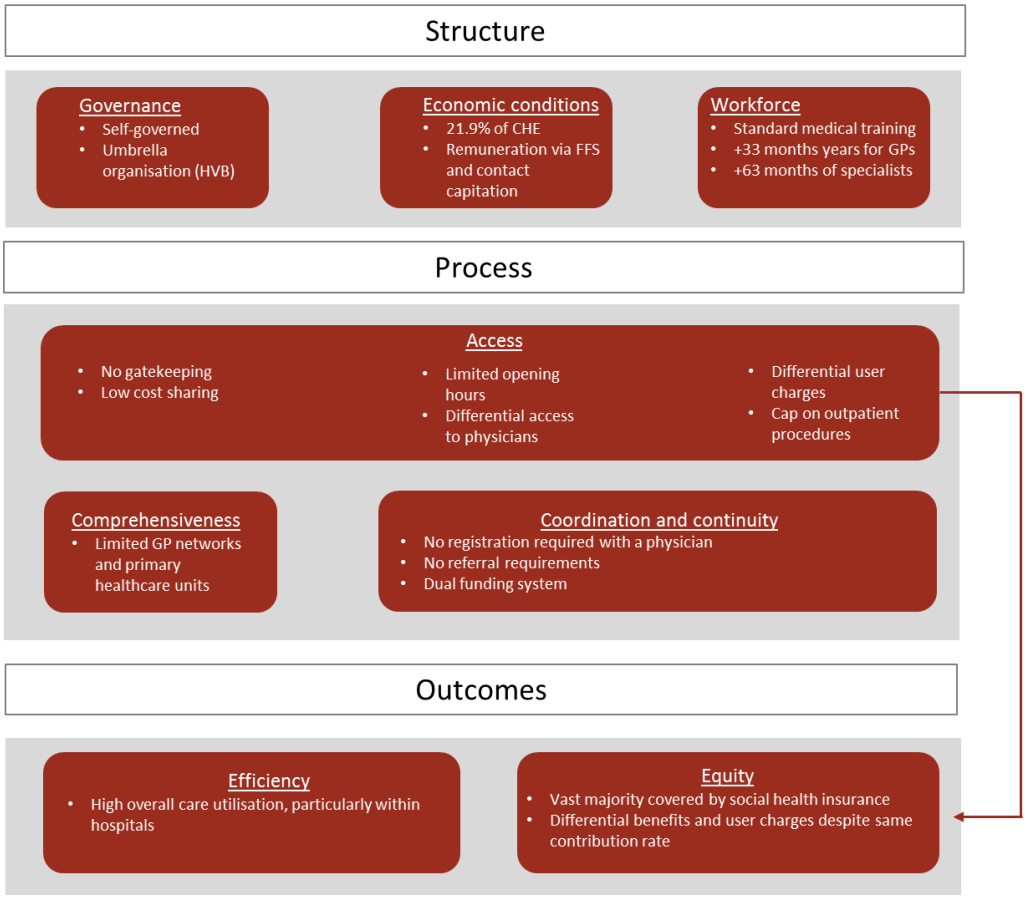
Table 61: Elements of primary and outpatient care

Group indicators	Element	Description
Structure	Governance	Vision, regulations
	Economic conditions	Expenditure, remuneration
	Workforce development	Training
Process	Access	Access to care, physicians and services

Group indicators	Element	Description
	Comprehensiveness	Breadth of services
	Coordination and continuity of care	Link between all levels of care
Outcomes	Efficiency	Cost-effective use of resources
	Equity	Systematic differences in healthcare access and outcomes

Source: Adapted from (262)

Figure 106: Conceptual framework for primary and outpatient care in Austria



Source: Adapted from (262)

6.1.1 Structure

Governance

Primary and outpatient specialist care operates within Austria's social insurance system. Social health insurers are self-governed institutions operating under various laws. Social insurance carriers must belong to the umbrella institution, the HVSV, which is responsible for the overall vision of social insurance. It is important to note that 15 KFAs, although by definition are a form of social insurance, do not operate under the HVSV.

Economic conditions

Ambulatory care accounts for 21.9% of current health expenditure in Austria, or €7.7 million. Of these funds, just under half (43%) are spent on services provided by physicians, followed by dentists (23%), and finally, other health practitioners, ambulatory healthcare centres, and home health care services (34%).

GPs and specialists who are contracted with a social health insurer are remunerated via a mix of FFS and contact capitated payments (see section 6.2 for further details). Non-contracted physicians, are paid directly by individuals, who are later partly reimbursed by their social health insurer (described further in section 6.2). According to Stigler *et al. (*2012), Austrian GPs, on average, earn between 33-50% of outpatient specialists income. This proportion indicates the relative inferior status of GPs within the healthcare system (263).

Workforce development

According to Hofmarcher (2013), those wanting to become a physician, of any sort, must first complete a degree in human medicines, which includes a minimum of 12 semesters of classes at a medical university (4). To become a specialist, individuals must complete an additional 63 months of postgraduate clinical training, and examinations. Post-graduate education for GPs, on the other hand, is limited to 33 months (4). Training during these three years primarily takes place within a hospital setting, however, six months is spent with a GP setting.

6.1.2 Process

Access

GPs do not have a formal gatekeeper role within the Austrian healthcare system, therefore patients are free to access any type of outpatient specialist and/or inpatient care. Access to healthcare is also facilitated by relatively low levels of cost-sharing, with most services being provided in-kind by social health insurers (263).

Opening hours for both GPs and specialists, as outlined within contractual agreements is low, which may force patients to access inpatient care, despite suffering from relatively minor conditions. For example, it is typical for the general agreement to state that GPs be open for at least 20 hours. Actual opening hours are likely to be longer, however, this figure is unknown as it is not formally recorded.[61] Actual working hours in other developed healthcare systems ranges from approximately 33-51 hours per week (264,265).[62]

Access to GPs and specialists differs across social health insurers as carriers with greater financial means are able to offer more attractive contractual agreements, that is, higher tariffs. As a result, insurees with wealthier carriers have greater access to GPs and specialists.

In regard to outpatient specialists, criteria for developing where posts are located has not based on robust needs-based factors, which may have led to a shortage of specialists within certain areas. Regional Structural Plans for health (*Regionaler Strukturplan Gesundheit*) aim to coordinate care between the Land and social health insurance, however, the initiative's success, to date, has been limited. Further, in recent years, a cap on certain outpatient specialist procedures has been implemented (e.g. a cap on MRIs, where Austria performs a relatively high number of exams (see figure below), has been met with frustration). Caps, which may either apply to specialists of GPs, differ across contractual agreements. As an example, carriers may apply points to services, which are linked to reimbursement, with the value of each point declining after certain thresholds are reached within a specific time period (this may be applied at the aggregate level, or at a specific service level). An alternate method is to limit the number of procedures

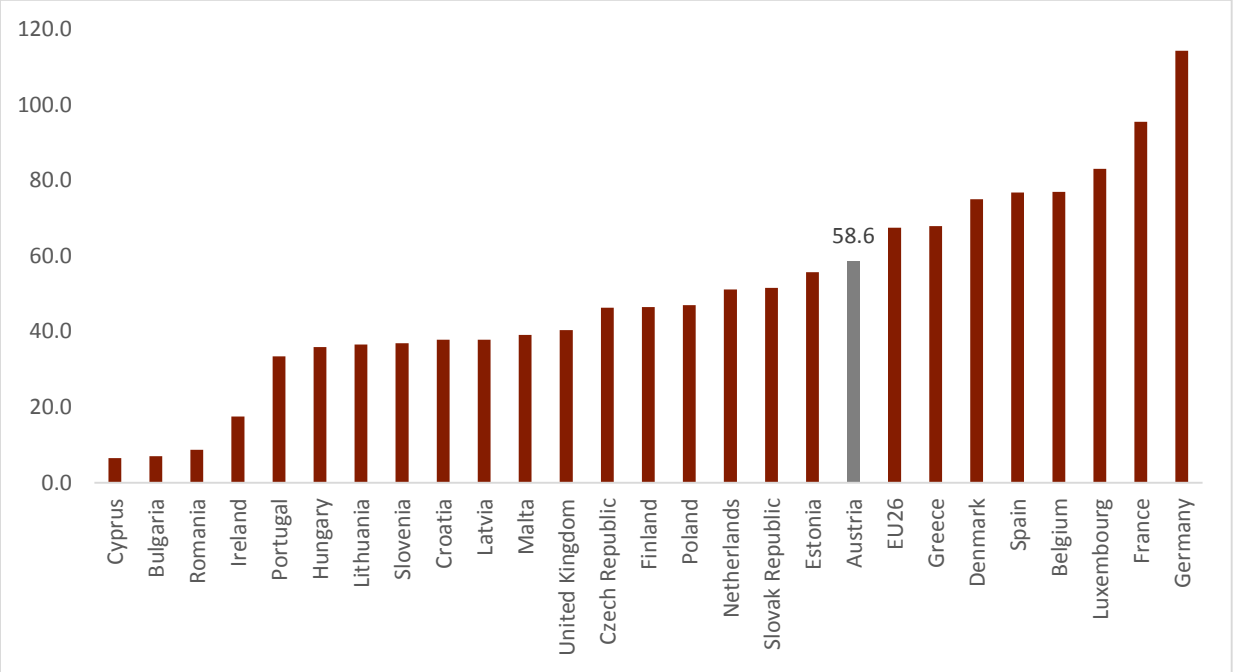
[61] The HVSV are currently undertaking a project using a web crawler to determine opening hours amongst contracted GPs.

[62] For example, Australian GPs, on average, work 33 hours per week, compared to 44 and 51 hours in the Netherlands and Belgium, respectively. These figures cannot be compared directly as findings were sourced from two surveys which used different methodologies (264,265).

physicians can perform over a specific period of time, after which no reimbursement is provided. Carriers may implement either or both forms of caps (266).

Implementing caps can be a positive move to reduce unnecessary care and contain costs. However, to ensure those in real need are not put at a disadvantage, they should be implemented alongside relevant guidelines.

Figure 107: MRI exams per 1,000 people (2014 or nearest year)



Source: (17)

Comprehensiveness

Despite recent efforts to expand physician and healthcare networks, the majority of GPs and specialists operate within single practices (4). This arrangement limits the breadth of services a patient receives when visiting their GP or specialist.

Coordination and continuity of care

As previously discussed, Austrian citizens have unregulated access to GPs and specialists. The principle of free provider of choice can act as a barrier to providing a high-quality healthcare system, given no single physician is responsible for managing and monitoring healthcare at the individual level. As frequently highlighted during roundtable stakeholder discussions, in Austria, this mean patients are often left

'wandering' the healthcare system, and thus accessing inappropriate levels of care. It is important to note that patient management is not required for all individuals, just those who suffer from one or multiple chronic conditions, and who therefore require access to a number of different healthcare providers.

Continuity of care between primary, ambulatory and inpatient care is further hindered by the dual financing system, where the Länder is responsible for inpatient care, and social health insurance for primary and ambulatory care.

6.1.3 Outcomes

Efficiency

Insufficient primary and ambulatory care has a negative impact on overall healthcare efficiency. This is evident in Austria, where there is a relatively high number of hospital admissions (see section 3.5 for further details). Frequency of access to care in Austria is also present across lower forms of care, specifically, at the outpatient and primary care level. For example, a report by Pichlhöfer and Maier (2014) found that unrestricted access to healthcare services has led to a relatively high overall utilisation rate (see section 3.5).

Equity

Equity of care is high in Austria given the vast majority of people have access to the social health insurance system. Inequity does however exist between social health insurers. Specifically, given multiple contractual agreements, the number of GPs and specialists available to patients, and reimbursable services, differ according to each health insurer. These differences occur despite harmonised contribution rates.

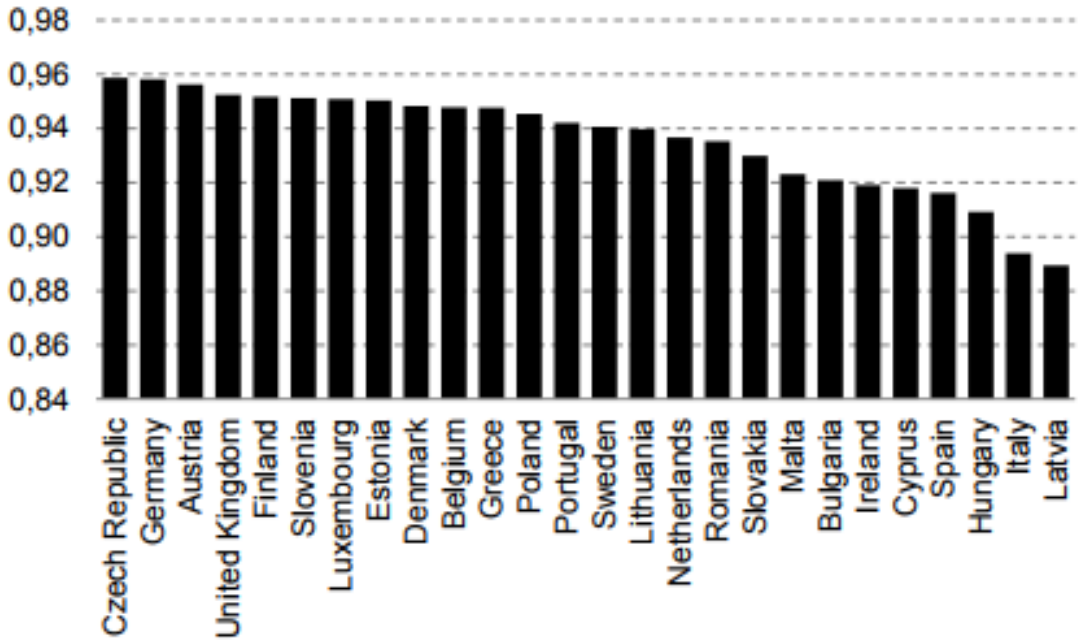
In terms of user chargers, social health insurance carriers have implemented differential user charges, which again may act as a barrier to healthcare for some. Further, the pharmaceutical expenditure cap (i.e. 2% of net income), although a positive initiative, is not in technical terms 'progressive' and thus adversely impacts those on lower incomes (see section 5.3 for further details on user chargers).

Summary

For the reasons outlined above, Austria frequently ranks poorly in terms of primary and outpatient care. For example, an international comparison of primary care by Stigler *et al*. (2012), classified Austria as a 'low primary care country' along with Belgium, France, Germany and the US (263). This finding was mirrored by Kringos *et al.* (2013) who also classified the system as 'weak' (267).

Despite this ranking, the vast majority of the population satisfied with the general outpatient sector (98%) and the treatment they receive (97%).[63] Further, a recent analysis comparing patient-provider interactions across all 28 EU Member States revealed Austria performs well in this area (see figure below). However, caution should be taken when interpreting these results given the authors had minimal knowledge of why patients report low or high levels of quality (65,268).

Figure 108: Quality of interactions between patient and primary care physician (score), EU(28), 2013



Source: Taken directly from (65,268)

6.2 Paying healthcare providers

6.2.1 Types of provider payment schemes

Predominate payment mechanism for primary/outpatient physicians and hospitals are fee-for-service (FFS) (healthcare providers are paid for each individual service), capitation (healthcare providers are paid a fixed amount per enrollee, which is independent of number of patients treated), physician salaries, and to a lesser extent, pay-for-performance (P4P) (269).

[63] Satisfaction survey (2015) completed as part of the Federal Health-Target contracts (objective 8.4.1).

In regard to outpatient services, the trend within this area has been towards blended payment, which incorporates elements of each of the four payment models outlined above (270). At the hospital level, payers of inpatient care have increasingly moved away from global budgets and

FFS to 'bundled' payments that group together components of healthcare (i.e. grouped packages of care, and grouped inputs to delivery of care) (270). Bundled payments within the hospital sector are generally classified under a DRG (diagnostic-related group) case-mix system. An overview of each of these payment methods is provided in Table 62.

Table 62: Type of provider payment methods

Payment method	Description	Unit of payment	Setting
Fee-for-service	Retrospective payment based on volume of individual services	Units of service	Hospital and physicians
Salary/global budget	Lump sum payment for a specific period of time	Time	Physicians
Capitation	Periodic lump sum payment per enrolled patient for specific services	Persons registered	Hospital and physicians
DRG	Statistical system that classifies inpatient stays for the purpose of reimbursement	Type of service	Hospitals
Pay-for-performance	Payment linked to quality of care provided	Performance	Hospital and physicians

Source: (270)

As outlined above, provider payments is one of the tools policy-makers can use to achieve health system objectives (271). Traditional methods of payment outlined above, however, do not directly align with all

health system priorities, such as efficiency, quality and equity. Further, many of these methods have inbuilt incentives that lower the quality of care. For example, FFS can lead to overprovision of services which inflates expenditure and, in certain circumstances, can worsen patient outcomes. Capitation, on the other hand, can control expenditure, however, it may lead to 'cream skimming' and cost-shifting. Lastly, the use of DRGs can encourage fraudulent behaviour given hospitals have an incentive to up-code in order to receive greater payments (see the following two tables for further details) (270,271).

In response to shortcomings associated with traditional payment methods, policy-makers have become increasingly interested in linking payments to the quality of care provided (i.e. P4P). In theory, P4P can overcome the principal-agent problem by aligning patient-provider incentives (269). Despite economic incentives, there is limited evidence to suggest P4P has a positive effect on health system objectives (further details on P4P is provided in section 6.4.4) (272).

Table 63: Payment mechanism objectives and unintended consequences

Payment method	Health system objective	Unintended consequences
Fee-for-service	Equity	Overprovision of services Superfluous care
Salary/global budget	Expenditure control	Under provision of services Creak skimming Quality skimping Cost-shifting
Capitation	Expenditure control	Cream skimming Quality skimping Cost-shifting
DRG	Expenditure control	Up-coding (fraud) Cream skimming Quality skimping

Payment method	Health system objective	Unintended consequences
Pay-for-performance	Quality	Gaming and risk selection Negative impact on intrinsic motivation Poor quality of care

Source: (272,273)

Table 64: Payment mechanism contribution to health system objectives

	Activity	Expenditure control	Quality	Equity	Efficiency
Fee-for-service	++	--	+/-	++	-
Salary/global budget	--	++	+/-	--	-
Capitation	-	++	+/-	-	+
DRG	+	+	+/-	0	++
Pay-for-performance	?*	+/-	+	?*	+

Source: (273) and author creation.
Note: ++ very positive impact; + positive impact; 0 neutral impact; - negative impact; --very negative impact; ? unknown. *Depends on the type of incentive associated with payment (e.g. incentive associated with treating more vulnerable groups, which would improve equity).

6.2.2 International case studies: Paying providers

Physician payment mechanisms across European social health insurance systems are similar. At the GP and outpatient specialist level, FFS dominates reimbursement, however, increasingly policy-makers are

introducing pay-for-performance (P4P) schemes to incentivise high-quality care. Despite this, P4P comprises a small proportion of overall income. At the hospital level, European social health insurance systems are reliant on diagnostic related groups (DRGs) to reimburse hospitals as a way to improve transparency and contain costs.

The remainder of this section provides a description of physician reimbursement schemes for GPs, outpatient specialists and hospitals, in Belgium, France, Germany, Netherlands, Switzerland and Austria.

Table 65: Physician reimbursement in Europe

Country	Primary care	Outpatient specialists	Inpatient care
Belgium	Largely FFS using national fee schedule, capitated budgets and P4P (lump sum payments)	FFS	Prospective budgets and FFS
France	FFS, capitation and P4P	FFS and P4P	DRGs
Germany	FFS and pay-for-performance	FFS	DRGs Set fees for highly specialised services
Netherlands	FFS, capitation, bundled payment	DRGs*	DRGs
Switzerland	FFS (national fee schedule) and capitation	FFS	DRGs
Austria	**FFS and capitated flat rate payments**	**FFS and flat rate payments**	**Budgets informed by DRGs (i.e. LKF in Austria)**

Source: See country descriptions below.
Note: *Dutch DRGs are referred to as DBCs, with the main difference being that they also include outpatient care.

Belgium

In Belgium, the majority of physicians work in in independent medical practices and are self-employed. Medical specialists work in health institutions (mainly hospitals) and/or in an outpatient private practice (82).

Independent medical practitioners are largely paid on a FFS basis, with less than 1% of physicians being paid via a salary. Those who are salaried generally work in integrated medical health care practices owned by physicians and remunerated by National Institute for Health and Disability Insurance (NIHDI) (who manage compulsory health insurance) according to a capitation payment (82).

The proportion of income GPs receive from FFS, although still large, has been declining due to the increase in lump-sum payments linked to quality of care (i.e. from 2.6% of income in 2000 to 20% in 2010). Specifically, for:

- Managing a patient's global medical file (file of patient information held by the GP to share with other providers to improve care coordination)
- Coordinating disease management programs (e.g. type II diabetes and chronic kidney failure)
- Participating in continuing education activities and peer review sessions
- Being on call (274).

Specialists working in hospitals are also reimbursed through a FFS model using rates negotiated at the national-level. Although specialists theoretically get paid directly for their work, in reality, hospitals retain a proportion of fees in order to compensate for capital and other overhead costs (82).

Hospitals in Belgium are reimbursed through two separate mechanisms depending on the type of service being provided. Specifically, services such as accommodation, nursing activities/units, operating rooms and sterilisation are paid through a prospective budget system. Medical services, such as polyclinics and laboratories, for example, are largely paid via FFS (82).

France[64]

The majority (58%) of GPs in France are self-employed in solo, group or multi-professional practices, and who are largely paid on a FFS basis (87% FFS, 13% on other forms of payments such as P4P and

[64] Information collected from D. Polton directly.

capitation[65]). In addition, there are approximately 400 health centres who employ salaried GPs. Other funds stem from payments that are linked to improvements in care coordination. Specifically, in 2008, the Ministry of Health launched a pilot to test prospective payment schemes to encourage the development of multi-professional group practices in primary care (*Expérimentation de Nouveaux Modes de Rémunération*). The pilots included multi-professional group practices, healthcare networks and health care centres, who participated on a voluntary basis. The prospective payment comprised approximately 5% of general medicine practice revenue and can be broken down into the following three groups:

- Payment for time and costs associated coordinating care
- Payment for provision of new services for targeted patient groups
- Payment for cooperation through skill-mix modifications between medical and nursing staff.

An independent evaluation of the pilots by IRDES suggested the pilot scheme achieved its overall objectives of encouraging group practice and improving, to a certain extent, the geographical distribution of GPs, efficiency structures and quality of care (with results varying according to group structures).

The pilot program was later generalised for all multi-professional group practices. Under the scheme, multi-professional group practices can claim additional performance-based payments for three targets: *accessibility of health care* (e.g. opening hours, range of services delivered), *intensity of teamwork* (e.g. implementation of multi-professional guidelines for chronic diseases), and *utilisation of computerised patient medical files*, which are shared among all providers in the practice. Assuming a patient population of approximately 4,000 people, a multi-professional group practice can earn an additional €17,850 to €51,800 per year, depending on their performance. Although multi-professional group practices continue to grow, they still are in the minority, comprising between 10-15% of all GPs in France. Further details on the points-based payment scheme are provided in the tables below.

Lastly, GPs who set up their practice in underserved areas can receive a lump-sum payment of €50,000 to cover set-up costs, in addition to other financial incentives for operating in these areas. Although not performance related, GPs can obtain additional remuneration to help set up their practices (e.g. electronic medical records, organisation, care coordination, teleservices, coding of medical data, training of young doctors). This additional payment, as of 2017, amounted to €1,750, and will increase to €4,620 by 2019.

[65] In 2016, the latter component of GP remuneration (i.e. 13%), as of 2016, includes P4P (indicators related to care), a weighted capitated payment, payment linked to the organisation or the practice (e.g. software, electronic communication with sickness funds, training of young doctors, as well as additional payment in underserved areas.

Table 66: Remuneration system for integrated group practices (medical homes and network) – basic remuneration (France)

Target	Details	Points*
	Fixed remuneration	
Access to care	• Open 8am to 8pm, Saturday morning and holidays • Access to unplanned care every day • Coordination function identified	1,200 points
Team work and coordination	• Multi-professional protocols for some diseases	500 points
IT system	Sharing of patients' records – 33% of patients in 1st year, and 66% in second year	850 points
Variable remuneration (depends on number of patients – following figures relate to 4,000 patients)		
Team work and coordination	Formalised multi-professional coordination on a regular basis for some disease, synthesis in the electronic patient record	1,000 points
IT system	As above	1,500 points

Note: *€7 per point.

Table 67: Remuneration system for integrated group practices (medical homes and networks) – basic remuneration (optional) (France)

Target	Details	Points*
	Fixed remuneration	

Target	Details	Points*
Access to care	• Consultations with specialist or midwife at one day per week • Range of specialists or types of professionals covered	900 points
Team work and coordination	• Training of young professionals	450 points
IT system	IT system labelled level 2	100 points
	Variable remuneration	
Access to care	• Public health missions	700 points
Team work and coordination	• Procedure to send health data to professionals and institution outside the medical home • Electronic medical record for all patients hospitalised to be shared with all professionals	200 points

Note: *€7 per point.

Specialists in the outpatient sector who are self-employed are reimbursed via FFS (approx. 36%), while the remainder are employed by hospitals and either fully salaried or have mixed income. In 2014, the P4P scheme was extended to all self-employed physicians, not just GPs. On average, self-employed specialists can earn €5,480 per year, which constitutes about 2% of specialist income (275).

Finally, since 2008, all hospitals in France have been reimbursed according to a DRG system, which is used to pay physician salaries.

Germany

Social health insurance contracted physicians working in the outpatient sector are largely reimbursed on a fee-for-service basis. The fees that SHI reimburse for are outlined within the Uniform Value Scale (UVS) (Einheitlicher Bewertungsmaßstab), which sets out the range of healthcare services reimbursable by sickness funds at the outpatient level (276,277). A limit on the amount each physician can invoice their regional doctor association ((Kassenärztliche Vereinigungen (KV)) is determined every quarter (276,277).

Physicians at the outpatient level also receive additional flat-rate payments for each patient enrolled in a disease management program (DMP) (e.g. Type I and II diabetes, breast cancer, ischemic heart disease, asthma, and chronic obstructive pulmonary disease). In 2015, the flat fee amounted to €120 per patient (275,277). Further information on Germany's DMP is provided in section 6.4.4.

In line with international trends, Germany in 2005 began to gradually phase in DRGs, which were based on the Australian Refined DRG system. Today there exist approximately 1,200 DRG categories (275). On top of DRGs, there are additional fees for highly-specialised services (i.e. services that cannot be appropriately reimbursed through the DRG system) (277).

Netherlands[66]

Payments for primary care consists of three layers. First, traditional primary care providers are reimbursed through a combination of capitation and FFS payments, which accounts for approximately 70% of turnover. Second, over the past decade primary care physicians have increasingly formed part of collaborative, joint regional out-of-office care centers; in addition, for certain chronic illnesses care pathways were funded (bundled payments). Forty care groups organise these forms of care on behalf of the participating primary care physicians (20%). Unlike FFS and capitated payments, these rates are not set by government. Thirdly, physicians can negotiate with insurance companies about 'innovation' funds (e-health, substitutions of care etc.) (which account for the remaining 10% of turnover).

Dutch insurers and hospitals negotiate on both the price and the volume of care. The prices of 70% of turnover are freely negotiable, which includes capital remuneration. The impact of rate setting is modest, although the Dutch Healthcare Authority sets the actual packages of care, which providers need to comply to. For certain expensive medicines, complex treatments and specific functions, separate sources of funding exist. Since 2014 just under half (45%) of self-employed hospital physicians are required to

[66] Information sourced directly from P. Jeurissen (member of the international evaluation committee)

negotiate with the hospital on their reimbursement, that is there are no longer formal negotiation partners for the insurance companies.

The Government's fiscal policy tries to ensure that provider payments comply with a central goal of total health expenses. Due to limited formal influence on actual payments (especially for hospitals), they have done this by negotiating subdued annual budget raises. An overrun of a certain subsector of providers can be recouped retrospectively according to each provider's market share. To date this instrument has never been used.

Switzerland

Outpatient GPs and specialists are paid by a mix of FFS and capitation. Specifically, 90% and 91% of GP and specialist payments are via FFS, with the remainder funded through capitated budgets. Since 2004, standardised fees for clinical outpatient procedures (both diagnostic and therapeutic services) have been set out in TARMED (278). Specifically, TARMED assigns a uniform tariff point to each service which is negotiated and agreed upon by the association of physicians and hospitals on the provider side, and by tarifsuisse SA or curafutura on the purchaser side (health insurance associations). The objective of introducing TARMED was to harmonise the amount healthcare providers were reimbursed across cantons (278).

Hospital outpatient acute care is also paid on a FFS basis using the TARMED points based system, however, the points differ for physicians working in ambulatory care (i.e. GPs and outpatient specialists) (278).

As of 2012, acute care hospitals in Switzerland have been paid according to the national SwissDRG system in order to harmonise hospital payments and improve transparency and efficiency. The SwissDRG model is based on the German DRG model, which was in turn was based on the Australian system. Just under half of inpatient admission costs are borne by health insurers, with the remaining amount under the responsibility of canton governments (278).

Austria

GPs and specialists who are contracted with a social insurance carrier and working in the outpatient sector are reimbursed though a mix of FFS and flat-rate payments. The proportion of reimbursement from each payment mechanism depends on the social insurance carrier. For example, ASVG GPs are largely paid through contact capitated payments, which are paid in full the first time a patient visits a GP within a three-month period (approximately 70%), and to a lesser extent FFS for specific services (approx. 30%)

(279). Within smaller health insurance carriers, however, physician payments are mainly based on FFS (approx. 90%).

In regard to outpatient specialists, again physician payment mechanism depends on which social health insurer the physician is contracted with. Unlike GPs, the primary form of payment for ASVG funds and smaller funds is FFS (i.e. 70% of ASVG and 90% of small carriers pay physicians on a FFS basis) (280).

For contracted physicians, treatment tariff levels are based on 'staffing plans', which are negotiated between individual health insurance carriers and regional physician chambers. For this reason, the income of a physician will depend on which health insurer(s) he/she is contracted with (37).

Non-contracted physicians, Wahlärzte, are paid directly by patients, with patients being reimbursed 80% of the cost charged by contracted doctors (37).

Hospital outpatient clinics and acute care are financed by a mix of social insurance carrier lump sum funds and by federal authorities, Länder and local authorities. Hospitals in Austria are reimbursed through budgets, which are informed by the country's DRG system (i.e. (Leistungsorientiertes KrankenanstaltenFinanzierungssystem (LKF) – performance-orientated hospital financing)) (270,279). In 2016, the Austrian DRG system was extended to outpatient departments within hospitals in order to prevent unnecessary hospitalisations (for example, for services such as colonoscopies, or for surveillance purposes).

Figure 109: Austria's DRG system (LKF)

Year

The Austrian DRG system was introduced in 1997.

Responsibility

Federal Health Commission (Bundesgesundheitskommission), Executive Body of the Federal Health Agency (Bundesgesundheitsgentur), is in charge of 'setting the terms related to the country's DRG model. The Commission is comprised of representatives from national government, social insurance carriers, local authorities, hospitals, Chamber of Physicians and patients.

The Commission has also set up a DRG Working Group who are responsible for maintenance and development of the system.

Objectives

- Increase transparency
- Contain costs
- Optimise use of resources
- Reduction of unnecessary and multiple procedures
- Shift care to the outpatient sector, where possible
- Reduction in acute beds.

LKF areas

There are two funding areas associated with the LKF, the *core area* and the *control area*. The first relates to inpatient hospital stays, which are awarded points based on diagnosis-related case groups (i.e. the 'core area') (Hauptdiagnoseugruppen). The core area determines budgets for hospitals. The budget of each State Health Fund is then dispersed across hospitals based on their total-point value. The control area, on the other hand, takes into account special care provisions that differ across each Land (medizinische Einzelleistungen). In essence, LKF points for the core area depend on main diagnosis, as opposed to the main services provided for the control area. Together, both areas form the performance-orientated case groups (Leisungsorientierte Diagnosefallgruppen, LDF).

Monies that are reserved for hospital financing through the State Health Funds are divided according to the total number of LKF points, which are invoiced by providers. To take into account different circumstances across the Lands, each LKF point differs according to regions. For example, as of 2015, remuneration per LKF point equated to €1.28 in Voralberg, compared to €0.35 in Burgenland (with an average of €0.82 across Austria).

Source: (279,281,282)

6.3 Contractual agreements between physicians and social health insurers

6.3.1 Overview of contractual agreements in Europe

Within social insurance systems, tariffs for outpatient services (i.e. GPs and specialists), and to a lesser extent, volume and quality, are negotiated between physicians and health insurers. It is typical within Europe for negotiations to occur between physician associations and health insurer associations, with the agreement being formalised within a collective agreement. One major exception occurs in the

Netherlands, where GPs are legally restricted from entering into collective agreements and can only jointly discuss contractual arrangements when in the best interest of patients.

Although collective agreements are the 'norm' in social health insurance systems, countries such as Germany and Switzerland have allowed insurers to sign selective contracts in regard to integrated care models. The objective of this arrangement is to improve competition and thus the quality of care.

The remainder of this section discusses contractual negotiation processes for the outpatient sector in a range of European countries operating social health insurance models. Contractual negotiations at the inpatient level (i.e. hospitals) have also been included, however, they are not the focus of this report given, in Austria, social health insurance carriers do not have a say in hospital contracts.

Table 68: Overview of contractual arrangements between physicians and health insurers in a selection of European countries (non-hospital based care only)

Country	Key players	Collective or selective contracts	Volume control
Belgium	Healthcare provider organisations and sickness funds	Collective contracts	No*
Germany	National and regional association of SHI physicians, and National Association of German Sickness Funds	Collective contracts, with selective contracts for integrated care models	Yes
France	Physician unions and national health insurance union Relevant health ministry	Collective contracts	No
Netherlands (primary care only)	Care groups and health insurers	Individual contracts	Yes
Switzerland	Healthcare insurance associations, tarifsuisse,	Collective contracts, with an option for	No

Country	Key players	Collective or selective contracts	Volume control
	and physician associations	selective contracts for integrated care models	
Austria	**Regional sickness funds and regional medical chambers**	**Collective contracts**	**Largely no****

Source: See country descriptions below. Note: *Regulations control exist, however, they are not discussed within contractual negotiations (e.g. the number of inexpensive medicines was imposed on all doctors by Royal Decree).**A limit on the number of procedures, which can be performed by outpatient specialists and GPs is applied (no such cap exists for services).

6.3.2 Belgium

Negotiation process: outpatient and inpatient care

The fee schedule for GPs, specialists and hospitals reimbursable by sickness funds (i.e. the nonmenclature) is negotiated annually or biennially between sickness funds and healthcare provider representatives (e.g. doctors' organisations and hospital federations) (283,284). These discussions also include arrangements pertaining to content, quality and quantity of care. For the purpose of these negotiations, sickness funds work collectively, and could be viewed as representing patient interests (283).

Discussions surrounding GPs and specialists (inpatient and outpatient) take place within the National Commission of Representatives of Physicians and Sickness Funds (also referred to as the 'Medico-Mut'), which sits within the National Institute for Health and Disability Insurance (INAMI) (285). The Medico-Mut is comprised of both provider organisation and sickness fund representatives (50/50 split).[67]

The agreement on tariffs/fees within the Medico-Mut must be accepted by the Minister of Social Affairs, and, in general, last for up to two years (284,286). An approval of fees by the Minister may be overturned if the following two scenarios occur:

- Over 40% of physicians within a region reject the agreement

[67] For general physicians: there are three members from the AADM, two members of the Cartel and one from the BVAS. For medical specialists: there are five members of the BVAS and one members from the Cartel (285). Members are elected every four years (285).

- Over 50% of GPs and 50% of other medical specialists in total reject the agreement (284,286).

Given the above two scenarios do not eventuate, fees agreed by the Minister will take effect 30 days after publication within the Belgium Official Journal (where laws, royal decrees, ordinances etc. are published) (286).

Physicians who sign up to the agreed fee level must charge these prices, and in return, receive benefits, such as a 'supplemental pension plan' (4, page 226). Physicians also have the option of not signing up or partially signing up to the set fee level. Those who do not sign up to the agreement have the flexibility to set their own fees. Any difference in the fee set by the physician and that agreed by the Minister must be paid by the patient. In 2015, 11.4% of GPs and 19.2% of specialists refused the set fee level (287). Refusal by specialists is particularly high for those working within obstetrics and gynaecology, ophthalmology, and orthopaedics (286).

If, however, the two scenarios occur, one of the following three paths will be taken: a) publically imposed fees; b) a restart of negotiations; or c) fixed reimbursement tariffs (82).

6.3.3 France

Negotiation process: outpatient care

Since the introduction of social security in France, prices and volumes of healthcare services have been negotiated between independent physicians and insurance funds (288,289). Prices for new and existing procedures is negotiated and agreed by physician unions' (of which there are three) and the National Union of Health Insurance Funds (Union Nationale des Caisses d'Assurance Maladie) (UNCAM) (288,289). The rates for healthcare services, that is, the tariff level, is defined within a *Tarif de convention* (tariff references) (288,289).[68] Nearly all healthcare professionals (99.2% in 2014) agree to the tariff. Specifically, of the 116,126 physicians in independent practices, 912 are not part of the collective agreement (707 are GPs and 205 are specialists).[69] Despite this, 50% and 8% of specialists and GPs have the right to bill more than the official tariff rate, respectively. The right to balance bill is a significant problem in France as it limits access to healthcare for those on low incomes.[70] Lastly, conventions are typically discussed and

[68] Conventions exist for doctors, nurses, physiotherapists, transport, medical device suppliers and biological laboratories.
[69] Information sourced from D. Polton (CNAMT) (2017).
[70] Ibid.

agreed upon every four to five years, however, regular amendments occur throughout this period (288,289).

The relevant ministry of health has two key roles during negotiations. Firstly, the financial mandate for each profession is discussed and defined with the Ministry prior to the negotiations, as well as the priorities and objectives. For example, in 2012, the new Government asked the UNCAM to open a negotiation to find a solution to the issue of 'sector 2' (physicians having the right to bill more than the official tariff). Secondly, in the case where negotiations breakdown, the Government appoints a single arbiter,[71] as was the case with dentists in France recently, who has the legal right to deliver a contract to the relevant ministry of health, if an agreement can still not be reached. The role of the Ministry in negotiations has only been made explicit in legislation recently. Specifically, the recent law of the future of the healthcare system states that the Ministry issues guidelines prior to all negotiations. This arrangement has been seen by the medical profession as a constraint on and limitation of their freedom to negotiate.[72]

As outlined by Chevreul *et al*. (2015) and Johnson *et al*. (2017), negotiations between providers and insurers is strained due to the high degree of power exercised by medical professional associations (288,289).

Negotiation process: inpatient care

At the hospital level, it is the responsibility of the Health Minister to set DRG rates, which determines the reimbursement rate paid by social health insurers. Most hospitals have an agreement with a social health insurer, however, for those that do not, patients are required to pay out-of-pocket for care, which is later reimbursed according to a specific statutory tariff (288).

6.3.4 Germany

Negotiation process: outpatient care

Reimbursement arrangements for private physicians in Germany are complex. Under the system, private physicians authorised to treat compulsory health insurance patients bill their regional association of social health insurance physicians (Kassenärztliche Vereinigungen (KV)) every quarter. KVs are then responsible

[71] In recent years, an arbiter from the Auditor Commission has been used.
[72] Information sourced from D. Polton (CNAMT) (2017).

for distributing pooled funds to physicians. For more details on KVs, see Table 69. At the national level, the 17 KVs are represented by the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung (KBV)) (290).

Table 69: Overview of Germany's regional association of social health insurance physicians

Characteristic	Description
Number	17 KVs in total (one in each region, except for North Rhine-Westpahalia, which has two)
Membership	Compulsory
Number of physicians covered	Approximately 141,000 physicians
Management	Each KV is governed by an executive board, which consists of physicians serving on a voluntary, part-time basis
Role	Ensure those covered by statutory health insurance have access to a sufficient level of outpatient care. They also represent physician interests, and enter into collective agreements with sickness funds regarding benefit packages and reimbursement.

Source: (89,276)

Services provided by social health insurance (SHI) physicians that will be reimbursed by sickness funds is outlined within a Uniform Value Scale (UVS) (Einheitlicher Bewertungsmaßstab). The medical services within the UVS are each assigned a rating score, thus each SHI physicians records the total number of his/her points each quarter and reports this to their regional KV for reimbursement (89,276) (further details of the UVS are provided in Figure 110).

Responsibility for the Uniform Value Scale falls under the remit of the Valuation Committee (Bewertungsausschuss), which is comprised of representatives from the KBV and the National Association

of the Germany Statutory Sickness Funds (GKV-Spitzenverband). Collective agreements made at the federal level act as a framework for discussions that occur at the regional level (291).

Figure 110: Germany's Uniform Value Scale

Purpose

Sets out the range of healthcare services reimbursable by sickness funds at the outpatient level. Specifically, each service that sickness funds will reimburse for is assigned a relative weight, which informs how much the physicians will get paid.

Responsibility

Valuation committee which is made up of representatives from the Federal Association of SHI Physicians and sickness fund federal associations. If a decision cannot be reached, the Federal Ministry of Health (MOH) can enforce extended Valuation Committee members be brought in to reach a decision. MOH can also define alternative arrangements if no resolution is reached.

Coverage

Social health insurance physicians can only invoice for services within the UVS.

Volume control

Each quarter social health insurance physicians are informed of how many UVS points they can be reimbursed for.

Source: (292)

To minimise the physician's incentive to over-supply services, since 2009, a limit on the volume of standard services has been applied. Specifically, at the beginning of each quarter, physicians are informed of the maximum volume of services they will be reimbursed for (89).

With the introduction of the Social Health Insurance Modernization Act (2004) (GKV-Modernisierungsgesetz), selective contracting has been permitted for models of integrated care. This allows individual health insurers to negotiate services and prices with individual or groups of healthcare providers (271). The ability for sickness funds to contract directly with healthcare providers is meant to increase competition and thus improve healthcare quality and efficiency (89,276).

Negotiation process: inpatient care

Capital investments are financed through the Länder, while hospital running costs are financed primarily by sickness funds, but also through private health insurers and patient out-of-pocket payments. Running costs are negotiated between individual hospitals and regional sickness funds associations (276).

Legally, sickness funds negotiate contracts with hospitals, which they are allowed to reject. However the final decision is taken by state governments (277).

6.3.5 Netherlands

The negotiation process between sickness funds and healthcare professionals has been broken down into the following segments: primary care and hospitals.

Negotiation process: outpatient care (GPs)

Up until 1998, GPs negotiated as a collective group regarding contractual arrangements on price, volume and service levels. The Dutch Competition Act in 1998 saw GPs come under intense scrutiny, which led to a ban on group negotiations. Later, in 2011, GPs were fined up to €7.7 million if they were found to be colluding. The fine was removed in 2015, and GPs were again allowed to cooperate when it is in the best interest of the patient (293). That is, GPs can legally discuss with one another conditions of the contract, however, they must sign individual contracts with health insurers, four of which control 90% of the market (294).

Health insurers contract independent GPs for core primary care services on the government set capitation and fee-for-service rates (approximately 70% of services). Remaining services for integrated care (bundled payments) (20% of services) and innovative care models (10% of services) are negotiated between GPs and health insurers (see Table 70 for further details).

Table 70: Overview of primary care payment models (Netherlands)

Segment	Proportion of funding (approx.)	Activities	Payment type	Price setting
Segment 1	75%	Core primary care services	FFS and capitation	Set by the Dutch

Segment	Proportion of funding (approx.)	Activities	Payment type	Price setting
				Healthcare Authority (government)
Segment 2	15%	Integrated care: diabetes, CVD management, asthma and COPD*	Bundled payment	Negotiated between care groups and insurers
Segment 3**	10%	Pay-for-performance and innovative care models***	Linked to quality	Negotiable between GPs and insurers****

Source: (293,295,296)
Note: *CVD = cardiovascular disease, and COPD = chronic obstructive pulmonary diseases. ** Segment 3 acts as a 'top-up' payment for GPs, therefore most GPs will include this in their contract. ***For example, accessibility and prescribing efficiency. ****This type of negotiation is less common.

During negotiations regarding bundled payments for chronic conditions, GPs are generally represented by care groups, of which there are 40. Care groups are legal entities that, on behalf of the self-employed GPs, act as the contracting organisation between providers and insurers (297). GPs are a central element of these care groups, with a median of 50 GPs in one care group (numbers vary between 4-150 GPs) (297).

Negotiation process: inpatient care (including outpatient specialists)

Prices and volumes of healthcare within this setting are negotiated between the nine independent insurers and the 110 hospitals (298). In theory, insurers and/or hospitals can engage

The amount paid to hospitals is determined, since 2005, by Diagnosis Treatment Combinations (DBCs), a concept similar to diagnostic-related groups (295).[73] Initially, only a small proportion (10%) of rates for hospital services were freely negotiable, however, this gradually increased to 70% in 2012 (298). The remaining 30% of hospital service rates are set nationally, and are non-negotiable. Specifically, the Dutch Healthcare Authority sets a ceiling price (296). Negotiations at the hospital level also determine outpatient specialist fees, who are reimbursed according to the same DBC system.

To avoid hospitals setting unreasonable high prices for services that are negotiable, insurers can enter into selective contracts with hospitals (298).

6.3.6 Switzerland

Collective contracts are negotiated between healthcare providers and healthcare insurance associations, of which there are three:

- *Santésuisse* (largest of all the three) (represents approx. 50% of insurers)
- *Curafutura* (represents approx. 40% of insurers)
- *Association of Small and Medium Insurers* (RVK) (represents approx. 10% of insurers) (99).

Contracts outline the tariff level for healthcare services, as well requirements regarding efficiency and quality. However, the latter are neither specific nor monitored (99).

Contracts may either be national or set at the canton level; within the former, contracts become valid if approved by the Federal Council, while the latter can be approved by cantonal governments (99).

An overview of the contracting arrangements in ambulatory care and hospitals is provided below:

Negotiation process: outpatient care

The tariff schedule for primary and specialised care in Switzerland is defined within TARMED, which is run by TARMED Suisse, a corporate institution. The reimbursement rate within TARMED is negotiated between the association of physicians and hospitals on the provider side, and by tarifsuisse SA or curafutura on the purchaser side. Tarifsuisse SA, was developed in 2010, and can be contracted by MHI

[73] Statistical system that classifies an inpatient stay according to various factors (e.g. patient age and sex, presence of co-morbidities, complications associated with the procedure). Cases with a DRG group are meant to economically and medically similar (299).

companies to negotiate contracts with healthcare providers. As of 2015, tarifsuisse represented approximately 75% of al MHI companies. In the case where an agreement is not reached, the cantonal government can define the reimbursement rate (99).

If an insurer does not wish to be part of a collective contract, it can choose to selectively contract with physician networks or health management organisations. Despite this, physicians within these contracts must follow the TARMED fee schedule (99).

Negotiation process: inpatient care

Similar to other developed countries, hospital reimbursement rates are defined within a DRG system, which acts as a national tariff framework. In Switzerland, DRG rates are specified within SwissDRG SA, a corporate institution. The rate for each DRG is negotiated between hospitals (either at an individual or group level) and healthcare insurance associations. These rates must be approved by cantonal authorities, who in the case of no agreement, can fix the DRG base rate. Recommended DRG rates are provided by the Price Supervisor, which sits within the Federal Department of Economic Affairs, Education and Research. DRG rates agreed by cantons that are above the recommended rate must be justified (99).

6.3.7 Austria

Formally, it is the responsibility of the HVSV to negotiate all contracts between health insurance carriers and the Chamber of Physicians (§341 ASVG). In practice, however, general contractual agreements (Gesamtvertrag) are negotiated and agreed between the respective Chamber of Physicians (regional or federal) and individual or groups of social insurance carriers, with the HVSV signing off on agreements once they have been reached. In regard to groups of carriers, an example are the BKK and SVB who partner partner with regional insurance carriers (GKKs) to streamline administrative processes and increase bargaining power (§2).

Contractual negotiations include discussion and agreement on fee schedules, which include reimbursable services, as well as the number of contracted physicians per region (§342 ASVG). Posts are filled using criteria developed by the Chamber of Physicians, which are proposed to the Ministry of Health and Women's Affair (§343 (1a) ASVG). General contractual agreements are then used as the basis for individual contracts, which are signed between the physician and the social health insurance carrier.

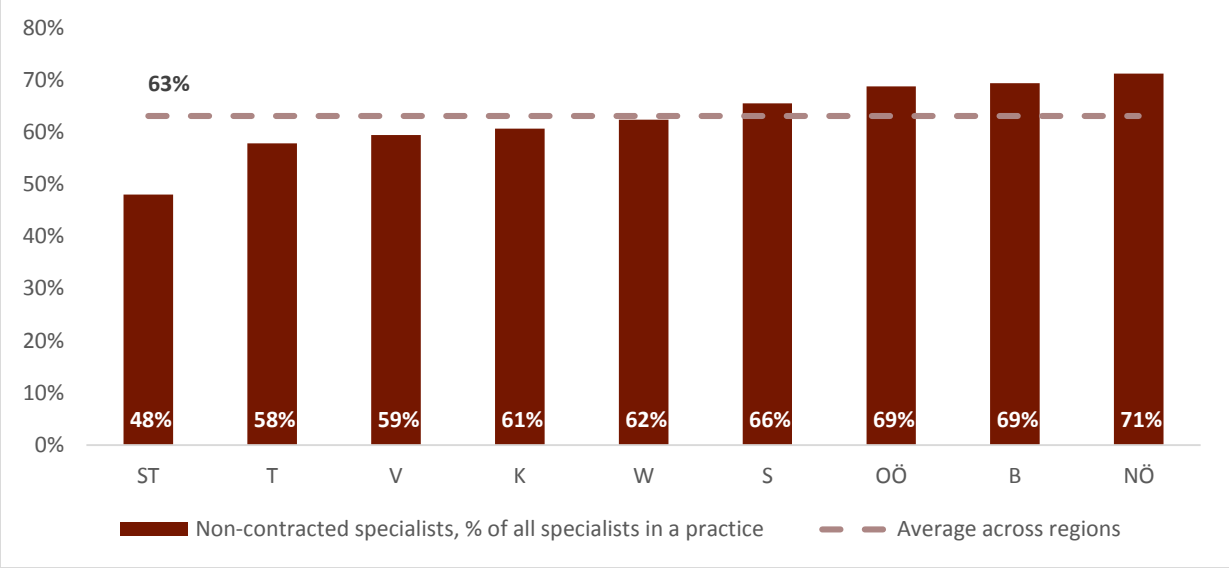
If an agreement between social health insurers and the Chamber of Physicians cannot be reached, the Federal Arbitration Committee can postpone the termination of the contract for up to three months. After this period, physicians have the power to charge their own prices (vertragsloser Zustand), which patients

must pay OOP for. If a patient visits a non-contracted doctor, social health insurers will generally only reimburse 80% of the cost charged by contracted doctors (it is only general as KFAs reimburse patients 100%, while other social insurers may fully reimburse for certain services).

By law (§338 (2) ASVG), insurance carriers are obliged to 'try hard' to conclude general contractual agreements, however, such agreements are not compulsory. As a result, the Chamber of Physicians can exercise significant power during negotiations. Even after an agreement is signed, physicians can continue to exercise power by terminating a contract, as long as three-months notice is given. Social health insurers, on the other hand, can only end a contract in the case of severe misconduct.

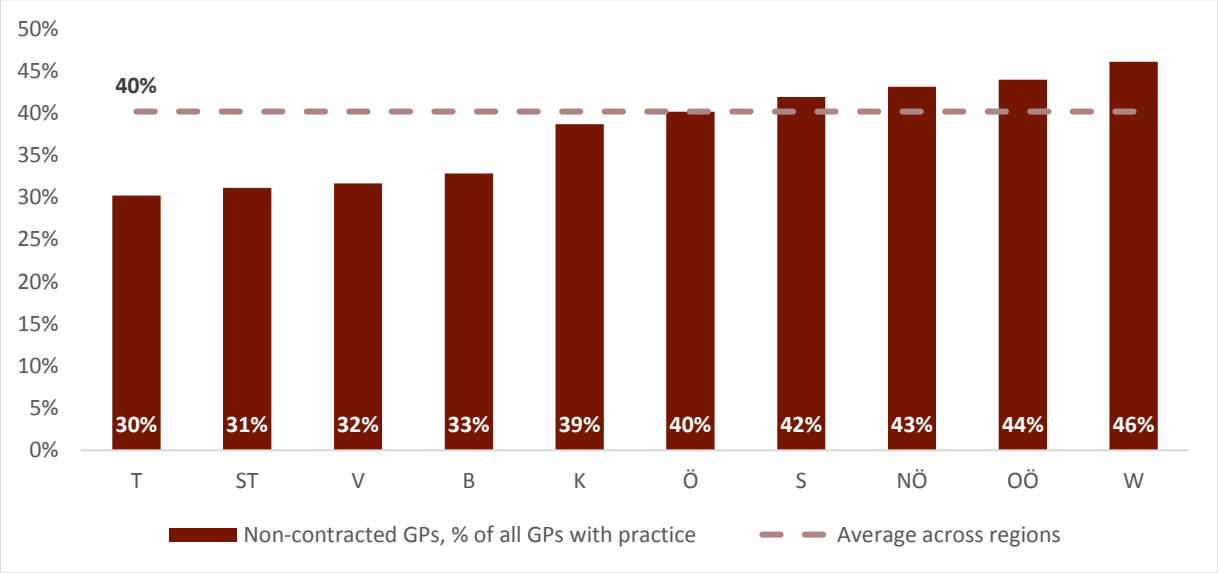
Not all physicians choose to enter into contractual agreements with social health insurers. Patients who choose to visit non-contracted doctors (i.e. Wahlarzt) pay OOP, and must apply for reimbursement from their social health insurer who will re-pay 80% of the cost charged by contracted doctors. On average, 63% of specialists working in practices, and 40% of GPs are not contracted with a social health insurance carrier. These figures appear significantly high given 99% of the population are covered by social health insurance.

Figure 111: Non-contracted specialists as a % of all specialists working in a practice (all regions)



Source: IHS (2017)

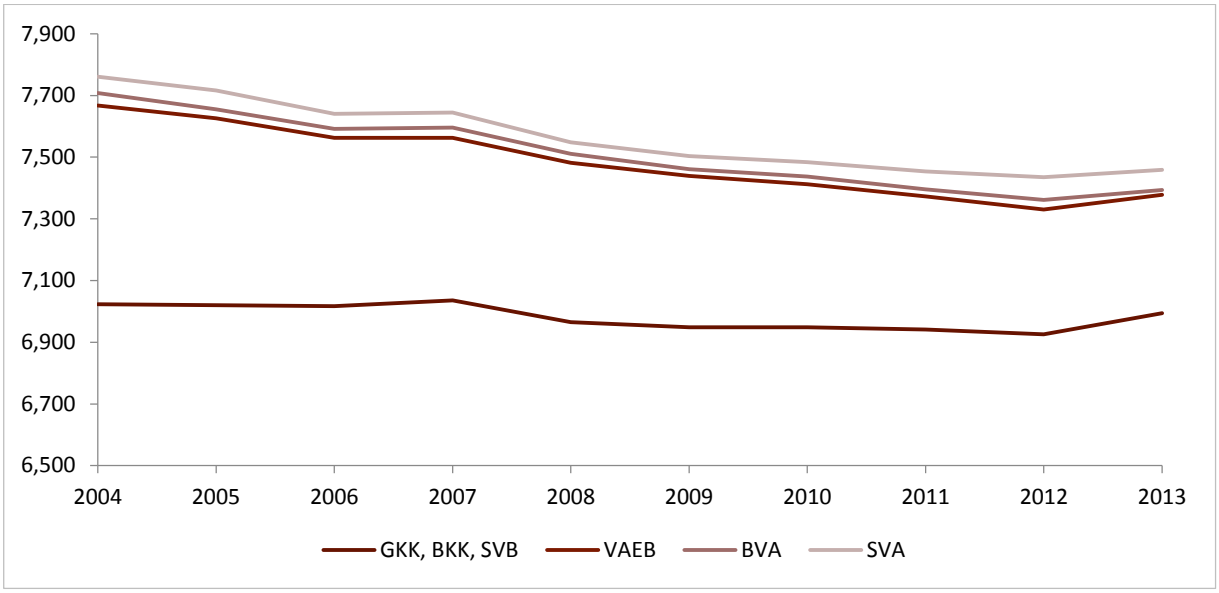
Figure 112: Non-contracted GPs as a % of all GPs working in a practice (all regions)



Source: IHS (2017)

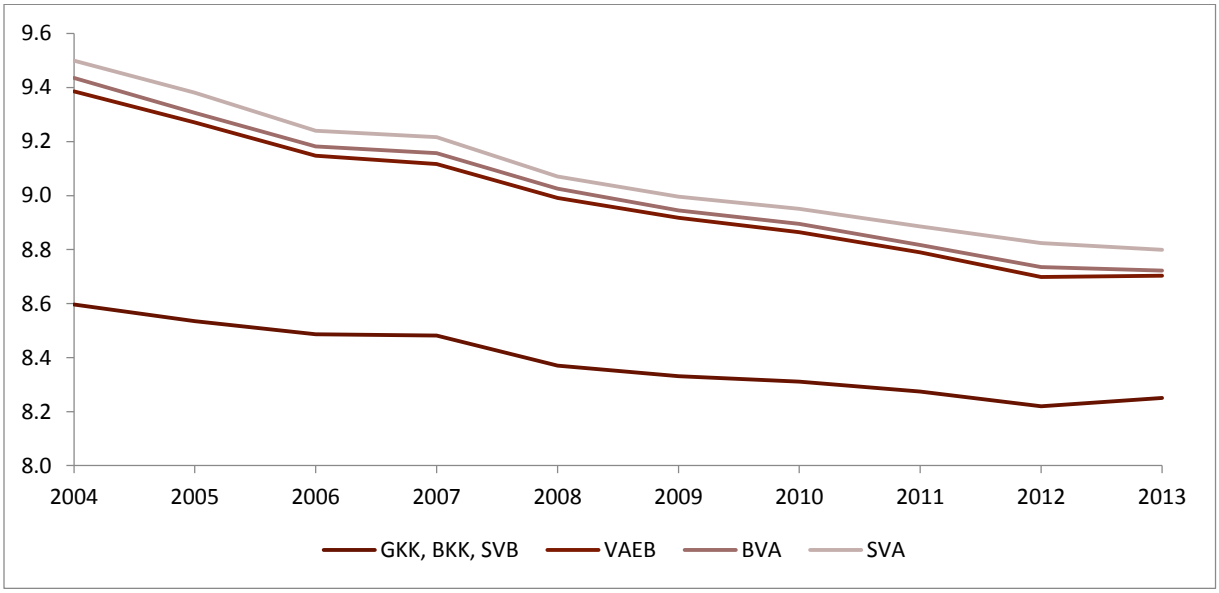
As outlined in the figures above (0% of doctors that are non-contracted), non-contracted doctors makeup a significant proportion of all doctors working within the primary and ambulatory care. This proportion may continue to rise with historical data showing a downward trend in the total number of contracted doctors per 10,000 people (despite there being an increase in the overall number of contracted doctors, between 2005-15). This may be a result of several factors such as: increasing population, more doctors joining group practices and/or the large number of students studying medicine (prior to university restrictions). Further, the overall headcount of doctors may not accurately reflect the number of full-time doctors.

Figure 113: Trend in the total number of contracted doctors by insurance carrier (2004—2013)



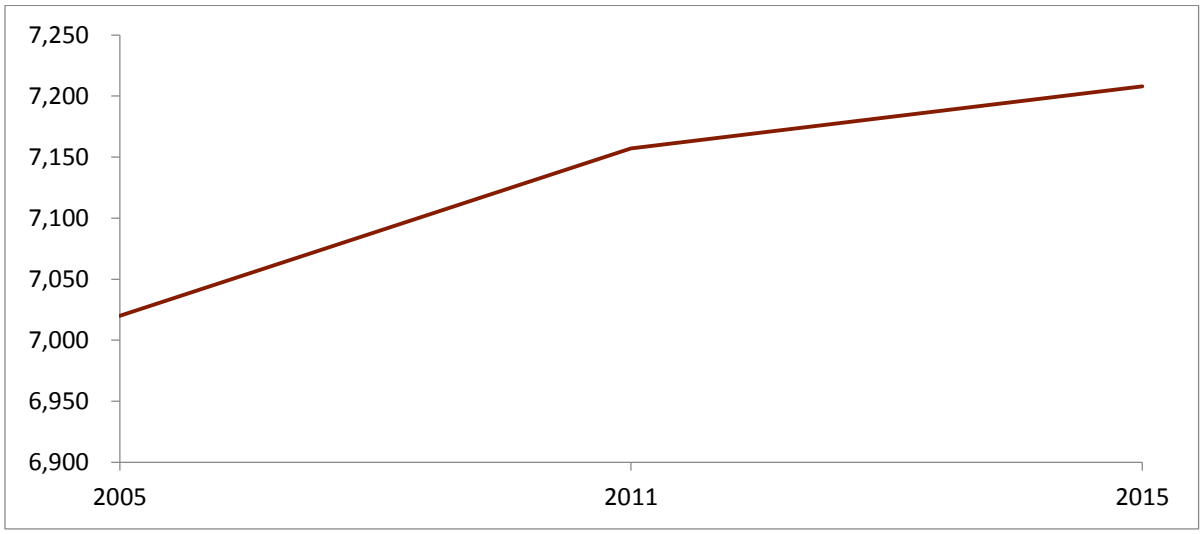
Source: IHS (2017)

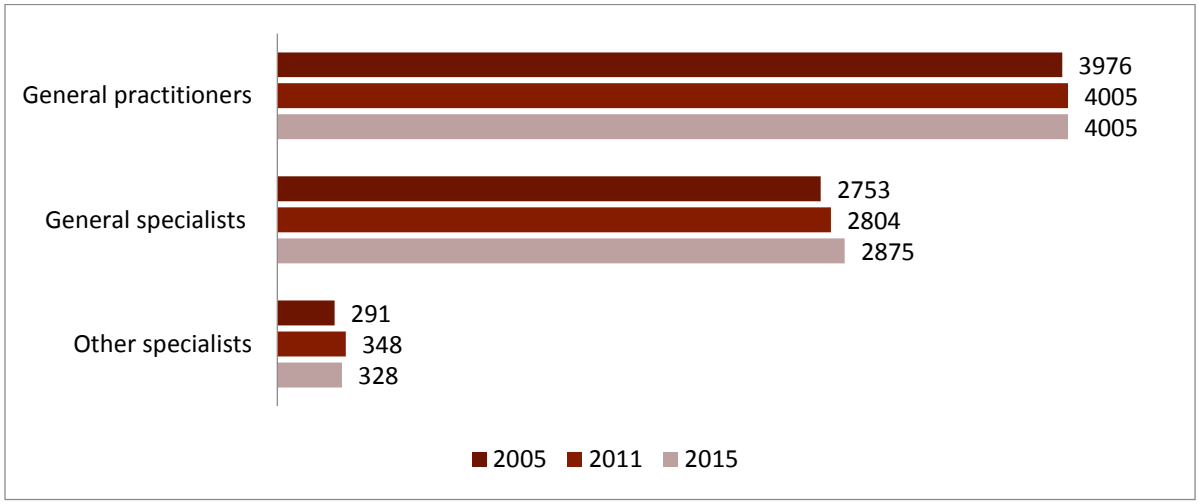
Figure 114: Trend in the number of contracted doctors per 10,000 people by insurance carrier (2004—2013)



Source: IHS (2017)

Figure 115: Trend in overall number of contracted § 2 physicians (2005-15)





Source: Analysis completed by IHS (2017).

Comparison with European countries

As evidenced by the above country descriptions, complex arrangements for contractual negotiations exist across Europe. At a high-level, the contractual arrangements in Austria closely mirror those in France and Germany. Systems in the Netherlands, Belgium and Switzerland differ in certain key aspects. For example, in the Netherlands, the government (Dutch Healthcare Authority), limits the role of health insurers and providers by setting prices for core primary care services and 30% of DBCs. Further, at the outpatient level, GPs are legally forbidden from negotiating as a group, thus only selective contracts are permitted. In Belgium, the Minister of Social Affairs must agree to the price agreed between insurers and providers, which can later be overturned if rejected by a certain proportion of physicians. Lastly, regarding inpatient

care in Switzerland, DRG prices are initially provided by an external Price Supervisor, which plays a significant role in determining DRG rates agreed between insurers and hospitals. Arrangements within Netherlands, Belgium and Switzerland may act to reduce the variability of contracts between health insurers and healthcare providers within respective countries.

6.3.8 Policy options: Contractual agreements between physicians and social health insurers

Based on a review of payment systems contractual arrangements in Austria and Europe, a range of policy options have been developed (see Table 71). Each of the 12 policies proposed aim to achieve one or more of the following objectives:

- Promote harmonisation of services and prices across physicians
- Enhance primary and outpatient care in order to reduce the number of hospital admissions
- Encourage coordination of care
- Promote financial sustainability within the healthcare system
- Create a level playing field during contractual negotiations between social health insurers and physicians.

Each policy option has been categorised by an implementation period, that is, short, medium or long term, which reflects its priority. Specifically, policies classified as being implemented in the short-term indicate that the policy is of high importance and should take precedence over medium and long-term policies.

Table 71: Contracting policy options overview

Policy option theme	Policy option description	Implementation period
Contractual negotiations	Introduce external arbiter to assist in contractual negotiations	**Short-term**
	Allow health insurance carriers to contract selectively for certain services	
Structural plans	Introduce an independent committee to provide advice on number and location of contracted physician posts	**Short-term**
Harmonisation amongst outpatient specialists	Harmonise coding among specialists to improve transparency	**Short-term**
Enhancement of primary and outpatient care	Continued investment in multi-professional practices	**Short-term**
	Better training for GPs within the system	
	Improved system coordination via ELGA	
	Further investment in Disease Management Programs	
Bundled payments	Introduced bundled payments for multi-morbid patients across the healthcare spectrum via joint SSI and Länder budgets	**Medium-term**
Rural GPs	Incentivise GP specialisation and networks in rural areas via a change in the payment scheme (i.e. risk-adjusted capitation and FFS)	**Medium-term**
GP remuneration (all GPs)	Extend risk-adjusted capitation and FFS to all GPs across Austria	**Long-term**
Enhance role of GPs	Introduce voluntary scheme to incentivise patients to have referrals from a GP to access certain outpatient specialists and inpatient care.	**Long-term**

Short-term policy options

Contractual negotiations

To create a more level playing field between social health insurance carriers and the Chamber of Physicians during contractual negotiations, the following two mutually exclusive options are proposed.

The first option would allow the Federal Arbitration Committee to postpone the termination of contracts from three to six months (where during this period the current contract would remain in place). If after six months, an agreement cannot be reached, an external arbiter would be introduced to facilitate discussions. Given the Chamber of Physicians and social health insurers are still unable to conclude contract negotiations, the Ministry of Health and Women's Affairs, based directly on the recommendations of the arbiter, would have the possibility to determine the final contractual agreement.

Regarding the arbiter, initially, social health insurance and the Chamber of Physicians should be given the option to mutually appoint an arbiter. If this is not possible, the arbiter could be set by the Ministry of Health and Women's Affairs.

The second option would allow social health insurers to contract selectively with physicians for certain items within contractual agreements, that is, items that cannot be agreed upon in the general contract. For example, social health insurance could be given the option to selectively contract physicians to fill vacancies. Such an arrangement exists for primary healthcare units, however, the Chamber of Physicians must be in favour.

Introducing selective contracting for general agreements is unlikely to be successful given physicians have the option to work as non-contracted physicians, with patients submitting invoices to social health insurers.

Legal considerations

Even though no particular constitutional impediments have to be faced with respect to both options, a number of amendments to the current system of conctractual agreements would be required.

Structural plans

Going forward, regional structural plans for health (Regionaler Strukturplan Gesundheit) will define the number of ambulatory physician units (ÄAVE) for each specialty within a region (both for contracted outpatient specialists and for those working in hospital outpatient departments). Given, social health insurers must then reach an agreement with the Chamber of Physicians (who are not involved in regional structural plan discussions) to either increase or decrease these numbers (former being easier to achieve,

given it is near impossible for social health insurers to terminate contracts), the impact regional structural plans will have on ensuring contracted physicians posts are needs-based is unclear.

If regional structural plans fail to achieve their desired objective, an independent committee could be established to provide recommendations on the number and location of GP and specialist physicians. Recommendations would form the basis of contractual negotiations between social health insurers and the Chamber of Physicians, with any deviation from recommendations being justified to the Ministry of Health and Women's Affairs. All new posts would be subject to findings from the independent committee, however, changes to existing posts should be phased in over a period of time (e.g. 10 years).

Legal considerations

Even though no particular constitutional impediments have to be faced with respect to this option, some amendments to the current system of conctractual agreements would be required.

Harmonisation among outpatient specialists

Contracts between social health insurance and the Chamber of Physicians set out services and associated fee schedules. As discussed in section 5.2, services across social health insurers are not harmonised, further, the naming of services/items also differs. In regard to the latter issue, different naming of services/items makes it extremely difficult to compare prices across insurers. For this reason, it is proposed that coding of services/items within contracts be made consistent across insurers, thus improving price transparency.

Legal considerations

No particular legal impediments have to be faced in this respect.

Enhancement of primary and outpatient care

It has been suggested that if a proportion of hospital admissions is reduced, immediate cost savings will be realised. Specifically, a recent report on efficiency potentials within the Austrian social insurance system (2016) quoted the Austrian Court of Auditors (Rechnungshof), which stated that shifting resources from the inpatient to outpatient sector (i.e. so that the number of acute beds equates to the European average) can lead to savings of €2.9 billion (300). However, in order to maintain high-quality care, whilst simultaneously reducing hospital admissions, significant investment in outpatient and primary care is required in the first instance. Therefore, in the short-term, costs may increase as hospitals will need to be subsidised for structural fixed costs, such as employee salaries and maintenance of buildings.

Austria has recently implemented reforms at both the outpatient and primary care level to reduce the relatively high burden placed on hospitals. At the outpatient level, Austria has recently extended DRGs to hospital outpatient departments to limit the number of unnecessary inpatient admissions (301).

At the primary care level, two primary healthcare units have been implemented, with plans to extend the number to 75 by year 2020 (see Figure 116). Further, since 2010, physicians have been given the right to develop group practices as limited liability companies, which is associated with small tax advantages (*Act to Strengthen Ambulatory Care*) (302).

Figure 116: 15a Agreement, Article 31 (Primary Healthcare Units)

Financing of cross-sector projects

The contracting parties agree to allocate financial resources, in accordance with the following contract provisions for financing cross-sectional projects. The projects are aimed at strengthening the provision of ambulatory care, in particular the establishment of primary care, which is primarily the responsibility of the social insurance system, as well as the establishment of multi-professional and/or interdisciplinary provision of care in the outpatient specialist care. A total of €200 million will be earmarked for these purposes for the duration of this agreement by 2020. The projects are carried out in accordance with the project-related planning decisions in the RSG and should contribute to the improvement of care and to the relief of hospitals. The aim is to realise at least 75 primary care units in primary care by the end of the terms of this agreement.

As outlined above, promising reforms have been introduced to enhance primary and outpatient care, however, further effort is required to ensure the sustainability of the healthcare sector. A range of potential options to reduce the burden on hospitals have been outlined below. These options are not necessarily mutually exclusive, and could be implemented in unison.

- **Primary healthcare units and group practices:** A total €200 million has been dedicated to the development of 75 PHUs by 2020. At this stage, it is unclear how these funds will be sourced, further, it has not been made explicit how and when those who invest and develop PHUs will be refunded for their efforts. Such an arrangement fosters uncertainty and reduces the incentive to invest in PHUs. A similar problem occurred under the Reform Pool of 2005, which outlined a commitment to funding to

improve extra- and intra-mural care, without defining specific funds for projects (303).[74] For this reason, it is recommended that it be made explicit where the €200 million is collected, and how it will be distributed to carriers.

- **Outpatient hospital departments:** Extend the number of DRGs applicable within hospital outpatient departments, so that an increasing number of procedures take place outside inpatient care.
- **System coordination:** The ELGA system to coordinate patient care is a relatively nascent initiative within Austria's healthcare system. However, further changes to the system are required to maximise its potential. For example, by collating patient records in an easy to interpret format for physicians accessing a patient's file for the first time.
- **Disease Management Programs:** At present, there exists just one national disease management program, the program for diabetics (Therapie Aktiv, 15a agreement 2008-13). In response to the rising number of multi-morbid patients, further investment in DMPs is recommended (e.g. for cancers, obstructive pulmonary disease, coronary disease, and asthma).[75] Given DMPs offer patients 'state of the art' treatment, it is advised that all physicians be required to offer such services.
- **GP training:** Postgraduate training for GPs primarily takes place in hospitals, with an additional six months required within a GP practice (Ärzteausbildungsordnung, ÄAO 2015). Although positive that young physicians (i.e. recently graduated) spend a portion of their training within a GP practice, six months is a relatively short amount of time when compared to countries such as the UK (18 months in a practice) and Australia (3 to 4 years, depending on rurality) (306–308).[76] A barrier to increasing physician time within a GP practice may arise from dual financing arrangements, given social health insurance is not provided with additional funds to cater to trainees. Therefore, we recommend that a portion of Länder funds be distributed to social health insurance to pay specifically for GP training. Enhanced GP training will improve primary care services, and therefore, in the medium- to long-term reduce hospitalisations and thus costs to the Länder. Given benefits may take a certain number of years to ensue, in the short-term, additional funds should be provided to the Länder to cover fixed costs.

[74] For inpatient and outpatient sector, 1% (2006) and 2% (2007-08) of total funding for be dedicated to programs facilitated coordination between the two sectors (304).
[75] Themes based on Germany's Disease Management Programs (305).
[76] Three years to complete a Fellowship of the Royal Australian College of General Practitioners (an option for an additional year to advance rural skills), or four years to complete a Fellowship of the Australian College of Rural and Remote Medicine.

- **GPs in outpatient care:** One full-time GP could be introduced into hospital outpatient departments to triage patient admissions. This approach has been implemented in various settings including in Deventer, a region with the Netherlands, where GPs operate hospital outpatient departments. Such efforts have already been made within Viennese hospitals.

Legal considerations

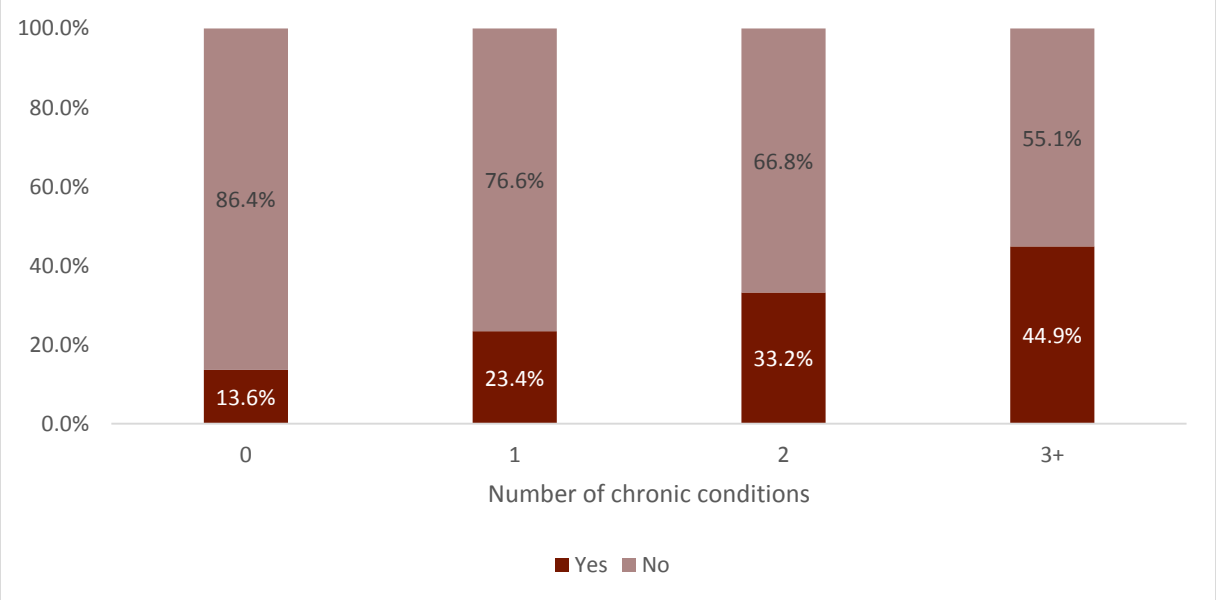
Even though no particular constitutional impediments have to be faced in this respect, a comprehensive legal assessment of consequences and issues arising from the recent reform is not possible at this stage.

Medium-term policy options

Bundled payments

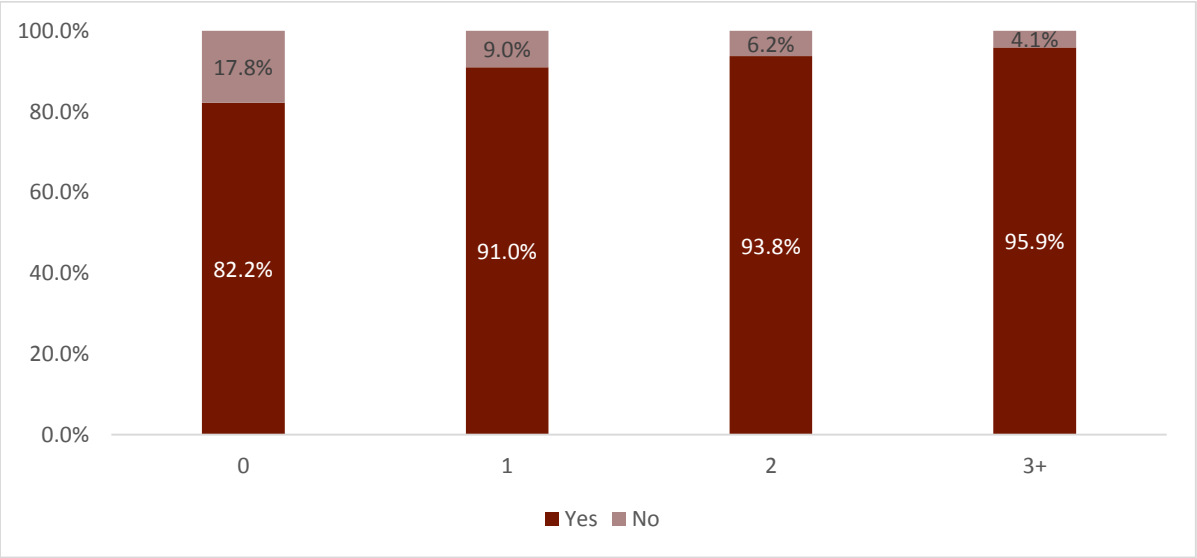
Multi-morbid patients consume a disproportionate amount of healthcare services. For example, in Austria, just under half (44.9%) of those with three or more chronic conditions access inpatient care compared to 13.6% of those with no chronic conditions (Figure 117). Similar patterns emerge at the outpatient level, where 95.9% of multi-morbid patients (i.e. three or more) see a doctor as opposed to 82.2% of healthy patients (i.e. those with no chronic conditions).

Figure 117: Probability of accessing inpatient care by number of chronic conditions in Austria (waves 1,2,4 and 5)



Source: SHARE data (Survey for health, ageing and retirement in Europe), analysis by LSE

Figure 118: Prevalence of access to doctors associated with number of chronic conditions (waves 1,2,4 and 5)



Source: SHARE data (Survey for health, ageing and retirement in Europe), analysis by LSE

To improve care, and reduce overall costs, risk-adjusted bundled payments for high-cost multi-morbid patients is recommended. Specifically, to encourage continuity of care and avoid patients 'wandering' through the healthcare system, joint budgets between social health insurance and the Lands would be created to cover costs across the spectrum of care (i.e. primary care, ambulatory care, hospital care and social care).

Prior to the implementation of bundled payments, a study should be commissioned to gain a better understanding of the types of multi-morbid patients in Austria (e.g. the proportion of multi-morbid patients: nearing death; with persistent chronic conditions; and short-term high need patients).

Legal considerations

Basically no constitutional impediments have to be faced in this respect. Anyhow multi-morbidity could be definitely an important risk-adjusment-factor and care for multi-morbid patients could be target for a specific fund such as the already existing ones for prevention or dental health (§§ 447h, 447i ASVG).

Rural and remote GP remuneration

Small populations in rural areas limits coverage of specialised healthcare services. To ensure insured patients in these areas receive adequate and appropriate care, it is advised that networks of specialised GPs be encouraged (e.g. specialisation in diabetes, arthritis, heart disease and other areas of care relevant to rural populations). For geographical reasons, these GPs do not need to be located within the one practice, rather, GP networks could develop robust internal referral systems.

Rural GP networks could be encouraged through changes to the current remuneration system outlined within contractual agreements. Specifically, by introducing risk-adjusted capitation payments, with elements of flat rate payments. The capitation component may incentivise physicians to move to rural areas as they will be guaranteed a certain income, thus reducing financial uncertainty. Rates for capitated budgets should take into account that, relative to urban posts, working in rural/remote areas is less desirable, involves treating more complex cases, and requires greater responsibility. Consideration could also be given to applying different rates depending on rurality, with, for example, higher capitated budgets being allocated to physicians working in poorer and/or less densely populated areas.

Flat rate payments could also be introduced to complement capitated budgets, and be linked to actions/services that promote overall improvements in care quality. For example, a once off payment for establishing a specialised GP network, in addition to bonus payments for networks which continually promote coordinated care (e.g. draw upon the French payment system, which provides physicians with additional payments related to time spent coordinating care, as well as the mix of health care professionals within a network, see section 6.2.2).

Legal considerations

No particular constitutional impediments have to be faced in this respect, but some amendments to the current system of conctractual agreements would be required.

Long-term policy options

GP remuneration

A change to a fully risk-adjusted capitated payment system represents a significant cultural and organisational change as it would require patients to register up with one physician. Therefore, risk-adjusted capitation should be trialed within rural and remote areas, where natural registration occurs (i.e. due to the limited number of physicians within a certain location). Given risk-adjusted capitation in rural

and remote areas achieves its stated objectives, consideration should be given to extending this form of payment to GPs working within urban settings. Similar to rural/remote GPs, additional flat rate incentive payments could be offered to encourage better value-care, such as participation in preventative care (e.g. smoking cessation programs), or minor surgeries to reduce the number of inpatient admissions.

To 'ease in' the introduction of risk-adjusted capitation, insurees could have the option of registering with either a GP or specialist (as is the case in France, where 99% of insurees choose a GP).

Legal considerations

Even though no particular constitutional impediments have to be faced in this respect, it has to be considered that 'registering' with a certain physician would impose restriction to the patients' right to choose which physician(s) they visit.

Enhanced role of GPs

Discussions with relevant stakeholders highlighted the value placed on freedom of choice within the healthcare sector. However, in the long-term, consideration could be given to enhancing the role of GPs within contracts by assigning them responsibility for referring patients onto outpatient specialists or inpatient care. Such a move should be voluntary, further insurees could be given the option to register with a specialist, as opposed to a GP (as is the case in France, however, 99% individuals choose a GP).

Enhancing the role of GPs would follow international trends including countries such as France and Denmark (see Figure 119). It is important to highlight that models outlined in the figure below, although considered best practice, are not directly applicable to the Austrian context given low levels of user charges (thus financial incentives to encourage insurees to access their chosen GP or specialist are limited). For this reason, other policies such as appropriate marketing and advertising are required.

Figure 119: The role GPs in France and Denmark

France

The 2005 health financing reform law aimed to encourage coordinate treatment pathways by requiring patients to register with a preferred physician of their choice (GP or specialist).* Patients who access specialists** with a referral from their preferred physician pay a lower co-insurance (user charge) rate, compared to patients who access specialists directly (i.e. 30% vs 70%).

Denmark

Denmark has introduced a novel initiative to improve the appropriateness of care provided by giving patients the following two options. Under option one, which 98% of the population opt for, a referral from a GP is required if a patient wishes to seek secondary care. Registration with a GP is necessary in this circumstance. For the second option, individuals have the freedom to choose their GP as well as uninterrupted access to specialists. However, copayments are required for both GPs and specialists. In either options 1 or 2, patients must obtain a referral before accessing hospital care (with the exception of emergencies).

Source: (309–312)
Note: *The scheme is in fact not compulsory, however, the vast majority of population believe it is (i.e. 82%). **With the exception of certain low-cost specialists such as gynecologists and ophthalmologists, which patients can continue to visit directly.

This policy option should only be introduced once appropriate structures and processes have been developed within the primary care sector. For example, further education and training would be required to increase the capacity of GPs to properly triage patients to outpatient specialists or inpatient care. Further, the number of GPs would also need to increase to cope with greater levels of demand.

Finally, enhancing the role of GPs to triage patient cases will be mitigated if patients choose to access primary healthcare units, given referrals to specialists will naturally occur. Therefore, as stated throughout this report, further effort should be directed at increasing the number of PHUs and encouraging patients to use these units as their first 'point of call'.

Legal considerations

No particular legal impediments have to be faced in this respect.

Summary of policy options for contracts between physicians and social health insurers

Decisions made within contractual negotiations have a significant impact on structures, processes and outcomes within outpatient healthcare settings. For example, they play a role in determining remuneration for physicians, and what and how services are delivered.

Based on a review of contractual negotiation arrangements in Austria and across Europe, 12 associated policy options have been developed. Each policy option has been categorised into three sub-groups to reflect their relative importance.

In the short-run, it is recommended that efforts are made to: enhance the power of social health insurers during contractual negotiations; introduce robust needs-based criteria for positioning contracted doctors; harmonise services across contracted physicians; and finally, to foster an environment which enhances the role of primary and outpatient care.

Once short-term policies have been implemented, policy-makers could consider changes to remuneration packages to: a) improve care coordination for multi-morbid patients by introducing bundled payments across outpatient, inpatient and social care; and b) improve access to care in rural and remote areas through risk-adjusted capitated payments, which reflect relative difficulties associated with working in such environments (e.g. more complex cases, less support).

Finally, in the long-term, risk-adjusted capitated payments could be extended to GPs in urban settings, in addition to flat-rate payments to encourage utilisation of high-value care. Concurrently, the role of GPs could be enhanced by requiring patients to obtain a referral before seeking specialist care.

6.4 Healthcare quality

6.4.1 Measuring health system performance

Rising demand for healthcare services, constrained resources and variations in healthcare provision have led to an increased interest from governments to measure and monitor healthcare quality. As a result, an increasing number of countries have implemented performance measurement and quality improvement tools (313).

Performance measurement within the healthcare sector aims to 'monitor, evaluate and communicate' the extent to which health care systems meet pre-defined objectives (314). Performance is often measured through the development and implementation of targets that provide a robust picture of the healthcare system of interest (314) . Targets are considered a desirable tool for both policy makers and the population, as they express a clear commitment to a specific goal within a set timeframe (314).

Modern economies are increasingly concerned with measuring the quality of healthcare provided. The growth in quality and performance measurement can be traced back to the World Health Organisation's

(WHO) 1981 report – *Health For All*, which specified that targets are a useful tool to improve health outcomes (314). Other factors that have contributed to the rise in the use of performance measurements include demand side changes such as, cost-containment, increasing patient expectations and demand for accountability, as well as improvements in technology, which have made collecting information more effective and efficient (314).

6.4.2 Defining healthcare quality

To measure the quality of healthcare, a robust definition of what constitutes 'quality in healthcare' is required. To date, several definitions of quality in healthcare have been developed, which differ across the lens in which the healthcare system is viewed (313,315,316). The most common definition comes from the Institute of Medicine (IOM) (US) which describes the term as 'the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (199). This is a high-level definition of healthcare quality, for this reason, researchers have broken down the concept down into domains. The OECD defined 10 dimensions of healthcare quality within their 'Health Care Quality Indicators Project', of most importance (or the most commonly cited dimensions) are those that overlap with IOM's dimensions, which are outlined in Table 72 below (3).

Table 72: Healthcare quality domains

Dimension	Definition
Effectiveness	Providing care processes and achieving outcomes which are supported by scientific evidence.
Efficiency	Maximising a unit of health delivered (or health benefit) for a given unit of healthcare resource used (i.e. getting the most output with a given level of input).
Equity	Providing healthcare of equal quality to individuals regardless of personal characteristics (other than preferences for care or clinical conditions).

Dimension	Definition
Patient centeredness	Meeting the needs and preferences of patients and providing education and support.
Safety	Patient bodily harm (actual of potential).
Timeliness	Accessing care in a timely manner with minimal delays.

Source: (317)
Note: Additional indicators stated by OECD are acceptability, accessibility, capacity, appropriateness, capability, continuity, and sustainability (318).

6.4.3 Measuring healthcare quality

Upon defining healthcare quality, a robust conceptual framework in which to measure healthcare performance is required. Such a framework ensures that all relevant areas of health system performance are measured, that healthcare priorities are identified, and lastly, that collection and analysis of data is neither misdirected nor duplicated (314).

Typically, healthcare performance is measured using indicators, which as outlined by Campbell *et al*. (2002), are explicitly defined, measurable items that allow policy-makers to assess the provision of healthcare (319). Historically, the literature and empirical evidence on quality indicators have focused on hospital care, however are today increasingly expanding into primary care services (319).

Indicator typologies

In his seminal 1996 paper, Donabedian developed a framework for measuring the quality of healthcare by grouping indicators into the following categories – structure, process and outcome (320).

Structure measures refer to the resources needed to provide care and relate to healthcare settings, such as personnel, equipment, or facilities (321). *Process* measures focus on how consistently or comprehensively healthcare providers follow a set of procedures or guidelines that outline best practice. Further, they focus on how care is delivered; however, they must be associated with health system outcomes (e.g. appropriate prescribing). This reinforces the idea that a provider has followed 'best practice', which may increase positive health outcomes. Lastly, *outcome* measures attempt to correlate medical care to optimum patient health status. Outcome measures monitor the effect of treatment and

can review patient experience in addition to physical health (321). Outcomes can be challenging to measure as numerous factors determine patient health status and are often out of the provider or health system's control. Typically, outcome measures are used within secondary care (i.e. inpatient care) given indicators are more readily available in this area (e.g. 30-day mortality) (321). Outcome measures are less common within outpatient care (e.g. GP practices) (322). Despite there being a separate category for outcome measures, high quality care can only be achieved with appropriate structures and processes.

Risks and benefits of indicators

Using indicators to measure and monitor health system performance can lead to a range of benefits. However, caution should be taken when designing relevant structure, process and outcome indicators, given there are a number of associated risks which may result in adverse health outcomes. The risks and benefits of using indicators to measure performance are outlined in the table below.

Table 73: Risks and benefits associated with measuring health system performance

Risks	Benefits
• May encourage fragmented rather than a holistic approach to care • May not cover all aspects relevant to measuring healthcare quality • May require data that is not readily available or is of low quality • May lead to provider backlash, if not developed in collaboration with the medical community • May not be cost-effective if designed poorly • Can lead to 'cream skimming' (choosing healthier patients) or cost-shifting • Can encourage a culture of blame and erode a provider's internal motivation • Can distract providers from providing optimal care	• Documents the quality of healthcare provision • Compares the performance of healthcare providers offering the same service/product (i.e. benchmarking) • Measures the performance of healthcare providers over time and thus establish trends (particularly relevant when evaluating the impact of a new policy) • Identifies areas of priority within the healthcare system, which assists in allocating resources appropriately • Holds healthcare providers accountable for their performance, which if made publically available, can assist the patient's choice of provider.

Risks	Benefits
• Can incorrectly attribute health outcomes to providers • Can encourage data manipulation • Indicators cannot cover all important aspects of healthcare quality and thus cover only a minority of clinical activity.	

Source: (323–325)

Best practice in designing indicators

A number of authors have developed best practice principles to guide policy-makers in developing healthcare indicators that minimise the risks outlined (see table below) (314,319,326). For the purpose of this paper, a summary of characteristics of good performance indicators has been drawn from Campbell *et al*. (2002), given these principles are based on primary care, which is the focus of this review (319).

Campbell *et al*. (2002) outlined seven characteristics that define a good healthcare performance indicator, namely: content validity, reproducibility, acceptability, feasibility, reliability, sensitivity, and predictive validity (see table below) (314,319). Despite these characteristics, the authors recognise that producing an 'error free' measure of quality may not be possible, however, to the extent possible, these characteristics should be adhered to (319).

Table 74: Indicator characteristics

Indicator characteristic	Description
Content validity	The indicator should accurately represent what it is trying to measure/assess.
Acceptability	Indicators should be accepted by both those who are being assessed as well as those who undertaken the assessment (e.g. indicators should be developed in collaboration with the medical community and patients).

Indicator characteristic	Description
Feasibility	Indicators should be valid, reliable and be measured using consistent and available data.
Reliability	Results from indicators should be associated with minimal measurement error, further, they should be easily reproducible across providers.
Sensitivity	The indicator should be able to detect changes in the quality of healthcare.
Predictive validity	The indicator should be able to detect quality of care outcomes.
Reproducibility	The indicator should yield the same result if the method was applied repeatedly.

Source: (319)

6.4.4 Uses of performance measurement

Once data on performance measurement has been collected, the next consideration is what to do with the available data. The two most widely advocated strategies to promote high-quality are reporting of performance and pay-for-performance. The former aims to stimulate interest in quality among healthcare providers, while the latter incentivises quality improvement by financially rewarding/penalising providers (327).

Reporting

Public reporting

Public reporting has two key objectives. First, to stimulate quality improvement by assisting patients in choosing top performing providers and identifying providers that are underperforming. And second, to increase transparency and hold individual healthcare providers, hospitals, or physician practices accountable (328).

Public reporting can focus on reviewing healthcare practices or individual physicians. Research has shown that hospital level public reporting increases quality improvement activities (314). According to Shekelle and colleagues, hospitals were more likely to implement quality measures after the release of performance data (2009). However, the positive impacts are relatively small (329). There is minimal evidence of the impact reporting has on quality at the primary care level.

Reviews of individual providers can be posted publicly. Provider performance can also be relatively ranked in comparison to their peers. This may inspire competition and lead to positive results, but may create conflict in the workplace. Additionally, articles speculate that public reporting may lead to adverse consequences, such as provider reluctance to operate on high risk patients or distort clinical priorities (329–333).

Professional improvement reporting

Reporting can also take place at the healthcare provider or individual physician level as a means to improve service provision. This type of reporting allows healthcare providers to compare their performance against peers, at either the regional, national or international level.

The debate on whether provider level performance should be made public or not is widely contested. However, literature on the topic reveals that performance measurement schemes should be 'designed and owned' by health professionals who in fact use the system (314).

Reporting targeted at professional improvement is primarily within the form of quality registers, where data is collected on behalf of providers who share results to a register. Such systems are popular within Scandinavian countries, such as Sweden and Norway (314).

Impact of reporting

Various studies evaluating the impact reporting schemes have on healthcare quality have been undertaken. Similar to P4P, consensus on the impact of reporting on healthcare quality has not been reached with studies finding both positive, neutral and negative effects (334,335). Proponents of public reporting highlight the impact it has on physician motivation, however, there is limited evidence to suggest that physician motivation and thus patient outcomes improve (335). Critics, on the other hand, point to the range of negative side effects that can occur from reporting, specifically:

- Limited accuracy and reliability of information
- High costs associated with collecting and analysing quality data

- Gaming among physicians, for example by refusing to care for chronically ill patients
- Misinterpretation of data among patients (334).

International case studies: Reporting

Examples of healthcare reporting in Sweden and Canada have been outlined below. Both systems have been recognised by the OECD as 'best practice' given the depth of data and availability.

Sweden

The National Board of Health and Welfare (hereafter, the National Board) is a government agency within Sweden's Ministry of Health and Social Affairs (336). The role of the National Board is to monitor and evaluate Sweden's healthcare and social services. As part of this role, the National board develops healthcare quality indicators as a way to measure the performance of care being delivered (336). Data for each of these indicators is summarised within National Quality Registers (NQRs), which are initiated and led by healthcare professionals (337). Sweden's NQRs include a range of information such as:

- Patient demographics
- Provider organisation characteristics
- Structure of care
- Process of care (including patient-reported experience measures (PREMS))
- Outcomes of care (including patient-reported outcomes measures PROMS)) (337).[77]

As of 2016, there were 96 NQRs covering 15 disease groups, which have been outlined in Table 75 below (338). Certain indicators receive 'national status' and are therefore made publically available online (today, results from over 800 indicators are made publically available) (339). Depending on the quality of data collected, results for each indicator may be published at the regional, county-city or healthcare provider unit level. For example, each year the National Board, in collaboration with the SALAR (Swedish Association of Local Authorities and Regions), releases a 'Quality and Efficiency in Swedish Health Care – Regional Comparisons' report, which publishes results from a range of indicators across Sweden's 21 counties (339). The Regional Comparison reports do not analyse why differences across counties occur or provide specific policy recommendations; this is seen as the responsibility policy makers at the regional level (339).

[77] The structure, process and outcome indicators cover both inpatient and specialist outpatient care.

There are three goals associated with publishing comparative healthcare data across counties: 1) to make publically financed healthcare systems more transparent and accountable; 2) to advance healthcare management and control by identifying satisfactory and unsatisfactory outcomes, which serve as the basis for implementing change (i.e. identifying areas of need and best practice); and, 3) to promote quality and availability of data relating to healthcare performance outcomes (i.e. encourages the collection of up-to-date, nationwide, robust data) (340).

A unique feature of Sweden's NQRs is the use of unique patient identifiers, which are based on individual social security numbers. By including a patient identifier, data from different quality registers can be linked, which provides a more robust picture of the type of care a patient receives (339,340).

Lastly, despite being an asset for Sweden's healthcare system, NQRs, in their current form, have certain limitations. Firstly, indicators within the NQRs are focused on hospital care and thus do not adequately cover primary or social care. Secondly, indicators do not capture the quality of on-going care, given indicators are clinically focused with well-defined beginning and end points. And thirdly, heterogeneity among data collection processes is inefficient, however, work is being undertaken to create a streamlined, automated approach data collection (340).

Table 75: NQR disease groups in Sweden

Disease groups within Sweden's NQRs	
• Cancer • Dental care • Emergency, anaesthesia and intensive care • Eyes • Lung diseases • Psychiatry • Paediatrics, obstetrics and gynaecology • Other areas	• Circulatory • Elderly palliative care • Endocrine organs • Infection • Musculoskeletal system • Nervous system • Stomach and intestines

Source: (338)

In-depth analyses of certain disease groups are published online within 'National Performance Assessments'. For example, recent National Assessment reports have covered diabetes (2014), musculoskeletal disease (2014) and stroke (2011). Typically, National Assessments cover 20-60 national-

guideline specific indicators relevant to the disease group under assessment (339). Results from the indicators are reported at the national, regional, county-council and healthcare unit level, and are also disaggregated by age, gender and socio-economic status. Unlike Regional Comparison reports, the National Board provides recommendations on where policy-makers can make improvements based on findings from the data (339).

In addition to Regional Comparison and National Assessment reports, each NQR publish annual reports within their specific field, as do a number of patient organisations and foundations (339).

Canada

The OECD have recognised Canada as an example of best practice example in terms of publically reporting on healthcare performance (341). Specifically, the OECD reference The Canadian Institute of Health Information's (an independent, not-for-profit cooperation focused on disseminating quality health information) *Your Health System* initiative as a model of healthcare reporting to be followed (341).

The online website, which is available to all, can be broken down into two key segments: 'In Brief' and 'In Depth'. The former, classified indicators as relating to either 'access', 'quality of care', 'spending', 'health promotion and disease prevention', and 'health outcomes' (see Table 76) (342). These groups were used as they were assessed as being of most importance to Canadians.

Data on each of the above indicators are reported at the national, and province and territory level. Results at the province and territory level are recorded as performing above, same or below average, which is benchmarked against the national average. Trends within and across regions is also available (342).

The *In Depth* section covers 37 nuanced indicators covering safety, health status, social determinants, person centeredness, appropriateness and effectiveness, and efficiency. The section also includes details on health service resourcing and activity. Performance against these indicators can be benchmarked at the province, territory, region, city of hospital level (341).

The online platform[78] is designed for the 'lay' viewer and is thus interactive and user-friendly.

[78] See: https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en

Table 76: CIHI's In Brief indicators

Indicator classification	Types of indicators
Access	• Access to a regular doctor • Specialist waiting times • Radiation treatment waiting times • Joint replacement waiting times
Quality of care	• Readmission rates to hospitals • Hospital deaths • Repeat hospital stays • Inappropriate use of antipsychotics in long-term care
Spending	• Age-adjusted public spending per person • Cost of a standard hospital stay
Health promotion and disease prevention	• Obesity rates • Smoking rates
Health outcomes	• Life expectancy at birth • Avoidable deaths • Children vulnerable in areas of early development

Source: (342)

Pay-for-performance

Despite strong intrinsic motivation, clinicians, like other professionals, respond to financial incentives. This is evident from the rise in pay-for-performance (P4P), which is being increasingly used in conjunction with other forms of payment, such as capitation and fee-for-service.

The academic and grey literature have provided numerous definitions of P4P (269,343). Partel (2014) describes P4P as using 'financial incentives, and sometimes disincentives, to encourage health services to behave in certain ways when undertaking certain activities, such as clinical care and resources used' (344). In simpler terms, the Agency for Healthcare Research and Quality (AHRQ) (US) defines P4P as 'paying more for good performance on quality measures' (345). Despite various definitions, at a basic-level P4P

represents payments to healthcare providers that are contingent on performance, which is defined through a set of pre-defined quality measures.

Advantages and disadvantages of P4P

P4P models were introduced as a tool to overcome the shortcomings associated with traditional payment methods such as fee-for-service and capitation. Empirical evidence supporting the impact of P4P on the delivery of quality healthcare is available, however, in developed countries it is minimal. For example, studies which find a positive association between quality/health outcomes and P4P note that improvements are modest and may be misleading given poor methodological evaluation design. For example, Eijkenaar *et al.* (2012) undertook a systematic review of systematic reviews regarding the effectiveness of P4P programs and found that, in general, improvements in performance were modest (272). Further, Scott *et al*. (2011) in their summary of primary care P4P programs noted only one of the various indicators within each program had a statistically significant positive impact, meaning that the authors could not say with confidence that P4P had an impact on the remaining indicators (346). Further advantages and disadvantages of P4P schemes is provided in Table 77.

Table 77: Advantages and disadvantages of P4P

Impact	Advantage/disadvantage	Explanation
Quality of care and health outcomes	Advantage	A number of studies in recent years have shown statistically significant improvements in healthcare quality and patient outcomes as a result of P4P.
Spillover effects	Advantage	Positive impacts on non-incentivized healthcare measures.
Gaming and risk selection	Disadvantage	Physicians have been shown to 'game' the system, for example by selecting healthier patients.

Impact	Advantage/disadvantage	Explanation
Physician motivation	Disadvantage	Financial rewards can have a negative impact on individual intrinsic motivation.
Quality of care	Disadvantage	P4P can lead to poor quality care (e.g. resentment towards recalcitrant patients).
Attribution	Disadvantage	Difficulties associated with attributing improved quality/health outcomes to P4P.

Note: (319,347–352)

International case studies: Outpatient P4P programs

Compared to the inpatient sector, P4P programs at the primary/outpatient level are limited. Nevertheless, this section outlines three prominent P4P programs locating in the UK, Australia and Germany.

Table 78: P4P country examples

Program name (country)	Performance domains	Incentive design	Funder/funding
Quality and Outcomes Framework (UK)	Process Clinical Outcome	Financial, absolute rewards are paid to GP practices (yearly) and are determined by a points-based system. Financial rewards comprise between 20-25% of GP income.	NHS Primary Care Trusts, Health Boards (Scotland), Regional Boards in Northern Ireland and Local Health Boards in Wales.

Program name (country)	Performance domains	Incentive design	Funder/funding
Practice Incentive Program (Australia)	Process Clinical	Financial, absolute incentives are paid quarterly to GP practices. Financial rewards comprise between 4-10% of GP income. GP practices are required to provide progress reports and aged milestones.	Australian Government
Disease Management Program (Germany)	Documentation Service Coverage	Flat rate payments Bonuses per patient treated. Patients incentivised through waived co-payments and reduced medicine costs.	German SHI system
France	Largely process indicators	Additional flat rate payments when a target has been achieved (points-based system).	Social health insurer

United Kingdom

In 2004, the UK Government introduced the Quality and Outcomes Framework (QoF) to reward GP practices for providing high-quality care. Although the QoF is voluntary, nearly all UK practices (99%) participate in the program (353).

The QoF is comprised of 81 indicators each attached to one of three health domains (areas of interest), namely, clinical, public health, and public health (additional services). Within each of these domains are a range of clinical areas.

QoF indicators are focused on improving quality of care via:

- Process measures (e.g. the percentage of patients with cancer diagnosed within the preceding 15 months, who have a patient review recorded as occurring within six months of the contractor receiving confirmation of diagnosis)
- Clinical outcomes (e.g. the percentage of patients with coronary heart disease in whom the last blood pressure reading is 150/90 mmHG less) (354).

GP practices are provided with financial rewards depending on the number of points they obtain. Points are rewarded based on a GP's adherence with an indicator. As of 2014-15, each GP practice could achieve up to 559 points, with a higher score translating into a greater financial reward (355). As of 2014-15, one point equated to £160.15,[79] with the final payment being adjusted for surgery workload, local demographics, and prevalence of chronic conditions in the local area (NHS Employers, 2016). In 2014-15, the average score for a GP practice was 529.6, with obesity and epilepsy clinical areas performing the best (356). Further details can be found in the table below.

Table 79: QoF areas of interest, clinical areas and maximum points awarded

Area of interest	Number of indicators /achievement measures	Number of clinical areas[a]	Example clinical areas	Maximum points GPs can obtain
Clinical	65	19	• Chronic kidney disease • Heart failure • Hypertension	435
Public Health	7	4	• Blood pressure • Cardiovascular disease	97

[79] This represents the payment in England. Different payments are made in Wales, Scotland and Northern Ireland.

Area of interest	Number of indicators /achievement measures	Number of clinical areas[a]	Example clinical areas	Maximum points GPs can obtain
Public Health – additional services	5	2	• Cervical screening • Contraception	27

Source: (356). *Note: [a]Each of the indicators fits within one of the clinical areas.*

As a proportion of total income, QoF provides GPs with a high level of additional income relative to other incentive schemes. For example, in 2005-06 the average additional income awarded to GP practices from QoF was £126,000, which when split across GPs, comprises approximately 20% of total GP income. Similar proportions continue to exist today (353).

A systematic review of the literature regarding the impact of the QoF has recently been undertaken[80] by Mandavia *et al.* (2017). Of the 21 articles used as part of the study, seven found a positive effect, 13 found intermediate effects and one had no effect.

Australia

The Australian Government introduced financial incentives into primary care in 1996 under the Better Practice Program. In 1998, the program was superseded by the Practice Incentives Program (PIP).

As of 2011, Medicare data found that 68% of GPs in Australia were registered for the PIP, however, this does not mean that all those who are registered receive payments. For example, the *Medicine in Australia: Balancing Employment and Life (MABEL*) survey found that in 2010-11 only 43% of GPs received an incentive payment. This represents a decrease from approximately 47% in 2008-09 (357).

Financial incentives are based on GP practices adherence to a range of indicators within the 11 clinical areas of interest. The payments are made quarterly to GP practices and are absolute in measurement (i.e. rewards are not based on performance relative to other practices) (358).

Incentive payments from PIP are part of a broader payment system for GPs, which also includes fee-for-service income. In general, incentive payments make up a small proportion of GPs overall income. For

[80] Working Paper.

example, in 2008-09 PIP payments represented between 3.8% and 10.3% of GP income in capital cities and rural areas, respectively (359).

Germany

Increasing healthcare costs and fragmented coordination of care led to the creation of the Disease Management Programs (DMPs) in 2001. The DMP strives to improve quality and coordination of care in order to reduce costly complications and hospitalisations associated with complex medical conditions Health funds were originally reimbursed by the Risk Compensation Structure (RCS) on per capita basis and adjusted by age and gender; however, this financing mechanism led to cream skimming and no incentive for physicians to treat the sickest patients, or to provide high quality of care (360). Sickness funds implemented 10,618 DMPs across all disease areas as of 2012 and six million people were covered (360).

The DMP first focused on diabetes, breast cancer, obstructive pulmonary disease, and coronary disease (360). These were proposed by the Joint Federal Commission, which is a group of physicians, representatives from sickness funds, and the German Hospital Organisation. Disease specific committees were also formed to create evidence based guidelines (360). These guidelines were verified by the Agency for Quality in Medicine and the Institute for Quality and Efficiency in Healthcare (361).

Sickness funds have freedom in interpreting and designing their DMPs, but they must follow specific guidelines. These guidelines specify the patient enrolment process, evidence based treatment, feedback to patients and providers, education to patients and providers, electronic record documentation, and quality assurance and evaluation (361). DMP programs have the following performance domains – documentation, follow-up of patients, additional services, and training. There are 10 indicators that are measured and rewards are absolute. These incentives are distributed as a flat-rate, additional payments per enrolled patient, per indicator met, and per service provided to enrolled patients (362).

Sickness funds receive flat rate payments as incentives based on the creation of DMPs and patient enrollment (360). Physicians are reimbursed directly related to the costs of providing education and coordinating patient care. Physicians also receive additional remuneration for the provision of DMP services in the form of lump sums per patient. According to Stock *et al.* (2011), physicians receive referral financial incentives per case if they send patients to a chronic disease specialist. Financial payments vary by region. Chronically ill patients are also incentivised to seek treatment through waived co-payments, reduced medicine costs, and payment exemptions from physical therapy (361).

France[81]

Pilot P4P programs were initially introduced into France's ambulatory care sector in 2009. The original P4P model included a small number of indicators, which were divided into one of the following groups: prevention, chronic disease management, and drug prescription efficiency. All but one of the indicators were directly calculated by the sickness funds based on claims, and thus, did not require additional data to be collected from GPs. In its initial phase, the P4P scheme awarded GPs, on average, €3,000 per year (with a maximum of €5,600).

P4P was initially met with hostility from: the physicians' union as P4P arrangements were implemented in individual, voluntary contracts; the drug industry, given the inclusion of efficient prescribing targets; and from various other institutions due to the mix of quality and efficiency indicators. Despite these objections, 40% of all GPs signed up to P4P.

In 2011, the physicians' union and sickness funds agreed to introduce P4P into collective agreements as a core component of GP remuneration. The scheme included all original indicators, in addition to a dimension on practice organisation, as well as separate P4P indicators for cardiologists and gastroenterologists in private practice.

An overview of current indicators, which were jointly developed between sickness funds and the physician's union is outlined below and have been grouped into the following categories: management of chronic diseases; prevention; and efficiency. Similar to international arrangements, the majority of indicators are process related.

Table 80: French P4P indicators – management of chronic disease[82]

Theme	Indicator	Target
Diabetes	% patients with 2 or more HBa1C tests process	>= 93 %
	% patients with eye exam process	>= 77 %
	% patients with follow-up of the renal function (specific exams) process	>= 61 %

[81] Information sourced directly from IEC member, Ms. Polton.
[82] Ibid.

Theme	Indicator	Target
	% patients with foot examination process	>= 95 %
Health technology assessments	% patients with follow-up of the renal function (specific exams) process	>= 14 %
Cardiovascular risk	% patients assessed with a scoring tool process	>= 95 %
	% patients with coronary heart disease or peripheral vascular disease under treatment with ACE inhibitors or angiotensin II receptor antagonists	>= 61 %
	% patients under vitamin K antagonist treatment with >= 10 dosages of INR	>= 95 %

Table 81: French P4P indicators – health prevention

Theme	Indicator	Target
Flu	% Patients 65 and over immunized	>=75%
	% patients >= 65 with a severe disease or a respiratory disease immunized	>=75%
Cancer screening	% patients 50 to 74 years old participating in breast cancer screening	>=80%
	% patients 25 to 65 years old with a Pap smears in the last 3 years	>=80%
	% patients 50 to 74 years old with a colorectal cancer screening in the last 2 years	>=70%
Iatrogenic risk	% patients with a benzodiazepine anxiolytics treatment > 12 weeks	

Theme	Indicator	Target
	% patients with a benzodiazepine hypnotics treatment > 4 weeks	<=24%
	% patients 75 and older (or 65 and older with a severe disease) with no psychiatric disorder having a prescription of 2 or more psychotropic drugs	0%
Antibiotics	Number of antibiotic treatments for patients 16 to 65 years old without any severe disease	14
	% patients 16 and over treated by antibiotics generating the most resistance	<=27%
Addiction	% smoking patients with a brief intervention (recommended in the HAS guidelines) recorded	>=75%
	% alcoholic patients with a brief intervention (recommended in the HAS guidelines) recorded	>=75%

Table 82: French P4P indicators – efficient prescription

Theme	Indicator	Target
Generic prescription	% prescription of generic statins	>=97%
	% prescription of anti-hypertensive drugs (some classes)	>=92%
	% prescription of generic urinary incontinence treatments	>=94%
	% prescription of generic asthma treatments	>=86%
	Global generic index	

Theme	Indicator	Target
Prescription of biosimilars	Prescription of biosimilars for insulin	>=20%
Efficient prescription	% low dose aspirin among platelet inhibitors	>=94%
	% type II diabetic patients treated by metformin	>=93%
	% patients with thyroid hormones dosage with TSH dosage only	>=99%

6.4.5 Measuring quality of healthcare within Austria

Managing healthcare quality

Table 83 builds upon Schmidt *et al.* (2012) by outlining, at a high-level, key policies to improve quality management within the Austrian healthcare system over the past 20 years (363). In addition, notable quality programs have also been included.

Salient changes to the way quality in healthcare is managed in Austria can be found below:

- The *Federal Health Quality Act (Gesundheitsqualitätsgesetz)* (2005): The objective of this Act was to intensify efforts to systematically manage quality of healthcare in Austria. Efforts to improve quality management, as stated within the Act, should consider patient orientation, transparency, patient safety and sustainability.
- *Health Care Structure Plans* (2006): As part of the 2005 Healthcare Reform, integrated health care structure plans were introduced at the federal (ÖSG) and regional level (Regionaler Struktuplan Gesundheit, RSG). The federal structure plan functions as a template for RSG plans, which are implemented according to the Länder configuration (agreement under article 15a). In short, the federal structure plan outlines capacity planning in the following areas: inpatient care, outpatient care, rehabilitation, biomedical equipment, and the interface of health and long-term care. Further, the structure plan includes guidelines related to structural quality standards and their implementation (363,364). At the regional level, requirements, as outlined by the federal structure plan, are implemented through the RSGs (between the Lands and social health insurance), which take into account the needs of individuals in each Land (363).

- *Federal Institute for Quality in the Healthcare Systems* (Bundesinstitut für Qualität im Gesundheitswesen, BIQG): the Health Quality Act (2005, §9) led to the development of BIQG, which sits within GÖG and cooperates with various stakeholders including social insurance, federal and regional governments, professional societies, chambers and professional representations, and patient advocacy and support groups. BIQG specialises in healthcare quality, and on behalf of the Federal Government develops, implements and regularly evaluates a nationwide quality system based on the mandatory principles of patient centeredness, transparency, effectiveness and efficiency (304,365).
- *Austrian Society for Quality Assurance and Quality Management in Medicine* (Österreichische Gesellschaft für Qualitätssicherung und –management in der Medizin GmbH, ÖQMed): In 2006, the Chamber of Physicians established ÖQMed, which includes representatives from the Federal Ministry of Health and Women's Affairs, GÖG, HVSV, social security institutions, Chamber of Physicians, academics, and the patient ombudsman. ÖQMed is tasked with developing and conducting the self-evaluation for physician practices.
- The ÖQMed acts as a Scientific Advisory Board which provides recommendations regarding how best to measure and monitor the quality of care provided by contracted and non-contracted physicians working within the outpatient sector. Each year ÖQMed publishes a Medical Quality Report outlining results from self-administered physician questionnaires (discussed in further detail in this section) (365).
- *National Quality Strategy* (2010): (366). As a result of the Federal Health Quality Act, in 2010, the Austrian Federal Health Commission assigned the Working Group on Quality to develop a nation-wide quality strategy. The strategy, which was developed by government, social health insurance and providers, was later agreed by the Federal Health Commission (BGK). Technically, the objectives of the strategy are binding, in practice, however, this is not the case (363,367). Similar to the Act, the strategy focuses on areas such as patient orientation, safety, equity, effectiveness, and cooperation and coordination (367).
- *Austrian Inpatient Quality Indicators* (2011): In 2011, the Federal Health Agency implemented A-IQI as a way to measure quality of care within hospitals. A-IQI, which is based on the German model, was first implemented in Lower Austria and later expanded to all Lands. Today, the A-IQI is explicitly stated in the law, therefore it is compulsory for all hospitals to record data against each of the indicators (368). Aligning outpatient indicators were introduced in 2013, however, this initiative is at an infancy stage.

- *Target control health (Zielsteuerung Gesundheit*) (2013): Target Control Health is a target-based, coordinated and cooperative control system involving social insurance, and federal and state governments. The primary instrument within Target Control Health is the Federal Target Control Agreement (Bundeszielsteuerungsvertrag, B-ZV), which was concluded in June 2013, and the Länder Target Control Agreements (*Landeszielsteuerungsverträge*) on the level of the states. One of the key objectives of the B-ZV agreement was to implement uniform federal quality management systems in hospitals and private practice, and to coordinate systems with the outpatient sector. In terms of structure, as part of the 2013 reform, the Federal Target Control Commission (*Bundeszielsteuerungskommission,* BZK), was established as a second body in the Federal Health Agency, which took over responsibilities once held by the Federal Health Commission (*Bundesgesundheitskommission*, BGK) (established in 2004-05). The BZK is comprised of 17 representatives from federal government (four), regional government (nine) and social health insurance (four). Under the supervision by the BZK, sits the Coordinating Committee (Ständiger Koordinierungsausschuss), who in turn oversees four professional working groups covering e-health, public health, supply processes (which includes the quality strategy) and supply structure. Each of these professional groups can undertake work in-house or commission projects to another organisation (e.g. the BIQG in regard to the Quality working group). In addition, there are State Target Control Commissions (Landszielsteuerungskommission, LZV) across each of the Länder, each comprising 11 representatives from federal government (one), regional government (five) and social health insurance (five). The Federal and State Target Control Commissions are aligned, in that targets developed at the federal level are implemented at the state level, which take into account local conditions. Responsibility for monitoring targets lies with GÖG. A new Federal Target Control Agreement was recently implement, which covers the period 2017-21.
- *Federal health targets:* Under the healthcare reform (2013), 10 over-arching (framework) health related targets were developed and adopted by the Council of Ministers and the Federal Health Commission. The 10 health targets were based on a number of guiding principles including 'orientation towards health determinants', 'health in all policies', and 'promoting health equity'. Together, the targets aim to increase the number of healthy life years by two between 2012 and 2032. The above targets are broad, therefore a number of sub-targets (*Wirkungsziele*) and aligning indicators have been developed. Most performance indicators are monitored by GÖG, with results being made publically available (annual). It is recognised that the 10th Federal Health Target ('to secure

sustainable and efficient healthcare services of high quality for all') aligns and complements Target Control Health (369).

In regard to quality initiatives, the following two examples may be considered the most important. First, introduction of a diabetes disease management program (Therapie Aktiv) (2007-08), and secondly, the introduction of primary healthcare units (PHUs) as part of the 2013 healthcare form.

Table 83: Healthcare quality management and major quality projects in Austria since 1997

Year	Milestones		Objectives
	Federal level	*Länder level*	
1997	**DRG**-based hospital financing		Improve efficiency
2004/05	**Federal Health Agency** introduced **Federal Health Commission** established Introduction of **e-card** (SHI)	**State health Funds** established **Regional Health Platforms** established **'Reform Pool'** to coordinate inpatient and outpatient care	Improved collaboration between Federal and Länder governments Better integration between in- and out-patient care
	Possibility to create **Federal quality directives** and **Federal quality guidelines**		Better patient pathways
2006	**Austrian Health Care Structure Plan** for integrated care introduced	**Regional Health Care Structure Plans** introduced	Capacity planning and quality management guidance
	Federal Institute for Quality in the Healthcare Systems (BIQG) established as part of Healthy Austria Ltd., and located with GÖG **Austrian Association of Quality Assurance and Management** (ÖQMed) within the Chamber of Physicians		Implementation of national quality standards Outpatient quality management
2007/08	**Austrian Health Care Structure Plan** for 2008 launched	Amendment of **Regional Health Care Structure Plans**	Capacity planning based on volumes and activities Capacity planning for all of health and social care
	Introduction of the **diabetes disease management program** (Therapie Aktiv)		Improve treatment of diabetic patients
2009	**HTA Strategy** launched by BIQG First Federal **quality guideline for diabetes** introduced **Reporting & Learning system** made available online by ÖQMed **Quality survey on outpatient care** published by ÖQMed		Improve transparency, patient safety and patient pathways

Year	Milestones		Objectives
	Introduction of **ELGA** to coordinate patient electronic health records		
2010	**National Quality Strategy** published by the Federal Health Commission		Outline of main quality objectives
	Online quality reporting platform launched by BIQG		Standardisation of federal clinical guidelines
	Meta guidelines approach introduced by BIQG		Improve patient safety
	Publication of Guideline for Reporting & Leaning Systems (BIQG)		
	Independent online **Health Portal**		
	Austrian Health Care Structure Plan for 2010	**Regional Health Care Structure Plans** for 2010	Improved planning for ambulatory and rehab care
2011	**National Quality Report** on hospitals by BIQG		Improved transparency
	Introduction **A-IQI** by the Federal Health Commission		Standardisation of data collection
	Cross-sector Patient Satisfaction Survey (national) results presented (GÖG)		Improved patient satisfaction
	Publication of the Reporting & Learning guidelines		
2012	Binding **regulations on waiting lists** for planned operations in hospitals		Improve access to care
2012	Pilot Critical Incident Reporting System implemented within Universtiy of Graz (intensive care, expanded to all units in 2013)		Identify potential hazards within healthcare
2013	Introduction of **target control health** to monitor several indicators. This initiative relates to typical healthcare services (e.g. hospitals, doctors) (part of the **Federal Target Control Agreement**). Monitoring of performance is undertaken by GÖG.	**State Target Control Agreements** (2013), deal with the design and implementation of quality measures	Improve overall healthcare system performance and patient outcomes
2013	As part of the healthcare reform**, 10 health targets** were developed with the overall purpose of increasing		Increase number of health years by two between 2012 and 2032.

Year	Milestones		Objectives
	health life years by two between 2012 and 2032 ('Health in All Policies' approach). There at 113 indicators which measure progress against each of the 10 targets. Monitoring responsibility largely falls under the remit of GÖG,		
2013	Development of **Austrian-Outpatient Quality Indicators** (Healthcare Reform 201. It is important to note that the A-OQI is in its infancy stage.		Coordinate quality indicators across healthcare spectrum
2013	**Concept for primary healthcare units –** established two PHUs (Healthcare Reform 2013)		Improve care coordination
2014	Implementation of **ELGA portal**, allowing patient access to care records		Improve patient understanding of healthcare
2015	**Patient Satisfaction Survey** undertaken by the Federal Health Target Commission		Understanding of perceived health system quality
2016	Implementation of **Kliniksuche**, which provides information on hospital quality (project of the Healthcare Reform 2013)		Inform public of hospital quality
2017		Introduction of TEWEB to provide patients with **telephone and web-based healthcare services** (only in Voralberg, Lower Austria and Vienna (first contact only).	Improve access to healthcare
2017	Commitment of €200 million to fund an **additional 75 PHUs/coordinated care centres** by 2020		Improve care coordination

Source: Format and information (up until 2011) taken directly from Schmidt *et al.* (2012) (363).

Measuring quality of physicians within social health insurance

Since 2006, quality standards among contracted and non-contracted physicians have been measured and monitored by the Austrian Society for Quality Assurance and Quality Management in Medicine (ÖQMed), a subsidiary of the Chamber of Physicians (291). Specifically, ÖQMed administers self-questionnaires (either online or on paper) covering a range of quality criteria largely related to structures, and to a lesser extent, processes (see table below) (291). Questions, in general, are broad and responses are limited to yes, no or not applicable. Given the questionnaire is self-administered, random checks are carried out by representatives of the Chamber of Physicians (Quality Assurance Officers), however, sufficient warning is provided to private practices prior to an inspection (approximately six weeks) (363).

ÖQMed comprises professionals from a range of different organisations including, the Federal Ministry of Health and Women's Affairs, GÖG, HVSV, social security institutions, Chamber of Physicians, academics, and the patient ombudsman (370). It is important to note that ÖQMed operates purely as an advisory board, in that the Chamber of Physicians is not required to implement their recommendations regarding which indicators should be measured.

Table 84: ÖQMed quality criteria categories (as of 2011)

Indicator categories *Evaluation criteria set out by ÖQMed includes 20 categories, with aligning sub-categories to measure the quality of care provided by physicians in social insurance.*	
Patient care availability	Professional qualifications
Premises of the healthcare facility	Personnel (employees)
Fire safety and job security	Patient history and documentation
Hygiene	Administration of results and findings
Emergency preparedness	Patient communication and education
Drug quality and availability	Interdisciplinary coordination
Clinical prescription of addictive drugs	Access to medical treatment and diagnosis

Medical consumables	Internal communication
Equipment	Adverse events/patient safety
Reliability of laboratory tests	Complaint management

Source: (371)

Measuring quality of hospital care

As previously outlined, countries are increasingly interested in evaluating, and paying for, health system performance. To do so, process or outcome measures are typically applied, with an increasing preference for the latter. Hospital discharge and readmissions are frequently evaluated for this purpose. The following section describes the existing uses of hospital discharge and readmission metrics in measuring and paying for performance, and reviews the primary evidence for this metric within the Austrian context.

Discharge care and post-discharge mortality and readmission rates

Discharge care and the incidence of post-discharge mortality and readmission events are used as process- and outcomes-based measures of hospital quality and performance.

One stream of evidence on hospital quality in acute coronary syndromes has relied on evaluations of discharge and secondary preventive pharmaceutical care, as well as hospital readmissions (372–378). This line of evidence typically evaluates whether, and to what extent, best clinical practices were met during discharge care for particular conditions. With regards to clinical outcomes, the incidence of all-cause and, in particular, unplanned hospital readmissions within some period after the hospital episode are taken as a measure of the quality of care delivered during the patient's hospital stay.

For example, the literature has often used care and outcomes surrounding acute myocardial infarction (AMI) events to evaluate hospital and health system performance. Once an AMI has occurred, studies have evaluated how the efficiency of admission processes – including rapidity of ambulance services and hospital-based pathways to initial treatment – predicts readmissions, as well as in-hospital and post-discharge AMI mortality (379). Once an admission has occurred, studies have also evaluated how patient course is influenced by delivery of invasive (e.g., PCI) and pharmaceutical (e.g., thrombolysis, statins, aspirin) treatments at any time prior to discharge (373,375,380).

Less developed, but growing, is the literature that uses hospital readmissions to measure cost efficiency (381). This dearth of evidence likely reflects technical difficulties in associating patient outcomes, including readmissions, with hospital inputs, which may be defined in financial or physical resource terms. Efficiency analyses of this sort may be facilitated with the emergence of micro-costing hospital data, such as patient-level information and costing systems (PLICS) in the UK.

Discharge care and readmissions in Austria

Bearing in mind that discharge care and the incidence of post-discharge mortality and readmission events are used as process- and outcomes-based measures of hospital quality and performance, this section now considers the Austrian experience in performance on both of these measures.

The OECD defines hospital discharge as 'important indicators of hospital activity', that may be affected by several factors, including: the capacity of hospitals to treat patients; the ability of the primary care sector to prevent avoidable hospital admissions; and the availability of post-acute care settings to provide rehabilitative and long-term care services (382).

The OECD finds that in 2013 (or nearest available year) Austria and Germany were the two countries with the highest hospital discharge rates of OECD countries (Figure 29). At 263 hospital discharges per 1,000 population, Austria had the highest discharge rate of all OECD countries examined. Austria's discharge rate was 55% higher than the OECD average of 169 hospital discharges per 1,000 population. Elsewhere, reports indicate that discharge rates are particularly high in Austria for hypertensive disease (383). It is important to evaluate these data with caution: for instance, an EC-sponsored research project in 2008 found low discharge rates in Spain, but attributed this to known underreporting (383).

The OECD argues that high discharge rates are generally observed in settings that have a larger number of hospital beds. Indeed, at 7.6 beds per 1,000 population, Austria ranks among the highest in countries evaluated by the OECD in number of hospital beds, adjusted by population (see Figure 19 and Figure 20). It should however be noted that Germany, which outranks Austria in number of hospital beds per 1,000 population, has a fewer number of hospital discharges per 1,000 population. This points to higher rates of use of hospital services in Austria: patients may genuinely have greater health needs, or may, for reasons that deserve further examination, overuse hospital services.

Indeed, an EC-sponsored report in 2008 indicated that higher rates of discharge in Austria were due to a higher rate of hospital readmissions for investigation and treatment of cancer patients than in other European countries (383). The report indicated that high rates of readmission were unlikely to be caused

by ‘morbidity reasons’ (383). The implications of this finding for patient health, and particularly the risks and benefits to cancer patients, remain to be investigated.

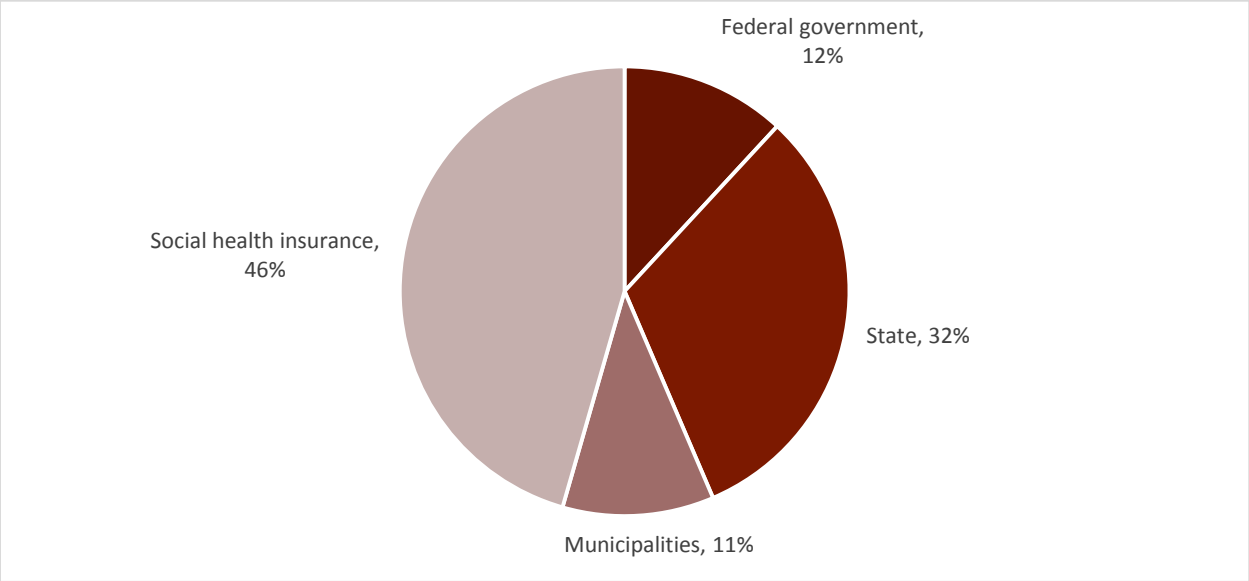
Factors contributing to high hospital admission rates in Austria

Fiscal illusion and political economy of hospitals

From the viewpoint of political economy, in an ageing society, political benefits can be reaped by providing ample healthcare services, e.g. in the form of hospitals. What is more, as most hospitals are eventually owned by the Länder, they provide the opportunity to exert power according to the theory of bureaucracy (384). Moreover, hospitals always provide employment for qualified personnel and improve economic activity in a region. All these effects reflect positively on regional (i.e. Länder and municipal) governments and thus create the tendency to over-provide.

The above scenario is normally outbalanced by the necessity to also tax the regional population to pay for the hospitals, as is the case in many other countries, e.g. Sweden. In Austria, however, nearly all taxes are levied by the Ministry of Finance, while social insurance contributions are collected by the health insurance funds. Therefore, the regional governments do not have to bear the negative consequences from taxing their populations for hospital services, while still benefitting, a phenomenon known as *fiscal illusion* (384). Also, the Länder, while endowed with ample control over hospitals (art. 12 of the Austrian constitution), pay only 32% of costs.

Figure 120: Public financing of fund hospitals



Source: Statistics Austria 2017

Indeed, there has been a continuous struggle between the federal government and local governments about hospital beds, with several attempts of the federal government to reduce their numbers, first the Austrian Hospital and Large Devices Plan (*Österreichischer Krankenanstalten- und Größgeräteplan*), then the ÖSG with a sanction mechanism in the 15a-agreement. Keeping hospitals open while the occupancy rate is low is politically infeasible. Therefore, also known as Roemer's law (385), there is the incentive to lower the requirements for hospital stays so that the capacities can be shown to be necessary, a phenomenon also found in empirical studies of the hospital sector (386).

The Länder also have the means to conduct such a policy as they command many competencies in the hospital sector. Specifically, they:

1. Enact hospital laws
2. Execute hospital laws
3. Regulate market entry (§3KaKuG)
4. Command the automatic majority in all decisions concerning hospitals in the state health funds
5. Own most hospitals
6. Finance hospitals partly.

In addition to this, most Länder hospitals have been organisationally privatised, and the 15a-agreement on the organisation and financing of the healthcare system explicitly states that state health funds shall be able to cover more than 50% of costs. This provision has the effect that the hospital companies owned by the Länder are treated as being entities of the private sector in the system of national accounts. Therefore, up until 2010, deficits and debts of the hospital companies did not count towards Austria's Maastricht deficit and debt. When Eurostat revised the rules of the manual on government deficit and debt, the debt burden of all Länder hospitals became known to the public for the first time amounting to €3.8 billion (6).

<u>Reasons lying in the domain of social health insurance</u>

For the management of Social Health Insurance, the main benchmark is not to keep the overall health budget in line, but to spend only as much as its own revenues allow (also known as *Einnahmenorientierte Ausgabenpolitik*), even more so as there is no competition for insurees in Austria.

As SHI pays a share of their revenues to the state health funds regardless of the number of patients actually attending hospitals, it is faced by the following decision problem:

Increasing the number of contract physicians will incur additional expenditure, while limiting the number of contracts helps contain costs. The external effect of this decision is that people are faced by a limited supply of services especially out-of-hours, while at the same time there is no user charge or restriction of using hospital outpatient departments.

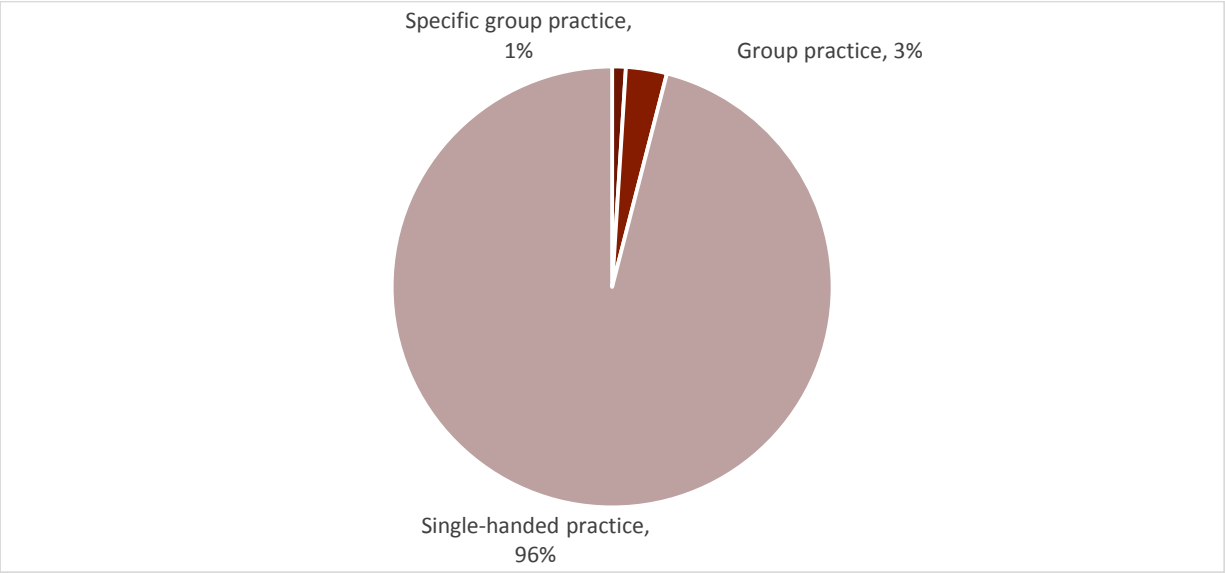
Figure 114 illustrates that despite a growing population, the number of contracts between SHI and the Chambers of Physicians remains the same, effectively reducing the relative capacity in the extramural sector, essentially constituting cost-shifting behaviour.

The fact that this is not an effect of a shortage of physicians can be shown when calculating the share of physicians who own practice and do not have a contract with any social insurance carrier (63% of specialists and 40% of GPs).

Structure of extra-mural sector and incentives for patients

Given the incentive for SHI to underprovide contracted physician services, and as the extramural sector consists mainly of single practices, patients with more complex problems must book several appointments, and spent an increased amount of time waiting for services. What is more, GPs up until 2015 received only three years of vocational training, all of which taking place in hospitals. More than 95% of contract physicians work in single practice, with only a practice aid but no nurse practitioners or other medical professions. Contact hours are therefore limited and often only 20 hours a week. Specialists work mainly in single practice as well, making it more difficult to integrate services. While Germany introduced outpatient facilities providing integrated specialists services a long time ago with its legislation on integrated care, efforts to do so in Austria were never successful (40). This leaves a gap in service provision of integrated care for the chronically ill between single practices on the one end and hospitals on the other, sometimes called intermediate or step-down facilities (387,388).

Figure 121: Practice settings of §2-Physicians



Source: (389)

By contrast, outpatient departments offer all services under one roof with same-day service, 24/7. Thus, in order to avoid long waiting times in the extramural sector as well as having to keep multiple appointments, patients will, given these circumstances, prefer to go to outpatient hospital departments.

Despite its importance, very little empirical work has been devoted to this topic. However, Haidinger *et al.* (2013) conducted a study on persons visiting outpatient departments without referral (390). They find that at least 60% of these could have been treated by a GP, while only 3% required treatment in a hospital.

The weakness of the primary care sector can also be seen when looking at avoidable hospital admissions. Austria performs very poorly in this respect (see Figure 33 to Figure 36).

Sonderklasse and payment system

According to political economy literature, hospital managers and department heads are not impartial when it comes to more or less funds allocated to their hospital even if the hospital is not-for-profit (see Mueller (2003) pp. 362ff and pp 373ff for a review of empirical studies) (384). More funds might not mean more profits in this case, but they offer the possibility to pay higher wages, to pursue scientific interests, to be held in higher esteem by peers or simply to exert power. In Austria, at least two factors set strong incentives reinforcing this mechanism, the *Sonderklasse* and the payment system.

Sonderklasse

Even in Austrian not-for-profit hospitals, patients can pay for better amenities and the right to be treated by a specific physician, either out-of-pocket or through their voluntary health insurance. The patients are then admitted to the *Sonderklasse*. The patients' payments go to the hospital but also increase the income of the physicians working at the department. Therefore, both the hospital management and the physicians have an incentive to admit and treat such patients. The hospital law KaKuG in § 16 sets some limits to this. Not-for-profit hospitals must not have more than 25% of beds in the *Sonderklasse*. In the long run though, this sets the incentive to increase the total number of beds, as only then also the number *Sonderklasse*-beds can be increased, contributing to what can be seen in Figure 19.

Payment system

While the inpatient sector of hospitals is paid through a DRG-like system called LKF, the outpatient departments only receive a global budget based on historical values. In effect, it is much more valuable for the hospital to have patients admitted to inpatient departments than treating them in the outpatient department. For this reason, even cataract surgery was mainly performed during an inpatient stay only some years ago.

In order to change the incentives, a first step was the introduction of the *Tagesklinikkatalog* in 2006, a list of procedures that could be performed in day clinics, while the hospital still received payment for an overnight stay. Since then, more and more services are provided in day clinics, albeit with considerable regional differences (391). Another step to improve the situation would be the introduction of a DRG-system for outpatient departments. Preparatory work has been undertaken with the implementation of the *Katalog Ambulanter Leistungen (KAL)*.

6.4.6 Policy options: Maximising quality of care

A key mechanism to enhance the quality of care provided by physicians is to measure their performance against a set of key indicators. These indicators can relate to healthcare structures, processes or clinical outcomes, and in many countries, are linked to financial rewards or penalties. The agency responsible for measuring and monitoring indicators has important implications for quality of care, given it is their role to ensure the data collected is used in a way to enhance patient care.

Based on a review of policies used to measure quality among Austrian physicians, and international experiences, the following policy options have been developed. These options can be divided into the three groups, and are aimed to maximising quality of care within the Austrian social health insurance system (see Figure 122 for an overview of policy options).

Figure 122: Summary of policy options

Role of ÖQMed

- Retain ÖQMed and create an additional independent quality committee responsible for monitoring the quality of care among social health insurance physicians.
- Relocate ÖQMed to the Ministry of Health and Women's Affairs, and give the organisation control over monitoring the quality of care among social health insurance physicians.
- Maximise the value of data collected through quality indicators through, for example, providing physician feedback and sharing best practice principles.

Data availability and quality indicators

- Code patient diagnosis.
- Increase focus on outcome indicators, and where possible link them to aligning process indicators.
- Link quality indicators across all levels of care.

Hospital admission, readmissions and discharge management

- Investigate the causes, as well as clinical and policy implications, of high rates of hospital discharge and readmission in Austria.
- Financial targets within Zielsteuerung Gesundheit if real values, as opposed to nominal values, are used as the basis for the target.
- ÖSG to base forecasts on epidemiological data and best practice service provisions.
- Integrate secondary care units in outpatient sector with primary care and hospitals.
- For the LKF, link payment to quality.
- Set up joint budgets for the chronically ill including both social health insurance and the Länder.

ÖQMed role

As previously discussed, the Chamber of Physicians is responsible for monitoring the quality of care provided by physicians within social health insurance. To assist the Chamber in measuring and monitoring healthcare quality, it has established a scientific advisory board, ÖQMed, comprising representatives from numerous organisations/levels of government, including two from social health insurance (see section 6.4.5 for further details).

Given ÖQMed is a subsidiary of the Chamber, it is not independent, further, its current role is purely advisory, with no requirement for the Chamber to implement recommendations made by the board. Such an arrangement is challenging given those measuring the quality of doctors are doctors themselves. To overcome a potential conflict of interest, the following two mutually exclusive options are proposed. The first option would be to retain ÖQMed within its current form in the Chamber, however, ultimate responsibility for monitoring physician quality would lie with an independent quality committee located within the Ministry of Health and Women's Affairs. Alternatively, ÖQMed could be relocated to the Ministry of Health and Women's Affairs, to ensure its independence. Under this new arrangement, ÖQMed would be responsible for developing indicators to measure physician quality, and deciding how information collected through the indicators are used.

If the former approach is adopted, consideration should be given to limit avoid/limit duplication between ÖQMed and the independent quality committee. Under both options, either ÖQMed or the independent quality committee would be jointly funded by the Ministry of Health and Women's Affairs, and the Chamber of Physicians.

To maximise the value of data collected on quality, it is recommended that the final agency responsible for measuring and monitoring physician quality employ one or several of the following approaches: providing physician feedback, sharing knowledge (best practice), intervention when poor performance is identified, and potentially, in the long-run, pay-for-performance (see Figure 123). To maximise the potential of all strategies outlined above, it is recommended all interventions be designed in cooperation with the Chamber of Physicians.

Figure 123: Maximising the value of data on quality indicators

Physician feedback

Each physician could receive a short 'scorecard' outlining their performance across the different quality indicators. In addition to their individual performance, physician performance at the relevant regional level and national level would also be provided, allowing for comparisons to be drawn. The scorecard would highlight areas where, in relative terms, the physician is performing well (i.e. above the regional/national level) or poorly. Scorecards would be provided biannually, by mail or online, allowing physicians to track their performance over time.

Given differences across regions, indicators will be risk-adjusted so that like-for-like comparisons are drawn (see following section for further details on quality indicators).

The public could also have access to performance data, however, it is recommended that data at the regional, as opposed to the individual provider level, only be made available.

Knowledge sharing

As previously outlined, data on quality indicators will be tracked across physicians and time. Therefore, significant positive changes in performance at the individual, practice or regional level will be tracked. Investigation into how improvements were made should be undertaken, with findings shared and promoted to all physicians. It is important to note that only regional aggregate data would be available to all physicians. That is, individual performance data would only be accessible by the physician themselves.

Intervention

Readily available data on quality indicators at the individual, regional and national level, will enable ÖQMed or the independent quality committee to identify areas of need within the system. For example, if physicians in an entire region perform poorly in certain indicators, investigation and appropriate intervention at the regional level will be required. Prior to intervention, a thorough analysis is needed to ensure the problem lies with physician quality, as opposed to external regional factors. At the individual level, poor performing doctors will be easily identified, allowing intervention at the earliest possible stage. If performance does not improve, disciplinary action may be taken.

Pay-for-performance

Governments across the world are increasingly interested in incentivising high-quality care through monetary rewards or penalties. Such an approach could be adopted in Austria, however, the evidence of its impact on quality is limited.

Legal considerations

No particular constitutional impediments have to be faced in this respect, but some amendments to the current system of contractual agreements would be required.

Quality indicators

Across all healthcare systems, collection and analysis of quality indicators at the outpatient level is in its early stages, when compared to hospital care. This is the case in Austria, where a limited number of structure and process quality indicators are collected to measure the performance of contracted and non-contracted physicians. The focus on structure and process indicators does not follow international trends, which is to measure patient outcomes directly.

To collect data on outcomes, information on patient diagnoses is required. At present, social health insurance physicians are not required to provide this information. This shortcoming was frequently highlighted in roundtable stakeholder discussions, and has also been recognised by government as evidenced by the topic's inclusion in the latest healthcare reform (i.e. health targets).

Given the above, the following recommendations are made to improve quality of care provided by contracted and non-contracted physicians:

Diagnosis coding

We support current thinking among a range of Austrian healthcare stakeholders that physicians be required to code patient diagnosis for each consultation. Such information would allow social health insurers to develop and implement of outcome quality indicators.

It is important to note that previous efforts have been implemented to introduce diagnosis coding at the primary care level. Specifically, discussions were had regarding the implementation of ICPC-2 (International Classification of Primary Care, 2nd edition), however, were never introduced.

Process and outcome indicators

Future evaluations of physicians should focus on both process and outcome indicators, and could, where possible link the two types of indicators to ensure results are interpreted correctly. Specifically, by linking outcome and process indicators, changes in patient health outcomes are more likely to be attributed to a change in the provision of care, as opposed to external factors outside the control of the physician. However, it is important to note that combining two indicators into one represents additional work on part of the physician. For this reason, the total number of indicators would have to be reduced. Put simply, there is a tradeoff between the total number of indicators, and the quality of each indicator.

Finally, it is important to note that measurement of outcome indicators, relative to those related to processes, are more burdensome given individual patient circumstances should be considered. So, although outcome indicators are ideal, process indicators may be more efficient, further, process indicators within the healthcare sector are relatively well developed.

Working Group

As part of the 2013 Healthcare Reform, a Federal Target Control Commission (*Bundeszielsteuerungskommission*, B-ZK) was implemented, and operationalised under the Federal Health Agency (*Bundesgesundheitsagentur,* BGA). It is the responsibility of the B-ZK to oversee a Coordinating Committee (Ständiger Koordinierungsausschuss) responsible for four professional groups covering e-health, public health, supply processes and supply structure. Responsibility for the quality strategy falls under the remit of the professional group dedicated to supply processes.

We recommend that, should there be an agreement to introduce additional process and outcome indicators, the professional group for supply processes be given responsibility for designing and implementing indicators. That is, the professional group could develop indicators in-house or commission a relevant organisation to undertake the work (e.g. Federal Institute for Quality in the Health Service, BIQG (Bundesinstitut für Qualitat im Gesundheitswesen), which sits within GÖG). Regardless of whether indicators are developed in-house or commissioned by an external organisation, members of the medical community should be involved in the decision-making process. Failing to adequately consult physicians is likely to delay implementation of and participation in the collection of quality indicators.

<u>Legal considerations</u>

No particular constitutional impediments have to be faced in this respect.

Data availability

Measurement of quality, in Austria and across the world, is largely focused on isolated aspects of care. Such an approach fails to holistically measure quality of care, thereby diminishing the utility of collected information (392,393). For this reason, any additional process and/or outcome indicators implemented at the primary/outpatient care level would ideally be linked with new or existing inpatient quality indicators. By doing so, patient pathways are created which facilitate understanding of healthcare performance at the system level (an example of a COPD patient pathway within the UK's NHS is provided in Table 85). Further, linking quality indicators across the spectrum of care fosters joint accountability across Federal Government, Länder and social health insurance.

Coordination of indicators across the spectrum of care was stipulated within the 2013 Healthcare Reform (Federal Target Control Agreement), however, to date, it is unclear what policies have been implemented to achieve this goal. For this reason, it is recommended that policy-makers enhance current efforts to better coordinate quality indicators across the spectrum of care be enhanced.

Table 85: Patient pathway quality indicators for COPD (UK, NHS)

Domain	Quality indicator
General practice (diagnosis)	Prevalence of COPD
	Asthma prevalence
	COPD diagnosis
	Exception rate for COPD indicators
General practice (treatment)	Adults with COPD who smoke
	Patients with long-term conditions with smoking status (recorded)
	Patients with long-term conditions offered education on smoking
	Successful smoking quitters at four weeks
	Prescribed nicotine replacement therapy or varenicline
	Eligible COPD patients offered rehabilitation
	COPD patients with a medical review

Domain	Quality indicator
Secondary care	Length of stay, emergency inpatient COPD admissions
	Emergency admissions for COPD
	Emergency readmissions within 28 days and 90 days
Mortality and end of life care	Deaths from COPD (all ages, and less than 75 years)
	Years of life lost due to mortality from COPD
	Deaths with mention of respiratory disease as a cause

Note: See Jonas *et al.* (2012) for a through overview of COPD patient pathways in the UK (392).

Legal considerations

No particular legal impediments have to be faced in this respect.

Hospital admission, readmissions and discharge management

Readmissions and discharge management

Hospital discharge and readmission rates in Austria are high compared with other countries. As additional evidence is generated on the causes of these phenomena, Austrian policymakers may wish to consider approaches to reduce hospital readmissions without compromising patient outcomes. To provide Austrian policymakers with a guide on how to do so, the following section reviews and synthesises two major and recent empirical contributions to the literature that evaluate this issue.

Couturier and colleagues (2016) conducted a systematic review of observational and interventional studies evaluating components of the hospital discharge process and patient outcomes following discharge (394). The authors find that all relevant studies (n=20) explored various discharge-process components, including: discharge summaries, discharge instructions, drug-related problems at discharge, transition from hospital to home, and continuity of care after hospital discharge. At the same time, most studies examined re-hospitalisations (n=18), emergency department visits (n=8), and mortality (n=5). Certain studies that examined patient re-hospitalisations and emergency department visits 'reported at least one significant association between the discharge process and these outcomes,' while none reported

an association with mortality. Evidence-based approaches to reducing hospital readmissions may therefore reduce healthcare spending without negatively impacting patient outcomes.

Leppin and colleagues (2015) highlight that policies aimed at reducing 30-day post-discharge hospital readmissions aim to improve hospital quality (395). Like Couturier and colleagues (2016), Leppin and colleagues (2015) therefore conduct a review of papers published between 1990 and 2013 to 'synthesize the evidence of the efficacy of interventions to reduce early hospital readmissions and identify intervention features that might explain their varying effects' (395). Of the trials that were published over this period and met eligibility criteria, 42 prevented early readmissions to hospital. Exploratory subgroup analyses also revealed that the following intervention characteristics were associated with greater effectiveness in reducing post-discharge hospital readmissions: interventions containing many components (1.4 times more effective than other interventions); interventions involving more individuals in care delivery (1.3 times more effective than other interventions); and interventions that support patient capacity for self-care (1.3 times more effective than other interventions). Consistent with Couturier and colleagues (2016), post-hoc regression analysis revealed that providing patients and caregivers with comprehensive, post-discharge support could help reduce 30-day post-discharge hospital readmissions. If hospital discharge is taken to represent one component of patient care, improving hospital discharge processes may therefore reduce unnecessary hospital readmissions, reduce costs, and indeed improve the care that is provided to patients.

Austrian policymakers should take this evidence review to indicate that it may be possible to reduce unnecessary and costly hospital readmissions by better managing the hospital discharge process. The empirical evidence also appears to suggest that doing so does not compromise patient outcomes. By reducing costs, while preserving or indeed improving patient care and outcomes, comprehensive approaches to improving patient discharge care may therefore provide unambiguously positive value to patients and the health system.

It is arguably acceptable from a clinical standpoint—albeit technically inefficient given lower-cost, alternative methods of care for non-urgent conditions—for Austrian patients to rely heavily on hospital services if it is for routine care. Should this be the case in Austria, policymakers should consider prioritising reforms that increase the efficiency of healthcare delivery. However, the findings presented above would be more concerning from a health systems and clinical perspective if high hospital discharge and readmission rates are due to unplanned, urgent medical needs. Further research is needed to investigate the causes, as well as clinical and policy implications, of high rates of hospital discharge and readmission

in Austria. Even as this research is undertaken, the existing empirical evidence suggests that comprehensive efforts to improve the hospital discharge process may reduce healthcare costs, while preserving or indeed improving patient care and outcomes, and may therefore provide unambiguously positive value to patients and the health system.

Hospital admissions

In order to outbalance political benefits and costs, federal government funds to Länder should be based on objective criteria that reflect the needs of the population. Additional pressure could come from the financial targets in the *Zielsteuerung Gesundheit* and the stability pact. The financial targets could be more effective in that real values instead of nominal values are used and concrete efficiency gains form the basis for this target.

The Austrian Structural Plan for Health (ÖSG) forecasts the capacities in the inpatient and outpatient sector that ought to be planned in detail on the state level and then implemented. But as the international comparison shows, its success in terms of reduction of beds is rather limited. One of the reasons might be that the planning is based on current provision of services, which might be too high. Ideally, the ÖSG would base its forecasts on epidemiological data and best practice of service provision, rather than taking the current demand as a proxy for need.

Alongside the planning in the ÖSG and the *Zielsteuerung Gesundheit*, the quantity and quality of services in the extramural sector should be determined with the goal to reduce avoidable hospital admissions and keep the vast majority of treatments in the outpatient setting, while hospitals only provide higher level services. A first step has been taken by the initiative to introduce a true primary care system, which has been shown to reduce unnecessary admissions. Nevertheless, the high number of single-handed practices and missing intermediate (step-down) facilities with specialists providing integrated services to chronically ill have to be tackled as well. A small first step is the commitment in the latest 15a agreement to set up secondary care units in the outpatient sector. While this is necessary, integration of these units with primary care and hospitals is not yet adequately addressed.

With regards to payment, the LKF system could be enhanced in several directions. Payment could be linked to quality, by, for example, paying a stay and possible readmissions only as a bundle. For the outpatient departments, the development of a DRG system seems to be crucial, also to improve the information on patient paths. In a later step, care for chronically ill in the inpatient and outpatient sector

could be paid for by a joint pool of funds by SHI and the Land using a bundled payment system. Pilots could be set up for high-cost patients.

When reducing hospital capacity, funds are needed in order to treat people elsewhere, while fixed costs in hospitals cannot be reduced at the same time. A mechanism could therefore be set up to compensate hospitals for a limited period of time for the money that might go to the extramural sector within the virtual budget between SHI and the Land. During this time, facilities either have to be wound down or their alternative use has to be implemented. Alternative uses will depend on the regional requirements. Inpatient capacities can be transformed into long term care facilities, for which demand will presumably increase in coming years. Outpatient departments could accommodate primary care units or specialist group practices providing integrated care services.

Summary of policy options to improve quality through contractual negotiations

As outlined in Table 83, numerous policies have been implemented in recent years to improve measurement and monitoring of quality within the healthcare sector. Despite this, Austria continues to lag behind international trends regarding quality management.

In response, a number of policies to improve healthcare quality have been proposed. The first set of options relates to the role of ÖQMed, which to date has not been fully utilised given its placement with the Chamber of Physicians. Under our proposals, ÖQMed could retain its current structure, however, it would sit as an independent body and be jointly funded by the Chamber of Physicians, and the Ministry of Health and Women's Affairs. Alternatively, in addition to the ÖQMed, an independent quality committee could be developed, which would have ultimate responsibility for monitoring physician quality. Under both options, we advise that information collected be used to provide physicians with regular feedback, better inform the public on healthcare quality, and potentially, in the long-run, link performance to financial incentives.

The second set of options relate to the types of indicators used to measure physician quality. Following international trends, it is recommended that indicators focus on process and outcomes, and to a lesser extent structures. Ideally, process and outcome indicators would be linked, however, consideration should be given to the additional burden this would place on physicians. It is important to note that before outcome indicators can be introduced, physicians must record patient diagnosis. Finally, to ensure the most appropriate indicators are chosen, we recommend that the existing the professional group for

supply processes take responsibility for designing and implementing additional process and outcome indicators.

The final set of policy options concerns data availability. Specifically, we propose that instead of collecting and analysing quality data in silos, efforts be made to coordinate quality indicators across the spectrum of care.

6.5 Demand and supply of physicians

This section examines the future supply and demand of physicians working within the Austrian healthcare system. Specifically, through an examination of potential policies to increase the availability of physicians, as well as measures to enhance physician productivity.

6.5.1 Measures to increase availability of physicians

The calculations outlined within this section are based on a static model, for which historical developments have been combined with, for example, legally justified changes, and extrapolated until 2030. The results of the model are for illustrative purposes as several of the assumptions need to be further validated. This is particularly relevant for results regarding the under- or over-supply of physicians.

Section 6.5.1 has been structured as followed: Follow a physician's education and employment path and discuss in a chronological order at which crossroads and in which situations inflows could be increased or outflows reduced, and which measures were already taken to achieve a higher supply of physician capacity, see Figure 124.

In the figure, green arrows represent an 'ideal' physician's path from achieving the 'Matura' (A-levels), passing the entrance examination into medical school, working as a physician and finally to retirement. In the course of this path, several 'control knobs' can be identified:

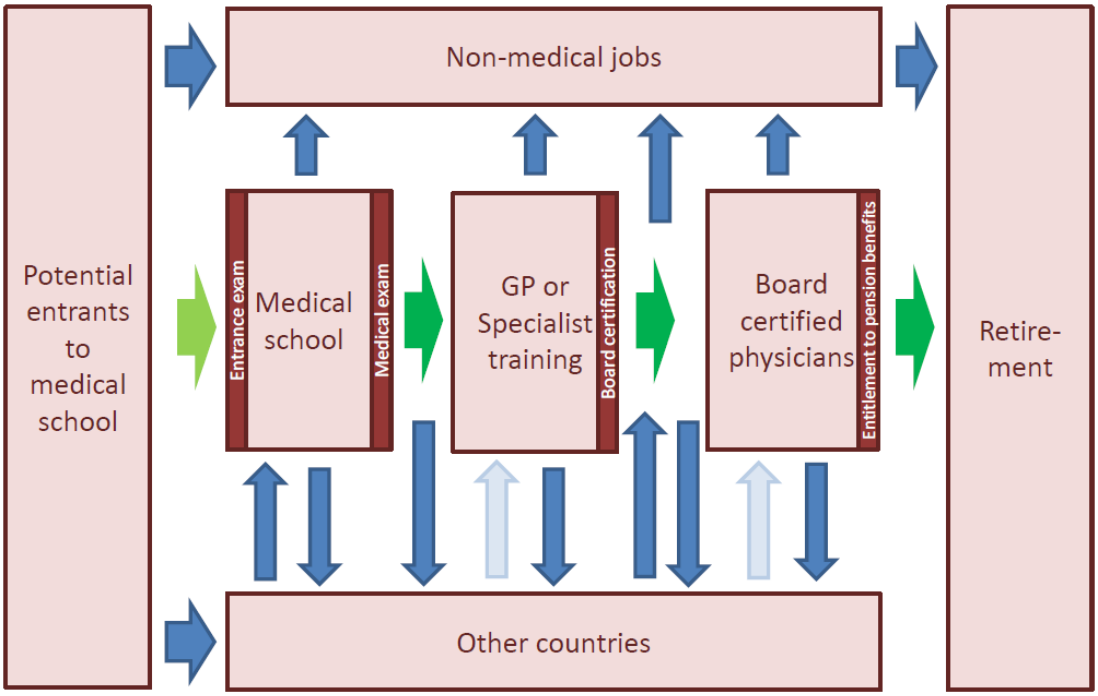
- Admission to medical school and continuing through the end. The annual number of graduates from public medical schools fell significantly around 2012 (Figure 125). This is directly related to the introduction of more restrictive admission procedures at all three public medical schools in 2006, and perhaps to some degree already to the new *Summative Integrative Prüfung* (SIP, the final exam after each year which is necessary to pass in order to continue medical school) in 2002, at the medical school in Vienna. Since 2006, there has been a fixed maximum annual number of first-year students in all (then) three public medical schools.

- Due to unrestricted access to medical schools before introduction of these restrictions, output from medical schools was so high that availability of internships was a bottleneck, and waiting several years before achieving a post as intern was quite common.[83] Today, several hospital administration managers complain about too few applicants for internship vacancies. However, we do not know any hard data on such vacancies.
- Also the chronologically next joint, the transition from professional training to autonomous work as a physician, is today characterised by much fiercer competition for the best applicants, resulting, for example, in rural communities offering generous help for young physicians replacing the retiring GPs.
- Chronologically the last transition, from work to retirement, has not yet been a topic for public discussion apart from the general retirement discussion. Over the last couple of years, however, some regulations with immediate impact on retirement decisions have been changed, which are discussed below.

In Figure 124, the blue arrows symbolise entries to and exits from the medical profession including education and training for the profession. These flows are in some cases of high and in most cases of not so large significance for the medical capacities in Austria. In most cases, hard data on these flows are not available. The following paragraphs discuss the green arrows in Figure 124 as well as the most relevant ones of the blue arrows, i.e. drop-outs from medical schools and emigration after medical school.

[83] As a consequence, oversupply of fresh graduates from medical school resulted in the perception of interns as "cheap labour", fulfilling many administrative tasks and tasks more suited to nurses than doctors. Payment was low, resulting in interns' desire for well-paid night-shifts and working many hours overtime.

Figure 124: A physician's path of education and employment



Admission to medical school from Austria and other countries

Austria has a long tradition of very open admission procedures at university, and this topic has been a hotly debated issue repeatedly in political elections. Due to high inflow of non-Austrian students – predominantly from Germany – who are expected to leave Austria once they finished medical school, also Austria restricted the number of admissions to medical school in 2006. For admission in October 2017, the number of places in public medical schools is displayed in Table 86. The medical school in Linz is not only the smallest, but also the youngest public medical school in Austria. Since 2014 and in cooperation with the Graz medical school, Linz is the first medical school to apply the bachelor-master-system. It is planned to stepwise increase capacity in Linz from 120 to 300 places per year by 2022/23. Currently, Linz covers only the first four semesters of the bachelor program, for semester 5 and 6 students have to move to Graz. It is planned to also start a master program (6 semesters) in Linz in 2017/18.[84]

[84] http://www.jku.at/.

Table 86: Capacities for first-year students in public medical schools, Austria, 2017

	Human medicine	Dentistry	Total
MedUni Wien	660	80	740
MedUni Graz	336	24	360
MedUni Innsbruck	360	40	400
JKU Linz	120	-	120
Total	**1476**	**144**	**1620**

Source: https://www.medizinstudieren.at/.
Note: In addition, there exists the Paracelsus Medizinische Universität Salzburg, however, this is tehcnicaly a private university.

Together with upper limits for admission to medical school also specific admission procedures had to be introduced. Realising that large numbers of German students outperformed Austrian applicants in these tests, admission to one of the public medical schools (Vienna, Graz, Innsbruck, Linz) furthermore has been linked to a quota. Per agreement with the EU Commission, the quota for Austrian students is 75% of each medical school's capacity, 20% for other EU students, and 5% for students with other nationalities. EU citizens with Matura from an Austrian school fall into the Austrian quota. The EU commission originally intended to phase out the quotas in 2016. But recently (2017) the application to medicine (not dentistry) was allowed to continue, subject to Austrian authorities providing proof for undersupply of physicians in Austria otherwise.

In the initial phase of selective admission, medical schools applied different admission procedures. For example, in Innsbruck, the Swiss EMS test was applied as time for developing an own instrument was rather short. Graz medical school in contrast to this developed their own instrument, fully aware that the initial test lacked a validation phase and consequently was found to lack proper testing for social-emotional competencies (396). Since 2013, all public medical schools apply a common test, MedAT-Z for dentists and MedAT-H for general medical school. The examination usually takes place on the same day, this year on 07.07.2017. Applicants have to pay a test fee of 110 Euro per applicant in order to be allowed

to sit; this fee is meant to cover the medical school's test costs.[85] Additionally, the test fee might serve as a deterrent for 'not so serious' applicants.

The MedAT-H test is a multiple-choice test that in 2016 comprised 40% questions from mathematics, biology, physics and chemistry, 40% questions regarding cognitive competences, 10% of social-emotional competences, and 10% questions regarding text comprehension. The test for admission to dental medicine deviates and also includes e.g. manual competences.

Drop-outs from medical school

Before 2006, in a very open admission regime, drop-out rates from medical school often reached 50% and duration at medical school often reached 9 rather than the scheduled 6 years, e.g. due to waiting times for labs (396). As expected, **drop-out rates** from medical school fell since selective admission into medical school, more students can finish in the scheduled time and performance in examinations improved. In Innsbruck, a comparison between 'open admission' (2002–2004), and 'selected admission' (2006–2009) showed a drop in the average annual number of study beginners from 602 in the open admission period to 349 during selected admission[86]. Despite this reduction, the number of students passing SIP 1 increased both in absolute and in relative terms. Seventy-one per cent of the admitted selected students passed SIP 1 compared with 49.1% of the unselected group. This effect, however, is restricted in so far as performance at SIP 3 seems to be closer related to performance at SIP 1 than to the admission test: 91.4% of the students with open admission who had passed SIP 1 were also successful in SIP 3, compared to 92.6% in the selected admission group (397).

Taking 'never trying to pass SIP 1' as the drop-out criterion, 36.7% of the students to Innsbruck medical school were regarded as drop-outs in the open admission group. In the selected admission group the number of drop-outs fell significantly to 17.5% (397).

Between 2006 und 2013, different admission procedures were applied, depending on the medical school. Graz applied a different test than Innsbruck, but also noted a significant decrease in drop-outs after restricting admission. Whereas only 20.1-26.4% of openly admitted students completed the first two study semesters within the scheduled time of 1 year, this percentage rose to 75.6-91.9% for the selected admission group (396). Applying hazard rate models, a comparison between academic years 2002–2003

[85] https://www.medizinstudieren.at/

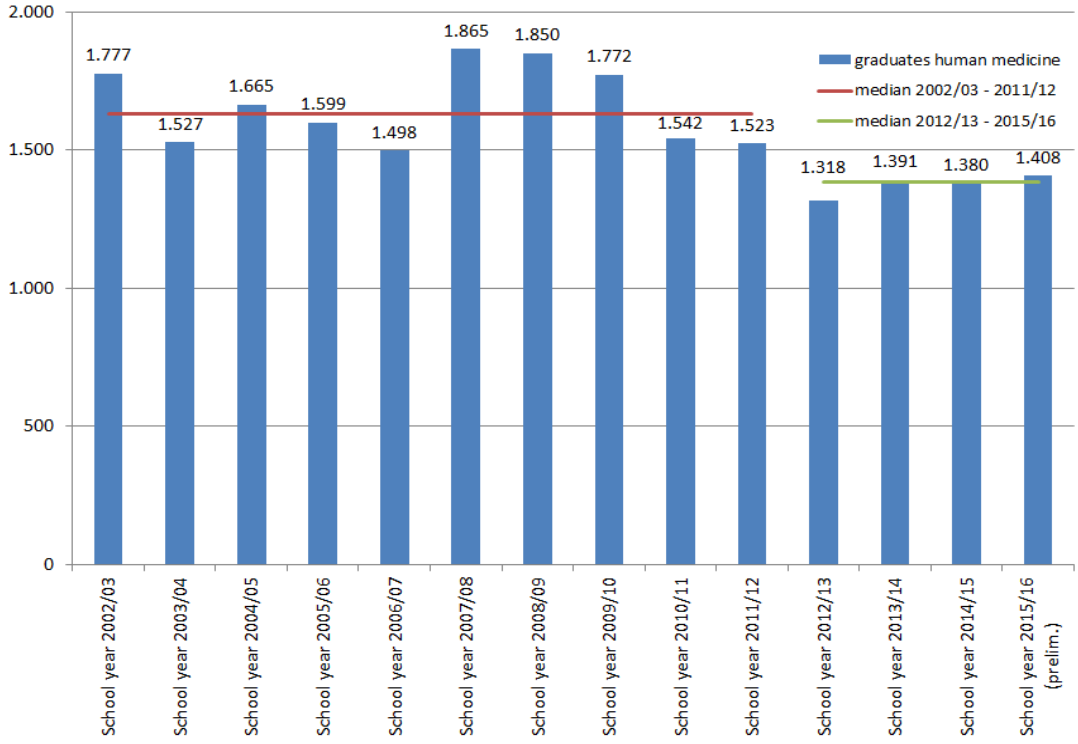
[86] This comparison was performed with regard to the then applied admission test, a predecessor of the current MedAT-H called EMS - Eignungstest für das Medizinstudium in der Schweiz.

to 2008–2009 showed in openly admitted students a significantly higher risk for dropout in female students and in older students, whereas no such effects were detected after admission testing (398).

Transition between medical school and practical training

Changed admission procedures including the limited number of available places for first semester students resulted in a **dropping number of graduates** approximately six years later. Students during unrestricted admission suffered from higher competition for lab places etc., which in many cases caused delays in their educational progress, and only few students managed to finish the program within the minimum time of 12 semesters. Due to this effect in combination with high drop-out rates, and perhaps also because there was no selection of the most suitable students at admission, we can perceive the effect of the changed admission rules on the annual number of graduates only at a high-level, see Figure 125.

Figure 125: Number of graduates, human medicine, 2002/03- 2015/16

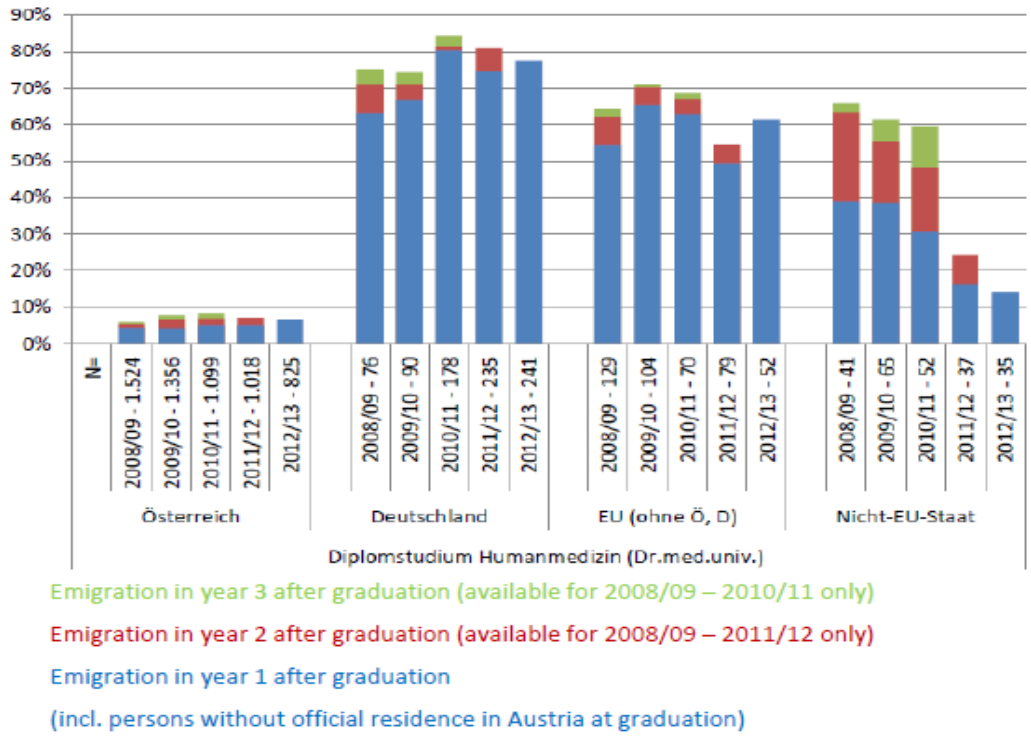


Source: Unidata (data-warehouse of the Federal Ministry of Science, Research and Economy), IHS.

We quantify the drop in graduate numbers as the reduction from the median of the period 2002/03 – 2011/2012 to the median of the period 2012/13 – 2015/16, which amounts to 1632-1386 = 247 graduates or 15% of the open admission period.

High rates of **emigration after graduation** can be perceived among medical graduates of all nationalities; among Austrian graduates those from medical schools have higher emigration rates than graduates from any other educational field. Statistics Austria calculated the percentage of persons without official residence in Austria in up to three years after graduation, with an increasing share of emigrants among German and Austrian citizens (399). In school year 2012/13, 6.7% of Austrian graduates left the country within one year after graduation, while in year 2008/09 it was only 6.1% within three years. Highest rates of emigration can be observed among German graduates of the years 2010/11 and 2011/12 (and presumably also the following years), exceeding 80% within three years (Figure 126). Note that in 2012/13 the first graduates after restricted admission finished medical school. It is therefore straightforward to assume similar rates of emigrants in the following years. This assumption corresponds to the idea that emigration among selected high-performers is systematically higher than among the not (or less effectively) selected students during the open admission period.

Figure 126: Emigration of medical school graduates (2008/09 – 2012/13)



Source: Adapted from Statistics Austria (2016) (399).

Board certification

In order to practice medicine, graduates from medical school need a board certification which can be achieved after a practical medical training program/internship consisting of 9 months basic medical training plus a minimum of 33 months (general practice) or 63 months (specialties) in pre-defined specialties and settings.

It is not exactly clear how many graduates from medical school continue with a medical career in a broader sense. For Austria, OECD Health Statistics reports *practicing physicians* (including interns, excluding physicians working without direct contact to patients in Austria), but not *physicians licensed to practice*. Also according to the Chamber of Physicians, the latter data are not collected in Austria.

The Chamber of Physicians registers board certifications of physicians. Over the period 2010-2015, we can observe a rising number of registrations for specialists, but a rather stable number of registrations for GPs (Figure 127). In 2016, however, preliminary data for GPs show a marked drop in the number of GPs, from 864 (median 2010-2015) to 660 (2016). Some licenses to practice as GP achieved in 2016 might be added later because the respective physicians do not have their licenses registered at the Chamber of Physicians before they actually need it (e.g. during not practicing while on maternity break, or while practicing and perhaps also achieving a license abroad). We do not, however, assume that this effect will change the overall picture of a remarkable drop in the number of annual new GP registrations in 2016. Furthermore, we should allow for the possibility that some of the registrations in 2016 are for persons who started medical school already before restricted admission, thus relating a constant number of 660 GPs per year to the fixed number of places in medical school is presumably an overestimation.

We rather assume that 2016 signifies the shift of the annual number of GP registrations to a lower level, due to a combination of reasons:

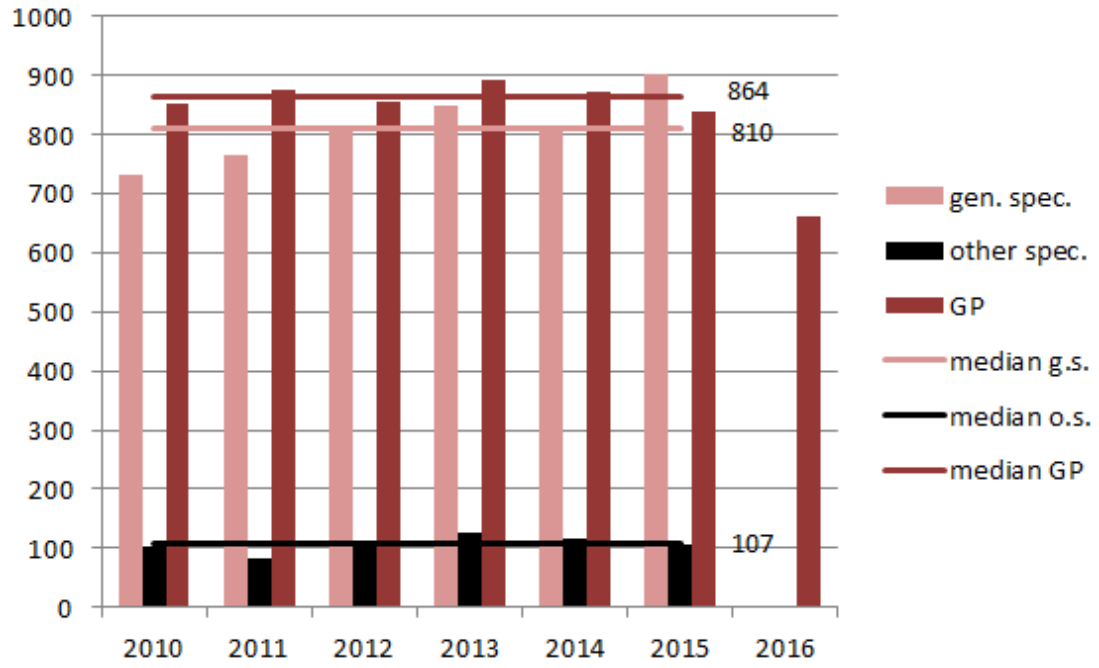
- 2016 is the first year that graduates under the new admission regime on medical schools can achieve a registration as licensed physician in Austria (2006 + 6 years medical school + 3.5 years *Turnus/*internship).
- In spite of the large number of reform activities affecting the medical profession, GPs are still not recognised as specialists in Austria, which reduces the incentive to choose this career.
- There is a high degree of dissatisfaction due to the lack of transparency concerning the internship in the practice setting (*Lehrpraxis*), including an insecure financing situation. Furthermore, there is some criticism that 6 months of training in a practice (out of 42 months) is not sufficient for independent

work in a practice. This again might draw some young physicians devoted to general practice to internships or even a career abroad.

- There is a high degree of dissatisfaction with the expected combination of workload, income and perhaps also appreciation during internship, especially when compared to internships abroad (this problem, however, is the same also for interns in specialties). There are reports that interns could earn three times more (e.g. in Germany).
- And finally, there is a high degree of dissatisfaction due to the missing information about what work in primary care in Austria looks like, under what conditions, in which teams, with which other health professionals in the near future.

The combination of these reasons reduces the attraction of a career as GP in Austria.

Figure 127: Number of board certifications by specialty group, head counts and median 2010-2015



Source: Chamber of Physicians (personal communication), IHS.

It should be kept in mind that some of these shortcomings apply also to the career as a specialist. The internship for specialists takes longer, and we do not have any data on the number of persons currently in internships for specialties. We assume that a somewhat less pronounced drop in specialist registrations will occur in 2018, compared to the drop in GP registrations in 2016.

Retirement of physicians

In 2014 following recommendations of the Austrian Court of Auditors (400), a reform of the *Wohlfahrtsfonds der Ärztekammer für* Wien reduced the level of mandatory contributions of active physicians and continued switching the basis of physician-specific retirement pensions towards the principle of equivalence, thus reducing the generosity of their retirement pension system. Also the *Wohlfahrtsfonds der Ärztekammer für Niederösterreich* was reformed and contribution levels reduced slightly earlier. As some older physicians now expect lower income during retirement than anticipated before the reform, this might delay retirement decisions somewhat.

Physicians contracted by sickness funds can determine their contract conditions only to an extremely limited degree, as most conditions are laid down in general contracts (*Gesamtvertrag*) between the Chamber of Physicians and the respective sickness fund. Until recently, retiring physicians could 'sell' their practice including the documentation of their patients to their successors. The current *Gesamtvertrag* for Vienna and Lower Austria, however, stipulates that payments to the successor cannot exceed 33% of the annual turnover. This regulation reduces possible payments considerably compared to usual payments for well-established practices before. This perceived 'income loss' at retirement may further delay the retirement decision in some cases.

According to ASVG §342, contracts[87] between GKKs and physicians have to be terminated when the physician reaches the age of 70 years at the latest, but other regulations can be agreed upon to avoid undersupply.

Summary of measures already taken to increase availability of physicians

- Restriction of admission to public medical schools reduced the average duration of time at medical schools and reduced drop-out rates to internationally comparable levels, but reduced also the average number of persons graduating from medical school.
- Opening a fourth public medical school (Linz) will make up for a fraction of this decline.
- A quota for national students at medical schools has been introduced.

[87] This regulation applies to contracts drawn up after 31.12.2010, several sickness funds added a phasing-out rule for older contracts.

- Changed regulations for the obligatory physicians' retirement funds and for 'selling' the practice to successors reduce financial incentives for premature retirement of practicing physicians, thus prolonging the active workings years per physician.

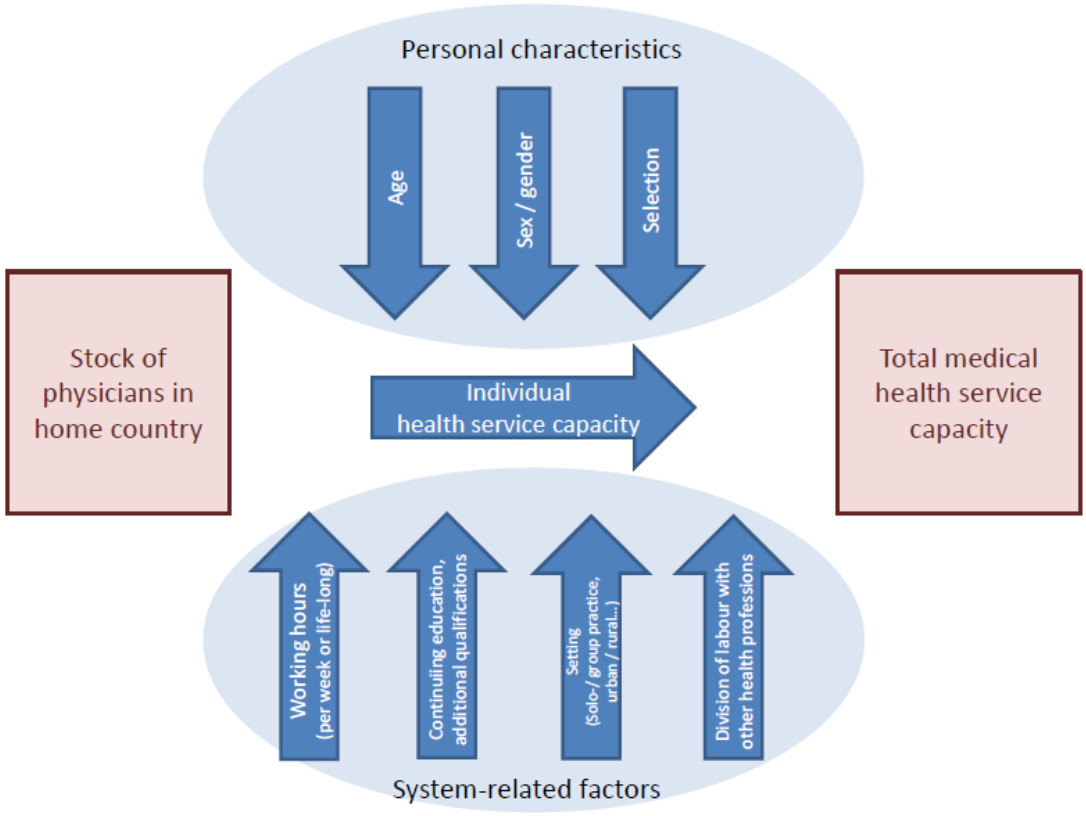
6.5.2 Measures to increase the productivity of the available stock of physicians[88]

While section 6.5.1 is devoted to discussing measures to increase the future number of physicians in Austria, this section discusses measures to increase the productivity per professionally active physician. Ideally, productivity in this context would be meant as *overall capacity to care for patients over the lifetime*, but we cannot measure such a concept. We therefore refer to measures like *patients seen per time unit* for physicians contracted by sickness funds and *working hours per person* for physicians working in hospital.

In this context, two groups of factors can be distinguished which influence the individual productivity: system-related factors and personal factors, see Figure 128.

[88] In technical terms, productivity is measured in pure output/input terms, and does not take into account outcomes or quality.

Figure 128: Personal and system-related factors affecting the available capacity of physicians



Source: IHS 2017.

Personal characteristics

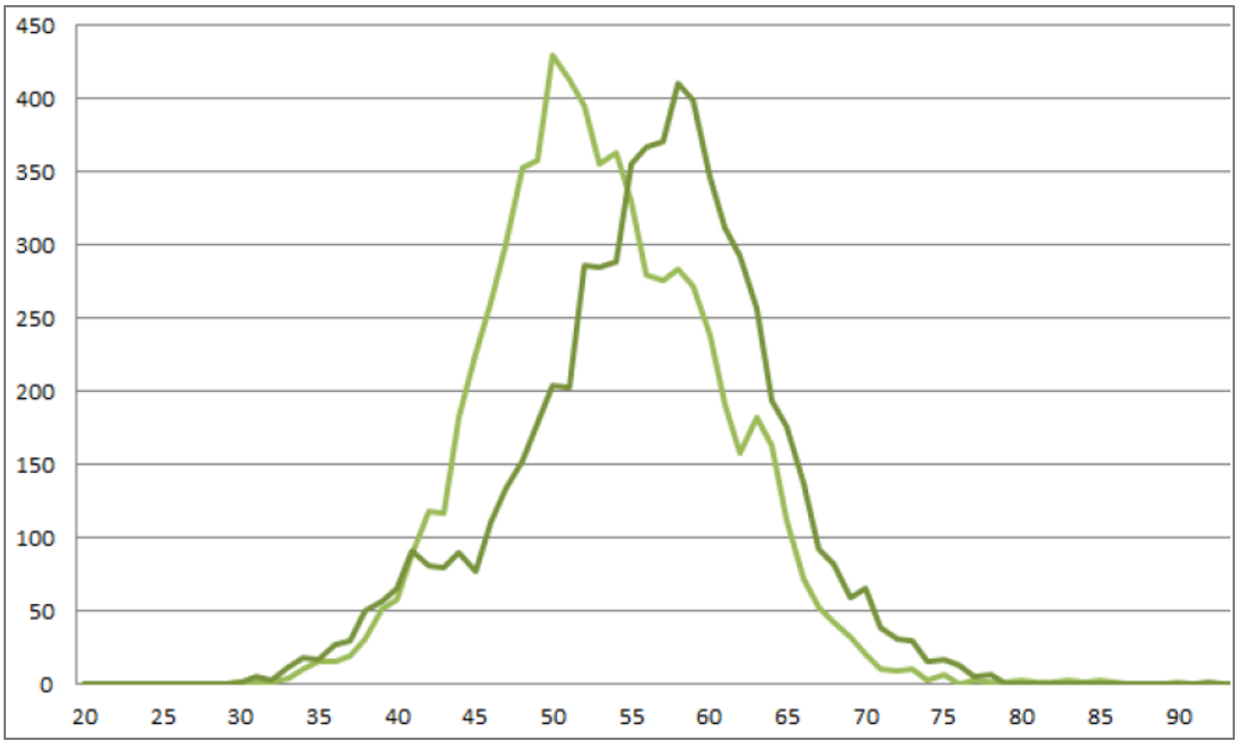
The looming reduction of the physician capacity due to the age composition has only recently begun to fuel the health policy discussion in Austria. For instance, it was shown that the mean age of contracted physicians[89] rose from 53.1 years (2007) to 55.9 years (2014) (Hauptverband der Österreichischen Sozialversicherungsträger –HVB 2017:28). The report highlights, that about half of all so-called §2-physicians will reach retirement age during the next 10-15 years (389) (HVB 2017:40). Therefore, retirement of physicians has come into focus, resulting in measures which might delay retirement somewhat as discussed above.

[89] The report refers to so-called §2- contract physicians, which includes holders of contracts with GKKs (regional health insurance funds), BKKs (company health insurance funds) or SVB (farmers health insurance fund).

Less is known, however, about the relative productivity of younger vs. older physicians in Austria. There is hardly any international literature on the relative 'productivity' of younger vs. older physicians. There are, however, studies on consultation length, which forms one of several elements of relative productivity. But this international literature is not clear on whether younger or older physicians have longer consultations per patient. In Slovenia, a survey among GPs found longer consultations for older physicians (401), while a study in six European countries did not find any difference in consultation length between younger and older GPs. Furthermore, the study found that 55% of the variance of consultation length depends on factors on the patient level, with the remainder almost equally split between factors on the physician and on the country level (402). Due to the lack of information in Austria, we do not incorporate any age-related productivity differences into our gap analysis.

Referring to work in own practice, to the best of our knowledge there is no evaluation on whether the number of working hours changes when physicians reach retirement age or the end of their contract, how many physicians reduce their working hours only after they return their contract and keep working in private practice, and how many stop work altogether when reaching this point in time. We therefore assume in the model that starting at retirement age, physicians reduce their workload annually by 50% until they reach the contractual retirement age. For employed (in contrast to self-employed) physicians, we assume that they retire completely at the legal retirement age. Even though early retirement has been quite common in Austria, Figure 130 supports our view of continued professional life after reaching retirement age for a considerable fraction of physicians in own practice, but hardly any employed physicians. We assume a continuation, if not a corroboration of this picture due to the recent policy changes which all in all made retirement more costly for physicians.

Figure 129: Age distribution among so-called §2- contract physicians in single-handed practices, 2007-2014, excluding dentists



Source: Hauptverband der Österreichischen Sozialversicherungsträger (2017:28).
Note: Light green: 2007; dark green: 2014.

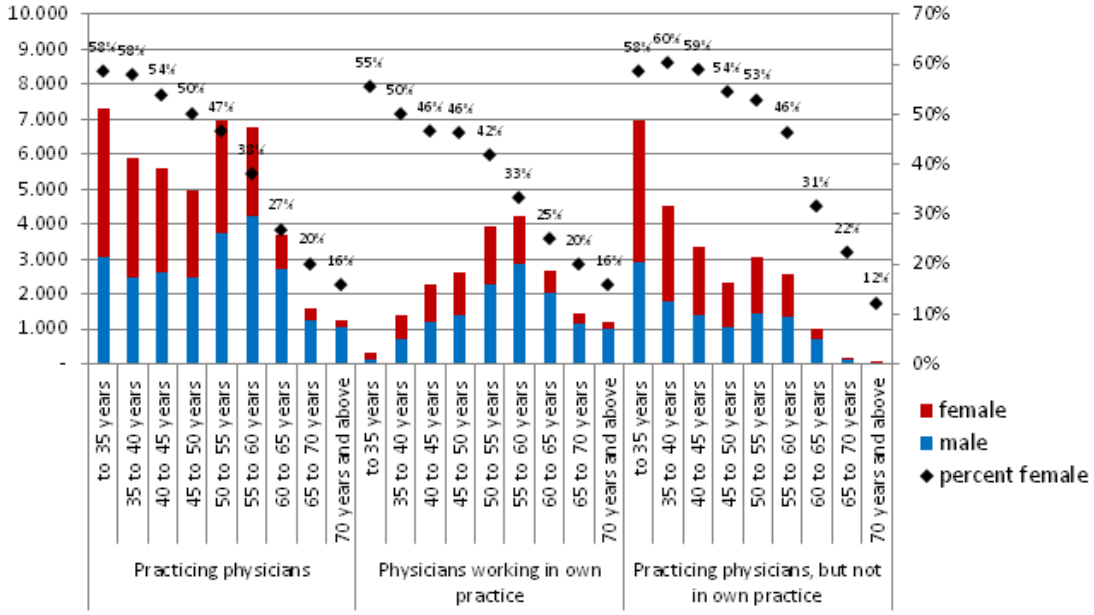
In addition to a de-composition by setting of work (in own practice or not), Figure 130 provides a decomposition by sex. We observe a high female share predominantly among younger physicians, and among those not (yet) working in own practice. Among physicians working in own practice, only in the youngest age group (up to 35 years) there are more women than men.

Policy has responded to the low share of female physicians contracted by sickness funds. the current regulations governing the choice of candidates for the next vacancy as a §2-physician in Vienna and in Lower Austria stipulate that in case of equal number of points, women are to be preferred over men.

We have limited information about sex-related productivity in Austria. Whenever a physician wants to demand payment for a patient's treatment, the patient's eligibility is checked via her/his e-card. Taking these e-card contacts as a rough measure for productivity, we see that in most specialties, male physicians charge for a larger number of contacts per contract period than female physicians. We cannot say, however, whether this difference stems from longer actual practice hours or from shorter consultation

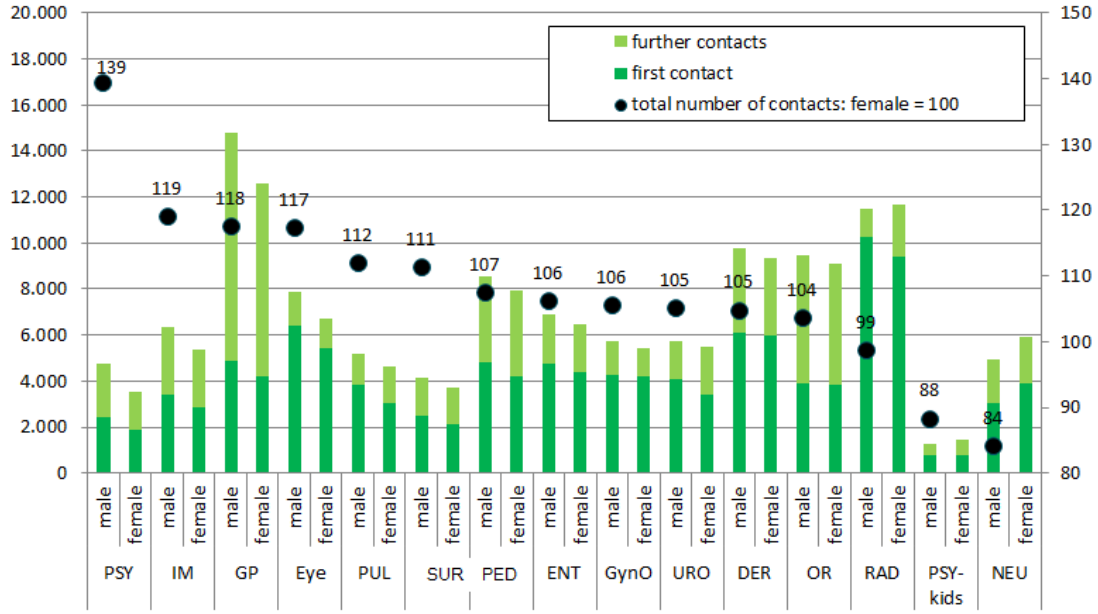
length or sex-related differences in treatment style. Psychiatry obviously is an outlier, with 39% more contacts for men, presumably due to a female preference for a more time-consuming treatment style (i.e. more psychotherapy, less drug-only treatment).

Figure 130: Practicing physicians by age and sex, 2015



Source: Adapted from(403)

Figure 131: Average number of contacts per contract physician, 2015



Source: Adapted from (403)

System-related characteristics: Working hours

In Austria, many stakeholders reacted only very late to the EU-working time directive limiting physicians' working hours to an average of 48h / week. This topic is mostly relevant for physicians in hospitals, as very few physicians with direct contact to patients are employed elsewhere. The *Krankenanstaltenarbeitszeitgesetz* (Act on working time in hospitals) allows under certain conditions, that for a limited time exceptions from the 48h-average can be agreed between employees' representatives and employers:

- Up to 60h/week until 31.12.2017,
- Up to 55h/week until 30.06.2021.

According to a survey commissioned by ÖÄK, actual average working hours among hospital physicians are already 48h/week, and 33% of physicians have signed an opting-out agreement (404). There are, however, rumors that in some cases there was pressure for signing such agreements in order to fulfil – at least on paper – the regulations, or that predominantly young physicians were requested to refrain from documenting some overtime.

Also the opting-out agreement will eventually phase out. We therefore assume that part of the adjustment process caused by the EU working time directive is still under way, but will not be a major effect. In our model calculations, we assume a further reduction of working time by one percentage point in 2016, 2018 and 2021 respectively, and a constant level of 97% compared to the base year 2015 from 2021 onwards.

It has to be noted, though, that phasing out of these agreements might increase demand for physician capacity in times of high retirement rates among physicians. It is therefore extremely urgent to put measures in place to improve the productivity / capacity of individual physicians. Some of such measures are discussed in the following paragraphs.

System-related characteristics: Division of labour between health professionals

The combination of unlimited access to medical schools until 2006 and absence of tuition fees at public medical schools has resulted in a high *physicians/population* ratio in Austria, which among OECD countries has been exceeded by only one country (Greece) according to OECD data. The bottleneck at a prospective physician's career path was timely access to labs and other practice-related training forms, and especially into internship after medical school. Austrian hospitals and their managers could presumably take

advantage of the relative abundance of graduates from medical school: As supply was high, the ones filling the available internships were in a weak position and had to fulfill many tasks that in other countries are performed by other medical professions. We therefore assume that there has been a large (but to the best of our knowledge, still not quantified) degree of misallocation of physician capacity.

This effect partly explains the Austrian paradox of high physician density and population-felt scarcity of physicians, accompanied by long waiting times for appointments with specialists in a growing number of regions and specialties. With the currently lower number of entrants into the medical profession, the traditional (inefficient) division of labour between professions is no longer sustainable. But it can be questioned whether this constitutes a 'real' or an 'artificial' shortage of physicians, thus constituting rather the necessity to re-allocate tasks between health professions (405).

Currently, many hospitals adjust to the fallen number of newly registered physicians by re-organising work (e.g. new non-medical posts for documentation, newly organized procedures before operations or at discharge). To our knowledge, these are grass-root developments rather than a coordinated approach. Legally, hospital owners (*Krankenhausträger*) are responsible for providing the suitable staff and skill mix, certain kinds of health workers are mentioned as necessary but without stating a required minimium quota. Human resources planning is delegated to 'suitable persons' in the individual hospitals or hospital groups, who annually report to the regional government.[90] Also national and regional hospital plans (ÖSG, RSG) do not explain how the amount of necessary staff and their skill mix are to be calculated (406). For the period 2006-2015, a comparison of the development of three groups of staff in publicly financed acute care hospitals (*Landesgesundheitsfondsfinanzierte Krankenhäuser*) still showed the by far highest growth rate among physicians (15%), compared to all other health workers (6%) and non-health employees (+3%)[91]. Thus, we see room for efficiency enhancing developments here, especially if sufficient transparency allows benchmarking and learning from each other.

Unlike other countries, there has been no systematic process of creating or up-grading new professions to support physicians (e.g. nurse practitioners, physician assistants), as has been the case in Germany, the

[90] KaKuG § 8d. Die Landesgesetzgebung hat die Träger von bettenführenden Krankenanstalten zu verpflichten, regelmäßig den Personalbedarf, bezogen auf Berufsgruppen, auf Abteilungen und sonstige Organisationseinheiten, zu ermitteln. Die Personalplanung, insbesondere die Personalbedarfsermittlung, der Personaleinsatz und der Dienstpostenplan, ist hiefür fachlich geeigneten Personen zu übertragen. Über die Ergebnisse der Personalplanung ist durch die kollegiale Führung bzw. in Krankenanstalten, in denen keine kollegiale Führung besteht, durch die für den jeweiligen Bereich Verantwortlichen, jährlich der Landesregierung zu berichten.

[91] http://www.kaz.bmgf.gv.at/fileadmin/user_upload/Personal/4_G_Personal_LGF.pdf

Netherlands, and UK. Also certain other health professions can work with more independence from physicians internationally, e.g. physiotherapists with respect to prescribing (407).

In Austria, some efforts were made, for example, by transferring the necessary educational path for some health professions from former 'academies' to universities for applied sciences, thus integrating the educational structure into the European Bachelor-Master system. Examples for these professions are physiotherapy, ergotherapy, speech therapy (408). It is, however, not clear whether the perceived low esteem for other-than-medical health professionals could be also lifted in course of lifting the educational path on the academic level.

A new law for the nursing education has been enacted in 2016. This law incorporates three supposedly permeable levels of education (one year/two years/ three years) and lifts the highest of these on the bachelor level. There is still some criticism that even in the brand-new law, the nursing profession is still very hospital-oriented and does not yet sufficiently reflect new roles like practice nurse, community nurse or school nurse. Several tasks that are planned for Primary Health Care Centers are tasks for specialised practice nurses in countries like Australia, Canada, Netherlands, New Zealand, and UK, with comparable outcome and costs (IAMEV2016:122). But the newly regulated educational path for nurses does not seem to incorporate these tasks into their realm, which might provide obstacles for the efficiency and long-term sustainability of the new form of primary care in Austria. Therefore, even though the concept for Primary Health Care Centers requires nurses in the core team, there are still many questions open, for example, regarding their role in PHC, how they will be prepared for their role in PHC as opposed to hospital care, and last but not least the available number of properly trained practice nurses.

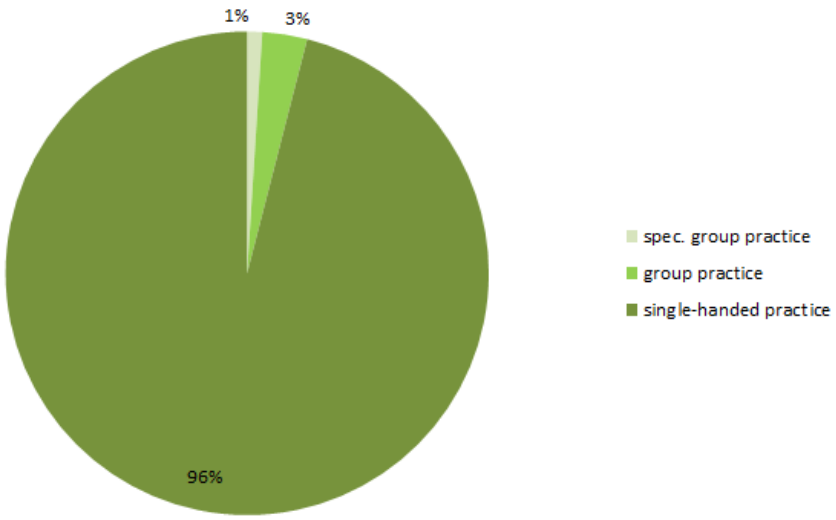
System-related characteristics: Practice settings

In general practice, Austria has a long and prevailing tradition of single-handed practices. There have been long discussions between the Chamber of Physicians and the sickness funds regarding partly replacing single-handed practices by group practices. Technically, the law allows for group practices, but as physicians are under contract with sickness funds on a personal and individual level, and physicians are not allowed to employ other physicians, the creation of a legal framework that is attractive for many physicians has not yet been agreed upon. Difficulties seem to concentrate mainly on financial issues, but also on questions of liability.

Therefore, 96% of all practices are still single-handed, as Figure 132 shows for physicians with §2-contract. Group practices are often formed when older physicians have sons or daughters who are also physicians

and plan to take over their parent's practice (and contract!) after their retirement: if they act as a partner in a group practice for a while, it is easier to achieve one of the few slots in the '*Stellenplan*'.

Figure 132: Practice settings among so-called §2-contract physicians, 2014



Source: (389)

Notes: spec. group practice = group practices with shared contracts, part-time contracts and other special forms. Includes general practice and all specialties, excludes dentistry.

The predominance of single-handed practices is found all over Austria: In no *Bundesland*, the share of single handed practices lies below 93%. Special group practices are concentrated in Upper Austria and Salzburg, 'normal' group practices in Vienna (389).

Summary of measured taken to increase productivity of physicians

- Reactions to accommodate the EU-working time directive were introduced extremely late. In most *Bundesländer*, negotiations between (Chamber of) physicians and public hospital administration were started only one or two years before the transition period expired. The chance to better coordinate the skill-mix between health professions (including physicians) already on the educational level was largely ignored.
- The education for medico-technical professions like physiotherapist was elevated to the bachelor degree, which might serve as a means to improve cooperation between and acceptance of other health workers and physicians.
- Similarly, the compulsory education level for nurses was also elevated to bachelor level, at the same time introducing two schemes for nurse assistants.

- In our opinion, the raised educational level can form just one element of a necessary multi-pronged approach to improve such cooperation and mutual acceptance and respect.
- The health reform 2013 envisaged the implementation of new settings of primary care, later defined as PHC units, which were planned to cover roughly 1% of the population in each *Bundesland* by the end of 2016, according to officially set goals (*Bundeszielsteuerungsvertrag Art. 6*). This goal was missed, a fact that seems closely related to missing clarity concerning financing, payment and ogranisational issues.

6.5.3 Policy options: Demand and supply of physicians

Policy options to increase availability of physicians

To better cope with the rising share of women among physicians and the increasing desire for a good work-life balance among both, male and female physicians, support measures to balance private life – especially care obligations for children as well as the elderly – and job demands. Considering the difficulties in recruiting suitable physicians for remote areas, special efforts will be needed, for example, in developing attractive models to provide out-of-hours care.

Reduce incentives to emigrate from Austria. Provide clarity over the future working conditions as a physician in Austria. Make work at the start of the career as physician more attractive and more calculable, by offering working conditions (including payment, cooperation possibilities in teams, but also work-life balance) that is comparable to conditions abroad, especially Germany. This refers to the number of working hours during internship, but also to the payment.

To reduce brain drain via migration at the transition between medical school and professional training as specialist, revise/improve training programs and ensure that sufficient time for actual training – rather than care provision – remains for both, trainers and trainees. Check if working time directive compliance necessitates prolongation of training periods, especially for specialists who need also dexterity, not only knowledge.

Policy options to increase productivity of current physicians

- Considering the low reputation of primary care as opposed to 'real specialists' in Austria, efforts need to be put into improving this reputation. Considering Austria's low achievements in primary care in international rankings (Kringos *et al.* 2013) it is worth checking whether additional training for GPs in order to fulfil their envisaged role in the new PHC units is necessary. Furthermore, a clear, well-aligned

and well accepted delineation of tasks between PHC units and hospital outpatient departments might improve efficiency of service provision.

- We still perceive a lack of supportive health professionals for GPs and perhaps also specialists, who could free them from some workload in their practices, thus improving the efficiency of physicians' working time.
- The lack in supportive health professionals for GPs is not only an issue of quantity, but very much also a lack of adequately designed and aligned professional roles.
- Development of such professional roles (like advanced practice nurses, more responsibilities for certain well-trained health workers) will necessitate that the physicians' job description will be redesigned, i.e. delegation of some relatively 'low skilled' tasks to other health workers, in order to enable physicians to focus more on core physician tasks, in hospitals as well as in practices.
- At the same time, this endeavor will necessitate that these professionals are adequately educated and trained. We do not see that the recently reformed nursing law already respects the special demands for nurses' roles in the envisaged PHC units, and therefore would support development of a clearer profile of the nurses' role in PHC.
- Obviously, professionals like nurses do not only need adequate skills, but also willingness to take over additional and responsible tasks. This includes also acceptance of the medical responsibility (where the task is suitable for this), while physicians need to be willing to hand over such responsibilities. To improve the acceptance of the new role by the involved professionals, it might be helpful to involve all professions – not almost exclusively physicians – in the development of these roles.
- Seeing the large number of physicians nearing retirement age, we assume that such shifts in skill-mix in the overall health workforce cannot be achieved by focusing exclusively on new entrants into the workforce. We rather assume that to some extent it will also be necessary to coach and motivate existing professionals to adjust to re-allocations of some tasks and responsibilities.

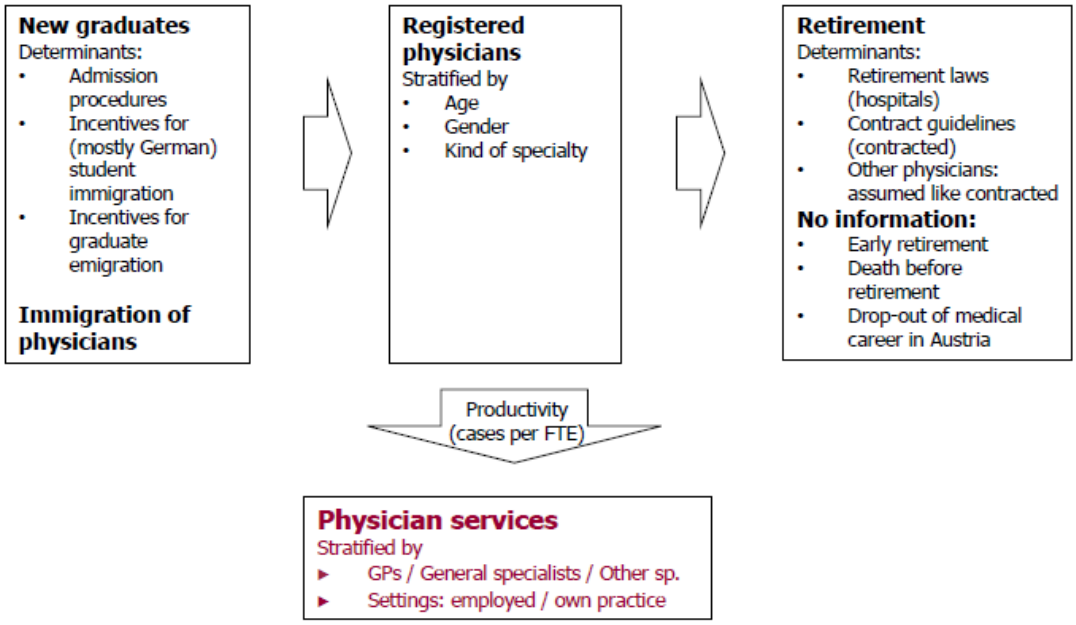
Legal considerations

Even though no particular constitution impediments have to be faced with respect to these options, some amendments to the professional law for nurses and similar groups (such as the Gesundheits- und Krankenpflegegesetz/GuKG) as well as to the current system of contractual agreements would be required (see also Volume 2 – Legal Analysis (Chapter 7.4)).

6.5.4 Demand and supply of physicians: inflow-outflow model

In calculating potential future demand for and supply of physicians, we adjust and extend the inflow-outflow model applied for a gap analysis of psychiatrists in Austria (409). We model three groups of physicians separately, general practitioners (GPs), and general specialists[92] (GS) and other[93] specialists (OS). Projections were calculated for 2017-2030.

Figure 133: Inflow-outflow model for physician capacity in Austria



Source: IHS.

Data sources and assumptions – physician supply

For physician supply, the Chamber of Physicians provided data segregated by age, sex, contractual status (exclusively employed physicians / physicians in practices: contracted and non-contracted), and medical field (general specialists: GS / other specialists: OS / general practitioners: GP). This detailed dataset was provided for the year 2016. Furthermore, the Chamber of Physicians provided the annual number of new

[92] Anästhesiologie und Intensivmedizin, Augenheilkunde und Optometrie, Allgemein-, Gefäß-, Herz- und Viszeralchirurgie, Frauenheilkunde und Geburtshilfe, Hals-Nasen-Ohrenkrankheiten, Haut- und Geschlechtskrankheiten, Innere Medizin inklusive Kombinationsfächern, Kinder- und Jugendheilkunde, Lungenkrankheiten, Mund-, Kiefer- und Gesichtschirurgie, Neurochirurgie, Neurologie, Orthopädie, Plastische Chirurgie, Psychiatrie, Thoraxchirurgie, Unfallchirurgie, Urologie.

[93] Technical specialties like radiology and lab medicine but also specialties with extremely low numbers.

registration as specialist or GP for the period 2010 – 2015 (GP: until 2016). For this information, however, we have only a single number per year and specialisation without any further stratification by age, sex, nationality, place of education, setting of work, or other characteristics.

Measuring inflows

All entrants were modeled as 30 years of age (GPs: 27 years) which is certainly inaccurate but does not pose any bias due to the short projection horizon. Sex of entrants was modeled proportional to the sex of medical graduates in 2015, which is close to 50:50.

All inflow proportions are based on graduates from public universities only. Our database does not include graduates from private medical schools (Salzburg, Sigmund Freud, Krems), which presumably does not pose serious biases as: (a) projections are retrospectively based primarily on new registrations in Austria, irrespective of the place of medical education, thus including graduates from the small[94] Salzburg medical school: while (b) Sigmund Freud and Krems cannot contribute graduates from specialist training any sooner than in the last two years of our projection period.

For GSs[95], the inflow into the pool of physicians was based on the median of observed registrations per specialty during the period 2010-2015 (Figure 127). Starting from this number, we model certain changes in the number of annual entrants:

- The introduction of strict admission regulation in 2006 reduces the number of registrations by 15% from 2018 onwards[96].
- Taking nationalities of medical students into account, net migration reduces the number of registrations by 10% throughout our projection period (see Figure 126).
- Due to the envisaged promotion of primary care, we assume a shift of 5% of internship training capacities from specialist to GP – training. This is the only mere assumption which was not based on observed data.
- 70 additional GSs per annum are expected due to the new medical school in Linz from 2026 onwards. For these graduates, we assume the same proportions (sex, migration, specialties) as for other graduates.

[94] 50 students per year start medical school since 2002.
[95] We do not calculate others specialists due to their heterogeneous structure and small number.
[96] (median 2012-2015) / (median 2002-2011) = 0.85

For GPs, the inflow into the pool of physicians was based on the observed number of new registrations in 2016 (660) for the whole period 2017-2030. In Figure 127, a sharp decrease in the number of new registrations between 2015 and 2016 can be observed, which we interpret as the result of the restricted admission to medical school since 2006. Note, though, that in the following years the number of new registrations might be somewhat lower since the observed 660 new registrations might include students who started before 2006 but could not finish medical school in minimum time. Further assumptions for modeling future new GP registrations are:

- An inflow reduction of 10% due to net migration.
- A shift from specialist to GP training places, increasing GP training capacities by 5%.
- Additional 57 new GP registrations per year due to graduates from Linz for the period 2024-2030.

Modelling outflows

We do not have any hard data on outflow patterns; further, we cannot derive outflow patterns from age distributions of two consecutive years as we received the age distribution for 2015 only. Taking the – compared to other professions – late entry into fully autonomous professional activity into account, we therefore use the legal retirement patterns to model outflows. We do not model premature outflows from the physician workforce due to reasons such as migration, shift to other work without contact to patients, illness, disability, death. Because we do not model premature outflows, our projections might bias capacities upwards.

As physicians often work in a private practice or with a sickness fund contract even after legal retirement age, we assume that after retirement age, 'productivity' of physicians drops each year by 50%. We assume this drop in productivity starts at age 66 for men as well as women throughout the period 2016-2030. Due to legal restrictions, we further assume that full retirement begins at increasingly lower age, starting at age 74 (2016) until age 70 (from 2019 onwards).

Data sources and assumptions – physician demand

Unfortunately, it is not possible for us to model true demand for physician capacity in the same way as economics textbooks would define 'demand'. Like most analyses of physician capacities, our calculations for physician demand are based on observed patterns of physician utilisation. If current (or rather: most recently observed) utilisation was restricted by insufficient capacities, any calculated supply gaps would be underestimated. Considering that Austria currently still boasts higher physician/population ratios than most countries, we would assume that we need not worry about undersupply for the base year on the

national level. Having discussed the issue of demand versus utilisation, however, we need to stress that undersupply can as easily be caused by wrong resource allocations as by low capacities.

We have two separate data sources for service utilisation in inpatient and outpatient care. For **inpatient care**, the Ministry of Health and Women's Affairs provided information on the number of inpatient stays by function code. We model the future development of physician demand in the inpatient setting as depending on two factors: previous development of utilisation, and future demography. The rationale for previous utilisation as a determining factor is that existing capacities form an upper limit of utilisation; thus also limiting future growth of the number of inpatient stays. Considering the high correlation between share of older population and number of inpatient stays, we assume that the number of inpatient stays (and thus demand for physician services) will pick up in line with the increase in the share of the 65+ population in 2020.

For **outpatient care**, the Main Association of Austrian Social Security Institutions provided the number of e-Card consultations at contracted physicians. We thus model the demand for physicians' outpatient services in line with the past development of consultations and with the population forecast.

To translate the demand for physicians' services into demand for physicians, we need to define **physicians' productivity** in terms of number of services or caseload per physician and time period. We model these in accordance with observed productivity in past years. For future development of productivity, we adjust for two factors:

First, the future stock of physician capacity contains increasingly more women, compared to the past. During their reproductive phase, women are more prone to absences from work and are protected by maternity laws limiting certain kinds of work like shift or night work. Furthermore, informal care work (child care, elderly care) traditionally rests more heavily on women than on men, which might pose additional burdens on their availability for full-time work or overtime. Lower caseloads by female compared to male physicians are supported by the data on e-card consultations, see Figure 131. We therefore model female specialists with 0.93 FTE per person and female GPs with 0.85 FTE per person, while male physicians are modeled as 1.0 FTE per person. We apply this proportion to the outpatient and the inpatient setting alike.

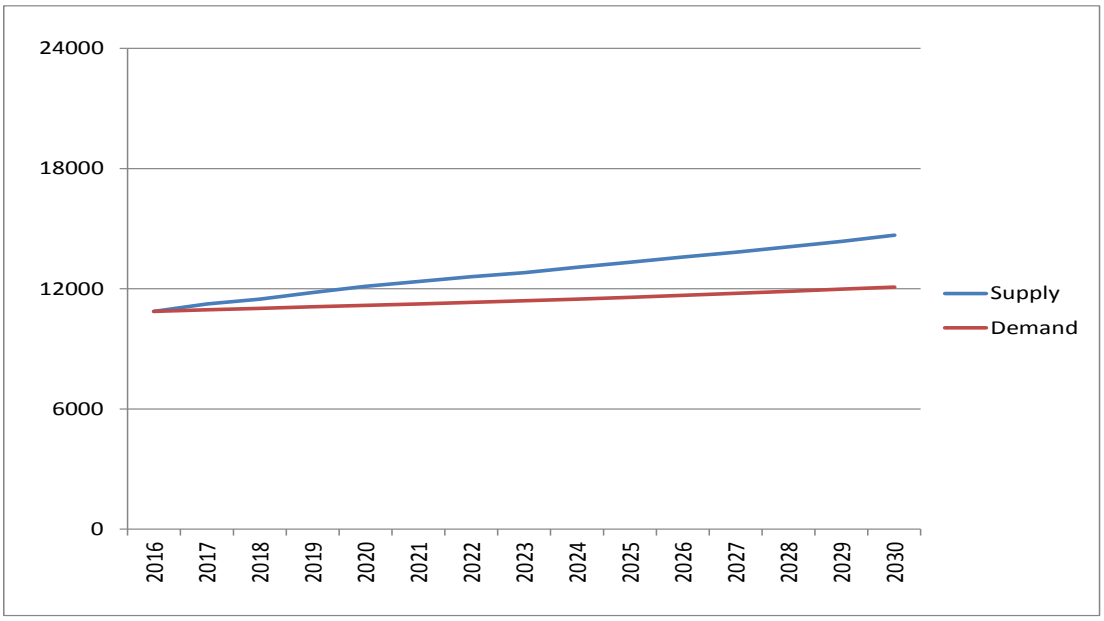
Second, the EU working time directive has not yet been fully implemented in Austria. As explained in 6.5.2, we assume a further reduction of working time by one percentage point in 2016, 2018 and 2021 respectively, and a constant level of 97% compared to the base year 2015 from 2021 onwards.

Results

Applying the assumptions sketched above, we calculate projections for supply of and demand for physicians for two groups of physicians (GPs and general specialists) in two scenarios (Scenario 1: utilization in 2016 represents exactly demand, scenario 2: utilization in 2016 represents 3% undersupply). Figure 134 to Figure 137 show a graphical representation of the projection results.

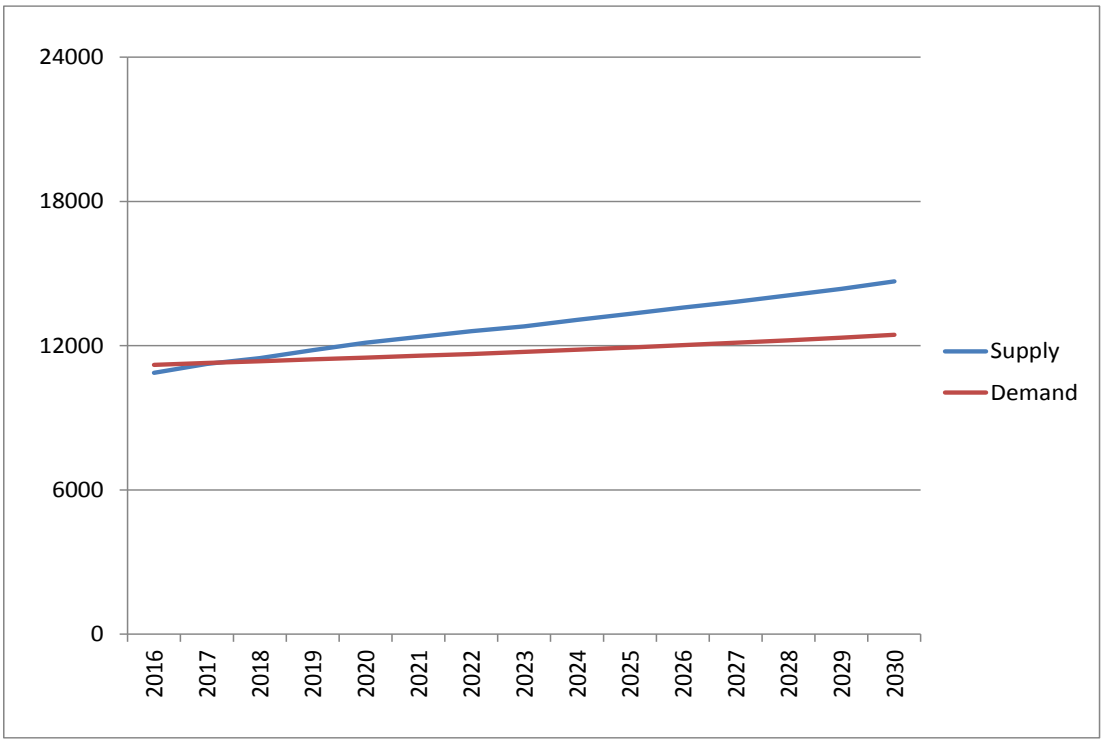
According to our projections, for the entire projection period (scenario 1) or starting from next year (scenario 2) there will be an over-supply of GPs which will keep growing throughout the projection period, amounting to almost 2,500 FTEs or about 21% of demand across Austria in 2030. For general specialists, we expect a far smaller over-supply, but only in scenario 1 and for about 7 years. For both scenarios we calculate that supply fails to meet demand for general specialists in 2030, in scenario 1 by 9% (ca. 1700 FTEs) and in scenario 2 by 11% (ca. 2300 FTEs).

Figure 134: Gap analysis for GPs 2016-2030, scenario 1, FTEs



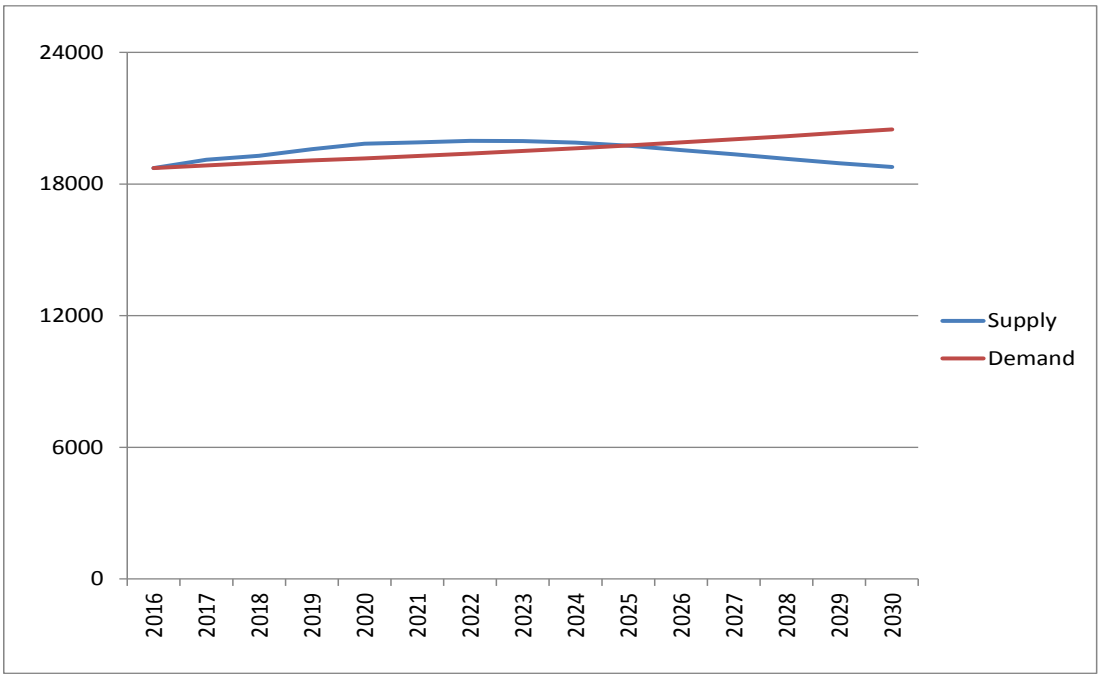
Source: IHS 2017.

Figure 135: Gap analysis for GPs 2016-2030, scenario 2, FTEs



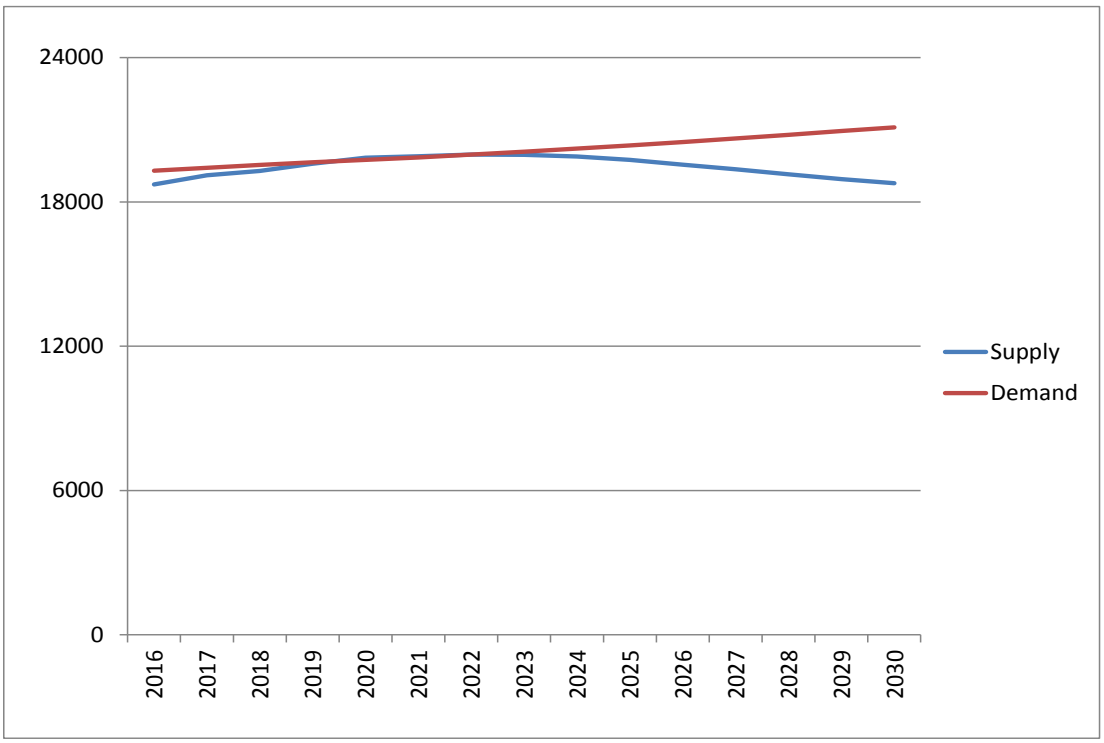
Source: IHS 2017

Figure 136: Gap analysis for general specialists 2016-2030, scenario 1, FTEs



Source: IHS 2017.

Figure 137: Gap analysis for general specialists 2016-2030, scenario 2, FTEs



Source: IHS 2017.

6.5.5 Discussion

It has to be kept in mind that these projections are purely quantitative and are calculated on the national level. Thus, they abstract from regional mismatches like simultaneous oversupply in urban and undersupply in rural areas[97]. Likewise, also mismatches between medical specialties are not taken into consideration, for example, we do not ask if we will have a sufficient number of gerontologists in 2030. Furthermore and perhaps more important, we cannot judge in how far qualifications of physicians actually meet the qualification demands of their workplace and their patients' conditions. The latter caveat applies not only, but especially to primary care.

Another caveat applies to the setting of work. We calculate overall supply of physicians. For physicians with practice, we do not calculate separate models for contracted and non-contracted physicians, which can seriously affect their workload. For certain specialties, this problem is more serious than for others:

[97] The issue of undersupply of physicians in rural Austria was discussed in the context of international best practice examples in Czypionka et al. (2012).

for example, many women preferring female gynecologists do not find contracted ones with reasonable waiting times and therefore retreat to non-contracted female gynecologists (410).[98] Across Austria, 40% of all GPs and 63% of all specialists with practice are not contracted. The high number of non-contracted specialists with practice needs to be seen in the context of typical working times in Austrian hospitals. In many hospitals, afternoons are not very busy, and many hospital-employed physicians run a private practice alongside their full-time hospital job. This can make sense if they succeed in attracting patients with private insurance, who – if cared for by them in hospitals – can provide a handsome additional income for these physicians. Nevertheless, these physicians provide also outpatient care, even though their role in the excessive number of hospital stays per person in Austria remains unclear.

We stressed already before that our calculations start from the assumption of more or less met demand in 2016. This assumption is made for technical reasons, which means that all interpretations regarding under- and oversupply are to be made with reference to the situation in 2016, and not with reference to 'optimal' supply levels. We are quite sure that we do not start from a situation with (overall) undersupply in 2016, but from a situation with significant misallocations in several dimensions: regional (urban oversupply, especially in the Vienna region, but also within *Bundesländer*), regarding setting of work and presumably also contract-status, regarding specialties, but also regarding the overall health workforce, as was already explained elsewhere in this chapter.

6.6 Monitoring and information needs

6.6.1 E-Health in Austria

Political and legal background

Following international developments in the area of e-health, Austria has initiated work on an electronic health record system (elektronische Gesundheitsakte, ELGA) since 2006. The information system enables the electronic documentation of patient health records and facilitates communication between patients and health service providers. The aim is to improve the quality and efficiency of health care provision through a standardised documentation of information and prevention of duplicative care. As such, the

[98] The question why in other countries a substantial part of their work is included in general practice - thus a field with many women doctors – fits again the discussion of possible misallocations and problematic skill-mix.

application is of particular importance to the care of elderly and dementia patients, who experience increased difficulties in maintaining an overview of all treatments received. Therefore, a working group (*Arge ELGA*) was set up by the Ministry of Health, together with the Main Association of Social Security Institutions, the federal health commission (*Bundesgesundheitsagentur*) and the federal states, in order to conduct preliminary feasibility studies and a detailed planning of the project (411,412).

The collaboration between the federal government, the federal states and social security led to an agreement on the content and financial implementation of ELGA as part of the 15-A framework treaty on the organisation and financing of the Austrian health system in 2008, and was further substantiated in the Federal targets agreement (*Bundeszielsteuerungsvertrag*). The efforts culminated in the creation of the ELGA GmBH in 2009, an implementation organisation, which is owned by the aforementioned collaborators (411). To date, the ELGA project constitutes one of the largest harmonisation processes in the health care system to standardise the infrastructure and regulations pertaining to health data.

In addition, the legal basis for the processing of electronic health data was specified in the ELGA Act in 2013, which constitutes an extension of the Health Telematics Act 2005, EU Data Protection Directive, Data Protection Act 2000, Medical Law 1998, Law on Documentation and Federal Law on Hospitals and Cure Facilities, among others (411).

Implementation of ELGA

ELGA GmBH

The ELGA GmBH, established in 2009, is a non-for profit limited liability company owned by the federal government (represented by the Ministry of Health), federal states and social insurance (represented by the HVSV). The line of business includes the coordination and integration of all operative measures regarding the implementation of ELGA, the establishment of system components and support of pilot projects pursuant to the provisions of the federal health commission, as well as the quality- and acceptance management. The key tasks encompass the on-going development of the IT architecture and standards (including standards that are in line with international developments), the overarching programme control over all necessary projects, the further development and control management of information security, as well as public relations. Therefore, the ELGA GmBH is dealing with the planning, monitoring and evaluation of all technical and organisational arrangements, including the monitoring of the individual implementation stages in accordance with the regulations and time schedule (412,413).

The financing of the company ensues in line with the agreement pursuant to Article 15a of the Federal Constitutional law on the financing and organisation of the health care system. Hence, expenditures for the establishment and operation of the central infrastructure are jointly borne by its owners and may amount to a maximum of EUR 60 Mio for the period 2008-2016 (15a B-VG, Punkt 38 Article 30 Abs. 6). Furthermore, an additional EUR 41 Mio were allocated for the period 2017 to 2020 (413).

Implementation phases

(1) In January 2014 the ELGA internet portal was set up, which enables insured persons to access, print and download their personal health records. In addition, the portal allows individuals to partially or fully opt out of the ELGA system, as well as to opt in again – either online or via a written statement to the responsible authority. Furthermore, individuals can authorise and manage a health care professional's access, as well as duration of access, to the files. The authentication process to access the portal is done through the so-called Citizen Card (*Bürgerkarte*) or a transaction code via mobile phone (411).

(2) Following technical and organisational difficulties in the simultaneous initiation of ELGA across all nine regions, which had been foreseen for the beginning of 2015, a gradual phasing in was assented to. Given their previous advances in e-health, Vienna and Styria were announced to lead the pilot. Following, the connection between the affinity domains run by public hospitals, as well as nursing care facilities, and the central ELGA components was started in December 2015.

(3) In 2016, the phasing in continued across the remaining regions, and by the end of 2017, all hospitals in eight regions are expected to be connected, except for Burgenland.

(4) In the second term of 2016, the e-medication application testing phase was initiated in Deutschlandsberg, Styria. A full roll out of the application is expected by early 2018.

Status quo

To date, approximately 140 health care providers are connected to the system, including hospitals, nursing care facilities, physicians, dentists and pharmacies. This encompasses 100% of all public acute hospitals and 90% of all acute hospitals in Austria. The step-by-step implementation across health care providers is specified in §27 of the ELGA Act; it starts with public hospitals and care homes and continues to expand across pharmacies and physicians, as well as private hospitals. Dentists are expected to join in 2022 (414). However, it must be noted that the intra- and extra mural sectors have a different focus when it comes to employing ELGA. The focus in inpatient care lies on discharge letters, while in the outpatient sector, it is the prescription of medications (i.e. e-medication). As such, there is currently no provision in

the law that requires outpatient physicians to electronically store medical findings, similar to the discharge letters at hospitals. Therefore, gaps in the collection of health information prevail, also due to the fact that patients may decide to opt out of the system.

In order to proceed with the roll out of the system, a political commitment ruled that 80% of contracted outpatient physicians need to integrate ELGA functions into the physician practice-based software by the end of 2017. To date, the number of physicians having completed the integration of functions amounts to approximately 75%. As part of this process, to enable the expansion of the ELGA network across physician practices, the Chamber of Physicians has requested EUR 4,000 per doctor in order to support the upgrade of the information system and software. Concurrent to the expansion of the system, an increasing number of ELGA patient advocates are taking up their duties at patient advocacy offices.

By early 2017, already one of five people in Austria (approximately 1.7 Mio) have already had contact with ELGA, while 3% of all possible ELGA users (approximately 260.000 people) have decided to opt out of the system. More than 4.1 Mio documents have been uploaded, which include physician and nursing discharge letters, medication data, laboratory and image-based diagnoses. Further documents to be included encompass an individual's living will (*Patientenverfügungen*), health care proxy (*Vorsorgevollmacht*), and legal medical registers (*gesetzliche medizinische Register*), as well as a pathology report and a patient summary. Furthermore, the Minister of Health can order further types of information to be included in ELGA via regulations (414). Currently not included is sensitive patient information that was noted and saved in a practice or hospital software, or information on health behaviours (413). According to the Ministry of Health, data should only be made available in the ELGA system if it is of relevance to the present treatment of a patient, if it constitutes an important information basis for aftercare facilities, or if it serves the protection of patient rights or the improvement of patient safety (412). Furthermore, a picture archiving system to store e.g. x-rays and other image-based data has not been implemented yet.

Technical set up of ELGA

IT architecture

ELGA provides for a decentralised storage of health data by storing it at the respective sites of origin or so-called affinity domains (such as hospitals or GP practices), which are also referred to as the ELGA area (*ELGA Bereich*). As such, the original documents are saved in so-called repositories that are found at the health care providers' practice or facility. In addition, there are a number of central components that play

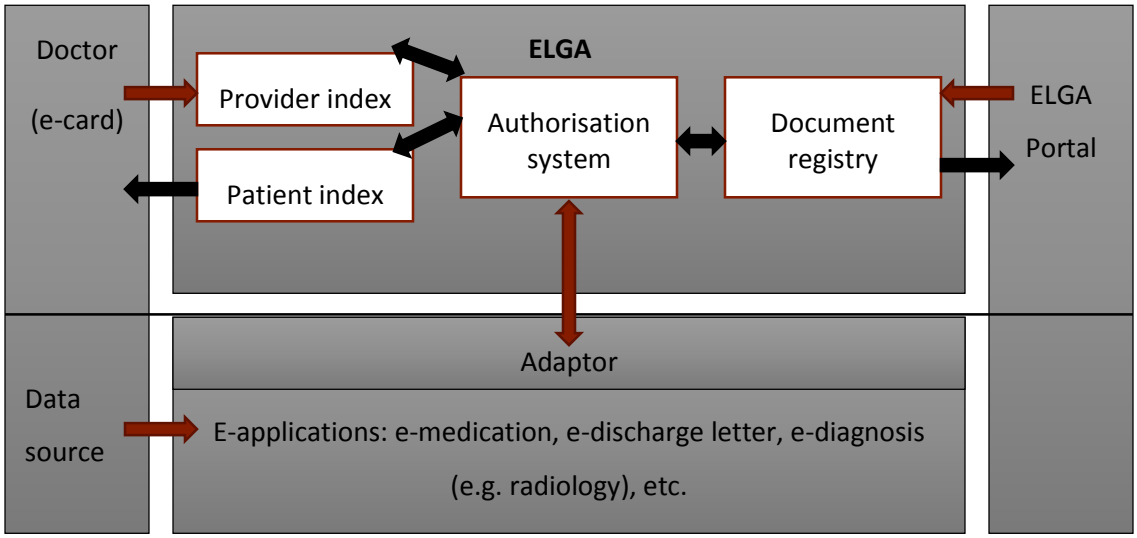
a role in the identification of patients and health care providers, as well as the management of access authorisation. A central database is also found in the e-medication application, i.e. the e-medication account (411). The technical implementation of ELGA is generally based on internationally recognised standards, such as those pertaining to safety (412).

The ELGA Act specifies that facilities need to store specific data in a specific structure, in order to render the data retrievable through ELGA, whereas it does not matter where the data storage is located. Even though the data could be stored in a single or two storage locations in the country, a decision ruled that each of the nine federal states would set up and finance a storage site, in order to also establish an infrastructure for local telemedicine. By the end of 2017, all regions, except for Burgenland, are expected to have set up the storage sites and in addition, the AUVA and two private providers have invested in their own data storages. As such, there are more than enough, if not too many, ELGA data storages to connect all health care providers in Austria.

In practice, the system works as follows. In order to access health data electronically, a treating health care provider needs to enter medical findings (i.e. ELGA documents) into an electronic register. As such, an entry is recorded, which references the document and the location at which it can be found. This document registry only contains meta-data, as well as the links to ELGA documents, which are structured and classified according to the CDA levels (for further information, please see health data structure below).

Other health care providers can then request access to a patient's health records through their own software (e.g. Ordinationsysteme, Krankenhausinformationssysteme), while patients can request access via the online ELGA portal. These requests need to pass the Central Authorisation System, which uses unique patient and health care provider indices to confirm, whether (a) the patient exists and (b) whether the requesting health care provider has the rights to access the information. The patient identification proceeds via a Centralised Master Patient Index (C-MPI), which is also linked to the affinity domains. As such, the index contains both the demographic data of individuals and the record locator service that allows for the locating of the affinity domain that stores the health data. Similarly, health care providers can be identified through a Centralised Healthcare Provider Index (C-HPD), which constitutes a register of all health care professionals and facilities that have legal access to the health data (411,412). The C-HPD is managed by the Federal Electronic Data Processing Centre (*Bundesrechenzentrum*). Please see Figure 138 for an overview of ELGA's IT architecture.

Figure 138: Technical set up of ELGA



Source: *Arge ELGA, 2007*

Health data structure

In order to render the health information usable across the different IT systems of health care providers (i.e. semantic interoperability), the documents and data must follow technical norms and semantic standards. Therefore, the Federal Health Commission has recommended the Clinical Document Architecture (CDA) as the official document standard. CDA is an international standard for the storage and transfer of health data, based on XML, which also constitutes the reference standard for the public procurement directive of the European Union. As such, the CDA format allows for a standardised saving of documents that is accessible to all ELGA participants. This national harmonisation process of the health data structure, initiated in 2007, involved approximately 200 voluntary stakeholder representatives, such as health care providers and social security representatives, and constitutes a good example of coordination efforts to foster the nation-wide standardisation of content and technology.

In addition, an ELGA reference style sheet has been developed to ensure usability, as CDA documents do not provide for any layout information themselves. The medical and administrative content within a CDA document are separated. For instance, the administrative data is located in the CDA header, while medical information is saved in the CDA body. Currently all documents are standardised in an XML format. While the header information is fully standardised across all health care providers, some providers continue to embed the body content in form of PDF. With regards to the standardisation of the body content, the law

outlines three different levels of ELGA interoperability, where level 1 is a reflection of the current situation, in which most providers continue to integrate body content in a PDF format. By contrast, level 3 specifies that all of the body content information is stored in an XML format. It must be noted that level 3 constitutes a prerequisite for the implementation of a patient summary. Meanwhile, semantic operability can be further enhanced by embedding machine-readable data, which allows e.g. for single data to be imported into the health care provider's IT system and the automatic highlighting of risks (411).

Access to health data and data safety

Health care providers generally have a period of 28 days, starting on the day of treatment or supervision (e.g. by scanning a patient's e-card), to access the relevant health data. The time period is intended for physicians to receive or read into additional information pertaining to the specific case and access can only be activated again in the case of renewed treatment or supervision. By contrast, pharmacies are given a 2-hour access to the list of prescribed medicines. However, individuals can modify these access provisions through their online ELGA portal, by either reducing the duration of access or increasing it to a year (e.g. in the case of a fiduciary physician). Furthermore, as stipulated in §20 ELGA Act, health data is to be de-centrally stored for ten years. In the case of e-medication, the storage of data runs for one year (412).

The protection of data and patient rights play a central role in the implementation of ELGA. For once, ELGA users have the opportunity to hide and un-hide documents, such as in the case if they wish to receive a second, unbiased opinion, or to delete files entirely. Patients may always opt out of the system, given they are not legally obliged to save health data electronically. Furthermore, users can track any downloads or viewings of the files by health care professionals via a protocol system. Concurrently, health care providers may only access patient information in the case of concrete treatment or supervision of the patient, in order to prevent the inappropriate insight into user files and as such to protect patients' personal information (412). The paragraphs 3 to 8 of the ELGA Act are specifically concerned with data security and specify necessary actions when required. For instance, the data transport is encrypted and the network security needs to be updated to the latest technical standards (413). In addition, the storage system is decentralised and communication takes place via own health networks. To prevent the misuse of the system, high penalties were introduced, including fines of up to €10,000.

E-medication

Another important part of ELGA is the e-medication application, which allows for the recording of prescribed and over-the-counter obtained pharmaceuticals in order identify and prevent contraindications and duplicate prescriptions (414). Given that patients may be prescribed a number of drugs simultaneously and by different health care providers, which may interact with each other and lead to adverse events, the system aims to improve patient safety and quality of treatment.

E-medication is an application (not a document) connected to ELGA, which offers an overview of all pharmaceuticals that have been prescribed and delivered to a patient in the last 12 months. Similar to other ELGA applications, the information can be accessed by patients, physicians, pharmacies, and hospitals (413,414). Furthermore, physicians can transfer the information into their own IT system. Therefore, it constitutes an important prescribing information basis on dosage, contra-indications and duplicative prescriptions, and allows for the electronic verification of possible drug-to-drug interactions, which can be particularly frequent during the simultaneous intake of OTC drugs. A database, which stores information on more than 13,000 combinations of active substances and their possible interactions, forms the basis of the analysis. The database also includes herbal medicine, such as St. John's Wort, that are known to interact with other drugs.

The e-medication testing phase started in the second term of 2016 in Deutschlandsberg, Styria (411). Prior to this, additional pilot projects were conducted in Wels-Grieskirchen, Upper Austria and in Reutte, Tirol, followed by an independent evaluation by the medical university Vienna in 2012 (412). By September 2016, the application had already been used by 11,000 people and encompassed approximately 57,000 prescriptions, as well as dispensing information on approximately 14,000 prescriptions and 9,000 OTC drugs (413). An Austria-wide roll out of e-medication is expected by early 2018, however, the date may be pushed back due to delays.

6.6.2 Policy options: Monitoring and information needs

Identifying synergy potentials between data storage sites

Currently each federal state, as well as the AUVA and a number of private providers provide access to ELGA data storage sites, which already constitutes a large, if not too large, number of costly storage sites that have the capacity to connect all health care providers in Austria. Therefore, cost-effectiveness should be taken into consideration with regards to the number of storage sites and further site establishments

should be avoided. Instead, already established sites should be evaluated, as to whether efficient use has been made of their data storage capacity, and areas of synergy should be identified. These evaluations could be performed by the ELGA GmbH, for example.

Automated electronic prescribing and recall system for medical adherence

Currently not initiated as part of ELGA or E-Medication in Austria, an electronic prescribing (e-prescribing) system (EPS) enables health care professionals, such as physicians and nurses, to write, send and re-fill prescriptions electronically to a (participating) dispenser, e.g. pharmacy, rather than using handwritten or faxed notes. As a result, prescriptions can be processed more efficiently by reducing errors related to illegible handwritten notes or faxes. The system also allows for improved control of prescriptions and reductions in time spent on prescription queries for health care professionals. For instance, patients could receive timesaving information on possible drug-to-drug interactions directly at the physician's office, rather than having to return to the practice for a renewed prescription in the case that interactions were identified by the pharmacist. Concurrently it enables dispensers to have better control of stock and to reduce the paper/administrative burden, while patients could directly collect (repeat-) prescriptions from a dispenser, without the risk of losing paper-based prescriptions, making the dispensing process both more efficient and convenient.

In addition to transmitting electronic prescriptions, the system could be extended to include an automated recall system for patients to support medical adherence. Similar to the already existent recall letter for the annual preventive check-up, a letter could be sent to patients if uncollected prescriptions were identified by the system. The letter would notify patients of uncollected prescriptions and may suggest further consultations with a physician, without naming the actual medication. As such, the recall letter could promote continuity of pharmaceutical care, while simultaneously ensuring confidentiality. The system could be further extended with additional applications that enhance convenience and continuity of care, such as the electronic scheduling of appointments.

E-vaccination

The vaccination status of residents living in Austria is often partially/not reported. Furthermore, documentation on immunisations, such as the paper-based WHO-compliant vaccination record, may get lost, in which case a vaccination database and electronic vaccine record may provide time- and site-independent access to information for both healthcare staff and patients. As such, individuals could obtain an optimised and more convenient overview of their immunisation status and vaccination schedule, while

preventing unnecessary or duplicate immunisations and possible adverse events from drug-to-drug interactions. In addition, a recall system, similar to the existing recall letter for the annual preventive check-up, could be introduced to ensure continuity of the vaccination schedule and thus ill-health prevention. Moreover, the introduction of a national electronic immunisation data collection system in Austria could improve the monitoring and evaluation of immunisation rates, which is currently based on a fragmented reporting system.

Expansion of digital imaging and communications in ELGA

At present, the ELGA database encompasses physician and nurse discharge letters, as well as laboratory and image-based diagnoses. However, a picture archiving and communication system to improve the utilisation of resources has not been fully adopted in ELGA, as the storage of image data is optional. Therefore, the creation of databases for digital images from different medical devices, including e.g. X-rays, MRI- and CT-scans, PC tomography and ultrasound, has the potential to improve site- and time-independent information sharing between medical professionals and health care enterprises, and as such to enhance operational efficiency. A structured representation of image data could facilitate the acquisition of image data objects from multiple sources and systems, in order to directly store these into ELGA. Concurrently, a digital imaging system could enhance patient care by preventing unnecessary repeat examinations, thus reducing radiation exposure for patients and costs to payers.

Standardisation of the diagnosis classification system

At present, the classification of diagnoses differs across different levels of care. For instance, hospitals employ the official WHO ICD-10 codes in order to specify inpatient diagnoses. By contrast, outpatient departments use codes based on the so-called catalogue of outpatient department services (*Katalog ambulanter Leistungen, KAL*) and are only required to specify diagnoses in concrete cases, as stated in the law. Even though the cross-sectoral diagnosis nomenclature for outpatient departments (KAL) was recently initiated as part of the operative goal (7.2.1) in the Health Target Agreement 2013 (*Bundeszielsteuerungsvertrag 2013)*, it will take time for health professionals to get used to the new system. Furthermore, there are no defined rules on classifying diagnoses for general practitioners and specialists in the extramural sector. Therefore, the nomenclature differs across individual physicians, and notes on diagnoses may be drafted in the form of a general description, in Latin or a code (such as ICPC-2 codes).

Consequently, diagnoses are currently only available for inpatient care, which comes with a number of limitations. Specifically, it does not provide for a detailed overview of the patient's overall health condition, as hospital care is focused on the treatment of specific conditions that do not necessarily capture other health conditions, such as in the case of multi-morbid patients. For example, a surgeon is less likely to classify psychological diseases. Furthermore, elderly patients and those with dementia may have difficulties recalling all previously diagnosed conditions by GPs and specialists. In addition, outpatient diagnoses tend to be more detailed and give an insight into a range of conditions that may have been diagnosed over a longer time period. Therefore, the inclusion of outpatient diagnoses may constitute a better representation of a patient's medical history and interoperability could be improved by standardising the diagnosis classification system. The latter would further allow for a faster search for specific diagnoses, in the case of the implementation of an ELGA search tool.

Evaluation and monitoring of a patient's medical history

The electronic health records accessible via the ELGA online portal are currently saved in form of a chronological list. This list does not include a search function and users need to click on each file individually in order to get an insight into information. Given that some patients may accumulate a large number of records over a longer time period, it is easy to lose track of information. The same applies to physicians and other health care professionals, who aim to make use of a patient's health data. As the body content of the documents is mostly in PDF format, a patient summary or a track mode to monitor the developments of specific health parameters have not been implemented and there is a need to improve the usability of the record system for both physicians and patients. For instance, a patient summary would allow for a quick and concise assessment of the latest treatment status of patients, setting free more time during a doctor visits to e.g. clarify questions. Furthermore, a tracking system with a search function to monitor the development of specific parameters, such as blood pressure, may enhance patient treatment, as it provides for a more thorough overview of a patient's health status and needs. Alternatively, this task could be outsourced to the private sector.

The current challenges in monitoring and evaluating the development of treatment are also found in the e-medication application. Prescriptions are listed one by one and users need to click on individual files in order to open these. Therefore, a combined list of medications with the options to search for or track specific medications could provide for an improved overview to both patients and physicians. It must be noted however, that e-medication information is only stored for a maximum of 12 months, which would

make it difficult to track long-term treatments and changes in dosage for e.g. chronically ill. Therefore an extension of information storage may be considered in the case of an introduction of a tracking mode.

Expansion of data collection

The present electronic patient record in Austria includes information on discharge letters by approved healthcare professionals, as well as laboratory and radiology diagnoses. Additional information approved for inclusion constitutes the living will of a patient, health care proxies and legal medical registers. As such, the database allows for an overview of the patient's medical history, however, does not provide further information on health behaviours, such as smoking, or family medical history, despite their relevance to treatment paths and prescribing. A more extensive patient record could further improve patient-centred care, provided an insured person has expressed interest in the service. For instance, physicians could gauge patients' interest in the sharing of information that is collected during the yearly preventive check-up, which could enable a more extensive monitoring of a patient's medical history and health behaviours and as such offer suggestions on interventions that are better tailored to the individual.

Immediate sharing of information on health care use

Following a statutory mandate, statutory insurance carriers are obliged to annually inform their insured members about the individual's use of healthcare services since 2004. Since 2013, individuals only receive the annual letter upon an explicit request. Furthermore, an annual overview may not inform patients in times of actual information need. Therefore, providing information on health care costs in addition to the utilisation of services through ELGA's online portal could enable year-round access to necessary information for patients and prevent billing errors, provided this service has been requested by the patient.

Dissemination of information on ELGA to health care providers

For the moment, health care providers receive information brochures on ELGA, which, to the inconvenience of health care providers, may not always clearly and effectively provide information on the use of ELGA. An option would be to develop ELGA showcases that could be presented to health care providers, such as pharmacies, to facilitate and support the roll out of ELGA across as many health care providers as possible.

Summary of policy options

The ELGA project, including its application on e-medication, is one of the largest harmonisation processes in the health care system to standardise the infrastructure and regulations pertaining to health data. Through facilitating the communication between patients and providers, the system supports the quality and efficiency of health care provision, whilst preventing duplication of care. In addition, the e-medication app, which is based on a large database of inpatient and outpatient drugs (including herbal medicine), allows for the recording of pharmaceuticals to prevent contraindications and duplicate prescriptions. Therefore, the step-by-step implementation of ELGA constitutes a positive development, and one that is important from a European perspective, as many countries continue to face obstacles to the introduction and expansion of e-health.

However, challenges to ELGA's full implementation remain, including the continued widespread use of PDF-based body contents as opposed to a full XML format, the complete integration of ELGA applications into physician practice-based software, and the different diagnosis codification systems across different levels of care.

Against this background, a number of policy options were outlined in this section. For instance, synergy potentials should be identified between data storage sites, in order to make better use of current capacity potentials and to prevent the costly establishment of new sites. Furthermore, applications that facilitate the treatment process and overview for patients should be further expanded and developed, including an automated electronic prescribing system with an integrated recall system for medical adherence, e-scheduling, e-vaccination and e-mother-child-passport. In addition, the implementation of a more user-friendly patient summary, as is currently in development, is highly supported, as well as the expansion of digital image storage. A standardisation of the diagnosis classification system could further improve interoperability.

In attempt to make further use of the system, additional patient data on, for example, health behaviours could be collected, while simultaneously the option to monitor and evaluate the development of specific health parameters for both patients and physicians could be introduced. Another possibility is to upload information on health care use immediately, rather than sending out a yearly letter to the insured. Regardless of which options are introduced, easily comprehensible information on ELGA and its applications to health care providers should be further disseminated, such as in the form of showcases, to further promote the expansion of the system.

Legal considerations

No particular constitutional impediments have to be faced with respect to these options, apart from data protection issues that have to be considered. Certain legal amendments as well as amendments to the current system of contractual agreements would be required, which might cause political impediments.

6.7 Pharmaceutical expenditure and procurement

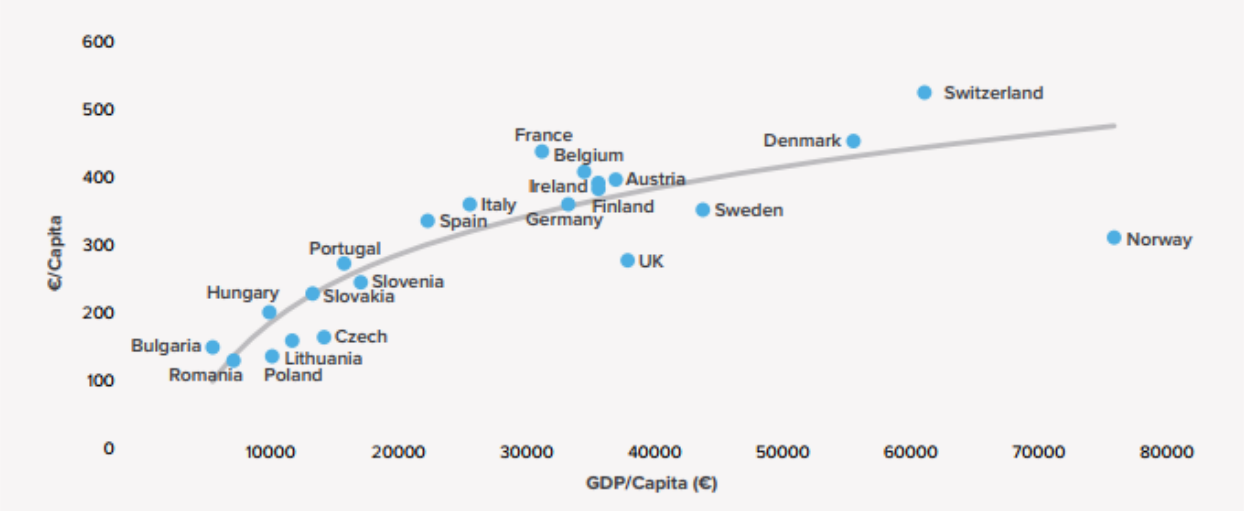
6.7.1 Pharmaceutical expenditure

Austria faces a situation that is increasingly common among the world's developed countries: rising healthcare costs, and related concerns over health system sustainability and affordability.

Total spending on pharmaceuticals, in particular, remains lower than in other OECD countries (415). In 2014 (latest available year), total drug sales in Austria equalled US$403.8 per capita (PPP-adjusted); this was lower than in 16 other OECD countries (416). Per capita pharmaceutical spending, however, is comparable to other major developed countries, including Germany, Finland, Ireland, Belgium, and France (see figure below).

While generic drug penetration is high in Austria—accounting for a large and growing volume of the reimbursed pharmaceutical market—the available evidence suggests that branded medicine prices in Austria are high compared with many other advanced economies. We conclude by providing policy recommendations to help address this issue.

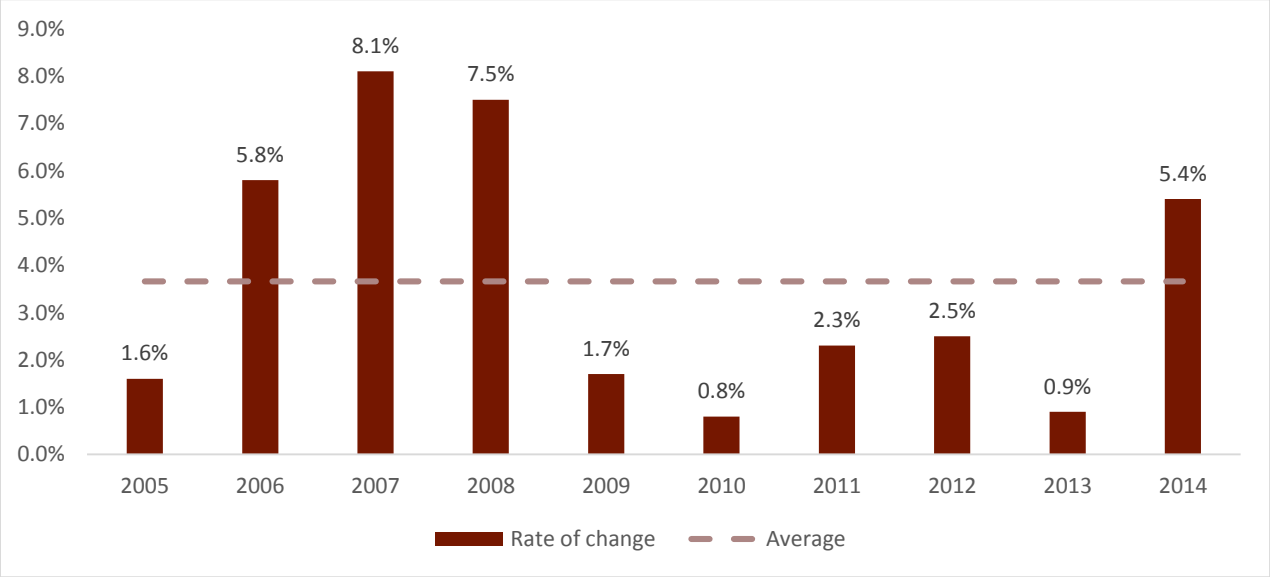
Figure 139: Relationship between GDP per capita and per capita pharmaceutical expenditure



Source: Taken directly from (417)

Austria is experiencing a high rate of growth in pharmaceutical spending per capita. Among the OECD countries for which data exists, Austria ranks sixth highest in the compounded annual rate of growth (CAGR) in spending on medicines, with a 3.3% CAGR between 2010 and 2014. Notably, pharmaceutical spending appears to have accelerated over recent years: while increases in spending on medicinal products by insurance carriers increased by between 0.8% - 2.5% on an annual basis between 2010 and 2012, expenditures increased by 5.4% in 2014 compared with 0.9% in 2013 (Figure 140) (418).

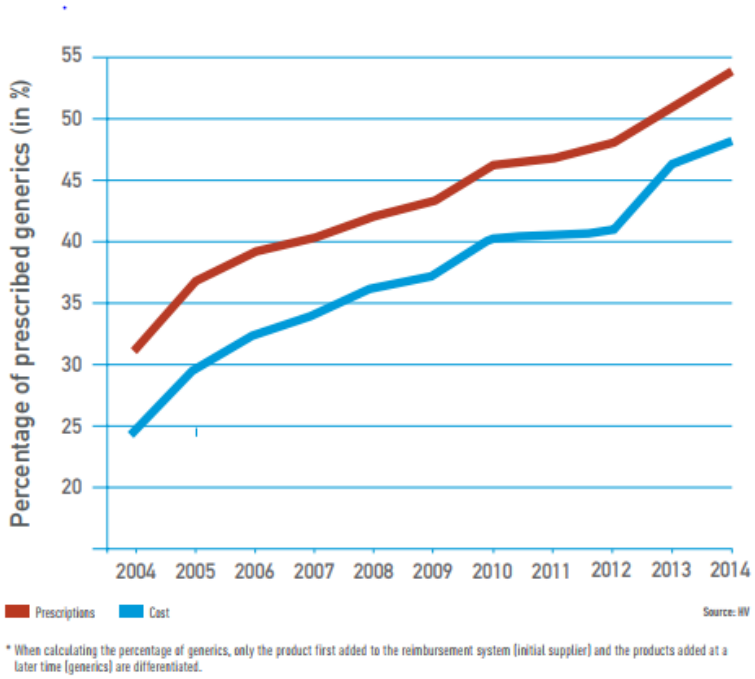
Figure 140: Change rates for expenditures for medicinal products



Source: (419)

High rates of growth in pharmaceutical spending are occurring even as the share of generics in Austria's market continues to grow. According to a recent report, 52% of the volume, and 47% of the value, of the reimbursement market is associated with generic medicines (418). Both figures have also risen steadily over time, suggesting proportionally greater use of, and expenditure on, generic medicines (see figure below).

Figure 141: Prescribed generic products in the reimbursement market



Source: Taken directly from (419)

That a growing share of the value of the reimbursable market belongs to generics could owe to growing prices or volumes of this class of medicines. A range of evidence suggests that the latter is the predominant factor contributing to long-term pharmaceutical market value trends. First, while considerable price reductions have been observed in Austria between 2005 and 2014, these have been lower than those observed in other major countries. Austria has, over the same period, witnessed a notable rise in the volume utilisation on medicines, though a smaller increase than that observed in several other European countries (Figure 142).

Figure 142: Prescribed generic products in the reimbursement market

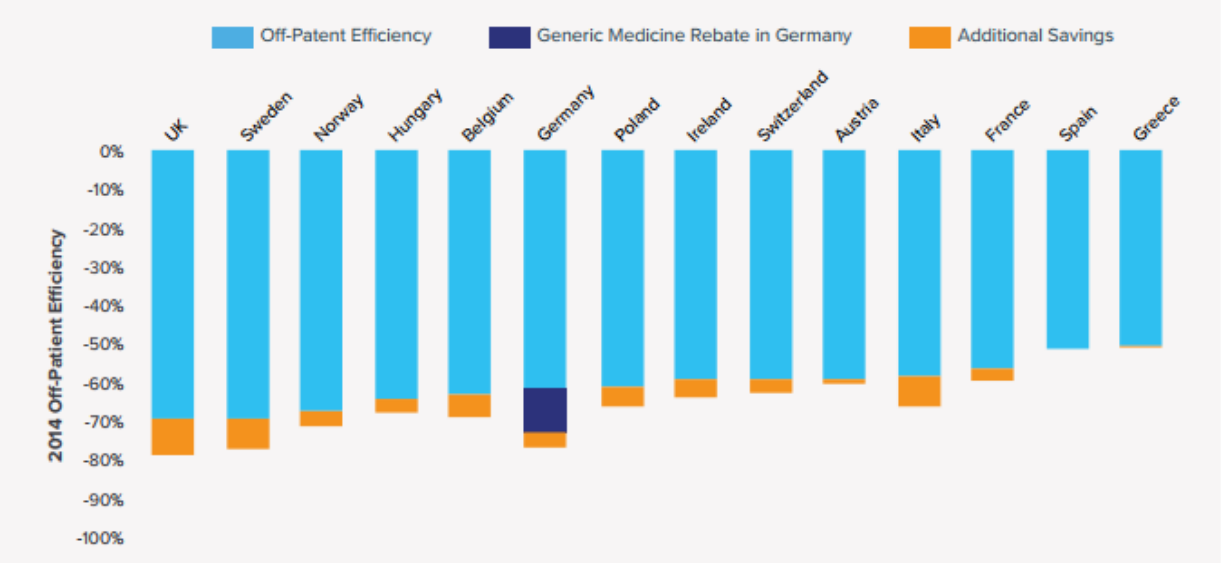
Country	(€/TD)	Volume (TD/cap)	Treatment cost	IMPACT
Germany	-62%	153%	-7%	
UK	-64%	143%	-13%	Impact of price decline > volume increase
France	-51%	40%	-31%	Decline in in overall treatment cost
Italy	-53%	121%	-9%	

Country	(€/TD)	Volume (TD/cap)	Treatment cost	IMPACT
Ireland	-59%	148%	-9%	
Sweden	-69%	108%	-40%	
Spain	-50%	109%	0%	Impact of price decline equal to volume increase
Czech	-53%	132%	2%	Stabilisation of overall treatment cost
Austria	-49%	133%	14%	
Slovenia	-69%	152%	-30%	Increased access in under-served markets
Poland	-51%	192%	33%	
Slovakia	-63%	207%	9%	

Source: (417)

Moreover, generics are slowly obtaining a larger share of the volume of the reimbursable drug market (419). Prices for medicines already on the market in Austria have decreased annually since 1996, even as the broader consumer price index has consistently trended upwards (418). Generics are also priced 66% lower in Austria than the prices of originator medicines prior to generic entry (420). There is evidence to suggest that this compares favourably with other countries in the region. In Finland, for instance, generics are priced 59% lower than the prices of originator medicines prior to generic entry, even though generic entry is higher in Finland than in Austria (266). These findings have led some to argue that the Austrian pricing system appears to be relatively 'more efficient [in lowering] prices' (420). Although Austria performs well in extracting savings from generic medicine competition, off-patent efficiency in the generics drug market could be further improved when evaluated against a broader set of reference countries.

Figure 143: Savings from generic medicine competition by country



Source: Taken directly from (417).

The Austrian experience in managing branded pharmaceutical spend is markedly different. Since the volume share of the reimbursable drug market in Austria associated with generics is high and continues to grow, rapid increases in total pharmaceutical spending appear driven in part by increases in the price of new—branded, and increasingly specialty—medicines.

Indeed, a recent price survey of 60 high-cost medicines in EU Member States found that:

> 'For 80 percent of all 60 surveyed medicines Austrian ex-factory prices were above the EU median. For all 15 medicines of the survey that were attributable to the in-patient sector, ex-factory prices were above the EU median. Thus, Austrian ex-factory prices of the surveyed medicines ranged among the highest prices in EU context' (421).

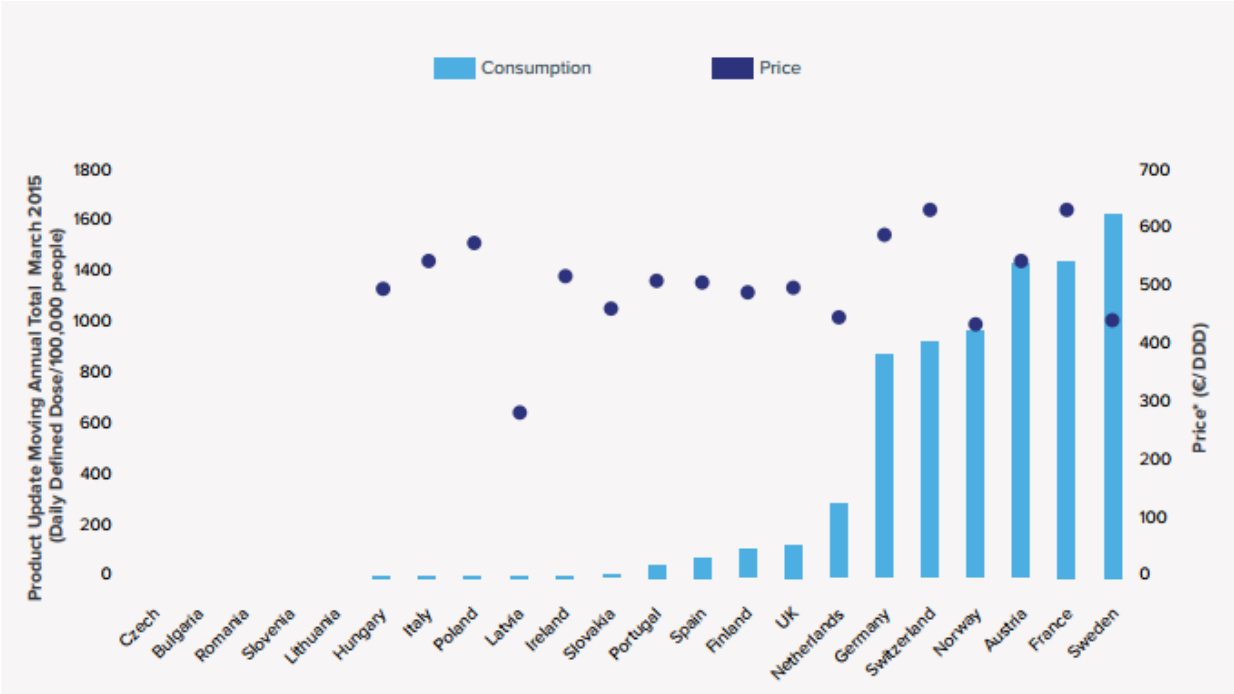
Vogler and colleagues (2016) suggest that, in comparison to other European countries, the prices of medicines that are used in-hospital—typically specialty medicines—are relatively higher than those given in outpatient settings (421). For example, given hospitals purchase directly from manufacturers and receive significant discounts (422).

Research is needed to evaluate the impact on originator pricing from generic drug entry in Austria. Branded, off-patent originators must cut their price by 30% once a generic alternative becomes available for reimbursement in Austria. This stipulation for statutory price cuts however requires that at least one generic alternative enter the market, and is therefore not directly tied to patent expiration. This policy

context may incentivise behaviours on the part of branded pharmaceutical manufacturers that are designed to restrict or delay generic drug entry (423). It remains unclear whether branded drug manufacturers adopt similar strategies in Austria, and how this effects generic drug entry and originator drug pricing.

Despite relatively high drug prices in the branded drug market, there is evidence to suggest that patient access remains strong, at least for certain medicines. With respect to Sovaldi (Hepatitis C drug), IMS Health recently found that Austria had the fifth highest price for the medicine across 22 European countries, but also had the third highest amount of defined daily doses administered per 100,000 people (Figure 144).

Figure 144: Solvaldi uptake and price, by country



Source: Taken directly from (417).

6.7.2 Procurement of pharmaceuticals: Tendering

In light of rising pharmaceutical prices, governments and health care providers are increasingly concerned with ensuring access to and affordability of medicines. To achieve the goal of access and affordability, drug prices should reflect not only production costs but also their added social value (424). Value assessments of existing and new pharmaceuticals through, for example, health technology assessment (HTA), price negotiations and tendering have been used as tools to achieve affordable prices (425).

The procurement process of pharmaceuticals is organised differently across Europe, which results in disparities in access to medicines (426). Efficient and transparent management of procurement is key to ensuring cost-effective drugs are selected at the right quantities, needs are adequately quantified and product quality is high (427). Tendering, which serves as a key mechanism during the procurement process, serves as a mechanism to stimulate competition and drive prices down to marginal costs of production (428). The success of tendering processes is, however, sensitive to a variety of factors, therefore, evidence of its impact on prices is not concrete (429).

This section introduces the concept of tendering and presents empirical evidence on its implementation across Europe. It highlights benefits of tendering, key legal and practical challenges and provides an outlook of tendering for the future. Country examples have been from six European countries, Norway, France, Germany, the United Kingdom (UK), Belgium and the Netherlands.

Objectives of tendering

Tendering refers to a concept whereby a payer (e.g. hospital association, insurance) purchases pharmaceuticals on the basis of a tendering procedure, with the contract being offered to the manufacturer(s) offering the best bid (430). Tendering can be used in both primary and hospital care, however, it is more common in the latter (430).

Tendering is used as a strategy for the reimbursement of pharmaceuticals as part of a country's social security system. Pharmaceutical reimbursement assumes the existence of a third-party payer at national, regional or local level who decides which medicines to cover at what price and at what co-payments, taking various factors into account (431). Public procurement of pharmaceuticals is pursued by different contracting entities across Europe varying from governments, hospitals, and public insurance funds, for example (432).

In a tendering process, contracting entities purchase drugs from the manufacturer with the best bid, which includes criteria such as price, quality, reliability, and ability to service the market (433). Nevertheless, the best or lowest price is usually considered the key criterion. The manufacturer, or in certain cases (e.g. Germany), manufacturers, who wins the bid is then awarded the right to service the relevant market for a specific period of time (434).

Tendering is based on the economic theory that a firm sets its bid subject to its reservation price, the minimum price it is willing to accept for a product, which is likely to be close to marginal costs where the firm makes zero economic profit. Tendering thereby encourages close to competitive prices in the absence

of perfect information on firms' production functions (433). However, it is important to distinguish the impact tendering has on prices for generics and on-patent drugs. Specifically, tendering is more likely to achieve its intended effect (i.e. significantly reduced prices) within the generic market, given the presence of multiple manufacturers all offering an identical molecule. In regard to on-patent medicines or those with market exclusivity, however, competition will be minimal if there is little scope for product substitution.

In Europe, tendering is organised separately across countries (435). The European Union legally regulates public procurement to ensure transparency and fairness in the tendering process and to promote European cooperation in this reagrd. In 2014, the European Union implemented a new legal directive for procurement, the Directive on Procurement (2014/24/EU), which is mandatory for European Union member states to adopt into their legal system (436). A common legal framework within the EU aims to improve efficiency through cross-border cooperation, for example, through joint procurement (425).

Benefits associated with tendering

Tendering aims to reduce pharmaceutical expenditures in face of fiscal constraints by introducing competition (429). Evidence from Germany and the Netherlands shows that in the short-run, tendering significantly decreases the price of generics leading to savings for national health insurers (437).

Tendering processes foster competition among suppliers thereby reducing prices to a level close or equal to marginal costs (428). If the tendering process is managed well, it can succeed in driving down prices sustainably without harming suppliers. Payers therefore gain power over the procurement process, which may limit price distortions caused by a concentration of suppliers in the market (428).

To ensure efficient and transparent management of the tendering process it is, however, key to identify the 'Most Economically Advantageous Tenders' (MEATs) (436). This entails choosing cost-effective drugs, quantifying patient needs, monitoring procurement processes and drug quality (427). When making tendering decisions, it is essential to consider the patients' interests and needs and not just prices. MEAT is part of the European legislative Directive on Procurement that states that both costs and quality need to determine procurement decisions (432). When MEATs are successfully identified, tendering has the potential of reducing costs without decreasing quality of products. The scope of this benefit depends, however, on the implementation of tenders (424). The organisation of tendering at a European Union level is of particular interest to smaller member states that otherwise lack bargaining power in the

tendering process but can gain substantial control over the procurement process and access to drugs through international cooperation (425).

Challenges associated with tendering

Despite the potential benefits from tendering, the success of public procurement strategies in reducing costs without harming stakeholders depends on a variety of factors. One key criticism of tendering is that even though it may increase competition in the short-run, by forcing pharmaceutical firms to enclose their bids, competition in the long-run may be minimised. Specifically, awarding a tender to one or a small number of manufacturers creates market power, which in long-run, may drive other manufacturers out of the market thus increasing supplier concentration (438). For example, Germany has seen a substantial increase in market concentration of its top ten suppliers, which increases the risk of an 'oligopolisation of the generics market' in the long-run (439). The fact that only one or a small number of suppliers remains in the market carries an additional risk or supply shortages (428). As was the case in the Netherlands, where substantial gaps occurred, specifically, 3-4% of preferred drugs were not readily available (440). This effect depends partly on the length of the tender, where longer tender periods reduce the likelihood of other suppliers producing the product. This effect might hurt particularly smaller producers that leave the market as a consequence of not being competitive (438).

Price competition may also lead to a reduction in quality of the products if quality assurance is not monitored effectively (428). The rapid decrease in prices from tendering processes may lead to a shift in strategy for pharmaceutical firms. They may start specialising in areas with low price elasticities and smaller market segments. Tendering hence also reduces innovation incentives for preferred drugs (441). Such general equilibrium effects may lead to the adverse effect of tendering of reduced supply of the preferred drug and increased prices in the long-run.

Tendering processes strongly depend on regulation and legal frameworks, the implementation of which is key for its sustainable success (428). If the selection of products in the tendering process is not organised transparently and fairly and if there is discrimination among products in the selection process, this may reduce competition in procurement and lead to higher prices (442). Winning prices in the tendering process are not publicly disclosed. This lack of transparency in the tendering process is particularly critical in the European context and resembles a Prisoner's Dilemma (425). Information asymmetries regarding prices between European countries makes countries reluctant to collaborate in procurement processes fearing that they would lose out on individually agreed discounts even though joint procurement may lead to lower prices overall given the increased bargaining power of countries from cooperation.

Outlook for tendering

At times of rising health expenditures and fiscal strains, tendering has the potential to lower prices for both inpatient and outpatient medicine. From the perspective of public policymakers, it is essential to weigh both public and patients' interests by ensuring access, affordability and quality of drugs (436). Incentivising innovation is another key rationale that needs to be promoted alongside price-reducing efforts. To achieve a sufficient level of innovation, research-based pharmaceutical companies should be considered in the procurement decision.

It is essential to address the multiplicity of interests of various stakeholders in the procurement process. Tendering seems an attractive option for health insurances as it decreases costs substantially. Manufacturers may, however, be disincentivised to produce generic medicines and innovate in areas that are particularly affected by tendering (428). Doctors and pharmacists are also key to the success of tendering. For example, tendering can impact patient-doctor relationships by forcing doctors to prescribe reimbursable medicines, which may not be the patient's preference (437). The potential impact of tendering is subject to each country's regulation, thus policies in this area must take potential negative implications into account (443).

Increasingly countries across Europe are turning to joint procurement, in particular, for medical countermeasures and orphan drugs. The European Directive on Procurement provides the framework for increasing joint procurement efforts. Joint procurement has the benefit of knowledge sharing, increasing bargaining power, preventing short-term supply gaps, and aiding price transparency. Joint procurement is particularly beneficial for small countries, who are responsible for servicing a relatively low number of people (425). Cooperation does, however, require effective communication, trust and commitment between member states, which can be supported by a well-designed legal framework for tendering (435).

6.7.3 International case studies: Procurement of medicines

Netherlands

In response to comparatively high generic prices, five health insurers in the Netherlands adopted tendering in 2005 as part of the Dutch Preference Pricing Policy. Tendering has since expanded significantly across the country.

Tendering criteria in the Netherlands are primarily based on combination of low prices and the best offer. Pharmacists can enter into negotiations with insurers, which involves categories such as quality, medical

and therapeutic benefits and needs and further qualitative factors such as storage, supply conditions, payment terms and frequency of delivery (424).

Medicines are clustered according to active ingredient, dosage form and strength, and tenders are chosen accordingly (434). In general, one company can win the tender and receive an exclusive contract for three to six months with the tender issuing company (444). Evidence on tendering shows that competition increased resulting from the implementation of tendering and that prices of widely used generics collapsed. Prices in the Netherlands decreased by up to 92% compared to pre-preference policy prices (445). This decrease generated savings of €355 million in 2008 and an average price concession of approximately 85% of the retail price before tendering (437). There is no evidence that the market is more concentrated in response to tendering mechanisms due to e.g. withdrawal from the markets by firms. This may, however, be confounded by mergers in the pharmaceutical industry the Netherlands.

Challenges facing tendering in the Netherlands include supply gaps, which was a result of inadequate timing between the announcement of winners and the implementation of the tender. For example, the drug supplier for pravastatin and simvastatin was unable to adequately supply the Dutch market for four weeks (428). Addressing supply shortages within pharmacies resulted in costs of approximately €60 million per year and strong opposition to tendering, particularly by pharmacists (440).

Key stakeholders involved in the tendering process are manufacturers, health insurers, pharmacists and patients. As a result of tendering, health insurers have managed to increase their bargaining power, which has led to lower prices and expenditures. Pharmacists, on the other hand, oppose tendering given they have experienced reduced incomes, high transaction costs from complying with preference of nine different insurers, supply gaps and stocking issues.

Given the impact of tendering on price reductions, the outlook for tendering in the Netherlands in strong. Specifically, fierce price competition, resulting from tendering, is likely to lead to additional saving for pharmaceutical expenditures. However, the success of tendering may be limited if supply gaps continue (440).

Finally, the effect of tendering on key stakeholders needs to be considered, in particular the remuneration model for pharmacists. One option would be to link remuneration of pharmacists to the number of packs sold and on the services provided, which is how it is organised in Germany (440).

Germany

Germany implemented tendering in 2004 under 'Rabattverträge"' which is characterised by fast uptake and implementation (446). Procured pharmaceuticals primarily include those in the ambulatory care, and are mainly comprised of generics. Through tendering, the contracting authority (sickness funds), have been able to increase their bargaining power (437).

The German tendering system relies on several criteria include quality, medical and therapeutic needs, and prices to determine the most economically advantageous tender (MEAT). MEAT does not presume only one winner, rather up to three manufacturers can supply the market for a certain drug (428). On average, the MEAT tender has the right to supply the market for approximately two years.

Tendering was first implemented to lower drug prices that were not included in reimbursement schemes (429). Pharmaceutical prices in Germany are not published publicly, however, price reductions as a result of tendering are likely to be around 90% of the patent expiry prices and close to marginal costs. For example, in 2007, rebate contracts led to a saving of €310 million to insurers, which is equivalent to 1.1% of total expenditures on drugs in Germany (193). Tendering, however, has also led to market concentration, with a smaller number of manufacturers supplying the market. Specifically, concentration of the top ten German seller increased from 91.4 % in 2009 to 93.7% in 2010 to 97% until 2013 (428). A reduction in the number of manufacturers, in the long-run, may led to price increases, however, evidence of this has not yet been determined (439).

Since 2007, pharmacists are obliged to prescribe the rebate drug unless the doctor specifically opposes. This right of doctors to write 'do not substitute' on prescriptions potentially restricts the success of tendering, particularly if patients are reluctant to switch medication (447). Shortages also occurred in the German market due to logistic mismanagement (448).

The main challenge of tendering in Germany is the increased seller concentration and its potential impact on long-term prices. The fact that the German insurance market is dominated by one single provider, the AOK, which make up 41% of the total insurance market, further exacerbates market concentration. The AOK can determine stocking decisions and the concentration of supplier in the market (429). Other than market concentration, tendering also increases administrative costs for dealing with rebate contracts, which potentially offset the savings gain from tendering (439). These administrative costs resulted from legal challenges and litigation cases that also increased administrative costs for pharmaceutical companies (439).

Since drug prices of successful tenderers are only made available to sickness funds, the German pharmaceutical market lacks transparency, which is legally contentious (428). The fact that individual sickness funds operate at a regional level and negotiate rebate contracts individually with pharmaceutical companies exacerbates transparency issues (447). An additional challenge to tendering in the German market is the fact that sickness funds have the right to provide a tender to three providers. The three preferred providers often differ in their sales force. This is often perceived as unfair competition and induces uncertainty to manufacturers about market uptake and penetration (428).

The impact of tendering on patient outcomes in Germany seems to be moderate. Seven per cent of patients and 11% of older patients reported problems (e.g. tolerance) with having to switch to alternative medicines in a survey of 2,500 individuals (428). General practitioners report, however, that in 87.4% of all cases, patients experienced compliance issues when having switch products (428). This indicates that there may be information asymmetries between doctors and patients that prevent patients from switching drugs successfully.

They key stakeholders in the German tendering process are sickness funds who are interested in maximising savings and the AOK as the main tendering body. Manufacturers are guaranteed a market when they win a tender, however, this win is subject to uncertainty given up to three pharmaceutical companies can supply the market. Manufacturers who are excluded from the tender may exit the market or shift manufacturing outside of Europe given the long tender periods in Germany. Pharmacists did not oppose to rebate contracts but still experienced stocking issues particularly with preferred drugs by AOK that needed to be stocked in large amounts. Patients did not oppose preferred drugs since other drugs included more co-payments and preferred drugs were discounted.

The outlook of tendering in Germany potentially involves further cost savings. The increase market concentration can lead to a restructuring of the manufacturing market where manufacturers redirect their research efforts to niche areas and stop producing preferred drugs. Manufacturers potentially also shift their production to products, which are irreplaceable by generics. About 80% of all drugs are sold as ‘aut idem’ meaning a doctor can replace prescriptions with another identical active agent. General equilibrium effects may be problematic in the German market where in the long-run prices increase and supply decreases as supplier start focusing on areas with lower price elasticities (438). Such adverse incentives would be contrary to the initial rationale of tendering to decrease pharmaceutical expenditure and increase access to preferred drugs.

Belgium

Tendering in Belgium was introduced in 2008 for pharmaceuticals in ambulatory care and hospital care. The focus of tendering was first on Simvastatin and hospital care including vaccines, specific therapeutic groups of pharmaceuticals, and pharmaceuticals for military and prisoner population. The main contracting authorities in Belgium are health insurers, pharmacists associations, and trade unions (449).

Belgium issues tenders at a national level and is hence transparent (447). The criteria for tenders include prices but also further qualitative factors such as storage, supply conditions, payment terms, frequency of delivery and packaging. The winner of a tender receives a preferential reimbursement rate of 75% while other versions of the same drug received just 50% (449). Tendering for Simvastatin was implemented in 2007-08, which led to €15 million reduction in costs due to direct savings on Simvastatin, and to a lesser extent, indirect increase in spending. In response to the Simvastatin tender, physicians changed their prescription behaviour and switched prescriptions from Simvastatin to other medicines with a similar therapeutic indication that were not subject to the tendering procedure (447). This adverse shift in demand increased total expenditures on statins by 6.5% thereby offsetting the savings from the Simvastatin tender (448). Belgium experienced further legal issues with manufacturers since the regulation concern successful tenderer was initially unclear. Overall, tendering has been unpopular in Belgium since both generics and originator markets feared severe losses.

The key challenge of tendering in Belgium was the reallocation of demand from Simvastatin to drugs of equal therapeutic indication and resulting cost increases (447). The overall budget impact of tendering in Belgium is ambiguous since marketing efforts were directed at high-cost alternatives of tender winners and prescribing patterns changed (449). The Belgian case of Simvastatin illustrates the potential adverse effects of tendering mechanisms if they are not implemented in a well-established framework. Legal challenges and changes in demand can offset savings from tendering entirely (424). Belgium withdrew its tendering policy for off-patent medicines due to its negative experiences in the Simvastatin case (424).

France[99]

Drugs which are subject to market authorisation from the European Medicine Agency are subject to the following processes. First, They are assessed by the French National Authority for Health (Haute Autorité de santé, HAS), which provides advice to the Government on: a) whether the drug should be included in

[99] Information sources directly from D. Polton (2017).

the benefit basket and the level of reimbursement; and b) the added value of the drug, that is, the drug's progress relative to existing treatments (with a score ranging from I (major improvement) to V (no improvement)). An economic evaluation (cost-effectiveness) is also performed for drugs claiming a high added value (I, II or III) and having a financial impact above a threshold. France is unique in that both the assessment and the appraisal are performed by the HAS and are scientifically drive.

Second, the added value is used in the negotiation of the price by the Economic Committee on health products, that is, the Pricing Committee. The committee is inter-ministerial, with members from the Ministry of Health, the Ministry of Economy, in addition to representatives from social health insurance and voluntary health insurance. Thus, the committee reflects different views about what should be a relevant price. Bargaining takes place in the framework of a four-year collective contract between the Committee and the organisation representative of the industry. One of the provisions of the current contract is that an added value of I, II or III leads to external reference pricing (specifically, using Germany, England, Italy, Spain). Besides the list price, the Committee negotiates managed-entry agreements (MEAs), which are essentially confidential rebates.

Third, once an agreement has been reached between the Committee and the manufacturer, the Ministry of Health takes the decision to include the drug in the benefit basket with the list price set by the Committee.

There may be an additional step if the drug which is being dispensed in inpatient care is very costly. Specially, under normal circumstances, the cost of a drug in inpatient care is included in the DRG system, that is, the lump sum payment by social health insurers to hospitals. However, for very expensive drugs, an additional payment is made on top of the DRG. Until recently these high cost drugs were appraised by a specific committee. Given the rapid growth of these expenditures, stricter rules have been issued in the recent years (i.e. only drugs with an added value of I, II or III, or drugs with a comparator which is already paid separately, can be on the list). This means that for a drug which has a modest improvement (IV) in comparison with a drug financed within the payment per case, the hospital will not receive extra money if the drug is prescribed.

United Kingdom

Tendering for hospital care in the UK has focused on the MEAT (most economically advantageous tenderer) approach since the 1950s, for both branded and generic drugs. MEAT includes considerations

of prices, quality, and medical and therapeutic needs. Low prices are, however, weighed more heavily in the tender decisions than other drug criteria in the UK.

Procured pharmaceuticals include vaccines, pharmaceuticals against communicable diseases and pandemics amongst others. The contracting authority for tendering in the UK is the NHS. The healthcare system and the tendering system is very homogeneous in the UK due to the NHS, which can use its contracting authority for collective purchasing. Traditionally, tendering was mostly used for hospital medicines at end of patent life, but today is also used for general medicines earlier in the patent period (432). Tendering procedures have led to cost cuts of around one third in 10 years without reduced access to medicines in specific pharmaceutical areas (436). An example of such cost cuts are replacement blood treatments for bleeding disorders that were facilitated by increased technologies.

A key challenge for UK tendering mechanisms in the UK is to ensure that it adopts the 2014 European Public Procurement Directive and complies with international cooperation in tendering, despite Brexit (436). To incentivise innovation, it is essential that tendering criteria are not only based on lowest prices but also entail quality measurements as indicated in the MEAT approach. Centralisation in tendering is increasingly important in the UK system, which can result in cost savings and improved transparency.

Norway

Tendering in Norway is focused on hospital care. Procured pharmaceuticals mainly include pharmaceuticals defined in pandemic plans. The contracting authority is the National Procurement Agency that procures all medicines at a centralised level (450).

The Norwegian Drug Procurement Cooperation LIS procures for all publicly funded hospitals on a yearly basis. Tender criteria include criteria such as lowest price and best economic offer based on qualitative factors such as storage, supply conditions, payment terms, frequency of deliver and packaging (450).

Tenders are given to one winner. The public tender process involves a cross-functional group with representatives from procurement agencies, clinicians and technical staff (451). The fact that pharmaceutical procurement is highly centralised in Norway increases buyer power and attracts new entrants into the market. Centralisation enables competition and circumvents problems of transparency when procurement is organised regionally. Centralisation by the LIS further enables cost savings since purchase and delivery agreements of pharmaceuticals are prepared jointly with state-owned hospitals (452).

LIS tenders led to a price reduction of 28% on average for Norwegian hospitals compared to statutory maximum prices. Cooperation contributes to more efficient and better use of the medicines in hospitals (453). The efficiency of LIS enables Norway to achieve lower prices compared to other European countries due to centralised tendering. Centralisation achieves more power for national procurement agency and Norway additionally implemented new tendering procedures (424).

6.7.4 Procurement of medicines in Austria

Overview

Austria's pharmaceutical system is characterised by the interplay of several actors. The Ministry of Health and Women's Affairs is responsible for reimbursement and pricing decisions within the country. The advisory councils and commissions in the pharmaceutical sector are also based at the BMGF. Figure 149 outlines the pharmaceutical system in Austria, which covers both the inpatient and outpatient sector (please note, this diagram has been taken directly from GÖG).

Authorisation and classification (all drugs)

The Austrian Federal Office for Safety in Health Care (Bundesamt für Sicherheit im Gesundheitswesen, BASG) is subordinate to the BMGF and is in charge of granting market authorisation for drugs, as well as classifying pharmaceuticals according to their prescription status. BASG sits within the Austrian Agency for Health and Food Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit GmbH, AGES). Specifically, within AGES Medizinmarktaufsicht (Austrian Medicines and Medical Devices Agency), which is a subdivision responsible for the pharmaceutical agenda. A number of criteria are used to assess whether a drug is authorised or not, namely quality, safety, efficacy (as outlined within the Directive 2004/27/EC) and the Austrian Medicines Act.

AGES, in consultation with the Prescription Committee and the Restriction Committee (located within BMFG), has ultimate responsibility for decisions regarding prescription, dispensing requirements, whether a medicine fulfills the appropriate criteria, as well as pharmacovigilance (i.e. detection, assessment, understanding and prevention of adverse drug effects) (454).

Pricing at ex-factory price level (outpatient)

The BMGF, which receives assistance from the Pricing Committee, is responsible for pharmaceutical pricing activities. The Pricing Committee (see Figure 145), which receives support from the Pharma Price

Information (located at GÖG), is tasked with calculating the EU average price[100] for pharmaceutical products reimbursable within the outpatient sector (Erstattungskodex, EKO) (using external reference pricing). If the price of a drug is considered too high, the BMGF, according to the Price Act (Preisgesetz), has the right to introduce an official price-fixing process. If the process does not begin within six weeks, the proposed manufacturer price will be implemented. Prices of drugs, which a submission for EKO has not been made, are notified to the BMGF. In this circumstance, the BMGF does not have control over the drug's price.

Figure 145: Pricing Committee

Role
The Pricing Committee, which meets once a month, assists the BMFG in pricing medicines.
Representatives
The BMFG acts as the Chair of the Pricing Committee, which includes representatives from the following federal ministries: Economy, Family and Youth; Finance; Agriculture, Forestry, Environment and Water Management. Additional members includes, the Chamber of Commerce, the Chamber of Labour, and the Presidential Conference of the Chambers of Agriculture.
Law
Activities undertaken by the Pricing Committee are governed by the Price Act (Preisgesetz).

Source: (455)

Amendments to the ASVG in May 2017 (made available on 24th April 2017) require the Pricing Committee to determine the EU average price within six months of receiving the application for inclusion in EKO (456). The price is revised after 18 months, and again at 24 months. Despite entering into force in May 2017, changes to the ASVG have been applied to all new submissions into EKO since April 2017, with the exception of those in the 'No Box' category (i.e. where the manufacturer does not apply for inclusion within EKO) (described in subsequent section).

[100] The EU average price can only be calculated if the on-patent medicine is marketed in at least half of the EU member states, and in at least two member states for generics.

Pricing at ex-factory price level (inpatient)

For medicines outside the outpatient sector, manufacturers are free to set their own prices. The BMGF therefore does not have control over these prices, however, it is notified when prices changes occur or when a drug is removed from EKO (455).

Pricing at wholesale and pharmacy price level (outpatient)

With respect to the wholesale pricing, the pricing is regulated by law and characterised by regressive mark-up schemes, which applies to all medicines. There exist two different schemes; one for medicines in the green and yellow boxes (see 'Reimbursement of pharmaceuticals (outpatient)'), and one for the remaining medication (as regulated within the *Verordnung der Bundesministerin für Gesundheit und Frauen über Höchstaufschläge im Arzneimittelgroßhandel*, 2004) (457). For an overview of each scheme relating to wholesale mark-ups, please refer to Figure 146 and Figure 147, which have been taken directly from the *PPRI/Pharma Profile 2012* document authored by Zimmermann & Vogler (455).

Figure 146: Wholesale mark-up scheme for products within EKO's yellow and green boxes

Ex-factory price	Maximum mark-up as % of ex-factor price	Pharmacy purchasing price (€)
€0.00-6.06	15.5%	-
€6.07-6.22	-	€7
€6.23-12.11	12.5%	-
€12.12-12.32	-	€13.62
€12.33-53.78	10.5%	-
€53.79-54.77	-	€59.43
€54.78-181.68	8.5%	-
€181.69-184.22	-	€197.12
€184.23-339.14	7.0%	-
€339.15+	Fixed amount of €23.74	-

Source: *(455)*

Figure 147: Wholesale mark-up scheme for remaining medicines (i.e. not within yellow and green box)

Ex-factory price	Maximum mark-up as % of ex-factor price	Pharmacy purchasing price (€)
€0.00-6.06	17.5%	-
€6.07-6.21	-	€7.12
€6.22-12.11	14.5%	-
€12.12-12.33	-	€13.87
€12.34-53.78	12.5%	-
€53.79-54.74	-	€60.50
€54.75-181.68	10.5%	-
€181.69-184.17	-	€200.76
€184.18-339.14	9.0%	-
€339.15+	Fixed amount of €30.52	-

Source: *(455)*

In addition, there are two regressive mark-up schemes which apply to community pharmacies. The first concerns 'privileged customers', for example, social health insurance carriers, Länder, or not-for-profit hospitals. The second scheme ('basic scheme') applies to 'private customers', whereby an additional 15% mark-up is applied. Both schemes are regulated by the Arzneitaxe. As is the case for wholesale mark-ups, pharmaceutical mark-ups are staggered across different price brackets (455).

Pricing at wholesale and pharmacy price level (inpatient)

Manufacturers launching a new medicine within a hospital only, are free to set their own price. The final price paid by individual or groups of hospitals (i.e. joint purchasing body, particularly for high-cost medicines) is subject to a tender process (as previously described) (422).

Reimbursement of pharmaceuticals (outpatient)

As previously discussed, drugs wholly reimbursable by social insurance must apply for inclusion within EKO. The final decision on whether a drug is reimbursed or not is taken by the HVSV, and is based on recommendations from the Pharmaceutical Evaluation Board (Heilmittel-Evaluierungs-Kommission, HEK) (which includes representatives from social insurance). Specifically, the HVSV must make a decision on

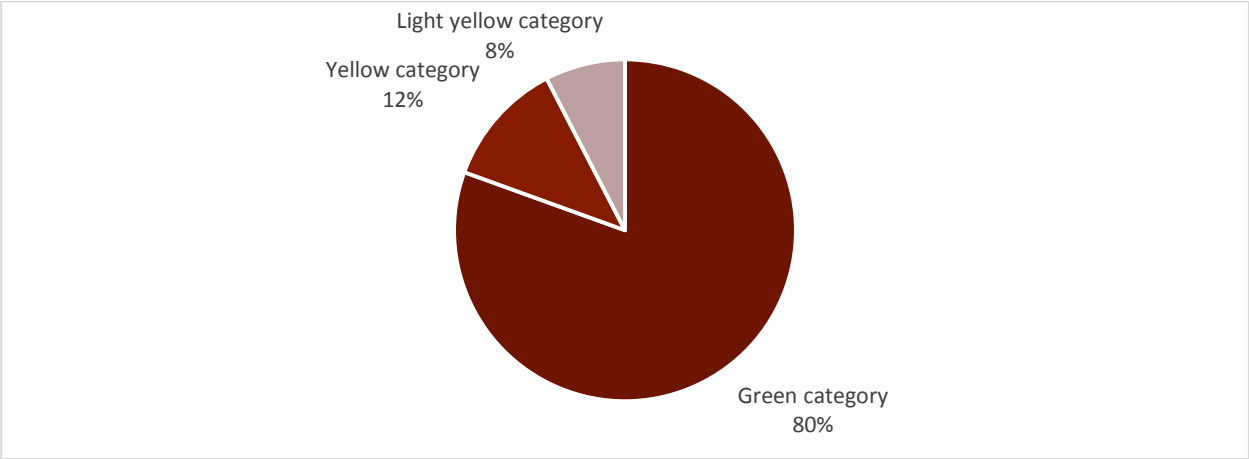
whether a drug is reimbursed within 90 days of receiving recommendations from the HEK. The HVSV is also responsible for publishing the reimbursement code (EKO) annually, with frequent updates made available online (279).

The EKO includes drugs that have been approved by the HVSV as being available and reimbursable by social health insurance carriers. Drugs within the EKO are assumed to have positive therapeutic effects on patients and can be broken down into the following groups:

- All new drugs applying for inclusion into the EKO first enter into the red box (§31 Abs. 3 Z. 12 lit. a ASVG) which are then re-distributed to either green or yellow boxes within 90 days, unless price is also considered, in which case the time period can extend up to 180 days. Insurees wishing to use drugs within the red box, must obtain prior approval from an insurance carrier's head physician. Finally, the drug will be removed from the red box if rejected by the HVSV.
    - The green box includes all medicines that quality for automatic reimbursement and can be prescribed by any contracted physicians (80% of all drugs within EKO, as of 2015) (§31 Abs. 3 Z. 12 lit. c ASVG). Prices of medicines within the green box must fall below the EU average price.
    - The yellow box contains medicines considered to have additional therapeutic value. Unlike the green box, an ex-ante approval from the social insurance carrier's chief physician must be sought from the prescribing doctor (12% of all drugs within EKO, as of 2015) (§31 Abs. 3 Z. 12 lit. b ASVG). The maximum price of a drug in this category is the EU average price.
    - The light-yellow box includes drugs which can be freely prescribed for certain conditions, however, prescription must be accompanied by written documentation (8% of all drugs within EKO, as of 2015) (279). The maximum price of a drug in this category is the EU average price.
    - In addition to the 'boxes' outlined above, there exists a 'no box' category containing medicines manufacturers do not submit to EKO.

For medicines within EKO, patients are required to pay a fixed flat-rate fee of €5.85 per drug packet, however, certain vulnerable groups, as outlined in section 5.3, are exempt. For non-exempt groups, OOP spending on pharmaceuticals is capped at 2% of the individual's net income.

Figure 148: Breakdown of EKO codes by category (number of drugs) (n=5,002 in 2015)



Source: Data based on Lesistungbericht (2015), HVSV

In regard to 'follower' medicines (i.e. 'me too' drugs or generics) applying for subsequent inclusion in EKO, automatic price reductions are enforced. Specifically,

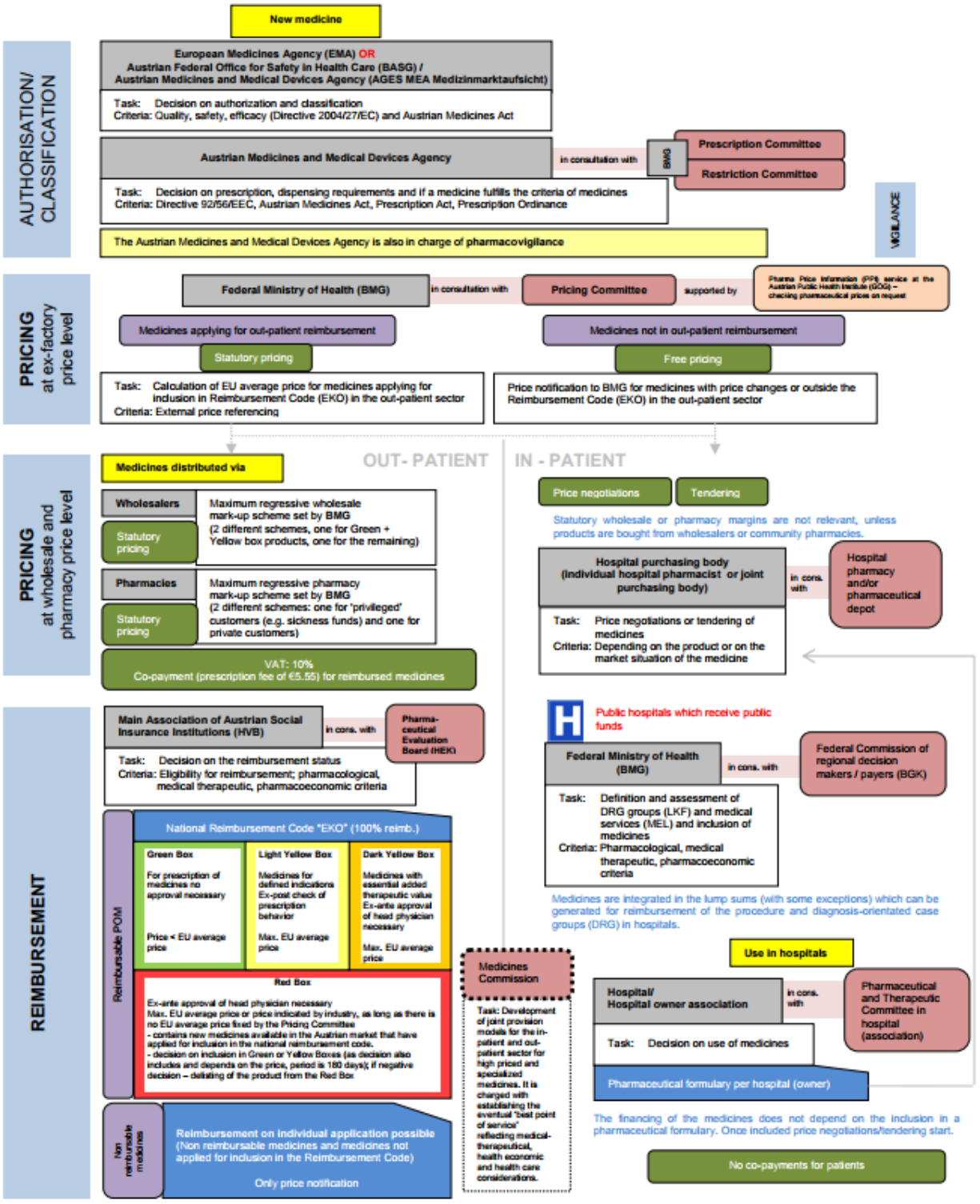
- The first follower must be priced at least 48% below the price of the original product
- The second follower must be at least 15% lower than the first follower
- The third follower must be at 10% lower than the second follower.

In addition to the above, the originator's price must be reduced by at least 30% within three months of a generic entering the market.

Changes to EKO will be implemented from 1 January 2018. Specifically:

- The prices of medicines that did not apply for inclusion within EKO, will not be able to exceed the EU average price, given sales in the previous year were in excess of €750,000. If the drug price is found to be above the EU average price, the manufacturer will be required to pay back the difference upon request of a social health insurer within six months. If an EU average price does not exist, the manufacturer's price will apply on a provisional basis.
- For medicines within the yellow and red boxes (which cover most on-patent drugs), price reviews will be undertaken 18 months once an initial price has been set, and every two years from then on.
- The overall price reduction of generics will increase from 60% to 65%, while for biosimilars the price reduction will reach 52.5%
- Drugs within the green box cannot be priced 30% higher than the lowest-priced equivalent at ATC level 5 (458).

Figure 149: Flowchart of Austria's inpatient and outpatient pharmaceutical sector



Note: The Medicines Commission no longer exists.

Reimbursement of pharmaceuticals (inpatient)

As outlined in section 6.2, hospitals within Austria are reimbursed via DRGs (i.e. the LKF model). Reimbursement for medicines, with the exception of oncological drugs, are integrated into DRG lump sum payments. Oncological drugs are excluded given these medicines are classified within their own diagnosis-orientated case group. Unlike the outpatient sector where a flat rate payment applies per packet, patients are not required to pay OOP for drugs (455).

No set list for the types of drugs to be offered in hospitals is provided. Rather, each individual hospital (or hospital association) is responsible for developing their own formulary (455).

International collaboration within the pharmaceutical sector

Rising healthcare costs and poor economic conditions have placed increasing strain on government budgets. Given health, including pharmaceuticals, comprise a significant component of public expenditure, there have been increasing efforts to reduce costs and stabilise spending on drugs. A popular method adopted by various European countries, including Austria, is to enhance collaboration with neighbouring countries. Such relationships can increase economies of scale thus lowering transaction costs. It also provides countries with greater leverage during negotiations, which in turn lower drug prices.

Although not considered a joint procurement initiative, in 2016, Austria entered into the BeNELuxA Agreement, along with Belgium, the Netherlands and Luxembourg (459,460,460). The BeNELuxA encourages each of the aforementioned countries to collaborate across the following areas: negotiating drug prices, HTAs, horizon scanning, and exchange of information on pharmaceutical practices. The purpose of entering into this voluntary collaboration is to improve national drug security by ensuring sufficient quantity of certain drugs at a fair price (i.e. vaccines, antivirals, antitoxins) (460,461).

6.7.5 Policy options: pharmaceutical expenditure and procurement of medicines

Pharmaceutical expenditure

Several recommendations are provided to help Austrian policymakers address growing pharmaceutical expenditures. These are either academic- or policy-oriented in nature. Please also see section on HTA, which also plays a role in containing pharmaceutical expenditure.

Evidence on drivers of pharmaceutical expenditure

The existing evidence appears to suggest that growing pharmaceutical expenditures are being driven primarily by increases in the price of branded medicines. Austrian health authorities should nevertheless prioritise research efforts that are designed to further examine how different components of the Austrian pharmaceuticals market are contributing to growing pharmaceutical expenditures in the country.

Such studies should examine cost and value trends for generic and branded pharmaceutical products, utilising unit-level pricing and volume data. Since medicines used in hospitals appear to be more expensive than those delivered through outpatient settings, such studies should also evaluate the impact from the prescription setting. This may involve quantitative, pharmaceutical pricing comparisons, with stratification by type of medicine and prescription setting, as well as availability and prescribing behaviour analyses that examine both the availability of medicines, and the reasons underlying pharmaceutical prescribing behaviours.

Pharmaceutical prices are often given in terms of list prices, rather than transaction prices that are more directly relevant to payers and patients. Much of the existing academic evidence is in fact based on the former, raising questions as to how well it reflects the experience of payers and patients. To the extent that it's possible, comparative pricing studies should therefore compare pharmaceutical cost trends based on list prices, as well as transaction prices.

Policy initiatives

There is growing recognition that external reference pricing (ERP) systems may incentivise initial entry in high-price markets, and delay or prevent entry in lower-income countries. This strategy may propagate high drug prices throughout referenced markets, and is further compounded by the fact that ERP systems often reference list prices rather than transaction prices that include negotiated discounts and/or rebates.

ERP systems should therefore consider the impact overlooking confidential discounts, which are now widespread in European and North America (462).

Austria should evaluate the design of its ERP system within this context, particularly since its domestic ERP system, which operates within the outpatient sector, targets in-patent medicines that often have few if any competitors (463). If they are to be used in the in-patent drug market, ERP systems should reference from a basket of countries that encompasses low and high pricing tiers. To the degree that it may be possible, Austria should also consider moving away from the use of list prices in its ERP systems. This could be achieved by enhancing information exchanges with health insurance carriers in neighbouring countries, particularly in regard to high-cost medicines. For example, through the BeNeLuxA agreement (as previously discussed), as well as the Medicine Evaluation Committee (MEDEV) of the European Social Health Insurance Forum. A move away from an ERP system may be of particular importance, given recent initiatives to rationalise spending on non-reimbursed medicines by referencing against European average prices.

Austria should consider modifying domestic regulations on statutory prescription drug price cuts so that they are linked to patent expiration rather than generic drug entry. By doing so, Austria may prevent anticompetitive behaviours and increase efficiency in prescription drug spending.

Finally, new medicines may not always bring additional health benefits to patients (464). To increase efficiency in pharmaceutical spending, Austrian policymakers should consider the use of financial- or performance-based managed entry agreements (MEAs), particularly where there is uncertainty over the clinical benefits of new medicines. By providing a platform for developing special terms of reimbursement, these policy instruments can be used to improve therapeutic affordability, decrease any clinical uncertainty that may exist—especially if coupled with stipulations for evidence development—and, if linked with clinical activity, improve value-based health spending.

Generic policies

To enhance the role of generics in the Austrian outpatient pharmaceutical sector, several policies have been introduced. Namely, generic price links (as previously discussed), prescription monitoring by health insurance carriers, as well as educational campaigns for patients and prescribers (465). Despite these efforts, Austria is considered as a 'second tier' country in this regard, lagging behind countries such as the UK, the Netherlands, Germany and Denmark (466).

It is therefore recommended that Austria consider implementing additional generic policies such as INN (International nonproprietary name) prescribing (i.e. where drugs are prescribed according to their active ingredient as opposed to their brand name) and generic substitution (i.e. where prescriptions for branded drugs are automatically substituted for a generic, given one is available). Generic substitution is the primary demand-side policy to enhance the use of generics in Europe, as evidenced by the number of countries in which it is compulsory or allowed (see Table 87). The primary objective of generic substitution is to contain costs by increasing the consumption of cheaper, generic products. However, it is important to note that there exist other policies to enhance generic consumption, such as financial or non-financial incentives for prescribers. For example, the UK, which has the lowest ex-manufacturer prices for generics and one of the highest rates of generic consumption, does not employ generic substitution, choosing rather to rely on other policies such as INN prescribing (encourage, not enforced), and incentives for prescribers (physicians and pharmacists) (467,468).

Table 87: Countries who employ INN prescribing and generic substitution

Generic policy	Compulsory	Allowed
INN prescribing	• France • Greece • Portugal • Spain	• Belgium • Germany • UK • Luxembourg
Generic substitution	• Germany • Sweden • Spain • Portugal • Norway • Finland	• Czech Republic • Denmark • France • Hungary • Italy • Latvia • Turkey

Source: (467)

Before such policies can be introduced, appropriate structures need to be put in place. Specifically, by increasing the role of pharmacists to promote the 'safe, effective and efficient use of drugs', particularly for those with multiple chronic conditions (e.g. by reducing drug-related adverse events and promoting adherence) (469,470). In the Netherlands, for instance, pharmacists are able to provide emergency prescription refills, renew and extend prescriptions, and change drug/dosage formulation. Further, England, which arguably is the most advanced in this area, also allows pharmacists to prescribe for minor

ailments (e.g. morphine, amphetamines, clonazepam),[101] initiate prescription drug therapy, as well as order and interpret laboratory tests (469,470).

Increasing the role of pharmacists has the added benefit of relieving some of the burden placed on physicians who are required to keep up to date to changes in the EKO (e.g. changes in price) in order to prescribe economically (as outlined within the Richtlinien über die ökonomische Verschreibweise von Heilmitteln und Heilbehelfen, RöV 2005). For example, INN prescribing could be handled solely by pharmacists.

Advanced generic policies in the outpatient market can contain pharmaceutical expenditure. For example, without such policies, patients who are prescribed originator drugs within hospitals are likely to continue using such drugs upon being discharged (i.e. within the outpatient sector) (465).

Procurement of medicines

In addition to the policies outlined below, please refer to the section on HTA, given the role of HTAs in determining which medicines should be procured and thus reimbursed through social health insurance.

Interface management

The dual financing of healthcare also applies to pharmaceuticals where inpatient and outpatient drugs are financed by hospitals and health insurance carriers, respectively. This arrangement is problematic for many reasons, including:

- Fostering an environment that encourages cost-shifting between the two sectors, particularly for high-cost medicines (noting that this issue has been partly addressed by the establishment of the Medikamentenkommission (Healthcare Reform 2013), who handles cases where inpatient and outpatient sectors cannot agree who is responsible for reimbursement; largely related to high-cost medicines)
- Poor coordination of pharmacotherapy for patients moving from the inpatient to outpatient sector (or vice versa)

[101] Pharmacists can prescribe any controlled drugs on within Schedules 2,3, 4 or 5 (excluding diamorphine, dipipanone or cocaine for the treatment of addiction) (see: https://www.gov.uk/government/publications/controlled-drugs-list--2/list-of-most-commonly-encountered-drugs-currently-controlled-under-the-misuse-of-drugs-legislation) (471,472).

- Patient uncertainty given EKO and hospital formularies may not be aligned, however, in theory this should be the case (as outlined within the 15a agreement of 2005 healthcare reform; §24(2) KaKuG) (see Figure 150) (465,473).

Debates regarding issues arising from Austria's dual financing system, specifically in regard to its impact on pharmacotherapy, are not new. For example, Vogler *et al*. (2014) noted that there 'has been increasing awareness of the need to learn about hospital-related pharmaceutical policies and to improve the management of pharmacotherapy at the interface of the inpatient and outpatient sectors' (465).

It is therefore recommended that further effort is undertaken to improve 'interface management' between inpatient and outpatient pharmaceutical sectors (i.e. building upon strategies outlined in Figure 150). For example, by:

- Developing a joint budget for pharmaceuticals across the spectrum of care, however, as detailed throughout this report, this policy is unlikely to be implemented in the near future. As a first step, however, serious consideration could be given to a unified budget for high-cost medicines to avoid significant cost-shifting.
- Enhancing the role of the Medikamentenkommission to include formal communications on all medicines, not just medicines which neither inpatient nor outpatient sector are willing to take responsibility for (474).
- Ensuring information regarding drug prescriptions within in ELGA are digestible for potential prescribers (i.e. physicians working in either/both inpatient and outpatient sectors) (refer to policy options regarding IT for further details).

Figure 150: Projects to improve interface management between inpatient and outpatient pharmaceutical consumption

Discharge letter

Within the 15a agreement of 2005 healthcare reform (§24(2) KaKuG), when a hospital discharges a patient, they are required to take into account rules outlined within EKO and the RöV, as applied within the outpatient sector. Within the discharge letter, a comment that there is no objection for switching recommended pharmaceutical to a generic, if available. However, as outlined by the PHIS Report (2009), failing to do so is not associated with a penalty.

Hospital medical staff (Medical Service)

Medical staff from social health insurance are placed within hospitals to provide assistance in regard to the provisions of drugs in the outpatient sector. This service aims to improve the transition of patient medical therapies between the inpatient and outpatient sector.

Transition nursing (Überleitungspflege)

Interface management is also enhanced by transition nursing, and case management coordinators.

Source: (473)

Summary of policy options for pharmaceutical expenditure and procurement

In regard to pharmaceutical expenditure, the following three policies are recommended. First, efforts to build international relationships should be encouraged in order to gain a better understanding of transaction prices associated with drugs in the outpatient market (which currently relies on ERP using list prices). Second, consideration should be given to modifying domestic regulation on statutory prescription drug price cuts so that they are linked to patent expiration as opposed to generic drug entry. Finally, to limit risk on behalf of the payer and to promote efficient use of resources, the implementation of MEAs is advised.

Further efficiency gains could be achieved through the implementation of more rigorous generic policies. To assist the implementation of generic policies and relieve administrative burden from physicians, consideration could be given to enhancing the role of pharmacists, which would follow trends in countries such as the UK and the Netherlands. Example generic policies include INN prescribing, generic substitution, and could also extend to incentives to encourage physicians to prescribe generics (e.g. linking payments to the proportion of prescriptions comprised of generics).

Lastly, it is recommended that further efforts are made to improve interface management between inpatient and outpatient pharmaceutical sectors. For example, via joint budgets, enhancement of the Medikamentenkommisison, and ensuring ELGA is fit for purpose.

Legal considerations

Even though no particular constitutional impediments have to be faced with respect to this option, some legal amendments would be required, for instance, pharmacists are not allowed to prescribe medicines themselves.

7 Public health and disease management

Chapter 7 explores topics related to public health and disease management. Specifically, the chapter covers ill-health prevention, health promotion and health literacy, in addition to case and care management, as ways to improve patient outcomes.

7.1 Health prevention, promotion and literacy

7.1.1 Overview

Health literacy is generally defined as the knowledge, motivation and competence to find, understand, appraise and use information in ways which promote and maintain good health. By improving people's access to health information and their capacity to use it effectively, health literacy can play a significant role in the empowerment of individuals, improvement of quality of life and reduction of inequities in health (475–477). The following section summarises recent efforts in strengthening health literacy in Austria and draws on good practice examples from the Netherlands and England.

7.1.2 Health literacy in Europe

The European Health Literacy Project

Background

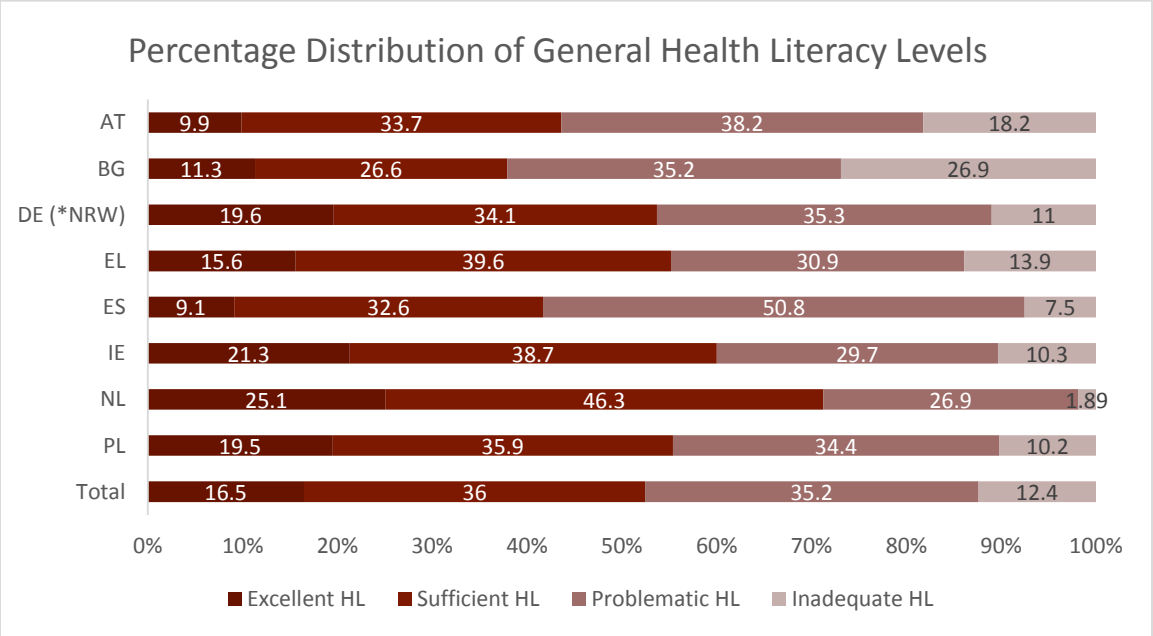
Despite playing a key role in health promotion, there is limited information about the status of health literacy in Europe (478). The European Health Literacy Project (HLS-EU) was initiated in 2011 to address these information gaps. As part of the initiative, eight EU member states (Austria, Bulgaria, Germany[102], Greece, Ireland, the Netherlands, Poland and Spain) took part in a survey to assess and compare health literacy competencies between countries (478). The survey found that health literacy levels varied substantially between these member states, reflecting health policy challenges of different degrees. Furthermore, the study highlighted a social gradient that needs to be considered in the design of effective public strategies. For instance, certain population groups, such as the elderly and those with lower education levels or social status, had higher proportions of people with limited health literacy (479).

[102] The survey only included the federal state North Rhine-Westphalia.

Austria's performance in the HLS-EU

Notably, Austria scored below the EU-8 average, with more than half of the surveyed population showing problematic or inadequate levels of health literacy in the areas of health care, disease prevention and health promotion (please see the figure below for an overview of the countries' performances in the HLS-EU). Specifically, only 9.9% of the Austrian study population had excellent general health literacy skills compared to the EU-8 average of 16.5%, and 25.1% in the Netherlands. Concurrently, 18.2% of the surveyed participants in Austria had inadequate general health literacy, which is significantly higher than the EU average of 12.4% and the Dutch score of 1.89%. However, significant differences also persist on a regional level in Austria. Findings show that merely 36% of residents in Vorarlberg had limited health competencies, as compared to almost twice as many in Styria (i.e. 63.3%) (479).

Figure 151: HLS-EU distribution of general health literacy levels across countries

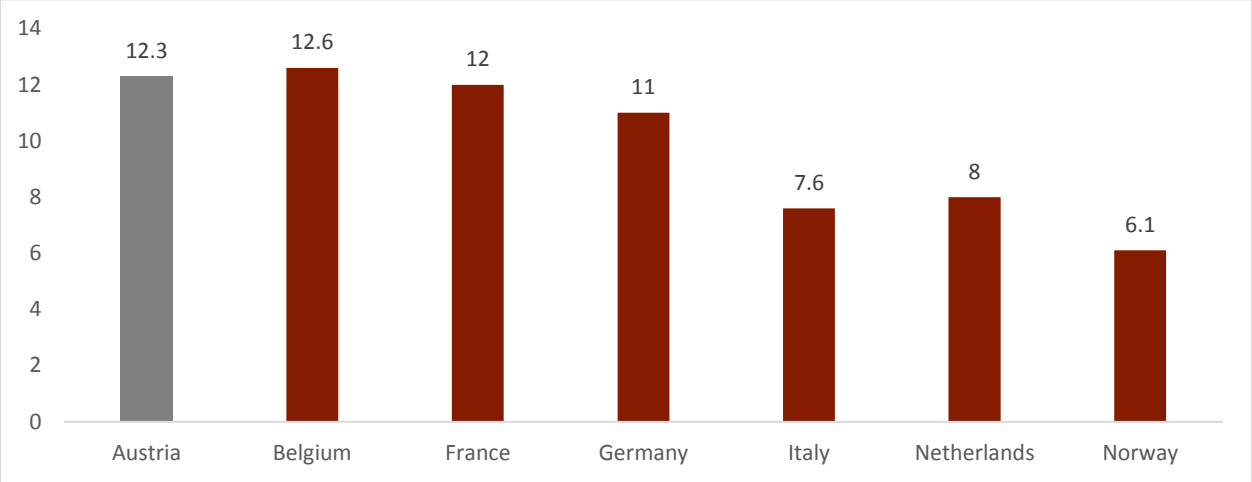


Health behaviours, health outcomes and health care use in Austria

Limited health literacy skills can have a significant impact on health behaviours, health outcomes and health care use, which is also captured in the strong association between low health literacy and poor self-assessed health (480). Some of the detrimental effects of low literacy levels on health care use may be reflected in Austria's high hospitalisation rates. For instance, in 2014, 26,276 people per 100,000 inhabitants were hospitalised for at least one night, resulting in more hospitalisations than in any other

OECD country (481). In addition, the low health literacy levels may be associated with unhealthy behavioural patterns. With only 11.5% of respondents reporting daily physical exercise, the rate is substantially lower than the European average of 26.2% (479), However, in spite of the low competency levels in Austria, no significant deviations from the EU average were observed for alcohol consumption and smoking among adults. By contrast, the share of adolescent smokers is significantly higher in Austria than in other European countries. For instance, the relative share of 15-year olds, who smoke at least once a week, is with 27.3% significantly higher than in other countries like Germany or Switzerland, where the share is 14.9% ad 16.9%, respectively.

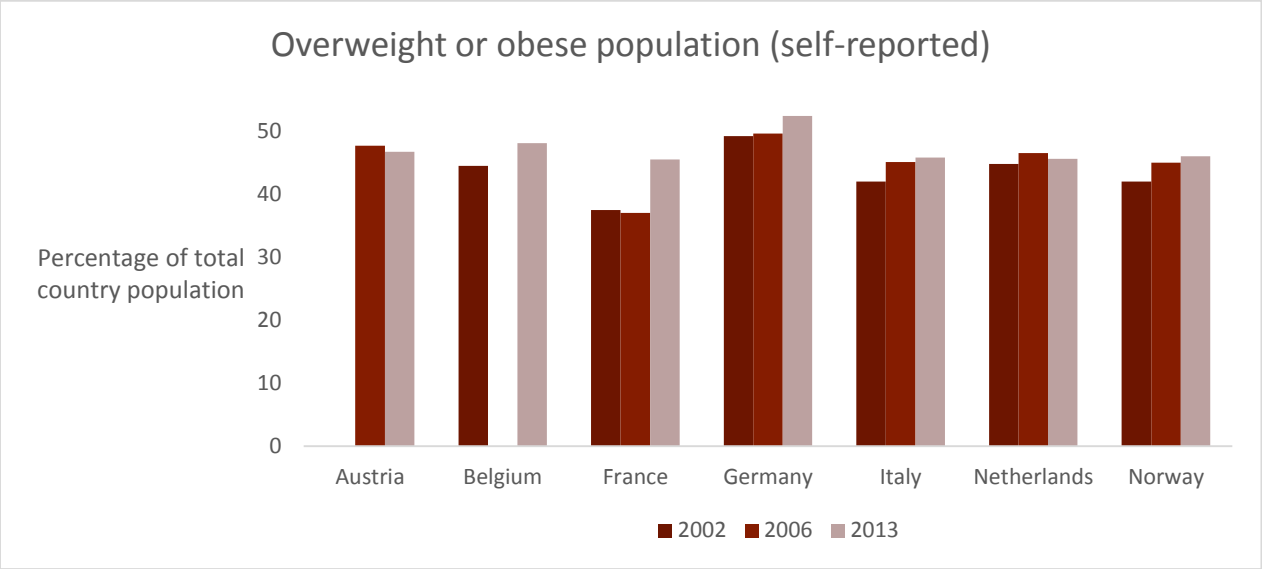
Figure 152: Alcohol consupmtion of individuals aged 15 years and older across European countries (litres per capits (15+))



Source: *OECD Health Statistics 2016*

Moreover, the share of men and women, who are overweight or obese, continues to increase. For instance, in 2012 17.9% and 9.7% of women have reported overweight and obesity, respectively, and the number rose to 10.7% and 20.6% in 2016. In contrast, the share of men, who are overweight, slightly decreased from 37.4% in 2012 to 37.2% in 2016, while the obesity rate decreased from 14.9% to 13.4%. However, compared to other countries, Austria has the lowest share of obese people in Europe (i.e. 20.2% of the population compared to the EU average of 25.7%) and the average BMI tends to be in the normal range, with 45.5% reporting a normal BMI compared to only 38.8% in Europe (please see the figure below for a comparison with other European countries) (479).

Figure 153: Overweight or obese population (self-reported) across European countries



Source: *OECD Health Statistics 2016*

Entities and practices promoting health literacy

Austria

With the aim to further promote health literacy competencies, some countries have established platforms and advisory bodies at a national level (482). For example, in line with the National Health Goals and the Health Promotion Strategy, the Ministry of Health Federal initiated, in collaboration with Health Commission, the Austrian Platform for Health Competence (*ÖPGK*) in 2014 (483). The main objective of the platform is to support the nationwide and sustainable attainment of the third National Health Goal, which aims to improve health literacy in the population, as well as the framework conditions for it and the provision of information. Measures for the implementation of the third goal include the following: (1) measures to improve health competency among adolescents, people of working age and the elderly, with particular attention to vulnerable groups, were set up, (2) the aforementioned measures reach the respective population groups, and (3) the relevant institutions and organisations at federal, state and municipal level are connected in a structured form. In addition, the Health Target partners (*Bundeszielsteuerungspartner*) have stipulated that the proportion of Austrians with 'adequate' and 'excellent' health competences in the overall HLS-EU index should be improved to 55% (i.e. operative objective 8.3.2). As part of the overall framework of the health goals, it was promulgated that 50% of the

financial resources of the Health Promotion Funds (*Gesundheitsförderungsfonds*) were to be used for prioritised goals, including health competency, for the period 2013 to 2016.

The five key functions of the ÖPGK encompass the support and improvement of long-term health literacy in Austria; the fostering of joint learning, network structures, collaborations and exchange of knowledge; the bridging and alignment of measures between politics and society; increasing comprehension, knowledge transfer and innovation; and lastly, the development of measures for monitoring, reporting, transparency and quality control (484). A prospective timeline until 2032 was foreseen for the ÖPGK, including regular evaluations of and adaptions for continuous development of the entity. For the year 2017, the following two areas were prioritised: qualitative written health information and quality of conversation in the health system.

In addition, the online self-information portal on health, *Gesundheit.gv.at*, was set up by the Ministry of Health to collate and provide an overview of relevant information on health promotion and ill-health prevention to the public. Information is available on healthy living, such as physical exercise, nutrition and mental health, as well as on specific diseases, including cancer and cardiovascular diseases.

Netherlands

Similarly to Austria, the Netherlands have initiated a platform for health literacy in 2010. The goals of the so-called National Alliance for Health Literacy are to improve healh literacy competencies and social inclusion (485). The alliance comprises more than 60 member organisations that represent patients, providers, health institutions, insurances, academia and the business community. Vital parts of its strategy include the promotion of health literacy courses and training programmes among clients and patients. In addition, the alliance supports health professionals with identifying and addressing health literacy issues in patients. It is also involved in work on making written, digital and oral health communication understandable to the general public (485).

Notably, the Dutch strategy to improve health literacy involves multiple stakeholders. Besides the alliance, these include patient groups and the legislative body. The patient groups, which tend to form alliances based on specific diseases, are well organised and represented by an umbrella organisation for patients (486). This organisation has considerate negotiation power in relation to health care and insurance providers. For example, at an institutional level this is reflected in the negotiations regarding the implementation of patient-friendly measures between the patient councils and management of providers (486).

In addition to the active work and lobbying by patient groups and the association, legislation plays a vital role in strenghtening efforts to improve health literacy. For example, in the Netherlands patient rights are defined in legislation, which specifies that health care providers must provide proper understandable information, e.g. regarding treatment (487). Additionally, providers must receive a patient's approval before treatment can be provided. Legislation is continously enhanced through contributions by the patient- and consumer organisations. However, insurance providers can contribute to this development as well. For instance, health insurers can request in their contracts that providers pay particular attention to vulnerable groups and imrpove health communiaction, if it is associated with cost-reductions (487).

England

Novel policies to foster health literacy are also underway in England. The NHS England and Public Health England have made investments in innovative projects to develop, test and implement a range of practical interventions to improve the former (488). Some of these activities will include an evaluation of medical staff training in different settings, as well as testing a module on health literacy in the higher education setting (488). The NHS England also supports other projects in this area, such as funding the Health Literacy Organisation. The aim is to curate a collection of health literacy resources in order to facilitate the access to information for practitioners (489).

In England particular emphasis is placed on improving health communication. As part of these efforts, the so-called Information Standard Certification Scheme was introduced. The scheme aims to ensure that organisations produce evidence-based health care information for the public, which is clear, accurate, balanced and updated (490). Furthermore, good health communication practiced by doctors plays a key role in helping patients develop their health literacy skills (491). Several studies have found that doctors do not necessarily adjust their communication, even though patients differ in their levels of health literacy (492). Therefore, several concrete steps must be taken to improve communication between doctors and patients. These include, for example, making sure that doctors correctly establish the patient's level of understanding at the beginning of the conversation; speaking slowly, avoiding jargon and asking patients to repeat critical information ('teach back') (491).

Health literacy programmes for migrants and refugees

Austria

The clear provision and dissemination of information could also play a significant role in reducing health disparities between population groups. For instance, findings show that persons with a migration

background living in Austria tend to report worse self-assessed health than native Austrians (493). They are also less likely to make use of preventive and health promoting measures. Instead, persons with a migration background are more likely to visit hospital outpatient departments than GPs or specialists (493). This may be due to limited knowledge of the Austrian health system and access to primary care, language barriers, fear over discrimination, and lack of social networks, among other reasons.

In order to improve access to care for individuals with a migration background, 12 European countries, including Austria, have joined in a pilot project called *The Migrant Friendly Hospitals Initiative*. The initiative is a collaboration between health experts, NGOs, and hospitals with the goal to further create awareness of migrant-friendly, culturally sensitive health care and promotion (494). It employs similar culturally adjusted communication strategies, as described below in England and the Netherlands.

Netherlands

Given the similar concerns in the Netherlands, the Dutch National Centre of Expertise on Health Disparities (Pharos) focuses on strengthening the primary care system in disadvantaged neighbourhoods (495). Concurrently, it also promotes the involvement of migrants and persons with lower education levels in patient organisation. Another key focus of Pharos is fostering the safe and responsible medication use among migrant patients. For example, in collaboration with the Dutch Association of Pharmacists (*KNP*), Pharos aims to complement pharmacist's guidelines in order to better equip professionals when issuing medicines to specific patient groups. This may also require additional education and training for pharmacists (495). Furthermore, the Netherlands has gained extensive experience in special health communication for migrants and minority groups (496). Policies include communicating health information, often in foreign languages, and employing information material, interpreters and trainers. One approach specifically designed for children with a migration background is based on making interventions and methods more culturally sensitive (496).

United Kingdom

A similar approach has also been welcomed in the UK, as studies show that in order to make information more accessible, it needs to incorporate and consider culturally relevant idioms, references and visuals (480). For instance, information on preventive measures is translated or delivered by persons with common cultural backgrounds. These initiatives, like in the case of Netherlands and Austria, are introduced at the local level (495).

7.1.3 Policy options: Health literacy

Improving the health communication between patients and doctors

Good health communication practices by physicians are central to helping patients develop their health literacy skills. As patients differ in their levels of health literacy, it is important that physicians adjust their communications. Several concrete steps can be taken to ensure the former. For instance, ensuring that physicians correctly establish the patient's level of understanding at the beginning of the conversation, speak slowly, avoid jargon and ask patients to repeat critical information. The current evaluation criteria developed by the Chamber of Physicians already includes assessments on whether a patient can receive in advance information on foreign language speaking practitioners in a practice (1.6). Section 15 focuses on patient communication and patient information, and includes for instance the evaluation criteria, as to whether relatives, attendants or other persons were made aware of the necessary information, in the case that a patient did not understand the contextual information (15.4). Therefore, additional criteria that encompass the communication process per se, such as speed of speaking, avoiding jargon and asking to repeat information, could be introduced in the evaluation criteria or in contracts to ensure good health communication practices by physicians. Physicians could also be requested to pay further attention to vulnerable groups and where possible, cater to these by incorporating and considering culturally relevant idioms, references, visuals and information material in other languages.

Ensure nationwide qualitative health information

With the large amount of health information of varying levels of quality available online, patients may often feel overwhelmed or access unreliable, non-evidence based material, which may undermine treatment. Therefore it is important to introduce national information portals that provide access to evidence-based health and care information for the public. Several efforts have already been undertaken in this field in Austria, including the set-up of an official self-information online portal and the ÖPGKs initiative on well-written health information. However, such information sites will only reach the right individuals if the written and digital information is understandable to the general public and promoted across all various groups of the population. Therefore, efforts to render the information clear and easily understandable, while concurrently ensuring it is in line with the latest scientific standards, need to be upheld. Furthermore, providing additional language settings for the national self-information online portal, which is currently only available in German, could facilitate and increase access to health information for vulnerable groups, such as migrants. An additional option could be to develop a similar, interactive online portal for children and young adolescents that could be promoted at schools.

Involvement of multiple stakeholders

The involvement of multiple stakeholders constitutes a vital part to identifying those with difficulties in health literacy and simultaneously ensuring, promoting and strengthening health literacy in the general population. One of the measures for the attainment of the third national health target on health literacy in Austria assesses, as to whether the relevant institutions and organisations at the federal, state and municipal level are connected in a structured form. Therefore, the monitoring of the strength and maintenance of these coordination efforts should be continued and evaluated on an on-going basis. Furthermore, specific patient contact points should be further strengthened and promoted, such as patient organisations and patient ombudsmen, who could provide support and directions to individuals with difficulties in health literacy. Similarly, physicians play a key role in identifying individuals with limited health literacy skills and could therefore refer the respective individual to patient contact points, health literacy courses and programmes. At the same time, the role of pharmacists in establishing a patient's level of health literacy could be increased. This may require additional education programmes, such as case-based learning to teach pharmacy students health concepts and skills to manage patients with limited health literacy.

Module on health literacy in the education setting

The development of health literacy competency starts with primary and secondary education. Children and young adolescents may receive education on nutrition and exercise e.g. as part of a Biology and sports courses, however, topics concerning overall lifestyle and health behaviours and how these are linked to health outcomes are not cohesively covered. Therefore, an introduction of a more coherent coverage of this topic at high schools could expose children to health information and knowledge from an early age on, while ensuring that children across all population groups are reached, which could establish a solid and uniform health literacy knowledge basis.

Summary of policy options

The European Health Literacy Survey in 2011 has highlighted significant gaps in health literacy in Austria compared to other European countries. Since then, large efforts have been made to improve the health literacy competency across the population. For instance, the topic was defined as a priority target in the 10 target controls and incorporated in the target control agreement, for which a project group was created to work on the quality of health communication. In 2014, the Ministry of Health Federal initiated, in collaboration with Health Commission, the Austrian Platform for Health Competence (*ÖPGK*) with the

objective to support the sustainable attainment of the third national health target. Furthermore, a national self-information portal was introduced to ensure nationwide access to reliable, evidence-based health information. Other initiatives include the Migrant Friendly Hospitals Initiative, which employs e.g. culturally adjusted communication strategies to facilitate access to care for individuals with a migration background.

Following the introduction of these initiatives, an upcoming health literacy survey (HLS-Neu) is planned to evaluate as to whether these efforts have had an effect on health literacy levels in Austria. Although important developments have already taken place in Austria, the following additional practices are suggested to support the attainment of higher literacy levels. (1) Clear health communication between patients and doctors could be further improved by specifying explicit criteria pertaining to the communication process (e.g. 'teach back'; avoiding jargon) in the Chamber of Physician's quality evaluation criteria of physician practices. (2) In order to further expand the dissemination of health information, the national self-information portal could offer a number of additional language settings, other than German, and a child-friendly information site could be developed as well. (3) The role of various stakeholders in promoting health literacy should be increased. For instance, a point of contact for patients with limited health literacy levels should be defined to offer trainings and support, such as patient ombudsperson offices, while physicians could direct the respective patients to these contact points. Pharmacists could be further trained to identify and manage patients with lower literacy levels. (4) Last, a module on health literacy in the education setting could be introduced.

Legal considerations

No particular constitutional impediments have to be faced with respect to these options.

7.1.4 Disease prevention

Overview

Disease prevention focuses on prevention strategies to reduce the risk of developing chronic diseases and other morbidities. There are three levels of prevention, which differ in the point in time when the preventive intervention takes place: primary prevention is initiated prior to the onset of a disease and is aimed at assisting in the elimination of health-damaging factors. For example, measures relate to hygiene, vaccinations, or preventive measures during pregnancy. By contrast, secondary prevention is focused on intervening existing health-damaging situations. Procedures in the area of secondary prevention include,

for example, the detection and treatment of pre-clinical pathological changes. Tertiary prevention concentrates on restoring health after the medical condition occurred and hence refers to the management of long-term or on-going illnesses to avoid re-hospitalisation. As a result of tertiary prevention, consequential health-damages may be prevented and the rehabilitation of patients facilitated[103]. Therefore, disease prevention plays an important role in supporting the general public health, whilst decreasing costs of preventable disease burdens.

Based on WHO data (2014) on country-specific proportional mortality from preventable chronic diseases as a percentage of total deaths, and by comparing Austria's performance to other European countries, the following section has identified two key areas that require further attention. These include the disease prevention of cardiovascular diseases and diabetes, as highlighted in the table below. Furthermore, with regards to the prevention of infectious diseases, a comparison of childhood vaccination rates has revealed notably lower rates in Austria than in other European countries that can lead to preventable burdens of disease. Therefore, this section will provide an overview of vaccination-preventable disease-, diabetes- and cardiovascular care in Austria and will outline policy options to improve performance in these areas.

Table 88: Country-specific proportional mortality as a percentage of total deaths across European countries (498)

Proportional mortality (% of total deaths, all ages, both sexes)	**Austria**	**Belgium**	**France**	**Germany**	**Italy**	**Netherlands**	**Norway**	**UK**
Cardiovascular diseases	43%	30%	28%	40%	37%	29%	33%	31%
Cancers	27%	27%	31%	26%	29%	33%	27%	29%
Chronic respiratory diseases	4%	7%	4%	5%	5%	6%	6%	8%
Diabetes	4%	2%	2%	3%	4%	2%	2%	1%
Other NCDs	14%	21%	22%	17%	17%	20%	19%	20%

[103] (497)

Proportional mortality (% of total deaths, all ages, both sexes)	Austria	Belgium	France	Germany	Italy	Netherlands	Norway	UK
Communicable, maternal, perinatal, and nutritional conditions	3%	7%	6%	5%	4%	6%	8%	7%
Injuries	5%	6%	7%	4%	4%	4%	5%	4%

Source: WHO, *Non-communicable diseases (NCDs) Country Profiles, 2014*

Vaccine-preventable diseases

Vaccines are one of the most cost-effective strategies to prevent infectious diseases in populations (499). Globally, an estimated 2-3 million lives are saved each year as a result of vaccines (500). Many developed countries have implemented robust child vaccination programmes and initiatives, and comprehensive vaccination coverage in childhood constitutes a main indicator for public health (501,502).

As immunisations play an important role in promoting public health, several countries have introduced policies to ensure or support vaccinations of children. These can either address the demand side, i.e. child's caretakers, or the supply side, including health care providers. For instance, in Germany a new proposal was passed to make kindergartens inform authorities, if parents fail to prove they have attended a doctors' consultation on child vaccinations. To date, authorities can already impose a fine of 2,500 euros on parents who persistently refuse to attend the vaccine consultations (503). A more stringent approach was taken in Italy, where children must be vaccinated against 12 common illnesses before they can enrol in public schools. If children are not vaccinated by the age of six, which is the school starting age, their parents will be fined (504). By contrast, the UK has shifted the focus from caretakers to health care providers. As part of the mass childhood immunisation programme (MCI), GPs receive payment for childhood immunisation through the PCT global sum and an additional target payment. More specifically, GPs receive a higher payment if they immunise 90% of all the children on the partnership list who are aged two. Lower payment is received if the average of courses completed is 70%, whilst there are no

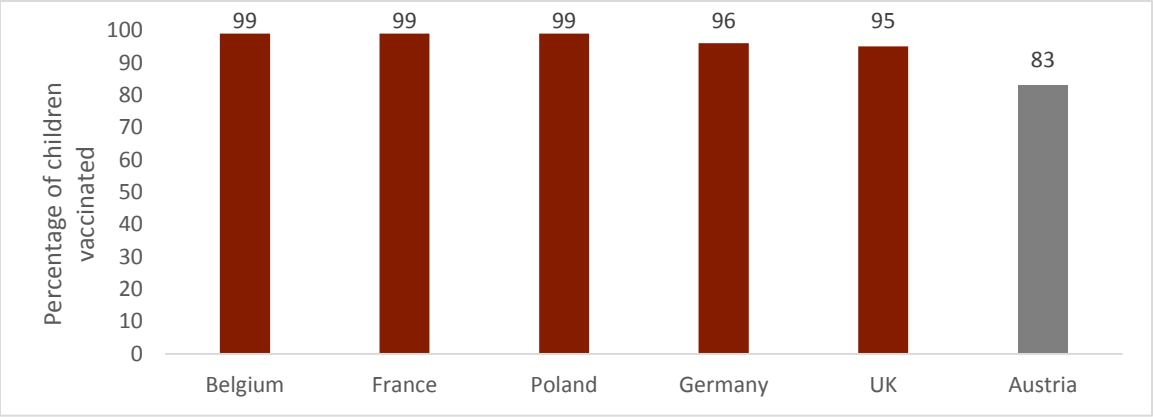
payments for any target below 70% (505). In comparison, no demand- and supply-side policies have been implemented in Austria to date, which is reflected in the relatively lower childhood vaccination rates.

Immunisation rates in Austria

Childhood immunisations

In comparison to other OECD countries, childhood immunisation rates are noticeably lower in Austria, which may be due to factors such as vaccine refusal due to personal beliefs and hesitancy, as well as barriers within the health care system (502). The low rates are particularly evident in the case of immunisations against diphtheria, tetanus and pertussis (DTP). For instance, in almost all OECD countries the proportion of one-year olds, who have received three doses of the combined DTP vaccine within the recommended timeframe, are greater than 90%, and in most countries the rates are equal to or above 95%. Merely three countries, namely Austria, Iceland and Mexico, reported vaccination rates at or below 90%, with Austria reporting the lowest rate at 83%, as shown in Figure 154 (506).

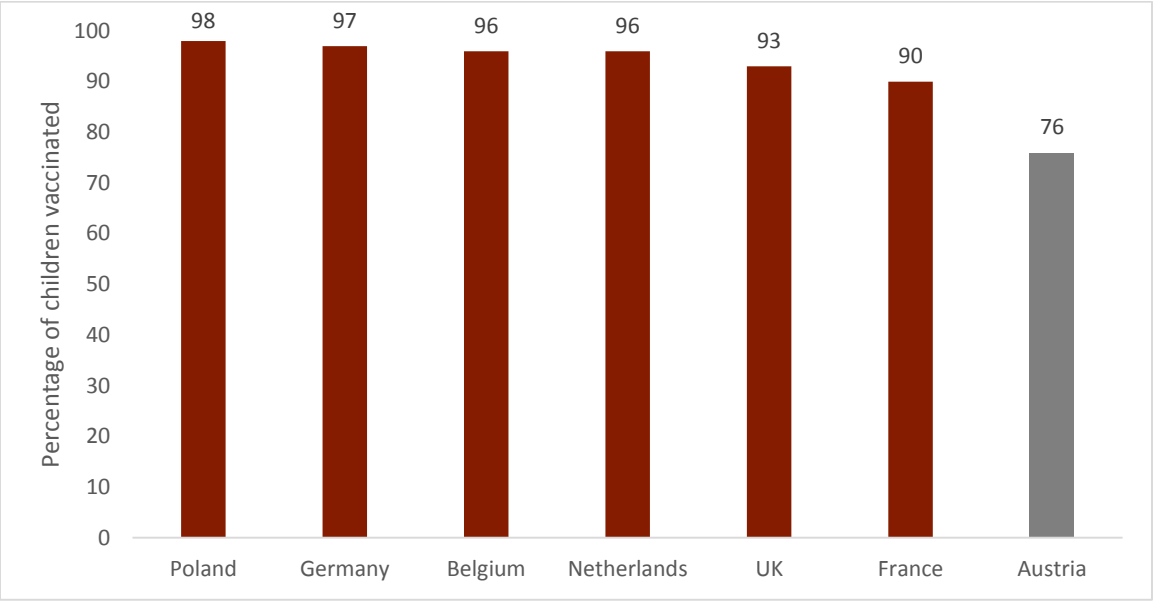
Figure 154: Childhood vaccination rates (%) for diphtheria, tetanus and pertussis (DTP) among one-year olds across a number of European countries (506)



Source: *OECD Health Statistics, 2016*

The comparatively low rate for measles vaccines in Austria is particularly outstanding. Even though vaccination rates for measles immunisations tend to be marginally lower than those for DTP, which may be due to concerns about possible associations between measles vaccinations and brain damage, all OECD countries, except for Austria, Denmark, France, Iceland and Italy, report rates that are above 90% or at least 95%. In fact, the proportion of children under the age of one, who have received at least one dose of measles-containing vaccine, is merely 76% in Austria, as depicted in Figure 155 (506).

Figure 155: Proportion (%) of children under the age of one, who have received at least one dose of measles-containing vaccine (506)



Source: *OECD Health Statistics, 2016*

Immunisation programme in Austria

Vaccination facilities and vaccine production

There are no dedicated vaccination facilities (*Impfservice der Gesundheitsämter*) in Austria, except for the regional and district public health centres, which are primarily located in larger cities. These centres are de-centralised and may differ in the types of vaccines offered. Furthermore, units at these centres tend to be small, with only few people making use of these centres. Generally, vaccines are administered by doctors or pediatricians in their private practices.

Most pediatric physicians store vaccines at their practice, given the predictable use of specific childhood vaccines. However, this is not necessarily the case for general practitioners treating adults. Except in the case of influenza vaccines, as some practices may buy these in stock during specific season, adults must usually make an appointment with a GP to first receive a prescription for a vaccine, which subsequently needs to be redeemed at a pharmacy, before being administered the vaccine during a second appointment at the physician practice. Contrary to recent international developments (507), community pharmacies do not provide walk in vaccination services.

Only a limited number of vaccines are produced in Austria, such as the vaccine against tick-borne encephalitis. However, there is no national vaccination company in Austria.

Coverage of vaccines

The vaccination programme for children is organised within the public health setting and financed by the federal government, the federal states and social insurance funds, which share the costs of vaccines. As such, all childhood vaccines, as well as the physician service, are free of charge for children up to the age of 15. The general coverage for childhood vaccinations is relatively homogenous, except for in the case of the vaccination for measles, mumps and rubella (MMR). In the case of adults, only the physician service is free of charge, not the actual vaccine.

Vaccination schedules

A national vaccination plan for the year 2017 has been defined and updated with the aim to provide physicians and those considering vaccinations a clearer overview of the recommended vaccines. This includes a special vaccination schedule for childhood vaccinations, which applies to all regions. In the case of adults, there exist guidelines for booster vaccinations. Furthermore, guidelines for travel-related vaccinations based on travel region and current risk are published as well.

An advisory vaccination schedule is developed annually by the Highest Sanitary Council (*Nationaler Impfgremium*). In consideration of the advice, which is generally accepted, the Ministry of Health publishes the official vaccination schedule, which is followed by all nine regions.

Documentation of vaccination rates

The regional level is given the task to provide vaccination coverage data to the national level, which is subsequently analysed and published. However, the vaccination status of residents living in Austria is often partially or not reported, and documentation may get lost. A nationwide, uniform collection of data has not been implemented yet.

7.1.5 Policy options: Vaccinations

Inclusion of vaccinations in the mother-child passport

The Austrian mother-child passport (*Mutter-Kind Pass*) supports health-related prevention for pregnant women and young children up to the age of 5 years by outlining all recommended and important check-ups, and is accessible to all pregnant female residents living in Austria. Following a successful completion of a number of the listed check-ups, families are eligible for a mother-child allowance (*Mutter-Kind-Zuschuss*). Currently, the passport does not include recommended childhood vaccinations. By adding a number of recommended vaccinations to the list of services, more families may become aware of

important vaccines and feel incentivised to immunise children, which could increase the overall rate of the currently low childhood vaccination rates in Austria.

Coverage of cost-effective vaccines for adults

While both the immunisation and related physician service are covered by health insurance for children up to the age of 15 in Austria, in the case of adults, only the treatment by a physician, not the vaccine, is reimbursed. Therefore, an additional coverage of adult vaccinations, where cost-effective, could potentially increase adult immunisation rates of a number of important vaccine-preventable diseases.

Introduction of vaccinations at pharmacies

Most pediatric physicians store vaccines at their practice, given the predictable use of specific childhood vaccines. However, this is not necessarily the case for general practitioners treating adults. Except in the case of influenza vaccines, which some practices may buy in stock during specific season, adults must usually make an appointment with a GP to first receive a prescription for a vaccine. Following, individuals need to buy the vaccine at the pharmacy and return to the GP for a second appointment, during which the vaccine is injected – a process that is time intensive and inconvenient to many individuals. Against this background, an increasing number of countries have started to offer walk in vaccination services at pharmacies (507). Therefore, by introducing walk in vaccination and injection services at community pharmacies, following a prescription by a physician, the immunisation process could be rendered more flexible, time-saving and convenient to patients.

E-vaccination to improve monitoring and re-calling of- as well as data collection on- vaccinations

The vaccination status of residents living in Austria is often partially or not reported. Furthermore, documentation on immunisations, such as the paper-based WHO-compliant vaccination record, may get lost, in which case a vaccination database and electronic vaccine record may provide time- and site-independent access to information for both healthcare staff and patients. As such, individuals could obtain an optimised and more convenient overview of their immunisation status and vaccination schedule, while preventing unnecessary or duplicate immunisations and possible adverse events from drug-to-drug interactions. In addition, a recall system, similar to the existing recall letter for the annual preventive check-up, could be introduced to ensure continuity of the vaccination schedule and thus ill-health prevention. Moreover, the introduction of a national electronic immunisation data collection system in Austria could improve the monitoring and evaluation of immunisation rates, which is currently based on a fragmented reporting system.

Summary of policy options

Vaccines are one of the most cost-effective strategies to prevent infectious diseases in populations and even though a number of initiatives to support the immunisation of children are in place in Austria, including a national vaccination schedule, free vaccines for children up to the age of 15, and the dissemination of information on vaccines, the childhood vaccinations rates are notably lower in Austria than in other countries. These low vaccination rates may reflect the absence of demand and supply side measures that have been introduced in other countries to ensure the immunisation of children, such as introducing legally binding consultations for caretakers, penalties for vaccination refusal or incentivising physicians to promote vaccinations. Furthermore, the Austrian care system primarily focuses on the immunisation of children rather than adults, which further increases gaps in the vaccination rates of the population. For instance, even though a physician's provision of a vaccine is covered by health insurance, the actual vaccines are not reimbursed for adults. In addition, the process to obtain vaccinations for adults is time-consuming and inconvenient, as most physicians do not store vaccines at their offices.

Therefore, a number of measures may be introduced to decrease disparities in immunisation rates between children and adults, whilst concurrently raising the overall rate of immunised persons in Austria. (1) For instance, further demand-side incentives could be implemented, such as including vaccinations in the mother-child-passport to incentivise immunisation of children, as well as extending coverage of cost-effective vaccines for adults. (2) A walk-in vaccination and injection services at community pharmacies, following a prescription by a physician, could render the immunisation process for adults more flexible, time-saving and convenient. (3) In addition, a vaccination database and electronic vaccine record may provide time and site-independent access to information for both patients and health care professionals, allowing for an optimised overview of immunisation status and vaccination schedule, whilst preventing unnecessary or duplicate immunisations, as well as possible adverse events from drug-to-drug interactions. A recall system could further ensure continuity of care. Concurrently, a national electronic immunisation data collection system in Austria could improve the monitoring and evaluation of immunisation rates, which is currently based on a fragmented reporting system.

Legal considerations

No particular constitutional impediments have to be faced with respect to these options.

7.1.6 Diabetes

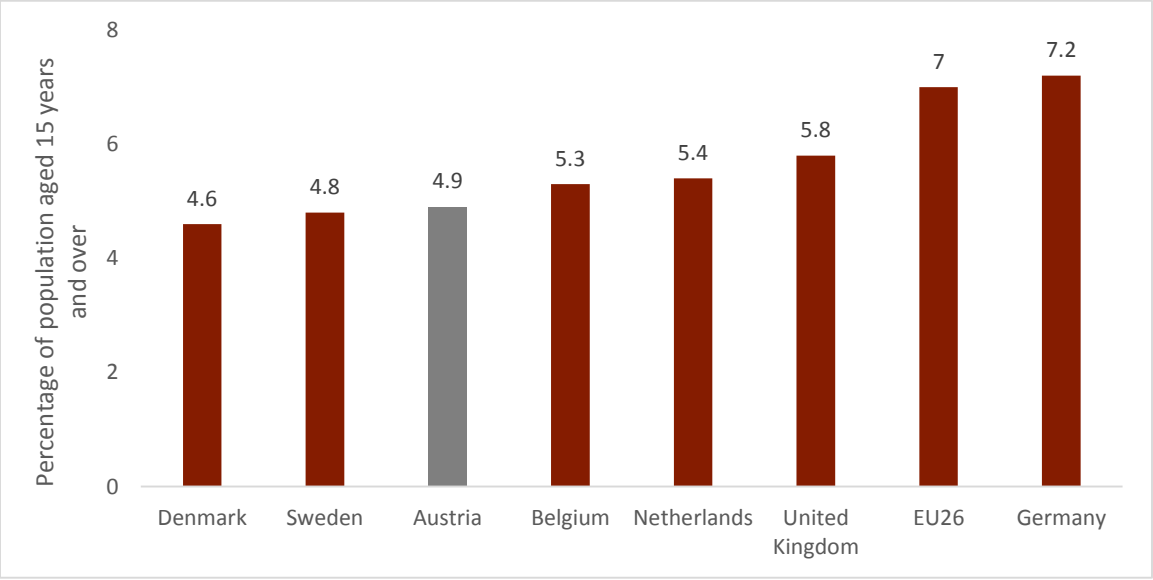
Diabetes is a chronic disease characterised by high levels of glucose in the blood. Type 1 diabetes occurs when the pancreas does not produce enough insulin, a hormone regulating the blood sugar. By contrast, Type 2 diabetes develops when the body cannot make effective use of the insulin it produces. As a consequence, untreated individuals with diabetes commonly have raised blood sugar, which can lead to serious damage over time. If left undiagnosed or poorly controlled, diabetic people have greater risks of developing cardio-vascular diseases, sight loss, renal failure, foot and leg amputation, as diabetes can damage several organs, including the heart, blood vessels, eyes, kidneys and nerves (17,508).

Simple lifestyle measures are effective in preventing or delaying the onset of type 2 diabetes in individuals. These include, for instance, the maintenance of healthy body weight through physical activity and healthy diet (i.e. decreasing intake of sugar and saturated fat), and avoidance of tobacco use (508).

Diabetes prevalence and trends in Austria

Approximately 6% of the Austrian population (i.e. 430,000 people) were diagnosed by a physician with diabetes (509). When comparing self-reported diabetes data based on the Health Interview Survey (2014), Austria appears to perform rather well, with merely 4.9% of people reporting diabetes. This prevalence rate is half of that reported in France, namely 10%, which constitutes the highest prevalence rate across the European countries. It is also 2.1% below the EU26 average of 7%, as depicted in the figure below (510). When looking at children specifically, approximately 0.1% of 0-14 year olds (i.e. 1,300 – 1,500 children) have been diagnosed with diabetes (509).

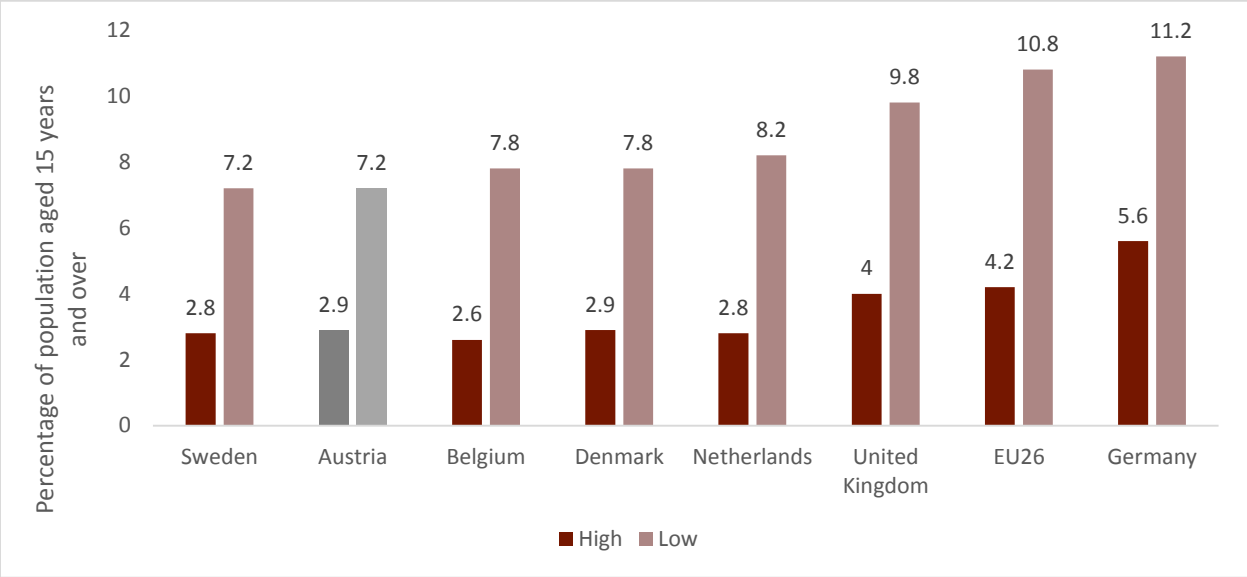
Figure 156: Self-reported diabetes in Europe, 2014



Source: *OECD Health Statistics, 2016*

However, self-reported data on diabetes can be susceptible to under-diagnosis and reporting errors (510). For instance, according to Federal Ministry of Health, approximately 8% to 9% of the Austrian population (i.e. 573,000 – 645,000) have diabetes. As such, an estimated 2% to 3% remain undiagnosed (i.e. 143,000 – 215,000). Furthermore, the rate of self-reported diabetes is particularly higher in those population groups with lower education, compared to those with higher education, as shown in the figure below. However, these differences are more pronounced in the female population. Furthermore, no differences in prevalence were found between genders, and between individuals with a migrant and a non-migrant background (509).

Figure 157: Self-reported diabetes by level of education in Europe, 2014



Source: *OECD Health Statistics, 2016*

Even though the prevalence rate may not seem as high as in other countries, the proportional mortality from diabetes as a percentage of all deaths in Austria is 4%, which is four times as high as in the UK and twice as high as in Belgium or France, as highlighted in country-specific proportional mortality as a percentage of total deaths across European countries (see table 88) (498).

Diabetes care in Austria

The treatment of diabetes patients takes place either through the recognised Disease-Management-Programme or the physician office. However, as highlighted in a report by the Federal Ministry of Health, the type and scope of these services may vary due to regional circumstances, regulations by federal states, variations in tariffs and training of personnel, as well as the in size of doctor's practices (509).

For patients with diabetes type 1, there are 95 diabetes outpatient departments for adults and 36 departments specifically for children and adolescents. These departments are within reach of 30 minutes for approximately 95% of the adult population (i.e. 19 years and older) and 79% of the children's population (15 years and younger) (509).

Disease-Management Programme (DMP) 'Therapie aktiv'

To further improve the treatment of diabetes mellitus type 2 patients and with the aim to reduce costs in the long-term, the disease management programme (DMP) 'Therapie aktiv – Diabetes im Griff' was

developed in 2004 by the Styrian sickness fund and the Institute for Biomedicine and Health Science of Johanneum Research on behalf of Austrian SHI, and subsequently implemented in 2007 across most regions in Austria (511,512). The programme has since then been adopted by other sickness funds (511).

In 2012, approximately 15.3% of eligible physicians participated in the DMP, which is voluntary and free of charge to both patients and physicians (511,512). Before signing up to the programme, physicians receive a basic training to become a so-called 'DMP-physician'. Upon completion of the training, DMP-physicians receive between 40 EUR – 72 EUR for each registered diabetes patient, as well as 21 EUR to 29 EUR per quarter[104] for supervisory care, depending on the federal state. Further training is also rewarded.

The programme encompasses the implementation of evidence-based clinical guidelines, performance of necessary medical examinations on a regular basis, as well the recording of information on medical parameters, treatment, target agreements and quality of life. Furthermore, patients receive lifestyle advice to improve health behaviours and both, the physician and patient agree on defining individual targets. To date, approximately 45,000 diabetic patients have signed up to the programme (512).

A number of studies have aimed to assess the impact of the programme on the patients enrolled. For instance, Ostermann *et al.* (2012) have found that the quality of outpatient care improved, while the rate of hospitalisations decreased for DMP-participants compared with controls in 2009 (513). Furthermore, a recent study by Riedl *et al*. (2016) observed a significantly lower mortality rate in the DMP-group, compared to those in routine care. The number of days spent in hospital, as well as the mean annual hospital cost were comparatively lower as well, which is reflected in the lower mean annual total costs of EUR 8226.80 for DMP-participants and EUR 9,321.10 for the control group. When looking at the cost of health care services, the study noted slightly higher outpatient physician services costs and lower hospital costs for the DMP group (512). Although these studies suggest a positive impact of the DMP programme on patients, it must be noted that the findings may be influenced by a number of confounding factors, such as severity of disease and education levels, which may affect whether a patient joins the DMP programme in the first place. As such, further evaluations of later stages of the DMP programme should be assessed.

[104] Some federal states only provide supervisory care benefits for a total of three quarters.

Programmes and initiatives

A number of initiatives to improve diabetes care have been implemented in Austria. For example, advanced training for diabetes counselling for physicians has been offered since the 1990s and approximately 850 physicians have received further training to date. In addition, a forum for quality assurance in diabetology (FQSD-Ö) had been founded in 1996 to improve the structural, process and outcome quality in diabetes care. A diabetes registry has already been established in Tirol, which aims to optimise the monitoring of diabetes patients, whilst simultaneously collecting epidemiological data (509). Furthermore, national action plans on nutrition (Nationaler Aktionsplan Ernährung, NAP.e) and physical exercise (Nationaler Aktionsplan Bewegung) have been introduced to focus on health risk factors to health, which also relate to diabetes. The Austrian Diabetes Association provides further information on regarding information events, and information contact points regarding diabetes care across the nine regions.

7.1.7 Policy options: Diabetes

Expansion of the diabetes disease-management-programme (DMP)

At present, type 2 diabetes patients can receive diabetes care either by voluntarily signing up to the established disease-management programme (DMP) or through routine care at a physician practice. However, differences in care and supervision between physicians within the DMP programme and those outside DMP prevail, as well as variations across non-DMP physician practices. For instance, two studies have found that outcomes, such as mortality, improved in the DMP programme, whilst concurrently decreasing costs compared to the control group (512,513). Although the findings may be influenced by other factors, such as selective sign up to the DMP programme, the studies may nevertheless reflect strengths of the programme, which is specifically outlined to rely on evidence-based practice and to offer patient-centred care with regular monitoring of patients. Therefore, in order to improve equity and quality of treatment, it suggested to further strengthen efforts in the disease management programme, which should be gradually expanded over time.

Remuneration of DMP-physicians

Patients with chronic diabetes require on-going care and supervision, in order to ensure adequate management of the disease. As a result, diabetic patients may constitute a comparatively more expensive patient group in a non-risk-adjusted contact capitation scheme, as is primarily the case in Austria, than single-case patients. Therefore, financial incentives have been introduced to further attract physicians

into the disease management programme. However, given the time-intensive treatment of diabetic patients, physicians may forfeit additional revenue. Therefore, the financial compensation should be assessed in order to ensure appropriate rewards in line with the time taken to manage diabetes patients, and to incentivise more physicians to enter the programme.

Training of physicians

Following the completion of a medical degree, post-graduate medical students in Austria undertake 5 to 6 year rotation training at hospitals (Postpromotionelle Ausbildung). A grid certificate (Rasterzeugnis) specified by the Chamber of Physicians outlines areas and procedures that need to be completed by trainees as part of their rotation. However, the grid certificate category 'basic training' does not include diabetes-specific training or how to manage patients, even though the management of diabetic patients may become particularly difficult in the case of secondary disease, such as kidney damage, where more attention needs to be paid to additional factors like dosage of medications. Therefore, inclusion of diabetes specific-tasks in the grid certificate may further expose physicians to additional training and as such improve the management of patients with diabetes.

Furthermore, continuing training constitutes an important factor to ensuring continuous high quality care. Consequently, a number of countries like Germany have introduced a re-certification of physicians e.g. every five years which may regulated by law and may even be connected to sanctions in the case of failed completion. In Austria further training is regulated through an ordinance (Verordnung) of the Chamber of Physicians. As such, physicians receive a diploma if 250 points are collected (or 150 points in specific cases). However, there are no specifications on follow-up measures in the case of incompletion. Therefore, it may be an option to make further training more binding by defining explicit follow-up measures in the case that physicians fail to follow the training.

Training of DMP-physicians

If part of the DMP programme, physicians are required to refer diabetic patients to diabetes outpatient departments in the case that management efforts (e.g. managing blood sugar levels) fail. This may lead to the decision of some physicians not to enter the programme in the first place, due to possibilities of losing patients. Therefore, the introduction of a voluntary training and a confidential supervision by experiences diabetes specialists may help overcome this issue.

Establishment of a national diabetes registry

About 2% to 3% of the Austrian population are estimated to live with undiagnosed diabetes (i.e. 143,000 – 215,000), a number that may be further underestimated. Although a diabetes registry has already been established in Tirol, which aims to optimise the monitoring of diabetes patients, whilst simultaneously collecting epidemiological data, fragmentation in the data collection prevails. By extending data collection efforts, a national diabetes registry could be implemented in order to improve the collection of data to monitor and evaluate trends in diabetes.

Summary of policy options

Even though the diabetes prevalence rate is below the EU average, diabetes constitutes a significant share of proportional mortality in Austria, after cardiovascular disease and cancer. A number of initiatives have been implemented since the 1990s to improve diabetes care in Austria, including a diabetes disease-management programme, diabetes counselling for physicians, a forum for quality assurance in diabetology, a diabetes registry, as well as national action plans for physical exercise and nutrition.

However, a significant number of diabetic patients remain undiagnosed, which may lead to further health deterioration. Furthermore, the quality and scope of care varies between patients enrolled in the disease management programme and those receiving routine care. And even though initial findings suggest the cost-effectiveness of the disease management programme, challenges to incentivise physicians to join the programme prevail.

Therefore, (1) an expansion of the diabetes disease management programme, which takes into consideration adequate financial incentives for physicians, whilst also ensuring training support through experienced diabetes specialists, may further harmonise the provision of diabetes care in Austria. Concurrently, recent efforts to build additional primary health care centres (PHCs) will complement the multi-disciplinary based delivery of diabetes care in Austria. (2) In addition, the grid certificate for trainee physicians could be extended to incorporate exposure to diabetes specific-measures, in order to further improve the management of (difficult) diabetes cases. (3) A national diabetes registry that could build on the existing registry in Tirol has the potential to enhance data collection and monitoring of diabetes developments in Austria. (4) Furthermore, efforts in the harmonisation of benefits packages across insurance carriers could further mitigate inequity in diabetes care, such as variations in the scope of benefits for services, including diagnostic tests.

Legal considerations

Even though no particular constitutional impediments have to be faced with respect to these options, some amendments to the professional law (especially the Ärztegesetz) as well as amendments to the current system of contractual agreements would be required, which might cause political impediments.

7.1.8 Cardiovascular diseases (CVD)

Cardiovascular disease (CVD) is a leading cause of mortality worldwide and causes more than half of all deaths across the European region. Although cardiovascular-related mortality has been decreasing in many countries in the past decades, cardiovascular diseases remain the most common cause of death (514). Yet, about 80% of premature heart disease and stroke is preventable (515). Prevention of CVD encompasses primarily the focus on reduction of risk factors that include tobacco consumption, serum cholesterol, systolic blood pressure, unhealthy diet, overweight and obesity, physical inactivity, and higher levels of alcohol consumption (514). Furthermore, preventive strategies include medical screenings for population groups at risk, as well as medical treatment e.g. in the form of cholesterol- and blood-pressure-lowering medications, in which case the latter has shown to be effective in reducing heart attacks (myocardial infarction) up to 75% among high-risk individuals (515). Therefore, the implementation and continuation of preventive strategies, including the management of blood pressure of patients at risks, is central to reducing morbidity and mortality of CVD.

Against this background, the community-based North Karelia Project was launched in Finland in 1972 to prevent cardiovascular diseases, and more specifically to assess the role of primary prevention in reducing observed coronary heart disease mortality. Based on previously identified risk factors in other large studies, including the British Medical Doctors Study and Framingham Study, the project targeted three classical risk factors of CVD, namely tobacco smoking, high serum cholesterol and high blood pressure. With the introduction of the project, several initiatives were taken to mitigate risks by focusing on behavioural change through community action and participation, in addition to screening of high-risk individuals and medical treatment. Furthermore, a systematic monitoring was introduced, with surveys being conducted on a 5-year basis (514).

A key finding of the project is that population-based prevention programmes constitute effective tools to reduce the disease burden and mortality from coronary heart disease (CHD). Such programmes included active anti-smoking campaigns and legislation that even led to the lowest smoking prevalence in Europe

in 2016, promotion of dietary change to reduce cholesterol levels (e.g. transition from fatty milk to low fat milk, reduction in butter consumption, increase in use of vegetables), and a combined strategy of lifestyle change (e.g. reduction of high salt intake) and use of screening and pharmaceutical drug treatment to lower blood pressure levels. Notably, more than 80% of the decrease in cholesterol levels could be attributed to dietary changes, while only 20% were explained by the use of drugs, such as statins. Therefore, primary prevention aimed at reducing CVD risk factors should be considered the main strategy to decrease the disease burden and mortality from coronary heart disease, while secondary prevention may confer additional benefit (514).

In addition, a recent modelling study to estimate the global premature cardiovascular mortality in 2025 highlighted that the reduction of specific risk factors, namely systolic blood pressure and tobacco use, may have a more substantial impact on future scenarios than other factors like levels of body mass index and fasting plasma glucose. Furthermore, a strategy focusing on multiple risk factors, rather than single factors, has a greater impact on reducing CVD-related premature death across all regions globally. However, in addition to focusing on combatting these major risk factors, decision-makers also need to take into consideration the capacity of the health care system to accomplish CVD reduction. This encompasses counselling patients with regards to e.g. glycaemic control and ensuring eligible high-risk patients receive drug therapy, as well as making affordable basic technologies and essential medicines (including generics) to treat NCDs available (516).

Prevalence and cost of CVD in Austria

Notably, CVD-related mortality as a percentage of all deaths in Austria is with 43% comparatively higher than in other European countries, as shown in the table below (498). For instance, in 2011 approximately 5,100 persons died because of a heart attack, 1,200 of a stroke and 500 of peripheral arterial disease (PAD). Specifically, men and the elderly had a higher likelihood of mortality than women and younger individuals (517).

Table 89: CVD-related mortality as a percentage of all deaths in 2013 (498)

Proportional mortality (% of total deaths, all ages, both sexes)	Austria	Belgium	France	Germany	Italy	Netherlands	Norway	UK
Cardiovascular diseases	43%	30%	28%	40%	37%	29%	33%	31%

Source: *WHO, Non-communicable diseases (NCDs) Country Profiles, 2014*

Given the large burden of disease, CVD is associated with high direct and indirect costs. For instance, in 2008 approximately €1.3 billion in costs were attributed to CVD care in the inpatient sector. This constitutes about 13% of public health expenditures. CVD was also associated with high indirect costs, such as inability to work, invalidity or premature death. For example, in 2011 approximately 600,00 sick leave days were due to cardiovascular disease. Furthermore, about 15,000 pensions were granted as a results of CVD-related reduced workability or incapacity to work (517).

Cardiovascular care and prevention initiatives in Austria

Given the high costs associated with CVD, the appropriate management of high-risk patients is paramount to preventing further morbidity, complications and hospitalisations. Individuals at risk are generally treated at general practices, and a recent trend in the development of primary healthcare centres allows for a multi-disciplinary management of CVD patients. Contrary to the management of diabetes, there are no disease management programmes for CVD in Austria.

An evaluation in 2014 of cross-national and cross-regional measures and projects to reduce CVD-related risk factors found that only a limited number of such measures are in place in Austria. Of these, approximately 45% constituted a combination of behaviour- and environment-related interventions, while 44% accounted for health behaviour-based interventions only. The majority of these measures focus on nutrition and physical activity, while other preventive areas are significantly underrepresented, which may be due to the fact that areas like tobacco and alcohol consumption are not explicitly covered in current strategy papers, such as the strategy for child and adolescent health or the Framework Health

Targets. Furthermore, the measures focus on multiple rather than single risk factors, and encompass workshops, trainings, information events, as well as coaching and consultations (517) .

7.1.9 Policy options: Cardiovascular disease

Large epidemiological studies have identified key risk factors of cardiovascular disease, including tobacco consumption, high systolic blood pressure levels, high serum cholesterol, obesity, physical exercise and diabetes mellitus. As previously highlighted, Austria has the lowest share of obese people in Europe and BMI tends to be in the normal range, in addition, the prevalence of diabetes is below the EU average. No significant deviations from the EU average were observed for alcohol consumption and smoking among adults. Furthermore, a number of initiatives with a multiple factor approach were introduced, as well as a national action plan on nutrition and physical exercise.

Despite the above, the proportional mortality of CVD-related deaths in Austria remains comparatively higher than in other EU countries. This may be explained by the low number of cross-national and cross-regional measures and projects to reduce CVD-related risk factors, with limited focus on key risk factors like tobacco and alcohol consumption. Concurrently the number of adolsecent smokers is high compared to other EU countries, although it must be noted that policies were introduced recently to target tobacco consumption among adolsecents and adults (e.g. smoking ban for adoslecents below the age of 18 in 2018; smoking ban in public spaces initiated in 2009). In addition, the lack of coordination between primary and secondary care in Austria may further undermine effective treatment of high-risk and CVD patients. As highlighted in a pioneering observational study in Finland, primary prevention aimed at reducing CVD risk factors should be considered the main strategy to decrease the disease burden and mortality from CVD, while secondary prevention may support the former. However, given the recent developments to strenghten primary care and establish more primary health care units, as well as Austria's comparatively good performance in risk factor levels, further investigations are needed to examine and identify underlying factors of the high CVD disease burden and mortality in Austria. Based on the findings, appropriate measures could be introduced to reduce CVD-related morbidity and mortality.

Legal considerations

No particular legal impediments have to be faced with respect to these options.

7.1.10 Health promotion

International initiatives to improve disease prevention and health promotion

Developed countries in the EU are experiencing rising rates of chronic conditions caused by, amongst other factors, an ageing population. Challenges arising from conditions such as cardiovascular disease and diabetes, are recognised by governments as evidenced by the recent Joint Action on Chronic Diseases and Health Ageing across the Life Cycle (JA-CHRODIS), which is funded by the European Commission (518).

JA-CHRODIS represents a three-year (2014-17) European collaboration to 'validate, exchange and disseminate good practice' on policies related to chronic diseases, specifically, on health promotion and prevention, multi-morbidity and diabetes. Today, JA-CHRODIS is made up of representatives from 25 European countries, which includes over 70 partners from national and regional health departments and research institutions (518).

To achieve the initiative's overarching objective of transferring knowledge among member states, a number of 'work packages' (WPs), outlining relevant activities, have been defined. An overview of each of the seven WPs is provided in Table 90. Details on each how each of the WPs work together is outlined in Figure 158 (518).

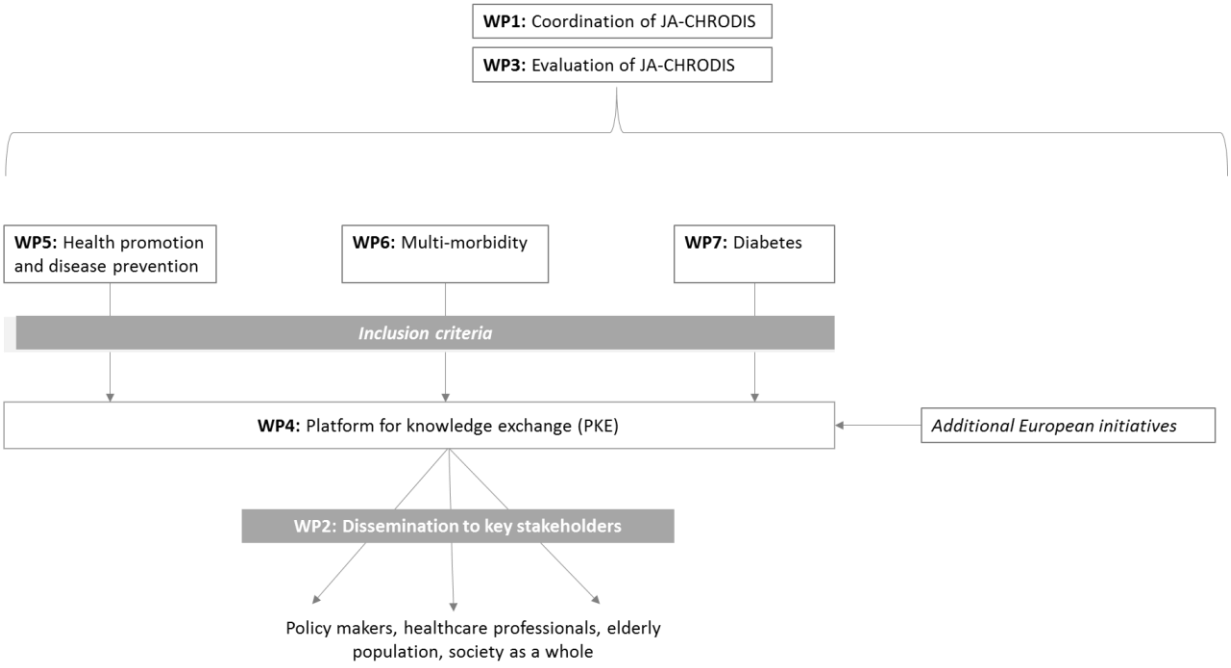
Table 90: Work packages within JA-CHRODIS

Work package	Description
WP1: Coordination	Coordinate the overall initiative, including relevant programs outside JA-CHRODIS, and ensure the initiative's sustainability
WP2: Dissemination	Disseminate findings from activities undertaken within JA-CHRODIS
WP3: Evaluation	Evaluate activities undertaken at JA-CHRODIS to determine whether it has achieved its objectives
WP4: Platform for knowledge exchange	Implementing key JA-CHRODIS activities, that is, the platform where information on good

Work package	Description
	practices are pooled (i.e. repository of best practice principles)
WP5: Health promotion and disease prevention	To screen potential good practices for health promotion and disease prevention, with successful programs being made available to stakeholders
WP6: Multi-morbidity	Similar to WP5, however, related to practices regarding multi-morbidity
WP7: Diabetes	Similar to WP5, however, related to practices regarding diabetes

Source: (518)

Figure 158: Overview of JA-CHRODIS work packages



Source: (518)

Relevant to this task, is WP5: Health promotion and disease prevention. As outlined above, only those programs considered 'best practice' are included within the PKE. For the purpose of this initiative, JA-CHRODIS have termed best practice as:

'Not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it.'(519)

Based on this definition, the following 10 criteria have been determined to select which health promotion and disease prevention models are included in the PKE:

1. Equity
2. Comprehensives of the intervention
3. Description of the practice
4. Ethical considerations
5. Evaluation
6. Empowerment and participation
7. Target population
8. Sustainability
9. Governance and project management
10. Potential of scalability and transferability (519).

Today, over 40 best practice models have been identified in regard to health promotion and disease prevention, which come from a range of countries including, Germany, the Netherlands, Ireland, Iceland, Greece, Norway and the UK (519). Best practice models take different approaches, however, in general, can be classified as either taking:

- A 'partnership approach', in which Departments/Ministries of Health are involved in developing and implementing health promotion and primary prevention policies and programmes, as well as non-governmental organisations.
- A 'Health in all Policies', as was used for the 10 Federal Health Targets in Austria (see section below).

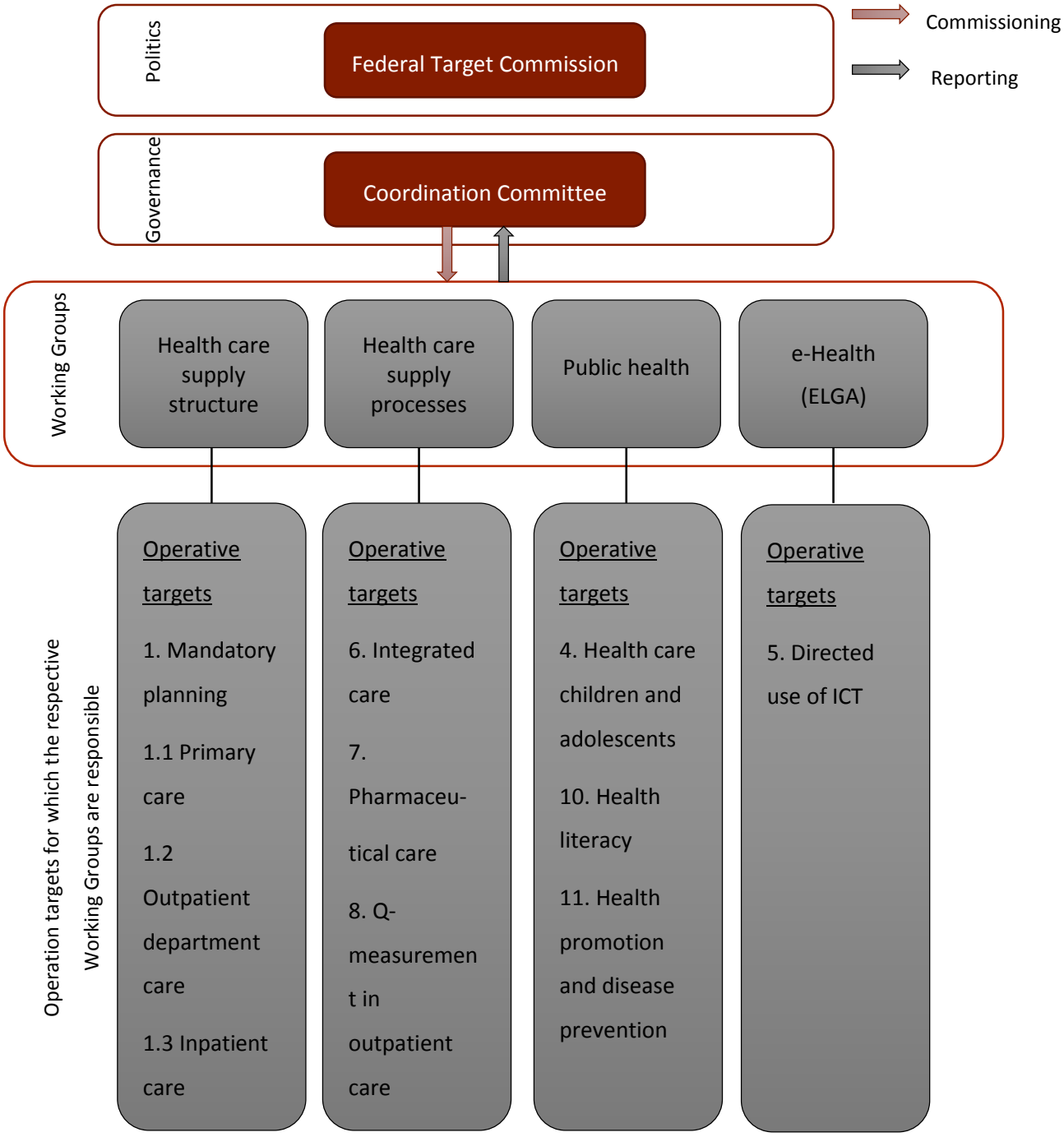
Austrian initiatives to address health promotion

In line with European efforts to strengthen health promotion and disease prevention, Austria too has implemented a range of initiatives, as evidenced by policies within the 2013 healthcare reform. Specifically, the latest reform introduced the Federal Health Target Agreement, and aligning Federal and State Target Control Commissions as part of Target Control health (*Zielsteuerung Gesundheit*). In addition to Target Control Health, 10 Federal Health Targets were introduced, which refer to the healthcare system more broadly (with the exception of Target 10, which s specific to the delivery of healthcare services).

Structure of the Public Health and Health Promotion Working Group

The concrete health strategies, operative targets, measures on a national and regional level, as well as on-going projects, are specified in the Federal Health Target Agreement. The 2017 agreement outlines the reform agenda up until 2021 and was proposed by the Federal Target Control Commission to the Curiae. The operationalisation on the national level is carried out via Federal Annual Work Programmes (Bundes-Jahresarbeitsprogramm). As such, the Federal Health Target Agreement and the Federal Annual Work Programmes form the basis for the work and mandate for action for the working groups (Fachgruppen), including the working group on public health and health promotion. The Coordination Committee then assigns which targets and projects are covered by a specific group, as depicted in the figure below.

Figure 159: Organisational structure of the Federal Target Control Commission in 2017



Source: HVSV, 2017

As shown in the figure above, in 2017 there are four working groups that focus on specific topics, including structure of care delivery, delivery processes, public health and e-health. This constitutes a significant reduction from the number of working groups for the previous years, which amounted to six and encompassed the areas innovation, planning, financing and control, quality, public health and health promotion, and law. The responsibility of the working groups includes the set-up of project groups, although the final responsibility is with the Coordination Committee. For the years 2013 to 2016, two project groups were established under the Working Group on Public Health and Health Promotion. These include one group for the identification and development of a range of important indicators to measure public health parameters (Outcome-Messung), and a second group that looked into the quality of health communication. The new project groups for the period 2017-2021 are yet to be established.

These groups consist of four representatives each from the federal state, the regions and social insurance. This also constitutes a change to the previous group constellation, as efforts were made to have a uniform and balanced representation of stakeholders. The Curiae then choose the individuals who will participate in the working groups.

Financing of the undertakings by the Federal Annual Work Programmes (Maßnahmen des Zielsteuerungsverrtages) takes place on a project base via the individual Health Target Partners or via common resources made available by the Federal Health Agency (Bundesgesundheitsagentur).

Based on the initial workings of the organisational structure of the Federal Target health (Zielsteuerung Gesundheit), the new structure aimed to consider lessons learned. For instance, this includes a reduction of the working groups from six to four in order to make better cost-effective use of resources. Furthermore, in the past specific target measures were allocated to working groups, however, these could sometimes overlap in content, which in some cases made it difficult to differentiate tasks across groups. Consequently, under the new structure, working groups are allocated on the basis of operative targets and the responsibility for execution of the tasks is clearly defined. Furthermore, the topic child health has been included as an area of focus. These changes in the organisation of the working group, in order to make processes more efficient, constitute positive developments, which are to be tried and evaluated once the new structure is implemented in mid-2017.

7.2 Case and care management

7.2.1 Introduction to case management

Over the last two to three decades, case management has gained prominence in various health and social care systems within high-income countries. While the concept of case management originated in the 1970s in mental health care and the accident insurance industry, its expansion to other parts of health care can be explained by a number of trends. As cost pressures have increased in national health care systems due to factors such as population ageing, increasing patient expectations, and technological progress that expands treatment-eligible population groups, policy makers and payers have been looking for efficiency gains. With advances in biomedical science, health care has become increasingly specialised. As a result, medical research is now organised along disease-specific specialties and health care delivery according to mutually isolated provider organisations, for example, hospitals that are designed to cure acute illness. Such a system is not well suited for patients who receive care from various providers. These patients also tend to account for most of the cost in health care systems (see Figure 78). Policy makers, payers and providers have thus looked to case management as a means of coordinating service delivery and increasing efficiency.

At a high-level, efficiency is a ratio of output to input. In the context of health care, efficiency can be increased by improving health outcomes, while simultaneously maintaining or reducing costs. Given the difficulty in attributing changes in health outcomes to specific services, health care output is often expressed in terms of proxy measures, such as the volumes of services delivered.

Case management is, in principle, expected to contribute to efficiency gains by making services more appropriate and effective, and/or by reducing costs caused by duplication of efforts and delivery of unnecessary services. However, as will be discussed below, case management is in itself a time- and resource-intensive process that can add financial cost to the delivery of health care. To the extent that case management uncovers unmet medical need among patients, it can also increase the volume of health care services provided, leading to cost increases. The ultimate effect of case management on health care efficiency thus depends on whether positive effects can be achieved in terms of health outcomes and whether these effects at least outweigh effects on cost or, in other words, whether case management is a *cost-effective* intervention compared to alternatives.

The aim of this section of the report is to describe the international experience with case management, which is relevant to the Austrian context. It provides a brief overview of the academic literature on case

management, in health and social care in general and in rehabilitation and return-to-work (RTW) programs more specifically, and selected case studies from other European countries and North America.

7.2.2 Definition of case management

Health and social care literature

There are varying definitions of 'case management' in the health and social care literature depending on the field of application. Terms such as 'care management' 'managed care' or 'comprehensive care' have also been used in prior research to refer to similar concepts and indeed these different labels are often used loosely or interchangeably. However, across different studies and terminology, the consistent underlying concept of case management is the same. Case management makes the individual patient, rather than diseases, care providers or services, the basic unit of care delivery to ensure coordinated delivery of all services required by a patient, usually overseen by a professional who acts as 'case manager' (520–522). This process usually also involves a formal needs assessment and the creation of an individual care plan. Case management is often part of broader interventions that aim to improve the delivery or effectiveness of healthcare services (523,524).

The underlying idea of organising the delivery of modern, and often specialised, healthcare around comprehensive needs of individual patients has been traced back to the 1970s. In particular, in a seminal article on the division between psychiatry and biomedicine, Engel (525) suggested the 'biopsychosocial model' to avoid reducing the definition of disease to deviations from normal in biological variables and integrate social, psychological and behavioural factors. This is model is often seen as the basis for a patient-centred and comprehensive delivery of health care.

In more practical terms, case management evolved in parallel in different areas of application. For patients with chronic diseases, for instance, the 'Chronic Care Model (CCM)' was proposed in the 1990s and provided six core principles to move care from a fragmented and episode-based approach towards a coordinated process led by primary care (526,527). One of the six principles suggests that the care delivery system be redesigned to encourage better collaboration and work in multidisciplinary teams (527,528).[105]

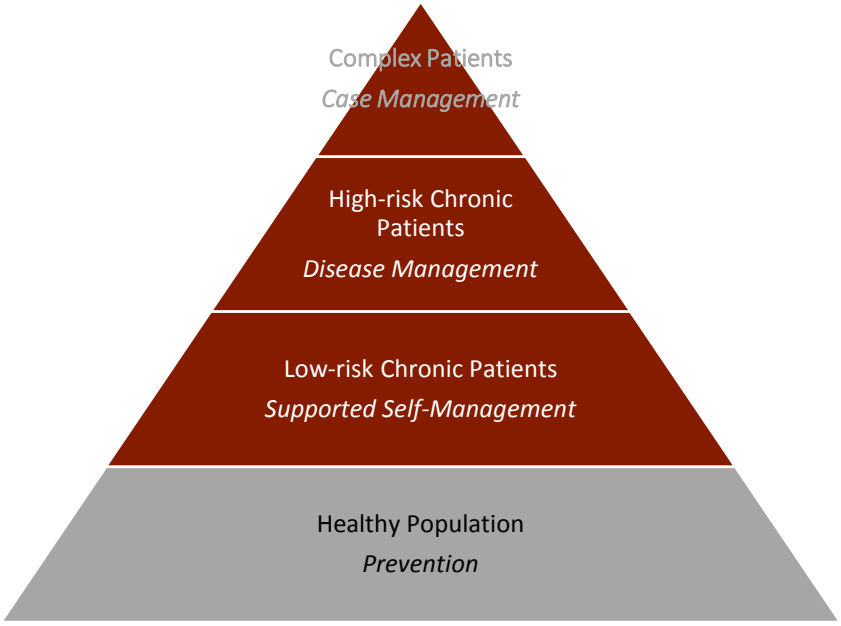
[105] The other five state, 1 – that healthcare systems should endorse improvement of chronic care overall by supporting improvement at all organizational levels and by providing the necessary structures and incentives; 2 – that clinical decision-making be supported by the adoption of evidence-based guidelines and protocols; 3 – that clinical information systems be used to collect, summarize and review individual or aggregate patient data to support providers and patients and to facilitate the smooth delivery of care; 4 – that patients and their families receive support in self-management to improve the confidence and skills of patients in managing the challenges of living with and treating their chronic illnesses; and 5 – that community resources

Principles of the CCM have been extended to patients who suffer from multiple chronic conditions (multi-morbidity) or a combination of various health problems that makes their care needs complex. In the literature on mental health and psychiatry, the use of the term case management dates back to the 1980s and has been used to refer to patient-specific delivery of mental health services, usually in community settings for patients with severe mental health illness (529–531).

Across health and social care services in general, case management is typically targeted at those patients who require support over long periods of time and whose care needs are complex. The 'Kaiser Pyramid' (see figure below), initially proposed by Kaiser Permanente, an integrated healthcare provider consortium in California, is a widely accepted conceptual framework suggesting that the delivery of care should be adapted to the level of patient complexity. As complexity increases, service provision moves from supported-self management for low-risk patients to disease management for high-risk patients and to case management for complex patients (532). Cases are considered complex when they require services from various providers, which increases the risk of fragmented care.

be activated and integrated with health care to expand support for chronically ill patients and fill gaps in needed services (527,528).

Figure 160: Kaiser Pyramid



Source: Adapted from Singh and Ham (532)

Rehabilitation and return-to-work interventions

Since the 1980s, case management has also appeared in occupational health literature and studies that examine rehabilitation and return-to-work (RTW) programs following injuries or absence from work, more generally (533–535). Case management has been introduced more recently in RTW programs in several OECD countries. In this context, case management typically aims to improve coordination between services of employment, services with health care, or services of social care providers with the overall goal of accelerating recovery and reintegration into the workforce. One institution usually provides the case management service to coordinate remaining services. Another common and important element of case management in RTW programs is a formal needs assessment and the definition of a plan, the execution of which is monitored and followed-up on by the case manager. The level of formality of the process and the intensity of support provided by case managers, however, can vary widely between countries and different models.

In Denmark for example, vocational rehabilitation is co-ordinated by the municipal job centre and involves health care services, social services and the education sector to prevent disability benefit claims (536). In co-operation with the mental health and welfare sectors, Flemish employment services in Belgium provide a 'job coach' who acts as case manager and provides not only support in the job search but also

coordination of services provided by a 'mental health coach' and an 'empowerment coach' from welfare (537).

Accelerating RTW should be a priority of social security systems given the two-way relationship between employment and health. While being healthy is a prerequisite for the ability to work productively, work can keep people healthy, further being out of work adversely affects physical and mental health. Evidence suggests that unemployment is associated with lower use of preventive and curative health services, which has an adverse impact on health outcomes (538,539). However, the positive impact of work is not present in poor quality, low paid and insecure employment (539). Unemployment, on the other hand, has been shown to increase mental distress and deteriorates mental health status through reduced social contact, a less defined social identity and through loss of structure in daily living (538). This suggests that cash payments and similar unemployment benefits are insufficient to preserve the health of people who are out of work and that services which integrate physical and mental health services with unemployment benefits are necessary.

7.2.3 Case management in the Austrian context and legislation

The 2008 agreement under article 15a of the Austrian federal constitution on organisation and financing of the health system (*Vereinbarung gemäß Artikel 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens*) made patient-oriented coordination of financing and service provision by various insurers and health service providers an overriding goal of a comprehensive medical service for the Austrian population. However, similar to the international context, there is no single and universally accepted definition of case management in the legislation or other sources of rules governing the Austrian health and social care system.

A German monograph (540) has defined case management as, 'a method tailored for individual cases that can be applied by various persons in diverse setting to realise patient focus and patient participation as well as outcome focus in complex and highly fragmented health and social care systems' (p.8). This definition has also been adopted in a prior review of case management in Austria by Czypionka *et al*. (541), published by the HVSV. This paper positions case management as an approach to organise treatment for complex patients, as a complement to disease management, and breaks the process down into a cycle with six steps: 1 – identification of patients; 2 – assessment of psychosocial patient status and patient needs; 3 – definition of a care plan; 4 – implementation of the care plan overseen by a case manager; 5 – monitoring of service provision by a case manager; and 6 – patient discharge and evaluation of the care plan (541).

While legislation does not provide a definition of case management, laws governing health and social care and employment services refer to the term case management in the contexts of rehabilitation and RTW, maintaining the ability to work and long-term care. Case management is mentioned in the following three statutes.

In the context of rehabilitation and RTW, §143b of the General Law on Social Security (ASVG) establishes obligations of sickness funds, the public employment service and pension funds to provide case management to persons who receive a rehabilitation allowance. This group includes persons who are temporarily, but not permanently, unable to perform duties that are part of their occupation, irrespective of their employment status. Case management in this context comprises patient needs assessment, coordination of services and holistic support in rehabilitation to regain the ability to work. Patients face no OPP costs for case management services but are legally required to cooperate with service providers. The rehabilitation allowance may be withheld if patients are found not to cooperate. From 2017, the law also provides for part-time return to work according to a reintegration plan, if agreed upon between employers and employees. During the reintegration period, working hours are reduced to between 25 and 50% of a full-time commitment and the employers pay a proportionate share of the salary with the rest covered by health insurance.

Legislation establishes a clear hierarchy of responsibilities between insurers for costs related to rehabilitation measures. Costs for health care and RTW after workplace accidents and work-related illnesses are borne by accident insurance. Pension insurance bears costs of services to avoid early retirement or long-term care due to longer-term health problems. Health insurance bears supplementary responsibility for medical services to persons no longer entitled to pension insurance benefits.

The law also provides for an interdisciplinary patient assessment team established by pension insurance, in cooperation with health insurance funds and the public employment service. Where these assessments establish that full recovery for RTW is not possible, the insured person can be eligible to claim benefits for incapacity to work or disability subject to a number of conditions. In this case, the person is no longer eligible for case management to support RTW.

In the related context of maintaining the ability to work of employed and unemployed persons, §1 of the Law on Work and Health (AGG) provides for the use of case management in early interventions to address health problems.

In the context of long-term care, §3 of the Law on the Fund for Long-term Care provides for the use of multi-professional care teams and case management, including services that 1 – involve planning of social and long-term care based on individual needs assessments; 2 – organise needed care; and 3 – manage provider interfaces.

In Austria, there exists three prominent case management programs, namely Fit2Work, rehabilitation allowance, and Early Interventions. Brief case studies for each of these programs are provided below. For more detailed information, please see Volume 4 – Situational analysis.

Figure 161: Fit2Work

Services

Fit2Work is designed for individuals who, due to a health impairment (defined by §33a RRK 2005), may find it either difficult to find work (i.e. unemployed), or to maintain their current job. Those who are employed and covered by GKKs, will be invited to participate if they have been away from work, due to illness, for 40 days or more over the past year. Those who are unemployed due to ill-health are invited by the Public Employment Services. In 2016, approximately 60% of participants were unemployed. Ultimately, the decision to participate in the program lies with the targeted individual.

Fit2Work offers free of charge advisory/mentoring services, which can be broken down into the following five categories: 1) information phase; 2) the status-quo-survey; 3) the analysis and development of improvement measures; 4) the implementation phase; 5) and the evaluation-phase.

Funding

In 2012, the Austrian Federal Government developed and implemented the Fit2Work program, which is funded by Public Employment Service Austria (AMS), GKKs, PVA, AUVA, the Ministry of Labour, Social Affairs and Consumer Protection, and the European Social Fund*.

Legal provision

The Fit2Work program is based on the Austrian Work and Health Law (Federal Act on Providing Information, Advisory and Support Services in the Areas of Health and Work, AGG) (§33a RRK 2005).

Participation

As of December 2016, approximately 17,000 participated in Fit2Work, covering 680 companies. The majority (70%) of participants were between the age of 40-59 years, and the share of female

participants outweighed male clients, reaching 57%. The majority of disease diagnoses related to either psychological disorders (about 40%), or injuries and damages relating to the musculoskeletal system (also, about 40%).

Source: See Volume 4, as well as (542)
Note: *Part of the European Commission, which aims to support jobs, help individuals gain better jobs and ensure fairer, more equitable job opportunities.

Figure 162: Rehabilitation allowance

In the case where an insuree (below 50 years of age) has a health impairment that is not permanent, and therefore only temporarily unable to work for at least six months, the health insurance carrier will be required to pay a rehabilitation allowance.

Those who receive the rehabilitation allowance will be assigned a case manager who provides assistance to the individual until they have recovered. More specifically, the case manager, for example, will set individual health targets to either stabilise or improve the patient's health status. Services provided by the case manager are offered free or charge to individuals.

The rehabilitation allowance is paid monthly and total 60% of the individual's salary, with a floor reimbursement of €889.84 per month (figure as of 2017 for single persons pegged to the equalisation supplement).

After one year, the health insurance carrier will assess whether the individual the allowance should continue.

Source: See Volume 4

Figure 163: Early Interventions

Insurees who have been absent from work for more than 28 days* due to one of the diseases outlined with §33a RRK 2005, are invited to participate in the Early Interventions Program. In this instance, the relevant GKK is responsible for inviting the individual to engage in a voluntary consultation as a way to analyse their health impairment and healing progress (§34a RRK 2005). Consultations are

predominantly led by case managers, with the objective of informing the individual of existing prevention and rehabilitation measures, such as Fit2Work.

The overall aim of the program is to identify individuals who are likely to retire early due to ill-health and assist them with their recovery process to raise the actual retirement age.

Source: See Volume 4
Note: *Excluding time spent in hospital care, inpatient or ambulatory rehabilitation, measures for health promotion undertaken by the pension insurance institutions, or any other measures to strengthen the health, as well as time spent for medical measures of rehabilitation in the accident insurance institutions.

7.2.4 Summary of the evidence

Case management in health and social care

This section summarises prior literature on interventions that provide case management for various population target groups. Evidence on the effects of interventions that comprise case management has been synthesised in a number of recent literature reviews. Evidence reviewed in these studies comes predominantly from the United States, with some studies from Canada and only a very small number of studies from European countries, including the Netherlands, Norway, Italy and the United Kingdom.

Populations targeted

Recent literature reviews have synthesised the effects of interventions that comprise case management for the following patient target groups:

- Persons with *multi-morbidity*, defined as any combination of two or more chronic diseases, in reviews published since 2010 (543–546); including an authoritative Cochrane review published in 2016 (546)
- Persons who have combinations of *physical and mental health problems* in reviews published since 2010 (547–549)
- *Frail elderly* persons in reviews published between 2003 and 2004 (550,551)

- Persons who have *terminal illnesses* or *receive palliative care* in reviews published since 2013, including broad patient groups with any severe or advanced disease who no longer respond to curative or maintenance treatment (552–555) and cancer patients (556).

Patients have also been targeted based on patterns in their use of services. Interventions have been targeted, for example, at frequent or repeated users of hospital and emergency department services (557,558) or at the point where elderly patients transition between healthcare providers, in particular at hospital discharge to avoid readmission (559). Similar to other studies, evidence synthesised by these reviews was predominantly from the United States, but also included a small number of studies from the Netherlands and the United Kingdom.

Interventions and services delivered

Two literature reviews on multi-morbid patients focused on interventions that were delivered in primary care or comparable community-based settings (543,546) while two other reviews included care delivered in any setting (544,545). In addition to providing case management, these reviews studied interventions that included improved processes for cooperation between primary care physicians and other health care professionals (543,546), other additional patient support services (546) or services following any of the five other principles of the CCM (544,545).

One literature review on patients with a combination of physical and mental health problems focused on care that was delivered in a primary care or comparable community-based settings (548), while one included any coordinated and multidisciplinary model of care in any setting (549), and a third did not explicitly specify the provider setting but included only interventions that aimed to improve cooperation between primary care physicians and other health care professionals (547).

One of the two literature reviews on interventions for frail elderly persons focused on studies of case management by a case manager only, usually a specialist nurse responsible for case finding, assessment, care planning, implementation, coordination and monitoring of care to prevent fragmentation and to optimise patient-centred care delivery (550). The other review synthesised evidence on an intervention that included case management but took a broader approach to integration of services between providers of acute and long-term care (551).

Two of the five reviews of interventions for patients with terminal illness or receiving palliative care focused on interventions similar to case management, with one (552) evaluating the effect of care coordination involving a palliative care specialist across provider settings and the other one (553) the

effect of team-based palliative care interventions delivered in patient homes. The three other reviews (554–556) were broader and included any type of palliative care intervention, of which two (554,556) did not restrict the setting in which care was delivered and one (555) restricted the setting to outpatient non-hospice care. Palliative care was usually defined as any approach that improves the quality of life of patients and their families facing the problems associated with a life-threatening illness. This often includes case management and self-management but also components such as symptom management, education and patient activation.

The review of interventions for frequent health care users (558) synthesised evidence on the effect of quality improvements to care based on the CCM, including case management, changes to professional teams, promotion of self-management, provision of decision support, and better use of clinical information systems. Case management was included in interventions evaluated by 29 of 36 randomised controlled trials (RCTs) included in the review. The review of interventions for frequent emergency department users (557) included any kind of intervention aimed at reducing emergency department attendance, and seven of eleven studies included were on case management. The review of interventions to improve hospital discharges and avoid readmissions (559) included studies of the effect of nurse-assisted case management including elements such as frequent follow-up and home visits or patient education by specialised nurses, with some variation in the scope of the services provided.

Impact

The most recent of four reviews of interventions for multi-morbid patients concluded that evidence of the effect of such interventions was growing but was still limited and not of high quality (545,546). Overall, the reviews of interventions for patients with any combination of chronic diseases found insufficient evidence or no effect of interventions on mortality and clinical outcomes related to physical health (543–546); some improvements to measures of mental health status, such as depression symptoms (546); some improvements in measures of functional status (546); some improvements in patient satisfaction (543–545) some improvements to process-measures such as medication and guideline adherence (546); and inconsistent effects on health care utilization or cost, with two reviews finding some evidence of reductions (543,544) while the other two reported insufficient evidence or found no effect (545,546).

The 2016 Cochrane review also concluded that interventions with a more narrow focus, for example on management of the risk factors of co-morbidity, medication management or improvement of functional limitations and similar areas of difficulty, were more likely to be successful than broader interventions, such as those that provide case management for all types of multi-morbid patients (546). The Cochrane

review further concluded that interventions that are mainly patient-oriented and are not linked to changes in health care delivery are less likely to be successful (546).

Three reviews of interventions for persons with combinations of mental and physical health problems found no effects on mortality but some improvement in measures of mental health, such as depression symptoms, anxiety and mental health-related quality of life, and improvements in some measures of physical health status when targeting patients with specific chronic diseases, such as HbA1c levels in depressed patients with co-morbid diabetes or a short-term reduction in major adverse cardiac events (MACE) in patients with depression and co-morbid coronary heart disease (547–549). None of these three reviews reported effects in terms of process-related measures or utilisation. Only one review investigated economic endpoints but found no effect on costs (547).

The review of case management for frail elderly persons found limited evidence of effects on health outcomes, with no effect on mortality and functional status and only one original study that was included showing improvements in cognitive status, depression and activities of daily living (ADL) (560). Evidence of the effects on patient satisfaction and emergency department use was not conclusive and no effect was found on inpatient and outpatient hospital use (560).

The review of interventions to integrate acute and long-term care for frail elderly patients found inconclusive evidence of effectiveness in terms of health outcomes but found improvements in process measures, such as enhanced feeling of empowerment among patients, increased appropriateness in the use of community-based services and reduced utilisation in other parts of the healthcare systems, including emergency department visits, specialist consultations and inpatient hospital or nursing home stays (551).

The review that focused on coordination of care for patients with terminal illnesses concluded that there was moderate evidence that such interventions improved patient and caregiver satisfaction and a low level of evidence of improved quality of life and symptom control and reduced health care utilization (552). Effects in terms of cost were not reported (552). The review of home-based palliative care did report an increased likelihood of dying at home but remained inconclusive on effects in terms of health care utilisation and cost-effectiveness (553).

Two of the three reviews of broader palliative care interventions (554,555) found that palliative care is generally more effective than usual care at alleviating pain, distress or depression and can improve physical function, symptom control or quality of life. Palliative care also had a positive effect on patient

and caregiver satisfaction (554,555). Evidence on mortality is less conclusive but suggests that palliative care is at least equally as effective as usual health care near the end of life (554,555). These two reviews (554,555) also reported that palliative care can be a substitute for usual hospital services and reduces costs through increases in use of end of life care, and reductions in hospital admissions, readmissions, emergency department visits and lengths of stays in intensive care units. One review that only looked at the effect of palliative care on emergency department use (556) found no clear evidence of reductions and concluded that substitution patterns were dependent on the designs and availabilities of alternative services in each individual health system.

Interventions for frequent users of healthcare were found to reduce hospital admissions among patients with chronic conditions but not among those with mental illness and also to reduce emergency department attendance among elderly patients (558). The reviews also concluded that case management, changes to teams of health care professionals, promotion of self- management and patient education were effective intervention components to reduce hospital admissions but that these specific components were not associated with reductions in emergency department visits among elderly patients (558). Authors speculated that the absence of an effect for patients with mental health conditions may have been caused by the fact that most original studies included a coordination strategy in the care provided to the control groups. The review on interventions for frequent emergency department users concluded cautiously that such interventions may reduce emergency department use, but also that the quality of studies was limited and that regression to the mean may have biased non-randomised studies (only three of eleven studies included were RCTs) (557). Case management was associated with reduced emergency department costs and improved health outcomes; however, cost analyses did not always include costs of the intervention so that, overall, case management may be cost neutral (557). The review of nurse-assisted case management in hospital discharge found that the interventions could reduce hospital readmission rates and reduced lengths-of-stay in case of readmission within the first twelve months of discharge and, as a result, reduce cost, but only found this result in about half of the 15 trials reviewed (559). The review was inconclusive as to which elements of the interventions were associated with the reductions (559). Limited evidence was found that the interventions reduced emergency department visits and no effects in terms of mortality were found (559).

Case management in return-to-work interventions

This section summarises prior literature on interventions that provide case management to persons who are temporarily on sickness absence from work. Several recent literature reviews have synthesised

evidence on the effectiveness of rehabilitation or RTW interventions that include case management. Evidence reviewed in these studies comes from OECD countries, mainly in North America and Europe, and are less concentrated in the United States than on case management in health care for complex patients.

Populations Targeted

Evidence has been reviewed for persons on sickness absence in general, irrespective of their specific health problems or diagnoses, in two reviews published in 2012 (561,562). One (561) of the two reviews, however, also investigated whether interventions for persons on sickness absence due to specific diagnoses were more effective than broader ones. Other reviews investigated the effectiveness of RTW interventions for persons on sickness absence due to musculoskeletal problems (563), which was also published in 2012, and musculoskeletal or other pain-related conditions (564), published in 2005. Interventions reviewed in these literature reviews typically target employees in their first two to eight weeks of sickness absence.

The UK National Institute for Health and Clinical Excellence (NICE) published public health guidance in 2009 on the management of long-term sickness absence and incapacity for work, which was defined as absence lasting more than four weeks (539). No restriction is applied in terms of the reason for sickness absence. NICE guidance is based on a systematic review of evidence to underpin the recommendations.

Interventions and services delivered

One of the two reviews on persons on sickness absence in general, irrespective of their specific health problems or diagnoses (561), synthesised evidence on the effects of a broad range of interventions, including case management or other improvements to information exchange among service providers but also elements such as employee activation and counselling, physical therapy, support by occupational physicians and workplace improvements. The other review of a broad group of persons on sickness absence (562) focused more narrowly on 'RTW coordination', a process similar to case management and involving an assessment leading to an individual RTW plan implemented by a RTW coordinator or team who coordinates services and communication among involved stakeholders.

The review on persons on sickness absence due to musculoskeletal problems (563) synthesised evidence on the effects of any intervention delivered in a primary-care or workplace setting or conducted in collaboration with primary-care providers or employers with the aim of improving work-related outcomes (sickness absence, job loss, RTW). These included physical, psychological, social and environmental

interventions directed at the person, such as physical therapy, the work or workplace, such as ergonomic adaptations, or health care and other services, including case management.

The reviews on persons on sickness absence due to musculoskeletal or other pain-related conditions (564) included a broad range of workplace-based interventions that aimed at improving RTW outcomes, including disability management, education, organisational changes and case management.

NICE guidance provides evidence-based recommendations for any type of intervention that aims to prevent or reduce moves from short- to long-term sickness absence (including the prevention of recurring short-term sickness absence); reduce recurring long-term absence; and support people on long-term absence or those with on incapacity or similar benefits with returning to work. Case management provided by employers is an element of recommended RTW interventions, if an initial assessment of the person on sickness absence establishes that case management can be beneficial.

There are also literature reviews on RTW and rehabilitation interventions in general that make no explicit reference to case management or similar planning and coordination activities in service provision but include intervention elements such as personal exercise, counselling, education, psychological support or ergonomic adaptations (565,566).

Impact

One of the two reviews on persons on sickness absence in general, irrespective of their specific health problems or diagnoses (561), found that early- and multidisciplinary interventions are effective most of the time and that providing gradual exposure back to the workplace, such as progressively augmented work tasks or partial RTW, and making work-related adaptations, such as ergonomic improvements of furniture, were effective elements. Activating interventions that stimulate employees to RTW and interventions with a pre-determined schedule of activities were found effective for physical complaints (but not for psychological complaints). The review also found that broad interventions, not targeted to persons with specific diagnoses, show no positive effect. Evidence suggested that narrow interventions for specific diagnoses were more likely to be effective but were not always effective either.

The review on RTW coordination for persons on sickness absence irrespective of diagnosis (562) found moderate evidence that coordination resulted in small increases in the likelihood of RTW by disabled or sick-listed persons by the end of study follow-up, and associated small improvements in functional status and pain.

The review on interventions for persons on sickness absence due to musculoskeletal disorders (563) found that most types of interventions included in the review appeared to be effective in achieving RTW, avoiding job loss or reducing the length of sickness absence but that no type of intervention could clearly be identified as superior to others. No specific findings were reported on the effectiveness of case management in isolation. The review also found that effects were small and smaller in in larger and higher-quality studies, suggesting publication bias. No evidence was found of significant net economic benefits.

The reviews of work-place based interventions on sickness absence due to musculoskeletal or other pain-related conditions (564) found that such interventions can reduce the duration of work disability and associated costs but found only weak evidence of effectiveness in terms of quality of life. The review found moderate evidence that case management reduced the duration of work disability and that this can also generate net cost savings within the first year of the intervention. It also found strong evidence that work disability duration was reduced by the presence of work accommodation officers and enhanced contact between health care providers and the workplace.

NICE guidance identified three main characteristics of interventions that were more likely to report positive results: early interventions, multidisciplinary approaches and interventions with a workplace component (567). Guidance recommends that employers or their designated occupational health specialists should make initial enquiries about reasons for the absence and to make a prognosis for RTW within two to six weeks of the start of the absence, and appoint a responsible case manager if necessary. If necessary, case managers are recommended to oversee a detailed assessment by specialists and produce a formal RTW plan that outlines the level, type and frequency of interventions and services needed. Such a plan can provide for gradual RTW in the original job or a return to partial duties. Finally, case managers are recommended to oversee delivery of the interventions, coordinate interactions with health care providers and other specialists and provide intensive support to people with a poor prognosis of RTW (539).

The reviews of RTW interventions that do not explicitly include case management generally found that interventions are effective when they are delivered early in the period of sickness absence, involve the workplace and are multidisciplinary (566,568).

Similar to reviews of interventions in healthcare for complex patients, most of these reviews conclude that evidence is of low or moderate quality.

7.2.5 International case studies: case management

The first three subsections of this section summarise experience in Denmark, the Netherlands and the United Kingdom with return-to-work policies in general and with case management as a component of such policies more specifically. The fourth subsection provides three case studies from the Netherlands, the United States and Spain to illustrate the use of case management for people with complex needs in health and social care.

Denmark: Broad return-to-work interventions

Since the early 2010s, Denmark has restricted access to disability benefits in favour of programs that aim directly at reintegrating people into the labour market and expanded responsibilities of municipalities for monitoring and assessing sickness benefit recipients. Employers have relatively limited responsibilities relative to other European countries and Danish municipalities, which now bear much of the financial burden of sickness absence, play a strong role in RTW. Municipalities also provide case management and multidisciplinary support for rehabilitation (569). Municipalities initially bear the costs related to such activities but receive reimbursement from the national government.

To incentivise municipalities to support people in RTW, reimbursement by the national government for people who are out of work have been reduced, especially for passive benefit payments (536). Municipal job centres are the single institution responsible all types of sickness absence and RTW benefits and all people regardless of insurance and employment status (536,570).

Denmark also maintains a flexible working scheme that provides significant wage subsidies for people with reduced work capacity, which encourages companies to employ people for fewer working hours or at lower productivity at full hours (536). The scheme was reformed in 2013 to improve targeting at people with limited work capacity and avoid attracting those who are fit for work to less demanding jobs while not reducing the number of disability benefit recipients (536,571). The reform also introduced multidisciplinary rehabilitation teams at municipal job centres (571).

Remaining weaknesses in RTW policies in Denmark are the insufficient systematic identification of people with mental health problems, who are overrepresented among the unemployed, and lack of support in RTW for such people (536). The varying levels of reimbursement of municipal costs by the national government may also lead to strategic behaviour by municipalities and allocation of beneficiaries to benefits that provide greater revenue to the municipality rather than those most suitable for the persons concerned (536).

The Netherlands: Return-to-work for people with mental health problems

Several policies have been introduced in the Netherlands to prevent long-term absence, disability and the potential permanent exit from labour markets. These policies have devolved government responsibilities to other stakeholders in the system, in particular employers but also employees, and have gone further than in many other countries in terms of legal obligations, financial incentives and potential sanctions (569). People with mental ill-health have been identified as a group with a particularly high risk of sickness absence from work (572,573).

Employers are required to appoint a prevention specialist and conduct several activities to identify, assess and address risk factors for sickness absence. They are also required to formulate a sickness management policy (574). In case of sickness absence, employers are required to continue paying 70 to 100% of the salary of the absent employee for two years and the employee cannot be laid-off. Within six weeks of the start date of the sickness absence, employees must see an occupational physician at expense of the employer (569). Occupational physicians are responsible by law for analysing workplace problems and producing return-to-work plans.

The provision of case management for return-to-work is also an obligation of employers, who are required to hire a case manager to oversee the return-to-work process. As is common in case management interventions, an action plan spelling out responsibilities in ensuring a quick return to work is part of the process, and has to be agreed upon between employer and employee within eight weeks of the start date of the sickness absence (569). Employers, often through the return-to-work case manager, monitor the return-to-work process and must record actions undertaken. Some companies also employ a social worker to provide support, in particular for those with psychosocial problems that impact their ability to work. The Employee Insurance Agency (UWV) may penalise employers and employees for not collaborating in the return-to-work process.

In case return to work is not possible, despite adjustments to the job by the employers, both the employer and employee are obliged to look for suitable work for the worker in another company. This is supported by public occupational health services, reintegration offices, and employer branch organisations (569).

It is not entirely clear how successful these policies have been. Compliance by employers with their obligations has been reported to be low, especially but not only among small companies (574). For example, fifty percent of employers have been found not to maintain guidelines for employees on when occupational physicians should be contacted in case of sickness absence and some twenty percent of

employers have been found not to meet their obligations related to sickness absences longer than two years (569). Although the independence of occupational physicians from treating physicians avoids conflicts of interest of the latter in sickness certification, the obligation of employers to fund consultations with occupational physicians has in turn raised concerns about their neutrality between employers and employees and assertions that these physicians primarily defend interests of employers (569). Sickness absence rates in the Netherlands have decreased since the 1990s and are now close to the OECD average (575). However, they remain high among people suffering from mental ill-health (569).

The lack of integration between mental health services and employment support is also a challenge. A more recent reform aimed at decentralising government responsibilities to reduce the fragmentation of services, including mental health, long-term care and employment support, and placing responsibility with municipalities (574). Fit-4-Work is an example of an initiative for people with multiple psychosocial problems who are not part of the labour market to achieve integration of services provided by social services, the UWV and the mental health care sector and accelerate return to sustainable employment (574). Services are provided by a multidisciplinary team in an individually tailored approach. The initiative was introduced in 2012 in five large municipalities and found to be effective in achieving return to work in a two-year randomised control trial (576).[106]

Another problem with policies relying on employers is that they do not support people with no permanent employment contract who do not have a work place to return to (569,577).

United Kingdom: Early intervention and focus on fitness for work

The relationships between employment and health has been recognised in the United Kingdom with policies aimed at gradually improving integration of employment and health services. Similar to other countries, reforms have included restriction of the disability benefits system, efforts to identify and address work barriers early and to increase take-up of employment services by claimants of disability benefits (578).

The United Kingdom has also aimed to transform the role of general practitioners (GPs) in improving work-related outcomes by acting as gatekeepers to benefits and supporting patients in RTW. A policy was introduced in 2010 that requires GPs to provide statements of fitness for work (also referred to as the "fit

[106] At the time of writing of this report, detailed results of the RCT evaluating Fit-4-Work in the Netherlands were not publicly available.

note") instead of the previous medical statement ("sick note") (579,580). In this process, GPs must describe the work patients who request sick leave can still do despite their health problems but go beyond certifying fitness and also take steps to help patients return to work earlier. Patients can be certified fit at various levels and GPs can request a phased return to work, amended duties, altered hours or workplace adaptations. Similar initiatives to refocus certification for sickness absence towards fitness for work have been implemented in Denmark, Sweden and Switzerland (569).

An initial survey-based evaluation of the UK fit notes found that a majority of respondents considered the process helpful in discussing necessary changes with their employers and reported that the fit note had a positive impact on employers' willingness to make changes (579). However, many fit notes were for short-term absences, stated that the patient was 'not fit for work' and did not recommend changes. Further, nearly half of respondents did not discuss changes with their employer (579,580).

In Scotland, the Early Access to Support for You (EASY) model was piloted with 11,000 staff of National Health Service (NHS) hospitals between 2008 and 2011 (581). The model provided RTW support and monitoring very early in sickness absence, from the first day, including case management by occupational nurses. Staff satisfaction with the service was high and sickness absence rates declined following the implementation (581). However, the pilot was conducted in the area with the highest absence rates in Scotland prior to the intervention, so that reductions could be related to regression to the mean, and declines followed similar trends to those the Scottish NHS in general so these effects cannot be clearly attributed to the intervention. A similar intervention, based on intensive case management by occupational health staff but focussing on staff who were absent for at least four weeks, was implemented in 2009 at an NHS hospital in Southampton in England (Return2Health - R2H) (582). The evaluation found a reduction in the rate of sickness absences that continued beyond eight weeks versus a control hospital but the methods used were also unable to attribute the effect to the intervention (582).

The Fit for Work Service (FFWS) program was piloted in England, Wales, and Scotland between 2010 and 2013. Its aim was to provide early-stage return-to-work support overseen by a case manager to reduce the drift into welfare benefits, including occupational assessments and multidisciplinary telephone advice. However, this program had difficulties in reaching the target group of employees at an early stage of sick leave, especially in the first year of operation. Initially, people who were still employed used the service most frequently. Among participants who were out of work, less than one-third had been off work for four to twelve weeks, which was the target group (569,583).

Permanent Fit for Work and national independent health and work advice and referral services have been implemented since 2014, based on best practices that were identified in the pilots (583). These services provide a work-focused biopsychosocial assessment to employees early in sickness absence, in addition it offers advice to employers and employees on needs for rehabilitation and RTW support for workers on sick leave and those still at work. It thus integrates advice to employers, particularly for small- and medium sized enterprises (SMEs), which were previously provided by the Occupational Health Advice Service (569).

Case management in health and social care for patients with complex needs

As previously discussed, case management has been widely applied to improve the delivery of health and social care for complex patients, who require services from various providers and whose care is at a particularly high risk of fragmentation. Between 2014 and 2016, LSE Health and the Commonwealth Fund, a private healthcare research foundation, led and international experts working group to identify good practices and innovative models of care delivery in care for patients with complex needs (584).

While not all of the models identified in this project have been rigorously evaluated in terms of effectiveness and cost-effectiveness, they share a number of features. For example, they commonly use routine data, from sources such as electronic health records (EHRs) or insurance claims, to target patients most suitable for the intervention; they also use information systems, such as shared EHRs, to facilitate communication between different professionals and providers involved in the process of care; they provide case management across all types of services, including physical and mental health care as well as social care, and usually embed case managers with primary care provider organisations; they support informal caregivers; and they make ensure that financial incentives for providers are aligned with the goals of the model. Figure 164 presents a case study of innovative models of care delivery for this patient group in Valencia, Spain.

Figure 164: Integrated Care Model for Complex Cases and Strategy for Chronic Care in the Valencia region, Spain

Background: An evaluation of home care in Valencia conducted in 2005/06 identified fragmentation of care between different health care providers and barriers between the health and social sector for patients with advanced chronic diseases or in need of palliative care, a complex group associated with high level of need and use of resources. An initial pilot to integrate health care for complex patients was conducted between 2007 and 2010 and scaled-up subsequently. In parallel, policies were developed nationally and in the Valencia region to respond to an aging population and the rising prevalence of chronic disease and reorient the health care provision from acute episodes to chronic disease management. More recently, the Valencia region launched a comprehensive Strategy for Chronic Care, comprising an Integrated Care Model for Complex Cases and based on earlier experience.

Objective: To improve care for complex chronic patients with multi-morbidity or in need of palliative care.

Year established: Piloted from 2007 to 2010, with gradual scale-up from 2011. The wider Chronic Care Strategy was launched in 2014.

Target group: The Integrated Care Model for Complex Cases targets patients at the apex of the Kaiser pyramid in need of complex chronic or palliative care. Electronic medical records (EMRs) are used to stratify the population monthly into "Clinical Risk Groups" (CRG) and identify high-risk patients. EMRs cover approximately 4.7M people of an entire population of 5M in the Valencia region.

Number of people enrolled: The model of care integration has been gradually expanded to cover approximately 1.2M patients in 2015 (26% of the population). Approximately 2.8% of general population covered are identified as "complex cases" using CRG, including palliative and multi-morbid patients.

Profile of patients enrolled: Complex cases are typically characterized by: age 75 or older; presence of chronic complex multi-morbidity or in need of palliative care; polypharmacy; high use of hospital resources; use of assistive and vital technologies; functional dependencies; fragile family, low capacity for self-care, adverse social or economic circumstances and high frequency of changes in clinical or nonclinical conditions.

Key model features and main intervention(s): The Strategy integrates hospital, primary and community-based health services, including hospital-at-home units and social workers, under a single management in each of the 24 health departments of the region. Social care, which is financed separately, is not formally integrated.

Newly introduced hospital nurse case managers (HNCM) and community nurse care manager (CNCM) have joint responsibility for complex cases. HNCMs identify complex cases at hospitals and are responsible for planning hospital discharge to ensure continuity of care. CNCMs are responsible for mobilizing the collaborative care process in the community and for arranging care at home. This process starts with a comprehensive assessment of the "case" (patient, informal carers and the environment) by a CNCM. The assessment is shared with a multidisciplinary primary care team (GP, nurses and social workers) to draft a care plan adapted to patient and family beliefs and preferences and including a medication review. Depending on the clinical and social complexity and acuity of the case, different resources, such as hospital-at-home, and other professionals are activated. Primary care physicians and their teams lead implementation of the plan with CNCM support. Both nurse care managers remain jointly responsible for monitoring the patient, interacting with multiple professionals and teams involved in the plan, ensuring appropriateness of care and continuity during transitions.

HNCMs and CNCMs attend 100 hours of specific training and a month of on-the-job training as pre-requisite to start working as case manager. Other professionals receive ongoing training related to care integration for complex cases.

Financing and payment methods: The Strategy is financed by the region of Valencia through its ordinary health care budget. All providers are paid as usual and staff, including nurse case managers, are salaried. There are no financial incentives for providers or staff specific to the Strategy or the Care Model for Complex Cases.

Information systems: An information system was implemented in the whole Valencia region in parallel to the Strategy. Each patient has a unique identifier and care providers, mainly in primary care, use the system in their daily practice to share patient information through electronic medical records (EMR). Data generated by hospitals is in the process of being integrated. The system is also used for stratifying the population and monitoring their conditions and drug use.

Evaluation methods: The model was not formally evaluated in terms of effectiveness or cost-effectiveness. The Valencia Regional Health Ministry monitors process measures related to scale-up of the project and health care utilization.

Evaluation results: Reduced unmet need through pro-active identification of complex cases, improved continuity of care, reduced emergency department visits and hospital admissions.

Source: Author based on personal communications with Juan Gallud; Barbabella *et al.* (585); Gallud *et al.* (586)

7.2.6 State of the evidence

In general, however, the evidence on the effectiveness of case management in improving outcomes and reducing costs remains weak. Furthermore, existing evidence also has to be interpreted with caution for a number of reasons.

First, available evidence is often of poor quality. Rigorous methods, such as RCTs, are difficult to employ in evaluations of complex interventions. Reasons for this include, but are not limited to, the inability to conceal intervention versus control group allocation from patients and professionals, spill-overs or 'contamination' of intervention and control groups when services in both are delivered by the same provider organisations or professionals, poor protocol adherence, the effects of professional behaviour and local contexts on outcomes that are difficult to control for, or ethical and political reservations around having control groups and not providing an improved intervention to all patients.

Second, evidence is difficult to synthesise, interpret and to generalise to other settings or countries because interventions that include case management are often designed in unique local contexts and are heterogeneous across original studies. Control groups often receive 'usual care', which also varies significantly between countries; for examples, the roles and responsibilities of specific health care professionals involved in providing usual care are not the same between countries. Most of the evidence is from the United States and only a small number of studies are available from Europe or other OECD member countries. This is a particular problem in applying evidence from the academic literature to the Austrian context because the United States health system relies on a mix of different private and public insurance and provider schemes and has, at the macro-level, little in common with Austrian social insurance and corporatist provider representation.

Third, case management is usually part of broader interventions designed to improve health care or health outcomes so that effects cannot be easily attributed to case management *per se* but, at best, to the entire intervention.

These limitations of study quality and the evidence notwithstanding, recent literature reviews of the effectiveness of interventions for complex patients that include case management have generally concluded that case management has no effect on mortality and little to no effect on outcomes related to physical health. They have, however, found some evidence of positive effects on mental health status, functional status, patient satisfaction or process-related measures such as adherence to medication regimens and treatment guideline. Evidence of effects on health care utilisation or cost is even more limited and generally not conclusive, with some studies reporting savings and other studies no effects or increases.

Evidence also indicates that interventions that include case management can be effective in specific subgroups of complex patients and when designed specifically for such subgroups. The 2016 Cochrane review of primary care-based interventions for multi-morbid patients, for example, concluded that narrow interventions were more likely to be successful than broader ones (546). The body of evidence on case management in palliative care for patients with terminal illness is larger than for other patient subgroups and suggests that such interventions improve quality of life and symptom control, patient and caregiver satisfaction and can also reduce costs through reducing utilisation of curative care that may have limited effect near the end of life. Evidence also suggests that such interventions are at least equally as effective as usual health care near the end of life in terms of survival. Finally, studies of interventions that provide case management for patients who are frequent users of health hospital services or emergency rooms and aim to improve transitions between provider settings and care post-hospital discharge suggest that such interventions reduce utilisation and cost and can also improve health outcomes.

Literature summarising the evidence on the effectiveness of case management in RTW interventions shows that case management, or, more generally, a formal assessment of the person out of work and personalised RTW plan, is a component of interventions that have a positive effect on work-related outcomes. Although the evidence shows that the effects achieved are small in magnitude, these studies also suggest cautiously that such interventions can be cost saving by offsetting costs of the service with accelerated return to work or increased employee productivity. Similar to health care for complex patient, case management it is usually part of broader RTW interventions and so that the effect cannot be easily attributed to case management per se based on these studies. Evidence shows that such RTW

interventions are more likely to be successful when they are provided early in the period of sickness absence, involve the workplace through elements such as improved communication between employers and care providers or adaptations to the workplace and are comprehensive in their service coverage and multidisciplinary. Successful interventions for persons on sickness absence due to musculoskeletal problems also include increased physical activity.

Evidence from the three case studies of case management in RTW interventions suggest that case management on its own may have limited effectiveness in terms of accelerating RTW or achieving sustained employment, especially when it is not targeted at and tailored for specific sub-groups of people who are out of work.

It also needs to be pointed out that, based on the current state of research described above, policy makers should not expect quick and straight-forward efficiency gains from case management. Rather, case management can provide a means of improving the process of care, is likely to improve satisfaction of beneficiaries and can achieve some improvements in health status or employment outcomes if provided to those people with the highest need. Particularly in the short term, however, it is also likely to require additional investments for providing the case management service and, in the longer term, a sustained effort in changing established and provider-specific structures in care delivery. Although the evidence on the effects of case management on healthcare costs is largely inconclusive as of yet, if targeted and executed appropriately, case management has the potential to reduce duplication and use of inappropriate services and can, together with improving the process of care or health outcomes, lead to efficiency gains. Such effects, can likely only be achieved in the longer run. This could also be a reason why many studies, that often use relatively short follow-up times of six to 24 months, do not find cost savings. Also, when case management is genuinely and proactively targeted at the patients with the highest need, interventions can uncover unmet need, which might lead to additional health care utilisation and cost increases.

7.2.7 Policy options: Case management

There are several general implications for the Austrian health and social care system that can be drawn from the international experience. These can be summarised as:

1. Target case management and other types of coordinated care based on need
2. Pilot new models, evaluate pilots rigorously and scale up successful ones
3. Increase organisational and financial integration of providers

4. Ensure comprehensiveness of the range of services covered by case management
5. Include inter-disciplinary cooperation in education and training programs of professionals
6. Continue strengthening the role of primary care and embed case management in primary care
7. Provide workplace and return-to-work interventions early
8. Embed case management in broad return-to-work interventions

Principles 1 through 5 apply to case management in general, regardless of whether it is used in health care for complex patients or by employment services to support rehabilitation and RTW. Principle 6 applies to case management for complex patients in health care only. The remaining principles apply to rehabilitation and RTW programs only.

For complex patients, the LSE Health and Commonwealth Fund International Experts Working Group on Patients with Complex Conditions provided a set of ten guiding principles (584), one of which is care coordination. These ten principles are also relevant for Austria.

It is also important to stress that the evidence clearly shows that success or failure of a given complex intervention that includes case management is highly context-dependent. Policy makers should therefore avoid copying successful models from other countries. Designing interventions specifically for the local context while taking into account factors for failure and success elsewhere and following some guiding principles is a preferable approach. Therefore, these principles are relatively broad and do not provide ready-made solutions that can be implemented easily.

Target case management and other types of coordinated care based on need

Case management should be targeted at persons with the highest need who are most likely to benefit from such a service. Targeting according to need can increase equity and also efficiency of services, because evidence indicates that targeted case management interventions are more likely to be successful than broader ones. Although the agreement under article 15a of the Austrian federal constitution on organisation and financing of the health system provides a broad obligation for stakeholders in the health and social cares system to improve patient-orientation and service coordination, current legislation on specific applications of case management takes an entitlement-based approach and defines case management as an insurance benefit for specific groups of insured persons. In particular, case management is mentioned in the contexts of services provided to persons, who are temporarily out of work and are eligible for rehabilitation allowance, employees who have health problems at work and for beneficiaries of long-term care insurance. Specifically, in the context of rehabilitation, the entitlement-

based approach linked to the rehabilitation allowance, for example, implies that persons whose health status is too poor to be considered able to regain working capacity may not receive beneficial services. More generally, there is an inherent risk in this entitlement-based approach that other population groups who might also be amenable to case management, such as people with mental health problems, multi-morbid or other groups of complex patients, or the long-term unemployed and permanently disabled, are not prioritised as target groups. Evidence also suggests that targeted case management interventions are more likely to be successful than broader ones. Persons who can benefit from case management should be identified in a holistic and needs-based approach, using person-specific information on health status or service use, rather than *a priori* based on insurance status or the responsibilities of individual insurers.

Generally, persons can be selected for case management, or other interventions, through screening, professional judgment or data-based algorithms. Each method of targeting has advantages and disadvantages and the selection of methods can influence the effectiveness of the intervention and equity in the distribution of services. Screening can achieve broad population coverage but might be impractical and expensive. Data-based algorithms offer an objective means of patient selection and equitable service distribution but are constrained by quality and availability of data. Professional judgment, on the other hand, can be more nuanced than data-based selection but is more likely to introduce bias and may lead to decisions in service provision that are based on factors other than need. However, data-based methods and clinical judgment can be combined sequentially to achieve a balance, for example, through automated analysis of patient-level data as a first step and subsequent decisions by professionals. Sources of routine data, such as claims databases maintained by insurers or EHRs (*Elektronische Gesundheitsakte – ELGA*), should be used where possible for the purpose of targeting case management.

In addition to targeting case management to patients with the highest and most complex needs, other types of coordinated care delivery should be provided to appropriate population groups, as suggested by the Kaiser Pyramid. This can include continued roll-out of disease management programs, which have been shown to be successful for patients with lower complexity (587) but are not suitable for complex patients. It should also be noted that case management is not the only appropriate approach to care for patients with complex needs. Rather, case management is usually provided in combination with other changes to health care delivery and there may be a range of suitable interventions. The Cochrane Effective Practice and Organisation of Care (EPOC) research group, for example, provides a recent and general taxonomy of 'interventions designed to improve professional practice and the delivery of effective health services' (524). The EPOC group distinguishes between four domains, 'delivery arrangements', 'financial

arrangements', 'governance arrangements' and 'implementation strategies', and provides a number of categories in each of them. The category, 'coordination of care and management of care processes' in the domain of delivery arrangements includes case management.

This principle of targeting should also apply to case management provided by employment services with the goal of accelerating rehabilitation and RTW. Persons can be targeted based on different criteria than for case management of complex cases in health care, but case management should also be provided to those persons who can benefit most. Broad RTW interventions that provide the same service to all persons on sickness absence are less likely to be effective in terms of RTW than targeted services that can provide more intensive support to a narrower group of beneficiaries.

Particularly in RTW programs where beneficiaries might not always have a regular contact with service providers in health or social care, persons who are most amenable to case management might often be difficult to reach. Achieving high enrolment rates among the target population, has, for example, been found to be a significant problem in the Austrian Fit2Work program (569). This requires engaging in active outreach in addition to making services available to the appropriate target group.

Pilot new models, evaluate pilots rigorously and scale up successful ones

Given the limited evidence on the effectiveness of case management and the dependence on context, models should be piloted and accompanied by rigorous evaluations. They can be adjusted subsequently to reflect insights from early evaluations, retaining successful elements, and scaled up gradually. Policy should avoid funding isolated pilot projects without addressing follow-on incentives or requirements that lead to adoption of successful models and the discontinuation or redesign of unsuccessful ones. The German Innovation Fund (*Innovationsfonds*) provides a useful example of how policy can encourage such an approach (588). Innovative models are selected to receive financial support by a central committee based on a funding application and a formal evaluation is required. Successful programs are required by law to be scaled up throughout the country.

Increase organisational and financial integration of providers

Linked to the first point on combining case management with other changes to the delivery of health care, policy should aim to achieve greater integration in the organisation and financing of the Austrian health and social care system. Continued fragmentation is likely to present an obstacle to coordinated care for complex patients, including case management that comprises services from all sectors of the system (589). In particular, separate financing streams for hospitals, office-based primary and specialist care and

social care services are not conducive to coordinated or integrated service delivery and provide no incentive for clinically meaningful substitution between services, for instance between hospitals and primary care providers. Also, the large number of separate insurers and corporatist stakeholders in the system have been identified as a barrier to a more strategic approach to integration and quicker take-up of initiatives at the state-level (589).

International experience with case management for complex patients indicates that financial incentives that encourage coordination are a necessary, but in and of themselves an insufficient, condition for providers to adopt coordinated approaches to care. This includes compensating professionals who take on the role of case managers, such as primary care nurses or physicians, for the time spent with patient assessment, planning and execution of care plans, and removing fee-for-service payments in favour of pooled budgets across different provider settings that incentivise the provision of services in the appropriate setting. In the Netherlands, for example, there are bundled payments for chronic care, which comprise prevention, early detection, treatment and rehabilitation (589). The lack of financial incentives has been identified as a barrier to success of prior case management programs in Austria, which were funded from the state health funds introduced in 2005 (541,589).

Ensure comprehensiveness of the range of services covered by case management

Efforts to integrate care for complex patients need to take a genuinely comprehensive approach and do not 'carve out' specific services. In some countries, this has in the past often been the case with mental health or social care, which may be subject to separate financing mechanisms and constraints from physical health care or separated as a result of organisational and cultural barriers. Although mental health care is funded through the same arrangements as physical health care in many OECD countries (590), it is often less prominent in policy debates and considered to be a field of medicine that is distinct from physical health. However, mental and physical health are strongly interrelated. Mental health problems frequently co-occur with physical illnesses and both types of illnesses may have mutually compounding effects. Moreover, people with mental health problems often receive poor care for their physical health needs. As a result, mental health patients have significantly higher mortality and morbidity related to physical health (591–595). For patients with complex needs, who, by definition, include a high number of people with a combination of physical and mental health problems, care for mental health needs to be integrated with physical health.

The principle of comprehensiveness should also apply to case management provided by employment services with the goal of accelerating rehabilitation and RTW. Contrary to case management for complex

patients in primary care, case management for people who are temporarily unfit to work is often provided by public employment services in other countries. However, even if the case management service is provided by employment service or disability insurance, it should cover the full range of health and social care services required to address all personal needs in the rehabilitation process. This can help prevent jobseekers with health problems from slipping into reliance on longer-term disability or pension benefits. It also requires integration in the funding of various services to avoid shifting beneficiaries between benefit schemes, which is costly and unproductive for society and the person concerned.

Include inter-disciplinary cooperation in education and training programs of professionals

Effective case management requires that professionals who take on case management responsibilities are adequately trained and that, more broadly, education for all professions involved in delivering health and social includes principles of interdisciplinary cooperation. Many prior examples of case management have relied on nurses to provide such services, because they already possess sufficient knowledge of clinical care and the health care system and can be trained relatively easily to act as strong coordinators of services provided by other health professionals. This does not necessarily imply that case managers have to be qualified nurses. However, successful models from other countries, such as those described in the case studies, usually establish formal job profiles for case managers and include training elements for case managers as well as other professionals involved.

Continue strengthening the role of primary care and embed case management in primary care

Coordination of care delivery should go beyond disease management that is implemented on top of current structures and aim to genuinely change existing structures in the delivery of care, particularly in the outpatient sector and in bridging in- and outpatient care. Evidence and the case studies reviewed in this section of the report indicate that interventions often suffer from insufficient take-up or poor protocol adherence by providers. It is therefore important that case management, and other forms of care coordination, becomes in integral part of care delivery. This includes a continued effort to strengthen the role of primary care, encouraging multi-disciplinary primary care teams and moving away from the traditional model of the individual family physician practice and placing greater responsibility for the entire process of care with primary care providers.

The responsibility for case management of complex patients should be placed within primary care. Experience from Germany and the United States suggests that case management and similar forms of care coordination provided by health insurers, often through remote coordinators, are not successful in

improving care or outcomes for complex patients. If provided by a single insurer, such case management programs run the risk of focusing only on the services paid by the specific insurer rather than a comprehensive range based on patient need and can add an additional layer of complexity to service delivery. On the contrary, case management can be more effective when case managers are embedded in provider organisations, in particular in primary care. Approaches that place case managers with insurance funds may thus not be the preferred approach. Rather, insurers could provide payments that provide appropriate incentives to primary care providers who take on the responsibility of case management. Although some prior examples of case management in the Austrian health and social care system (541) have focused on patient groups that can likely benefit, such as complex patients discharged from hospital, greater efforts should be made to identify and target the patients with the highest need proactively and embed case management in provider organisations rather than with insurers.

Provide workplace and return-to-work interventions early

Programs to reduce sickness absence should not only include reactive RTW programs, but be integrated into the work place and comprise preventive components, in particular for high-risk groups, such as employees with mental health problems. For people already on sickness absence, the probability of RTW is high early during sickness absence. Although there is no universal and precise definition in the literature of 'early' in terms of days, weeks or months (539), interventions should target such persons in the first few weeks of absence. Guidance by the UK NICE recommends that, if considered appropriate for the person based on an initial assessment, a case manager be appointed within the first two to six weeks of sickness absence (539).

Embed case management in broad return-to-work interventions

There is no evidence that case management on its own improves work-related outcomes in RTW interventions. Rather, case management can be an element of successful interventions but these should also address a range of needs that cannot be addressed by improving the coordination of existing services. When provided by insurers, RTW programs should actively involve the employer and the workplace, for instance through adapting working conditions to allow for earlier RTW or permitting a phased RTW, and provide a range of needs-based support to persons on sickness absence, such as exercise for persons with musculoskeletal conditions or counselling for persons with mental health problems.

Legal considerations

No particular constitutional impediments have to be faced with respect to these options, but some legal amendments would be required.

8 Additional efficiency potentials

Chapter 8 outlines additional ways to improve efficiency within healthcare systems. Specifically, this chapter explores issues related to administrative costs, healthcare fraud and business processes.

8.1 Typologies of waste in healthcare systems

Berwick and Hackbarth (2012) identified six categories of waste in the healthcare system – failures of care delivery, failures of care coordination, overtreatment, pricing failures, fraud and abuse, and lastly, administrative complexity (see Table 91) (596).

Table 91: Forms of waste within healthcare systems (Berwick and Hackbarth, 2012)

Form of waste	Description
Care delivery failure	Poor delivery of healthcare services that fail to maximise patient outcomes with given resources
Care coordination failure	Failure to coordinate patient care across relevant healthcare providers within all levels of the system
Overtreatment	Provision of unnecessary services
Pricing failures	Where prices deviate from those expected within 'well-functioning markets'
Administrative complexity	Inefficient processes that led to unnecessary administrative tasks
Fraud	Costs caused by those who intentionally abuse the system for their own gain

Source: (596)

This report has previously discussed waste regarding care delivery (for example, see section 3.5), care coordination (for example, section 6.1) and overtreatment (for example, see section 3.5). This chapter explores two outstanding forms of waste, namely administrative costs, and healthcare fraud. For each

category of waste, the financial cost in Austria has been compared with similar countries. Based on these findings, a range of policy options have been developed to further reduce waste in the healthcare system.

8.2 Administration costs

Administrative costs within the healthcare system represent funds spent on activities not directly targeted at improving health outcomes (597). At the health insurance level, administration costs can include claims processing, planning, management, regulation and collection of funds (597).

A relatively high proportion of healthcare costs consumed by administrative tasks is viewed as wasteful, and is therefore often the first component governments/payers try to cut (598). Such treatment of administrative costs should be approached with caution, given administration represents a core element of running any healthcare system. Further, additional administration is often required to meet new policy objectives targeted at measuring health performance. Therefore, higher administration costs can in fact assist improvements in healthcare quality (598). For example, P4P schemes involve additional data collection, reporting and analysis, and thus lead to higher administration costs.

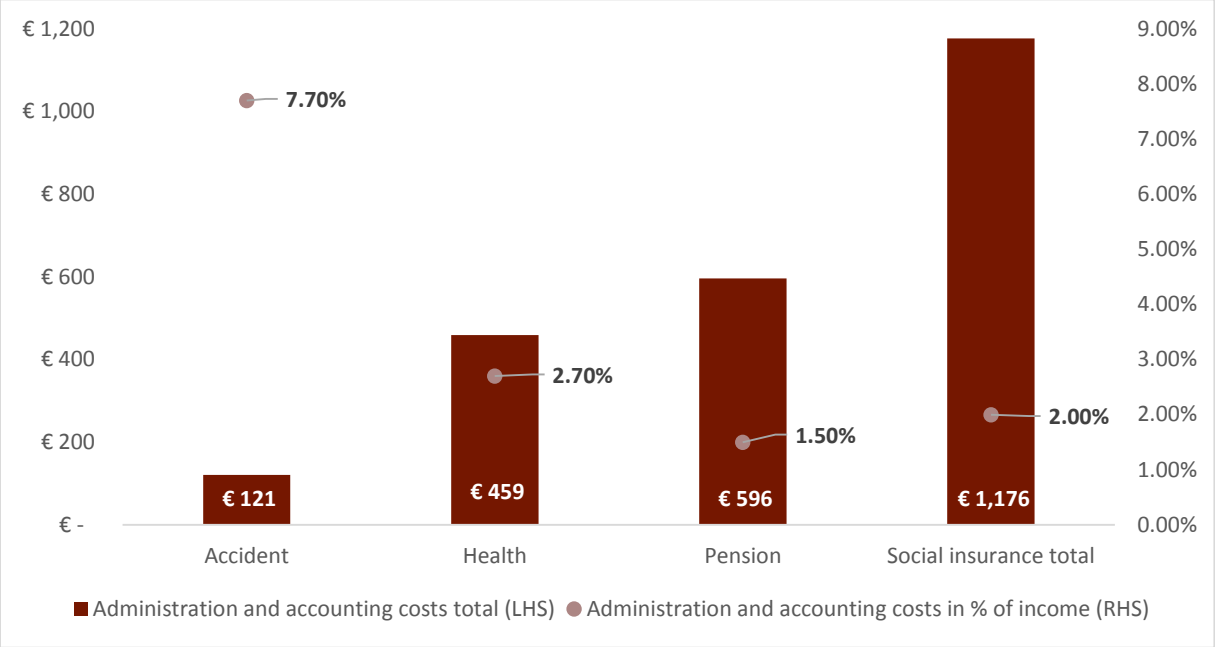
For the reasons outlined above, it is not always appropriate to equate administration with wasteful spending. Thus any analysis of trends in health administration costs should aim to tease out administrative outputs that contribute little to no additional value (598).

8.2.1 Administration costs within Austrian social insurance

Administration costs across all insurance types

In 2015, administration expenditure within Austria's social insurance system totalled €1.2 billion, which on average, accounted for 2% of total income. The figure below outlines actual administration cost (in million euros) as well as administrations costs as a proportion of income for each of the three insurance pillars. Findings from the figure show that pension insurance recorded the highest gross expenditure on administration at €596 million, followed by health (€459 million) and accident (€121 million). This order is reversed when measuring administration costs as a proportion of total income. Specifically, 7.7% of total income within accident insurance was spent on administration followed by health (2.7%) and pension (1.5%).

Figure 165: Administration costs (gross in millions, and % of income) by insurance type (2015)



Source: Data from Verwaltungsstatistik (2015) and Finanzstatistik (2015)
Note: LHS = Left-hand side, RHS = Right-hand side.

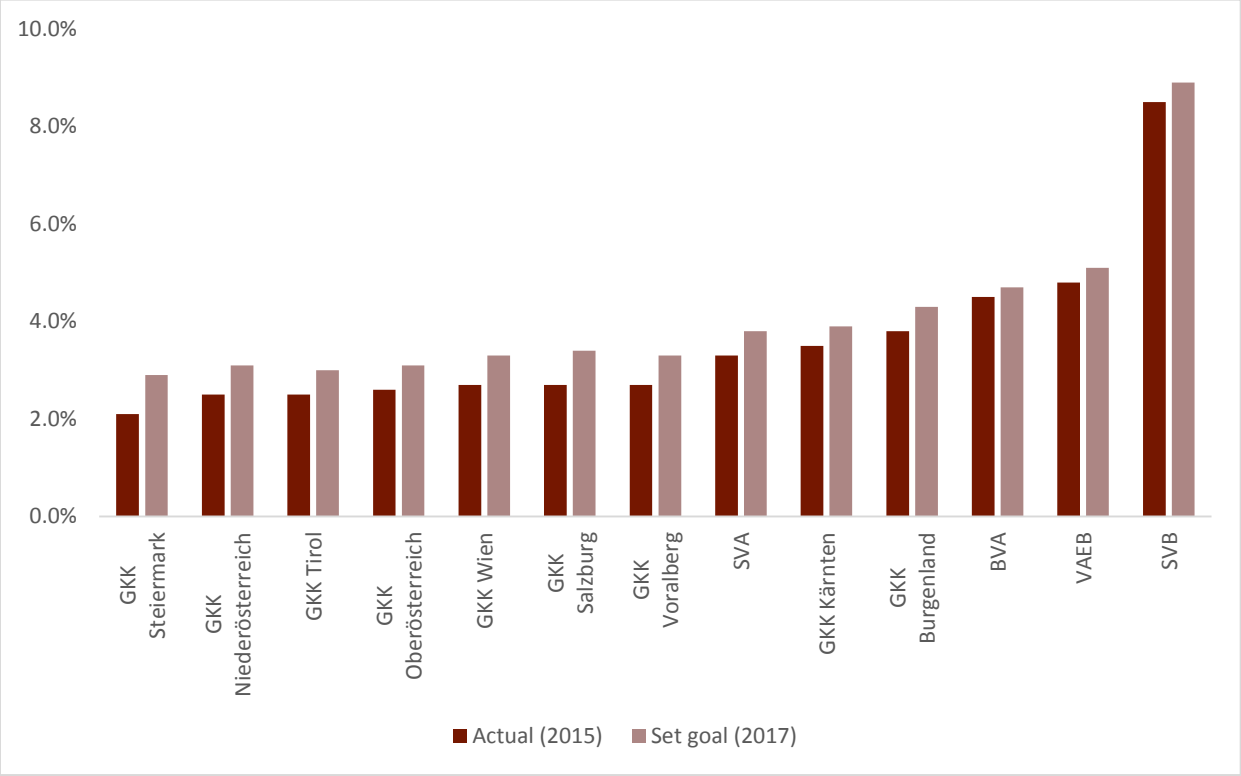
Administration costs by social health insurance carrier

In 2012, a simplified more transparent system for setting administration cost targets, as a proportion of contributions paid, was introduced (§441e ASVG). Social insurance carriers as well as the Ministry of Labour, Social Affairs and Consumer Protection, and the Ministry of Health and Women's Affairs must agree to these targets. An overview of actual (2015) and set (for 2017) administrative costs for each health insurance carrier has been depicted in the figure below. The figure suggests that those carriers offering multiple forms of insurance (e.g. health, accident and/or pensions) have higher administration costs, which could arise from diseconomies of scope.

The latest administration cost targets were calculated using historical administration costs as a proportion of contribution incomes (i.e. between 2008 and 2010). Specifically, the average historical administration cost plus an additional 0.4 percentage points of the historical value, plus an additional amount to cover costs arising from changes to the law. Once the cap has been set, social health insurance carriers do not have the power to change it.

Implementing simpler more transparent administrative cost caps is a positive move, however, efficiency potentials arising from this policy are not being maximised. For example, high (low) administrative costs are not linked to penalties (rewards), further, adherence to the cap is neither published nor analysed.

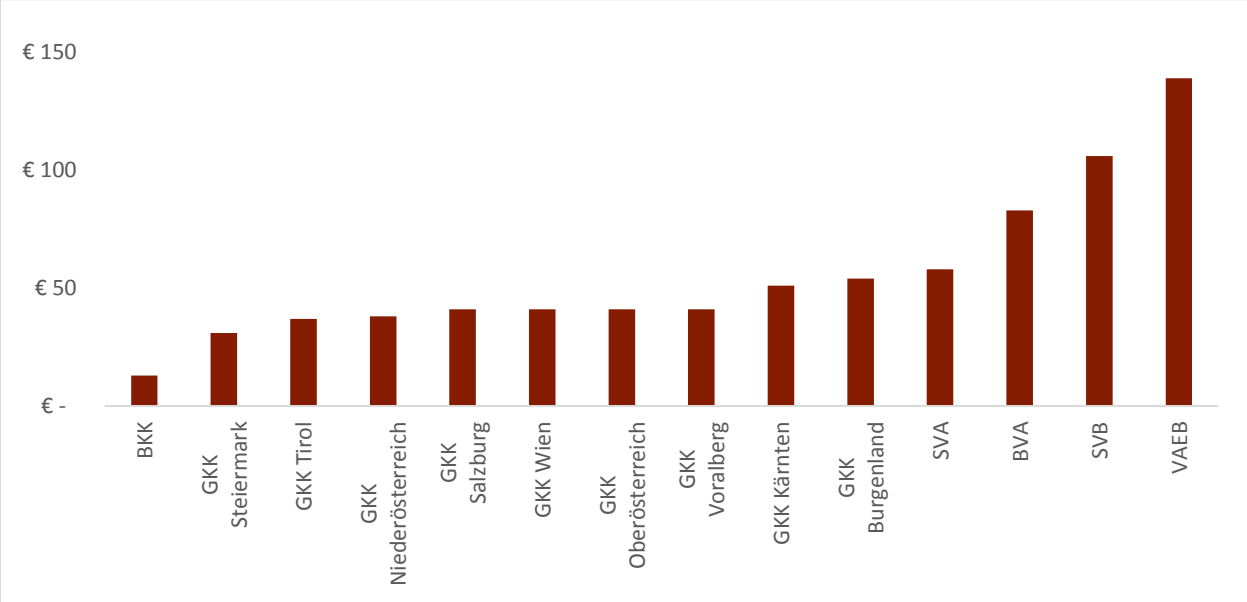
Figure 166: Actual (2015) and set administrative costs (2017) as a proportion of contributions paid



Source: Based on data from Verwaltungsstatistik 2015 and HVSV BSC 2017.

Average administrative costs per person for individual social health insurance carriers has also be examined and outlined in the figure below (total figure including dependents). Administrative costs per insure range between just €13 and €138, with the average cost equating to €75. It is important to note that the majority of administrative costs associated with BKKs is borne by the employer, and therefore not directly comparable with other health insurance carriers.

Figure 167: Average administrative costs per person by social health insurance carrier (2015) (including dependents)



Source: Data from Finanzstatistik 2015, Hauptverband and Handbuch der Österreichischen Sozialversicherung, 2016.

Caution should be taken when interpreting administrative costs per insurance carrier above. Specifically, lower administrative costs doesn't necessarily indicate greater efficiency given figures do not take into account relevant factors such as:

- Number of claims
- Differences in benefits
- Healthcare risks within the insured population
- Geographical distribution of insured population
- Administrative costs related to provision of services (e.g. hospitals, dental clinics, rehabilitation centres).

For this reason, comparison of administrative costs is more informative when taken at the national aggregate level and compared to similar healthcare systems, that is, social health insurance systems.

8.2.2 International administration costs within healthcare systems

Methodology and caveats

To compare healthcare expenditure and financing data across numerous countries, the OECD developed a System of Health Accounts (SHA), which is based on common concepts, definitions, classifications and accounting rules (599). SHA therefore, in theory, provides a framework for uniform reporting which enables cross-country comparisons and analysis of trends over time (599).

Health administration activities, as defined by SHA, include 'planning, management, regulation, and collection of funds and handling of claims of the delivery system', and exclude administration from healthcare providers (599). To date, OECD provides the highest-quality comparisons of healthcare administration costs, however, a number of caveats exist. Namely:

- Administrative costs are likely to be underestimated as they exclude healthcare provider costs
- Countries are not always clear on what should be included within 'administrative expenditure', however, the OECD have found that from 'limited feedback' most countries use similar methods
- Difficulty disentangling healthcare costs and costs within other forms of care (e.g. social care) and general government activities, which can lead to non-reporting
- Identifying available data sources
- Administrative costs may be the responsibility of a different agency than the health ministry/department, and therefore may be omitted
- An appropriate level of administrative costs does not exist, therefore developing a goal level of administrative cost is difficult
- Administrative costs across countries are not necessarily directly comparable given health insurance carrier responsibilities differ (e.g. all healthcare, or just outpatient care, as in Austria) (598,600).

Social health insurance administrative costs

Figure 168 provides an overview of administrative costs financing scheme as a proportion of current health expenditure (CHE),[107] for countries with social health insurance systems – Austria, Belgium, France,

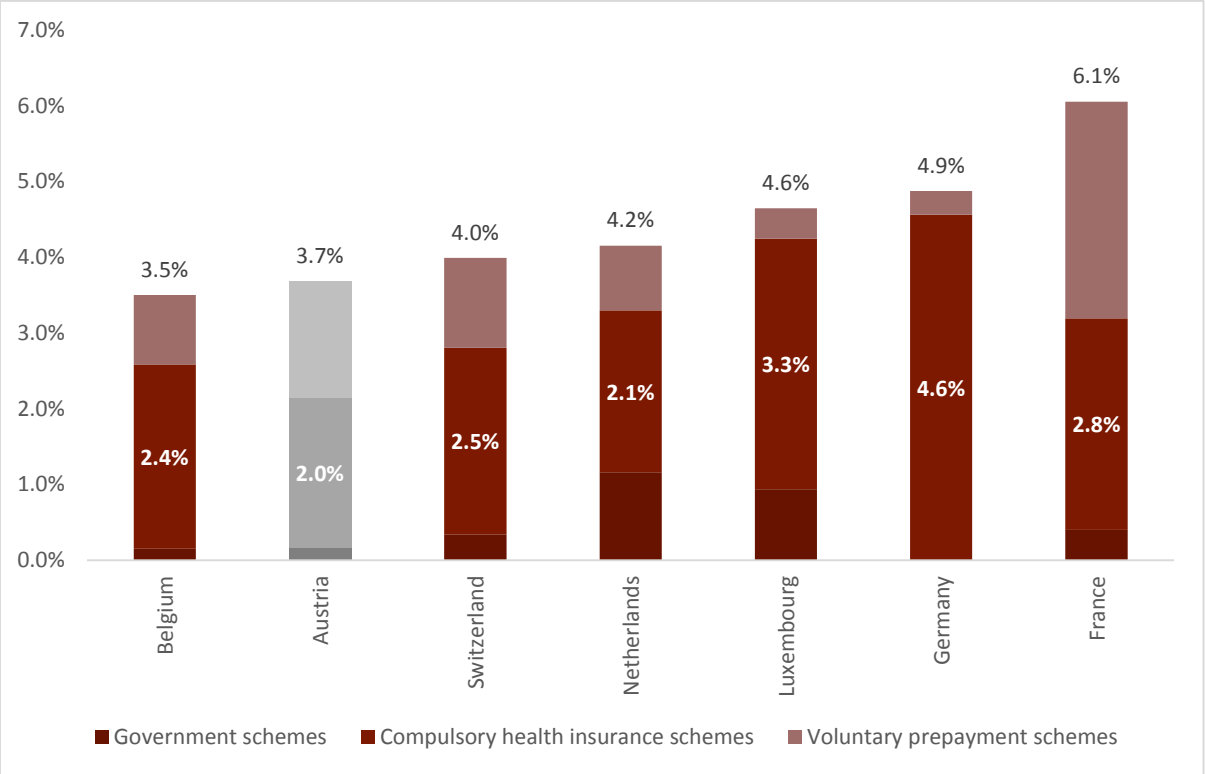
[107] The following criteria were used within OECD SHA to calculate costs: **Function** – governance and health system and financing administration; **Financing scheme** – government schemes, compulsory contributory health insurance schemes/CMSA, and voluntary prepayment schemes; **Measure** – share of current expenditure on health (see link for relevant platform: http://stats.oecd.org/index.aspx?DataSetCode=SHA) .

Germany, Luxembourg, Netherlands and Switzerland. This report has only explored these countries given the significant impact of organisational and financial structure on administration costs (601).

Results from the data show that Austria, relative to other SHI countries, has low administrative costs at 3.7% of CHE. Of this amount, 54% can be attributed to compulsory health insurance, 42% to voluntary prepayments and 5% to government schemes. These proportions differ across countries, for example, in Germany, 94% of administrative costs relate to those accrued within compulsory health insurance schemes.

Lastly, the figure for France could be considered an outlier at 6.1%, which reflects the high proportion of people who purchase voluntary health insurance to cover OOP payments (i.e. approximately 95%).[108,109]

*Figure 168: Administrative costs by financing scheme, % current health expenditure (2014)**



Source: (52)

Note: **Government schemes** - Administrative and operational services related to compulsory

[108] Private health insurance is associated with higher administration cost, for example, due to administrative tasks to assess an individual's risk, set appropriate premiums, designing benefits packages, and reimbursing/refusing claims (7(603)).

[109] Private health insurance is associated with higher administration cost, for example, due to administrative tasks to assess an individual's risk, set appropriate premiums, designing benefits packages, and reimbursing/refusing claims (7(603)).

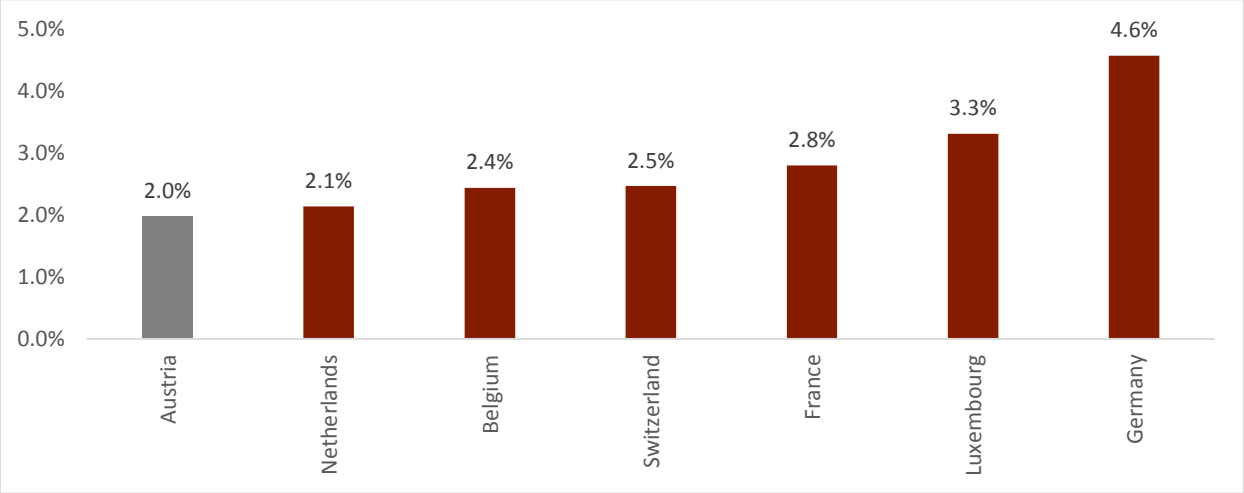
governmental health delivery schemes, involving the provision of benefits due to sickness, childbirth or temporary disablement. **Compulsory health insurance schemes** - Administrative and operational services related to compulsory health insurance schemes, involving the provision of benefits due to sickness, childbirth or temporary disablement.*This graph estimates administration as a % of CHE at 2.4%, this is slightly below the 2.7% recorded previously given a different based was used (i.e. contributions paid).

The data from Figure 168 has been broken down in Figure 169 to show administrative costs for compulsory health insurance only. Similar to overall administrative costs, it is evident that administrative costs within Austria's social health insurance system are low (at 1.97%). Czypionka *et al*. (2017) noted that this is likely due to: a) the non-competitive nature of the insurance market (i.e. no choice of provider), which means insurance carriers do not expend funds on marketing/advertising; b) bundled transaction costs across service providers; and c) no upfront patient costs that require patient reimbursement and management of significant number of claims (as is the case in France and Switzerland) (604).

Germany recorded the highest administrative costs across the seven countries at 4.56%. Reasons for this may include:

- Low economics of scale due to the high number of sickness funds (over 100 competing sickness funds)
- The nature of the German health insurance system, which require sickness funds to negotiate prices and packages from individual service providers at both the regional and national level (604).

Figure 169: Administrative costs for compulsory insurance schemes, % current health expenditure (2014)



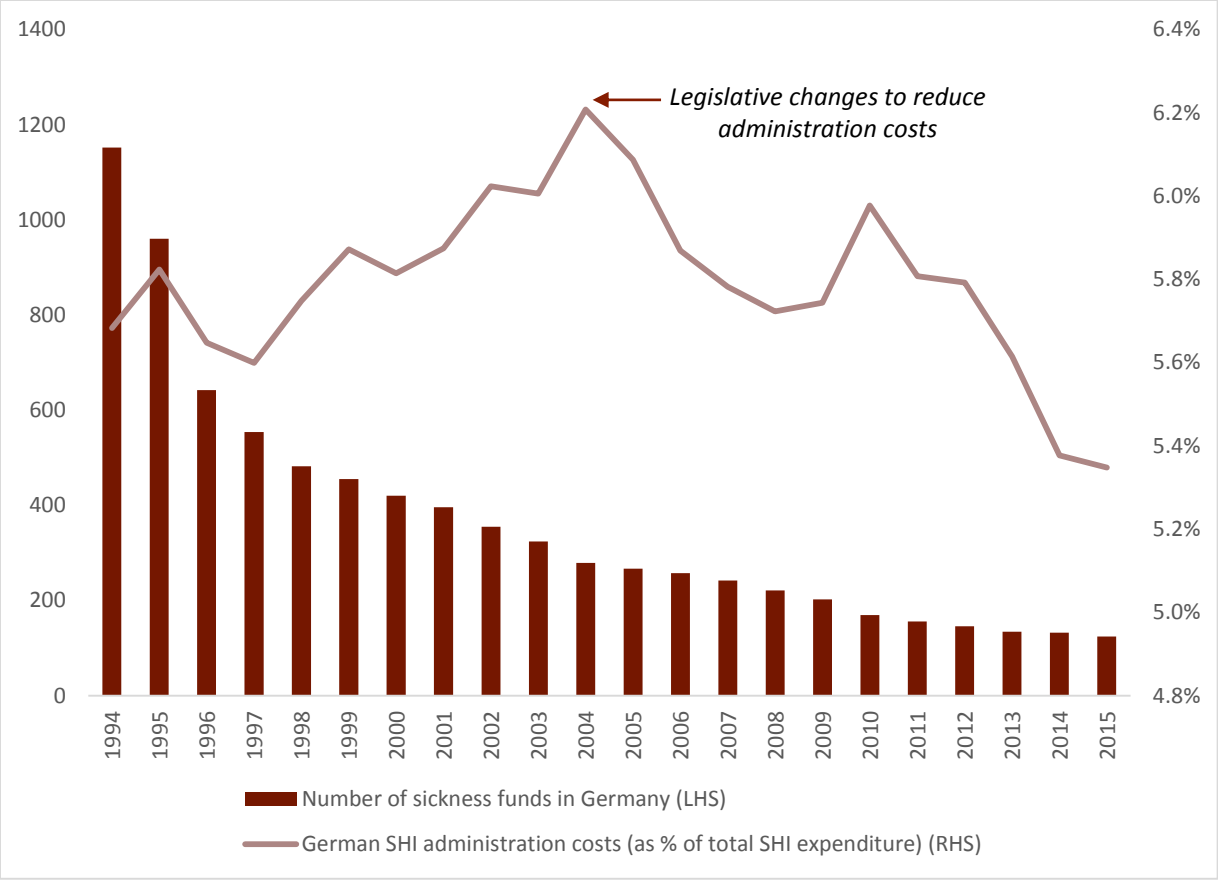
Source: (52)

Note: Health insurance carrier responsibilities differs across countries, therefore figures are not directly comparable.

Impact of carrier numbers on administrative costs

The figure below outlines the change in the number of sickness funds and associated administrative costs within Germany's social health insurance system between 1994 and 2006. Findings from the data show that amalgamation may not necessarily result in greater efficiency as measured by lower administrative costs. Specifically, in Germany, administration costs continued to rise despite the falling number of sickness funds. Only legislative changes in 2004 were able to limit administrative costs within the country's social health insurance system.

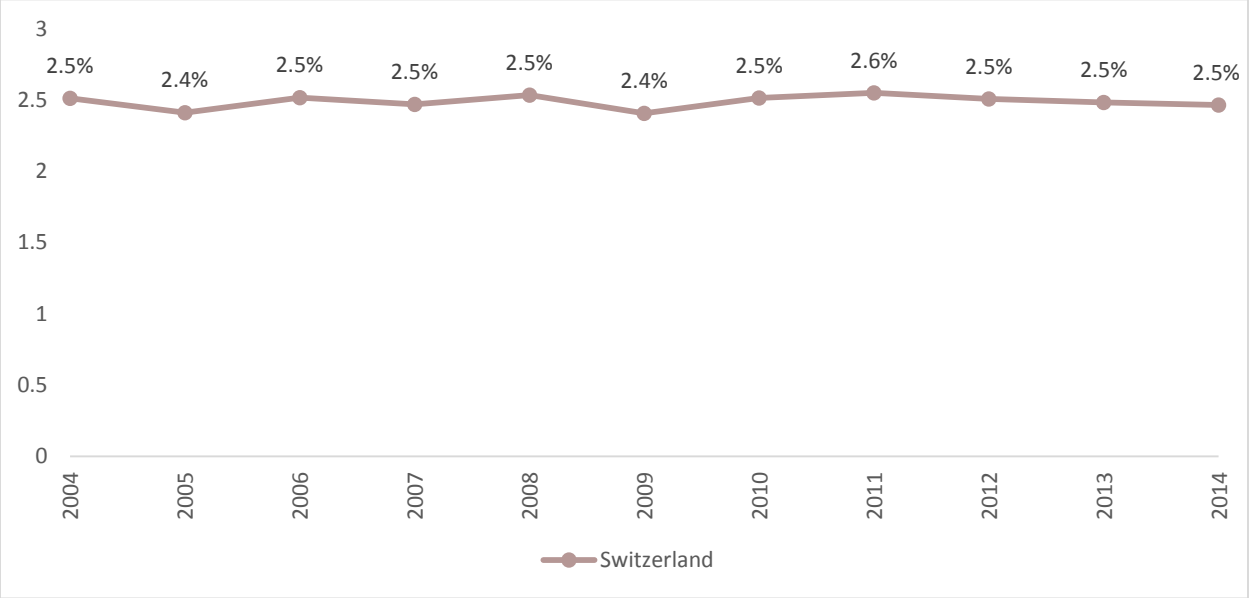
Figure 170: Number of sickness funds and administrative costs (% total expenditure) (Germany, 1994-2015)



Note: LHS = Left axis, RHS = right axis.

Similar findings occurred in Switzerland where the number of carriers fell significantly between 2006 and 2016 (i.e. from 87 to 57). Despite this, administration costs as a proportion of current health expenditure did not change significantly (see figure below).

Figure 171: Administrative costs in Switzerland (% CHE, 2004-14)



Source: (52)

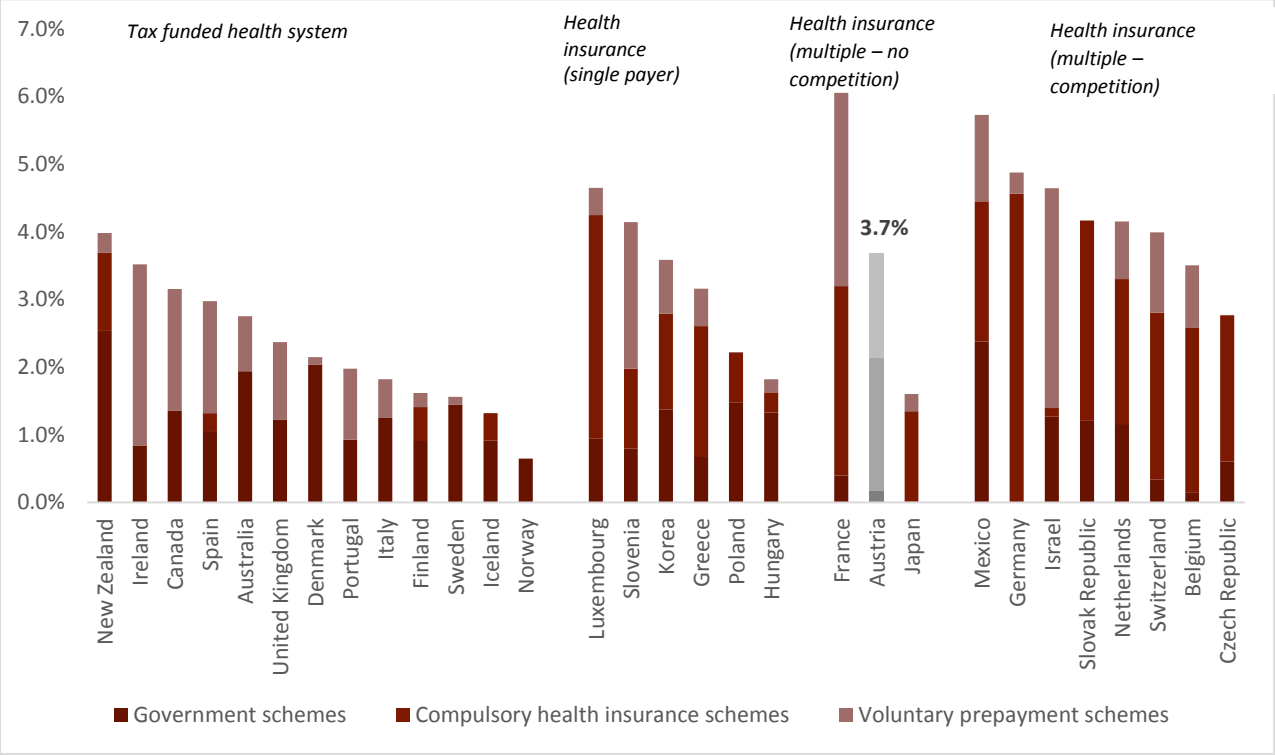
These findings reflect those from Wieser *et al*. who noted that, in Switzerland, 'there is no link between the size of the funds and the amount of administrative costs per insured person'. For example, within a competitive environment, although carriers may amalgamate, they continue to compete by trying to select insurees with good risks, which results in higher administrative costs (605).

Administrative costs across all healthcare system typologies

Figure 172 maps out administration costs across the following types of health care systems – tax funded, health insurance (single payer), health insurance (multiple insurers with no competition), and health insurance (multiple insurers with competition). In general, single funded systems have lower administration costs compared to those that have multiple insurers (payers). Differences in administrative costs between single and multiple payers may arise from differences in economies of scale (for example, multiple payers have multiple collection agencies, exemption policies and claims processing systems) (598,602). Further, multi-payer systems require sophisticated risk-adjustment mechanisms to ensure all insurers are on the same 'level playing field'. Such systems are costly and require updating (598).

Multiple insurers with competition have the highest administrative costs, given the associated marketing and advertising costs, developing and executing multiple selective contracts, and keeping the list of insured people up-to-date.

Figure 172: Administrative costs across different types of healthcare systems (2014)



Source: (52)

Summary

There exist systematic differences in administrative costs across different types of healthcare systems. Specifically, healthcare systems that have a single payer and/or in systems whereby insurers do not compete have lower administrative costs. Austria, being a country with multiple healthcare payers (i.e. health insurance carriers) that do not compete, has neither high nor low administrative expenditures when compared to all forms of healthcare systems.

Given significant differences across healthcare system types (see Figure 172), administration costs in Austria should only be compared with other social health insurance systems, namely, Belgium, France, Luxembourg, Germany, the Netherlands, and Switzerland. Using the latest available data from the OECD (2014), it is evident that across social health insurance systems, Austria has the lowest administrative costs at 1.97% of current health expenditure. Caution should be taken when interpreting results given there are numerous caveats associated with using and comparing this type of cost data across countries.

8.2.3 Policy options: Administration costs

Relative to other social insurance systems, Austria has low administration costs. However, among social insurance carriers there exists significant variability, with administrative costs per insurance case (excluding dependents) ranging from €18 (BKK) to €188 (VAEB) (see Figure 167). It is unclear whether these disparities are justified by factors such as number of claims, differences in benefits and/or geographical distribution of insurees. For this reason, it is recommended that a detailed study into factors impacting administration costs at the individual insurance carrier level be undertaken.

Based on the study's findings, a more appropriate system for developing administration cost caps could be implemented. Specifically, given targets are set above historical rates (i.e. 0.4 percentage points above), carriers have already achieved their target (see Figure 166), thus removing any incentive to reduce administrative costs. Instead of using historical values, administrative cost targets could be based on potential economies of scale arising from more streamlined administrative functions. For example, by implementing structural models 1, 2 or 3, or by coordinating current activities, as proposed under model 4. If, however, the current calculation method is retained, it is recommended that health insurance carriers be required to document how additional administration costs were spent. For example, to improve overall health system performance by collecting and analysing additional data to monitor quality of care. Such activities may in the medium- to long-term increase overall system performance and savings, which could be used to enhance front-line services. Concurrently, it is advised that social health insurers be encouraged to implement practices that reduce other forms of administration costs, that is, those that do not directly enhance service provision.

Legal considerations

No particular constitutional impediments have to be faced in this respect.

8.3 Healthcare fraud

8.3.1 Definition of healthcare fraud

A number of researchers and institutions have developed succinct definitions of fraud (also commonly referred to as corruption) within the healthcare sector. The definition used by the European Healthcare Fraud & Corruption Network (EHFCN) refers to that developed by the Institute of Medicine of the National Academies (USA), which differs according to whether corruption occurs in the public or private sector:

'*Passive corruption in the public sector occurs whenever a public official, directly or indirectly, intentionally or in circumstances where it should have been known to him or her, requests or receives any undue advantage for himself or herself or for a third person, or accepts an offer or a promise of such advantage, in order to act or refrain from acting in the exercise of his or her official functions*'

'Directly or through an intermediary, requesting or receiving an undue advantage of any kind, or accepting the promise of such an advantage, for oneself or a third party, while in any capacity directing or working for a private sector entity, in order to perform or refrain from performing any act, in breach of one's duties.'

Source: (606)

Transparency International, an international non-profit, non-governmental organisation dedicated to combating corruption, along with Vian (2007) define corruption more succinctly as misuses of entrusted power for one's private gain (607,608).

8.3.2 Types of healthcare fraud

Multiple studies summarise types of fraud in the healthcare sector. Of most significance are the typologies developed by Vian (2007) and Transparency International (2016), which can be grouped by the following themes:

- Financial and workforce management
- Delivery of healthcare services
- Regulation
- Research and development
- Marketing
- Product distribution and storage
- Budget and resource management
- Governance (further details provided in the table below).

Types of fraud in Austria's healthcare system include informal payments, favouritism, and instances of doctors in public hospitals encouraging patients towards private health care facilities. For example, a report undertaken by Czypionka *et al*. (2007) found that 15% of respondents (nine in total) had been suggested that they visit a private clinic to ensure an earlier operation date (609).

Table 92: Types of fraud in the healthcare sector

Type of fraud	Examples
Financial and workforce management	Inappropriate selection for jobs, promotions and training
	Accreditation of health professionals
	Absenteeism
	Embezzlement and misuse of funds
	Up coding
	User fee revenue
Delivery of healthcare services	Informal payment from patients
	Unnecessary referrals and procedures
	Private use of public products, equipment, facilities or time
	Favouritism by healthcare providers for certain clients
	Overcharging for services or providing inferior services
	Manipulation of outcome data
	Unnecessary referrals and procedures
Regulation	Inappropriate approval of products
	Improper product quality inspection
	Improper approval of professional accreditation
	Inappropriate health facility/workers certification
	Abuse of power
Research and development	Abuse of researching funding systems
	Improper trial/study design

Type of fraud	Examples
	Misleading dissemination of results
	Conflict of interest
	Recruitment for trials
Marketing	Improper inducements to healthcare providers and facilities
	Improper advertisement
	Improper advertisement
	Improper post-marketing trials/studies
	False or misleading product claims
	Disease/fear mongering
Product distribution and storage	Theft and diversion of products
	Infiltration of falsified and substandard products (biased application of accreditation, certification or licensing procedures and standards)
	Re-packaged non-sterile and expired products
Budget and resource management	Payroll management
Governance	Abuse of power

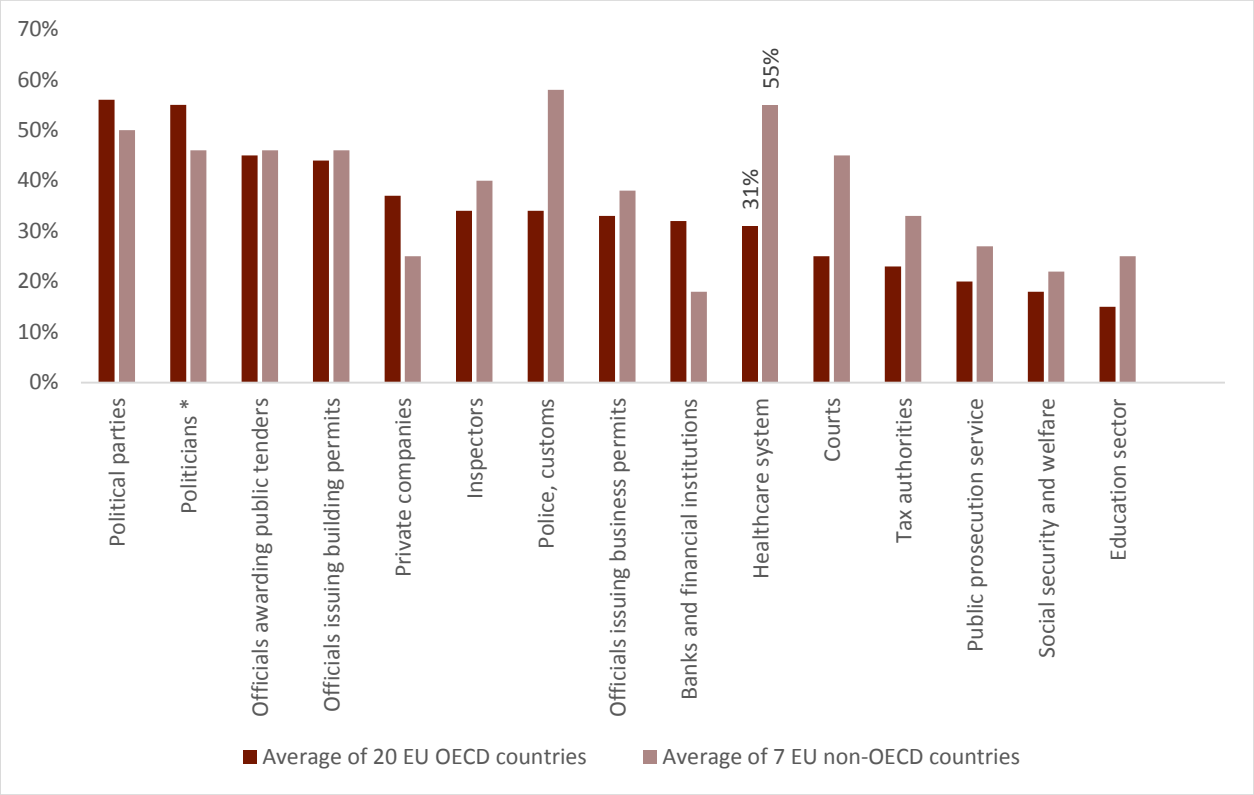
Source: (607,610)

8.3.3 Causes of healthcare fraud

Weak internal controls and minimal government oversight, foster fraud and error amongst citizens and agency employees within a social welfare system. For example, if there is a perception that the penalty for committing fraudulent behaviour is unlikely or minimal, individuals are more likely to engage in such behaviour.

The healthcare sector is susceptible to fraud for a number of reasons (see figure below for the perception of corruption in a range of sectors) (611). These include, but are not limited to: information asymmetry (where the provider has more information/knowledge than the patient), patient susceptibility, complexity of products and services, uncertainty (e.g. outcomes from treatment), significant amounts of public money, sector decentralisation/fragmentation, opaque pricing (i.e. supply and demand do not determine the 'right' market price), and the high-level of private sector involvement (598,610).

Figure 173: Corruption perception across sectors in EU OECD countries versus EU non-OECD countries (2014)



Source: (612)
Note: data not available at the country level.

8.3.4 Consequences of healthcare fraud

Measuring the financial cost of fraud and medical error has gained prominence among policy-makers and researchers over the last 15-20 years. This is reflected by the growing number of agreements and studies estimating this type of waste. For example, the number of fraud and error measurement exercises increased from 25 to 268 between years 1997-2001 to 2012-2016 (613). The majority of this work has been undertaken in the US with the introduction of the *Improper Payments Information Act* (IPA) (2002),

which mandates US public authorities to: a) identify programs and activities that may be susceptible to improper payments (payment that should not have been made or that was of the incorrect amount); and b) to estimate the annual cost of the improper payment (614). In Europe, no legal requirement to measure fraud and error has been implemented, however, in 2004, 28 EU member states agreed to the *European Healthcare Fraud and Corruption Declaration*. The declaration outlines eight objectives, including the 'development of a European common standard or risk measurement, with annual statistically valid follow-up exercises to measure progress in reducing losses to fraud and corruption throughout the EU' (615).

In addition to financial consequences, fraud and error in the healthcare sector has both direct and indirect negative impacts on patients and human lives. For example, through provision of substandard medicines, inequality in access to care (e.g. through informal payments), distorted allocation of resources and poor quality care. In addition to these, fraud and error has an adverse impact on healthcare budgets.

For the purpose of this review, only specific information on the financial consequences of fraud and error have been explored.

Cost of healthcare fraud

As outlined with the OECD's 2016 paper, 'Tackling Wasteful Spending on Health', measuring the frequency and associated cost of fraud and error in the healthcare sector is challenging (616). Reasons for this are: the existence of multiple definitions for what constitutes fraud and error in the healthcare sector, the inability to define and contain fraud into one basic metric that can be adopted by different countries, and the fact that fraudulent activities are hidden.

Despite these caveats, several international studies have been undertaken to measure the cost of fraud in the healthcare sector (see table below for further details). Using data from the various studies, it could be stated that approximately 5-6% of all healthcare spending is lost to fraud (with estimates ranging from 0.01% in the UK to 10% in the US).

Given the shortcomings outlined above, results from the studies are not comparable across countries. Further, caution should be taken when interpreting figures of detected healthcare fraud as these are likely to be underestimated (613).

Table 93: Overview of studies estimating the cost of fraud in the healthcare sector

Author	Year	Country	Cost
NHS Protect	2016	UK	£6.5 billion lost to fraud in 2015-16 or 0.01% of NHS net expenditure
National Institute for Health and Disability Insurance	2016	Belgium	Health insurers unjustly billed €11.6 million
Gee & Button	2015	UK, France, Belgium, Netherlands, Australia, and New Zealand	6% of total healthcare between 1997-2013
CNAMTS (France)	2014	France	€200 million lost to healthcare fraud in 2014 (or 1% of health insurance benefits)
Ley & Button	2013	Italy	5.59% of healthcare expenditure, on average
Association of Health Insurance Funds	2013	Germany	Detected €43 million in fraud
Accenture	2013	US	Between 2-10% of healthcare spending is lost to fraud (on average, this costs US$60 billion)

Author	Year	Country	Cost
EHFCN	2013	EU countries	€56 billion lost annually to fraud and error
EHFCN	2010	Germany	5-8% of total healthcare in 2010

Source: See country profiles (in addition to (611)).

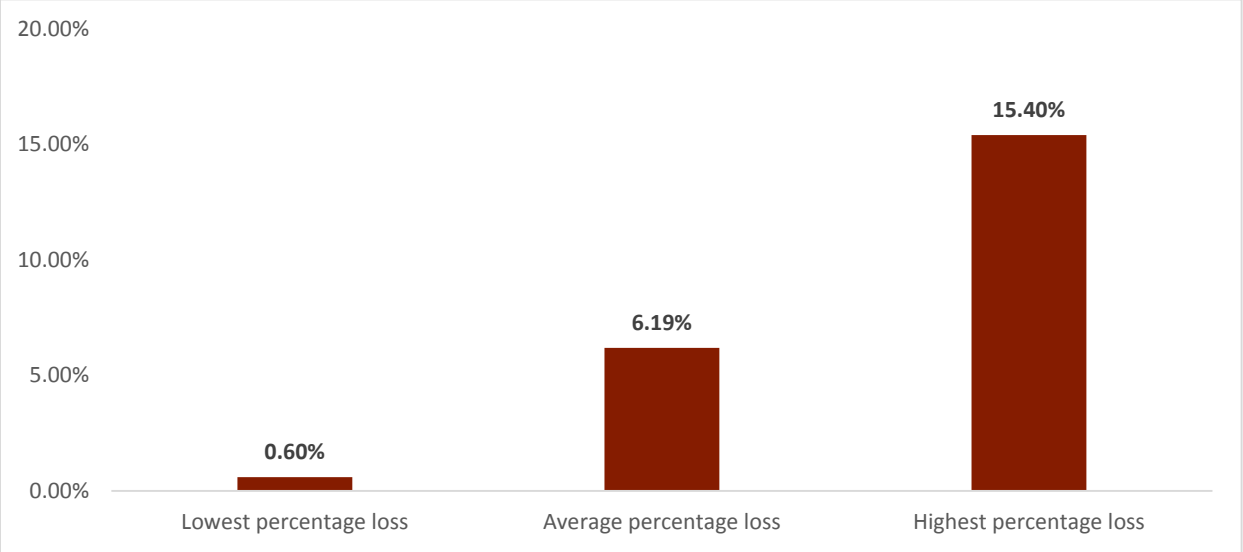
Multiple countries

The most commonly referred to study on the cost of fraud and error in the healthcare sector is undertaken by Gee & Button, who provide frequent estimates across a number of countries (617). Within their calculations, the authors include the following areas to measure healthcare fraud: fraudulent sickness certificates, prescription fraud by pharmacists and patients, in addition to fraud and error concerning: capitated payments to GPs and doctors to manage a patient's care, evasion of dental charges by patients, opticians regarding eye tests, healthcare organisation employees, inpatient, long-term, home and community-based services, provision of services and supplies, health insurance for children, foster care, and finally, childcare (618).

The latest available report is from 2015 and includes the following six countries: UK, France, Belgium, Netherlands, Australia, and New Zealand. Results from the study show that, on average, 6% of total health expenditure (or £229 billion) was lost to fraud and error between 1997 and 2013 (see figure below) (617).[110]

[110] The authors do not disaggregate between the total cost by fraud and the total cost of medical errors.

Figure 174: Proportion of healthcare expenditure lost due to fraud and error (1997-2013)



Source: (617)
Note: Data not provided at the country level.

Belgium

The Medical Evaluation and Inspection Department (MEID) within the National Institute for Health and Disability Insurance in Belgium is responsible for ensuring the accountability of healthcare providers, and deter fraudsters and abusers. The latest available data show that healthcare providers inappropriately billed €11.6 million to health insurance. Of this amount, €5.3 million was reimbursed by health insurance on a voluntary basis (619).

Italy

In Italy there are 12 main drivers of fraud in the healthcare sector, four are associated with supply-side and 12 on the demand-side (see the table below for further details) (620). A report undertaken by Ley and Button (2013) estimated that the average rate of fraud in the country's healthcare system is 5.59%, with a minimum and maximum rate of 3.29% and 10%, respectively (620). As a proportion of total health expenditure, this translates into €6 billion a year (620).

Table 94: Drivers of corruption in Italy's healthcare sector

Demand-side drivers	Supply-side drivers
• Uncertain or weak regulatory framework • Information gaps across health system users • Fragmentation for the demand for health services	• Political interference in technical-administrative choices • System complexity • Far-reaching powers • Low level of accountability • Low ethical standards • Information gap between health system and private suppliers • Growth of private health care • Pack of transparency in use of resources

Germany

A report undertaken by EHFCN estimated that between €5 and €18 billion was spent on healthcare expenditure in 2010. Of this, 5-8% was lost to fraud and corruption, specifically from:

- Billing for series that were never rendered
- Providing unnecessary treatments or tests
- Up-coding (billing for a more expensive diagnosis than was provided)
- Falsifying or exaggerating the severity of a patient's illness
- Kickbacks for referrals
- Offering incentives to actual or potential referrals
- Counterfeit drugs (621).

The cost of fraud among social insurance carriers in Germany has also be calculated. In 2013-14, for example, the Association of Health Insurance Funds detected €43 million in fraud (616).

United Kingdom

Each year NHS Protect, which works to protect NHS staff and resource from crime, publishes an annual report providing an estimate on the cost of fraud, bribery and corruption. In 2015-16, NHS Protect

received 5,000 reports concerning fraud and corruption, of these, 900 were investigated. Following the conclusion of investigations, NHS Protect in collaboration with Local Counter Fraud Specialists (LCFS) in 2015-16 estimated the total cost fraud in healthcare at £6.5 million. This figure equates to 0.01% of NHS net expenditure within the same financial year (622,623). Finally, as noted in NHS Protect's 2015-16 annual report, the organisation is currently investigating allegations of fraud, bribery and corruption that equate to over £25 million (623).

8.3.5 Strategies to combat potential sources of healthcare fraud

Findings from the literature

Within the peer-reviewed literature on healthcare corruption, Vian, T. is one of the most cited researchers. In 2008, Vian released a paper outlining a conceptual model of corruption in the healthcare sector. Within this framework, six institutional factors that impact the level and opportunity for healthcare fraud have been identified, namely: monopoly power, discretion, accountability, citizen voice, transparency and enforcement (607). Each of these factors and aligning high-level strategies have been explained in detail in Table 95.

Table 95: Institution factors impacting corruption in the healthcare sector

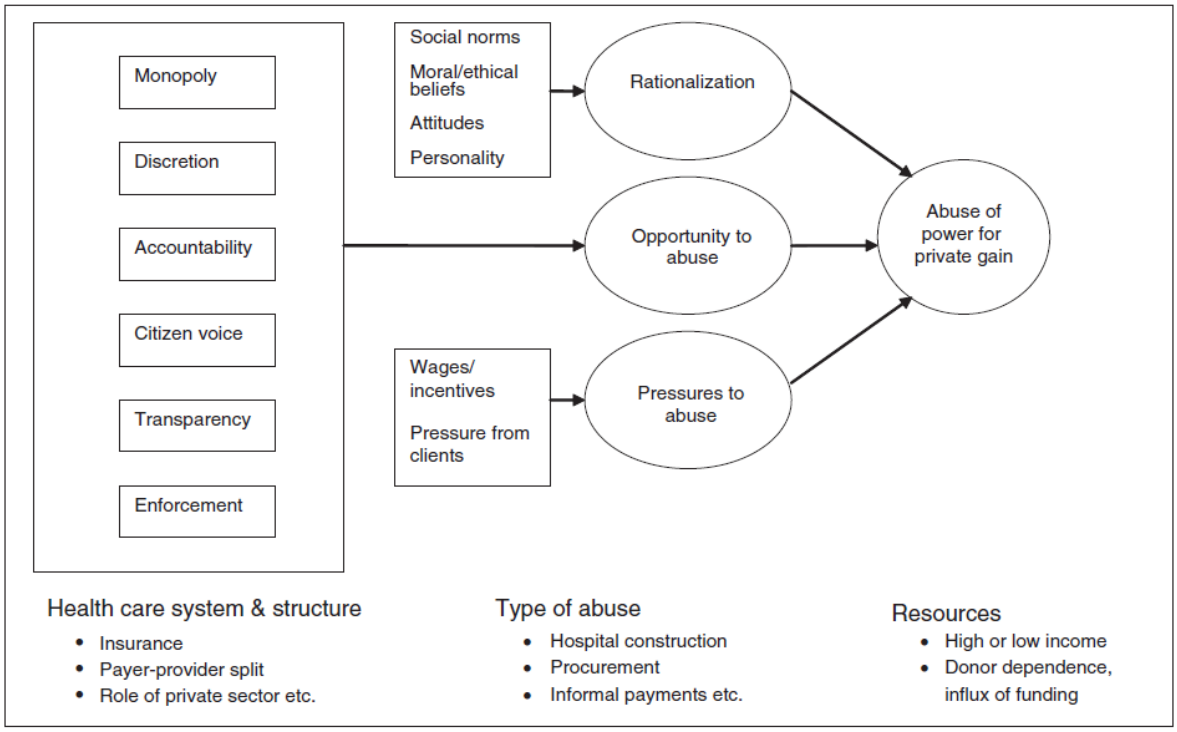
Institution factor impacting level of corruption	Description	Example high-level strategies
Monopoly power	Monopoly power refers to a situation where there is only one provider of healthcare goods and services. Such a situation limits individual choice and increases the opportunity for corruption (e.g. the provider may demand bribes to access certain services).	• Reforms to separate payer and provider • Privatisation
Discretion	Discretion describes the situation where a government agency has full autonomy over	• Create a system of checks and balances

Institution factor impacting level of corruption	Description	Example high-level strategies
	key decisions in the healthcare sector. High levels of discretion increase the likelihood of corruption.	across different people/departments • Strengthening information systems • Develop standard operation policies and procedures that all must follow
Accountability	Accountability ensures that providers are held accountable to the objectives and services they are funded to deliver. Low levels of accountability encourage corruption.	• Robust information systems outlining how inputs are translated into outputs • Incentives that rewards (penalises) good (bad) performance
Citizen voice	Citizen voice refers to mechanisms that allow individuals to actively participate in the planning and provision of services. High levels of citizen involvement reduce the possibility of corruption.	• Implementation of local health boards • Patient surveys • Complaint offices
Transparency	Transparency is closely related to accountability, and specifies that providers disclose information on decision making processes and performance.	• Legally enforced disclosure of information

Institution factor impacting level of corruption	Description	Example high-level strategies
	Greater transparency lowers the possibility of corruption.	• Publically available information performance
Detection and enforcement	Detection and enforcement relates to the 'steps' taken to collate evidence on corruption and penalise those who are caught engaging in such practices. Better detection and enforcement policies lower the possibility of corruption.	• Surveillance • Internal security • Investigations • Anonymous centres for reporting corruption

Source: (607)

Figure 175: Conceptual framework of corruption in the healthcare sector



Source: Taken directly from (Vian, 2008) (607)

More recently, Gaitonde *et al*. (2016) undertook a review of interventions aimed at reducing corruption in the healthcare sector (624). The interventions identified within the review can be broken down into seven categories, which largely overlap with those produced by Vian (2008). Specifically, information dissemination, detection and enforcement, establishment of an independent agency, transparency and accountability, discretion, incentives, and monopolies (624). Interventions within each of these categories were then assessed according to their impact on corruption (as well as adverse effects, resource use, and health and health outcomes). Results from this exercise show that information dissemination, detection and enforcement, transparency and accountability, and establishing an independent agency (who coordinates anti-corruption behaviour) had desirable effects on corruption. However, there was only high certainty of evidence for the impact of an independent agency. The impact of remaining factors on corruption had medium to very low certainty of evidence and have therefore not been reported in this review (624).

8.3.6 International case studies: Strategies to address healthcare fraud

This section outlines healthcare fraud and error strategies implemented within Australia, Belgium, France and the UK. Arrangements for each of the institutional factors, as identified by Vian's conceptual framework (2008), have been mapped for each of the countries outlined above.

Although each country has adopted a unique approach to combating healthcare fraud, one component they all have in common is the existence of a specific institution/body responsible for addressing healthcare fraud.

Australia

In Australia, fraud against the Australian Government is defined as 'dishonestly obtaining a benefit, or causing a loss, by deception or other means' (625). The Audit and Fraud Control Branch of the Australian Federal Department of Health is responsible for detecting and investigating cases of fraud within the healthcare system. Specifically, for fraud that occurs within Medicare (universal healthcare system for Australians), the Pharmaceutical Benefits Scheme (PBS) (government subsidises for eligible medicines, the Child Dental Benefits Scheme, and other health relative incentives programs (626).

Cases of fraud against healthcare providers within any of the above schemes can be reported by anyone using an online 'tip-off form', which allows user to confidentially report on any fraudulent or suspicious activity. Alternatively, users can call the 'Provider Compliance Tip-off Line' (since its establishment in February 2016, the hotline has received 850 tip-offs) (625,627). Online links and resources are also available to those who wish to report against Australian Public Servants or to report cases of fraudulent behaviour occurring at the administration level of Australian healthcare programs (625).

In Australia, potential cases of fraud within the healthcare system are investigated at the state level. If serious enough, the Department will coordinate investigations with state or Federal Police. Such cases may also be referred to the Commonwealth Director of Public Prosecution (CDPP) for consideration of criminal prosecution (625).

In 2015-16, the department continued to deliver a range of fraud minimisation strategies. These included a whole-of-government fraud awareness eLearning package, as well as presentations to public healthcare sector staff on fraud awareness (627).

In the financial year 2015-16, the Department undertook 190 investigations into fraud, up from 169 in 2014-15. The Department referred 35 investigations to the CDPP, which included: 31 matters relating to corporate entities/employers, employees or their associations, three matters concerning health providers, one matter relating to pharmacists (627).

Belgium

The Law Concerning Compulsory Healthcare and Disability Insurance (July 1994) (H&D Insurance Law hereafter), established the National Insurance for Health and Disability Insurance (NIHDI), a public social security institution that manages and supervises compulsory health care and benefits in Belgium. Within NIHDI sits the Department of Inspection and Control, which can be broken down into two sub-groups, namely the Department for Administrative Control and the Medical Evaluation and Inspection Department (MEID) (619).

MEID is a national institute with regional branches and is the most relevant body for tackling fraud and error within the Belgium healthcare system. Further information regarding the institution's role, mission, strategy, budget and staffing are outlined in Table 96.

Table 96: Medical Evaluation and Inspection Department (Belgium) characteristics

Characteristic	Description
Role	• Raise accountability of healthcare providers • Deter potential fraudsters and abusers • 'Fight' healthcare fraud
Mission	Support the optimal use of resources within the compulsory healthcare and disability insurance
Budget	€30 million annually
Staffing	261 staff, including 73 'back office' staff and 188 working within regional branches. Team is multi-disciplinary including doctors, nurses, analysts and lawyers. Medical inspectors each have an

Characteristic	Description
	area of expertise and professional training is continuous.

Source: (619,628)

To be specific, under the H&D Insurance Law, MEID has legal competences to investigate and prosecute the following eight forms of healthcare fraud:[111]

- Billing for healthcare that has not been provided: fine ranging between 5-200% of the total amount defrauded
- Billing for healthcare provisions non-compliant with coding rules (i.e. incorrect pricing): fine ranging from 5-150%
- Billing for healthcare provisions that cannot be considered preventative nor curative: fine ranging between 5-100%
- Healthcare provisions that can be considered as unnecessary and/or unnecessarily expensive: a fine ranging between 5-100%
- Prescriptions that can be considered as unnecessary and/or unnecessarily expensive: fine ranging between €500-€50,000
- Overprescribing of specific (expensive) medication: a fine between €500-€20,000
- Billing with documents that do not comply with administrative formalities: a fine between €50-€500
- Incitement of healthcare providers to provide or to prescribe unnecessary and/or unnecessarily expensive provisions: fine between €1,000-€250,000 (619).

Since 2016, MEID has begun reporting frequency of fraud by healthcare profession according to a 'waste typology matrix', which distinguishes different types of infringements. Within the matrix there exists four categories, namely: **error** (benefiting by unintentionally breaking a rule), **abuse** (benefiting by 'stretching a rule', thus taking advantage of limited rules/guidelines), **fraud** (benefiting by intentionally breaking a rule), and **corruption** (benefiting from abusing power with third party involvement) (619).

[111] Information taken directly from Vincke. P (2017), within *Healthcare Fraud, Corruption and Waste in Europe: National and academic perspectives*. Edited by Mikkers et al.

Between 2014 and 2015, the number of infringements sanctioned by MEID increased by 93% (i.e. from 635,325 to 1,225,585). Of these infringements, 887 led to investigations which found that €11.6 million of healthcare providers unjustly billed; of this amount, 60% (€6.9 million) was voluntarily refunded, while an additional 46% was paid after receiving a warning (4% was not re-paid) (619).

Although fraud-related investigations only comprise 8.4% of all investigations (i.e. 75 of the 887), these cases made up 38.57% unjustly billed costs (as a result of billing for services not rendered, or performing unnecessary care). Of this amount, just 32.53% of was voluntarily refunded, highlighting the difficulty associated with recuperating healthcare fraud costs.[112]

An evaluation into the long-term impact of MEID revealed that the institution has been successful in changing people's attitudes towards healthcare fraud. For example, action to reduce the number of redundant restorative fillings in 2011 continues to save approximately €8 million annually. Further, in 2010, action to ensure correct use of evoked potentials (i.e. measures the time taken for nerves to respond to stimulation), on average, saves €7 million each year (619).

In addition to MEID, in 2014, the Anti-Fraud Commission for healthcare was established. NIHDI and the seven mutual health funds are represented within the Commission, which aims to combine efforts to address fraud involving patients and providers (e.g. certificate theft, billing for healthcare not provided) (619).

France

At the national level, the Audit Department and Counter Fraud Office (DACCRF, Direction of audit, control and sanctioning of fraud), which is attached to the CNAMTS, is responsible for 'investigating, prosecuting and preventing fraud' by developing a national strategy. The strategy is then defined within a set of guidelines, which are disseminated to local health insurers (see the table below for an overview of healthcare fraud responsibilities at the national, regional and local level).

[112] Data provided directly from NIHDI.

Table 97: Healthcare fraud responsibilities by level of government (France)

Level	Responsibilities
National	DACCRF responsible for investigation, prosecution and prevention of fraud
Regional	Coordinates investigation programs at the national level, in addition to local and regional activities
Local	Implemented fraud prevention policies (e.g. handling of fraud reports)

Source: (619)

To undertake healthcare fraud related activities, CNAMTS is provided with a budget of approximately €104 million (as of 2014). Part of this budget is used for staffing, which includes statistical experts, legal experts, and administrative and medical expert investigators. There are approximately 1,572 full-time employees within sickness insurance who are involved in activities directly related to investigation, prosecution and prevention of healthcare fraud (619).

Prevention of healthcare fraud was identified as a key priority within the 2004 *Assurance Maladie* (sickness insurance) Law. The importance placed on healthcare fraud is also evident from changes to Social Security Law, which are outlined in Table 98.

Table 98: Changes to Social Security Law to combat healthcare fraud (France, 2004)

Measures	Example actions*
Administrative	• Warning to the provider • Range of financial penalties • Prior authorisation for prescriptions provided by targeted physicians • Physicians with unusual prescription behaviour must accept to change his/her practice, if not prior authorisation will be implemented

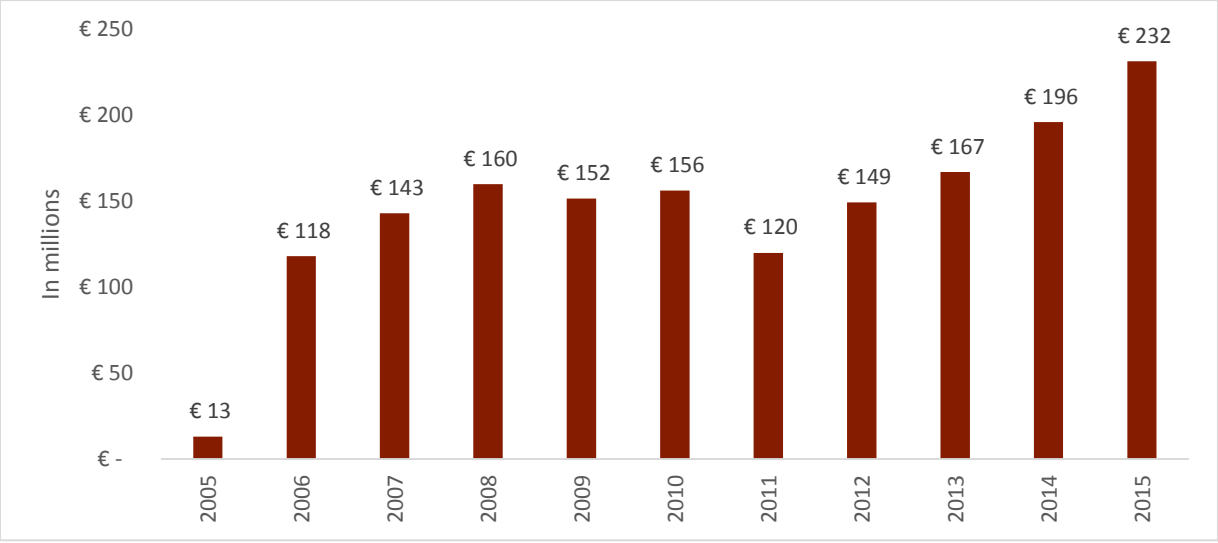
Measures	Example actions*
Legal	• Referral to the Chamber of Doctors • Referral to the court (with criminal sanctions of up to seven years in jail, and a financial penalty of €750,000

Source: Data provided by IEC member.

The specific action taken by social health insurance depends on how the act is classified, that is, as either fraudulent, wrongful or abuse. **Fraud**, which involves intentionally committing an illegal act results in a financial penalty and legal consequences; **wrongful unintentional activities** that are irregular lead to financial penalties; while providers who **abuse** services or their prerogatives are notified to their relevant professional body (619).

By intensifying and professionalising efforts to combat healthcare fraud, the total amount of fraud and abuse detected and stopped, in terms of undue payments by sickness funds, increased from €13 million in 2005 to €231.5 million in 2015 (see figure below) (619).

Figure 176: Amount of fraud and abuse detected and stopped (in millions)



Source: (619)

England

NHS Protect is the agency responsible for tackling fraud, bribery and corruption, within NHS England and NHS Wales (629). NHS Protect takes a multi-faceted approach to tackling fraud in the healthcare sector, which is both proactive and reactive (630). Within the current NHS Protect Strategy (as of October 2016), three 'key principles for action' have been defined to deal with incidences of crime (including fraud and corruption). At a high-level these are to 'inform and involve', 'prevent and deter', and 'hold to account' (further details provided in the table below

Table 99).

Table 99: NHS Protect's principles for action

Principle	Description
Inform and involve	NHS Protect is to inform and involve NHS staff on fraud, bribery and corruption in order to increase understanding of the impact of crime against the NHS.
Prevent and deter	NHS Protect works to remove opportunity for fraudulent behaviour to occur and discourage those who may commit such crimes (e.g. by reporting on successful prosecutions).
Hold to account	NHS Protect professionally trains specialists to tackle crime (including fraud, corruption and bribery). This assists in ensuring crimes are detected and investigated, and where appropriate, suspects prosecuted.

Source: (630)

In 2015, NHS Protect launched a new online fraud and corruption reporting tool. The online tool[113] allows anyone to report concerns of fraud within the NHS (i.e. when fraud led to loss of NHS funds); reporters can choose to provide their name and contact details, or report anonymously (631). Information on fraud within the NHS is also collected through data sharing arrangements with the wider NHS, public sector bodies, and professional regulatory bodies.

Investigations into instances of fraud are undertaken by Local Counter Fraud Specialists (LCFSs) who are nominated and accredited by NHS Protect. All LCFSs receive university accredited training, which ensures they have nationally recognised qualifications. LCFSs are supported by NHS Protect Area Anti-fraud Specialists (AAFSs), who are the link between NHS Protect and NHS commissioners and providers. A key role of these specialists is to ensure investigations into allegations of fraud follow legislative guidelines and are of the highest standard (632).

NHS Protect also plays a role in education NHS staff and the public on fraud, bribery and corruption within the healthcare sector. For example, NHS Protect in 2015-16:

- Produced an aide-memoire for the Department of Health and NHS Improvement on anti-fraud safeguards in the provision of agency staff
- Developed guidance for providers within the NHS and NHS commissioners, as well as employment agencies, on pre-employment checks and invoicing for agency staff as a way to reduce fraud in these two areas
- Developed material on agency fraud that is made available on the NHS employers online tool for NHS managers
- Provided university-accredited training and key skills development training to 266 LCFSs and Local Security Management Specialists (LSMSs) working for NHS health bodies
- Produced significant material for the media to inform the public and NHS staff on their anti-crime message (over 34 million opportunities to view anti-crime adverts); a further 416 media articles were published on successful anti-crime work undertaken by NHS Protect
- Ran a total of six workshops on anti-fraud standards to NHS commissioners which explained the role of the commissioners under NHS Protect standards

[113] See: https://www.reportnhsfraud.nhs.uk/

- Required 251 NHS providers and 190 NHS commissioners to undertake self-reviews of fraud, bribery and corruption standards (623).

In the financial year 2015-16, NHS Protect received 5,000 reports relating to potential fraud and corruption within NHS England and NHS Wales. Of these, the AAFSs authorised investigations into 900 of these cases. In the same year, nine criminal prosecutions were carried out successfully following investigations into the most complex cases of fraud, bribery and corruption.[114] A further 258 civil, disciplinary and other internal sanctions were applied by NHS Protect, other NHS organisations and professional bodies following successful investigations (623). In terms of financial costs, in 2014-15, the value of fraud, bribery and corruption in the NHS amounted to £11.9 million, of which £2.4 million was recuperated by NHS Protect and LCFSs (619).

8.3.7 The Austrian situation

When assessing possible types of fraud, one must differentiate between fraud committed by providers or consumers of health care. Consumer-related types of fraud encompass the evasion of paying health insurance (or social insurance) contributions (e.g. via illegal work in the private sector, fictitious self-employment, illegal occupations or dummy concerns) and misuse of healthcare (or social insurance) services. Examples of the latter include subreption of social insurance coverage (e.g. via complaisance), identity fraud and use of services by non-entitled parties (e.g. use of other persons' e-cards), fraudulent use of services due to wrong depiction of earning capacity or pretense of place of residence. By contrast, provider-related fraud includes, amongst other, the submission of false claims, corruption (e.g. acceptance of informal payments), and misuse of working hours (633).

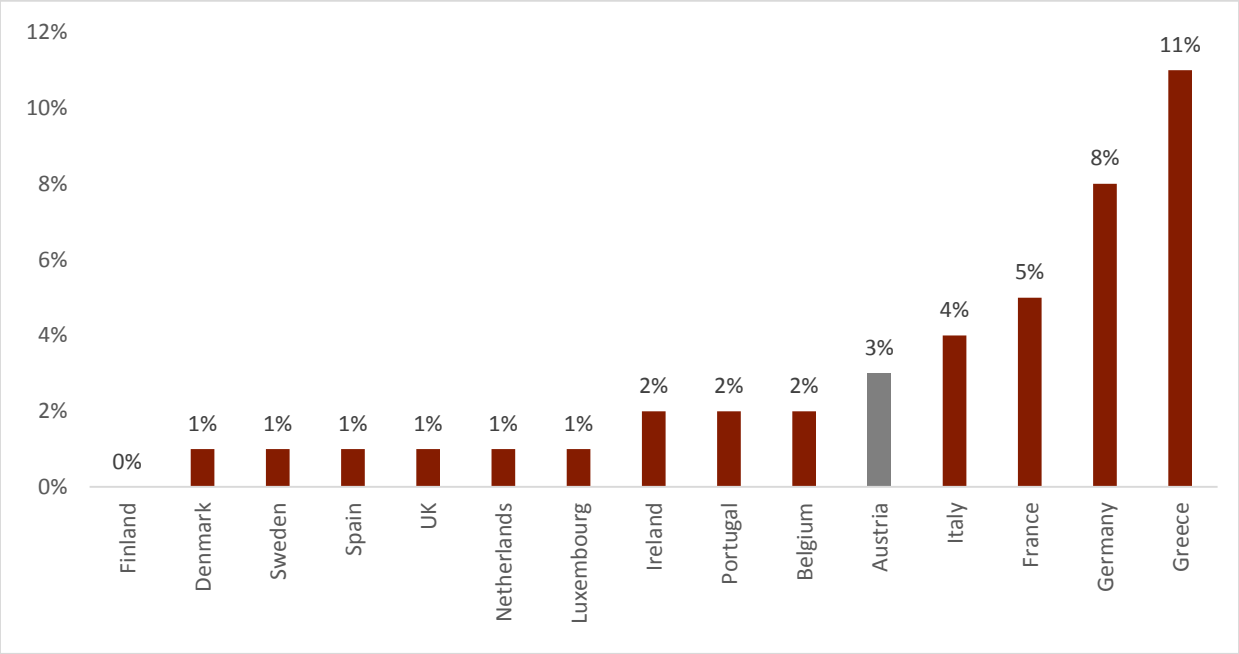
To date, there has been limited research into the types and costs associated with healthcare fraud in Austria. As a result, only two forms of healthcare fraud have been quantified (2014), specifically within the *Special Eurobarometer Report on Corruption* (612).

Results from the survey identified two forms of provider-related healthcare fraud in Austria. The first, relates to informal payments (or gifts) to providers to skip waiting lists. Specifically, 3% of those surveyed stated that they provided their physician/nurse with a gift or made a donation to the hospital. Although this figure may be considered low, in the same survey, 19% of interviewees felt that such additional

[114] It is not clear whether the nine criminal prosecutions were those relating to cases received in the same financial year or previous years.

payments were necessary after care has been provided (which is 3 percentage points above the EU15 average) (612).

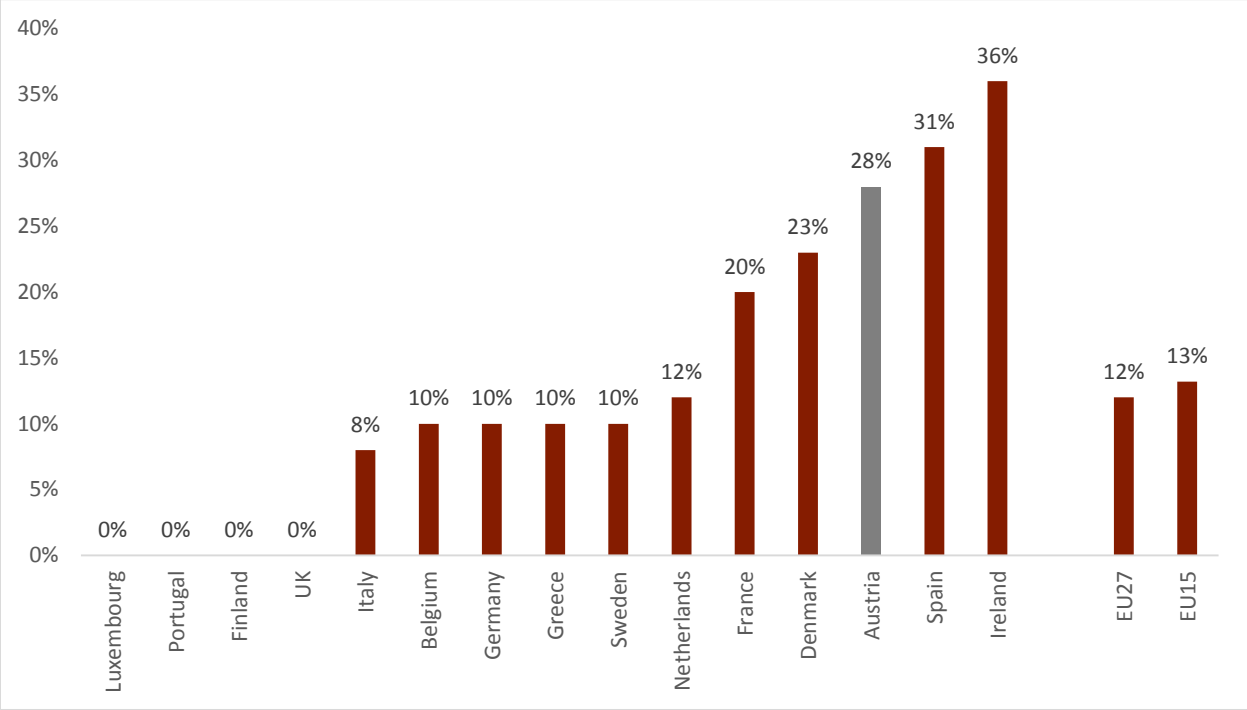
Figure 177: Proportion of interviewees who, in addition, to official fees provided an extra payments or gift to their nurse of physician, or provided a donation to the hospital (2014)



Source: (612)

The second relates to the provision of additional services within private practices in order to be treated within a public facility. In this regard, Austria performed poorly with 28% of interviewees acknowledging that this occurred (compared to 13% across EU15) (612). Caution, however, should be taken when reviewing results. Specifically, the context of the Austrian healthcare system should be taken into account whereby patients have significant access to private specialists; therefore, it is not clear to what extent patients have been encouraged to engage in a follow-up consultation or whether this was asked within the initial consultation, and therefore not considered fraudulent.

Figure 178: Proportion of interviewees who were asked to go for a private consultation in order to be treated in a public hospital (2014)



Source: (612)

In addition, there is anecdotal evidence of various other forms of fraud. However, such claims have not been substantiated. Nevertheless, they are reported as the current environment enables such fraudulent behaviour to occur.

Table 100: Potential types of fraud within Austria's healthcare sector

Type of fraud	Description
Preferential treatment	Better treatment offered to private patients given physicians receive greater amounts from these patients. Illegal under hospital law (KaKug, paragraph 16).
Working hours	Is it theoretically possible that physicians in hospitals work in a private setting during their dedicated hours at a public hospital.
Contributions	Establishment of fake companies who employ individuals for legal reasons (e.g. so that individuals can access loans).

Type of fraud	Description
	Employees in fact earn money in the informal market, therefore they pay a lower contribution rate than what they actually earn (lower contributions for the same level of benefit).
E-cards	People illegally using e-cards that do not belong to them to access healthcare services. For example, un-registered migrants who do not formally have access to the insurance system.

Strategies to combat healthcare fraud in Austria

Combatting fraud plays an important role in securing the financing system of social benefits, ensuring a comprehensive social protection of the insured, guaranteeing fair competition in the economy, preventing external influences on the social insurance system and maintaining the trustworthiness of the social insurance system (633). Therefore, a range of strategies and initiatives have been implemented in Austria to prevent, detect and prosecute fraud.

For instance, some activities defined as 'fraudulent' may arise due to errors rather than actual fraud. In order to prevent misunderstandings, efforts are undertaken by the social insurance to effectively and transparently inform insured persons and contractual partners of their responsibilities. Moreover, to prevent identity fraud and use of services by non-entitled parties, it was ruled that new E-cards will include a photo of the card owner, starting in 2019 (634). To prevent further fraud arising from dummy concerns and to create an overview of the problem, a website was established, which reports all dummy concerns involved in social insurance fraud. However, the collection of data on and monitoring of fraudulent activities to inform policies and to estimate the actual scope of the problem remains a challenge. Therefore, initiatives have been introduced to harmonise the monitoring infrastructure across carriers to support a transparent quantification of fraud in the social insurance system (633).

In order to detect fraud pertaining to the payment of contributions, both the social insurance carriers and finance authorities conduct collective checks on the declaration of income and contributions by individuals. Furthermore, in the area of provider-related fraud, the social insurance has introduced mystery shopping, which is conducted on a random basis, as well as in suspected cases. However, the scope of this strategy remains unknown, as it has only been implemented in 2016 and was countered with

significant resistance by the medical chamber. In addition, the individual carriers aim to increase initiatives for the detection of fraud. For example, the WGKK has established a working group on the detection and prevention of fraud in 2008, which primarily focuses on the submission of false claims by physicians. In 2013, 597 cases of fraudulent or erroneous claims by contracted physicians have been identified, whereby EUR 307,135 were claimed back successfully by the WGKK. Contracts with physicians were terminated in five cases, and in three cases a criminal charge was placed (633).

In order to effectively persecute social insurance fraud, a legal base for the combat of fraud was established recently. This includes the law on Combatting Social Insurance Fraud (Sozialbetrugsbekämpfungdgesetz, SBBG), which came into effect in January 2016 to regulate the combatting of fraud, particularly the evasion of contribution payments, and to strengthen the cooperation between authorities. Furthermore, the law on Combatting Wage- and Social Dumping (Lohn-und Sozialdumping-Bekämpfungsgesetz, LSD-BG) was introduced in January 2017. In addition, the Directives for the Implementation, Documentation and Quality Assurance of Controls of Contractual Partners (Richtlinien für die Durchführung, Dokumentation und Qualitätssicherung von Kontrollen im Vertragspartnerbereich (RLVPK) were established in April 2016. Different authorities are responsible for the persecution of offences. For instance, minor crimes are governed by administrative criminal law and therefore involve the federal and regional administrative courts, as well as the financial police. By contrast, major crimes are dealt with by the Anti-Corruption Agency and the public prosecution department.

The cooperation between national authorities is central to combatting fraud. In addition, efforts have been made to expand cooperation across other countries, in order to exchange best practice examples and analyses pertaining to the combat of fraud on an international level. For instance, Austria is a member of the EU platform on informal labour, as well as the international anti-corruption academy to improve the exchange of data and information (633).

8.3.8 Policy options: Combating healthcare fraud

As previously outlined, comprehensive studies into the extent and cost of fraud within the healthcare system are limited. For example, only two forms of healthcare fraud have been confirmed and quantified. To gain a better understanding of the types of healthcare fraud that exist within the system, and their associated cost, it is recommended that first and foremost, a review of fraud in the Austrian healthcare system be undertaken including all a payers, providers and patients. To the extent possible, the cost of healthcare fraud should be quantified, with the final figure used to determine future levels of funding into

anti-fraudulent activities. In the absence of this information, it is difficult to a) prioritise activities, and b) determine an appropriate level of investment.

Federal and Länder governments, and social health insurance could jointly fund the study, given all-inclusive approach to healthcare fraud should be taken.

Finally, we are cognisant of the challenges associated with identifying and calculating healthcare fraud, therefore, as a starting point, it suggested that information be drawn from patient ombudsmen run by health insurance carriers, Chamber of Physicians, as well as patient attorneys implemented at the state level (see Figure 179).

Figure 179: Patient ombudsman within social health insurance

Social health insurance carriers employ patient ombudsman, however, there is no legal provision for them to do so under the ASVG (for example). Ombudsman for health insurance carriers deal with a variety of complaints, however, it is not under their remit to legally represent clients. For example, ombudsman may deal with complaints regarding waiting times or prices. Ombudsman within the Chamber of Physician's performs a similar role. The only patient ombudsman/attorney to be defined by law is that offered by each Land. Patient ombudsman/attorney's in this context perform a variety of roles including informing patients of their rights, mediating disputes, investigating failures within the healthcare system, and assisting patients when malpractice settlements are made outside of court.

Source: (68)

Once there is a better understanding of the types and cost of healthcare fraud within the system, appropriate strategies, which target problem areas, can be developed. For example, if the problem is significant, a Joint Specialist Centre (should model 4 be employed, see section 4.1.2) or competence centre (under current arrangements) could be dedicated to combating healthcare fraud.

Finally, digitalising patient healthcare records, as is being done under ELGA, improves transparency within the system therefore minimising the possibilities to engage in fraudulent behaviour. For example, ELGA will allow patients to map services that were referred for, actual services performed and services recorded as being completed. Therefore, patients are able to easily identify instances where a physician overbills. Given low co-payments within the system, there is limited incentive for patients to report such behaviour. For this reason, health insurance carriers should encourage insurees to report overbilling, which would

require them to provide relevant links and services on how to report physicians. In addition, as ELGA becomes more sophisticated (e.g. providing information in a digestible format), health insurance carriers will be able to juxtapose healthcare consumption patterns over time for each insuree. This will allow carriers to more easily identify instances of e-card fraud, by juxtaposing past and current utilisation.

Summary of policy options for combating healthcare fraud

To understand the types of healthcare fraud and their associated cost, a comprehensive study into the topic is required. By collecting this information, policy-makers will have a better understanding of where anti-fraudulent activities should be targeted and associated cost-savings. Given the problem is significant, social health insurance carriers could dedicate a Joint Specialist Centre or competence centre to combating healthcare fraud. Finally, enhancing digisalition within the system will continue to improve transparency and limit the opportunity for healthcare fraud to occur. Given patients can more readily identify instances of healthcare fraud, carriers should encourage insurees to report such behaviour, which may act as a deterrent.

Legal considerations

No particular legal impediments have to be faced with respect to these options.

8.4 Business processes with respect to IT systems

8.4.1 Introduction

The study conducted by Hausermann in 1992 on the organisational analysis of the Austrian social insurance system pointed out that the different EDV should be harmonised and the lack of cooperation among the providers is a central challenge in the context of administrative activities. It was identified as an obstacle that this would initially incur costs to the provider, and that it would not directly benefit them. With the 52nd amendment to the ASVG. The coordination function in the field of automation-assisted data processing was transferred to the Main Association of Social Security Institutions (HVSV) under the 52nd amendment to the ASVG. The guidelines for the cooperation of the social security providers amongst themselves and with the main association in automation-assisted data processing, that were issued by the main association following § 31 para. 5 clause 4 ASVG, intend a step-by-step production of compatible computer structures to the extent that this is necessary for the joint development, procurement and application of the software.

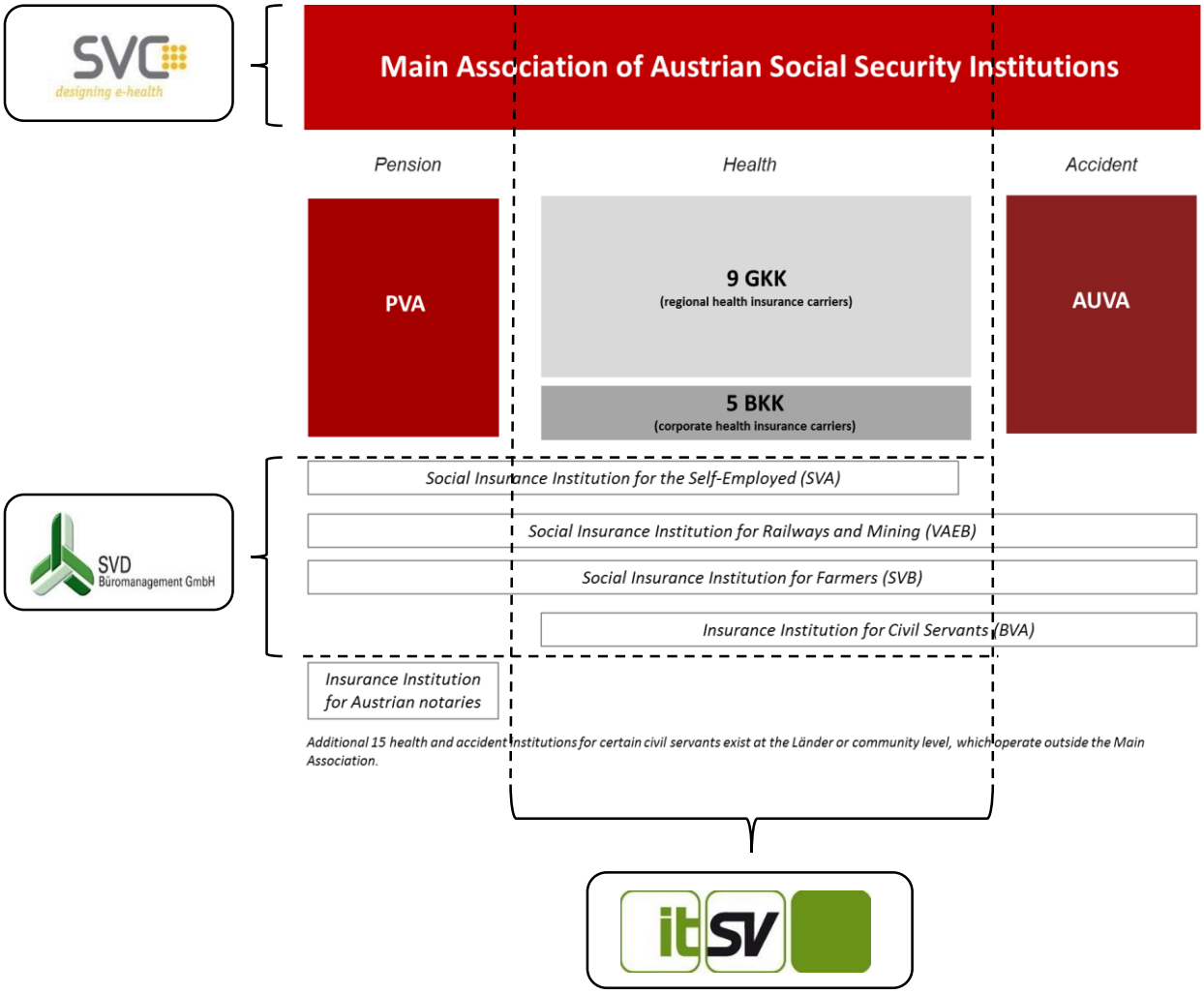
In the study carried out by KPMG Consulting GmbH in 1998, it was stated that due to standard products (IT applications used by several social insurance funds), as well as due to the creation of competence centers, positive examples of harmonisation of computer science were created. KPMG Consulting GmbH also criticised the fact that at the time many synergy potentials across providers remained underutilised since cooperation was based on the individual initiatives of providers and did not always include all providers whose cooperation would be useful. The image has changed considerably in this sector. A collaborative structure was created due to the foundation of subsidiaries across providers, the consolidation of the data centre and a joint IT-management, which contained costs and could reduce parallel tasks.

The following chapter describes the organisations and their division of tasks for electronic data processing, as well as the developments in the IT business processes and work process facilitation through IT solutions in Austria, and considers potential efficiency potentials. Further detailed information on this topic and possible efficiency potentials can be found in chapter 2.5 in Volume 4 – Situational Analysis.

8.4.2 Organisations and their division of work into electronic data processing

The process of the division of labour between the HVSV, the IT services of the social insurance GmbH (ITSV GmbH), social insurance chip cards provider and operator SVC (SVV GmbH) and SVD office management GmbH (SVD GmbH) are based on the binding directives agreed by the HVSV on the cooperation of the social security funds and the main association in electronic data processing (REDV), which are valid for all social insurance funds.

Figure 180: The Austrian social insurance funds including subsidiaries, own research



IT–Services of the Social insurance GmbH (ITSV GmbH)

ITSV GmbH was established at the end of 2004 by the HVSV in accordance with Section 31 (4) 3 lit. A ASVG as the central coordinating company of the main association and the social insurance institutions for the field of information technology.

In accordance with the founding purpose, 20 further social insurance funds other than HVB also participated in the ITSV (HVB, SVA, WGKK, OÖGKK, NÖGKK, BVA, SVB, STGKK, TGKK, SGKK, KGKK, VGKK, BGKK, VAEB, BKK WVB, BKK Kapfenberg, BKK Mondi, BKK Austria Tabak, BKK Zeltweg, BKK Voestalpine). At the time of the foundation of the ITSV GmbH, AUVA and PVA decided not to purchase any owner shares.

Both funds still draw benefits from the ITSV independent from this decision. These include standard products which all funds need in all divisions (e.g. standard product PERS - Personnel Management).

As business purpose and according to point 3.1 of the shareholder agreement, ITSV GmbH was provided with the control and coordination of the IT services, the development of strategies and standards as well as the provision of services for the partners in the areas of information technology and communication under consideration of promoting business efficiency. According to point 3.5 of the shareholder agreement, this objective particularly incorporates the creation of compatible IT structures and the joint software development, procurement and application considering the fundamental principles of business efficiency and practicality.

In a first phase, ITSV GmbH consolidated the 18 computer centres of the social health insurance that existed at the time of the founding period almost completely, in accordance with § 23 (2) no. 1 REDV, into a target data processing centre operated by ITSV GmbH. After the successfully executed consolidation of computer centres of the social health insurance, the focus of the ITSV GmbH is now, according to § 12 REDV concentrated on the coordination of the software landscape of the Austrian social health insurance. The objective of this intervention is cost saving from establishing a license management across providers and from creating joint software engineering architectures. In addition, the IT-controlling across providers is to be supported by the ITSV GmbH and according to § 6 REDV a central project controlling has to be ensured.

In addition, the call centers, which were originally required for internal technical purposes (service-desk system), are increasingly used for important tasks such as breast cancer screening, electronic health care, thus assumes central health policy tasks.

Furthermore, the call centre, which was originally required and established for internal technical purposes (service desk system) across providers, is increasingly also used for important content-related tasks (e.g. breast cancer screening, electronic health record service line, e-card service line for insurees and contract partners etc.) and thus assumes central health policy tasks. In this business area, a cooperation between the Federal Government and ITSV GmbH is currently being developed and strived for, for reducing administrative costs for the federal government and social security. A further co-operation between the Federal Government, the Länder and the social insurance is being pursued in the area of the mutual provision of cost-effective storage space meeting the high-security requirements.

The IT governance model of the IT services of the social insurance GmbH (ITSV GmbH)

IT Governance is an instrument that supports the implementation of the strategic IT goals and aligns the IT with the strategic company objectives. The IT Governance model encompasses the entire IT value chain and applies to HVB, all social insurance providers (except AUVA and PVA), ITSV Gmbh and the social insurance chip card company m.b.H. (SVC GmbH) with respect to all company-wide IT issues and also to architecture, infrastructure and standards within each segment. This IT Governance model of the social insurances applies to AUVA and PVA only in the standard product area and ELGA. The alignment of additional IT Governance structures of AUVA and PVA can be undertaken in a further step.

The normative and strategic level is the responsibility of IT management and the operational level that of the IT coordination. The IT strategy applies according to the IT Governance model to social insurance providers (for AUVA and PVA in the case of standard products and ELGA), the HVB and all IT subsidiaries. The IT control is responsible for the creation and further development of the IT strategy. The IT governance model therefore provides a common approach.

SVD Office Management GmbH (SVD GmbH)

The SVD Office Management GmbH (SVD GmbH) was founded in 2003 and has four nationwide insurance providers as owners (BVA, SVB, VAEB und SVA). The SVD GmbH offers a broad range of services to its members such as procurement, facility management, construction industry, printing company and IKT. Even the ITSV GmbH and the SVC GmbH use the cleaning and supplementary facility services of the SVD GmbH at the office locations in Vienna, which could save administrative costs in comparison to previous suppliers. By bundling the services at SVD GmbH, the company was able to build up know-how in the business areas. The SVD GmbH is interested in expanding its services across further providers and to offer the know-how gained more widely. The SVD GmbH supports approximately 4,500 user in the ITK area. Regarding the range of services offered, it should be mentioned that it can be regarded as comprehensive with a few exceptions for the owner providers (in the area of outpatient clinics).

The social insurance chip card provider and operator m.b.H. (SVC GmbH)

The social insurance chip card provider and operator m.b.H. (SVC) was founded by the HVB on the basis of the §§ 31 a bis c ASVG. According to point 1 of the company agreement, the business purpose consists of the introduction, operation and further development of an electronic administration system (ELSY) for the entire social security administration.

The task of SVC GmbH is to make the processes between insurees, service providers, doctors' offices, hospitals, pharmacies, other health service providers, ELGA health service providers, as well as social insurance carriers IT-based to a large extent paperless, to ensure and continuously improve the operability. The SVC GmbH guarantees an availability of 99.7% for the e-card data processing centres. SVC GmbH also operates the Social Security Internet Portal, which receives around 1.8 million hits a month. The main products of SVC GmbH are technological solutions in the healthcare sector. Some examples are the e-card system, ELGA, e-medication within the framework of ELGA or eSV.

8.4.3 Developments in the area of IT business processes in Austria

Harmonisation of IT systems by standard products

Before the harmonisation by standard products, each provider had its own systems in operation. Many operations were carried out parallel because of that. The new philosophy is that applications are developed (for example, by competence centres) and made available to the remaining providers.

With the standard products (STP) / competence centers (CC) across providers, the legacy systems (Host) at the end of the life cycle of providers were/will be replaced and processes will be also standardised. The business processes to the customer are considered across providers, e.g. by eSV (‘electronic social insurance’) or rather e-innovation. The IT hence creates the basis for the subject area to implement further optimisation measures. Based on the IT master plan, all standard products, their commissioning and releases are controlled for all providers. The IT master plan is used for controlling the project and program management.

The competence centres of providers, the ITSV GmbH and the HVSV are involved in the development of standard applications. The tasks will be assigned to the most suitable body for the project. Given that the compentence centres program standard products, it can be guaranteed that the end product meets the required requirements and that the know-how in social insurance can be upheld and does not need to be purchased. This further ensures that the system remains safe and stable, as well as that only a minor dependence on third-party providers. This approach also reduced the number of externally purchased developer by more than half. Know-how can hence be ensured sustainably in the social insurance.

Joint use of data processing centres

The Austrian social insurance has decided to reduce the number of data processing centres step-by-step from previously 18 to maximally 5 data processing centres. Since the end of 2013, 5 physical data

processing centres are run by the Austrian social insurance: Geiselberg, Wienerberg, Neu, AUVA, PVA and SVD.

Furthermore, there is a customer relation to ITSV GmbH and SVC GmbH in the areas SAP, internet connection, web hosting of the website, video calls, MDM solutions for Apple products. The server for the e-card system and eSV (Online presence of all social insurance providers) are operated by the SVC GmbH at the data processing centre location 'Geiselberg' and at the 'T-Centre'.

The IT cost cap

In connection with IT costs, the so-called IT cost cap was introduced in 2008. The result since the introduction of the cost cap is that the IT costs remained nearly constant since 2007 despite massive challenges (roll out of standard applications) and even fell to the lowest absolute value of the last ten years in 2015. The audit division confirms that the overall IT costs only increased by about 1.7% since 2007 and could hence be kept constant. Simultaneously, it could be observed that the proportion of IT costs of administration costs constantly fell (from 17.9%- 2007 to 14.2 %- 2015). This development proves the functioning of the IT cost cap as cost containment instrument.

8.4.4 Developments in the area of work process facilitation through IT solutions in Austria

E-nnovation

A program ('e_nnovation') was implemented between 2014 and 2016 with the objective of providing the insured with a wide range of up-to-date electronic interaction facilities around the clock and via all relevant channels. This facilitated the interaction of the insured and relieved the administration of social insurance funds.

A key component of this programme was 'My social insurance' ('Meine SV'): The internet portal that exists since 01.04.2015, in which all services for insured requiring authentication can be bundled. All Regional Health Insurance Funds, all employer-based health insurances, PVA, SVA and VAEB and from mid-2017 also SVB and BVA currently participate in 'Meine SV'.

A further relevant topic for IT support and facilitation of work processes is Cognitive Computing: Cognitive Computing describes technical platforms, which are based on the scientific disciplines of artificial intelligence and through which computer programmes can act in a similar way as the human brain. In 2017 it is planned to carry out a tender for cognitive computing, so that from 2018 concrete implementation projects can be carried out.

The electronic medical record (ELGA)

The electronic medical record (in short ELGA) is a joint project of the federal government, the social health insurance and all federal states. ELGA has the objective to connect the health data of patients and to create a location- and time-independent access to ELGA health data through the ELGA portal. Detailed information about this topic can be found in section 6.6.

Accounting of medicines (HEMA)

The 'Accounting of Medicines' HEMA operates the accounting of the public pharmacies and the primary care pharmacies. The basis for the accounting of pharmacy data are the electronic data of the public pharmacies, which are transferred by the general salary fund of Austrian pharmacists (Pharmazeutische Gehaltskasse für Österreich) to the HVSV.

The division into the corresponding insurance providers occurs through the HVSV. Data is sent to insurance providers via the data hub (DDS). The data of the pharmacies submitted electronically (via data media or ELDA) or in paper format. The master data (physicians, insured, reimbursement code- EKO) will be played in once per month. The administration of pharmacy master data occurs in HEMA.

The HEMA data will be transferred in further dispositive systems (BIG, FOKO, LIVE, ALVA Insurance) for various analyses and evaluations. In HEMA, a prescription economy evaluation can be made (frequency of prescription medicines, quota of generics, contract partner control). The evaluations of the prescription economy are transferred to the providers. Further, it is up to the providers to decide whether they contact their contract partner and point to possible peculiarities. All evaluations are risk- and age-standardised. The data of HEMA can also be used as basis for buying decisions, but there are no procurement functionalities.

Reimbursement of optional physician

Patients have the right to submit bills of optional physicians. A technical solution about 'My SV' is already in use at most health insurance providers. Currently, the diffusion is supposed to be increased through an information campaign.

As basis for an automatic cost reimbursement, online services for cost reimbursement for regional health insurance funds were already created in 2015: The insured can transfer bills to the responsible social insurance provider as PDF online for the reimbursement. An important prerequisite for an automatic bill of optional physicians, which is that data must exist electronically, is hence satisfied.

8.4.5 Potential efficiency potentials

The IT of the social insurance experienced in the last years and will also in further future a strategy of consolidation, both regarding costs and processes, which are constantly becoming standardised and jointly usable for the joint needs of social insurance providers. After all, the social insurance managed to perform this big IT transformation mainly with the engagement of its own employers. According to this, the potential for efficiency gains is identified and already being implemented

Expiration data transfer (e.g., application) between the providers

Insofar as applications and data transmissions are not already submitted electronically by the applicant (insured, employer and contract partner), applications are electronically recorded and / or forwarded to the responsible provider.

Through the universal service, applications, notifications and notifications can be submitted to each insurance institution, in any state, irrespective of the actual jurisdiction. All insurance providers that are organised according to the general ASVG as well as the Social Insurance Institution of the commercial economy and the Social Insurance Institution of the farmers participate in the universal service. The data hub is available for the electronic transfer of data between social insurance providers. It standardises the communication channel between the involved IT products. The data hub takes care of the ordered technical data communication, but the organizational processing is within the competence area of the individual partners / providers. In the area of rehabilitation as well, particularly in the case of rehabilitation allowances, the processing between the PV and the CP is now largely electronic.

There are applications of the electronic act at almost all providers, albeit with a different focus. The NÖGKK, for example, has implemented the contract partner record, the medical record and a customer record electronically, the PVA the personnel record and the patient record and the TGKK has implemented a regress and legal record electronically. The transferability of the applications for the electronic act is secured through the application of standard products. Particularly in this regard the STP ECM (Enterprise Content Management) should be noted: The majority of work processes that occur at the social insurance are document- and information-driven.

The solutions for the ECM cover the processes of recording, administration, storage, preservation and provision of documents and their contents for the support of professional as well as organisational processes. With an overall concept, different ECM activities and ECM projects will be implemented in the years 2016 to 2018, and technological aspects as well as the independent single solutions will be

strategically bundled. There exists also the possibility for a better coordination and coordinated procedure.

IT-Strategy

Within the framework of the IT governance model, the IT strategy is defined as an essential component of the IT governance. It is the responsibility of the IT control team to develop those under consideration of relevant environmental conditions. Starting from the defined scope of the IT governance, the IT strategy is valid for all SV providers (for AUVA and PVA in the case of standard products and ELGA), the HVB and all IT subsidiaries. The IT-strategy is influenced by different environments such as the strategy of the social insurance, developments in technology, framework conditions, etc., but also by findings from the control mechanisms of the operative implementation of the strategy. An examination and potentially adaption of the IT strategy and hence also of the guiding principles is to be executed regularly.

The electronic management system (ELSY) implemented by the ASVG §31a is already designed as efficiency model by the legislator. Its objective is to consolidate processes between social insurance providers and the 'outside world' (insured, employer, contract partner, health care provider). The efficiency potentials have been identified and remain to be increased. A challenge in the increase of efficiency potential is the coalition pressure with the contract partners through which sensible process changes can be blocked for general political reasons.

Digitalisation of administration tasks in the social insurance

Through the use of standard products and provider-internal workflow and software support, a large number of social insurance companies could be digitized and thus structured cost-efficient.

The main focus in digitalisation lies now with the processes with insured and contract partners. The initiatives of 'My SV' and the further expansion of e-card functionalities (eBS, e-medication, e-prescription, etc.) with physicians, pharmacies, hospitals and other contract partners serve this purpose. Efficiency potentials exist mainly in administration processes in this area, which can be digitized. To increase these potentials, the agreement of the contract partners needs to be obtained.

The internal administration processes run mainly electronically. For example for:

Standard products FIWI (Finance and economy of the social insurance providers):

Already digitised:

- Transmission of orders, material lists of supplier to the social insurance provider

- Work flow supported audit and approval and release processes within social insurance funds

To be digitised:

- Transmission of electronic bills of suppliers to the social insurance providers
- Exchange of electronic bills between social insurance providers.

Standard products PERS (Human Resources):

Already digitised:

- Use of ESS (Employee Self Service) and MSS (Manager Self Service) scenarios to support of business processes between employers and managers or rather employers and the human resource department

To be digitised:

- Administration of applicants across providers.

Enterprise Content Management (ECM):

The following institutions use ECM (Enterprise Content Management):

Regional Health Insurance Funds:

- Burgenländische Gebietskrankenkasse (Burgenland)
- Niederösterreichische Gebietskrankenkasse (Lower Austria)
- Kärntner Gebietskrankenkasse (Carinthia)
- Oberösterreichische Gebietskrankenkasse (Upper Austria)
- Steiermärkische Gebietskrankenkasse (Styria)
- Tiroler Gebietskrankenkasse (Tyrol)
- Vorarlberger Gebietskrankenkasse (Vorarlberg)
- Wiener Gebietskrankenkasse (Vienna).

Special Insurance providers:

- Social Insurance service for commerce and industry (SVA)
- Pensionsversicherungsanstalt (Pension Insurance)
- Social insurance institution for farmers
- Austrian railways insurance institution

- Public Servant Insurance Corporation
- Main Association of Austrian Social Security Institutions
- ITSV GmbH.

In addition, there are solutions implemented in SAP, SharePoint or other technologies. The complete alignment of workflows is difficult to implement due to different internal processes. Depending on the provider size, the work sharing is differently pronounced. An adjustment of the workflow systems is not possible without the alignment of the internal organization.

Automatic difference assessment/reimbursement of contributions

The different assessment/reimbursement of contributions are relevant in the area of multiple insurance. A multiple insurance in health insurance occurs when one exercises multiple employments that are subject to compulsory insurance simultaneously and/or receives cash benefits, which are also connected to health insurance. An automatic solution would result in a facilitation of processes for the insured. Currently, professional questions are being clarified concerning this matter. Both is technically possible and partly already exists (reimbursement of contributions in the ASVG in STP-MVB). The effort can currently not yet be estimated.

Reimbursement of the optional physician

As basis for an automated cost reimbursement, online services for cost reimbursement for the Regional Health Insurance Funds were already created in 2015. One can expand this process even further. In addition, additional requirements or rather alternatives for an automatic optional physician bill will be evaluated:

- Treatment of the incoming PDF bills by means of OCR (text recognition) to transform the picture of the bill into characters
- Replication of activities that are currently carried out by the administration employers in a suitable software; this is a potential area of application for cognitive computing
- Obligation of optional physicians to collect the data that is necessary for the reimbursement (requires the nationwide cooperation of optional physicians and is hence not feasible in the short-run and just by the social insurance)
- Imprint of a QR code on the related forms so that they can be automatically assigned to a health insurance provider; if the form is filled out online by the insured, the QR code could even contain this information.

The automatic optional insurance bill is online accessible since April 2015 and currently generates 50.000 access monthly. In Vienna, circa 25% of optional physician bills are processed online.

In total, it can be stated that in the area of EDV significant advancements towards a standardisation and an intensified coordination have occurred. There exist further efficiency potentials, which can be increased.

Currently, the issue of a joint licence management is processed, which one could have probably already started earlier. Among the individual EDV companies, the coordination and the division of work could be developed further since here tasks are partly administered or rather executed parallel. In the area of the Regional Health Insurance Funds, this occurs through the IT SV, at the special insurance provider through the SVD and at the AUVA and PVA independent.

Further, the EDV effort could be reduced if the individual organisations standardised the internal processes before the implementation of standard products to be able to reduce the complexity of the EDV applications.

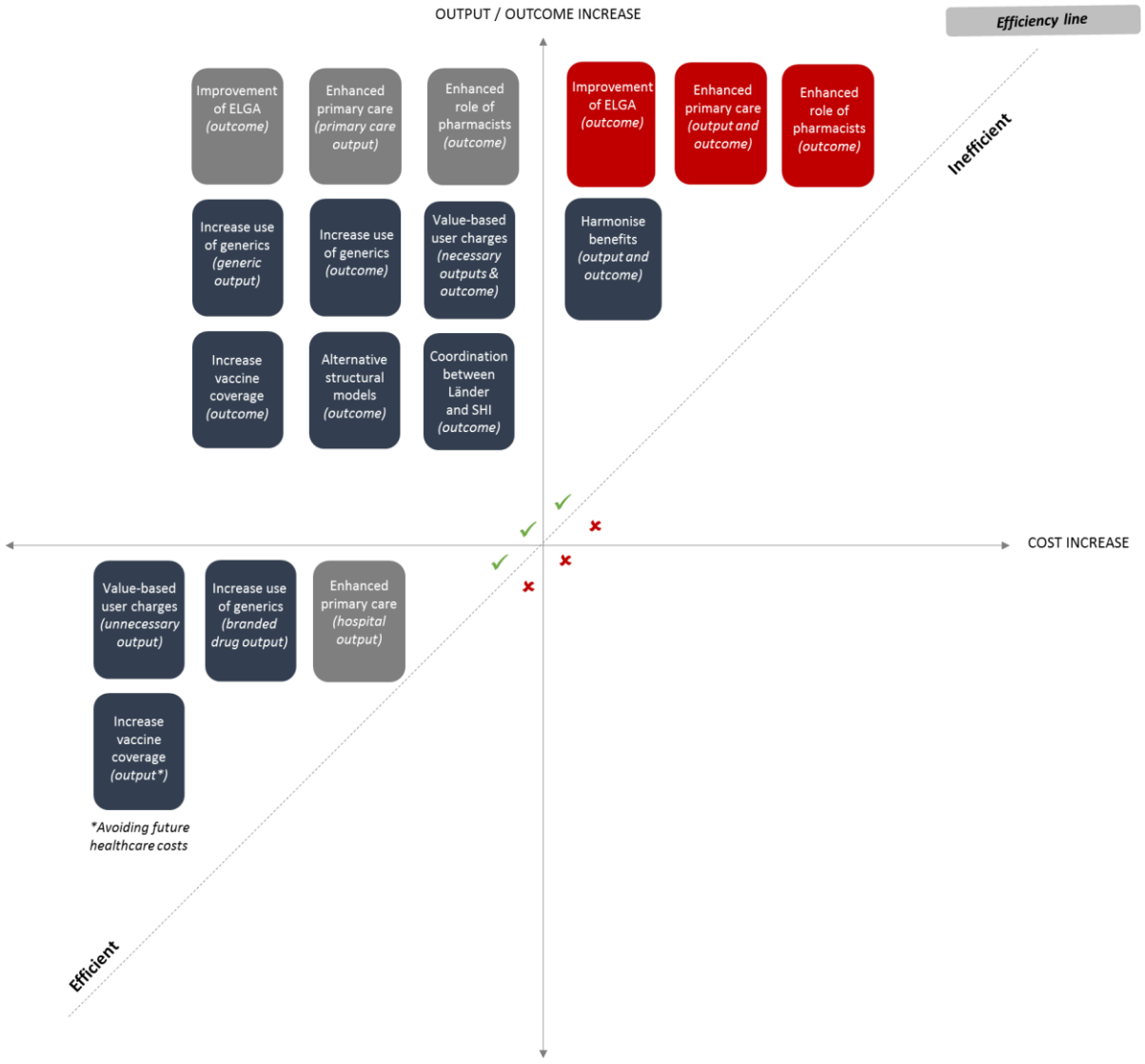
9 Conclusion

A review of the Austrian social insurance system revealed that the system is both complex and fragmented due to multi-level governance structures and dual financing arrangements. This finding is not unique to this review, as evidenced by numerous reports undertaken by Austrian institutions and organisations who also come to this conclusion. In response, policy-makers in recent years have implemented various policies to enhance coordination and align incentives. These efforts should be recognised and commended, however, ultimately, major constitutional reform, enhancement of joint responsibilities between social health insurance and the Länder, or joint budgets are required to streamline the healthcare system. Given the extreme difficulty in passing such reforms, this review has chosen to take a pragmatic approach by developing a range of policy options to improve efficiency and equity within the current system.

Policy options have been designed to increased efficiency, equity and possibly outcomes within the Austrian social insurance system. As an example, key policy options to enhance the use of generics, primary care and vaccinations, as well as harmonising benefits, introducing value-based user charges, enhancing the role of pharmacists, and improving coordination between states and social health insurance have been mapped on a cost-efficiency plane (please see figure below).

The figure outlines the medium- (red box) and long-term (grey box) impact of each of the aforementioned policies has on cost, outcomes and outputs (navy blue boxes indicates both medium- and long-term). This exercise demonstrates that each of the options put forward are, theoretically, efficient, given they fall to the left of the efficiency line. For example, enhancing primary care will increase outcomes, outputs and costs within the medium-term, however, in the long-term, this policy will reduce costs by decreasing the number of inpatient admissions.

Figure 181: Cost-efficiency plane



Note: Red boxes = medium-term, Grey boxes = long-term, Navy blue boxes = medium- and long-term.
Source: Author's own creation

It is important to highlight that the remit of this review was limited, given it was restricted to the social insurance system. However, given the complex nature of the healthcare system, where directly applicable, consideration was given to healthcare under the jurisdiction of federal and Länder governments.

Finally, and as previously stated, when developing future options to enhance efficiencies within the healthcare system, policy-makers and stakeholders should:

- Ensure that development and implementation of policies is transparent and inclusive.
- Be aware that no healthcare system is perfect, and that any changes should build upon strengths within the current system.

The remainder of this chapter outlines, at a high-level, a range of policy options to enhance efficiency within the system. For detailed information on each policy option, it is highly recommended that readers view the relevant sections within the main body of the report.

For each topic, multiple policy options have been provided, further, no option has been ranked as superior given, ultimately, it is the responsibility of Austrian policy makers and stakeholders to make decisions regarding the direction of the healthcare system, however, we briefly outline several advantages and disadvantages of different options. Finally, we recommend that policy options within this report are viewed in conjunction with previous research undertaken by Austrian experts, as well those outlined by stakeholder views in Volume 3 of this review.

9.1 Policy options: Structure of the social insurance system

Four alternative models have been proposed to improve efficiency and equity within the system. Models 1-3 involve structural change to the social insurance system through an amalgamation of carriers. Amalgamation, in the short-run, can lead to cost increases given the expenses associated with structural change and implementation. However, in the medium- to long-term, if implemented correctly, these models could lead to efficiency gains, for example, through economies of scale and scope, and enhanced knowledge transfers. It is important to note that sub-options for models 1-3 have also been developed, however, they have not been included in this summary (please see section 4.1.2 for further details on these sub-options). Model 4 could increase efficiency and equity by extending risk-adjustment and enhancing coordination within the current structural model.

- **Model 1 (partial amalgamation):** one national accident insurance carrier, one national pension insurance carrier, one employed health insurance carrier (GKKs, BVA, VAEB, BKKs and KFAs) and one self-employed health insurance carrier (i.e. SVA and SVB)
- **Model 2 (limited amalgamation):** one national pension insurance carrier, one self-employed health insurance carrier, one employed health insurance carrier (excluding civil servants, i.e. BVA, VAEB and KFAs), one accident insurance carrier (excluding civil servants), and one joint accident and health insurance carrier for civil servants
- **Model 3 (health and accident amalgamation):** one national pension insurance carrier, one health and accident insurance carrier divided by each of the nine states
- **Model 4 (insurance coordination):** model 4 aims to improve the current social insurance system by enhancing risk-adjustment between health insurance carriers, as well as improving coordination between carriers through Joint Specialists Centres. Joint Specialist Centre 'themes' would be defined by a joint Working Group (including HVSV, and both the Ministry of Health and Women's Affairs, and the Ministry of Labour, Social Affairs and Consumer Protection), however, it will be the responsibility of carriers who takes on each theme. Although not compulsory, carriers will be incentivised to actively participate in the scheme to minimise duplication.

9.2 Policy options: Risk-adjustment

Given model 4, as outlined above, is introduced, the following five risk-adjustment options have been proposed to improve equity and efficiency within the system. RA1 and RA2 are considered the most comprehensive and thus mutually exclusive, RA3-5, however, could be implemented in unison.

- **RA1:** All funds received by social health insurance carriers to be risk-adjusted through a central agency (i.e. HVSV). Alternatively, a step-wise approach could also be considered, whereby the proportion of funds risk-adjusted are increased over time until it is felt there is an equitable distribution of funds.
- **RA2**: This option would involve a simultaneous reduction to contribution rates and the implementation of an earmarked levy dedicated to risk-adjustment across social health insurance carriers.

- **RA3**: RA3 would amalgamate existing risk-equalisation schemes into one pool of funds to be used for risk-adjustment purposes. Using the most recent data, risk-equalisation schemes amount to €3 billion annually (including the Hebesätze, or €1.4 billion, excluding the Hebesätze).
- **RA4**: Under this option, social health insurance carriers would subsume responsibility for hospital outpatient departments using an appropriate level of funds from State Health Funds. A central agency (i.e. HVSV) would be responsible for redistributing funds to carriers based on a range of risk-adjustment factors. Funds could be used, for example, to enhance primary care and hospital outpatient departments.
- **RA5**: Finally, RA5 would pool a proportion of contributions into a central fund (managed by the HVSV), which would then be used to reimburse GPs on a capitated risk-adjusted basis. Given the significant cultural change associated with this policy (i.e. by registering with one GP), this policy is should only be considered in the long-term.

See section 4.2.7 for further details.

9.3 Policy options: Collection of contributions

The following policy options relating to the collection of contributions are provided below:

Collection of contributions

- **Base SVB contributions on actual income**: a shift in taxation base towards actual income promotes an alignment between BSVG and ASVG funds in regards to the collection mechanism of contributions, and improves equity in the financing system.
- **Introduction of a proportional fiscal system with maximum contributions in the SVB**: a shift from the regressive to a more proportional fiscal system in conjunction with the introduction of a maximum contribution amount could promote a more equitable collection of contributions, which can be rendered fiscally neutral.
- **Aligning the BVA contribution base with that of regional carriers**: lower BVA's employee contributions, whilst raising employer contributions to harmonise the collection of contributions across funds, which could be rendered fiscally neutral. Gradually lower user charges for BVA insured to the regional fund level (GKK) to foster equity in the collection of contributions across funds.

Multiple insured persons in Austria

- **Single collection of contributions without a choice of carrier***:* introduce a single location for the collection of contributions, in addition to keeping maximum contribution bases in place. This can either be in the form of an independent entity or by nominating regional funds to collect contributions on behalf of all funds, in order to simplify the administration process. As such, the refund for excess contributions could be automatically calculated through an official channel, without the need for manual applications. An absolute hierarchy, or a hierarchy based on the main income source of an individual could be introduced to determine the carrier membership of an individual. Further studies on the financial impact on carriers need to be conducted prior to application of this option.
- **Single collection of contributions with a choice of carrier***: similar to the option presented above,* with the main difference that insured persons could choose their carrier of preference, based on their professions. While this option does not entirely eliminate inequity in the system, it may reduce the former, as insured could only switch carriers on an, for example, yearly basis, rather than intermittently charging different carriers.
- **Multiple collections of contributions without a choice of carrier**: insured individuals continue to pay to multiple carriers, however, the insured would be automatically assigned to a default carrier. This constitutes the carrier for which the insured pays the largest share of contributions and the insured is only entitled to benefits of the default carrier. All carriers receiving contributions for the insured would re-direct these contributions to the respective default carrier. In addition, the refund process for excess contributions could be automated, in order to reduce the administrative burden of manual applications and to eliminate inconveniences to the insured.
- **Multiple collections of contributions with a choice of carrier**: similar rationale to the option presented above, with the main difference that individuals have the option to choose a default fund to access services from, while the second carrier will conduct transfers of funds to the former. However, this would only lead to partial improvements in equity.
- **Retrospective payments between carriers**: one of the carriers conducts retrospective payments to the second insurance carrier, which was predominantly used by the insured person to access services. This system constitutes a modification of the current mechanism in that it adds a compensatory mechanism to ensure the financial stability of funds. However, it must be noted that

this option may be more difficult to implement and does not render the system more equitable. See section 5.1.8 for further details.

9.4 Policy options: Defining and harmonising benefits

The following the policy options to define benefits within the healthcare system are proposed.

- **Outpatient drugs**: disclosure of outpatient drug assessments would render the current process more transparent.
- **Inpatient drugs:** enhance and strengthen coordination and procurement policies across regions and introduction of a transparent decision-making process for inpatient pharmaceuticals.
- **Establishment of an independent, arm's length HTA body**: transition into an independent, arm's length HTA body that undertakes HTA for different types of technology and provides advice to relevant decision-makers in order to increase transparency.
- **Promote a full HTA for a subset of technologies**, particularly those that have important resource implications (high cost/high volume). Formal evaluations should be introduced across costly technologies and a threshold for this purpose should be established.
- **Establish clear parameters regarding the conduct of HTA**, such as type of evidence requirements and the types of evidence that can be admitted into assessment and appraisal.
- **Provide guidance on** methods of assessment and criteria (beyond costs and effects); the role of stakeholder involvement; the appeals process and associated timelines; timelines for assessment and re-assessment for rapid reviews, full HTAs and multiple HTAs; and, the monitoring and implementation of decisions.
- **Provide information on** the structure and composition of the relevant committee (technology Appraisal Committee – TAC), which needs to reflect the stakeholder complexity in the context of each technology type and the national-regional-local trade-offs that exist in different circumstances.

The following the policy options to harmonise benefits within the healthcare system are proposed.

- **Estimated cost of harmonising a specific set of benefits**: initial costs of a harmonisation for specific goods and services (i.e. medical aids and therapeutic devices; dentures; health care services including psychotherapy, physiotherapy and logopedics) were estimated by increasing the per

capita expenditure levels of those funds that are (1) below the average per capita expenditures across all funds and (2) below 70% of the highest per capita expenditure across all funds. **Total additional costs per year of harmonising specific benefits across all funds**:

- (1) €171.075.130 (Risk-adjustment (age and gender) for medical aids and therapeutic devices: €176.988.291). Percentage change in expenditure of SHI for these benefits: ↑19.4% (↑20.1).
- (2) €390.177.440 (Risk-adjustment (age and gender) for medical aids and therapeutic devices: €394.090.543). ↑42.8% (↑43.6).

- While this study provides initial cost calculations, the harmonisation of benefits is a political decision to be taken by the government and stakeholders. Even though a harmonisation of benefits is central to ensuring equity, it is noteworthy that Austria has one of the lowest levels of unmet need in Europe.
- **Data collection**: a unified collection of high-quality data that is comparable across funds is of central importance to supporting the harmonisation of benefits. Further efforts are required to ensure uniform data storage and structure.
- **Financing options** in the case of a political decision to harmonise benefits:
  - (1) Partial funding could ensue through a risk-adjustment scheme, or enhanced risk-adjustment scheme
  - (2) Alternatively, or in addition, government funds could be directed to insurance carriers that offer a slightly less comprehensive benefits package compared to other funds.
  - (3) Further funds could be directed to the project by improving efficiency in the system. For instance, a reduction in hospitalisations could lead to significant savings. However, significant investments in outpatient and primary care are required in the first instance to maintain high-quality care, whilst simultaneously reducing hospital admissions, meaning that savings to be used for a harmonisation could be generated in the mid- to long-term.
  - (4) In addition, better coordination and consolidation could also lead to efficiency gains, which could be directed in the form of savings to increase coverage of benefits in Austria.

See section 5.2.6 for further details.

9.5 Policy options: User charges

The following policy options to enhance efficiency and equity via user charges have been proposed. Please note, none of the policy options recommend an increase in user charges, rather a change in their composition to maximise efficiency within the system.

- **Pharmaceutical cap:** under this option, the universal 2% net income pharmaceutical cap would be replaced by a three-tiered cap, with insurees being allocated to caps according to their total income. Those in the lowest income band would be subject to a lower cap (i.e. 1.5%), middle income earners would see no change in their cap (i.e. remain at 2%), while high-income earners would see their cap increase to 2.5%. Depending on the success of the cap, consideration could be given to expanding the cap to all inpatient and outpatient healthcare services.
- **Value-based user charges**: once a robust HTA system is in place, it is advised that rates of user charges be linked to HTA findings, with insurees paying less (or nothing) the more effective a product/service is. Ideally user charges would take into account individual circumstances, however, this is associated with high-levels of administrative burden. Therefore, it is recommended that value-based user charges be linked to the effectiveness of products/medical devices/services (i.e. inverse relationship between effectiveness and co-insurance/payment rate). In the interim, policy-makers could encourage 'softer' value-based user charges, following the lead of the SVA and VAEB.
- **Convergence of user charges to the lowest level:** finally, it is recommended that current trends continue by encouraging convergence of user charges across health insurance carriers to improve equity within the system.

See section 5.3.8 for further details.

9.6 Policy options: Investment in healthcare services

Three policy options to enhance investments in healthcare services are proposed. These relate to accounting practices, reserves, and whether carriers should make or buy healthcare services.

- **Accounting**: to improve clarity, it is recommended that carriers only term liquid assets as 'reserves', that is, monies which can be used for investment purposes.
- **Enhance use of reserves:** to improve access to healthcare services for all, it is advised that the use of reserves be enhanced, for example by: a) pooling all or a part of a carrier's contributions into

one fund for investment purposes (e.g. to enhance primary healthcare), b) encourage joint investment across carriers (without pooling reserves), or c) encouraging carriers to open up their facilities to all individuals, not just their insured population.

- **Make or buy**: before investing in healthcare services, carriers should be encouraged to undertake a comprehensive analysis before investing, to determine whether it is most appropriate to make or buy (or concurrently source). However, to improve capacity within each health insurance carrier, it is encouraged that carriers invest, at least partly, in their own healthcare services.

See section 5.4.3 for further details.

9.7 Policy options: Broadening the social welfare base

Austria is a strong economic performer, with a relatively high level of employment and GDP per capita. Economic growth is expected to grow over the next few years, however, consideration should be given to current and future challenges facing the economy including an ageing population, and a rise in self-employment, digitalisation and automation. Based on these challenges, the following policy options have been developed to ensure sustainability of the social insurance system.

- **Education and skills**: Align education with future skills required within the workforce, and encourage lifelong learning.
- **Retirement policies**: encourage further efforts to increase the actual retirement age (i.e. encourage people to stay in the workforce for longer).
- **Workforce participation**: continue efforts to increase the proportion of women working within the formal economy.
- **Taxation policies**: after 'softer' policy options, as those outlined above, have been introduced, consider changes to the tax system if further funds are required. Specifically, by using total income as opposed to earned income as the basis for contributions, raising company contributions, and/or introducing additional earmarked health taxes.

See section 5.5.4 for further details.

9.8 Policy options: Contractual agreements

To improve efficiency within the healthcare system via a change to contractual agreements, the following policy options are recommended. These policy options have been broken down according to broad timelines, which reflect their relative importance.

Short-term:

- **Arbitration:** to ensure a level playing field during contractual negotiations, the following option is proposed; allow the Federal Arbitration Committee to postpone the termination of contracts from three to six months, after six months an external arbiter would be introduced to facilitate negotiations. Given no agreement is reached, the Ministry of Health and Women's Affairs would set the contractual agreement based on feedback from the external arbiter.
- **Selective contracts:** If certain items cannot be agreed upon in the general contract, allow social health insurance carriers to selectively contract (e.g. to fill physician vacancies).
- **Structural plans:** if current regional structural plans fail to achieve their desired objective, it is advised that an independent committee be developed to provide recommendations on the number and locations of physicians. Recommendations would form the basis of contractual negotiations, with a requirement to justify any deviations to the Ministry of Health and Women's Affairs.
- **Harmonisation among specialists:** Harmonise naming of services/items across outpatient specialists to improve transparency.
- **Primary and outpatient care:** given the high number of hospital admissions, it is clear that primary care within the healthcare system requires improvement. Multiple policies could be introduced to achieve this, for example, by encouraging group practices, primary healthcare units, and extending hospital outpatient departments and disease management programs. It is important to note that efficiency gains from enhancing primary care are only realisable in the medium- to long-term given fixed supply-side costs within the inpatient sector (e.g. buildings, labour).

Medium-term:

- **Bundled payments:** to enhance coordination and continuity of care, social health insurance and Länder could implement joint budgets for chronically ill patients who frequently access healthcare services. Such an approach would avoid patients 'wandering' the system and ensure that appropriate care is provided.

- **Rural and remote GP remuneration**: to increase the number of physicians working in rural and remote areas, it is recommended that GPs in these areas be paid on a risk-adjusted capitated budgets, which takes into account the unique circumstances of working in these areas. To further incentivise physicians, flat rate payments could be introduced to complement capitated budgets, such payments should be linked to actions/services that promote overall improvement in healthcare quality (e.g. smoking cessation programs).

Long-term:

- **GP remuneration**: if the capitated system amongst rural and remote GPs is successful, consideration could be given to extending the scheme to urban GPs, who would also receive additional flat rate payments.
- **Role of GPs**: it is recommended that the role of GPs in the healthcare system be enhanced to relieve the burden placed on inpatient care, specifically, by encouraging individuals to register with a single GP who would take responsibility for the individual's overall healthcare plan. Such a system would be voluntary, and only realisable once appropriate structures and processes have been put in place (e.g. more advanced GP training, greater number of GPs).

See section 6.3.8 for further details.

9.9 Policy options: Healthcare quality

Policy options to improve healthcare quality within the system have been grouped into three categories. First, changes to the role ÖQMed, second, changes to data availability and quality indicators, and third, changes to hospital admissions, readmissions and discharge management.

In regard to the **role of ÖQMed:**

- Retain ÖQMed and create an additional independent quality committee responsible for monitoring the quality of care among contracted and non-contracted physicians.
- Relocate ÖQMed to the Ministry of Health and Women's Affairs, and give the organisation control over monitoring the quality of care among contracted and non-contracted physicians.
- Maximise the value of data collected through quality indicators through, for example, providing physician feedback and sharing best practice principles.

In regard to **data availability and quality indicators**:

- Develop a coding system for outpatient diagnosis, this would allow outcome indicators to be implemented.
- Increase focus on outcome indicators, and where possible link them to aligning process indicators.
- Link quality indicators across all levels of care to develop patient pathways.
- Allocate responsibility for developing and implementating indicators to the relevant professional group within the Ständiger Koordinierungsausschuss. However, any new indicators should be developed in consultation with the medical community.

In regard to **hospital admissions, readmissions and discharge management:**

- Research is needed to investigate the causes, as well as clinical and policy implications, of high rates of hospital discharge and readmission in Austria (outside remit of this review).
- In order to outbalance political benefits and costs, federal government funds to Länder should be based on objective criteria that reflect the needs of the population.
- Apply additional pressure from the financial targets within the *Zielsteuerung Gesundheit* and the stability pact (i.e. using real values instead of nominal values).
- Austrian Structural Health Plan to base its forecasts on epidemiological data and best practice of service provision, rather than using current demand as a proxy for need
- Further integrate secondary care units in the outpatient sector with primary and hospital care
- In regard to payment of care, for hospitals, the LKF system could be linked to quality of care, while in the first instance, a DRG system within the outpatient sector is advised, given this would improve information on patient pathways. Finally, and as previously mentioned under 'medium term' contractual agreements, bundled payments using funds from a joint budget (between Länder and social insurance) could be introduced, with pilots first being run for multi-morbid, high cost patients.

See section 6.4.6 for further details.

9.10 Policy options: Demand and supply of physicians

Policy options to increase the availability of physicians include:

- **Improving work-life balance** for both male and female physicians, especially in regard to child and elderly care (with a specific focus on those working in rural and remote areas).
- **Reducing incentives for physicians to emigrate**, for example, by providing clarity over future work conditions, ensuring working conditions are compatible with those abroad in regard to hours worked and reimbursement.
- **Reducing the 'brain drain'** occurring during the transition phase between medical school and professional training, for example, by improving training programs and ensuring these programs are allocated sufficient time.
- **Checking if working time directive compliance necessitates prolongation of training periods**, especially for specialists who need also dexterity, not only knowledge.

Policy options to increase the productivity of physicians include:

- **Improving the reputation of physicians working in primary care**, for example, via additional GP training requirements to fulfill their responsibilities within newly established primary healthcare units.
- **Delineating physician roles** within primary healthcare units and those performed within a hospital outpatient department**.**
- **Free-up time of physicians** by allocating relatively 'low-skilled' tasks to other healthcare professionals (such an approach may require additional education training for other health care professionals). **Training and motivating existing professionals to adjust to re-allocations of tasks and responsibilities** given the number of physicians nearing retirement age.

See section 6.5.3 for further details.

9.11 Policy options: Monitoring and information needs

The following policy options relating to e-health are provided below:

- **Synergy potentials in data storage**: identify synergy potentials between data storage sites, while avoiding the construction of new sites, in order to make efficient use of existing capacity.

- **E-prescribing and recall system**: introduce automated electronic prescribing and a recall system for medical adherence to reduce prescribing-related errors, while concurrently improving control of prescriptions, reducing time spent on prescription queries and promoting continuity of care.
- **E-vaccination**: implement an e-vaccination application with a recall system in order to create an optimised overview of immunisation status and vaccination schedule, whilst preventing duplicate immunisations and possible adverse events from drug-to-drug interactions. A national electronic immunisation data collection system could further improve the monitoring and evaluation of immunisation rates in Austria.
- **Digital imaging in ELGA**: expand the database for digital images from different medical devices to improve site- and time-independent information sharing between medical professionals and health care enterprises to enhance operational efficiency and to prevent unnecessary repeat examinations.
- **Standardisation of the diagnosis classification system**: inclusion of outpatient diagnoses may constitute a better representation of a patient's medical history and interoperability could be improved by standardising the diagnosis classification system.
- **Evaluation and monitoring of a patient's medical history**: a tracking system with a search function to monitor the development of specific parameters, such as blood pressure, may further enhance patient treatment. Further efforts should be undertaken to implement a patient summary.
- **Expansion of data collection**: a more extensive patient record, which, for example, includes information from the yearly medical check-up, could further improve patient-centred care, provided an insured person has expressed interest in the service.
- **Immediate sharing of information on health care use**: providing information on health care costs in addition to the utilisation of services through ELGA's online portal could enable year-round access to necessary information for patients and prevent billing errors.
- **Dissemination of information on ELGA to health care providers:** develop ELGA showcases that could be presented to health care providers, such as pharmacies, to facilitate and support the roll out of ELGA across as many health care providers as possible.

See section 6.6.2 for further details.

9.12 Policy options: Pharmaceutical expenditure and procurement

The following three policies are recommended in regard to pharmaceutical expenditure:

- **Enhance international relationships** to gain a better understanding of drug transaction prices within the outpatient market. Currently, external reference pricing, which draws upon list prices, is used, which doesn't necessarily reflect actual prices paid for drugs.
- Austria should consider **modifying domestic regulations on statutory prescription drug price cuts** so that they are linked to patent expiration rather than generic drug entry.
- **Limit the risk faced by payers and promote efficient use of resources** by introducing managed entry agreements.

To enhance the use of generics, the following policies are suggested:

- Given the increasing demand for healthcare services, we recommend **increasing the role of pharmacists** within the healthcare system, which would enhance efficiency and reduce the burden placed on physicians.
- **Incentivise physicians to prescribe more generics,** where appropriate**.**

Finally, to enhance procurement policies:

- Effort should be directed at **improving interface management between inpatient and outpatient pharmaceutical sectors** to limit cost-shifting and improve coordination of patient treatment. For example, by developing a joint budget for all pharmaceuticals, enhancing the role of the Medikamentenkommission, and /or enhancing ELGA so that information regarding a patient's drug treatment (in both inpatient and outpatient settings) is easily understood by prescribers.

See section 6.7.5 for further details.

9.13 Policy options: Health literacy, disease prevention, health promotion

The following policy options relating to health literacy and disease prevention are provided below:

Health literacy

- **Improving health communication between patients and doctors**: Clear health communication between patients and doctors could be further improved by specifying specific criteria pertaining

to the communication process (e.g. 'teach back'; avoiding jargon) in the Chamber of Physician's quality evaluation criteria of physician practices or in contracts.

- **Expand the dissemination of health information**: the national self-information portal could offer a number of additional language settings, other than German, in order to increase use of the site. A child-friendly, interactive information site could be developed as well.
- **Increase role of different stakeholders**: the role of various stakeholders in promoting health literacy should be increased. For instance, a point of contact for patients with limited health literacy levels should be defined to offer training and support, such as patient ombudsperson offices, while physicians could direct the respective patients to these contact points. Pharmacists could be further trained to identify and manage patients with lower literacy levels.
- **Module on health literacy**: a module on health literacy in the education setting (e.g. primary or secondary education) could be introduced to establish a solid and uniform health literacy knowledge basis across population groups.

Disease prevention

Immunisation

- **Inclusion of vaccinations in the mother-child passport**: create awareness and incentivize immunisation of children to increase low childhood immunisation rates.
- **Coverage of cost-effective vaccines for adults**: an additional coverage of adult vaccinations, where cost-effective, could potentially increase adult immunisation rates of a number of important vaccine-preventable diseases.
- **Walk-in vaccination and injection services at pharmacies**: by introducing walk in vaccination and injection services at community pharmacies, following a prescription by a physician, the immunisation process could be rendered more flexible, time-saving and convenient to patients.
- **E-vaccination to improve monitoring and re-calling of-, as well as data collection on vaccinations**: implement an e-vaccination application with a recall system in order to create an optimised overview of immunisation status and vaccination schedule, whilst preventing duplicate immunisations and possible adverse events from drug-to-drug interactions. A national electronic immunisation data collection system could further improve the monitoring and evaluation of immunisation rates in Austria.

Diabetes

- **Expansion of the diabetes disease-management-programme (DMP)**: in order to improve the equity and quality of diabetes treatment in Austria, it is suggested to further strengthen efforts in the disease management programme, which should be gradually expanded over time.
- **Remuneration of DMP-physicians**: the financial compensation of DMP-physicians should be assessed in order to ensure appropriate rewards in line with the time taken to manage diabetes patients, and to incentivise more physicians to enter the programme.
- **Training of physicians**: inclusion of diabetes specific-tasks in the grid certificate may further expose physicians to additional training and as such improve the management of patients with diabetes. Another option is to render further training more binding by defining explicit follow-up measures in the case that physicians fail to follow the training.
- **Training of DMP-physicians**: the introduction of a voluntary training and a confidential supervision by experiences diabetes specialists may increase physician participation in the DMP programme.
- **Establishment of a national diabetes registry**: By extending data collection efforts, a national diabetes registry could be implemented in order to improve the collection of data to monitor and evaluate trends in diabetes.

Cardiovascular diseases

- **Comprehensive study:** Undertake a comprehensive study into the underlying factors of the high CVD disease burden and mortality in Austria. Based on the findings, appropriate measures could be introduced to reduce CVD-related morbidity and mortality.

See sections 7.1.3, 7.1.5 and 7.1.9 for further details.

9.14 Policy options: Case and care management

A total of eight policy options to enhance case and care management within Austria have been proposed:

- Target case management and other types of coordinated care based on need
- Pilot new models, evaluate pilots rigorously and scale up successful ones
- Increase organisational and financial integration of providers
- Ensure comprehensiveness of the range of services covered by case management
- Include inter-disciplinary cooperation in education and training programs of professionals

- Continue strengthening the role of primary care and embed case management in primary care
- Provide workplace and return-to-work interventions early
- Embed case management in broad return-to-work interventions.

See section 7.2.7 for further details.

9.15 Policy options: Administration costs

The following policy option relating to administration costs is provided below:

- **Administration caps:** link caps to potential economies of scale arising from more streamlined activities, as opposed to historical allocations. Alternatively, require health insurance carriers to justify higher administration costs, given such costs are often required to improve equality (e.g. performance measurement).

See section 8.2.3 for further details.

9.16 Policy options: Healthcare fraud

Healthcare fraud leads to a significant amount of waste in healthcare systems across the world, including Austria. To combat healthcare fraud and limit waste within the system, the following two policy options are recommended:

- **Comprehensive study:** Jointly undertake a comprehensive study into the types of healthcare fraud within the system, including an estimate of their associated costs based on findings within the study, implement appropriate policies to create an environment that limits the opportunity for fraud to occur
- **Digitalisation:** enhance the sophistication of ELGA to enable health insurance carriers to better identify instance of healthcare fraud

See section 8.3.8 for further details.

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Appendix A: Concept note

Einleitung

Zentrales Ziel für die Bundesregierung ist der effiziente Einsatz von Ressourcen bei gleichzeitiger Harmonisierung des Leistungsstandards und Ausbau der Services für die Versicherten.[115] Zur Verbesserung der Effizienz und der für die Menschen zur Verfügung stehenden Leistungen sollen in dieser Studie grundlegende Fragestellungen der Sozialversicherung und der damit verwandten Themenbereiche analysiert werden.

Dies umfasst auch in Zukunft eine flächendeckende und wohnortnahe Versorgung mit Gesundheitsleistungen, die unabhängig von Alter, Einkommen, Geschlecht, Herkunft, Religion und Gesundheitszustand in bestmöglicher Qualität sicherzustellen sind. Damit soll das Erfolgsmodell der österreichischen Sozialversicherung auch für die Zukunft abgesichert werden, wobei im Bereich des Gesundheitswesens die PatientInnen im Mittelpunkt stehen. Zu prüfen ist in diesem Zusammenhang, ob und in welchem Umfang eine Reform des Sozialversicherungssystems zur Verbesserung der Versorgungssicherheit und -qualität im Gesundheitswesen, bzw. zu einer Steigerung der Effizienz und Effektivität beitragen kann. Eine erfolgreiche Weiterentwicklung des derzeitigen Systems ist jedoch aufgrund der hohen Gesamtsystemkomplexität des Gesundheitswesens nur in Verbindung mit einem verbesserten Zusammenspiel der unterschiedlichen Akteure möglich. Eine Modernisierung und eine Steigerung der Transparenz sollte in Verbindung mit einer nachhaltigen Sicherstellung der Finanzierung, des hohen Niveaus der medizinischen Versorgung und der Leistungen der sozialen Sicherheit erreicht werden. Nachfolgende Fragestellungen sind in diesem Zusammenhang unter anderem zu prüfen:

- Effiziente und effektive Nutzung der eingesetzten Finanzmittel durch die Sozialversicherung in Verwaltung und im Leistungsbereich
- Prüfung der Reduzierung der Trägerlandschaft
- Leistungsharmonisierung auf ein einheitliches Niveau
- Vereinfachung der Beitragseinhebung (unter anderem durch Streichung von Spezialbestimmungen)
- Vereinfachung der Abwicklung von Mehrfachversicherungen
- Stärkung der Prävention und Gesundheitskompetenz
- Einführung eines flächendeckenden Case Managements
- Modernisierung des Vertragspartnerrechts und der Tarifkataloge mit den Gesundheitsdiensteanbietern

[115] Unter Versicherten werden Voll- bzw. Teilversicherte nach den Sozialversicherungsgesetzen, wie auch sonstige Versorgte verstanden

Klar ist, dass Fragen der Organisation und der Finanzierung ein Ziel haben müssen: Die Sozialversicherung ist zukunftsfit zu machen – in diesem Zusammenhang muss auch die Finanzierung für die kommenden Generationen sichergestellt werden.

UMFASSENDE VERSORGUNG FÜR DIE MENSCHEN: Mehr Leistungen und weniger Bürokratie

Die nachhaltige Absicherung des öffentlichen Gesundheitssystems, der Ausbau der Sachleistungsversorgung am Letztstand der Wissenschaft, sowie die Stärkung der Gesundheitsförderung sind zentrale Eckpunkte des gesundheitspolitischen Handelns. Zudem ist das System der solidarischen Krankenversicherung nachhaltig abzusichern und allen Menschen ein solidarischer Zugang zu umfassender, qualitativ hochstehender Gesundheitsversorgung zu ermöglichen. Diese Grundsätze sind den Überlegungen zu Effizienzverbesserungen im Gesundheitswesen zu Grunde zu legen.

Staatsziel „Soziale Absicherung“

Die Republik Österreich steht für ein **solidarisches System der sozialen Sicherheit, ausgehend von dem Prinzip der Pflichtversicherung**. Die Menschen können darauf vertrauen, dass die hochwertige Versorgung durch die Sozialversicherung für sie, ihre Kinder und Enkel nachhaltig gesichert bleibt. Die Selbstverwaltung als Governance-Instrument, bestehend aus VertreterInnen der ArbeitnehmerInnen und der ArbeitgeberInnen, schafft Stabilität und langfristige Planbarkeit. Daher ist die Selbstverwaltung einer der Erfolgsfaktoren für die nachhaltige soziale Absicherung der Menschen in Österreich.

Die vorangestellten Grundsätze sollen, um die Weiterentwicklung der Systeme zu fokussieren, durch ein Staatsziel gestützt werden. Die Idee der Staatsziele verfolgt eine grundsätzliche strategische Ausrichtung des österreichischen Gemeinwesens. **Staatsziele** sind als über die Legislaturperioden hinausgehende **Handlungsanleitungen** des **Gesamtstaates** zu sehen. Staatsziele definieren Querschnittsmaterien, die von allen Politikfeldern im Rahmen der jeweiligen Zuständigkeiten bearbeitet werden müssen.

Im Rahmen dieser Untersuchung soll eine Formulierung für ein soziales **Staatsziel „nachhaltige soziale Absicherung für die in Österreich lebenden Menschen“** gefunden werden. Dabei soll einerseits auf die besonderen Merkmale der bestehenden sozialen Sicherungssysteme abgestellt, andererseits internationale Best-Practice Beispiele als Vorbilder herangezogen werden. Die Grundsätze der Selbstverwaltung und der öffentlichen sozialen Sicherungssysteme sollen abgesichert werden. Das Prinzip der Pflichtversicherung, das garantiert, dass alle Menschen, unabhängig von der individuellen ökonomischen Stärke, einen gleichen gesetzlichen Leistungsanspruch haben, soll auch in Zukunft unverändert fortbestehen.

Aufgabenstellung: Entwicklung einer Formulierung für ein soziales Staatsziel „nachhaltige soziale Absicherung für die in Österreich lebenden Menschen“.

Leistungsrecht harmonisieren

Das Leistungsrecht ist für die Versichertengemeinschaft von zentraler Bedeutung. Unterschiede werden von den versicherten Menschen im Alltag wahrgenommen, stoßen auf Unverständnis und führen zu Systemkritik. In einem Versicherungssystem mit einer gesetzlichen Zuordnung der Versicherten zu den einzelnen Sozialversicherungsträgern hat die Harmonisierung des Leistungsrechts oberste Priorität. Dabei ist als Basis zu erheben, in welchem Ausmaß Leistungen derzeit schon über die verschiedenen Träger harmonisiert sind. Das betrifft sowohl die rechtliche Ausgestaltung als auch den Zugang zu den Leistungen und die konkreten Leistungen selbst. In Hinblick auf die bereits bestehende Leistungskonvergenz ist ein internationaler Vergleich anzustellen.

Es gilt folgende Arten der Leistungsdifferenzierung zu prüfen:

- gesetzliche Leistungsdifferenzierung
- satzungsmäßige Leistungsdifferenzierung
- tatsächliche Leistungsdifferenzierung
- vertragspolitische Leistungsdifferenzierung

Ziel der Harmonisierung des Leistungsrechts muss es sein, allen Versicherten gleiche und umfassende Leistungen – *state of the art* – anzubieten. Dabei ist eine Verbesserung des Leistungsangebots anzustreben – ein *race to the bottom* wird abgelehnt. Ziel ist es, die Leistungen, unabhängig von der Kasse, der ein Versicherter zugeordnet ist, auf ein einheitliches Niveau zu bringen. Das betrifft insbesondere die gesetzlichen Kranversicherungsträger, wie auch die Versorgungssysteme von Bundes- und Landesbediensteten und die Betriebskrankenkassen. Der Bereich der Rehabilitation ist miteinzubeziehen. Zudem soll eine nachhaltige Klärung der Leistungszuständigkeit im Bereich **Kur und Rehabilitation** erfolgen. Die Leistungen sollen über alle Versicherungen betrachtet steigen. Die Verhältnismäßigkeit und Finanzierbarkeit ist bei der Entwicklung der Leistungsharmonisierung im Auge zu behalten, wobei klar ist, dass die Harmonisierung der Leistungen eine Verbesserung für die Bevölkerung bringen soll. Als eines der Hauptelemente bei der Harmonisierung des Leistungsrechts soll der **Fokus auf den Ausbau der Sachleistungen** gerichtet werden. Der Mittelbedarf ist zu beziffern und in einem Stufenplan zur Implementierung dazustellen. Im Rahmen eines vorzulegenden **Umsetzungs-Prozesses (Umsetzungspakete)** wird darauf Rücksicht zu nehmen sein, inwieweit verfassungsrechtliche Gesichtspunkte, wie „Vertrauensschutz“, in eine Modellierung der Übergangsbestimmungen einzufließen hätten.

Aufgabenstellung: Analyse, bis zu welchem Grad Leistungen bereits jetzt harmonisiert sind. Dabei ist auf die rechtliche Ausgestaltung als auch den Zugang zu den Leistungen und die konkreten Leistungen selbst abzustellen. Ein internationaler Vergleich ist zu ziehen.

Aufgabenstellung: Erarbeitung von Vorschlägen zur Leistungsharmonisierung zwischen allen Versichertengruppen. Dabei soll eine Leistungsharmonisierung, bei der im Ergebnis das Leistungsniveau für alle Versicherten in Summe auf ein relativ höheres Niveau gehoben wird, erreicht werden. Dabei soll ein Fokus auf Sachleistungen gelegt werden. Die Grundsätze der Verhältnismäßigkeit und Finanzierbarkeit sind zu berücksichtigen.

Aufgabenstellung: Zur Umsetzung soll – auch unter Bedachtnahme auf die Finanzierung – ein Vorschlag für die Implementierung der Umsetzungspakete in einem Stufenplan erarbeitet werden.

Aufgabenstellung: Analyse der Leistungszuständigkeit für Kur und Rehabilitation unter Effizienz- und Qualitätsgesichtspunkten.

Prävention und Gesundheitsförderung

Österreich hat ein ausgezeichnetes kuratives Gesundheitssystem. Die Prävention und Gesundheitsförderung ist in Zukunft strategisch – auf der Grundlage der Gesundheitsreform 2013, entlang der Rahmengesundheitsziele – zu stärken. Es ist zu erheben, wie Investitionen in diesen Felder ausgestaltet sein müssen, um gute Ergebnisse erzielen zu können.

Aufgabenstellung: Erarbeitung von konkreten Maßnahmen zur Stärkung von Prävention und Gesundheitsförderung für die Versicherten, aufbauend auf der Gesundheitsreform 2013, den Rahmengesundheitszielen und der Gesundheitsförderungsstrategie. Dabei ist auch auf Fragen der Gesundheitskompetenz (*health literacy*) einzugehen.

Case Management

Ein aktivierender Sozialstaat nutzt die Instrumente des Case- und Care Managements zur Stützung der Krankheitsbewältigung und zur Stärkung der Gesundheitschancen. Bestehende Instrumente wie fit to work, Case Management im Rahmen des Rehabilitations-Geldes und die betriebliche Gesundheitsförderung sollen systemisch ineinandergreifen. Dadurch sollen Frühpensionierungen vermieden werden. Dabei sind auch die Grenzen des Case Managements aufzuzeigen.

Aufgabenstellung: Welche internationalen Erkenntnisse im Bereich des Case- und Care Managements sind für Österreich anwendbar und umsetzbar?

Beitragseinhebung

In den letzten Jahren wurden viele Sonderbestimmungen im Bereich der Beitragseinhebung geschaffen. Für BeitragszahlerInnen führen diese Bestimmungen im Alltag zu einer hohen Verwaltungskomplexität. Diese Komplexität ist durch die Streichung von Spezialbestimmungen zu reduzieren. Dazu ist die Beitragsgrundlagenbildung zu analysieren.

Aufgabenstellung: Vorlage eines Konzepts zur Vereinfachung der Beitragseinhebung durch Streichung von Spezialbestimmungen.

Aufgabenstellung: Analyse der Beitragsgrundlagenbildung unter dem Aspekt der Beitragsgerechtigkeit.

Bürokratieabbau für Mehrfachversicherte

Eine der Grundsäulen der Pflichtversicherung ist, dass für jede Art von Erwerbseinkommen Versicherungsbeiträge zu entrichten sind. An diesem Grundsatz soll festgehalten werden. In der Praxis ist die Abwicklung der Mehrfachversicherung für BeitragszahlerInnen über der Höchstbeitragsgrundlage mit nicht notwendigem Verwaltungsaufwand verbunden. In diesen Fällen gilt es daher, Entbürokratisierungsmaßnahmen zu setzen.

Aufgabenstellung: Erarbeitung von Endbürokratisierungsmaßnahmen für Mehrfachversicherte im Beitragsbereich – etwa die amtswegige Rückerstattung von geleisteten Sozialversicherungsbeiträgen über der Höchstbeitragsgrundlage.

NORMATIVE GRUNDLAGEN: Analyse des Ist-Stands

Verfassungsfragen

Kompetenzverteilung des Bundesverfassungsgesetzes

Basis der Überlegungen ist die **zwischen Bund und Ländern** bestehende **Kompetenzlage** des Bundesverfassungsgesetzes (B-VG), insbesondere im Gesundheitswesen: Die Zuständigkeit der Sozialversicherung betrifft den extramuralen Bereich, verbunden mit einem großen Anteil derKrankenanstalten-Finanzierung. Dem gegenüber steht der Versorgungsauftrag der Länder für die Krankenanstalten. Sozialversicherungsrecht ist verfassungsgesetzlich Bundessache in Gesetzgebung und Vollziehung (Art 10 B-VG). Im Bereich der Krankenanstalten liegt die Grundsatz-Gesetzgebung beim Bund, die Ausführungs-Gesetze, sowie die Vollziehung sind Landessache (Art 12 B-VG). Das bedeutet, dass die Kompetenzlage mehrfach asymmetrisch verteilt ist. Demgegenüber sind die Krankenfürsorgeanstalten der Länder dienstherrliche Einrichtungen von Gebietskörperschaften (Art. 21 B-VG).

Das **Prinzip** der **Selbstverwaltung** ist in der Bundesverfassung verankert. Von diesem Prinzip als funktionierende Grundlage der Sozialversicherung auf der einen Seite und den Ärztekammern, der Apothekerkammer, der Wirtschaftskammern, der Zahnärztekammern und weiterer Leistungsanbieter auf der anderen Seite ist auszugehen.

Organisationsstruktur-Änderungen durch Verfassungs- oder einfachen Bundesgesetzgeber?

Als Basis der juristischen Analyse sind vor allem die verfassungsrechtlichen Fragestellungen einer Prüfung zu unterziehen. Es ist aus rechtlicher Sicht zu klären, ob die bestehende Trägerlandschaft einfachgesetzlich oder nur mit **Verfassungsmehrheit** einer **Strukturanpassung** unterworfen werden kann.

Aufgabenstellung: Gibt es eine verfassungsgesetzlich verankerte Bestandsgarantie für die nach Berufsgruppen und/oder regional und/oder bundesweit organisierten Kranken-, Unfall- und Pensionsversicherungsträger und die Krankenfürsorgeanstalten?

Aufgabenstellung: Gebietet die Bundesverfassung die Bildung von unterschiedlichen Versichertengemeinschaften (Unselbstständige, Selbstständige) oder ist dem Gesetzgeber die Strukturgestaltung der Selbstverwaltung frei überlassen?

Kompetenzbereinigung in der Gesetzgebung im Bereich der Krankenanstalten Gesundheitsversorgung ist nicht auf die Sozialversicherungen zu beschränken, sondern wird zu einem großen Teil auch in den Krankenanstalten geleistet. Daher ist auch die verfassungsrechtliche Kompetenzverteilung in diesem Bereich zu betrachten.Die **Kompetenzverteilung im Krankenanstaltenbereich** ist historisch gewachsen und komplex. Derzeit ist die Grundsatzgesetzgebung Bundessache und die Ausführungsgesetzgebung obliegt den Ländern. Dies führt im Detail zu unterschiedlichen Regelungen in den neun Bundesländern. Daher ist zu prüfen, ob es weiterhin zehn Krankenanstaltengesetze geben soll, oder ob es sowohl ökonomisch, als auch staatsrechtlich effektiver wäre, die Gesetzgebung (nicht aber die Verwaltung) beim Bund zu bündeln. Neben der juristischen Analyse ist auch eine ökonomische Bewertung einer Änderung der Kompetenzverteilung zu erstellen und das Ergebnis der Beibehaltung des Status-Quo gegenüberzustellen.

Aufgabenstellung: Prüfung der verfassungsrechtlichen Möglichkeiten einer Kompetenzverschiebung im Bereich des Krankenanstaltenrechts.

Aufgabenstellung: Ökonomische Analyse der Effizienzpotentiale einer geänderten Kompetenzverteilung.

Vertragspartnerrecht modernisieren

Das bestehende Vertragspartnerrecht geht auf die 1950er Jahre zurück. Es determiniert die für die PatientInnen relevanten Leistungen der Gesundheitsversorgung und hat daher einen besonderen Stellenwert. Die Verbesserungen der Leistungen durch eine österreichweite Leistungsharmonisierung sind daher eng mit einer effizienten Organisation von Gesundheitsdienstleistungen durch die Sozialversicherungen verknüpft. Das **Vertragspartnerrecht** regelt die Leistungsabgeltung von Gesundheitsdienstleistungen zwischen der sozialen Kranken-, Unfall und Pensionsversicherung und Gesundheitsdiensteanbietern. Die Gesundheitsdiensteanbieter werden auf kollektiver Ebene, in dieser Konstellation primär durch neun Landesärztekammern, die österreichische Ärztekammer, bzw. durch die

Wirtschaftskammern und die Zahnärztekammer vertreten. Im bestehenden System haben die VertreterInnen der **Gesundheitsdiensteanbieter** starke **Gestaltungsrechte**, die nicht mit einer Beschaffung auf freien Markt vergleichbar sind.

Zu klären ist, wie das **Verhältnis zwischen Sozialversicherung** auf der einen Seite und **Gesundheitsdiensteanbietern** auf der anderen Seite modernisiert werden kann, beziehungsweise wie entsprechende Regelungen ausgestaltet sein müssten. Dabei sind internationale Best-Practice Beispiele heranzuziehen.

Das **Kostenoptimierungspotential** durch die **Beschaffung von Gesundheitsdienstleistungen unter flexibleren Rahmenbedingungen** ist zu erheben. Dabei ist immer auf das Leistungsniveau für die PatientInnen, auch im Zusammenhang mit der Leistungsharmonisierung auf ein relativ höheres Niveau, Bedacht zu nehmen.

Aufgabenstellung: Unter der Prämisse, die Versorgung der Versicherten zu verbessern, soll eine Analyse des derzeitigen Vertragspartnerrechts erstellt werden. Die Frage, ob eine flexiblere und transparente Organisation von Gesundheitsdienstleistungen Effizienzpotentiale gegenüber dem Status-Quo bietet, ist zu beantworten. Dabei ist auf international vergleichbare Best-Practice Modelle zu referenzieren. Besonders die Rolle der Systempartner für eine moderne Sachleistungsversorgung ist zu analysieren. Im Rahmen des Vertragspartnerrechts gilt es Sachleistungen zu stärken.

Aufgabenstellung: Erarbeitung von Vorschlägen zur Modernisierung des Vertragspartnerrechts, um die Organisation von Gesundheitsdienstleistungen nach flexibleren und transparenten Konditionen zu ermöglichen. Dabei ist das Ziel, Gesundheitsdienstleistungen auch weiter von österreichischen Anbietern zu beziehen, zu berücksichtigen.

Aufgabenstellung: Wie kann die Qualität der bezogenen Gesundheitsdienstleistungen und die transparente Weiterentwicklung im Patienteninteresse sichergestellt werden?

Aufgabenstellung: Gesundheitsdienstleistungen für die Bevölkerung anzubieten ist keine Beschaffung wie jede andere. Daher ist eine Abgrenzung, in welchen Bereichen das Vergaberecht nicht zur Anwendung kommen soll – vor allem um die Versorgungssicherheit durch inländische Anbieter sicherzustellen – zu treffen.

FINANZIERUNG: Fragestellungen aus dem Ist-Stand

Finanzstromanalyse: Weg der Geldmittel; Verteilung Einnahmen, Bedarf der Versicherten und Aufgaben

Die Finanzierung des Gesundheits- und Pensionssystems ist komplex. Dabei gibt es – vor allem was den Eigendeckungsgrad aus Beiträgen der Versicherten betrifft – große Unterschiede zwischen den

Sozialversicherungsträgern. Das Delta zwischen Eigendeckung und Bedarf wird aus Steuermitteln bedeckt. Gleichzeitig ist im Krankenanstaltenbereich die Finanzierung Ländersache und die Gesetzgebung zwischen Bund und Ländern geteilt. Um durch zielgerichtete Reformen die Kostenwahrheit und Effizienz zu steigern braucht es eine gesamtstaatliche Finanzstromdarstellung von Bund, Ländern und Gemeinden, sowie Sozialversicherung und anderen Versorgungssystemen. Als Basis für die Analyse sind bestehende Aufbereitungen – etwa *reporting tools* im Rahmen der Gesundheitsreform – heranzuziehen. Zudem soll eine kritische Analyse der Unterschiede, der Wirksamkeit und des Lenkungseffekts von **Behandlungsbeiträgen,** sowie deren Gesamtbelastung erfolgen.

Des Weiteren soll eine österreichweite **Gesamtdarstellung der Finanzströme im Ruhegenuss- und Pensionsbereich auf Bundesebene** erfolgen (inklusive Bundesbeamte und Vertragsbedienstete des Bundes).

Ebenso sollen die Einnahmen im Sozialversicherungs- und Gesundheitssystem einer umfassenden Analyse unterzogen und auf potentielle Systemwidrigkeiten – vor allem Zuschüsse aus dem Steuertopf für die verschiedenen Sparten der Pensionsversicherung (Partnerleistung) in Betracht ziehend – untersucht werden.

Eine weitere Fragestellung ist, ob die **strategische Position der Sozialversicherung** im Bereich der Systemsteuerung gestärkt werden soll. So könnten Gesundheitsdienstleistungen im niedergelassenen Bereich nicht nur über Vertragsbeziehungen zugekauft werden, sondern verstärkt selbst angeboten werden. Eine ökonomische Analyse möglicher Vorteile und der potentiellen Kosteneinsparungseffekte ist zu erarbeiten. Die Vorteile einer Kombination aus ***make and buy*** im Bereich der eigenen Einrichtungen soll dargestellt werden.

Es ist darüber hinaus ein System der mittelfristigen verbindlichen **Investitionsplanung** der gesamten Sozialversicherung in Verwaltungs- und Gesundheitseinrichtungen, Bau- und IT-Investitionen für ambulante Versorgung samt IT-Infrastruktur zu entwickeln.

Die derzeitige Finanzierungslandschaft birgt **Schieflagen** zwischen den einzelnen Versichertengruppen und den SteuerzahlerInnen insgesamt. Es gibt nur einen **unzureichenden Risikostrukturausgleich**. Die Gebietskrankenkassen schultern besondere **Risiken der Versichertenstruktur** (z.B. Arbeitslose, Mindestsicherungsbezieher, Asylwerber usw.), die andere Träger nicht zu tragen haben. Unabhängig von der organisatorischen Ausgestaltung als bundesweiter Träger oder regionaler Träger sollen zusätzliche Risikofaktoren ausgeglichen werden (Unterschied zwischen urbaner und ruraler Risikoverteilung). Das **deutsche Modell** des **morbiditätsorientierten Risikostrukturausgleichs** ist ein Beispiel der risikoorientierten Finanzierung, das beleuchtet werden soll. Modelle zum Risikoausgleich, welche mit der österreichischen Systemlogik in Einklang gebracht werden können, sind zu erstellen.

Mehrfachversicherte und ihre Angehörigen sind unter Umständen mehreren Trägern zugeordnet. Beiträge fließen an mehrere Träger und die Leistungen können von Versicherten pro Versicherungsfall bei unterschiedlichen Trägern konsumiert werden (persönliche Wahlfreiheit). Daher sind die typischen unterschiedlichen Fallvarianten zu Mehrfachversicherungen (mehrere Erwerbstätigkeiten, Eltern von mitversichertem Kind, die bei verschiedenen Trägern versichert sind, usw.) zu untersuchen. Es soll ein in Österreich implementierbarer Ausgleichsmechanismus entwickelt

werden. Ein Ziel des Ausgleichsmechanismus soll die Ermöglichung der **Zusammenrechnung der Beitragsgrundlagen von Beamten und sonstigen Versicherten** sein.

Aufgabenstellung: Erstellung einer gesamtheitlichen Finanzstromanalyse über alle relevanten Systeme und Gebietskörperschaften (einschließlich der dienstrechtlichen Versorgungssysteme) mit besonderem Fokus auf Fragen der Kostenwahrheit. Dabei ist auf die Eigendeckungsgrade der Träger, die unterschiedliche Höhe der Partnerleistung und die Hebesätze einzugehen.

Aufgabenstellung: Analyse der Wirksamkeit von Behandlungsbeiträgen, insbesondere in Hinblick auf Lenkungseffekte und dadurch resultierende vermeidbare Folgekosten.

Aufgabenstellung: Prüfung der potentiellen Vorteile einer Kombination von *make and buy* in Bezug auf Effizienz und Qualitätssteigerungen. Dabei ist insbesondere auf den Bereich der eigenen Einrichtungen einzugehen.

Aufgabenstellung: Erstellung einer einheitlichen mittelfristigen Investitionsplanung durch die Träger unter Bündelung der Ressourcen.

Aufgabenstellung: Analyse der Risikostruktur zwischen den Trägern und Erarbeitung eines risikobasierten Ausgleichsmechanismus und Analyse der Ungleichverteilung der Kostentragung der Träger bei Mehrfachversicherten und Erarbeitung eines Ausgleichsmechanismus.

Aufgabenstellung: Analyse der Gründe für die bestehende komplette Trennung der Systeme von BeamtInnen und allen anderen Versicherten (insbesondere Beitragsgrundlagenbildung), darauf aufbauend Erarbeitung eines Vorschlags zur Beseitigung der Trennung.

Bekämpfung von Betrug und Irrtum (*fraud and error)*

Das österreichische Gesundheitssystem bietet Leistungen auf höchstem Niveau. Allerdings ist in jedem System Betrugsbekämpfung und die Eindämmung von Abrechnungsfehlern von hoher Priorität. Auf **EU-Ebene** ist ein Projekt zur Bekämpfung von *transborder fraud and error* im Gesundheitssystem aufgesetzt. Dieses Thema soll umfassender, unter Einbeziehung der österreichischen Dimension, aufgearbeitet werden. In Deutschland wird von einem Verlust durch *fraud and error* von € 7,5 bis € 12,5 Milliarden ausgegangen, das ist ein Potential von drei bis fünf Prozent der öffentlichen Gesundheitsausgaben. Auf Österreich umgelegt wären das € 0,75 bis € 1,25 Milliarden.

Die Bekämpfung von *fraud and error* ist internationaler Standard. **Starke Strukturen in Österreich** sind zu entwickeln. Es ist ein angemessenes Verhältnis zwischen dem Aufwand bei der Beitragseinbringung und der ungenügenden Kontrolle der Geldflüsse im Ausgabenbereich (Leistungsbereich) herzustellen.

Aufgabenstellung: Abschätzung der durch *fraud and error* in Österreich verlorenen Mittel.

Aufgabenstellung: Erarbeitung von Vorschlägen zur Bekämpfung von *fraud and error*.

Investition in neue Themenfelder

Marktveränderungen im Medikamentenbereich machen internationales Handeln und Kooperieren nötig. Systemrelevante Steuerungsfunktionen müssen in ausreichender Dimension, Qualität und Quantität sichergestellt sein (Markbeobachtung usw.). Internationale Beispiele für Kooperationen bei Beschaffung sind auf ihre Übertragbarkeit zu prüfen. **Aufgabenstellung**: Internationale Analyse der Beschaffung von Medikamenten mit besonderem Fokus auf Synergiepotentiale.

ZUKUNFTSFIT 2030 – die Finanzierung sicher für die Zukunft machen

„**Arbeit und Industrie 4.0**" (*crowd working*, Digitalisierung, A-Typische Erwerbskarrieren) erfordert eine den Gedanken der Solidarität verankernde **Modernisierung von Sozial-, Arbeits-, Sozialversicherungs- und Steuerrecht**. Als weiteres Phänomen ist Steuerflucht und Abgabenvermeidung ein nicht unwesentlicher Störfaktor in Bezug auf eine umfassende Finanzierung des Sozialsystems. Am sich abzeichnenden Übergang vom postindustriellen in das digitale Zeitalter ist die Mittelaufbringung eines bisher am Faktor Arbeit anknüpfenden beitragsorientierten Sozialversicherungssystems rechtzeitig grundlegend neu auszurichten.

Eine **Verbreiterung und Ergänzung der Finanzierung** soll bei gleichzeitiger Entlastung des Faktors Arbeit angedacht werden. Die Produktivität der Volkswirtschaften steigt, ohne dass das Arbeitsplatz-Angebot immer zwingend nachzieht. Deshalb soll eine Mittelaufbringung erarbeitet werden, die am Faktor der Produktivität und nicht mehr nur an den Beschäftigen ausgerichtet ist, bzw. weiters Steuerflucht hintanhalten oder kompensieren kann.

Aufgabenstellung: Erarbeitung von Modellen zur Verbeiterung der Finanzierungsbasis der Sozialversicherung, insbesondere in Hinblick auf die Effekte der Digitalisierung, neuer Arbeitsformen und Versicherungskarrieren.

STRUKTURANALYSE: Modernisierung vorantreiben

Das österreichische Sozialversicherungssystem ist stabil und bietet den Menschen hervorragende Leistungen. Gleichzeitig gilt es, das System – um es für die Herausforderungen der Zukunft zu rüsten – weiterzuentwickeln und zu modernisieren. Dabei ist insbesondere die Reduktion der Trägerlandschaft zu prüfen. Hier ist vor allem die historisch gewachsene Struktur der Dreigliedrigkeit des Sozialversicherungssystems einer Analyse zu unterziehen.

Organisation der sozialen Sicherungssystem

Neuere Sozialversicherungssysteme bestehen aus zwei Sparten, der Pensionsversicherung und der Krankenversicherung. Das bereits in der Monarchie wurzelnde österreichische System hat zusätzlich die Unfallversicherung als eigene Sparte. Daher sind die Vor- und Nachteile der Organisation in drei Sparten zu benennen und einem zweispartigen Modell gegenüberzustellen. Sollte die Zweispartigkeit sowohl effizienter, als auch effektiver erscheinen, ist die Verortung des bestehenden Haftungsprivilegs, das sowohl in der Pensionsversicherung, als auch der Krankenversicherung systematisch eingeordnet werden kann, zu klären. Es sind daher Vorschläge zu erarbeiten, wie das Haftungsprivileg analog der bestehenden Logik in Zukunft ausgestaltet werden kann.

Auch die Gliederung in Berufsständische und teilweise sogar durch den Dienstgeber determinierte sozialen Sicherungssysteme sind einer Analyse zu unterziehen. Die Vor- und Nachteile sind herauszuarbeiten und darzustellen. Ebenso ist die – die Mehrheit der Versicherten umfassende – regionale Gliederung zu bewerten.

Aufgabenstellung: Erstellung einer Stärken/Schwächen Analyse des bestehenden Systems der drei Sparten, insbesondere in Hinblick auf Effizienz und Effektivität.

Aufgabenstellung: Analyse, ob die Verbindung der Sparten in einem Träger (Mischträger) eine effektive und effiziente Organisationsform darstellt.

Aufgabenstellung: Wie kann bei einer Systemumstellung auf ein zweispartiges System das bestehende Haftungsprivileg – analog der bestehenden Logik – ausgestaltet werden?

Aufgabenstellung: Welche weiteren Modelle zur Ausgestaltung der Trägerlandschaft können auf Basis der vorangegangenen Analysen zur Diskussion gestellt werden. Dabei ist insbesondere zu analysieren, ob die bestehende Gliederung nach Berufen, teilweise sogar nach Dienstgebern, oder nach Regionen, eine effiziente und effektive Form der Organisation darstellt. Die maßgeblichen Bewertungskriterien sind Service für die Versicherten, wirkungsvolle Leistungserbringung und deren Organisation, finanzielle Stabilität, sowie effiziente administrative Abwicklung. Dabei sind die Kosten, Nutzen und Risiken umfassender Umstrukturierungen einzuschätzen.

Analyse der strategischen Verwendung der Rücklagen

Bestehende **Rücklagen** sollen zielgerichtet für strategisch wichtige Themen der Gesundheitsreform verwendet werden. Im Fokus stehen insbesondere die Schaffung von Infrastruktur von Primärversorgungseinrichtungen, die Modernisierung eigener Einrichtungen der Sozialversicherung, ambulanter Einrichtungen, sowie die Leistungsharmonisierung und Fragen der gemeinsamen IT.

Aufgabenstellung: Erarbeitung eines Konzepts zur zielgerichteten Verwendung der Rücklagen zur Verbesserung der Leistungen für die Versicherten.

Verwaltung: Effizienzsteigerung und Synergiepotentiale

Die bestehenden Verwaltungsstrukturen sind auf ihre Effizienz zu überprüfen. Vorschläge zur Schärfung der **Managementstruktur und -prozesse** (Governance) der gesamten Sozialversicherung sind zu erarbeiten. Die Stringenz der Überarbeitung von Geschäftsprozessen vor der Neu- und Weiterentwicklung von **IT-Anwendungen** ist zu hinterfragen. Es ist zu prüfen, ob durch umfassendere straffe Führung der Sozialversicherungs-IT und die verbindliche Einbindung aller Versicherungsträger eine Effizienzsteigerung erreicht werden kann.

Einerseits sind die **Verwaltungskosten** einem **internationalen Vergleich** zu unterziehen, um ein objektives Bild zu erhalten. Andererseits zeigen rezente Studien aus Deutschland, dass in Folge von Fusionen von Krankenversicherungsträgern die Verwaltungskosten mit bis zu einem Fünftel über dem früheren Wert liegen. Die Analyse von Rürup (GKV. Verwaltungskosten und Kassengröße, 2006) weist im Verhältnis Verwaltungskosten je Versicherten und Größe der Versicherung ***diseconomies of scale*** aus. Dies ist einer qualitativen Analyse zu unterziehen und auf die österreichische Situation herunterzubrechen.

Aufgabenstellung: Analyse der Führungsstrukturen der Verwaltung der Sozialversicherungsträger und Prüfung, ob eine Verschlankung der Führungsstrukturen der Verwaltung sinnvoll ist und wenn ja, Erarbeitung eines Vorschlags.

Aufgabenstellung: Analyse der Geschäftsprozesse in Hinblick auf die IT-Systeme.

Aufgabenstellung: Internationales Benchmarking der Verwaltungskosten der österreichischen Sozialversicherungsträger.**Aufgabenstellung**: Evaluierung der bestehenden Erfahrungen zur optimalen Größe von Sozialversicherungsträgern, insbesondere in Hinblick auf *diseconomies of scale*.

Aufgabenstellung: Evaluierung der Kosten bei einer potentiellen Reduktion der Trägerlandschaft

Appendix B: Stakeholder interviews

Stakeholder invitation

Outlined below is the invitation sent to each stakeholder including broad questions to discuss during roundtable discussions. Please note that the exact format of the interviews differed according to each stakeholder.

Houghton Street

London WC2A 2AE

United Kingdom

www.lse.ac.uk/lsehealthandsocialcare/home.aspx

20th January 2017

EINLADUNG ZUR TEILNAHME AN DER DISKUSSSIONSRUNDE ÜBER DAS ÖSTERREICHISCHE SOZIALVERSICHERUNGSSYSTEM

Sehr geehrte(r)_____ [insert name],

Das LSE Health Forschungszentrum an der London School of Economics and Political Science wurde vor kurzem vom österreichischen Ministerium für Arbeit, Soziales und Konsumentenschutz beauftragt eine Studie zur Analyse des Sozialversicherungssystems durchzuführen. Die Analyse wird mehrere wichtige Komponenten innerhalb des österreichischen Sozialversicherungs- und Gesundheitswesens begutachten und bewerten, um eine Reihe von struktur- und gesundheitspoltischen Optionen zur Erhebung von Effizienz- und Qualitätspotentialen der zur Verfügung stehenden Dienstleistungen zu entwickeln.

Für die Begutachtung hat LSE Health einen internationalen Evaluierungsausschuss mit hochrangigen nationalen und internationalen Experten in den Bereichen Gesundheitspolitik, Gesundheitsökonomie und Recht gebildet. Der Ausschuss, der eine rein beratende Funktion ausüben wird, wird mit mehreren Interseenvertretern Gespräche führen, um Rückmeldungen und Einschätzungen zu verschiedenen Themen, die sich auf das österreichische Sozialversicherungssystem beziehen, zu erfassen.

Als Mitglied von [insert organisation] möchten wir Sie gerne offiziell zu einer einstündigen Diskussionsrunde mit Mitgliedern des Internationalen Evaluierungsausschusses und hochrangigen Vertretern des Ministeriums einladen.

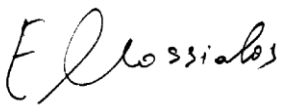
Die Diskussionsrunden mit Interessenvertretern der [enter stakeholder group] finden am [insert date] im Ministerium für Arbeit, Soziales und Konsumentenschutz [insert address of Ministry] statt. Die Diskussionen werden auf English durchgeführt, jedoch kann ein Übersetzer auf Anfrage zur Verfügung gestellt werden.

Eine Liste mit allgemeinen Fragen, die wir gerne mit Ihnen besprechen möchten, befindet sich am Ende dieser Einladung. Bitte beachten Sie, dass Diskussionen über diese Fragen hinausgehen können, um Ihnen die Möglichkeit zu geben, zusätzliche Kommentare zu äußern. Nach Abschluss der Diskussion bitten wir die Teilnehmer, schriftliche Rückmeldungen zu verfassen, welche in den Abschlussbericht eingehen werden.

Wenn Sie Interesse an einer Teilnahme an den Diskussionsrunden haben, würden wir uns sehr freuen, wenn Sie Ihre Teilnahme bestätigen und Ihre Verfügbarkeit für das angegebene Datum frühestmöglich mitteilen könnten. Falls Sie es vorziehen, eine andere Person in Ihrer Organisation zu empfehlen, senden Sie uns bitte deren Namen, Position und Email Adresse.

Für weitere Information finden Sie hier einen Link zur offiziellen Pressemitteilung des Ministeriums. Sollten Sie noch weitere Fragen haben, stehen Ihnen [insert Ministry representative and contact email] oder Inna Thalmann von LSE Health (I.N.Thalmann@lse.ac.uk) gerne zur Verfügung.

Mit freundlichen Grüßen



Univ.-Prof. Dr Elias Mossialos

Brian Abel-Smith Professor of Health Policy

Department of Social Policy, LSE

Director of LSE Health

Fragen zur Diskussionsrunde

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

UNIVERSITÄT SALZBURG

„Bessere Leistungen für die Menschen: Effizienzpotentiale in der Gesundheits-versorgung und im Bereich der Pensionen“

Studie im Auftrag des Bundesministeriums für Arbeit, Soziales und Konsumentenschutz

(Teil 2)
Rechtliche Fragestellungen

Univ.-Prof. Dr. **Walter J. Pfeil** (Universität Salzburg)

unter **Mitwirkung** von

Hon.-Prof. Dr. **Rudolf Müller**, Mitglied des Verfassungsgerichtshofs, Senatspräsident des Verwaltungsgerichtshofs im Ruhestand (Universität Salzburg/ Wien)

sowie mit **Beiträgen** von

Univ.-Prof. Dr. **Rudolf Mosler** (Universität Salzburg) und

Hon.-Prof. Dr. **Walter Pöltner**, Leiter der Sektion II im BMASK im Ruhestand (Universität Salzburg/ Wien)

mit **wesentlicher Unterstützung** von

Univ.-Ass.in Mag.a **Anna-Lisa Engelhart**

Univ.-Ass.in MMag.a Dr.in **Birgit Schrattbauer**

Univ.-Ass.in Mag.a **Stella Weber** (alle Universität Salzburg)

Salzburg, Juli 2017

Übersicht

Inhaltsverzeichnis

Abkürzungsverzeichnis

ABGB	Allgemeines Bürgerliches Gesetzbuch
Abs	Absatz
AG	Arbeitgeber/in(nen)
AN	Arbeitnehmer/in(nen)
APG	Allgemeines Pensionsgesetz
ASVG	Allgemeines Sozialversicherungsgesetz
arg	argumento (folgt aus)
Art	Artikel
ÄrzteG	Ärztegesetz
AUVA	Allgemeine Unfallversicherungsanstalt
BEinstG	Behinderteneinstellungsgesetz
BGBl	Bundesgesetzblatt
Bgld	Burgenländisch/e(r)
BGStG	Bundes-Behindertengleichstellungsgesetz
BKK	Betriebskrankenkasse(n)
B-KUVG	Beamten-Kranken- und Unfallversicherungsgesetz
BlgNR	Beilagen zu den Stenografischen Protokollen des Nationalrats
BMASK	Bundesminister(ium) für Arbeit, Soziales und Konsumentenschutz
BMGF	Bundesminister(ium) für Gesundheit und Frauen
BSVG	Bauern-Sozialversicherungsgesetz
BVA	Versicherungsanstalt öffentlich Bediensteter
B-VG	Bundes-Verfassungsgesetz
bzw	beziehungsweise
ca	circa
DG	Dienstgeber/in(nen)
dh	das heißt
DN	Dienstnehmer/in(nen)
DRdA	Das Recht der Arbeit (Zeitschrift)
EMRK	Europäische Menschenrechtskonvention
ErläutRV	Erläuterungen zur Regierungsvorlage
etc	et cetera

EuGH	Gerichtshof der Europäischen Union
EvBl	Evidenzblatt der Rechtsmittelentscheidungen, veröffentlicht in der Österreichischen Juristen-Zeitung
f(f)	und der (die) folgende(n)
FN	Fußnote
FSVG	Freiberuflichen-Sozialversicherungsgesetz
GehG	Gehaltsgesetz
GGP	Großgeräteplan
GKK	Gebietskrankenkasse(n)
GmbH	Gesellschaft mit beschränkter Haftung
GmbHG	Gesetz über Gesellschaften mit beschränkter Haftung
GP	Gesetzgebungsperiode
GSPVG	Gewerblich-Selbständigen-Pensionsversicherungsgesetz
GSVG	Gewerbliches Sozialversicherungsgesetz
G-ZG	Gesundheits-Zielsteuerungsgesetz
Hg	Herausgeber
idF	in der Fassung
insb	insbesondere
iSd	im Sinne des/der
iVm	in Verbindung mit
KAKuG	Krankenanstalten- und Kuranstaltengesetz
Kap	Kapitel
KFA	Krankenfürsorgeanstalt(en)
KRAZAF	Krankenanstalten-Zusammenarbeitsfonds
Ktn	Kärnten/Kärntner
Lfg	Lieferung
LKAP	Landes-Krankenanstaltenplan
LZVG	Landwirtschaftliches Zuschußrentenversicherungsgesetz
NÖ	Niederösterreich(ische/r)
NÖ GBDO	Niederösterreichische Gemeindebeamtendienstordnung 1976
oa	oben angeführt
oä	oder Ähnliches
OGH	Oberster Gerichtshof
OÖ	Oberösterreich(ische/r)
ÖKAP	Österreichischer Krankenanstaltenplan

ÖSG	Österreichischer Strukturplan Gesundheit
PG	Pensionsgesetz
ProtNR	Protokoll der Sitzungen des Nationalrats
PrimVG	Primärversorgungsgesetz
PVE	Primärversorgungseinheit
RdM	Recht der Medizin (Zeitschrift)
RSG	Regionale Strukturpläne Gesundheit
Rz	Randziffer
s	siehe
Sbg	Salzburg(er)
SozSi	Soziale Sicherheit (Zeitschrift)
StGBl	Staatsgesetzblatt
Stmk	Steiermark/Steiermärkisch/e/r
SVA	Sozialversicherungsanstalt der gewerblichen Wirtschaft
SVB	Sozialversicherungsanstalt der Bauern
SV-ÜG	Sozialversicherungs-Überleitungsgesetz
Tir	Tirol/er
ua	unter anderem; und andere
uU	unter Umständen
VAEB	Versicherungsanstalt für Eisenbahnen und Bergbau
Vbg	Vorarlberg(er)
VfGH	Verfassungsgerichtshof
VfSlg	Sammlung der Erkenntnisse und wichtigsten Beschlüsse des VfGH/Ausgewählte Entscheidungen des VfGH
vgl	vergleiche
Vol	Volume (Nummer des Teils dieser Studie)
Wr	Wien/er
Z	Ziffer
zB	zum Beispiel
zT	zum Teil

0. Kurzzusammenfassung

Im Rahmen einer wissenschaftlichen Studie, die „Effizienzpotentiale in der Gesundheitsversorgung und im Bereich der Pensionen“ in Österreich herausarbeiten soll, stellen sich auch zahlreiche **rechtliche Fragen**. Diese werden im vorliegenden zweiten Teil der Studie einer rechtswissenschaftlichen Analyse unterzogen, aus der dann allenfalls rechtspolitische Empfehlungen abgeleitet werden. Die Auseinandersetzung mit diesen Fragen erfolgt in Form von **Gutachten** zu den einzelnen **Aufgabenstellungen**, wie sie in dem der Studie zu Grunde liegenden **Auftrag** formuliert sind, und folgt auch der dort vorgegebenen Reihenfolge.

Task 1a: Staatsziel „Nachhaltige Soziale Absicherung“

Ein solches Staatsziel wäre wohl am besten in Form eines allgemeinen Bekenntnisses zu formulieren, wobei die zu erfassenden Bereiche ausgehend von den derzeit erfassten Risiken demonstrativ aufgelistet werden sollten und zudem die staatliche (Mit-)Verantwortung für die Finanzierung der Vorkehrungen für diese Risiken festgehalten werden sollte.

Task 2a: Harmonisierung des Leistungsrechts

Die zwischen den Krankenversicherungsträgern bestehenden Unterschiede im Leistungsrecht könnten in den meisten Fällen durch (einfach)gesetzliche Regelungen (unter Wahrung des verfassungsrechtlich gewährleisteten Vertrauensschutzes) überwunden werden. Dabei ist aber den Unterschieden im Tatsächlichen Rechnung zu tragen, so dass (jeweils ohne sachliche Rechtfertigung) nicht nur für gleiche Risiken keine unterschiedlichen Leistungen, sondern auch für unterschiedliche Risiken keine gleichen Leistungen vorgesehen sein dürfen. Auf eine Harmonisierung abzielende einfachgesetzliche Eingriffe in bestehendes Vertragspartnerrecht können als im öffentlichen Interesse gelegen angesehen werden, müssen aber verhältnismäßig sein.

Harmonisierungen sind auch durch Rechtsetzung der Sozialversicherungsträger selbst möglich. Zum einen könnten die Krankenversicherungsträger die ihnen vom Gesetz eröffneten Spielräume in der gleichen Weise nutzen und ihre Satzungen (bzw Krankenordnungen) von sich aus abstimmen. Zum anderen könnte die Mustersatzung geändert werden, wobei die diesbezüglichen rechtlichen Spielräume des Hauptverbandes im Hinblick auf die Ausweitung des Kreises der von Verbindlicherklärungen erfassten Träger weiter sind als im Hinblick auf die für verbindlich erklärten Leistungsinhalte. Weitergehende Möglichkeiten für die

Mustersatzung würden gesetzliche Änderungen erfordern, die aber nicht alle Bestimmungen der Mustersatzung erfassen dürften, soweit die dafür erforderliche Beschlussfassung auch gegen den Willen der betroffenen Träger erfolgen könnte.

Die Einbeziehung der Krankenfürsorgeanstalten, bei denen die Unterschiede zT noch größer sind bzw die Rechtslage wenig transparent ist, in eine Harmonisierung ist durch einfachgesetzliche Maßnahmen auf Bundesebene (oder Änderungen im Bereich des Sozialversicherungs-Satzungsrechts) allein nicht zu erreichen.

Task 2d: Harmonisierung bei Kur und Rehabilitation

Bei Leistungen der medizinischen Rehabilitation bzw Kuraufenthalten (oder anderen Maßnahmen zur Festigung der Gesundheit bzw der Gesundheitsvorsorge) bestehen Zuständigkeitsprobleme im Verhältnis zwischen den Sozialversicherungsträgern und den Ländern, aber auch zwischen den Trägern der Kranken- und jenen der Pensionsversicherung. Im Verhältnis zu den Ländern ist regelmäßig entscheidend, ob bei der betreffenden Person ein Zustand vorliegt, der eine Krankenbehandlung notwendig macht oder im unmittelbaren Zusammenhang mit einer solchen Krankenbehandlung steht, womit regelmäßig eine Zuständigkeit der Krankenversicherungsträger ausgelöst wird, die auch medizinische Rehabilitation (insb auch für „behinderte“ Kinder) einschließt.

Die im Verhältnis zwischen Kranken- und Pensionsversicherungsträgern praktizierte Aufteilung (Erwerbstätige und BezieherInnen einer Pension bei geminderter Arbeitsfähigkeit bei den Pensionsversicherungsträgern, andere PensionistInnen und bloße Angehörige bei den Krankenversicherungsträgern) ist sinnvoll, bedürfte aber einer gesetzlichen Grundlegung. Eine solche wäre umso mehr notwendig, wenn die Rehabilitation für alle „SeniorInnen“ generell von der Pensionsversicherung angeboten werden soll.

Vorrangig sollte freilich die (auch verfassungsrechtlich) problematische Differenzierung zwischen Krankenbehandlung und medizinischen Maßnahmen der Rehabilitation überwunden werden, zumal Rehabilitationsmaßnahmen oft auch schon während einer Krankenbehandlung notwendig und vielfach bereits als deren integrativer Bestandteil zu sehen sind.

Auch im Hinblick auf Kuraufenthalte etc wäre eine deutlichere gesetzliche Abgrenzung erforderlich, was die – gerade unter Transparenz- wie Harmonisierungsgesichtspunkten gebotene – Einräumung von Rechtsansprüchen erleichtern würde.

Task 7a-7b: Organisationsstruktur der Sozialversicherungsträger

Eine verfassungsrechtliche Bestandsgarantie für die nach Berufsgruppen und/oder regional bzw bundesweit organisierten Kranken-, Unfall- und Pensionsversicherungsträger besteht nicht. Eine solche ist weder aus dem Kompetenztatbestand „*Sozialversicherungswesen*“ noch aus den Regelungen über die Selbstverwaltung abzuleiten. Die entscheidende verfassungsrechtliche Grenze für die Umgestaltung der Trägerlandschaft ist das Sachlichkeitsgebot, das dem einfachen Gesetzgeber aber einen weiten Gestaltungsspielraum eröffnet, und zwar sowohl dahingehend, ob die Bildung von Versichertengemeinschaften weiterhin nach Berufsgruppen erfolgt, als auch im Hinblick darauf, wie die Abgrenzung zwischen den einzelnen Berufsgruppen vorgenommen wird. Eine allzu weit reichende personelle und räumliche Ausdehnung der Risikogemeinschaft würde allerdings deren Organisation im Rahmen der Selbstverwaltung unzulässig machen.

Auch für die Krankenfürsorgeanstalten gibt es keine solche Bestandsgarantie. Deren Auflösung liegt freilich ebenso in der Kompetenz des jeweiligen Landesgesetzgebers wie die Beseitigung jener Hindernisse, die eine gleichzeitige Erfassung dieser Personen im Rahmen eines Sozialversicherungssystems (die an sich bundesgesetzlich möglich wäre) wohl verfassungswidrig machen dürfte. Für grundlegende Änderungen in diesem Bereich bedürfte es daher einer Verfassungsmehrheit. Bei den Wohlfahrtseinrichtungen der freien Berufe besteht dieses Problem nicht, weil hier der einfache Bundesgesetzgeber selbst zur Erlassung entsprechend abgestimmter Regelungen befugt ist.

Die Bundesverfassung gebietet auch nicht a-priori die Bildung von unterschiedlichen Versichertengemeinschaften. Die hier bestehende Vielfalt ist begründbar und nicht unsachlich, zwingt den Gesetzgeber aber lediglich, das damit geschaffene Ordnungssystem nicht in unsachlicher Weise zu unterlaufen (zB durch finanzielle Umverteilung zwischen Versichertengemeinschaften, zwischen denen es keine ausreichenden sachlichen und persönlichen Verbindungen gibt).

Gerade im Hinblick auf die von der Krankenversicherung erfassten Risiken und vor dem Hintergrund der tiefgreifenden Änderungen in der Arbeitswelt spricht wohl nicht zuletzt aus ökonomischer Sicht mehr für eine stärkere Konzentration von Versichertengemeinschaften als für eine Beibehaltung der derzeitigen Vielfalt. Diese Konzentration setzt aber nicht nur die Gemeinsamkeit der Risiken, sondern auch eine weitgehende Vereinheitlichung des Beitrags- und Leistungsrechts sowie wohl auch Vorkehrungen für eine angemessene Vertretung aller Gruppen in den jeweiligen Selbstverwaltungskörpern voraus.

Task 7c: Kompetenzbereinigung im Krankenanstaltenrecht

Die bestehende Zersplitterung kann letztlich nur durch eine Verfassungsänderung überwunden werden, für die nur eine Konzentration der Gesetzgebungs- und der zur Steuerung erforderlichen Vollzugskompetenzen beim Bund sinnvoll erscheint.

Die an Stelle einer Verfassungsänderung bisher gesuchten „Ersatzlösungen" stoßen an rechtliche wie faktische Grenzen: Vereinbarungen nach *Art 15a B-VG* sind für Dritte nicht unmittelbar rechtsverbindlich, sondern müssen erst durch entsprechende Rechtsakte des Bundes bzw der Länder umgesetzt werden. Ob dies durch die nun im Rahmen des *G-ZG* vorgesehene Einrichtung einer GmbH (mit Bund, Ländern und Hauptverband als Gesellschafter), die durch Verordnung die von den Zielsteuerungs-kommissionen entsprechend ausgewiesenen Teile der Strukturpläne in rechtsverbindliche Anordnungen transformieren soll, leichter möglich sein wird, bleibt abzuwarten. Dies gilt umso mehr, als die Entscheidung, welchen Teilen der Strukturpläne normativer Charakter zukommen soll, in den Zielsteuerungskommissionen nur einvernehmlich gefällt werden kann.

Task 8a: Modernisierung des Vertragspartnerrechts

Für eine Effizienzsteigerung im und durch das Vertragspartnerrecht müssten einige grundsätzliche Änderungen vorgenommen werden: Zum einen bedürfte es einer nachhaltigen Verknüpfung von ambulantem und stationärem Bereich insb durch Finanzierung und Steuerung „aus einer Hand", zum anderen sollten strukturelle Schwachstellen wie die Differenzierung zwischen Gruppenpraxen und Ambulatorien überwunden werden.

Ein anderer Aspekt betrifft den Ausbau der Primärversorgung, für den mit dem *GRUG 2017* ein (freilich höchstens erster) wichtiger Schritt gesetzt wurde. Hier bedarf es wohl einer stärkeren Erweiterung des Spektrums vom bisher dominierenden kurativen Ansatz hin in Richtung Gesundheitsförderung, Prävention und Vorsorge sowie einer weitergehenden Einbindung von Angehörigen nichtärztlicher Gesundheitsberufe. Ebenso sollte ein Ausbau der Rahmenbedingungen für Psychotherapie angestrebt werden.

Im Vertragspartnerrecht selbst besteht Anpassungsbedarf insb in Bezug auf die (ungleiche) Einkommensverteilung zwischen den Ärzten des niedergelassenen Bereichs, die Notwendigkeit einer gesamtvertraglichen Differenzierung im Hinblick auf „technische" Fächer sowie die Rahmenbedingungen für die Ermittlung des Bedarfs an Planstellen für Vertragsärzte und deren Vergabe. Einer „Modernisierung" bedürfen wohl nicht zuletzt auch die Regelungen über die Qualitätssicherung im

niedergelassenen Bereich bzw den Kündigungsschutz der Vertragsärzte, wobei insb das Verfahren mit den Schiedskommissionen nicht mehr zeitgemäß erscheint.

Task 9e: Risikostrukturausgleich

Die Bildung eines breiten Risikostrukturausgleichs setzt grundsätzlich einen persönlichen und sachlichen Zusammenhang zwischen den in den jeweiligen Versichertengemeinschaften zusammengefassten Versicherten voraus und ist daher umso eher verfassungsrechtlich zulässig, je geringer die Unterschiede im Beitrags- wie im Leistungsrecht (einschließlich dem Honorarrecht der LeistungserbringerInnen) sind.

Das schließt einen Ausgleich von Strukturnachteilen, insb in Abhängigkeit von der Wirtschaftsentwicklung oder Umständen in der Schichtung der Versichertengemeinschaft nicht aus. Die Erfassung von nicht erwerbstätigen Gruppen (insb Arbeitslosen) könnte ein solches Strukturproblem darstellen und einen trägerübergreifenden Ausgleich insofern ermöglichen, als auch andere Träger am Risiko der Krankenversicherung Arbeitsloser verhältnismäßig beteiligt würden.

Eine andere und verfassungsrechtlich grundsätzlich unbedenkliche Möglichkeit der Schaffung eines Risikostrukturausgleichs stellt die Einhebung von Beiträgen in Form von Abgaben im übertragenen Wirkungsbereich (also weisungsgebunden und nicht in Selbstverwaltung) für den Bund dar, auch wenn diese Beiträge – eben für einen Risikoausgleich zwischen den Krankenversicherungsträgern – zweckgebunden wären.

Task 9g: Trennung der Systeme der BeamtInnen und der anderen Versicherten

Eine Zusammenführung der Systeme der Beamtinnen und der anderen (insb unselbständig) Erwerbstätigen müsste am Dienstrecht ansetzen und das Prinzip des lebenslangen Dienstverhältnisses samt der Unterworfenheit unter das Disziplinarrecht beseitigen. Auf diese Weise könnte auch die Harmonisierung der Pensionssysteme „vollendet“ werden.

Soweit die bestehenden Unterschiede im Hinblick auf die Kranken- und Unfallversicherung auf den dienstrechtlichen Sonderstatus der BeamtInnen zurückgehen, ist eine Einbeziehung dieser öffentlich Bediensteten in dieselbe Versichertengemeinschaft wie mit anderen (unselbständig) Erwerbstätigen schwierig. Bei grundsätzlicher Angleichung des Beitrags- und Leistungsrechts und entsprechenden Vorkehrungen zur Sicherstellung, dass auch BeamtInnen in den der Gremien der betreffenden Selbstverwaltungskörper vertreten sind, würde ein Zusammenschluss im Rahmen eines gemeinsamen oder mehrerer (allenfalls auch

regional gegliederter) „gemeinsamer Träger der Unselbständigen“ verfassungsrechtlich nicht ausgeschlossen sein.

Task 13c: Umstellung auf ein Zwei-Sparten-System

Die Umstellung der Struktur der österreichischen Sozialversicherung auf ein Zwei-Sparten-Modell (Kranken- bzw Pensionsversicherung) ist grundsätzlich möglich und würde wohl nur Änderungen auf einfachgesetzlicher Ebene erfordern. Insb könnten die bestehenden Besonderheiten im Leistungsrecht ebenso wie das Haftungsprivileg der DG auch bei einer Auflösung der Unfallversicherung als eigener Zweig beibehalten werden. Dies gilt grundsätzlich sowohl für den Fall, dass andere Träger – als Mehrspartenträger (wie derzeit BVA oder SVB) – auch als Unfallversicherungsträger fungieren würden, als auch für den Fall, dass die Aufgaben einem oder mehreren anderen Trägern überantwortet würden.

Die (allenfalls auch nur teilweise) Zusammenlegung der Unfallversicherung mit der Kranken- bzw Pensionsversicherung könnte allerdings die Beibehaltung der Einbeziehung versicherungsfremder, aber kausaler Risiken schwieriger machen. Dieser Aspekt sowie die Gefahr der Zerschlagung bisher gebündelter Kompetenzen lässt eine Aufteilung der bisherigen Aufgaben der Unfallversicherung auf mehrere andere Sozialversicherungsträger zumindest rechtspolitisch zweifelhaft erscheinen.

Task 14a: Verwendung von Rücklagen

Rücklagentransfers sind verfassungsrechtlich unproblematisch, sofern sich die Versichertenkreise überschneiden und zumindest indirekt an der jeweiligen Finanzierung beteiligt sind; Gleiches gilt zwischen Versicherungsträgern mit vergleichbarer Rechtslage bei der Beitragsaufbringung, sofern zwischen diesen Trägern die Vorteile der einen zu Nachteilen der anderen führen. Kein Ausgleich ist dagegen zulässig mit bundesweiten Trägern, soweit die Strukturprobleme geographischen Ursprungs sind (da diese innerhalb des jeweiligen Trägers ohnehin ausgeglichen werden), und Unterschiede in der Beitragsaufbringung zwischen den betreffenden Trägern bestehen.

Verfassungsrechtlich weitgehend risikolos wäre ein Ausgleich, für den die Beiträge als Abgaben im übertragenen Wirkungsbereich (also nicht in Selbstverwaltung) für den Bund eingehoben werden, wobei die Beiträge für den Risikoausgleich der Krankenversicherungsträger zweckgebunden sein könnten, und sie das Gesetz – sicherheitshalber – ausdrücklich zB als „Strukturausgleichabgabe bezeichnen sollte. Die Verteilung dieser Mittel könnte dann nach Maßgabe bestimmter Kennzahlen über Strukturunterschiede (wie zB Krankheitskosten pro versicherter Person) zielgerichtet erfolgen. Der damit verbundene Eingriff in das Eigentumsrecht der

Sozialversicherungsträger ist auf Grund des öffentlichen Interesses an der Erhaltung des finanziellen Gleichgewichts der Sozialversicherung an sich gerechtfertigt, darf aber die betreffenden Krankenversicherungsträger nicht an der Erfüllung ihres Versorgungsauftrages hindern und müsste zudem – aus Gleichheitsgründen – wohl bei allen Trägern nach denselben Bemessungskriterien erfolgen, die ihrerseits für eine Umschichtung von Mitteln zwischen strukturbegünstigten und strukturschwachen Trägern geeignet sein müssen.

Executive Summary

A comprehensive study aiming to identify "Potential efficiencies in the delivery of healthcare and in the realm of pensions" in Austria has to cope with **numerous legal issues** as well. These issues shall be examined by a legal analysis laid down in Volume 2 of this study including recommendations in terms of legal policy. The respective problems are tackled according to the **tasks** as laid down in the assignment and following the order as determined in the concept set by the Federal Ministry.

Task 1a: Social State Goal "Sustainable social protection"

A social state goal should be based preferabily upon a constitutional declaration listing demonstratively the risks that shall be covered at least and should clarify as well that there is a public responsibility for financing (at least part of) the measures aiming to cope with those risks.

Task 2a: Harmonisation of benefits and services

Most of existing distinctions between the different branches of the Austrian health care system with respect to benefits and services could be harmonized by legal acts passed by the Federal Parliament (even without 2/3-majority, but, of course, taking into account the principle of "Vertrauensschutz"). Legislation aiming to harmonization has to observe "differences in reality", however, which would neither allow to cope with identical risks in different ways nor to treat different risks in the same way without objective justification. Legal interventions aiming to harmonization concerning collective agreements can be justified under constitutional law by "public interest" as long as the respective intervention is appropriate.

Harmonization could be pursued by the different health insurance carriers themselves by coordinating their respective "Satzungen" which would be possible with regards to all services and benefits which are not strictly determined by law. The same applies to the "Mustersatzung" released by the "Hauptverband" which is authorized to declare certain (but – at present – not all) provisions of that Mustersatzung as binding. Harmonization measures could be pursued most of all by widening the scope of those binding provisions by covering all health insurance carriers which is subject, though, to unanimity in the "Trägerkonferenz", and thus is requiring consent between all carriers.

Harmonization with respect to the "Krankenfürsorgeanstalten" is much more difficult as they are based on regional law under the competencies of the Regional Parliaments ("Landtage"). So covering KFAs, too, would require an amendment to the Fe-

deral Constitution or at least coordinated legal acts passed by Federal Parliament and each Landtag.

Task 2d: Harmonisation in the area of cure and rehabilitation

The responsibilities for providing for cure and rehabilitation are quite unclear. This applies firstly with respect to the competencies of social insurance carriers on one hand and the "Länder" on the other hand, as the latter are responsible for persons with disabilities which cannot claim benefits and services otherwise. The main question in this respect is whether there is a need of medical treatment or a specific rehabilitation following such a treatment: If so, basically there are entitlements under the health insurance system including "medical measures of rehabilitation" (especially for children with disabilities).

Secondly, there are competences for providing for cure and rehabilitation both for the health insurance carriers as well as the pension insurance carriers but without a clear distinction. The actual differentiation between pension insurance (in charge for still [self-]employed persons and recipients of invalidity pensions) and health insurance (family members of insured persons and recipients of old-age and survivors' pensions) is quite feasible, but cannot be derived clearly from the legal provisions. Even worse is the legal situation with respect to the distinction between "Krankenbehandlung" and "medizinische Maßnahmen der Rehabilitation". The lack of such a distinction causes problems both from a legal as well as a medical point of view.

With respect to cures a clearer legal distinction would be necessary, too. This could facilitate moreover the implementation of legal entitlements in order to improve the access to cures for the person who are in need of those measures.

Task 7a-7b: (Re-)Arrangement of different groups of insurees

There is no existence guarantee for the present health care institutions, neither under the Federal Constitution's competence rules nor derived from the principle of self-government. The main issue for any rearrangement is whether the respective (re-)allocation of groups can be considered as reasonable and justified. Thus the Federal legislator is given a quite wide range of ways for restructuring the "landscape of existing institutions" especially with respect to the health care system, provided that legislation is able to present significant grounds why the current arrangements are not appropriate any more and that the distinctions between the respective professional groups are not of the same importance as they were when the different schemes have been implemented. An arrangement of a comprehensive "Versichertengemeinschaft" covering (more or less) the entire population, however, would not comply any more with the principle of self-governance, however, but would be subject to the im-

plementation of a “national health service” or the transfer of administration competencies to Federal authorities.

There is no existence guarantee for the “Krankenfürsorgeanstalten” on regional or municipal level either. New arrangements in this respect especially by having those civil servants covered by a health care scheme ruled under Federal law are not possible without (corresponding) regional legislation. In contrary the particular health care schemes for freelancers could be included by Federal legislation, too.

Task 7c: Redistributing competencies with respect to hospital law

The problem of fragmented legal competencies with respect to (providing for) hospitals could be solved sustainably only by concentrating the legal and adminstrative competencies on federal level as it is already the case with respect to “Gesundheitswesen” and “Sozialversicherungswesen”.

As this cannot be achieved without an amendment to the Federal Constitution which is very unlikely, alternative solutions have been developed but all of them suffer from shortcomings: Treaties between “Bund” and “Länder” (under *Art 15a B-VG*) are not binding for third parties but have to be transformed by specific legal acts both on federal as well as regional level. It is quite uncertain whether the new concept as laid down in the “*G-ZG*” establishing a limited company under private law (with Bund, Länder and Hauptverband as shareholders), whose only task is to enact binding orders (“Verordnungen”), will be a sustainable improvement, most of all when taking into accout that creating such an order is subject to an unanimous agreement between all shareholders.

Task 8a: Modernisation of contractual partnership law

In order to achieve a modernisation of the law for contractual partnerships at least the following issues should be addressed: Finding ways for funding and controlling both ambulatory as well as stationary from a “single source; overcoming the legal distinctions between medical group practices (to which Gesamtverträge are applicable including the regulations aiming to protect originally individual physicians from unfair dismissals) and “Ambulatoriums” (which are regarded as hospitals and thus need a specific approval.

Furthermore the Primary Health Care-concept as recently passed in Federal Parliament should be extended consequently most of all by widening the legal authorizations for nurses and other health care providers.

With respect to the contractual agreements themselves the following issues should be addressed: No more uniform “Gesamtverträge” for all groups of physicians but

different rules for radiologists, laboratories etc in order to reduce income disparities between different groups of doctors should be concluded; legal framework for planning of supply with contracted physicians should be enhanced; quality assessment with respect to outpatient medical care should be improved; dismissal protection regulations should be reduced (as they are much more effective in favour of doctors in free practice than those employed in a hospital), including a review of the procedural structure with the “Schiedskommissionen”.

Task 9e: Risk adjustment

According to the case law ruled by the Constitutional Court, a mechanism aiming to compensate risks between different institutions and groups does not violate constitutional principles as long as there is a “sufficient personal and material link” between the respective “Versichertengemeinschaften”. A sufficient link in this respect can be assumed the more, the less differences can be identified with regards to contributions and benefits (including the framework of contractual partnership law) of the respective schemes.

So a risk adjustment scheme covering all carriers would meet the requirements under Constitutional Law only insofar as fundamental structural disadvantages (for instance with respect to unemployed persons) can be proofed in an evidence-based way (and these dsiadvantages are not caused only by regional disparities which are already compensated within national-wide carriers themselves). Otherwise a risk adjustment scheme could be implemented only by an amendment to Federal Constitution (i.e. with a two-third majority).

Another and much more promising option would be the implementation of a system for compensating different structural risks based on taxes that should be collected by the Hauptverband on behalf of the “Bund” (or directly by a Federal authority) and should be explictly declared as “tax”. Revenue collected from these taxes may by used for a specific purpose to the benefit of health insurance.

Task 9g: Separation of civil servants from all other employees

Amalgamation of the social security schemes for civil servants with those for all other employees is subject to fundamental changes with respect to public employment law: Most of all an elimination of the principle of life-long-employment including the application of strict disciplinary law is required in order to enable a complete harmonization of the respective pension schemes.

With respect to health and accident insurance amalgamation of the respective carriers is subject to a basic harmonization of the schemes ruling benefits and collecting

of contributions including as well provisions in order to enable appropriate representation of civil servants within the (amalgamated) self-governance bodies.

Task 13c: Switch to a two-pronged-system

Changing the structure of the Austrian social insurance system into a two-pronged model (comprising only health- and pension insurance) basically would not have to face constitutional impediments. Special provisions as laid down under the current accident insurnace scheme such as particular benefits and services as well as the employers' "liability privilege" could be maintained even after an abolition of accident insurance as a separate branch.

Problems might have to be faced, however, with respect to the coverage of risks that are not at all linked to employment (such as live-savers). Furthermore there are concerns about the destruction of those high capabilities and knowledge allocated at the accident insurance carriers.

Task 14a: Deployment of reserves

There are no explicit provisions under Constitutional Law with respect to the deployment of reserves accumulated by certain social insurance funds. According to the jurisdiction of the Constitutional Court it can be stated that transfers would be lawful with respect to reserves, as long as the same groups of insured persons are concerned (which is applicable most of all within the frame of "ASVG") and/or with respect to structural compensations, as long as there are no substantial distinctions with regards to the respective system of collecting contributions.

Again a much more promising option would be the implementation of a system for compensating different structural risks based on taxes that should be collected on behalf of the "Bund" and should be explictly declared as "tax". Revenue collected from these taxes may by used for a specific purpose to the benefit of health insurance.

1. Einleitung

Eine Studie, mit der die österreichische Bundesregierung „Effizienzpotentiale in der Gesundheitsversorgung und im Bereich der Pensionen“ herausarbeiten und analysieren lassen und daraus Vorschläge gewinnen will, wie diese Potentiale auch nutzbar gemacht werden könnten, enthält naturgemäß auch **zahlreiche rechtliche Fragestellungen**. Die zu diesen Fragen angestellte Analyse und die daraus allenfalls zu ziehenden Schlussfolgerungen haben bereits im ersten Teil der vorliegenden Studie Eingang gefunden. Dies gilt namentlich für die rechtliche Bewertung der im Rahmen der „Policy Options“ vorgeschlagenen Möglichkeiten und Maßnahmen, für deren Auswahl bzw Priorisierung gerade die rechtlichen Aspekte eine nicht unwichtige Rolle gespielt haben.

In diesem zweiten Teil der Studie werden diese Rechtsfragen näher erörtert und einer **rechtswissenschaftlichen Analyse** unterzogen. Dem Auftrag entsprechend handelt es sich dabei freilich nicht um eine umfassende Ausleuchtung der im Zusammenhang mit der jeweiligen Frage auftauchenden bzw erkennbaren Probleme. Vielmehr erfolgt stets eine **Ausrichtung auf die jeweilige Aufgabenstellung**, wie sie in dem der Studie zu Grunde liegenden Konzept formuliert und dann im Rahmen der Projektumsetzung einem bestimmten Themenfeld zugeordnet wurde (daher „Task 1a“ etc). Die aufgeworfenen Rechtsfragen wurden daher in zunächst getrennten **Gutachten** aufgearbeitet,[1] die für die nunmehrige Endfassung der Studie aneinandergefügt und – nicht zuletzt durch entsprechende Verweise – miteinander verknüpft sind.

Die Aufgabenstellungen bleiben dennoch insofern voneinander **getrennt**, als jeder von ihnen ein eigenes Kapitel gewidmet ist, wobei die **Reihenfolge** dieser Kapitel jener im Konzept für die Studie folgt. Jedem dieser Kapitel wird grundsätzlich derselbe **Aufbau** zu Grunde gelegt:[2] Zu Beginn wird die jeweilige Aufgabenstellung noch einmal kurz beschrieben, daran schließt sich eine Bestandsaufnahme, sei es im Hinblick auf die bestehende Rechtslage, sei es im Hinblick auf die Einbettung der Fragestel-

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[1] Im Gegensatz zu den anderen Teilen der vorliegenden Studie erfolgte die Bearbeitung der rechtlichen Fragestellungen – zur Vermeidung von durch eine doppelte Übersetzung möglicherweise zu befürchtenden Verlusten im Hinblick auf die inhaltliche Aussagekraft – von vornherein auf **Deutsch**. Die einzelnen Teile wurden aber jeweils durch entsprechende „summaries“ in englischer Sprache ergänzt, welche wiederum die Grundlage für das diesem Teil der Studie vorangestellte „Executive Summary“ bildeten (**0.**).

[2] Auf allfällige **Abweichungen** wird im Zuge der Beschreibung der Aufgabenstellung des betreffenden Kapitels hingewiesen.

lung in einen theoretischen Rahmen. Daraus werden dann regelmäßig Schlussfolgerungen für rechtspolitische Gestaltungsmöglichkeiten gezogen und Grenzen bzw Hindernisse aufgezeigt, die bei der Umsetzung einzelner Vorschläge zu überwinden wären, woraus sich wiederum – wie schon angedeutet – mitunter eine **Präferenz** für bestimmte Optionen gegenüber anderen ergeben könnte.

Entsprechend der Aufarbeitung der Aufgabenstellungen nach Art eines Gutachtens werden zum einen Abkürzungen nur ausnahmsweise und im Grunde dort verwendet, wo sie – im allgemeinen oder im allgemeinen juristischen Sprachgebrauch – üblich sind,[3] und beschränken sich zum anderen die Nachweise auf das unbedingt erforderliche Ausmaß. Auch die dabei verwendeten **Quellen** sind in einem gesonderten Verzeichnis dokumentiert (**12.**). Dazu kommen schließlich **Anhänge**, die vor allem Aufstellungen umfassen, auf die in einzelnen Kapiteln Bezug genommen wird, deren Behandlung den Rahmen der betreffenden Aufgabenstellung gesprengt hätte.

Die Verantwortung für den vorliegenden Text liegt natürlich bei seinem Autor bzw dort, wo es ausgewiesen ist, bei den jeweiligen AutorInnen. In dessen (deren) Ausarbeitung ist jedoch eine Vielzahl von Anregungen eingeflossen, die auf zahlreiche und ebenso intensive wie ertragreiche Diskussionen zurückgegangen sind. Diese wurden nicht nur innerhalb des mit der „legal analysis“ für diese Studie betrauten Teams geführt, sondern gehen auch auf einen überaus bereichernden interdisziplinären Austausch mit anderen an der Ausarbeitung dieser Studie beteiligten Personen und Vertretern des Auftraggebers zurück.[4]

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[3] Ein **Abkürzungsverzeichnis** ist dennoch vorangestellt.

[4] Besonders zu danken ist hier *Elias Mossialos* (auch für seine umsichtige Projektleitung), *Thomas Czypionka* (Institut für Höhere Studien) sowie *Werner Hoffmann* und *Julia Raupp* (beide Ernst & Young).

2. Task 1a:
Entwicklung einer Formulierung für ein soziales Staatsziel „Nachhaltige soziale Absicherung für die in Österreich lebenden Menschen“

2.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„UMFASSENDE VERSORGUNG DER MENSCHEN … Staatsziel „Soziale Absicherung“** folgende Passage (4):

„Die Republik Österreich steht für ein **solidarisches System der sozialen Sicherheit, ausgehend von dem Prinzip der Pflichtversicherung**. Die Menschen können darauf vertrauen, dass die hochwertige Versorgung durch die Sozialversicherung für sie, ihre Kinder und Enkel nachhaltig gesichert bleibt. Die Selbstverwaltung als Governance-Instrument, bestehend aus VertreterInnen der ArbeitnehmerInnen und der ArbeitgeberInnen, schafft Stabilität und langfristige Planbarkeit. Daher ist die Selbstverwaltung einer der Erfolgsfaktoren für die nachhaltige soziale Absicherung der Menschen in Österreich.

Die vorangestellten Grundsätze sollen, um die Weiterentwicklung der Systeme zu fokussieren, durch ein Staatsziel gestützt werden. Die Idee der Staatsziele verfolgt eine grundsätzliche strategische Ausrichtung des österreichischen Gemeinwesens. **Staatsziele** sind als über die Legislaturperioden hinausgehende **Handlungsanleitungen** des **Gesamtstaates** zu sehen. Staatsziele definieren Querschnittsmaterien, die von allen Politikfeldern im Rahmen der jeweiligen Zuständigkeiten bearbeitet werden müssen.

Im Rahmen dieser Untersuchung soll eine Formulierung für ein soziales **Staatsziel „nachhaltige soziale Absicherung für die in Österreich lebenden Menschen“** gefunden werden. Dabei soll einerseits auf die besonderen Merkmale der bestehenden sozialen Sicherungssysteme abgestellt, andererseits internationale Best-Practice Beispiele als Vorbilder herangezogen werden. Die Grundsätze der Selbstverwaltung und der öffentlichen sozialen Sicherungssysteme sollen abgesichert werden. Das Prinzip der Pflichtversicherung, das garantiert, dass alle Menschen, unabhängig von der individuellen ökonomischen Stärke, einen gleichen gesetzlichen Leistungsanspruch haben, soll auch in Zukunft unverändert fortbestehen.“

Daraus wurde folgende **Aufgabenstellung** abgeleitet (4):

„Entwicklung einer Formulierung für ein soziales Staatsziel ‚nachhaltige soziale Absicherung für die in Österreich lebenden Menschen".

2.2. Grundsätzliches zur Formulierung eines Staatsziels

Unter Staatszielbestimmungen[5] sind **verfassungsrechtliche** Regelungen zu verstehen, die an staatliche Organe gerichtet sind und mitunter Verbote, meist aber Gebote in Form bestimmter Prinzipien enthalten, die als im öffentlichen Interesse liegend angesehen werden. Sie unterscheiden sich von Grundrechten vor allem dadurch, dass sie an den **Staat und dessen Organe adressiert** sind und daher **keine subjektiven Rechte** Einzelner (zB in Form konkreter Leistungsansprüche) begründen.

Staatszielbestimmungen erlangen aber sehr wohl Verbindlichkeit für die nachgeordnete (einfache) Gesetzgebung wie die Rechtsanwendung, also sowohl für die Vollziehung als auch die Rechtsprechung. Mit anderen Worten wohnt solchen Bestimmungen eine Pflicht staatlicher Organe zur Beachtung der entsprechenden Ziele inne, sie bilden insofern einen Teil des **Maßstabs für das Handeln des Staates**.

In der Sache bedeutet ein Staatsziel für die **Gesetzgebung** eine verfassungsrechtliche Vorgabe, die bei der Erlassung einfachgesetzlicher Regelungen zu berücksichtigen ist und gegebenenfalls auch bei einer Prüfung durch den VfGH zu Grunde zu legen ist. Dieser könnte vor allem dann zu einer Verfassungswidrigkeit der betreffenden Regelung kommen, wenn die Staatszielbestimmung mangelhaft umgesetzt wurde und daraus ein Problem der fehlenden sachlichen Rechtfertigung erwächst oder wenn ein offensichtlicher Widerspruch mit diesem Staatsziel vorliegt, der auch nicht durch ein anderes Staatsziel (entsprechend gewichtig) gerechtfertigt werden kann.[6]

Für die **Rechtsanwendung** dienen Staatszielbestimmungen vor allem als Auslegungshilfe, nicht nur, aber vor allem bei unbestimmten Rechtsbegriffen. Diese sind dann – selbstverständlich im Rahmen der sonstigen Interpretationsmethoden – so zu verstehen, wie sie dieser verfassungsrechtlichen Vorgabe am ehesten entsprechen.

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[5] Vgl dazu nur jüngst die instruktive Darstellung von *Bertel*, Staatszielbestimmungen, in *Breitenlechner* ua (Hg), Sicherung von Stabilität und Nachhaltigkeit durch Recht, 139 ff, mit weiteren Nachweisen.

[6] Vgl noch einmal nur *Bertel*, Staatszielbestimmungen 148 f.

Damit wird deutlich, dass der Spielraum sowohl für die Gesetzgebung als auch für die Rechtsanwendung umso geringer wird, je konkreter eine Staatszielbestimmung formuliert ist. Ist diese dagegen sehr allgemein gehalten (zB „hohe Standards"), wird sie vielfach höchstens als eine Art Optimierungsgebot zu sehen sein, dh die Vorgabe stellt kein Ziel dar, das zu 100% erreicht werden muss, sondern einen Zustand, den es weitest möglich anzustreben gilt.[7]

Regelungstechnisch finden sich Staatszielbestimmungen meist in zwei Grundformen, zum einen als Bekenntnisse, zum anderen in einer Umschreibung bestimmter Ziele und Grundsätze staatlichen Handelns, wobei natürlich auch Mischformen denkbar sind. Während der Ansatz mit Handlungszielen und -grundsätzen in Österreich vor allem in Landes-Verfassungen anzutreffen ist, enthält die Bundes-Verfassung einige Beispiele für Staatsziele in Form von Bekenntnissen. Insb seien hier das Bekenntnis zur umfassenden Landesverteidigung in *Art 9a B-VG* sowie jenes zu den Prinzipien der Nachhaltigkeit, zum Tierschutz, umfassenden Umweltschutz, der Sicherstellung der Wasser- und Lebensmittelversorgung und der Forschung im *Bundesverfassungsgesetz BGBl I 2013/111* genannt.Explizit soziale bzw sozialstaatliche Ziele finden sich auf Bundesebene bisher nicht.[8] Sehr wohl Anknüpfungspunkte dafür finden sich dagegen in der Mehrzahl der Verfassungen der Länder. Das Spektrum reicht hier von Sozialstaatsklauseln, die offenbar jene in *Art 20* des *deutschen Grundgesetzes* zum Vorbild haben,[9] über die allgemeine Umschreibung der Aufgaben des jeweiligen Landes[10] bis hin zur Hervorhebung der Verantwortung für bestimmte Personengruppen bzw soziale Risiken.[11]

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7 Vgl erneut nur *Bertel*, Staatszielbestimmungen, 143.

8 Vgl nur die Übersicht bei *Schäffer*/*Klaushofer*, Zur Problematik sozialer Grundrechte, in *Merten*/*Papier*/*Kucsko*-Stadlmayer (Hg), Handbuch der Grundrechte VII/1², 761 ff (Rz 8 ff).

9 Vgl *Art 1 Abs 1* ***Burgenländisches*** *Landes-Verfassungsgesetz* („*Burgenland ist ein demokratischer und sozialer Rechtsstaat*").

10 Vgl *Art 4 Z 1* ***Niederösterreichische*** *Landesverfassung* („*Das Land Niederösterreich hat in seinem Wirkungsbereich dafür zu sorgen, dass die Lebensbedingungen der niederösterreichischen Bevölkerung … unter Berücksichtigung der abschätzbaren, wirtschaftlichen, sozialen … Bedürfnisse gewährleistet sind. Dabei kommt der Schaffung und Erhaltung von entsprechenden Arbeits- und Sozialbedingungen … besondere Bedeutung zu*"); *Art 9 Abs 1 Z 2* ***Oberösterreichisches*** *Landesverfassungsgesetz* („*Das Land Oberösterreich hat die Aufgabe, …für eine geordnete Gesamtentwicklung des Landes zu sorgen, die den wirtschaftlichen, sozialen, gesundheitlichen … Bedürfnissen der Bevölkerung … Rechnung trägt*."); *Art 9* ***Salzburger*** *Landes-Verfassungsgesetz* („*Aufgabe des Landes ist es, für eine geordnete Gesamtentwicklung des Landes zu sorgen, die den wirtschaftlichen, sozialen, gesundheitlichen … Bedürfnissen seiner Bevölkerung … Rechnung trägt*"); *Art 7 Abs 2* ***Tiroler*** *Landesordnung* („*Das Land Tirol hat für die geordnete, den sozialen, wirtschaftlichen … Bedürfnissen der Landesbewohner entsprechende Gesamtentwicklung des Landes zu sorgen,*

Auf Grund der bisherigen Regelungsstruktur der Bundes-Verfassung scheint die Verankerung des Ziels einer nachhaltigen sozialen Absicherung oder deren Normierung als **Grundsatz staatlichen Handelns** auf dieser Ebene **wenig zweckmäßig**. Zum einen wird schwer zu rechtfertigen sein, warum gerade dieser Politikbereich besonders hervorgehoben werden soll. Zum anderen ist die Regelungsdichte gerade im Sozialrecht schon sehr hoch,[12] so dass weder ein besonderer Zusatznutzen für die Rechtsanwendung noch eine stärkere (und zumal durch den VfGH überprüfbare) Bindung des einfachen Gesetzgebers zu erwarten ist.

Auch die Verankerung einer **institutionellen Garantie** für die Sozialversicherung, wie sie im oa Teil des Konzepts anzuklingen scheint, erscheint **wenig zielführend**. Zum einen wäre wieder schwer zu rechtfertigen, warum gerade diese Institution der ohnedies bereits verfassungsrechtlich verankerten „sonstigen Selbstverwaltung" ein besonderer Status verliehen werden sollte (und nicht etwa auch der beruflichen Selbstverwaltung in Form der Kammern, einschließlich jener der Freiberufler). Immerhin hat doch der VfGH deutlich gemacht hat, dass auch aus *Art 120a ff B-VG* keine Bestandsgarantie für Einrichtungen der Selbstverwaltung resultiert.[13] Zum anderen würde eine institutionelle Verankerung der Sozialversicherung auch „systeminterne" Probleme aufwerfen und den Spielraum für zukünftige Entwicklungen unverhältnismäßig einengen.[14] Nur beispielshaft sei hier darauf verwiesen, dass bestimmte soziale Risiken (wie zB Pflegebedürftigkeit oder Familienlasten) bisher gerade nicht sozialversicherungsrechtlich erfasst sind, oder dass das verfassungsrechtlich grundgelegte Konzept „Sozialversicherung" eine (überwiegende) Finanzierung aus Beiträgen von Erwerbstätigen bzw für diese voraussetzt und dass das Prinzip „Selbstverwaltung" einer Erfassung der Gesamtbevölkerung in einem einheitlichem System entgegensteht.[15]

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wobei der Schaffung und Erhaltung von ausreichenden Arbeits- und leistbaren Wohnmöglichkeiten ein besonderer Stellenwert zukommt. …").

[11] So etwa in Art 12 **Oberösterreichisches** Landesverfassungsgesetz („*Das Land Oberösterreich gewährt im Rahmen der Gesetze 1. Krankenpflege …, 2. Behindertenhilfe …, 3. Sozialhilfe* …") oder *Art 7 Abs 3* ***Vorarlberger*** *Landesverfassung* („*Das Land bekennt sich zur Verpflichtung der Gesellschaft, betagte Menschen und Menschen mit Behinderung zu unterstützen und die Gleichwertigkeit ihrer Lebensbedingungen zu gewährleisten*").

[12] Vgl noch einmal nur *Schäffer*/*Klaushofer*, Zur Problematik sozialer Grundrechte, Rz 14 ff.

[13] VfGH VfSlg 19.919/2014.

[14] *Schäffer*/*Klaushofer*, Zur Problematik sozialer Grundrechte, Rz 97, weisen in diesem Zusammenhang besonders auf die Dysfunktionalität und die tendenziell versteinernde Wirkung von Einrichtungsgarantien sowie darauf hin, dass auch ein Rückschrittsgebot nicht über das ohnehin etablierte Vertrauensschutzprinzip hinausginge; zu letzterem vgl nur *Pfeil*, Vertrauensschutz im Sozialrecht, DRdA 2015, 420 ff.

[15] Näher dazu bei **Task 7a-7b**, unten 5.2.2.1.

Insofern erscheint die Implementierung eines Staatsziels „soziale Sicherheit“ in Form eines Bekenntnisses, das in der Folge noch näher konkretisiert wird, nicht nur als die **politisch realistischste**, sondern auch von der **rechtlichen** Tragfähigkeit her auch **zweckmäßigste** Option. Die erhoffte (politische) Signalwirkung einer Verfassungsbestimmung würde auch mit der Einführung eines derart konzipierten Staatsziels erreicht werden können. Aber auch die möglichen **rechtlichen Effekte** sollten – natürlich abhängig von der konkreten Ausgestaltung einer solchen Bestimmung – **nicht zu gering** geschätzt werden:[16]

Zuallererst würde ein solches Staatsziel bewirken, dass das System der sozialen Sicherheit nicht vom einfachen Gesetzgeber abgeschafft und – je nach Ausgestaltung der Verfassungsbestimmung – auch nicht beliebig umgestaltet werden kann. Auch wenn damit keine durchsetzbaren Rechtsansprüche des Einzelnen begründet werden (und insofern die Wahrscheinlichkeit einer Überprüfung beim VfGH wohl geringer sein wird), würde ein solches Staatsziel im Fall des Falles vom VfGH doch als verfassungsrechtlicher Maßstab im Rahmen einer Gesetzes-, Verordnungs- oder Entscheidungsprüfung dienen. Und schließlich würde eine Staatszielbestimmung bei der Auslegung von Gesetzes- oder Verordnungsregelungen, insb wenn es um die Anwendung unbestimmter Rechtsbegriffe oder die Auflösung von Normwidersprüchen geht, durch Verwaltung und Gerichtsbarkeit von Bedeutung sein.

2.3. Formulierungsvorschläge

Vor diesem Hintergrund soll daher ein **mehrstufiger** Ansatz vorgeschlagen werden. Im **ersten** Schritt wird demnach nach dem Vorbild des *Bundesverfassungsgesetzes BGBl I 2013/111* ein allgemeines **Bekenntnis** formuliert, das folgendermaßen lauten könnte:

> „*Art xy*
>
> *(1) Die Republik Österreich (Bund, Länder und Gemeinden) bekennt sich zu einer nachhaltigen sozialen Absicherung der österreichischen Bevölkerung*.“

Damit würde zum einen gewährleistet, dass das Bekenntnis für **alle Ebenen des Staates** gilt und dass – ähnlich wie in den vergleichbaren Bestimmungen in Landes-

[16] Vgl noch einmal nur *Schäffer/Klaushofer*, Zur Problematik sozialer Grundrechte, Rz 98 ff.

Verfassungen – die **gesamte Bevölkerung** erfasst wird. Das impliziert auch die Absicherung von NichtösterreicherInnen, würde aber nicht ausschließen, die Leistungen etwa von der Rechtmäßigkeit des Aufenthalts der betreffenden Person abhängig zu machen.

Die Absicherung müsste zum anderen **nachhaltig** sein, dürfte also nicht auf eine kurzfristige bzw punktuelle Hilfe beschränkt bleiben, sondern sollte möglichst dauerhaft und effektiv wirken. Schließlich und vor allem müsste die Absicherung eine soziale sein, dh das jeweilige Risiko wäre (weiterhin) **gesellschaftlich** zu erfassen, womit dessen Bewältigung nicht auf das Individuum oder allenfalls sein unmittelbares Umfeld allein abgewälzt werden dürfte. Eine Mitverantwortung der potentiell Leistungsberechtigten, wie sie gerade dem Sozialversicherungsmodell inhärent ist, wäre damit keineswegs ausgeschlossen.

Da der Begriff der „sozialen Absicherung" überaus schillernd ist und – wie die Geschichte des Sozialrechts zeigt – einem steten gesellschaftlichen und wirtschaftlichen Wandel unterliegt, empfiehlt es sich, die „abzusichernden" Bereiche in einem **zweiten** Schritt etwas näher zu **umschreiben**. Dafür würde sich eine – gerade angesichts dieses Wandels – fast notwendigerweise nur **demonstrative** Auflistung der (damit jedenfalls) zu erfassenden **Risiken** anbieten. Diese könnte etwa so aussehen:

> „(*2) Eine nachhaltige soziale Absicherung umfasst insbesondere Vorkehrungen zum angemessenen Schutz bei Krankheit, [Arbeitsunfall,]*[17] *Minderung der Arbeitsfähigkeit, Alter, Pflege- und Betreuungsbedürftigkeit, Arbeitslosigkeit sowie zum angemessenen Ausgleich für Kinderbetreuungspflichten*."

Damit würde zum einen sichergestellt, dass bestimmte (seit längerem als im Grunde unabdingbar zu erfassend angesehene) Risiken nicht vom einfachen Gesetzgeber ausgeschieden werden könnten, zum anderen aber durchaus neue, als gleichwertig anzusehende Risiken erfassbar wären. Die Umschreibung dieser Risiken würde nach dem aktuellen Verständnis vorzunehmen sein, was sich auch darin niederschlagen würde, dass der Schutz **angemessen** sein müsste. Das eröffnet zwar dem einfachen Gesetzgeber und in weiterer Folge auch der Rechtsanwendung einigen **Spielraum**. Was aber in einer Problemlage angemessen ist, kann (und soll) wohl nicht festgeschrieben werden, sondern von den gesellschaftlichen, wirtschaftlichen und natürlich auch individuellen Umständen abhängig gemacht werden (können).

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[17] Die ausdrückliche Anführung dieses klassischen (historisch sogar als erstes sozialversicherungsrechtlich erfassten) Risikos setzt natürlich voraus, dass es die Unfallversicherung als eigenen Zweig weiterhin gibt, vgl dazu bei **Task 13c**, unten 10.

Schließlich sollte auch noch Vorkehrung dafür getroffen werden, dass die **Finanzierung** der Maßnahmen nicht daran scheitert, dass die Beitragsleistungen oder sonstige Eigenleistungen (zB Selbstbehalte, Kostenbeiträge) der vom jeweiligen Risiko betroffenen Personen nicht ausreichen. Darin sollte einerseits eine Prolongierung des **Versicherungsmodells** enthalten sein, andererseits aber auch eine Art „**Ausfallhaftung**“, die aus öffentlichen Mitteln zu bestreiten wäre, aber eben nur bis zu jenem Niveau reichen soll, das für die Erreichung eines „angemessenen Schutzes“ erforderlich gehalten wird. Mit dieser Regelung sollten auch die nicht auf (unmittelbaren) Beitragszahlungen aufgebauten Leistungen erfasst werden, die derzeit – notabene nur teilweise – eine Abdeckung von Risiken wie Pflege- und Betreuungsbedürftigkeit oder den Ausgleich für Kinderbetreuungspflichten bewirken.

Dies könnte etwa folgendermaßen aussehen:

> *„(3) Soweit die Vorkehrungen nach Abs 2 nicht durch Beiträge oder sonstige Eigenleistungen der vom jeweiligen Risiko betroffenen Personen gesichert werden können, ist deren Finanzierung aus öffentlichen Mitteln sicherzustellen*.“

3. Task 2a: Harmonisierung des Leistungsrechts – rechtliche Aspekte[18]

3.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„LEISTUNGSRECHT HARMONISIEREN“** folgende Passage (4f):

„Das Leistungsrecht ist für die Versichertengemeinschaft von zentraler Bedeutung. Unterschiede werden von den versicherten Menschen im Alltag wahrgenommen, stoßen auf Unverständnis und führen zu Systemkritik. In einem Versicherungssystem mit einer gesetzlichen Zuordnung der Versicherten zu den einzelnen Sozialversicherungsträgern hat die Harmonisierung des Leistungsrechts oberste Priorität. Dabei ist als Basis zu erheben, in welchem Ausmaß Leistungen derzeit schon über die verschiedenen Träger harmonisiert sind. Das betrifft sowohl die rechtliche Ausgestaltung als auch den Zugang zu den Leistungen und die konkreten Leistungen selbst. In Hinblick auf die bereits bestehende Leistungskonvergenz ist ein internationaler Vergleich anzustellen.

Es gilt folgende Arten der Leistungsdifferenzierung zu prüfen:

gesetzliche Leistungsdifferenzierung

satzungsmäßige Leistungsdifferenzierung

tatsächliche Leistungsdifferenzierung

vertragspolitische Leistungsdifferenzierung.

Ziel der Harmonisierung des Leistungsrechts muss es sein, allen Versicherten gleiche und umfassende Leistungen – *state of the art* – anzubieten. Dabei ist eine Verbesserung des Leistungsangebots anzustreben – ein *race to the bottom* wird abgelehnt. Ziel ist es, die Leistungen, unabhängig von der Kasse, der ein Versicherter zugeordnet ist, auf ein einheitliches Niveau zu bringen. Das betrifft insbesondere die gesetzlichen Kranversicherungsträger, wie auch die Versorgungssysteme von Bundes- und Landesbediensteten und die Betriebskrankenkassen. Der Bereich der Rehabilitation ist miteinzubeziehen. Zudem soll eine nachhaltige Klärung der Leistungszuständigkeit im

[18] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* und unter Berücksichtigung von Hinweisen von *Walter Pöltner* und *Birgit Schrattbauer* verfasst.

Bereich **Kur und Rehabilitation** erfolgen. Die Leistungen sollen über alle Versicherungen betrachtet steigen. Die Verhältnismäßigkeit und Finanzierbarkeit ist bei der Entwicklung der Leistungsharmonisierung im Auge zu behalten, wobei klar ist, dass die Harmonisierung der Leistungen eine Verbesserung für die Bevölkerung bringen soll. Als eines der Hauptelemente bei der Harmonisierung des Leistungsrechts soll der **Fokus auf den Ausbau der Sachleistungen** gerichtet werden. Der Mittelbedarf ist zu beziffern und in einem Stufenplan zur Implementierung darzustellen. Im Rahmen eines vorzulegenden **Umsetzungs-Prozesses (Umsetzungspakete)** wird darauf Rücksicht zu nehmen sein, inwieweit verfassungsrechtliche Gesichtspunkte, wie „Vertrauensschutz", in eine Modellierung der Übergangsbestimmungen einzufließen hätten."

Daraus wurden ua folgende **Aufgabenstellungen** abgeleitet (5):

„Analyse, bis zu welchem Grad Leistungen bereits jetzt harmonisiert sind. Dabei ist auf die rechtliche Ausgestaltung als auch den Zugang zu den Leistungen und die konkreten Leistungen selbst abzustellen. …

Erarbeitung von Vorschlägen zur Leistungsharmonisierung zwischen allen Versichertengruppen. Dabei soll eine Leistungsharmonisierung, bei der im Ergebnis das Leistungsniveau für alle Versicherten in Summe auf ein relativ höheres Niveau gehoben wird, erreicht werden. Dabei soll ein Fokus auf Sachleistungen gelegt werden. Die Grundsätze der Verhältnismäßigkeit und Finanzierbarkeit sind zu berücksichtigen."

Die folgenden Ausführungen sollen die **rechtlichen Aspekte** der geforderten Analyse zum Stand der Harmonisierung des Leistungsrechts beleuchten. Die Darstellung der Unterschiede würde bereits bei einer Beschränkung auf die verschiedenen Sozialversicherungssysteme fast jeden Rahmen sprengen. Daher wurde eine **mehrstufige** Vorgangsweise gewählt: Zunächst wurde eine Übersicht der verschiedenen Leistungsbereiche in jener systematischen Reihenfolge erstellt, wie sie auch im *ASVG* vorgesehen ist. Diese Übersicht findet sich in einem **Anhang** zum vorliegenden Text (**13.A.**). Dieser selbst enthält nach einer tabellarischen Zusammenfassung der Übersicht eine Bestandsaufnahme, in der nicht inhaltlich, sondern danach differenziert wird, wo die bestehenden **Unterschiede**, welche durch Beispiele illustriert werden,[19] **rechtlich verortet** sind (3.2.). Daraus können dann **Schlussfolgerungen** abgeleitet werden, auf welcher rechtlichen Ebene angesetzt werden könnte oder müsste, um die bestehenden Unterschiede zu beseitigen oder zumindest zu vermindern (3.3.).

[19] Eine genauere Auflistung findet sich in einer vom Hauptverband der österreichischen Sozialversicherungsträger zusammengestellten Übersicht der **unterschiedlichen Satzungsregelungen** zum Stand **1.1.2017**. S im Übrigen auch Vol 1, Kap **5.2.**1.6.5.

Wegen der Sonderstellung, die dabei den **Krankenfürsorgeanstalten** zukommt, werden diese auch **gesondert** behandelt (3.4.).

3.2. Bestehende Unterschiede im Leistungsrecht der Krankenversicherung und ihre rechtliche Verortung

Das Leistungsrecht der gesetzlichen Krankenversicherung kennt derzeit folgende **Kategorien und Arten** von Leistungen, wobei die Auflistung der Reihenfolge wie im Gesetz entspricht:

Risiko/Kategorie	Bezeichnung der Leistung	Untergliederung	Vorgesehen in
Früherkennung von Krankheiten	Jugendlichenuntersuchung		*§ 132a ASVG;* *§ 88 GSVG;* *§ 81 BSVG;* *§ 84 Abs 1 B-KUVG*
	Vorsorge(Gesunden)unter-suchung		*§ 132b ASVG;* *§ 89 GSVG;* *§ 82 BSVG;* *§ 61a B-KUVG*
Volksgesund-heit	Impfungen etc		*§ 132c ASVG;* *§ 89a GSVG;* *§ 82a BSVG;* *§ 61b B-KUVG*
Krankheit	Krankenbehandlung	Ärztliche Hilfe/ Gleichgestellte Leistungen	*§ 135 ASVG;* *§ 91 GSVG;* *§ 85 BSVG;* *§ 63 B-KUVG*
		Kostenerstattung	*§ 131 ASVG;* *§ 85 Abs 2 lit b GSVG;* *§ 80 Abs 2 BSVG;* *§ 59 B-KUVG*
		Heilmittel	*§ 136 ASVG;* *§ 92 GSVG;* *§ 86 BSVG;* *§ 64 B-KUVG*
		Heilbehelfe	*§ 137 ASVG;* *§ 93 GSVG;* *§ 87 BSVG;* *§ 65 B-KUVG*

	Medizinische Hauskrankenpflege		*§ 151 ASVG;* *§ 99 GSVG;* *§ 94 BSVG;* *§ 71 B-KUVG*
	Anstaltspflege	Pflegekosten-zuschuss	*§ 150 ASVG;* *§ 98a GSVG;* *§ 93 BSVG;* *§ 68a B-KUVG*
	Medizinische Rehabilitation		*§ 154a ASVG;* *§ 99a GSVG;* *§ 96a BSVG;* *§ 65a B-KUVG*
Festigung der Gesundheit	Krankheitsverhütung		*§ 155 ASVG;* *§ 100 GSVG;* *§ 100 BSVG;* *§ 70a B-KUVG*
Zahnmedizin	Zahnbehandlung/ Zahnersatz		*§ 153 ASVG;* *§ 94 GSVG;* *§ 95 BSVG;* *§ 69 B-KUVG*
	Kieferregulierungen		*§ 153a ASVG;* *§ 94a GSVG;* *§ 95a BSVG;* *§ 69a B-KUVG*
Körperliche Gebrechen	Hilfsmittel		*§ 154 ASVG;* *§ 93 GSVG;* *§ 96 BSVG;* *§ 65 B-KUVG*
Arbeitsunfähigkeit infolge Krankheit	Krankengeld		*§§ 138 ff ASVG;* *§§ 9, 104a, 105 ff GSVG;* *BSVG --;* *§§ 84, 85 B-KUVG*
Geminderte Arbeitsfähigkeit	Rehabilitationsgeld		*§ 143a ASVG;* *GSVG, BSVG: --;* *§§ 84, 85 B-KUVG*
Mutterschaft	Sachleistungen	Ärztlicher - bzw Hebammenbeistand; Pflegepersonal; Heilmittel/Heilbehelfe; Anstaltspflege	*§§ 159-161 ASVG;* *§ 102 Abs 2-4 GSVG;* *§ 97 Abs 4-7 BSVG;* *§§ 76-78 B-KUVG*
	Wochengeld	(Betriebshilfe) (Betriebshilfe)	*§ 162 ASVG;* *§ 102a GSVG;* *§ 98 BSVG;* *§§ 84 B-KUVG*

Die bestehenden **Unterschiede** hinsichtlich dieser Leistungen zwischen den verschiedenen Bereichen der gesetzlichen Krankenversicherung sind im Detail im

Anhang (**13.A.**) ersichtlich. Diese Diskrepanzen könnten unter verschiedenen Gesichtspunkten systematisch erschlossen werden, so etwa nach der Tragweite der Auswirkungen der Differenzierungen für die einzelnen Versicherten, nach der Zahl der jeweils davon betroffenen Personen oder auch nach den Kosten, die mit einer Harmonisierung verbunden wären. Aus **rechtlicher** Hinsicht bietet sich freilich ein anderer Ansatz zur Systematisierung an. Dieser besteht darin, danach zu differenzieren, auf welcher rechtlichen Ebene die jeweiligen Unterschiede verortet sind. Bei diesem Zugang lassen sich im Grunde **sechs** Gruppen unterscheiden:

3.2.1. Keine gesetzlichen Unterschiede

Die erste Gruppe betrifft jene Leistungen, hinsichtlich derer bereits jetzt **keine** (nennenswerten) **Unterschiede** zwischen den einzelnen Bereichen der gesetzlichen Krankenversicherung bestehen. In diesem Sinne bereits **de facto harmonisiert**[20] sind die folgenden Leistungen:

- medizinische Maßnahmen der Rehabilitation
- Gesundheitsförderung / Prävention
- Jugendlichenuntersuchungen
- Krankheitsverhütung
- Vorsorgeuntersuchungen
- Heilmittel und Heilbehelfe bei Mutterschaft
- Heilmittel.

3.2.2. Keine gesetzlichen Unterschiede, aber Unterschiede auf Grund des Vertragspartnerrechts

Die zweite Gruppe betrifft jene Leistungen, für die zwar für die anspruchsberechtigten Personen zunächst keine Unterschiede vorgesehen sind, bei denen sich aber daraus Differenzierungen ergeben, dass es unterschiedliche Regelungen im Hinblick auf die Vorsorge für die betreffenden Leistungen gibt. Diese **Unterschiede im Vertragspartnerrecht** schlagen dann auf die Anspruchsberechtigten in folgenden Fällen durch:

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[20] Dieser Befund betrifft die **gesetzliche** Ebene. Unterschiede im **Vollzug**, etwa auch durch eine unterschiedlich strenge Genehmigungspraxis durch den jeweiligen chefärztlichen Dienst sind **nicht** auszuschließen, können im Rahmen einer normativen Untersuchung aber nicht erfasst werden.

- Bei der **ärztlichen Hilfe** und den dieser **gleichgestellten Leistungen** bestehen zwar keine unmittelbaren Unterschiede für die jeweiligen Anspruchsberechtigten im Hinblick auf die ihnen gebührenden (Sach-)Leistungen. Sehr wohl gibt es aber dann Unterschiede für die Leistungserbringer, insb im Hinblick auf Höhe und Abrechnung der Abgeltung, aus denen dann **unterschiedliche faktische** Bedingungen für die Inanspruchnahme der Leistungen (zB Wartezeiten, Einsatz anderer Therapiemethoden) resultieren können.

- Bei den **Kostenerstattungsregelungen** entstehen die Unterschiede unmittelbar daraus, dass der Erstattungsbetrag an den jeweiligen Tarifen für die VertragspartnerInnen anknüpft (s aber auch unten 3.2.4.).

- Gleiches gilt beim **Kostenzuschuss bei Eintritt eines vertragslosen Zustands**, der ebenfalls an die (unmittelbar zuvor gültigen) Vertragstarife anknüpft, wenngleich das Ausmaß dieser Kostenerstattung im Wege der Satzung erhöht werden kann (s daher 3.2.6.4.).

- Auch bei der **Medizinischen Hauskrankenpflege** gelten analoge Kostenerstattungsregelungen. Die praktisch häufigere Konstellation dürfte hier allerdings jene sein, dass es keine Verträge gibt, womit nur Kostenzuschüsse beansprucht werden können, deren Höhe in der Satzung festzulegen ist (s auch dazu 3.2.6.2.).

3.2.3. Gesetzliche Unterschiede bereits auf Grund der Risiken

Eine dritte Gruppe von Unterschieden ist bereits **gesetzlich** grundgelegt und geht darauf zurück, dass es **Unterschiede bei den Risiken** gibt, die mit der jeweils unterschiedlichen **Erwerbstätigkeit** zusammenhängen.

Das betrifft zunächst das **Krankengeld**, das eine Arbeitsunfähigkeit infolge Krankheit und einen daraus resultierenden Einkommensausfall voraussetzt. Die Leistung kommt damit nur für **unselbständig** Erwerbstätige in Betracht, deren **Einkommen** bei Krankheit (zumindest wenn diese eine bestimmte Dauer übersteigt) **wegfällt**.[21] Beim Krankengeld bestehen aber auch noch weitere Differenzierungen auf Grund der hier der jeweiligen Satzung eröffneten Spielräume (dazu 3.2.6.2).

Für **selbständig** Erwerbstätige gibt es eine funktional vergleichbare Leistung in Form der **Unterstützungsleistung bei lang andauernder Krankheit** nach *§ 104a GSVG*, die aber wesentlich später einsetzt und nur für Personen in Betracht kommt, bei de-

[21] Für nach dem *B-KUVG* Versicherte besteht daher ein Anspruch auf Krankengeld nur ausnahmsweise, vgl den Verweis auf die einschlägigen Regelungen des *ASVG* in *§ 84 Abs 1 B-KUVG*.

nen die Aufrechterhaltung ihres Betriebes von ihrer persönlichen Arbeitsleistung abhängt und die weniger als 25 DN beschäftigen. Ein eigener Anspruch auf Krankengeld besteht dagegen nur bei Vorliegen einer Zusatzversicherung nach *§ 9* iVm *§§ 105 f GSVG*.

Ganz ähnlich gelagert ist die Situation beim **Wochengeld** für die Zeit des Beschäftigungsverbots von **unselbständig** erwerbstätigen Frauen vor und nach einer Entbindung.[22]

Auch hier ist für Selbständige zunächst eine andere Leistung in Form der Beistellung einer **Betriebshilfe** vorgesehen,[23] während der Anspruch auf Wochengeld nur subsidiär und in eingeschränktem Ausmaß besteht (vgl *§ 102a GSVG*, *§ 98 BSVG*).

Kein Gegenstück kennt die Krankenversicherung für **Selbständige** zum für *ASVG*-Versicherte der Jahrgänge 1964 und jünger (sowie für die *in § 84 Abs 1 B-KUVG* genannten, nach diesem Gesetz Versicherten) vorgesehenen **Rehabilitationsgeld** nach *§ 143a ASVG*. Dies ist aber insofern entbehrlich, als in der Pensionsversicherung der Selbständigen weiterhin befristete Erwerbsunfähigkeitspensionen möglich sind (vgl *§ 133b GSVG* bzw *§ 124b BSVG*, im Gegensatz zum außer Kraft getretenen *§ 256 ASVG*).

3.2.4. Wohl politisch/historisch zu begründende gesetzliche Unterschiede

Andere Unterschiede zwischen den einzelnen Systemen gehen zwar ebenfalls auf das jeweilige **Gesetz** zurück, lassen sich aber **nicht** aus Besonderheiten der betreffenden **Risikolage** oder der für die Bildung der jeweiligen Versichertengemeinschaft maßgebenden Art der **Erwerbstätigkeit** erklären. Die Unterschiede dürften vielmehr vor allem politischer bzw historischer Natur sein.

Das gilt zunächst für die unterschiedliche Höhe der **Kostenerstattung** bei Inanspruchnahme von Wahlärzten/ Wahleinrichtungen: Während im *ASVG*, *BSVG* und B-*KUVG* das Ausmaß der Kostenerstattung auf den Aufwand abstellt, den der jeweilige Träger bei Inanspruchnahme eines Vertragspartners gehabt hätte (und grundsätzlich jeweils 80% des daraus resultierenden Betrages ersetzt werden), ist im

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[22] Auch hier ist der (nur für wenige nach diesem Gesetz Versicherte maßgebende) Verweis in dessen *§ 84 Abs 1 B-KUVG* auf die für DN geltenden Regelungen des *ASVG* zu nennen.

[23] Derselben Logik folgt die Möglichkeit der Beistellung einer Betriebs- bzw Haushaltshilfe als Maßnahme zur Festigung der Gesundheit jeweils nach *§ 100 Abs 2 Z 4* im *GSVG* wie im *BSVG*.

GSVG bei Geldleistungsberechtigten ein Ersatz vorgesehen, der mit 80% der tatsächlich erwachsenen Kosten begrenzt ist (*§ 85 Abs 1 lit c GSVG*).

Diese Grenze ist auch maßgebend bei der **Optionsmöglichkeit** nach *§ 85a GSVG*, die für nach diesem Gesetz Versicherte bei Zahlung eines durch die Satzung festgelegten Zusatzbeitrages den Wechsel von einem Sach- auf einen Geldleistungsanspruch erlaubt. Eine solche Möglichkeit ist im ***BSVG*** **nicht** vorgesehen, von den diesbezüglichen Satzungsermächtigungen in *§ 132 ASVG* bzw *§ 61 B-KUVG* wurde bisher nicht Gebrauch gemacht.

Nur im Bereich des *ASVG* und des *BSVG* vorgesehen ist der **Kostenbeitrag** für die Inanspruchnahme von **Anstaltspflege durch Angehörige** des/der jeweiligen Versicherten (*§ 447f Abs 7 ASVG*).

Dieser Kostenbeitrag ist dann auch (nur) bei *ASVG*- und *BSVG*-Versicherten von dem bei Inanspruchnahme von Anstaltspflege in einer nicht landesfondsfinanzierten oder Vertrags-Krankenanstalt gebührenden **Pflegekostenzuschuss** in Abzug zu bringen (*§ 150 Abs 3 ASVG*, *§ 93 Abs 3 BSVG*). Die Höhe dieses Pflegekostenzuschusses wird in allen Systemen durch die jeweilige Satzung festgelegt (s daher 2.6.e).

Einen **allgemeinen Kostenbeitrag** („Selbstbehalt“) für ärztliche Hilfe etc kennt dagegen das ***ASVG*** grundsätzlich **nicht**, zumal von der Verordnungsermächtigung für den Hauptverband in *§ 31 Abs 5a ASVG* kein Gebrauch gemacht wurde.[24] Auch der 20%-ige Behandlungsbeitrag für die Inanspruchnahme von Psychotherapie durch einen Vertragspartner (*§ 135 Abs 6 ASVG*) spielt mangels Vorliegens eines Gesamtvertrags derzeit keine Rolle.

Sehr wohl **Kostenbeteiligungen** der Versicherten nach Maßgabe der jeweiligen Satzung sind in den **anderen** Systemen vorgesehen (vgl *§ 86 GSVG*, *§ 80 BSVG*, *§ 63 Abs 4 B-KUVG*; s auch unten 2.6.a).

Geringfügige Unterschiede bestehen schließlich bei den gesetzlichen Regelungen für **Sachleistungen** im Fall der **Mutterschaft**. So ist die Pflege in einer Krankenanstalt in Zusammenhang mit einer Entbindung in den meisten Systemen mit zehn Tagen begrenzt (vgl § 161 ASVG, § 102 Abs 4 GSVG, § 97 Abs 7 BSVG), während das B-KUVG eine solche Begrenzung nicht kennt. Die Möglichkeit zur (freiwilligen) Bereitstellung von Behelfen zur Mutter- und Säuglingspflege wiederum ist nur im

[24] *§ 31 Abs 5a ASVG* enthält zwar einen Auftrag an den Hauptverband („*hat jährlich … zu erlassen*“), dieser umfasst aber auch die Entscheidung darüber, **ob** ein (zumal einheitlicher) Selbstbehalt vorzusehen ist, und steht zudem unter dem **Vorbehalt** der Zustimmung der Trägerkonferenz sowie der Genehmigung durch den BMGF.

GSVG nicht vorgesehen (vgl dagegen § 160 ASVG, § 97 Abs 6 BSVG, § 77 B-KUVG).

3.2.5. Gesetz differenziert zwischen Pflicht- und freiwilligen Leistungen

Die fünfte Gruppe von Unterschieden geht darauf zurück, dass das jeweilige Gesetz manche Leistungen als **gesetzliche Pflichtleistung** qualifiziert, andere dagegen als **satzungsmäßige Mehrleistung** oder gar nur als **freiwillige** Leistung.

- Das betrifft vor allem die unterschiedliche Kategorisierung bei den **Hilfsmitteln**. Diese sind teilweise nur als **satzungsmäßige** Pflichtleistung ausgestaltet (so in *§ 154 ASVG* bzw *§ 96 BSVG*), mitunter handelt es sich sogar nur um **freiwillige** Leistungen (vgl jeweils den **letzten Satz** in *§ 154 Abs 1 ASVG* bzw *§ 96 Abs 1 BSVG*). In den anderen Systemen handelt es sich bei den Hilfsmitteln dagegen bereits um **gesetzliche Pflichtleistungen** (*§ 93 GSVG*, *§ 65 B-KUVG*).

Dieser Unterschied wird im Ergebnis noch verstärkt, wenn die betreffenden Hilfsmittel auf Dauer benötigt werden (zB bei Inkontinenzbedarf) und sich insofern der von den Leistungsberechtigten zu tragende Eigenanteil aufsummiert. Zu einer gewissen Begrenzung der Unterschiede kommt es aber dadurch, dass es in allen Systemen **Höchstgrenzen** für die Kostenübernahme gibt, wenngleich die bereits direkt im *GSVG* bzw *B-KUVG* vorgesehenen Begrenzungen über jenen liegen, die sich für nach *ASVG* und *BSVG* Berechtigte erst aus der jeweiligen Satzung ergeben.

- **Kein Unterschied** besteht letztlich – auf Grund der Judikatur – im Hinblick auf das Bestehen eines Anspruchs auf **Zahnbehandlung** und **Zahnersatz**, da diese trotz scheinbar gegenteiliger Formulierungen im *ASVG* bzw B-*KUVG* („*nach Maßgabe … der Satzung*“) als Pflichtleistungen anzusehen sind. Die nähere Ausgestaltung dieser Ansprüche obliegt dann aber in der Tat der **Satzung** (s daher 3.2.6.5.).

3.2.6. Gesetz überlässt Regelung der Satzung

Bei der letzten Gruppe gehen die Unterschiede darauf zurück, dass das jeweilige Gesetz keine Regelung trifft oder nur eine Mindestleistung bzw einen Rahmen normiert, die **(nähere) Ausgestaltung** aber dann **der Satzung** überlässt. Innerhalb dieser Gruppe kann aber noch weiter danach differenziert werden, wie groß der **Spielraum** ist, welcher der jeweiligen Satzung eingeräumt wurde.

Reiht man diese Varianten nach der Größe des Spielraums für die Satzung, lassen sich **fünf Unterkategorien** bilden: Am größten ist der Spielraum dort, wo weder gesetzliche Vorgaben noch solche auf Grund der **Mustersatzung** (nach *§ 455 Abs 2 ASVG*) bestehen (1.), was letztlich auch der Fall ist, wenn die Regelungen letzterer nicht verbindlich sind (2.). Etwas eingeschränkt ist dieser Spielraum, wenn durch Gesetz oder Mustersatzung eine Bandbreite vorgegeben ist, innerhalb derer sich die betreffende Satzung bewegen kann (3.), oder wenn das Gesetz Determinanten für die Gestaltungsmöglichkeiten enthält (4.). Schließlich gibt es noch jene Konstellation, wo zwar das Gesetz Spielraum eröffnet, dieser aber dann durch die verbindliche Mustersatzung (so gut wie) nicht mehr besteht (5.).

3.2.6.1. Am **meisten** Spielraum ist der jeweiligen Satzung demnach dort eingeräumt, wo **keine gesetzlichen Vorgaben** bestehen und/oder **keine verbindlichen Regelungen** in der Mustersatzung getroffen wurden.

Zweiteres ist an sich für den Bereich des *GSVG*, *BSVG* und *B-KUVG* der Fall, weil die Mustersatzung zwar grundsätzlich alle Träger der Krankenversicherung erfasst (vgl *§ 1 Abs 2* ihrer *Einführungsbestimmungen*), die **Verbindlicherklärung** aber für SVA, SVB und BVA **nicht** gilt (*§ 2 Abs 2 der Einführungsbestimmungen zur Mustersatzung*).

Diese Freiheit besteht allerdings nicht im Hinblick auf die allgemeinen **Selbstbehalte**, deren Festlegung das jeweilige Gesetz zwar der Satzung überantwortet, dafür aber selbst Obergrenzen sowie Determinanten normiert: Nach *§ 86 Abs 1* ***GSVG*** darf der „**Kostenanteil“ 30%** der dem Versicherungsträger erwachsenden Kosten nicht überschreiten und ist dessen Höhe „*unter Bedachtnahme auf 1. die finanzielle Leistungsfähigkeit des Versicherungsträgers, 2. die Art und Frequenz der Leistungserbringung, 3. Gesundheitspolitische Zielvorgaben, 4. die wirtschaftlichen Verhältnisse der Versicherten festzusetzen*“. Nach *§ 63 Abs 4* ***B-KUVG*** darf der dort vorgesehene **Behandlungsbeitrag 20%** der dem Versicherungsträger erwachsenden Kosten nicht überschreiten und ist (lediglich) „*unter Bedachtnahme auf die finanzielle Leistungsfähigkeit des Versicherungsträgers festzusetzen*“.

3.2.6.2. Keine verbindlichen Vorgaben bestehen weiters (im Bereich des *ASVG*) etwa im Hinblick auf die Kostenerstattung im **vertragslosen Zustand** (*§ 131a ASVG*, *§ 36 Mustersatzung*), die Kostenzuschüsse bei **Fehlen vertraglicher Regelungen** *(§ 131b ASVG*, *§ 38 Mustersatzung*; s aber auch unten 3.2.6.5.), die Übernahme von **Reisekosten** in Zusammenhang mit der Inanspruchnahme von ärztlicher Hilfe etc (zB *§ 135 ASVG*, *§ 46 Mustersatzung*) und teilweise auch für **Transportkosten** (*§ 47 Mustersatzung*).

Schließlich sind **Abweichungen** auch von den **verbindlichen** Bestimmungen der *Mustersatzung* nach *§ 4 Abs 1* ihrer *Einführungsbestimmungen* für die **BKKen** und die **VAEB** zulässig, wenn dies aus ganz bestimmten Gründen **notwendig** ist. Solche Gründe können in der sachlichen Zuständigkeit dieser Träger, der Eigenart von Beschäftigungs- oder Entlohnungsverhältnissen der bei ihnen versicherten Personen, der Beistellung von Bediensteten durch den Betriebsunternehmer oder anderen organisatorischen Umständen liegen.

3.2.6.3. Bandbreiten für die jeweilige Satzung bestehen teilweise auf **gesetzlicher** Ebene und teilweise auf Grund der Mustersatzung.

Ersteres gilt insb für das **Krankengeld**, wo das *ASVG* zum einen eine **Mindestbezugsdauer** (von 26 [bei Versicherten, die in den letzten 12 Monaten zumindest sechs Monate Versicherungszeiten aufweisen, sogar 52] Wochen) vorsieht, die durch Satzung auf bis zu 78 Wochen **verlängert** werden kann (*§ 139 Abs 2 ASVG*).[25] Zum anderen kann auch das **Ausmaß** des Krankengeldes **erhöht** werden, wenn die versicherte Person für bestimmte **Angehörige** zu sorgen hat (*§ 141 Abs 3 ASVG*).[26]

Eine **verbindliche** Bandbreite auf Grund der **Mustersatzung** (die also wieder für SVA, SVB und BVA nicht gilt) besteht im Hinblick auf die **Höchstgrenzen der Kostenübernahme bei Heilbehelfen** (*§ 38 Mustersatzung* iVm *§ 5 Abs 1* ihrer *Einführungsbestimmungen*);[27]

weiters im Hinblick auf die **Höchstgrenzen für Zuschüsse für Hilfsmittel** (*§ 43 Mustersatzung* iVm *§ 5 Abs 3* ihrer *Einführungsbestimmungen*);[28]

oder bei den **Zuzahlungen der Versicherten für Kieferregulierungen** (*§ 33 Abs 1* und *Anhang 4 Mustersatzung* iVm *§ 5 Abs 4* ihrer *Einführungsbestimmungen*):

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[25] Von der Verlängerungsmöglichkeit haben einige BKKen, aber etwa auch die OÖGKK oder die VAEB Gebrauch gemacht, diese aber jeweils an die Voraussetzung geknüpft, dass auf Grund einer entsprechenden chefärztlichen Begutachtung eine Wiederherstellung der Arbeitsfähigkeit bzw eine Wiedereingliederung in den Arbeitsprozess erwartet werden kann.

[26] Solche Erhöhungen finden sich ebenfalls bei einigen BKKen, aber auch bei der OÖ- sowie der VbgGKK, wobei die Erhöhung meist erst ab dem 43. Tag zum Tragen kommt und bei EhegattInnen durchwegs 10%, bei anderen Angehörigen meist nur 5% ausmacht.

[27] Von der dort vorgesehenen Bandbreite zwischen dem Drei- und dem Achtfachen der Höchstbeitragsgrundlage wurde in ganz unterschiedlicher Weise Gebrauch gemacht: Während sich die Mehrzahl der GKKs am unteren Rand bewegen, haben alle Sonderversicherungsträger, die meisten BKKen und auch die OÖ-, Sbg- und VbgGKK den Rahmen ausgeschöpft.

[28] Auch hier besteht eine Bandbreite zwischen dem Drei- und Achtfachen (bei Hilfsmitteln, die geeignet sind, die Funktionen fehlender oder unzulänglicher Körperteile zu übernehmen und bei Krankenfahrstühlen: 20-fachen) der Höchstbeitragsgrundlage, die in ähnlicher Weise genutzt wird wie bei den Heilbehelfen (s vorherige FN).

Bandbreite zwischen 25 und 50 % der mit den Vertragspartnern vereinbarten Tarifsätze.

3.2.6.4. Auf Beispiele, in denen das **Gesetz** einen Rahmen für die Satzung eröffnet, aber **Kriterien** formuliert, wie dieser Rahmen zu nutzen ist, wurde bereits oben bei 3.2.6.1 (*GSVG*, B-*KUVG*) und 3.2.6.2. (BKKen bzw VAEB) hingewiesen.

Darüber hinaus wären hier noch die Ermächtigung zu nennen, im Weg der Satzung **Kostenzuschüsse zu Maßnahmen zur Erhaltung der Volksgesundheit** (Impfungen) „*unter Bedachtnahme auf die finanzielle Leistungsfähigkeit*“ vorzusehen (*§ 132c Abs 3 ASVG*);[29]

weiters etwa die auf die „finanzielle Leistungsfähigkeit und das wirtschaftliche Bedürfnis der Versicherten“ abstellende Regelung von **Kostenzuschüssen bei Fehlen vertraglicher Regelungen** mit den jeweiligen Leistungserbringern (*§ 131b ASVG*);[30]

oder die an die gleichen Voraussetzungen geknüpfte Möglichkeit einer Erhöhung **des Kostenerstattungsanspruchs im vertragslosen Zustand** (vgl *§ 131a ASVG*, *§ 85 Abs 4 GSVG*, *§ 80 Abs 2 BSVG*, *§ 60 B-KUVG*).

3.2.6.5. Zahlreiche andere Materien sind an sich der Regelung durch Satzung vorbehalten, werden aber bereits durch **verbindliche Anordnungen in der Mustersatzung** determiniert.

Das gilt namentlich für die Leistungen bei **Zahnbehandlung und Zahnersatz** (*§§ 31, 32 und 35 Mustersatzung*);

die **Kieferregulierungen bei Kindern und Jugendlichen** (*§ 34 Mustersatzung*);

den **Pflegekostenzuschuss** bei stationärer Behandlung in einer weder Landesfonds-finanzierten noch Vertragskrankenanstalt (*§ 41 Mustersatzung*);[31]

oder die meisten Regelungen im Hinblick auf **Transportkosten** (*§ 47 Mustersatzung*).

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[29] Die Spannbreite liegt hier etwa beim Kostenzuschuss für FSME-Impfungen zwischen € 2 (WrGKK) und € 19 (BKK Mondi).

[30] Das führt etwa bei Behandlungen durch nicht-ärztliche PsychotherapeutInnen für eine Einzelsitzung zu Unterschieden zwischen € 21,80 (BgldGKK) und € 50,- (BKK Mondi).

[31] Dennoch zahlt etwa die OÖGKK ebenso wie die SVA oder die VAEB einen Zuschuss von € 228,07 pro Tag.

3.3. Rechtliche Ansatzpunkte für eine Harmonisierung

3.3.1. Grundsätzliches

Ausgehend von den oben 3.2. herausgearbeiteten Unterschieden lassen sich auch verschiedene Ansatzpunkte für den Abbau dieser Differenzierungen identifizieren. Vorweg ist allerdings eine allgemeine Anmerkung zur Frage der Rechtfertigung dieser Differenzierungen erforderlich. Aus dem verfassungsrechtlichen Gleichheitssatz folgt zwar bekanntlich die grundsätzliche Notwendigkeit, dass Differenzierungen **sachlich gerechtfertigt** sein müssen, der dafür anzustellende Vergleich setzt aber eine **Vergleichbarkeit** der Regelungen voraus. Eine solche ist nicht gegeben, wenn die Unterschiede daraus resultieren, dass verschiedene Normsetzungsautoritäten im Rahmen ihrer Kompetenzen ähnliche Sachverhalte in unterschiedlicher Weise regeln. Genauso wie daher landesrechtliche Vorschriften nicht deswegen unsachlich werden, weil das betreffende Sachproblem in einem oder mehreren anderen Bundesländern anders geregelt ist, [32] können auch die Unterschiede von Satzungsregelungen, die sich im jeweiligen gesetzlichen Rahmen bewegen, nicht wegen Gleichheitswidrigkeit angegriffen werden. Gleiches gilt grundsätzlich auch für Unterschiede, die sich aus den jeweiligen Gesetzen ergeben, wenn und weil diese ihrerseits jeweils unterschiedliche Versichertengemeinschaften betreffen, die – offenbar aus guten Gründen – getrennt voneinander gebildet wurden, so dass für diese jeweils **unterschiedlichen „Ordnungssysteme“** auch andere Regelungen gelten können (oder sogar müssen).[33] In der Folge werden daher die **bestehenden Unterschiede nicht im Lichte des Gleichheitssatzes** problematisiert, sondern nach den rechtspolitischen Möglichkeiten gefragt, wie diese Unterschiede überwunden werden könnten.

Das könnte natürlich zunächst durch entsprechende **gesetzliche** Regelungen erfolgen. Solche könnten in **akkordierter** Weise in den bestehenden Sozialversicherungsgesetzen getroffen werden, wie es ja bei vielen Änderungen der Fall ist.[34] Denkbar wäre freilich auch ein **eigenes** (zB „Krankenversicherungs-Harmonisierungs-“)Gesetz mit einem Geltungsbereich, der ähnlich wie beim *Allgemeinen Pensi-*

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[32] Vgl nur *Pöschl*, Gleichheit vor dem Gesetz, 443f.

[33] Vgl auch zu dieser „Ausnahme“ von einer Vergleichbarkeit im Rahmen des Gleichheitssatzes nur *Pöschl*, Gleichheit vor dem Gesetz, 280ff.

[34] Vgl etwa zuletzt BGBl I 2017/33.

onsgesetz (vgl dessen *§ 1*) **alle** Sozialversicherungsgesetze erfasst.[35] Dieser Ansatz steht jedenfalls für jene Unterschiede zur Verfügung, die oben zu **3.2.4.**, **3.2.5.** und **3.2.6.** beschrieben wurden.

Eine solches „Harmonisierungs-Gesetz" könnte demnach zB aus bisher freiwilligen Leistungen gesetzliche Pflichtleistungen machen, einheitliche Höchstgrenzen für die von den Versicherten zu tragenden Selbstbehalte oder umgekehrt einheitliche (und höhere) **Mindestbeträge** für die bisherigen Kostenzuschussregelungen vorsehen. Es könnten aber auch **materielle** Regelungen getroffen werden, die eine einheitliche Definition bzw Klärung der Abgrenzung von Heilbehelfen und Hilfsmitteln oder auch im Hinblick auf das unklare Verhältnis von Krankenbehandlung und medizinischen Maßnahmen der Rehabilitation[36] bewirken würden. Solche Vorgaben würden wohl zu einem **höheren Aufwand** für die jeweiligen Träger führen. Soweit dieser aber durch entsprechende Risikostrukturausgleichmaßnahmen[37] bzw Zuführung von Steuermitteln aufgefangen würde, könnte darin auch keine Verletzung des Prinzips der Selbstverwaltung[38] gesehen werden.

Für die Unterschiede, die zu **3.2.2.** zusammengefasst wurden, wäre eine gesetzliche Regelung möglicherweise nicht adäquat. Dort bedürfte es vielmehr einer Beseitigung/Reduzierung der unterschiedlichen Regelungen in den jeweiligen **Verträgen**. Das setzt nicht nur die „Bereitschaft zu Harmonisierung" zwischen den jeweiligen Trägern voraus, sondern auch und vor allem bei den jeweiligen Vertragspartnern. Für Eingriffe in diese Beziehung bestehen hier zum einen also faktische **Grenzen**, zum anderen könnten sich aber auch Grenzen aus der Rechtsordnung, insb der Verfassung, ergeben. Diese Frage stellt sich in ähnlicher Weise auch im Fall der Zusammenlegung von Trägern und bedarf daher einer grundsätzlichen Betrachtung. Diese soll unter **3.3.3.** angestellt werden.

Auch bei den Unterschieden, die in **3.2.3.** aufgelistet sind, würden gesetzliche Maßnahmen zu einer Harmonisierung problematisch sein. Die betreffenden Regelungen könnten dem Verdacht der mangelnden sachlichen Rechtfertigung ausgesetzt sein,

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[35] Dieser Ansatz würde im Hinblick auf die Harmonisierung letztlich zum gleichen Ergebnis führen wie eine Zusammenlegung von Versicherungsträgern, wobei in beiden Fällen Fragen des **Übergangs** natürlich **gesondert** geprüft werden müssten.

[36] Vgl dazu bei **Task 2d**, unten 4.2.1.

[37] Vgl dazu bei **Task 7a-7b** bzw **Task 9e**, unten 8.2.

[38] Nach *Art 120a Abs 1 B-VG* kann die Zusammenfassung zu Selbstverwaltungskörpern nur insoweit erfolgen, als diesen Aufgaben übertragen werden, die im gemeinsamen Interesse der betreffenden Personen „*gelegen und geeignet sind, durch sie gemeinsam besorgt zu werden*", s dazu bei **Task 7a-7b**, unten 5.2.2.2.

aber vor allem deswegen, weil die jeweils adressierten Risiken eben nicht bei allen Versicherten(gruppen) gleich gestaltet sind. Da jedoch der verfassungsrechtliche Gleichheitssatz insb auch verlangt, dass sich wesentliche Unterschiede im Tatsächlichen (hier also in der Ausgestaltung der Risiken) auch in den Regelungen niederschlagen, wird hier eine Harmonisierung kaum in Betracht kommen. Sie wird aber in der Regel auch **nicht erforderlich** sein, weil etwa einer unselbständig erwerbstätigen Frau, die gerade ein Kind entbunden hat, mit einer Betriebshilfekraft in natura nicht geholfen ist, und umgekehrt dem Risiko einer Arbeitsunfähigkeit infolge Krankheit zB bei einer Bäuerin nicht durch Zahlung eines Krankengeldes begegnet werden kann.

Bei den in **3.2.5.** und **3.2.6.** beschriebenen Unterschieden könnte eine Harmonisierung zunächst auch **ohne gesetzliche Änderungen** herbeigeführt werden. Dies könnte zum einen dadurch erfolgen, dass die jeweiligen Träger die ihnen vom Gesetz eröffneten Spielräume in der gleichen Weise nutzen und ihre **Satzungen** (allenfalls auch Krankenordnungen) **von sich aus abstimmen**. Die Harmonisierung könnte zum anderen dadurch erreicht werden, dass diese Spielräume beseitigt werden, was entweder durch **Verringerung der Bandbreite** für die Satzung (vgl 3.2.6.3.) oder **Erweiterung** des Katalogs **verbindlicher** Bestimmungen in der **Mustersatzung** (3.2.6.1. bzw 3.2.6.2.) erfolgen könnte.

Die beiden letztgenannten Ansätze bedeuten eine **Einschränkung der Autonomie der jeweiligen Selbstverwaltungskörper**. Zu einer solchen käme es auch, wenn der Gesetzgeber selbst die Determinanten für die Satzungsregelungen enger als bisher (vgl 3.2.6.4.) formulierte. Gesetzliche Maßnahmen wären aber möglicherweise auch erforderlich, wenn in der **Mustersatzung mehr verbindliche Bestimmungen** enthalten sein sollten. Die diesbezüglichen Rahmenbedingungen sind daher in der Folge zu analysieren.

3.3.2. Harmonisierung durch Mustersatzung

Nach *§ 455 Abs 2 ASVG* hat der **Hauptverband** für den Bereich der Krankenversicherung eine Mustersatzung zu erlassen, deren Wirksamkeit von der Genehmigung durch die zuständige Bundesministerin (derzeit BMG) abhängt. In gleicher Weise der Genehmigung bedarf die Erklärung der **Verbindlichkeit** von Bestimmungen der Mustersatzung, die dieser dann die Wirkung einer (Rechts-)**Verordnung** verleiht.[39]

[39] Damit unterliegt die Mustersatzung auch der Normenkontrolle durch den VfGH nach *Art 139 B-VG*, während Satzungsbestimmungen, die zu verbindlich erklärten Bestimmungen der Mustersatzung in

Diese Verbindlichkeit kann zwar für **alle Versicherungsträger** oder auch nur für **bestimmte Gruppen** von Versicherungsträgern angeordnet werden, sie kann sich aber **nicht auf alle Bestimmungen** der Mustersatzung beziehen, wie die gesetzliche Formulierung „*und Bestimmungen der Mustersatzung … für verbindlich*“ deutlich macht. Die Verbindlicherklärung ist zudem nur zulässig, „*insoweit dies zur Wahrung der Einheitlichkeit der Durchführung sozialversicherungsrechtlicher Bestimmungen notwendig erscheint*“.

Dem Hauptverband, genauer der **Trägerkonferenz** (vgl *§ 441d Abs 2 Z 4 ASVG*), ist hier also ein gewisser **Spielraum** bei der Beurteilung der Frage eingeräumt, **ob** diese Notwendigkeit gegeben ist (arg „*insoweit … erscheint*“). Wenn sie aber für bestimmte Bereiche angenommen wird, **hat** eine Verbindlicherklärung zu erfolgen. Für die **Objektivierbarkeit** dieser Entscheidung nennt das Gesetz zwei Aspekte, die zusätzlich (arg „*auch*“) zur Wahrung der Einheitlichkeit zu beachten sind. Es handelt sich dabei um das Interesse der Versicherten bzw jenes ihrer DG „*an einer bundeseinheitlichen Vorgangsweise der Versicherungsträger*“.

Diese **Bundeseinheitlichkeit** ist bei den bundesweit tätigen Krankenversicherungsträgern SVA, SVB und BVA bereits gegeben, was ihre bisherige Ausnahme von den für verbindlich erklärten Bestimmungen der Mustersatzung (vgl noch einmal *§ 2 Abs 2* ihrer *Einführungsbestimmungen*) erklären dürfte. Bereits die **geltende** gesetzliche Ermächtigung zur Verbindlicherklärung lässt dennoch die diesbezügliche Einbeziehung **aller** Krankenversicherungsträger zu, wenn nach dem (insoweit politischen) **Willen** in der Trägerkonferenz die Einheitlichkeit der Durchführung sozialversicherungsrechtlicher Bestimmungen – und dann zwischen den bundesweit tätigen und den regional oder auf bestimmte Betriebe beschränkten Trägern – angestrebt wird.

Nach der geltenden Gesetzeslage bestehen hierfür **drei inhaltliche Einschränkungen**. Zunächst kann eine Vereinheitlichung durch verbindliche Regelung in der Mustersatzung naturgemäß dort nicht erreicht werden, wo die **Unterschiede** im **gesetzlichen** Leistungsrecht grundgelegt sind (vgl oben 3.2.4.). Des Weiteren kann eine völlige Vereinheitlichung auf diesem Weg nicht erfolgen, soweit es sich um über die gesetzlichen Mindestleistungen hinausgehende **Mehrleistungen** (iSd *§ 121 Abs 3 ASVG*) handelt, weil für diese in der Satzung eine zwar verbindliche Regelung, aber doch **nur** in Form einer **Bandbreite** getroffen werden darf, bei deren Festlegung auf die finanzielle Leistungsfähigkeit des jeweiligen Versicherungsträgers Rücksicht zu nehmen ist (vgl 3.2.6.3.).

Widerspruch stehen, ihrerseits als (im materiellen Sinn) gesetzwidrig anzusehen und ebenso vom VfGH aufzuheben sind.

Und schließlich ist noch einmal zu betonen, dass **nicht alle** – und daher wohl auch nicht alle leistungsrechtlich relevanten – **Bestimmungen** der Mustersatzung für verbindlich erklärt werden dürfen. Das Gesetz verpflichtet den Hauptverband vielmehr gleichsam zu einer punktgenauen Dosierung sowohl hinsichtlich des Adressatenkreises als auch der Inhalte der Mustersatzung:[40] Auf der einen Seite darf die Autonomie der Versicherungsträger nicht in Bausch und Bogen beschränkt werden, auf der anderen Seite muss aber auch das allgemeine Interesse der Sozialversicherung (*§ 31 Abs 2 ASVG*) sowie das verfassungsrechtliche Gleichheitsgebot beachtet werden, das ausschließt, manchen Trägern ohne sachlichen Grund mehr Autonomie zu belassen als anderen. Sehr wohl zulässig ist es bei dieser Feinabstimmung freilich, dass die Mustersatzung die jeweils verpflichteten Träger ermächtigt, unter näher umschriebenen Bedingungen von den verbindlichen Vorschriften abzuweichen.[41]

Wollte man die Bedeutung der Mustersatzung als Instrument zur Harmonisierung noch **weiter ausbauen**, bedürfte es entsprechender **Änderungen** in der **gesetzlichen Grundlage**. Diese könnten etwa den Kreis der für eine Bandbreitenregelung in Betracht kommenden Leistungen verändern oder den Spielraum für die Bandbreite näher determinieren. Sie dürften aber **nicht** so weit gehen, dass **alle** (zumindest leistungsrechtlichen) Bestimmungen der Mustersatzung verbindlich erklärt werden dürften, soweit die dafür erforderliche Beschlussfassung in der Trägerkonferenz auch gegen den Willen der betroffenen Träger erfolgen könnte[42] und insoweit in den Kernbereich ihrer Selbstverwaltungsrechte eingreifen würde. Eine solche Harmonisierung müsste daher grundsätzlicher ansetzen und hätte über eine Neuordnung der Trägerlandschaft selbst durch Umgestaltung der jeweiligen Versichertengemeinschaften zu erfolgen,[43] was ja auch in der Sache zweckmäßiger erscheint.

3.3.3. Harmonisierung im Hinblick auf das Vertragspartnerrecht

Die Unterschiede, die oben zu 3.2.2. zusammengefasst wurden, gehen auf die Unterschiede in den **Verträgen** der Krankenversicherungsträger mit den Erbringern von Gesundheitsdienstleistungen und deren Vertretungen zurück. Auch wenn auf Seite

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[40] Vgl nur *Brenneis*/*Pöschl* in *Mosler*/*Müller*/*Pfeil*, Der SV-Komm § 455 ASVG Rz 52.

[41] Das ist derzeit bei den BKKen sowie der VAEB nach Maßgabe des *§ 4 Abs 1* der *Einführungsbestimmungen der Mustersatzung* der Fall (vgl bereits oben 4.2.6.2.).

[42] Nach *§ 441a Abs 2 ASVG* bedarf ein gültiger Beschluss der Trägerkonferenz der Zustimmung der (einfachen) Mehrheit der abgegebenen Stimmen, wobei die Beschlussfähigkeit die Anwesenheit zumindest der Hälfte der Mitglieder voraussetzt.

[43] S daher bei **Task 7a-7b**, unten 5.2.2.

der Sozialversicherung der Hauptverband abschließt, gewährleistet das bereits dort keine Einheitlichkeit, weil der Hauptverband nur **für** die jeweiligen Krankenversicherungsträger tätig wird und der konkrete Abschluss der **Zustimmung** des betreffenden **Trägers** bedarf (vgl nur *§ 341 Abs 1 ASVG*). Diese (potenzielle) Uneinheitlichkeit wird dadurch verstärkt, dass es stets der **Zustimmung** des jeweiligen **Vertragspartners** bedarf und bislang weder ein Kontrahierungszwang noch eine Zwangsschlichtung bei Nichteinigung vorgesehen ist.

Der Gesetzgeber hat sich hier also weitestgehend jeglicher Eingriffe enthalten und auf die Kompromissbereitschaft der Vertragsparteien gesetzt.[44] Dies müsste aber nicht immer so bleiben, gerade wenn eine Harmonisierung des Leistungsrechts angestrebt werden soll. Dafür sind theoretisch verschiedene Eingriffsmöglichkeiten vorstellbar, besonders naheliegend erscheint aber die Option zu sein, **bestehende Gesamtvertragsregelungen auf andere Bereiche zu erstrecken**. Inwieweit das durch Gesetz erfolgen kann, soll daher etwas näher betrachtet werden.

Diese Möglichkeit könnte insb in dem Fall in Betracht kommen, in dem die Harmonisierung im Zuge einer Zusammenlegung von Versicherungsträgern erfolgt. Diese Vorgangsweise wurde etwa beim Zusammenschluss der beiden seinerzeitigen Pensionsversicherungsanstalten der unselbständig Erwerbstätigen zur nunmehrigen PVA sowie bei der Zusammenlegung der Versicherungsanstalten des Bergbaus und der Eisenbahnen zur nunmehrigen VAEB gewählt. In beiden Fällen gab es umfangreiche Übergangsregelungen, die vor allem die Umgestaltung der Selbstverwaltungskörper betroffen haben (vgl zum einen *§§ 538h ff*, zum anderen *§§ 538a ff ASVG*).

Ohne Übergangsvorschriften würden aber auch die **bestehenden Verträge** zu den jeweiligen Vertragspartnern **hinfällig** werden: Der rechtliche Untergang der Partei eines Gesamtvertrages führt nämlich zu dessen sofortiger Beendigung[45] und bewirkt auch ein Erlöschen der Einzelverträge (vgl nur *§ 343 Abs 2 Z 1 ASVG*). Eine bloße Rechtsnachfolgeregelung würde hier wenig weiterhelfen, weil unklar wäre, welche Regelungen aus den bisherigen unterschiedlichen Gesamtverträgen nach der Zusammenlegung maßgebend sein sollen.

Für einen solchen Fall wurde bei der Errichtung der VAEB mit *§ 609 Abs 5 ASVG* (teilweise) Vorsorge getroffen und eine Verpflichtung des Hauptverbandes begrün-

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[44] Die einzige, aber auch sehr begrenze Ausnahme ist die Möglichkeit nach *§ 348 ASVG*, im Falle eines vertragslosen Zustands den Gesamtvertrag durch die Bundesschiedskommission festsetzen zu lassen, im Ergebnis also den Inhalt dieses Gesamtvertrags um (lediglich) bis zu drei Monate zu verlängern.

[45] Vgl nur *Mosler* in *Grillberger*/*Mosler*, Ärztliches Vertragspartnerrecht, 97.

det, bis zu einem gewissen Termin (konkret war es der 31.3.2005) einen Gesamtvertrag für den neu gegründeten Träger mit der Ärztekammer abzuschließen, wobei die damals bestehenden Einzelverträge vorläufig weiter in Geltung geblieben sind. Mit einer solchen Regelung wird aber noch **keine Harmonisierung** bewirkt, zumal auch eine derartige „Verpflichtung" nicht zu einem Gesamtvertrag führen muss, wenn es keine Einigung mit dem jeweiligen Vertragspartner gibt. Offenkundig aus diesem Grund wurde im Zuge der – dann bekanntlich nicht umgesetzten – Überlegungen für eine Zusammenlegung der SVA und der SVB vor etwas mehr als zehn Jahren ein weitergehender Ansatz erwogen: Damals war im Wesentlichen eine **gesetzliche Vorkehrung** für den Fall angedacht, dass bis zu einem gewissen Termin **keine Einigung** über einen neuen, für alle Selbständigen maßgebenden Gesamtvertrag erzielt wird. Bei einem Scheitern dieser Verhandlungen hätte nach diesen Plänen gesetzlich angeordnet werden sollen, dass die für die betreffende Region geltenden Verträge zwischen der jeweiligen GKK und der örtlich zuständigen Ärztekammer auch für den neuen Träger gelten sollten und dieser kraft Gesetzes (ebenfalls) zur Vertragspartei wird.

Ein solcher Eingriff in ein ansonsten „freies Spiel der Kräfte" ist zwar ungewöhnlich, aber für sich genommen **nicht unzulässig**, weil es wohl keinen verfassungsrechtlichen Anspruch der Gesamtvertragsparteien auf eine völlig autonome Rechtsetzung gibt, die frei von (einfach)gesetzlichen Eingriffen ist, zumal die Fähigkeit, Gesamtverträge mit normativer Wirkung für dritte, am Vertragsabschluss nicht unmittelbar beteiligte Personen abzuschließen, nicht in der im Eigentumsgrundrecht verorteten Privatautonomie begründet ist, sondern vom einfachen Gesetzgeber verliehen wird und insb auf keiner verfassungsrechtlichen Gewährleistung beruht.[46] Rechtliche Bedenken wären hier nur insoweit angebracht, als ein **nicht zu rechtfertigender und/oder unverhältnismäßiger Eingriff in verfassungsrechtlich geschützte Positionen, insb unter dem im Gleichheitssatz verorteten Gesichtspunkt des Vertrauensschutzes** vorläge. Dies könnte möglicherweise auch im Hinblick auf die besondere Konstruktion des Vertragspartnerrechts im Kontext der verfassungsrechtlichen Regelungen über die **soziale Selbstverwaltung** (*Art 120a ff B-VG*)[47] der Fall sein. Eine verlässliche ex-ante-Einschätzung der Vereinbarkeit allfälliger gesetzlicher Eingriffe in das bestehende Vertragspartnerrecht mit diesen Vorgaben kann freilich schon

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[46] Vgl VfGH VfSlg 15.697/1999 und VfSlg 19.858/2014; die Fähigkeit der beruflichen Vertretungen der AG und der AN zum Abschluss von Tarifverträgen zur Regelung der Arbeitsbedingungen dürfte demgegenüber durch Art 11 EMRK auch grundrechtlich gewährleistet sein (vgl nur *Grabenwarter/Pabel*, Europäische Menschenrechtskonvention[5], § 23 Rz 86).

[47] Vgl dazu bereits bei **Task 7a-7b**, insb 5.2.2.2.

deshalb nicht erfolgen, weil es auf die konkrete Ausgestaltung solcher Maßnahmen ankommt. Einige **Eckpunkte** für die Möglichkeiten einer gesetzlichen Harmonisierung im Hinblick auf die aus dem Vertragspartnerrecht resultierenden Unterschiede können aber doch genannt werden.

Eingriffe in den Gesamtvertrag müssten auf einer **gesetzlichen** Grundlage beruhen, einem zulässigen **Ziel** des Gesetzgebers dienen, zur Erreichung dieses Ziels geeignet sowie **verhältnismäßig** sein. Dass eine Harmonisierung des Leistungsrechts – zumal bei einer Umgestaltung der Trägerlandschaft in der gesetzlichen Krankenversicherung – und eine damit verbundene Eindämmung der Ausgabenentwicklung grundsätzlich im öffentlichen Interesse liegen, wird kaum in Frage zu stellen sein.[48] Vorkehrungen, die für die (potenziellen) Vertragsparteien Druck erzeugen, um deren Einigung auf einen neuen einheitlichen Vertrag zu befördern, erscheinen auch als grundsätzlich geeignete Maßnahmen. Es würde aber darauf zu achten sein, ob vom Eingriff Regelungen betroffen sind, durch welche Vertragsärzte typischerweise zu Dispositionen veranlasst wurden, die durch den Eingriff frustriert werden. In diesem Fall dürfte der Eingriff nach der Rechtsprechung zum Vertrauensschutz nicht plötzlich und intensiv erfolgen, dh es geht allenfalls um Übergangsregelungen je nach Gegenstand für einen längeren oder kürzeren Zeitraum. Im Hinblick auf die **Verhältnismäßigkeit** des Eingriffs ist zu bedenken, dass eine völlige Abkehr vom System des Vertragspartnerrechts in der derzeit bestehenden Form oder die Einführung einer rigiden staatlichen Zwangsschlichtung wesentlich weitergehende Eingriffe darstellen würden als etwa die Anordnung der Geltung von anderen Gesamtverträgen (die ja auch von den Vertretungen der Vertragspartner der Krankenversicherungsträger abgeschlossen wurden!), noch dazu, wenn diese etwa auf den Fall beschränkt ist, dass auch nach einer angemessenen Verhandlungszeit keine Einigung über einen neuen einheitlichen Vertrag erzielt wird.[49]

Eine aus verfassungsrechtlicher Sicht bedeutsame Schranke dürfte nur darin liegen, dass der Kompetenztatbestand „*Sozialversicherungswesen*“ wohl keinen Übergang zu einer Art staatlichem Gesundheitsdienst zB nach britischem Muster zulässt (also

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[48] Vgl insb VfGH VfSlg 17.071/2003, wo gesetzliche Eingriffe in vertraglich begründete Pensionsansprüche von ÖBB-Bediensteten als verfassungskonform beurteilt wurde, insb weil dadurch die finanzielle Belastung des Bundes reduziert und eine Harmonisierung der Pensionssysteme erleichtert werden sollte; ähnlich zuletzt etwa auch VfGH 14.3.2017, G 405/2015 (Pensionsordnungen der Österreichischen Nationalbank).

[49] Der Umstand, dass das derzeitige System des Zusammenspiels von normativ wirkendem Gesamtvertrag und darauf aufbauenden Einzelverträgen zweckmäßiger sein dürfte, als es ein System wäre, das zum Aushandeln von Einzelverträgen mit jedem einzelnen Leistungserbringer zwingen würde, dürfte kein verfassungsrechtlicher Gesichtspunkt sein, vgl zB VfGH VfSlg 16.911/2003.

die Erbringung von Sachleistungen durch staatlich angestelltes ärztliches Personal); darauf deutet jedenfalls das „Versteinerungsmaterial“ hin.[50]

Vor diesem Hintergrund kann sich auch das Problem der behaupteten, aber ohnedies nicht überzeugend begründbaren „verfassungsrechtlichen Bestandsgarantie“ für das Vertragspartnermodell[51] nicht stellen. Dies schon deshalb nicht, weil aus *Art 120a ff B-VG* nicht einmal eine Bestandgarantie für die berufliche oder soziale Selbstverwaltung als solche abgeleitet werden kann,[52] umso weniger daher eine solche für die Fähigkeit zum Abschluss von Gesamtverträgen, welche ja an die Eigenschaft der mit dieser Befugnis ausgestatteten Institutionen als Selbstverwaltungskörper anknüpft. Sehr wohl ein Thema könnte nach dem Gesagten aber der aus dem Gleichheitssatz abgeleitete **Vertrauensschutz** sein, der jedenfalls abrupte und massive Eingriffe in bisher anerkannte Rechtspositionen (zB bereits entstandene Honoraransprüche von Ärzten) unzulässig machen würde. Diesem Problem könnte insb durch angemessene Übergangsvorschriften begegnet werden.

3.4. Besonderheiten der Krankenfürsorgeanstalten

Auf die Besonderheiten der Krankenfürsorgeanstalten in struktureller und organisatorischer Hinsicht wird bei **Task 7a-7b** (5.2.3.1.) näher eingegangen. Im vorliegenden Zusammenhang soll nur die **Sonderstellung** dieser Einrichtungen im **Leistungsrecht** dargestellt werden. Da nicht alle Informationen zu diesen KFA zugänglich sind, kann diese Darstellung nur **exemplarisch** ausfallen und soll in der Folge auch auf einige grundsätzliche Punkte beschränkt bleiben. Eine detailliertere Übersicht der verfügbaren Informationen findet sich dann im **Anhang (13.B.)**.

3.4.1. Grundsätzliches

Die aufgrund der Dienstrechtskompetenz der Länder eingerichteten KFA sind **nicht in das System der gesetzlichen Krankenversicherung integriert**. Sie gehören

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[50] Vgl nur das Erkenntnis VfGH VfSlg 18.738/2009.

[51] Vgl zuletzt *N. Raschauer*, Verfassungsrechtliche Vorgaben für die Weiterentwicklung des ärztlichen Vertragspartnerrechts, RdM 2016/135, 240 ff.

[52] Vgl noch einmal VfGH VfSlg 19.919/2014.

nicht dem Hauptverband der österreichischen Sozialversicherungsträger an, die von diesem erlassene Mustersatzung ist auf sie nicht anzuwenden und es kommt grundsätzlich auch zu keiner Beitragsrückerstattung bei Mehrfachversicherung und einem (Gesamt-)Einkommen über der Höchstbeitragsgrundlage.

Bereits **organisationsrechtlich** sind die verschiedenen KFA sehr unterschiedlich ausgestaltet. Bei den Einrichtungen handelt es sich **teilweise** um **Körperschaften öffentlichen Rechts**, die teilweise **mit** (zB KFA für oö Landesbeamte, KFA der Bediensteten der Stadt Wien), teilweise auch **ohne Rechtspersönlichkeit** (zB KFA für Magistratsbedienstete der Stadt Salzburg; KFA der Bediensteten der Stadt Graz) einzurichten sind. In den gesetzlichen Grundlagen bzw in den Satzungsbestimmungen sind teilweise **Aufsichtsrechte** der jeweiligen Landesregierung (zB KFA für oö Landesbeamte, KFA für oö Landeslehrer) bzw des Gemeinderates (zB KFA der Bediensteten der Stadt Graz) angeordnet.

Teilweise werden die KFA **weisungsfrei** tätig (zB KFA der oö Landeslehrer), teilweise unterliegen sie aber auch den **Weisungen der Aufsichtsbehörde** (zB KFA der oö Landesbeamten); in der Satzung der KFA der Bediensteten der Stadt Wien wird die gesamte Geschäftsgebarung der KFA ausdrücklich der Überprüfung und Überwachung durch den Stadtrechnungshof unterworfen. Auch hinsichtlich der **Ausgestaltung der Organe** unterscheiden sich die einzelnen KFA stark voneinander.

Nur für **fünf** KFA (oö Landesbeamte, oö Landeslehrer, Tiroler Gemeindebeamte, Tiroler Landesbeamte, Tiroler Landeslehrer) bestehen bereits auf **gesetzlicher** Ebene detailliertere Vorgaben insb zu Anspruchsberechtigung, Beitrags- und Leistungsrecht bzw Verwaltung der jeweiligen KFA. Für die übrigen KFA finden sich die entsprechenden Bestimmungen dagegen auf Ebene der Satzung bzw auf Verordnungsebene bzw teilweise auch in den Krankenordnungen.

Diese **Rechtsgrundlagen** sind **nur teilweise öffentlich zugänglich**, so dass insb ein umfassender Überblick bzw ein Vergleich des Leistungsrechts schwer fällt. Besonders **intransparent** ist die Rechtslage hinsichtlich der KFA der oö Statutarstädte (Linz, Steyr, Wels) sowie der KFA der Beamten der Stadtgemeinde Baden, der Beamten der Stadt Villach und der Beamten der Stadtgemeinde Hallein. Hinsichtlich der KFA der Magistratsbediensteten der Landeshauptstadt Salzburg ist nur die Satzung, nicht aber die Krankenordnung einsehbar, in der insb Art, Ausmaß, Tarife und Kostenbeiträge geregelt werden. Nicht öffentlich zugänglich ist ferner die Satzung der KFA der oö Landesbeamten sowie die Verordnung zu den Leistungen der KFA der Tiroler Gemeindebediensteten. Die Verordnungen der beiden anderen Tiroler KFA

(Tiroler Landesbeamte, Tiroler Landeslehrer) sind zwar im Internet veröffentlicht, allerdings jeweils ohne den Anhang, der die jeweiligen Tarifsätze enthält.

Umfassend zugänglich sind damit **nur** die Informationen betreffend KFA der oö Landeslehrer, KFA der oö Gemeindebediensteten, KFA der Beamten der Landeshauptstadt Graz sowie KFA der Bediensteten der Stadt Wien.

3.4.2. Beitragsrecht

Die KFA sind auch beitragsrechtlich nicht an das System der Sozialversicherung angekoppelt. Die **Beitragssätze** der KFA **unterscheiden** sich durchaus voneinander sowie vom Beitragssatz des Sozialversicherungsrchts (2017: 7,65 % der Beitragsgrundlage – 3,87 % DN-Anteil, 3,78 % DG-Anteil). Nicht überall sind Informationen zum Beitragssatz zugänglich (zB KFA der oö Landesbeamten, KFA Villach, KFA Hallein).

Teilweise ist der **Beitragssatz** an jenen nach dem ***B-KUVG*** gebunden (nö GBDO: Beitragssatz der KFA darf jenen der BVA um höchstens 0,2 % übersteigen; tatsächlicher Beitragssatz der KFA Baden nicht eruierbar). **Größtenteils** werden die Beitragssätze aber **unabhängig** von den Vorgaben des *B-KUVG* festgelegt.

Die **DN-Anteile** dieser Beitragssätze liegen durchgehend **über** jenen nach den Sozialversicherungsgesetzen (zwischen 3,95 % [KFA Wien] und 5,5 % [KFA der Tiroler Gemeindebediensteten – DN-Anteil für Beamte der Landeshauptstadt Innsbruck]). Die **DG-Anteile** liegen teilweise **unter** (geringster Beitragssatz KFA Graz: 3,2 %), zT **über** den Sätzen nach den Sozialversicherungsgesetzen (höchster Beitragssatz KFA der Tiroler Gemeindebediensteten – Beitragssatz der Stadtgemeinde Innsbruck für die bei ihr beschäftigten Beamten: 5,5 %).Teilweise können **Beitragszuschläge** für besondere/ zusätzliche/ freiwillige **Leistungen** bezahlt werden (zB KFA oö Gemeinden, KFA Magistrat Salzburg, KFA Graz); teilweise sind solche Zuschläge für (bestimmte) **Angehörige** zu entrichten (KFA oö Gemeinden: Einbeziehung in die Krankenfürsorge bei Schul-/Berufsausbildung; KFA Graz: Zusatzbeitrag für Angehörige wie nach *B-KUVG*).

Auch hinsichtlich einer etwaigen **Höchstbeitragsgrundlage** unterscheiden sich die KFA von den Sozialversicherungsgesetzen und auch untereinander: **Keine** Höchstbeitragsgrundlage ist etwa in der KFA Wien vorgesehen. Eine **niedrigere** Höchstbeitragsgrundlage als nach *ASVG* (2017: € 4.980,-) findet sich etwa für die KFA der oö Landesbeamten (€ 3.299,-; bei Vertragsbediensteten ist aber die Höchstbeitragsgrundlage nach *§ 45 ASVG* anzuwenden). Bei der KFA Magistrat Salzburg gilt die Höchstbeitragsgrundlage nach dem *B-KUVG* zuzüglich eines Steigerungsbetrages von € 480,-, sie beträgt also für das Jahr 2017 **€ 5.460,-.** Bei der KFA der oö Ge-

meindebediensteten ist die Höchstbeitragsgrundlage faktisch (fast) an das Niveau nach *ASVG* angeglichen (2017: € 4.889,-), es gibt hier aber auch eine **Mindestbeitragsgrundlage in Höhe** von 15 % der Höchstbeitragsgrundlage (im Jahr 2017 also in der Höhe von ca € 732,-).

3.4.3. Leistungsrecht

Hinsichtlich des Leistungsrechts ist die **einzig** verbindliche Vorgabe für alle KFAs, dass die Leistungen der landesrechtlichen KFA den Leistungen nach dem B-KUVG **zumindest gleichwertig** sein müssen (vgl *§ 2 Abs 2 B-KUVG*). Bei einem Teil der KFAs ist das Leistungsrecht darüber hinaus gar **nicht oder kaum gesetzlich determiniert** (vgl insb KFA Villach - *§ 77 Kärntner Stadtbeamtengesetz*; KFA Baden - *§ 54 nö GBDO*; KFA oö Gemeindebedienstete [nähere Regelungen durch eigenes Landesgesetz in *§ 83 oö Gemeindebedienstetengesetz* zwar vorgesehen, es existiert aber kein derartiges Landesgesetz]; KFA Salzburger Magistratsbedienstete). Im oö Statutargemeinden-BeamtenG ist über *§ 2 Abs 2 B-KUVG* hinausgehend normiert, dass die Leistungen zumindest das Ausmaß erreichen müssen, das für oö Landesbedienstete vorgesehen ist.

Teilweise wird im Leistungsrecht **unmittelbar auf** Bestimmungen des ***B-KUVG* verwiesen** (zB KFA Graz: Kostenbeiträge zulässig bis zum Höchstausmaß der nach dem *B-KUVG* geltenden Kostenbeiträge; Verweis auf Bestimmungen des *B-KUVG* hinsichtlich Gebrauchsdauer von Heilbehelfen/Hilfsmitteln), **größtenteils** werden aber **eigene** Regelungen getroffen.

Dass das Leistungsrecht **im Detail** durchaus **sehr unterschiedlich** ausgestaltet ist, ist aufgrund fehlender verbindlicher Vorgaben (keine bindenden vereinheitlichenden gesetzlichen Vorgaben, keine Bindung an die Mustersatzung) nicht überraschend. Ein umfassender Vergleich ist schon aufgrund des fehlenden Zugangs zu den Rechtsgrundlagen nicht möglich. Im Folgenden sollen daher nur ein paar **Beispiele** für **markante Abweichungen** von den Bestimmungen nach dem *B-KUVG* bzw nach den anderen Sozialversicherungsgesetzen angeführt werden:

- **Kostenerstattung bei Inanspruchnahme von Wahlärzten**: ZT Kostenerstattung im Ausmaß von 100% des Vertragstarifes (zB KFA oö Lehrer, KFA Graz, KFA Wien), bei anderen KFA Erstattung von 90% (KFA oö Gemeindebedienstete, KFA Tiroler Landeslehrer) bzw 95% der Vertragstarife (KFA Tiroler Landesbeamte).
- **Behandlungsbeitrag für die Inanspruchnahme ärztlicher Hilfe:** Bei einigen KFAs in Höhe von 10% wie nach B-KUVG (KFA oö Gemeindebedienstete, KFA Ti-

roler Landeslehrer); bei KFA Tiroler Landesbeamte nur 5%-iger Behandlungsbeitrag; für Mitglieder der KFA oö Lehrer oder KFA Wien kein Behandlungsbeitrag. Einen **höheren** Behandlungsbeitrag als für Bundesbedienstete (in Höhe von 15% des Vertragstarifes) sieht die Satzung der KFA Graz vor, allerdings nur für einzelne Leistungen; bei anderen Leistungen besteht dagegen offensichtlich kein Selbstbehalt.

- **Anstaltspflege:** Hier fällt beispielsweise auf, dass einzelne KFA auch die Aufnahme in der **Sonderklasse** vergüten (mit geringen Selbstbehalten: zB KFA oö Gemeindebedienstete, KFA oö Lehrer); für Mitglieder der KFA Graz kann diese Leistung nur von jenen Mitgliedern in Anspruch genommen werden, die einen besonderen Beitrag (iSd *§ 25* der Satzung) leisten. Nach der Satzung der KFA Wien werden auch die Kosten für eine **Asylierung** für bis zu 28 Tage übernommen.

- **Keine nennenswerten Unterschiede** zeigen sich, soweit überblickt, einerseits im Hinblick auf die Regelungen zu **Heilmitteln** (Rezeptgebühr, Rezeptgebührenbefreiung) sowie andererseits (für Vertragsbedienstete) zu den **Geldleistungen Kranken- und Wochengeld**. Ein Verweis auf die Bestimmungen zum Rehabilitationsgeld findet sich nicht in allen Satzungen (vgl KFA oö Gemeindebedienstete, KFA Graz).

- Sehr **schwer zu überblicken** sind die **Unterschiede im Bereich der Heilbehelfe/Hilfsmittel** bzw hinsichtlich allfälliger **Kostenzuschüsse/Vergütungssätze** (zB für Hilfsmittel, Impfungen, der ärztlichen Hilfe gleichgestellte Leistungen etc). In vielen Bereichen zeigen sich hier (bei den meisten KFA) vergleichsweise **großzügige** Leistungen (insb im Vergleich zu den Ansprüchen von GKK-Versicherten); zB Kostenzuschuss in Höhe von € 60,- für Psychotherapie (KFA oö Gemeindebedienstete).
Teilweise liegt **das Leistungsniveau (mancher KFA) aber auch unter jenem der BVA** (zB FSME-Impfung: Zuschuss KFA Wien: € 3,63; Zuschuss BVA: € 16,-).

3.5. Zusammenfassung

➔ Die bisher zwischen den verschiedenen Krankenversicherungsträgern bestehenden Unterschiede im Leistungsrecht könnten in den **meisten** Fällen durch (**einfach)gesetzliche Regelungen** überwunden oder zumindest gemindert werden. Soweit es sich dabei um keine massiven bzw abrupten Eingriffe in bisher bestehende Leistungsansprüche handelt (was nach den Vorgaben für diese Studie auszuschlie-

ßen ist), kann sich dadurch auch **kein Problem** im Hinblick auf den **Vertrauensschutz** der bisher anspruchsberechtigten Personen ergeben.

➔ Fraglich könnte allenfalls die **sachliche Rechtfertigung** von gesetzlichen Harmonisierungen sein, die den vorhandenen Unterschieden im Tatsächlichen nicht Rechnung trägt, indem unterschiedliche Risiken gleich behandelt oder für gleiche Risiken völlig unterschiedliche Leistungen vorgesehen würden.

➔ Einfachgesetzliche Eingriffe könnten auch dann problematisch sein, wenn sie bestehendes **Vertragspartnerrecht** betreffen. Das Ziel einer Harmonisierung des Leistungsrechts, vor allem, wenn diese mit einer Neuordnung der Trägerlandschaft verbunden ist, könnte solche Eingriffe aber – als im öffentlichen Interesse gelegen – rechtfertigen, wenn sie **verhältnismäßig** sind. Das wäre etwa bei Maßnahmen zur Beförderung der Einigung auf neue einheitliche Verträge der Fall, wie sie bei der geplanten Zusammenlegung von SVA und SVB – insb in Form der gesetzlichen Anordnung der Geltung anderer bestehender Gesamtverträge – angedacht worden waren. Allerdings müsste auch hier der verfassungsrechtlich gewährleistete **Vertrauensschutz** (insb im Hinblick auf abrupte bzw massive Eingriffe in ärztliche Honoraransprüche) beachtet werden.

➔ Weitgehende Harmonisierungen sind auch im Rahmen der Rechtsetzung der Sozialversicherungsträger selbst – und damit bereits ohne gesetzliche Änderungen – möglich. Zum einen könnten die jeweiligen **Krankenversicherungsträger** die ihnen vom Gesetz eröffneten Spielräume in der gleichen Weise nutzen und ihre **Satzungen** (allenfalls auch Krankenordnungen) von sich aus **abstimmen.** Die entsprechende Willensbildung begegnet keinen rechtlichen, sondern höchstens politischen und finanziellen Hürden.

➔ Gleiches gilt zunächst für Änderungen in der **Mustersatzung**, wobei die diesbezüglichen rechtlichen Spielräume für den Hauptverband im Hinblick auf die Ausweitung des Kreises der von **Verbindlicherklärungen** erfassten **Träger** ungleich weiter sind als im Hinblick auf die für verbindlich erklärten Leistungsinhalte. Die Eröffnung weiter gehender Gestaltungsmöglichkeiten für die Mustersatzung würde erneut wieder gesetzliche Änderungen erfordern. Diese dürften aber **nicht** so weit gehen, dass **alle** (leistungsrechtlichen) Bestimmungen der Mustersatzung verbindlich erklärt werden dürften, soweit die dafür erforderliche Beschlussfassung auch gegen den Willen der betroffenen Träger erfolgen könnte und insoweit in den Kernbereich ihrer Selbstverwaltungsrechte eingreifen würde.

➔ Die Unterschiede zu den einzelnen **Krankenfürsorgeanstalten** bzw auch zwischen diesen sind zum Teil noch größer, zudem ist die Rechtslage dort sehr intrans-

parent. Die Einbeziehung der dort erfassten Personen mit dem Ziel einer Harmonisierung wäre wünschenswert, aber durch einfachgesetzliche Maßnahmen auf Bundesebene (oder gar durch Änderungen im Bereich des Sozialversicherungs-Satzungsrechts) allein nicht zu erreichen.[53]

4. Task 2d: Harmonisierung des Leistungsrechts bei Kur und Rehabilitation – rechtliche Aspekte[54]

4.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„LEISTUNGSRECHT HARMONISIEREN“** im Rahmen der bereits oben 3.1. wiedergegebenen Passage folgende Formulierung (4f):

> „Das Leistungsrecht ist für die Versichertengemeinschaft von zentraler Bedeutung. Unterschiede werden von den versicherten Menschen im Alltag wahrgenommen, stoßen auf Unverständnis und führen zu Systemkritik. In einem Versicherungssystem mit einer gesetzlichen Zuordnung der Versicherten zu den einzelnen Sozialversicherungsträgern hat die Harmonisierung des Leistungsrechts oberste Priorität. …
>
> Der Bereich der Rehabilitation ist miteinzubeziehen. Zudem soll eine nachhaltige Klärung der Leistungszuständigkeit im Bereich **Kur und Rehabilitation** erfolgen. …“

Daraus wurden ua folgende Aufgabenstellung abgeleitet (5):

„Analyse der Leistungszuständigkeit für Kur und Rehabilitation unter Effizienz- und Qualitätsgesichtspunkten.“

Die folgenden Ausführungen sollen die **rechtlichen Aspekte** der geforderten Analyse zur Leistungszuständigkeit für **Kur und Rehabilitation** beleuchten. Sie stellen insofern eine **Ergänzung** zu den bereits zu **Task 2a** (oben 3.) angestellten allgemeinen rechtlichen Einschätzungen zur Ausgangssituation und den Perspektiven einer Harmonisierung des Leistungsrecht insb im Bereich der Krankenversicherung dar. Dabei stehen zwei Fragen im Vordergrund:

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[53] Vgl näher bei **Task 7a-7b**, unten 5.2.3.1.

[54] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* und unter Berücksichtigung von Hinweisen von *Walter Pöltner* verfasst.

Zum einen die **Kompetenzverteilung** auf der Ebene der Bundesverfassung, nach der bestimmte Aufgaben, die nicht unmittelbar der Krankenbehandlung zuzurechnen sind, in die Zuständigkeit der **Länder** fallen (könnten). Dieses Problem ist zuerst zu behandeln (s daher 4.3.), da die andere Frage bereits eine sozialversicherungsrechtliche Zuständigkeit voraussetzt. Zum anderen geht es nämlich vor allem um die Klärung der **internen** Aufgabenverteilung **zwischen** den Trägern der **Krankenversicherung** und jenen der **Pensionsversicherung** (dazu 4.4.). Vorweg sind kurz die bestehenden Regelungen im Hinblick auf Kur bzw Rehabilitation mit einem Schwerpunkt im Sozialversicherungsrecht darzustellen (4.2.).

4.2. Die bestehenden Regelungen im Bereich Kur und Rehabilitation im Überblick

Maßnahmen in Zusammenhang mit Kuraufenthalten und Rehabilitation gehören zum Aufgabenbereich **mehrerer** Zweige der Sozialversicherung. In der gesetzlichen Krankenversicherung finden sich dazu Anknüpfungen im Rahmen der Maßnahmen zur Festigung der Gesundheit sowie in eigenen Bestimmungen zu den medizinischen Maßnahmen der Rehabilitation. In der gesetzlichen Pensionsversicherung sind Maßnahmen der Rehabilitation und der Gesundheitsvorsorge systematisch enger miteinander verknüpft, wobei medizinische Maßnahmen der Rehabilitation in Zusammenhang mit Pensionen bei geminderter Arbeitsfähigkeit (bzw deren Vermeidung) seit einiger Zeit eine eigenständige Bedeutung erhalten haben. Auch in der gesetzlichen **Unfallversicherung** gibt es Maßnahmen, die im weiteren Sinn der Rehabilitation oder der Festigung der Gesundheit dienen. Diese Maßnahmen sind dort aber regelmäßig einem sehr **weit** verstandenen Begriff der Unfallheilbehandlung zu unterstellen (vgl nur *§§ 189 ff ASVG*), für den insb das Wirtschaftlichkeitsgebot der Krankenversicherung (vgl nur *§ 133 Abs 2 ASVG*) nicht gilt, und werfen keine besonderen Zuständigkeitsfragen auf, so dass sie hier **ausgeblendet** bleiben können.[55]

[55] Vgl aber bei **Task 13c**, unten 10.2.

4.2.1. Krankenversicherung

In der gesetzlichen Krankenversicherung ist für den vorliegenden Zusammenhang wesentlich, dass regelmäßig zwischen medizinischen Maßnahmen der Rehabilitation und Maßnahmen zur Festigung der Gesundheit unterschieden wird.

4.2.1.1. Medizinische Maßnahmen der Rehabilitation

Erstere sind praktisch **wortgleich** in allen Sozialversicherungsgesetzen geregelt (vgl im Einzelnen *§ 154a ASVG*, *§ 99a GSVG*, *§ 96a BSVG* bzw *§ 65a B-KUVG*). Diese Einheitlichkeit wird durch **Richtlinien** erhöht, die der Hauptverband nach *§ 31 Abs 5 Z 19* und *20 ASVG* auch im Hinblick auf die Koordination mit den entsprechenden Leistungen der Pensionsversicherung (dazu unten 4.2.2.) erlassen hat.[56]

Die medizinischen Maßnahmen der Rehabilitation stehen daher durchwegs im Kontext der **Krankenbehandlung** und sind im **Anschluss** an diese zu gewähren, um deren Erfolg zu sichern oder die Folgen der Krankheit zu erleichtern. Auch die **Zielsetzung** dieser Maßnahmen ähnelt jener der Krankenbehandlung, geht es doch darum, „*den Gesundheitszustand der Versicherten und ihrer Angehörigen so weit wiederherzustellen, daß sie in der Lage sind, in der Gemeinschaft einen ihnen angemessenen Platz möglichst dauernd und ohne Betreuung und Hilfe einzunehmen*“ (vgl nur *§ 154a Abs 1 letzter Halbsatz ASVG*). Parallelen gibt es schließlich im Hinblick auf die Ausgestaltung der Leistung, die wie die Krankenbehandlung „ausreichend und zweckmäßig sein“ muss, „*jedoch das Maß des Notwendigen nicht überschreiten*“ darf (*§ 133 Abs 2 Satz 1 ASVG*).

Dennoch bestehen einige markante **Unterschiede** zur Krankenbehandlung. Der erste betrifft das **Leistungsspektrum**, das **enger** ist und lediglich 1. die Unterbringung in Krankenanstalten, die vorwiegend der Rehabilitation dienen, 2. die Gewährung von Körperersatzstücken, orthopädischen Behelfen und anderen Hilfsmitteln umfasst, jedoch die Gewährung der Kernleistungen im Rahmen der Krankenbehandlung (also ärztliche Hilfe, Heilmittel und Heilbehelfe) nur 3., wenn diese unmittelbar im Anschluss oder im Zusammenhang mit einer der beiden erstgenannten Maßnahmen er-

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[56] Vgl die „*Richtlinien für die Erbringung von Leistungen im Rahmen der Rehabilitation sowie von Leistungen im Rahmen der Festigung der Gesundheit und der Gesundheitsvorsorge*“ (***RRK 2005***), *avsv 114/2005, zuletzt idF 177/2016*, die nach ihrem *§ 1 Abs 3* für **alle** Sozialversicherungsträger mit Ausnahme der Versicherungsanstalt des österreichischen Notariats gelten.
Diese Richtlinien enthalten auch leistungsrechtliche Vorgaben, die zwar nichts am grundsätzlich freiwilligen Charakter der jeweiligen Leistungen ändern, aber dann bindend sind, wenn die betreffenden Leistungen gewährt werden (vgl *§ 1 Abs 4 RRK 2005*).

forderlich sind (vgl nur *§ 154a Abs 2 ASVG*). Eine weitere Einschränkung ergibt sich aus *Abs 6* dieser Bestimmung, der klarstellt, dass Maßnahmen zur Festigung der Gesundheit (dazu unten 4.2.1.2.) nicht zu den Aufgaben der medizinischen Maßnahmen der Rehabilitation gehören.

Der zweite wesentliche Unterschied besteht im Hinblick auf die **Durchsetzbarkeit** der Leistung. Während auf Leistungen der Krankenbehandlung ein grundsätzlich auch gerichtlich einklagbarer **Rechtsanspruch** besteht, ist dies bei medizinischen Maßnahmen der Rehabilitation **nicht** der Fall, weil diese vom Krankenversicherungsträger lediglich nach **pflichtgemäßem Ermessen** gewährt werden. Damit rücken die Maßnahmen in die Nähe einer völlig freiwilligen Leistung, auch wenn bei solchen „Pflichtleistungen" die – praktisch freilich kaum ins Gewicht fallende – Möglichkeit einer gerichtlichen Überprüfung besteht, ob von dem Ermessen in gesetzmäßiger Weise Gebrauch gemacht wurde.[57]

Der dritte Unterschied betrifft die Zuständigkeit zur **Leistungserbringung**. Diese liegt nur **subsidiär** beim jeweiligen Krankenversicherungsträger, dh nur dann, wenn nicht bereits ein Träger der Pensions- oder der Unfallversicherung (bei welchem im Übrigen der Antrag zu stellen ist!) diese Leistungen selbst zu gewähren hat oder gewährt (vgl nur *§ 154a Abs 3 ASVG*). Der Krankenversicherungsträger kann aber auch sonst die Durchführung der betreffenden Maßnahmen einem Pensionsversicherungsträger gegen (allenfalls auch pauschalierten) Ersatz der Kosten übertragen (vgl nur *§ 154a Abs 4 ASVG*). Für diese Leistungen sind **Kostenbeiträge** zu entrichten, wenn es sich dabei um die Unterbringung in Krankenanstalten handelt, die vorwiegend der Rehabilitation dienen (vgl nur *§ 154a Abs 7 ASVG*).

Obwohl die Sozialversicherungsgesetze somit zwischen Krankenbehandlung und medizinischer Rehabilitation differenzieren, sind die Grenzen zwischen beiden Leistungsbereichen sehr **unscharf**. Das ist zunächst rechtspolitisch problematisch, weil wohl nach dem Stand der medizinischen Wissenschaft Rehabilitationsmaßnahmen häufig bereits begleitend zur eigentlichen Behandlung durchgeführt werden (sollten);[58] die Unterscheidung im Hinblick auf die Durchsetzbarkeit wirft sogar verfassungsrechtliche Bedenken auf.[59] Insofern schiene es daher durchaus geboten, in Hinkunft entweder die **Abgrenzung** überhaupt **aufzugeben oder** zumindest

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[57] Vgl nur *Windisch-Graetz*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm § 154a ASVG Rz 3f.

[58] Vgl nur *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm § 302 ASVG Rz 4; bzw *Burger*/*Ivansits*, Medizinische und berufliche Rehabilitation in der Sozialversicherung, DRdA 2013, 106 (111).

[59] Vgl nur *Felten*, in *Tomandl* (Hg), System des österreichischen Sozialversicherungsrechts, 2.2.3.5. (245).

deutlicher vorzunehmen als nur über die zeitliche Abfolge („*im Anschluss an die Krankenbehandlung*“) und die vage Zielsetzung (Sicherung des Erfolgs der Krankenbehandlung oder Erleichterung der Folgen der Krankheit).

4.2.1.2. Maßnahmen zur Festigung der Gesundheit

Die zweite hier interessierende Leistungskategorie der gesetzlichen Krankenversicherung umfasst Leistungen zur Festigung der Gesundheit. Auch bei den dafür maßgebenden Regelungen besteht weitgehende **Übereinstimmung** zwischen den Sozialversicherungsgesetzen (vgl *§ 155 ASVG*, *§ 100 GSVG*, *§ 100 BSVG*, *§ 70a B-KUVG*), die erneut durch die *RRK 2005* des Hauptverbandes noch verstärkt wird. AdressatInnen dieser Leistungen sind die von der jeweiligen Krankenversicherung erfassten Personen, also **Versicherte** und deren **Angehörige** (letztere iSd *§ 123 ASVG*, *§ 83 GSVG*, *§ 78 BSVG* bzw *§ 56 B-KUVG*).

Bei allen Krankenversicherungsträgern handelt es sich bei den Maßnahmen zur Festigung der Gesundheit nur um **freiwillige** Leistungen, die „*unter Berücksichtigung des Fortschritts der medizinischen Wissenschaft sowie unter Bedachtnahme auf ihre finanzielle Leistungsfähigkeit*“ gewährt werden können. Eine gerichtliche Überprüfungsmöglichkeit besteht hier – zumindest nach der wohl herrschenden Lehre – auch, aber wieder höchstens im Hinblick auf gesetzmäßige Ermessensausübung.[60]

Spielräume bestehen weiters hinsichtlich des **Inhalts** dieser Leistungen, da die jeweiligen Gesetze nur demonstrative Aufzählungen der in Betracht kommenden Maßnahmen enthalten. Als solche gelten „*insbesondere*“ Landaufenthalte, Aufenthalte in Kurorten oder die **Unterbringung in Kuranstalten**, letzteres wenn dadurch eine unmittelbar drohende Krankheit oder die Verschlimmerung einer bestehenden Krankheit verhindert werden kann (vgl nur *§ 155 Abs 2 Z 1* und *2 ASVG*). In all diesen Fällen kann es zu einer Übernahme von **Reisekosten** nach Maßgabe der jeweiligen **Satzung** kommen.[61]

Neben der Leistungserbringung in natura ist auch die Gewährung von **Kostenzuschüssen** für Kuraufenthalte etc nach Maßgabe der schon mehrfach erwähnten *RRK 2005* möglich (vgl nur *§ 155 Abs 4 ASVG*). Auf der anderen Seite bestehen jedoch durchwegs **Zuzahlungsverpflichtungen**, die in gleicher Weise geregelt sind

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[60] Vgl nur *Felten*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 155 ASVG Rz 2; anders freilich noch der OGH 2010, DRdA 2012/2, 28 [kritisch Binder].

[61] Dies ist derzeit nur in den Satzungen der SVA bzw der BVA vorgesehen, und zwar jeweils bloß für Personen, die wegen besonderer sozialer Schutzbedürftigkeit auch von der Rezeptgebühr befreit sind.

wie bei Unterbringung in einer Krankenanstalt, die vorwiegend der Rehabilitation dient (vgl nur *§ 155 Abs 3* iVm *§ 154a Abs 7 ASVG*).

Besonderheiten finden sich in den Krankenversicherungssystemen der **Selbständigen**, die für die Dauer des Kuraufenthaltes die Übernahme der Kosten für **Betriebshelfer** bzw **Haushaltshelferinnen** vorsehen (vgl jeweils *§ 100 Abs 2 Z 4* im *GSVG* wie im *BSVG*).

Eine andere, aber für alle Systeme geltende Besonderheit betrifft den Umstand, dass **Kuraufenthalte** auch gewährt werden können, **ohne** dass bereits eine **Krankheit** (iSd *§ 120 Z 1 ASVG*) vorzuliegen braucht. Da eine solche lediglich unmittelbar drohen muss, können Kuraufenthalte auch **präventiv** gewährt werden. Die Voraussetzung ist hier also großzügiger ausgestaltet als bei der Krankenbehandlung, wenngleich die Umsetzung durch das Fehlen von Rechtsansprüchen wieder deutlich relativiert wird.

4.2.2. Pensionsversicherung

Wie schon angedeutet, finden sich im Recht der gesetzlichen Pensionsversicherung ganz ähnliche Regelungen wie in der Krankenversicherung. Diese werden sogar in jeweils eigenen Abschnitten zusammengefasst, die mit „*Rehabilitation und Maßnahmen der Gesundheitsvorsorge*“ überschrieben sind. Diese Regelungen sind weitgehend **wortgleich** (vgl *§§ 300ff ASVG*, *§§ 157 ff GSVG*, *§§ 150 ff BSVG*), wobei auch hier die Übereinstimmung durch die *RRK 2005* noch verstärkt wird.

4.2.2.1. Medizinische Maßnahmen der Rehabilitation

Die Regelungen über die medizinischen Maßnahmen in der Pensionsversicherung unterscheiden sich zunächst kaum von jenen in der Krankenversicherung. Anders als dort wird aber beim **Ziel** der Rehabilitation ausdrücklich nicht nur auf die weitestmögliche (Wieder-)Herstellung der Befähigung abgestellt, einen angemessenen Platz in der Gemeinschaft einnehmen zu können, sondern auch – und nach der gesetzlichen Systematik offenbar sogar **vorrangig** – auf die Rehabilitation „*im beruflichen und wirtschaftlichen Leben*“ Bezug genommen (so jeweils *Abs 3* in *§ 300 ASVG*, *§ 157 GSVG* bzw *§ 150 BSVG*).

Dieser Ausrichtung entspricht auch die Umschreibung des AdressatInnenkreises für medizinische Maßnahmen der Rehabilitation. Dieser umfasst zunächst nur **Versi-**

cherte und **BezieherInnen einer Pension wegen Invalidität,** Berufsunfähigkeit oder Erwerbsunfähigkeit, deren **Arbeitskraft infolge einer körperlichen, geistigen oder psychischen Beeinträchtigung herabgesunken ist** (vgl jeweils *Abs 1* in *§ 300 ASVG, § 157 GSVG* bzw *§ 150 BSVG*). **Angehörige** dieser Personen sind daher – anders als in der Krankenversicherung – **nicht** erfasst. Ihnen **können** aber unter bestimmten Voraussetzungen[62] Maßnahmen in Form der Unterbringung in Krankenanstalten, die vorwiegend der Rehabilitation dienen, gewährt werden (vgl *§ 301 Abs 2 ASVG, §§ 158 Abs 2* und *159 GSVG, §§ 150a Abs 2* und *151 BSVG*).

Für bloße Angehörige kommen somit medizinische Maßnahmen der Rehabilitation im Rahmen der Pensionsversicherung nur ausnahmsweise in Betracht. Auch für Versicherte und BezieherInnen einer der genannten Pensionsleistungen ist freilich **kein Rechtsanspruch** auf die betreffenden Maßnahmen vorgesehen, sondern erfolgt die Leistungsgewährung – wie in der Krankenversicherung – nur im **pflichtgemäßen Ermessen** der jeweiligen Träger (vgl jeweils *Abs 1* in *§ 301 ASVG*, *§ 158 GSVG* bzw *§ 150a BSVG*).

Davon bestehen im Hinblick auf medizinische Maßnahmen der Rehabilitation im Bereich des ASVG Ausnahmen, die allesamt mit dem Prinzip „Rehabilitation vor Pension“ zusammenhängen: Dementsprechend ist für Personen, für die bescheidmäßig eine zwar vorübergehende, aber doch zumindest sechs Monate dauernde **geminderte Arbeitsfähigkeit** festgestellt wurde, ein **Anspruch** vorgesehen, wenn die medizinischen Maßnahmen der Rehabilitation zur Wiederherstellung der Arbeitsfähigkeit notwendig und infolge des Gesundheitszustands auch zweckmäßig sind (*§§ 253f*, *270b* bzw *276f ASVG*).[63]

Durch diesen Anspruch wird das (schon oben 4.2.1.1. angesprochene) **Abgrenzungsproblem** zwischen Maßnahmen der Krankenbehandlung und jenen der medizinischen Rehabilitation noch wesentlich **verschärft**, da hier nun zwei unterschiedliche Träger (oder zumindest zwei unterschiedliche Zweige eines Trägers) zuständig sind. Daran ändert auch der Umstand nichts, dass die Leistungen der Pensionsversicherungsträger gegenüber jenen der Krankenversicherungsträger **subsidiär** sind, die Pensionsversicherungsträger aber die Gewährung der betreffenden Maßnahmen

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[62] Hier ist zum einen die Auslastung der eigenen Einrichtungen des betreffenden Trägers zu berücksichtigen, zum anderen kommen diese Maßnahmen nur in Betracht, wenn der/die Angehörige oder der/die BezieherIn einer Waisenpension an einer körperlichen, geistigen oder psychischen Behinderung leidet (zu diesem Begriff unten 4.3.) und wenn ohne die Maßnahmen dem Versicherten (Pensionisten) Auslagen erwachsen würden, die seine wirtschaftlichen Verhältnisse übersteigen.

[63] In den anderen Pensionsversicherungsgesetzen sind solche Ansprüche nur im Hinblick auf berufliche Maßnahmen der Rehabilitation vorgesehen (vgl § 131 GSVG bzw § 122 BSVG).

an sich ziehen können (vgl jeweils *Abs 2* in § 302 ASVG, § 160 GSVG bzw § 152 BSVG).

Die Schwierigkeiten der Abgrenzung zwischen Krankenbehandlung und medizinischen Maßnahmen der Rehabilitation werden noch durch einen weiteren Umstand gesteigert: **Zusätzlich** zu den auch im Rahmen der Krankenversicherung vorgesehenen Rehabilitationsmaßnahmen (einschließlich der auch hier bestehenden Regelungen über die Zuzahlung bei Aufenthalten in Krankenanstalten, die vorwiegend der Rehabilitation dienen, sowie der ebenfalls vorgenommenen ausdrücklichen Abgrenzung gegenüber Maßnahmen zur Festigung der Gesundheit bzw der Gesundheitsvorsorge[64]) sind in der Pensionsversicherung auch Maßnahmen der **ambulanten Rehabilitation** umfasst (vgl jeweils *Abs 1 Z 1a* in *§ 302 ASVG*, *§ 160 GSVG* bzw *§ 152 BSVG*). Diese Maßnahmen sind funktional offenkundig als (zumindest teilweise) **Alternative** zum Aufenthalt in Rehabilitationskliniken gedacht, kommen sie doch nach *§ 12a Abs 2 RRK 2005* unmittelbar nach Aufenthalt in einer Krankenanstalt, vor Beginn eines stationären Heilverfahrens, im Anschluss an ein solches oder als Alternative zu einem solchen in Betracht.[65]

4.2.2.2. Maßnahmen der Gesundheitsvorsorge

Auch die gesetzliche Pensionsversicherung kennt Leistungen der Gesundheitsvorsorge. Der erste Unterschied zu den Maßnahmen zur Festigung der Gesundheit im Rahmen der Krankenversicherung besteht wieder im Hinblick auf den jeweiligen **AdressatInnenkreis**: Während in der Krankenversicherung auch die Angehörigen erfasst sind, kommen hier grundsätzlich[66] nur Leistungen für **Versicherte** und **Pensionisten** in Betracht (vgl jeweils *Abs 1* in *§ 307d ASVG*, *§ 169 GSVG* bzw *§ 161 BSVG*).

Nach den eben genannten Bestimmungen handelt es sich aber auch in der Pensionsversicherung nur um **freiwillige** Leistungen, die jeweils „*unter Berücksichtigung*

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[64] Vgl dazu einerseits jeweils *Abs 4* in *§ 302 ASVG, § 160 GSVG* bzw *§ 152 BSVG*, andererseits jeweils *Abs 4* in *§ 300 ASVG, § 157 GSVG* bzw *§ 150 BSVG*.

[65] Unter „*stationären Heilverfahren*“ wird hier offenkundig nicht die – eine bestimmte Art der Krankheit voraussetzende – Anstaltspflege (etwa iSd *§ 144 ASVG*) verstanden, sondern die Leistungen in Krankenanstalten, die vorwiegend der Rehabilitation dienen (vgl *§ 12 RRK 2005*). Zu den praktischen Vorteilen einer ambulanten Rehabilitation vgl im Übrigen etwa *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 302 ASVG Rz 23.

[66] Lediglich bei der Gefahr einer tuberkulösen Erkrankung können auch Angehörigen Maßnahmen der Gesundheitsvorsorge im Rahmen der Pensionsversicherung gewährt werden, vgl jeweils *Abs 4* in *§ 307d ASVG*, *§ 169 GSVG* bzw *§ 161 BSVG*.

des Fortschritts der medizinischen Wissenschaft sowie unter Bedachtnahme auf ihre finanzielle Leistungsfähigkeit“ gewährt werden können.

Der Leistungskatalog ist zwar hier ebenfalls lediglich ein demonstrativer, wurde aber erst jüngst durch das *SRÄG 2015* (*BGBl I 2015/162*) gestrafft. Seither werden ausdrücklich nur mehr die **Aufenthalte in Kurorten bzw Kuranstalten** oder **Zuschüsse** (wiederum nach Maßgabe der *RRK 2005*) zu solchen, die Unterbringung in Krankenanstalten, die vorwiegend der Rehabilitation dienen, sowie die Übernahme der mit diesen Aufenthalten zusammenhängenden **Reise- und Transportkosten** nach Maßgabe der jeweiligen **Satzung** genannt (vgl jeweils *Abs 2* in *§ 307d ASVG, § 169 GSVG* bzw *§ 161 BSVG*).

Bemerkenswert in diesem Zusammenhang ist, dass mit der Anführung der „*Unterbringung in Krankenanstalten, die vorwiegend der Rehabilitation dienen*“ jeweils in *Z 2* aller eben genannten Bestimmungen, eine **Rehabilitation auch** für Pensionisten vorgesehen ist.[67] Mit Blick auf den eigentlichen AdressatInnenkreis für Rehabilitationsmaßnahmen (vgl noch einmal jeweils *Abs 1* in *§ 300 ASVG*, *§ 157 GSVG* bzw *§ 150 BSVG*) wird deutlich, dass es hier nur um BezieherInnen einer **Alters- bzw Hinterbliebenenpension** geht. Angesichts dieser unterschiedlichen Zielgruppe kann der primäre Maßstab für die Gewährung der Maßnahmen nicht in den auf die (Wieder-)Herstellung einer Erwerbsfähigkeit gerichteten Zielen der Rehabilitation liegen, sondern – wie in der Krankenversicherung (vgl nur *§ 154a Abs 1 letzter Halbsatz ASVG*) – „nur“ darin, die betreffenden Personen in die Lage zu versetzen, „*in der Gemeinschaft einen ihnen angemessenen Platz möglichst dauernd und ohne Betreuung und Hilfe einzunehmen*“.[68] Vor diesem Hintergrund bekommt auch die Abgrenzungsregel in *§ 154a Abs 3 ASVG* wieder Sinn, die im Übrigen teilweise durch die Möglichkeit einer Übertragung der Durchführung von Maßnahmen der Gesundheitsvorsorge an einen Krankenversicherungsträger (aber auf Kosten des jeweiligen Pensionsversicherungsträgers) ergänzt werden (vgl *§ 307d Abs 5 ASVG*).

Wie bei den Maßnahmen zur Festigung der Gesundheit in der Krankenversicherung sind auch hier **Zuzahlungsverpflichtungen** vorgesehen, die ebenfalls auf jene Regeln verweisen, welche bei stationären Aufenthalten im Rahmen der medizinischen

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[67] Der Pensionsversicherungsträger kann solche Krankenanstalten aber auch für diagnostische Zwecke zugänglich machen (vgl jeweils *Abs 3* in *§ 307d ASVG*, *§ 169 GSVG* bzw *§ 161 BSVG*). Damit ist offenbar eine Öffnung der Diagnostikkapazitäten dieser Einrichtungen für **alle** Versicherten angestrebt (vgl die ErläutRV 1098 BlgNR 17. GP 15).

[68] In diesem Sinn auch *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 307d ASVG Rz 19f.

Rehabilitation gelten (vgl *§ 307d Abs 6 ASVG* sowie jeweils *Abs 5* in *§ 169 GSVG* bzw *§ 161 BSVG*)[69].

4.3. Abgrenzung der Zuständigkeiten gegenüber den Ländern

Trotz dieser Vielzahl von Regelungen im Sozialversicherungsrecht tauchen immer wieder Unklarheiten auf, inwieweit die Sozialversicherungsträger – jenseits der spezifischen Maßnahmen der Unfallversicherung nach Arbeitsunfällen oder Berufskrankheiten (und damit namentlich die Träger der gesetzlichen Krankenversicherung) – überhaupt für Rehabilitation zuständig sind. In der Sache handle es sich dabei nämlich (auch und vielleicht sogar vorrangig) um Maßnahmen für Menschen mit „Behinderungen", für die auf Grund der **verfassungsrechtlichen Kompetenzverteilung** zunächst die Länder zuständig seien.[70]

Diese Auffassung ist nur bedingt richtig. Dafür ist vorauszuschicken, dass es in Österreich eine **klare rechtliche Abgrenzung** zwischen Krankheit bzw Gebrechen und Behinderung weder im nationalen Verfassungsrecht noch in internationalen Dokumenten und auch **nicht** auf einfachgesetzlicher Ebene **gibt**. Das hängt nicht zuletzt damit zusammen, dass eine eindeutige und einheitliche Definition von „Behinderung" in der österreichischen Rechtsordnung fehlt: Eine solche findet sich im Bundesrecht insb in *§ 3 Bundes-Behindertengleichstellungsgesetz* (*BGStG*, *BGBl I 2005/82* zuletzt idF *BGBl I 2013/138*) und *§ 3 Behinderteneinstellungsgesetz* (*BEinstG*, *BGBl 1970/22* zuletzt idF *BGBl I 2017/35*).[71] In den Sozialversicherungsgesetzen wird der Begriff der Behinderung zwar verwendet (wie etwa in der schon erwähnten Bestimmung des *§ 301 Abs 2 ASVG*), aber nicht näher definiert. Definitionen finden sich sehr wohl auf landesrechtlicher Ebene in den verschiedenen **Landes-Behindertengesetzen**. Die-

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[69] Insofern scheinen die jeweils im letzten Satz von *§ 307d Abs 2 ASVG* bzw *§ 169 Abs 2 GSVG* sowie in *§ 161 Abs 2 Z 2 letzter Halbsatz BSVG* enthaltenen Verweise auf die jeweiligen Zuzahlungsbestimmungen des Krankenversicherungsrechts überflüssig.

[70] Zu dieser Frage wurde erst im November 2013 zusammen mit Univ.-Prof. Dr. *Benjamin Kneihs* (ebenfalls Universität Salzburg) ein umfangreiches Gutachten für den Hauptverband erstellt, das im April 2014 noch ergänzt wurde und auf dessen Ergebnisse hier über weite Strecken zurückgegriffen wird.

[71] Beide Bestimmungen lauten: „*Behinderung im Sinne dieses Bundesgesetzes ist die Auswirkung einer nicht nur vorübergehenden körperlichen, geistigen oder psychischen Funktionsbeeinträchtigung oder Beeinträchtigung der Sinnesfunktionen, die geeignet ist, die Teilhabe am Leben in der Gesellschaft zu erschweren. Als nicht nur vorübergehend gilt ein Zeitraum von mehr als voraussichtlich sechs Monaten*."

se ähneln der Begrifflichkeit im *BGStG* bzw *BEinstG*, stellen aber nicht nur auf die Beeinträchtigung gesellschaftlicher Teilhabe, sondern etwa auch jener im Arbeitsleben oder bei Schulausbildung ab.[72]

Ein ähnlicher Ansatz liegt auch dem verfassungsrechtlich gewährleisteten Benachteiligungsverbot in *Art 7 Abs 1 Satz 3 B-VG* („*Niemand darf wegen seiner Behinderung benachteiligt werden*“) zu Grunde, das durch eine Staatszielbestimmung in *Satz 4* dieser Bestimmung ergänzt wird.[73] Dieser Behinderungsbegriff ist wohl weit zu verstehen und differenziert nicht nach Grad oder Schwere der jeweiligen Beeinträchtigung, sofern es sich um eine nicht bloß vorübergehende Beeinträchtigung handelt, die auf einem regelwidrigen körperlichen, geistigen oder psychischen Zustand beruht.[74] Bloß vorübergehende oder aber im natürlichen Alterungsprozess jeden Menschen betreffende Beeinträchtigungen sind von diesem Begriff somit nicht erfasst.

Dabei handelt es sich freilich um **keinen Kompetenzbegriff**. Die verfassungsrechtliche Kompetenzverteilung nimmt auf das Tatbestandsmerkmal „Behinderung“ keinen Bezug und weist weder dem Bund noch den Ländern explizit Zuständigkeiten zur Regelung von Lebenssachverhalten zu, die mit diesem Tatbestandsmerkmal in Beziehung stehen. Es handelt sich vielmehr um eine sogenannte **Querschnittsmaterie**,[75] deren Regelung in jeweils einschlägigen Zusammenhängen den jeweiligen Materiengesetzgebern zukommt, die daher zB im Rahmen des Abgabenrechts für eine Berücksichtigung von Aufwendungen für die Überbrückung einer Behinderung, im Rahmen des Baurechtes für eine behindertengerechte Bauweise oder im Rahmen des Arbeitsrechtes für Förderung und Gleichbehandlung am Arbeitsplatz sorgen sollen.

In diesem Rahmen können Leistungen für Menschen mit Behinderungen insb auch dem Kompetenztatbestand **Sozialversicherungswesen** unterstellt werden. Ob dieser Kompetenztatbestand eröffnet ist, ist vor allem eine Frage des **Regelungszusammenhangs** (näher dazu bei **Task 7a-7b**, 5.2.2.1.): Die Minderung der Risiken aus einer und für eine Erwerbstätigkeit einschließlich des Risikos, für nahe Angehörige aufkommen zu müssen, kann (nur) unter dem Gesichtspunkt des Sozialversicherungsrechts geregelt werden und fällt damit in die Zuständigkeit des **Bundes**. Auch die Überbrückung von Gebrechen und Unterstützung von betroffenen

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[72] Vgl nur die im Wesentlichen noch zutreffende Übersicht bei *S. Mayer/Pfeil*, Behindertenhilfe, in *Pürgy* (Hg), Das Recht der Länder, Band II/1, 385 ff (insb Rz 20ff).

[73] Diese lautet: „*Die Republik (Bund, Länder und Gemeinden) bekennt sich dazu, die Gleichbehandlung von behinderten und nichtbehinderten Menschen in allen Bereichen des täglichen Lebens zu gewährleisten*“.

[74] Vgl dazu nur *Pöschl*, Gleichheit vor dem Gesetz, 676 ff.

[75] Vgl etwa die ErläutRV zum BGStG 836 BlgNR 22. GP 6.

Menschen – unabhängig von einer Heilungschance – stellt ebenso wie die Heilung von Krankheiten kompetenzrechtlich ausschließlich Sozialversicherungsrecht dar, auch wenn der Sozialversicherungsgesetzgeber diese Kompetenz nicht ausschöpft.

Damit sind jedenfalls Maßnahmen zur **Wiederherstellung der Arbeitsfähigkeit** erfasst, die durch das Auftreten einer Behinderung ganz oder teilweise verloren gegangen ist. Aber auch soweit die Arbeitsfähigkeit nicht wieder hergestellt werden kann, fallen **Hilfen zur Überbrückung** ganz oder teilweise **ausgefallener Körperfunktionen**, die für die Arbeitsfähigkeit wesentlich sind, in dieser Konstellation kompetenzrechtlich unter das Sozialversicherungsrecht. Ebenfalls kann die Befriedigung von für den Fall einer Behinderung auftretenden Bedürfnissen – etwa zur **Besorgung der notwendigen täglichen Verrichtungen** und zur Sicherung einer angemessenen Stellung in der Gesellschaft – als Anspruch aus früherer Erwerbstätigkeit bei Verlust der Arbeitsfähigkeit unter dem Gesichtspunkt des Sozialversicherungsrechts geregelt werden.

Im Lichte der verfassungsrechtlichen Kompetenzverteilung erstreckt sich daher die (mögliche) **Zuständigkeit der Krankenversicherung** auf (insb wegen ihrer [früheren] Erwerbstätigkeit, daneben auch auf freiwillig) Versicherte und deren Angehörige, und wird dann einfachgesetzlich auf jene Personen fokussiert, deren Körper- oder Geisteszustand regelwidrig ist, aber durch (im weitesten Sinn) medizinische Maßnahmen mit vertretbarem Aufwand gebessert oder zumindest stabilisiert werden kann. Die **Ursache** dieser Regelwidrigkeit ist dabei grundsätzlich **unerheblich**, eine Differenzierung zwischen „angeborenen“ oder später erworbenen Beeinträchtigungen kommt – jedenfalls derzeit – nicht in Betracht. Insofern gelten auch für Menschen mit Behinderungen und ganz besonders für Kinder mit psychischen Störungen die auch sonst maßgebenden allgemeinen Voraussetzungen für einen Anspruch auf Krankenbehandlung bzw für die Gewährung einer medizinischen Maßnahme der Rehabilitation oder einer Hilfe bei körperlichen Gebrechen.

Eine Zuständigkeit der **Länder** kommt hier daher nur über den Kompetenztatbestand „**Armenwesen**“ nach *Art 12 Abs 1 B-VG* in Betracht, da der Bund seine dort bestehende Grundsatzgesetzgebungskompetenz nicht ausgenützt hat und die Länder damit nach *Art 15 Abs 6 B-VG* in der Regelung frei sind. Die subsidiäre Generalkompetenz der Länder nach *Art 15 Abs 1 B-VG* kommt dagegen nur zum Tragen, wenn keine Anknüpfung zu einem anderen Kompetenztatbestand (zB Dienstrecht, Sozialentschädigung oder eben Sozialversicherungsrecht) besteht.

Diese Subsidiarität kommt in den **einfachgesetzlichen** Regelungen auf **Landesebene** ebenfalls zum Ausdruck. Diese enthalten auch Regelungen im Hinblick auf Leis-

tungen der Heilbehandlung oder in Form von Hilfsmitteln etc. Trotz aller Unterschiede in Terminologie und Systematik dieser Vorschriften über die „**Behindertenhilfe**“ lassen sich in allen Ländern Regelungen ausmachen, die im weiteren Sinn der gesundheitlichen Rehabilitation dienen.[76] Dort finden sich durchwegs Leistungen der Heilbehandlung, die teilweise erkennbar jenen der Krankenversicherung nachgebildet sind, auch wenn sie der Behebung, Besserung oder Linderung von Leiden oder Gebrechen dienen, oder zumindest die Gewährung von (Zuschüssen zu) Hilfsmitteln etc zum Gegenstand haben.[77]

Diese Leistungen sind meist sogar mit **Rechtsansprüchen** ausgestattet,[78] wobei aber durchwegs Vorbehalte hinsichtlich der Verfügbarkeit der entsprechenden Ressourcen und/oder ein Auswahlermessen der zuständigen Behörden hinsichtlich der konkreten Leistungsform vorgesehen sind.[79] Vor allem aber gilt in allen Ländern strenge **Subsidiarität**, die nicht nur dann zum Tragen kommt, wenn bzw insoweit die betreffende Leistung bereits von anderer Seite tatsächlich bereits zur Verfügung steht, sondern auch, wenn diese bei anderen Stellen erlangt oder geltend gemacht werden könnte,[80] wobei es in der Regel sogar unerheblich ist, ob nach den jeweils anderen Rechtsvorschriften ein Anspruch besteht oder nicht.[81]

Damit kann **zusammenfassend** festgehalten werden, dass Leistungspflichten der Träger der gesetzlichen Krankenversicherung (oder allenfalls der Pensionsversicherung) nicht bereits deshalb ausgeschlossen sind, weil der jeweilige körperliche, geistige oder psychische Zustand einer Person (auch) als „Behinderung“ zu qualifizieren ist und daher allenfalls Ansprüche im Landesrecht auslöst: **Krankheit** und Gebrechen auf der einen und **Behinderung** auf der anderen Seite sind Begriffe, die einan-

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[76] Vgl erneut nur *S. Mayer/Pfeil*, Behindertenhilfe, in *Pürgy* (Hg), Das Recht der Länder II/1, insb Rz 24 ff.

[77] Vgl *§§ 21, 22 Burgenländisches Sozialhilfegesetz* (*BgldLGBl 2000/5 – BgldSHG*); *§ 9 Kärntner Chancengleichheitsgesetz* (*KtnLGBl 2010/85 – K-ChG*); *§§ 27, 29 Niederösterreichisches Sozialhilfegesetz* (*NÖLGBl 9200 – NÖSHG*); *§ 9 Oberösterreichisches Chancengleichheitsgesetz* (*OÖ-LGBl 2008/41 – OÖChG*); *§§ 6, 7 Salzburger Behindertengesetz* (*SbgLGBl 1981/93 – SbgBehG*); *§§ 5, 6 Steiermärkisches Behindertengesetz* (*StmkLGBl 2004/26 – StmkBHG*); *§ 5 Tiroler Rehabilitationsgesetz* (*TirLGBl 1983/58 – TirRG*); *§ 1 Vorarlberger Integrationshilfeverordnung* (*VbgLGBl 2007/22*); *§ 5 Wiener Chancengleichheitsgesetz* (*WrLGBl 2010/45 – CGW*).

[78] Grundsätzlich anders in Vorarlberg, wo das Land generell nur als Träger von Privatrechten tätig wird (vgl *§ 1 Abs 2 Vbg Chancengesetz*, *VbgLGBl 2006/30*).

[79] Vgl nur die Nachweise bei *S. Mayer*/*Pfeil* Behindertenhilfe, in *Pürgy* (Hg), Das Recht der Länder II/1, Rz 34 ff.

[80] So nach *§ 6 K-ChG*, *§ 2 Abs 5 lit c StmkBHG*, *§ 3 Abs 1 lit e TirRG* bzw *§ 5 Z 5 CGW*.

[81] So nach *§ 20 BgldSHG*, *§ 25 Abs 1 Z 2 NÖSHG*, *§ 4 Abs 1 Z 3 OÖChG* bzw *§ 2 Abs 2 lit c SbgBehG*.

der nach österreichischem Recht (einschließlich seiner internationalen bzw unionsrechtlichen Bezüge) **nicht ausschließen**, **sondern** zumindest teilweise **überlagern.**

Um das für die Krankenversicherung zuzuspitzen, heißt das: Sollte eine Maßnahme daher (1) wegen einer Regelwidrigkeit erfolgen, (2) aus medizinischer Sicht erfolgversprechend sein, (3) dem gesetzlichen Ökonomiegebot („*Maß des Notwendigen nicht überschreiten*“) entsprechen, und (4) als eine anerkannte Maßnahme im Rahmen der Krankenbehandlung anzusehen sein, besteht ein Anspruch auf eine solche Krankenbehandlung auch für die Bewältigung (der Auswirkungen) eines Zustands, der als Behinderung qualifiziert wird. Wegen des engen Krankheitsbezugs gelten diese Voraussetzungen auch für die Gewährung von medizinischen Maßnahmen der Rehabilitation und – innerhalb der Grenzen von Bestimmungen wie *§ 154 ASVG* – auch für Hilfen bei körperlichen Gebrechen.

Eine **Zuständigkeit der Krankenversicherung für die „Rehabilitation** von Menschen mit Behinderungen“ kann demnach derzeit im Grunde nur in folgenden Fällen **ausgeschlossen** werden:

(1) Es handelt sich um Personen, die **weder** als (Pflicht- oder auch freiwillig) **Versicherte noch** als **Angehörige** von der gesetzlichen Krankenversicherung erfasst sind. Für diese Personen besteht weder von Verfassungs wegen noch auf Grund sozialversicherungsrechtlicher Regelungen eine Leistungspflicht, auch wenn der Zustand der Betroffenen als Krankheit oder Gebrechen zu qualifizieren wäre. Solche Fälle werden sehr **selten** sein. Sollte diese Konstellation dennoch auftreten, können die auf landesrechtlicher Ebene durchwegs bestehenden Subsidiaritätsvorbehalte nicht durchschlagen, der im jeweiligen Land zuständige Träger hätte vielmehr – meist sogar auf Grund von Rechtsansprüchen – Leistungen im Rahmen der gesundheitlichen Rehabilitation zu gewähren.

(2) Praktisch wichtiger ist gewiss die Abgrenzung an Hand des **Inhalts** der Maßnahme und der (**berufsrechtlichen**) Voraussetzungen für deren Erbringung. Eindeutig aus der Zuständigkeit der gesetzlichen Krankenversicherung auszuscheiden sind damit Maßnahmen, die keinen (nennenswerten) medizinischen Bezug (und auch keinen Bezug zu einer iSd *§ 135 Abs 1 ASVG* [oder analogen Bestimmungen in den Sondergesetzen] gleichgestellten Gesundheitsdienstleistung) und damit zur Krankenbehandlung aufweisen. Dazu gehören vor allem solche, bei denen der (insb sozial- oder sonder)pädagogische, sozial- oder familienarbeiterische Aspekt oder die unmittelbare Hilfe bei der alltäglichen Lebensführung im Vordergrund steht. Auch Hilfsmittel, bei denen diese Zwecke dominieren (zB spezielle Lernmaterialien oder Lernhil-

fen), sind weder der Krankenbehandlung oder der medizinischen Rehabilitation noch den Hilfen bei Gebrechen zuzurechnen.

(3) Weitere Einschränkungen können sich im Einzelfall ergeben, wenn ein Zustand als nicht mehr besserbar und auch nicht mehr stabilisierbar zu qualifizieren ist.[82]

4.4. Abgrenzung der Zuständigkeiten zwischen den Trägern der Kranken- bzw der Pensionsversicherung

Wenn nun eine weitgehende grundsätzliche Zuständigkeit der Träger der Sozialversicherung auch für Kuren und Rehabilitation anzunehmen ist, stellt sich noch die Frage, welcher Zweig der Sozialversicherung der „wirklich zuständige" ist. Die (oben 4.2. angestellte) Bestandsaufnahme hat dazu nur teilweise ein klares Bild ergeben. Wie zuvor soll hier ebenfalls zwischen medizinischen Maßnahmen der Rehabilitation und solchen zur Festigung der Gesundheit bzw der Gesundheitsvorsorge differenziert werden.

4.4.1. Medizinische Maßnahmen der Rehabilitation

Zunächst sei noch einmal daran erinnert, dass jene Konstellationen völlig unproblematisch erscheinen, bei denen der Bedarf durch einen Arbeitsunfall oder eine Berufskrankheit ausgelöst wurde. In diesem Fall hat der **Unfallversicherungsträger** im Rahmen der **Unfallheilbehandlung** „mit allen geeigneten Mitteln" die Gesundheitsstörung, Körperschädigung und Minderung der Erwerbsfähigkeit bzw der Fähigkeit zur Besorgung der lebenswichtigen persönlichen Angelegenheiten zu beseitigen oder zumindest zu bessern bzw eine Verschlimmerung zu verhüten (vgl jeweils *Abs 1* in *§ 189 ASVG, § 148p BSVG* bzw *§ 96 B-KUVG*). Diese Maßnahmen sind dann – und zwar auf Grund von **Rechtsansprüchen** – **so lange und so oft** zu gewähren, als eine Besserung zu erwarten ist oder eine Verschlimmerung verhütet werden kann (*§ 190 ASVG, § 148q BSVG, § 97 B-KUVG*).

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[82] Abgesehen von den mit einer Ablehnung der Gewährung von Leistungen verbundenen sozialen Härten ist hier freilich (wohl gerade wegen dieser) zu erwarten, dass die **Judikatur** insb bei Kindern den Krankheitsbegriff bzw die Erreichbarkeit der Ziele der Krankenbehandlung, der Hilfen bei Gebrechen oder der medizinischen Rehabilitation eher weit verstehen und eine Leistungspflicht der Krankenversicherung tendenziell bejahen wird.

Bei allen anderen Fällen könnte es insofern Abgrenzungsprobleme geben, als sich sowohl im Kranken- als auch im Pensionsversicherungsrecht **Subsidiaritätsvorbehalte** finden, die eine eigene Leistungsgewährung erst dann vorsehen, wenn nicht bereits ein Träger aus dem jeweils anderen Zweig Leistungen gewährt.[83] Dieser Widerspruch lässt sich – zumindest teilweise – auflösen, wenn man die einzelnen **AdressatInnenkreise** der jeweiligen Regelungen näher betrachtet. Dabei lassen sich grundsätzlich **drei Fallgruppen** bilden.

4.4.1.1. Zuständigkeit der Pensionsversicherung

Die erste umfasst jene Personen, für die eindeutig die Pensionsversicherungsträger zuständig sind, so dass insofern die Vorbehalte wie in *§ 154a Abs 3 ASVG* durchschlagen und daher die Gewährung medizinischer Maßnahmen der Rehabilitation für den betreffenden **Krankenversicherungsträger nicht** in Betracht kommt.

Das gilt zunächst für nach dem ***ASVG* Pensionsversicherte**, für die bescheidmäßig eine zwar vorübergehende, aber doch zumindest sechs Monate dauernde **geminderte Arbeitsfähigkeit** festgestellt wurde, sofern diese Maßnahmen zur Wiederherstellung der Arbeitsfähigkeit notwendig und infolge des Gesundheitszustands auch zweckmäßig sind (*§§ 253f, 270b* bzw *276f ASVG*). **Unklar** und (wohl nicht nur im vorliegenden Zusammenhang) ohne gesetzgeberische Klarstellungen in vielen Fällen nicht überzeugend lösbar ist hier freilich die Frage, wo die **Grenze zwischen medizinischen Maßnahmen der Rehabilitation und Krankenbehandlung** zu ziehen ist.

Der Kreis der nach *§§ 253f, 270b* bzw *276f ASVG* Anspruchsberechtigten weist Ähnlichkeiten mit einer der Zielgruppen nach *§ 300 Abs 1 ASVG* auf, weil auch bei den dort erfassten „*Beziehern einer Pension aus einem Versicherungsfall der geminderten Arbeitsfähigkeit*“ vorausgesetzt ist, dass „*deren Arbeitskraft infolge einer körperlichen, geistigen oder psychischen Beeinträchtigung herabgesunken ist*“. Zwar wird für einen Anspruch auf medizinische Maßnahmen im Rahmen des „Rehabilitation vor Pension“-Konzepts ein solches Herabsinken regelmäßig vorliegen, bei den betreffenden Personen handelt es sich aber gerade nicht um PensionsbezieherInnen. Wird nun aber eine Pension bei geminderter Arbeitsfähigkeit[84] – wegen dauerhafter Invalidität oder Berufsunfähigkeit – **bezogen**, liegt ein Fall des *§ 300 Abs 1 ASVG* und damit grundsätzlich auch eine Zuständigkeit des **Pensionsversicherungsträgers** für

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[83] Vgl noch einmal einerseits jeweils *Abs 3* von *§ 154a ASVG, § 99a GSVG* bzw *§ 96a BSVG,* andererseits jeweils *Abs 2* in *§ 302 ASVG, § 160 GSVG* bzw *§ 152 BSVG*.

[84] Mit Ausnahme der ausdrücklich ausgeschlossenen Sonderform für im Bergbau tätig gewesene Versicherte, der Knappschaftspension iSd *§§ 277, 278 ASVG*.

medizinische Maßnahmen der Rehabilitation vor. Gleiches gilt auf Grund der *§ 157 Abs 1 GSVG* bzw *§ 150 Abs 1 BSVG* für erwerbsunfähige **Selbständige**.

Als einzige **Hürde** für die Zuständigkeit des Pensionsversicherungsträgers bleibt für BezieherInnen einer Pension wegen geminderter Arbeitsfähigkeit damit die Erreichbarkeit des **Ziels** der Rehabilitationsmaßnahmen, das in allen Pensionsversicherungsgesetzen mit der weitestmöglichen beruflichen und wirtschaftlichen bzw sozialen Integration umschrieben wird (vgl jeweils *Abs 3* in *§ 300 ASVG, § 157 GSVG* bzw *§ 150 BSVG*). Damit kommen Rehabilitationsmaßnahmen hier nicht in Betracht, wenn die wirtschaftliche und soziale Integration der versicherten Person von dem jeweils in *Abs 1* der genannten Bestimmungen geforderten Herabsinken der Arbeitskraft gar nicht nachteilig betroffen ist.[85]

In allen **anderen** (und praktisch wohl ungleich häufigeren) Fällen ist bei BezieherInnen einer Pension wegen geminderter Arbeitsfähigkeit grundsätzlich eine Zuständigkeit des jeweiligen Pensionsversicherungsträgers für medizinische Maßnahmen der Rehabilitation gegeben. Da es sich bei diesen Personen aber auch um Versicherte in der Krankenversicherung handelt, ist auch der AdressatInnenkreis der dortigen Regelungen eröffnet. Eine **Abgrenzung** in diesen Fällen scheint nicht über die – nahezu wortgleich formulierten – Ziele der jeweiligen Rehabilitation möglich, sondern nur im Hinblick darauf, dass medizinische Maßnahmen der Rehabilitation in der Krankenversicherung nur im Anschluss an eine Krankenbehandlung möglich sind (dazu sogleich 4.4.1.3.).

4.4.1.2. Zuständigkeit der Krankenversicherung

Ebenfalls eindeutig ist die Zuständigkeit für medizinische Maßnahmen der Rehabilitation für bloße **Angehörige**. Im Rahmen der Pensionsversicherung können diesen Personen nur Maßnahmen in Form der Unterbringung in Krankenanstalten, die vorwiegend der Rehabilitation dienen, gewährt werden. Auch dies setzt aber (nach jeweils *Abs 2* in *§ 301 ASVG, § 158 GSVG* bzw *§ 150a BSVG*) voraus, dass zum einen die eigenen Einrichtungen des betreffenden Trägers nicht ausgelastet sind, und dass zum anderen der/die Angehörige (oder die eine **Waisenpension** beziehende Person) an einer körperlichen, geistigen oder psychischen **Behinderung** leidet und dem/der Versicherten (Pensionsbezieher/in) ohne die Maßnahmen Auslagen erwachsen würden, die seine/ihre **wirtschaftlichen Verhältnisse** übersteigen würden.

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[85] Vgl *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 300 ASVG Rz 33.

Von diesen von Leistung wie von der Zielgruppe eng umschriebenen Ausnahmefällen abgesehen, kommen medizinische Maßnahmen der Rehabilitation für (Nur-)**Angehörige** im Rahmen der Pensionsversicherung **nicht** in Betracht.[86] Die Verantwortung für die Erbringung dieser Maßnahmen liegt also (nach *§ 154a ASVG, § 99a GSVG, § 96a BSVG* bzw *§ 65a B-KUVG*) allein bei den Trägern der **Krankenversicherung**. Diese können lediglich die Durchführung der betreffenden Maßnahmen einem Pensionsversicherungsträger gegen (allenfalls auch pauschalierten) Ersatz der Kosten übertragen. Deren originäre Zuständigkeit ist dagegen nach jeweils *Abs 2* in *§ 302 ASVG, § 160 GSVG* bzw *§ 152 BSVG* ausgeschlossen.

Klar geregelt scheint die Aufgabenverteilung im Hinblick auf medizinische Maßnahmen der Rehabilitation weiters für BezieherInnen einer Pension, die nicht aus einem der Versicherungsfälle der geminderten Arbeitsfähigkeit resultiert, also BezieherInnen einer **Alters- oder Hinterbliebenenpension**,[87] denen durch die ebenfalls schon erwähnte ausdrückliche Ausnahme in *§ 300 Abs 1 ASVG* auch die Knappschaftspension gleichgestellt ist. Auch für diese Personen kommt eine Rehabilitationsleistung aus der Pensionsversicherung **nicht** in Betracht, so dass die Subsidiaritätsregeln jeweils in *Abs 3* von *§ 154a ASVG, § 99a GSVG* bzw *§ 96a BSVG* ins Leere gehen und damit eine Zuständigkeit der **Krankenversicherungsträger** besteht.[88] Gleiches gilt – dort in Ermangelung einer Subsidiaritätsregelung – auch für die nach *B-KUVG* erfassten Versicherten (vgl dessen *§ 65a*).

Die Leistungsgewährung durch diese erfordert freilich noch das Vorliegen der dortigen Voraussetzungen, also zum einen die Erreichbarkeit der **Ziele** der Rehabilitation, dh der Sicherung des Erfolgs der Krankenbehandlung bzw der Erleichterung der Folgen der Krankheit, und damit zum anderen, dass **vorher eine Krankenbehandlung** stattgefunden hat. Fehlt eine dieser Voraussetzungen, kann die medizinische Rehabilitation solchen PensionsbezieherInnen nicht nur vom Träger der Pensionsversicherung, sondern auch von jenem der Krankenversicherung verweigert werden. An-

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[86] Von diesem Prinzip wollte das *Regierungsübereinkommen der Bundesregierung aus 2013* offenbar abgehen, war doch dort (52) vorgesehen, dass „im Rahmen einer Rehabilitations-Gesamtstrategie sichergestellt werden“ sollte, „dass ab 2015 Rehabilitation für alle SeniorInnen von der Pensionsversicherung angeboten wird“. Diese Zuordnung scheint im Hinblick auf Personen, die weder erwerbstätig sind noch als solche bereits in der Pensionsversicherung erfasst waren, nicht unproblematisch.

[87] Noch einmal sei auf die ausnahmsweise Möglichkeit der Gewährung von Maßnahmen der medizinischen Rehabilitation durch die Pensionsversicherung an BezieherInnen einer Waisenpension erinnert, die an einer körperlichen, geistigen oder psychischen Behinderung leiden (vgl jeweils *Abs 2* in *§ 301 ASVG, § 158 GSVG* bzw *§ 150a BSVG*).

[88] Nach dem Plan im *Regierungsübereinkommen 2013* sollte die Pensionsversicherung dagegen in Hinkunft auch für die Rehabilitation dieser Personen zuständig sein.

deres gilt nur, wenn es sich bei dieser Person um eine/n „**Versicherte/n**“ handelt. Auf diese Konstellation ist daher jetzt einzugehen.

4.4.1.3. Zuständigkeit der Kranken- wie der Pensionsversicherung (?)

Medizinische Maßnahmen der Rehabilitation kommen sowohl in der Kranken- als auch in der Pensionsversicherung – von der Systematik sogar vorrangig – für die jeweils **Versicherten** in Betracht. Soweit es sich dabei um Vollversicherte handelt, sind die betreffenden Personen in beiden Zweigen vom grundsätzlichen Geltungsbereich der Rehabilitationsbestimmungen erfasst. Neben den „Nur-**Erwerbstätigen**“ gilt das insb auch für Personen, die neben einem Pensionsbezug noch erwerbstätig sind. Sowohl in der Kranken- wie in der Pensionsversicherung versichert sind allerdings etwa auch **BezieherInnen** von Leistungen aus der **Arbeitslosenversicherung**, aber allenfalls auch von Kinderbetreuungsgeld.

Diese Überschneidung wird tendenziell noch größer, weil nach den ***RRK 2005*** als in der Pensionsversicherung versichert nicht nur Personen gelten, die zum Zeitpunkt der Antragstellung oder der Einleitung des Verfahrens durch den Versicherungsträger aktuell in der Pensionsversicherung pflicht- oder freiwillig versichert sind. Nach deren *§ 2 Abs 2 lit b* sind vielmehr auch Personen erfasst, die **unmittelbar zuvor** gewisse **Mindestversicherungszeiten** erworben haben.[89] Damit soll offenbar sichergestellt werden, dass die Pensionsversicherung ihrer Rehabilitationsaufgabe auch bei – vielleicht sogar wegen des Herabsinkens der Arbeitskraft (vgl *nur § 300 Abs 1 ASVG*) – aus dem Erwerbsleben herausgefallenen Versicherten erfüllen kann.[90]

Dies entspricht auch der offenkundigen **Praxis**, nach der medizinische Maßnahmen der Rehabilitation für **Erwerbstätige**[91] durchwegs von der **Pensionsversicherung** gewährt werden.[92] Das mag angesichts des Umstandes, dass die Pensionsversicherungsträger (mehr als andere Träger) über – zumal offenbar besonders geeignete – Rehabilitationseinrichtungen verfügen, durchaus sinnvoll sein. Aus den bestehenden gesetzlichen Regelungen ergibt sich das freilich nur insoweit zwingend, als die sachlichen Voraussetzungen im Bereich der Krankenversicherung enger formuliert sind, weil dort medizinische Maßnahmen der Rehabilitation nur im **Anschluss an eine**

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89 Konkret reicht alternativ eine der folgenden Anzahlen von Versicherungsmonaten im Zeitraum der letzten Kalendermonate: drei in 12 (aa), 12 in 36 (bb) oder 60 in 120 (cc).

90 Vgl *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 300 ASVG Rz 7.

91 Und zwar auch, wenn sie bereits eine Pension beziehen, weil sie nach *§ 4 Abs 1 RRK 2005* für die Feststellung der Leistungszugehörigkeit als „Versicherte“ gelten.

92 Vgl nur *Burger*/*Ivansits*, DRdA 2013, 106 (109).

Krankenbehandlung gewährt werden können. Daraus ist aber gerade keine schematische Abgrenzung des Personenkreises zu gewinnen.

Auch dieser engere Spielraum für die Krankenversicherungsträger lässt die generelle Erfassung von Erwerbstätigen durch die Pensionsversicherungsträger pragmatisch und zweckmäßig erscheinen. Eine präzisere Abgrenzung der Zuständigkeiten könnte (und sollte) aber **rechtspolitisch** über die **gesetzliche Definition des jeweiligen AdressatInnenkreises** erreicht werden. Das muss freilich mit einer **Klärung des Verhältnisses zwischen Krankenbehandlung und medizinischer Rehabilitation** einhergehen.

4.4.2. Maßnahmen zur Festigung der Gesundheit bzw der Gesundheitsvorsorge

Auch bei den Maßnahmen zu Festigung der Gesundheit bzw der Gesundheitsvorsorge, insb in Form von Kuraufenthalten bestehen ähnliche Abgrenzungsprobleme, wenngleich diese Maßnahmen ausdrücklich nicht zu den Maßnahmen der medizinischen Rehabilitation zählen (vgl nur *§ 154a Abs 6* bzw *§ 300 Abs 4 ASVG*).

Eindeutig ist die Rechtslage wieder im Hinblick auf **Angehörige**, bei denen die Gewährung von Kuraufenthalten etc in die Zuständigkeit der **Krankenversicherungsträger** fällt (vgl *§ 155 ASVG, § 100 GSVG, § 100 BSVG, § 70a B-KUVG*).[93]

Die letztgenannten Bestimmungen erfassen aber auch **Versicherte** (in der Krankenversicherung) und damit auch PensionistInnen. Für **Versicherte** (in der Pensionsversicherung), wobei in diesem Fall unerheblich ist, um welche Art der Pension es sich handelt, und **BezieherInnen einer Pension** sind jedoch die Träger der **Pensionsversicherung** ebenfalls zuständig (vgl jeweils *Abs 1* in *§ 307d ASVG, § 169 GSVG bzw § 161 BSVG*).

Abgrenzungsregelungen wie bei den medizinischen Maßnahmen der Rehabilitation bestehen hier nicht. **Praktisch** dürfte die Abgrenzung so erfolgen, dass die Träger der Krankenversicherung sich auf Erholungs- und Genesungsaufenthalte beschränken, während die „höherwertigen" Kuraufenthalte bzw (in Bestimmungen wie *§ 155 ASVG* ohnedies nicht vorgesehenen) Aufenthalte in Rehabilitationskliniken von den Pensionsversicherungsträgern gewährt werden.[94] Diese faktische Aufteilung wurde durch die Straffung der Leistungskataloge der einschlägigen pensionsversicherungs-

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[93] Noch einmal ist aber auf die Ausnahmen nach jeweils *Abs 4* in *§ 307d ASVG, § 169 GSVG* bzw *§ 161 BSVG* zu verweisen, nach denen bei der Gefahr einer tuberkulösen Erkrankung auch Angehörigen Maßnahmen der Gesundheitsvorsorge im Rahmen der Pensionsversicherung gewährt werden können.

[94] Vgl *Bergauer*, in *Mosler*/*Müller*/*Pfeil* (Hg), Der SV-Komm, § 307d ASVG Rz 7.

rechtlichen Bestimmungen im Zuge des *SRÄG 2015* (*BGBl I 2015/162*) unterstrichen. Eine **präzise Abgrenzung der Zuständigkeit wäre rechtspolitisch** gleichwohl **wünschenswert**, wenn nicht sogar geboten.

4.5. Zusammenfassung

➔ Für die Gewährung von Leistungen im Rahmen der medizinischen Rehabilitation bzw von Kuraufenthalten oder anderen Maßnahmen zur Festigung der Gesundheit oder der Gesundheitsvorsorge bestehen derzeit zahlreiche Regelungen. Diese unterscheiden sich im Leistungsinhalt, vor allem aber im Hinblick auf die – häufig wenig klaren – Zuständigkeiten, die für die Personen, die diese Leistungen in Anspruch nehmen wollen, nicht selten mit Schwierigkeiten und Unsicherheiten verbunden sind.

Zuständigkeitsprobleme bestehen zum einen im Verhältnis zwischen den Sozialversicherungsträgern und den Ländern, die durchwegs Regelungen im Rahmen der „Behindertenhilfe“ getroffen haben. Zuständigkeitsprobleme bestehen aber auch zwischen den Träger der Krankenversicherung und jenen der Pensionsversicherung.

➔ Im Verhältnis zu den Ländern ist regelmäßig entscheidend, ob bei der betreffenden Person ein Zustand vorliegt, der eine Krankenbehandlung notwendig macht oder im unmittelbaren Zusammenhang mit einer solchen Krankenbehandlung steht. Ist dies der Fall, besteht regelmäßig auch eine Zuständigkeit der Krankenversicherungsträger, die auch medizinische Maßnahmen der Rehabilitation (insb auch für Kinder und Jugendliche) einschließt.

Die Krankenversicherungsträger können diese Zuständigkeit nicht mit dem Hinweis abwehren, dass es sich hier um „Menschen mit Behinderungen“ handelt, für die insoweit die Länder zuständig sind. Diese Auffassung lässt sich weder aus der verfassungsrechtlichen Kompetenzverteilung noch aus der einfachgesetzlichen Rechtslage (nicht zuletzt vor dem Hintergrund der strengen Subsidiaritätsbestimmungen auf Landesebene) ableiten.

Eine Zuständigkeit der Krankenversicherungsträger für Rehabilitationsmaßnahmen kann letztlich nur dort nachhaltig verneint werden, wo Maßnahmen nach ihrem Inhalt und den (insb berufsrechtlichen) Voraussetzungen für deren Erbringung keinen nennenswerten Bezug zur Krankenbehandlung aufweisen (zB sozial- oder sonderpädagogische Maßnahmen bzw solche der Sozial- oder Familienarbeit), oder wo im Ein-

zelfall ein Zustand eindeutig als nicht mehr besserbar und auch nicht mehr stabilisierbar zu qualifizieren ist.

➔ Während die Abgrenzung zur Unfallversicherung im Hinblick auf deren kausale Ausrichtung regelmäßig unproblematisch ist, ist jene zwischen Kranken- und Pensionsversicherung nicht eindeutig. Die praktizierte Aufteilung (im Wesentlichen: Erwerbstätige und BezieherInnen einer Pension bei geminderter Arbeitsfähigkeit bei den Pensionsversicherungsträgern, andere PensionistInnen und bloße Angehörige bei den Krankenversicherungsträgern) macht zwar durchaus Sinn, bedürfte aber einer deutlicheren gesetzlichen Grundlegung. Eine gesetzliche Grundlage wäre auch notwendig, wenn das noch im Regierungsübereinkommen der Bundesregierung aus 2013 formulierte Ziel umgesetzt werden soll, die Rehabilitation für alle SeniorInnen (gemeint war dort wohl: alle BezieherInnen einer Pension) generell von der Pensionsversicherung anzubieten.

➔ Auch damit wäre freilich die problematische Differenzierung zwischen Krankenbehandlung und medizinischen Maßnahmen der Rehabilitation nicht überwunden. Das gilt zunächst im Hinblick auf das (weitgehende) Fehlen von Abgrenzungskriterien, die jedoch angesichts der zersplitterten Zuständigkeiten und der Unterschiede hinsichtlich des Bestehens von Rechtsansprüchen unbedingt erforderlich wären. Diese Unterschiede sollten zur Vermeidung von verfassungsrechtlich bedenklichen Situationen abgebaut werden.

Noch wichtiger wäre freilich eine Überwindung der – sachlich nicht mehr aufrecht zu erhaltenden – Trennung zwischen Krankenbehandlung und medizinischen Maßnahmen der Rehabilitation, und zwar in inhaltlicher Hinsicht wie im Hinblick auf deren zeitliche Abfolge: Rehabilitationsmaßnahmen sind oft auch schon während einer Krankenbehandlung notwendig und sind vielfach bereits als deren integrativer Bestandteil zu sehen.

➔ Im Hinblick auf Kuraufenthalte etc wäre ebenfalls eine deutlichere gesetzliche Abgrenzung erforderlich. Eine solche würde auch die – gerade unter Transparenz- wie Harmonisierungsgesichtspunkten gebotene – Einräumung von Rechtsansprüchen (die auch an bestimmte Voraussetzungen wie Wartezeit oä geknüpft sein könnten) erleichtern.

5. Task 7a-7b:
Änderungen der Organisationsstruktur der Sozialversicherungsträger aus verfassungsrechtlicher Sicht[95]

5.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„NORMATIVE GRUNDLAGEN: Analyse des Ist-Stands“** folgende Passage (6f):

> **„Verfassungsfragen**
>
> **Kompetenzverteilung des Bundesverfassungsgesetzes**
>
> Basis der Überlegungen ist die **zwischen Bund und Ländern** bestehende **Kompetenzlage** des Bundesverfassungsgesetzes (B-VG), insbesondere im Gesundheitswesen: Die Zuständigkeit der Sozialversicherung betrifft den extramuralen Bereich, verbunden mit einem großen Anteil der Krankenanstalten-Finanzierung. Dem gegenüber steht der Versorgungsauftrag der Länder für die Krankenanstalten. Sozialversicherungsrecht ist verfassungsgesetzlich Bundessache in Gesetzgebung und Vollziehung (Art 10 B-VG). Im Bereich der Krankenanstalten liegt die Grundsatz-Gesetzgebung beim Bund, die Ausführungs-Gesetze, sowie die Vollziehung sind Landessache (Art 12 B-VG). Das bedeutet, dass die Kompetenzlage mehrfach asymmetrisch verteilt ist. Demgegenüber sind die Krankenfürsorgeanstalten der Länder dienstherrliche Einrichtungen von Gebietskörperschaften (Art 21 B-VG).
>
> Das **Prinzip** der **Selbstverwaltung** ist in der Bundesverfassung verankert. Von diesem Prinzip als funktionierende Grundlage der Sozialversicherung auf der einen Seite und den Ärztekammern, der Apothekerkammer, der Wirtschaftskammern, der Zahnärztekammern und weiterer Leistungsanbieter auf der anderen Seite ist auszugehen.
>
> **Organisationsstruktur-Änderungen durch Verfassungs- oder einfachen Bundesgesetzgeber?**
>
> Als Basis der juristischen Analyse sind vor allem die verfassungsrechtlichen Fragestellungen einer Prüfung zu unterziehen. Es ist aus rechtlicher Sicht zu klären, ob die be-

[95] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* und unter Berücksichtigung von Hinweisen von *Walter Pöltner* verfasst.

stehende Trägerlandschaft einfachgesetzlich oder nur mit **Verfassungsmehrheit** einer **Strukturanpassung** unterworfen werden kann."

Daraus wurden folgende **Aufgabenstellungen** abgeleitet (7):

„Gibt es eine verfassungsgesetzlich verankerte Bestandsgarantie für die nach Berufsgruppen und/oder regional und/oder bundesweit organisierten Kranken-, Unfall- und Pensionsversicherungsträger und die Krankenfürsorgeanstalten?

Gebietet die Bundesverfassung die Bildung von unterschiedlichen Versichertengemeinschaften (Unselbstständige, Selbstständige) oder ist dem Gesetzgeber die Strukturgestaltung der Selbstverwaltung frei überlassen?"

Diese beiden Aufgabenstellungen sind von grundlegender Bedeutung für einige andere Aufgabenstellungen im Rahmen dieser Studie. Ihre Behandlung erfolgt daher in der Form, dass zunächst der verfassungs- und einfachgesetzliche Rahmen für die bestehende Organisation der Sozialversicherung und andere Formen der öffentlichen Absicherung gegen Risiken wie Krankheit dargestellt werden. Auf dieser Basis ist dann der Frage nachzugehen, welche (insb verfassungs-)rechtlichen Hindernisse einer Änderung der Organisationsstruktur (also einer Umgestaltung der bestehenden „Trägerlandschaft") entgegenstehen (5.2.). Die Ergebnisse dieser Analysen und die daraus für die Studie zu ziehenden Schlussfolgerungen (5.3.) werden dann auch im Hinblick auf die Möglichkeiten eines Risikostrukturausgleichs ergänzt (5.4.).

5.2. Bestehender rechtlicher Rahmen

5.2.1. Eingrenzung des Untersuchungsgegenstandes

Die Studie zielt erklärtermaßen auf die Gesundheitsversorgung und nur am Rande auch auf das Pensionssystem ab. Im Mittelpunkt des Interesses steht daher eindeutig das **öffentliche Gesundheitssystem**, dessen organisatorische und institutionelle Ausgestaltung in der Folge näher zu untersuchen ist.

Dieses System ist geprägt von einer nahezu die gesamte Wohnbevölkerung erfassenden **sozialen Krankenversicherung**, deren gesetzliche Grundlagen auf der einen Seite Leistungsansprüche und auf der anderen Seite rechtliche Vorkehrungen (wie zB privatrechtliche Normenverträge) vorsehen, um diese Ansprüche grundsätzlich durch private Anbieter, ausnahmsweise auch durch eigene Einrichtungen zu erfüllen. Die Krankenversicherung beruht auf **bundesgesetzlichen** Regelungen, die

ihrerseits auf dem verfassungsrechtlichen Kompetenztatbestand „*Sozialversicherungswesen*“ (*Art 10 Abs 1 Z 11 B-VG*) basieren. Nach dieser Bestimmung liegt nicht nur die Gesetzgebung, sondern auch die Vollziehung dieser Materie beim Bund, der diese Aufgabe aber nicht staatlichen Behörden, sondern gesetzlich eingerichteten **Selbstverwaltungseinrichtungen**, den Sozialversicherungsträgern, überantwortet hat. Für diese Selbstverwaltung – deren Verfassungsmäßigkeit der VfGH nie in Zweifel gezogen hat – bestehen seit der *B-VG-Novelle BGBl I 2008/2* mit den *Art 120a* bis *120c B-VG* besondere verfassungsrechtliche Regelungen.

Ebenfalls dem Kompetenztatbestand „*Sozialversicherungswesen*“ unterstellt sind die gesetzliche Unfallversicherung und Pensionsversicherung, die in ihrer Vollziehung auch von Selbstverwaltungseinrichtungen besorgt werden: Die **Unfallversicherung** trifft – neben der Aufgabe zur Mitwirkung an Maßnahmen der Unfallverhütung – Vorsorge für den Schutz bei Arbeitsunfällen und Berufskrankheiten, wobei sich das Leistungsspektrum (Geldleistungen, Heilbehandlung, Anstaltspflege, Rehabilitation) weitgehend mit jenem der Krankenversicherung deckt und die Durchführung der Maßnahmen (ausgenommen Geldleistungen und Rehabilitation) primär in der faktischen Verantwortung der Krankenversicherungsträger gegen nachträgliche (allerdings weitgehend pauschalierte) Verrechnung mit den Trägern der Unfallversicherung liegt.[96]

Die **Pensionsversicherung** trifft Vorsorge bei Alter und dauernder Arbeitsunfähigkeit durch Geldleistungen (Pensionen), aber auch durch Maßnahmen medizinischer und beruflicher Rehabilitation.[97] In beiden Zweigen der Sozialversicherung werden also auch Aufgaben wahrgenommen, die dem Gesundheitssystem zugerechnet werden können: Man denke etwa an besondere Behandlungsmethoden oder -Einrichtungen für Menschen, die einen Arbeitsunfall erlitten haben, und für die daher die Unfallversicherungsträger (vorrangig) zuständig ist, oder an Maßnahmen der (auch medizinischen) Rehabilitation für Menschen mit geminderter Arbeitsfähigkeit, für welche die Verantwortung (zu einem großen Teil) bei den Pensionsversicherungsträgern liegt. Die im vorliegenden Abschnitt zu behandelnden strukturellen Fragen hängen freilich vor allem mit dem Kompetenztatbestand „*Sozialversicherungswesen*“ und dem Prinzip der Selbstverwaltung sowie allenfalls mit dem insb aus dem *Art 7 B-VG* abzuleitenden allgemeinen Sachlichkeitsgebot zusammen und stellen sich somit für alle Zweige der Sozialversicherung in (weitgehend) gleicher Weise. Daher ist in diesem Kontext ein Eingehen auf Unfall- bzw Pensionsversicherung nicht erforderlich.

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96 Näher dazu bei **Task 13c**, unten 10.2.

97 Vgl dazu bereits bei **Task 2d**, oben 4.2.2.

Von der damit **vorrangig** interessierenden **gesetzlichen Krankenversicherung** sind fast alle Erwerbstätigen und deren Angehörige erfasst. Dazu kommen auch die BezieherInnen von meist (aber nicht notwendigerweise) aus einer vorherigen Erwerbstätigkeit abgeleiteten Geldleistungen aus anderen Teilen des Sozialsystems,[98] sowie freiwillig versicherte Personen (vgl nur *§ 16 ASVG*). All diese Personen sind im Wesentlichen nach **Berufsgruppen** zusammengefasst und unterschiedlichen Systemen zugeordnet, für die – zumindest teilweise – jeweils eigene gesetzliche Regelungen gelten und unterschiedliche Träger zuständig sind.

Diese Regelungen finden sich für die meisten unselbständig Erwerbstätigen, namentlich für DN, freie DN sowie in Eisenbahn- oder Bergbaubetrieben Beschäftigte im ***ASVG***, und für die anderen unselbständig Tätigen, insb wenn sie bei einer Gebietskörperschaft beschäftigt sind, im ***B-KUVG***. Für die meisten selbständig Erwerbstätigen ist die Krankenversicherung im ***GSVG*** geregelt, das insb für in der gewerblichen Wirtschaft Tätige, aber wegen des Auffangtatbestandes in *§ 2 Abs 1 Z 4 GSVG* auch für die meisten anderen selbständigen Tätigkeiten, die eine betriebliche Tätigkeit ausüben (die sogenannten „Neuen Selbständigen"), sowie auf Grund der Verweisung im ***FSVG*** auch für einige Gruppen der freiberuflich Selbständigen maßgebend ist.[99] Die Krankenversicherung der in der Land- und Forstwirtschaft selbständig Erwerbstätigen richtet sich nach dem ***BSVG***.

Übt eine Person mehrere unterschiedliche Tätigkeiten aus, ist sie grundsätzlich bei jeder dieser Tätigkeiten im betreffenden System pflichtversichert. Eine **Wahlmöglichkeit** in dem Sinne, dass nur eine Pflichtversicherung aus mehreren ausgewählt werden könnte, besteht dagegen **nicht**.[100] Im Hinblick auf den Grundsatz der **Mehrfachversicherung** erscheint wesentlich, dass diese derzeit in der gesetzlichen Krankenversicherung und in der Unfallversicherung für unselbständig Erwerbstätige und

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[98] Vgl auf der einen Seite etwa BezieherInnen einer Pension oder von Geldleistungen bei Arbeitslosigkeit, auf der anderen Seite etwa AsylwerberInnen oder BezieherInnen einer Leistung der bedarfsorientierten Mindestsicherung (vgl *§ 1 Z 17* bzw *20* der *Verordnung BGBl 1969/420* zuletzt idF *BGBl II 2010/262*).

[99] Allerdings enthält *§ 5 GSVG* die Möglichkeit eines „opting-out" für eine gesamte Berufsgruppe auf Grund eines Antrags ihrer jeweiligen gesetzlichen beruflichen Vertretung (zB Rechtsanwaltskammer). Diese Möglichkeit bestand bis 1999 und führt nur dann zu einer Ausnahme von der Pflichtversicherung, wenn es für diese Berufsgruppe ein „*zumindest annähernd gleichwertiges*" internes System gibt. Zu den in diesem Zusammenhang für Angehörige freier Berufe bestehenden berufsständischen Versorgungsystemen s unten 5.2.3.2.

[100] Eine Wahlmöglichkeit besteht allerdings dann im Leistungsrecht insofern, als Mehrfachversicherte in der Krankenversicherung wählen können, auf Grund welcher Versicherung sie Sachleistungen in Anspruch nehmen wollen, was insb zu einer Wahlmöglichkeit in Bezug auf die LeistungerbringerInnen und hinsichtlich der Selbstbehalte führt; s bereits bei **Task 2a**, oben 3.2.2.

Landwirte[101] insofern gemildert ist, als Beiträge insgesamt nur eingehoben werden, soweit die Summe der jeweils maßgebenden Beitragsgrundlagen die Höchstbeitragsgrundlage[102] nicht überschreitet. Wird diese für eine Erwerbstätigkeit bereits ausgeschöpft, tritt für eine (allenfalls auch in einem anderen System erfasste) weitere Erwerbstätigkeit keine Beitragsbelastung mehr ein; wird sie nicht ausgeschöpft, erfolgt nur eine Differenzvorschreibung bis zu der genannten Grenze. Diese Zuordnung ergibt zusammengefasst folgendes Bild:

(Grundsätzlich erfasste) Personengruppe	Maßgebendes Gesetz	Zuständiger Träger	Besondere Zuordnungskriterien
DN, freie DN	*ASVG*	eine der **neun Gebietskrankenkassen** (subsidiäre Generalkompetenz)	(vorangig) Bundesland der Beschäftigung (vgl *§§ 26 Abs 1 Z 1 und 30 ASVG*)
		eine der **fünf** verbliebenen **Betriebskrankenkassen**	Beschäftigung in diesem Betrieb *(§§ 23 Abs 3, 26 Abs 1 Z 3 ASVG*)
(Freie) DN bei Eisenbahnen bzw im Bergbau	*ASVG*	**VAEB**	Beschäftigung in einem Betrieb nach *§ 26 Abs 1 Z 4 ASVG*
Öffentlich Bedienstete	*B-KUVG*	**BVA**	Anknüpfung nach *§§ 1, 2 B-KUVG*
Gewerblich Selbständige	*GSVG*	**SVA**	Anknüpfung nach *§§ 2, 3 GSVG*
Selbständige ohne Gewerbeberechtigung			Anknüpfung nach *§ 2 Abs 1 Z 4 GSVG, §§ 2, 4 FSVG*

[101] Für **Gewerbetreibende** wird in der Unfallversicherung jeweils eine Untergrenze der Bemessungsgrundlage im Gesetz festgelegt, wobei die versicherte Person die Versicherung alternativ auf der Basis einer von zwei höheren Stufen wählen kann. Die jeweilige Summe drückt eine (virtuelle) Jahresbeitragsgrundlage aus, von der dann auch gegebenenfalls Unfallrenten bemessen werden (vgl *§ 8 Abs 1 Z 3 lit a* iVm *§§ 20, 181* und *77 Abs 4 ASVG*).

Bei den **Landwirten** erfolgt die Beitragsbemessung hingegen wie in der Kranken- und Pensionsversicherung nach *§§ 30* iVm *23 BSVG*, die Rentenbemessung aber nach festen Bemessungsgrundlagen *(§ 148f BSVG*). In der Unfallversicherung nach dem ***B-KUVG*** sind Bemessungsgrundlage der Beiträge wie auch der Unfallrente grundsätzlich die Bezüge, aber es gibt keine Höchstbeitragsgrundlage (*§ 26 Abs 1* und *§ 93 B-KUVG*). Daher wird auch bei Arbeitsunfällen, die sich im unfallversicherungsrechtlichen Schutzbereich des *ASVG* oder *BSVG* ereignen, für die Bemessungsgrundlage nur jene nach dem *ASVG* und dem *BSVG* herangezogen, nicht aber jene nach dem *B-KUVG* (*§ 178 Abs 1 ASVG*).

[102] Diese beträgt für das Jahr 2017 € 4.980,- und gilt für jedes Monat, aber darüber hinaus auch für zwei Sonderzahlungen, also im Ergebnis 14mal pro Jahr.

Bauern	BSVG	**SVB**	*§§ 2, 4 BSVG*

Zu diesen insgesamt **18** für die Vollziehung der jeweiligen Krankenversicherungsregelungen zuständigen Trägern kommen weitere Einrichtungen, die Bedienstete von bestimmten Gebietskörperschaften erfassen, womit die betreffenden Personen von der **Krankenversicherung** nicht nur nach dem *ASVG* (vgl dessen *§ 5 Abs 1 Z 3* bzw *3b*), sondern auch und vor allem nach dem *B-KUVG* **ausgenommen** sind. Nach dessen *§ 2 Abs 1 Z 2* sind das die KFA bzw Einrichtungen der Krankenfürsorge der Bediensteten der Stadt Wien, der Beamten der Stadtgemeinde Baden, der Beamten der Landeshauptstadt Linz, der oö Gemeinden, der oö Landesbeamten, der oö Lehrer, der Beamten des Magistrates Steyr, der Beamten der Stadt Wels, der Beamten der Landeshauptstadt Graz, der Beamten der Stadt Villach, der Magistratsbediensteten der Landeshauptstadt Salzburg, der Tir Landeslehrer, der Tir Landesbeamten, der Tir Gemeindebeamten und der Beamten der Stadtgemeinde Hallein. Neben den 18 (auch) für die Krankenversicherung zuständigen Sozialversicherungsträgern bestehen also zumindest **15 weitere Einrichtungen**, die für die jeweiligen Landes- bzw Gemeindebediensteten an Stelle der Krankenversicherung Leistungen erbringen, die deren Leistungen zumindest gleichwertig sind bzw sein müssen.

Diese Einrichtungen haben durchwegs eine landesrechtliche Grundlage, mag auch ihre nähere Ausgestaltung teilweise durch Beschlüsse auf Gemeindeebene erfolgt sein. Die **Regelungs- und Vollziehungskompetenz der Länder** beruht auf dem Kompetenztatbestand „*Dienstrecht der Bediensteten der Länder, Gemeinden und Gemeindeverbände*“ nach *Art 21 Abs 1 B-VG*.

Sollte eine Änderung der Organisationsstruktur im öffentlichen Gesundheitssystem auch im Hinblick auf diese Einrichtungen erfolgen, ist das Verhältnis dieser Kompetenzgrundlage zum Tatbestand „*Sozialversicherungswesen*“ zu untersuchen (dazu 5.2.2.3.).

Davor ist freilich Klarheit über dessen Reichweite zu gewinnen. Diese Frage ist von grundlegender Bedeutung für die Auslotung der Möglichkeiten und Grenzen einer Änderung der Organisationsstruktur im Hinblick auf die bestehenden Sozialversicherungsträger. Sie ist daher vorrangig zu klären (5.2.2.1.), wobei zusätzlich zu prüfen ist, inwieweit sich Besonderheiten aus dem Umstand ergeben, dass diese Träger Selbstverwaltungseinrichtungen sind, denen verfassungsrechtlich eine besondere Stellung eingeräumt ist (5.2.2.2.).

5.2.2. Verfassungsrechtlicher Rahmen für Änderungen im Hinblick auf bestehende Sozialversicherungsträger

5.2.2.1. Vorgaben auf Grund des Kompetenztatbestandes „*Sozialversicherungswesen*“

Für die Beantwortung der Frage, welche (Art von) Regelungen der Bund im „Sozialversicherungswesen“ nach *Art 10 Abs 1 Z 11 B-VG* erlassen darf, ist dessen Auslegung erforderlich. Nach dem für die Auslegung der verfassungsrechtlichen Kompetenztatbestände vorherrschenden Verständnis („**Versteinerungstheorie**“) sind diese nach dem Stand der Gesetzgebung zum Zeitpunkt ihres Inkrafttretens zu beurteilen. Da der Tatbestand „*Sozialversicherungswesen*“ bereits in der Stammfassung des *B-VG* enthalten war, ist damit grundsätzlich vom Rechtsbestand zum **1.10.1925**, dem Zeitpunkt des Inkrafttretens der Kompetenzartikel des *B-VG*, auszugehen. Es gibt zwar gute Gründe, als maßgebenden Zeitpunkt den 1.1.1974 anzusehen,[103] für die vorliegende Fragestellung macht das aber letztlich keinen Unterschied:

Zum einen zählt die soziale Krankenversicherung seit jeher zum **Kernbestand** der in der Sozialversicherung erfassten Risiken. Deren Organisation im Rahmen der Selbstverwaltung besteht sogar seit 1889,[104] dieses Prinzip stammt somit aus der Zeit vor Inkrafttreten der geltenden Bundesverfassung. Dementsprechend wurde sie in langer Rechtsprechung des VfGH als vom historischen Verfassungsgesetzgeber vorgefunden und damit als mit den Prinzipien der Bundesverfassung vereinbar angesehen.[105]

Zum anderen begründet ein Kompetenztatbestand nur die **Befugnis** zur Erlassung entsprechender Regelungen und nicht auch die Verpflichtung dazu.[106] Wenn der Gesetzgeber daher zunächst bestehende Befugnisse nicht ausgeschöpft hat, schließt das eine Weiterentwicklung nicht aus:

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[103] Vgl nur *Runggaldier/Pfeil* in *Kneihs/Lienbacher* (Hg), Rill-Schäffer-Kommentar Bundesverfassungsrecht, Art 10 Abs 1 Z 11 Rz 10; s dagegen etwa VfGH VfSlg 16.474/2002.

[104] In diesem Jahr ist das erste Sozialversicherungsgesetz, das „*Gesetz betreffend die Unfallversicherung der Arbeiter*“ (UVG 1887), RGBl 1888/1, in Kraft getreten.

[105] Die Schaffung von Selbstverwaltungskörpern mit Organen, die gegenüber staatlichen Organen nicht weisungsgebunden sind, entspricht nach herrschender Lehre und Rechtsprechung dem „Organisationsplan der Bundesverfassung" (vgl nur VfGH VfSlg 17.023/2003; näher *Eberhard*, Nichtterritoriale Selbstverwaltung, 118 ff, zur Rechtsprechung des VfGH 127 ff).

[106] Das ist nicht unstrittig, muss aber hier nicht weiter vertieft werden, zumal an eine Abschaffung der gesetzlichen Sozialversicherung (etwa zugunsten privater Versicherungssysteme) nicht gedacht ist und eine solche Abschaffung zudem auf Grund verfassungsrechtlicher Schranken (insb dem Vertrauensschutz) nur mit einer langen Vorlaufzeit, vermutlich von Jahrzehnten, zulässig wäre.

Die allen Kompetenztatbeständen innewohnende Möglichkeit der **intrasystematischen Fortentwicklung**, also die Zulässigkeit der Erlassung neuer Regelungen, sofern diese ihrem Inhalt nach dem betreffenden Rechtsgebiet, wie es durch den „Versteinerungszeitpunkt“ bestimmt ist, systematisch zugehören, ist für die Sozialversicherung von besonderer Bedeutung. Der VfGH hat bereits früh betont, dass es sich hier um ein **dynamisches**, durch eine unaufhörliche Fortentwicklung gekennzeichnetes Rechtsgebiet handle, und dass die Sozialversicherungsgesetzgebung eine Einrichtung sei, die den Wandel in den Auffassungen über die Aufgaben des Staates auf dem Gebiete der Sozialordnung veranschauliche.[107] Dies gilt sowohl hinsichtlich des Umfangs des Kreises der **Versicherten** als auch des **Gegenstands** der Versicherung. Die Einbeziehung weiterer Personen in das Sozialversicherungssystem ist damit vom Standpunkt der Kompetenzverteilung ebenso wenig grundsätzlich ausgeschlossen wie die Erfassung neuer Risiken. Angesichts dieser Dynamik müssen auch „**Umverteilungen**“ im Hinblick auf den Kreis der erfassten Personen bzw die Zuständigkeit für bestimmte Risiken grundsätzlich möglich sein. In allen Fällen sind aber Änderungen (nur) dann kompetenzrechtlich gedeckt, wenn sie sich in die Grundstrukturen der Sozialversicherung einfügen.

Zu den damit zu beschreibenden **Grundstrukturen** wird üblicherweise vorrangig die Anknüpfung an eine **Erwerbstätigkeit** gezählt. Diese Anknüpfung kann freilich nicht nur – unmittelbar – darin bestehen, dass nur Personen erfasst werden, die einer Erwerbstätigkeit nachgehen und daraus ein Einkommen erzielen, das dann die Grundlage für die Entrichtung und Bemessung von entsprechenden Beiträgen bildet. Vielmehr kann auch eine **mittelbare** Anknüpfung ausreichen, sei es etwa im Hinblick auf den Schutz der Krankenversicherung für Angehörige einer erwerbstätigen Person, für die diese ansonsten im Wege der Unterhalts- bzw Obsorgepflicht einzustehen hat, sei es in der Erfassung von Personen, die gerade keiner Erwerbstätigkeit nachgehen (können), im Wege der (früheren) Anerkennung von „Ersatzzeiten“ in der Pensionsversicherung oder der Ermöglichung einer freiwilligen Versicherung. All diese Aspekte sind bereits versteinerungstheoretisch grundgelegt, würden aber unschwer als intrasystematische Fortentwicklung angesehen werden können.[108] Einer grundsätzlich flächendeckenden Erfassung der Wohnbevölkerung in der Krankenversicherung in Kombination der genannten Anknüpfungen steht der Kompetenztatbestand „Sozialversicherungswesen“ also insoweit nicht im Weg.

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[107] VfGH VfSlg 3670/1960; VfSlg 3836/1960.

[108] *Runggaldier/Pfeil* in *Kneihs/Lienbacher* (Hg), Rill-Schäffer-Kommentar Bundesverfassungsrecht, Art 10 Abs 1 Z 11, Rz 12, 13; zur Erfassung von Angehörigen ausdrücklich VfGH VfSlg 16.381/2001; zur freiwilligen Versicherung VfGH VfSlg 14.593/1996.

Diese Frage braucht daher hier nicht weiterverfolgt werden. Gleiches gilt für jene nach der sozialversicherungsrechtlichen Erfassbarkeit von Risiken, die möglicherweise überhaupt nichts mit der Erwerbstätigkeit zu tun haben.[109] Dieses Problem ist im vorliegenden Zusammenhang schon deswegen zu vernachlässigen, weil auftragsgemäß vom bestehenden Leistungsspektrum der Krankenversicherung ausgegangen wird, dessen kompetenzrechtliche Deckung nicht in Frage steht.

Sehr wohl von Bedeutung ist aber ein anderes mit der grundsätzlichen Anknüpfung an die Erwerbstätigkeit verbundenes Strukturmerkmal der Sozialversicherung, das den durch sie angestrebten Risikoausgleich und damit auch die Finanzierung der Leistungen betrifft: Die Sozialversicherung beruht auf dem Zusammenschluss von Personen zu einer **Risikogemeinschaft**. Die Bildung dieser Risikogemeinschaften erfolgt nicht freiwillig, sondern durch Gesetz im Wege der **Pflichtversicherung**. Der dabei jeweils erfasste Personenkreis muss durch generelle und objektive Merkmale bestimmt werden (können). Die Abgrenzung dieses Personenkreises ist insoweit eine Aufgabe, die dem rechtspolitischen Spielraum des einfachen Gesetzgebers überlassen bleibt, der dabei allerdings dem allgemeinen Sachlichkeitsgebot entsprechen muss.[110] Diese Auffassung gewinnt der VfGH nicht allein aus dem Kompetenztatbestand bzw dem Gleichheitssatz des *Art 7 Abs 1 B-VG*, sondern auch oder sogar vorrangig aus dem Charakter dieser Versichertengemeinschaften als **Selbstverwaltungskörper**. Schon vor Schaffung der *Art 120a ff B-VG* (dazu sogleich 5.2.2.2.) wurde klargestellt, dass eine wesentliche Voraussetzung der verfassungsrechtlichen Zulässigkeit für Selbstverwaltung darin besteht, dass der eigene (dh eigenverantwortlich und ohne Bindung an Weisungen zu besorgende) Wirkungsbereich jedes Selbstverwaltungskörpers auf Angelegenheiten beschränkt bleiben muss, die im **ausschließlichen oder überwiegenden Interesse** der zum Selbstverwaltungskörper zusammengeschlossenen Personen gelegen und **geeignet** sind, von dieser Gemeinschaft besorgt zu werden.[111] Welche Personen dabei zu einem Selbstverwaltungskörper zusammengeschlossen werden, liegt im rechtspolitischen Ermessen des (einfachen) Gesetzgebers, solange der erfasste Personenkreis durch „objektive und sachlich gerechtfertigte Momente“ abgegrenzt ist.[112] Dh im vorliegenden Kontext vor allem, dass es sich um Personen handeln muss, die sich in einer vergleichbaren

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[109] Vgl nur die Problematisierung bei *Tomandl* in *Tomandl* (Hg), System des österreichischen Sozialversicherungsrechts 0.2.1 (6).

[110] Vgl etwa VfGH VfSlg 6582/1971; VfSlg 14.842/1997; VfSlg 9551/1982.

[111] Grundlegend VfGH VfSlg 8215/1977 (488).

[112] Vgl etwa VfGH VfSlg 3753/1960; VfSlg 8485/1979; VfSlg 12.021/1989; VfSlg 12.417/1990.

Situation befinden und daher **grundsätzlich den gleichen Risiken** ausgesetzt sind.[113]

Keine Rolle spielt es dagegen, ob der Eintritt des betreffenden **Risikos** besonders **wahrscheinlich** oder besonders unwahrscheinlich ist. Ein weiteres Strukturmerkmal der Sozialversicherung besteht nämlich darin, dass schlechte Risiken grundsätzlich nicht ausgeschlossen werden dürfen bzw dass die Beitragshöhe nicht (vorrangig) an die Wahrscheinlichkeit des Risikoeintritts gekoppelt sein darf.[114] Dies schließt zwar eine (Verstärkung der) Bindung an das Äquivalenzprinzip nicht aus, schon allein die in *Art 10 Abs 1 Z 11 B-VG* vorgesehene Unterscheidung zwischen den Kompetenztatbeständen Sozial- bzw Vertragsversicherungswesen gebietet, dass im Rahmen der Sozialversicherung der Grundgedanke des **sozialen Ausgleichs** im Vordergrund steht.[115] [116] In diesem Sinn hat auch der VfGH – unter Bezugnahme auf den Gleichheitssatz – festgehalten, dass die risikounabhängige Zusammenfassung zu einer Risikogemeinschaft und deren Unterstellung unter ein einheitliches Beitragsrecht ein „Charakteristikum der gesetzlichen Sozialversicherung“ sei, wobei Vorteile, die einer sozialen Gruppe durch die Einbeziehung in die Versicherung erwachsen, bei der Bemessung der Beitragspflicht unberücksichtigt bleiben müssten, da ansonsten die Gruppen der sozial Schwächsten zu den größten Beitragsleistungen heranzuziehen wäre, was aber „dem Gedanken einer sozialen Versicherung widerspricht“.[117]

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[113] Vgl ausdrücklich zu Art 120a B-VG VfGH VfSlg 19.919/2014: [Dies bedeutet,] „dass der Wirkungsbereich jedes Selbstverwaltungskörpers auf Angelegenheiten beschränkt werden muss, die im ausschließlichen oder überwiegenden Interesse der zum Selbstverwaltungskörper zusammengeschlossenen Personen gelegen und geeignet sind, von dieser Gemeinschaft besorgt zu werden. Daraus folgt, dass – ausgehend vom Wirkungsbereich eines Selbstverwaltungskörpers – nur solche Personen in einem Selbstverwaltungskörper zusammengefasst werden dürfen, die im Hinblick auf diesen Wirkungsbereich in gleicher Weise betroffen sind."

[114] Vgl ein weiteres Mal VfGH VfSlg 3670/1960.

[115] Der VfGH betont sogar, dass es Wesensmerkmal der Sozialversicherung ist, dass das Äquivalenzprinzip grundsätzlich von den Prinzipien der Einkommens- und Risikosolidarität verdrängt ist, vgl insb VfGH VfSlg 18.786/2009.

[116] Davon abgesehen ist mit Nachdruck darauf hinzuweisen, dass jede Annäherung der Sozialversicherung an die Prinzipien der Privatversicherung die Gefahr mit sich bringt, dass die weitgehende Ausnahme der Sozialversicherungsträger (als Unternehmen für Dienstleistungen von allgemeinem Interesse) aus dem **europäischen Wettbewerbsrecht** in Frage gestellt werden kann (vgl nur *Voet van Vormizeele* in Schwarzer [Hg], EU-Kommentar, Art 106 AEUV Rz 60 ff, sowie EuGH 23.4. 1991, C 41/90 - *Höfner und Elser*, ECLI:EU:C:1991:161). Dabei dürfte es nämlich entscheidend darauf ankommen, ob das System als Umsetzung des Grundsatzes der Solidarität angesehen werden kann und ob es der Aufsicht des Staates, der es eingeführt hat, unterliegt; diese Umstände können den wirtschaftlichen Charakter einer Tätigkeit ausschließen (EuGH 27.10.2009, C‑437/09, AG2R Prévoyance, ECLI:EU:C:2011:112).

[117] Vgl nur VfGH VfSlg 15.859/2000.

Aus all dem ergibt sich also noch nicht zwingend eine Beschränkung der Optionen für eine Aus- bzw Umgestaltung der Trägerlandschaft insb im Bereich der Krankenversicherung. Das Risiko, krank zu werden oder einen Freizeitunfall zu erleiden und deswegen auf die Inanspruchnahme von Gesundheitsdienstleistungen oder Kompensationen zum Ausgleich einer eingeschränkten Erwerbsfähigkeit angewiesen zu sein, besteht in der Tat grundsätzlich unabhängig davon, ob jemand unselbständig oder selbständig erwerbstätig ist. **Unterschiede** könnten allenfalls im Hinblick auf einzelne **Teilbereiche** dieser Risiken bestehen, wie sich am Beispiel des Versicherungsfalls der Arbeitsunfähigkeit bei Krankheit und den dazu derzeit bestehenden (einfachgesetzlichen) Regelungen gut veranschaulichen lässt:[118]

Dieser Versicherungsfall setzt eine krankheitsbedingte Einschränkung der Erwerbsfähigkeit und einen daraus resultierenden Einkommensausfall voraus. Er kommt daher bei Personen, die den Schutz der Krankenversicherung nur auf Grund ihrer Angehörigeneigenschaft oder einer nicht auf eine Erwerbstätigkeit zurückgehenden freiwilligen Versicherung (zB nach *§ 16 ASVG*, anders aber nach *§ 19a ASVG*) genießen, nicht in Betracht. Bei auf Grund einer unselbständigen Tätigkeit Versicherten führt dieses Risiko dagegen regelmäßig zum Ausfall der einzigen bzw wichtigsten Einkommensquelle, welcher daher durch den Anspruch auf Krankengeld (*§§ 138 ff ASVG*) zumindest vorübergehend ausgeglichen werden soll. Das Risiko besteht nicht, solange ohnedies der AG das bisherige Entgelt weiterzuzahlen hat.[119] Auch bei Selbständigen ist dieses Risiko nicht oder in wesentlich geringerem Ausmaß gegeben, sofern die Aufrechterhaltung ihrer betrieblichen Tätigkeit nicht vorrangig von der persönlichen Arbeitsleistung der versicherten Person abhängt.[120] Ähnliche Unterschiede könnten im Versicherungsfall der Mutterschaft für die Zeit unmittelbar vor und nach der Entbindung bestehen, für welche das bei den Unselbständigen vorrangig vorgesehene Wochengeld bei Selbständigen nur subsidiär zur Betriebshilfe, also zur Beistellung einer geeigneten Ersatzkraft, beansprucht werden kann (vgl *§ 102a GSVG*, *§ 98 BSVG*).

Diese Unterschiede im Tatsächlichen beim zu versichernden Risiko, führten nicht nur bisher – wie eben gezeigt – zu unterschiedlichen Versicherungsleistungen, sie legen an sich eine differenzierte Erfassung der betreffenden Personenkreise nahe. Die Dif-

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[118] Vgl auch bereits bei **Task 2a**, oben 3.2.3.

[119] Daher ruht auch der Anspruch auf Krankengeld für diese Zeiträume (vgl *§ 143 Abs 1 Z 3 ASVG*) oder kommt gar nicht zur Anwendung, weil die Entgeltfortzahlung durch den DG bei Beamten nicht begrenzt ist, solange es nicht zur Versetzung in den Ruhestand kommt (vgl *§ 84 Abs 1 B-KUVG*).

[120] Vgl die – im Übrigen erst durch *BGBl I 2012/123* eingeführte – „*Unterstützungsleistung bei lang dauernder Krankheit*“ nach *§ 104a GSVG*.

ferenzierung könnte sich nicht nur in der Leistungsart, sondern etwa auch in einer anderen Umschreibung der jeweiligen Leistungsvoraussetzungen oder allenfalls auch in unterschiedlichen Beitragssätzen (siehe dazu aber sogleich) niederschlagen. Dass deswegen unterschiedliche Risikogemeinschaften gebildet oder auch beibehalten werden müssten, ist dagegen **kompetenzrechtlich** nicht zwingend indiziert.

Dieser Einschätzung scheint die Judikatur des VfGH entgegenzustehen, die unterschiedliche Beitragssätze zwischen unterschiedlichen Gruppen innerhalb derselben Versichertengemeinschaft grundsätzlich nicht,[121] sondern nur ausnahmsweise bei Vorliegen besonderer Gründe (zu denen aber nicht die Risken zählen dürfen) zulässt,[122] einen Ausgleich zwischen verschiedenen Versichertengruppen aus den jeweils eingehobenen Beiträgen aber als unzulässig ansieht, weil ein solcher Ausgleich nur innerhalb einer von verschiedenen Risikogemeinschaften im engeren Sinne gebildeten Risikogemeinschaft im weiteren Sinne zulässig sei. Es sei gerade **nicht** anzunehmen, dass alle Sozialversicherten eine **große gemeinsame Risikogemeinschaft** bilden.[123] Die Umverteilung der Risiken, die der gesetzlichen Sozialversicherung immanent ist, finde vielmehr ihre Grenze in der Notwendigkeit der **Homogenität** der versicherten Risiken, für welche die Zugehörigkeit zu einer bestimmten Berufsgruppe entscheidend sei.[124]

Aus dieser Rechtsprechung ergibt sich jedoch zunächst nur, dass eine **Umverteilung** zwischen verschiedenen Versicherungsträgern unzulässig ist, die jeweils verschiedene Risikogemeinschaften zusammenfassen, weil und soweit es dann an einem sachlichen und persönlichen Zusammenhang zwischen den versicherten Personen und Risiken fehlt: Ein solcher Zusammenhang wurde etwa zwischen den jeweils für die DN zuständigen Trägern der Kranken- bzw der Pensionsversicherung anerkannt und damit ein Ausgleich zwischen diesen Trägern für zulässig erachtet.[125] Dagegen erwies sich die Einbeziehung der SVB, der SVA oder der BVA in einen solchen Ausgleich als verfassungswidrig; bei genauerer Betrachtung erfolgte diese allerdings nicht wegen der Verschiedenartigkeit der Erwerbstätigkeiten, sondern deswegen, weil die jeweils verschiedenen Erwerbstätigen vom Gesetzgeber zuvor in verschiedene Risikogemeinschaften in Gestalt verschiedener Sozialversicherungs-

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[121] VfGH VfSlg 12.739/1991, 15.859/2000.

[122] VfGH VfSlg 18.607/2008 - Unterschiede bei Versicherungsbeginn; VfSlg 16.492/2002 - Freiberufler mit zeitlich unterschiedlicher Einbeziehung in die Pflichtversicherung.

[123] VfGH VfSlg 10.451/1985.

[124] VfGH VfSlg 4714/1964; VfSlg 4801/1964; VfSlg 5241/1966; vgl idS auch VfGH VfSlg 12.739/1991 und VfSlg 14.842/1997.

[125] VfGH VfSlg 11.013/1986.

träger zusammengefasst wurden und ihr jeweiliges Beitrags- und Leistungsrecht unterschiedlich ausgestaltet wurde.[126] Ähnlich scheiterte die Verpflichtung zur Überweisung von Beiträgen aus dem Insolvenz-Ausgleichsfonds an den Ausgleichsfonds der Pensionsversicherungsträger vor allem an der Verschiedenheit der jeweils zahlungspflichtigen Versicherungsträger, nicht auch jener der Versicherten.[127]

Das kann zunächst nur so verstanden werden, dass der VfGH den Gesetzgeber primär zur Einhaltung eines einmal gewählten **Ordnungssystems**,[128] also dazu verhält, die **Konsequenzen aus einer von ihm vorgenommenen Abgrenzung** der Risikogemeinschaften zu ziehen und nicht die von ihm selbst getroffenen Systementscheidungen ohne sachliche Rechtfertigung zu unterlaufen. Bei der **Bildung** dieser Ordnungssysteme ist der Gesetzgeber dagegen, wie schon angedeutet, weitgehend **frei** und kann davon grundsätzlich – dh insb vorbehaltlich des Vertrauensschutzes – abgehen:[129] Der VfGH hat es grundsätzlich dem rechtspolitischen Gestaltungsspielraum des Gesetzgebers überlassen, „die Grenzen für die Einbeziehung bestimmter Berufsgruppen in die Sozialversicherungspflicht zu ziehen und zu entscheiden, welche bisher nicht versicherten Berufsgruppen in die Sozialversicherungspflicht einbezogen werden".[130] Gleiches gilt für die Umgruppierung bzw Zusammenlegung von Versicherungsträgern, wie sie in der jüngeren Vergangenheit mehrfach erfolgt und verfassungsrechtlich unbeanstandet geblieben sind.[131]

In diesem Zusammenhang kann nur angemerkt werden, dass die Zusammenfassung unterschiedlicher und bisher getrennt erfasster Berufsgruppen in eine gemeinsame Risikogemeinschaft nicht nur eine Angleichung im Leistungsrecht ermöglichen, wenn nicht sogar erfordern würde.[132] Vielmehr wird damit wohl auch eine **Angleichung** der

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[126] VfGH VfSlg 17.172/2004. Zu den aus diesem Erkenntnis zu ziehenden Schlussfolgerungen im Hinblick auf einen Risikostrukturausgleich s unten 8.2.

[127] VfGH VfSlg 17.677/2005.

[128] VfGH VfSlg 13.829/1994; VfSlg 10.451/1985; VfSlg 17.172/2004; vgl grundlegend *Berka* in *Kneihs/Lienbacher* (Hg), Rill–Schäffer–Bundesverfassungsrechtskommentar, Art 7 B-VG Rz 58 ff; *Frank* in *Mosler/Müller/Pfeil* (Hg), Der SV-Komm § 447a ASVG Rz 3.

[129] Daraus resultiert eine allenfalls unterschiedliche Beurteilung der verfassungsrechtlichen Zulässigkeit der Veränderung der Zusammensetzung von Versichertengemeinschaften, die wohl tendenziell **weiter** reicht als die Möglichkeit, Mittel zwischen bestehenden Versichertengemeinschaft im Wege eines Risikostrukturausgleichs bzw durch den Zugriff auf Rücklagen eines anderen Trägers zu verschieben, dazu bei **Task 9e**, unten 8., bzw **Task 14a**, unten 11.

[130] VfGH VfSlg 14.842/1997; VfSlg 9551/1982; VfSlg 6582/1971.

[131] Vgl insb die Zusammenlegung der Versicherungsanstalten der Eisenbahnen bzw des Bergbaus sowie der Pensionsversicherungsanstalten der Arbeiter und der Angestellten, jeweils durch *BGBl I 2003/145*.

[132] Siehe bei **Task 2a**, oben 3.3.

Art der **Beitragsaufbringung** einher gehen müssen, die derzeit etwa zwischen Bauern und Gewerbetreibenden völlig verschieden geregelt ist (Anknüpfung am steuerlichen Wert landwirtschaftlicher Grundstücke auf der einen und am tatsächlichen steuerpflichtigen Erwerbseinkommen auf der anderen Seite). Wenn nämlich – wie angedeutet – unterschiedliche Beitragssätze innerhalb einer Risikogruppe (von bestimmten risikofernen Sonderfällen abgesehen) verfassungsrechtlich nicht zulässig sind, wird dasselbe gelten müssen, wenn die Ermittlung der Beitragspflichten bei in einer Versichertengemeinschaft zusammengefassten Personengruppen auf jeweils unterschiedliche und nicht vergleichbare Weise erfolgt.

Davon abgesehen ist nicht ausgeschlossen, dass bei der Prüfung der Sachlichkeit eines Zusammenschlusses im Einzelfall auch auf die hinter dem jeweiligen Zusammenschluss stehenden Personen und ihre spezifischen Risiken durchgegriffen wird: Noch einmal sei auf das Erk VfSlg 17.677/2005 verwiesen, in dem der VfGH eine Überweisung aus dem Insolvenz-Ausgleichsfonds an die SVA als unzulässig qualifiziert hat, weil damit die natürlichen und juristischen Personen benachteiligt wurden, die an diesen Fonds Beiträge zahlen, weil es sich bei diesen ausschließlich um AG handelt, die AN beschäftigen, während in der SVA auch solche Selbständige versichert sind, die keine AN beschäftigen. Auch hier war also letztlich die **Homogenität** der versicherten **Risiken** bzw des zusammengefassten **Personenkreises** der entscheidende Gesichtspunkt.

Dieser Aspekt erweist sich somit als das Ausschlag gebende verfassungsrechtliche Abgrenzungskriterium für die Bildung von Risikogemeinschaften, die dann freilich auch grundsätzlich nach denselben Regeln versichert gehalten werden müssen.[133] Das bestätigen auch jene Entscheidungen des VfGH, in denen er **Differenzierungen innerhalb** einer Risikogemeinschaft verfassungsrechtliche Grenzen setzt.[134] Dabei erfolgt die Festlegung der Grenzen zwar nach **gleichheitsrechtlichen** und nicht

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[133] VfGH VfSlg 12.739/1991; VfSlg 14.842/1997. So wohl auch VfGH VfSlg 6004/1969 und VfGH VfSlg 9753/1973..

[134] Vgl insb die Erkenntnisse VfGH VfSlg 3721/1960: Aufhebung des seinerzeitigen *§ 18 Abs 1 GSPVG* wegen Verletzung des Gleichheitssatzes auf Grund unsachlicher Differenzierungen der Beitragssätze; VfSlg 10.100/1984: Differenzierungen im Beitragsrecht müssen mit Differenzierungen im Leistungsrecht korrespondieren; VfSlg 10.451/1985: gemeinsame Risiken mit gemeinsamen Beitrags- und Leistungsrecht innerhalb der Risikogemeinschaft im engeren Sinn, die durch den jeweiligen Sozialversicherungsträger abgegrenzt ist; VfSlg 11.469/1987: Differenzierung innerhalb der Risikogemeinschaft nach der wirtschaftlichen Leistungsfähigkeit verfassungsrechtlich zulässig; VfSlg 13.743/1994: keine Benachteiligung einer wirtschaftlich schwächeren Gruppe innerhalb der Risikogemeinschaft; VfSlg 15.859/2000: innerhalb der Risikogemeinschaft keine Unterscheidung zwischen „guten“ und „schlechten Risiken“; VfSlg 16.492/2002: innerhalb einer Risikogemeinschaft keine relativ stärkere Belastung der sozial Schwächeren, die relativ größere Vorteile aus der Versicherung beziehen.

nach kompetenzrechtlichen Überlegungen. Dennoch ist davon auszugehen, dass diese Grenzen auch für die kompetenzrechtlich vorgegebene Abgrenzung jener Berufsgruppen relevant sind, auf die sich die sozialversicherungsrechtliche Abgrenzung der Risikogemeinschaften beziehen: Sofern nämlich das im Gleichheitssatz angelegte Differenzierungs**gebot** Unterscheidungen erfordern würde, die **innerhalb** einer Risikogemeinschaft wegen des ebenfalls gleichheitsrechtlichen Differenzierungsverbots **nicht zulässig** sind, so spricht dies **gegen** die Homogenität der Risikogemeinschaft. Mit anderen Worten wäre in diesem Fall die Abgrenzung unter dem Gesichtspunkt der sozialversicherungsrechtlichen Gruppensolidarität, die ein Wesensmerkmal des kompetenzrechtlichen Sozialversicherungsbegriffes darstellt, nicht mehr zutreffend.

Als **Zwischenbilanz** kann daher festgehalten werden, dass die Zusammenfassung verschiedener Personengruppen zu einem Sozialversicherungsträger (erst) dann unzulässig sein wird, wenn diese Gruppen derart unterschiedlich sind, dass zwischen ihnen in einer Weise differenziert werden muss, die innerhalb einer Risikogemeinschaft unsachlich ist. Anders gewendet wird die Zusammenfassung insoweit zulässig sein, als die hinsichtlich der **Ausgestaltung der jeweiligen Pflichtversichertengemeinschaft bedeutsamen Gemeinsamkeiten die Unterschiede überwiegen**. Solange diese Grenze nicht überschritten wird, wäre also auch die Zusammenlegung oder Umstrukturierung der bestehenden Versicherungsträger verfassungsrechtlich zulässig. Die Tatsache, dass eine Risikogemeinschaft bisher in der einen oder anderen Weise gebildet wurde, schließt eine auf andere Anknüpfungen abstellende Gestaltung für die Zukunft – selbstverständlich unter Wahrung eines geordneten Rechtsübergangs – jedenfalls nicht aus.

5.2.2.2. Vorgaben auf Grund der Selbstverwaltung

Damit stellt sich die Frage, ob der Umstand, dass es sich bei den bestehenden Sozialversicherungsträgern um Selbstverwaltungseinrichtungen handelt, eine andere Sichtweise zur Folge hat. Die Qualifikation der Sozialversicherungsträger und des Hauptverbandes als Selbstverwaltungskörper ergibt sich aus den gesetzlichen Organisationsvorschriften, die einerseits eine (wenngleich indirekte) demokratische Generierung des jeweiligen satzungsgebenden Organs vorsehen und die diese Körperschaften zugleich der bloßen Aufsicht staatlicher Behörden unterstellt:[135] Bei Selbstverwaltungskörpern muss es sich nach *Art 120a Abs 1 B-VG* um eine durch Gesetz

[135] Vgl zum Folgenden nur *Stöger* in *Mosler/Müller/Pfeil* (Hg), Der SV-Komm, § 32 ASVG Rz 8 ff.

erfolgte Zusammenfassung von Personen zu einer Körperschaft des öffentlichen Rechts handeln, deren Zweck in der Wahrnehmung öffentlicher Aufgaben liegt, die in ihrem ausschließlichen oder überwiegenden gemeinsamen Interesse gelegen und auch geeignet sind, in diesem Rahmen gemeinsam besorgt zu werden. Solche Selbstverwaltungskörper haben dann nach *Art 120b Abs 1 B-VG* insb das Recht, ihre Aufgaben in eigener Verantwortung und frei von Weisungen zu besorgen sowie im Rahmen der Gesetze Satzungen zu erlassen. Nach *Art 120c Abs 3 B-VG* handelt es sich dabei im Übrigen um selbständige Wirtschaftskörper, die im Rahmen der Gesetze zur Erfüllung ihrer Aufgaben Vermögen erwerben, besitzen und darüber verfügen können.

Mit den durch *BGBl I 2008/2* eingefügten Regelungen der *Art 120a* ff hat der Verfassungsgesetzgeber Einrichtungen der nicht-territorialen Selbstverwaltung ausdrücklich im *B-VG* verankert. Dadurch werden zwar Einrichtungen der Selbstverwaltung wie die Sozialversicherungsträger geschützt, die Organisation der Selbstverwaltung als solche und die Einrichtung von einzelnen Selbstverwaltungskörpern bleibt aber der einfachen Gesetzgebung überlassen: Wie der VfGH erst vor kurzem anlässlich der Auflösung eines Fachverbandes der Wirtschaftskammer und dessen Zusammenlegung mit einem anderen Fachverband ausgesprochen hat, resultiert daraus insb **kein Bestandschutz jeder einzelnen Einrichtung im Rahmen der Selbstverwaltung**.[136] Der VfGH versteht die *Art 120a ff B-VG* – wie schon (oben 5.2.2.1.) ausgeführt – vielmehr im Sinne seiner bisherigen Rechtsprechung und damit als Zusammenfassung von Merkmalen der nicht-territorialen Selbstverwaltung und Errichtungsschranken, die bereits (aus einzelnen Vorschriften des *B-VG* abgeleitet und durch die Judikatur des VfGH) geltendes Verfassungsrecht waren.[137] Zu diesen Grundsätzen zähle eben, dass der Wirkungsbereich jedes Selbstverwaltungskörpers auf Angelegenheiten beschränkt werden muss, die im ausschließlichen oder überwiegenden Interesse der zum Selbstverwaltungskörper zusammengeschlossenen Personen gelegen und geeignet sind, von dieser Gemeinschaft besorgt zu werden. Daraus folge – so der VfGH –, dass nur solche Personen in einem Selbstverwaltungskörper zusammengefasst werden dürften, die im Hinblick auf dessen Wirkungsbereich in gleicher Weise betroffen sind. Die anschließenden Ausführungen des VfGH zu einer der Interessenvertretung dienenden Einrichtung der wirtschaftlichen Selbstverwaltung können unschwer auf die Selbstverwaltung in der Sozialversicherung übertragen werden: Wenn dort nur Personen zusammengefasst werden dürfen, die unter dem Ge-

[136] Vgl das schon erwähnte Erkenntnis VfGH VfSlg 19.919/2014.

[137] Im Erkenntnis VfGH 19.919/2014 wird dazu insb auf VfGH VfSlg 18.731/2009 und VfSlg 19.017/2010 verwiesen.

sichtspunkt der Teilnahme am Wirtschaftsleben typischerweise ähnliche Interessen bzw in die gleiche Richtung weisende Interessenlagen aufwiesen,[138] heißt das hier, dass nur Personen in einer als Selbstverwaltungskörper organisierten Versichertengemeinschaft zusammengefasst werden dürfen, **die vergleichbaren sozialen Risiken** ausgesetzt sind. Der VfGH erachtet auch vor dem Hintergrund der *Art 120a ff B-VG* den (einfachen) Gesetzgeber bei der Abgrenzung der jeweiligen Gemeinschaften (nur) allgemein an das **Sachlichkeitsgebot** gebunden und billigt ihm dabei **großen Ermessenspielraum** zu.[139] Diese auch im Schrifttum vorherrschende Auffassung[140] führt im Grunde zum gleichen Ergebnis, wie es bereits aus der Analyse des Kompetenztatbestandes zu gewinnen ist: Der einfache Gesetzgeber hat relativ große rechtspolitische Spielräume bei der Bildung, Auflösung und Umgestaltung von Versichertengemeinschaften, auch wenn diese als Selbstverwaltungskörper organisiert sind. Die Spielräume dürften aber insoweit eingeengt sein, als die Selbstverwaltung im satzungsgebenden Organ demokratischer Legitimation bedarf, die Legitimation der satzungsgebenden Organe der Sozialversicherungs-Selbstverwaltung aber von jener der beruflichen Selbstverwaltung (also Arbeiterkammer, Wirtschaftskammer, Landwirtschaftskammern etc), also berufsgruppenspezifisch abgeleitet wird. Ein diese Berufsgruppen übergreifender Zusammenschluss auf der Sozialversicherungsebene müsste entweder dort die Berufsgruppen erneut kurial abbilden oder man müsste die Wahl in die Organe der Sozialversicherung grundlegend umgestalten (s auch unten).

Dies gilt insb auch im Lichte des *Art 120a Abs 2 B-VG*, der die Anerkennung der Rolle der **Sozialpartner** zum Ausdruck gebracht und die Achtung ihrer Autonomie sowie die Förderung des sozialpartnerschaftlichen Dialogs verankert hat. Daraus ist zwar eine grundsätzliche, hier freilich nicht näher zu analysierende Bestandsgarantie der Sozialpartner abzuleiten, denen damit auch eine angemessene Teilhabe an der Vollziehung des grundsätzlich auf Beiträgen der DN und der DG beruhenden Sozialversicherungsrechts einzuräumen ist; eine Einrichtungsgarantie für die Selbstverwaltungskörper der Sozialversicherung ist damit jedoch nicht verbunden: Auch bei der

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[138] Neuerlich wird auf VfGH VfSlg 19.017/2010 verwiesen.

[139] VfGH VfSlg 19.919/2014 unter Verweis auf VfGH VfSlg 17.023/2003 bzw VfSlg 19.017/2010 und VfSlg 19.751/2013.

[140] Vgl nur *Rill/Stolzlechner* in *Kneihs/Lienbacher* (Hg), Rill-Schäffer-Kommentar Bundesverfassungsrecht, Art 120a B-VG Rz 8; bzw *Mayer/Muzak*, B-VG[5] Art 120a II.

Förderung des sozialpartnerschaftlichen Dialogs geht es um den Bestand der Dialogpartner und nicht um den Bestand der Sozialversicherungsträger.[141]

Angesichts der Prämissen für die vorliegende Studie braucht der folgende Aspekt zwar nicht vertieft werden, im Rahmen einer gesamthaften Betrachtung darf er aber auch nicht ausgeblendet bleiben: Da die nicht-territoriale Selbstverwaltung anders als die territoriale Selbstverwaltung der Gemeinden bundesverfassungsgesetzlich unter bestimmten Voraussetzungen zugelassen, aber eben nicht verfassungsrechtlich garantiert ist, würde es dem (einfachen) Bundesgesetzgeber grundsätzlich etwa auch frei stehen, die Sozialversicherungsträger in ausdrücklicher, gesetzlich angeordneter Weisungsbindung an die obersten Organe (wie zB den BMASK oder den BMG) lediglich mit dem **Vollzug des Sozialversicherungsrechts zu beleihen**.[142] Er könnte dafür aber auch gemäß *Art 102 Abs 2 B-VG* eigene, per se **weisungsgebundene Bundesbehörden** zB in Form von „Sozialversicherungs-" oder „Sozialleistungsämtern" einrichten.

Der letztgenannte Aspekt könnte freilich in anderer Hinsicht für die vorliegende Aufgabenstellung von Bedeutung werden. Dabei geht es um die Frage, ob der **Kreis** der im Rahmen einer Sozialversicherungsgemeinschaft in Selbstverwaltung erfassten Personen **beliebig ausgedehnt** werden darf. Dazu ist weder Rechtsprechung noch Literatur ersichtlich. Es spricht jedoch Einiges dafür, die verfassungsrechtlichen Anforderungen an die Gruppenbildung bei der Einrichtung von Selbstverwaltungskörpern so zu verstehen, dass neben der Gruppe der nach bestimmten Kriterien in die Risikogemeinschaft einbezogenen (dh in einem Selbstverwaltungskörper zusammengefassten) Personen auch **andere Gruppen** existieren müssen, die sich in ihren Interessen oder in ihren Belangen von der einbezogenen Gruppe unterscheiden.[143] Diese müssen sich von der erstgenannten Risikogemeinschaft noch unterscheiden lassen, da es ja darauf ankommt, an jene Gemeinsamkeiten anzuknüpfen, hinsichtlich derer – nach dem insoweit verfassungsrechtlich vorgegebenen Konzept der Selbstverwaltung – auch gesagt werden kann, dass sie die betreffende Gruppe selbst und mit eigenen Mitteln besorgen kann. Dies korrespondiert auch mit dem staatsrechtlichen Konzept der Selbstverwaltung als einer nach persönlichen oder regionalen Grundsätzen differenzierten, in relativer Unabhängigkeit von den obersten staatlichen Behörden agierenden Form staatlicher Verwaltung.

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[141] Vgl erneut nur *Rill/Stolzlechner* in *Kneihs/Lienbacher* (Hg), Rill-Schäffer-Kommentar Bundesverfassungsrecht, Art 120a B-VG Rz 54 f.

[142] Vgl etwa VfGH VfSlg17.023(2003.

[143] Vgl *Eberhard*, Nichtterritoriale Selbstverwaltung, 235 ff.

Das legt den Schluss nahe, dass eine „berufsübergreifende“ Zusammenfassung der gesamten Wohnbevölkerung in einer „einheitlichen Gemeinschaft der Krankenversicherten“ insofern **nicht** mit dem Konzept der Selbstverwaltung in Einklang zu bringen wäre, als sich damit der räumliche oder personelle Geltungsbereich der betreffenden Selbstverwaltung de facto mit jenem der Staatsverwaltung decken würde. Damit würde gleichsam unterhalb der Ebene der Staatsverwaltung eine umfänglich annähernd gleiche Ebene der Selbstverwaltung (wenn auch nur für den Bereich der Krankenversicherung) eingezogen, die weder regional noch berufsspezifisch gegliedert ist, also eine Art „Staat im Staate“ bildete. Ein derartiges Verständnis von Selbstverwaltung entspricht wohl weder den historisch vorgefundenen, der Gemeindeselbstverwaltung nachgebildeten Modellen noch entspricht es dem Konzept der *Art 120a* und *120b B-VG*.

Bei aller gebotenen Vorsicht ist daher festzuhalten, dass die Inanspruchnahme des Rechtsinstituts der **Selbstverwaltung** verfassungsrechtlich umso **problematischer** erscheint, **je umfangreicher die Gruppe** jener wäre, die in einer solchen Risikogemeinschaft zusammengefasst werden soll (und je kleiner daher die Gruppe der davon nicht erfassten Personen) und je **umfassender zugleich der räumliche Geltungsbereich** wäre. Für den Zusammenschluss (praktisch) der gesamten Wohnbevölkerung in einer einheitlichen Risikogemeinschaft wäre daher wohl die – wie bereits ausgeführt: verfassungsrechtlich zulässige – Umstellung auf **reine Staatsverwaltung** erforderlich.[144] Die von Anfang an berufsgruppenspezifische Gliederung der österreichischen Sozialversicherung (Arbeiter und Angestellte, unselbständig Beschäftigte im Bergbau bzw bei den Eisenbahnen, Landwirte, selbständig erwerbstätige Gewerbetreibende, Freiberufler, Beamte) ist freilich ein starkes Indiz dafür, dass sich diese Gruppen in ihren – uU auch für die Risiken der Sozialversicherung relevanten – beruflichen Umständen objektiv unterscheiden. Diese Unterschiede waren bei unselbständig Erwerbstätigen, die im Wesentlichen seit 1.1.1956 im ASVG (wenngleich nicht auch durchgehend organisatorisch) zusammengefasst sind, wahrscheinlich schon immer sehr gering und sind es heute dank der weitgehenden arbeitsrechtlichen Angleichung zwischen Arbeitern und Angestellten wohl noch mehr. [145] Eine Zusammenfassung von Versicherten, die über diese Grenzen

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[144] Da eine solche Umstellung offenkundig nicht angedacht ist, brauchen auch deren allfällige Auswirkungen auf den rechtlichen Rahmen für die Organisation der Gesundheitsdienstleistungen (Stichwort staatlicher Gesundheitsdienst statt Verträgen mit externen Leistungserbringern) nicht weiter verfolgt werden.

[145] Vgl jedoch auch *Steiner*, Reinhold Melas und die österreichische Sozialversicherung, 26 ff, wonach sich anlässlich der Wiederherstellung der österreichischen Sozialversicherung nach 1945 die Gruppeninteressen selbst innerhalb der Berufsgruppen der unselbständig Erwerbsstätigen im Sinne eines berufsgruppenspezifischen Aufbaus der Trägerlandschaft (Eisenbahn, Bergbau, Land-

hinausgehen soll, bedarf aber jedenfalls einer **genauen Analyse der Gründe**, aus denen **bisher** getrennte Versicherungsträger bestanden haben und der Frage, ob diese Gründe weggefallen sind. Die „Beweislast“ für eine verfassungsrechtliche Verträglichkeit eines solchen Zusammenschlusses trifft den Gesetzgeber.

Eine gewisse Erschwernis weitreichender organisatorischer Reformschritte könnte sich zudem daraus ergeben, dass der Gliederung der Sozialversicherungsträger nach verschiedenen Berufsgruppen eine ebensolche in den **gesetzlichen beruflichen Vertretungen** der versicherten Personen bzw von deren DG entspricht, deren Wahl des jeweils satzungsgebenden Organs wieder maßgebend ist, für die Zusammensetzung der satzungsgebenden Organe der Sozialversicherungsträger. Wer die Verschiedenheit der Interessen der diversen Berufsgruppen für die Zwecke der Kranken-, Unfall- und Pensionsversicherung leugnet (und jeder Berufsgruppe in einem erweiterten Träger die Mitwirkung der jeweils anderen an der Verwaltung der Beiträge und in allen anderen Fragen der Verwaltung zumutet), wird erklären müssen, aus welchem Grund das Fortbestehen der grundlegenden Verschiedenheit der Interessen auf der Ebene der gesetzlichen beruflichen Vertretungen dem nicht entgegensteht. Mit anderen Worten: Solange die Berufsgruppen in verschiedenen gesetzlichen Vertretungen in beruflicher Selbstverwaltung tätig sind, könnte es schwierig sein, für den Bereich der sozialen Selbstverwaltung die für diese relevanten Unterschiede erfolgreich zu bestreiten.

Viel hängt daher davon ab, unter welchen Gesichtspunkten man den berufsgruppenübergreifenden Zusammenschluss beurteilt: Genügt es, dass die sozialen Risken (im Großen und Ganzen) dieselben sind, ohne dass auf die Art der Berufsausübung geblickt werden muss, dann fallen die wesentlichen Hindernisse für eine tiefer greifende Reform weg. Für diesen Fall wäre freilich zu überlegen, ob es vertretbar ist, die demokratische Legitimierung des gemeinsamen satzungsgebenden Organs im Wege indirekter Wahl weiterhin berufsbezogen über die gesetzlichen beruflichen Vertretungen zu gewährleisten, da gerade in der **Berufsbezogenheit** die Differenz und nicht die Gemeinsamkeit liegt.

Mit dieser Maßgabe kann daher zusammengefasst werden, dass auch die *Art 120a ff B-VG* nichts an dem Befund ändern, dass für eine maßvolle Umgestaltung der Trägerlandschaft insb im Bereich der gesetzlichen Krankenversicherung jedenfalls der unselbständig Erwerbstätigen keine grundsätzlichen verfassungsrechtlichen Einschränkungen bestehen. Darüber hinaus hängt alles davon ab, inwieweit die für die

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wirtschaft, Arbeiter, Angestellte) gegen die Bestrebungen zu einem einheitlichen Träger durchgesetzt haben.

gesetzliche Sozialversicherung maßgebenden Interessen als zumindest überwiegend gemeinsame definierbar sind, die eine selbstverwaltete gemeinsame Risikengemeinschaft rechtfertigen.[146] **Die betreffenden Maßnahmen können in dem genannten Rahmen daher auch vom einfachen Bundesgesetzgeber getroffen werden, der dabei freilich an das allgemeine Sachlichkeitsgebot gebunden ist**. Über diesen Rahmen hinaus wäre freilich eine verfassungsrechtliche Absicherung erforderlich.

5.2.3. Verfassungsrechtlicher Rahmen für Änderungen im Hinblick auf Systeme außerhalb der Sozialversicherung

5.2.3.1. Krankenfürsorge der Länder und Gemeinden

Als nächstes ist der Frage nachzugehen, inwieweit auch die Einrichtungen der Krankenfürsorge der öffentlich Bediensteten auf Landes- und Gemeindeebene in eine Umgestaltung der Trägerlandschaft einbezogen werden könnten. Diese Einrichtungen stützen sich nach zutreffender herrschender Auffassung nicht auf den Kompetenztatbestand „*Sozialversicherungswesen*“, sondern auf die jeweiligen **Dienstrechtskompetenzen** nach *Art 21 Abs 1 B-VG*.[147]

Das schließt aber noch nicht aus, dass dem Bund auch hier eine Regelungsbefugnis im Hinblick auf das Sozialversicherungsrecht und zwar in der Hinsicht zukommt, dass er auch öffentlich Bedienstete zumindest in die allgemeine Unfall- und Krankenversicherung einbeziehen darf, wovon ja mit dem *B-KUVG* auch Gebrauch gemacht

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[146] Nicht einschlägig für unseren Zweck hingegen sind in VfGH VfSlg 17.023/2003 (Hauptverbandsreform) die Ausführungen, es könne dahinstehen, ob „Sozialversicherungsträger als Selbstverwaltungskörper und mit der Führung von Angelegenheiten der Sozialversicherung (im eigenen, aber auch im übertragenen Wirkungsbereich) betraute Behörden einerseits und die in diesen Selbstverwaltungskörpern jeweils zusammengefassten Gruppen von Versicherten andererseits überhaupt solche gemeinsamen Angelegenheiten haben könnten, die es als verfassungsrechtlich zulässig erscheinen ließen, sie zur relativ autonomen Besorgung dieser Angelegenheiten zu einem gemeinsamen Selbstverwaltungskörper zusammenzuschließen". Unter dem Gesichtspunkt der Repräsentation im Hauptverband wurde es nämlich als verfassungswidrig beurteilt, wenn nicht die Soziaversicherungsträger in den Hauptverband ihre Vertreter entsenden, sondern unter Umgehung der Sozialversicherungsträger direkt die gesetzlichen beruflichen Vertretungen, sodass auf diese Weise eine Repräsentation der Träger und zugleich der Versicherten bewirkt wurde.

[147] Vgl nur VfGH VfSlg 17.260/2004, unter Verweis auf die Vorerkenntnisse VfGH VfSlg 6181/1970 bzw VfSlg 16.767/2002; s auch *Thienel*, Dienstrecht und Kompetenzverteilung, 48 ff.

wurde.[148] Bereits zum – für dessen Auslegung zunächst maßgebenden (vgl bereits 5.2.2.1.) – Zeitpunkt des Inkrafttretens der Stammfassung dieses Kompetenztatbestandes bestand zwar auch eine Art Krankenfürsorge der „Staatsbediensteten", in der Form, dass Personen „*auf Grund eines Dienstverhältnisses zum Staate oder zu einem öffentlichen Fond von der Republik Österreich oder von diesem Fond einen Dienstbezug" erhalten, „der im Falle der Krankheit durch mindestens sechs Monate weitergebührt*"[149]. Ein auf diese Weise gesetzlich ausgestaltetes konkretes Element der **Fürsorgepflicht** des öffentlichen DG schließt indes die Regelung eines Ersatzeinkommens im Krankheitsfall im Rahmen des Kompetenztatbestandes „*Sozialversicherungswesen*" (für die Zeit nach dem Ende der Entgeltfortzahlung im Krankheitsfall durch den DG) nicht aus. Aus der Existenz derartiger, auf den Fall einer Dienstunfähigkeit infolge Krankheit bezogener dienstrechtlicher Regelungen kann jedenfalls nicht der Schluss gezogen werden, dass eine Regelung der Krankenversicherung für die öffentlich Bediensteten nicht unter *Art 10 Abs 1 Z 11 B-VG* fallen würde.

Dies gilt in gleicher Weise für **Vertragsbedienstete** und vor allem auch für Bedienstete der **Länder oder Gemeinden**. Angesichts der schon beschriebenen Möglichkeit einer dynamischen Weiterentwicklung des Kompetenztatbestandes, der gerade im Sozialversicherungsrecht und im Hinblick auf die Erweiterung des erfassten Personenkreises eine besondere Bedeutung zukommt, ist eine Einbeziehung auch die-

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[148] Die Einbeziehung von Beamten in die **Pensionsversicherung** dürfte – vor diesem kompetenzrechtlich bedeutsamen, versteinerungstheoretischen Hintergrund – somit **nicht** in Betracht kommen, solange die Konstruktion des Beamtendienstverhältnisses als ein lebenslanges Rechtsverhältnis zur jeweiligen Gebietskörperschaft ausgestaltet ist, das zunächst ein Aktiv- und danach ein Ruhestandsverhältnis ist, aber zB davon gekennzeichnet ist, dass Beamte im zeitlichen Ruhestand erneut aktiviert werden können und auch im dauernden Ruhestand der Disziplinargerichtsbarkeit unterliegen, jedenfalls aber ein Ruhegehalt beziehen. Mit zunehmender Verwirklichung des politischen Ziels einer Angleichung der Ruhegenüsse für Beamte an jene in der gesetzlichen Sozialversicherung (durch Angleichung der Pensions-Berechnung, Wegfall der vollen Ruhegenussgarantie durch die Einführung einer „Höchstbeitragsgrundlage", Einhebung von Pensionsbeiträgen analog jenen der gesetzlichen Sozialversicherung etc) **verschwimmen** freilich die Grenzen, aufgrund derer es sich „beim öffentlich-rechtlichen Dienstverhältnis und bei der Materie des Sozialversicherungswesens um tiefgreifend verschiedene Rechtsgebiete handelt" (vgl daher insb VfGH VfSlg 19.884/2014, wo bereits betont wird, dass diese Unterschiede nur mehr „grundsätzlich noch" bestehen); s im Übrigen bei **Task 9g**, unten 9.2.

Der VfGH hat in der Vergangenheit sogar Bestimmungen als gegen den Gleichheitssatz verstoßend aufgehoben, die auf eine Einebnung dieser Unterschiede abzielten (zB VfGH VfSlg 11.665/1988 - Ruhen der Pension); die Rechtsprechung der letzten Jahre tendierte dann eher in die Richtung der Akzeptanz des politischen Ziels einer solchen Angleichung, die beim Bund zumindest keine kompetenzrechtlichen Fragen aufwirft, aber sehr wohl bei den Ländern solche aufwerfen könnte, wenn die Kompetenztatbestand „*Dienstrecht*" verlassen und in Wahrheit Sozialversicherungsrecht normiert würde.

[149] *§ 1* des *Gesetzes über die Krankenversicherung der Staatsbediensteten, StGBl 1920/311*.

ser Personengruppen kompetenzrechtlich jedoch nicht ausgeschlossen.[150] Von diesem Verständnis geht auch der Bundesgesetzgeber aus, wenn er in *§ 5 Abs 1 Z 3* bzw *3b ASVG* und *§ 2 Abs 1 Z 2 B-KUVG* Regelungen im Hinblick auf die Krankenversicherung auch der Landes- und Gemeindebediensteten trifft, mögen diese auch einen dienstrechtlichen Versorgungsanspruch haben. Noch wesentlicher ist im vorliegenden Zusammenhang allerdings, dass der VfGH diese grundsätzliche Inanspruchnahme der Regelungszuständigkeit auch für die Krankenversicherung der Landes- und Gemeindebediensteten ausdrücklich akzeptiert hat.[151]

Im selben Erkenntnis hat der VfGH aber auch den **Unterschied** zwischen dem sozialversicherungs- und dem dienstrechtlichen Zugang deutlich gemacht: Während die soziale Krankenversicherung vom Solidargedanken geprägt ist und im Wesentlichen in berufsständischer Selbstverwaltung besorgt wird, und die (insb durch die Ausgleichsfonds miteinander auch rechtlich verbundenen) Krankenversicherungsträger daher Leistungen für die jeweilige Versichertengemeinschaft erbringen, stellt in einem Krankenfürsorgesystem das Land, die Gemeinde oder der Gemeindeverband als DG jeweils für seine (ihre) DN die im Krankheitsfall zur Krankenbehandlung erforderlichen Leistungen selbst bereit. Die jeweiligen Regelungen werden also unter einem jeweils **anderen Gesichtspunkt** getroffen, so dass insoweit unterschiedliche Kompetenzen **nebeneinander** stehen können.[152] Auf Grund der hier maßgebenden „Gesichtspunktetheorie“ ist somit der Bundesgesetzgeber befugt, die Vorsorge bei Erkrankung von Beamten und Vertragsbediensteten der Länder, Gemeinden und Gemeindeverbände unter dem Aspekt der Solidarität im Rahmen einer – die erforderlichen Mittel durch (einkommens- und risiko)solidarische Beiträge aufbringenden – Versichertengemeinschaft (also als Krankenversicherung!) einzurichten, es ist aber auch dem jeweiligen Landesgesetzgeber erlaubt, die Krankenfürsorge für dieselben Personengruppen unter dem Aspekt der DG-Fürsorge zu regeln. An diesem Systemunterschied ändert auch der Umstand nichts, dass auch in der Krankenfürsorge die DN zu Beiträgen verhalten werden und dieses System möglicherweise organisatorisch in gewisser Weise dem Sozialversicherungssystem des Bundes nachgebildet ist. [153] Es könnte sich lediglich die Frage stellen, wie sehr der Dienstrechtsgesetzgeber in den Ländern die dortigen Krankenfürsorgeeinrichtungen

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[150] Vgl die Nachweise bei *Koprivnikar*, Krankenfürsorge und Sozialversicherung – Eine Untersuchung unter dem Blickwinkel des Verfassungsrechts, DRdA 2004, 424 (430 f).

[151] Vgl noch einmal VfGH VfSlg 17.260/2004.

[152] Vgl noch einmal nur *Thienel*, Dienstrecht und Kompetenzverteilung, 50 f.

[153] Vgl noch einmal VfGH VfSlg 17.260/2004.

den Einrichtungen der Sozialversicherung nachbilden darf, ohne dadurch auch den Kompetenztatbestand zu wechseln.[154]

Erneut liegt also die Grenze der Möglichkeiten für eine Umgestaltung der Trägerlandschaft nicht in der Kompetenzverteilung, sondern im **Sachlichkeitsgebot**: Die Einbeziehung der Landes- und Gemeindebediensteten in die gesetzliche Krankenversicherung wäre zwar vom Kompetenztatbestand Sozialversicherungswesen gedeckt. Sie wäre aber wohl insoweit unsachlich, als sie zu einer **mehrfachen Beitragspflicht** führen würde, der – jedenfalls im Sachleistungsbereich – keine adäquaten Leistungsansprüche gegenüberstehen würden. Diese Situation ist auch nicht vergleichbar mit den vom VfGH als zulässig qualifizierten Konstellationen einer Mehrfachversicherung bzw mehrfachen Erfassung in verschiedenen Beschäftigungen, weil anders als dort[155] nicht die gleichzeitige Zugehörigkeit zu verschiedenen Risikogemeinschaften auf Grund mehrerer unterschiedlicher Tätigkeiten, sondern die Zugehörigkeit zur einheitlichen Risikogemeinschaft der Landes- und Gemeindebediensteten auf Grund ein und derselben Tätigkeit Anknüpfungspunkt für die jeweilige Einbeziehung wäre.

Diese sachlich wohl nicht zu rechtfertigende Konstellation könnte auch der Bundesgesetzgeber nicht korrigieren, indem er gleichsam einen Vorrang des Sozialversicherungsmodells anordnete, weil er dafür die dienstrechtliche Krankenfürsorge abschaffen oder zumindest beschneiden müsste, was aber ausschließlich in die Kompetenz der Länder nach *Art 21 Abs 1 B-VG* fiele.[156] **Sofern hier also keine zwischen Bundes- und Landesgesetzgebung akkordierte Vorgangsweise erreicht werden kann, wäre eine „Bereinigung der Trägerlandschaft" unter Einbeziehung auch der landesrechtlichen Krankenfürsorgeeinrichtungen nur durch (Bundes-)Verfassungsgesetz möglich.**

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[154] Die Einrichtung dieser idR unselbständigen Fürsorgeanstalten in den Ländern in Selbstverwaltung, die dazu führen würde, dass die Beitragsleistung an und die Leistungserbringung durch den DG diesem nicht mehr unmittelbar zugerechnet werden könnte, würde wohl die Dienstrechtskompetenz der Länder überschreiten und daher verfassungswidrig sein.

[155] Vgl insb VfGH VfSlg 4801/1964; VfSlg 6181/1970; VfSlg 12.417/1990; VfSlg 12.739/1991; VfSlg 16.814/2003 und natürlich noch einmal VfSlg 17.260/2004.

[156] Dazu kommt noch das Problem des **Vertrauensschutzes** im Falle von (insb leistungsrechtlichen) Verschlechterungen, die möglicherweise durch eine solche Neuregelung bewirkt würden. Diesbezüglich **unproblematisch** wäre dagegen die Etablierung eines neues Systems nur mit Geltung für die „**neuen**", dh erst nach einem bestimmten „Stichtag" aufgenommenen Landes- oder Gemeindebediensteten.

5.2.3.2. Wohlfahrtseinrichtungen der Kammern der freien Berufe

Als problematisch könnte sich schließlich auch die Bereinigung der Trägerlandschaft in bzw im Umfeld der gesetzlichen Krankenversicherung im Hinblick auf die verschiedenen Wohlfahrtseinrichtungen der Kammern der freien Berufe[157] erweisen. Diese beruhen auf dem für die jeweilige Kammer(organisation) einschlägigen Kompetenztatbestand.[158] Alle danach in Frage kommenden Kompetenzgrundlagen weisen zwar die Gesetzgebung dem Bund zu;[159] die Vollziehung liegt aber zum einen in einigen Bereichen bei den Ländern und fällt zum anderen auch in den verbleibenden Bereichen nicht in die unmittelbaren Bundesverwaltung nach *Art 102 Abs 2 B-VG*.

Es ist daher nicht unwesentlich, ob die versteinerungsmethodisch begründete Zuordnung der Vorsorge für den Krankheitsfall im Bereich der freien Berufe und ihrer Kammern damit aus der Kompetenzzuweisung des *Art 10 Abs 1 Z 11 B-VG* herausfällt, womit kein Raum für eine Regelung dieser Vorsorge durch das Sozialversicherungsrecht bleibt. Anders als in der bei den landesrechtlichen Einrichtungen der Krankenfürsorge maßgebenden Konstellation Dienstrecht/Sozialversicherungsrecht sind hier die **Gesichtspunkte**, unter denen die Erfassung von Risiken wie Krankheit jeweils geregelt würden, nämlich nicht unterschiedlich: In beiden Fällen ist die Zugehörigkeit zu einer Berufsgruppe Anknüpfungspunkt für eine Regelung, die für die Verteilung der Chancen und Lasten innerhalb dieser Risikogemeinschaft sorgt. Der sozialversicherungsrechtlich Ausschlag gebende Gesichtspunkt der Berufsgruppenzugehörigkeit unterscheidet sich damit vom Gesichtspunkt der Kammerzugehörigkeit gerade nicht. Sofern man bei der Abgrenzung der Risikogemeinschaften nicht bloß nach Wirtschaftssparten und Beschäftigungstypen, sondern nach **Berufsgruppen** differenziert, müsste daher die kompetenzrechtliche Zuordnung der Krankenfürsorge zu den kammereigenen Einrichtungen eine gleichzeitige Zuständigkeit nach *Art 10*

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[157] Vgl den – freilich nicht mehr ganz aktuellen – Überblick bei *Frank*, Opting-in, Opting-out: Die Eigenvorsorge der freien Berufe auf dem Prüfstand, in *Kneihs/Lienbacher/Runggaldier* (Hg) Wirtschaftssteuerung durch Sozialversicherungsrecht? 165 (189 ff).

[158] Insb *Art 10 Abs 1 Z 6* („*Angelegenheiten der Notare, der Rechtsanwälte und verwandter Berufe*"), *Z 8* („*Ingenieur- und Ziviltechnikerwesen*") oder *Z 12* („*Gesundheitswesen*"), *Art 11 Abs 1 Z 2* (*sonstige „berufliche Vertretungen"*) *B-VG*. Vgl zum Folgenden mit den notwendigen Nachweisen zum Versteinerungsmaterial *Kneihs*, Rechtsprobleme der Errichtung kammereigener Wohlfahrtseinrichtungen, ZÖR 2002, 1 (3 ff).

[159] Dieser hat von dieser Befugnis freilich nur insofern Gebrauch gemacht, als gesetzlich nicht die Versorgungssysteme selbst geregelt werden, sondern nur der Rahmen bestimmt wird, innerhalb dessen die jeweiligen Selbstverwaltungskörper dann kraft Verbandsautonomie und demokratisch legitimiert durch die Mitglieder ein eigenes Versorgungssystem schaffen dürfen, das daher durchaus auch nach dem Kapitaldeckungsprinzip eingerichtet sein kann und in manchen Fällen auch ist.

Abs 1 Z 11 B-VG schlagen. Der verfassungsrechtlichen Kompetenzverteilung – die auf Kompetenztrennung und nicht auf Kompetenzverbindung angelegt ist – ist nicht zuzusinnen, dass sie die Zuständigkeit zur Regelung der Vorsorge für diesen Fall zugleich verschiedenen Regimen unterstellen wollte. Eine Einbeziehung der Angehörigen dieser freien Berufe in die gesetzliche Sozialversicherung würde dann an der jeweils unterschiedlichen Vollzugskompetenz scheitern.

Dieser in der Lehre vertretenen Auffassung[160] ist der VfGH freilich bisher nicht gefolgt. Er hat vielmehr – ähnlich wie im Verhältnis zwischen Sozialversicherungs- und Dienstrecht – sowohl die Einbeziehung freiberuflich tätiger Ärzte in das *FSVG* als auch die Mehrfacherfassung der unselbständig tätigen Ärzte durch *ASVG* und kammereigene Wohlfahrtseinrichtungen genauso akzeptiert wie die durch das *GSVG* geschaffene Möglichkeit der Ausnahme der Angehörigen der freien Berufe aus der gesetzlichen Sozialversicherung, die allerdings bereits eine Regelungskompetenz für diese Sozialversicherung in Anspruch nimmt und die grundsätzliche Einbeziehung der jeweiligen Berufsgruppen in das *GSVG* unterstellt.[161] Der VfGH hat dabei aber zur Kompetenzrechtslage nie dezidiert Stellung bezogen und nimmt daher entweder an, dass die Zuordnung der kammereigenen Wohlfahrtsvorsorge zu den jeweils einschlägigen Kompetenztatbeständen unrichtig ist oder er geht erneut davon aus, dass eine Regelung dieser Wohlfahrtsvorsorge unter unterschiedlichen **Gesichtspunkten** nach verschiedenen Kompetenztatbeständen zulässig ist. Das ließe sich auch mit dem Kompetenztatbestand des *Art 10 Abs 1 Z 11 B-VG* vereinbaren, wenn man ihn nicht – was wohl unzulässig eng wäre – auf eine rein berufsgruppenbezogene, sondern auf eine nach **Wirtschaftssparten bzw Beschäftigungstypen** differenzierte Gruppensolidarität bezieht.

Der VfGH zieht auf diesem Gebiet die Grenzen der Kompetenzbestimmungen innerhalb der Bundeskompetenzen aber ohnedies weniger strikt: So liegt es im rechtspolitischen Ermessen des Gesetzgebers, Berufsanwärter auf einen freien Beruf entweder mit Blick auf die langfristig gleichlaufenden beruflichen Interessen der betreffenden gesetzlichen beruflichen Vertretung des freien Berufs oder aber mit Blick auf ihre Interessenlage als DN der Arbeiterkammer zuzuordnen.[162] Der VfGH hatte – eine den Anforderungen des Legalitätsprinzips nach *Art 18 B-VG* entsprechende

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[160] Insb von *Kneihs*, Rechtsprobleme der Errichtung kammereigener Wohlfahrtseinrichtungen, ZÖR 2002, 1 (3 ff).

[161] VfGH VfSlg 12.417/1990; VfSlg 16.814/2003. In VfGH VfSlg 15.641/1999 und VfSlg 15.860/2000 wies der VfGH gegen *§ 5 GSVG* gerichtete Individualanträge mangels Antragslegitimation zurück; aus diesen Entscheidungen folgt daher für eine materielle Beurteilung der Regelung nichts.

[162] VfGH VfSlg 12.021/1989 – Wirtschaftstreuhänder.

gesetzliche Ermächtigung an das jeweilige satzungsgebende Organ vorausgesetzt[163] – auch nie Bedenken dagegen, dass die Vertretung der sozialen Interessen der Mitglieder einer gesetzlichen beruflichen Vertretung umfassend, dh die Schaffung einer kammereigenen Altersversorgung einschließend, verstanden worden sind. Man kann diese Judikatur so verstehen, dass die Kompetenz zur Regelung des Berufsrechts und zur Wahrnehmung der sozialen Interessen der Kammerangehörigen ebenso die Befugnis zur gesetzlichen Zulassung der Schaffung eines Versorgungssystems mit einschließt, wie dies aufgrund der Kompetenz zur Regelung des Dienstrechts der Fall ist. Der Kompetenztatbestand "Sozialversicherung" lässt hingegen die Schaffung von Versorgungssystemen „an sich“ (dh losgelöst von dienst- oder berufsrechtlichen Belangen) zu.

Vor diesem Hintergrund ist auch die Einbeziehung der Angehörigen der Kammern der freien Berufe in die gesetzliche Sozialversicherung[164] kompetenzrechtlich zulässig. Sie müsste sich aber wegen der damit uU bewirkten Mehrfachversicherung ebenfalls unter dem Gesichtspunkt des Gleichheitssatzes verfassungsrechtlich prüfen lassen. Das ist auch der Weg, den der VfGH beschritten hat, der in seiner Rechtsprechung sowohl die Pflichtmitgliedschaft der Kammerangehörigen zu den jeweiligen Wohlfahrtseinrichtungen als auch ihre grundsätzliche Erfassung im System der gesetzlichen Sozialversicherung für zulässig hielt und (lediglich) auf ihre Sachlichkeit hin geprüft hat, ohne dort freilich allzu strenge Grenzen zu ziehen.[165]

Die Einbeziehung der Angehörigen der Kammern der freien Berufe in die gesetzliche Sozialversicherung erscheint daher auf dem Boden der bisherigen Rechtsprechung verfassungsrechtlich zulässig. Dies gilt umso mehr, als der Bundesgesetzgeber allenfalls unsachliche Auswirkungen insb einer Mehrfachversicherung und sogar die Mehrfachversicherung als solche – selbstverständlich unter

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[163] VfGH VfSlg 18.660/2008, 16.344/2001; 16.206/2001 - jeweils Wirtschaftstreuhänderkammer; in der zuletzt genannten Entscheidung vertrat der VfGH darüber hinaus die Auffassung, dass es bei Berufsgruppen, die in der gesetzlichen Sozialversicherung pensionsversichert gewesen sind und in ein kammereigenes System wechseln, „anders als im Falle von Berufsgruppen, die erstmals in das *GSVG* einbezogen werden - weitreichenderer Vorkehrungen in bezug auf die nach dem *GSVG* erworbenen Anwartschaften bedurft hätte“. Daraus scheint sich zu ergeben, dass das kammereigene Versorgungssystem auf die Anwartschaften nach dem *GSVG* Bedacht zu nehmen hat; auf welche Weise bleibt in dieser Entscheidung freilich offen.

[164] Bei den Wirtschaftstreuhändern war das viele Jahre hindurch auch der Fall. Die Ziviltechniker sind aus der kammereigenen Versorgung in das *GSVG* gewechselt, wo die Ärzte, Zahnärzte, Apotheker und Patentanwälte schon länger, zT parallel zur kammereigenen Versorgungseinrichtung, unangefochten pflichtversichert sind, vgl *§ 2 FSVG*.

[165] Vgl insb VfGH VfSlg 12.417/1990; VfSlg 16.814/2003. Näher *Pöschl*, Höchstbeitragsgrundlage und Mehrfachversicherung als Instrumente der Umverteilung und als verfassungsrechtliches Problem, in *Kneihs/Lienbacher/Runggaldier* (Hg), Wirtschaftssteuerung durch Sozialversicherungsrecht? 106 ff.

übergangsrechtlicher Wahrung vertrauensschutzrechtlicher Aspekte – beseitigen könnte, da er – in diesem Fall auf Basis der Kompetenzen nach *Art 10 Abs 1 Z 6, 8* oder *12* bzw *Art 11 Abs 1 Z 2 B-VG* – die Pflichtmitgliedschaft zu deren Wohlfahrtseinrichtungen, aber auch diese selbst abschaffen oder die Beiträge bzw Leistungen entsprechend anpassen könnte. Eine Einbeziehung einer kammereigenen Wohlfahrtseinrichtung in die gesetzliche Sozialversicherung hat auch bereits – zumal verfassungsrechtlich unbeanstandet, wenngleich im Einvernehmen der Beteiligten – stattgefunden: Die Ziviltechnikerkammer hat ihren Wohlfahrtsfonds aufgelöst, und ihre Mitglieder wurden in die SVA und in die Pflichtversicherung nach *§ 2 Abs 1 Z 3 FSVG* aufgenommen (vgl auch die durch *BGBl I 2013/4* im *FSVG* eingefügten Übergangsbestimmungen der *§§ 20c ff*).

5.3. Schlussfolgerungen

Die Analyse der verfassungsrechtlichen Rahmenbedingungen für eine Umgestaltung der Trägerlandschaft, die zunächst einmal auf den Bereich der Krankenversicherung fokussiert war, ergibt zusammengefasst folgendes Bild:

Die bisherige Gliederung der für die Gesundheitsversorgung zuständigen Träger und die dadurch bedingte Differenzierung, welche Personenkreise jeweils erfasst werden, ist an sich begründet und verfassungsrechtlich solide fundiert. Die verfassungsrechtlichen Rahmenbedingungen würden aber durchaus größere Umgestaltungen zulassen: Der Kompetenztatbestand „*Sozialversicherungswesen*“ knüpft zwar **grundsätzlich** an die **Erwerbstätigkeit** an, erlaubt aber die **Erweiterung** des erfassten Personenkreises im Wege der Einbeziehung von Angehörigen der Versicherten, von Personen, die noch nicht oder nicht mehr einer Erwerbstätigkeit nachgehen und schließlich auch ergänzend durch die Ermöglichung einer freiwilligen Versicherung. Im Lichte einer – gerade bei der Sozialversicherung möglichen, wenn nicht sogar gebotenen – dynamischen intrasystematischen Fortentwicklung dieses Kompetenztatbestandes ist grundsätzlich die Erfassung der **gesamten Wohnbevölkerung** durch die soziale Krankenversicherung möglich.

Diese weitreichende Erfassung besteht im Grunde schon bisher, die Einbeziehung der verschiedenen Personengruppen erfolgt jedoch segmentiert dadurch, dass **unterschiedliche Versichertengemeinschaften** etabliert sind. Diese sind vorrangig nach der Art der Erwerbstätigkeit differenziert, wobei den einzelnen Gruppen dann

andere nicht erwerbstätige Personen gleichsam als Annex zugerechnet werden. Die grundsätzliche Trennlinie wird zunächst zwischen den **Selbständigen** und den Unselbständigen gezogen. Bei ersteren wird dann im Wesentlichen nur zwischen in der Land- und Forstwirtschaft Tätigen und sonstigen Selbständigen unterschieden, wobei die Angehörigen der freien Berufe teilweise noch eine Sonderstellung einnehmen, die Bildung der Versichertengemeinschaften erfolgt aber ansonsten bundesweit.

Bei den **Unselbständigen** wird dagegen nach der Art des DG und nach regionalen Gesichtspunkten unterschieden, was gewiss auch mit der Tatsache zu tun hat, dass die Zahl der erfassten Personen hier ungleich größer ist als bei den Selbständigen.[166] Die Differenzierung erfolgt in der Form, dass bestimmte unselbständig Tätige einem **Sondersystem** unterstellt werden, weil und wenn sie für einen öffentlichen DG oder in einem Bergbau- oder Eisenbahnbetrieb tätig sind oder bei einem (der inzwischen nur mehr fünf) privaten DG beschäftigt sind, dessen DN zu einer Versichertengemeinschaft auf betrieblicher Ebene zusammengeschlossen sind. Diese Sondersysteme sind in gewisser Weise ebenso nur historisch erklärbar wie die **Krankenfürsorgeeinrichtungen** für (bestimmte) Landes- bzw Gemeindebedienstete. In beiden Fällen werden damit Ausnahmen vom jeweiligen „allgemeinen" System begründet, das bei den (sonstigen) Bediensteten öffentlicher DG bundesweit organisiert ist, während bei den bei privaten DG Beschäftigten – wohl schon wegen der Anzahl von zu erfassenden Personen – die Versichertengemeinschaften nach Bundesländern differenziert werden.

Diese Vielfalt ist begründbar und durchaus sachlich, die Verfassungsrechtslage schließt aber andere Lösungen nicht aus. Rechtlich grundsätzlich möglich sind dabei, wie auch die bisherige und insoweit unbeanstandet gebliebene Situation zeigt, **größere oder kleinere** ebenso wie **bundesweit** organisierte **oder regional gegliederte** Gemeinschaften. Die Verfassung ist diesbezüglich **neutral**, wenngleich unter dem Gesichtspunkt des Risikoausgleichs wohl größere Träger zu bevorzugen wären, weil es dort in der Regel leichter möglich ist, auch (mehr) schlechtere Risiken zu erfassen. Genau das macht eigentlich das Wesen eines Sozialversicherungssystems aus, so dass es von Verfassungs wegen unzulässig wäre, Personen nur wegen eines schlechteren Risikos auszuschließen oder sie nur zu höheren Beiträgen an der Risikogemeinschaft teilhaben zu lassen etc.

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[166] So waren im Jahresschnitt 2016 von rund 8,615 Mio in der Krankenversicherung erfassten Personen (einschließlich der Angehörigen und Pensionisten) lediglich etwa 1,15 Mio den beiden für die Krankenversicherung der Selbständigen zuständigen Trägern zugewiesen, vgl Die österreichische Sozialversicherung im Jahr 2016, SozSi 2017, 195 (211).

Die Verfassung fordert auch nicht, dass zwischen den jeweils in einer Risikogemeinschaft erfassten Personen besondere Verbindungen oder soziologische Gemeinsamkeiten bestehen müssten. Es reicht vielmehr aus, dass die betreffenden Personen gleichartigen sozialen Risiken ausgesetzt sind und daher zwischen ihnen ein Risikoausgleich erfolgen kann und in der Folge auch nur zwischen ihnen erfolgen soll. Hinsichtlich der **Gleichartigkeit** der Risiken kann gerade bei der gesetzlichen **Krankenversicherung kein strenger** Maßstab gelten. Die dort erfassten Risiken sind strukturell weitegehend dieselben, egal ob die betreffende Person selbständig oder unselbständig erwerbstätig ist, ob sie bei einem privaten oder öffentlichen DG beschäftigt ist, ob ihr DG eine Eisenbahn betreibt oder ob es sich dabei um ein Land oder eine Gemeinde handelt. Diese Gleichartigkeit schlägt sich im Übrigen auch in inzwischen gleich hohen Beitragssätzen[167] und – trotz aller Unterschiede im Detail[168] – zumindest sehr ähnlichen Leistungsvoraussetzungen und Leistungskatalogen nieder. Eine Zusammenlegung unter dem Gesichtspunkt gleicher Risiken würde gemessen an der bisherigen Rechtsprechung des VfGH allerdings „gleiche Antworten" auf diese Risiken notwendig machen, dh eine **weitgehende Vereinheitlichung des Beitragsrechts und auch des Leistungsrechts** für die gesamte Versichertengruppe, möglicherweise auch eine Reform der **demokratischen Kreation** des satzungsgebenden Organs abseits der gesetzlichen beruflichen Vertretungen erfordern.

Die verfassungsrechtlichen Vorgaben würden daher einer Zusammenlegung bestehender Träger – vorbehaltlich entsprechender übergangsrechtlicher Vorkehrungen insb im Hinblick auf Fragen der Rechtsnachfolge und des Vertrauensschutzes – nicht a-priori im Wege stehen. Grundsätzlich wäre daher etwa die **Konzentration** auf je einen Träger für die Unselbständigen und die Selbständigen und allenfalls noch ein Sondersystem für die öffentlich Bediensteten ebenso denkbar wie die Zusammenfassung aller Versicherten im Rahmen von regional gegliederten Trägern. Aus rechtspolitischer, wenngleich nicht verfassungsrechtlicher Sicht ist hier auch zu bedenken, dass die Zahl der für alle Beteiligten, vor allem aber für die Versicherten überaus unangenehmen Abgrenzungsprobleme[169] deutlich verringert werden könnte, wenn größere Versichertengemeinschaften eingerichtet wären.

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[167] Auf das Problem der gleichwohl unterschiedlich gebildeten Beitragsgrundlagen kann hier nur noch einmal hingewiesen werden.

[168] Näher dazu **Task 2a**, oben 3.2.

[169] Man denke nur an die häufig unklare Zuordnung DN (§ 4 Abs 2 ASVG) – freie/r DN (*§ 4 Abs 4 ASVG*) – „neue/r Selbständige/r" *(§ 2 Abs 1 Z 4 GSVG).*

Selbst die Bildung einer einheitlichen Versichertengemeinschaft für alle in der Krankenversicherung zu erfassenden Personen scheint nicht ausgeschlossen, solange innerhalb dieser nach den Unterschieden im Tatsächlichen differenziert wird.[170] Allerdings dürfte mit zunehmender personeller und territorialer Ausdehnung einer solchen Risikogemeinschaft die Nutzung des Rechtsinstitutes der Selbstverwaltung an verfassungsrechtliche Grenzen stoßen, so dass möglicherweise die Schaffung eigener Sozialversicherungsbehörden erforderlich wäre.

Für eine Konzentration spricht noch ein weiterer Gesichtspunkt, der zumindest **mittelbar** aus den verfassungsrechtlichen Vorgaben abzuleiten ist. Sowohl der Kompetenztatbestand als auch die Regelungen zur Selbstverwaltung erfordern, dass die jeweiligen Zusammenschlüsse nach **sachlichen** Gesichtspunkten zu erfolgen haben bzw voneinander abzugrenzen sind. Diese sachliche Differenzierung zuallererst nach der Art der Erwerbstätigkeit oder dem rechtlichen Status oder gar dem Betriebssitz des jeweiligen DG vornehmen zu wollen, wird in der **modernen Arbeitswelt zunehmend schwieriger**: Die Grenzen zwischen den einzelnen Tätigkeitsformen verschwimmen, die einzelnen Personen wechseln häufiger die Tätigkeit oder üben unterschiedlichen Versichertengemeinschaften zugeordnete Tätigkeiten nebeneinander aus, Phasen der Erwerbstätigkeit wechseln häufiger mit Phasen der Erwerbslosigkeit ab usw. All das stellt auch eine Herausforderung für die Neukonstituierung von nach rechtlich sauberen Kriterien gegliederten Risikogemeinschaften dar. Gegen eine Umgestaltung der Trägerlandschaft können diese Schwierigkeiten aber rechtlich gerade nicht ins Treffen geführt werden.

Die Frage, welche Arten von Neuordnung den verfassungsrechtlichen Anforderungen entsprechen würden, kann dennoch an dieser Stelle nur **abstrakt** beantwortet werden, hängt sie doch zuallererst von den Kriterien ab, die der jeweiligen Zuordnung zu Grunde gelegt werden. Würde zB ein einheitlicher Krankenversicherungsträger für alle selbständig Erwerbstätigen geschaffen, bedürfte es einer besonderen sachlichen Rechtfertigung, einzelne Gruppen von Selbständigen einer anderen Versichertengemeinschaft zuzuordnen.[171] Dagegen wäre es wohl grundsätzlich sachlich, bestimmte Gruppen von Erwerbstätigen deswegen nicht in eine Risikogemeinschaft einzubezie-

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[170] Noch einmal sei hier beispielhaft auf die grundsätzliche unterschiedliche Risikolage im Hinblick auf die Arbeitsunfähigkeit wegen Krankheit bei Erwerbstätigen und nicht Erwerbstätigen einerseits und die Unterschiede zwischen DN und gewerblich Selbständigen andererseits hingewiesen.

[171] Eine solche Rechtfertigung wäre uU bei Einpersonen-Unternehmen vorstellbar, deren grundsätzliche Risikolage bestimmten Unselbständigen eher entsprechen könnte als einem Gewerbetreibenden mit einer Vielzahl von MitarbeiterInnen.

hen, weil sie bereits in einem anderen System gleichartige Leistungen zu ähnlichen Bedingungen erhalten und dieses System beibehalten werden muss.

Die letztgenannte Konstellation betrifft insb die Frage der **Krankenfürsorgeeinrichtungen auf Landes- bzw Gemeindeebene**. Hier hätte es der einfache Bundesgesetzgeber zwar in der Hand, die bisher dort erfassten Personen auch in eine breiter gefasste Versichertengemeinschaft (zB aller Unselbständigen, aller öffentlich Bediensteten oder aller in einem Bundesland Beschäftigten) einzubeziehen.[172] Ohne korrespondierende landesrechtliche Regelungen würde es damit aber im Ergebnis zu einer „Mehrfachversicherung" auf Grund ein und derselben Tätigkeit kommen, die jedenfalls dann nicht sachlich zu rechtfertigen sein wird, wenn daraus nicht auch entsprechend höhere Leistungsansprüche resultierten, was jedenfalls bei den Sachleistungen der Krankenversicherung regelmäßig nicht der Fall sein dürfte.

Bei den Wohlfahrtseinrichtungen der freien Berufe könnte dieses Problem vermieden werden, weil hier ja der einfache Bundesgesetzgeber selbst zur Erlassung entsprechend abgestimmter Regelungen befugt wäre.

Damit können die beiden in der Aufgabenstellung formulierten Fragen wie folgt beantwortet werden:

> *„Gibt es eine verfassungsgesetzlich verankerte Bestandsgarantie für die nach Berufsgruppen und/oder regional und/oder bundesweit organisierten Kranken-, Unfall- und Pensionsversicherungsträger und die Krankenfürsorgeanstalten?"*

➔ Eine solche verfassungsrechtliche Bestandsgarantie besteht nicht. Sie ist insb weder aus dem Kompetenztatbestand „*Sozialversicherungswesen*" noch aus den Verfassungsregelungen über die Selbstverwaltung abzuleiten. Die entscheidende verfassungsrechtliche Grenze für die Umgestaltung der Trägerlandschaft ist vielmehr das Sachlichkeitsgebot. In diesem Rahmen kommt dem einfachen Gesetzgeber aber ein weiter Gestaltungsspielraum zu, und zwar sowohl dahingehend, ob die Bildung von Versichertengemeinschaften überhaupt (weiterhin) nach Berufsgruppen erfolgt, als auch im Hinblick darauf, wie die Abgrenzung zwischen den einzelnen Berufsgruppen vorgenommen wird. Eine allzu weit reichende personelle und räumliche Ausdehnung der Risikogemeinschaft könnte allerdings deren Organisation im Rahmen der Selbstverwaltung unzulässig machen.

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[172] Das brächte sozialpolitisch auch den Vorteil, dass die betroffenen Personen für den Fall mehrfacher Beschäftigung in den Genuss der gemeinsamen Höchstbeitragsgrundlage kämen, wie dies bei herkömmlichen Mehrfachversicherungen der Fall ist.

➔ Auch für die Krankenfürsorgeeinrichtungen auf Landes- bzw Gemeindeebene gibt es keine solche Bestandsgarantie. Deren Auflösung liegt freilich ebenso in der Kompetenz des jeweiligen Landesgesetzgebers wie die Beseitigung jener Hindernisse, die eine gleichzeitige Erfassung dieser Personen im Rahmen eines Sozialversicherungssystems (die an sich bundesgesetzlich möglich wäre) mit hoher Wahrscheinlichkeit unsachlich und damit verfassungswidrig machen würde. Für grundlegende Änderungen in diesem Bereich bedürfte es daher einer Verfassungsmehrheit im National- wie im Bundesrat (*Art 44 Abs 2 B-VG*).

➔ Bei den Wohlfahrtseinrichtungen der freien Berufe besteht dieses Problem nicht, weil hier der einfache Bundesgesetzgeber selbst zur Erlassung entsprechend abgestimmter Regelungen befugt ist.

> *„Gebietet die Bundesverfassung die Bildung von unterschiedlichen Versichertengemeinschaften (Unselbstständige, Selbstständige) oder ist dem Gesetzgeber die Strukturgestaltung der Selbstverwaltung frei überlassen?“*

➔ Die Bundesverfassung gebietet auch nicht a-priori die Bildung von unterschiedlichen Versichertengemeinschaften. Die hier bestehende Vielfalt ist begründbar und nicht unsachlich, zwingt den Gesetzgeber aber lediglich, das damit geschaffene Ordnungssystem nicht in unsachlicher Weise zu unterlaufen (zB durch finanzielle Umverteilung zwischen Versichertengemeinschaften, zwischen denen es keine ausreichenden sachlichen und persönlichen Verbindungen gibt).

➔ Gerade im Hinblick auf die von der Krankenversicherung erfassten Risiken und vor dem Hintergrund der aktuellen tiefgreifenden Änderungen in der Arbeitswelt und nicht zuletzt aus ökonomischer Sicht spricht wohl mehr für eine stärkere Konzentration von Versichertengemeinschaften als für eine Beibehaltung der derzeitigen Vielfalt, mag diese auch historisch gewachsen und immer noch verfassungsrechtlich zu rechtfertigen sein, sofern die Gemeinsamkeit der Risiken, dann aber auch jene der Beiträge und Leistungen im Vordergrund stehen.

6. Task 7c: Kompetenzbereinigung im Bereich des Krankenanstaltenrechts[173]

6.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„NORMATIVE GRUNDLAGEN: Analyse des Ist-Zustands. Verfassungsfragen"** folgende Passage (6f):

> „**Kompetenzbereinigung in der Gesetzgebung im Bereich der Krankenanstalten**
>
> Gesundheitsversorgung ist nicht auf die Sozialversicherungen zu beschränken, sondern wird zu einem großen Teil auch in den Krankenanstalten geleistet. Daher ist auch die verfassungsrechtliche Kompetenzverteilung in diesem Bereich zu betrachten. Die **Kompetenzverteilung im Krankenanstaltenbereich** ist historisch gewachsen und komplex. Derzeit ist die Grundsatzgesetzgebung Bundessache und die Ausführungsgesetzgebung obliegt den Ländern. Dies führt im Detail zu unterschiedlichen Regelungen in den neun Bundesländern. Daher ist zu prüfen, ob es weiterhin zehn Krankenanstaltengesetze geben soll, oder ob es sowohl ökonomisch, als auch staatsrechtlich effektiver wäre, die Gesetzgebung (nicht aber die Verwaltung) beim Bund zu bündeln. Neben der juristischen Analyse ist auch eine ökonomische Bewertung einer Änderung der Kompetenzverteilung zu erstellen und das Ergebnis der Beibehaltung des Status-Quo gegenüberzustellen."

Daraus wurde folgende **Aufgabenstellung** abgeleitet (7):

„Prüfung der verfassungsrechtlichen Möglichkeiten einer Kompetenzverschiebung im Bereich des Krankenanstaltenrechts."

Die folgenden Ausführungen sollen den **bestehenden** verfassungsrechtlichen **Rahmen** (2.) und die **Möglichkeiten** einer Kompetenzverschiebung beleuchten (3.). Da eine solche eine Änderung der Bundesverfassung voraussetzen würde, für die nicht nur eine Zweidrittelmehrheit im Nationalrat, sondern auch im Bundesrat erforderlich

[173] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* und *Birgit Schrattbauer* sowie unter Berücksichtigung von Hinweisen von *Walter Pöltner* verfasst.

wäre (vgl *Art 44 Abs 1* und *2 B-VG*), erscheint diese Option politisch wenig realistisch. Daher sollen auch **andere Möglichkeiten** geprüft, die zu ähnlichen Ergebnissen führen könnten, wie sie mit einer „Kompetenzbereinigung" erreicht werden könnten (4.).

6.2. Der bestehende verfassungsrechtliche Rahmen für das Krankenanstaltenrecht

Die Regelung im Hinblick auf Heil- und Pflegeanstalten gehört gemäß *Art 12 Abs 1 Z 1 B-VG* zu jenen Angelegenheiten, in denen die Gesetzgebungskompetenzen zwischen Bund und Ländern geteilt sind. Dem **Bund** kommt die **Grundsatzgesetzgebung**, den **Ländern** die Erlassung von **Ausführungsgesetzen** und die **Vollziehung** zu. Auf dieser Basis wurde 1957 als Bundesgrundsatzgesetz das Krankenanstaltengesetz (*KAG, BGBl 1957/1*) erlassen. Im Zuge des *VerwaltungsreformG 2001* (*BGBl I 2002/65*) wurde der Regelungsgegenstand um die Kuranstalten erweitert und das Gesetz in *Krankenanstalten- und Kuranstaltengesetz* (***KAKuG***) umbenannt. Das *KAKuG* wird durch neun Landes-Krankenanstaltengesetze landesrechtlich ausgeführt.[174]

6.2.1. Allgemeines zum Verhältnis Grundsatz-/Ausführungsgesetz

Dem *B-VG* sind noch einige **zusätzliche Vorgaben** zum Kompetenztypus des *Art 12* zu entnehmen. In *Art 12 Abs 2 B-VG* wird zunächst verpflichtend angeordnet, dass Grundsatzgesetze und einzelne Grundsatzbestimmungen ausdrücklich als solche zu **bezeichnen** sind. Dies soll der Rechtssicherheit und der Transparenz dienen. Bezeichnungsmängel führen zur Verfassungswidrigkeit der betreffenden Rechtsvorschrift.[175]

Art 15 Abs 6 B-VG enthält weitere Determinanten für das Verhältnis zwischen bundesrechtlichem Grundsatzgesetz und den landesrechtlichen Ausführungsgesetzen.

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[174] *Burgenländisches Krankenanstaltengesetz 2000* (*BgldLGBl 2000/52*); *Kärntner Krankenanstaltenordnung 1999* (*KtnLGBl 1999/26*); *Niederösterreichisches Krankenanstaltengesetz* (*NÖLGBl 9440-0*); *Oberösterreichisches Krankenanstaltengesetz 1997* (*OÖLGBl 1997/132*); *Salzburger Krankenanstaltengesetz 2000* (*SbgLGBl 2000/24*); *Steiermärkisches Krankenanstaltengesetz 2012 (StmkLGBl 2012/111); Tiroler Krankenanstaltengesetz* (*TirLGBl 1958/5*); *(Vorarlberger) Spitalgesetz* (*VbgLGBl 2005/54*); *Wiener Krankenanstaltengesetz 1987* (*WrLGBl 1987/23*).

[175] Vgl nur *Adamovich*, Österreichisches Staatsrecht Band 1^2 Rz 19.015.

Demnach steht es dem Bund offen, eine **Frist** für die Erlassung der Ausführungsgesetze vorzusehen; soll diese Frist kürzer als sechs Monate oder länger als ein Jahr sein, so ist dafür allerdings die Zustimmung des Bundesrates erforderlich. Wird die Frist von einem Land nicht eingehalten, so geht die Zuständigkeit zur Erlassung des Ausführungsgesetzes für dieses Land auf den Bund über (**Devolution**). Das Ausführungsgesetz des Bundes tritt allerdings außer Kraft, sobald das betreffende Land ein Ausführungsgesetz erlassen hat. Hat der Bund seinerseits keine Grundsätze erlassen („grundsatzgesetzfreier Raum"), so können die Länder die betreffenden Angelegenheiten frei regeln; die Grundsatzgesetzgebung ist damit nicht Voraussetzung, sondern (nur) **inhaltliche Schranke für die Landesgesetzgebung**.[176] Sobald aber der Bund Grundsätze aufgestellt hat, sind die landesgesetzlichen Bestimmungen binnen der bundesgesetzlich festzulegenden Frist dem Grundsatzgesetz anzupassen.

Grundsatzgesetze sind ausschließlich an die Landesgesetzgeber adressiert und von den vollziehenden Behörden **nicht unmittelbar anwendbar**; in der Vollziehung ist allein das Landes-Ausführungsgesetz maßgeblich, auch wenn das Grundsatzgesetz inhaltlich hinreichend konkret und damit einer unmittelbaren Vollziehung prinzipiell zugänglich wäre.[177]

Hat der Bund von der Möglichkeit zur Fristsetzung für die landesgesetzliche Anpassung keinen Gebrauch gemacht, so sind die Länder nach der Rechtsprechung des VfGH zur Erlassung eines Ausführungsgesetzes nicht verpflichtet.[178] Wenn aber grundsatzgesetzliche Regelungen bestehen, so führt ein **Widerspruch** des Ausführungsgesetzes zu diesen Vorgaben zur **Verfassungswidrigkeit** der landesgesetzlichen Regelung. Dies gilt auch dann, wenn das Landesgesetz das Grundsatzgesetz in seiner Wirkung verändert oder einschränkt.[179] Der Bund kann ein grundsatzgesetzwidriges Ausführungsgesetz nicht von sich aus korrigieren, die Aufhebung des Ausführungsgesetzes ist vielmehr dem VfGH vorbehalten. Bis zur Aufhebung durch den VfGH bleibt das grundsatzgesetzwidrige Landesgesetz damit in Geltung.

Die (inhaltliche) **Grenze** zwischen Grundsatz- und Ausführungsregelungen ist insofern **unscharf**, als keine abstrakte Abgrenzung vorgenommen werden kann, sondern diese Grenze jeweils im Einzelfall abzustecken ist. Generell lässt sich anhand der

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[176] Vgl zB VfGH VfSlg 12.415(1990.

[177] Vgl nur *Adamovich*, Österreichisches Staatsrecht Rz 19.019; s auch *Kopetzki*, Krankenanstaltenrecht, in *Holoubek/Potacs* (Hg), Öffentliches Wirtschaftsrecht 1[3], 388.

[178] Vgl wieder nur *Adamovich*, Österreichisches Staatsrecht Rz 19.018, mwN.

[179] Vgl zB VfGH VfSlg 18.894/2009.

Rechtsprechung des VfGH nur festhalten, dass Grundsatzgesetze **nicht überdeterminiert** und zu detailliert sein dürfen, sondern sich auf grundsätzliche Fragen beschränken müssen, für die ein Bedarf nach bundeseinheitlicher Regelung besteht. [180] Das Grundsatzgesetz darf über diese im *Art 12 B-VG* gezogene Grenze hinaus nicht Einzelregelungen treffen, die der Landesgesetzgebung vorbehalten sind.[181] Das bedeutet, dass dem Landesgesetzgeber für die Ausführungsgesetzgebung ein gewisser **Spielraum** eingeräumt werden muss bzw dieser Spielraum nur insoweit eingeschränkt werden darf, als es um Fragen geht, die angesichts ihrer **grundsätzlichen** Bedeutung einer **bundeseinheitlichen** Regelung **bedürfen**.[182] Der VfGH sieht im Bereich des Krankenanstaltenrechts etwa die untergesetzliche **Krankenanstaltenplanung** als eine jener Angelegenheiten an, die zwar nach der Kompetenzverteilung als Maßnahme der Vollziehung letztlich in die Zuständigkeit der Länder fällt, die allerdings aufgrund des besonders wichtigen öffentlichen Interesses an einer effizienten Planung nach bundesweit einheitlichen Grundsätzen und Zielen erfolgen muss, wenn sie ihren Zweck erfüllen soll.[183]

6.2.2. Zum Kompetenztatbestand „*Heil- und Pflegeanstalten*“

Der Kompetenztatbestand „*Heil- und Pflegeanstalten*“ ist ein Spezialtatbestand, der zugunsten der in *Art 12 B-VG* angesiedelten, zwischen Bund und Ländern geteilten Kompetenz vom umfassenden Tatbestand „*Gesundheitswesen*“ in *Art 10 Abs 1 Z 12 B-VG* ausgenommen worden ist; er umfasst nach herrschender Lehre in erster Linie **organisationsrechtliche** Regelungen (zB zur Errichtung/Auflassung einer Krankenanstalt, zur inneren Organisation/Verwaltung von Krankenanstalten, Mindestanforderungen an die Erbringung ärztlicher bzw pflegerischer Leistungen, Versorgungspflichten), darüber hinaus aber auch Regelungen betreffend Maßnahmen, die mit dem **Betrieb** der Krankenanstalt in Zusammenhang stehen (zB Führung/Aufbewahrung der Dokumentation, Werbung etc), Regelungen betreffend die Modalitäten der **Leistungserbringung** (zB Regelungen zur Qualitätssicherung) sowie Regelungen betreffend die Ausgestaltung der **Rechtsbeziehungen** zwischen Anstalt und Patient (zB

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[180] Vgl wieder nur *Adamovich*, Österreichisches Staatsrecht Rz 19.019, mwN.

[181] Vgl etwa VfGH VfSlg 16.058/2000, mit weiteren Judikaturnachweisen.

[182] Vgl etwa VfGH VfSlg 16.244/2001.

[183] VfGH VfSlg 17.232/2004: keine Verfassungswidrigkeit des *§ 10a KAKuG* idF *BGBl I 2001/5,* worin die jeweilige Landesregierung bei der Erlassung des Landeskrankenanstaltenplanes an den Inhalt des Österreichischen Krankenanstaltenplans (ÖKAP) bzw an den Großgeräteplan (GGP) gebunden wurde; zu diesem Erkenntnis s auch unten 6.4.

Patientenrechte, Aufklärung/Einwilligung in die Heilbehandlung im stationären Bereich; Gebühren/Kostenersätze).[184]

Die Zuordnung dieser Regelungsbereiche zu *Art 12 B-VG* setzt jeweils voraus, dass es sich bei der entsprechenden Einrichtung um eine „*Heil- und Pflegeanstalt*" iSd *Art 12 B-VG* handelt, wobei hier insb die Abgrenzung zu ärztlichen Ordinationen immer wieder Gegenstand von Diskussionen war. Als weitere unter *Art 12 B-VG* fallende Regelungsbereiche werden in der Literatur ua die Rechtsbeziehung zwischen Krankenanstalten und Sozialversicherungsträgern, die Parteistellung von Interessenvertretungen im Genehmigungsverfahren sowie die Etablierung einheitlicher Grundsätze im Bereich der Krankenanstaltenplanung genannt.

Die Einordnung des Krankenanstaltenrechts als Materie nach *Art 12 B-VG*, die nur aus der historischen Entwicklung heraus erklärbar ist,[185] wirft vor allem insofern Probleme auf, als es sich dabei – wie schon erwähnt – inhaltlich eigentlich um eine **Teilmaterie des Gesundheitswesens** handelt, das im Übrigen in *Art 10 Abs 1 Z 12 B-VG* umfassend in den Kompetenzbereich des Bundes verwiesen wird. Dadurch ergeben sich in vielen Bereichen **Spannungsfelder** (zB zwischen den organisationsrechtlichen Bestimmungen des Krankenanstaltenrechts und den in die alleinige Regelungskompetenz des Bundes fallenden berufsrechtlichen Regelungen der medizinischen Gesundheitsberufe) bzw **Abgrenzungsfragen** (zB zwischen Krankenanstalten und ärztlichen Ordinationen). So zählen Regelungen über zulässige Behandlungsmethoden unter dem Gesichtspunkt der Abwehr von Gefahren für die Volksgesundheit kompetenzrechtlich zum „*Gesundheitswesen*", unabhängig davon, ob diese in Krankenanstalten oder außerhalb derselben angewendet werden. Dies gilt auch für Normen, die regeln, dass bestimmte Eingriffe nur in Krankenanstalten durchgeführt werden dürfen, aber durch die Bezugnahme auf Krankenanstalten keine Norm iSd Kompetenztatbestandes „*Heil- und Pflegeanstalten*" werden. Generell lässt sich sagen, dass Behandlungsfragen, die nicht mit den Besonderheiten der arbeitsteiligen Organisation der Krankenanstalt zusammenhängen, zum *Gesundheitswesen* iSd *Art 10 Abs1 Z 12 B-VG* zählen.[186] Die kompetenzrechtliche Zersplitterung im Gesundheitswesen führt aber insb auch dazu, dass eine **effiziente bundeseinheitliche** und sektorenübergreifende (also sowohl den stationären als auch den ambulanten Gesundheitsbereich einschließende) Planung und Steuerung des Gesundheitswesens

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[184] Ausführlich *Kopetzki* in *Holoubek/Potacs* (Hg), Öffentliches Wirtschaftsrecht 1^3 388 f.

[185] Ausführlich *Stöger*, Krankenanstaltenrecht, 15 ff.

[186] Vgl zu dieser Abgrenzung mit ausführlicher Begründung und Hinweisen auf die Vorjudikatur jüngst VfGH 2016, RdM 2016/110, 148 (*Stöger*) - Werbeverbot für ästhetische Behandlungen und Operationen.

trotz der Möglichkeit der Überbindung bundeseinheitlicher Grundsätze und Ziele im Wege der Grundsatzgesetzgebung großen **Schwierigkeiten** begegnet.

6.3. Kompetenzbereinigung nur durch Verfassungsänderung

Die – vorsichtig gesprochen – segmentierende Wirkung der Aufsplitterung der Kompetenzen im Gesundheitswesen wäre zweifellos am effektivsten im Wege der Konzentration der aufgeteilten Regelungskompetenzen bei einem einzigen Kompetenzträger zu beseitigen. Eine Kompetenzbereinigung im Sinne einer **einheitlichen** kompetenzrechtlichen Zuweisung der Materien des Gesundheitswesens inklusive des Krankenanstaltenrechts wurde in der Vergangenheit vor diesem Hintergrund zwar in regelmäßigen Abständen eingefordert und diskutiert,[187] scheiterte bislang aber offensichtlich daran, dass dafür keine politischen Mehrheiten zu gewinnen waren.[188]

Eine solche Kompetenzbereinigung wäre nämlich nur über eine entsprechende **Verfassungsänderung** zu erreichen. Dafür erscheint im Bereich des Gesundheitswesens – und wegen der vielfältigen Beziehungen zum (nach *Art 10 Abs 1 Z 11 B-VG* ebenfalls in die alleinige Bundeskompetenz fallenden) Sozialversicherungsrecht – wohl nur eine Konzentration der Gesetzgebungskompetenzen beim **Bund** sinnvoll. Im Falle einer „Verländerung" der Kompetenzen in diesem Bereich könnte bestenfalls die Aufspaltung in einen ambulanten und einen stationären Sektor überwunden, das Problem der fehlenden bundesländerübergreifenden Planung und Steuerung des Gesundheitswesens indes nicht behoben werden.

Eine solche Verfassungsänderung würde zu einer Einschränkung der Zuständigkeit der Länder führen, so dass nicht nur eine Verfassungsmehrheit im **Nationalrat** (*Art 44 Abs 1 B-VG*), sondern auch eine **Zweidrittelmehrheit** in der Länderkammer des Bundesparlaments, dem **Bundesrat**, erforderlich wäre (vgl *Abs 2 dieser Bestimmung*).

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[187] Die Entflechtung der Kompetenzverteilung und die Schaffung klarer Regelungs- und Verantwortungsstrukturen zwischen den Gebietskörperschaften wird auch im Arbeitsprogramm der Bundesregierung 2017/18 (abrufbar etwa http://archiv.bundeskanzleramt.at/DocView.axd?CobId=65201) als „zentrale und überfällige Maßnahme" bezeichnet, als Ziel wird hier freilich die generelle Abschaffung des *Art 12 B-VG* ins Visier genommen.

[188] Das Hauptproblem ist wohl die Finanzierungsfrage: Nach *§ 2 F-VG* folgt aus der Aufgabenzuweisung auch die Finanzierungsverantwortung, die daher derzeit in erster Linie bei den Ländern liegt, faktisch aber im Wege einer *Art 15a-B-VG*-Vereinbarung zwischen Ländern, Bund und Sozialversicherungsträgern geteilt wird.

6.4. „Ersatzlösungen“ und deren rechtliche Grenzen

Sind Verfassungsmehrheiten für eine Änderung der Kompetenzverteilung im Bereich des Gesundheitswesens zugunsten des Bundes nicht erzielbar, so bleibt im Ergebnis nur der Einsatz von Instrumenten zur **Koordination** der Gesetzgebung bzw zur **Kooperation** von Bund und Ländern bei der Ausübung ihrer Kompetenzen.

Dieser Weg wird derzeit mit zwei **Bund-Länder-Vereinbarungen nach *Art 15a B-VG*** betreffend die Planung und Steuerung im Gesundheitswesen beschritten.[189] Es handelt sich dabei um nur zwischen den Vertragsparteien (Bund und Länder) verbindliche (Glied-)Staatsverträge, mit Hilfe derer die strikte Trennung der beiden Sektoren im Gesundheitswesen zumindest in der Planung überwunden und darüber hinaus letztlich die langfristige Finanzierbarkeit des österreichischen Gesundheitssystems sichergestellt werden soll.[190] Die Regelungen dieser Vereinbarungen sind **für Dritte nicht unmittelbar rechtsverbindlich**, sondern müssen erst durch entsprechende Rechtsakte des Bundes bzw der Länder in ihren jeweiligen Kompetenzbereichen **umgesetzt** werden.

Mit den genannten *Art 15a-B-VG*-Vereinbarungen wurden insb die **Planungsinstrumente** „Österreichischer Strukturplan Gesundheit“ (ÖSG) und „Regionale Strukturpläne Gesundheit“ (RSG) eingeführt, mit Hilfe derer eine bundesweite sektorenübergreifende Planung sichergestellt werden soll.

Wichtigstes Ziel des **ÖSG** war es im Unterschied zum davor maßgeblichen Österreichischen Krankenanstaltenplan (ÖKAP), dass die Planungsvorgaben nicht nur den stationären Bereich erfassen, sondern **sukzessive** auch die **ambulante** Versorgung, die Versorgung im **Rehabilitationsbereich** sowie die Nahtstellen zum **Pflegebereich** einbeziehen sollen. Der ÖSG stellt in seiner derzeitigen Ausprägung (ÖSG 2012) einen Rahmenplan für vier festgelegte Versorgungszonen bzw 32 Versorgungsregionen in Österreich dar und soll im Endausbaustadium für diese den Rahmen für die Erbringung von Gesundheitsdienstleistungen in allen Sektoren des Ge-

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[189] *Vereinbarung gemäß Art 15a B-VG über die **Organisation und Finanzierung des Gesundheitswesens*** (*BGBl I 2008/105 idF BGBl I 2013/199*) sowie *Vereinbarung gemäß Art 15a B-VG **Zielsteuerung Gesundheit*** (*BGBl I 2013/200*).
Beide Vereinbarungen wurden mittlerweile neu verhandelt und auch bereits Ende 2016 von Nationalrat und Bundesrat beschlossen, sind aber noch nicht rechtsgültig, da die **Genehmigungen der neun Landtage** noch nicht vorliegen. Teile dieser neuen Vereinbarungen wurden dennoch auf bundesrechtlicher Ebene mit dem neuen *Gesundheits-Zielsteuerungsgesetz* (*BGBl I 2017/26, G-ZG*) bereits umgesetzt.

[190] Vgl die Gesetzesmaterialien zur ersten *Art 15a-B-VG-Vereinbarung über die Organisation und Finanzierung des Gesundheitswesens (BGBl I 2008/105*), ErläutRV 308 BlgNR 23. GP insb 3.

sundheitswesens vorgeben (und damit eine bundesländerübergreifende Planung ermöglichen).

Die **RSG** stellen die Detailplanungen auf regionaler Ebene dar. Sie müssen sich im Rahmen des ÖSG bewegen und dessen Vorgaben in Abstimmung zwischen dem jeweiligen Land und der Sozialversicherung auf Landesebene umsetzen.

Die Strukturpläne werden in **Zielsteuerungskommissionen** auf Bundes- und auf Länderebene, in die jeweils Bund,[191] Länder und Sozialversicherung eingebunden sind, verhandelt. Beschlüsse dieser Gremien kommen nur **einvernehmlich** zustande, erfordern also ein Einvernehmen zwischen der Kurie des Bundes, der Kurie der Länder und der Kurie der Sozialversicherung [192] (Ebene des ÖSG) bzw ein Einvernehmen zwischen der Kurie des Landes und der Kurie der Sozialversicherung (Ebene der RSG). Determiniert werden die Planungen seit der Gesundheitsreform 2013 (*BGBl I 2013/199*) durch übergeordnete **Bundes- und Landes-Zielsteuerungsverträge**, also durch auf privatwirtschaftlichem Wege zustande gekommene Vereinbarungen.

Das mittlerweile recht komplexe und komplizierte Geflecht an Vereinbarungen und Planungen im Gesundheitswesen wirft nicht nur zahlreiche (insb verfassungs)rechtliche Fragen auf, [193] sondern hatte bislang auch den Nachteil, dass den (überregionalen) **Strukturplänen** selbst nach herrschender Ansicht **kein normativer Charakter** und damit keine rechtliche Verbindlichkeit für nicht an den Verhandlungen und Verträgen beteiligte Dritte zukommt – und aus kompetenzrechtlicher Sicht auch nicht zukommen kann, weil nur die zur Vollziehung zuständigen Länder generelle Verwaltungsakte, wie Verordnungen, erlassen können, nicht aber der Bund. Eine rechtliche Verbindlichkeit konnte bislang nur dadurch hergestellt werden, dass die Planungen von den Gesetzgebungsorganen in ihren jeweiligen Kompetenzbereichen in **Rechtsnormen transformiert** werden, wobei allerdings ein unmittelbares Anknüpfen an die Planungen verfassungsrechtlich problematisch ist, da es sich dabei um eine unzulässige dynamische Verweisung auf eine andere Rechtsetzungsinstanz handeln könnte.

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[191] In den Landes-Zielsteuerungskommissionen kommt dem Vertreter des Bundes allerdings kein Stimmrecht, sondern nur ein Vetorecht insb gegen Beschlüsse zu, die nicht dem geltenden Recht bzw geltenden *Art 15a*-Vereinbarungen entsprechen oder die dem Bundes-Zielsteuerungsvertrag oder Beschlüssen der Bundes-Zielsteuerungskommission widersprechen.

[192] Vgl *§ 26 Abs 3 Z 1 G-ZG*.

[193] Ausführlich dazu *Schrattbauer*, Rechtsnatur und rechtliche Verbindlichkeit der Strukturpläne im Gesundheitswesen, SozSi 2016, 168 ff.

Der VfGH hat allerdings derartige verfassungsrechtliche Bedenken in bislang zwei Entscheidungen verworfen. Unter Hinweis auf die Notwendigkeit einer Krankenanstaltenplanung nach einheitlichen Grundsätzen und Zielen hat er in seinem Erkenntnis vom VfSlg 17.232/2004, **keine Überschreitung** der Grundsatzgesetzgebungskompetenz durch *§ 10a KAKuG* gesehen, mit dem die Landesgesetzgeber bei der Erlassung des Landeskrankenanstaltenplanes an den (zum damaligen Zeitpunkt noch einschlägigen) Österreichischen Krankenanstaltenplan/Großgeräteplan (ÖKAP/ GGP) gebunden wurden. Dass dies **nicht** als verfassungswidrige **dynamische** Verweisung auf den Rechtsakt einer anderen Rechtsetzungsautorität zu werten sei, wurde im Wesentlichen damit begründet, dass sich die Bindung des Landesgesetzgebers bereits aus der *Art 15a-B-VG*-Vereinbarung über die Organisation und Finanzierung des Gesundheitswesens ergebe, *§ 10a KAKuG* also nur eine Wiederholung der Inhalte der Bund-Länder-Vereinbarung darstelle. Die Bindung der Landesregierung an den ÖKAP in seiner Stammfassung sowie in seinen künftigen Weiterentwicklungen sei deshalb verfassungsrechtlich nicht zu beanstanden, weil Änderungen des ÖKAP ohnehin nur in Form weiterer *Art 15a*-Vereinbarungen festgelegt und unter Einschaltung der verfassungsmäßig vorgesehenen Organe der Gesetzgebung von Bund und Ländern umgesetzt werden können.

Dies trifft aber auf die **aktuelle** Konstruktion nicht zu, da sich ÖSG und RSG gerade **nicht** als Bestandteil der Bund-Länder-Vereinbarung präsentieren, sondern vielmehr durch Beschlüsse der Zielsteuerungskommissionen (und ohne Änderung der *Art 15a-B-VG*-Vereinbarung) weiterentwickelt und geändert werden können, so dass die Bedenken hinsichtlich der Verfassungskonformität nicht gänzlich ausgeräumt scheinen. Dennoch hat der VfGH in einer jüngeren Entscheidung[194] ausdrücklich an seiner Judikatur festgehalten und sieht auch nach Einführung der Strukturpläne ÖSG und RSG – allerdings ohne nähere Auseinandersetzung mit den geänderten Rahmenbedingungen der Entstehung dieser Planungsgrundlagen – in der unmittelbaren Anknüpfung an die Strukturpläne keine verfassungswidrige dynamische Verweisung. Im Bereich des Krankenanstaltenrechts werden die Planungsvorgaben der Strukturpläne dadurch für Dritte **verbindlich**, dass deren Vorgaben in den als **Verordnung** des Landes zu erlassenden Landes-Krankenanstaltenplan (**LKAP**) übernommen werden (*§ 10a KAKuG*).[195] In Form des LKAP entfalten die den **stationären**

[194] VfGH VfSlg 18.730/2000.

[195] Diese Form der Verbindlichmachung findet ihre Grundlage in *Art 4 Abs 5* der *Art 15a-Vereinbarung über die Organisation und Finanzierung des Gesundheitswesens*.

Bereich der Gesundheitsversorgung betreffenden Planungsvorgaben normative Wirkung für die weiteren Akteure im Gesundheitswesen.[196]

Im **extramuralen** Bereich ist bislang eine strikte Verbindlichkeit nur für einen **kleinen** Teilbereich, nämlich für den in den ÖSG integrierten und nicht nur für den stationären Bereich geltenden **Großgeräteplan** vorgesehen, den die Sozialversicherungsträger gemäß *§ 338 Abs 2a ASVG* bei Abschluss von Gesamt- und Einzelverträgen bei sonstiger Ungültigkeit der Verträge einzuhalten haben.[197] In anderen Bereichen ist zwar ebenfalls von der „*Beachtung*"[198] oder „*Berücksichtigung*"[199] der bzw von der „*Bedachtnahme*"[200] auf die Strukturpläne die Rede, eine strikte Bindung an die Planungsvorgaben und eine zuverlässige Umsetzung derselben wird dadurch aber nicht erreicht.

Der Nachteil der fehlenden Verbindlichkeit soll **in Zukunft** nach den neu verhandelten *Art 15a-B-VG*-Vereinbarungen dadurch behoben werden, dass eine privatrechtliche Gesellschaft (in der Rechtsform einer GmbH) gegründet und mit der Verbindlicherklärung von ausgewählten Teilen der Strukturpläne betraut werden soll (vgl *§ 23 G-ZG*). Gesellschafter dieser „**Gesundheitsplanungs GmbH**" sind der Bund, die Länder und der Hauptverband der Sozialversicherungsträger, die jeweils einen Vertreter in die Generalversammlung entsenden, wobei die in *§ 23 Abs 3 G-ZG* enthaltenen näheren Bestimmungen gesellschaftsrechtlicher Art (Quorum in der Generalversammlung, Gesellschafter, Bestellung der Geschäftsführer) durchaus als Vorgaben an die für das Gesundheitswesen zuständige Bundesministerin für den Inhalt des abzuschließenden Gesellschaftsvertrages gedeutet werden können. Diese Regelungen zwingen jedenfalls nicht zu der Annahme, dass damit abseits des GmbH-Rechts bundesgesetzlich eine spezialgesetzliche Entität des Bundes und der Länder geschaffen werden sollte, was in der Tat verfassungsrechtlich problematisch wäre. Es steht den Gebietskörperschaften im Rahmen der Privatwirtschaftsverwaltung wohl frei, eine gemeinsame Gesellschaft nach dem GmbHG zu gründen. Diese ist eine

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[196] Diese Form der Überbindung der Planungsvorgaben der Strukturpläne begegnet insofern verfassungsrechtlichen Bedenken, als einerseits die Bindung der Landesregierung an die Vorgaben des RSG bei der Erlassung der Verordnung mit deren Stellung als oberstes Organ des Landes (ohne verfassungsrechtliche Grundlage) nicht vereinbar erscheint und andererseits auch der Vorwurf einer verfassungswidrigen dynamischen Verweisung auf den Rechtsakt einer anderen Rechtsetzungsautorität schwer zu entkräften ist, da ja nicht auf einen bestimmten Strukturplan (statisch) Bezug genommen wird, sondern die Landesregierung an den RSG in seiner jeweiligen Fassung gebunden ist.

[197] Auch hier stellt sich allerdings das Problem einer unzulässigen dynamischen Verweisung.

[198] Vgl zB *§ 84a ASVG*.

[199] ZB *§ 52c ÄrzteG*; *§ 3 Abs 2c KAKuG*.

[200] ZB *§§ 342 Abs 1 Z 1, 342a Abs 5 ASVG; § 52b Abs 2 ÄrzteG*.

GmbH wie jede andere, mit der Besonderheit, dass ihre Gesellschafter Gebietskörperschaften sind.

Damit dürfte auch der Weg offenstehen, diese GmbH als eine Gesellschaft des Privatrechts im Rahmen der jeweiligen Kompetenzen der Länder und des Bundes von diesen mit hoheitlichen Aufgaben[201] zu **beleihen**, zumal die Verfassung die Übertragung der Verordnungserlassung an einen Beliehenen nicht schlechthin ausgeschlossen hat, sofern die möglichen Gegenstände der Verordnung gesetzlich genau bezeichnet sind und gleichzeitig für eine gesetzlich ausdrücklich geregelte Weisungsbindung an das jeweils oberste Organ des Bundes bzw an jenes des jeweiligen beleihenden Landes gesorgt ist (vgl dazu hier: *§ 23 Abs 7* und *8 G-ZG*). Auch dürfte es keine verfassungsrechtliche Vorschrift verbieten, mehr als eine Beleihung vorzunehmen, dh dass eine Beleihung durch den Bund mit einer Bundesaufgabe es weder ausschließt, dieselbe GmbH mit weiteren Bundesaufgaben, noch, sie mit Aufgaben eines Landes (oder mehrerer Länder) zu beleihen.[202] Die verfassungsrechtlichen Grenzen einer solchen Beleihung sind einerseits die „Kernaufgaben" des Staates (was hier auszuschließen ist) und andererseits das Verbot der Überschreitung dessen, dass nur mit „vereinzelten Aufgaben" beliehen werden darf,[203] wovon hier wohl auch auszugehen ist, unabhängig davon, ob man den Aufgabenbereich insgesamt mit Gesundheitswesen oder/und mit Krankenanstaltenrecht umschreiben wollte. Ginge man hingegen von einer öffentlichen Aufgabe namens „länder- und sektorenübergreifenden Planung des Gesundheitswesens" aus, wäre wohl die gesamte Angelegenheit Gegenstand der Beleihung. Es spricht aber wohl mehr dafür, auch diese Umschreibung eher entlang der Kompetenztatbestände vorzunehmen.[204]

Zentrale Aufgabe der GmbH ist die **Erlassung von Verordnungen**, mit denen bestimmte, zuvor von den Zielsteuerungskommissionen ausdrücklich für die Verbindlicherklärung ausgewiesene Teile der Strukturpläne in normative, also **rechtsverbindliche** Anordnungen **transformiert** werden sollen. Diese Transformierung ist in Angelegenheiten des *Art 10 B-VG* in *§ 23 Abs 4 G-ZG* bundesgesetzlich, und soweit

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[201] Wie zB der Erlassung von Verordnungen, vgl VfGH VfSlg 16.995/2003, unter Hinweis auf VfGH VfSlg14.473/1996.

[202] In diesem Sinne auch *Souhrada*, Verbindliche Planung, SV-Verträge und Krankenanstalten, SozSi 2017, 104 (117 f).

[203] Vgl noch einmal VfGH 14.3.1996, B 2113/94 ua, VfSlg.14.473 sowie VfGH 12.12.2001, G 269/01 ua, VfSlg 16.400.

[204] Die Rechtsprechung des VfGH macht zwischen Beleihung und Ausgliederung insofern keine Unterschiede, vgl erneut nur VfGH VfSlg 16.995/2003.

sie Angelegenheiten des *Art 12 B-VG* betrifft, in *§ 23 Abs 5* grundsatzgesetzlich geregelt (dh grundsatzgesetzlich den Ländern aufgetragen, solche Regelungen landesgesetzlich vorzusehen).[205] Die Verbindlicherklärung durch Verordnungen kann freilich nur **getrennt** für jeden „Auftraggeber" erfolgen, nicht aber für mehrere gemeinsam.[206] Der Bund kann dafür allerdings keine gemeinsamen Kundmachungsvorschriften erlassen, sodass *§ 23 Abs 6 G-ZG* höchstens verfassungskonform dahin zu deuten sein wird, dass diese Bestimmung nur für Angelegenheiten des *Art 10 B-VG* gilt.

Ein weiteres Problem könnte darin liegen, dass das *G-ZG* der GmbH offenbar zwingend aufträgt, die von der Bundes-Zielsteuerungskommission nach *§ 23 Abs 1* und den jeweiligen Landes-Zielsteuerungskommissionen nach *§ 23 Abs 2* ausgewiesenen Teile des ÖSG und der jeweiligen RSG für verbindlich zu erklären, und damit die beliehene Tätigkeit der GmbH an die Beschlüsse der Zielsteuerungskommissionen (unter Mitwirkung der Sozialversicherung) bindet, worin ein gewisser Widerspruch zur (verfassungsrechtlich aber notwendigen) ausdrücklichen Weisungsbindung nur an die jeweiligen obersten Organe gesehen werden könnte. Dieses Spannungsverhältnis lässt sich aber wohl argumentativ dahin auflösen, dass die Bindung nur insoweit eintritt, als gegenteilige Weisungen der obersten Organe im Einzelfall nicht vorliegen.

Ein zusätzliches, zunächst aber nur **faktisches** Problem besteht darin, dass die Entscheidung, welchen Teilen normativer Charakter zukommen soll, in den Zielsteuerungskommissionen nur **einvernehmlich** gefällt werden kann. Hinsichtlich jener Teile der Strukturpläne, für die sich die maßgeblichen Akteure der Zielsteuerungskommissionen nicht auf eine Verbindlicherklärung einigen können, bleibt es weiterhin bei der oben beschriebenen eher losen Bindung Dritter an die Planungsvorgaben im Sinne einer „Berücksichtigungspflicht", die zumindest ein begründetes Abweichen von den Planungsvorgaben zulässt.

Damit ist freilich eine wesentliche **Schwachstelle** der letzten Neuerungen aufgezeigt, die gleichzeitig auch die Grenzen der beschriebenen Koordinationstechniken erkennen lässt. Die mittlerweile an Komplexität kaum noch zu überbietende Konstruktion führt nämlich nur dann zum Ziel (einer verbindlichen länder- und

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[205] Zwar ungewöhnlich, wenngleich nach Einschätzung von *Stöger* (in *Mosler/Müller/Pfeil* [Hg], Der SV-Komm, § 84a ASVG Rz 9 [in Druck]) „möglicherweise noch durch die Befugnisse der Grundsatzgesetzgebung iSd Art 12 B-VG gedeckt", ist auch schon die Anordnung selbst, dass im Rahmen einer *Art 12 B-VG*-Materie eine vom Bund geschaffene juristische Person von den Ländern mit Hoheitsbefugnissen zu beleihen ist und für die Länder tätig wird.

[206] Vgl noch einmal *Souhrada*, SozSi 2017, 104 (117).

sektorenübergreifenden Planung im Gesundheitswesen), wenn ein **Einvernehmen** der maßgeblichen Akteure Bund, Länder und Sozialversicherung im Hinblick auf die erforderlichen Planungen (und zwar hinsichtlich jeder einzelnen Planungsvorgabe und in jedem einzelnen Bundesland) erzielbar ist. Es stellt sich die Frage, ob dieses Einvernehmen insb in der Detailplanung tatsächlich erzielbar sein wird, wenn doch das Auseinanderklaffen der Interessen dieser Akteure bislang eine (verfassungsrechtliche) Kompetenzbereinigung im Bereich des Gesundheitswesens verhindert hat.[207]

Dazu kommen weitere, bereits im Schrifttum aufgeworfene Probleme, die vorliegend aber nicht weiter verfolgt werden können.[208] Angemerkt sei lediglich, dass sich die Rechtsprechung des VfGH in organisatorischen Belangen der Bundesverfassung häufig einer eher formalen Betrachtungsweise bedient, was insofern für die Zulässigkeit der getroffenen Lösung sprechen könnte.

6.5. Zusammenfassung und Perspektiven

➔ Die bestehende Zersplitterung im Gesundheitswesen und im Krankenanstaltenrecht kann letztlich nur überwunden werden, wenn es zu einer Kompetenzbereinigung in der Bundes-Verfassung kommt. Eine solche **Verfassungsänderung** erscheint – auch wegen der vielfältigen Beziehungen zum (ebenfalls in die alleinige Bundeskompetenz fallenden) Sozialversicherungsrecht – nur im Sinne einer **Konzentration** der Gesetzgebungs- und der zur Steuerung erforderlichen Vollzugskompetenzen beim **Bund** sinnvoll.

➔ Da eine solche Verfassungsänderung bisher nicht möglich war, wurden „Ersatzlösungen“ gesucht, die aber an rechtliche wie faktische Grenzen stoßen. Bei den Bund-Länder-Vereinbarungen nach *Art 15a B-VG* liegt das Grundproblem darin, dass deren Regelungen **für Dritte nicht unmittelbar rechtsverbindlich** sind, sondern

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[207] So auch *Schrattbauer*, Ergänzung zum Beitrag „Zur Bedarfsprüfung bei der geplanten Änderung einer Krankenanstalt“, DRdA 2017, 186 (190).

[208] Hier geht es wohl weniger darum, dass die Gesundheitsplanungs GmbH ein „Mischorgan“ ist, das funktionell sowohl im Kompetenzbereich des Bundes als auch in jenem der Länder tätig werden soll, zumal es sich ja um eine Gesellschaft des Privatrechts handelt. Problematisiert werden hier vielmehr die verfassungsrechtlichen Grenzen für eine Schaffung gemeinsamer Organe des Bundes und der Länder (vgl *Kopetzki*, Editorial, RdM 2017/1; s auch *Raschauer*, Allgemeines Verwaltungsrecht[5], Rz 216 ff); dagegen jüngst *Souhrada*, SozSi 2017, 104 ff (117).

erst durch entsprechende Rechtsakte des Bundes bzw der Länder in ihren jeweiligen Kompetenzbereichen **umgesetzt** werden müssen.

➔ Der VfGH hat zwar bisher verfassungsrechtliche Bedenken gegen die Transformierung der Planungen ins Landesrecht sowohl im Hinblick auf eine Überschreitung der Grundsatzgesetzgebungskompetenz (durch *§ 10a KAKuG*) als auch das Vorliegen einer verfassungsrechtlich unzulässigen dynamischen Verweisung verworfen. Ob das auch für die **Strukturpläne Gesundheit** (auf Bundes- [ÖSG] wie auf regionaler Ebene [RSG]) gelten kann, die gerade nicht Bestandteil der Bund-Länder-Vereinbarungen sind, und vielmehr durch Beschlüsse der Zielsteuerungskommissionen (und ohne Änderung der *Art 15a-B-VG-Vereinbarung*) weiterentwickelt werden, erscheint **unsicher**.

➔ Die nunmehrige Neuregelung im Rahmen des ***G-ZG*** sieht die Einrichtung einer „**Gesundheitsplanungs GmbH**“ vor, deren Gesellschafter der Bund, die Länder und der Hauptverband der Sozialversicherungsträger sind. Diese GmbH soll mit **hoheitlichen Aufgaben beliehen** werden, da ihre zentrale Aufgabe die Erlassung von **Verordnungen** ist, mit denen von den Zielsteuerungskommissionen ausdrücklich für die Verbindlicherklärung ausgewiesene Teile der Strukturpläne in rechtsverbindliche Anordnungen transformiert werden sollen. Auch hier könnten sich aber möglicherweise noch verfassungsrechtliche Fragen stellen.

➔ Zu all dem kommt das **faktische** Problem, dass die Entscheidung, welchen Teilen normativer Charakter zukommen soll, in den Zielsteuerungskommissionen nur **einvernehmlich** gefällt werden kann. Es ist fraglich, ob dieses Einvernehmen insb in der Detailplanung erzielbar sein wird, wenn doch das Auseinanderklaffen der Interessen dieser Akteure bislang eine (verfassungsrechtliche) Kompetenzbereinigung im Bereich des Gesundheitswesens verhindert hat.

7. Task 8a:
Modernisierung des Vertragspartnerrechts – rechtliche Aspekte[209]

7.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„VERTRAGSPARTNERRECHT MODERNISIEREN“** folgende Passage (7f):

> „Das bestehende Vertragspartnerrecht geht auf die 1950er Jahre zurück. Es determiniert die für die PatientInnen relevanten Leistungen der Gesundheitsversorgung und hat daher einen besonderen Stellenwert. Die Verbesserungen der Leistungen durch eine österreichweite Leistungsharmonisierung sind daher eng mit einer effizienten Organisation von Gesundheitsdienstleistungen durch die Sozialversicherungen verknüpft. Das **Vertragspartnerrecht** regelt die Leistungsabgeltung von Gesundheitsdienstleistungen zwischen der sozialen Kranken-, Unfall und Pensionsversicherung und Gesundheitsdiensteanbietern. Die Gesundheitsdiensteanbieter werden auf kollektiver Ebene, in dieser Konstellation primär durch neun Landesärztekammern, die österreichische Ärztekammer, bzw durch die Wirtschaftskammern und die Zahnärztekammer vertreten. Im bestehenden System haben die VertreterInnen der **Gesundheitsdiensteanbieter** starke **Gestaltungsrechte**, die nicht mit einer Beschaffung auf freien Markt vergleichbar sind.
>
> Zu klären ist, wie das **Verhältnis zwischen Sozialversicherung** auf der einen Seite und **Gesundheitsdiensteanbietern** auf der anderen Seite modernisiert werden kann, beziehungsweise wie entsprechende Regelungen ausgestaltet sein müssten. Dabei sind internationale Best-Practice Beispiele heranzuziehen.
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> In Hinblick auf die Versorgungssicherheit und der Sicherung der Beschaffung bei österreichischen Anbietern ist zu klären, wo **Vergaberecht** nicht zur Anwendung gelangen soll. Weiters ist zu klären, inwieweit das bestehende Vergaberecht (EU, national) auch im Sozial- und Gesundheitsbereich eine Rolle spielen sollte. Darüber hinaus ist im Zusammenhang mit dem europäischen und nationalen Vergaberecht das Verhältnis zwischen dem genannten Rechtsbestand und den Gesamtverträgen zu prüfen.

[209] Dieses Kapitel wurde gemeinsam mit *Rudolf Mosler* und mit Unterstützung durch *Birgit Schrattbauer* sowie unter Berücksichtigung von Hinweisen von *Rudolf Müller und Walter Pöltner* verfasst.

Das **Kostenoptimierungspotential** durch die **Beschaffung von Gesundheitsdienstleistungen unter flexibleren Rahmenbedingungen** ist zu erheben. Dabei ist immer auf das Leistungsniveau für die PatientInnen, auch im Zusammenhang mit der Leistungsharmonisierung auf ein relativ höheres Niveau, Bedacht zu nehmen.

Daraus wurden ua folgende **Aufgabenstellungen** abgeleitet (8):

„Unter der Prämisse, die Versorgung der Versicherten zu verbessern, soll eine Analyse des derzeitigen Vertragspartnerrechts erstellt werden. Die Frage, ob eine flexiblere und transparente Organisation von Gesundheitsdienstleistungen Effizienzpotentiale gegenüber dem Status-Quo bietet, ist zu beantworten. … Besonders die Rolle der Systempartner für eine moderne Sachleistungsversorgung ist zu analysieren. Im Rahmen des Vertragspartnerrechts gilt es Sachleistungen zu stärken.

Erarbeitung von Vorschlägen zur Modernisierung des Vertragspartnerrechts um die Organisation von Gesundheitsdienstleistungen nach flexibleren und transparenten Konditionen zu ermöglichen. Dabei ist das Ziel, Gesundheitsdienstleistungen auch weiter von österreichischen Anbietern zu beziehen, zu berücksichtigen.“

Die folgenden Ausführungen sollen die **rechtliche Grundlage** für die geforderte Analyse darstellen (7.3.) und Hinweise für **Vorschläge zur Modernisierung** des Vertragspartnerrechts **aus rechtlicher Sicht** geben (7.4.), wobei Fragen des **Vergaberechts** vereinbarungsgemäß **ausgeblendet** und einer späteren Untersuchung vorbehalten bleiben müssen. Zum besseren Verständnis der Darstellung seien zuvor noch einmal die Eckpfeiler des österreichischen Gesundheitssystems in Erinnerung gerufen.

7.2. Eckpfeiler des österreichischen Gesundheitswesens

Es besteht eine staatlich organisierte **Pflichtversicherung**, welche die österreichische Wohnbevölkerung zu fast 100% einschließt. Der Versichertenkreis erfasst die Erwerbstätigen beinahe vollständig und darüber hinaus auch die meisten Angehörigen über die Mitversicherung (sofern diese nicht ohnehin selbst erwerbstätig sind). Auch PensionistInnen und BezieherInnen von Sozialleistungen sind fast ausnahmslos pflichtversichert.

Die **Finanzierung** erfolgt im niedergelassenen Bereich fast zur Gänze über Beiträge der Versicherten bzw ihrer DG. Im stationären Bereich werden zusätzlich Steuermittel aufgewendet.

In der Krankenversicherung besteht Anspruch in erster Linie auf **Krankenbehandlung**. Das umfasst ärztliche Hilfe, Heilmittel und Heilbehelfe, im ausreichenden, zweckmäßigen und notwendigen Umfang (vgl nur *§ 133 ASVG*). Rehabilitationsleistungen und Prävention haben ergänzenden Charakter. Die Wahl des Leistungserbringers ist freigestellt.

Die Versorgung im niedergelassenen Bereich erfolgt überwiegend durch **Vertragsärzte** (Kassenärzte). Sie haben Verträge mit den Krankenversicherungsträgern, die zur Behandlung der Versicherten (Leistungsberechtigten) gegen Direktverrechnung mit der jeweiligen Kasse verpflichten. Die ärztliche Hilfe in eigenen Einrichtungen und Vertragseinrichtungen der Kassen ist für die Versicherten ebenso kostenfrei.

Auch alle anderen niedergelassenen Ärzte sind als **Wahlärzte** indirekt in das sozialversicherungsrechtliche Versorgungssystem eingebunden. Konsultiert der Versicherte einen Wahlarzt, hat er diesem das Honorar zu entrichten, es werden ihm aber 80% des Vertragstarifs von der jeweiligen Kasse rückerstattet (vgl nur *§ 131 ASVG*). Der Wahlarzt ist nicht tarifgebunden, sondern kann sein Honorar frei mit dem Patienten vereinbaren.

Dazu kommen selbständige **Ambulatorien**, für die als Krankenanstalten eigene Regeln gelten (insb fallen sie in die Zuständigkeit der Wirtschaftskammer und nicht der Ärztekammer). Sie haben zT ebenso Verträge mit den Kassen abgeschlossen. Das gilt ebenso für die Ambulanzen der öffentlichen und privaten Krankenanstalten, die daher als Vertragspartner auch im ambulanten Bereich Kassenleistungen erbringen.

Die ambulante Versorgung ist weitgehend **privatwirtschaftlich** und nicht staatlich organisiert. Über 21.000 niedergelassenen Ärzten und Zahnärzten (davon ca 50% Vertragsärzte) und Vertragseinrichtungen (selbständigen Ambulatorien) stehen eine relativ geringe Anzahl von kasseneigenen Einrichtungen (80 Zahnambulatorien und 38 selbständige Ambulatorien, alle freilich mit jeweils mehreren Ärzten) gegenüber.

Behandlungen durch Angehörige **anderer Gesundheitsberufe** (zB Physiotherapeuten, Heilmasseure) können auf Kassenkosten nur mit ärztlicher Verschreibung in Anspruch genommen werden. Eine Ausnahme besteht für Psychotherapeuten, bei denen eine vorherige ärztliche Untersuchung ausreicht.

Die **stationäre Versorgung** erfolgt als Sachleistung in erster Linie durch öffentliche Krankenanstalten, zu einem geringeren Teil auch durch private Krankenanstalten,

mit denen Verträge abgeschlossen werden. Bei notwendiger Anstaltspflege in Krankenanstalten, mit denen keine Verträge bestehen, besteht Anspruch auf einen Pflegekostenzuschuss (in relativ geringer Höhe).

Heilmittel und **Heilbehelfe** dürfen auf Rechnung der Kasse grundsätzlich nur aufgrund der Verordnung durch einen Vertragsarzt abgegeben werden. Heilmittel müssen zudem nach dem vom Hauptverband herausgegebenen Erstattungskodex verschreibbar sein, für Heilbehelfe bestehen relativ dichte, aber häufig divergierende Vorgaben in den Satzungen.[210]

7.3. Das geltende Vertragspartnerrecht im Überblick[211]

Bei einem internationalen Vergleich lassen sich verschiedene Modelle der Gesundheitsversorgung erkennen. Die Bandbreite reicht von einem staatlichen Gesundheitsdienst bis zu einem strikt marktwirtschaftlichen System, in dem der Patient die Behandlungsleistung bei einem privaten Anbieter „einkauft“ und allenfalls Eigenvorsorge im Wege einer privaten Versicherung betreibt. Ein Aspekt davon ist die Frage, ob bzw in welchem Ausmaß Sachleistungen bereitgestellt werden oder ob nur (zT) eine Kostenerstattung für privat beschaffte Leistungen vorgesehen ist. Aus einem juristischen Blickwinkel betrachtet geht es um die Unterscheidung zwischen öffentlich-rechtlicher oder privatrechtlicher Organisation.

In Österreich besteht ein **Mischmodell**. Der öffentlich-rechtliche Leistungsanspruch aufgrund einer Pflichtversicherung wird von der Sozialversicherung in erster Linie durch privatrechtliche Verträge mit den Leistungserbringern erfüllt. Im **ambulanten** Bereich sind die Vertragspartner idR freiberuflich tätig, eigene Einrichtungen der Sozialversicherung oder Vertragseinrichtungen mit angestellten Ärzten haben bisher keine große quantitative Bedeutung. Auch mit anderen Erbringern von Gesundheitsdienstleistungen als Ärzten werden Verträge abgeschlossen. Im **stationären** Bereich erfolgt die Versorgung überwiegend durch öffentliche Krankenanstalten, mit denen zwar Verträge abgeschlossen werden, denen aber aufgrund der detaillierten gesetzlichen Regelung der Behandlung sozialversicherter Patienten weniger Bedeutung zu-

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[210] Vgl zu den wesentlichen Unterschieden bei diesen Leistungen bereits **Task 2a**, oben 3.2.

[211] Die folgende Darstellung basiert im Wesentlichen auf *Grillberger*/*Mosler*, Ärztliches Vertragspartnerrecht, und soll nur einen groben Überblick der derzeitigen Situation geben, ohne dass auf Detailfragen eingegangen werden kann.

kommt. Ergänzend sind auch private Krankenanstalten in die stationäre Sachleistungsvorsorge eingebunden, auch mit ihnen schließt die Sozialversicherung Verträge ab. **Ziel** des gesamten Versorgungsmodells ist es, eine **möglichst umfassende Sachleistungsvorsorge** zu gewährleisten und gleichzeitig auch die **Interessen der Leistungserbringer zu schützen**.

Die Beziehungen der Sozialversicherung zu Ärzten und Zahnärzten, Gruppenpraxen, Dentisten, Hebammen, Apothekern, Psychologen, Psychotherapeuten, Heilmasseuren, Pflegepersonen, die Hauskrankenpflege erbringen, Krankenanstalten und anderen Vertragspartnern (zB Physiotherapeuten, Logopäden und Ergotherapeuten) werden also durch **privatrechtliche Verträge** geregelt (*§§ 338 ff ASVG*). Dabei handelt es sich einerseits um solche zwischen den Leistungserbringern und den Sozialversicherungsträgern als Leistungsbesteller (**Einzelverträge**), andererseits um solche zwischen den Interessenvertretungen der Leistungserbringer und der Sozialversicherung (**Gesamtverträge**). IdR werden die Einzelverträge durch den Gesamtvertrag fast vollständig inhaltlich bestimmt. Vom Gesamtvertrag abweichende oder diesen ergänzende Vereinbarungen im Einzelvertrag sind nur ausnahmsweise zulässig. Dieses Modell der kollektiven Rechtsgestaltung gilt vor allem für Ärzte, Zahnärzte, Dentisten und Gruppenpraxen. Letztere sind Zusammenschlüsse von Ärzten in einer privatrechtlichen Gesellschaft (OG oder GmbH). Dabei schließt die Gesellschaft selbst den Einzelvertrag mit dem Krankenversicherungsträger ab.

Abweichend von diesem Regelmodell gibt es bei den **Apothekern** nur einen unmittelbar rechtsverbindlichen Gesamtvertrag, aber keine Einzelverträge. Bei **Psychologen und Psychotherapeuten** ist bei Nichtbestehen eines Gesamtvertrags als Alternative vorgesehen, dass Einzelverträge nach einheitlichen Grundsätzen abgeschlossen werden können. Die **Krankenanstaltenverträge** sind grundsätzlich Einzelverträge, in bestimmten Fällen sind aber auch Gesamtverträge vorgesehen. In Bezug auf **andere** Vertragspartner mit gesetzlicher beruflicher Vertretung (zB Hebammen, Optiker, Bandagisten) ist der Abschluss eines Gesamtvertrags fakultativ. Wird ein solcher abgeschlossen, kann er unmittelbare verbindliche Wirkung ohne Abschluss eines Einzelvertrags vorsehen. Gibt es keine gesetzliche berufliche Vertretung, können (nur) Einzelverträge zwischen Leistungserbringern (zB Logopäden, Krankenpfleger) und Sozialversicherung abgeschlossen werden.

Eigene Verträge sind noch hinsichtlich der Durchführung von Vorsorgeuntersuchungen und über die Durchführung medizinischer Begutachtung in der Pensionsversicherung vorgesehen.

Gesamtverträge sind Vereinbarungen zwischen kollektiven Verbänden, die einerseits wie jeder Vertrag zwischen den Vertragspartnern wirken, andererseits aber die Rechtslage der Vertretenen (Leistungserbringer) gestalten. Sie sind den Kollektivverträgen des Arbeitsrechts nachgebildet. Der einzelne Leistungserbringer wird ohne seine Zustimmung wie durch ein Gesetz berechtigt und verpflichtet. Die Bindung bezieht sich nicht nur auf den Inhalt des Gesamtvertrags, der zum Zeitpunkt des Einzelvertrags-Abschlusses gegolten hat, sondern auch auf spätere Änderungen und Ergänzungen, man spricht daher von **Normenverträgen**.

Die hier vorgenommene Übertragung einer Rechtsetzungsbefugnis an die Parteien des Gesamtvertrags erfolgt offenkundig deshalb, weil sich der Staat erwartet, dass die wegen der gegensätzlichen Interessen erforderliche Konfliktlösung besser von den Betroffenen und ihren Vertretungen als vom Staat selbst erledigt werden kann. Auf diesem Weg soll ein gerechter Interessenausgleich zustande kommen, dem nach der Rechtsprechung die **Vermutung der Richtigkeit** zukommt.

Um das Kräftegleichgewicht nicht zu beeinträchtigen, gibt es bisher **weder** einen **Abschlusszwang noch** eine dauerhafte **Zwangsschlichtung** (es kann nur die Geltung eines aufgekündigten Ärzte-Gesamtvertrags für höchstens drei Monate behördlich festgesetzt werden, *§ 348 ASVG*). Die Sozialversicherungsträger trifft hinsichtlich des Zustandekommens eines Gesamtvertrags nur eine **Bemühungspflicht**, sie dürfen einen Vertragsschluss nicht aus unsachlichen Motiven ablehnen. Als Sanktion könnte es – theoretisch – zu einer Haftung des Sozialversicherungsträgers auf Ersatz der Behandlungskosten kommen. Allerdings gibt es dafür keine praktischen Anwendungsbeispiele.

Wird ein Gesamtvertrag aufgelöst, verliert auch der Einzelvertrag seine Wirksamkeit. Daher besteht in der Folge ein **vertragsloser Zustand**, die Inanspruchnahme einer Sachleistung ist nur in einer eigenen Einrichtung des Versicherungsträgers (oder allenfalls in Vertragseinrichtungen) möglich. Bei Behandlung durch niedergelassene Ärzte, Zahnärzte und in Gruppenpraxen besteht Anspruch auf Kostenerstattung in Höhe von 80% des Vertragstarifs (des außer Kraft getretenen Gesamtvertrags); eine Erhöhung der Kostenerstattung ist unter bestimmten Voraussetzungen möglich (vgl nur *§ 131a ASVG*). Soweit für eine Berufsgruppe noch **keine Verträge** bestehen (zB Psychotherapeuten), wird ein (niedrigerer) **Kostenzuschuss** gewährt (vgl nur *§ 131b ASVG*).

Das Regelungsmodell mit der Übertragung einer Rechtsetzungsbefugnis auf die „Sozialpartner des Gesundheitswesens“ ist verfassungsrechtlich zulässig. Gesamtverträge unterliegen zwar auch einer **Bindung an die Grundrechte**, diese ist aber im Ver-

gleich zu Gesetzen abgeschwächt Sie unterliegen im Unterschied zu Gesetzen und Verordnungen **nicht der Normenkontrolle** durch den VfGH. Ein Verstoß gegen Grundrechte (zB unsachliches Verfahren bei der Vertragsarztauswahl) kann (nur) zur von den ordentlichen Gerichten festzustellenden (Teil-)Nichtigkeit des Gesamtvertrags führen. Gleiches gilt, wenn Verträge gegen den Großgeräteplan verstoßen.

Der Abschluss von Gesamtverträgen unterliegt **weder** dem europäischen noch dem österreichischen **Wettbewerbs- bzw Kartellrecht**. Die Tätigkeit gesetzlicher Krankenversicherungsträger ist nämlich keine wirtschaftliche, weshalb sie nicht als Unternehmen iSd Kartellrechts anzusehen sind.[212]

Die Gesamtverträge werden vom **Hauptverband** der Sozialversicherungsträger im Namen der jeweils betroffenen Träger der Krankenversicherung und mit deren Zustimmung mit den jeweils zuständigen **Interessenvertretungen der Gesundheitsdienstleister** (Ärztekammern, Österreichische Zahnärztekammer, Österreichische Apothekerkammer, Österreichisches Hebammengremium, Berufsverbände der PsychologInnen und PsychotherapeutInnen ua) abgeschlossen. Für private Krankenanstalten einschließlich Ambulatorien sowie Optiker, Bandagisten und orthopädische Schuhmacher ist die **Wirtschaftskammer** zuständig.

Soweit vorhanden, können Versicherte auch **eigene Einrichtungen** der Krankenversicherungsträger in Anspruch nehmen. Quantitative Bedeutung hat dies (fast) nur im Bereich der Zahnbehandlung. Zum Schutz der Vertragszahnärzte wurde die Erbringung bestimmter Zahnersatzleistungen in kasseneigenen Zahnambulatorien **eingeschränkt**. Darüber hinaus muss vor Errichtung, Erwerb oder Erweiterung eines kasseneigenen Ambulatoriums das **Einvernehmen** mit der Ärztekammer bzw Zahnärztekammer hergestellt (vgl *§ 339 ASVG*) oder eine **wesentliche Verbesserung des Versorgungsangebots** im Einzugsgebiet nachgewiesen werden.

Die Gesamtverträge der Ärzte, Zahnärzte und Gruppenpraxen (zT auch die für andere Gesundheitsdienstleister) müssen nach dem Gesetz einen bestimmten **Mindestinhalt** aufweisen (vgl nur *§ 342 ASVG*). Jedenfalls müssen ein **Stellenplan** und seine Bewirtschaftung, die **Pflichten** der Vertragspartner (einschließlich die Festlegung der **wirtschaftlichen Behandlungs- und Verschreibweise**) und das dafür gebührende **Honorar** geregelt werden. Der Gesamtvertrag hat dabei eine ausreichende

[212] EuGH 23.4.1991, C 41/90 - *Höfner und Elser*, ECLI:EU:C:1991:161; dies dürfte jedenfalls solange gelten, als das System der Krankenversicherung als Umsetzung des Grundsatzes der Solidarität angesehen werden kann und der Aufsicht des Staates, der es eingeführt hat, unterliegt; diese Umstände können den wirtschaftlichen Charakter einer Tätigkeit ausschließen (EuGH 27.10.2009, C-437/09, *AG2R Prévoyance*, ECLI:EU:C:2011:112 - tarifliche Zusatzkrankenversicherung mit Pflichtmitgliedschaft).

Versorgung der Versicherten mit den **gesetzlich** und durch die jeweilige **Satzung** vorgesehenen Leistungen vorzusehen. Eine völlige Übereinstimmung der Vertragsleistungen mit dem Leistungsanspruch des Versicherten ist allerdings nicht erforderlich, es müssen nicht alle erdenklichen und medizinisch möglichen Leistungen in den Gesamtvertrag aufgenommen werden. Auf einzelne Teilbereiche beschränkte Abschlüsse (zB nur allgemeinmedizinische oder nur gynäkologische Leistungen) sind jedoch unzulässig.

Im **Stellenplan** des Gesamtvertrags sind die **Zahl** und die **örtliche Verteilung** der Vertragsärzte sowie der Gruppenpraxen unter Bedachtnahme auf die regionalen Strukturpläne Gesundheit mit dem Ziel festzulegen, dass unter Berücksichtigung sämtlicher ambulanter Versorgungsstrukturen, der örtlichen Verhältnisse einschließlich der Verkehrsverhältnisse sowie der demographischen Entwicklung für die in der gesetzlichen Krankenversicherung Versicherten und ihre Angehörigen eine **ausreichende ärztliche Versorgung gesichert** ist. Dabei soll in der Regel die Auswahl zwischen wenigstens zwei in angemessener Zeit erreichbaren Vertragsärzten bzw zwischen einem Vertragsarzt und einer Gruppenpraxis mit Vertrag möglich sein, insoweit besteht also **freie Arztwahl** (vgl *§ 342 Abs 1 Z 1 ASVG*).

Ziel ist es, sowohl eine Unterversorgung zu vermeiden als auch zu verhindern, dass Überangebote Nachfrage generieren, die sonst nicht entstünde. Dadurch besteht grundsätzlich die Möglichkeit, regional differenziert auf Kassenarztstellen auch zu verzichten, um etwa die öffentlichen Investitionen zu schützen, die in Spitalsinfrastruktur getätigt werden (insb in den technischen Fächern). In der **Praxis** ist dies aufgrund der Verhandlungsmacht der Ärztekammern allerdings **kaum** möglich. Allerdings gelingt auch die politisch oft propagierte Verlagerung von der Behandlung im Krankenhaus hin zur extramuralen Versorgung (wenn also eine stationäre Versorgung nicht zwingend erforderlich ist) kaum.

Im Gesamtvertrag sind weiters die **Auswahl der** konkret zur Besetzung der vorgesehenen Stellen berufenen **Ärzte bzw Gruppenpraxen** sowie der Abschluss der Einzelverträge zu vereinbaren. Die Stellenvergabe hat diskriminierungsfrei auf der Basis eines eigenen Verfahrens und vorgegebener Reihungskriterien zu erfolgen. Faktisch wird das Verfahren weitgehend von den Ärztekammern durchgeführt, dem Krankenversicherungsträger als Vertragspartner des Arztes/der Ärztin bleibt letztlich eine Art **Vetorecht**. Vom zuständigen Krankenversicherungsträger abgeschlossene Einzelverträge sind für alle Gebiets- und Betriebskrankenkassen sowie für die SVB wirksam. SVA und BVA schließen regelmäßig eigene Gesamtbverträge.

Detailliert werden in den Gesamtverträgen die Rechte und Pflichten der Ärzte und Gruppenpraxen geregelt. Es besteht eine **umfassende Pflicht** des Vertragsarztes **zur Behandlung** der in der Krankenversicherung Leistungsberechtigten. Die Krankenbehandlung muss ausreichend und zweckmäßig sein, darf jedoch das Maß des Notwendigen nicht überschreiten (vgl nur *§ 133 Abs 2 ASVG*). Es sind grundsätzlich alle Leistungen zu erbringen, die auf Grund der ärztlichen Ausbildung und der dem Vertragsarzt zu Gebote stehenden Hilfsmittel sowie zweckmäßigerweise außerhalb einer stationären Krankenhausbehandlung durchgeführt werden können. Wissenschaftlich nicht erprobte Heilmethoden dürfen für Rechnung des Krankenversicherungsträgers nicht angewendet werden, weshalb der Vertragsarzt auch nicht zu deren Erbringung verpflichtet sein kann. Die Behandlungspflicht besteht an sich uneingeschränkt in der Ordination während der im Einzelvertrag vereinbarten Ordinationszeiten, in medizinisch dringenden Fällen auch außerhalb dieser. In **begründeten Fällen** (zB Auslastung) darf die **Behandlung abgelehnt** werden.

Der Vertragsarzt ist grundsätzlich zur **persönlichen Ausübung** seiner Tätigkeit verpflichtet. Der **Einsatz von Hilfspersonen** ist zwar berufsrechtlich insoweit zulässig, als diese nach seinen genauen Anordnungen und unter seiner ständigen Aufsicht handeln. Eine Verrechnung der Leistungen von Hilfspersonen im Rahmen des Einzelvertrags kommt aber nur in Betracht, wenn dies zu keiner Ausweitung des Leistungsspektrums führt. Da nach herrschender Meinung die Anstellung von Ärzten in einer Ordination unzulässig ist, kann es auch diesbezüglich zu keiner Verrechnung von Leistungen kommen. Als Ausnahme wird allerdings von der Rechtsprechung anerkannt, wenn in einer Lehrpraxis der Kassenpatient von einem Turnusarzt unter Aufsicht des ausbildenden Vertragsarztes behandelt wird und die dabei erbrachten Leistungen dem Krankenversicherungsträger verrechnet werden. Ausnahmen von der persönlichen Behandlungspflicht gibt es nach den Gesamtverträgen auch im Fall der vorübergehenden **Verhinderung** des Vertragsarztes.

Zu den **Nebenpflichten** des Vertragsarztes zählen va die administrative Mitarbeit, die Zusammenarbeit mit dem chefärztlichen Dienst des Krankenversicherungsträgers, Aufzeichnungs- und Auskunftspflichten, die (gegenseitige) Unterstützungspflicht sowie das (ebenfalls gegenseitige) Verbot, das Ansehen des Vertragspartners bei den Anspruchsberechtigten und in der Öffentlichkeit herabzusetzen. Den Vertragsarzt trifft auch eine Pflicht zur **Gleichbehandlung** aller Patienten, daher sind getrennte Wartezimmer und unterschiedliche Ordinationszeiten für Kassen- und Privatpatienten unzulässig. Es ist dem Vertragsarzt auch **verboten, Zuzahlungen** für Sondertermine oder eine „bessere“ (zB zeitaufwändigere) Behandlung zu verlangen. Ge-

nerell dürfen Zuzahlungen für vertragsärztliche Leistungen weder gefordert noch entgegengenommen werden.

Faktisch können die Vertragsärzte idR selbst bestimmen, ob bzw welche Leistungen und in welchem Ausmaß Leistungen erbracht werden. Daher sind verschiedene Maßnahmen vorgesehen, eine wirtschaftliche Behandlungs- und Verschreibweise zu erreichen. Dies betrifft auch die **ärztlich veranlassten Kosten** (Verordnungen, Zuweisungen und Überweisungen zu anderen Leistungserbringern). Bei **Verletzungen dieses Ökonomiegebots** durch den Vertragsarzt kann der Krankenversicherungsträger das Honorar zurückfordern. Bei mehrmaligen Verstößen kommt eine Kündigung des Einzelvertrags in Betracht.

Bei der Vereinbarung der **Honorarordnungen** ist auf gesetzlich festgelegte Kriterien zu achten, um die Ziele einer qualitativ hochwertigen Versorgung, einer nachhaltig ausgeglichenen Gebarung der Krankenversicherungsträger und einer angemessenen Honorarentwicklung zu erreichen (vgl *§ 342 Abs 2a ASVG*). Die Vergütung der Tätigkeit von Vertragsärzten ist nach Einzelleistungen oder nach Pauschalmodellen zu vereinbaren. Die Gesamtverträge sollen eine Gesamtausgabenbegrenzung einschließlich der Aufwendungen für die Kosterstattung bei Inanspruchnahme von Wahlärzten enthalten. In der gesamtvertraglichen Praxis kommen überwiegend **Mischformen** bei der Honorargestaltung vor. Meist sind die Grundleistungen durch ein Pauschale abgedeckt. Zur Aufwandsbegrenzung werden Limitierungen, Degressionsregelungen, Deckelungen und andere **Honorarbegrenzungen** vereinbart. Auch die Einschränkung der Verrechenbarkeit von Leistungspositionen auf bestimmte Vertragsärzte (**Fachgebietsbeschränkung**) ist möglich und zulässig. Umstritten ist dagegen, ob Leistungen, die in den Honorarordnungen nicht als Sonderleistung enthalten sind (va neue Untersuchungs- und Behandlungsmethoden, Alternativmedizin) dem Patienten privat verrechnet werden dürfen („kassenfreier Raum“) und dann Kostenerstattung von der Krankenversicherung verlangt werden kann.

Schließlich ist im Gesamtvertrag auch eine **Altersgrenze** von 70 Jahren oder darunter festzulegen. Ausnahmen dürfen nur bei drohender ärztlicher Unterversorgung vorgesehen werden. Kommt keine Einigung im Gesamtvertrag zustande, gilt das vollendete 70. Lebensjahr als Altersgrenze (*§ 342 Abs 1 Z 10 ASVG*).

Die **Auflösung des Einzelvertrages** ist detailliert – gesetzlich (vgl *§ 343 ASVG*) und ergänzend auch im Gesamtvertrag – geregelt. Dabei wird zwischen verschiedenen Arten der Auflösung unterschieden. Das Vertragsverhältnis erlischt, **ohne** dass es einer **Auflösungserklärung** bedarf:

wenn der Krankenversicherungsträger aufgelöst oder seine Tätigkeit so eingeschränkt wird, dass die Vertragsarzttätigkeit nicht mehr in Frage kommt;

im Fall des Todes des Vertragsarztes;

der Auflösung einer Vertrags-Gruppenpraxis;

bei bestimmten strafrechtlichen Verurteilungen sowie einschlägigen zivilrechtlichen Urteilen;

dem Erreichen der Altersgrenze;

der Aufnahme zusätzlicher Gesellschafter in die Vertrags-Gruppenpraxis bzw Änderung ihrer Fachgebiete, beides ohne Zustimmung der Gesamtvertragsparteien.

Zur **Vertragsauflösung** ist der Krankenversicherungsträger ferner **verpflichtet**, wenn die Voraussetzungen für die Berufsausübung bzw für die Tätigkeit als Vertragsarzt nicht mehr vorliegen bzw von Anfang an nicht gegeben waren.

Von besonderer Bedeutung ist das Kündigungsregime. Ein freies Kündigungsrecht (es ist nur eine Kündigungsfrist einzuhalten) besteht nur von Seiten des Arztes, nicht von Seiten der Sozialversicherung. Der Vertragsarzt hat einen **Kündigungsschutz**, der deutlich über den Schutz von AN hinausgeht und am ehesten mit dem Kündigungsschutz der beim Staat beschäftigten Vertragsbediensteten vergleichbar ist.

Die **Kündigung durch den Krankenversicherungsträger** kann unter Einhaltung einer dreimonatigen Frist zum Quartalsende erfolgen, muss aber schriftlich unter Angabe der Gründe ausgesprochen werden. Der Krankenversicherungsträger kann nur wegen **wiederholter nicht unerheblicher oder** wegen s**chwerwiegender Vertrags- oder Berufspflichtverletzungen** kündigen. Bei weniger schwerwiegenden Vertragsverletzungen ist vor einer Kündigung das vorhandene Schlichtungsinstrumentarium auszuschöpfen. Wiederholte Vertragsverletzungen können nur als Kündigungsgrund geltend gemacht werden, wenn der Vertragsarzt vorher verwarnt bzw ihm die Kündigung angedroht wurde. Bei schwerwiegenden Vertragsverletzungen ist eine Abmahnung nicht erforderlich. Als **schwerwiegende Vertragsverletzung** wurden zB angesehen: die Verrechnung nicht erbrachter Leistungen; vorsätzliche Falschverrechnungen, auch wenn diese durch die Ordinationsgehilfin vorgenommen werden, weil der Vertragsarzt eine diesbezügliche Überwachungspflicht hat; das Verschreiben von Anabolika und Begleitpräparaten für Zwecke des Bodybuildings auf Kassenkosten durch mindestens zwei Monate hindurch; das Verlangen und die Entgegennahme von Zuzahlungen des Versicherten; Verletzung der Pflicht zur persönlichen Ausübung der ärztlichen Tätigkeit dadurch, dass Patientenuntersuchungen von der Ordi-

nationshilfe vorgenommen werden, oder dass der Vertragszahnarzt Füllungen im Mund der Patienten von der Ordinationshilfe durchführen lässt.

Zur **Schlichtung und Entscheidung von Streitigkeiten**, die in einem Zusammenhang mit dem Einzelvertrag stehen, wird im Einzelfall eine paritätische Schiedskommission errichtet (*§ 344 ASVG*). Zur Schlichtung und Entscheidung von Streitigkeiten zwischen den Parteien des Gesamtvertrags über die Auslegung oder die Anwendung eines bestehenden Gesamtvertrags sowie zur Entscheidung über die Wirksamkeit einer Kündigung ist die **Landesschiedskommission** zuständig (*§ 345 ASVG*). Auch sie ist paritätisch (Hauptverband und Ärztekammern entsenden je zwei Beisitzer, ein Richter des Ruhestands ist Vorsitzender) zusammengesetzt. Die Festsetzung des Inhalts eines Gesamtvertrags nach dessen Kündigung erfolgt durch die **Bundesschiedskommission** (*§ 346 ASVG*, Richter des OGH als Vorsitzender, Hauptverband und Österreichische Ärztekammer entsenden je zwei Beisitzer). Gegen Entscheidungen dieser Kommissionen kann Beschwerde an das Bundesverwaltungsgericht erhoben werden (*§§ 347a, 347b ASVG*).

7.4. Wesentlicher Reformbedarf aus rechtlicher Sicht

7.4.1. Schnittstelle ambulanter und stationärer Bereich

Eines der Hauptprobleme des österreichischen Gesundheitswesens liegt zweifellos darin, dass es unterschiedliche **Zuständigkeiten** für Gesetzgebung und Vollziehung im stationären Bereich einerseits und im ambulanten Bereich andererseits gibt. Für die Krankenanstalten sind nach *Art 12 B-VG* der Bund für die Grundsatzgesetzgebung und die Länder für die Ausführungsgesetzgebung und Vollziehung zuständig.[213] Die Sozialversicherung bezahlt für ihre Versicherten einen Pauschalbeitrag, die öffentlichen Krankenanstalten und die Vertragskrankenanstalten sind dafür zur stationären Aufnahme verpflichtet. Hingegen ist für den ambulanten Bereich (Ausnahme Spitalsambulanzen und selbständige Ambulatorien, die zu den nicht bettenführenden Krankenanstalten zählen, vgl *§ 2 Abs 1 Z 5 KAKuG*) der Bund für die Gesetzgebung zuständig, die Vollziehung erfolgt weitgehend durch die Sozialversicherung. Diese schließt selbst Verträge mit den niedergelassenen Ärzten (und sonstigen Leistungserbringern im Gesundheitswesen).

[213] Näher dazu bei **Task 7c**, oben 6.2.

Diese Konstruktion hat zwei wesentliche Auswirkungen: Erstens bestehen aufgrund der Finanzierung **gegenläufige Interessen zwischen Sozialversicherung und Ländern**. Die Länder möchten in den niedergelassenen Bereich verlagern, um die von ihnen finanzierten Krankenanstalten zu entlasten. Die Sozialversicherung möchte in den stationären Bereich verlagern, weil die Kosten pauschaliert sind, während im niedergelassenen Bereich (vor allem auch, weil die Honorierung überwiegend nach Einzelleistungen erfolgt) ein Zusatzaufwand entsteht. Es wird aber nicht danach entschieden, ob die Leistung bei einem niedergelassenen Arzt oder in der Krankenanstalt besser und/oder kostengünstiger erbracht werden kann. Im Zusammenhang mit invasiven Eingriffen gilt der Grundsatz, dass die Krankenanstalt alle erforderlichen Vorbereitungs- und Nachsorgetätigkeiten selbst durchzuführen hat.[214]

Zweitens gibt es **keinen Anreiz**, zwischen Krankenanstalten und niedergelassenen Bereich **zu kooperieren**. Dies betrifft vor allem den radiologischen Bereich. Es gilt als fast unmöglich, nicht ausgelastete bzw volkswirtschaftlich unrentable Radiologenstellen im niedergelassenen Bereich zu schließen und die Leistungen im nächstgelegenen Krankenhaus zu erbringen. Stattdessen wird zT überlegt, solche Stellen im niedergelassenen Bereich zu subventionieren. Umgekehrt wäre eine kürzere Verweildauer im Krankenhaus in vielen Fällen erreichbar, wenn die Nachbehandlung durch Vertragsärzte und Hauskrankenpflege besser organisiert wäre.

Vordringlich erforderlich wäre daher eine **Finanzierung und Steuerung** der ambulanten und stationären Betreuung „**aus einer Hand**“, wie sie schon vielfach gefordert wurde. Da dies politisch nicht durchsetzbar ist, begnügt man sich mit zweit- und drittbesten Lösungen. Es gibt zwar Strukturpläne Gesundheit, mit denen eine österreichweite Steuerung versucht wird. Sie sind aber nicht unmittelbar verbindlich. Immer wieder werden dazu Bund-Länder-Vereinbarungen geschlossen und wird mit komplexen Konstruktionen versucht, diesen Vereinbarungen Verbindlichkeit zu verleihen (zuletzt *Vereinbarungsumsetzungsgesetz 2017*). [215] Auch hier ist daher abzuwarten, ob eine erfolgreiche Steuerung gelingt und das Schnittstellenmanagement verbessert wird.

Ein anderes Problem betrifft den Unterschied zwischen **Gruppenpraxen und Ambulatorien**, der nur historisch und mit Standesinteressen zu erklären ist. Nach der Hartlauer-Entscheidung des EuGH[216] wurden zwar die Gruppenpraxen vor allem bei der Bedarfsprüfung den Ambulatorien angenähert. Es ist aber nach derzeitiger Rechts-

[214] Vgl etwa VfGH VfSlg 15.987/2000.

[215] Vgl dazu jüngst *Schrattbauer*, DRdA 2017, 186 ff.

[216] Rs C-169/07, ECLI:EU:C:2009:141.

lage möglich, große Gruppenpraxen (zB in der Rechtsform einer GmbH) mit einer an sich unbeschränkten Anzahl von Ärzten und mit bis zu 30 Angestellten aus anderen Gesundheitsberufen (uU sogar mehr) einzurichten, die sich äußerlich nicht von einem Ambulatorium unterscheiden, ja ein Ambulatorium kann sogar deutlich kleiner sein. Die diffizile Unterscheidung, die bei der Gruppenpraxis letztlich die Selbständigkeit des Arztes betont, während in einem Ambulatorium auch Ärzte angestellt werden können, ist wenig überzeugend. Die Rechtsfolgen sind doch weitgehend: Während für Gruppenpraxen (nur) das *ÄrzteG* und das ärztliche Vertragspartnerrecht (einschließlich des dort vorgesehenen Kündigungsschutzes) zur Anwendung kommt, gilt für Ambulatorien das Krankenanstaltenrecht. Ein wesentlicher Unterschied liegt etwa darin, dass die Errichtung eines Ambulatoriums einer Errichtungs- und Betriebsbewilligung bedarf.

Zusätzlich erschiene es notwendig, dass die **Bedarfsprüfung für Kassenambulatorien** nach dem *KAKuG* nur auf das bestehende Sachleistungsangebot durch Vertragsärzte und Vertragseinrichtungen und nicht auch auf – insoweit nicht schutzwürdige – Wahlärzte und Wahleinrichtungen abstellt.

7.4.2. Primärversorgung

Aus internationalen Daten ergibt sich eine vergleichsweise **hohe Spitalslastigkeit** des österreichischen Gesundheitswesens. Einerseits ist die Aufenthaltsdauer in den Spitälern hoch, andererseits werden die Spitalsambulanzen auch dann in Anspruch genommen, wenn dafür keine Notwendigkeit besteht.

Eine Änderung würde allerdings ua voraussetzen, dass die niedergelassenen Ärzte mehr als bloß wenige Stunden am Tag erreichbar sind (nach den Einzelverträgen besteht eine Ordinationsöffnungspflicht von nur 20 Stunden/Woche), dass Angehörige anderer Gesundheitsberufe verstärkt in der Primärversorgung eingesetzt werden, dass größere Einheiten mit längeren Öffnungszeiten gebildet werden und dass es einen funktionierenden Nacht- bzw Wochenenddienst im niedergelassenen Bereich gibt.

All das spricht dem Grunde nach für die Einrichtung von **Primärversorgungseinheiten**, die ein mögliches Mittel gegen die Spitalslastigkeit der Versorgung, insb die überfüllten Ambulanzen, gegen die Arztlastigkeit der Versorgung, die fehlende Steuerung und die derzeit latent bestehende Gefahr einer diagnostischen und therapeutischen Überversorgung, sowie gegen die geringe interdisziplinäre Zusammenarbeit und oft fehlende ganzheitliche Sichtweise sein könnten. Es

bestünde auch die Möglichkeit, die Öffnungszeiten patientenfreundlicher zu gestalten.

Pilotprojekte gibt es in OÖ und Wien. Ziel ist die niederschwellige, wohnortnahe und ganztägige Gesundheitsversorgung mit Teams aus verschiedenen Fachrichtungen von Ärzten (idR Allgemeinmediziner) und anderen Gesundheits- und Sozialberufen, die auch Gesundheitsförderung, Prävention und die Stärkung der Selbst- und Laienversorgung miteinbezieht. Die Primärversorgungseinheit soll auch die Funktion einer Steuerung zum „best point of service" für die Facharztbehandlung im niedergelassenen Bereich und die stationäre Behandlung in einer Krankenanstalt haben.

Theoretisch ließe sich eine Primärversorgungseinheit sowohl als Gruppenpraxis als auch als Ambulatorium betreiben. Es bedarf aber wohl einer ausdrücklichen Regelung, um die Einbeziehung auch von Gesundheitsförderung, Prävention und Beratung und die Zusammenarbeit zwischen Angehörigen verschiedener Gesundheits- und Sozialberufe zu ermöglichen. Denkbar wären Einzelverträge mit den Primärversorgungseinheiten nach gesetzlich festgelegten Kriterien oder auch Gesamtverträge mit Ärztekammer oder Wirtschaftskammer. Dann müsste freilich bei den Einzelverträgen ein Gestaltungsspielraum gegeben sein, um örtliche Besonderheiten und verschiedene Schwerpunktsetzungen zu ermöglichen. Auch die Honorierung müsste wohl flexibler als in den Gesamtverträgen geregelt sein, bei denen Abweichungen vom Gesamtvertrag nur ganz ausnahmsweise zulässig sind.

Einige dieser Vorhaben finden sich inzwischen auch im Rahmen eines „*Gesundheitsreformumsetzungsgesetzes* ***(GRUG) 2017***" [217], mit dem insb die Regelung der „Primärversorgung iSd *§ 3 Z 9 G-ZG*" [218] angestrebt wird. Die Beschlussfassung über dieses Gesetz ist im Nationalrat am 28.7.2017 erfolgt.

Vorgesehen sind zwei unterschiedliche Primärversorgungs-Typen: Eine Primärversorgungseinheit (PVE) kann einerseits an einem Standort betrieben werden („**Zentrum**"), wobei dies entweder in der Organisationsform einer Gruppenpraxis nach *§ 52a ÄrzteG* oder als selbständiges Ambulatorium iSd *§ 2 Abs 1 Z 5 KAKuG* zulässig ist. Alternativ kann eine PVE auch als **Netzwerk** an unterschiedlichen Standorten betrieben werden; dieses Netzwerk darf nur aus freiberuflich tätigen ÄrztInnen, Gruppenpraxen sowie anderen nichtärztlichen

[217] Vgl derzeit den Text idF des Berichts des Gesundheitsausschusses 1714 BlgNR 25. GP; alle folgenden Gesetzeszitate beziehen sich auf diese Fassung.

[218] Dort findet sich folgende Definition von Primärversorgung: „*Die allgemeine und direkt zugängliche erste Kontaktstelle für alle Menschen mit gesundheitlichen Problemen im Sinne einer umfassenden Grundversorgung. Sie soll den Versorgungsprozess koordinieren und gewährleistet ganzheitliche und kontinuierliche Betreuung. Sie berücksichtigt auch gesellschaftliche Bedingungen*."

Angehörigen von Gesundheits- und Sozialberufen oder deren Trägerorganisationen gebildet werden.[219] In jedem Fall muss die PVE mit eigener **Rechtspersönlichkeit** ausgestattet sein, wobei für Netzwerke als mögliche Rechtsform der Verein angeführt wird, und sie muss im RSG abgebildet sein.[220] Die PVE muss bestimmten gesetzlich geregelten Anforderungen genügen, ua wird eine wohnortnahe Versorgung sowie gute verkehrsmäßige Erreichbarkeit, bedarfsgerechte Öffnungszeiten mit ärztlicher Anwesenheit jedenfalls von Montag bis Freitag, einschließlich der Tagesrandzeiten sowie die Organisation der Erreichbarkeit für Akutfälle auch außerhalb der Öffnungszeiten gefordert.[221]

Das **Kernteam** der PVE hat sich aus ÄrztInnen für Allgemeinmedizin sowie Angehörigen des gehobenen Dienstes für Gesundheits- und Krankenpflege zusammenzusetzen; orts- und bedarfsabhängig ist auch die Einbindung von FachärztInnen für Kinder- und Jugendheilkunde bzw darüber hinaus von weiteren Angehörigen von Gesundheits- und Sozialberufen möglich.[222]

Voraussetzung für die Etablierung einer PVE ist ferner der Abschluss eines auf dem Sachleistungsprinzip beruhenden **Primärversorgungsvertrages** mit den in Betracht kommenden Krankenversicherungsträgern, wobei jedenfalls die örtlich zuständige GKK Vertragspartner der PVE sein muss.[223] Die Beziehungen zwischen den Krankenversicherungsträgern und den PVE in Form einer Gruppenpraxis oder eines Netzwerks aus Einzelordinationen sollen durch einen bundesweit einheitlichen, zwischen Hauptverband und Österreichischer Ärztekammer abzuschließenden **Primärversorgungs-Gesamtvertrag** geregelt werden,[224] der ua das Mindestleistungsspektrum sowie Regelungen über die Grundsätze der Vergütung zu enthalten hat. Im Bereich der Vergütung ist eine Kombination aus Elementen wie Grund- und Fallpauschalen, Einzelleistungsvergütungen sowie uU auch Bonuszahlungen für die Erreichung bestimmter Ziele vorgesehen; die Leistungen von Angehörigen nicht-ärztlicher Gesundheitsberufe sollen offensichtlich durch die Grundpauschale mit abgegolten werden, gesonderte Regelungen sind für diese Berufsgruppen bisher nicht vorgesehen. Die konkrete Ausgestaltung der Honorare soll auf regionaler Ebene durch gesamtvertragliche Honorarordnungen erfolgen;

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[219] *§ 2 Abs 5 PrimVG*.

[220] *§ 2 Abs 4 PrimVG*.

[221] *§ 4 PrimVG*.

[222] *§ 2 Abs 2 und 3 PrimVG*.

[223] Näher *§ 8 PrimVG*.

[224] Vgl *§ 342b ASVG* idF AB 1714 BlgNR 25. GP.

diese sollen zwar Teil des Primärversorgungs-Gesamtvertrages sein, jedoch gesondert gekündigt werden können.

Das **Auswahlverfahren** ist zweistufig aufgebaut, wobei zunächst jene VertragspartnerInnen zur Bewerbung einzuladen sind, deren Planstellen für die konkrete PVE vorgesehen sind. Liegen binnen sechs Monaten keine geeigneten Bewerbungen vor, so kann der Bewerberkreis – ua auch auf selbständige Ambulatorien – erweitert werden.[225] Durch die Invertragnahme des PVE soll es dann zu einer entsprechenden Reduktion des gesamtvertraglichen Stellenplanes um die in der PVE gebundenen ärztlichen Vollzeitäquivalente kommen.[226] Es soll also zu einer schrittweisen Überführung von Planstellen in die neuen PVE kommen. Angepeilt ist ein **Zielwert von 75 PVE** bundesweit bis Ende 2021.

Kritisch anzumerken ist, dass der innovative Grundgedanke des neuen Primärversorgungskonzeptes, nämlich der Erweiterung des Spektrums vom bisher im Mittelpunkt stehenden kurativen Ansatz in Richtung Gesundheitsförderung, Prävention und Vorsorge, im vorliegenden Gesetzesbeschluss nur schwach zum Ausdruck kommt. Insb die Mitwirkung von Angehörigen nichtärztlicher Gesundheitsberufe, die ein zentrales Element der Primärversorgung sein sollten,[227] ist nicht angemessen abgebildet. Es gibt weder klare Regelungen zur Leistungsvergütung noch explizite Mitspracherechte der nichtärztlichen Berufsgruppen oder deren Interessenvertretungen bei der Gestaltung des Primärversorgungs-Gesamtvertrages.

7.4.3. Nichtärztliche Gesundheitsberufe

Die verstärkte Einbindung der nichtärztlichen Gesundheitsberufe ist also auch zumindest teilweise ein Anliegen des *GRUG 2017*. Deren Stärkung wäre freilich unabhängig von der Einrichtung von Primärversorgungseinheiten sinnvoll. Dies betrifft vor allem die **Gesundheits- und Krankenpflege**. Voraussetzung dafür ist zunächst eine Einschränkung des Ärztemonopols. Wie internationale Vergleiche zeigen, reicht es in vielen Fällen aus, wenn der Behandlungsplan vom Arzt festgelegt wird. Es muss nicht jede einzelne Behandlungsleistung vom Arzt angewiesen werden (ein erster Schritt wurde jüngst durch die *GuKG-Novelle 2016* [*BGBl I 2016/75*]

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[225] *§ 14 PrimVG*.

[226] Vgl *§ 342 Abs 3 ASVG* idF AB 1714 BlgNR 25. GP.

[227] Vgl *§ 5 Abs 1 PrimVG*: „*Durch die Primärversorgung ist (…) eine breite diagnostische, therapeutische und pflegerische Kompetenz (…) abzudecken*."

bereits gesetzt). Dies würde auch den vermehrten Einsatz der **Hauskrankenpflege**, auf die an sich ein gesetzlicher Anspruch besteht (vgl nur *§ 151 ASVG*), die aber wenig praktische Bedeutung hat, erleichtern.

Auch ein Ausbau der **Psychotherapie** sollte angestrebt werden.[228] Dazu müssten ein Gesamtvertrag oder – alternativ – Einzelverträge nach einheitlichem Muster abgeschlossen werden. Gleichzeitig ist die Vernetzung mit dem psychiatrischen Bereich zu verstärken. Der Großteil der Psychopharmaka wird von den Hausärzten, also Ärzten für Allgemeinmedizin, verschrieben. Es ist zu vermuten, dass in vielen Fällen Psychopharmaka zu schnell und zu leichtfertig verordnet werden. Ein besseres **Zusammenspiel** von facheinschlägigen Ärzten und Psychotherapeuten könnte die Qualität der Behandlung verbessern. Um die Abgrenzung medizinisch orientierter Psychotherapie von Coaching und der Behandlung von Verhaltensstörungen ohne Krankheitswert zu gewährleisten, sollten allerdings zusätzliche einschlägige Ausbildungsvoraussetzungen für Psychotherapeuten im Gesetz vorgesehen werden (zB Tätigkeit im Krankenhaus).

7.4.4. Ärztliche Gesamtverträge

Der Anpassungsbedarf im Bereich des Vertragspartnerrechts ist vor allem vor dem Hintergrund zu sehen, dass das derzeitige System im Grunde in den 1950er-Jahren entstanden und seither historisch gewachsen ist, ohne dass grundlegende Korrekturen zur Bewältigung veränderter Rahmenbedingungen erfolgt wären. Die folgenden Hinweise beziehen sich freilich nicht auf alle, sondern aus rechtlicher Sicht vordringliche Probleme.

Die **Einkommensverteilung** zwischen den Ärzten des niedergelassenen Bereichs wird vielfach als nicht fair angesehen und ist wohl auch aus Sicht einer patientengerechten Steuerung nicht sinnvoll. Ärzte für Allgemeinmedizin und einzelne Facharztgruppen (zB Kinderärzte) verdienen tendenziell weniger als andere Facharztgruppen (zB Radiologen, Labormediziner). Niedergelassene Laborärzte sind generell teuer, die Verlagerung der Leistung in größere Einrichtungen ist wohl kostengünstiger, ohne dass es zu Qualitätsverlusten käme. Ähnliches gilt zT für die Radiologie.

Derzeit gibt es einen **einheitlichen Gesamtvertrag** für alle Fächer. Es erscheint überlegenswert, die technischen Fächer herauszunehmen und gesonderten Regeln

[228] Auch hierfür gibt es jüngst Ansätze, vgl den Beschluss der Trägerkonferenz im Hauptverband vom 13.7.2017, der auf einen Ausbau der Sachleistungskapazitäten für Psychotherapie bis 2019 um ein Viertel abzielt.

zu unterwerfen oder sie überhaupt generell als Ambulatorien einzurichten. Tendenziell könnte hier nämlich gelten, dass je dienstleistungsorientierter die Leistung ist, desto eher sollte sie im niedergelassenen Bereich erfolgen, je technischer bzw geräteorientierter, desto eher sollte sie in Ambulatorien oder Krankenanstalten erbracht werden.

Fraglich ist, ob mit Maßnahmen im Bereich des Vertragspartnerrechts der (angebliche oder tatsächliche) **Ärztemangel** beeinflusst werden kann. Richtig ist, dass die Zahl der Wahlärzte zunimmt, während die der Vertragsärzte relativ abnimmt und Kassenverträge nicht mehr so begehrt sind wie früher. Viele Wahlärzte führen ihre Praxis allerdings mit wenigen Stunden als Nebenbeschäftigung zum Hauptberuf (meist im Krankenhaus). Das ist zT eine Folge der kürzlich erfolgten Umsetzung der Arbeitszeitrichtlinie in den Krankenanstalten. Die Arbeitszeitverkürzung wird also in vielen Fällen für eine Wahlarzttätigkeit verwendet. Es ist zu überlegen, ob die Kostenerstattung auch bei Inanspruchnahme von Wahlärzten gelten soll, die nur in geringfügigem Ausmaß versorgungsrelevant sind.

Verstärkt wird die Attraktivität der Wahlarzttätigkeit im Vergleich zum Vertragsarzt auch dadurch, dass eine ökonomische Leistungserbringung praktisch nicht kontrolliert werden kann. Die Kosten der Wahlarztbehandlung sind teilweise wesentlich höher als die der Vertragsarztbehandlung.

Die **hohe Ärztedichte** (die mit dem Ärztemangel in Teilbereichen zusammenhängt), steht auch damit im Zusammenhang, dass frei gewordene Stellen im niedergelassenen Bereich meist automatisch nachbesetzt werden. Die Krankenkasse kann die Nachbesetzung ohne Zustimmung der Ärztekammer kaum verhindern. Auch in Fällen, in denen eine ganze Stelle nicht ausgelastet wäre, ist es fast unmöglich, die Stelle einzusparen und das zusätzliche Leistungsvolumen auf andere Anbieter zu übertragen. Die entsprechende Regelung in *§ 343 ASVG* ermöglicht hier zu wenig Flexibilität. Die **Stilllegung einer Planstelle** sollte von der Sozialversicherung bei nachgewiesenem Bedarfsmangel alleine entschieden werden können. Allenfalls wäre eine Überprüfung auf anderer Ebene, etwa durch das BMGF vorzusehen. Dies könnte zumindest dann erfolgen, wenn (in angemessener Zeit) keine Einigung der Gesamtvertragsparteien erzielt werden kann.

Kassenstellen am Land sind tendenziell schwerer zu besetzen als in der Stadt. Das ist freilich ein Phänomen, das wohl tiefergehende Ursachen hat. Letztlich ist die gesamte Infrastruktur am Land betroffen. Es bedarf einer politischen Entscheidung, wie man mit dünn besiedelten Regionen am Land umgeht. Man kann wohl auch darüber diskutieren, ob in Zeiten, in denen viele Menschen mindestens eine halbe Stunde ins

Einkaufszentrum fahren, längere Wege zum Arzt nicht auch zumutbar sind. Für Notfälle muss ohnehin für schnelle Transporte ins nächste Krankenhaus vorgesorgt werden. Dazu könnte der Ausbau von Primärversorgungseinheiten und die bessere Versorgung mit Pflegekräften Abhilfe schaffen. Überlegenswert ist auch, Honorardifferenzierungen in den Gesamtverträgen zu ermöglichen (zB Entfernungszuschläge bei der Betreuung eines größeren Gebiets) und Anreize für die Annahme von Kassenstellen am Land zu schaffen. UU könnten auch Teilzeitstellen die Situation im Einzelfall verbessern.

Äußerst zweifelhaft ist, ob die **Qualitätssicherung** im niedergelassenen Bereich ausreichend ist. Sie wurde der Gesellschaft für Qualitätssicherung, eine Gründung der Österreichischen Ärztekammer, übertragen, die entsprechende Kriterien zu entwickeln hat. Faktisch beschränkt sich die Qualitätssicherung weitgehend auf einen Fragebogen zur Selbstevaluierung, der bestimmte Fragen zur Struktur- und Prozessqualität enthält. Spezielle Sanktionen bei Mängeln gibt es genauso wenig wie eine externe Evaluierung. Nur in krassen Fällen drohen disziplinarrechtliche Folgen durch die Ärztekammer und allenfalls die Kündigung des Kassenvertrags.

Generell stellt sich die Frage, ob ein **Kündigungsschutz** für Freiberufler, der weit über den Kündigungsschutz im Arbeitsrecht hinausgeht und am ehesten mit dem öffentlichen Dienstrecht verglichen werden kann, noch zeitgemäß ist. Es bedarf schwerwiegender oder wiederholter nicht unerheblicher Verstöße gegen die Vertrags- bzw Berufspflichten. Es ist sogar leichter, einen AN fristlos zu entlassen als einen Arzt zu kündigen. Dass eine Kündigung wegen Bedarfsmangel gar nicht möglich ist, selbst wenn die Stelle überflüssig geworden ist, scheint auch überzogen. Der Kündigungsschutz für Vertragsärzte wurde vor allem deshalb eingeführt, weil der Arzt Investitionen in die Praxis getätigt hat, deren Amortisierung durch die Kündigung gefährdet würde. Dabei ist man davon ausgegangen, dass ein wirtschaftliches Überleben ohne Kassenvertrag schwierig ist. Ob das tatsächlich der Fall ist, wird aber beim Kündigungsschutz nicht geprüft. Hier haben sich auch zweifellos die Rahmenbedingungen geändert: Die Hälfte der Ärzte hat keinen Kassenvertrag mehr, viele können auch mit einer Wahlarztpraxis gut verdienen. Eine Kündigung auch wegen Bedarfsmangels allenfalls mit längerer Kündigungsfrist sollte daher möglich sein. Strukturänderungen würden damit erleichtert (zB mehr Ärzte für Allgemeinmedizin statt Laborärzte). Spätestens wenn in Hinkunft eine Anstellung von Ärzten bei niedergelassenen Ärzten zulässig sein soll, müsste auch der Kündigungsschutz überdacht werden. Dass der angestellte Arzt dem Arbeitsrecht mit einem grundsätzlich freien Kündigungsrecht unterliegt, während der selbständige Arzt einen insoweit fast beamtenähnlichen Status genießt, ist sachlich kaum zu rechtfertigen.

Bei Überweisungen und Verordnungen sollte das bestehende **Ökonomieprinzip** ausgebaut bzw konkretisiert werden. Der überweisende Arzt entscheidet zwar im Rahmen seiner Therapiefreiheit darüber, welche diagnostische oder therapeutische Maßnahme erforderlich ist. Es gibt aber aus der Sicht des Zwecks der Krankenbehandlung keinen vernünftigen Grund, warum an Anbieter überwiesen werden sollte, welche die gleiche Leistung teurer erbringen. Die freie Wahl des Leistungserbringers durch den Versicherten macht in den technischen Fächern keinen Sinn und ist dort daher einzuschränken. Der Aspekt des Vertrauensverhältnisses zum Arzt, der die freie Arztwahl rechtfertigt, spielt insb beim Allgemeinmediziner, Kinderarzt und Gynäkologen zweifellos eine gewichtige Rolle, ist aber beim Facharzt für Labormedizin bzw für Radiologie wohl irrelevant: In den meisten Fällen gibt es – vor allem bei der Labormedizin – nicht einmal einen unmittelbaren Kontakt zwischen dem Patienten und dem Arzt. Überweisungen im Labor- und Radiologiebereich sollten daher an den kostengünstigsten Anbieter (Vertragsarzt oder Vertragseinrichtung) erfolgen müssen. Aufgabe der Krankenversicherungsträger ist es, die Ärzte über die kostengünstigsten Anbieter zu informieren.

Ansonsten gäbe es noch einige Punkte zur **Modernisierung der Gesamtverträge**:

So gibt es derzeit offenbar keine **elektronische Diagnoseerfassung** im niedergelassenen Bereich, damit sind Gesundheitsforschung und Effizienzanalysen enorm erschwert.

In den Gesamtverträgen sind viele **Einzelleistungen** enthalten, die medizinisch nicht mehr Standard sind, gleichzeitig fehlen oft neuere Leistungen. Eine perfekte Lösung gibt es hier nicht, die Honorarkataloge sollten aber jedenfalls durchforstet werden. Tendenziell spricht Vieles für eine Stärkung der Pauschalabgeltung, bei welcher der Arzt eher für die Gesamtleistung honoriert wird und kein Anreiz für die Erbringung gut abgegoltener Leistungen besteht. Die damit verbundene Gefahr, dass das frühere „Krankenscheinsammeln“ ohne Leistungserbringung wieder aktuell werden könnte, ist zwar nicht ganz von der Hand zu weisen, dürfte aufgrund der elektronischen Abrechnung aber schwieriger geworden sein. Es wäre aber auch möglich, den Ärzten generell für die Betreuung ihrer Patienten eine pauschale Abgeltung zu bezahlen. Freilich würde das voraussetzen, dass die freie Arztwahl eingeschränkt wird.

Fraglich ist schließlich auch, ob das Verfahren mit den **Schiedskommissionen** noch zeitgemäß ist. Die Qualität der Entscheidungen könnte möglicherweise durch eine Übertragung auf die Arbeits- und Sozialgerichte verbessert werden.

8. Task 9e: Risikostrukturausgleich – rechtliche Aspekte[229]

8.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„FINANZIERUNG: Fragestellungen aus dem Ist-Stand“** ua folgende Passage (9):

> „Die derzeitige Finanzierungslandschaft birgt **Schieflagen** zwischen den einzelnen Versichertengruppen und den SteuerzahlerInnen insgesamt. Es gibt nur einen **unzureichenden Risikostrukturausgleich**. Die Gebietskrankenkassen schultern besondere **Risiken der Versichertenstruktur** (z.B. Arbeitslose, Mindestsicherungsbezieher, Asylwerber usw.), die andere Träger nicht zu tragen haben. Unabhängig von der organisatorischen Ausgestaltung als bundesweiter Träger oder regionaler Träger sollen zusätzliche Risikofaktoren ausgeglichen werden (Unterschied zwischen urbaner und ruraler Risikoverteilung). Das **deutsche Modell** des **morbiditätsorientierten Risikostrukturausgleichs** ist ein Beispiel der risikoorientierten Finanzierung, das beleuchtet werden soll. Modelle zum Risikoausgleich, welche mit der österreichischen Systemlogik in Einklang gebracht werden können, sind zu erstellen.“

Daraus wurden ua folgende **Aufgabenstellungen** abgeleitet (10):

„Analyse der Risikostruktur zwischen den Trägern und Erarbeitung eines risikobasierten Ausgleichsmechanismus und Analyse der Ungleichverteilung der Kostentragung der Träger bei Mehrfachversicherten und Erarbeitung eines Ausgleichsmechanismus.“

8.2. Schlussfolgerungen aus Task 7a-7b im Hinblick auf einen Risikostrukturausgleich

Die zu Task 7a-7b (oben 5.) angestellten verfassungsrechtlichen Überlegungen sind nicht nur für eine allfällige Umgestaltung der Trägerlandschaft in der Krankenversi-

[229] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* verfasst.

cherung von Bedeutung, sondern auch für die bei Fortführung der bestehenden Strukturen – und daher weniger weit gehende – Frage der Zulässigkeit der Etablierung von (zusätzlichen) Mechanismen für einen **Risikostrukturausgleich zwischen den einzelnen Trägern**. Dieses Thema wird in dem der Studie zu Grunde liegenden Konzept in einem anderen Kontext angesprochen und wurde auch im LSE-proposal nicht explizit als rechtliche Aufgabe identifiziert (vgl **Task 9e**: „… development of a risk-based adjustment mechanism …“), soll aber hier dennoch behandelt werden.

Dafür ist zunächst davon auszugehen, dass Ausgleichsmechanismen zwischen den einzelnen Trägern sich schon seit langem im **geltenden** Recht finden. Die wichtigste derartige Einrichtung ist der **Ausgleichsfonds der Gebietskrankenkassen** nach *§§ 447a* und *447b ASVG*. Dieser soll eine ausgeglichene Gebarung bzw ausreichende Liquidität der GKKs gewährleisten und wird dementsprechend vorrangig aus Beiträgen dieser Träger gespeist.[230]

Grundsätzlich **alle** Sozialversicherungsträger[231] sind dagegen beim Ausgleichsfonds für die **Krankenanstaltenfinanzierung** erfasst (vgl *§ 447f ASVG*). Neben Beiträgen all dieser Träger (vgl derzeit *§ 447f Abs 10* und *11 ASVG*) erfolgt noch eine Überweisung aus den Einnahmen aus der **Tabaksteuer** über den Ausgleichsfonds der Gebietskrankenkassen (*§ 447a Abs 10 und 11 Z 1 ASVG*).

Auf demselben Weg und damit ebenfalls aus den Einnahmen aus der Tabaksteuer gespeist wird der **Fonds für Vorsorge(Gesunden)untersuchungen und Gesundheitsförderung** nach *§ 447h ASVG*. Da hier ebenso wie beim **Zahngesundheitsfonds** (vgl *§ 447i* und *§ 80c ASVG*) die Finanzierung im Wesentlichen aus Steuermitteln erfolgt, stellt sich die Frage nach den rechtlichen Grenzen einer Umverteilung der Lasten zwischen den einzelnen Sozialversicherungsträgern nicht.

Sehr wohl ein Thema war das insb bei der schon mehrfach angesprochenen Entscheidung des VfGH VfSlg 17.172/2004. In diesem Erkenntnis war die damalige Konstruktion des Ausgleichsfonds nach *§ 447a ASVG* zu prüfen, nach der nicht nur die Gebietskrankenkassen, sondern auch die (damalige) VAB (inzwischen VAEB), die SVA und die SVB als Träger der Krankenversicherung erfasst waren. Der VfGH hat die Einbeziehung dieser Träger und die Regeln für die Gewährung von Mitteln aus diesem Fonds für **verfassungswidrig** erklärt. Dies wurde im Wesentlichen mit einem Verstoß gegen den **Gleichheitssatz** begründet, mit dem es nicht vereinbar

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[230] Jede Gebietskrankenkasse hat in diesen Fonds einen Beitrag in Höhe von 1,64 (ab 2021: 2,0)% ihrer Beitragseinnahmen zu entrichten (*§ 447a Abs 4 ASVG*), dazu kommen weitere Einnahmen nach Maßgabe des *Abs 3* dieser Bestimmung.

[231] Keine Beiträge hat lediglich die Versicherungsanstalt der Notare zu leisten.

sei, Beitragseinnahmen, und seien es auch Überschüsse oder Rücklagen, einer Versichertengemeinschaft an eine andere Versichertengemeinschaft zu übertragen, sofern zwischen diesen beiden Gemeinschaften **kein persönlicher und sachlicher Zusammenhang** besteht. Aus diesem Erkenntnis und der Vor- bzw Folgejudikatur[232] können für die vorliegende Fragestellung einige grundlegende Schlussfolgerungen gezogen werden:

Zunächst ist festzuhalten, dass die **Übertragung von Überschüssen** eines Versicherungsträgers auf einen anderen Versicherungsträger zwar grundsätzlich zulässig ist, selbst wenn es sich dabei um unterschiedliche Zweige handelt, sofern zwischen den „Versicherten der belasteten und der begünstigten Sozialversicherungsträger ... eine Versicherungs(Risken-)gemeinschaft im weiteren Sinn" besteht.[233] Dass ein Träger Überschüsse hat, berechtigt dagegen **allein nicht** zur Umschichtung auf andere Träger.[234]

Der demnach primär Ausschlag gebende **persönliche und sachliche Zusammenhang** zwischen den im Rahmen eines Sozialversicherungsträgers zusammengeschlossenen Versichertengemeinschaften ist – derzeit – etwa im Verhältnis der Krankenversicherung nach *B-KUVG* und *ASVG* nicht gegeben.[235] Zudem ist zu berücksichtigen, dass allfällige Strukturnachteile, die sich aus der regionalen Gliederung (wie bei den Gebietskrankenkassen) ergeben, keine Rechtfertigung für die Einbeziehung eines bundesweit tätigen Trägers (wie der BVA) sein können, weil bei diesem solche (aus der unterschiedlichen Geographie sich ergebende) Strukturnachteile bereits intern zum Ausgleich kommen.[236]

Als solche **Strukturnachteile** werden im zuletzt genannten Erkenntnis insb der Umstand anerkannt, dass die Beitragsgestaltung in der Sozialversicherung nicht zwischen guten und schlechten Risiken unterscheiden darf (vgl bereits oben 5.2.2.1.), was dazu führen kann, dass manche Krankenversicherungsträger in Abhängigkeit von der Wirtschaftsentwicklung, aber auch von strukturellen Umständen in der **Schichtung der Versichertengemeinschaft**, von nicht beeinflussbaren Risiken stärker betroffen sind als andere, sodass die – insoweit „ungerechtfertigte“ – Nachtei-

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232 Vgl insb VfGH VfSlg 17.677/2005, bzw VfSlg 19.158/2010.

233 Vgl insb VfGH VfSlg 11.013/1986: Beiträge aus der Krankenversicherung an den Ausgleichsfonds der Pensionsversicherungsträger; aber auch bereits VfSlg 6039/1969: Übertragung von Überschüssen aus der Unfall- in die Krankenversicherung.

234 Vgl VfGH VfSlg 17.172/2004.

235 Vgl insb VfGH VfSlg 10.779/1986.

236 So noch einmal ausdrücklich VfGH VfSlg 17.172/2004.

le erleiden, während anderen ebensolche „Vorteile“ entstehen. Auch die **Betreibung eines öffentlichen Krankenhauses** ist ein gegebenenfalls zu berücksichtigender Strukturnachteil.

Ebenfalls anerkannt wurde in VfSlg 17.172, dass die **Versorgung von Großstädten** ein Strukturnachteil sein kann, der eine Umschichtung rechtfertigen könnte. Die bloße Nennung dieses Umstandes reicht noch nicht aus, so dass der (seinerzeit in *§ 447b Abs 2 a ASVG* verwendete) Begriff „Großstadtfaktor“ als zu unbestimmt qualifiziert wurde, da er nicht hinreichend zum Ausdruck bringe, welche konkreten Strukturnachteile zulässigerweise Grundlage von Ausgleichszahlungen sein dürfen und in welchem Ausmaß ein „Großstadtfaktor“ - im Verhältnis zu anderen Strukturnachteilen - die Höhe der Ausgleichszahlungen beeinflusse. Der Gesetzgeber müsste daher jene Umstände **evidenzbasiert festmachen**, die zu besonderen finanziellen Belastungen der betreffenden Träger im Verhältnis zu für andere Versorgungsgebiete verantwortlichen Trägern führen.

Nicht anerkannt wurde in VfSlg 17.172 dagegen ein Ausgleich zwischen verschiedenen Versichertengruppen mit **unterschiedlichen Beitragssätzen** und/oder **unterschiedlichem Leistungsrecht**, wozu auch die Unterschiede in der **Honorierung** leistungserbringender **Dritter** (insb also auf Grund der gesamtvertraglichen Regelungen)[237] zählen. Eine solche Regelung könne, so der VfGH ausdrücklich, aus verfassungsrechtlicher Sicht nur dann als zulässig beurteilt werden, wenn durch entsprechende Vorkehrungen sichergestellt wäre, dass die durch die Einbeziehung in einen solchen Strukturausgleich entstehenden finanziellen Nachteile oder Vorteile der einzelnen Krankenversicherungsträger allein den (günstigen oder ungünstigen) Strukturen, die nach dem Willen des Gesetzgebers zur Bildung der Risikengemeinschaft führen, zuzuschreiben sind. Der Umstand, dass bestimmte Personen, die typischerweise einem höheren Risiko ausgesetzt sind, nur bestimmten Trägern zugeordnet sind, würde daher – die Belegbarkeit dieses höheren Risikos vorausgesetzt (zB inwieweit sind Arbeitslose tatsächlich häufiger/länger krank?) – grundsätzlich einen trägerübergreifenden Ausgleich rechtfertigen.

Zu groß wären die Unterschiede dagegen angesichts des Beitragsrechts im *BSVG*. An dem Hauptargument dafür, dass die **Einbeziehung der SVB** in den seinerzeitigen Ausgleichsfonds in VfSlg 17.172 als **verfassungswidrig** qualifiziert wurde, hat sich nämlich nichts geändert: Nach dem *BSVG* ist als monatliche Beitragsgrundlage

[237] Aber wohl auch Unterschiede bei den Selbstbehalten oder dahingehend, ob es ein (nahezu) reines Sachleistungssystem (wie im *ASVG*) oder ein gemischtes Geld-Sachleistungssystem (wie im *GSVG*) gibt.

nicht das Einkommen des Versicherten, sondern der „Versicherungswert“ seines land- oder forstwirtschaftlichen Betriebes, also ein degressiv gestaffelter Prozentsatz des steuerrechtlichen Einheitswertes des Betriebes (*§ 23 Abs 2 BSVG*) heranzuziehen. Die Einbeziehung der SVB in den Ausgleichsfonds der Krankenversicherungsträger hätte wie damals zur Konsequenz, dass der an die SVB fließende (der Sache nach einer Subvention gleichkommende) Beitrag zu einer ausgeglichenen Gebarung der SVB im Ergebnis von allen anderen Versichertengemeinschaften zu tragen wäre; darin wäre jedoch eine systematische Begünstigung dieser Sozialversicherungsanstalt zu Lasten aller übrigen zu erblicken, wobei unerheblich wäre, ob im Zeitablauf immer dieselben oder auch je verschiedene Versichertengemeinschaften von diesen Vor- und Nachteilen betroffen sind, weil selbst ein „Ausgleich“ in dieser Hinsicht nichts an der Unsachlichkeit des Systems ändern könnte.

Weniger problematisch erscheinen dagegen die Unterschiede in der Beitragsgrundlagenbildung zwischen **selbständig** Erwerbstätigen nach *GSVG* und unselbständig Erwerbstätigen. Bei ersteren gibt es zwar – mit Ausnahme der „neuen Selbständigen“ – keine Versicherungsgrenze. Dieser Unterschied, der ja auch innerhalb der Versichertengemeinschaft des *GSVG* besteht, hat jedoch bisher soweit ersichtlich keine verfassungsrechtlichen Bedenken aufgeworfen.[238] Es sollte daher auch **grenzüberschreitend** (also im Verhältnis *ASVG/GSVG*) kein Problem sein, dass bei einem Teil der Versicherten eine Mindestbeitragsgrundlage normiert ist, die auch bei Verlusten greift, weil dies vor allem dazu dient, für diese Personen auch in Jahren des Verlustes möglichst geschlossene Versicherungsverläufe sicherzustellen.

➔ **Insgesamt** betrachtet erscheint die Bildung eines breiten Risikostrukturausgleichs natürlich **umso eher verfassungsrechtlich zulässig**, **je geringer die Unterschiede** zwischen den in den jeweiligen Versichertengemeinschaften zusammengefassten Versicherten im **Beitrags- wie im Leistungsrecht** (einschließlich dem **Honorarrecht** der LeistungserbringerInnen) sind.

➔ Wenn auf diese Weise „grenzüberschreitende“ Strukturnachteile zwischen den einzelnen Versicherungsträgern ausgeglichen werden dürfen, dann dürfen wohl – **umso mehr – auch Versicherungsträger zum Zwecke dessen zusammengelegt werden, dass ein solcher Strukturnachteil gar nicht erst entsteht**. Diesbezüglich sei noch einmal auf die Schlussfolgerungen oben 5.3. verwiesen. Die Verwendung

[238] Vgl nur VfGH VfSlg 18.607/2008 zur Unbedenklichkeit unterschiedlicher Regelungen in dieser Hinsicht bei Versichertengruppen innerhalb des *GSVG*.

von bestehenden **Rücklagen** eines aufgelösten Versicherungsträgers auch für eine andere Versichertengruppe im neuen gemeinsamen Versicherungsträger wäre ein weitgehend zu vernachlässigendes, weil leicht regelbares **Übergangsproblem**.[239]

➔ Eine andere und **verfassungsrechtlich** grundsätzlich **unbedenkliche** Möglichkeit der Schaffung eines Risikostrukturausgleichs stellt die Einhebung von Beiträgen in Form von **Abgaben** im **übertragenen Wirkungsbereich** (also weisungsgebunden und nicht in Selbstverwaltung) für den Bund dar, auch wenn diese Beiträge – eben für einen Risikoausgleich – **zweckgebunden** wären.[240]

[239] Vgl dagegen die Fragestellung zu **Task 14a**, unten 11.

[240] Näher dazu bei **Task 14a**, unten 11.2.1. bzw 11.3.

9. Task 9g: Sozialrechtliche Trennung der Systeme der Beamt-Innen und allen anderen Versicherten – rechtliche Aspekte[1]

9.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„FINANZIERUNG: Fragestellungen aus dem Ist-Stand“** ua folgende Passage (9f):

> „**Mehrfachversicherte** und ihre Angehörigen sind unter Umständen mehreren Trägern zugeordnet. Beiträge fließen an mehrere Träger und die Leistungen können von Versicherten pro Versicherungsfall bei unterschiedlichen Trägern konsumiert werden (persönliche Wahlfreiheit). Daher sind die typischen unterschiedlichen Fallvarianten zu Mehrfachversicherungen (mehrere Erwerbstätigkeiten, Eltern von mitversichertem Kind, die bei verschiedenen Trägern versichert sind, usw.) zu untersuchen. Es soll ein in Österreich implementierbarer Ausgleichsmechanismus entwickelt werden. Ein Ziel des Ausgleichsmechanismus soll die Ermöglichung der **Zusammenrechnung der Beitragsgrundlagen von Beamten und sonstigen Versicherten** sein.“

Daraus wurden ua folgende **Aufgabenstellung** abgeleitet (10):

„Analyse der Gründe für die bestehende komplette Trennung der Systeme von BeamtInnen und allen anderen Versicherten (insbesondere Beitragsgrundlagenbildung), darauf aufbauend Erarbeitung eines Vorschlags zur Beseitigung der Trennung.“

Diese Fragestellung ist keine genuin juristische, sondern zunächst eine (allenfalls rechts-)historische bzw eine solche, die der Politikwissenschaft oder der Staats- bzw Verwaltungslehre zuzurechnen ist. Da die Trennung zwischen BeamtInnen und anderen Erwerbstätigen aber nicht unbeträchtliche Auswirkungen im und für das Sozial(versicherungs)recht hat, ist die Frage nach den Gründen dieser Differenzierung von erheblicher Bedeutung für die **Möglichkeiten einer künftigen Überwindung dieser Trennung**. Die folgenden Überlegungen sollen dazu einige Anhaltspunkte liefern, beschränken sich aber – im Einvernehmen mit den Auftraggebern der Studie – auf jene Aspekte, die für eine Harmonisierung und

[1] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* verfasst.

letztlich für eine Steigerung der Effizienz der Gesundheitsversorgung besonders wichtig erscheinen.

9.2. Gründe für eine Differenzierung der Systeme und Anhaltspunkte für deren Überwindung

Die historische **Hauptursache** für die Trennung der Systeme der sozialen Sicherung der BeamtInnen von jenen für andere Erwerbstätige liegt gewiss darin, dass die Vorsorge für – in heutiger Sichtweise und Terminologie – soziale Risiken wie Krankheit, Invalidität und Alter bei BeamtInnen schon lange vor der Schaffung sozialversicherungsrechtlicher Regelungen eine Angelegenheit des **Dienstrechts**, also der jeweiligen DG, war. Diese gewährten ihren Bediensteten im Rahmen eines im Wesentlichen unkündbaren, lebenslangen Dienstverhältnisses Bezüge, wobei jene im Ruhestand (auch heute noch „*Ruhegenuss*“ genannt, vgl nur *§ 3 PG 1965*) etwas geringer waren als die Aktivbezüge. Bemessungsgrundlage war idR der letzte Aktivbezug, der Ruhegenuss belief sich im Allgemeinen auf 80% davon; eine Einkommensgrenze in Form einer Höchstbeitragsgrundlage war ebenso unbekannt, wie – nach dem Konzept als Leistung des DG folgerichtig – Pensionsbeiträge der BeamtInnen.

An die Stelle des persönlichen Treuebandes gegenüber dem Kaiser ist mit dem Zusammenbruch der Monarchie zwar das Verständnis der „Verwaltung“ als Rechtsfunktion getreten.[2] Die sozialrechtliche Sonderstellung ist allerdings auch in der Republik fortgeschrieben worden, wobei die Vorsorge für den Krankheitsfall schon bald nach dem Versicherungsprinzip erfolgte, während die Absicherung bei Alter oder Arbeitsunfähigkeit weiterhin als DG-Leistung organisiert war.[3] Diese Differenzierung besteht auch noch bei den derzeit geltenden Regelungen: Das *B-KUVG* fasst BeamtInnen und andere öffentlich Bedienstete in einem durchaus weit verstandenen Sinn[4] zu einer Versichertengemeinschaft für den Bereich der Kranken- und Unfallversicherung zusammen, das schon erwähnte *PG 1965* regelt die

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[2] *Kucsko-Stadlmayer*, Das Disziplinarrecht der Beamten, 1.

[3] Vgl einerseits insb das *Gesetz über die Krankenversicherung der Staatsbediensteten* (*StGBl 1920/311*) bzw andererseits das *Pensionsgesetz 1921* (*BGBl 1921/735*).

[4] Vgl die einzelnen Tatbestände in *§ 1 Abs 1 B-KUVG*.

pensionsrechtlichen Ansprüche von BeamtInnen und deren Hinterbliebenen im Rahmen des Dienstrechts.

In beiden Bereichen hat es jedoch erhebliche **Annäherungen** an das (allgemeine) Sozialversicherungssystem gegeben. Im *B-KUVG* wurden bereits von Anfang an beträchtliche Teile des ASVG als entsprechend anwendbar erklärt,[5] wenn auch zunächst mit der Begründung, damit „*den Gesetzestext zu entlasten*“.[6] Bemerkenswert ist in diesem Zusammenhang auch, dass die mit dem *B-KUVG* erstmals in umfassender Weise und im Grunde nach dem Vorbild des *ASVG* erfolgte Regelung einer Unfallversicherung für öffentlich Bedienstete verfassungsrechtlich umstritten war, weil zT die Meinung vertreten wurde, dass neben dem Dienstrecht kein Platz für eine auch sozialversicherungsrechtliche Erfassung von Risiken wie dem Arbeits- bzw Dienstunfall oder Berufskrankheiten wäre.[7]

Diese Auffassung hat sich inzwischen fast ins Gegenteil verkehrt, wie sich am *PG* gut dokumentieren lässt. Die – auch kompetenzrechtlich begründete – Verschiedenheit zwischen dem lebenslangen Beamtendienstverhältnis und dem Dienstverhältnis von AN prägte die unterschiedliche Entwicklung der Altersversorgung der beiden Gruppen durch Jahrzehnte. Bereits relativ früh wurde jedoch der Umstand, dass BeamtInnen anders als DN keine Pensionsbeiträge zu bezahlen hatten, als Privileg empfunden und wurden auch für diese Beiträge eingeführt.[8] Die in der Rechtsprechung des VfGH lange beschworene „tiefgreifende Verschiedenheit“ der beiden Rechtsgebiete war schon länger umstritten[9] und wurde seit 2004 im Zuge der „**Pensionsharmonisierung**“ durch das *APG* aufgeweicht, wobei zwei Maßnahmen besonders wichtig erscheinen: Zum einen die schrittweise Schaffung eines langen Durchrechnungszeitraumes auch für BeamtInnen statt der früheren Pensionsbemessung ausgehend vom letzten Bezug,[10] zum anderen die Einführung einer Höchstbeitragsgrundlage (und damit Entfall der hohen, den Bezügen entsprechenden Pensionen insb von akademisch

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5 Vgl nur die inzwischen auch weite Teile des Leistungsrechts umfassenden Verweise auf das *ASVG* in *§ 84 Abs 1 B-KUVG*.

6 Vgl etwa die ErläutRV 463 BlgNR 11. GP 42.

7 Vgl noch einmal die ErläutRV 463 BlgNR 11. GP 39ff.

8 In *§ 22 GehG* war schon nach der Stammfassung ein Pensionsbeitrag in Höhe von 4% des Gehaltes und der für die spätere Pension zu berücksichtigenden Zulagen vorgesehen. Dazu ist später ein auch von PensionistInnen zu entrichtender Beitrag nach Maßgabe des *§ 13a PG* gekommen.

9 Vgl nur die Nachweise bei *Pfeil*, Vertrauensschutz im Sozialrecht, DRdA 2015, 420 (426).

10 Dieser beträgt grundsätzlich – dh abgesehen von der Anpassung durch Übergangsbestimmungen – wie im *ASVG* (vgl dessen *§ 238 Abs 1*) 480 Monate (vgl *§ 4 Abs 1 Z 3 PG*).

ausgebildeten BeamtInnen).[11] Das hat im Zusammenspiel mit anderen Faktoren[12] inzwischen bewirkt, dass auch der VfGH von der Notwendigkeit einer Differenzierung abgerückt ist,[13] so dass eine **weitergehende Annäherung der Systeme durchaus möglich** erscheint.

Im Hinblick auf das Pensionsrecht bedürfte das aber letztlich einer **Abschaffung** des Modells des **lebenslangen** Dienstverhältnisses bei BeamtInnen, das auch eine lebenslange Disziplinargerichtsbarkeit einschließt, durch die Gebietskörperschaften, die das Dienstrecht regeln können (vgl *Art 10 Abs 1 Z 16* bzw *Art 21 B-VG*). Das **Disziplinarrecht** kann dazu führen, dass sowohl aktive als auch bereits im Ruhestand befindliche BeamtInnen aus dem Staatsdienst ausgeschlossen werden, eine Sanktion, die auch den Verlust des Pensionsanspruches zur Folge hat. In einem solchen Fall wechselt dieser Anspruch in das *ASVG*, wobei beim Ausscheiden aus dem Beamtendienstverhältnis pauschalierte „*Überweisungsbeiträge*" nach *§ 311 ASVG* an den Pensionsversicherungsträger zu zahlen sind. Damit geht die Zuständigkeit für den Pensionsanspruch auf die Pensionsversicherungsanstalt über, wird aber dann auch nach *ASVG* bzw *APG* berechnet. Würde nun die Pensionsgewährung durch den DG entfallen, dann verlöre dieses Modell auch seine (synallagmatische) Grundlage und damit würde wohl auch die sachliche Rechtfertigung für die Aufrechterhaltung der Disziplinargerichtsbarkeit verloren gehen.[14]

Damit lassen sich für die vorliegende Aufgabenstellung zwei wesentliche **Schlussfolgerungen** ziehen:

➔ Eine **Zusammenführung** der Systeme der Beamtinnen und der anderen (insb unselbständig) Erwerbstätigen müsste daher zuallererst am **Dienstrecht** ansetzen und das Prinzip des lebenslangen Dienstverhältnisses samt der Unterworfenheit unter das Disziplinarrecht beseitigen. Auf diese Weise könnten auch die mit dem *APG* bereits weit vorangetriebenen Schritte zur **Harmonisierung der Pensionssysteme** „vollendet" werden.

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[11] Vgl die nunmehrige Fassung des *§ 22 GehG*.

[12] Stellvertretend sei hier nur die Angleichung der Inflationsanpassung der Beamtenpensionen an jene nach dem *ASVG* erwähnt.

[13] Grundlegend VfGH VfSlg 19.884/2014:. „*grundsätzlich noch … verschiedene Rechtsgebiete*".

[14] In diesem Zusammenhang stellt sich natürlich die Frage, ob es von Verfassungs wegen BeamtInnen mit lebenslangem Dienstverhältnis geben muss oder ob der öffentliche Dienst – mit Ausnahme insb der Justiz – nicht auch durch Privatangestellte betrieben werden könnte. Diese Frage braucht vorliegend aber nicht verfolgt werden.

➔ Für eine Harmonisierung im Hinblick auf die **Kranken- und Unfallversicherung** ist zwar keine Systemumstellung erforderlich. Soweit die bestehenden Unterschiede aber auf den dienstrechtlichen Sonderstatus der BeamtInnen zurückgehen (und dieser Sonderstatus eben nicht – im Dienstrecht – beseitigt wird), ist eine Einbeziehung dieser öffentlich Bediensteten in ein und dieselbe Versichertengemeinschaft wie mit anderen (unselbständig) Erwerbstätigen schwierig. Bei grundsätzlicher **Angleichung des Beitrags- und Leistungsrechts** zwischen den dafür derzeit bestehenden Systemen und entsprechenden Vorkehrungen zur Sicherstellung, dass auch BeamtInnen im Rahmen der Gremien der betreffenden **Selbstverwaltungskörper vertreten** sind, würde jedoch ein Zusammenschluss im Rahmen eines gemeinsamen oder mehrerer (allenfalls auch regional gegliederter) „gemeinsamer Träger der unselbständig Erwerbstätigen“ verfassungsrechtlich nicht ausgeschlossen sein.[15]

[15] Näher bei **Task 7a-7b**, oben 5.2.2. bzw 5.3.

10. Task 13c:
Auswirkungen einer Umstellung auf ein Zwei-Sparten-System auf die Unfallversicherung[16]

10.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift **„STRUKTURANALYSE: Modernisierung vorantreiben“** folgende Passage (11f):

> „Das österreichische Sozialversicherungssystem ist stabil und bietet den Menschen hervorragende Leistungen. Gleichzeitig gilt es, das System – um es für die Herausforderungen der Zukunft zu rüsten – weiterzuentwickeln und zu modernisieren. Dabei ist insbesondere die Reduktion der Trägerlandschaft zu prüfen. Hier ist vor allem die historisch gewachsene Struktur der Dreigliedrigkeit des Sozialversicherungssystems einer Analyse zu unterziehen.
>
> Organisation der sozialen Sicherungssysteme
> Neuere Sozialversicherungssysteme bestehen aus zwei Sparten, der Pensionsversicherung und der Krankenversicherung. Das bereits in der Monarchie wurzelnde österreichische System hat zusätzlich die Unfallversicherung als eigene Sparte. Daher sind die Vor- und Nachteile der Organisation in drei Sparten zu benennen und einem zweispartigen Modell gegenüberzustellen. Sollte die Zweispartigkeit sowohl effizienter, als auch effektiver erscheinen, ist die Verortung des bestehenden Haftungsprivilegs, das sowohl in der Pensionsversicherung, als auch der Krankenversicherung systematisch eingeordnet werden kann, zu klären. Es sind daher Vorschläge zu erarbeiten, wie das Haftungsprivileg analog der bestehenden Logik in Zukunft ausgestaltet werden kann.
>
> Auch die Gliederung in Berufsständische und teilweise sogar durch den Dienstgeber determinierte sozialen Sicherungssysteme sind einer Analyse zu unterziehen. Die Vor- und Nachteile sind herauszuarbeiten und darzustellen. Ebenso ist die – die Mehrheit der Versicherten umfassende – regionale Gliederung zu bewerten.“

Daraus wurde ua folgende **Aufgabenstellungen** abgeleitet (12):

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[16] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* und unter Berücksichtigung von Hinweisen von *Walter Pöltner* verfasst.

„Erstellung einer Stärken/Schwächen Analyse des bestehenden Systems der drei Sparten, insbesondere in Hinblick auf Effizienz und Effektivität.

Wie kann bei einer Systemumstellung auf ein zweispartiges System das bestehende Haftungsprivileg – analog der bestehenden Logik – ausgestaltet werden?“

Die folgenden Ausführungen sollen die **rechtlichen Aspekte** der geforderten Analyse zur zukünftigen Stellung der gesetzlichen Unfallversicherung und der im Falle einer Umstellung auf ein Zwei-Sparten-Modell zu bedenkenden Probleme beleuchten, wobei die Frage des Haftungsprivilegs der DG im Vordergrund steht. Dazu bedarf es zunächst einer Herausarbeitung der Besonderheiten der Unfallversicherung als eigenständiger Zweig der Sozialversicherung (10.2.). Daran schließt sich eine erste Erörterung der möglichen rechtlichen „Knackpunkte“ im Fall einer Auflösung dieses Zweigs, der freilich bestimmte Modellannahmen zu Grunde zu legen sind (10.3.).

10.2. Besonderheiten der gesetzlichen Unfallversicherung

Die gesetzliche Unfallversicherung war historisch der erste Bereich der Sozialversicherung.[17] Sie war funktional zuerst eine **gesetzliche Haftpflichtversicherung** der DG für Arbeitsunfälle und Berufskrankheiten, von denen die bei ihnen beschäftigten DN betroffen waren. Dies schlägt sich auch durchaus noch in der gesetzlichen Umschreibung der **Aufgaben** der Unfallversicherung in *§ 172 Abs 1 ASVG* nieder. Diese Bestimmung lautet:

> „*Die Unfallversicherung trifft Vorsorge für die Verhütung von Arbeitsunfällen und Berufskrankheiten, für die erste Hilfeleistung bei Arbeitsunfällen sowie für die Unfallheilbehandlung, die Rehabilitation von Versehrten und die Entschädigung nach Arbeitsunfällen und Berufskrankheiten. Die Vorsorge umfaßt auch die Forschung nach den wirksamsten Methoden und Mitteln zur Erfüllung dieser Aufgaben sowie der sonstigen Aufgaben im Bereich der arbeitsmedizinischen Betreuung der Versicherten, soweit deren Durchführung der Unfallversicherung übertragen ist. Darüber hinaus hat sie nach pflichtgemäßem Ermessen Kosten der arbeitsmedizinischen Betreuung im Sinne des 7. Abschnittes des ArbeitnehmerInnenschutzgesetzes - ASchG und Zuschüsse zur teilweisen*

[17] Vgl das *Arbeiter-Unfallversicherungsgesetz RGBl 1888/1*.

Vergütung des Aufwandes für die Entgeltfortzahlung nach § 53b zu übernehmen.“

Der Schutzbereich der Unfallversicherung wurde allerdings **sukzessive ausgeweitet** und erfasst inzwischen nicht nur Situationen, die noch in einem (mehr oder weniger) engen Zusammenhang mit der – weiterhin primär geschützten – **Erwerbstätigkeit** stehen (vgl nur *§ 175 Abs 2 ASVG*), sowie Personen, die sonst von der Pflichtversicherung wegen ihres geringfügigen Einkommens ausgenommen sind (vgl *§ 5 Abs 1 Z 2* iVm *Abs 2* und *§ 7 Z 3 lit a ASVG*). Vielmehr gelten insb auch Unfälle in Zusammenhang mit Schulbesuch oder Studium als Arbeitsunfälle (näher *§ 175 Abs 4* und *5 ASVG*), und sind diesen darüber hinaus eine Reihe von anderen Ereignissen, insb solche, von denen ehrenamtlich oder altruistisch tätig werdende Personen betroffen sind, ausdrücklich gleichgestellt (vgl nur *§ 176 ASVG*).

Gemeinsam ist all diesen Fällen ein **Kausalzusammenhang** mit der Erwerbstätigkeit oder dem sonst geschützten Bereich. Diese Kausalität unterscheidet die Unfallversicherung ganz wesentlich von der Kranken- und auch der Pensionsversicherung, wo jeweils (weitestgehend[18]) unerheblich ist, auf welche Ursache etwa eine Krankheit oder eine geminderte Arbeitsfähigkeit zurückgeht.

Bei Vorliegen einer aus derart besonderen Ursachen resultierenden Gesundheitsstörung sieht die Unfallversicherung auch **besondere Leistungen** vor, die vor allem dann von Bedeutung sind, wenn die Störung oder deren Folgen länger dauern: So ist die **Unfallheilbehandlung**, die an sich dieselben Leistungsarten einschließt wie die Krankenbehandlung in der Krankenversicherung, „*mit allen geeigneten Mitteln*“ (*§ 189 Abs 1 ASVG*) und zudem zeitlich unbegrenzt (*§ 190 ASVG*) zu leisten; sie kann außerdem – ungeachtet der grundsätzlichen Vorleistungspflicht der Krankenversicherung – vom Träger der Unfallversicherung jederzeit an sich gezogen werden (*§ 191 ASVG*).[19]

Hat der Arbeitsunfall oder ein diesem gleichgestelltes Ereignis bzw die Berufskrankheit nicht bloß vorübergehende Auswirkungen, sieht die Unfallversicherung überdies Leistungen vor, die es (zumindest unter diesen Bedingungen) in anderen Zweigen

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[18] Dort sind lediglich einzelne Leistungen auf Grund bestimmter Kausalverläufe ausgeschlossen, wobei auch diese Bestimmungen, die eine Verwirkung von Geldleistungsansprüchen (zB bei vorsätzlicher Selbstbeschädigung, vgl nur *§ 88 ASVG*) oder deren Versagung (zB wegen Suchtgiftmissbrauchs, vgl *§ 142 ASVG*) vorsehen, die große Ausnahme bleiben.

[19] Nicht zuletzt zu diesem Zweck betreibt die AUVA als größter Träger der Unfallversicherung eigene Einrichtungen, insb in Form von Unfallkrankenhäusern und Rehabilitationszentren (wie den „Wießen Hof“), die fachlich einen besonderen Ruf genießen und insofern als besonders „erhaltungswürdig“ gelten, selbst wenn die Unfallversicherung nicht mehr als eigener Zweig bestehen sollte.

der Sozialversicherung nicht gibt. Dabei handelt es sich zum einen um **Sachleistungen** im Rahmen der **Rehabilitation**, die zum Teil anders als in den übrigen Versicherungszweigen mit Rechtsansprüchen ausgestattet sind (vgl nur den Anspruch auf Körperersatzstücke und sonstige Hilfsmittel nach *§ 202 ASVG*), oder die Bereiche abdecken, die so sonst nicht vorgesehen sind (vgl insb die sozialen Maßnahmen der Rehabilitation nach *§ 201 ASVG*).[20]

Zum anderen sieht das Unfallversicherungsrecht **Geldleistungsansprüche** vor, bei denen der **Entschädigungscharakter** stärker ausgeprägt ist als der Ausgleich eines Einkommensausfalls, wie er etwa durch Pensionen oder das Kranken- bzw Rehabilitationsgeld gewährleistet werden soll. Dabei handelt es sich einmal um die **Versehrtenrente**, die nach dem Grad der Minderung der Erwerbsfähigkeit (soweit diese mindestens 20% ausmacht) bemessen wird (vgl *§§ 203 ff ASVG*) und auch beansprucht werden kann, wenn der Arbeitsunfall zu keinem unmittelbaren Einkommensverlust geführt hat.[21] Von dieser Rente abgeleitet gibt es allenfalls auch Hinterbliebenenleistungen wie die Witwen/Witwer- bzw Waisenrente (vgl *§§ 215 ff ASVG*).[22] Schließlich gibt es für die erhebliche Beeinträchtigung der körperlichen oder geistigen Integrität auf Grund von Arbeitsunfällen oder Berufskrankheiten unter bestimmten (eher strengen) Voraussetzungen eine Integritätsabgeltung als einmalige Entschädigungsleistung (*§ 213a ASVG*).

All diese Geldleistungen treten in der Regel neben die Ansprüche der geschädigten Person, welche dieser nach allgemeinem Schadenersatzrecht zukommen. Zur Vermeidung einer Doppelliquidation sieht *§ 332 ASVG* – und zwar nicht nur für Arbeitsunfälle, sondern auch für alle anderen Schadensfälle außerhalb des Schutzbereiches der Unfallversicherung, aufgrund derer aus der Sozialversicherung Leistungen gebühren – einen **Übergang aller kongruenten zivilrechtlichen Leistungsansprüche** auf den jeweiligen Sozialversicherungsträger vor. Dieser ist dann berechtigt, sich aus den übergegangenen Ersatzansprüchen vorrangig den Ersatz für die von ihm erbrachten Leistungen zu sichern. Der geschädigten Person bleiben damit neben den Leistungen der Sozialversicherung nur der Ersatz von Sachschäden und die Ansprüche auf Schmerzengeld gegenüber dem Schädiger.

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[20] Vgl näher bei **Task 2a** bzw **2d**, oben 3.2. bzw 4.2.

[21] Insoweit nimmt die Versehrtenrente Anleihen bei schadenersatzrechtlichen Renten iSd *§ 1325 ABGB*, die nach der Rechtsprechung auch „abstrakte Renten" (dh solche ohne Nachweis eines Verdienstausfalls) umfassen (vgl etwa schon OGH 1957, EvBl 1958/42).

[22] Auch hier gibt es besondere, in anderen Systemen so nicht vorgesehene Leistungen wie insb die Eltern- und Geschwisterrenten (*§ 219 ASVG*) oder den Bestattungskostenersatz (*§ 214 ASVG*).

Hat hingegen im Falle eines Arbeitsunfalls (also eines Unfalls im Schutzbereich der Unfallversicherung) den Personenschaden der **DG**, dessen **Vertreter** oder ein in der konkreten Situation des Unfalls zur **Aufsicht befugter** (insoweit also vorgesetzter) DN (*„Aufseher im Betrieb*“ iSd *§ 333 Abs 4 ASVG*) verursacht, dann haften diese Personen dem DN nur bei vorsätzlichem Handeln.[23] Bei Verursachung aus grober oder gar leichter Fahrlässigkeit ist deren Haftung für alle Personenschäden (nicht aber auch Sachschäden) ausgeschlossen. Eine Ausnahme davon gibt es nur für Verursachung des Unfalls mit einem Verkehrsmittel mit erhöhter Haftpflicht, also etwa wenn der DG als Halter eines Kraftfahrzeugs haftet.[24]

Dem Nachteil dieses Ausschlusses von Schadenersatzansprüchen (insb auch solcher auf Schmerzengeld, *§ 1325 ABGB*) steht der Vorteil gegenüber, dass in der Unfallversicherung ein allfälliges **(Mit-)Verschulden des DN** am Eintritt des Arbeitsunfalls (der Berufskrankheit) grundsätzlich **keine Rolle** spielt, während dieses im Schadenersatzrecht zu einer Schadensteilung nach *§ 1304 ABGB* und damit Minderung, wenn nicht sogar zu einem Ausschluss der diesbezüglichen Ansprüche führen könnte. Dieses **Alles-oder-Nichts-Prinzip** erfordert freilich im Einzelfall scharfe Abgrenzungen, die bewirken können, dass bei Zusammentreffen von Ursachen aus dem sogenannten geschützten Bereich mit solchen, die der Privatsphäre der verunfallten Person entstammen, die Leistungspflicht der Unfallversicherung zur Gänze ausgeschlossen sein kann. Dies gilt namentlich dann, wenn nicht die aus dem geschützten Bereich, sondern die aus der Privatsphäre stammende Ursache für das Unfallereignis „wesentlich“ war.[25]

Davon abgesehen sind **andere Vorteile** des Konzepts der Unfallversicherung darin zu sehen, dass der DN – bei Anerkennung eines Arbeitsunfalls (einer Berufskrankheit) – mit klar definierten gesetzlichen Ansprüchen rechnen kann und keine Sorge haben muss, die Leistungen etwa deshalb nicht zu erhalten, weil der DG insolvent wird oder aus welchen Gründen immer nicht mehr verfügbar ist. Die Rechtsdurchsetzung ist auch sonst ein wesentlicher Vorzug der Verdrängung des Schadenersatz-

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[23] Auch im Verhältnis zu den Sozialversicherungsträgern ist die Haftung des DG (und der ihm gleichstellten Personen) auf Vorsatz und grobe Fahrlässigkeit eingeschränkt (vgl *§ 334 ASVG*).

[24] Die Geltung des Haftungsprivilegs auch in diesem Fall hätte eine Begünstigung der privaten Haftpflichtversicherung zur Folge, obwohl der DG dort die normalen Prämien zahlen müsste. Allerdings ist die Haftung mit der für die jeweilige (zB Kraftfahrzeug-)Haftpflichtversicherung bestehenden Versicherungssumme begrenzt.

[25] Die hier angewendete „Theorie der wesentlichen Bedingung“ (näher etwa *Müller* in *Mosler/Müller/Pfeil* (Hg), Der SV-Komm, vor §§ 174-177 ASVG Rz 36 ff) bewirkt im Ergebnis auch eine Berücksichtigung von Verschulden des DN im Sinne eines besonders Gefahren erhöhenden Verhaltens des DN (zB eine für den Unfall wesentliche Alkoholisierung des DN).

durch das Unfallversicherungsrecht, da der DN in keinen Streit mit dem DG (oder mit dessen wirtschaftlich uU noch mächtigerem Haftpflichtversicherer) eintreten muss, der das Verhältnis zum DG belasten und ein (zur bereits auf Grund des Unfalls bestehenden Beeinträchtigung hinzutretendes) Risiko im Hinblick auf den Verlust des Arbeitsplatzes darstellen könnte.

Die Vermeidung innerbetrieblicher Streitigkeiten ist auch ein **Vorteil für den DG**. Der Hauptvorzug der gesetzlichen Unfallversicherung ist freilich ein unmittelbar **ökonomischer**, da der DG das Risiko uU hoher Haftungen durch die Zahlung vergleichsweise **geringer Beiträge** (in Höhe von 1,3% des Bruttoentgelts des DN, *§ 51 Abs 1 Z 2* iVm *§§ 44, 49* und *54 ASVG*) weitestgehend abwehren kann. Die alleinige Zahlung dieser Beiträge durch den DG ist auch der entscheidende Aspekt für die Rechtfertigung des Haftungsprivilegs nach § 333 ASVG.[26]

Die relativ **geringen** Beiträge zur Abdeckung des Risikos von Arbeitsunfällen (Berufskrankheiten) sind auch ein wesentlicher Vorzug der gesetzlichen Unfallversicherung für **selbständig Erwerbstätige**.[27]

Von diesen sind nur die Selbständigen in der **Land- und Forstwirtschaft** (seit 1998) in einem gesonderten Träger zusammengefasst, der mit der Vollziehung aller drei Sparten der Sozialversicherung im engeren Sinn betrauten Sozialversicherungsanstalt der Bauern (**SVB**, vgl *§ 13 BSVG*). Alle anderen **Selbständigen** sind in der Unfallversicherung nach dem *ASVG* teilversichert (vgl dessen *§ 8 Abs 1 Z 3 lit a*), der für sie zuständige Unfallversicherungsträger ist wie für die DN die Allgemeine Unfallversicherungsanstalt (**AUVA**, *§ 24 Abs 1 Z 1 ASVG*). Ebenfalls nach dem *ASVG* richtet sich die gesetzliche Unfallversicherung für bei Eisenbahnen oder im Bergbau beschäftigte DN, für welche aber die Versicherungsanstalt für Eisenbahnen und Bergbau (**VAEB**) zuständig ist (*§ 24 Abs 1 Z 3 ASVG*).

Als vierter und letzter Unfallversicherungsträger fungiert derzeit die Versicherungsanstalt Öffentlich Bediensteter (**BVA**), die für die Unfallversicherung der nach dem ***B-KUVG*** erfassten Personen zuständig ist. Nach dessen *§ 26a* ist der Beitragssatz dort nur ausnahmsweise gesetzlich vorgegeben (vgl *Abs 2* dieser Bestimmung) und kann daher bis zu einem Höchstausmaß von 0,5% der Beitragsgrundlage durch die **Sat-**

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[26] Allerdings bestand das Haftungsprivileg von allem Anfang an schon im UnfallversicherungsG 1888, obwohl die Beitragslast damals noch zwischen DG und DN geteilt gewesen ist. Daher dürfte es auch bei Beibehaltung der alleinigen Beitragslast beim DG aus **verfassungsrechtlicher Sicht nicht geboten sein, auch das Haftungsprivileg aufrecht zu erhalten**.

[27] Der Unfallversicherungsbeitrag für Selbständige nach dem *GSVG* liegt derzeit pauschal bei € 9,33 pro Monat (*§ 74 Abs 1 Z 1 ASVG*), jener für (betriebsführende) Bauern etc bei 1,9% auf Basis einer Mindestbeitragsgrundlage von € 785,56 pro Monat *(§ 30* iVm *§ 23 Abs 10 lit a BSVG*).

zung festgesetzt werden, allerdings nur in jenem Ausmaß, als dies zur Erfüllung der Aufgaben der Unfallversicherung notwendig ist (*§ 26a Abs 1 B-KUVG*).[28] Im B-KUVG findet sich auch die einzige gesetzliche Unfallversicherung, die nicht auf Arbeitsunfälle abstellt: Der dort geregelte „**Dienstunfall**“ entspricht allerdings in der Sache ebenso wie die diesem gleichgestellten Unfälle (vgl *§§ 90, 91 B-KUVG*) im Wesentlichen den in *§§ 175, 176 ASVG* erfassten Ereignissen. Auch das Leistungsrecht deckt sich weitgehend mit den für die anderen Versichertengruppen bei der AUVA maßgebenden Vorschriften.

10.3. Änderungen im Falle einer Umstellung auf ein „Zwei-Sparten-Modell“

Für den Fall einer Umstellung des bestehenden Systems auf ein „Zwei-Sparten-Modell“ stellt sich natürlich die Frage, inwieweit die bisherigen Besonderheiten der gesetzlichen Unfallversicherung aufrecht erhalten werden können oder ob vielleicht doch bestimmte Modifikationen erforderlich wären. Diese Frage ist abstrakt kaum zu beantworten, sondern hängt wesentlich davon ab, wie die „Trägerlandschaft“ in der Sozialversicherung sonst ausgestaltet ist.

Daher wird in der Folge von der **Grundannahme** ausgegangen, dass grundsätzlich weder das bestehende Leistungsrecht noch der derzeit von der Unfallversicherung erfasste Personenkreis geändert werden und lediglich die **Wahrnehmung der Aufgaben anderen Trägern, zB jenen der Pensionsversicherung, zugewiesen oder auf mehrere andere Träger verteilt** werden soll. Für letztere Option würde es etwa nahe liegen, die Auszahlung der Geldleistungen (insb der Renten) einem Pensionsversicherungsträger zu überantworten, während die Bereitstellung von Sachleistungen (im Rahmen der Unfallheilbehandlung oder der Rehabilitation) von einem Krankenversicherungsträger wahrgenommen würde.

Eine solche Umstellung könnte grundsätzlich auf **zweifache** Weise erfolgen: Zum einen in der Form, dass es zwar die Unfallversicherung als **eigenen Zweig** noch gibt, dass dafür aber nicht mehr ein eigener Träger (namentlich die AUVA), sondern ein **Mehrspartenträger** zuständig ist, wie es derzeit bei der BVA, der VAEB sowie der SVB der Fall ist. Eine solche Änderung würde zunächst nur eine Anpassung der Trä-

[28] Nach *§ 9* der *Satzung der BVA 2016* beträgt der Beitragssatz derzeit 0,47%.

gerzuordnung in Bestimmungen wie *§ 24 ASVG* sowie Änderungen im Organisationsrecht der dann zuständigen Träger und eine Klärung der Rechtsnachfolge im Hinblick auf bestehende Rechtsbeziehungen erfordern. Grundlegende strukturelle Umstellungen wären damit aber wohl nicht verbunden.

Zum anderen könnte auch die Institution **Unfallversicherung als solche beseitigt** werden. Ausgehend von der Prämisse gleichbleibender Aufgaben und Leistungen hätte diese (wesentlich weiter gehende und wohl im Ausgangskonzept auch angesprochene) Option freilich entsprechende Veränderungen im Recht der Kranken- bzw Pensionsversicherung zur Folge. Diese würden sowohl den Kreis der im jeweiligen Versicherungszweig erfassten Personen und die von diesen bzw für sie entrichteten Beiträge betreffen als auch Differenzierungen im Leistungsrecht erforderlich machen.

Was zunächst den erfassten **Personenkreis** angeht, ist dieser derzeit in der Unfallversicherung sehr **weit** gefasst und geht vor allem über den Kreis der Erwerbstätigen hinaus. Das steht zumindest nicht im Widerspruch zur Reichweite des Krankenversicherungsschutzes, der in seiner Grundtendenz sogar die gesamte Wohnbevölkerung mit einschließt. Soweit der Zusammenschluss die jeweiligen **Erwerbstätigen** betrifft, ist der Kreis der Versicherten in der Kranken-, aber auch in der Pensionsversicherung, und zwar sowohl für die Selbständigen als auch die Unselbständigen, mit jenem in der Unfallversicherung im Wesentlichen ident. Insoweit würde einer Auflösung der AUVA und ihrer „Aufteilung“ auf die jeweiligen Träger der Kranken- bzw Pensionsversicherung (oder in einer anderen Option einer Verschiebung zur Pensionsversicherung) **aus verfassungsrechtlicher Sicht grundsätzlich nichts entgegenstehen**.

Probleme im Hinblick auf die Zusammensetzung der **Versichertengemeinschaften** könnten aber möglicherweise doch auftreten: Zunächst ist hier an Ausführungen in anderem Zusammenhang zu erinnern,[29] wonach der Zusammenschluss von bestimmten Personengruppen im Rahmen der Selbstverwaltung voraussetzt, dass die betreffende Gemeinschaft dann (nur) Aufgaben wahrzunehmen hat, „*die in ihrem ausschließlichen oder überwiegenden gemeinsamen Interesse gelegen und auch geeignet sind, in diesem Rahmen gemeinsam besorgt zu werden*“ (*Art 120a Abs 1 B-VG*). Insofern könnte zweifelhaft sein, ob die Erbringung von – sonst nicht (in dieser Form oder diesem Ausmaß) vorgesehenen – kausalen Leistungen im überwiegenden Interesse der jeweiligen Versichertengemeinschaften in der Kranken- bzw Pen-

[29] Vgl insb bei **Task 7a-7b**, oben 5.2.2.2.

sionsversicherung liegen und daher durch deren Beitragsleistungen finanziert werden sollen.

Das war ja auch schon bisher für die **versicherungsfremden** und daher eigentlich versorgungsrechtlichen Leistungen in der Unfallversicherung strittig.[30] Die bestehenden Regelungen können immerhin damit gerechtfertigt werden, dass es sich jeweils um kausale Leistungen handelt, die von ihrer Struktur her Berührungspunkte zu den klassischen Risiken Arbeitsunfall und Berufskrankheit aufweisen und wie dort vor allem nicht vorhandene oder nicht durchsetzbare Schadenersatzansprüche ersetzen sollen; sie passen daher hier viel eher als „Annex" dazu als zu anderen Zweigen der Sozialversicherung, zumal sie (auch finanziell) nur einen kleinen Teil der von der Unfallversicherung zu tragenden Risiken ausmachen. Mit einem ähnlichen Ansatz kann ja in der Krankenversicherung die freiwillige Selbstversicherung oder die Einbeziehung nicht erwerbstätiger Personen (insb im Wege der Verordnung nach *§ 9 ASVG*) in den Schutz der Krankenversicherung verfassungsrechtlich gerechtfertigt werden.[31]

Wie dort könnte sich aber auch hier das (Folge-)Problem eines „**Risikostrukturausgleichs**" im weiteren Sinn stellen, weil – und zwar uU nicht bloß rechtspolitisch – nicht einsichtig ist, warum bestimmte Personen (derzeit: Erwerbstätige und allenfalls ihre DG) für das Risiko von Schülern, Studierenden, Lebensrettern etc aufkommen müssen und dies nicht aus allgemeinen **Steuermitteln** finanziert wird. Ohne eine solche öffentliche Finanzierung könnte das Problem der verfassungsrechtlichen Zulässigkeit der Zuordnung dieser an sich versicherungsfremden Risiken zur betreffenden Gemeinschaft, nicht mehr der Unfallversicherten, sondern der Kranken- bzw Pensionsversicherten noch deutlich **schärfer** werden.

Dies gilt umso mehr, wenn es (wie bisher) in „kausalen Fällen" andere und zumal regelmäßig **großzügigere** Leistungen geben sollte als sie sonst im betreffenden System vorgesehen sind. Eine derartige Differenzierung bedürfte auch bei Erwerbstätigen einer **besonderen sachlichen Rechtfertigung**, würden dann doch etwa im Rahmen der Krankenversicherung Leistungen in höherem Ausmaß oder für einen längeren Zeitraum gewährt, wenn sie aus Anlass eines Arbeitsunfalls (einer Berufskrankheit) erbracht werden; Ähnliches gilt für einen (höheren) Geldleistungsanspruch in der Pensionsversicherung, der nur deswegen (in diesem Ausmaß) gebühren würde, weil die betreffende Person zB nicht nur für einen Einkommensausfall wegen ge-

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[30] Vgl nur *Tomandl*, in *Tomandl* (Hg), System des österreichischen Sozialversicherungsrechts, 2.3. (265 f).

[31] Vgl noch einmal bereits bei **Task 7a-7b**, oben 5.2.2.1.

minderter Arbeitsfähigkeit, sondern auch dafür entschädigt werden soll, dass diese auf einen Arbeitsunfall zurückgeht.

Die Rechtfertigung für diese Differenzierung könnte grundsätzlich dadurch gelingen, dass die zusätzliche (kausale) Leistung wegen eines **zusätzlichen Risikos** gebührt, für das auch ein **zusätzlicher bzw höherer Beitrag** geleistet wurde. Derartige Zuschläge für ein „erhöhtes Risiko" kennt die Krankenversicherung auch jetzt schon, und zwar auch im Rahmen der Pflichtversicherung, namentlich bei der Einbeziehung von Angehörigen in den Krankenversicherungsschutz (vgl etwa *§ 51d ASVG*) oder bei der Zusatzversicherung für ein Krankengeld für Selbständige (vgl *§ 9* iVm *§§ 105f GSVG*).

Würde dieser **Beitrag** weiterhin vom jeweiligen **DG** – und zwar ungeachtet der von ihm zu tragenden Anteile vom Kranken- bzw Pensionsversicherungsbeitrag – geleistet, könnten wohl auch zwei andere Strukturmerkmale des bestehenden Unfallversicherungsrechts beibehalten werden. Zum einen könnte gewährleistet werden, dass die **geringfügig Beschäftigten** wie bisher zumindest jene kausalen Leistungen erhalten, die ihnen wegen eines Arbeitsunfalls bzw einer Berufskrankheit gebühren.

Zum anderen könnte auch das **Haftungsprivileg** der DG weitergeführt werden, wenn und weil diese durch ihre Beiträge weiterhin jene Leistungen finanzieren, die an die Stelle der Schadenersatzansprüche treten, welche ansonsten gegen den betreffenden DG wegen von diesem – wegen Verletzung seiner Fürsorgepflicht (vgl nur *§ 1157 ABGB*) – zu verantwortender Arbeitsunfälle (Berufskrankheiten) bestünden. Eine allfällige Auflösung der Unfallversicherung würde hier also **keinen besonderen legistischen Handlungsbedarf** auslösen, könnte aber zum Anlass genommen werden, das Haftungsprivileg umzugestalten, um die gegen seine (zumindest teilweise überschießende) Konstruktion schon länger bestehenden verfassungsrechtlichen Bedenken zu entkräften.[32]

Insgesamt scheint eine Umstellung auf ein „Zwei-Sparten-Modell" somit **keinen grundlegenden rechtlichen Problemen** zu begegnen. Dennoch sei darauf hingewiesen, dass eine organisatorische Auflösung der Unfallversicherung zu Gunsten einer Verlagerung bzw Verteilung der Aufgaben auf Träger der Pensions- bzw der Krankenversicherung einen erheblichen **Nachteil** bringen würde: Damit würde nämlich eine völlige Zersplitterung der Aufgabenstellungen „Unfallverhütung" und „Rehabilitation" bewirkt, obwohl nicht zuletzt die bisherige **Konzentration** der Aufgaben auf eine weitgehend einheitliche Organisation (einschließlich des Betreibens spezialisier-

[32] Vgl nur *Auer-Mayer* in *Mosler/Müller/Pfeil* (Hg), Der SV-Komm, § 33 ASVG Rz 2 ff, mit weiteren Nachweisen.

ter Unfallkrankenhäuser und Rehabilitationszentren und das dort erworbene Know-how) wesentlich zum hohen (auch internationalen) Ansehen der österreichischen Unfallversicherung beigetragen hat. Eine Zerschlagung dieser Ressourcen im Sinne einer Aufteilung auf die Pensions- bzw Krankenversicherungsträger wäre insofern **kontraproduktiv**, als bei einem **Nebeneinander** der Unfallversicherung innerhalb mehrerer Träger diese Aufgaben nicht mehr in der bisherigen Weise erfüllt werden könnten. Aus diesen Gründen läge wohl eine Verschiebung der Aufgaben zu einem Träger, allenfalls auch die Zusammenfassung der gesamten Unfallversicherung in einem einheitlichen Unfallversicherungsträger wesentlich näher.[33]

10.4. Zusammenfassung

➔ Die Umstellung der Struktur der österreichischen Sozialversicherung von einem Drei- auf ein Zwei-Sparten-Modell ist aus rechtlicher Sicht grundsätzlich möglich und würde voraussichtlich nur Änderungen auf einfachgesetzlicher Ebene erfordern.

➔ Die bestehenden Besonderheiten im Leistungsrecht könnten ebenso wie das Haftungsprivileg der DG auch bei einer Auflösung der Unfallversicherung als eigener Zweig beibehalten werden. Dies gilt grundsätzlich sowohl für den Fall, dass andere Träger – als Mehrspartenträger (wie derzeit die BVA oder die SVB) – auch als Unfallversicherungsträger fungieren würden, als auch für den Fall, dass die Aufgaben als solche einem oder mehreren anderen Trägern überantwortet würden.

➔ Die (allenfalls auch nur teilweise) Zusammenlegung der Unfallversicherung mit der Kranken- bzw der Pensionsversicherung könnte allerdings – unter Selbstverwaltungs-, aber uU auch kompetenzrechtlichen Aspekten – die Beibehaltung der Einbeziehung versicherungsfremder, aber kausaler Risiken schwieriger machen.

➔ Dieser Aspekt sowie die Gefahr der Zerschlagung bisher gebündelter Kompetenzen lässt eine Aufteilung der bisherigen Aufgaben der Unfallversicherung auf mehrere andere Sozialversicherungsträger zumindest rechtspolitisch zweifelhaft erscheinen.

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[33] Bei dieser Variante würde auch das Problem der (weiteren) Erfassung versicherungsfremder Risiken wesentlich entschärft.

11. Task 14a:
Verwendung von Rücklagen – rechtliche Aspekte[34]

11.1. Aufgabenstellung

In dem der Studie zu Grunde liegenden Konzept findet sich unter der Überschrift „Analyse der strategischen Verwendung der Rücklagen**“ folgende Passage (10):**

> „Bestehende **Rücklagen** sollen zielgerichtet für strategisch wichtige Themen der Gesundheitsreform verwendet werden. Im Fokus stehen insbesondere die Schaffung von Infrastruktur von Primärversorgungseinrichtungen, die Modernisierung eigener Einrichtungen der Sozialversicherung, ambulanter Einrichtungen, sowie die Leistungsharmonisierung und Fragen der gemeinsamen IT.“

Daraus wurde folgende **Aufgabenstellung** abgeleitet (10):

„Erarbeitung eines Konzepts zur zielgerichteten Verwendung der Rücklagen zur Verbesserung der Leistungen für die Versicherten.“

Diese Aufgabenstellung ist zunächst keine juristische. Die Frage der Zulässigkeit der Verwendung von Rücklagen hängt aber wesentlich von (insb verfassungs)rechtlichen Einschätzungen ab, die ihrerseits eng mit den schon unter **Task 7a-7b** angestellten Überlegungen verknüpft sind. Zur Verwendung von Rücklagen gibt es keine ausdrücklichen Regelungen, aber mehrere Judikaturlinien des VfGH, die es in der Folge darzustellen und auszuwerten gilt (11.2.). Daraus können dann Schlussfolgerungen gezogen werden (11.3.).

11.2. Rahmenbedingungen für den Zugriff auf Rücklagen von Sozialversicherungsträgern nach der Judikatur des VfGH

Für den vorliegenden Zusammenhang sind **drei Judikaturlinien** des VfGH von Bedeutung, die alle mit der Frage der Bildung solidarischer Gruppen im Sozialversicherungsrecht zusammenhängen: Die erste betrifft das Beitragsrecht, und zwar das

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[34] Dieses Kapitel wurde gemeinsam mit *Rudolf Müller* verfasst.

Problem der Finanzierung der Sozialversicherung durch Gruppenfremde; als Zweites gibt es eine Judikaturlinie zur Frage unterschiedlich hoher Beitragssätze innerhalb derselben Versichertengemeinschaft – eine Frage, die im Folgenden nur insoweit behandelt wird, als sich die anderen Rechtsprechungslinien des VfGH darauf beziehen; die dritte Linie beschäftigt sich zum einen mit der bilateralen Übertragung von Rücklagen von einem Versicherungsträger auf einen anderen und zum anderen mit multilateralen Ausgleichssystemen, die mehrere Versicherungsträger umfassen. Die wesentlichen Elemente dieser Judikatur sollen in der Folge wiedergegeben werden.

11.2.1. Zur Beitragsfinanzierung durch Gruppenfremde

Der VfGH hat bereits mit Erkenntnis VfSlg 3670/1960 eine Regelung im damaligen *LZVG* als **kompetenzwidrig** aufgehoben, aufgrund derer von allen land- und forstwirtschaftlichen Betrieben iSd *§ 1 Abs 2 Z 1 Grundsteuergesetz 1955* und – aber auch hier ohne Ausnahme – von Grundstücken iSd *§ 1 Abs 2 Z 2 des Grundsteuergesetzes 1955*, soweit es sich um unbebaute Grundstücke handelte, die nachhaltig land- und forstwirtschaftlich genutzt wurden, Zuschläge an die Landwirtschaftliche Zuschussrentenversicherungsanstalt *(§§ 8, 10 LZVG*) zu entrichten gewesen sind (*§ 18 Abs 1 LZVG*).

Der VfGH erachtete es für die Annahme der Kompetenzwidrigkeit als Ausschlag gebend, dass zu dieser Beitragsleistung auch Personen verpflichtet waren, die entweder wegen Unterschreitens der damaligen Versicherungsgrenze oder wegen Bestehens einer anderen Pflichtversicherung aus der Pflichtversicherung nach dem *LZVG* ausgenommen gewesen sind, ferner aber auch solche Personen, die definitionsgemäß der landwirtschaftlichen Zuschussrentenversicherung nicht unterlagen. Das waren die Grundeigentümer, die keinen Betrieb iSd *Landarbeitsgesetzes* führten (wie zB Kleingärtner oder Handwerker), aber auch (nicht versicherte) Gesellschaften, die landwirtschaftliche Betriebe führten.

Dem VfGH kam es ausdrücklich darauf an, dass im Rahmen der Sozialversicherung jeder Versicherte einen Rechtsanspruch auf die im Gesetz vorgesehenen Leistungen hatte, was für außenstehende grundsteuerpflichtige Personen nicht zutraf. Das Ziehen einer Parallele zu den beitragspflichtigen DG lehnte der VfGH ab. Die Zuschläge seien keine Beiträge im Sinne der Sozialversicherungsgesetzgebung, sondern Abgaben im wirtschaftlichen Sinn. Maßnahmen dieser Art gehörten nicht zur Materie des Sozialversicherungswesens, denn sie seien im Zeitpunkt des Wirksamwerdens dieser Kompetenzbestimmung in keinem Gesetz vorgesehen gewesen und könnten

auch nicht als die Weiterentwicklung eines aus diesen Gesetzen abzuleitenden Grundgedankens angesehen werden.[35]

Nicht zuletzt unter Berufung auf VfSlg 3670/1960 hat der VfGH mit Erkenntnis VfSlg 16.474/2002 Bestimmungen des ASVG betreffend **pauschalierte Dienstgeberbeiträge für geringfügig Beschäftigte** in der Kranken- und Pensionsversicherung als kompetenzwidrig aufgehoben: Zum einen da mangels Zuordnung zu konkreten Versicherten kein Sozialversicherungsbeitrag vorlag, zum anderen aber auch keine Abgabe, weil der pauschalierte Dienstgeberbeitrag einem Sozialversicherungsträger und nicht direkt dem Bund zugeflossen ist. Zur Frage des Sozialversicherungsbeitrags sprach der VfGH aus, dass es sich bei der sozialversicherungsrechtlichen Pflichtversicherung um eine dem „Regel-Ausnahme-Verhältnis" insoweit vergleichbare Konstellation handle, als (wie auch im Vertragsversicherungsrecht) ein untrennbarer Zusammenhang zwischen Beitragspflicht und – zumindest potentiell gegebenem – Leistungsanspruch bestehe. Die Normierung einer Beitragspflicht des DG **ohne gleichzeitiges Entstehen eines Sozialversicherungsverhältnisses** (im Sinne eines Versicherthaltens des DN gegen den Eintritt bestimmter Versicherungsfälle) kann nicht als (intrasystematische) Fortentwicklung des Rechts innerhalb des Begriffsinhaltes des Kompetenztatbestandes „*Sozialversicherungswesen*" verstanden werden. Die den DG von geringfügig Beschäftigten auferlegten Beiträge fließen nämlich nicht einer Gebietskörperschaft – wie es für eine „öffentliche Abgabe" iSd *F-VG 1948* begriffswesentlich ist, sondern den Sozialversicherungsträgern zu.[36]

Kurz danach hat der VfGH allerdings im Erkenntnis VfSlg 16.454/2002 zugelassen, dass der Gesetzgeber die Einführung einer **Abgabe**, deren Ertrag ausschließlich dem Bund zustehen soll (mit gesetzlicher Zweckwidmung zugunsten der Finanzierung von Zuschüssen zur Künstler-Sozialversicherung), auch ungeachtet dessen bewirken kann, dass mit der Einhebung der Beiträge der Künstlersozialversicherungsfonds betraut wurde. Das wurde damit begründet, dass dieser Fonds in dieser Funktion als **beliehenes Unternehmen** tätig wurde und damit die fraglichen Beiträge **für den Bund** eingehoben wurden, auch wenn über den vereinnahmten Ertrag bereits im Wege einer Zweckbindung verfügt worden ist, und dass dieser „Kabelrundfunkbeitrag" überdies (in *§ 3 Abs 1 KFBG 1981*) als „Bundesabgabe" bezeichnet wurde.

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[35] Vgl zu dieser Judikatur bereits bei **Task 7a-7b**, oben 5.2.2.1.

[36] Vgl schon VfGH VfSlg 10.451/1985, Pkt. III.1., wo ausgesprochen wurde, dass die der Versicherungsanstalt öffentlich Bediensteter durch die 11. und 12. Novelle zum *B-KUVG* auferlegten Zahlungen an den Ausgleichsfonds der Pensionsversicherungsträger mangels Zufließens an eine Gebietskörperschaft nicht als öffentliche Abgaben iSd *F-VG 1948* anzusehen seien.

In weiterer Folge wurde unter Zugrundelegung dieser Grundsätze in VfSlg 17.414/ 2004 der (dann neu geregelte) DG-Beitrag nach dem *Dienstgeberabgabegesetz* als Abgabe als verfassungskonform beurteilt, obwohl die Abgabe von den Gebietskrankenkassen im übertragenen Wirkungsbereich eingehoben wurde. Dazu hat der VfGH ausgeführt, dass eine **Abgabe** vorläge, wenn die Ertragshoheit, dh die primäre Verfügungsberechtigung über den Ertrag der Geldleistung, bei einer **Gebietskörperschaft** liegt. Diese primäre Verfügungsberechtigung könne auch in einer (vom Träger der Ertragshoheit vorgenommenen) generellen Vorausverfügung, insb einer gesetzlichen Zweckbindung, zum Ausdruck kommen. Die die weitere Mittelverwendung regelnden Vorschriften seien nicht mehr entscheidend. Zumindest in Grenzfällen könne für die Qualifizierung als Abgabe auch eine entsprechende, explizite Einordnung durch den Gesetzgeber, somit die erschließbare Absicht des Gesetzgebers, eine Abgabe regeln zu wollen, maßgebend sein.

Daraus ist zu folgern, dass daher grundsätzlich **Beiträge**, welche der Kompetenztatbestand „*Sozialversicherungswesen*“ – insb der Überschreitung der Grenzen, die durch die Zusammensetzung der jeweiligen Versichertengemeinschaft gezogen sind – nicht zulässt, **auch als Abgabe eingehoben werden können, ohne dass sich am Zweck und der Ausgestaltung der Einhebung etwas ändern müsste**, sofern nur die finanzverfassungsrechtlichen Vorgaben des Abgabenbegriffs beachtet werden.

Soweit wegen des Eigentumseingriffs, der darin liegt, dafür ein öffentliches Interesse benötigt wird, hat der VfGH schon entschieden, dass Maßnahmen zur Erhaltung des finanziellen Gleichgewichts des Systems der sozialen Krankenversicherung im **öffentlichen Interesse**, und überdies sogar auch im Interesse der davon betroffenen Marktteilnehmer (also außenstehender Dritter) liegen, wie zB vertriebsberechtigter Unternehmen auf dem Arzneimittelsektor angesichts der evidenten (Markt-)Vorteile, welche diese aus der Abgabe von Arzneimitteln auf Kosten der gesetzlichen Krankenversicherung ziehen.[37] Dieses öffentliche Interesse ist jedenfalls allen Krankenversicherungsträgern gemeinsam.

11.2.2. Die bilaterale Übertragung von Rücklagen

Die zweite hier interessierende Judikaturlinie hatte ihren Ausgang in den nach 1945 wiederholt festzustellenden Versuchen des Gesetzgebers, von den an die **Unfallversicherung** zu leistenden Beiträgen Teile **zugunsten anderer**

[37] Vgl VfGH VfSlg 18.821/2009.

Versicherungsträger abzuzweigen. [38] Es gab aber auch Regelungen für Überweisungen in die **andere Richtung**: So war in der *3. Novelle zum SV-ÜG* die Abzweigung eines Betrages aus Mitteln der (damaligen) Angestelltenversicherungsanstalt zugunsten der AUVA vorgesehen (*Art I Z 4 BGBl 1954/165*), so wie es auch eine Zuwendung von Mitteln zwischen anderen Zweigen der Sozialversicherung gab (*Art I Z 5 des gleichen Gesetzes*). In den Beratungen des Nationalrates über dieses Gesetz wurde daher auch von einem „internen Lastenausgleich zwischen den Sozialversicherungsinstituten" gesprochen.[39]

In seinem Erkenntnis **VfSlg 6039/1969** hat es der VfGH akzeptiert, dass trotz Überschüssen der AUVA die Beiträge zur Unfallversicherung nicht gesenkt wurden, und es für verfassungsgemäß gehalten, die Überschüsse stattdessen zur Herbeiführung „eines gewissen finanziellen Ausgleichs innerhalb der Sozialversicherung zu verwenden". Die unterschiedliche Art der Beitragsaufbringung (in der Unfallversicherung durch DG allein bzw zwischen DG und DN geteilte Beitragslast in der Kranken- und Pensionsversicherung) mache einen solchen Ausgleich innerhalb der Sozialversicherung unter dem Gesichtspunkt des Verfassungsrechtes nicht unzulässig. Es würde ja auch eine andere Aufteilung der Beiträge auf den Versicherten und den DG möglich sein. Wenn der Gesetzgeber, etwa um eine Erhöhung des auf den DG entfallenden Beitrages in anderen Versicherungen zu vermeiden, aus Mitteln der Unfallversicherung eine Überweisung an andere Versicherungen anordne, verstoße dies nicht gegen den Gleichheitssatz.

Den Rechtssatz aus VfSlg 3670/1960, wonach die Versicherungsgemeinschaft in der Sozialversicherung nur so weit reiche, als einer Beitragsverpflichtung im Prinzip ein Leistungsanspruch gegenüberstehe, hat der VfGH im Erkenntnis **VfSlg 10.451/ 1985** aufgegriffen und wegen Verletzung dieses Grundsatzes *Art III* der *11.* und *12. B-KUVG-Novelle, BGBl 1981/592* bzw *1983/78*, mit denen die BVA jeweils zur Leistung bestimmter Beträge an den Ausgleichsfonds der Pensionsversicherungsträger verpflichtet worden war, als sachlich nicht gerechtfertigt und daher verfassungswidrig aufgehoben.

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[38] Solche Regelungen fanden sich schon in der *3. Novelle zum Sozialversicherungs-Überleitungsgesetz (SV-ÜG), BGBl 1949/114* (vgl *Art I Z 19*), in der *7. Novelle zum SV-ÜG, BGBl 1951/190* (*Art I Z 7*), und im *Bundesgesetz BGBl 1955/137 (§ 2*). Auch im *ASVG* war für die Jahre 1956 bis 1960 eine derartige Regelung vorgesehen (vgl *§ 51 Abs 1 Z 2*). Später wurde die Überweisung eines festen Betrages aus Mitteln der AUVA an andere Versicherungsträger vorgesehen, so für 1964 in der *13. Novelle zum ASVG, BGBl 1963/320 (Art IV Abs 3*), für 1965 in der *14. Novelle zum ASVG, BGBl 1964/301 (Art IV Abs 10*), für 1966 im *Pensionsanpassungsgesetz, BGBl 1965/965 (Art V Abs 1*), für 1968 in der *21. Novelle zum ASVG, BGBl 1968/6 (Art IV Abs 2*) und für 1969 und 1970 im *Bundesgesetz BGBl 1968/303 (Art I Abs 1*).

[39] Vgl die ProtNR 43. Sitzung 7. GP, vom 30.6.1954, S 1853.

Die Meinung der Bundesregierung, wonach es dem Gesetzgeber nicht verwehrt werden könne, „ein solidarisches Zusammenstehen aller in der Pflichtversicherung der Sozialversicherung erfassten Personen und damit auch der einzelnen Riskengemeinschaften in begrenztem Umfang zu normieren“, sofern durch diese Überweisung ein finanzieller Ausgleich zwischen der BVA und Pensionsversicherungsträgern erfolge, der die Erfüllung der Aufgaben der BVA sowie die finanzielle Lage der Krankenversicherung der öffentlich Bediensteten nicht beeinträchtige, die Finanzlage der Pensionsversicherung aber verbessere, hat der VfGH verworfen: Anders als die oa Transferierungen von der Kranken- bzw Unfall- in die Pensionsversicherung gehe es nicht um einen Fall, in dem der begünstigte Personenkreis zumindest indirekt auch Beiträge an den belasteten Versicherungsträger zu leisten hatte.

Dazu im Erkenntnis wörtlich: „Die nach dem *B-KUVG* Versicherten haben unmittelbar gegenüber ihrem DG den Anspruch auf Ruhe(Versorgungs)bezüge. Sie sind deshalb von der Pensionsversicherung ausgeschlossen. Zwischen der Sozialversicherung nach dem *B-KUVG* und der Pensionsversicherung besteht daher **kein persönlicher und kein sachlicher Zusammenhang**. Insb fehle auch jeder Zusammenhang zwischen den Beiträgen der Angehörigen der einen Versicherungsgemeinschaft und dem Leistungsanspruch der Angehörigen der anderen Versicherungsgemeinschaft. Unzutreffend ist jedoch die Vorstellung der Bundesregierung von einem alle Sozialversicherten umfassenden Solidaritätsprinzip. Die Versicherungsgemeinschaft in der Sozialversicherung reicht jedenfalls nur soweit, als einer Beitragsverpflichtung im Prinzip ein Leistungsanspruch gegenübersteht. Gemäß *§ 447g ASVG* können aus dem Ausgleichsfonds der Pensionsversicherungsträger nur Pensionsversicherungsträger nach dem *ASVG* Überweisungen erhalten. Unter diesen Umständen lässt sich aber jedenfalls eine gesetzliche Anordnung der Überweisung von Geldbeträgen durch die BVA an den Ausgleichsfonds der Pensionsversicherungsträger nach *§ 447g ASVG* sachlich nicht rechtfertigen.“[40]

11.2.3. Multilaterale Ausgleichsmaßnahmen

Im Erkenntnis **VfSlg 11.013/1986** hat der VfGH ebenfalls an das Erkenntnis VfSlg 6039/1969 angeknüpft: Es ging um die Überweisung von Zahlungen aller Krankenversicherungsträger an den Ausgleichsfonds der Pensionsversicherungsträger: Die gesetzliche Anordnung der Überweisung von Geldern eines Sozialversicherungsträgers an einen anderen sei dann sachlich gerechtfertigt, wenn es sich beim Personen-

[40] Zum gleichgelagerten Fall des *Art III Abs 1* der *13. Novelle zum B-KUVG* vgl VfSlg 10.779/1985.

kreis des begünstigten Sozialversicherungsträgers um einen solchen handelt, der auch – wenn auch nur indirekt – Beiträge für den belasteten Sozialversicherungsträger zu leisten hat. Zwischen den Versicherten der belasteten und der begünstigten Sozialversicherungsträger müsse somit eine **Versicherungsriskengemeinschaft** im weiteren Sinn zu bestehen.

Das Bestehen einer solchen Riskengemeinschaft im weiteren Sinn hat der VfGH in diesem Erkenntnis als zentrales Argument **für die sachliche Rechtfertigung von Überweisungen von** (allen) **Krankenversicherungsträgern an den Ausgleichsfonds der Pensionsversicherungsträger** herangezogen. Weder dass die gesetzliche Verpflichtung der Krankenversicherungsträger zu einer Finanzierung der Pensionsversicherung den Bundeshaushalt entlastete, noch der Umstand, dass die Gruppen der Krankenversicherten und der Pensionsversicherten einander nur zT überschneiden, aber nicht deckungsgleich sind, war für den VfGH von Bedeutung. Die Abschöpfung durch die bekämpften Bestimmungen sei zwar „nicht unbeträchtlich“, wäre aber nur dann als unsachlich zu qualifizieren, wenn die Gebietskrankenkassen und die anderen betroffenen Krankenversicherungsträger durch die Überweisungen an die Pensionsversicherungsträger nicht mehr in der Lage wären, ihren gesetzlichen Aufgaben und Verpflichtungen mit ihren eigenen Mitteln und mit den Mitteln des Ausgleichsfonds der Krankenversicherungsträger nachzukommen. Die Bundesverfassung enthalte nämlich keine Gewährleistung einer vollständig autonomen Gebarung der Selbstverwaltungskörper.[41] Im vorliegenden Fall bestehe eine Versicherungsgemeinschaft im weiteren Sinn, weil sowohl die SVA, die SVB, die VAE und die BVA als auch die übrigen im Ausgleichsfonds miteinbezogenen Krankenversicherungsträger Beiträge an den Fonds entrichten und Ansprüche auf Gewährung von Zuschüssen hatten.

Was der VfGH noch 1986 für zulässig erachtet hatte, nämlich einen zwischen allen Trägern wirksamen Ausgleich zwischen Kranken- und Pensionsversicherung, hat er in der Folge jedoch innerhalb der Krankenversicherung verworfen: Im Erkenntnis **VfSlg 17.172/2004** wurde die Neuorganisation der Krankenkassenfinanzierung für verfassungswidrig erklärt, und zwar wegen der Einbeziehung der SVA, der SVB, der BVA und der VAE in den Ausgleichsfonds. Es sei wegen **Verstoßes gegen den Gleichheitssatz** unzulässig, Beitragseinnahmen, und seien es auch Überschüsse oder Rücklagen, einer Versichertengemeinschaft an eine andere Versichertengemeinschaft zu übertragen, sofern zwischen diesen beiden Gemeinschaften kein persönlicher und sachlicher Zusammenhang bestehe.

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[41] Ebenso schon VfGH VfSlg 8215/1977.

Es sei aus verfassungsrechtlicher Sicht zwar nicht schlechthin unzulässig, **besondere Nachteile**, die einem Versicherungsträger (einer Versichertengemeinschaft) auf Grund einer bestimmten Gestaltung des Gesamtsystems, insb also durch Bestimmungen entstehen, die Wirkungen (wie etwa die „Wanderversicherungsverluste") erzeugen, welche die Grenzen der in Selbstverwaltung organisierten Versichertengemeinschaften überschreiten, durch Zahlungen zwischen den Versicherungsträgern auszugleichen. Eine die einzelnen Versichertengemeinschaften übergreifende „**Quersubventionierung**" sei jedoch grundsätzlich **unzulässig**. Auch im Falle der Bildung einer Solidargemeinschaft aller Krankenversicherungsträger vermöge nicht schon der Umstand, dass ein Versicherungsträger Überschüsse besitze, während ein anderer Versicherungsträger defizitär sei, Mittelüberweisungen sachlich zu rechtfertigen.

Die Einbeziehung der SVA, der SVB, der VAE und der BVA in den Ausgleichsfonds führe zu systemimmanenten Benachteiligungen von Krankenversicherungsträgern auf der einen und ebensolchen Begünstigungen auf der anderen Seite und verstoße daher insoweit gegen den Gleichheitssatz.[42] Dabei sei es unerheblich, ob im Zeitablauf immer dieselben oder auch je verschiedene Versichertengemeinschaften von diesen Vor- und Nachteilen betroffen seien, weil selbst ein „Ausgleich" in dieser Hinsicht nichts an der Unsachlichkeit des Systems ändern könnte.

Die allgemeinen Aussagen des VfGH in diesem Erkenntnis aus 2004 lassen erkennen, dass er derartige Ausgleichsfonds skeptisch betrachtet. Auch wenn natürlich nicht ausgeschlossen werden kann, dass der Gerichtshof inzwischen einer differenzierteren Sicht zuneigen könnte, ist doch in der Folge von den in diesem Erkenntnis ausdrücklich geprägten **zwei Rechtsätzen** auszugehen:[43] Es sei (zum einen) wegen Verstoßes gegen den Gleichheitssatz unzulässig, Beitragseinnahmen, und seien es auch Überschüsse oder Rücklagen, einer Versichertengemeinschaft an eine andere Versichertengemeinschaft zu übertragen, sofern zwischen diesen beiden Gemeinschaften kein persönlicher und sachlicher Zusammenhang besteht. Es sei aber (zum anderen) aus verfassungsrechtlicher Sicht nicht schlechthin unzulässig, besondere Nachteile, die einem Versicherungsträger (einer Versichertengemeinschaft) auf Grund einer bestimmten Gestaltung des Gesamtsystems, insb also durch Bestim-

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[42] Vgl bereits VfGH VfSlg 14.598/1996.

[43] Im Erkenntnis VfSlg 19.158/2010 hat der VfGH neuerlich Teile der Regelungen über den Krankenkassenausgleichsfonds als verfassungswidrig aufgehoben, und zwar wegen Bevorzugung der Wiener GKK bei Auflösung der Rücklagen des Ausgleichsfonds der Gebietskrankenkassen mangels adäquater Strukturnachteile und wegen Abgehens vom gewählten Ordnungssystem. Diese Entscheidung kann wegen der Besonderheit des Einzelfalls im Folgenden ausgeklammert bleiben.

mungen entstehen, die Wirkungen erzeugen, welche die Grenzen der in Selbstverwaltung organisierten Versichertengemeinschaften überschreiten, durch Zahlungen zwischen den Versicherungsträgern auszugleichen. Diese Grundsätze seien auf das Verhältnis der Krankenversicherungsträger untereinander zu übertragen. Daraus ist im Einzelnen zu **folgern**:

(1) Eine die einzelnen Versichertengemeinschaften übergreifende „**Quersubventionierung**“ ist grundsätzlich als **unzulässig** zu qualifizieren, wobei die vom VfGH zur Rechtfertigung unterschiedlicher Beitragssätze im Verhältnis zum Leistungsrecht entwickelten Grundsätze[44] umso mehr für das Verhältnis ganz unterschiedlicher Versichertengruppen mit unterschiedlichen Beitragssätzen zueinander gelten.

(2) Zulässig ist es hingegen, **systembedingte Nachteile**, wie sie zB in der Pensionsversicherung als „Wanderversicherungsverluste“ in Erscheinung treten, aber auch in der Krankenversicherung nicht auszuschließen sind,[45] im Wege einer trägerübergreifenden Solidargemeinschaft auszugleichen und zu diesem Zweck auch Beitragseinnahmen zu anderen Versichertengemeinschaften umzuleiten.

Solche Nachteile können auch daraus entstehen, dass der Gesetzgeber in der sozialen Krankenversicherung nicht zwischen „guten“ und „schlechten“ Risiken unterscheiden und daran etwa beitragsrechtliche Konsequenzen knüpfen darf, sodass manche Krankenversicherungsträger insb in Abhängigkeit von der Wirtschaftsentwicklung, aber auch von strukturellen Umständen in der Schichtung der Versichertengemeinschaft, von solchen nicht steuerbaren Risiken stärker betroffen sind als andere. Dadurch erleiden die einen – insoweit „ungerechtfertigte“ – Nachteile, während anderen ebensolche „Vorteile“ entstehen.

(3) Wenn der Gesetzgeber solche systembedingten Strukturprobleme zum Anlass nimmt, trägerübergreifende Ausgleichsmaßnahmen zu setzen, ist jedoch das bloße Bestehen eines **„Überschusses“** bei einem Versicherungsträger **allein nicht** geeignet, die Bildung einer „trägerübergreifenden Risikengemeinschaft“ sachlich zu rechtfertigen. Ein solches Ausgleichssystem muss vielmehr so gestaltet sein, dass weder

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[44] Vgl VfGH VfSlg 9365/1982 - höhere Beitragssätze für freiberuflich Erwerbstätige im Verhältnis zu Gewerbetreibenden; VfSlg 16.492/2002 – Sachlichkeit höherer Beitragssätze für Ärzte und Apotheker im Verhältnis zu Gewerbetreibenden; VfSlg 15.859/2000 - Unsachlichkeit höherer Beitragssätze für „neue Selbständige“ – unter Hinweis auf VfSlg 12.739/1991.

[45] ZB auf Grund der – den Grundsatz der Mehrfachversicherung einschränkenden – gemeinsamen Höchstbeitragsgrundlage in Verbindung mit den in den einzelnen Gesetzen geregelten Verpflichtungen zur „Differenzvorschreibung“ (vgl *§ 35b GSVG, § 33b BSVG*), jedenfalls aber zur Beitragserstattung (vgl *§ 70a ASVG, § 36 GSVG, § 33c BSVG, § 24b B-KUVG*).

einzelne Krankenversicherungsträger systematisch benachteiligt noch andere Versicherungsträger systemimmanent privilegiert werden.[46]

(4) Weiters hat sich die Beitragsleistung der einzelnen Versicherungsträger zu einem solchen Ausgleich – auch in diesem Bereich einer sozialen Risikengemeinschaft entsprechend – am Verhältnis ihrer **Leistungsfähigkeit** zu orientieren. Dies erfordert insb, die Beiträge nach Kriterien zu bemessen, die zwischen den Versicherungsträgern vergleichbar sind, wobei sichergestellt sein muss, dass die Beitragsleistungen die Gebarung des Versicherungsträgers nicht so belasten, dass die Erfüllung seiner Aufgaben gefährdet wäre.[47]

(5) Die Einbeziehung **bundesweit** tätiger Träger scheitert dagegen am unterschiedlichen Beitragsrecht (vor allem der SVB) sowie daran, dass bei diesen Trägern Strukturnachteile, die sich aus der regionalen Gliederung ergeben, innerhalb der in diesen Krankenversicherungsträgern verkörperten Risikengemeinschaften bereits zum Ausgleich gebracht worden sind.

11.3. Schlussfolgerungen

➔ Aus dieser Rechtsprechung ist zu folgern, dass zwischen Sozialversicherungsträgern **zulässig** sind:

- **Rücklagentransfers**, sofern sich die Versichertenkreise überschneiden und zumindest indirekt an der jeweiligen Finanzierung beteiligt sind (also zwischen Kranken-, Pensions- und Unfallversicherung nach dem *ASVG* unproblematisch; ebenso zwischen Kranken- und Pensionsversicherung nach dem *GSVG* , Kranken- und Unfallversicherung nach dem *B-KUVG* bzw Kranken-, Pensions- und Unfallversicherung nach dem *BSVG*);

- **Strukturausgleichstransfers** zwischen Versicherungsträgern mit vergleichbarer Rechtslage bei der Beitragsaufbringung, sofern zwischen diesen Trägern die Vorteile der einen zu Nachteilen der anderen führen (zwischen den Gebietskrankenkassen kein Problem).

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[46] So schon VfGH VfSlg 14.598/1996: Schlüssel für die Jahresausgleichszahlungen der Krankenversicherungsträger an den KRAZAF.

[47] Vgl VfGH VfSlg 11.013/1986 (191).

➔ **Kein Strukturausgleich ist zulässig** mit bundesweiten Trägern, da deren Strukturprobleme, soweit sie geographischen Ursprungs sind, innerhalb des jeweiligen Trägers ohnehin ausgeglichen werden und Unterschiede in der Beitragsaufbringung bestehen (also grundsätzlich unzulässig zwischen SVA und SVB bzw zwischen SVA und SVB im Verhältnis zu Gebietskrankenkassen).

➔ Ein demgegenüber aus verfassungsrechtlicher Sicht relativ risikoloses Modell eines Strukturausgleichs könnte aber iSd Erkenntnisse VfSlg 16.454/2002 und 17.414/2004 so gestaltet werden, dass die **Beiträge zum Strukturausgleich als Abgaben der Krankenversicherungsträger im übertragenen Wirkungsbereich (also weisungsgebunden, und nicht in Selbstverwaltung) vom Hauptverband der SV-Träger (oder einer Bundesbehörde) für den Bund eingehoben werden, wobei diese Beiträge im betreffenden Gesetz zugleich für den Risikoausgleich der Krankenversicherungsträger zweckgebunden sein könnten**, und sie das Gesetz – sicherheitshalber – ausdrücklich als Abgabe (zB „Strukturausgleichabgabe“) iSd *Art 13 Abs 1 B-VG* iVm *§§ 5 ff F-VG 1948* bezeichnen sollte. Die Verteilung dieser Mittel könnte dann nach Maßgabe bestimmter Kennzahlen über Strukturunterschiede (wie zB Krankheitskosten pro versicherter Person) zielgerichtet erfolgen.[48]

➔ Eine derartige Abgabe stellt einen **Eingriff in das Grundrecht** der Sozialversicherungsträger auf Eigentum dar. Dieser Eingriff ist vor dem Hintergrund des in der Rechtsprechung des VfGH anerkannten **öffentlichen Interesses** an der Erhaltung des finanziellen Gleichgewichts der Sozialversicherung an sich gerechtfertigt. Der Eingriff muss **gesetzlich** festgelegt werden und darf nicht **unverhältnismäßig** sein, dh er darf die betreffenden Krankenversicherungsträger nicht an der Erfüllung ihres Versorgungsauftrages hindern. Die Abgabe müsste allerdings aus Gleichheitsgründen wohl bei allen Krankenversicherungsträger nach **denselben gesetzlich festgelegten Bemessungs-Kriterien** eingehoben werden. Es ist daher erforderlich, geeignete Bemessungskriterien zu finden, mit denen die Umschichtung von Mitteln zwischen strukturbegünstigten und strukturschwachen Trägern erzielbar ist.

➔ Angesichts dieser Option scheint es nur ein Detailproblem zu sein, dass die Pensionsversicherungsträger die **Krankenversicherungsbeiträge der Pensionsbezieher** mit einem Zuschlag („Hebesatz“) an die Krankenversicherungsträger zu entrichten haben, und zwar an die Gebietskrankenkassen zu 178%, an die BVA zu 171%, an die VAEB zu 308%, an die SVA zu 196 % und an die SVB zu 387%,[49] wo-

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[48] Vgl daher auch **Task 9e**, oben 8.

[49] Vgl jeweils *Abs 2* in *§ 73 ASVG, § 29 GSVG* und *§ 26 BSVG*, jeweils idF des *Steuerreformgesetzes 2015/2016, BGBl I 2015/118*.

bei bei der VAEB, der SVA bzw der SVB der Transfer jeweils innerhalb des Trägers erfolgt. Dadurch wird die Gebarung der Pensionsversicherung über die bloße Durchleitung der einbehaltenen Krankenversicherungsbeiträge der PensionsbezieherInnen hinaus ausgabenseitig belastet und die Gebarungsdifferenz zwischen Einnahmen und (Pensions-)Ausgaben der Pensionsversicherung durch den Bundeszuschuss ausgeglichen, womit der Sache nach **Steuermittel für die Gebarung der Krankenversicherung** verwendet werden.

Soweit dadurch Gebarungsüberschüsse entstehen, dürfte in diesem Umfang weder gegen die Abschöpfung des Überschusses zugunsten des Bundeshaushaltes noch zugunsten der Gebarung der betreffenden Pensionsversicherung verfassungsrechtliche Argumente ins Treffen geführt werden können. Da dieser Ausgleich zwischen Kranken- und Pensionsversicherung aber in der Regel denselben versicherten Personenkreis betrifft, innerhalb dessen nach der Rechtsprechung des VfGH bilaterale Umschichtungen ohnehin keinen Bedenken begegnen (vgl oben 11.2.2.), ist damit aber **kein Argument für einen multilateralen Finanzausgleich** gewonnen.

➔ Was dagegen die Versicherung **Arbeitsloser** betrifft, handelt es sich insofern um ein **trägerübergreifendes** Problem, als Arbeitslose in ihrer vorherigen Beschäftigung bei verschiedenen Trägern (nicht nur nach dem *ASVG*, sondern auch nach *GSVG, BSVG* oder *B-KUVG*) pflichtversichert gewesen sein konnten, aber in der Arbeitslosigkeit bei der jeweiligen Gebietskrankenkasse versichert werden. Unter der Voraussetzung, dass die **Krankenversicherung Arbeitsloser ein Strukturelement ist, das die Gebietskrankenkassen mehr Geld kostet, als es an Beiträgen bringt** (also ein nachteiliges Strukturmerkmal darstellt), stünde es dem (einfachen) Gesetzgeber wohl frei, deren **vorherige Versicherungsträger am Risiko der Krankenversicherung Arbeitsloser verhältnismäßig** zu beteiligen. Für die Erfassung anderer Personengruppen (zB BezieherInnen von Mindestsicherung) sollte Ähnliches gelten.

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12.3. Sonstige Quellen

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13. Anhänge

13.A. Bestehende Unterschiede im Leistungsrecht der Krankenversicherung

Leistungen	Gesetzliche Unterschiede	Mustersatzung	Unterschiede Satzungen
Jugendlichenuntersuchung	völlig deckungsgleiche Regelungen in ASVG, GSVG und BSVG B-KUVG: Verweis auf § 132a ASVG; gilt nur für Versicherte iSd § 1 Abs 1 Z 17 – 19 und 21 – 23 B-KUVG (insb Vertragsbedienstete, Pensionsbezieher, AN der Universitäten, Bedienstete der BVA - Mindestalter für öffentlich-rechtliche DV: 18 Jahre		in den Satzungen nur Regelungen zu den Fahrtkosten aus Anlass der Inanspruchnahme einer Jugendlichenuntersuchung (s. Fahrt-/Transportkosten)
Vorsorgeunter-suchungen	deckungsgleicher Anspruch nach ASVG, GSVG, B-KUVG, BSVG: Rechtsanspruch auf jährliche Vorsorgeuntersuchung; Verweis in GSVG, BSVG und B-KUVG auf die gem § 132a Abs 2 ASVG zu erlassenden RL des HV Auffangtatbestand § 132b AVG: Gleichstellung		

	anderer Personen mit Wohnsitz oder gewöhnlichem Aufenthalt im Inland, die nicht bereits durch eine eigene Pflicht- oder freiwillige Versicherung oder ihre Angehörigeneigenschaft von Abs 1 erfasst sind Ersatz der Fahrtkosten: Verweis auf § 135 ASVG, § 103 Abs 6 GSVG, § 85 BSVG; § 83 Abs 1 B-KUVG ➔ dh Anspruch auf Fahrtkosten nach Maßgabe der jeweiligen Satzung ansonsten keine Delegation an Satzung/KO		
Maßnahmen zur Erhaltung der Volks-gesundheit	GSVG, BSVG und B-KUVG verweisen hinsichtlich der Maßnahmen zur Erhaltung der Volksgesundheit auf § 132c ASVG – insofern deckungsgleiche Regelungen		Kostenzuschuss FSME-Impfung: unterschiedliche Beträge in Satzungen – siehe Dokument Maßnahmen zur Erhaltung der Volksgesundheit Ebenso Zuschüsse zu weiteren Impfungen durch Satzungen möglich – siehe Dokument Maßnahmen zur Erhaltung der Volksgesundheit

Ärztliche Hilfe und gleichgestellte Leistungen	Gesetzliche Regelungen gleich Gesamtverträge mit Ärzten, Zahnärzten, klinischen Psychologen, Gruppenpraxen – § 338 ASVG		
Kostenbeitrag	ASVG: kein Kostenbeitrag GSVG: Satzung – darf aber 30% nicht überschreiten; bei ambulanten Leistungen (Landesgesundheitsfonds) 20% von Pauschalbetrag – Satzung; B-KUVG: Satzung – darf 20% nicht übersteigen; Leistungen Landesgesundheitsfonds: Pauschalbetrag - Satzung; BSVG: 20%; Landesgesundheitsfonds 20% von Pauschalbetrag – Satzung; für ärztliche Hilfe, und chirurgisch konservierende Zahnbehandlung Kostenanteil 9,61€ - vervielfacht sich mit Aufwertungszahl pro Jahr; Bei Anstaltspflege: Kostenbeitrag nach § 447f Abs 7 ASVG Ausnahmen von Kostenbeitrag in GSVG und		BVA: 10% bei ärztlicher Hilfe oder gleichgestellten Leistungen; für kieferorthopädische Behandlungen im Sinn des § 21 Abs. 1 Z 4 und 5 – 20%; für konservierend-chirurgische Zahnbehandlung und Zahnersatz 10% SVA: 20%; kann sich unter gewissen Voraussetzungen auf 10% reduzieren; Zuzahlung von 50% bei gewissen Leistungen möglich; Befreiung von Kostenanteil, der über 5% des Jahreseinkommens; Pauschalbetrag bei Landesgesundheitsfonds: 119,32 € SVB: 20% von 77,04 € pro

	BSVG fast gleich		Behandlungsfall im Quartal bei ambulanten Leistungen, die durch Zahlungen der Landesfonds abgegolten werden VAEB: fast immer 14% des Vertragstarifs – Ausnahme: psychotherapeutische und psychologisch-diagnostische Behandlung bei freiberuflich tätigen Vertragspsychotherapeuten und klinischen Vertragspsychologen und in Vertragseinrichtungen 20%
Kostenerstattung	§ 131 ASVG: 80% § 85 Abs 2 lit c GSVG: Kosten minus Behandlungsbeitrag § 59 B-KUVG: Kosten minus Behandlungsbeitrag § 80 BSVG: 80% ASVG, B-KUVG, BSVG: Ersatz tatsächlicher Kosten bei Unfall oder plötzlicher Erkrankung – Satzung GSVG keine Regelung	(verbindlich) § 23 Erstattung von Kosten der ärztlichen Hilfe § 27 Kostenerstattung für Leistungen, die der ärztlichen Hilfe gleichgestellt sind sowie für medizinische Haus-krankenpflege (n. verbindlich) – Regelung von allen GKK übernommen Arzt-Wechsel nur unter best.	Zusätzliche Regelungen bei gleichgestellten Leistungen: STGKK, WGKK BKK: 80% siehe genauer Dokument Kostenerstattung SVA: sieht Vergütungstarife in Anhängen vor BVA: § 10 leistet nur, wenn

	ASVG, BSVG: keine Bergungskosten und Taltransport – GSVG (§ 103) und B-KUVG (§ 83) ASVG, B-KUVG, BSVG: best. Voraussetzungen für Leistungen eines approbierten Arztes GSVG keine Regelung	Voraussetzungen möglich: Musterkrankenordnung (verb.), SVA, BVA, VAEB, SVB	Wahlarzt gleiche Kriterien wie Vertragsarzt erfüllt VAEB: vertraglich oder anderweitig nicht sichergestellte bzw. geregelte Behandlungs-, Untersuchungsmethoden und Leistungen, die vom chefärztlichen Dienst als zweckmäßig und das Maß des Notwendigen nicht überschreitend erkannt werden – 60%
Kostenerstattung/-zuschüsse bei Fehlen vertraglicher Regelungen	ASVG: Kostenzuschuss, wenn noch kein Vertrag mit Berufsgruppe; Kostenerstattung wie bei Wahlarzt bei fehlender Regelung mit Vertragsärzten/-zahnärzten/-Gruppenpraxen GSVG: Kostenersätze wie auch bei Kostenerstattung bei Inanspruchnahme eines Wahlarztes bzw bei Geldleistungsberechtigten B-KUVG: Kostenerstattung wie bei Inanspruchnahme eines Wahlarztes usw zu leisten gewesen wäre; wenn noch keine Verträge	§ 36 Mustersatzung: bei vertragslosem Zustand wegen Beendigung der vertraglichen Beziehungen mit freiberuflich tätigen Ärzten usw werden die Kosten nach der Regelung im Anhang zur Satzung erstattet (n. verbindlich) § 38 Mustersatzung: Kostenzuschüsse bei fehlenden Vertragspartnern im Bereich der	BGKK, KGKK, SGKK, TGKK, STGKK, OÖGKK, NÖGKK, BKK Kapfenberg, BKK voestalpine, BKK Wiener Verkehrsbetriebe, BKK Zeltweg: „Über den Gesetzeswortlaut hinaus wird keine zusätzliche Regelung getroffen.“ VGKK: § 36 – Kostenerstattung bei vertragslosem Zustand in Höhe von 80% der Beträge bzw Tarife nach den Anhängen 1, 3, 5 Pkt. I. und 6

	für Berufsgruppe bestanden haben, dann legt Satzung Kostenzuschüsse fest BSVG: Kostenzuschüsse durch Satzung; 80 v. H. der tatsächlich erwachsenden Kosten nicht übersteigen	ärztlichen Hilfe gleichgestellten Leistungen (§ 135 Abs. 1 Z 1 bis 4 ASVG), der medizinischen Hauskrankenpflege (§ 151 ASVG), des Beistands durch diplomierte Kinderkranken- und Säuglingsschwestern aus dem Versicherungsfall der Mutterschaft (§ 159 ASVG), der Versorgung mit Heilbehelfen oder Hilfsmitteln, der Hebammenberatung gem § 7 Abs. 1 KBGG nach Regelungen im Anhang der Satzung (nicht verbindlich)	zur Satzung; WGKK: § 36 – Kosten einer Krankbehandlung werden im Ausmaß von 100% des Betrages, der vor Eintritt des vertragslosen Zustands bei Inanspruchnahme eines Wahlarztes zu leisten gewesen wäre, erstattet; BKK Mondi: § 36 Kostenersatz in Höhe von 100% Alle GKKs + BKKs: bei Fehlen von Verträgen mit Gruppenpraxen Kostenzuschuss in der Höhe von 80% der um 10% verminderten in der Honorarordnung für einen vergleichbaren Vertragsarzt vorgesehenen Vergütung Wie § 38 Mustersatzung: § 37 BKK Wiener Verkehrsbetriebe; § 38 BGKK; § 38 VGKK; § 38 WGKK Regelungen bei anderen GKKs +

			BKKs siehe Dokument Kostenzuschuss bei Fehlen vertraglicher Regelungen Regelung zu Ambulanz-kostenzuschuss – siehe Dokument Kostenzuschuss bei Fehlen vertraglicher Regelungen SVA: Satzung (§ 31) regelt nur Kostenerstattung für eine als Krankenbehandlung erbrachte ambulante Tumorbehandlung durch eine punktförmige Bestrahlung des Tumors mit Protonen und/oder Kohlenstoffionen BVA: § 14 Satzung: Zuschuss zu den tatsächlichen Kosten einer notwendigen und zweckmäßigen Pflichtleistung bis zu dem in besonderen Bestimmungen oder in Anhang 1 genannten Betrag. Ist für die Leistung ein Zuschuss nicht

			ausdrücklich vorgesehen, werden je Behandlung oder Untersuchung 60 % der notwendigen tatsächlichen Kosten ersetzt; dieser Zuschuss beträgt höchstens 7,5 % der Höchstbeitragsgrundlage; SVB § 28: Kostenzuschuss 80% jener Tarifposten in Anlage 1, mit denen Leistung übereinstimmt oder vergleichbar ist; bei ärztlicher Hilfe oder gleichgestellten Leistungen sind in § 28 Höchstsätze festgelegt – auf jeden Fall aber nicht mehr als 80% der tatsächlichen Kosten VAEB: Kostenzuschüsse nach Maßgabe des Anhang 1, wenn Verträge noch nicht zustande gekommen sind; wenn Verträge beendet, Kostenerstattung in Höhe des Betrages, der vor Eintritt des vertragslosen Zustandes bei Inanspruchnahme eines Wahlpartners oder einer Wahl-

			Gruppenpraxis zu leisten gewesen wäre
Bare Leistungen	ASVG, B-KUVG: Satzungsermächtigung – wurde aber nicht in Anspruch genommen GSVG: Geldleistungsberechtigte, wenn Sachleistungsobergrenze überschritten; Satzung kann Optionsmöglichkeit vorsehen; 80% der Kosten erstattet – keine Sachleistungen, wie Privatpatient		§ 15 SVA: wenn Einkommen, 12fache der Höchstbeitragsgrundlage übersteigt oder GSVG weiterversichert sind und Beiträge nach § 30 Abs. 1 GSVG leisten oder Pension das 12fache übersteigt § 33 SVA: Optionsmöglichkeit
Reisekosten	Gesetzlichen Regelungen prinzipiell gleich – Delegation an Satzungen: Benützung der billigsten öffentlichen Verkehrsmittel	§ 46 Mustersatzung (n. verbindlich): • Begleitperson bei Kindern und gebrechlichen Personen • Kostenerstattung: Kilometersatz 0,09 € und 0,14 € bei Fahrten mit Begleitperson • Keine Kostenerstattung innerhalb des Ortsgebietes bzw wenn Entfernung Wohnort-Behandlungsstelle 20km nicht übersteigt	BGKK (§ 46), KGKK (§ 45), NÖGKK (§ 46), SGKK (§ 46; ausgenommen sind Jugendlichenuntersuchungen sofern diese nicht an der Berufsschule durchgeführt werden), TGKK (§ 45), WGKK (§ 46), BKK Wiener Verkehrsbetriebe (§ 45) ersetzen keine Reisekosten OÖGKK, STGKK, VGKK, BKK

			Kapfenberg, BKK Mondi, BKK voestalpine, BKK Zeltweg ersetzen unter gewissen Voraussetzungen Reisekosten – siehe Dokument Reisekosten SVA Satzung (§§ 32, 39), BVA (§ 24), SVB (§ 15), VAEB (§ 28) sehen Reisekostenerstattung unter gewissen Voraussetzungen vor – siehe Dokument Reisekosten
Transportkosten	Gesetzlichen Regelungen prinzipiell gleich – Delegation an Satzungen: Benützung der billigsten öffentlichen Verkehrsmittel	§ 47 Mustersatzung (verbindlich): Übernahme der Transportkosten, wenn ärztlich bescheinigt, dass öffentliche Verkehrsmittel nicht benutzt werden können: • zur Anstaltspflege in die nächstgelegene geeignete Krankenanstalt bzw in die Wohnung zurück, • bei notwendiger Überstellung zur stationären Behandlung von einer Krankenanstalt in die nächstgelegene geeignete Krankenanstalt, • zur ambulanten Behandlung zum	Abweichende Regelung hinsichtlich des Kostenanteils bei allen GKKs + BKKs

		nächstgelegenen geeigneten Vertragsarzt (Vertragszahnarzt), der nächstgelegenen geeigneten Vertrags-Gruppenpraxis oder zur nächstgelegenen geeigneten Einrichtung (Vertragseinrichtung) bzw. in die Wohnung des/der Erkrankten zurück, • zur körpergerechten Anpassung von Heilbehelfen und Hilfsmitteln […] Kostenanteil in Höhe der Rezept-gebühr (n. verbindlich); Regelung bei Transport zu Wahlärzten (verbindlich); Regelungen bei Transport mittels Luftfahrzeug (verbindlich); Regelung bei Transport ins Ausland (n. verbindlich);Regelung bei Transport im Rahmen der medizinischen Maßnahmen der Rehabilitation (n. verbindlich)	
Heilmittel § 136 ASVG § 92 GSVG	im Wesentlichen gleichlautende Regelungen in ASVG, GSVG, BSVG, B-KUVG, insb hinsichtlich Höhe Rezeptgebühr + überall Bindung an die vom HV erlassene RL zur Rezeptgebührenbefreiung		

§ 86 BSVG § 64 B-KUVG	(RRZ 2008 idF 9. Änderung avsv Nr. 179/2016) einzige **Abweichung BSVG**: **Ermächtigung an Satzung**, anstelle der Rezeptgebührenbefreiung eine verminderte Rezeptgebühr von max. 50 % festzulegen, soweit dies für die Sicherstellung der finanziellen Leistungsfähigkeit des Versicherungsträgers erforderlich ist – **derzeit keine entsprechende Regelung** in der Satzung der SVB		
Heilbehelfe § 137 ASVG § 93 GSVG § 87 BSVG § 65 B-KUVG	GSVG und B-KUVG regeln Heilbehelfe und Hilfsmittel in einer Bestimmung. Kostenanteil des Versicherten nach ASVG, BSVG und B-KUVG 10% der Kosten; nach GSVG richtet sich der Kostenanteil nach § 86 GSVG → nach der Satzung; In allen vier G wird aber ein Mindestanteil von 20% der HBG (bei Brillen und Kontaktlinsen 60% der HBG) festgelegt. ASVG, BSVG, B-KUVG Übernahme der Kosten einer zweckentsprechenden Instandsetzung von Heilbehelfen; GSVG Kostenübernahme für Instandsetzung bis zu zwei Drittel der Kosten, die	Bandbreitenregelung 3-8 fache HBG, für Kontaktlinsen auch niedriger möglich.	Unterschiede in Satzungen/KO: Höchstbeträge für Kostenübernahme allgemein; Höchstbeträge für Kontaktlinsen; Höchstbeträge für zweckentsprechende Instandsetzung; Weitere Sonderregelungen; Festlegung einer Gebrauchsdauer; Alle diese Beträge bewegen sich im Wesentlichen innerhalb der Bandbreitenregelung, lediglich die

	dem VTr bei Neuanschaffung; ASVG, BSVG: Möglichkeit der Festlegung einer Gebrauchsdauer durch KO; GSVG, B-KUVG: Möglichkeit der Festlegung einer Gebrauchsdauer durch Satzung; ASVG, BSVG, B-KUVG: Möglichkeit der **leihweisen Zurverfügungstellung von Heilbehelfen**, die nur vorübergehend gebraucht werden durch VTr/ Vertragspartner bzw Kostenübernahme bei Entleihung von Nichtvertragspartnern bereits gesetzl vorgesehen; GSVG: **Satzung** kann diese Möglichkeit vorsehen. **<u>Delegation an die Satzung:</u>** Höchstbetrag der vom VTr zu übernehmenden Kosten, max 10% der HBG (nach GSVG alternativ auch Festlegung eines Vergütungstarifes, der Bestandteil der Satzung ist) GSVG, B-KUVG: Festlegung Gebrauchsdauer GSVG: leihweise Zurverfügungstellung von Heilbehelfen Reise(Fahrt)-bzw Transportkosten im		TGKK und die SVA sehen keine Regelung zu den Höchstbeträgen für zweckentsprechende Instandsetzung vor. Für Genaueres siehe Dokument zu Heilbehelfen.

	Zusammenhang mit körpergerechter Anpassung von Heilbehelfen; **<u>Delegation an die KO:</u>** ASVG, BSVG: Festlegung einer Gebrauchsdauer (Brillen: mind 3 Jahre)		
Medizinische Hauskrankenpflege § 151 ASVG § 99 GSVG § 94 BSVG § 71 B-KUVG	Grundsätzlich gleiche Regelung, es wird nur auf unterschiedliche Regelungen zum Kostenersatz/-zuschuss verwiesen. Siehe Dokument zur Kostenerstattung: ASVG: Kostenersatz gem § 131 ASVG GSVG: Kostenersatz gem § 85 Abs 2 lit b GSVG BSVG: Kostenzuschuss gem § 88 bzw 239 BSVG B-KUVG: Kostenersatz gem § 59 B-KUVG		
Pflegekostenzuschuss § 150 ASVG § 98a GSVG § 93 BSVG § 68a B-KUVG	**ASVG, BSVG**: Rechtsanspruch auf Pflegekostenzuschuss, wenn Anstaltspflege notwendig war. **GSVG:** Rechtsanspruch auf Pflegekostenzuschuss, wenn Anstaltspflege als Sachleistung gegeben ist. **B-KUVG:** Pflegekostenzuschuss gebührt zu den	**§ 41 Mustersatzung verbindlich** • Stationäre Krankenbehandlung: € 215,86 pro Tag • Für tagesklinische Leistungen Betrag offen gelassen, jedoch nicht höher als tatsächliche Kosten. • Pauschalbeträge verringern sich um 10%, sofern nicht nach § 447f Abs 7 Z 1 bis 3 ASVG	Gleichen Betrag wie Mustersatzung für stationäre Krankenbehandlung sehen § 41 BGKK, § 41 BKK Mondi, § 40 BKK Wiener Verkehrsbetriebe, § 38 BKK Zeltweg, § 11 Abs 2 BVA, § 40 KGKK, § 41 NÖGKK, § 41 SGKK, § 38 STGKK, § 40 TGKK, § 41

	Kosten einer anderweitigen Inanspruchnahme der Anstaltspflege. **<u>Alle:</u>** Pflegekostenzuschuss in der Höhe, die sich aus Anwendung des § 149 Abs 3 ASVG ergibt. Im übrigen **Satzungsermächtigung** bezüglich der Höhe des Pflegekostenzuschusses. **ASVG, BSVG:** 10% Kostenbeitrag	davon abzusehen ist.	VGKK, § 41 WGKK vor. € 228,07 pro Tag sehen § 41 OÖGKK, § 27 SVA und § 13 VAEB vor. Unterschiedliche Regelungen in Satzungen siehe Dokument zu Pflegekostenzuschuss.
Krankengeld	Regelungen in ASVG, GSVG (Zusatzversicherung), B-KUVG B-KUVG verweist auf ASVG – nur unterschiedliche Bemessungsgrundlage	Wenn Höchstdauer überschritten, kann für die Dauer einer notwendigen, unaufschiebbaren stationären Aufenthalt durch die Satzung Krankgeld gewährt werden: § 30 Mustersatzung (verbindlich): „Die Kasse leistet Personen, 1. deren Anspruch auf Leistungen aus der Arbeitslosenversicherung während der Unterbringung in einer Heil- oder Pflegeanstalt nach § 16 Abs. 1 lit. c des Arbeitslosenversicherungsgesetzes 1977 (BGBl. Nr. 609/1977 in der Fassung des Bundesgesetzes BGBl. I Nr. 162/2015) ruht, 2. bei denen die Höchstdauer ihres Krankengeldanspruches (§ 139 Abs. 1 und 2 ASVG) abgelaufen ist und 3. bei denen mangels Wiedererlangung der	Satzung kann Krankengeld erhöhen, wenn Versicherte Angehörige im Sinne des § 123 Abs. 2, 4, 7 oder 8 hat, die sich gewöhnlich im Inland aufhalten, wenn Angehöriger nicht mehr als 510,21€ an Einkommen bezieht – Betrag jedes Jahr mit Aufwertungszahl zu vervielfachen – § 29 BKK Mondi; § 29 BKK voestalpine, § 29 BKK Zeltweg; § 29 OÖGKK; § 39 VGKK haben Regelungen getroffen – siehe Dokument Krankengeld § 30 Mustersatzung umgesetzt von: § 30 BGKK, § 30 BKK Mondi, § 30 BKK voestalpine, § 30 NÖGKK, § 30 OÖGKK, § 30 SGKK, § 29a STGKK, § 30 VGKK, § 33 VAEB

		Arbeitsfähigkeit nach § 139 Abs. 4 ASVG noch kein neuer Krankengeldanspruch entstanden ist, Krankengeld in der zuletzt bezogenen Höhe für die Dauer notwendiger, unaufschiebbarer stationärer Aufenthalte (Krankenhaus- sowie Rehabilitations-aufenthalte im Anschlussheilverfahren)."	SVA: Satzung kann Höchstdauer auf 52 Wochen erhöhen – § 35 der Satzung: Höchstdauer 26 Wochen; Höhe des tägl. Krankgeldes wird durch Satzung festgelegt, darf aber 80% der Beitragsgrundlage / 30 nicht überschreiten – § 35 der Satzung: 60% der jeweiligen vorläufigen Beitrags-grundlage in der KV geteilt durch 30; Anspruch ruht solange keine Meldung der Arbeitsunfähigkeit erfolgt – Satzung kann besondere Gründe vorsehen, wenn trotz später Meldung, Krankengeld rückwirkend gewährt werden kann – § 35 Satzung verweist auf § 34, der eine rückwirkende Gewährung bei Vorliegen von persönlichen Verhältnissen des Versicherten oder bei Vorliegen besonderer Gründe, die eine nicht rechtzeitige Meldung rechtfertigen, vorsieht; Satzung kann außerdem festlegen, dass wenn der Versicherte einer Ladung zum Chef(Vertrauens)arzt ohne wichtigen Grund nicht Folge leistet oder wiederholt Bestimmungen der Kranken-ordnung oder Anordnungen des behandelnden Arztes verletzt hat, der Anspruch ruht – ebenso Verweis auf § 34

			der ein gänzliches Ruhen von 4 Wochen in eben jenen Fällen vorsieht BVA § 27 der Satzung: leistet bei Arbeitsunfähigkeit infolge Krankheit ausgenommen die nach § 84 B-KUVG in Verbindung mit § 122 Abs. 2 Z 2 und 3 ASVG Anspruchsberechtigten – Krankengeld bis zur Höchstdauer von 78 Wochen. Für ein und denselben Versicherungsfall wird über die Dauer von 26 Wochen hinaus Krankengeld nur längstens bis zum Ende des Kalender-monates erbracht, in dem ein Bescheid über die Zuerkennung einer Pension aus eigener PV zugestellt worden ist. Fällt eine Pension aus den Versicherungsfällen der geminderten Arbeitsfähigkeit erst nach der Bescheidzustellung an, weil der Versicherte die Tätigkeit, aufgrund welcher er als invalid (berufsunfähig, dienstunfähig) gilt, nicht aufgegeben hat, wird das Krankengeld bis zum Ende des Kalendermonates geleistet, in dem die Pension angefallen ist, längstens jedoch bis zum Ende des auf die Bescheid-zustellung

			folgenden Kalendermonates.
Reha-Geld	Gesetzliche Regelungen nur in ASVG und B-KUVG Bemessungsgrundlage unterschiedlich		
Ärztlicher Beistand, Hebammenbeistand und Beistand durch diplomierte Kinderkranken- und Säuglingsschwestern **(Mutterschaft)** § 159 ASVG § 102 Abs 2 GSVG § 97 Abs 4 BSVG § 76 B-KUVG	Gesetzliche Regelungen gleich, außer: § 159 ASVG und § 76 B-KUVG verweisen auf Regelung zu Kostenersatz für den Fall, dass die Anspruchsberechtigte nicht die Vertragspartner oder die eigenen Einrichtungen der Versicherungsanstalt in Anspruch genommen hat.	--	--
Heilmittel und Heilbehelfe (Mutterschaft) § 160 ASVG	Gesetzliche Regelungen gleich, außer: § 160 ASVG, § 97 Abs 5, 6 BSVG, § 77 B-KUVG enthalten eine Ermächtigung an die Versicherungsanstalt, freiwillig Behelfe zur Mutter-	--	--

§ 102 Abs 3 GSVG § 97 Abs 5 und 6 BSVG § 77 B-KUVG	und Säuglingspflege beistellen zu können.		
Pflege in einer Krankenanstalt (Mutterschaft) § 161 ASVG § 102 Abs 4 GSVG § 97 Abs 7 BSVG § 78 B-KUVG	ASVG und BSVG sehen den Ersatz der Beförderungskosten in die und aus der Anstalt vor, soweit es der Zustand der Wöchnerin oder die Entfernung ihres Wohnortes erfordert. ASVG, GSVG und BSVG begrenzen die Pflege in einer KA auf längstens 10 Tage, das B-KUVG sieht keine dementsprechende Regelung vor. ASVG regelt, dass die Zeiten einer Pflege nach Abs 1 auf die Höchstdauer des Krankengeldanspruches nicht anzurechnen sind.	--	--
Wochengeld/Betriebs-hilfe (Mutterschaft) § 162 ASVG § 102a GSVG § 98 BSVG	Bezüglich unterschiedlicher gesetzlicher Regelungen siehe Dokument zu Mutterschaft	§ 22 Krankengeld (verbindlich) § 45 Berücksichtigung der Sonderzahlungen bei der Bemessung des Wochengeldes (verbindlich)	Krankengeld geregelt wie Mustersatzung: § 22 BGKK, § 22 BKK Kapfenberg, § 22 BKK Mondi, § 22 BKK voestalpine, § 22 BKK Wiener Verkehrsbetriebe, § 22 BKK Zeltweg, § 22 KGKK, § 22 NÖGKK,

§ 84 B-KUVG			§ 22 OÖGKK, § 22 SGKK, § 22 STGKK, § 31 VAEB, § 22 VGKK, § 22 WGKK Berücksichtigung der Sonderzahlungen bei der Bemessung des Wochengeldes gleich wie in Mustersatzung: § 45 BGKK, § 42 BKK Kapfenberg, § 45 BKK Mondi, § 45 BKK voestalpine, § 44 BKK Wiener Verkehrsbetriebe, § 42 BKK Zeltweg, § 44 KGKK, § 45 NÖGKK, § 45 OÖGKK, § 45 SGKK, § 42 STGKK, § 34 VAEB, § 45 VGKK, § 45 WGKK **§ 28.** Die **BVA** berücksichtigt die auf die letzten drei Kalendermonate entfallenden Sonderzahlungen bei der Bemessung des Wochengeldes, in dem sie den

			nach § 84 B-KUVG in Verbindung mit § 162 Abs. 3 ASVG ermittelten Nettoarbeitsverdienst um 17 % erhöht. In den Satzungen der SVA und SVB wurden keine diesbezüglichen Regelungen getroffen.
Zahnbehandlung und Zahnersatz § 153 ASVG § 94 GSVG § 95 BSVG § 69 B-KUVG	**<u>Chirurgische Zahnbehandlung:</u>** ASVG, BSVG, B-KUVG: Kommt als Leistung in Betracht; GSVG: ist eine Pflichtleistung, soweit zur Verhütung von Gesundheitsschädigungen oder zur Beseitigung von berufsstörenden Verunstaltungen notwendig. <u>ASVG:</u> **Satzung** kann Erfüllung einer Wartezeit vorsehen; § 121 Abs 3 ASVG: durch Satzung können über gesetzl Mindestleistungen hinausgehende Mehrleistungen vorgesehen werden. Versicherte hat bei Inanspruchnahme	§§ 31, 32, 33, 35 Mustersatzung verbindlich	Trotz verbindlicher Mustersatzung einige Abweichungen in Satzungen, vor allem auch hinsichtlich der Beträge in den Anhängen. Siehe Dazu Dokument zu Zahnbehandlung und Zahnersatz.

	chirurgischer Zahnbehandlung einen Kostenbeitrag nach Maßgabe der Verordnung nach § 31 Abs 5a zu leisten. **<u>Konservierende Zahnbehandlung:</u>** ASVG, BSVG, B-KUVG: kommt als Leistung der Zahnbehandlung in Betracht; GSVG: ist eine Pflichtleistung, soweit sie zur Verhütung von Gesundheitsschädigungen oder zur Beseitigung von berufsstörenden Verunstaltungen notwendig sind. <u>ASVG</u>: **Satzung** kann Erfüllung einer Wartezeit vorsehen; § 121 Abs 3 gilt entsprechend. Versicherte hat Kostenbeitrag nach Maßgabe der VO nach § 31 Abs 5a zu leisten. **<u>Kieferregulierungen</u>**: ASVG, GSVG und B-KUVG sehen gleiche Voraussetzungen vor: zur Verhütung von		

	schweren Gesundheitsschädigungen oder zur Beseitigung von berufsstörenden Verunstaltungen. BSVG: sieht keine derartigen Voraussetzungen vor; ASVG: **Satzung** kann Erfüllung einer Wartezeit vorsehen; § 121 Abs 3 gilt entsprechend; **Zahnersatz**: ASVG: kann unter Kostenbeteiligung des Versicherten gewährt werden; an Stelle der Sachleistung können auch Zuschüsse zu den Kosten des Zahnersatzes geleistet werden, Näheres wird durch **Satzung** bestimmt; GSVG: ist eine Pflichtleistung, wenn er notwendig ist, um eine Gesundheitsstörung oder eine wesentliche Störung der Berufsfähigkeit hintanzuhalten; BSVG: **KO** kann Gebrauchsdauer vorsehen; B-KUVG: Versicherungsanstalt hat		

	unentbehrlichen Zahnersatz zu gewähren. ASVG, B-KUVG: Zahnbehandlung und Zahnersatz werden als Sachleistungen erbracht. GSVG, BSVG: Satzungsermächtigung. Bezüglich genauerer Bestimmungen siehe Tabelle in Dokument zu Zahnbehandlung und Zahnersatz.		
Kieferregulierungen für Kinder und Jugendliche § 153a ASVG § 94a GSVG § 95a BSVG § 69a B-KUVG	GSVG, B-KUVG enthalten gleiche Regelung zum Anspruch auf Kostenerstattung. ASVG, GSVG, BSVG und B-KUVG verweisen auf unterschiedliche Regelungen zur Kostenerstattung (siehe Dokument zur Kostenerstattung) ASVG gibt in Abs 3 vor, dass der Hauptverband für die Leistungserbringung nach Abs 1 ein Qualitätssicherungssystem vorzusehen hat. In Abs 4 sieht das ASVG weitere Voraussetzungen für den Anspruch auf Kostenerstattung vor.	§ 34 Mustersatzung (verbindlich)	Gleiche Regelung wie Mustersatzung: § 34 BGKK, § 34 BKK Mondi, § 34 BKK voestalpine, § 33 BKK Wiener Verkehrsbetriebe, § 32a BKK Zeltweg, § 33 KGKK, § 34 NÖGKK, § 34 OÖGKK, § 34 SGKK, § 32a STGKK, § 23 SVA, § 25 SVB, § 33 TGKK, § 25 VAEB, § 34 VGKK, § 34 WGKK, § 21 BVA In der Anlage 5 der SVA Satzung sind Beträge für die drei Leistungen

	ASVG, GSVG, BSVG, B-KUVG sehen eine Ermächtigung an die Satzung vor, die den Anspruch, die Höhe und die Qualitätsanforderungen für die Zuerkennung eines Kostenzuschusses für den Fall des Fehlens einer flächendeckenden Sachleistungsversorgung bundesweit einheitlich regeln soll.		aufgelistet. Die BKK Kapfenberg enthält keine Regelung zur Kieferregulierung bei Kindern und Jugendlichen
Hilfsmittel § 154 ASVG § 93 GSVG § 96 BSVG § 65 B-KUVG	GSVG, B-KUVG: Rechtsanspruch auf Hilfsmittel; ASVG, BSVG: Mögl der Vorsehung von Zuschüssen zu Hilfsmitteln als satzungsmäßige Pflichtleistung; ASVG, BSVG: **Satzungsermächtigung** zur Vorsehung von Zuschüssen zur Instandsetzung notwendiger Heilbehelfe; GSVG: Kostenübernahme bis zu 2/3 der Kosten, die dem VTr bei Neuanschaffung des Hilfsmittels entstehen würden; B-KUVG: Rechtsanspruch auf Übernahme der zweckentsprechenden Instandsetzung; **Kostenanteil des Versicherten** nach ASVG,	Höchstbeträge für Kostenzuschüsse allgemein: Bandbreitenregelung 3-8 fache HBG, bei orthopädischen Schuhen auch geringerer Betrag zulässig. Höchstgrenze bei Krankenfahrstühlen: Bandbreitenregelung 3-20fache HBG Höchstgrenzen bei Hilfsmitteln, die geeignet sind, die Funktionen fehlender oder unzulänglicher Körperteile zu übernehmen: Bandbreitenregelung 3-20fache HBG.	Unterschiedliche Höhe des Selbstbehaltes: ASVG, BSVG, B-KUVG: 10%, GSVG: 20% Höchstbeträge für Kostenzuschüsse allgemein (innerhalb Bandbreite der Mustersatzung). Höchstgrenze bei Krankenfahrstühlen: innerhalb der Bandbreitenregelung. Höchstgrenzen bei Hilfsmitteln, die geeignet sind, die Funktionen fehlender oder unzulänglicher

	BSVG, B-KUVG: 10% der Kosten, mind 20% der HBG → Kostenzuschuss = 90% der Anschaffungskosten; GSVG: Selbstbehalt mind 20% der HBG, ansonsten nach § 86 GSVG → nach Satzung → Kostenzuschuss = 80% der Anschaffungskosten bis zur Höchstgrenze. ASVG, BSVG: Mögl der Festlegung einer Gebrauchsdauer durch die **Krankenordnung**; GSVG, B-KUVG: Mögl der Festlegung einer Gebrauchsdauer durch **Satzung;** ASVG, BSVG, B-KUVG: Mögl der leihweisen Zurverfügungstellung von Hilfsmitteln, die nur vorübergehend gebraucht werden, durch VTr/ Vertragspartner bzw Kostenübernahme bei Entleihung von Nichtvertragspartnern bereits gesetzl vorgesehen; GSVG: **Satzung** kann diese Mögl vorsehen; **<u>Delegation an Satzung:</u>** ASVG, BSVG: Ermächtigung an die Satzung, Zuschüsse vorzusehen;	Höchstgrenzen bei Hilfsmitteln, die nur 1x verwendet oder kurzfristig verwendet werden können: Bandbreitenregelung 3-8fache HBG.	Körperteile zu übernehmen: Innerhalb der Bandbreitenregelung. Höchstgrenzen bei Hilfsmitteln, die nur 1x verwendet oder kurzfristig verwendet werden können: Innerhalb der Bandbreitenregelung. Bzgl weiterer Sonderregelungen siehe Dokument zu Hilfsmittel.

	Höchstbetrag der vom VTr zu übernehmenden Kosten, max 10% der HBG; bei Krankenfahrstühlen max 25% der HBG; GSVG, B-KUVG: Festlegung einer Gebrauchsdauer; GSVG: leihweise Zurverfügungstellung von Heilbehelfen; Reise(Fahrt)- bzw Transportkosten, die im Zusammenhang mit der körpergerechten Anpassung von Heilbehelfen stehen; **<u>Delegation an KO:</u>** ASVG, BSVG: Festlegung einer Gebrauchsdauer		
Reha-Maßnahmen	Gesetzlichen Regelungen alle gleich		
Gesundheitsförderung/Prävention	völlig deckungsgleiche Regelungen in ASVG, GSVG, BSVG und B-KUVG		
Maßnahmen zur Festigung der Gesundheit	GSVG und BSVG sehen als zusätzliche Maßnahme die Übernahme der Kosten von Betriebshelfern (nach dem BSVG auch von Haushaltshelferinnen) vor – im GSVG allerdings nur bei besonderer sozialer Schutzbedürftigkeit		Fahrtkosten nur in den Satzungen von SVA (§ 37 Abs 2) und BVA (§ 24 Abs 1 Z 8) gewährt, und zwar jeweils nur für Personen, die wegen besonderer sozialer

	des Versicherten		Schutzbedürftigkeit von der Rezeptgebühr befreit sind; nach der Satzung der BVA Beschränkung auf Reisekosten im Inland
Krankheitsverhütung	ASVG, GSVG, BSVG und B-KUVG deckungsgleich; einzige Abweichung: nur im ASVG werden in der demonstrativen Auflistung der möglichen freiwilligen Maßnahmen auch Maßnahmen der Betriebsfürsorge genannt		Übernahme der Reisekosten im Zusammenhang mit Maßnahmen zur Krankheitsverhütung (ebenfalls als freiwillige Leistung) – s. Reisekosten

13.B. Unterschiede Krankenfürsorgeanstalten

1. Allgemeines / organisatorische Vorgaben:

- aufgrund der Dienstrechtskompetenz der Länder eingerichtete KFA **nicht in das System der gesetzlichen KV integriert**
- KFA **gehören auch nicht dem HV an**
- **Mustersatzung** auf die KFA **nicht anzuwenden** (*Brenneis/Pöschl* in *Mosler/Müller/Pfeil,* Der SV-Komm § 455 ASVG Rz 43)
- **keine Beitragsrückerstattung bei Mehrfachversicherung** und Einkommen über der Höchstbeitragsgrundlage (vgl zB *Steiger*, Mehrfachversicherung im Sozialversicherungsrecht [Teil 1], taxlex 2007, 23 [25])
- unterschiedlichste Ausgestaltung der **Organisationsformen** der KFA in den verschiedenen Bundesländern: zB
    - **KFA für oö Landesbeamte:**
        - Rechtsgrundlage: **oö KFLG**
        - **Körperschaft öffentlichen Rechts mit Rechtspersönlichkeit** (§ 1 Abs 2 oö KFLG)
        - **Aufsichts- und Weisungsrecht der LReg** (§ 71 leg cit)
        - **Organe: Aufsichtsrat** (3 DG- / 3 DN-Vertreter), **Verwaltungsrat** (3 Landesbedienstete als DG-Vertreter, 7 Landesbedienstete auf Vorschlag der DN-Vertretung, Direktor) und **Direktor**
        - dem Verwaltungsrat obliegt ua die Beschlussfassung über die **Satzung der KFL** (§ 61 Abs 5 Z 1 KFLG) – Inhalte der Satzung geregelt in § 52 KFLG; Satzung selbst nicht öffentlich zugänglich (Veröffentlichung im Intranet)
    - **KFA für oö Lehrer**:
        - Rechtsgrundlage: **oö LKUFG**
        - ebenfalls **Körperschaft öff. Rechts**
        - Aufsichtsrecht der LReg, aber **weisungsfrei** (§§ 1 Abs 2, 44 Abs 1 oö LKUFG)

- **Organe**: **Aufsichtsrat**, **Verwaltungsrat** (in beide Gremien werden Mitglieder von der LReg sowie vom Zentralausschuss der Personalvertretung der Lehrer für allgemeinbildende Pflichtschulen bzw jenem für Berufsschulen entsendet), **Direktor** (§§ 33 ff leg cit)

- **KFA der oö Statutarstädte**:
  - Rechtsgrundlage: **§ 87 oö Statutargemeinden-BeamtenG**
  - können nach der gesetzlichen Vorgabe mit oder ohne Rechtspersönlichkeit ausgestaltet sein
  - Geschäfte sind durch ein **Kuratorium** zu führen, in dem Stadt und Beamte zu gleichen Teilen vertreten sind (§ 87 oö Statutargemeinden-BeamtenG)
  - keine gesetzlichen Vorgaben betreffend Organe etc - Näheres ist durch **VO des Stadtsenats** zu regeln
- **KFA für oö Gemeindebedienstete**:
  - Rechtsgrundlage: **§ 83** iVm **§ 3 Abs 3a oö GemeindebedienstetenG**, § 7a oö Gemeinde-BezügeG (Einbeziehung der Bürgermeister), § 35 oö GemO (Einbeziehung der Vizebürgermeister, Fraktionsobmänner und Mitglieder des Gemeindevorstands)
  - gem § 83 Abs 3 GBG wäre „*das Nähere über die Krankenfürsorge (…) durch ein eigenes Landesgesetz*“ zu regeln ➔ dieses LG existiert aber nicht
  - organisatorische Regelungen finden sich im **8. Abschnitt der Satzung der KF der oö Gemeinden**: als **Organe Hauptversammlung** (bestehend aus 48 von der Gewerkschaft der Gemeindebediensteten nominierten Bediensteten+ den 6 Bürgermeistern des Verwaltungsausschusses), **Verwaltungsausschuss** (6 von der LReg bestellte Bürgermeister als Vertreter der Gemeinden + Obmann + Obmann-Stellvertreter + 5 weitere Mitglieder), **Obmann** und **Direktor** vorgesehen
  - **Satzung der KF der oö Gemeinden als VO zu qualifizieren**: VfGH 11.12.2002, V 104/01

- **<u>KFA für Magistratsbeamte der Stadt Salzburg</u>**:
  - Rechtsgrundlage: **§ 204 Sbg MagBeG**
  - **Einrichtung ohne eigene Rechtspersönlichkeit** (§ 204 sbg MagBeG)
  - für die Verwaltung als **Organe** mind. vorzusehen: **Generalversammlung, Ausschuss** (Mitglieder: 3 Mitglieder des Gemeinderates als DG-Vertreter, 4 Bedienstete als DN-Vertreter (§ 204 Sbg MagBeG)
  - nähere Bestimmungen durch die vom Ausschuss zu beschließende **Satzung** festzulegen
  - Satzung sieht zusätzliche Organe vor: Obmann, GF, Chefarzt, rechnungsprüfer
- **<u>KFA für die Beamten der Landeshauptstadt Graz</u>**:
  - Rechtsgrundlage **§ 37 Dienst- und Gehaltsordnung der Beamten der Landeshauptstadt Graz**:
    - Abs 3: Verwaltung der KFA durch einen **Ausschuss** (je 8 DG- und DN-Vertreter); Ausschuss vom Bürgermeister nach jeder Neuwahl des Gemeinderates für dessen Funktionsdauer zu bestellen (DN-Vertreter aufgrund von Vorschlägen der Personalvertretung, DG-Vertreter aus der Mitte des Gemeinderates nach dem Stärkeverhältnis der im Gemeinderat vertretenen Parteien zu bestellen) - weitere detaillierte Regelungen zum Ausschuss und seinen Mitgliedern in § 37 Abs 3
    - Näheres zu Verwaltung, anspruchsberechtigten Personenkreis, Leistungsrecht in **Verordnung des Gemeinderates** = **KFA-Satzung** zu regeln – vgl §§ 19 ff KFA-Satzung Graz
      - insb Aufgaben des Ausschusses
      - Aufsicht durch den Gemeinderat
      - Einrichtung eines Berufungsausschusses für Berufungen gegen Entscheidungen des Ausschusses über Ansprüche nach der Satzung

- **<u>KFA der Tiroler Landeslehrer und Landesbeamten</u>**:
  - Rechtsgrundlage **Tir Beamten- und Lehrer-Kranken und UnfallfürsorgeG** (BLKUFG)

- Verwaltung der KF durch je eine **Verwaltungskommission** für die KF der Landesbeamten und die KF der Landeslehrer, errichtet beim Amt der LReg
    - § 61 BLKUFG **Verwaltungskommission der KF der Landesbeamten**: 3 von der LReg zu bestellende Beamte, 4 von der LReg auf Vorschlag der Personalvertretung der Tir Landesbediensteten zu bestellende Beamte
    - § 71 BLKUFG **Verwaltungskommission der KF der Landeslehrer**: 3 von der LReg zu bestellende Beamte, vier von der LReg auf Vorschlag der Personalvertretung der Pflichtschullehrer zu bestellende Landeslehrer, je ein von der LReg auf Vorschlag der Personalvertretung der Landeslehrer für berufsbildende Pflichtschulen und jener der land- und forstwirtschaftlichen Lehrer zu bestellende Landeslehrer
    - Entscheidung ua über Bestand und Umfang von Ansprüchen und von Beitragsverpflichtungen
    - **Verordnungsermächtigung an die Verwaltungskommissionen** in §§ 9 Abs 3 (Höhe des Kostenersatzes, Höchstgrenzen für Leistungen, Festlegung einer Gebrauchsdauer, außerordentliche Unterstützungen), § 13 Abs 1 (Kostenersatz für Anstaltspflege) und § 18 Abs 2 (Einschränkung der Leistungen für Angehörige)

      ➔ vgl **Landesbeamten-Krankenfürsorgeordnung** vom 21.6.2011, **Landeslehrer-Krankenfürsorgeordnung** vom 2.6.2014

- **KFA der Tiroler Gemeindebeamten**:
    - Rechtsgrundlage **Tir Gemeindebeamten-Kranken- und UnfallfürsorgeG** (GKUFG)
    - umfasst sowohl die Kranken-(und Unfall-)fürsorge für die **Beamten der Landeshauptstadt Innsbruck** als auch jene für die **Beamten der übrigen Gemeinden Tirols**
    - **Verwaltung der KF der Beamten der Stadt Innsbruck**
        - durch eigene, beim Magistrat der Stadt Innsbruck errichtete **Verwaltungskommission** (§ 57 GKUFG): 4 vom Stadtsenat auf Vorschlag der Personalvertretung der Gemeindebediensteten zu bestellende, 3 ohne Vorschlagsbindung zu bestellende Beamte

- beim Stadtmagistrat errichtete **Verwaltungsoberkommission** (§ 58 GKUFG) zur **Entscheidung über Berufungen** gegen Bescheide der Verwaltungskommission; gegen deren Entscheidung kein ordentliches Rechtsmittel zulässig

- **Verwaltung der KF der übrigen Gemeindebeamten Tirols**:
  - Zur Erfüllung der Ansprüche **eigener Gemeindeverband** mit Sitz in Innsbruck geschaffen
  - **Organe:** Gemeindeverbandsversammlung, Gemeindeverbandsausschuss, Gemeindeverbandsobmann und die **Verwaltungskommission** der KUF der Tir Gemeindebeamten: 4 vom Gemeindeverband auf Vorschlag der Gewerkschaft der Gemeindebediensteten. Landesgruppe Tirol zu bestellende Gemeindebeamte und 3 ohne Vorschlagsbindung zu bestellende Gemeinde- oder Landesbeamte
- Entscheidung der Verwaltungskommissionen ua über Bestand und Umfang von Ansprüchen und von Beitragsverpflichtungen
- **Verordnungsermächtigungen** an die Verwaltungskommissionen in den §§ 8 Abs 3 (Höhe des Kostenersatzes, Höchstgrenzen für Leistungen, Festlegung einer Gebrauchsdauer, außerordentliche Unterstützungen), § 12 Abs 1 (Kostenersatz für Anstaltspflege) und § 17 Abs 2 (Einschränkung der Leistungen für Angehörige) – **Verordnung** im Internet allerdings **nicht auffindbar**

- **<u>KFA der Bediensteten der Stadt Wien</u>**
  - Rechtsgrundlage **§ 43 Dienstordnung der Bundeshauptstadt Wien**
  - KFA nach **dem Grundsatz der Parität zwischen DG und DN** zu verwalten; Näheres in der **Satzung** zu regeln = **Verordnung des Gemeinderates der Stadt Wien**
  - **Vorgaben der Satzung**:
    - KFA als **Einrichtung mit Rechtspersönlichkeit**
    - **Organe: Vorstand** (30 Mitglieder je zur Hälfte Vertreter der DG und der Anspruchsberechtigten), **Verwaltungsausschuss, Überwachungsausschuss, Schiedsgericht**

- **Satzungsänderungen** durch den **Gemeinderat der Stadt Wien** auf **Antrag des Vorstandes** (§ 2 Abs 2 Satzung)
- Weitere **Aufgaben des Vorstandes** (§ 42 Abs 10 Satzung): ua Festsetzung der Höchstvergütung von Leistungen, der Kostenbeteiligung, der Rezeptgebühr; Genehmigung von Verträgen zB mit Ärzten, Dentisten, Apothekern etc; Erlassung/Abänderung der Krankenordnung

- **keine gesetzlichen Vorgaben zur Organisationsform** auffindbar für
  - **KFA der Beamten der Stadt Villach** (Rechtsgrundlage § 77 Ktn StadtbeamtenG)
  - **KFA der Beamten der Stadtgemeinde Baden** (Rechtsgrundlage § 54 Nö GBDO)
  - **KFA der Beamten der Stadtgemeinde Hallein** (Rechtsgrundlage § 11 Sbg Gemeindebeamtengesetz)

Effizienzanalyse des östereichischen Sozialversicherungs- und Gesundheitssystems

Band 3 – Originalbeiträge der Stakeholder

LSE Health, Contrast E&Y and the University of Salzburg ▪ August 2017 ▪

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Einleitung

2016 wurde ein Konsortium von Partnern unter Leitung der London School of Economics and Political Science (LSE Health) vom österreichischen Ministerium für Arbeit, Soziales und Konsumentenschutz beauftragt, eine Effizienzstudie des österreichischen Sozialversicherungssystems durchzuführen.

Um Rückmeldungen von österreichischen Stakeholdern miteinzubeziehen, wurden im Februar und im Mai 2017 eine Reihe von Diskussionsrunden gehalten. Zusätzlich fanden Expertenbefragungen im Verlauf der Studie statt.

Im Laufe dieser Diskussionen wurden die Interessenvertreter gebeten, schriftliche Stellungnahmen zu folgenden Themenschwerpunkten abzugeben:

- Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich
- bestimmte Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Maße im österreichischen Gesundheitssystem enthalten oder implementiert sind
- Stärken und Herausforderungen des österreichischen Sozialversicherungssystems
- Bereiche, die einer Verbesserung innerhalb des Sozialversicherungssystems bedürfen, und
- wie die Effizienz und die Effektivität des gegenwärtigen Sozialversicherungssystems weiter verbessert werden könnten.

Insgesamt haben 30 Stakeholder Stellungnahmen abgegeben, darunter Sozialversicherungsträger, der Hauptverband der österreichischen Sozialversicherungsträger, Sozialpartner, Systempartner und Vertreter von Gesundheitsdienstleistern. Alle 30 Beiträge wurden in diesen Bericht aufgenommen

- Allgemeine Unfallversicherungsanstalt (AUVA)
- BKK voestalpine Bahnsysteme
- Bundesarbeitskammer (BAK)
- Burgenländische Gebietskrankenkasse (BGKK)
- Dachverband der gehobenen medizinisch-technischen Dienste Österreichs (MTD)
    - biomed austria, Österreichischer Berufsverband der Biomedizinischen AnalytikerInnen
    - Diaetologen,Verband der Diaetologen Österreichs
    - Ergotherapie Austria, Bundesverband der ErgotherapeutInnen Österreichs
    - logopädieaustria, Berufsverband der Österreichischen LogopädInnen
    - orthoptik austria, Verband der OrthoptistInnen Österreichs

    - Physio Austria, Bundesverband der PhysiotherapeutInnen Österreichs
    - rtaustria, Berufsfachverband für Radiologietechnologie Österreich
- Hauptverband der österreichischen Sozialversicherungsträger (HVSV)
    - Herr Dr. Probst
    - Frau Reischl
    - Frau Rabmer-Koller
- Gesundheitslandesrat Steiermark
- Landeswirtschaftskammer Österreich (LKO)
- Niederösterreichische Gebietskrankenkasse (NÖGKK)
- NÖ Patienten- und Pflegeanwaltschaft
- Oberösterreichische Gebietskrankenkasse (OÖGKK)
- Österreichische Apothekerkammer (ÖApK)
- Österreichische Ärztekammer (ÖÄK)
- Österreichische Gesellschaft für Allgemein- und Familienmedizin (ÖGAM)
- Österreichischer Gesundheits- und Krankenpflegeverband (ÖGKV)
- Österreichischer Gewerkschaftsbund (ÖGB)
- Pensionsversicherungsanstalt (PVA)
- Salzburger Gebietskrankenkasse (SGKK)
- Sozialversicherungsanstalt der Bauern (SVB)
- Sozialversicherungsanstalt der gewerblichen Wirtschaft (SVA)
- Städträtin für Soziales, Gesundheit und Frauen der Gemeinde Wien
- Steiermärkische Gebietskrankenkasse (StGKK)
- Tiroler Gebietskrankenkasse (TGKK)
- Verband der pharmazeutischen Industrie Österreichs (PHARMIG)
- Versicherungsanstalt für Eisenbahnen und Bergbau (VAEB)
- Versicherungsanstalt öffentlich Bediensteter (BVA)
- Vorarlberger Gebietskrankenkasse (VGKK)
- Wiener Gebietskrankenkasse (WGKK)
- Wirtschaftskammer Österreich (WKÖ)
- Österreichische Zahnärztekammer (ÖZAK)

Stellungnahme der AUVA in Zusammenhang mit der Studie „Bessere Leistungen für die Menschen: Effizienzpotentiale in der Gesundheitsversorgung und im Bereich der Pensionen“

INHALTSVERZEICHNIS

1. Allgemeines

Die konkrete Gestaltung der Systeme der sozialen Sicherheit und die Ausformung der vollziehenden Körperschaften sind unterschiedlich. Sie variieren entsprechend den unterschiedlichen politischen, sozialen und ökonomischen Rahmenbedingungen, unter denen sie entwickelt wurden.

Der internationale Vergleich der sozialen Sicherungssysteme zeigt, dass in der bei Weitem überwiegenden Zahl aller Staaten der Welt eigene Unfallversicherungssysteme bestehen – also Regelwerke, die sich speziell mit beruflich bedingten Risiken und deren versicherungsmäßiger Abdeckung beschäftigen.

Eine allgemeingültige Aussage darüber, welche Organisationsform der Sozialversicherung im Allgemeinen und der Versicherung von Berufsschäden im Besonderen als „die Optimale“ anzusehen ist, kann aus einem internationalen Systemvergleich nicht abgeleitet werden.

Jedoch zeigen aktuelle Weiterentwicklungen der Systeme eine klare Tendenz zur Orientierung an bewährten Strukturen, wie es sie in Deutschland, Österreich und der Schweiz gibt. Dies zeigt sich z.B. an den Überlegungen in Frankreich, die Unfallversicherung wieder aus der Krankenversicherung herauszulösen, sowie an der Entwicklung in Italien, wo die Systemdiskussion zu einer Stärkung der Unfallversicherung als eigener Sparte mit einem eigenen Träger geführt hat. Neu geschaffen wurden eigene Unfallversicherungssparten mit eigenen Trägern z.B. in Neuseeland und Südkorea.

2. Die gesetzliche Unfallversicherung in Österreich

Die Unfallversicherung ist in Österreich für alle Versichertengruppen als eigene Sparte organisiert, wobei die Unfallversicherung für selbständig Erwerbstätige in der Landwirtschaft, öffentlich Bedienstete und Eisenbahnbedienstete in Mischträgern angesiedelt ist.
Für alle anderen Versichertengruppen wird die Unfallversicherung durch eine ausschließlich für diese Sparte zuständige Körperschaft – die Allgemeine Unfallversicherungsanstalt (AUVA) – durchgeführt.

Das österreichische System, das die Durchführung der Unfallversicherung als eigene Sparte vorsieht, hat sich bewährt, ist sehr erfolgreich und weist eine Reihe von Stärken auf.

Im Folgenden wird auf die „Allgemeine Unfallversicherung“ im Sinne des ASVG Bezug genommen, deren Träger die AUVA ist.

3. „Alles aus einer Hand“ – Nur das Gesamtsystem aus vier Säulen sichert maximale Synergien

Der Slogan „Alles aus einer Hand“ drückt die Stärke dieses Systems aus.

Die Vereinigung von Prävention, Unfallheilbehandlung in spezialisierten eigenen Einrichtungen, umfassender Rehabilitation (medizinische Rehabilitation in eigenen Zentren, berufliche und soziale Rehabilitation) und finanzieller Entschädigung in einem Gesamtsystem bringt maximale Synergien.

Die Maßnahmen zur Verhütung von Arbeitsunfällen und Berufskrankheiten kommen über die Reduktion von finanziellen Entschädigungszahlungen und medizinischen Sachleistungen der Versichertengemeinschaft wirtschaftlich zugute. Die Erfahrungen aus den eigenen medizinischen Einrichtungen sind wiederum Innovationstreiber für die Präventionsarbeit.

Die in der Arbeitswelt angesiedelten Risikopotenziale unterscheiden sich von den allgemein bestehenden Problemlagen der Krankheit und des Alters. Die Kompetenz der Unfallversicherung bei der Verhütung von Arbeitsunfällen zeigt sich darin, dass die jährliche Anzahl allein in den vergangenen 25 Jahren um fast die Hälfte gesunken ist (1990: 233.439 Arbeitsunfälle, 2015: 156.153 Arbeitsunfälle), während sich bei der Entwicklung der Freizeitunfälle kein signifikanter Rückgang zeigt.

Durch die Reduktion der Zahl der Arbeitsunfälle wurde vielen Erwerbstätigen und ihren Familien Schicksalsschläge erspart. Nicht zuletzt wurden auch massive Kosten vermieden:

- Kosten für Betriebe durch Ausfallszeiten der Beschäftigten,
- Kosten für andere Träger des Gesundheitssystems durch Krankenbehandlung und
- Kosten für Pensions-, bzw. Sozialhilfesysteme durch Arbeitsunfähigkeit.

Im Bereich der Unfallverhütung und der laufenden Verbesserung der Arbeitsumwelten ist die AUVA ein verlässlicher Partner der österreichischen Unternehmen und ihrer Beschäftigten. Den besonderen Bedürfnissen der Klein- und Mittelbetriebe entspricht die AUVA durch einen spezialisierten Beratungsansatz, nämlich AUVAsicher. Diese Unternehmen profitieren auch von den Zuschüssen der AUVA zu den Löhnen und Gehältern verunfallter oder erkrankter Mitarbeiter und Mitarbeiterinnen. Kein anderer Sozialversicherungsträger wendet in Relation zum Gesamtbudget so viel für die Prävention auf, wie die AUVA. Bei einer Zerschlagung der Unfallversicherung kann ein derart fokussierter Mitteleinsatz im Bereich der Arbeitswelt nicht mehr länger gewährleistet werden.

Das zentrale Element der Unfallversicherung ist die Verlagerung der Schadenersatzpflicht des Arbeitgebers auf die Risikogemeinschaft. Arbeitnehmerinnen und Arbeitnehmern ist es verwehrt, gegenüber dem Arbeitgeber eine zivilrechtliche Kompensation für Schäden durchzusetzen. Der Anspruch auf individuelle und optimale Lösungen für die Opfer von Berufsschäden gegenüber der dienstgeberfinanzierten Unfallversicherung ist die Kompensation für diesen Umstand. Dies dient nicht zuletzt auch dem Betriebsfrieden.

Eine wichtige Konsequenz aus der Schadenersatzpflicht besteht darin, dass die Unfallheilbehandlung mit allen geeigneten Mitteln (§ 189 (1) ASVG) zu erfolgen hat, was für ein Unfallopfer die bestmögliche Versorgung garantiert.

Die Abschaffung einer eigenen Unfallversicherung und Übertragung der Aufgaben in andere Sparten (Kranken- oder Pensionsversicherung) würde also zusammenfassend im Ergebnis die Einheit von Prävention, Unfallheilbehandlung, Rehabilitation und Entschädigung für den Bereich der Arbeitsunfälle und Berufskrankheiten durch ein systemisches Zusammenwachsen mit anderen Sparten zerstören und wesentliche Synergien verunmöglichen.

4. Vorteile des 4-Säulen-Modells – Beispiele

Die Zusammenarbeit zwischen den 4 Säulen ermöglicht ein optimiertes Nahtstellenmanagement für Verletzte:

- Arbeitsverunfallter trifft in Unfallkrankenhaus ein;
- schnelle Kontaktaufnahme mit Rehabilitationszentrum, um nahtlose Weiterbetreuung zu gewährleisten;
- direkte Information der zuständigen Leistungsabteilung beschleunigt die Prüfung der Ansprüche bzw. hilft bei der Wahl geeigneter Umschulungsmaßnahmen;
- Informationen an den Unfallverhütungsdienst führen zu einer entsprechenden Betreuung des betroffenen Betriebes.

In den Krankengeschichten, die in den Unfallkrankenhäusern und Rehabilitationszentren erstellt werden, wird bereits bei der Datenerhebung auf die möglichen Leistungsansprüche des Verletzten (Bereich Entschädigung) Rücksicht genommen (z.B. die Erfassung des genauen Unfallherganges sowie ein möglicher Ausschluss von Vorerkrankungen erleichtern die Feststellung der Kausalität).

Auffälligkeiten bei Verletzungsmustern können an die Prävention weitergegeben werden, die diese Information weiterverwenden oder entsprechende Schulungsmaßnahmen entwickeln kann.

Erkenntnisse aus der Prävention, Heilbehandlung und Entschädigung (z.B. hohe Umschulungskosten) sind Anstoß für neue berufsspezifische Konzepte in der Rehabilitation. Beispielsweise hat ein Projekt im Bereich der Prävention und Rehabilitation von berufsbedingten Hauterkrankungen (Berufsdermatosen) gezeigt, dass durch eine strukturierte Betreuung über 90% der Betroffenen in ihrem bisherigen Beruf verbleiben können.

Die hohe Kompetenz der AUVA zeigt sich auch in der sozialen und beruflichen Rehabilitation. Eine Evaluierung der beruflichen Situation von Schwerversehrten (Minderung der Erwerbsfähigkeit > 50%) zeigt, dass 69% einer Erwerbstätigkeit nachgehen, bei Schwerstversehrten (Minderung der Erwerbstätigkeit = 100%) sind es noch mehr als 60%. Konkret wurde festgestellt, dass von jenen Schwer- und Schwerstversehrten, für die in den Jahren 2012 bis 2015 Maßnahmen der beruflichen oder sozialen Rehabilitation durch die AUVA gesetzt wurden, mit Stichtag 10.02.2017 die oben genannten Anteile im Erwerbsleben stehen.

Hochspezialisierte Software-Systeme werden auf die Bedürfnisse einzelner Bereiche abgestimmt, gleichzeitig können die Anforderungen anderer Säulen mitberücksichtigt werden.

Es ergeben sich Vorteile durch die fachliche Kooperation unterschiedlicher Berufsgruppen (z.B. durch interdisziplinäre Fortbildungsmaßnahmen). Diese erleichtert durch translationale

Effekte die fachliche Zusammenarbeit über die unterschiedlichen Aufgabengebiete hinweg. Eine gesetzeskonforme Nutzung unterschiedlicher bereichsspezifischer Datenbasen aus allen 4 Säulen ermöglicht die Herleitung von bereichsübergreifendem Wissen.

5. Vorteile der bundesweiten Spartenorganisation – Beispiele

Den größten Vorteil einer bundesweiten Spartenorganisation stellt die einheitliche Umsetzung von Gesetzen, Vorschriften und anderen Regularien dar, da eine Hauptstelle die Koordination übernehmen kann.

Spezielle Aufgabengebiete können höchst effizient in Kompetenzzentren abgewickelt werden, da spezifisches Fachwissen an einer Stelle gebündelt und anderen Organisationseinheiten zur Verfügung gestellt werden kann, sodass die Versichertennähe trotzdem gewährleistet wird (z.B.: allgemeine Anfragen zur möglichen Selbstversicherung/Höherversicherung in der Unfallversicherung werden in den Landesstellen behandelt, für Spezialfragen in diesem Zusammenhang ist jedoch die Hauptstelle zuständig).

Effizienzsteigerungen innerhalb eines bundesweiten Spartenträgers kommen immer der gesamten Versichertengemeinschaft zugute. Insofern besteht ein erhebliches Interesse aller Beteiligten Synergien zu heben und die Arbeit möglichst effizient zu gestalten. So kommen Erfahrungen (z.B. best practices) aus einer dem Träger zugeordneten Landesstelle den anderen Landesstellen zugute.

Ein weiterer Vorteil ergibt sich aus der Konzentration der Ressourcen und der damit einhergehenden optimalen Verteilung der Risiken. Ein bundesweiter Träger hat mehr Mittel innerhalb seiner Bereiche zur Verfügung, als dies kleinere Träger haben können. Diese Finanzmittel können zentral verwaltet und in Abstimmung mit den dezentralen Einheiten des Trägers optimal eingesetzt werden. So kann eine große Unfallpräventionskampagne wie „Baba und fall net“ in einem bundesweiten Träger effizient und breitenwirksam umgesetzt werden.

Die Expertise, die in einer bundesweiten Sparte generiert wird, kann genutzt werden, um Standards zu setzen (z.B. Begutachtung nach Arbeitsunfällen etc.)

Innerhalb einer bundesweiten Spartenorganisation können Fragestellungen der Mehrfachversicherungen effizient gelöst werden.

6. Die Bedeutung für das österreichische Gesundheitssystem

Die medizinischen Einrichtungen der Unfallversicherung, Unfallkrankenhäuser und Rehabilitationszentren, stehen auch Freizeitunfallopfern zur Verfügung. Dieses Konzept wurde bereits seit der Errichtung des ersten Unfallkrankenhauses in den 20er Jahren des vorigen Jahrhunderts verfolgt. Dadurch konnte über hohe Fallzahlen die entsprechende Expertise entwickelt werden. Die AUVA verfügt über eine international anerkannte Kernkompetenz in der Versorgung von Schwerverletzten.
Die AUVA nimmt mit dem Unfallkrankenhaus Salzburg seit dem Jahr 2010 am Traumaregister der Deutschen Gesellschaft für Unfallchirurgie (DGU) teil.
An diesem Traumaregister beteiligen sich über 700 Kliniken – hauptsächlich aus Deutschland – sowie aus Belgien, Luxemburg, der Schweiz und Österreich

Die Ergebnisse lassen sich z.B. für das UKH Salzburg für den Zeitraum seit August 2010 folgt zusammenfassen:

Die Patienten des UKH Salzburg liegen mit einem mittleren ISS (Injury Severity Score) – ein international gebräuchliches Instrument zur Angabe des Schweregrads von Verletzungen – von 24,6 unter den Top 10 der teilnehmenden Zentren.

Die nach dem Instrumentarium des Traumaregisters erwartbare (und damit „akzeptable“) Letalität läge für das Unfallkrankenhaus Salzburg beim gegebenen durchschnittlichen IS-Score bei 15,4%. Tatsächlich liegt sie bei 11,9%.

Die Qualität der Behandlung in den UKH wird auch durch die Ergebnisse der regelmäßig durchgeführten Befragung nach nationalen Standards von Patienten bestätigt, die eine 97% Zufriedenheit mit der Behandlung angeben.

In den sieben Unfallkrankenhäusern werden jährlich ca. 58.000 operative Eingriffe durchgeführt und insgesamt ca. 365.000 Patienten ambulant und/oder stationär versorgt.
Die AUVA betreibt 867 von insgesamt rund 3.700 unfallchirurgischen Akutbetten in Österreich, das ist ein Anteil von über 23%.
Das zeigt nicht nur die große Bedeutung dieser Einrichtungen für die Unfallversorgung in Österreich, sondern macht die AUVA qualitativ und quantitativ zu einem weltweit renommierten Anbieter im Bereich der traumatologischen Versorgung.

Der Betrieb der UKH durch die AUVA bedeutet für die Krankenversicherungsträger und die Bundesländer auch finanziell eine erhebliche Entlastung.

Die Kosten des ambulanten Falls betragen im Jahr 2015 EUR 238,85, der Kostenersatz der KV-Träger dafür liegt bei EUR 137. Die Kosten des stationären Tages liegen bei EUR 835, der Kostenersatz der Krankenversicherungsträger liegt bei EUR 201 (die Abgeltung erfolgt in Form von Pauschalbeträgen, die Sätze ergäben sich durch Division dieser Beträge durch die Zahl der ambulanten Fälle bzw. stationären Tage). Die Unterdeckung durch aus der Behandlung von Patientinnen und Patienten auf Rechnung der Krankenversicherungsträger beläuft sich ambulant auf EUR 36,6 Millionen und stationär auf EUR 156,4 Millionen. Selbst wenn man jenen Betrag heranzieht, den die Krankenversicherungsträger an andere Krankenanstalten durchschnittlich für den stationären Tag zahlen (EUR 313,25), läge die Abgeltung um 27,7 Millionen höher.
Im Gegensatz zu Krankenanstalten mit Öffentlichkeitsrecht erhalten die UKH darüber hinaus keinerlei Abgangsdeckungsmittel der Bundesländer.

Für Personen mit hoher Querschnittlähmung und schweren Schädel-Hirn-Traumata stellen in Österreich nahezu ausschließlich die Zentren der AUVA adäquate Rehabilitationsplätze zur Verfügung. In den vier Rehabilitationszentren werden jährlich ca. 4.800 Patienten – mit insgesamt mehr als 180.000 Verpflegstagen – stationär behandelt, davon rund 850 Rückenmarkgeschädigte und 410 Schädel-Hirn-Verletzte. Auch in diesem Bereich wurde die Zufriedenheit der Patientinnen und Patienten mit 95% erhoben.
Die Kosten pro stationärem Tag in einem RZ liegen bei EUR 446. Die Abgeltung pro Tag liegt bei EUR 350, wobei bei diesem rechnerischen Wert zu beachten ist, dass die PV-Träger fast kostendeckend abgelten und die KV-Träger (mit einer geringeren Anzahl der Fälle) einen deutlich ermäßigten Satz zahlen. Insgesamt beträgt die Unterdeckung für die Rehabilitation von Versicherten anderer Träger rund 6,2 Millionen Euro.

Ein Abgehen vom Drei-Sparten-System würde die Rolle der AUVA in der traumatologischen Akut- und Rehabilitationsversorgung beenden. Die Akutkrankenanstalten und die Rehabilitationszentren müssten – der Logik des österreichischen Gesundheitswesens folgend – auf unterschiedliche Träger aufgeteilt werden.

Damit würden nicht nur die erwähnten Synergien des Gesamtsystems Unfallversicherung zerstört, woraus zwangsläufig ein Qualitätsverlust resultiert. Zusätzlich käme es zu erheblichen Kostenverschiebungen zu anderen Körperschaften. In Hinblick auf die angespannte budgetäre Situation mancher Spitalserhalter ist daher die Gefahr eines weiteren Qualitätsverlustes nicht auszuschließen.

Dies würde aber wiederum nicht nur dem gesetzlichen Auftrag, nämlich Unfallheilbehandlung mit allen geeigneten Mitteln – also auf dem höchstmöglichen Niveau zu garantieren – sondern auch einem Wesenselement der Unfallversicherung widersprechen.

7. Beibehalten und verbessern

Die AUVA tritt daher für die Beibehaltung des Drei-Sparten-Systems der österreichischen Sozialversicherung ein.

Innerhalb dieses Drei-Sparten-Systems soll der in der AUVA verwirklichte Grundsatz „alles aus eine Hand“ beibehalten werden. Die AUVA soll ihrer Rolle im österreichischen Gesundheitswesen weiterhin gerecht werden können.

Darüber hinaus sieht die AUVA auch Möglichkeiten zur Verbesserung des bestehenden Gesundheitssystems beizutragen.

Dazu gehört der Ausbau der bereits bestehenden Beteiligung der Unfallkrankenhäuser an der diagnostischen Versorgung der Bevölkerung (MRT, CT) und damit Reduktion der teilweise langen Wartezeiten bei gleichzeitiger Kostendämpfung für die Krankenversicherungsträger.

Die Weiterentwicklung der Primärversorgung könnte unter Nutzung der bestehenden Ambulanzinfrastrukturen der Unfallkrankenhäuser gefördert werden. Diese dienen bereits jetzt als Anlaufstellen für diverse Indikationen im Sinne der Primärversorgung.

Ein verstärktes Engagement der AUVA in der traumatologischen Akutversorgung – insbesondere dort, wo sich keine Unfallkrankenhäuser befinden – ist anzustreben.

Die führende Rolle in der traumatologischen Rehabilitation wird ausgebaut, und es erfolgt eine Anpassung an die sich ändernden Bedürfnisse der Patientinnen und Patienten (ambulante und tagesklinische Angebote).

Da die Unfallverhütung und Berufskrankheitenbekämpfung unterschiedliche Arbeitswelten betrifft, sollen Kooperationen im Sinne von „health in all policies“ mit jenen Institutionen weiter verstärkt werden, die für diese Arbeitswelten Multiplikatoreffekte erzielen (z.B.: die Verankerung des Themas Unfallprävention in der Ausbildung von Pädagogen und Pädagoginnen).

Stellungnahme für London School of Economics

bkk
Betriebs-
krankenkasse
voestalpine
Bahnsysteme

Betreff: Fragen zur Diskussionsrunde über das österreichische Sozialversicherungssystem

Sehr geehrter Herr Dr. Mossialos,

wir nehmen Ihre Einladung, unsere Sichtweisen als Betriebskrankenkasse schriftlich darzulegen, gerne an und dürfen Ihnen dazu nachstehende Stellungnahme übermitteln:

Im österreichischen Sozialversicherungssystem bestehen 5 Betriebskrankenkassen, die mit Agenden der gesetzlichen Krankenversicherung betraut sind:

- Betriebskrankenkasse der Wiener Verkehrsbetriebe (ca. 19.500 Anspruchsberechtigte)
- Betriebskrankenkasse voestalpine Bahnsysteme (ca. 13.000 Anspruchsberechtigte)
- Betriebskrankenkasse Kapfenberg (ca. 9.900 Anspruchsberechtigte)
- Betriebskrankenkasse Zeltweg (ca. 4.000 Anspruchsberechtigte)
- Betriebskrankenkasse Mondi (ca. 2.600 Anspruchsberechtigte)

Die Betriebskrankenkassen sind historisch gewachsen und im ASVG gesetzlich verankert. Sie werden im Wesentlichen durch die Krankenversicherungsbeiträge der Versicherten und die jeweiligen Betriebsunternehmen finanziert, welche gem. § 445 ASVG den Personal- und Sachaufwand tragen. Zuschüsse durch die öffentliche Hand werden nicht geleistet und sind aufgrund der gegebenen rechtlichen Rahmenbedingungen auch nicht erforderlich, zumal die jeweiligen Betriebsunternehmen eine gesetzliche Ausfallhaftung trifft.

Als kompakte, effizient strukturierte Einheiten können die Betriebskrankenkassen vor allem durch gelebte Versichertennähe, kurze und klare Entscheidungswege sowie durch individuelle Service – Leistungen am Versicherten punkten. Darüber hinaus legen die Betriebskrankenkassen auch ein besonderes Augenmerk auf die Prävention sowie auf die Förderung und Festigung der Gesundheit ihrer Versicherten.

Die von Ihnen gestellten Fragen dürfen wir wie folgt beantworten:

1.) Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Unsere Prioritäten sind:

- leichte Erreichbarkeit
- niederschwelliger Zugang
- solidarische Finanzierung
- Ausrichtung der Struktur und der Kapazitäten am tatsächlichen Bedarf der Menschen

Betriebskrankenkasse voestalpine Bahnsysteme
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Dabei sollen die demografische Entwicklung und der Gesundheitszustand der Bevölkerung ebenso berücksichtigt werden wie die Bevölkerungsentwicklung. Die Kapazitäten in den einzelnen Versorgungsregionen und in den einzelnen Versorgungsebenen orientieren sich am tatsächlichen Bedarf. Die Notfallversorgung und das Rettungswesen sind ebenfalls an diesen Kriterien ausgerichtet. Dabei steht der Gesundheitsnutzen für die Menschen im Mittelpunkt.

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2.) Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Die einzelnen Versorgungsebenen und Versorgungseinheiten müssen besser aufeinander abgestimmt werden.

- Die Patienten müssen qualitätsgesichert durch das Gesundheitssystem gelotst werden (keine Doppelgleisigkeiten, kein Drehtüreffekt, die richtige Leistung muss zur richtigen Zeit am richtigen Ort und mit der besten Qualität erbracht werden. So wird die Qualität der Versorgung verbessert, die Sicherheit für die Leistungserbringer wie auch jene für die Patienten erhöht und gleichzeitig wird dadurch gewährleistet, dass es zu keinem Ressourcenverbrauch ohne Gesundheitsnutzen für die Patienten kommt. In diesem Zusammenhang kommt den Primärversorgungseinrichtungen eine ganz wesentliche Bedeutung zu.

In sinnvoller Ergänzung zum Aufbau der Primärversorgungsstrukturen, welche wir als wichtig und unabdingbar erachten, könnten aus Sicht der Betriebskrankenkasse voestalpine Bahnsysteme auch in größeren Betrieben entsprechende Rahmenbedingungen für eine medizinische Erstversorgung geschaffen und für die konkrete Umsetzung bereits bestehende Strukturen wie Betriebskrankenkassen und Arbeitsmedizinische Zentren genützt werden. Dadurch wäre für die Mitarbeiter eine medizinische Erstversorgung bzw. eine ärztliche Erstberatung am Arbeitsplatz gewährleistet. Dem Arzt vor Ort kommt zudem eine Routingfunktion zu, d.h. er trägt dafür Sorge, dass der Mitarbeiter im Bedarfsfall zum entsprechenden Facharzt bzw. Spezialisten weiter geleitet wird.

- Die Grundlage für Entscheidungen in der Gesundheitsversorgung muss evidenzbasiertes Wissen sein. Dort wo ein solches nicht oder nicht im ausreichenden Maße vorhanden ist, wird sichergestellt, dass evidenzbasiertes Wissen im notwendigen Ausmaß und in der notwendigen Gliederung aufgebaut wird. Zur Feststellung des Gesundheitszustandes und der Entwicklung des Gesundheitszustandes der Bevölkerung, aus dessen Kenntnis erst der tatsächliche Versorgungsbedarf für die jeweilige Versorgungsregion und für die jeweilige Versorgungsebene abgeleitet werden kann, wird eine Verpflichtung zur diagnosebezogenen Leistungsdokumentation eingeführt.

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- Für alle Versorgungsebenen und für alle Versorgungseinheiten braucht es verbindliche Standards betreffend Struktur-, Prozess- und Ergebnisqualität.

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3.) Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- Die Vergütungssysteme müssen sich in Zukunft sehr stark an der Erfüllung der Prozess- und Ergebnisqualität sowie am Gesundheitsnutzen der Patienten orientieren.

4.) Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität, im jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Indem die vorhin angeführten Vorschläge realisiert werden.

Mit freundlichen Grüßen,

Betriebskrankenkasse voestalpine Bahnsysteme

Obmann | Leitender Angestellter

BRV Josef Gritz | Dir. Dr. Eduard Haider - Raimund MBA

Leoben, am 21.03.2017

Betriebskrankenkasse voestalpine Bahnsysteme
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06.04.2017

Beantwortung der Fragen im Rahmen der Effizienzstudie der London School of Economics zum Sozialversicherungssystem und Gesundheitswesen in Österreich durch das Büro der Bundesarbeitskammer

1. Was sind ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Wesentlich ist es, bei jeder Reformbemühung die Vorzüge des österreichischen Sozialversicherungs- und Gesundheitssystems zu erhalten:

Die **Pflichtversicherung** ist einer bloßen Versicherungspflicht vorzuziehen: Die klare Zuordnung der Sozialversicherten zu den zuständigen Versicherungsträgern vermeidet einen kostenintensiven Wettbewerb zwischen den Trägern um die „besten" Versicherten und bildet die Basis für die demokratisch legitimierte Selbstverwaltung.

Die **Selbstverwaltung** – also die Führung der Versicherungsträger durch demokratisch legitimierte Funktionärinnen und Funktionäre – ist ein weiteres unbedingt erhaltenswertes Element: Es hat sich gezeigt, dass eine hohe Identifikation der in der Selbstverwaltung tätigen Menschen mit den Versicherten bzw BeitragszahlerInnen besteht, was sich in entsprechendem Engagement und Praxisnähe niederschlägt.

Der **solidarischen** Mittelaufbringung – Beitragsleistung im Wesentlichen entsprechend der ökonomischen Leistungsfähigkeit der Versicherten – ist unbedingt der Vorzug zu geben vor Kopfquoten oder gar einer am jeweiligen Risiko orientierten Prämienfestsetzung (höheres Krankheitsrisiko – höhere Prämie).

Auch das Prinzip der **Sachleistungsversorgung** muss unbedingt erhalten bleiben – eine finanzielle Vorlage durch die PatientInnen mit nachträglicher Refundierung erschwert den Zugang sozial schwächerer Schichten zum Gesundheitssystem. Zusätzlich zur Sachleistungsversorgung sind die im Wesentlichen **freie Wahl** des Arztes oder sonstigen Gesundheitsdienstleisters und die möglichst weitgehende **Vermeidung von Selbstbehalten** wesentliche Elemente eines egalitären Zugangs zum Gesundheitssystem.

Ausgehend von diesen Grundsätzen ist an Prioritäten zu nennen:

- Die **Sicherstellung der weiteren Finanzierung** des Systems (insbesondere durch eine Verbreitung der Beitragsgrundlage) angesichts der Herausforderungen durch demographische Verschiebungen (längere Lebenserwartung, steigender Älterenanteil), Erosion der Beitragsgrundlagen (prekäre und Teilzeitbeschäftigung, Arbeitslosigkeit) und medizinischen Fortschritt.

- Weitere **Modernisierung** der Gesundheitsversorgung, **Schließung von Systemlücken**.

- Erhöhung der **Effektivität** und **Effizienz** des Systems insbesondere an den **Schnittstellen** zwischen den verschiedenen Playern.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Ein Problem wird durch die **geteilte Kompetenzlage** betreffend mehrere gesundheitsrelevante Handlungsfelder zwischen Bund (Sozialversicherung) einerseits und den Bundesländern (Behindertenwesen, Sozial-, Familien- und Jugendhilfe) andererseits gebildet: So entstehen etwa überschneidende Zuständigkeiten für die Betreuung von Gesundheits- und Entwicklungsproblemen von Kindern und Jugendlichen, die und deren Eltern dann zwischen Landesbehörden und Sozialversicherungsträgern hin und hergeschickt werden. Eine Vereinheitlichung der Kompetenzen erscheint illusorisch, aber zur Verbesserung der Situation ist ein **one-stop-shop-System** anzustreben. Ein solches System wäre auch für pflegebedürftige Personen bzw deren Angehörige sinnvoll, um im oft auch plötzlich eintretenden Pflegefall das nicht immer übersichtliche Pflegeangebot niederschwellig zugänglich zu machen.

Ein anderes **Kompetenzproblem** besteht darin, dass die Länder im Wesentlichen hauptzuständig für den **Spitalsbereich** sind, während die Sozialversicherung die **niedergelassene Versorgung** organisiert. Beide Seiten profitieren nach der jetzigen Kostenteilung davon, wenn PatientInnen im jeweils anderen Sektor

behandelt werden – ein Anreiz dafür, PatientInnen nicht im jeweils versorgungstechnisch und gesamtwirtschaftlich sinnvollsten **best point of service** zu behandeln. Die denkbare Forderung, einer Seite die gesamte Versorgungsverantwortung zu übertragen („**Versorgung aus einer Hand**"), erscheint jedoch unrealistisch und überzogen. Sinnvoller ist es vielmehr, den bereits eingeschlagenen Weg der **Gesundheitsreform** (gemeinsame Zielsteuerung des Gesundheitswesens) konsequent fortzusetzen.

Das System neigt – vor allem wegen der überstarken gesetzlichen Position der ärztlichen Vertragspartner und deren Interessenvertretungen – stark dazu, die investierten Mittel bei den historisch gewachsenen Leistungskatalogen so zu binden, dass eine **Verschiebung zu mittlerweile entstandenen Bedürfnissen blockiert** wird. Überhaupt wird das Leistungsgeschehen nicht von den Zahlern und VersichertenvertreterInnen (also der Selbstverwaltung), sondern von den Anbietern dominiert. Damit ist es insbesondere für die Sozialversicherungsträger mit ihrem ohnehin unter Druck stehenden Beitragsaufkommen äußerst schwierig, das Leistungsangebot systematisch zu modernisieren und zu vervollständigen, sodass in manchen Gebieten Verbesserungsbedarf besteht: Mehr Prävention statt des überdominanten kurativen Ansatzes, besserer Zugang zu Psycho- und den funktionalen Therapien, eine gewisse Wartezeitenproblematik bei manchen diagnostischen und therapeutischen Verfahren, hohe Selbstbehalte bei Heilbehelfen und Hilfsmitteln, wie zB bei Rollstühlen und Sitzschalen für spastisch Gelähmte – siehe die oben geschilderte Schnittstellenproblematik zwischen Krankheit und Behinderung.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

und

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Ein wichtiger Faktor ist die **Stärkung der Sozialversicherungsträger im Verhältnis zu den** – vor allem ärztlichen – **Anbietern** bzw deren Interessenvertretungen. Dass – ähnlich einem Kollektivvertragssystem – die Einkommen der DienstleisterInnen mit den Sozialversicherungsträgern durch kollektive Interessenver-

tretungen verhandelt werden, dient dem Schutz des als einzelnen Verhandlungspartner Schwächeren und ist in Ordnung. Dass diesem System aber nicht nur die Preisbildung, sondern auch das Leistungsangebot (wo erbringt welche Fachrichtung welche Angebote) unterworfen wird, konterkariert jede rationale Gesundheitsplanung und stellt die Standesinteressen der Anbieter vor die Versorgungsinteressen der Versicherten.

In diesem Zusammenhang sind als zu bereinigende Problemlagen auch zu nennen: Die notwendige Umstellung der derzeitigen Abrechnungserlaubnis („Speisekartensystem“) von Einzelleistungen auf einen **umfassenden Versorgungsauftrag** gegenüber den PatientInnen; die Verschiebung der **Qualitätskontrolle** der Anbieter von deren eigener Interessenvertretung (derzeit kontrollieren sich die Anbieter selbst!) auf eine unabhängige Stelle; und die Zulassung von **mehr Wettbewerb** (derzeit hat die Ärztekammer eine Vetomöglichkeit gegen in der Wirtschaftskammer organisierte Anbieter ärztlicher Leistungen).

Eine Unterstützung des Versorgungsauftrags der Sozialversicherungsträger und der Modernisierung des Leistungsangebots könnte in der Schaffung einer **„golden rule“ für Investitionen in die Zukunft** liegen. Die Träger sind angehalten, auf das Kalenderjahr bezogen ausgeglichen zu haushalten. Derzeit nicht aus eigenem ausreichend finanzierbare Investitionen in Angebote für Versicherte und Angehörige, die deren zukünftige gesundheitliche Entwicklung wesentlich verbessern könnten (insbesondere die Lückenschließung in der psychosozialen und funktionalen Versorgung Kinder und Jugendlicher sowie in Prävention und beruflicher Rehabilitation) würden sich mittelfristig im Gesundheitssystem, aber auch auf dem Arbeitsmarkt – und damit im Beitragsaufkommen – mehr als rechnen. Die Erlaubnis, das Ziel einer ausgeglichenen Gebarung bezüglich solcher Investitionen erst über längere Zeiträume hinweg zu erreichen, könnte damit mittelfristig nicht nur die Versorgung verbessern, sondern auch zur finanziellen Systemstabilität mehr beitragen als der kurzfristige Blick. Dass die Sozialversicherungsträger dazu befähigt wären, zeigen sie zB in bemerkenswerten Pilotprojekten im Rahmen ihrer „Kinder- und Jugendgesundheitsstrategie“, etwa mit einem Programm „Früher Hilfen“, das die Chancen von Kindern mit schwierigen gesundheitlichen Startbedingungen auf eine gesunde Entwicklung massiv verbessern kann.

Zur Steigerung der Effizienz des Systems ist eine konsequentere und systematischere **Primärversorgung** durch den niedergelassenen, allgemeinmedizinischen Bereich erforderlich (derzeit werden zu viele Leistungen im teureren Spitalsbereich erbracht). Wartezeiten bei niedergelassenen FachärztInnen deuten darauf

hin, dass diese zu schnell und ohne Notwendigkeit den HausärztInnen vorgezogen werden. Der jetzt begonnene systematische Einsatz von multiprofessionellen **Erstversorgungszentren** rund um ein allgemeinmedizinisches Angebot mit wesentlich besseren Öffnungszeiten als die typische Einzelpraxis ist daher rasch und konsequent auszubauen. Wichtig ist dabei auch, dass der Grundsatz „**Geld folgt der Leistung**" eingehalten wird, also die Entlastung des Spitalsbereichs und seiner Ambulanzen eine entsprechende Mittelverschiebung zur Konsequenz hat. Dafür ist – wie schon oben festgestellt – die **konsequente Fortsetzung der Gesundheitsreform** die geeignete Grundlage.

Vor allem wegen einer ungleichen Verteilung der Versichertengruppen, was Einkommen und Gesundheitsrisiken betrifft, können derzeit einzelne Träger hohe Rücklagen bilden, während andere kaum ausgeglichen gebaren können bzw wünschenswerte Versorgungsergänzungen nicht finanzieren können. Hier bedarf es eines **umfassenderen Risikostrukturausgleiches** als er nach derzeitigem Recht vorgesehen ist. Mitzubedenken ist dabei auch, dass den Gebietskrankenkassen Versichertengruppen zugewiesen sind (Arbeitslose, Asylwerber), bei denen klar ist, dass angesichts der gesetzlich vorgegebenen Beitragsgrundlagen keine Beitragsdeckung besteht.

Hohe Qualität im Gesundheitswesen erfordert auch **gute Ausbildung und gute Arbeitsbedingungen für die dort Beschäftigten**. Aufgrund der Arbeitszeitvorgaben der EU sind kürzlich die erlaubten Arbeitszeiten der in den Krankenanstalten beschäftigten Ärzte von durchschnittlich 60 auf 48 Wochenstunden reduziert worden. Die dadurch entstandenen Einkommensverluste sind zu einem guten Teil kompensiert worden, sodass bei verringerten Arbeitszeiten die Stundenlöhne gestiegen sind. Im Rahmen der jüngst stattgefundenen Reform der Pflegeberufe sind (ohne zu den ÄrztInnen vergleichbare Einkommenssteigerungen) deren Kompetenzen teilweise verschoben und erweitert worden, sodass sehr darauf zu achten sein wird, dass die Verteilung von Arbeitsaufgaben und Einkommen innerhalb der Gesundheitsberufe gerecht und funktional gestaltet wird, damit es nicht zu Demotivierung und negativen Arbeitsanreizen kommt. Ein wichtiger Monitor und damit Steuerungsinstrument für den Einsatz der Angehörigen der verschiedenen Gesundheitsberufe wird die ab Sommer 2018 vor allem (nämlich im unselbständigen, nicht-ärztlichen Bereich) von den Arbeiterkammern durchzuführende **Registrierung der Gesundheitsberufe** sein, für die die Politik entsprechende legistische und organisatorische Rahmenbedingungen zu schaffen hat.

From: janine.plank@bgkk.at <janine.plank@bgkk.at> on behalf of bgkk@bgkk.at <bgkk@bgkk.at>
Sent: 14 March 2017 12:11
To: David.Mum@sozialministerium.at; Thalmann,IN
Subject: Effizienzstudie

Sehr geehrte Damen und Herren,

nachstehend die Antworten der BGKK auf Ihre Fragen vom 27. Feber 2017 sowie einige Anmerkungen:

1. Die Prioritäten im Gesundheitswesen sind unserer Meinung das Absichern des erreichten Standards der Versorgung der Bevölkerung mit Gesundheitsleistungen unter den wider- sprüchlichen Rahmenbedingungen einer einseits steigenden Kostenintensität durch den medizinischen Fortschritt und durch teurere Strukturen und andererseits limitierter Budgetmittel. Die Ziele, die Politik, Bevölkerung und Stakeholder verfolgen, weichen stark voneinander ab. Wie überall sind verstärkte Egoismen festzustellen, die eine gemeinsame Verantwortung für diesen Bereich zunehmend erodieren lassen.

Mit der neuartigen Primärversorgung sollen Strukturen geschaffen werden, die der Bevölkerung auch in Zukunft eine qualitativ hochstehende Versorgung garantieren. Inwieweit diese Form der geplanten Primärversorgung auch in ländlichen Gebieten umsetzbar ist, wird sicherlich noch Stoff für Diskussionen sein. Hier eine klare Linie zu zeichnen, wäre eine prioritäre Aufgabe der Gesundheitspolitik.

2. Der Gedanke einer neustrukturierten Primärversorgung ist nicht ausreichend durch gesetzliche Maßnahmen präsent. Inwieweit eine weitgehende Freiwilligkeit bei der Umsetzung - insbesondere durch die Ärzteschaft - eine erfolgreiche Entwicklung beeinträchtigt, wäre zu beachten.

Grundsätzlich befürchten wir, dass die Arbeit am und mit dem Patienten zunehmend zugunsten von Dokumentation und Administration in das Hintertreffen gerät. Es fehlt an Ressourcen für die Arbeit am Patienten - das betrifft weniger die medizinische Versorgung als vielmehr die pflegerische Komponente. Grundsätzlich mangelt es bei der Pflege sowohl im stationären (medizinischen) Bereich, als auch im Alter an Geld und Personal. Ausländische Pflegerinnen zum Billigtarif können sicher keine Dauerlösung sein!

3. Ein großer Problembereich ist der Nachwuchs an Ärzten, von dem sowohl die stationäre als auch der niedergelassene Bereich betroffen ist. Die neue Ausbildungsordnung für Ärzte benachteiligt die Ausbildung zum Allgemeinmediziner, die aber für eine funktionierende Primärversorgung unverzichtbar sind.

Die Dualität bzw. Parallelität Sozialversicherung und Länder begünstigt Ressourcenverschwendung.

Die unterschiedlichen Finanzlagen der Krankenkassen bedingen unterschiedliche Entwicklungs- geschwindigkeiten beim Ausbau des Leistungsspektrums.

4. Keine Antwort

Zur Thematik "Gleiche Beiträge - gleiche Leistungen" weist die Burgenländische Gebietskrankenkasse darauf hin, dass es derzeit für die Kassen entgegen vielfacher Aussagen **keine** gleichen Beiträge gibt, sondern nur gleiche Beitragssätze. Da aber die Beitragsgrundlagen (abhängig vom regionalen Lohnniveau) deutlich unterschiedlich sind (Burgenland: € 2.271,-, Österreichschnitt: € 2.688,-, Stand: 2015 inkl. Sonderzahlungen), wirkt sich das spürbar auf die Einnahmen aus. Hätte die BGKK durchschnittliche Beitragsgrundlagen, so wären die Beitragseinnahmen bei den Erwerbstätigen um ca. 31 Mio. Euro höher, das entspricht 8,5 % der Gesamtaufwendungen. Diese Mindereinnahmen werden auch bei weitem nicht durch den Ausgleichsfonds kompensiert. Finanzschwache Kassen wie die BGKK sind daher - im Sinne einer einnahmeorientierten Ausgabenpolitik - gezwungen, im Leistungsbereich strengere Maßstäbe als andere Kassen anzulegen. Das betrifft sowohl den Leistungsumfang im Pflichtleistungsbereich (geringere Anzahl an Einzelleistungspositionen) als auch die Leistungen im Ermessensbereich.

Ein weiterer Bereich, der von den Versicherten als Leistungsunterschied wahrgenommen wird, sind die unterschiedlichen Beträge, die bei Kostenerstattungen nach Wahlarztbehandlungen refundiert werden. Die Höhe der Kostenerstattungen hängt ab von den zugrunde liegenden Tarifsätzen, die zwischen den Kassen zum Teil deutlich unterschiedlich sind. Beseitigt könnte diese Problematik nur durch die Anpassung der unterschiedlichen Honorarordnungen werden, was in letzter Konsequenz die weitgehende Abschaffung der

Trägerautonomie bedeuten würde.

Freundliche Grüße

Obmann Hartwig Roth
Dir. Mag. Christian Moder

Allgemeines Statment von MTD-Austria zur Sozialversicherungseffizienzstudie

März 2017

Dachverband der gehobenen medizinisch-technischen Dienste Österreichs

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1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Starker Fokus auf kurativmedizinischem Ansatz
- Hierarchie innerhalb der Gesundheitsberufe, an der Spitze der/die Arzt/Ärztin (Ärztegesetz mit der Berechtigung zur gesamten Heilkunde). Wünschenswert ist ein Einsatz orientiert an in formalen Qualifikationsprozessen erworbenen Kompetenzen
- Chefarzt/ärztin als Gatekeeper/Regelung der Kosten durch die KK nach wirtschaftlichen und nicht fachlichen Aspekten
- Abrechnungsmöglichkeiten für alle gehobenen medizinisch-technischen Dienste Österreichs dh Aufnahme von DiätologInnen, OrthoptistInnen, RadiologietechnologInnen und Biomedizinsche AnalytikerInnen in das ASVG, §135
- Da die Primärversorgung erst im Entstehen und die definitive Rolle der Berufsgruppen innerhalb des Teams noch nicht klar ist, kann hier noch keine Priorität dargestellt werden. Wünschenswert ist ein Einsatz orientiert an in formalen Qualifikationsprozessen erworbenen Kompetenzen

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Gesundheitsförderung und Prävention
- Empowerment und Health Literacy (Aufklärung über Wechselwirkung von Behandlung und Medikation)
- HIAs
- Geregelte und standardisierte Kommunikation
- Strukturierte PatientInnen- Führung und Behandlungspfade - nach gesetzlich definiertem Behandlungsbedarf und Behandlungswegen
- Einsatz von Health Professionals gemäß den erworbenen Kompetenzen/Fähigkeiten anstelle eines Denkmusters, das davon ausgeht, dass je höher der formale Qualifikationsgrad ist, umso höher auch die Fähigkeit/Kompetenz in einem Fachbereich ist
- Abrechnungsmöglichkeiten für alle gehobenen medizinisch-technischen Dienste Österreichs dh Aufnahme von DiätologInnen, OrthoptistInnen, RadiologietechnologInnen und Biomedizinsche AnalytikerInnen in das ASVG, §135

Allgemeines Statment von MTD-Austria zur Sozialversicherungseffizienzstudie

März 2017

Dachverband der gehobenen medizinisch-technischen Dienste Österreichs

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3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- siehe Pkt. 2
- Übersicht über Behandlungen, einsehbar für Health Professionals
- Doctor Shopping/TherapeutInnen Hopping ohne Einbeziehung von anderen Health professionals (Diagnostics and Therapeuticts) – möglicherweise Doppeluntersuchungen/-behandlungen und derzeit keine Regelung dazu
- Herausforderung demographische Entwicklung - ältere, betagte und hochbetagte Personen sowie MigrantInnen

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Vermeidung von Doppelgleisigkeiten (Bsp: Sturzassessment Pflege, Ergotherapie, Physiotherapie) in Befundung inklusive validen Assessments, Anamnese und Dokumentation aber Ergänzung in relevanten Detailfragen (multiprofessionell, mit Ergänzungen aus dem jeweiligen Fachbereich, sowie Medikation seitens des/der Arztes/Ärztin)
- Standards definieren, verbindlich machen und honorieren (Befundung, Fallbesprechungen, Angehörigenberatung und Schulung, aber auch Fallführung)
- Rahmenbedingungen für standardisierten, multiprofessionellen, strukturellen Austausch schaffen
- Erhöhte Kompetenzeinräumung für „nicht-ärztliche Gesundheitsberufe“ und Kommunikation darüber den PatientInnen gegenüber →z.B. Erhöhung des Behandlungserfolgs durch frühzeitige diagnostische und therapeutische Interventionen in Bezug auf Vorbereitung auf OPs, Nachsorgeschemata
- PatientInnenzentrierung sowie Orientierung an Krankheitsbildern und Symptomkomplexen
- Leitlinienkonformes Arbeiten und entsprechender Einsatz der Health Professionals
- integrierte Patientendokumentation zu der alle Health Professionals beitragen orientiert am definierten übergeordneten Behandlungsziel inklusive ICD Codierung und Anwendung der ICF
- Stringenter, fairer und chancengleicher bundesweiter Zugang zu Sachleistungen und Regelung von Kostenzuschüssen bzw. Kostenerstattung
- Siehe Pkt.2
- Ressortübergreifendes Arbeiten von Ministerien und Gremien
- Abbau von Bürokratismus und vereinfachter Zugang für PatientInnen zu notwendiger Diagnostik und Therapie

1. **Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?**

- Entlastung von Spitalsambulanzen
- Entlastung von krankenhausinternen Laboren
- Fokus Gesundheitsförderung/Prävention, gerade im Hinblick auf die Zunahme von Lifestyle Diseases (Diabetes II, KHK, Hypertonie etc.)
- Optimale Ausschöpfung bereits vorhandener Ressourcen

2. **Gibt es bestimmte Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?**

- Legitimierung aller MTD-Berufe zur Mitarbeit in der Gesundheitsförderung/Prävention
- Legitimierung aller MTD-Berufe im erweiterten PHC-Kernteam
- Wegfall der ärztlichen Anordnung für bestimmte Routineuntersuchungen und -leistungen

3. **Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?**

- **Direkte Abrechnung von Leistungen mit der SV muss für alle MTD-Berufe möglich sein** - Begründung: Mündige PatientInnen, im Speziellen jene mit chronischen Erkrankungen, wissen gut darüber Bescheid, welche Medikamente, Therapien und Untersuchungen sie in regelmäßigen Abständen benötigen. Für diese PatientInnenklientel wäre es eine immense Entlastung und Erleichterung, wenn diese Leistungen auch ohne vorherige ärztliche Überweisung zugänglich wären.
- **Beispiel Biomedizinische AnalytikerInnen:** Jede/r chronisch kranke PatientIn muss bestimmte Laborwerte (z. B. HbA1c für DiabetikerInnen) in vorgesehenen Intervallen kontrollieren lassen. Diese Parameter werden von Biomedizinischen AnalytikerInnen gemessen und ausgewertet. Auf lange Sicht könnten vor allem FachärztInnen für Allgemeinmedizin nachhaltig entlastet werden, wenn nicht für jede Laboruntersuchung eine eigene Überweisung erforderlich wäre und Biomedizinische AnalytikerInnen ihre Leistungen direkt mit der Sozialversicherung abrechnen könnten.

4. **Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität im derzeitigen österreichischen Sozialversicherungssystem weiter verbessert werden?**

- Befundausgabe an PatientInnen ohne zeitliche Verzögerung (ist das Warten auf eine ärztliche Vidierung wirklich immer erforderlich/sinnvoll?)
- PatientInnen müssen Sicherheit darüber haben, dass ihre Gesundheitsleistungen von qualifiziertem Fachpersonal erbracht wurden: Nachvollziehbarkeit des Leistungserstellers muss gewährleistet sein!
- Kompetenzerweiterung für nicht-ärztliche Gesundheitsberufe: s. Best Practice Modelle in Skandinavien und im anglosächsischen Raum

Ort und Datum: Wien, am 10.03.2017
Autorin: Mag. Birgit Luxbacher, BSc, Geschäftsführerin von biomed austria – Österreichischer Berufsverband der Biomedizinischen AnalytikerInnen

DIAETOLOGEN

Verband der Diaetologen Österreichs

Studie zum österreichischen Sozialversicherungssystem - Fragenkatalog

Einleitung

Ernährungsbedingte Erkrankungen wie Adipositas, Diabetes, Herz-Kreislauferkrankungen sind für unsere Gesellschaft und die Gesundheitspolitik eine große Herausforderung. Die Prävention und Therapie dieser Erkrankungen sind national und international ein wichtiger gesundheitspolitischer Faktor (NAP.e, 2013).

DiaetologInnen sind gesetzlich anerkannte ErnährungsexpertInnen und sie unterstützen Menschen bei Ernährungsproblemen aller Art. Sie werden bei sämtlichen ernährungsrelevanten Problemstellungen sowohl in Therapie als auch Prävention eigenverantwortlich eingesetzt.

Die Bedeutung einer richtigen Ernährung für die Gesunderhaltung des menschlichen Körpers ist heute unbestritten. Im Rahmen von zahlreichen Erkrankungen, beispielsweise des Stoffwechsels, des Gastrointestinaltrakts, bei Herz-Kreislauferkrankungen, Allergien und Unverträglichkeiten, Lungenerkrankungen (COPD) Übergewicht und Adipositas, Mangelernährung, Nierenerkrankungen, Schluckstörungen und onkologischen Erkrankungen sind ernährungstherapeutische Maßnahmen unerlässlich und ein wesentlicher Bestandteil des Behandlungskonzeptes. Die Planung, Durchführung und Evaluierung von Ernährungstherapien zählen zu den wichtigsten Aufgaben. DiaetologInnen arbeiten in multidisziplinären Teams.

Die ernährungstherapeutische Behandlung von Menschen verlangt ein hohes Wissen und ist mit einer großen Verantwortung verbunden. Heutzutage sind die Menschen zunehmend verunsichert aufgrund der Vielfalt von Ernährungsinformationen und selbsternannten Ernährungsexperten. Umso wichtiger erscheint es, ausgewiesene ErnährungsexpertInnen einzusetzen, die über die erforderlichen Kompetenzen verfügen.

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

1.1. Die Prioritäten liegen bei der **kurativen Medizin.** Laut European Observatory on Health Systems and Policies gehört Österreich zu jenen Ländern mit den niedrigsten Ausgaben für Prävention und Gesundheitsförderung:

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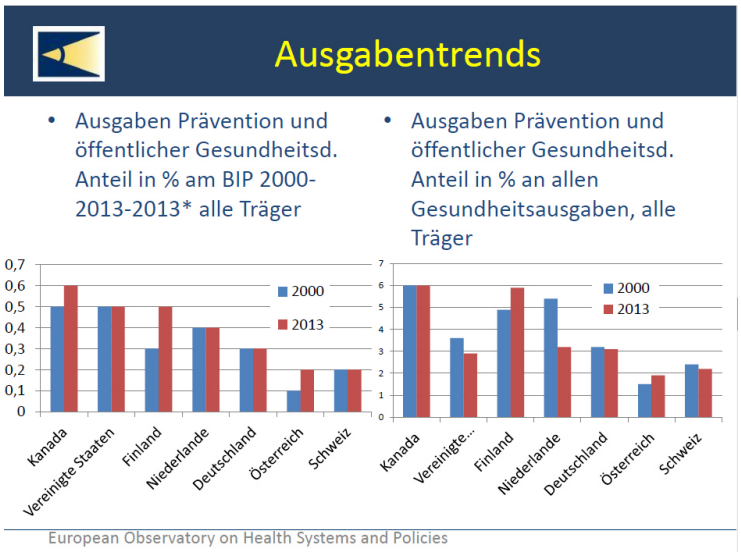

1.2. die **Primärversorgung** existiert erst in Ansätzen. Ein Ausbau und eine Stärkung des multidisziplinären Angebots ist dringend erforderlich.

DiaetologInnen (Dietitians) können im Bereich der PHC einen wesentlichen Beitrag für die Verbesserung von Gesundheit und Lebensqualität der PatientInnen leisten und auch dazu beitragen, Gesundheitskosten zu senken (Howatson et al, 2015).

Diese Leistungen können sowohl im zentralen PHC-Setting als auch im PHC-Netzwerk erbracht werden.

- Durchführung des diaetologischen Prozesses, Screening
- Therapieplanung,
- Beratung und Schulung von PatientInnen und deren Angehörigen
- Verlaufskontrolle
- Diabetesschulung und –beratung
- Gruppenschulungen
- Gewichtskontrolle, -Verlauf, BIA Messungen
- Multiprofessionelle Fallbesprechungen
- Qualitätsmanagement
- Hausbesuche bei pflegebedürftigen Menschen

Erweiterte Leistungen im Bereich der Gesundheitsförderung und Prävention

- Planung und Durchführung von Ernährungsprojekten in Kindergärten, Schulen, Mutter-Kind-Zentren, geriatrischen Einrichtungen, etc.

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- Betriebliche Gesundheitsförderung: Beratung und Schulung von MitarbeiterInnen in ernährungsrelevanten Problemstellungen, Beratung der Gemeinschaftsverpflegungs-einrichtung, Speiseplangestaltung;
- Ernährungsworkshops, Kochworkshops und Seminare für div. Zielgruppen

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Ernährungstherapie MUSS für Alle leistbar werden

Die ernährungstherapeutische Versorgung von Menschen mit Ernährungsproblemen ist im derzeitigen Sozialversicherungssystem nicht als Leistung definiert. Diaetologische Interventionen / Leistungen (z.B. Ernährungs- und Diätberatung) müssen von PatientInnen selbst bezahlt werden. Dadurch ist Ernährungstherapie für viele Menschen nicht leistbar. Insbesondere zum Tragen kommt diese Tatsache bei sozial Schwachen, AlleinverdienerInnen, AlleinerzieherInnen, älteren und alten Menschen und schwer erkrankten bzw. pflegebedürftigen Menschen. Eine Gleichstellung der Leistungserbringung durch DiaetologInnen (§ 135 Abs. 1 Z1 ASVG) ist unerlässlich.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

3.1. Alle großen Studien zu nichtübertragbaren Erkrankungen fokussieren bezüglich Verhältnisprävention auf Instrumente wie Steuergesetzgebung, Gesundheitsförderung in verschiedensten Settings etc., aber in der Verhaltensprävention immer auf Stärkung der Gesundheitskompetenz der/des Einzelnen in Sachen Ernährung und Bewegung. Informations-Kampagnen und das Verteilen von Broschüren sind wichtig für die Bewusstseinsbildung. Letztlich muss Ernährungs- und Bewegungsberatung aber eine Versicherungsleistung sein, damit sie niederschwellig von den Risikopersonen auch in Anspruch genommen wird. Diese Menschen erreicht man mit Kampagnen bekanntlich kaum. Sie gehen aber zum Arzt und könnten sowohl präventiv als auch kurativ niederschwellig zu Ernährungs- und Bewegungsberatung überwiesen werden, wenn diese bezahlt wird.

3.2. Mangelernährung ist eine bekannte Tatsache in Krankenhäusern und Pflegeheimen. 20 – 60 % aller hospitalisierten PatientInnen sind mangelernährt[1] (Norman et al. 2008; Roller et al 2015). In Pflegeheimen sind es 23 – 85 % (Valentini et al 2009; Schönherr et al 2014). Die Folgen sind längere Liegedauer, höhere Komplikationsraten, höhere Wiederaufnahmeraten, sowie erhöhte Morbidität und Mortalität, verminderte Lebensqualität. Die Kosten, die durch Mangelernährung verursacht werden, belaufen sich auf 2,1 % bis 10 % der nationalen Gesundheitsausgaben (Khalatbari-Soltani et al. 2015); Investitionen von € 5,4 Mio in Ernährungsinterventionen würde 50 Mio pro Jahr sparen (Elia et al. 2005). Der Einsatz von DiaetologInnen im klinischen und Pflegebereich spart Kosten und gibt Sicherheit in der PatientenInnenversorgung.

[1] Abhängig von der Station und der verwendeten Definition

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3.3. Herausforderung demografische Entwicklung: Anstieg der älteren, betagten und hochbetagten Menschen sowie Menschen mit Migrationshintergrund.
Mit zunehmendem Alter steigen ernährungsbezogene Probleme, die die Entstehung von Mangel- und Fehlernährung begünstigen. Die Anfälligkeit für viele Erkrankungen steigt (Infektionen, schlechtere Wundheilung, kognitive Defizite). Pflegebedürftigkeit und Spitalsaufenthalte steigen.
Durch Screenings und dementsprechende diaetologische Maßnahmen können diese Entwicklungen positiv beeinflusst werden, was wiederum zu mehr Lebensqualität der Betroffenen und weniger Kosten im Gesundheitssystem führt.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

4.1. gut ausgebildetes Personal, das nicht nur medizinisch-therapeutisch, sondern auch sozialkommunikativ kompetent ist.

4.2. finanzielle Ressourcen für Innovationen: unser Gesundheitssystem muss sich den Anforderungen der sich laufend verändernden Rahmenbedingungen anpassen. Mit Innovationen sind hier jedoch technische Innovationen erst in zweiter Linie gemeint, diese finden laufend statt. Die Innovation muss sich auf die Settings beziehen, in denen sich die Menschen bewegen. Beispiel: ein niedergelassener Kinderarzt, der sich jeden Tag am zeitlichen Limit bewegt, muss auch noch Ernährungsberatung durchführen, weil es derzeit niemanden gibt, der ihm diese Tätigkeit qualifiziert abnehmen kann. Eine Diaetologin, die regelmäßig in der Praxis als Ansprechpartnerin da ist, kann den Arzt entlasten und gleichzeitig entsprechende Präventions- und Kurationsleistungen erbringen.

Ansprechperson:
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Literatur bei Verfasserin

Stellungnahme Ergotherapie Austria

Ergotherapie Austria, die freiwillige Interessenvertretung der Ergotherapeutinnen und Ergotherapeuten in Österreich bedankt sich für die Möglichkeit, unsere Ideen und Vorstellungen beim Review of Austria's Social Insurance System einzubringen.

1. *Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?*
   - *Derzeit starker Focus auf Ärzteschaft, andere Gesundheitsberufe werden nicht gleichwertig wahrgenommen und auch nicht entsprechend ihrer ExpertInnenexpertise berücksichtigt*
   - *Der Zugang zum Gesundheitssystem ist für alle Patienten in allen Ebenen möglich, Patienten mit hoher Kompetenz können alle Möglichkeiten nutzen, Patienten mit geringerer Kompetenz können die komplexen Strukturen nicht verstehen und oft auch nicht adäquat nutzen*

2. *Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?*
   - *Die flächendeckende Versorgung im extramuralen Bereich mit allen therapeutischen Leistungen ist derzeit nicht gegeben. Je nach Gebietskrankenkasse werden unterschiedliche Sachleistungen angeboten, auch die Kostenrückerstattungen sind sehr unterschiedlich. Da für die PatientInnen keine Wahlmöglichkeit in Bezug auf ihre Krankenkasse möglich ist, müssen sie die Leistungen ihrer Kasse so hinnehmen, ohne Möglichkeit zu wechseln. Es gibt sehr große regionale Unterschiede für PatientInnen im Bereich der Ergotherapie, so ist Ergotherapie als Sachleistung in der Steiermark, in Kärnten und Vorarlberg nicht möglich, in Wien und im Burgenland werden die Leistungen aus einem von der GKK vorgegebenen Poolkontingent bespielt und dadurch gedeckelt. Die Anzahl der Poolstunden in Wien entspricht bei weitem nicht dem tatsächlichen Bedarf.*
   - *Für die Ergotherapie und andere therapeutische Leistungen gibt derzeit noch keine politische Einigung, welche Leistungen in der Primärversorgung und welche Leistungen von einer spezialisierten ErgotherapeutIn oder anderen TherapeutInnen erbracht werden sollen.*
   - *Die Finanzierung von präventiven und gesundheitsförderlichen Massnahmen findet nur sehr eingeschränkt statt.*
   - *In der Primärversorung werden die erweiterten Angebote, abgesehen von DGKP und Ordinationsassistenz, durch den Arzt vorgegeben. Welche*

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Health Professionales er sich dazu holt, liegt in seinem Ermessen, wodurch keine Garantie für PatientInnen gegeben ist, alle möglichen Leistungen zu erhalten.

3. *Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?*

   - *Deutliche Stärkung der Prävention und Gesundheitsförderung durch gesetzlichen Anspruch dieser Leistungen*
   - *Obwohl alle Leistungen für PatientInnen gegeben sind, ist der Zugang oft durch komplizierte Zugangswege erschwert. PatientInnen mit geringer Kompetenz können dadurch nicht alle für sie erforderlichen Therapien ausfindig machen, eine Vereinfachung der Wege durch das System ist erforderlich oder eine flächendeckende Betreuung durch Case Manager notwendig.*
   - *Die Trennung der Bereiche „Krankheit" und „Behinderung" sind in vielen Fällen, vor allem bei Kindern mit angeborenen Behinderungen, sehr unscharf und sowohl für Eltern als auch TherapeutInnen nicht nachvollziehbar. Während Untersuchungen beim Kinderarzt sehr wohl über die Sozialversicherung abgerechnet werden können, fallen viele Therapien unter den Begriff „Behinderung" und müssen dadurch über das zuständige Bundesland abgewickelt werden, wodurch der Zugang zu Therapien erschwert wird.*
   - *Im Bereich von PatientInnen mit Demenz wird oftmals eine Erhaltung des Ist-Zustandes nicht als therapeutisches Ziel anerkannt. Da aber bei diesen aber auch anderen chronisch erkrankten Menschen keine Verbesserung möglich ist, werden wichtige Therapien nicht bewilligt und bezahlt, sodass eine Verschlechterung noch schneller erfolgt.*
   - *Die Leistungen in der Primärversorung sind nicht nach „Muss" oder „Kann" Leistungen definiert. Ebenso sind im therapeutischen Bereich noch keine Leistungen definiert, die eindeutig der Primärversorung zufallen oder aber eine Spezialisierung - ebenfalls in der extramuralen Versorgung – benötigen.*

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

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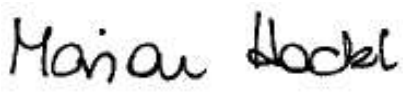
- Einheitliche Dokumentation und festgelegte Kommunikationswege verpflichtend für alle Beteiligten
- Evidenzbasierte medizinische Versorgung und Therapie

Mit freundlichen Grüßen,



Marion Hackl
Präsidentin Ergotherapie Austria

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logopädieaustria

Gedankensplitter zur in Auftrag gegebenen Studie der österreichischen Sozialversicherungsträger aus Sich der österreichischen Logopädie
(März 2017)

Die österreichischen Logopädinnen und Logopäden sind die Expertinnen und Experten für das Atmen, die Stimme, das Sprechen, die Sprache, das Hören, das Schlucken, das Lesen und das Schreiben. Daher sind unsere Kernaufgaben die Prävention, Beratung, Untersuchung, Diagnose, Therapie, Rehabilitation und wissenschaftliche Erforschung von Störungen und Behinderungen der Sprache, des Sprechens, der Atmung, der Stimme, der Mundfunktionen, des Schluckens, des Hörvermögens und der Wahrnehmung, die bei allen Altersgruppen auftreten können.

1.Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Neben der wohnortnahen Zugänglichkeit und einer verbesserten Versorgungskoordination steht die Stärkung der Gesundheitskompetenzen der Bevölkerung im Mittelpunkt, damit eine. best point of service Versorgung möglich werden kann. Für die Logopädie bedeutet dies, dass eine zeitnahe Diagnostik von logopädischen Problemen für ALLE Betroffenen möglich wird und eine (wenn nötige) Indikationsstellung rasch zur Anwendung von logopädischen Maßnahmen führt.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Aus Sicht der Logopädie ist es zurzeit so, dass (besonders im ländlichen Raum) eine ausreichende und zweckmäßige logopädische Versorgung nicht gegeben ist. Dies zeigt sich derzeit bereits im intramuralen Bereich, hat jedoch im extramuralen Bereich umso stärkere Auswirkungen. Wünschenswert - und durch eine optimale PHC Versorgung möglich erscheinend - ,ist die notwendige Versorgung mit logopädischen Maßnahmen auch abseits der Ballungszentren für alle Menschen.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Die Unterschiedlichkeit der Leistungsabrechnung in den neun österreichischen Bundesländern erweist sich aus Sicht der LeistungserbringerInnen als wenig nachvollziehbar. Dasselbe gilt für jene die logopädische Leistungen in Anspruch nehmen (müssen). Es gibt in Bezug zur Logopädie noch immer Bundesländer die logopädische Leistungen nicht als Vertragsleistungen anbieten. Patientinnen und Patienten in diesen Bundesländern können daher im niedergelassenen Bereich nur mit geringfügigen Kostenrückerstattungen bzw. Refundierungen rechnen. Eine fortlaufende notwendige logopädische Behandlung wird somit (auch) zur Frage der Leistbarkeit – dies entspricht in keiner Weise dem österreichischen Versorgungsauftrag.

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4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

In Bezug zur Logopädie ist es notwendig eine ausreichende logopädische Versorgung zu ermöglichen. Die Schaffung von genügend Vertragsstellen zu adäquaten Bedingungen, die Durchlässigkeit für notwendige logopädische Maßnahmen mit dem Ziel, die Erhaltung, Verbesserung und/oder Wiederherstellung menschlicher Kommunikation für alle die es benötigen, zu gewährleisten, sollte im Fokus der Betrachtungen stehen. Effizienz und Effektivität im Bereich der logopädischen Prävention, Diagnostik, Therapie und Rehabilitation könnten damit verbessert werden.

Ansprechpartnerin

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Sehr geehrter Herr Prof. Dr. Elias Mossialos,

sehr geehrter Herr Dr. David Mum,

herzlichen Dank für die Möglichkeit die Sichtweise und Ansichten der Orthoptistinnen und Orthoptisten zur Weiterentwicklung des Gesundheits- und Sozialversicherungssystems einbringen zu können.

Die Berufsgruppe der Orthoptistinnen und Orthoptisten gehört zu den gehobenen medizinisch-technischen Diensten. Die Orthoptik ist ein Spezialgebiet in der Augenheilkunde und befasst sich mit der Zusammenarbeit der Augen.

Die augenärztliche Untersuchung gibt Aufschluss über den organischen Zustand der Augen, aber nicht immer über die Qualität des Sehvermögens. Besonders bei behinderten und dementen Personen sowie Personen nach Hirnschädigungen (z.B. nach Schlaganfall) korreliert der Augenbefund nicht immer mit dem Sehvermögen. Außerdem braucht es Orthoptistinnen und Orthoptisten als speziell ausgebildete Fachkräfte um die Sehfunktionen bei Personen mit verminderter Aufmerksamkeit und /oder Sprachbehinderungen überhaupt feststellen zu können.

Orthoptistinnen und Orthoptisten behandeln Personen aller Altersstufen mit Seh- und Wahrnehmungsdefiziten und können die Qualität des Sehvermögens ohne aufwändige Geräte feststellen.

Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die größte Herausforderung ist die Versorgung der „Babyboomer" Generation. Stichwort Langezeitpflege und Langzeittherapie.

Die Gesundheitsförderung und Prävention sollte für alle Altersgruppen forciert werden.

Primärversorgung: Dies ist unserer Meinung nach ein sehr guter Weg um die ganzheitliche medizinische Behandlung und soziale Versorgung sicher zu stellen.

Präsidentin Elisabeth Schandl, A – 1140 Wien, Leyserstr. 15/19

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Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind

Visuelle (Re)Habilitation:

Sowohl in der Neurorehabilitation als auch in der Neuropädiatrie ist der Zugang zur visuellen Habilitation / Rehabilitation für die LangzeitpatientInnen im intramuralen Bereich nur schwer und im extramuralen Bereich praktisch nicht möglich. Die Therapie von Sehproblemen ist im extramuralen System nicht vorgesehen, obwohl der Bedarf an visueller Therapie (vor allem in der Geriatrie) steigend ist.

Eine erfolgreiche (Re)Habilitation bei Kindern kann nur erfolgen, wenn auch der Sehsinn des Kindes berücksichtigt wird, denn ca. 60% aller äußeren Sinneswahrnehmungen werden über den visuellen Kanal aufgenommen - wir lernen in etwa 83% durch Sehen. Visueller Input dient als Anreiz zur motorischen Entwicklung, zur Kommunikation und ist extrem wichtig für den sozialen Kontakt.

Bis zu 60% der Patienten[1] mit Gehirnschädigungen leiden an BEHANDLUNGSBEDÜRFTIGEN visuellen Problemen und können derzeit nicht adäquat betreut werden. Die visuellen Störungen behindern die gängige Therapie nach einer erworbenen Gehirnschädigung (Physiotherapie, Ergotherapie, Logopädie und Neuropsychologie) sehr, oder machen sie bei starker Ausprägung sogar unmöglich.

Visuelle (Re) Habilitation ist mehr als die normale Sehhilfenversorgung. Die PatientInnen müssen Sehen (wieder) erlernen oder, falls dies nicht möglich ist, lernen mit den Seh- und visuellen Wahrnehmungsstörungen den Alltag zu bewältigen.

Welche Bereiche bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Vermeidung von Doppelgleisigkeiten in der Diagnostik und Therapie.

Rahmenbedingungen für den multiprofessionellen Austausch sollten geschaffen werden.

Es braucht strukturierte Patientenführung und Behandlungspfade.

Die Zusammenarbeit der Gesundheits- und Sozialberufe muss verbessert werden.

[1] Kerkhoff, G. (2010). Evidenzbasierte Verfahren in der neurovisuellen Rehabilitation. *Neuro Rehabil* (Vol.16), S. 82-90.

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Die intramuralen und extramuralen Bereiche müssen besser abgestimmt werden. Es kann nicht sein, dass Patienten nach einem Spitals- oder Rehabilitationsaufenthalt ohne weitere Behandlung oder soziale Versorgung in häusliche Pflege entlassen werden.

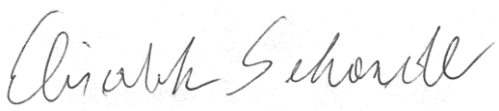
Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Es sollten mehr Informationen auf der e-card gespeichert sein. Zumindest die Medikamente, Allergien und chronische Erkrankungen sollten aufscheinen.

Es braucht eine bessere Einbeziehung der nicht ärztlichen Gesundheitsberufe. Im ASVG § 135 sind derzeit nur die physiotherapeutische, logopädisch-phoniatrische-audiologische und ergotherapeutische Behandlung der ärztlichen Hilfe gleichgestellt.

Wien, 12. März 2017

Mit freundlichen Grüßen



Elisabeth Schandl

Präsidentin von **orthoptik** autstria

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z.Hdn.Herrn Dr.David Mum

Wien, am 11.03.2017

Statement zur Sozialversicherungseffizienzstudie

Sehr geehrte Damen und Herren!

Betreffend zur Sozialversicherungseffizienstudie erlaubt sich Physio Austria, der Bundesverband der PhysiotherapeutInnen Österreichs als Vertretung der Interessen der PhysiotherapeutInnen Österreichs, ergänzend zum von MTD-Austria, Dachverband der gehobenen medizinisch-technischen Dienste eingebrachten Papier, folgende Beantwortung der von Ihnen gestellten Fragen in Bezug auf die derzeitige physiotherapeutische Versorgung in Österreich einzubringen

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die Primärversorgung ist in Österreich derzeit im Sinne eines Konzeptes von multiprofessionellen Netzwerken bzw. Zentren im Entstehen und die definitive Rolle der Berufsgruppen innerhalb des Teams noch nicht klar. Priorität sollte aus physiotherapeutischer Sicht im Sinne einer effizienten und ökonomischen PatientInnenversorgung ein Einsatz entsprechend der in formalen Qualifikationsprozessen erworbenen Kompetenzen haben,. So könnten z.B. PatientInnen mit Erkrankungen des Stütz- und Bewegungsapparates in einem ersten Schritt von dem/r PhysiotherapeutIn nach einem vorher definierten Screening Prozess mit validen Assessments begutachtet werden und dann entsprechend gültigen Leitlinien innerhalb des PHC Zentrums oder Netzwerks weiter geleitet werden. Die Fallführung wäre dabei auch bei dem/r PhysiotherapeutIn bestens aufgehoben. Das setzt ein Denken weg von der Hierarchie innerhalb der Gesundheitsberufe, an deren Spitze aktuell der Arzt (Ärztegesetz mit der Berechtigung zur

gesamten Heilkunde) steht, voraus und die Bereitschaft der Politik, diesbezügliche Änderungen zu initiieren um adäquate Rahmenbedingungen zu schaffen. Derzeit fungiert auch der Chefarzt als Gatekeeper für die Regelung der Kosten für die Krankenkassen (Kostenkontrolle durch Bewilligung oder Ablehung verordneter physiotherapeutischer Leistungen), obwohl die Kostentragung im Wahlbereich zu einem hohen Prozentsatz ohnehin durch die PatientInnen erfolgt. Die Bewilligung erfolgt nahezu ausschließlich nach wirtschaftlichen und nicht fachlichen Aspekten, ohne dass der bewilligende Arzt den/die PatientIn jemals gesehen hat. Die Bewilligungsrichtlinien sind im Regelfall nicht transparent dargestellt.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Der Public Health Ansatz „Health in all Policies“ existiert zwar formal, allerdings ist ein ressortübergreifendes Arbeiten noch nicht ausreichend vorhanden. Beispiel: Zuständigkeit für Sport und Bewegung an Schulen.

Zu Gesundheitsförderung und Prävention existieren viele einzelne Projekte, die im Rahmen der Erarbeitung der RGZ auch an das BMG(F) übermittelt und in Übersichten eingepflegt wurden. Allerdings fehlen ein erkennbarer Gesamtansatz und die strukturierte Umsetzung und Finanzierung konkreter bundesweiter, flächendeckender Projekte, in denen PhysiotherapeutInnen für den Bereich Bewegungsförderung zum Einsatz kommen. Dabei sollten Empowerment und Stärkung der Health Literacy forciert betrieben werden. Eine Dequalifizierung erfolgt durch laschen Umgang mit dem Begriff der Prävention und den Einsatz gering ausgebildeter und finanziell günstiger Personen die keine Health-Professionals sind und über kein Hintergrundwissen zur Pathologie verfügen. Dementsprechend wird von den Organisatoren der Bundes- und Landesverwaltung und auch Sozialversicherung (freiwillige Leistungen) nur unklar zwischen Bewegungsförderung und professioneller Prävention unterschieden bzw. bewusst geringere Qualität nachgefragt. Gesundheitsförderung ist keine Pflichtleistung der Krankenkassen, dies wäre aber wünschenswert, um hier einen chancengerechten Zugang für alle zu gewährleisten.

Die Vorrausetzungen für geregelte und standardisierte Kommunikation unter den an dem/r jeweilige/n PatientIn tätigen Health Professionals sowie die Rahmenbedingungen dafür sind kaum vorhanden. Alle Krankenkassen müssten Leistungspositionen wie „Fallbesprechung“ oder „Helferkonferenz“ stringent in ihren Leistungskatalogen aufnehmen und eine Honorierung des oft nicht unerheblichen Zeitaufwands gewährleisten („You get what you pay and value“). Vorteil wäre, dass Informationen direkt und standardisiert für alle BehandlerInnen zur Verfügung stünden und dadurch eine effizientere Behandlung der PatientInnen erfolgen könnte. In diesem Kontext vermissen wir auch strukturierte PatientInnen - Führung und Behandlungspfade nach gesetzlich definiertem Behandlungsbedarf und Behandlungswegen, die bisher vor allem im extramuralen Bereich kaum vorhanden sind. Wo vorhanden, richten sich die Pfade primär nach strukturellen Gesichtspunkten nicht jedoch nach Krankheitsbildern und dem Behandlungsbedarf der PatientInnen – wir vermissen eine Kodierung der Krankheiten im niedergelassenen Bereich (ICF,

ICD-10), wonach der Bedarf an physiotherapeutischer Behandlung transparent festzustellen wäre. Ein Pilotprojekt des HVB gibt es, jedoch fürchtet die SV ausdrücklich die finanziellen Auswirkungen der notwendigen Transparenz und den möglicherweise daraus ableitbaren Rechtsanspruch für PatientInnen. Die wären mit einer systematischen, objektiven Verknüpfung zwischen Krankheitsbildern (mit/ohne Kodierung) und dem bereits bestehenden gesetzlichem Leistungsanspruch untrennbar verbunden.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Ein am besten elektronischer Zugang zur Übersicht über Behandlungen, einsehbar für PhysiotherapeutInnen als Teil des Behandlungsteams auch im extramuralen Bereich würde Doppelgleisigkeiten vermeiden lassen und Effizienz steigern. So könnten auch mögliche Wechselwirkungen durch verschiedene Behandlungen rechtzeitig erkannt werden und der/die PatientIn darüber aufgeklärt (Stärkung der Health Literacy) werden.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Durch die Berücksichtigung und Lösung der in Punkt 1-3 erwähnten Beispiele.

Weiters durch eine Modernisierung der Leistungskataloge in Bezug auf physiotherapeutische Leistungen sowie eine Novellierung des gesetzlichen Berufsbildes (§ 2 MT im Sinne eines Konzeptes von multiprofessionellen Netzwerken/Zentren“D-G) konform internationalen physiotherapeutischen Standards. Kassenverträge und Leistungskataloge sollten entsprechend der bisherigen Erfahrungen unter Beiziehung der Berufsvertretung modernisiert werden um die fachliche Kompetenz und bisherige Verhandlungserfolge, sowie Best Practice-Beispiele zu berücksichtigen, anstelle einer rein ökonomisch motivierten Vereinheitlichung von Leistungen auf einem niedrigen Niveau (das sieht man jetzt bereits eklatant im Vergleich der Leistungskataloge der 5 GKKs mit Einzelverträgen mit den 4 GKKs ohne solcher).

Ein Wegfall der Notwendigkeit der ärztlichen Verordnung für physiotherapeutische Behandlung, so wie bereits in vielen Ländern Europas und weltweit Standard, würde Bürokratismus reduzieren, Kosten sparen, eine raschere Behandlung ermöglichen (somit z.B. das Risiko für die Chronifizierung von Schmerz reduzieren) und die PatientInnenzufriedenheit erhöhen. Diese Punkte sind durch internationale Evidenz belegt.

Wesentlich sind auch ein stringenter, fairer und chancengleicher bundesweiter Zugang zu Sachleistungen und nur eine ersatzweise Regelung von niedrigen Kostenzuschüssen (§ 131b ASVG). Derzeit existieren nur in 5 von 9 Bundesländern Einzelverträge mit freiberuflichen

PhyisotherapeutInnen. Somit ist der durchgängige Zugang zur Sachleistung vor allem für die vulnerable Gruppe der älteren, immobilen Menschen, die einen Hausbesuch benötigen, nicht adäquat gewährleistet. Ein Verweis auf Angebote in Krankenanstalten ist nicht gleichwertig, da eben nicht lokal und niederschwellig erreichbar. Die Folgen sind erhöhte Pflegebedürftigkeit und Kosten für die Solidargemeinschaft, da oft aus finanziellen Gründen Physiotherapie nicht rechtzeitig zum Einsatz kommt, mit Hilfe derer allerdings noch ausreichend Mobilität erhalten werden könnte um die ADL zu bewältigen.

Eine Bedarfsstudie und darauf aufsetztende Versorgungsplanung für Physiotherapie orientiert an der demografischen Entwicklung sowie internationalen, qualitätsvollen Behandlungsleitlinien (i.V.m. Diagnosecodierung) durch die Krankenkassen würden ein adäquate Versorgungsplanung ermöglichen, damit zu Effizienz und Effektivität beitragen sowie eine transparente Gleichbehandlung der Versicherten ermöglichen.

Silvia Mériaux-Kratochvila, M.Ed. e.h.

Präsidentin

Elektronischer Anhang:

Die Physiotherapeutin/Der Physiotherapeut - Kompetenzprofil
https://www.physioaustria.at/system/files/general/phy_kompetenzprofil_deutsch_fin_022016.pdf

English Version: The Physiotherapist – Profile of Competencies
https://www.physioaustria.at/system/files/general/phy_kompetenzprofil_englisch_fin_02106.pdf

Europäische Kernstandards für die Physiotherapeutische Praxis
https://www.physioaustria.at/system/files/general/kernstandardsv2010_0.pdf

English Version: European Corestandards of Physiotherapy Practise
http://www.erwcpt.eu/physiotherapy_and_practice/tools_and_resources

Positionspapier: PhysiotherapeutInnen in Primary Health Care – Best Point of Service
https://www.physioaustria.at/system/files/general/positionspapier_physiotherapeutinnen_in_phc_062014.pdf

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1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Starker Fokus auf „Arzt ist für alles verantwortlich und für alles zuständig".
  - Obwohl Radiologietechnologen eigenes Berufsrecht und eigenen Verantwortungsbereich haben.
- Qualitätssicherung wird nur über die ÄK durchgeführt
  - Anstatt, dass wie in anderen Staaten (z.B. GB, Skandinavien) die Berufsverbände ein Audit zur Qualitätssicherung ihrer eigenen Berufsangehörigen durchführen (CPD-Audit).
- Gesamtverträge - die Krankenkassen kontrollieren nicht ihre Zahlungen für Leistungen
  - kein Ansatz ob diese Leistungen auch rechtskonform zustande gekommen sind (ob berechtigtes Personal eingesetzt, bzw. beauftragt wurde, obwohl mit öffentlichen Geldern bezahlt).
- 26 Krankenkassen in Österreich
  - Unterschiedliche Sätze und unterschiedliche Behandlungsfinanzierungen
- ASVG muss aktualisiert werden, die Leistungen der gehob.MTD sind ärztich gleichgestellt, daher müssen auch alle gehob.MTD einbezogen werden.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Gesundheitsförderung und Prävention
- Mobile Versorgung durch Radiologietechnologen/innen
  - Durch einen mobilen Einsatz klären Radiologietechnologen/innen vor Ort ab und haben wesentlichen Anteil an einer erstdiagnostischen Erfassung von Krankheitsbildern. Wir optimieren durch unsere Mobilität die Leistungserbringung im Bereich Transport und sanitätsrechtliche Versorgung während des Transports.
  - Auch vor Ort kann dadurch schnell ärztliche Kompetenz angefordert werden, ohne dass doppelte Wege für den Patienten, Wartezeiten vor Ort sowie inadäquate Transportlogistik für das Gesundheitssystem anfallen durch Triage und Gating.
  - Wir erhöhen durch unsere Präsenz die Qualität der Entscheidung im Sinne der Leistungsannahme und Leistungserbringung. Wir können die geforderte Sichtdiagnose machen und weiters die klinische Plausibilität im Sinne der Interdisziplinarität und den adäquaten Mitteleinsatz prüfen.
- Großgeräteplan soll nur als Katalog wo Geräte stehen genützt werden, aber nicht nur mit dem Hintergrund der wirtschaftlichen Limitation.
  - Eigene Praxen von Radiologietechnologen/innen mittels Großgeräten und Anbindung zur teleradiologischen Befundung.
  - Schnelle Versorgung von PatientInnen auch in dünn besiedelten Gebieten
  - Volkswirtschaftlicher Nutzen der schnelleren Diagnostik und damit kürzeren Verweildauer im Krankenstand.
-

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- siehe Pkt. 2
- Deckelung der MRT-Untersuchungen
  - Verschiebung der öffentlich verfügbaren Leistung der Krankenkassen hin zu Privatversicherungen ist ein Problem der Gesundheitsversorgung (Public health)
  - Und dadurch auch eine Verschiebung der Untersuchung z.B. zu CT, das jedoch nicht dieselben Aussagen treffen kann.

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4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Erbringung von Leistungen im häuslichen Umfeld durch mobile Radiologietechnologie, dadurch Verminderung von erforderlichen Krankentransporten.
- Einsehen der Radiologietechnologen/innen auf Patienten-Vor-Daten (Bilddaten) – Vermeidung von belastenden Doppeluntersuchungen (Einbindung von Bilddaten in ELPA und ELGA)
- Multidisziplinarität: Optimierung der Versorgung durch Einbeziehung der Health professionals und Vernetzung der Kompetenzen (z.B. mobil tätige/r Radiologietechnologe/in ist in der Lage bei Auffälligkeiten auch andere Health professionals hinzu zu ziehen.)
- Alle gehob. MTD-Berufe üben Berufe aus, die ärztlich gleichgestellt sind und abgeschlossene Prozesse beinhalten.
    - Der ärztliche Dienst ist nicht im MTD-Gesetz geregelt, im Gegenteil, verweist doch der § 204. (ÄrzteG BGBl. I Nr. 169/1998 idgF, 2015) dass die dem MTD-Gesetz unterliegenden Vorschriften und Tätigkeiten nicht berührt werden. Dies muss analog zur Erledigung des (BMAGS 285.245/2-VIII/D/13/97, 1997) betreffend der Klarstellung zum Verhältnis Hebammen zu Arzt gesehen werden: „In Österreich ist es daher einem Arzt verwehrt, ohne Ausbildung zur Hebamme den Beruf der Hebamme auszuüben, auch wenn er ununterbrochen auf der Geburtenstation und der gynäkologischen Abteilung tätig war […]." Daher ist analog dazu auch einem Arzt verwehrt, ohne Ausbildung zum/r Radiologietechnologen/in den Beruf der Radiologietechnologie auszuüben.
- Eine Basisversorgung im Sinne des PHC ohne Bildgebung wird nicht möglich sein. Ein "klassisches Röntgen" wie Lunge, Skelettröntgen bei Entzündungen oder geringen Verletzungen fallen täglich beim Hausarzt an, somit auch in der Basisversorgung des PHC.
- Ebenso ist der Ultraschall ein Instrument der Basisversorgung.
- Ärztliche Anforderung =>
    - Radiologietechnologe/-technologin prüft auf Plausibilität der Anforderung => prüft Kontraindikationen, führt die Untersuchung eigenverantwortlich auf Basis des Anforderungsprofils durch, optimiert die Untersuchungsparameter. Die Untersuchungs- und Behandlungsdaten werden dokumentiert sowie die Ergebnisse analysiert und ausgewertet.
    - Sendung der Auswertungsergebnisse und Bilddaten und radiologietechnologischen Befunddaten an medizinische Befunder/in zur abschließenden medizinischen Interpretation und Empfehlungen für den/die Zuweiser/in.Berufsbild: MTD-Gesetz BGBl. Nr. 460/1992 idgF.

- Durch den raschen und direkten Einsatz bei den PHC Zentren kommt es rasch zur Diagnosestellung und Weiterbehandlung, Therapie.
    - Radiologietechnologen können entweder bei einem PHC-Zentrum verortet sein oder in einem Netzwerkverbund mehrere PHC-Stellen versorgen.
    - Mobile Versorgung mittels Röntgen-Kleingeräten und Ultraschall z.B. zur schnellen Abklärung von bettlägerigen Patienten sowohl in Altersheimen, als auch im häuslichen Umfeld. Radiologietechnologen übermitteln die Bilddaten und Auswertungsergebnisse dann über Datenleitungen zur ärztlichen Begutachtung im Rahmen der telemedizinischen Versorgung. Krankentransporte können gezielter eingesetzt werden und immobilen Patienten kann ein beschwerlicher Transport, der ev. gar nicht notwendig wäre, erspart werden. Die Versorgung durch den Hausarzt wäre dann schneller möglich.
    - Dezentrale Versorgung von Patienten mit verschiedenen stationären Geräten und Anbindung mittels Datenleitungen an medizinische Versorgungseinrichtungen zur ärztlichen Begutachtung der Bilddaten und Auswertungsergebnisse. Gerade bei unfallchirurgischen Fragestellungen ist eine schnelle Abklärung wichtig um durch gezielte Therapien Personen schon nach kurzer Zeit wieder in den Arbeitsprozess einzugliedern.
- Siehe Pkt.2

Hauptverband der
österreichischen
Sozialversicherungsträger

Bundesministerium für Arbeit, Soziales
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ZI/GSA/2017/Gv/Alm

Wien, 21. März 2017

Betreff: Schriftliche Stellungnahme anlässlich der Diskussionsrunde über das österreichische Sozialversicherungssystem im Rahmen der Effizienzanalyse

Sehr geehrter Bundesminister,

herzlichen Dank für die Einladung zum Hearing. Wir fassen nochmals die wichtigsten Punkte zusammen:

Soziale Sicherheit als zentraler Wert der österreichischen Gesellschaft

Gegenüber dem Haupteingang des Hauptverbands der österreichischen Sozialversicherung ist ein Satz des ersten Präsidenten Johann Böhm angebracht. „Soziale Sicherheit ist die verlässlichste Grundlage der Demokratie!". Dieser Leitsatz ist nach wie vor gültig, ganz besonders in unruhigen Zeiten. Soziale Sicherheit, Inklusion, Partizipation, Solidarität und Verteilungsgerechtigkeit sind essentielle Bedingungen für eine erfolgreiche österreichische Gesellschaft die von Kreativität und Innovation lebt. Österreich ist weltweit gesehen ein Vorbild für umfassende soziale Sicherheit (universal coverage) und das soll auch zukünftig so bleiben.

Selbstverwaltung und Sozialpartnerschaft als solides Umsetzungsprinzip

Das österreichische Sozialversicherungssystem folgt den Grundzügen des Bismarck-Modells aufbauend auf dem Prinzip Pflichtversicherung und umfasst die Zweige Kranken-, Unfall- und Pensionsversicherung. Die Sozialversicherung ist in Selbstverwaltung der Beitragszahler organisiert. Die Interessen der Versicherten werden durch Vertreter der Sozialpartner in den Entscheidungsgremien der Sozialversicherung wahrgenommen.

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Dies hat in Österreich zusätzliches Gewicht. Der Sozialpartnerschaft der Arbeitgeber- und Arbeitnehmerverbände kommt bekanntlich in Österreich besondere Bedeutung zu. Sie ist politisch vielfältig eingesetzt Interessengegensätze durch Konsenspolitik zu lösen.
Die Sozialversicherung führt auch administrative Tätigkeiten des Sozialstaats im übertragenen Wirkungsbereich aus. Dazu gehören beispielsweise die Verwaltung des Kinderbetreuungsgeldes, des Pflegegeldes und die Einhebung von Beiträgen für verschiedene Institutionen.

Der Hauptverband der österreichischen Sozialversicherungsträger ist das organisatorische Dach über der solidarischen Kranken-, Unfall- und Pensionsversicherung

Die Aufgaben des Hauptverbandes sind im § 31 ASVG festgelegt. Dazu gehört vor allem Strategieentwicklung für die gesamte Sozialversicherung. Als Instrument verwenden wir eine mehrjährige Balanced Score Card. Die Ziele sind jährlich mit beiden MinisterInnen für Gesundheit und Soziales abzustimmen. Der Hauptverband pflegt systematische Wissenschaftskooperationen entlang der strategischen Ziele und der Innovations- und Reformbereiche. Ein zentraler operativer Geschäftsbereich des Hauptverbandes ist der „Medikamenteneinkauf", technisch gesprochen Preisverhandlung und Listung von Medikamenten im Erstattungskodex. Einige Bereiche der Vertragspartnerverhandlungen werden vom Hauptverband durchgeführt oder koordiniert. Internationale Sozialversicherung und IT-basierte Abwicklung des internationalen Zahlungsverkehrs ist ein Bereich der sich dynamisch entwickelt und zentral vom Hauptverband für alle Sozialversicherungsträger und alle öffentlichen Krankenanstalten abgewickelt wird. Der IT Aufgabenbereich ist umfangreich: e-card, Elektronischer Gesundheitsakt, e-Medikation und elektronische Anwendungen für Versicherte und Dienstgeber (Meine SV), sowie Gesamtkoordination der IT. Seit Sommer 2015 betreibt der Hauptverband ein Büro in Brüssel in Gemeinschaft mit der deutschen und französischen Sozialversicherung. Eine wichtige Rolle erfüllt der Hauptverband im Rahmen der Gesundheitsreform gemeinsam mit Bund und Ländern.

Umfassendes Sachleistungsprinzip garantiert gleiche Zugänglichkeit für alle Menschen

Das öffentliche Gesundheitssystem wird im Wesentlichen durch die Sozialversicherung und einen Steueranteil im Spitalsbereich finanziert. Nahezu 100% der Menschen in Österreich sind in der Krankenversicherung pflichtversichert und haben damit Zugang zu einer umfassenden Gesundheitsversorgung mit allen notwendigen Leistungen.

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Das österreichische Gesundheitswesen zeichnet sich durch ein ausgeprägtes Sachleistungsprinzip, mit hohem Leistungsniveau sowie modernster Technik aus. Das spiegelt sich in der Zufriedenheit der Bevölkerung mit dem Gesundheitssystem wider. 96% der befragten Bevölkerung finden die Qualität unseres Gesundheitssystems „sehr gut" oder gut[1]. Die Bevölkerungsbefragung 2016 ergab, dass nur 4%[2] mit der medizinischen Versorgung in Österreich eher unzufrieden bzw. 2% sehr unzufrieden sind.
Bei der Weiterentwicklung des Gesundheitssystems sind die essentiellen Werte mit in die Zukunft zu nehmen und problematische Schwachstellen zu beseitigen.

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die Umsetzung der Gesundheitsreform

Derzeit werden in Österreich 6,6%[3] des Bruttoinlandsproduktes für laufende öffentliche Gesundheitsausgaben ohne Langzeitpflege ausgegeben. Bei der Zahl der in Gesundheit verbrachten Jahre liegt Österreich hingegen im Vergleich der EU 28 mit rund 58 Jahren unter dem EU-Durchschnitt[4].
Angesichts der älter werdenden Gesellschaft und der Zunahme chronischer Krankheiten sind folgende Herausforderungen besonders kritisch:

- Sehr starke Fragmentierung des österreichischen Gesundheitssystems auf Grund der Kompetenzverteilung zwischen Bund und Ländern und den damit einhergehenden Finanzierungsströmen
- Ein spitalslastiges und auf akute Krankenbehandlung fokussiertes Gesundheitssystem
- Schwache Primärversorgung

Seit 2013 wird das österreichische Gesundheitssystem durch kontinuierliche Reformarbeit schrittweise weiterentwickelt. Im Vordergrund stehen dabei die Stärkung der Gesundheitsförderung und Prävention und die Reduktion der Spitalslastigkeit. Die Initiative zur Reformarbeit ist von der Sozialversicherung ausgegangen und wird stark von ihr vorangetrieben. Durch ein gemeinsames von Bund, Ländern und Sozialversicherung vereinbartes Zielsteuerungssystem wird die

[1] Europäische Kommission: Special Eurobarometer 411 - Patient Safety and Quality of Care, 2014
[2] http://www.hauptverband.at/portal27/hvbportal/content?contentid=10007.770606&viewmode=content
[3] Laufende Gesundheitsausgaben ohne Ausgaben für Langzeitpflege, in % des BIP, STATISTIK AUSTRIA, Volkswirtschaftliche Gesamtrechnungen, eigene Berechnungen/Schätzungen, Rechnungsabschlüsse, Geschäftsberichte. Rundungsdifferenzen wurden nicht ausgeglichen. Erstellt am 13.02.2017. - 1) Bis 2010 laut SHA 1.0 (OECD), ab 2011 laut SHA 2011 (OECD/Eurostat/WHO).
[4] http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Healthy_life_years,_2014_(years)_YB16.png

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starke Fragmentierung des Systems entschärft. Maßgeblich für das Gelingen der Reformarbeit ist gute sektorenübergreifende Zusammenarbeit im operativen Bereich.
Die Bedürfnisse der PatientInnen sowie die digitalen und technischen Möglichkeiten haben sich verändert. Damit das Gesundheitssystem für unsere Eltern, Kinder und Enkelkinder langfristig finanzierbar bleibt und in hoher Qualität und modernster Technik zur Verfügung steht, dürfen nicht nur einzelne Bereiche verändert werden, sondern es muss das gesamte System modernisiert werden.
Auf einzelne zentrale Bausteine der Gesundheitsreform wird im Folgenden eingegangen:

- **Umsetzung der Gesundheitsziele, Outcomemonitoring**

Im Jahr 2012 wurden zehn Gesundheitsziele in einem breit angelegten Prozess mit zahlreichen Stakeholdern partizipativ entwickelt. Sie sind richtungsweisend und bilden einen gemeinsamen Handlungsrahmen für die nächsten 20 Jahre.
Die Gesundheitsziele setzen bei den Gesundheitsdeterminanten an: Bildung, Arbeitssituation, soziale Situation und Umwelt. So wird die Gesundheit der Bevölkerung verbessert, und gleichzeitig auch eine Entlastung des Gesundheitsversorgungssystems bewirkt. Die zehn Gesundheitsziele werden in einem gemeinsamen Stakeholderprozess systematisch abgearbeitet. Begonnen haben wir mit dem Ziel 3 Gesundheitskompetenz. Eine regelmäßige systematische Messung von gesundheitlichen und gesundheitsrelevanten Outcomes wurde entwickelt.
Weitere Informationen: http://www.gesundheitsziele-oesterreich.at/die-10-ziele/

- **Ausgaben für Gesundheitsförderung und Prävention**

Die österreichischen Ausgaben für Gesundheitsförderung werden von OECD aktuell mit 2,5% des BIP beziffert. Wir haben diesen Ausgabenbereich in einer Studie der Gesundheit Österreich GmbH genauer erhoben. Ohne Tertiärprävention sind dies 3,1 % der Gesundheitsausgaben der öffentlichen Hand[5]. Das analysierte Jahr war 2012. Der von der OECD / Statistik Austria ausgewiesene Anteil für 2012 von 1,9 % an den laufenden öffentlichen Gesundheitsausgaben für Prävention und den öffentlichen Gesundheitsdienst bezieht sich auf die Berechnung nach dem System of Health Accounts (SHA). Der Unterschied zu den von der Gesundheit Österreich erhobenen Zahlen liegt in der genaueren Erhebungsmethodik begründet.

[5] Öffentliche Ausgaben für Gesundheitsförderung und Prävention 2012, Antony, Fröschl, Haas et al Hrsg: Bundesministerium für Gesundheit

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- **Gemeinsame Gesundheitsförderungsstrategie**

Bisher war die Gesundheitsförderung in Österreich von föderalen Strukturen, einer Vielzahl von unterschiedlichen Institutionen und zahlreichen Einzelprojekten geprägt. Mit der im Jahr 2014 in der Bundeszielsteuerungskommission beschlossen Gesundheitsförderungsstrategie und der Neugründung von neun Landesgesundheitsförderungsfonds wurde die Grundlage für eine abgestimmte Vorgehensweise zwischen Bund, Ländern und Sozialversicherung für die nächsten zehn Jahre gelegt.

- **Verbesserung der Krankenbehandlung, Best Point of Service**

Das Leitprinzip ist: Stärkung der ambulanten Versorgung bei gleichzeitiger Entlastung des akutstationären Bereichs und Optimierung des Ressourceneinsatzes.
Die Services im Gesundheitssystem müssen im Interesse der Patienten übersichtlicher und verbindlich gestaltet werden. Voraussetzung dafür sind vertrauenserweckende Patientenpfade samt definierter Versorgungsaufträge und Kompetenzprofile. Diese sind in Ausarbeitung.

- **Der Rollout der Gesundheitshotline TEWEB (Telefon- und webbasiertes Erstkontakt- und Beratungsservice) beginnt am 1.4.2017**

TEWEB ist ein Service zur Einholung qualifizierter medizinischer Auskünfte für BürgerInnen, bietet niederschwelligen Zugang zu allen Gesundheitsfragen und hilft bei der Identifikation des Best Point of Service (siehe auch Seite 5).

- **Rascher Ausbau der Primärversorgungsstrukturen**

Das neue Primärversorgungskonzept wurde im Juni 2014 von Bund, Ländern und Sozialversicherung gemeinsam beschlossen und fand damals die Zustimmung der Ärztekammer. Das Hauptmodell für den städtischen Bereich ist das Primärversorgungszentrum, für den ländlichen Bereich das Primärversorgungsnetzwerk, weil wir keine Versorgungsstandorte aufgeben wollen. Auch in den neuen Organisationsformen hat jeder Patient seinen Hausarzt. Die Schaffung der legistischen Rahmenbedingungen gestaltet sich schwierig. Dennoch gibt es bereits extrem erfolgreiche Pilotprojekte (Wien Mariahilf, Enns, Haslach, Marchtrenk und Mariazell)[6].

[6] Siehe dazu ergänzend Beilage 1

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- **Facharztzentren als nächster Schwerpunkt**

An den Grundlagen für multiprofessionelle, interdisziplinäre Facharztzentren wird gearbeitet. Ziel ist die Zusammenarbeit von ÄrztInnen unterschiedlicher Fachrichtungen gemeinsam mit anderen Gesundheitsdiensten unter einem Dach.

Stärkung der Patientenorientierung durch Stärkung der Selbsthilfe

Die Patienten stehen im Mittelpunkt unseres Handelns. Die Sozialversicherung setzt sich für die Stärkung der Partizipation der PatientInnen im Gesundheitswesen durch Förderung von unabhängigen Selbsthilfeorganisationen ein. Eine stabile Basisfinanzierung der Österreichischen Selbsthilfe soll zur Stärkung der Selbsthilfegruppen im Sinne eines systematischen Kapazitätsaufbaus beitragen und das bisher volatile System grundlegend stärken.

Sicherstellung und Stärkung des Sachleistungsprinzips durch verbesserte zeitadäquate Services

Im Rahmen der Finanzausgleichsverhandlungen 2016 haben sich Bund, Länder und Sozialversicherung darauf geeinigt, der Stärkung des Sachleistungsprinzips in der zweiten Periode der Gesundheitsreform besondere Aufmerksamkeit zu widmen. Es geht darum örtliche, zeitliche und soziale Zugangsbarrieren im Vertragspartnerbereich abzubauen. Dazu gehören: Längere Öffnungszeiten, Verkürzung der Wartezeiten und Steigerung der Attraktivität für den vertragsärztlichen Beruf. Ohne entsprechende Aktivitäten besteht die Gefahr des Abrutschens in eine 2-Klassen-Medizin.

Erweiterung der Sachleistung im Bereich Psychotherapie

Im Regierungsprogramm für den letzten Teil der Legislaturperiode ist festgelegt, dass das Sachleistungsangebot im Bereich der Psychotherapie um 25 % erhöht werden soll.

Die Möglichkeiten e-health für die Bürger nutzbar machen

E-health in Österreich baut auf dem e-Card System auf das 2005 österreichweit umgesetzt wurde. Die aktuellen Großprojekte sind die Gesundheitshotline TEWEB die elektronische Gesundheitsakte ELGA[7] und die e-Medikation[8].

7 Siehe dazu ergänzend Beilage 2
8 Siehe dazu ergänzend Beilage 3

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Die genannten Großprojekte bedürfen im Interesse der Patienten einer entschlossenen Umsetzung durch die Systempartner.

Qualität in der ambulanten und stationären Versorgung laufend verbessern

Im Sinne des Prinzips, dass Transparenz das wirksamste und kostengünstigste Steuerungsinstrument ist, sind die Qualitätsindikatoren für den stationären Spitalsbereich systematisch weiterzuentwickeln (www.kliniksuche.at) und Ergebnisqualitätsmessungen für den extramuralen Bereich zu entwickeln. Hilfreich wäre die verbindliche Umsetzung einer Diagnosecodierung im ambulanten Bereich.

Gemeinsame verbindliche Angebotsplanung

Die Systempartner haben für die zweite Reformperiode neue gesetzliche Rahmenbedingungen für die Angebotsplanung geschaffen. Die abgestimmte Angebotsplanung wird mittels Verordnungen der Gesundheitsplanungs-GmbH verbindlich. So ist sichergestellt, dass die Verantwortlichen gemeinsam handeln und der Bedarf der Menschen - nicht die Interessen einzelner Akteure - im Mittelpunkt stehen. Damit einhergehend müssen neue sektorenübergreifende Finanzierungsmodelle vereinbart werden.

Rascher Zugang zu neuen Medikamenten und sparsamer Umgang mit Ressourcen

Dort wo es im Medikamentebereich Markt gibt, ist die Einkaufsmacht zu bündeln. Politisch ist festgelegt, dass Sozialversicherung und Länder gemeinsame Vergabeverfahren zur Medikamtebeschaffung für den intra- und extramuralen Bereich durchführen können. Der gemeinsame Einkauf mit den Benelux-Ländern ist politisch in die Wege geleitet.
Nun sind rasch die legistischen Grundlagen zu schaffen. Eine Datenbank über Menge und Kosten ist aufzubauen.

Reallokation von Finanzmitteln aus dem stationären in den niedergelassenen Bereich

Das österreichische Gesundheitssystem ist zu spitalslastig. Die Verlagerung des Leistungsangebotes in den extramuralen Bereich muss logischerweise mit einer Verlagerung der Finanzmittel einhergehen.
Ein Teil der Finanzmittel ist für den Ausbau der Primärversorgung zweckgewidmet.

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2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Personalressourcenplanung für das Gesundheitswesen

Wir haben in Österreich aufgrund von Organisations- und Strukturschwächen eine extrem hohe Ärztedichte und damit einen entsprechend hohen Nachbesetzungsbedarf. In neuen, wirksameren Organisationsformen müssen verstärkt die Fähigkeiten weiterer Gesundheitsberufe zum Einsatz kommen. Ein Instrument zur transparenten Darstellung des Personalbedarfes und der Ausbildungskapazitäten ist zu entwickeln. Zu analysieren sind die Konsequenzen der Arbeitszeitverkürzung in den österreichischen Spitälern entsprechend der EU Richtlinie.

Harmonisierung des Leistungsportfolios

In großen Bereichen sind die Leistungen der Sozialversicherung einheitlich. Der Erstattungskodex gilt für alle Versicherten in Österreich und jeder Patient kann jedes öffentliche Spital auf Rechnung der Versicherung aufsuchen.
Tatsache ist aber, dass unterschiedliche Leistungen in manchen Bereichen maßgebliche Unzufriedenheit erzeugen. Die Unterschiede sind zum Teil gesetzlich grundgelegt. Daneben gibt es satzungsmäßige Unterschiede und Unterschiede die aus vertragspolitischen Festlegungen resultieren.
Das bedeutet, dass bei einer Harmonisierung alle genannten Handlungsebenen angesprochen sind.
Die Sozialversicherung hat mit der Beschlussfassung der Trägerkonferenz am 10. Oktober 2016 einen ersten Schritt in diese Richtung gesetzt.

Die Versorgung mit modernen Medikamenten muss für die Versichertengemeinschaft finanzierbar bleiben

Dazu bedarf es intensiver gemeinsamer Anstrengungen auf österreichischer, europäischer und internationaler Ebene[9].

Gesundheitsorientierte Gesamtpolitik
Dem Grundsatz *health in all policies* folgend müssen die Anstrengungen in Richtung gesundheitsorientierte Gesamtpolitik verstärkt werden. Entwicklung und

[9] Siehe dazu ergänzend Beilage 4

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Umsetzungsstand der Gesundheitsziele sind dafür eine gute Ausgangsvoraussetzung.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Die Herausforderungen für das österreichische Sozialversicherungssystem sind mannigfaltig:

Arbeit und Industrie 4.0
Durch Digitalisierung und neue Arbeitsformen wie Crowd- & Cloudworking ergeben sich besondere Fragen für die zukünftige stabile Finanzierung der Sozialsysteme.

Gesundheit 4.0
Über die bereits in Arbeit befindlichen IT Projekte hinaus, ergeben sich aus Robotics, Artificial Intelligence und Big Data maßgebliche neue Chancen und Herausforderungen.

Prüfung der unterschiedlichen Risikostrukturen des Sozialversicherungssystems
Die Verteilung der Risiken innerhalb der Sozialversicherung sollte einer kritischen Analyse unterzogen und die notwendigen Schlussfolgerungen daraus gezogen werden.

Entwicklung moderner Geschäftsmodelle
Das Vertragspartnerrecht der Sozialversicherung stammt aus der Mitte des vorigen Jahrhunderts. Modernisierte rechtliche Rahmenbedingungen sollen einen bedarfsgerechten Einkauf im Interesse der Versicherten besser ermöglichen, um Leistungsqualität, Servicequalität, Versorgungssicherheit und Wirtschaftlichkeit abzusichern. Neue Geschäftsmodelle sind zu entwickeln.
Für neue Versorgungsformen sind neue Bezahlungssysteme zu entwickeln. Derzeit geltende Bezahlungssysteme sind auf ihre Anreizwirkung zu hinterfragen und zu modernisieren.

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4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Die drei Kernleistungen der österreichischen Sozialversicherung sind Gesundheitsförderung und Prävention, Einkommensersatz und Krankenbehandlung.

In allen drei Bereichen fragen wir systematisch nach der Wirksamkeit des Systems und unseres Handelns. Die Entwicklung der gesundheitlichen Outcomes werden im Rahmen der Gesundheitsreform gemeinsam analysiert, ebenso die Zufriedenheit der Bevölkerung. Die Entwicklung des Sachleistungssystems und die Wirkung der Geldleistungen der Sozialversicherung werden zukünftig in der Sozialversicherung laufend evaluiert und die notwendigen Schlussfolgerungen daraus gezogen.

Stärkung der PatientInnenorientierung

Die Gesundheitsreform enthält eine Reihe konkreter Handlungsfelder die Patientenorientierung verstärken sollen. Maßgeblich sind vertrauenserweckende Patientenpfade und nicht Verwirklichungswünsche von Institutionen.
In den Augen der Bürger ist die Sozialversicherung für **Servicequalität und inhaltlich für Qualität** der Leistungserbringer verantwortlich. Dem müssen wir im operativen Geschäft und in der Vertragspolitik verstärkt Rechnung tragen.

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Die Sozialversicherung hat hohes Interesse an innovativer Weiterentwicklung der sozialen Sicherheit. Wir waren erfolgreich in der Finanzkonsolidierung 2010-2013 und haben mit dem Masterplan Gesundheit im Jahr 2010 die wesentlichen Eckpunkte der Gesundheitsreform zur Diskussion gestellt. Vieles davon wurde in die Gesundheitsreform übernommen.
Es ist eine der zentralen laufenden Aufgaben des Hauptverbandes notwendige Veränderungen voranzutreiben, Zukunftsfragen zu stellen und die Nachhaltigkeit des Systems der sozialen Sicherheit zu gewährleisten. Wir wollen einerseits die zentralen, unverzichtbaren und positiven Bausteine mit in die Zukunft nehmen und andererseits notwenige Veränderungen in die Wege leiten, damit dieses exzellente System auch für nachfolgende Generationen stabil abgesichert bleibt.

Mit freundlichen Grüßen
Für den Hauptverband:

Dr. Josef Probst
Generaldirektor

Beilagen:

1. Beilage 1: neue Primärversorgung
2. Beilage 2: ELGA Kurzbeschreibung
3. Beilage 3: e-Medikation
    a. Kurzbeschreibung
    b. Statusbeschreibung
4. Beilage 4: Artikel Soziale Sicherheit Juni 2016: Dürfen lebenswichtige Medikamente so teuer sein?

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Fragen der London School of Economics and Political Sciencs zum österreichischen Gesundheitswesen im Rahmen der „Effizienzstudie zur Sozialversicherung“

Beantwortung durch die Vorsitzende der Trägerkonferenz

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Pflichtversicherung & Solidaritätsprinzip

Die Pflichtversicherung und das Solidaritätsprinzip sind wesentliche Grundkomponenten des österreichischen Gesundheitswesens. Das System der Pflichtversicherung ist **effizient und effektiv**, weil es große **Gruppen unterschiedlicher Risiken** (hinsichtlich Alter, Branche, Angehöriger etc.) umfasst und einen **niedrigen Verwaltungsaufwand** gewährleistet. In Systemen mit Versicherungspflicht bzw. einer Kassenwahl und einem damit einhergehenden Kassenwettbewerb fallen insgesamt nicht nur höhere Verwaltungsausgaben an, sondern Versichertenbeiträge werden auch zu einem nicht unbeträchtlichen Teil beispielsweise für Werbung anstatt für die Versorgung der Versicherten ausgegeben. Das Anpassungsverhalten der Versicherungsanbieter im Wettbewerb trifft die Einkommensschwachen und Kranken im System. Es kommt zu einer adversen Selektion bzw. zum Werben um „gute“ Risiken (cream skimming). Darüber hinaus erfordert ein System der Versicherungspflicht wie in Deutschland einen komplizierten Risikoausgleich (z.B. Morbi-RSA), der auch zu Fehlanreizen führen kann.

Eine der größten Stärken des österreichischen Sozialversicherungssystems und Gesundheitswesens besteht im **Solidaritätsprinzip**. Es **ist Baustein für eine gleiche Gesundheitsversorgung der Bevölkerung unabhängig von sozioökonomischen Faktoren**. Dies wird durch eine große Versichertenzahl und einer Risikodurchmischung, zum Beispiel bei wachsenden und schrumpfenden Branchen in einer gemeinsamen Versichertengemeinschaft, gewährleistet. Die Schaffung ausreichend großer Versichertengemeinschaften gilt somit als logische Voraussetzung zum Erhalt der Vorteile.

Im österreichischen System der Pflichtversicherung mit unterschiedlichen Sozialversicherungsträgern ist ein Vergleich der Träger untereinander hinsichtlich einer

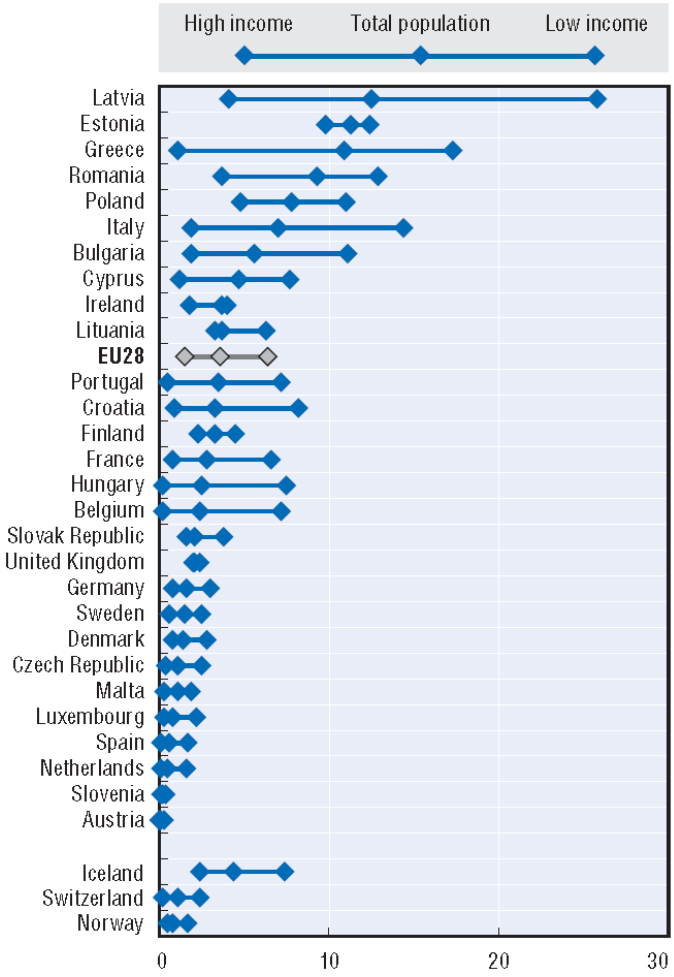
effizienten Verwaltung ein maßgeblicher Vorteil. Das ermöglicht ein Benchmarking zwischen den Trägern und eine **bessere, objektive Kontrolle** durch unabhängige Institutionen (z.B. Rechnungshof) als bei einem Träger oder Trägern, die untereinander nicht vergleichbar wären.

Für ein effizientes und nachhaltiges System der Pflichtversicherung mit mehreren Trägern sind **ausreichend große Versicherungsgemeinschaften** je Träger mit einer in sich ausgeglichenen Risikostruktur, aber auch einer **ausgeglichenen Risikostruktur** zwischen den Trägern notwendig. Sofern Unterschiede in der Risikostruktur der Versicherungsgemeinschaften bestehen, müssten diese zwischen den Versicherungsgemeinschaften ausreichend ausgeglichen werden (Risikoausgleich). Auf diese Weise werden eine ausgeglichene Finanzbasis zwischen den Versicherungsgemeinschaften, gleiche Leistungen und eine finanzielle und politische Stabilität des Gesamtsystems gewährleistet.

Die **Pflichtversicherung und das Solidaritätsprinzip gewährleisten einen gleichen, guten und generationenübergreifenden Zugang zum Gesundheitswesen** und schaffen gleichzeitig eine **hohe Patientenzufriedenheit**. In Österreich sind 99,9 Prozent der Bevölkerung sozialversichert und haben Zugang zum öffentlichen Gesundheitssystem.

Der aktuelle OECD Bericht (Health at Glance 2016, S 155) veranschaulicht im internationalen Vergleich den **sehr guten und gleichen Zugang zum Gesundheitssystem** in Österreich - unabhängig von Einkommen, Wohnort oder zeitlichen Ressourcen (siehe Abbildung 1).

Abbildung 1: Unmet need for medical examination for financial, geographic or waiting times reasons

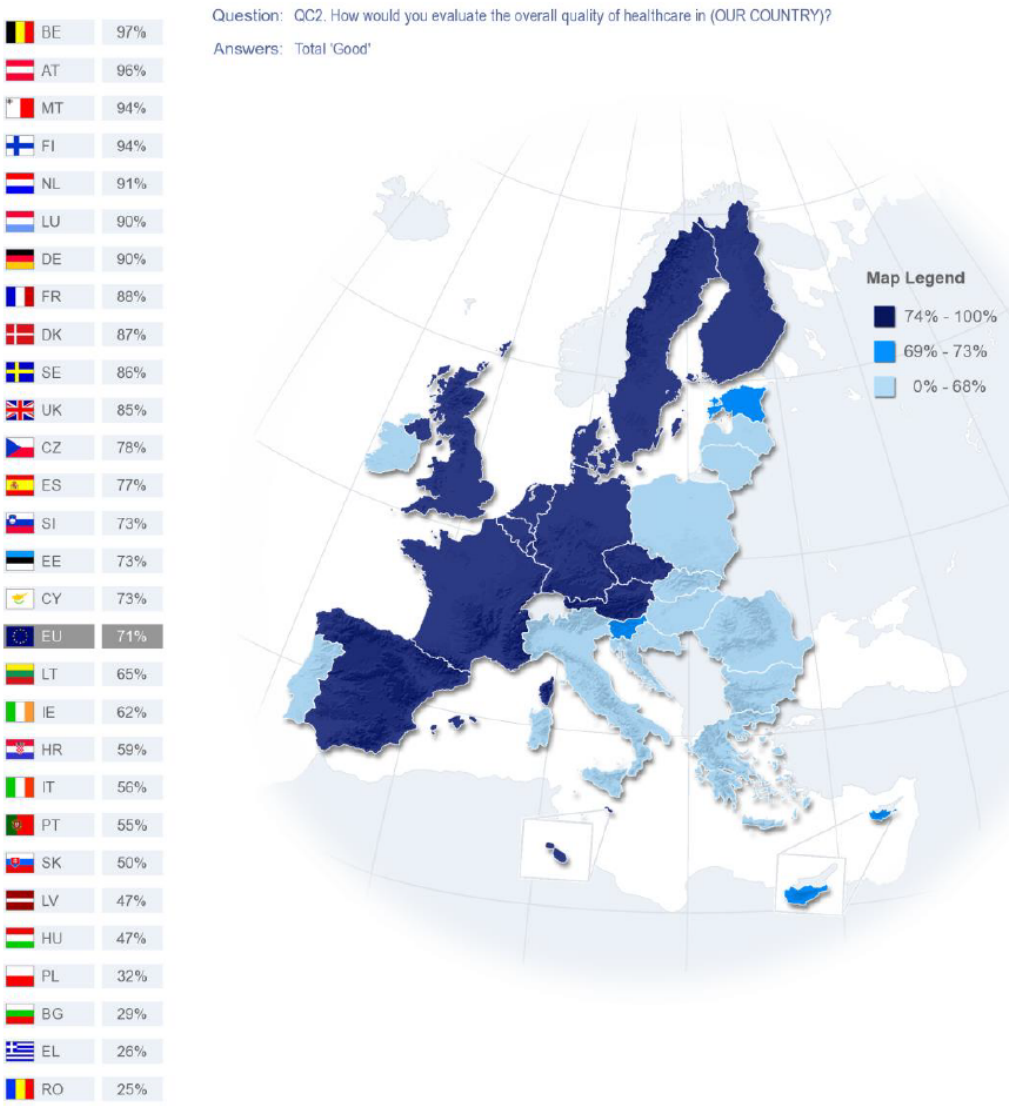


Quelle: OECD Health at Glance (2016), S155.

Im österreichischen Gesundheitssystem besteht das **Recht auf die freie Arztwahl im niedergelassenen Bereich**. Diese freie Arztwahl umfasst in der Praxis nicht nur die freie Wahl der Ärztin und des Arztes, sondern sieht auch die freie Wahl der Versorgungsebene vor. Somit besteht in Österreich ein **freier Zugang zu Allgemeinmedizinerinnen bzw. -medizinern, Fachärztinnen bzw. -ärzten und Spitalsambulanzen sowie anderen Gesundheitsleistungen gleichermaßen**. Aus diesem Grundsatz ergibt sich unter anderem der gute Zugang zum Gesundheitssystem und die **hohe Zufriedenheit der Bevölkerung**. Der Eurobarometer der europäischen Kommission zeigt die hohe Zufriedenheit der österreichischen Bevölkerung mit dem Gesundheitssystem

Abbildung 2). Nachteile freier Gesundheitssysteme liegen jedoch vor allem **bei schwächer ausgeprägter Gesundheitskompetenz in einer unkoordinierten und teilweise ineffizienteren Inanspruchnahme** (siehe Gesundheitskompetenz und Gesundheitsinformationen). Diese Nachteile sollen durch die Stärkung der Primärversorgung verbessert werden, ohne dabei die freie Arztwahl einzuschränken.

Abbildung 2: Anteil der Bevölkerung mit hoher Zufriedenheit mit dem Gesundheitswesen



Quelle: European Commission (2014): Special Eurobarometer 411 "Patient Safety and Quality of Care", S 11.

Selbstverwaltung

Das **System der selbstverwaltenden Sozialversicherungsträger in Österreich hat sich bewähr**t. Die Geschäftsführung der Sozialversicherungsträger wird vom Vorstand und der Generalversammlung bzw. im Hauptverband durch den Verbandsvorstand und die Trägerkonferenz, bestehend aus entsandten Versicherungsvertreterinnen und –vertretern, geführt. Die Versicherungsvertreterinnen und -vertreter werden von Dienstgeber- und Dienstnehmer-Vertretenden Institutionen (Arbeiterkammer, Wirtschaftskammer ua.) entsandt. Das **fördert die Versichertennähe**, eine indirekte **demokratische Legitimität** durch Wahlen der Vertreter der entsendenden Institutionen und ein **Verständnis für Bedürfnisse**

der Versichertengruppe. Essentiell ist dabei, dass in der Selbstverwaltung die **Zusammensetzung der Versicherungsvertreter der versicherten Personengruppen** entspricht.

Es muss gewährleistet sein, dass in Trägern die Dienstnehmerinnen und Dienstnehmer versichern, auch künftig die Mehrheit der Versicherungsvertreter durch Dienstnehmerinnen und Dienstnehmer gestellt werden. Bei den Gebietskrankenkassen sind ausschließlich Dienstnehmerinnen und Dienstnehmer versichert und sie erwirtschaften mit ihrer Arbeitsleistung die Wertschöpfung für Dienstgeber- und Dienstnehmer-Beitragsanteile. Es widerspricht dem Grundsatz der Selbstverwaltung, wenn Dienstgebervertreter über die Gesundheitsversorgung der Dienstnehmerinnen und -nehmer ein Vetorecht durch eine paritätische Besetzung der Gremien ausüben könnten. Die Selbstverwaltung zu einem Aufsichtsrat zu degradieren und die operative Geschäftsführung einem nicht der Selbstverwaltung entsprechenden Management zu übertragen, bedeutet ein Ende der Selbstverwaltung und somit ein Ende des Einflusses der entsendenden Institutionen, ein Ende der Sozialpartnerschaft in diesem Bereich und weitestgehend ein Ende der demokratischen Legimitation und Mitbestimmung der Versicherten.

Sachleistungsversorgung

Um den sehr guten Zugang zum österreichischen Gesundheitssystem weiterhin gewährleisten zu können, ist das **Sachleistungsprinzip durch Vertragspartner der wesentliche Bestandteil**. Die Sachleistungsversorgung wird daher unter anderem durch die Stärkung der Primärversorgung weiter ausgebaut.

In diesem Zusammenhang werden oftmals der Anstieg an Wahlärztinnen und -ärzten und ein vermeintlicher Anstieg der Privatausgaben als eine Entwicklung weg vom Sachleistungsprinzip missverstanden. Dem muss jedoch entgegen gehalten werden, dass die **Versorgungswirksamkeit pro Wahlärztin bzw. Wahlarzt gering** ist und die Tätigkeit vielfach als Nebentätigkeit ausgeführt wird. Das geringe Zusatzeinkommen pro Wahlärztin bzw. Wahlarzt zeigt das geringe Ausmaß der Versorgungswirksamkeit in Summe und dass eine **Betrachtung der Wahlärtzinnen und –ärzte, gezählt anhand von Personenköpfen, zu falschen Schlüssen führt**.

Darüber hinaus ist der Anteil der **privaten Gesundheitsausgaben** an den gesamten laufenden Gesundheitsausgaben rückläufig (von 26,5% im Jahr 1995, über 25,5% im Jahr 2004, zu 24,1% im Jahr 2014).[1] Der Anteil der Ausgaben für **private Kranken-Zusatzversicherungen** (Teil der privaten Gesundheitsausgaben) an den gesamten laufenden Gesundheitsausgaben ist ebenfalls rückläufig (von 6,9% im Jahr 2004 auf 4,9% im Jahr 2014).[2]

Selbstbehalte

Der – im internationalen Vergleich nicht unbeträchtliche – **Anteil der out-of-pocket Ausgaben** ist in Österreich **rückläufig**. Eine Abkehr von diesem Trend durch die Einführung weiterer **Selbstbehalte bildet eine Entwicklung mit negativen Folgen** für alle Systembeteiligten – von der Patientin bzw. vom Patienten über die Leistungserbringer bis hin zur Sozialversicherung als Leistungseinkäuferin.

Eine Analyse der WGKK belegt, dass Selbstbehalte bei Arztbesuchen von Vertragsärzten bzw. -ärzten in der Versicherungsgemeinschaft der Gebietskrankenkassen aufgrund der relativ hohen Anzahl an Versicherten mit niedrigen Einkommen **kontraproduktive Auswirkungen** hätten. Selbstbehalte haben generell eine abschreckende Wirkung auch auf notwendige Leistungen und können weiterführend **zu einem schlechteren Gesundheitszustand führen** – **vor allem bei Personen mit niedrigem Einkommen**. Dadurch wird nicht nur **erhöhtes Leid bei den Versicherten** in Kauf genommen, sondern es entstehen auch **höhere Folgekosten durch spätere Inanspruchnahme bei schlechterem Gesundheitszustand**. Zusätzlich erwachsen nicht unwesentliche **Verwaltungskosten** mit der Einhebung der Selbstbehalte. Für Gebietskrankenkassen sind Selbstbehalte **gesundheitsökonomisch daher kontraproduktiv**.

Oftmals argumentierte positive Effekte von Selbstbehalten bei Arztbesuchen bezüglich Steuerung und Eigenverantwortung liegen der Annahme zu Grunde, dass Personen **vollständig über ihren Gesundheitszustand**, die Medizin und das Gesundheitssystem **informiert** sind. Diese Annahmen entsprechen nicht der Realität. (Zur asymmetrischen

[1] Statistik Austria Gesundheitsausgaben (SHA)
[2] OECD Health Stats Auswertung

Information und mangelnde Gesundheitskompetenz – siehe Kapitel Gesundheitskompetenz und Gesundheitsinformationen.)

Hinsichtlich der aktuellen Entwicklungen stehen Selbstbehalte dem Primärversorgungsgedanken eines **niederschwelligen Zugangs zur besseren Versorgung und höheren Effizienz im Gesundheitswesen diametral entgegen**. Gleichzeitig zeigen internationale Trends aufgrund der negativen Erfahrungen wiederum eine **Abkehr von Selbstbehalten**. In den Niederlanden wurden sogenannte No-Claim-Arrangements (NCA) nach nicht mal zwei Jahren 2008 wieder abgeschafft, da diese als ungerecht, medizinisch zweifelhaft und verwaltungstechnisch zu teuer eingeschätzt wurden. In Deutschland wurde im Jahr 2012 die Praxisgebühr aus ähnlichen Gründen wieder abgeschafft.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Eine Erhöhung der Effizienz und Effektivität des Gesundheitswesens ist maßgeblich für eine nachhaltige Finanzierbarkeit der Sozialversicherung und des Gesundheitssystems. Das **Verhältnis von Input** (finanzielle und personelle Ressourcen) **zu Outcome/Ergebnis** (z.B. Erhöhung der gesunden Lebensjahre) gilt es dabei zu verbessern. So zeigt sich im internationalen Vergleich, dass Österreich einerseits - gemessen an der Patientenzufriedenheit - einen sehr hohen Outcome hat (Platz 2 im europäischen Vergleich, siehe

Abbildung 2). Andererseits steht dem auch ein enormer (spitalslastiger) Input gegenüber.

Die Stärkung der Primärversorgung liefert die entsprechenden Ansatzpunkte für eine kontinuierliche Versorgung und Prävention, welche **sogar bei geringeren Inputs zu einer verbesserten gesundheitlichen Gesamtsituation** der Bevölkerung bzw. einem höheren Outcome führen kann. Auch der Ausbau der Gesundheitsinformationen und die Stärkung der Gesundheitskompetenz sind im Hinblick auf eine effizientere Zielerreichung im österreichischen Gesundheitswesen prioritär zu behandeln. Um die Effizienz des Gesundheitssystems weiter zu verbessern, sind die Maßnahmen der Gesundheitsreform im Rahmen der Zielsteuerung voran zu treiben.

Gesundheitsreform „Zielsteuerung Gesundheit“

Ineffizienzen im System werden im Rahmen der Reform *„Zielsteuerung Gesundheit“* analysiert und verbessert. Dieser Pfad muss durch **intensive Zusammenarbeit von Bund, Ländern und SV** im Rahmen des bestehenden verbindlichen Zielsteuerungssystems weiter fortgeführt werden.

Die Kompetenzteilung im Gesundheitswesen zwischen Bund, Ländern und Sozialversicherung (SV) ist in der Verfassung vorgeschrieben. Solange die föderale Gliederung der öffentlichen Verwaltung, eine Konzentration der Gesundheitskompetenzen auf Landesebene und eine regionale Struktur diverser Kammern besteht, ist es für Entscheidungen und Verhandlungen effizient, regionale Krankenversicherungsträger beizubehalten und mit der Gesundheitsreform durch Zusammenarbeit von Bund, Ländern und SV die Effizienz des Gesundheitssystems zu erhöhen.

Ziel der Reform ist es, die Versorgung der Bevölkerung am best-point-of-service zu optimieren und Doppelgleisigkeiten zu vermeiden. Es soll vor allem eine **Stärkung der Primärversorgung** nach internationalem Vorbild, eine **effizientere Gestaltung des fachärztlichen ambulanten Bereichs** durch niedergelassene Fachärztinnen und -ärzte und Spitalsambulanzen und eine **Reduktion** des teuren und im internationalen Vergleich stark **ausgeprägten stationären Bereichs** erfolgen.

Durch die Bestrebungen der **SV konnten im Rahmen der Gesundheitsreform bereits wichtige** Erfolge erzielt werden:

- Dämpfung des Anstiegs der Gesundheitsausgaben
- Angleichung des Wissensniveaus und Verständnis für Probleme der anderen Partner
- Stärkung der Primärversorgung (Umsetzungskonzept und erste Primärversorgungszentren)
- TEWEB (telefon- und webbasierte Erstberatung)
- gemeinsame Planung der Versorgung (ÖSG/RSG) durch Bund, Länder und Sozialversicherung
- und vieles mehr

Ein **wichtiger Bestandteil** für den Start der Gesundheitsreform war die **politische Entscheidungsfindung in einem kleinen politischen Gremium** bestehenden aus dem Bundesministerium für Finanzen, dem Bundesministerium für Gesundheit, zwei politischen Vertreter/innen der Länder und der zwei höchsten Vertreter/innen der Sozialversicherung (Vorsitzender des Verbandsvorstandes und Vorsitzende der Trägerkonferenz). Für den **weiteren Erfolg der Gesundheitsreform** wäre eine effiziente und gut abgestimmte politische Entscheidungsstruktur aus Vertreterinnen und Vertreter von **Bund, Ländern und Sozialversicherung, in bewährter Weise im Verhältnis 2:2:2**, von Vorteil.

Primärversorgung

Aufgrund des technologischen Fortschritts und der voranschreitenden Spezialisierung im Gesundheitswesen kam es über die vergangenen Jahrzehnte zu weitreichenden Verbesserungen in der Behandlung im Gesundheitswesen. Diese Veränderungen zu immer spezialisierten Behandlungseinrichtungen haben in der jüngeren Vergangenheit aber auch immer mehr das **Fehlen einer zentralen, ständig verfügbaren, gleichen Anlaufstelle** verdeutlicht, die entsprechend den zur Verfügung stehenden modernen Kommunikationsmöglichkeiten eine **kontinuierliche Versorgung bei chronischen Erkrankungen bzw. eine abschließende Behandlung bei einfachen akuten Fällen** leistet. Die im Gesundheitswesen weniger effizient eingesetzten Ressourcen müssen abhängig vom Versorgungsbedarf je Versorgungsbereich **statt im Spitalssektor in den niedergelassenen Sektor** und vor allem in der Primärversorgung eingesetzt werden.

Darüber hinaus ist es notwendig, im Rahmen der Primärversorgung **weitere Gesundheitsberufe**, wie Pflegekräfte, verschiedene Therapeuten und Sozialberufe

koordiniert einzubinden. Diese Berufe können mit ihrer, dem Tätigkeitsbild entsprechenden, **Expertise die Versorgung verbessern, ärztliche Berufsgruppen entlasten** und so die Effizienz bzw. Qualität der Versorgung verbessern.

Im Rahmen der neuen Primärversorgung müssen auch **anreizoptimierte Honorierungssysteme** etabliert werden. Aktuell bestimmen im niedergelassenen Bereich Einzelleistungshonorierungen und Fallpauschalen (z.B. Kontakt je Quartal) die Leistungserbringung. Dies führt zu einer Maximierung der Leistungen und teilweise der Frequenzen. Durch die verstärkte Etablierung von Grundpauschalen und Pay-for-Performance-Honorierungselementen soll die Leistungserbringung **mehr auf die Qualität und das Ergebnis** der Versorgung und weniger auf Leistungsmaximierung ausgerichtet werden. In diesem Zusammenhang sollen auch **verbindliche Leistungsaufträge und Qualitätskriterien** festgelegt werden. Statt eines Systems der vertraglichen Abrechnungserlaubnis mit den Krankenversicherungsträger soll ein System der verbindlichen und ergebnisorientierten Leistungsverpflichtung etabliert werden.

Eine verpflichtende Evaluation, ein unabhängiges Qualitätsmanagement und eine standardisierte Diagnosedokumentation führen zu einer effizienteren und transparenteren Versorgung und ermöglichen eine Ausrichtung am best-practice-Modell.

Durch die **Primärversorgung als erster Ansprechpartner und Weichensteller** ergeben sich nachfolgende Vorteile auf unterschiedlichen Ebenen im System:

Patientenebene:

- Verbesserung der Zugänglichkeit zur Primärversorgung (z.B. erweiterte Öffnungszeiten und weniger Wartezeiten)
- Leicht zugängliche erste Anlaufstelle für Menschen mit gesundheitlichen Anliegen
- Reduktion unnötiger Patientenwege
- Einbindung von Pflegekräften, professionellem Ordinationsmanagement und weiteren Gesundheitsberufen für eine umfassendere Behandlung

Ebene der Ärztinnen, Ärzte und weiterer Gesundheitsberufe:

- Attraktivierung der Tätigkeitsfelder
- Verstärkte Kommunikation und Kooperation zwischen den Versorgungsbereichen

- Erleichterung und Unterstützung der Zusammenarbeit und Kommunikation zwischen den verschiedenen Gesundheits- und Sozialberufen
- Verbesserung der Arbeits- und Rahmenbedingungen

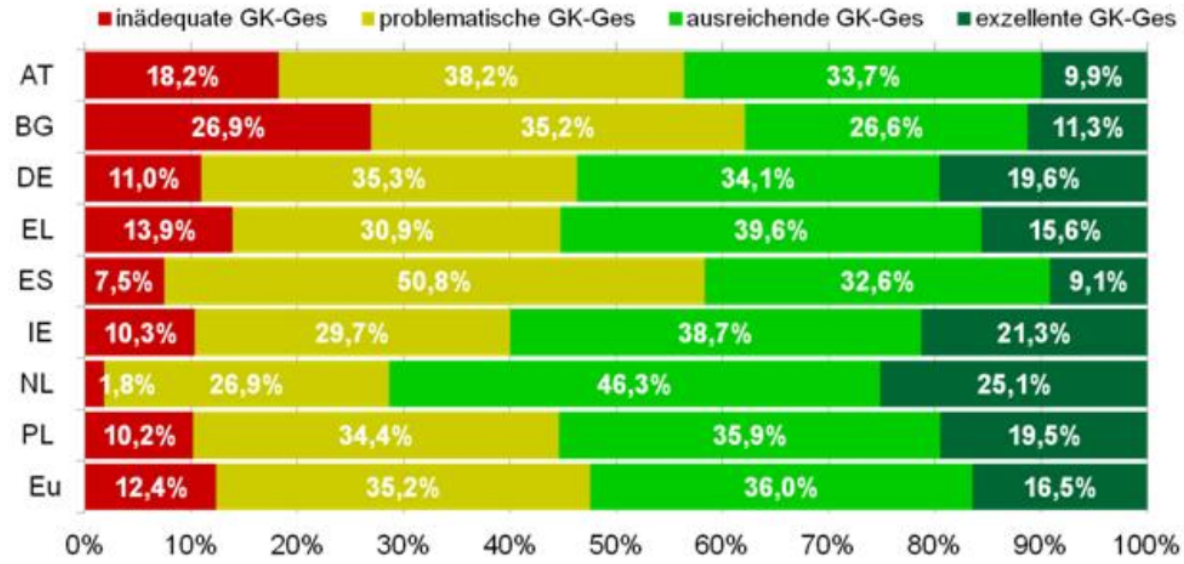
Systemebene:

- Zielgerichtete Versorgung auf der richtigen Versorgungsebene
- Effizientere Behandlung und neue Honorierungsmodelle (inkl. Grundpauschalen, Pay-for-Performance, etc.)
- Sicherstellung einer patientenorientierten Medikamentenversorgung
- Entlastung der fachärztlichen bzw. spitalsambulanten Versorgungsebene

Gesundheitskompetenz und Gesundheitsinformationen

Das österreichische Gesundheitswesen weist im internationalen Vergleich eine unterdurchschnittliche **Gesundheitskompetenz** auf („health literacy“). Dies kann zu weniger gesundheitsförderlichem Verhalten, geringerer Therapietreue oder ineffizienter Inanspruchnahme von medizinischen Leistungen bzw. Einrichtungen führen.

Abbildung 3: Gesundheitskompetenz im internationalen Vergleich



Quelle: Pelikan et al. 2012

Grundvoraussetzung für ein gesundheitsförderliches Verhalten bzw. **eine informierte Wahl und Entscheidung** der Leistungsebene, des Leistungserbringers und der Behandlung, ist neben der Voraussetzung diese Informationen nutzen zu können, vor allem auch eine **Bereitstellung verständlicher Informationen**. Diese Informationsbereitstellung ist auf erster

Ebene etwa eine eindeutige Auflistung welche Leistungen welcher Leistungserbringer nicht nur anbieten kann, sondern auch anbieten muss. Gerade im österreichischen System ergibt sich im Zusammenhang mit der freien Arztwahl aus Sicht internationaler Versorgungsforschung eine Herausforderung. Die Patientin bzw. der Patient hat absolute **Entscheidungsfreiheit, aber eine sehr schlechte Informationslage**, um diese Entscheidung zu seinem besten zu treffen.

Eine effizientere Inanspruchnahme des Gesundheitswesens kann somit durch eine bessere **Information und damit Steuerung der Patienten bzw. des Patienten zum „best-point-of-service“** bzw. einer Verbesserung der Gesundheitskompetenz erzielt werden. Neben der Etablierung von Primärversorgungseinheiten als erste Anlaufstelle im Gesundheitswesen für die Patientin und den Patienten, ist TEWEB (standardisierte, telefon- und webbasierte Dringlichkeitseinschätzung bei gesundheitlichen Anliegen) eine - neben anderen nun startenden - prioritäre Maßnahme, um den notwendigen Voraussetzungen gerecht zu werden.

Neben der Informationsbereitstellung für Patientinnen und Patienten gilt es auch moderne Informations- und Kommunikationstechnologie (IKT) Systeme für einen **verbesserten Informationsfluss zwischen den Gesundheitseinrichtungen** zu etablieren. **ELGA** ist eine solche Maßnahme und unterstützt damit die medizinische, therapeutische und pflegerische Behandlung und Betreuung der Patientinnen und Patienten. Der Ausbau von eHealth erleichtert der Ärztin und dem Arzt eine **informierte Entscheidungsfindung**, **erspart der Patientin und dem Patient Wege, Doppelbehandlungen und medikamentöse Wechselwirkungen**.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Pflichtversicherung mit gleichen Risikostrukturen und Risikoausgleich

Ein effizientes System der Pflichtversicherung bedingt neben einer möglichst ausgeglichenen Risikostruktur innerhalb der Versicherungsgemeinschaft eines Sozialversicherungsträgers auch möglichst ausgeglichener Risikostrukturen zwischen den verschiedenen Sozialversicherungsträgern. Um die finanzielle Basis des Sozialversicherungs- und Gesundheitssystems nachhaltig zu sichern, ist es notwendig, gleiche Risikostrukturen zwischen den Trägern herzustellen oder einen **ausreichenden finanziellen Risikoausgleich** zwischen Sozialversicherungsträgern mit unterschiedlichen Risikostrukturen zu etablieren, um gleiche Finanzsituationen zwischen den Versicherungsgemeinschaften und Sozialversicherungsträgern herzustellen. Ungleiche Risikostrukturen der Versicherungsträger ohne etwaigen Risikoausgleich führen zu ungleichen Finanzsituationen und durch die gesetzliche Ermächtigung zu Leistungsunterschieden – auch wenn diese im Vergleich zu den Gesamtleistungen sehr gering sind. Durch eine ausgeglichene Risikostruktur oder eines finanziellen Risikoausgleiches können **Leistungsunterschiede abgebaut** und die Finanzierung des Gesamtsystems nachhaltig sichergestellt werden.

Der Ursprung der negativen Finanzsituation einiger Träger liegt nicht in steuerbaren Aspekten (z.B. Bewilligungen von Heilmittel und Heilbehelfen, Höhe von Honoraren etc.), sondern hauptursächlich an der **Risikostruktur der Versichertengemeinschaft** und der Versorgungssituation in der Region (z.B. Großstadt). Es bedarf eines ausreichenden Ausgleichs der unterschiedlichen Risikostrukturen aller Krankenversicherungsträger. Daher ist es erforderlich, nicht nur Gebietskrankenkassen, sondern auch **Sonderversicherungsträger in den Ausgleichsfonds einzubeziehen** und diesen finanziell auszuweiten.

Kein Preiswettbewerb bei innovativen Medikamenten (EKO, No-Box, ASVG)

Das System der **Preisbildung für Medikamente,** die im Erstattungskodex (EKO) angeführt sind, greift in zunehmendem Maße zu kurz. Immer häufiger werden Produkte mit der

Strategie auf den Markt gebracht, niemals in den EKO aufgenommen zu werden und somit den Unternehmen volle **Freiheit in der Preisgestaltung** zu gewähren. Dies gilt vor allem für jene innovativen Produkte, für die den Krankenversicherungsträgern **keine alternativen Therapieoptionen im EKO offenstehen** und für die daher eine Kostenübernahme gesetzlich erfolgen muss. Durch das bewusste Negieren der zwischen Pharmaindustrie und Sozialversicherung gelebten Partnerschaft (z.B. EKO) - in Hinblick auf die Preise von Arzneimitteln - gelingt es der pharmazeutischen Industrie, in diesem Bereich ihre **Profite auf Kosten der Versichertengemeinschaft** zu maximieren.

Daneben gerät aber auch das allgemeine Preisgefüge aus den Fugen. In zunehmendem Maße drängen **überdurchschnittlich teure Produkte auf den Markt** und die Kostenentwicklungen werden jüngst ausschließlich durch **neue und hochpreisige Präparate** getrieben. In diesem Bereich bietet das **Verfahren zur Aufnahme von Produkten in den EKO keine ausreichenden Lösungen,** um die Preise effizient und effektiv zu gestalten. Wenn das Geld, auf Grund der Hochpreis-Strategie der Unternehmen, für überteuerte Medikamente ausgegeben wird, fehlt es an anderer Stelle im System.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Der öffentliche Versorgungsauftrag der Bevölkerung mit Gesundheitsleistung liegt im Verantwortungsbereich der gesetzlichen Krankenversicherung. Zur Erfüllung des öffentlichen Versorgungsauftrages bedient sich die Krankenversicherung ihrer Vertragspartner. Ein **Wettbewerb zwischen verschiedenen Gesundheitsanbietern** wäre notwendig, um den Versorgungsauftrag effizienter erfüllen zu können und eine effiziente Leistungserbringung im Verhandlungswege durch die Krankenversicherung im Sinne der Patientinnen und Patienten sowie einer effizienten Verwendung öffentlicher Beitragsmittel sicherzustellen. Aktuell ist der Wettbewerb aufgrund der Rechts- und Vertragssituation mit der Ärztekammer **nur sehr bedingt gegeben**. In diesem System zeigt sich ein Bild einer de-facto-Monopolstellung der Ärztekammer als Vertretung der ärztlichen Leistungserbringung im extramuralen Bereich. Ein Preis- und Qualitätswettbewerb zwischen verschiedenen Leistungserbringern besteht durch die gemeinsame Vertretung aller Ärztinnen und Ärzte durch die Ärztekammer, dem Gesamtvertragsregime sowie dem **Behindern alternativer Leistungserbringer** nicht. Andere Gesundheitsdienstanbieter, wie selbständige Ambulatorien oder eigene Einrichtungen der Krankenversicherung, können durch Rechtsmittel der Ärztekammer – zumindest in der Entstehungsphase – zeitlich stark behindert werden und scheiden daher de facto als Alternative für die Leistungserbringung aus. Um eine effiziente **Verteilung der Mittel des Gesundheitswesens durch die öffentliche Hand** nach internationalem Vorbild zu gestalten, sollte ein gesunder **Wettbewerb zwischen verschiedenen Leistungserbringern** ermöglicht werden.

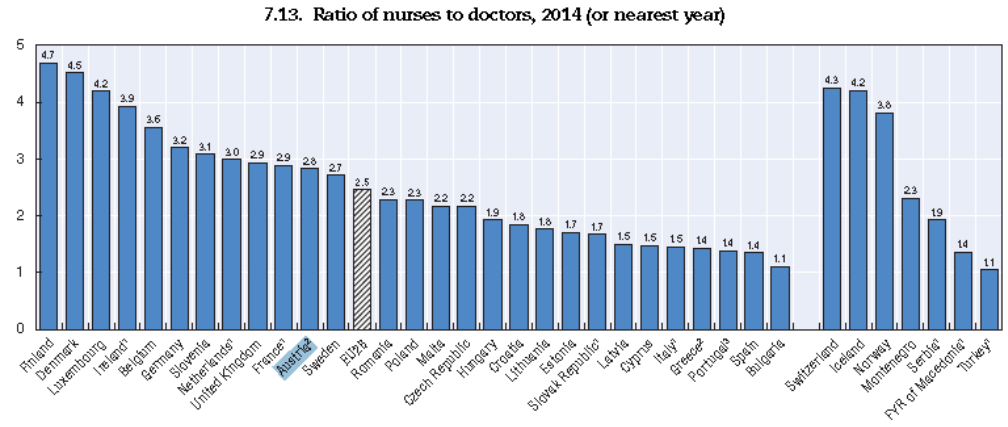
Nachfolgende Standards der Leistungserbringung müssen im **Sinne der Effizienz, der Qualität, des Leistungseinkaufs und der Umsetzung der Bedarfsplanung** eines modernen Gesundheitswesens prioritär geändert werden:

State of the Art Versorgung durch neue Honorierungsformen und Delegation an die Pflege statt Fall- und Arztzentriertheit

Im aktuellen System steht eine monopolistische Verhandlungsposition der Vertretung der Leistungserbringer bzw. ein Honorarsystem mit teils **fehlgeleiteten Anreizen einer effizienten und effektiven Leistungserbringung entgegen**. So finanziert sich der monopolistische Verhandler der Leistungserbringer über Pflichtbeiträge seiner Mitglieder bzw. der Ordinationen. Die Standesvertretung beharrt somit auf Einzelleistungsvergütungen, da diese Volumenkomponente oftmals unabhängig von Angebot und Bedarf stetig ausweitbar ist. So werden seit jeher Änderungen in der Honorierung hin zu einer effizienteren Vergütung (beispielsweise mehr Pauschalen) von der Ärztekammer verhindert. Obwohl eine solche breitere Honorierungsaufstellung durch die entsprechenden Anreize nicht nur dem Patientinnen und Patienten in Form von **mehr Zeit für das Arzt-Patientengespräch**, sondern auch den (jungen) Ärztinnen und Ärzten durch eine **fixere und planbarere Honorierungskomponente entgegenkommen**.

Die arztbasierte Einzelleistungsvergütung führt mitunter zu **einer geringen Delegation bzw. Substitution von Leistungen an sonstige Gesundheitsberufe**. Diese könnten jedoch zu einer Effizienz- und Qualitätssteigerung im Gesundheitswesen führen. Österreich rangiert unter den führenden europäischen Industrienationen im internationalen Vergleich beim Verhältnis zwischen Pflege- und ärztlichem Personal nur am unteren Ende.

Abbildung 4: Internationaler Vergleich des Verhältnisses zwischen Pflege- und ärztlichem Personal



1. For those countries which have not provided data for practising nurses and/or practising doctors, the numbers relate to the "professionally active" concept for both nurses and doctors.
2. For Austria and Greece, the data refer to nurses and doctors employed in hospital.
3. The ratio for Portugal is underestimated because the numerator refers to professionally active nurses while the denominator includes all doctors licensed to practice.

Source: OECD Health Statistics 2016; Eurostat Database.

Quelle: OECD Health Statistics (2016): Health at Glance, S161

Offener und freier Leistungseinkauf statt Blockade moderner Versorgungsformen

Um Innovationen wie neue Primärversorgungseinrichtungen umsetzen zu können, sollte die **Verhandlungsmacht nicht bei einem de-facto-monopolistischen Leistungserbringer** liegen (Interessenskonflikte). Jedenfalls sollte **keine Vetoposition** einer Berufsgruppenvertretung bezüglich öffentlich finanzierter und politisch gewünschter Leistungen und Qualität möglich sein. Aktuell können politisch geforderte **Innovationen** mangels Wettbewerb bei Leistungserbringern **lange behindert und de facto verhindert** werden. Das Gesundheitswesen ist ständigen Veränderungen auf unterschiedlichsten Ebenen unterworfen. Diese Umstände bedingen jedoch eine flexiblere Ausgestaltung des Leistungsangebotes in Form von ausreichend großen Versorgungseinheiten, die den **modernen Anforderungen** der Versorgung aber auch den Ansprüchen der Leistungserbringer gerecht werden. Gleichzeitig braucht es eine **offenere und freiere Form des Leistungseinkaufs** der Sozialversicherung in Vertretung der versicherten Personen. Nur so kann die gesetzliche Krankenversicherung ihrem Versorgungsauftrag inkl. der notwendigen Innovationen gerecht werden.

Leistungsverpflichtung statt Speisekartensystem

Benötigt wird außerdem eine **Leistungsverpflichtung** statt einer Abrechnungserlaubnis der Leistungserbringer. Aktuell besteht eine reine Abrechnungserlaubnis von Leistungen nach einem „Speisekartensystem“ ohne verbindlichen Versorgungsauftrag.

Unabhängige Qualitätssicherung statt Qualitätsmonopol

Mangels verbindlicher Qualitätsstandards in Form von Leitlinien und einem weitgehenden **Fehlen einer unabhängigen, öffentlichen Qualitätskontrolle** liegt ein **Qualitätsmonopol** durch die Ärztekammer vor. Die Qualitätssicherung im Bereich der Ärzte erfolgt durch die in der Ärztekammer eingerichtete ÖQMed selbst. Die Verpflichtung zur Qualitätssicherung durch die ÖQMed ist im Ärztegesetz festgelegt. Die **Kriterien**, der Evaluierungsablauf und die Führung eines bundesweiten Qualitätsregisters **werden jedoch bloß durch eine Verordnung der Österreichischen Ärztekammer festgelegt**. Die ÖQMed hat laut Ärztegesetz zwar einen wissenschaftlichen Beirat, der die Organe der ÖQMed und der Österreichischen Ärztekammer bei der Wahrnehmung der Qualitätssicherung berät. In diesem sind unter anderem auch die Gesundheit Österreich GmbH (GÖG), das Bundesministerium für Gesundheit und Frauen (BMGF) und der Hauptverband der österreichischen Sozialversicherungsträger (HVB) vertreten. Die **Qualitätssicherung** der durch niedergelassene Ärztinnen und Ärzte erfolgten Behandlungen wird jedoch de facto **ausschließlich durch deren Berufsvertretung vorgenommen**. Einzig die Einhaltung eigener Verordnungen (z.B. zu Hygienevorschriften oä) wird durch öffentliche Institutionen durchgeführt.

Allgemeine und evidenzbasierte Ausbildungskriterien statt Ausbildungsmonopol

Zusätzlich hat die Ärztekammer erheblichen **Einfluss auf die Ausbildung angehender Ärztinnen und Ärzte** und darüber indirekt auch auf die **Anzahl und Qualität der dem System zur Verfügung stehenden Ärztinnen und Ärzte**. So ist die Ärztekammer zuständig für die Verordnung über die konkret von Lehrpraktikantinnen bzw. -praktikanten zu erwerbenden Kenntnisse, Erfahrungen und Fertigkeiten in der Ausbildung (§ 24 Abs. 2 ÄrzteG), für die Erstellung eines Lehr- und Lernzielkataloges für die Ausbildungsstätten (§ 25 ÄrzteG), für die

Verordnung über die Ausgestaltung und Form bzw. Einführung von Ausbildungsbüchern und die Ausgestaltung der Prüfungszertifikate (§ 26 ÄrzteG) und für die Organisation und Durchführung der Eignungsprüfung sowie Festsetzung des Prüfungsentgelts (§ 37 Abs. 11 ÄrzteG). Diesbezügliche Verordnungen durch das BMG erfolgen **nach Anhörung durch die österreichische Ärztekammer**.

Hauptverband der
österreichischen
Sozialversicherungsträger

Verbandsvorsitzende
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Sehr geehrter Herr Professor,
sehr geehrte Damen und Herren,

ich bedanke mich herzlich für die Einladung zum Gespräch betreffend Effizienzstudie in der Sozialversicherung, an dem ich leider urlaubsbedingt nicht persönlich teilnehmen konnte.

Gerne sende ich Ihnen aber untenstehend meine schriftlichen Anmerkungen zu den übermittelten Fragen.

Zum Fragenkomplex 1-3

1. **Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?**
2. **Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?**
3. **Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?**

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Zu den Fragen 1 – 3, die ins. die Prioritäten im Gesundheitswesen sowie im Sozialversicherungssystem betreffen, möchte ich zusammenfassend Stellung nehmen.

Rund 99,9 % der in Österreich lebenden Menschen sind aufgrund der gesetzlich verankerten Pflichtversicherung durch eine Krankenversicherung geschützt. Der Großteil der Österreicherinnen und Österreicher sind – so die Ergebnisse von Umfragen – mit den Leistungen und Angeboten des heimischen Gesundheitswesens zufrieden (96% befinden die Qualität unseres Gesundheitssystems als „gut").

Österreich wendet über 36 Mrd. Euro pro Jahr (öffentlich und privat) für die Gesundheitsversorgung auf, allein für die Finanzierung des öffentlichen Gesundheitswesens werden insgesamt über 27 Mrd. Euro pro Jahr aufgewendet – so viel wie kaum ein anderes Land der Welt gemessen an der Wirtschaftsleistung. Bei der Zahl der in Gesundheit verbrachten Jahre liegen wir hingegen international betrachtet nur im Mittelfeld (59 Jahre). Um auch für unsere Kinder und Enkeln eine qualitativ hochwertige, leistungsfähige und vor allem finanzierbare Gesundheitsversorgung zu gewährleisten, sind laufende Weiterentwicklungen und Reformen nötig.

Wir müssen mehr Effizienz im Gesundheitswesen verwirklichen – das reicht vom effizienten und vor allem zielgerichteten Einsatz der vorhandenen Mittel, laufender Anpassung und Modernisierung des Leistungsspektrums bis zu neuen Strukturen.

Aus meiner Sicht sind u.a. folgende Schwerpunkte wesentlich:

Umsetzung der Gesundheitsreform:

Derzeit wird das österreichische Gesundheitssystem durch kontinuierliche Reformarbeit seit 2013 umgebaut und weiterentwickelt. Die Initiative zur Reformarbeit ist von der Sozialversicherung ausgegangen und wird stark von ihr vorangetrieben. Durch ein gemeinsames von Bund, Ländern und Sozialversicherung vereinbartes Zielsteuerungssystem wird die hohe Fragmentierung des Systems auf Grund der Kompetenzverteilungen zwischen Bund und Länder deutlich verbessert. Eine gute sektorenübergreifende Zusammenarbeit in den operativen Bereichen ist ein zentrales Ziel der Gesundheitsreform. Die Gesundheitsreform sah im Rahmen des Bundeszielsteuerungsvertrages insgesamt 12 strategische Ziele mit insgesamt 27 operativen Zielen und 86 Einzelmaßnahmen vor. Es gibt Monitoring-Berichte zur Zielsteuerung, diese sind aber leider wenig aussagekräftig. Zu hinterfragen sind hier deshalb, welche der geplanten 86 Einzelmaßnahmen wurden tatsächlich gesetzt und welche Auswirkung hatte dies auf das Gesundheitswesen? Welche Ziele wurden neben der Finanzzielsteuerung in den vergangenen 5 Jahren erreicht und welche Auswirkungen hatten diese auf das Gesundheitswesen?

Etablierung neuer Versorgungsformen und „Best point of Service" sowie Sicherstellung Ärztepotential:

Es gibt drei wesentliche Anforderungen der Bevölkerung: Mehr Zeit für das ärztliche Gespräch, längere Öffnungszeiten und eine durchgehende wohnortnahe medizinische Behandlung und Betreuung. Priorität muss sein, allen, die es brauchen, die richtigen Leistungen (Versorgungsaufträge) am richtigen Ort, gesamtwirtschaftlich

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sinnvoll und mit hoher medizinischer und pflegerischer Qualität zur Verfügung zu stellen. Dabei sollte man den Kreis der möglichen Anbieter – unter Beachtung der notwendigen Qualitätskriterien - offen und breit gestalten. Die Etablierung neuer Versorgungsformen muss nach den Bedürfnissen der Patienten und Patientinnen erfolgen sowie auch für die Anbieter möglichst einfach und ohne große Bürokratie möglich sein. Unter-, Über- oder Fehlversorgungen müssen vermieden werden.

Wesentlich ist eine Stärkung der ambulanten Versorgung bei gleichzeitiger Entlastung des akutstationären Bereichs und Optimierung des Ressourceneinsatzes: weniger stationäre Spitalsaufenthalte, mehr angemessene zeitadäquate Betreuung im ambulanten Bereich (fragmentiertes System – sektorenübergreifende Versorgung).

Ein wichtiger Faktor hierbei ist der flächendeckende Ausbau der Primärversorgungsstruktur, sowie Ausbau von Facharztzentren: Primärversorgung mit klaren Versorgungsaufträgen und dahinterliegenden definierten Aufgabenprofilen. Die Zusammenarbeit von Allgemeinmediziner mit anderen Gesundheitsberufen muss ausgebaut werden. Die Organisation kann entweder in Zentren oder in Netzwerken erfolgen. Die Primärversorgung muss auch zur Stärkung der Prävention und Gesundheitsförderung sowie Gesundheitskompetenz beitragen. Einführung eines flächendeckenden Casemanagements (inklusive einer Betreuung falls im Einzelfall notwendig rund um die Uhr) für chronisch Kranke und multimorbide Menschen.

Auch die Frage, ob in Zukunft genug Ärzte zur Verfügung stehen ist in diesem Zusammenhang wesentlich. Derzeit sind noch so viele Ärzte und Ärztinnen wie noch nie in Österreich tätig. Doch diese Situation wird sich stark verändern, denn ein Großteil der Ärzte kommt ins Pensionsalter. Es gibt also einen großen Bedarf an „Nachfolgern". Deshalb muss analysiert werden, wie hoch der künftige (mittelfristig bis 2027) Bedarf an Ärztinnen und Ärzten ist. Insbesondere im Hinblick auf die Altersstruktur, regionale Versorgung, Vertragssituation bei den KV- Trägern (Altersgrenze) sowie die demografische Entwicklung (Patienten und Ärzte).

Welche Maßnahmen sind auf Bundes- und Landesebene zu setzen, damit die zahlreichen Medizin-Absolventen im Land gehalten werden und nicht ins Ausland abwandern? Weiters ist zu überprüfen, ob das derzeitige Ausbildungsregime für Gesundheitsberufe sowie die Zahl der Ausbildungsplätze in den Krankenanstalten und die neue Ärzteausbildung ausreichend sind um den künftigen Bedarf abzudecken - insbesondere auch hinsichtlich der Versorgung im ländlichen Bereich? Zu überlegen ist auch, wie die künftige Ausbildung sowie Aufgabenverteilung der jeweiligen Gesundheitsberufe gestaltet sein muss, damit einerseits den veränderten Anforderungen der Demografie entsprochen und andererseits eine bessere Arbeitsaufteilung erzielt werden kann? Wie kann die Attraktivität der Arbeit im Gesundheitswesen erhöht werden?

Finanzierung aus einer Hand

Die Finanzierung des österreichischen Gesundheitswesens ist stark fragmentiert. Die Finanzströme für den intra- und extramuralen Bereich sind verflochten und zeichnen sich durch Parallelität und Komplexität aus. Die

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Finanzierungsverantwortung von Bund, Ländern, Gemeinden und Sozialversicherungsträgern deckt sich nicht mit ihrer Aufgaben und Ausgabenverantwortung. Die uneinheitliche Finanzierung, Bezahlung, Planung, Gestaltung des Gesundheitswesens führt zu gesamtgesellschaftlichen Effizienzverlusten. Die Schnittstellen- und Effizienzprobleme erschweren die dringend notwendige Optimierung der Angebotsstruktur.

Österreich weist im internationalen Durchschnitt eine überdurchschnittlich hohe Anzahl an Spitalsbetten auf (7,7 Betten pro 1000 Einwohner, OECD Durchschnitt: 5 Betten, OECD: health at a glance 2015). Österreich hat im Verhältnis zu seinen Einwohnern in der gesamten OECD die höchste Zahl an Spitalsbehandlungen (Österreich kommt auf 266 Spitalsentlassungen je 1000 Einwohner und damit um 70% mehr als der OECD-Schnitt mit 155 Entlassungen je 1000 Einwohner). Der Rechnungshof hat durch den Abbau von Spitalsbetten ein Einsparpotenzial von 4,75 Mrd. Euro errechnet. Zu hinterfragen ist in diesem Zusammenhang, ob sich aus dem derzeitigen Krankenanstalten-Finanzierungssystem, der hohen Bettendichte, der Häufigkeit von Spitalsaufenthalten und der durch die Kompetenzverteilung vorgegebenen Zuständigkeiten ein Zusammenhang ableiten lässt und welche Maßnahmen es für eine raschere Optimierung braucht?

Ermöglicht eine „Finanzierung aus einer Hand" eine schnellere Verlagerung vom intramuralen auf den extramuralen Bereich und Hebung wesentlicher Effizienzpotentiale?

Leistungsharmonisierung

Durch die Autonomie der Träger haben sich über die Jahre hinweg - selbst bei gleichen Beiträgen die Leistungen unterschiedlich entwickelt. Diese Unterschiedlichkeit ist für die Menschen nicht nachvollziehbar und in einem modernen Gesundheitssystem auch nicht vertretbar. Deshalb müssen die Leistungen bei gleichen Beiträgen harmonisiert werden. Es braucht eine Sichtung der einzelnen Leistungen, Hinterfragen, ob deren Angebot auf dem letzten Stand der Wissenschaft sind und letztlich Erstellung eines modernisierten und einheitlichen Kataloges, wobei im Vergleich zum Status Quo Aufkommensneutralität anzustreben ist.

Hierzu hat die Trägerkonferenz im HVB auch bereits einen Beschluss gefasst, der insb. neue Leistungen umfasst.

Auszuarbeiten ist auch ein **neues Honorierungssystem**, welches richtige Anreize schafft und verschiedene Module enthält: Infrastrukturpauschale für Investitionen, E-Health und Öffnungszeiten, Fallpauschale, Fallpauschale für besondere Krankheitsbilder (chronische Kranke), Bonus z.B. für die Betreuung von chronisch Kranken oder der Durchführung von Präventionsangeboten. Bezahlung von Einzelleistungen, die forciert werden sollen sowie Berücksichtigung von Qualität und sinnvoller „Pay for Performance". Wir brauchen ein modernes neues System, das ärztliche Leistungen entsprechend honoriert, Bürokratie reduziert und dabei hilft, nicht nur Krankheiten zu behandeln, sondern Menschen gesund zu erhalten.

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Prävention/Gesundheitsförderung

Viele Krankheiten und gesundheitliche Probleme lassen sich durch Prävention und einen entsprechenden Lebensstil vermeiden. Die Gesundheitsversorgung ist in Österreich nach wie vor sehr fokussiert auf den Bereich der Reparaturmedizin und setzt leider noch viel zu wenig Akzente im Präventionsbereich. Vorrangige Verantwortung eines modernen Gesundheitssystems ist es, die Menschen möglichst lange gesund und im aktiven Arbeitsleben zu halten. Es geht um den Erhalt von Lebensqualität, aber auch darum unsere Leistungsträger durch ein gesundes, selbstbestimmtes Leben zu begleiten. Jeder Mensch, der krank wird, muss die beste medizinische Betreuung bekommen – das ist seit jeher ein Paradigma in der sozialen Krankenversicherung. Höchste Zeit nun, ein weiteres Paradigma einzufügen: Jeder Mensch der gesund ist, braucht Unterstützung beim Gesundbleiben. Dazu muss vor allem die Gesundheitskompetenz und auch die Eigenverantwortung gestärkt werden. Es gibt österreichweit bereits eine Vielzahl von Maßnahmen, es braucht aber eine einheitliche Strategie, eine stärkere Kooperation aller Stakeholder sowie einen stärkeren Fokus auf die Kinder- und Jugendgesundheit. Wichtige Maßnahmen sind hier z.B. Entwicklung der Schulärzte zu Gesundheitsmanagern an Schulen mit Übermittlung und Auswertung der Gesundheitsdaten der Kinder und Jugendlichen an eine zentrale Stelle, Einführung eines Unterrichtsfaches „Gesundes Leben", Weiterführung des Mutter-Kind-Passes bis zum 18. Lebensjahr u.v.m.

E-Health und Information der Versicherten:

Es bedarf noch mehr Anstrengungen im Ausbau moderner, effizienter Informationstechnologien und von E-Health, M-health, ELGA und nutzbarmachen weiterer innovativer Technologie für das Gesundheitswesen (z.B. Teleradiologie, Analyse zur Behandlung von schwierigen Erkrankungsfällen, Robotics). Die Elektronische Gesundheitsakte ELGA oder die 2016 ins Leben gerufene Plattform spitalskompass.at schaffen höhere Transparenz und ermöglicht jedem Patienten einen besseren Überblick und Planung seiner Entscheidungen über die eigene Gesundheit. Zusätzlich kann durch Vermeidung von Mehrfachuntersuchungen auch die Effizienz gesteigert werden. Ein Meilenstein in der Weiterentwicklung der Elektronischen Gesundheitsakte ist der 2016 gestartete Betrieb der E-Medikation, womit insbesondere durch Vermeidung von Wechselwirkungen mehr Sicherheit für die Patienten verbunden ist. Das Projekt Teweb, also die telefon- bzw. internetbasierte medizinische Erstauskunft, startet 2017. Bei all diesen Vorhaben braucht es eine schnellere Ausrollung und den flächendeckenden Einsatz. Welche Maßnahmen braucht es, um diesen möglichst schnell zu gewährleisten? Welche innovativen E-Health Technologien würden noch zur Verbesserung der Versorgung und zu mehr Effizienz beitragen?

Zu Frage 4:

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Ziel ist es, dass der weitaus größte Teil der geleisteten Beiträge für die Versicherungsleistungen aufgewendet werden kann - also den Versicherten in Form von

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Leistungen zugutekommt. Wenn wir die Effizienz und Effektivität des Systems verbessern, können wir auch die Standards der Leistungserbringung weiter voranbringen und die Finanzierung unserer Gesundheitsversorgung auch für künftige Generationen sicherstellen. Daher sollten zusätzlich zu oben erwähnten Themen insbesondere folgende Bereiche analysiert und Empfehlungen für mehr Effizienz und Effektivität vorgelegt werden.

Effizienz in den Trägern:

Die aktuelle Struktur der SV-Träger muss analysiert und modernisiert werden. D.h. es braucht einen Vergleich unterschiedlicher Varianten, wobei der Fokus dabei auf die Servicequalität und Betreuung der Versicherten sowie auf die Effizienz in der Verwaltung und Abwicklung gelegt werden muss. Dabei stellen sich für mich folgende Fragestellungen: Welche Modelle der Trägerlandschaft (ohne Vorgabe bestimmter Modelle) gibt es? Gegenüberstellung möglichen Varianten der Aufstellung der SV-Struktur mit einer Darstellung der Für- und Wider sowie jeweils Folgerung hinsichtlich der Auswirkungen auf die Effizienz. Welche Aufgaben sollten einheitlich/österreichweit und welche regional/vor Ort wahrgenommen werden (z.B.: Planung, Beitragseinhebung, Einkauf, Finanzzielsteuerung, Leistungsverträge, Leistungsrecht, Service). Welche Effizienzpotentiale sind durch Strukturreformen zu heben z.B. durch geringeren Personal- und Sachaufwand (weniger Immobilienbedarf, einheitliche IT-Versorgung, Energiereduktion etc.), bessere Tarife für Leistungen, bessere Preise bei Beschaffungen?

Eine Reform der Sozialversicherung muss aber mehr als eine reine Trägerstrukturdiskussion sein. Im Grunde geht es darum, dass den Bürgerinnen und Bürgern optimale Leistungen effizient und effektiv zur Verfügung gestellt werden. Finanzwirtschaftlich soll das SV-System insgesamt durch die Reform nachhaltig eine schwarze Null und im besten Fall auch eine substantielle Lohnnebenkostensenkung erwirtschaften. Weiters sollten alle Träger für sich ein positives EGT und die nachhaltige Finanzierung sicherstellen. Geprüft werden muss dazu auch wie sich eine bundesweite Steuerungskompetenz sowie die Installierung eines Systems mit Kennzahlenvergleich und Benchmarkvorgaben auf dieses Ziel auswirken.

Zielsteuerung, Kontrolle und Governance:

Es bedarf einer Analyse der gegenwärtigen Zielsteuerungsprozesse (gesetzliche Ausgabenobergrenze, BSC-Ziele des HVB, Zielsteuerung einzelner Träger, Anreizmechanismen) und deren Geeignetheit zur Kostendämpfung bzw. effektiven finanziellen Steuerung der SV-Träger. Ebenso sind die Strukturen zur Kontrolle in den Trägern und im Hauptverband und deren Effektivität zu analysieren. Zudem soll die Governance-Struktur in der Sozialversicherung verbessert werden.

Verwaltungsaufwand und Personal:

Es bedarf Maßnahmenvorschläge, die den Verwaltungsaufwand der österreichischen SV-Träger sowie des HVB - bei gleichbleibender Qualität der Leistungen - weiter verringern. Welche Potenziale zur Effizienzsteigerung in der Verwaltung können zusätzlich noch ausgeschöpft werden?

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Interessant sind in diesem Zusammenhang auch folgende Fragestellungen: Ist die Umstellung des Rechnungswesens auf internationale Rechnungslegungsvorschriften sinnvoll?

Wie gestaltet sich ein Vergleich der Verwaltungskosten der österreichischen SV-Träger mit SV-Trägern anderer vergleichbarer Länder? Wie stellen sich die Verwaltungskosten österreichischer SV-Träger im Vergleich mit Unternehmen der Privatwirtschaft bzw. mit der öffentlichen Hand (bspw. Gebäudeabschreibungen, Rücklagenzuweisungen, Pauschalüberweisungen an Spitäler etc.) dar?

Wo liegen die Unterschiede im Dienstrecht der SV-Träger im Vergleich zur Privatwirtschaft und im Vergleich zum öffentlichen Dienst (Leistungsanreize, Kündigungsschutz, Urlaubsanspruch etc.)? Ist eine unterschiedliche Behandlung von SV-Mitarbeitern gerechtfertigt?

Beschaffung und IT:

Welche Maßnahmen bedarf es, die das Beschaffungswesen weiter optimieren und Synergieeffekte stärken. Ebenso sollen Vorschläge zum Einsatz von IT zur Effizienz-, aber auch Qualitätssteigerung in der SV-Verwaltung erarbeitet werden.

Finanzströme innerhalb des Systems:

Im Sinne der Kostenwahrheit und -transparenz müssen Pauschalvergütungen innerhalb des SV-Systems auf ihre tatsächliche Kostendeckung analysiert werden.

Beitragseinhebung:

Im Sinne einer Entbürokratisierung braucht es Maßnahmen, die die Beitragseinhebung und -abfuhr vereinfachen. Ziel soll es dabei sein, der Sozialversicherung sowie den Betrieben die Tätigkeit der Beitragseinhebung und -abfuhr zu erleichtern und sie von Verwaltungsaufwand zu entlasten. Auch die Vorteile einer bundesweit einheitlichen Beitragseinhebung sollten geprüft werden.

Anreizsysteme/Selbstbehalte:

Es bedarf einer Gesamtschau, wie sich alle Zuzahlungen und Eigenleistungen, die im derzeitigen System geleistet werden, darstellen. Daraus abgeleitet sollte ein System entwickelt werden, dass verschiedene Zuzahlungen und Eigenleistungen vereinheitlicht und damit auch eine steuernde Wirkung erzielt werden kann.

Eigenbetriebe:

Der Betrieb von „Eigenen Einrichtungen" muss auf Effizienzpotenziale hin geprüft werden, dies vor allem auch im Vergleich zur Inanspruchnahme von privaten Vertragspartnern. In welchen Bereichen ist es sinnvoll Eigenbetriebe zu betreiben? In welchen ist es effizienter diese auszulagern?

Ich hoffe, dass die Studie der LSE zu den angesprochenen Herausforderungen, vor denen das österreichischen Gesundheitssystem steht, Lösungsvorschläge macht, die zu einer Effizienz- und Qualitätssteigerung im österreichischen Gesundheitssys-

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tem führen. Ich bin überzeugt, dass wir rasch Reformschritte setzen müssen, um das Gesundheitssystem und insbesondere die Sozialversicherung zukunftsfähig aufzustellen. Für Rückfragen stehe ich gerne zur Verfügung.

Beste Grüße

Mag.[a] Ulrike Rabmer-Koller
Verbandsvorsitzende

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23. Februar 2017 von 14.45 bis 16.15 im Ministerium für Arbeit, Soziales und Konsumentenschutz im Alfred Dallingersaal, BMASK, Stubenring 1, 1010 Wien

Invitation: Review of Austria's Social Insurance System

Prof. Dr. Elias Mossialos (The London School of Economics and Political Science; Director of LSE Health), Prof. Dr. Reinhard Busse (Technische Universität Berlin), Prof. Dr. Patrick Jeurissen (Radboud University Medical School; Ministry of Health, Welfare and Sports in the Netherlands), Ms. Dominique Polton (CNAMTS, France), Univ.-Prof. Dr. Walter J. Pfeil (Universität Salzburg); Univ.-Prof. Dr. Werner H. Hoffmann (Wirtschaftsuniversität Wien; Contrast Ernst &Young). Prof. Dr. Thomas Czypionka (IHS Wien), Martin Zach (BMASK), Dr. Ulrike Windischhofer (BMGF)

on behalf of LR Mag. Christopher Drexler: LTAbg. Prof.Dr. Sandra Holasek

Roundtable discussion questions

1. In your opinion, what are the primary care and public health priorities within Austria?

We do have an excellent health care system, which developed enormously during the last 100 years. Since the knowledge of medical sciences doubles every 5 to 7 years, we do have to face the positive challenge to transfer these new possibilities of understanding and treatment to our people. Styria is a good example for how this can be realized. We have a dense platform of universities, called the "Steirische Hochschulkonferenz", which gives us the necessary condition to continuously exchange science outcomes in interdisciplinary areas. Health care is therefore very well embedded in the scientific communities.

The Austrian care system has a priority in building and strengthening the bridge from acute basic care to top medical specialized care in our Medical Hospitals.

Besides the basic and highly specialized treatment of patients we focus on modifiable risk factors with high preventive impact, like nutrition and exercise in national action plans, another example is vaccination, where campaigning is necessary again.

The care of the Styrian population ranges from acute basic care to top medical maximum care at the Graz University Hospital, which is among the best medical research and teaching facilities in Austria.

2. Are there any important healthcare priorities currently not (sufficiently) included or implemented in the Austrian healthcare system?

Important healthcare priorities currently not (sufficiently) included or implemented in the Austrian healthcare system are the following.

The Health Plan 2035 of Styria, as a current example, is focusing on these changes in our demographic landscape, new diagnosed diseases, digitalization and other new altered condition in our present and near future society.

- The aging population (on average we reached 40 years of age 100 years ago, today we reach on average about 80 years) requires a different treatment and care: mobile, part-time inpatient, inpatient services are urgently needed. Increase in individuals requiring care: By 2025, an increase in the number of people receiving care allowances is estimated from currently around 78,000 to 93,000. In order to suitably cover the care and treatment needs of these people, coordinated provision of mobile, part-time inpatient and inpatient services is needed. Increase in mobile care hours: In terms of mobile care, an increase in the number of care hours of around 60% is assumed (from around 1 million hours in 2013 to around 1.6 million hours in 2025). This covers demographic developments as well as the additional requirements that will arise out of facilitated financial access and more intensive care per client in the future.
- Inpatient care - use of surplus capacities for short-term care places: In terms of inpatient care, due to the significantly reinforced mobile care and the development of non-stationary offers, only a small increase in clients, from currently around 11,200 to around 11,500 is expected by 2025. The resulting need of around 12,100 beds is compared to just under 13,000 already existing or approved beds. The surplus beds should therefore be converted to short-term care places, of which a total of around 1,420 should be used.
- Major expansion in alternative forms of accommodation: Major expansion is aspired to in terms of alternative types of housing. Accordingly, in 2025, 2,250 (currently 1,400) places should be available. In this area especially, creativity is called for since new models will have to be developed and pilot projects launched in order to enable people with changed needs not to have to change their place of residence but rather only their care model.
- Additional increase in 24 hour care: 24 hour care has a significant effect on care and is, even if it cannot be planned, still considered in the remaining structures. We can assume that the number of patients will increase from currently around 5,300 to 9,200 in 2025.
- The impending lack of doctors as well as the new hospital labour law require reforms in hospitals. We know that in the next ten years around half of the 1,800 registered country doctors will retire. As of January 1, 2016, 246 doctors between 60 and 64 years old (of which 168 general practitioners) and 208 doctors will be 65 and older (of which 137 general practitioners).
- The migration of the population from outlying regions to urban concentration areas also represents major challenges for us.

3. What areas, if any, require attention within the current Austrian social insurance system and why?

- We do need a better qualified identification of our patients´ needs. This is very important for saving money and to avoid best possibly burden for individuals, - health professionals and patients.
- International health care: for example we do offer 16 different languages in our university hospital in patient care at the moment.

All of these are problems that simultaneously overlap with rapid medical-technology progress. We must meet these challenges and conditions timely and with a view to the future in order to continue to be able to offer the population optimal medical care.

4. How could standards of service provision, efficiency and effectiveness be further improved within Austria's current social insurance system?

High quality health care is a balancing act between feasibility and financing possibilities. Harmonization is urgently needed to minimize logistic burden for doctors and treatment of patients. We urgently need to generate a law of primary care to fight against the peoples´ fears. Interdisciplinary teams with possibilities of full and part time working for all health professionals are needed. We have to strengthen the regional family doctors and team care. Highly specialized medicine should be guaranteed in hospitals. High quality teaching for top medicine and high quality medical science has to be guaranteed in our university medical hospitals in tight cooperations with other universities and the scientific community.

Präsidentenkonferenz der
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Wien, 6. März 2017

Studie zur Analyse des österreichischen Sozialversicherungssystems

Die Landwirtschaftskammer Österreich gestattet sich, dem Bundesministerium für Arbeit, Soziales und Konsumentenschutz zum oben genannten Begutachtungsentwurf folgende Stellungnahme zu übermitteln:

Anläßlich des Gespräches, das am 24.2.2017 zwischen Vertretern des BMASK, der London School of Economics an Political Science, der Landwirtschaftskammer Österreich und der Sozialversicherungsanstalt der Bauern stattgefunden hat, wurde vereinbart, dass die Landwirtschaftskammer Österreich ihre Standpunkte zur Studie schriftlich darlegen soll und dass dies in einen Anhang zur Studie aufgenommen werden. Dementsprechend gestattet sich die Landwirtschaftskammer Österreich, folgende Ausführungen einzubringen:

a. Sozialversicherung aus einer Hand – One-Stop-Shop

Obwohl das Konzept zur Studie den Titel „bessere Leistungen für die Menschen“ trägt und einleitend davon gesprochen wird, dass der Patient im Bereich des Gesundheitswesens im Mittelpunkt stehe, findet sich die Sichtweise der Versicherten in der Folge nicht mehr wieder. Für die Landwirtschaftskammer Österreich als Vertretung von Versicherten bzw einer Versichertengruppe liegt aber auf der Hand, dass dem Blickwinkel der Versicherten, für die das System letztendlich geschaffen wurde, prioritär Rechnung getragen werden sollte.
Aus der Sicht der Versicherten ist es von außerordentlichem Wert, dass eine zentrale Institution sämtliche Leistungen der sozialen Sicherheit anbieten kann, von der Kranken-, Unfall- und Pensionsversicherung bis hin zum Kinderbetreuungs- und Pflegegeld. Diese Überzeugung resultiert nicht zuletzt aus den negativen Erfahrungen anderer Berufsgruppen, die diesen organisatorischen Vorteil nicht genießen, mit sogenannten Drehtüreffekten, also damit, dass sie mit ihren Anliegen zwischen den Institutionen hin und her verwiesen werden. In vielen Vorhaben der österreichischen Bundesregierung wird das „One-Stop-Shop“-Prinzip

als Ziel formuliert, dies sollte auch hier der Fall sein. Besonders deutlich zeigt sich der Wert dieses Prinzips beim – auch im Studienkonzept angesprochenen – Case Management, das natürlich dann umso besser funktioniert, wenn der Case Manager nicht erst die Vorgaben verschiedener Institutionen auf einen gemeinsamen Nenner bringen muss. Die Erfahrungen der Case Manager, die die Sozialversicherungsanstalt der Bauern zur Bewältigung komplexer Problemlagen zur Verfügung stellt, einerseits und von organisatorisch anspruchsvollen Koordinierungsinstrumenten wie „fit2work“ andererseits zeigen, dass mit einem zentralen Anbieter für eine bestimmte Versichertengruppe nicht nur den Bedürfnissen der Versicherten besser Rechnung getragen werden kann, sondern auch eine wesentlich effizientere Leistungserbringung möglich ist. Dies trifft letztlich überall zu, wo die Befassung mehrerer Institutionen zu Schnittstellenproblemen führt, wie zum Beispiel auch in Fragen der Prävention/Früherkennung/Frühintervention.

Die Kleinstrukturiertheit der österreichischen Landwirtschaft zwingt viele Familienbetriebe zu Erwerbskombinationen. Diese spezifische Struktur mit vielen Kleinbetrieben, die oftmals neben einem außerlandwirtschaftlichen Einkommen des Ehepartners auch von Frauen weiter bewirtschaftet werden und dadurch als Arbeitsplatz für die Gesamtgesellschaft erhalten bleiben, ist nicht zuletzt auch auf die berufsständische Versicherbarkeit dieser Klein- und Kleinstbetriebe zurückzuführen. Der im Vergleich zu anderen Mitgliedstaaten nur gedämpft stattfindende Strukturwandel ist insbesondere auch in der sozialversicherungsrechtlichen Absicherung dieser Tätigkeiten (Urlaub am Bauernhof etc.) im Rahmen eines eigenständigen Versicherungsmodells begründet.

b. Selbstverwaltung als Governance-Instrument

Das Studienkonzept spricht davon, dass die Selbstverwaltung als Governance-Instrument, bestehend aus VertreterInnen der ArbeitnehmerInnen und AbeitgeberInnen, Stabilität und langfristige Planbarkeit schaffe. Die Landwirtschaftskammer Österreich bekennt sich ebenfalls zum Instrument der Selbstverwaltung in der gesetzlichen Sozialversicherung, weist aber darauf hin, dass deren Vorteile in der Sozialversicherung der Selbständigen, die naturgemäß keine Rollenverteilung zwischen ArbeitgeberInnen und ArbeitnehmerInnen kennt, ebenso wirken.

c. Leistungsharmonisierung zwischen allen Versichertengruppen

Aus dem Prinzip der Selbstverwaltung folgt aber, dass – soll diese tatsächlich einen Anwendungsbereich behalten – eine vollständige und zwingende Harmonisierung logisch

nicht denkbar ist. Gerade das derzeit geltende Berufsgruppenprinzip ermöglicht dabei auch Lösungen, die auf die Bedürfnisse der jeweiligen Berufsgruppe zugeschnitten sind; dafür bietet die bäuerliche Unfallversicherung überzeugendes Beispiel, bei dem manche Elemente stärker als bei anderen Versichertengruppen eingesetzt werden, andere hingegen hinter dem allgemeinen Niveau zurückbleiben können. Jenseits solcher berufsgruppenspezifischer Bedürfnisse trifft es natürlich zu, dass gravierende Unterschiede im Leistungsspektrum auf Unverständnis bei den Versicherten stoßen. Diese Erfahrung machen die Landwirtschaftskammern in ihrer täglichen Arbeit am Beispiel des Berufsschutzes in der Pensionsversicherung: Während gelernte und sogar angelernte Arbeiter sowie Angestellte diesen ohne Alterslimit und gewerblich Selbständige ab dem 50. Lebensjahr genießen, steht Land- und Forstwirten – ohne Rücksicht auf das jeweilige Ausbildungsniveau – nur der allgemein geltende Tätigkeitsschutz ab Vollendung des 60. Lebensjahres zu. Wenn also eine Leistungsharmonisierung in Angriff genommen werden soll, ist dies sicher der vordringlichste Aspekt, weil es für eine solch gravierende Differenzierung zwischen den einzelnen Versicherten keine sachliche Rechtfertigung gibt.

Selbiges gilt für Einbeziehung von Bäuerinnen in den Anwendungsbereich des neu geschaffenen erhöhten Ausgleichszulagenrichtsatzes für Alleinstehende. Ein eigener Pensionsversicherungstatbestand für Bäuerinnen existiert erst seit 1.1.1992. Für Bäuerinnen ist es daher noch nicht möglich, zum Inkrafttreten des erhöhten Ausgleichszulagenrichtsatzes die dafür vorgesehene Voraussetzung von 360 Beitragsmonaten zu erfüllen, obwohl sie nahezu ausnahmslos seit frühester Jugend durchgehend erwerbstätig waren. Der Ausschluss von dieser Maßnahme auf Grund historischer Ausnahmen, die heute kaum noch erklärbar sind, sollte rasch repariert werden.

Die Vorgabe, den Fokus auf den Ausbau von Sachleistungen zu richten, ist aus der Sicht der Landwirtschaftskammer Österreich nicht uneingeschränkt zielführend, weil verschiedene Sachleistungen nicht im gesamten Bundesgebiet in gleicher Intensität bzw Qualität erhältlich sein werden. Bei undifferenzierter Verfolgung dieser Vorgabe droht eine Diskriminierung des ländlichen Raumes.

Ein Harmonisierungselement ist dem Konzept auch hinsichtlich der Beitragsseite zu entnehmen, und zwar in Gestalt der Aufgabenstellung, Spezialbestimmungen bei der Beitragseinhebung zu streichen. Auch in diesem Zusammenhang müssen Berufsgruppenspezifika beachtet werden: Nicht in jedem Fall kann ein Arbeitgeber oder eine andere Behörde zur Unterstützung bei der Beitragseinhebung herangezogen werden.

d. Finanzierungsaspekte

In mehreren Zusammenhängen werden Aspekte der Finanzierung bei der Aufgabenstellung beleuchtet: Aus der Sicht der bäuerlichen Versichertengemeinschaft sticht hiebei zunächst jene Passage ins Auge, wonach „Zuschüsse aus dem Steuertopf für die verschiedenen Sparten der Pensionsversicherung (Partnerleistung)“ als „potentielle Systemwidrigkeiten“ untersucht werden sollen. Nicht erwähnt wird, dass die Partnerleistung in der bäuerlichen Pensionsversicherung nicht einfach einen „Zuschuss aus dem Steuertopf“ darstellt, sondern ihre Wurzel in der Anrechnung eines pauschalen Ausgedinges, der Abgabe von land- und forstwirtschaftlichen Betrieben, dem Solidaritätsbeitrag der Pensionisten und einem Äquivalenzbeitrag für budgetfinanzierte Ersatzzeiten hat (Ministerialentwurf zum Pensionsharmonisierungsgesetz, 201/ME der Beilagen zu den stenographischen Protokollen des Nationalrates, 22. Gesetzgebungsperiode); daran hat sich dem Grunde nach nichts geändert. Eine zutreffende Beurteilung der Partnerleistung ohne diesen Hintergrund ist nicht möglich.

Ein weiterer Finanzierungsaspekt betrifft die Verwendung von Rücklagen: Diese sollen nach dem Konzept für Primärversorgungseinrichtungen, eigene Einrichtungen der Sozialversicherung, ambulante Einrichtungen, die Leistungsharmonisierung und Fragen der gemeinsamen IT verwendet werden. Abgesehen davon, dass eine ohnedies schon so konkrete Vorgabe keinen Raum für die Erstellung einer Studie mehr lässt, wird hier völlig übersehen, dass allenfalls jetzt bestehende Rücklagen nicht auf Dauer Bestand haben müssen. Dies ist insbesondere dort der Fall, wo auf Grund der Altersstruktur mit einer raschen Verschlechterung der finanziellen Basis zu rechnen ist. Dann verstieße eine derartige Verplanung von Rücklagen gegen jede kaufmännische Sorgfalt.

In diesem Zusammenhang erstaunt auch, dass besondere Risiken der Versichertenstruktur, die die Gebietskrankenkassen treffen (Arbeitslose, Mindestsicherungsbezieher, Asylwerber), Beachtung finden, besondere Nachteile auf Grund der Altersstruktur, wie sie in der bäuerlichen Versichertengemeinschaft vorliegen, aber mit keinem Wort erwähnt werden.

So hat beispielsweise die bäuerliche Sozialversicherung die höchste Pensionsbelastungsquote im Trägervergleich. 2015 kamen in der Krankenversicherung auf einen versicherten Aktiven bereits mehr als ein Bauern-Pensionist, dh Pensionistenquote 52,1%, bei den Gebietskrankenkassen beträgt der Wert 31,4 %. Viele Pensionisten zu haben bedeutet niedrigere Beitragssätze und -einnahmen und höhere Ausgaben, weil der Großteil der Gesundheitskosten im letzten Lebensabschnitt anfällt. Ein weiterer Faktor sind die im Durchschnitt niedrigsten Pensionen im Trägervergleich und daraus resultierend niedrigeren

Beitragseinnahmen, die dazu führen, dass die Einnahmen pro Anspruchsberechtigtem unter denen der Gebietskrankenkassen liegen.

In einer Risikogemeinschaft, die zu einem größeren Teil aus Pensionisten als aus aktiv Berufsausübenden besteht, hat dies aber massive nachteilige Auswirkungen, während andere Risikogemeinschaften, die von der Zuwanderung der Kinder bäuerlicher Versicherter profitieren, die entsprechenden Vorteile genießen. Redlicherweise müsste auch dieses Phänomen berücksichtigt werden.

Ferner fällt noch die Aufgabenstellung „Erarbeitung von Modellen zur Verbreiterung der Finanzierungsbasis der Sozialversicherung“ auf. Derartige Modelle werden nahezu zwangsläufig Mittelverschiebungen zwischen Versichertengruppen bzw Branchen mit sich bringen. Die Erarbeitung solcher Konzepte hat aus diesem Grund hauptsächlich eine politische Dimension und sollte daher nach den Grundsätzen demokratischer und partizipativer Entscheidungsfindung und nicht durch eine Studie erfolgen.

Zu den gestellten Fragen ist folgendes anzumerken:

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Grundsätzlich sollte ein längeres selbstbestimmtes Leben bei guter Gesundheit für alle Menschen in Österreich angestrebt, also die Zahl der in Gesundheit verbrachten Lebensjahre erhöht und die Lebensqualität von erkrankten Menschen verbessert werden. Ferner ist sicherzustellen, dass der ländliche Raum bei der Gesundheitsversorgung nicht gegenüber Ballungszentren benachteiligt werden darf. Dabei wird der Einrichtung von Netzwerk-PHCs, der Ermöglichung der Anstellung von Ärzten, der Frage der Berufsberechtigungen von gehobenen Pflegeberufen und der Rolle von Spitalsambulanzen in ländlichen Gebieten für die fachärztliche Versorgung eine wesentliche Bedeutung zukommen. Des Weiteren wird es notwendig sein, die Arbeitsbedingungen für niedergelassene Ärzte in dünn besiedelten Regionen zu verbessern. Das bedingt auch eine Anpassung des Honorierungssystems an die geringere Frequenzsituation von Landpraxen (höhere Basisabgeltungen oder „Peripheriezuschlag“). Gleichzeitig muss ein Ausbau der Transportinfrastruktur stattfinden, um den Verlust bei der Versorgungsqualität durch fehlende Nachbesetzungen bei Landarztpraxen zumindest teilweise kompensieren zu können. Ebenso sollte die ambulante Versorgung ausgebaut werden und korrespondierend ein Rückbau des akutstationären Bereichs erfolgen. Ein wesentlicher Aspekt betrifft auch die

künftige Sicherstellung der Versorgung des ländlichen Raumes mit Apotheken-Dienstleistungen.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Insbesondere sollten Gesundheitsförderung und Prävention, evidenzbasierte Früherkennung und Frühintervention verstärkt werden. Ebenso sollte der Aspekt der Eigenverantwortung stärker betont und die Einführung von Kostenbeteiligungsmodellen geprüft werden. Auf die Sicherung der Gesundheitsversorgung im ländlichen Raum wurde bereits zu Frage 1. eingegangen.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Wesentlich erscheint aus der Sicht der bäuerlichen Versichertengemeinschaft, dass einerseits auf berufsgruppenspezifische Bedürfnisse weiterhin eingegangen werden kann, andererseits aber grobe Diskriminierungen wie beim Berufsschutz beseitigt oder zumindest gelindert werden – s dazu die Ausführungen unter Punkt b.

Besonderes Augenmerk wird auch auf die Kostenentwicklung im Heilmittelbereich zu legen sein. In diesem Zusammenhang wird es geeigneter Instrumente wie einer europaweit einheitlichen Zulassung mit Höchstpreisregelung bedürfen.

Die Notwendigkeit eines Ausgleichs der Nachteile, die sich aus der Altersstruktur der Versicherten in der bäuerlichen Sozialversicherung ergeben, wurde unter Punkt d. bereits angesprochen.

4. Wie können die Standards der Leistungserbringung, die Effizienz und Effektivität im jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Von zentraler Bedeutung ist hier der Grundsatz, dass einer versicherten Person alle Leistungen der sozialen Sicherheit aus einer Hand gewährt werden (One-Stop-Shop-Prinzip). Dies liegt – wie unter Punkt a. dargelegt – nicht nur im Interesse des Versicherten, sondern vermeidet auch mannigfache Reibungsverluste und erleichtert die Früherkennung und Frühintervention. Das Berufsgruppenprinzip ermöglicht ferner die Berücksichtigung spezifischer Problemlagen. Beide Faktoren tragen dazu bei, durch vorausschauende

Maßnahmen – neben individuellem Leid – hohe Kosten durch Krankheit und Erwerbsunfähigkeit in späteren Lebensphasen zu dämpfen.

Die bäuerliche Sozialversicherung hat schon sehr früh Effizienzmaßnahmen gesetzt und ab dem Jahr 2003 ihren gesamten "Backoffice-Bereich" mit EDV, Einkauf, Druckerei, Hausverwaltung und Bauwesen in der SVD Büromanagement GmbH gebündelt, einem gemeinsamen Unternehmen der SVB sowie der Sozialversicherungsanstalten für Beamten, Gewerbetreibende und der Eisenbahner/Bergbau. Dadurch wurde im Bereich der SVB kumuliert ein zweistelliger Millionen Euro-Betrag eingespart.

Auch die vor rund zehn Jahren durchgeführte Teilprivatisierung der eigenen Einrichtungen der Sozialversicherungsanstalt der Bauern hat wesentlich zur Hebung von Effizienzpotenzialen und damit zur langfristigen Absicherung der Versorgung beigetragen. Dieser Schritt hat die zur Gewährleistung eines hohen medizinischen Niveaus notwendigen Investitionen, die aus eigener Kraft nicht zu stemmen gewesen wären, erst möglich gemacht und dadurch den Fortbestand der Häuser gesichert.

Mit freundlichen Grüßen

gez. Hermann Schultes
Präsident der
Landwirtschaftskammer Österreich

gez. Josef Plank
Generalsekretär der
Landwirtschaftskammer Österreich

EFFIZIENZSTUDIE

1. **Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?**

   Die österreichische Sozialversicherung ist einer der wichtigsten Eckpfeiler zur Sicherstellung der sozialen Sicherheit in Österreich, wobei folgende Grundsätze hervorzuheben sind:

   Das Prinzip der Selbstverwaltung:
   Der Staat hat die Erledigung bestimmter Aufgaben der öffentlichen Hand jenen Personengruppen überlassen, welche unmittelbar davon betroffen sind. Die Selbstverwaltung im Bereich der Träger innerhalb der Sozialversicherung repräsentiert unterschiedliche Riskengemeinschaften deren Interessen zum Teil sehr spezifisch sind. Die Versichertenvertreter sind durch Entsendung durch die jeweiligen Interessenvertretungen, bei deren Wahlen der Wille der Versicherten zum Ausdruck kommt, demokratisch legitimiert.

   Das Prinzip der Pflichtversicherung:
   Auf Grund der gesetzlich vorgesehenen Pflichtversicherung – sprich der Entstehung des Versicherungsverhältnisses kraft Gesetzes unabhängig von bestimmten Risken – wird die Gesundheitsversorgung des überwiegenden Teils der österreichischen Bevölkerung gewährleistet. Die Finanzierung der Sozialversicherung erfolgt zum größten Teil durch an der Höhe der jeweiligen Einkommens orientierte Beiträge unabhängig vom zu versichernden Risiko. Das bedeutet die Leistungen können zu leistbaren Bedingungen in Anspruch genommen werden. Dem gegenüber stellt sich die Versicherungspflicht als ineffizienter in Punkto Verwaltungsausgaben dar.

   Das Solidaritätsprinzip:
   Im Zusammenhang mit der Pflichtversicherung kommt dem Solidaritätsprinzip ein wesentlicher Anteil zu, denn dadurch erfolgt ein sozialer Ausgleich zwischen besser verdienenden und sozial schwächeren Menschen, zwischen Gesunden und Kranken sowie zwischen Jungen und Alten. Durch die beitragsfreie Mitversicherung von Kindern und Lebenspartnern wird zu dem ein wesentlicher Beitrag zur Stärkung von Familien geleistet.

   Das Sachleistungsprinzip:
   Wichtig ist in diesem Zusammenhang auch, dass das Sachleistungsprinzip, das im Wesentlichen durch die Vertragspartner der Krankenversicherungsträger erbracht wird, weiterhin gestärkt und ausgebaut wird und die Erbringung von Privatleistungen im Wesentlichen ausgeschlossen wird.

Föderalistische Struktur:
Die Struktur der Träger der Krankenversicherung kann nicht isoliert betrachtet werden, sondern ist im Kontext mit anderen Organisationen (wie Kammer, Länder etc.) zu sehen. Solange eine derartige föderalistische Struktur auf Grund der Verfassung in Österreich in diesen Bereichen besteht, muss auch eine Krankenversicherung derart organisiert sein.

Auf der Basis dieser Prinzipien wurde das österreichische Sozialversicherungssystem ständig weiterentwickelt, sodass ca. 99,9 % der Bevölkerung sozialversichert sind und somit freien Zugang zum öffentlichen System haben.

Nachdem die Sozialversicherung bereits seit vielen Jahren mit dem Zielsteuerungsinstrument Balanced Scorecard arbeitet, konnte auch bei den Gesundheitsreformen der letzten Jahre die Intention, das Gesundheitssystem in Richtung eines Zielsteuerungssystems zu entwickeln, beeinflusst werden. So konnte ab 2013 ein partnerschaftliches Zielsteuerungssystem zwischen den Systempartnern Bund, Länder und Sozialversicherung vereinbart und im Bundeszielsteuerungsvertrag handlungsleitende Prinzipien, strategische und operative Ziele (mit Messgrößen, Zielwerten und Maßnahmen versehen) zu den Steuerungsbereichen Versorgungsstrukturen, Versorgungsprozesse und Ergebnisorientierung verankert werden. Der derzeit in Verhandlung stehende Bundeszielsteuerungsvertrag für die Periode 2017 bis 2020 soll zu einer Weiterentwicklung dieses Zielsteuerungssystems führen.

Daraus ergibt sich, dass die Prioritäten im Gesundheitswesen vor allem bei den Themen der Gesundheitsreform zu sehen sind und diese Themen auch weiter voranzutreiben sind. Dies bedeutet einerseits im Steuerungsbereich Versorgungsstrukturen das Erreichen einer Entlastung der Spitäler durch Stärkung der Primärversorgung und Entwicklung von multiprofessionellen Versorgungsformen, Implementierung von Versorgungsaufträgen und Entwicklung von neuen Honorierungssystemen.

Dazu gehört im Steuerungsbereich Prozesse auch eine Weiterentwicklung der Prozesse in Hinblick auf eine zielgerichtete Patientensteuerung zur richtigen Versorgungsstufe, wobei eben der Primärversorgung hier eine große Rolle in Hinblick auf Gate-Keeper-Funktion bzw. Lotsenfunktion durch das Gesundheitssystem zukommt. Auch die Implementierung von TEWEB eines telefon- und webbasierten Erstkontakt- und Beratungsservice (Gesundheitshotline), das derzeit in Pilotprojekten in Vorarlberg, Wien und Niederösterreich gestartet wird, sollte vorangetrieben werden.

Im Steuerungsbereich Ergebnisqualität liegt der Fokus vor allem auf der Sicherstellung von Ergebnisqualität auf allen Versorgungsebenen insbesondere durch Auf- und Ausbau der Qualitätsmessung im ambulanten Bereich.

2. **Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Maß im österreichischen Gesundheitssystem enthalten oder implementiert sind?**

   Das österreichische Gesundheitswesen ist geprägt durch eine hohe Spitalslastigkeit auf der einen Seite und auf der anderen Seite durch eine hohe Arztlastigkeit im Behandlungsbereich der Versicherten. Die hohe Spitalslastigkeit des österreichischen Systems ist vor allem darin bedingt, dass sich der freie Zugang zum System nicht nur darauf beschränkt eine freie Auswahl der Gesundheitsdiensteanbieter innerhalb einer Versorgungsstufe zu haben, sondern dieser sich auch auf den Zugang zu den einzelnen Versorgungsstufen bezieht. Hier wäre eine Implementierung von bestimmten Patientensteuerungsmechanismen in Hinblick auf die richtige Versorgungsstufe sowie die richtige Diagnostik und Therapie weiter voranzutreiben.

   Ärztelastigkeit wird vor allem dadurch hervorgerufen, dass in Österreich viele Aufgaben im Gesundheitswesen, die in anderen Ländern von anderen Gesundheitsdiensteanbietern als Ärzten wahrgenommen werden, rein auf die Ärzte fokussiert sind. Hier wäre eine verbesserte Aufgabenverteilung zwischen Ärzten und anderen Gesundheitsberufen durch klare Aufgabendefinitionen und Abgrenzungen weiter voranzutreiben. Die Erarbeitung von Versorgungsaufträgen für die Primärversorgung und einzelne Fachbereiche sind hier ein guter Ansatz, der unbedingt weiter zu verfolgen ist, um von der derzeitigen „Speisekartenmedizin“ zu einer echten Leistungserbringungspflicht der Gesundheitsdiensteanbieter zu kommen.

   In diesem Zusammenhang ist auch auf die defakto bestehende Verhandlungsmacht der Ärztekammern hinzuweisen, wodurch eine starke Mitbestimmungs- bzw. Vetoposition dieser Leistungsgruppe von Leistungserbringern manifestiert wird. Diese Monopolstellung wird vor allem dann spürbar, wenn es darum geht österreichweit einheitliche (Gesamt)verträge abzuschließen oder zu verändern.

3. **Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?**

   Die Gesundheitsreform bietet eine gute Basis für die Weiterentwicklung des Gesundheitswesens, daher sind die Themen der Gesundheitsreform weiter voranzutreiben. Dazu

ist es notwendig, dass der Krankenversicherung auch die entsprechenden Rahmenbedingungen und Instrumente zur Verfügung stehen, um diese Ziele auch weiter vorantreiben zu können.

Die Regionalität und die lokale Infrastruktur der Krankenversicherungsträger muss erhalten bleiben um weiterhin Kundennähe zu gewährleisten und auf regionale Unterschiede Rücksicht nehmen zu können.

Die Sozialversicherung beschäftigt sich auch mit dem Thema Leistungsharmonisierung, wobei eine grundsätzliche aber nicht generelle Harmonisierung des Leistungsangebotes bereits intendiert ist. Unterschiede im Leistungsangebot sollen dort, wo sie sinnvoll und auch argumentierbar sind (z. B. Allgemeinmediziner in Wien vs. Flächenbundesländern) weiterhin bestehen bleiben können. Dies bezieht sich aber auf die Leistungsansprüche und das Leistungsangebot für die Versicherten, für die das Sachleistungsangebot aller Gebietskrankenkasse im Wesentlichen gleichartig gestaltet werden soll. Dem gegenüber stehen die Bezahlkataloge für Ärzte und andere Leistungsanbieter. Gerade im Bereich der Honorierung der Leistungsanbieter sind territorial unterschiedliche Gesamtverträge im Hinblick auf Verhandlungspartner und Laufzeiten klar zu befürworten um eine Risikostreuung in Bezug auf vertragslose Phasen zu erhalten und die Verhandlungsmacht nicht auf einen österreichweiten Verhandlungspartner zu konzentrieren.

Hohe Aufmerksamkeit ist auch darauf zu legen, dass durch den Bereich der Privatmedizin das öffentlich finanzierte Gesundheitswesen und das Sachleistungsprinzip nicht unterlaufen werden. Die Schere der Ungleichheit zwischen zahlungskräftigen und finanziell weniger gut ausgestatteten Menschen soll nicht weiter aufgehen.

Besonderes Augenmerk ist dem Bereich der Heilmittelkosten und hier vor allem dem Prozess der Medikamentepreisbildung zu widmen. Auch Abhängigkeiten zwischen der gesetzlichen Fortbildungsverpflichtung der Ärzte und durch die Pharmaindustrie gesponserte Fortbildungsveranstaltungen und dadurch beeinflusste Verschreibemodalitäten sind ein Thema, das behandelt werden muss.

4. **Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?**

Die Sozialversicherung hat in den letzten Jahren durch die Entwicklung eines Zielsteuerungssystems unter Nutzung des Instrumentes der Balanced Scorecard eine abgestimmte

Planung und Steuerung implementiert und eine Weiterentwicklung in Richtung Wirkungsorientierung in Angriff genommen.

Für bestimmte Aufgaben, die im Wesentlichen gleichartig abzuarbeiten sind, wurden Standardprodukte eingeführt. Dadurch sind sämtliche Massenprozesse standardisiert und werden technisch abgewickelt. Diese technischen Prozesse wurden einmal entwickelt und in der Folge auf alle Träger ausgerollt und in Betrieb genommen.

Dasselbe gilt für andere arbeitsteilige Aufgaben in der Sozialversicherung. Durch die Einrichtung von Competence Centern werden bestimmte Themen von einem Träger aufbereitet, entwickelt oder verhandelt und die Ergebnisse stehen allen anderen Trägern zur Verfügung.

Diese Vorgangsweise eines arbeitsteiligen Verfahrens und der Bündelung der Kräfte führt so zu einer höheren Effizienz und Effektivität und steht in keiner Relation zu den wohl eher marginalen Einsparungen im ohne dies sehr niedrigen Verwaltungskostenbereich, die durch Trägerzusammenlegungen lukriert werden könnten.

NÖ Patienten- und Pflegeanwaltschaft PPA

NÖ Patienten- und Pflegeanwaltschaft, 3109

Herr
Prof. Dr. Elias Mossialos
Director of LSE Health
z.H. Frau Imma Thalmann

Beilagen

PPA-SK-3/005-2017
Kennzeichen (bei Antwort bitte angeben)

- Bezug	BearbeiterIn	(0 27 42) 9005 Durchwahl	Datum
	Mag. Michael Prunbauer	15752	10. März 2017

Betrifft
LSE Health - Review of Austria's Social Insurance System

Sehr geehrter Herr Prof. Dr. Mossialos!

Wir danken für die Einladung zur Diskussionsrunde vom 23.03.2017 und dürfen Ihnen im Folgenden die Beantwortung Ihrer Fragen übermitteln:

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Aktuell ist die Primärversorgung in Österreich im Vergleich zur Versorgung durch Spitäler stark unterrepräsentiert.[1] Dies mag auch eine Folge verschiedenen Finanzierungsströme sein, da der niedergelassene Bereich vorrangig durch die Krankenversicherungsträger finanziert wird, während deren Anteil im Spitalsbereich zwischen 40% und 50% liegt.[2] Im Übrigen erfolgt die Finanzierung im Spitalsbereich durch Bund, Gemeinden und

[1] *Stigler, Florian L.* (2010): The Future of Primary Care in Austria. Master Thesis Public Health. Faculty of Medical and Human Sciences, Manchester

insbesondere durch die Länder. Der Primärversorgungsbereich (niedergelassene) Ärzte kommt seiner Steuerungs- bzw. Triagierungsfunktion nicht nach, zunehmend wird von Patientin direkt die Spitalsambulanz aufgesucht.[3] Dabei ist zu bemerken, dass eine Großteil dieser Patienten aber keiner Spitalsbehandlung bedurfte: Eine in Vorarlberg durchgeführte Studie ergab, dass die Hälfte der 120.000 Patienten, die von sich aus (also ohne ärztliche Zuweisung oder nicht im Rahmen eines Kontrolltermins) die Ambulanzen der Vorarlberger Krankenhäuser aufsuchten, auch im niedergelassenen Bereich adäquat hätte versorgt werden können.[4]

Wir sehen derzeit folgende Prioritäten:

- **Ausbau der Primärversorgung** unter den Prinzipien
    - der Patientenorientierung, das heißt die Leistungserbringung fokussiert auf die Bedürfnisse der Patienten und nicht auf jene einzelner Berufsgruppen („Das Team um den Patienten“ anstatt „Das Team um den Hausarzt)
    - interdisziplinärer Zusammenarbeit der Gesundheitsberufe,
    - hoher und transparenter Versorgungsqualität,
    - einer zum Wohnort der Patienten ortsnahen Leistungserbringung,
    - eines zeitlich flexiblen Zugangs („Versorgung rund um die Uhr“),
    - vorbeugender Gesundheitsversorgung (Prävention),
    - bei einer öffentlich-solidarischer Finanzierung aus einer Hand unter Berücksichtigung der Qualität der erbrachten Leistung.

    Dem Ausbau der Primärversorgung kommt insofern besondere Bedeutung zu, als eine Entlastung des Spitalbereiches unbedingt geboten erscheint.[5] Die derzeit bestehende Doppelgleisigkeit im extra- und intramuralen Bereich ist sowohl aus gesundheitsökonomischer Sicht, als auch insbesondere aus Sicht einer durchgängigen, interdisziplinären Patientenbetreuung (Behandlungspfad) hoch problematisch.

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[2] https://www.gesundheit.gv.at/gesundheitssystem/leistungen/krankenhausaufenthalt/selbstbehalt-krankenhaus
[3] *Pöttler* Gesundheitswesen in Österreich, S 230, 2. Auflage, 2014, Goldegg-Verlag, Wien.
[4] Vorarlberger Spitalsambulanzstudie 2010

- Definition von **Qualitätsindikatoren** und **qualitätsbezogene Leistungsvergütung**.

- **Finanzierung** der öffentlichen Gesundheitsdienstleistungen **aus einer Hand**, um einerseits eine einheitliche Finanzierung zu gewährleisten und andererseits zu vermeiden, dass Patientenströme aus finanziellen Erwägungen (wie derzeit) umgeleitet werden. So könnte kein oder nur ein geringer Ausbau des niedergelassenen Bereichs erfolgen, wenn die finanziellen Lasten der Krankenanstalten auch von anderen mitgetragen werden. In diesem Fall hätte der (ausschließliche) Finanzier des niedergelassen Bereiches naturgemäß wenig Interesse an einem Ausbau der Leistung in „seinem" zu finanzierenden Bereich.

- **Trennung von Leistungserbringer und Finanzier**: dem oben ausgeführten Gedanken folgend ist auch eine Trennung zwischen Leistungserbringern (z. B. Länder oder Sozialversicherungen als Träger der Krankenanstalten) und Finanziers einzufordern, da – ähnlich wie bei den verschiedenen Finanziers (s.o.) – die Gefahr besteht, dass Patientenströme unter dem Aspekt einer ökonomischen Optimierung der eigenen Versorgungseinrichtungen gelenkt werden.
  Kritisch ist in diesem Zusammenhang auch das Zusammenfallen von Finanzier, Leistungserbringer und Aufsichtsbehörde (etwa bei den Ländern als Krankenanstaltsträgern) zu sehen, da hier unterschiedlicher Interessenslagen in einer Rolle zusammenfallen.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Der Versorgung **chronisch Kranker** wird zu wenig Rechnung getragen. Exemplarisch hierfür ist die Versorgungssituation von Schmerzpatienten, die sich in den letzten Jahren zunehmend verschlechtert hat. Bereits im Rahmen des 20. Wiener Schmerzsymposiums 2016 wurde kritisiert, dass drei Viertel der rund 1,5 Millionen Menschen in Österreich, die unter chronischen Schmerzen leiden, keine zufriedenstellende Versorgung haben.[6] Diese Situation verschlechterte sich weiter: In den letzten drei Jahren wurde in 13 Krankenhäuser der Schmerzambulanzbetrieb eingeschränkt, neun Ambulanzen wurden in

[5] *Pöttler* Gesundheitswesen in Österreich, S 234, 2. Auflage, 2014, Goldegg-Verlag, Wien.
[6] APA Presseaussendung vom 11.03.2016

den letzten 5 Jahren überhaupt geschlossen.[7] Ursachen sind hauptsächlich Ressourcenmangel (Personal und Medikamentenkosten) sowie das Fehlen eines „Patientenpfades“, der Schmerzpatienten durch das Gesundheitssystem leitet.

In diesem Zusammenhang ist auch eine verstärkter Fokus auf den Bereich der **Vorsorge** zu lenken (vgl. z. B. Diabetes Disease Management).[8]

Qualitäts- und Risikomanagementinstrumente sind insbesondere im niedergelassenen Bereich nicht strukturell vorhanden, sondern dem Engagement einzelner Akteure überlassen, die nicht immer den Zweck erfüllen.[9]

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- **Gleiche Leistungserbringung** bei gleichen Beiträgen in der Sozialversicherung. Es ist aus Patientensicht nicht vertretbar, dass zwar der Sozialversicherungsbeitrag für die Versicherten grundsätzlich gleich ist, das Leistungsangebot jedoch zwischen den einzelnen Sozialversicherungsträgern unterschiedlich ist.

- Einheitliche, sich an der **Qualität** der Leistung orientierende Standards

- **Kontrolle**, ob die eingesetzten Mittel entsprechend diesen Standards verwendet werden (z. B. ob ein Arzt die Qualitätskriterien erfüllt hat)

- Seit Längerem kommt es zu einer Verschärfung der **Zwei-Klassen-Medizin**. Ist die Zahl der Kassen-Ärzte seit dem Jahr 2000 beinahe gleich geblieben, kam es hingegen zu einer Verdoppelung der Wahlarztordinationen.[10] Offenkundig wurde dieser Trend bei Wartezeiten auf CT bzw. MRT Untersuchungen, bei denen es in 28 von 61 angefragten radiologischen Instituten möglich war, durch private Zahlung

[7] *Szilagyi, Bornemann-Cimenti, Messerer, Vittinghoff, Sandner*-Kiesling „Schmerzmedizin – Österreichs peinlicher Weg“, Ärzte Woche, 11.02.2016
[8] Vgl. *Pongratz*, Diabetes im Griff, Newsletter der NÖ Patienten- und Pflegeanwaltschaft vom Juni 2015, www.patientenanwalt.com
[9] Vgl. Bachinger, CIRS a la Österreichische Ärztekammer, Newsletter der NÖ Patienten- und Pflegeanwaltschaft vom Oktober 2009, www.patientenanwalt.com
[10] „Immer mehr Wahlärzte, Zahl der Vertragsärzte stagniert“, *Der Standard,* 04.08.2016, Datenquelle: APA/Ärztekammer

der Leistung die teils erhebliche Wartezeit auf einen Untersuchungstermin wesentlich zu verkürzen.[11]

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- **Finanzierung aus einer Hand**, etwa ausschließlich durch die Sozialversicherungsträger unter der Voraussetzung des nächsten Punktes
- **Zentrale Steuerung**, möglicherweise umsetzbar durch ein Durchgriffsrecht des Hauptverbandes auf die einzelnen Sozialversicherungsträger.

Wir hoffen, Ihnen mit unserer Beantwortung weiter geholfen zu haben und stehen Ihnen für Rückfragen gerne zur Verfügung.

Ergeht zur Information an:
1. **Herr Dr. David Mum Bundesministerium für Arbeit, Soziales und Konsumentenschutz**

Mit freundlichen Grüßen
NÖ Patienten- und Pflegeanwaltschaft
Dr. Alexander O r t e l

[11] „Magnetresonanz-Tomographie: Wartezeit“, *Konsument*, Ausgabe 4/2016.

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Studie zu den Effizienzpotentialen in der österreichischen Sozialversicherung – Stellungnahme der OÖGKK

Sehr geehrte Frau Thalmann,

anbei übermitteln wir Ihnen die Stellungnahme der OÖGKK zur Studie zu den Effizienzpotentialen in der österreichischen Sozialversicherung. Im Anhang finden Sie ergänzende Dokumente sowie jene Materialien, die nicht publiziert wurden und daher nicht öffentlich verfügbar sind.

Für Fragen stehen wir Ihnen gerne zur Verfügung.

Freundliche Grüße

Albert Maringer
Obmann der OÖGKK

OBERÖSTERREICHISCHE GEBIETSKRANKENKASSE

Mag. Dr. Andrea Wesenauer
Direktorin der OÖGKK

Elektronische Kopie an: Dr. David Mum
Professor Elias Mossialos

Stellungnahme der OÖGKK zu den Fragen zur Diskussionsrunde über das österreichische Sozialversicherungssystem

Ein Thema, das die Menschen bewegt

Gesundheit, und damit auch die Gesundheitspolitik, ist in den vergangenen zehn Jahren vom Rand des politischen Spektrums mitten ins Zentrum gerückt. Medien, ob Print oder online, widmen immer größere Flächen diesem Themenbereich.

Das Gesundheits- oder genauer das Versorgungssystem ist von höchst untypischen ökonomischen Gesetzen geprägt – unter anderem durch ein komplexes Stakeholdersystem mit mächtigen Lobby-Groups. Versorgungsprobleme, Krankheiten und die damit zusammenhängenden Folgen wie Schmerz und Abhängigkeit von Pflege machen Menschen Angst. Entsprechend emotional fallen gesundheitspolitische Diskussionen oft aus.

Die in der Studie grundlegenden Fragestellungen der österreichischen Sozialversicherung und der damit verwandten Themenbereiche sollen im Hinblick auf den effizienten Einsatz von Ressourcen bei gleichzeitiger Harmonisierung des Leistungsstandards und Ausbau der Services für die Versicherten analysiert werden. Dabei ist aber Bedacht zu nehmen, auf welcher Basis diese Analysen stattfinden. Wird ein echtes dezentrales, zweifellos verbesserungswürdiges System mit einem theoretischen, idealistischen, zentralen System verglichen, führt dies zu Erwartungshaltungen, die in dieser Form nicht eintreten können. Ein derartiger Vergleich sollte daher vermieden werden.

Veränderung gelingt mit einer klaren Vision, einer durchdachten Strategie und gemeinsamen Werten – das hat die OÖGKK bereits bewiesen

Noch Mitte der 1990er Jahre hatte die OÖGKK die schlechtesten Werte aller Gebietskrankenkassen auszuweisen: Hohe Verwaltungskosten, ein schlechtes Image, die höchsten Defizite.

Nicht selten sind gerade solche Situationen der Ausgangspunkt für Change. Veränderungen komplexer Systeme sind nicht einfach. Mut und Durchsetzungsvermögen genügen nicht. Es braucht auch fundierte Strategien.

Die OÖGKK hat dies erkannt und eine umfassende Organisationsentwicklung initiiert. Ob beim Projekt „GKK2000", das mit den führenden Linzer Universitätsprofessoren Dr. Wolf Böhnisch und Dr. Gerhard Reber aufgesetzt wurde, oder bei der Einführung der Balanced Scorecard (BSC) in einem der ersten Unternehmen in Österreich überhaupt, bis hin zur laufenden Mit-Gestaltung des Curriculums an der neuen Medizinischen Fakultät an der Kepler-Universität Linz. Dabei wurde auf modernste Managementmethoden, Innovationen, Outcome-Orientierung, eine Einnahmenorientierte Ausgabenpolitik sowie

Kundenorientierung und Gesundheitsförderung gesetzt. Schon damals war für die OÖGKK der Turnaround „Vom Verwalter zum Gestalter" und damit eine klare, am Menschen ausgerichtete Strategie unumgänglich.

Nur die Zusammenarbeit mit den besten Köpfen aus der Wissenschaft ermöglicht es, die richtigen Hebel zu bewegen und die Risken im Griff zu behalten. Großer Wert wurde darauf gelegt, aus dieser Kooperation selbst zu lernen und Kompetenz im eigenen Haus aufzubauen – vom Management bis zu den Mitarbeitern. So entstand eine Kultur, die Weiterentwicklung und Innovation – gleichsam als permanenten Prozess – in der Organisation verankert. Wir sind uns sicher, dass das Gesundheitssystem in Österreich erfolgreich gestaltet und auch gesteuert werden kann, und zwar durch Verantwortung vor Ort als Dienstleister für die Versichertengemeinschaft und als Treuhänder der anvertrauten Beitragsgelder. Die OÖGKK sieht das Bilanzergebnis nicht einfach als Subtraktion von gesetzlichen Einnahmen und gesetzlichen Leistungsansprüchen, sondern als Verantwortung, die nach Steuerung verlangt.[1] Damit gelingt es auch, Spielraum für weitere Innovationen zu schaffen.

Die Selbstverwaltung – eine Erfolgsgeschichte

Die Selbstverwaltung (bestehend aus VertreterInnen der ArbeitnehmerInnen und ArbeitgeberInnen) gilt als Grundstein für eine soziale Krankenversicherung und somit auch als einer der Erfolgsfaktoren für ein solidarisches System der sozialen Sicherheit – ausgehend von dem Prinzip der Pflichtversicherung. Dies wird in der gegenständlichen Studie nochmals klar zum Ausdruck gebracht und ist für das österreichische Gesundheitssystem unerlässlich.

Das Selbstverwaltungsprinzip ist in der Bundesverfassung verankert. Zu beachten ist, dass der Gesetzgeber nicht die Freiheit besitzt, die Organisation der Sozialversicherungsträger ausschließlich nach Zweckmäßigkeitsüberlegungen zu gestalten. Der Gesetzgeber hat vielmehr den verfassungsrechtlich vorausgesetzten Selbstverwaltungsbegriff zu beachten. *„Eine gesetzliche Regelung, die sich nicht innerhalb jenes Spielraumes hält, den der Typusbegriff der Selbstverwaltung*[2] *eröffnet, ist verfassungswidrig."*[3] Das würde etwa für eine

[1] Das zeigen umfassende Projekte der OÖGKK: Organisationsreform GKK 2000, FOKO, Orientierung Kunde, BSC Erfolgsplan oder die Kooperations-BSC mit der Ärztekammer OÖ vgl dazu *Wesenauer*, Balanced Scorecard als Teil eines integrierten Managementsystems der OÖGKK, Soziale Sicherheit 2004, 100; *dieselbe*, Gesundheitspartnerschaft – Kooperation als problemadäquate Lösung im Gesundheitswesen, Soziale Sicherheit 2004, 480; *dieselbe*, Von der Balanced Scorecard zum Erfolgsplan. Erfolgreiche Strategien systemisch entwickeln und umsetzen (2008); OÖGKK medien info service 57/2016.

[2] Vgl *Korinek/Leitl* in Tomandl, System des österreichischen Sozialversicherungsrechts, 19. Erg-Lfg 491: zu den Typusmerkmalen gehören die Einrichtung als juristische Person und zwar als Körperschaft durch einen Hoheitsakt, die obligatorische Zugehörigkeit, die Bestellung der Organe aus der Mitte der Verbandsangehörigen durch Wahl, die Kompetenz zur Besorgung öffentlicher Aufgaben, eine gewisse Befehls- und Zwangsgewalt gegenüber den Mitgliedern, eine relative Unabhängigkeit

Änderung des Verhältnisses von Dienstnehmer- und Dienstgebervertretern in den Krankenversicherungsträgern hin zu einer paritätischen Besetzung zutreffen.[4] Bestmögliche Ergebnisse können nur durch ein wirksames Zusammenspiel der Ebenen, in diesem Fall zwischen politisch-orientierter Selbstverwaltung und fachlich kompetentem Management im Sinne von „multi-level governance" erreicht werden.[5] Darauf gehen einige wichtige Meilensteine der Sozialversicherung zurück: Von der Vorreiterrolle bereits seit Ende der 1990er Jahre bei der Betrieblichen Gesundheitsförderung, der Einführung der e-card, der Forderung nach der bundesweiten „Gratis-Zahnspange" (Kieferorthopädie für Kinder und Jugendliche) oder der Einführung des sozialversicherungsweiten Competence-Center für Risiko- und Auffälligkeitsanalyse im Dienstgeberbereich (RAD – um Sozialmissbrauch von Dienstgebern und Dienstnehmern im Melde-, Versicherungs- und Beitragsbereich besser begegnen zu können).
Zudem wurden Programme zur integrierten Versorgung für die Bereiche Diabetes, Demenz, Schlaganfall oder Herzinsuffizienz entwickelt. Schließlich soll noch erwähnt werden, dass der Obmann der OÖGKK gemeinsam mit dem Management, maßgeblich bei vielen Verhandlungen und Einigungen zu wichtigen Themen für die Gesundheitsversorgung in (Ober)Österreich beteiligt war bzw. diese – wie auch seine Vorgänger – auf den Weg gebracht hat: Dazu zählen die flächendeckende Kinder-Rehabilitation für ganz Oberösterreich, die Neuregelung über die CT/MR-Versorgung, der Lehrpraxis-Gesamtvertrag oder Österreichs erstes vollausgebaute Primärversorgung in Enns. Gerade auch im Bereich der Gesundheitsreform gibt es seitens der Selbstverwaltung ein klares Bekenntnis zur Kostenverantwortung und wichtige inhaltliche Übereinstimmungen in den Bereichen Sachleistungsversorgung oder Qualität. Weitere Informationen dazu finden Sie im Anhang unter „Starke Selbstverwaltung, kompetentes Management – Beispiele für OÖGKK-Initiativen, -Innovationen und -Beiträge zu österreichweiten Vorhaben".
Es liegt im Interesse der Selbstverwaltung, die Sozialversicherung sparsam, kundenorientiert, unbürokratisch und sozial zu gestalten – da sie als Beitragszahler und Versicherte (als Arbeitgeber und Arbeitnehmer) selbst unmittelbar betroffen sind.

Zusammenführungen von anderen Sozialversicherungsbereichen führen nicht zwangsläufig zu wirtschaftlichen Vorteilen oder Einsparungen

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durch Weisungsfreiheit aber Bindung an die Aufsicht durch den Staat, eine gewisse finanzielle Selbstständigkeit.
[3] *Öhlinger*, Die Bedeutung der Selbstverwaltung in der Sozialversicherung, DRdA 2002, 191 ff.
[4] *Öhlinger*, Rechtsgutachten: Parität in den Verwaltungskörpern der Krankenversicherungsträger? Verfassungsrechtliche Fragen einer Organisationsreform der Träger der gesetzlichen Krankenversicherung (2004).
[5] Vgl *Wesenauer*, Komplexe Mehrebenensysteme zukunftsorientiert steuern und ausrichten, in Bauer/Wesenauer (Hrsg), Zukunftsmotor Gesundheit. Entwürfe für das Gesundheitssystem von morgen (2015) 25.

Aufgrund der Ähnlichkeit mit der gegenwärtigen Diskussion in Österreich, sollte zunächst – trotz wesentlicher Unterschiede zwischen den beiden Systemen – auf den Bericht des deutschen Bundesrechnungshofes über die Prüfung der freiwilligen Vereinigung von Krankenkassen der Gesetzlichen Krankenversicherung eingegangen werden[6]. In Deutschland wurde im Jahr 1992 die Anzahl der Krankenversicherungsträger von 1.397 auf 160 im Jahr 2010 reduziert. Der Bundesrechnungshof prüfte 2010 mehr als ein Viertel der in den Jahren 2007 bis 2009 vollzogenen Fusionen auf ihre wirtschaftlichen Auswirkungen. Er stellte fest, dass das Ziel der Krankenkassen, durch Fusionen vor allem Leistungs- und Verwaltungsausgaben einzusparen, oft nicht erreicht werden konnten. Bei den Leistungsausgaben konnten die Krankenkassen nach der Fusion nur in wenigen Fällen günstigere Vertragskonditionen aushandeln. Erreichten die Kassen Preissenkungen, waren diese im Vergleich zu den gesamten Leistungsausgaben gering. Vereinzelten Einsparungen standen fusionsbedingte Mehrausgaben gegenüber. Bei fast allen untersuchten Zusammenlegungen stiegen die Verwaltungskosten im Jahr der Fusion an, im Einzelfall um bis zu 18 Prozent. Auch in den ersten drei Folgejahren sanken die Verwaltungsausgaben nicht. Nach Ansicht des Bundesrechnungshofes sind Fusionen keine notwendige Voraussetzung, um Marktanteile oder Fachwissen zu bündeln. Mengeneffekte lassen sich mit deutlich weniger Aufwand auch durch Kooperationen erreichen.[7]
Auch bei der Fusion der Pensionsversicherungsanstalten in Österreich gestaltete sich die Zusammenführung im Jahr 2003 schwierig. Der österreichische Rechnungshof zeigte auf, dass das Einsparungsziel von 10% des Verwaltungs- und Verrechnungsaufwandes aufgrund einer Reihe von Planungs- und Durchführungsmängeln wie beispielsweise dem kurzen Übergangszeitraum nicht erreicht wurde. Eine beabsichtigte Beschleunigung der Verfahrensdauer war ebenso nicht nachweisbar.[8] Die geplante Zusammenlegung der

[6] vgl Deutscher Bundestag, 17. Wahlperiode, Drucksache 17/7600, „Fusionen von Krankenkassen müssen wirtschaftlich sein", 51 vom 14.11.2011, <http://dip21.bundestag.de/dip21/btd/17/076/1707600.pdf> (Datum des letzten Abrufs 08.03.2017); Deutscher Bundesrechnungshof, Jahresbericht 2011, Teil III Einzelplanbezogene Entwicklung und Prüfungserkenntnisse, Bemerkungen Nr. 70 „Fusionen von Krankenkassen müssen wirtschaftlich sein" , Kapitel 1502 Titel 63606, vom 15.11.2011, <https://www.bundesrechnungshof.de/de/veroeffentlichungen/bemerkungen-jahresberichte/jahresberichte/2011/teil-iii-einzelplanbezogene-entwicklung-und-pruefungserkenntnisse/bundesministerium-fuer-gesundheit/langfassungen/2011-bemerkungen-nr-70-fusionen-von-krankenkassen-muessen-wirtschaftlich-sein> (Datum des letzten Abrufs 08.03.2017)
[7] Vgl *Biberauer*, RH-Bericht über Fusionierungen von Krankenkassen in Deutschland (2011) zu finden im Anhang.
[8] Vgl Rechnungshof Bund 2007_08_03 Bericht „Fusion der Pensionsversicherungsanstalten der Arbeiter und Angestellten <http://www.rechnungshof.gv.at/fileadmin/downloads/2007/berichte/teilberichte/bund/Bund_2007_08/Bund_2007_08_3.pdf> (Datum des letzten Abrufs 14.03.2017)

Sozialversicherungsanstalt der gewerblichen Wirtschaft mit der Sozialversicherungsanstalt der Bauern scheiterte schließlich an der Frage der Honorierung der Ärzteleistungen.[9]

Diese Erkenntnisse aus konkreten Fusionsvorhaben sind betriebswirtschaftlich alles andere als überraschend. Kernargument für viele der Fusionsprojekte waren und sind angestrebte Skaleneffekte – im konkreten Fall also erhoffte Einsparungen in der Verwaltung und/oder in der Leistungsbereitstellung aufgrund größerer Einheiten. Diesen positiven Skaleneffekten stehen aber in der Betriebswirtschaftslehre ab einer (v.a. branchenabhängigen) Größe auch negative Skaleneffekte bzw. diseconomies of scale gegenüber, die sehr gerne ausgeblendet oder vergessen werden. Die Kostenentwicklung zeichnet aber mit steigender Größe keine rein sinkende, sondern eine U-Kurve.[10] Konkret bedeutet das, dass ab einer bestimmten Idealgröße die erzielbaren Kostenvorteile bzw. economies of scale so stark von negativen Skaleneffekten überlagert werden, dass sich der Vorteil ins Negative umkehrt und ein weiteres Größenwachstum zu (Stück-)Kostensteigerungen führt. Berechnungen der OÖGKK sowie der SV-interne NÖGKK-Betriebsvergleich weisen darauf hin, dass die Idealgröße eines Krankenversicherungsträgers in Österreich bei oder knapp über einer Million geschützten Personen liegen dürfte.
Neben der rein kostenmäßigen Betrachtung sind aber auch systemische Überlegungen hier zu berücksichtigen: So würde die Schaffung eines bundesweit einheitlichen, monolithischen Verwaltungsorganisation jede Möglichkeit des Benchmarkings unterbinden und jeglichen Anreiz zur Innovation, höherer Kundenzufriedenheit, gesundheitspolitisch verantwortungsvoller ökonomischer Steuerung oder höherer Effizienz nehmen.

Berücksichtigung der verfassungsrechtlichen Grenzen einer finanziellen Umverteilung zwischen den Sozialversicherungsträgern

In den letzten 10 Jahren hatten einige Gebietskrankenkassen ein negatives Nettoreinvermögen. Wie an obiger Stelle bereits ausgeführt, hat die OÖGKK hat durch frühzeitige Strategieveränderungen die Zeichen der Zeit erkannt und einen umfassenden Change-Management-Prozess eingeleitet. Dadurch entwickelte sich die OÖGKK zu einer Gebietskrankenkasse mit kontinuierlich steigenden Rücklagen (im Jahr 2015 sind es 230 Millionen Euro). Seit 1995 liegt die OÖGKK jedes Jahr beim EGT besser als der Schnitt der Gebietskrankenkassen.
Richtig ist, dass die unterschiedlichen Versicherungsträger unterschiedliche Risikostrukturen für ihr Handeln vorfinden, mit unterschiedlichen Einnahmenquoten, verschiedenen

[9] Josef Striegl in OÖ Nachrichten <http://www.nachrichten.at/nachrichten/politik/landespolitik/Krankenkassen-Skepsis-gegenueber-Fusionsplaenen;art383,2249660> (Datum des letzten Abrufs 15.03.2017).
[10] Vgl WIFO 2010: <https://www.bmf.gv.at/budget/finanzbeziehungen-zu-laendern-und-gemeinden/Gemeindestruktur_und_Gemeindekooperation(1).pdf?5te3k7> (Datum des letzten Abrufs 17.03.2017).

Altersstrukturen, usw. Dabei liegt Oberösterreich gerade bei den Beitragseinnahmen mit Wien und Vorarlberg im höchsten Segment. Gleichzeitig gibt es aber auch Belastungsfaktoren, wie etwa die deutlich ältere Versicherten-Zusammensetzung in Oberösterreich, den höchsten Anteil an beitragsfrei Mitversicherten oder die höchste Pro-Kopf Belastung in der Krankenanstaltenfinanzierung[11]. Die Risikostruktur allein vermag also die Unterschiede im erzielten EGT keineswegs vollständig zu erklären. Andere Faktoren, wie etwa die effektive Steuerung, der Aufbau von strategischer Kooperation mit den Leistungsanbietern usw. wirken sich ebenfalls in erheblichem Ausmaß auf die finanziellen Ergebnisse, aber auch auf die Zufriedenheit und die Versorgungsqualität aus.
In einem solidarischen System scheint es naheliegend, für einen finanziellen Ausgleich zwischen den Trägern zu sorgen. Dabei sind aber verfassungsrechtliche Grenzen wie der Gleichheitssatz, das Grundrecht auf Eigentum sowie das Selbstverwaltungsprinzip zu beachten. Der Verfassungsgerichthof betrachtet Maßnahmen des finanziellen Ausgleichs durchaus als heikel: Finanzielle Umverteilungen sind nur dann zulässig, wenn die betroffenen Versicherungen (Versicherungszweige) in persönlicher und sachlicher Hinsicht einen solchen Zusammenhang aufweisen, der es erlaubt, die in diesen Versicherungen (Versicherungszweigen) Versicherten als Versicherungsgemeinschaft im weiteren Sinne zu qualifizieren.[12] Die „*Vorstellung von einem alle Versicherten umfassenden Solidaritätsprinzip*" ist daher abzulehnen.[13] Bestimmungen, die eine finanzielle Umverteilung vorsehen und außerhalb der derzeit geltenden Systematik des Ausgleichsfonds getroffen werden, müssen sich zudem entweder in diesen Rahmen einfügen oder bedürfen einer besonderen sachlichen Rechtfertigung. Jedoch stellt ein bloß vorübergehender Geldbedarf einer Gebietskrankenkasse in einer bestimmten Situation keinen sachlichen Grund dar, der es rechtfertigen könnte, von dem durch den Ausgleichsfonds geschaffenen Ordnungssystem abzugehen.[14]
Vor dem Hintergrund, dass es sich bei den Rücklagen um Vermögen des Versicherungsträgers bzw. der Versichertengemeinschaft handelt, sind Eingriffe, je nachdem in welcher Art und Weise sie erfolgen, als Enteignungen oder zumindest Eigentumsbeschränkungen zu qualifizieren. In Folge des bestehenden Gesetzesvorbehaltes ist ein Eingriff dann erlaubt, wenn ein solcher durch Gesetz erfolgt, im öffentlichen Interesse liegt, geeignet ist, diesem öffentlichen Interesse zu dienen und zudem verhältnismäßig ist.[15] Einer finanziellen Umverteilung zwischen den Sozialversicherungsträger sind demnach auch durch das Grundrecht auf Eigentum enge Grenzen gesetzt.

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[11] Siehe dazu auch unten Beantwortung Frage 3 Große Ungerechtigkeiten bei der Finanzierung (Pro-Kopf-Zahlungen in KH-Finanzierung).
[12] VfGH G 66, 67/83; *Frank* in Mosler/Müller/Pfeil, Der SV-Komm § 447e ASVG Rz 3.
[13] VfGH G 66, 67/83; G 74/83, VfSlg 10.451 = JBl 1986, 710 zitiert nach *Frank* in Mosler/Müller/Pfeil, Der SV-Komm § 447e ASVG Rz 3.
[14] Vgl VfGH G 166/09 mit weiteren Nachweisen.
[15] *Mayer/Kucsko-Stadlmayer/Stöger*, Bundesverfassungsrecht[11] Rz 1341 ff.

Die geltenden Rahmenbedingungen geben den Krankenversicherungen aber kaum Anreize und Spielräume, selbst aufgebaute finanzielle Reserven wieder im Sinne ihrer Versicherten in die Entwicklung, Evaluation und Ausrollung innovativer neue Leistungen zu investieren, und so einen Beitrag zur systemweiten Dynamik zu leisten. Vor allem aber nehmen Modelle, die in erwirtschaftete finanzielle Reserven eingreifen, letztlich jeden Anreiz für Effizienz, Innovation und die oft erforderliche Auseinandersetzung mit den Systempartnern, Leistungsanbietern und Versicherten.
Die OÖGKK plädiert daher für neue Regelungen im Bereich der Rücklagen, die es den Krankenversicherungen, im Interesse der jeweiligen Versichertengemeinschaft, ermöglichen, das über die notwendige Leistungssicherungsrücklage zur Risikoabdeckung hinausgehende Eigenkapital im Sinne des Innovations- und Versorgungsauftrags für die Eigentümer und somit für die Versicherten zu investieren, ohne dabei – wie es die gegenwärtige Regelung verlangt – gleichzeitig einen Bilanzverlust ausweisen zu müssen, was die Leistungsfähigkeit des Trägers insgesamt in Frage stellen würde.

1. **Was sind Ihrer Ansicht nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?**

Im österreichischen Gesundheitssystem wurde mit der Gesundheitsreform 2012 ein organisationsübergreifendes, partnerschaftliches und zielorientiertes Governance-System unter dem Titel „Zielsteuerung Gesundheit" implementiert. Insofern könnte die Frage bereits mit einem Verweis auf den offiziellen Ziele-Katalog laut Bundes-Zielsteuerungsvertrag 2013 und dem in Arbeit befindlichen Bundes-Zielsteuerungsvertrag 2017 beantwortet werden, wo ein von allen Finanzierungs- und Steuerungspartnern gemeinsam beschlossener Zielekatalog für die Weiterentwicklung des österreichischen Gesundheitssystems festgeschrieben ist. Inhaltlich können aber aus unserer Sicht folgende Themen besonders herausgearbeitet werden, die bereits prioritär auf der Agenda der österreichischen Gesundheitspolitik bzw. -verwaltung stehen:

Suche nach dem Best Point of Service

Österreichs Gesundheitssystem zeichnet sich durch ein hohes Maß an Freiheiten und Wahlmöglichkeiten für Patienten bei der Inanspruchnahme von Versorgungsleistungen aus – die freie Arztwahl und die Möglichkeit, ohne rechtliche Hürden grundsätzlich jede Versorgungsebene in Anspruch nehmen zu können, werden hoch geschätzt. Analog finden auch Gesundheitsdiensteanbieter (GDA), vor allem Ärzte, ein hohes Maß an Freiheit vor, sei es in Form der Niederlassungsfreiheit (zumindest als Wahlarzt) oder auch in der Behandlungsentscheidung.
Im Umkehrschluss erscheinen aber strukturierte, evidenzbasierte Versorgungsprozesse und vor allem die Qualitäts- und Outcomeorientierung in der Versorgung noch

verbesserungswürdig. Diese Themen finden daher vielfachen Niederschlag in den Ziel- und Maßnahmenkatalogen der Zielsteuerung Gesundheit. Eine Facette dieser Problematik ist, dass im österreichischen Gesundheitssystem fast flächendeckend nur geregelt ist, welcher Leistungsanbieter welche Leistungen erbringen und in der Folge mit den zuständigen Financier abrechnen darf. Nicht geregelt ist hingegen in aller Regel, welcher Versorgungsauftrag für die jeweilige Arzt- oder Therapeutenstelle oder auch Krankenhauseinrichtung gilt. Konkret ausgedrückt fehlt es an klaren Zuständig- und Verantwortlichkeiten für die öffentlichen Gesundheitsangebotsstrukturen, was unter dem Schlagwort des „best point of service" im Rahmen der Gesundheitsreform bearbeitet wird und sich in den Rahmensetzungen insbesondere im ÖSG (Österreichischer Strukturplan Gesundheit) und RSG (Regionaler Strukturplan Gesundheit) wiederfinden soll.
Für Patienten zieht das nicht nur Fragen der Qualität, insbesondere bei komplexen und/oder chronischen Krankheitsbildern nach sich. Trotz international sehr hoher Versorgungsstruktur-Werte kommt es zu inakzeptablen Wartezeiten auf bestimmte Leistungen und/oder in bestimmten Regionen. So erhebt die OÖGKK regelmäßig in Zusammenarbeit mit dem Qualitätsinstitut der oberösterreichischen Ärztekammer die Wartezeitensituation, konkret die Wartezeit auf einen Arzttermin. Diese lag 2014 zB im Bereich Augenheilkunde, bezogen auf nicht-akute Routineuntersuchungen für Stammpatienten eines Vertragsarztes je nach Bezirk bei durchschnittlich 18 bis 167 Tagen. Eine Analyse, die die Wartezeitenvergabe in Zusammenhang mit der Auslastung der jeweiligen Arztordination setzte, ergab interessanterweise, dass es keinen Zusammenhang zwischen Auslastung und Terminvergabepraxis gab – dass also teilweise auch sehr stark frequentierte Ordinationen sehr rasch Termine vergaben, während Ordinationen mit deutlich unterdurchschnittlichen Patientenzahlen exorbitant lange Wartezeiten vorgaben.
Die Verbesserung dieser Wartezeitenproblematik, etwa im Bereich CT/MR, bei elektiven Operationen oder auch bestimmten Facharztleistungen, ist daher prominent auf der österreichischen gesundheitspolitischen Agenda vertreten, wobei die Ursachen nach unseren Analysen nicht vorrangig in einem Mangel,[16] sondern in Organisations- und Steuerungsproblemen bzw. mangelnder Patientenorientierung zu suchen sind.

Ausbau von Primärversorgungseinrichtungen

Die OÖGKK hat sich nicht zuletzt aus diesen Gründen federführend in die Konzeption des österreichischen PHC-Konzepts[17] eingebracht, sondern mit dem Projekt „Enns" auch das

[16] Vgl GÖG im Auftrag des BMG, Das österreichische Gesundheitswesen im internationalen Vergleich, 4. Auflage (2015) 45, wonach Österreich bei der Anzahl von MRT-/CT-Geräten im gesamteuropäischen Vergleich an 7. Stelle liegt.
[17] Vgl *Fischer/Schauppenlehner*, Der „Hausarzt Neu". Bausteine für den Weg zu einer hausarztbasierten medizinischen Primärversorgung, Soziale Sicherheit 2012, 60; *Hauptverband der Sozialversicherungsträger*, Primärversorgung in Österreich, Soziale Sicherheit 2014, 110; *Endel*, Reform – Planung – Ist-Zustand (Teil II). Primärversorgung, Soziale Sicherheit 2015, 228;

erste Primärversorgungszentrum (in voller Umsetzung des Konzepts) in Betrieb nehmen können.[18] Weitere konkrete Primärversorgungszentren sind in Oberösterreich bereits in Planung und teilweise auch in Umsetzung. Hier ist zu betonen, dass es der OÖGKK nicht nur gelungen ist, die Pilotstandorte in Abstimmung mit der oberösterreichischen Ärztekammer festzulegen und auszurollen; darüber hinaus konnte auch mit dem Land Oberösterreich ein entsprechendes Modell für die Kostenbeteiligung vereinbart werden, das vor allem Leistungen abdecken soll, die über das Leistungsspektrum der gesetzlichen Krankenversicherung hinausgehen (zB Sozialarbeit), sowie für den spitalsentlastenden Auftrag der Primärversorgungszentren (PVZ).
Die zentrale Herausforderung in Oberösterreich im Zusammenhang mit den PVZ und den darüber hinaus angedachten Primärversorgungs-Netzwerken und analogen Strukturen im spezialisierten/fachärztlichen Bereich ist es, Ärzte für die Beteiligung an solchen Modellen zu gewinnen. Da diese neuen Angebotsstrukturen nicht additiv zur bestehenden Struktur aufgebaut, sondern aus den bestehenden Stellenplänen usw. (teilweise) in neue Organisationsformen überführt werden sollen, sind zum einen bestehende Vertragsärzte als Zielgruppe angesprochen. Diese müssten aus einer aufrechten, bekannten und sehr sicheren Vertragssituation für eine neue, in Österreich noch weitestgehend unbekannte Organisationsform gewonnen werden. Hinzu kommt, dass PHC-Strukturen organisatorisch entweder als Ärzte-GmbH oder als Ärzte-Personengesellschaften betrieben werden können, in denen alle Ärzte grundsätzlich gleichberechtigte Miteigentümer sind und gemeinsam die betriebswirtschaftlichen Risken – von der Finanzierung der Räumlichkeiten bis zur Personalanstellung – zu tragen haben.
Diesen Herausforderungen stehen aber die überaus positiven ersten Erfahrungen aus Enns gegenüber, die eine hohe Attraktivität dieser Modelle im Hinblick auf Teamarbeit, planbare Arbeitszeiten, Vereinbarkeit von (ärztlichem) Beruf und Familie usw. erkennen lassen.

Finanzierungsfragen

Die sehr ärzteintensive Versorgungsstruktur Österreichs erfordert ausreichend ärztlichen Nachwuchs, um die bestehenden Strukturen aufrechterhalten zu können. Zu diesem Ziel sind Strategien erforderlich, die an mehreren Stellen ansetzen. Zum einen werden Maßnahmen entwickelt, um in Zukunft Ärzte zielgerichteter und effizienter einzusetzen und Aufgabenbereiche sinnvoller auf die verschiedenen qualifizierten Gesundheitsberufsgruppen aufzuteilen. Daneben muss es das Ziel sein, bestehende Ärzte im versorgungsrelevanten Sachleistungsbereich zu halten. Selbstverständlich müssen ausreichend Ärzte in den erforderlichen Fachbereichen ausgebildet werden. Hier besteht insbesondere ein Bedarf im Bereich Allgemeinmedizin.

Ivansits/Prinzinger, Rechtspolitische und juristische Aspekte einer Primärversorgung in Österreich, RdM 2015, 44.
[18] Vgl OÖGKK medien info service 7/2017.

Ein generelles Ziel der österreichischen Gesundheitspolitik lautet, die stationäre Versorgung zu entlasten und zu reduzieren und im Gegenzug die ambulante Versorgung zu stärken. Dabei kann und soll es auch zu Verlagerungen zwischen intra- und extramuralem Bereich kommen. Da in diesen beiden Bereichen unterschiedliche Finanzierungslogiken implementiert sind[19] – die Zahlungen der Krankenversicherung an den Spitalssektor erfolgen grundsätzlich auf Basis einer jährlich valorisierten Pauschale und sind damit mengen- und leistungsunabhängig,[20] während im extramuralen Bereich ein Mischsystem aus Einzelleistungs- und Fallpauschalenfinanzierung vorhanden ist – wirft eine Verlagerung vom intra- in den extramuralen Bereich ein Problem auf: Denn die reduzierten Spitalsleistungen führen nicht zu reduzierten Finanzierungsströmen, es wird also weiterhin für in diesem Fall nicht mehr erbrachte Leistungen bezahlt. Diese Mittel fehlen selbstverständlich bei der Finanzierung der mengenabhängigen extramuralen Leistungen. Oder einfacher ausgedrückt: Da die Krankenversicherung jeden Euro nur einmal ausgeben kann, muss eine Verlagerung von Leistungen zwischen Spitals- und niedergelassenem Sektor eine Änderung in den Finanzströmen nach sich ziehen. Diese „Geld folgt Leistung"-Logik wird seit langem kontroversiell zwischen Ländern und Krankenversicherung diskutiert, wobei die Länder oft darauf verweisen, dass weniger Patienten bzw. Leistungen im Spitalsbereich nicht unbedingt sinkende Kosten bedeuten (Remanenzkosten, Fixkosten), bzw. dass frei gewordene Ressourcen sich nach dem Prinzip der angebotsinduzierten Nachfrage teilweise wieder neue Nachfrage / neue Patienten verschaffen. Eine Lösung dieses Problems, also konkrete Modelle, die finanzielle Ausgleichsmechanismen für Leistungsverlagerungen ermöglichen, konnten in Österreich bisher nicht vereinbart werden.

Dem österreichischen Gesundheitssystem wird regelmäßig der Befund ausgestellt, dass zu viel Geld für die Kuration, aber zu wenig für Prävention ausgegeben wird. Eine aktuelle Analyse der Gesundheit Österreich GmbH (GÖG) relativiert diesen Befund deutlich und weist für Österreich mit 3,1 Prozent einen deutlich besseren Präventionsausgabenanteil aus als bisher angenommen (1,9 Prozent).[21] Grund für die Differenz sind vor allem „versteckte" Präventionsausgaben, die in Österreich – da über die Vertragspartner der Krankenkassen erbracht und abgerechnet – im kurativen Aufwand bilanziell dargestellt wurden. Beispiele dafür sind etwa Früherkennungs-Untersuchungen der Fachärzte für Gynäkologie, präventive Leistungen der Zahnärzte und Ähnliches. Auch die OÖGKK hat nach dem Rechenmodell der GÖG ihre Leistungsaufwendungen nach präventiven Leistungen durchforstet und so

[19] Der extramurale Bereich wird beinahe ausschließlich von der sozialen Krankenversicherung gesteuert und finanziert, während der Spitalssektor über die bei den Ländern angesiedelten Landesfonds finanziert wird. Gespeist werden allerdings auch die Landesfonds überwiegend aus Mitteln der Sozialversicherung, was aber keine Mitsprache- und Steuerungsrechte nach sich zieht.
[20] Vgl auch die Grafik zur Krankenanstaltenfinanzierung im Anhang.
[21] Vgl <http://www.hauptverband.at/portal27/hvbportal/content?contentid=10007.769329&viewmode=content> (Datum des letzten Abrufs 14.03.2017).

Präventionsausgaben von 86,3 Millionen Euro (das sind rund 4 Prozent des Leistungsaufwandes) ausweisen können.[22] Dennoch: Auch die OÖGKK sieht im Bereich der Gesundheitsförderung und Prävention noch maßgebliche Weiterentwicklungschancen (dazu unten).

Entwicklungen im Case- und Care-Management und Public Health

Ein Schlüssel zur besseren Versorgung und Betreuung von Personen mit schwerwiegenden, komplexen Gesundheitsproblemen ist das Case- und Caremanagement. Die OÖGKK hat als erste Krankenversicherung Österreichs auf dieses Konzept gesetzt und es Mitte der 2000er Jahre unter dem Namen „Netzwerk Hilfe" allen ihren Versicherten landesweit verfügbar gemacht.[23] Waren es anfangs noch knapp 70 Mitarbeiter im gesamten Landesgebiet, sind es nun über 100 intensiv im Case- und Caremanagement ausgebildete Kundenservice-Mitarbeiter, die Betroffene und ihre Angehörigen unterstützen. Diese Vorreiterrolle manifestiert sich auch in der auf Initiative der OÖGKK gegründeten Österreichischen Gesellschaft für Case- und Caremanagement (ÖGCC)[24], die ihren Sitz in Linz hat.
Zudem wurde in Oberösterreich die Public-Health-Bewegung auch wegweisend mitgestaltet – seit 1999 gibt es eine Intensive Kooperation mit der österreichischen Gesellschaft für Public Health. Dabei hat die OÖGKK bereits früh erkannt, dass dadurch wissenschaftlich fundierte Strategien wie zum Beispiel Gesundheitsförderung und neue Methoden in einen gesundheitlichen Gesamtkontext stehen, damit die Bevölkerungsgesundheit mittel- bis langfristig effektiv gefördert, erhalten und wiederhergestellt werden kann[25].

Zufriedenheit von Patienten und Bevölkerung

Es war ein großes Anliegen der OÖGKK, im Rahmen der Zielsteuerung Gesundheit auch die Zufriedenheit von Patienten und Bevölkerung mit dem Gesundheitssystem als zentrales Ziel mit messbaren Ergebnissen festzuschreiben. Nun liegen erste Ergebnisse vor, die eine strukturierte Verbesserung und Weiterentwicklung des Gesundheitssystem mit speziellem Blickwinkel auf die Patienten- bzw. Bevölkerungsperspektiven ermöglichen.
Die OÖGKK selbst arbeitet bereits seit den späten 1990er Jahren mit Kundenzufriedenheitsbefragungen. Heute sind die Ziele einer hohen Kundenzufriedenheit, der Systemakzeptanz sowie der Reputation der OÖGKK als leistungsfähiger sozialer Krankenversicherungsträger als zentrale Ziel- und Messgrößen in der Balanced Scorecard der OÖGKK verankert und werden regelmäßig auf hohem methodischem Niveau gemessen.

[22] OÖGKK medien info service 48/2016.
[23] <www.ooegkk.at/netzwerkhilfe> (Datum des letzten Abrufs 14.03.2017).
[24] Vgl <www.oegcc.at> (Datum des letzten Abrufs 15.03.2017).
[25] Oskar Meggeneder, Stv. Direktor der OÖGKK, war jahrelang Präsident der österreichischen Gesellschaft für Public Health.

Die Früchte dieser frühen und seither immer wieder weiterentwickelten Beschäftigung mit der Zufriedenheit lassen sich aus einigen Kennzahlen ablesen:

- In der bundesweiten Erhebung im Auftrag des Hauptverbandes erzielt die OÖGKK regelmäßig den besten Wert aller Gebietskrankenkassen[26]
- Die von der OÖGKK regelmäßig in Auftrag gegebenen Studien belegen eine seit 2007 stabile Kundenzufriedenheit mit einem Wert von 1,8 (öst. Schulnotensystem)[27].
- 50 Prozent der Auskunftspersonen sprechen sich für das derzeitige System der Krankenversicherung in Selbstverwaltung durch die Versichertengemeinschaft aus.[28]
- Im Reputation Scoring des Corporate Communication Cluster Vienna (eine Initiative, die aus einer Arbeitsgruppe des österreichischen PR-Verbandes hervorgegangen ist und einige der namhaftesten privaten und öffentlichen Unternehmen Österreichs umfasst) erreicht die OÖGKK einen überdurchschnittlichen Score von 68.[29]
- Besondere Bedeutung misst die OÖGKK der strukturierten Einbeziehung des Patientenwissens in die Weiterentwicklung der Versorgung zu: So wurden etwa psychisch erkrankte Personen im Rahmen von anonymen Fokusgruppen über ihre Erfahrungen und Einschätzung der psychischen Versorgung in Oberösterreich befragt. Die Erkenntnisse fließen bereits in die Struktur- und Prozessplanung ein.

Fokus Gesundheitskompetenz

Ein strategischer Hebel, der sowohl der Weiterentwicklung der Gesundheitsversorgung dienen als auch die Gesundheit der Bevölkerung verbessern kann, ist die Gesundheitskompetenz (health literacy).[30] Österreich erzielt hier im internationalen Vergleich sehr schwache Werte,[31] erreicht in einem Ranking von acht europäischen Staaten den vorletzten Rang; 16,7 Prozent der erwachsenenen Bevölkerung weisen eine mangelnde health literacy auf, nur 10,4 Prozent eine exzellente health literacy. Eine ganze Reihe von Maßnahmen und Strategien wurde daher – häufig unter federführender Mitarbeit der OÖGKK – implementiert, um die Kompetenz der Bevölkerung nachhaltig zu heben. Vor allem an der Verbesserung des Arzt-Patientengesprächs, aber auch an der besseren Verständlichkeit von Gesundheitsinformationen, nicht zuletzt der Sozialversicherung selbst, wird intensiv gearbeitet. Von der OÖGKK durchgeführte Pilotierungen, etwa im Bereich des

[26] Marketmind im Auftrag des Hauptverbandes der öst. Sozialversicherungsträger 2016.
[27] Marketmind im Auftrag der OÖGKK 2014/2015.
[28] Marketmind im Auftrag der OÖGKK 2014/2015.
[29] Marketmind für den Corporate Communication Cluster Vienna 2016.
[30] Gesundheitskompetenz wird in Österreich nach Soerensen et. Al (2012) folgendermaßen definiert: „Fähigkeit und Motivation der Menschen, sich Zugang zu gesundheitsrelevanten Informationen zu verschaffen, diese zu verstehen, zu beurteilen und anzuwenden, um für sich die richtigen Entscheidungen in den Bereichen Gesundheitsversorgung, Prävention und Gesundheitsförderung zu treffen."
[31] *Pelikan/Röthlin/Ganahl*, LBIHPR, Gesundheitskompetenz (Health Literacy) in Österreich im internationalen Vergleich – Ergbnisse aus dem Health Literacy Survey – Europe (2012).

Kundenservices, der Kurheime oder der ambulanten Rehabilitation zeigen erste Erfolge.[32] Spezielle Zielgruppenmaßnahmen, beispielsweise zum Thema Ernährung bei jungen Erwachsenen, werden derzeit entwickelt. Für Migranten wurden von der OÖGKK gemeinsam mit der Volkshochschule Linz eigene Sprachlern-Unterlagen erstellt, die den Erwerb der deutschen Sprache mit zentralen Aspekten der Gesundheitskompetenz verbinden.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Strategie für den Wahlarztbereich

Die Versicherten haben in Österreich die Möglichkeit, auch Ärzte und Therapeuten in Anspruch zu nehmen, die keinen Vertrag mit der Sozialversicherung abgeschlossen haben (Wahl-Ärzte und -Therapeuten). In diesem Fall haben sie Anspruch auf Erstattung von 80 Prozent des Betrages, den ein Vertragsbehandler für die gleiche Leistung von der Krankenversicherung erhalten hätte. Diese Kostenerstattung erfolgt auf Antrag, den der Versicherte an die Krankenkasse stellen kann. Gleichzeitig haben Ärzte und Therapeuten in Österreich rechtlich die Möglichkeit, praktisch ohne Einschränkungen eine eigene Ordination zu eröffnen und Leistungen anzubieten, für deren Ausübung sie qua Ausbildung befugt sind. Es existieren de facto keinerlei Rahmenvorgaben wie Mindestordinationszeiten, Versorgungsverpflichtungen, Qualitätsauflagen oder Vorgaben zur Behandlungsökonomie. Qualitätsaufsicht findet in diesem Bereich unseres Wissens de facto nicht statt.
Die Inanspruchnahme, aber auch die Zahl der Wahlärzte, stiegen in den letzten Jahren deutlich. So leistete die OÖGKK 2010 12,1 Mio. Euro an Wahlarzt-Kostenerstattung, 2015 lag der Wert bei 19 Mio. Euro (+ 57 Prozent), während im gleichen Zeitraum die Honorare an Vertragsärzte um 19,4 Prozent auf 257,2 Mio. Euro stiegen.
Auswertungen der eingereichten Kostenerstattungen durch die OÖGKK zeigen aber interessante Ergebnisse. So wurden 2016 von OÖGKK-Versicherten Kostenerstattungen für Leistungen von 1.532 Wahlärzten mit Sitz in Oberösterreich eingereicht. Zum Vergleich: Die Zahl der OÖGKK-Vertragsärzte liegt bei gut 1.100. Von den 1.532 Wahlärzten verursachen aber nur 148 mehr als 1.000 Kostenerstattungs-Anträge. Auch wenn man davon ausgeht, dass die Versicherten aus verschiedenen Gründen nicht alle Wahlarzt-Rechnungen zur Erstattung einreichen, deutet das darauf hin, dass gerade einmal 10 Prozent der Wahlärzte auf mehr als 20 (eingereichte) Patientenkontakte pro Arbeitswoche kommen. 750 Ärzte kommen auf unter 50 eingereichte Fälle pro Jahr, also gerade auf einen bis zwei Fälle pro Arbeitswoche. Man kann daraus schlussfolgern, dass der allergrößte Teil der Wahlärzte ihre

[32] Vgl *Soffried/Bencic/Block*, Die Sozialversicherung ist auf dem richtigen Weg, Soziale Sicherheit 2017, 90.

Ordination neben einer Hauptbeschäftigung und in einem sehr überschaubaren Ausmaß betreiben – eine Versorgungswirkung solcher Ordinationen kann stark bezweifelt werden. Probleme in diesem Bereich sind:

- Die sehr freizügige Niederlassungsfreiheit entzieht dem Sachleistungs- und Versorgungssystem massiv Personalressourcen. Die Möglichkeit der freien Niederlassung wird aufgrund der (indirekten) Querfinanzierung durch die Krankenversicherung, die erzielbaren hohen effektiven Stundensätze, das Fehlen jeglicher Einschränkungen und Vorgaben zB im Hinblick auf Ökonomie, Dokumentation und Qualität, die Möglichkeit der Patientenselektion und auch die Fokussierung auf besonders attraktive Leistungen bis hin zu steuerlichen Anreizen von Ärzten als sehr attraktiv wahrgenommen.
- Wahlärzte übernehmen aber zum allergrößten Teil keine Versorgungsverantwortung, sondern erbringen Leistungen, die sie selbst erbringen wollen, für Patienten, die bereit sind, privat für Krankenbehandlung und ärztliche Zuwendung zu bezahlen.
- Teilweise Erbringung von zweifelhaften oder auch nicht krankenbehandlungsrelevanten Leistungen
- Kaum sinnvolle Leistungs- oder Qualitätskontrollen möglich
- Patienten beschreiben immer wieder, dass ihnen im Krankenhaus ein Besuch in der Privatordination eines ranghohen Spitalsarztes empfohlen wird, was sich günstig auf eine kürzere Wartezeit auf einen Operationstermin auswirken könne.

Die OÖGKK respektiert das Recht ihrer Versicherten auf freie Arztwahl und auf Inanspruchnahme von Nicht-Vertragsärzten. So wurde etwa in den letzten Jahren der Service für diese Versicherten erheblich verbessert, eine einfache und komfortable Online-Einreichung der Anträge auf Kostenerstattung ermöglicht usw. Gleichzeitig bedarf dieser Bereich aber dringend sinnvoller Rahmensetzungen und Qualitätskriterien, um einerseits eine Unterwanderung der Sachleistungsversorgung und des Vertrauens der Bevölkerung in eine bedarfsgerechte Gesundheitsversorgung zu verhindern, andererseits auch um die Verschwendung von personellen und finanziellen Ressourcen für nicht versorgungsrelevante Leistungen zu minimieren. Daher plädiert die OÖGKK auf einen breit angelegten, auf Basis wissenschaftlicher Erhebungen aufgesetzten Prozess, der dazu beitragen soll, tragfähige Rahmenbedingungen für den wahlärztlichen Bereich zu finden, die neben der Lösung der oben angeführten Probleme vor allem dem Schutz der Patienteninteressen (Qualität, Konsumentenschutz ...) dienen sollen.

Strategie für Umgang mit Sonderklasse

Die private Zusatz-Krankenversicherung ermöglicht ihren Kunden – dem Gesetz nach – einen höheren Komfort im Fall einer Spitalsbehandlung („Hotelkomponente"). Darüber

hinaus werden auch Leistungen wie etwa eine höhere Kostenerstattung bei Wahlarztleistungen angeboten.
De facto wird als Leistung der Zusatzversicherung die freie Arztwahl im Krankenhaus und ein schnellerer Zugang zu (elektiven) Operationen und Behandlungen beworben und wahrgenommen.[33] Zu diesem Paradoxon passt, dass die Honorierung der privaten Krankenversicherung – vereinfacht ausgedrückt – an die Spitalsärzte auf Basis von Verträgen mit der Ärztekammer erfolgt, während die Länder gesetzlich einen Prozentschlüssel festlegen können, welchen „Hausrücklass" ihre Spitalsärzte davon für die Nutzung der Spitalsressourcen an die Spitalsbetreiber abzutreten haben. In Oberösterreich liegt dieser derzeit bei 31 Prozent der privaten Ärztehonorare,[34] wovon nach einem definierten Prozentschlüssel sehr dominant die leitenden und ranghohen Ärzte profitieren[35].
Die Bezahlung der – dem Gesetz nach als „Hotelleistung" definierten Zusatz-Krankenversicherung – erfolgt also im Effekt an die Spitalsärzte und wird bei diesen (je nach Bundesland) teilweise sogar als selbstständiges Einkommen im steuerrechtlichen Sinn gewertet.
Von den rund 11,3 Mrd. Euro, die 2012 in Österreich für intramurale Behandlung (stationär und tagesklinisch) aufgewendet wurden, stammten rund 1,4 Mrd. aus privaten Zahlungen,[36] wovon wiederum der Großteil von der privaten Krankenversicherung stammt. Dieser Finanzierungsanteil von rund einem Zehntel des Spitalsbudgets fließt aber sehr gezielt an die (ärztlichen) Führungskräfte und Experten. Diese ärztlichen Entscheidungsträger im öffentlichen Spitalswesen erhalten letztlich oft deutlich über 50 Prozent ihres effektiven Einkommens nicht vom (meist öffentlich-rechtlichen) Dienstgeber, sondern von Dritten.
Eine solche Honorierungsstruktur führt zwangsläufig zu Interessenskonflikten und kaum vom Eigentümer/Financier steuerbaren Organisationen und Prozessen, was sich in der Praxis auch deutlich bestätigt, etwa am Beispiel des Ziels einer Verlagerung von Operationen aus dem stationären Bereich in die Sonderklasse. Das scheinbare „Sparen" der öffentlichen Hand bei den ärztlichen Personalkosten unter Verweis auf die erzielbaren Nebeneinkünfte kommt aus Systemsicht sehr teuer.
Auch hier plädiert die OÖGKK für einen offenen und ehrlichen politischen Diskurs, der zu einer systemkonformen Rahmensetzung für den Bereich der Sonderklasse führen soll.

Behandlungsnahe telemedizinische Konzepte, eHealth Anwendungen

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[33] Vgl zur Diskussion Die Presse Online Ausgabe vom 17.11.2010 <http://diepresse.com/home/innenpolitik/611122/Korruption_Privatpatienten-haben-im-OPSaal-Vorrang> (Datum des letzten Abrufs 14.03.2017).
[34] § 54 Abs 3 oö. KAG
[35] *Maurer*, Übersicht über die Ärztehonorierungsmodelle in Österreich (2010) <http://webopac.fh-linz.at/dokumente/Bachelorarbeit_Maurer.pdf> (Datum des letzten Abrufs 14.03.2017).
[36] GÖG im Auftrag des BMG, Das österreichische Gesundheitswesen im internationalen Vergleich (2015) 11.

Österreich hat mit ELGA auch im internationalen Vergleich eine beachtlich fortschrittliche eHealth Struktur geschaffen, die vor allem die übergreifenden Behandlungsprozesse durch einen strukturierten Informationsfluss erheblich verbessern kann. Im Bereich der behandlungsnäheren eHealth- und Telemedizinanwendungen dürfte aber noch einiges an Potenzial vorhanden sein – wobei die OÖGKK aber wie in allen Bereichen für ein evidenzbasiertes Vorgehen eintritt. Gleichzeitig erscheint es gerade in diesem Bereich geboten, Innovationen, deren Nutzen sich bestätigt, rasch in das öffentliche Gesundheitssystem zu integrieren, um nicht durch zu langsames Vorgehen dem massiven Marktdruck zu erliegen. Es besteht ansonsten das Risiko, dass höchst sensible Daten – gesetzlich unzureichend geregelt – im Bereich kommerziell-privater Dienstleister verarbeitet werden und letztlich nicht mehr kontrollierbare Monopole in bestimmten Bereichen entstehen.

Ressourcenschonender Ärzteeinsatz

Obwohl Österreich bei den Ärzten je 1.000 Einwohner im OECD-Vergleich[37] einen absoluten Spitzenplatz belegt und auch weiterhin eine hohe Ausbildungsquote erzielt, beherrscht der Begriff eines „Ärztemangels" den politischen und medialen Diskurs.[38] Das Kernproblem ist aber nach Analysen der OÖGKK nicht in einem Mangelphänomen gelegen, sondern in einem extrem hohen Ärztebedarf, der sich aus einer Reihe, teilweise spezifisch österreichischer, Ursachen erklärt: Zum einen wurden die Organisationsstrukturen im Spitalsbereich aufgrund der zuvor bestehenden jahrzehntelangen „Ärzteschwemme" durch den Druck aufgebläht, die hohen medizinischen Absolventenzahlen rasch auf Turnusplätzen unterzubringen. Das Verhältnis zwischen Ärzten und diplomiertem Pflegepersonal ist in Österreich laut OECD-Vergleichen extrem ärztelastig. Geringe Gesundheitskompetenz, fehlende Versorgungsaufträge und nicht gelenkte Patientenströme führen zu Fehlinanspruchnahmen der Versorgungsstrukturen.

Eine immer wieder behauptete massive Ärzteabwanderung aus Österreich, kann unseres Wissens nicht mit Zahlen belegt werden bzw. wurden auch die nach Österreich zuwandernden Ärzte dabei (bewusst) ausgeblendet.[39]

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[37] Vgl OECD, Health at a glance: Europe 2016, 159.

[38] Vgl *Rehberger/Kerzner*, Ärzteschwemme versus Ärztemangel in Österreich. Eine Analyse der medialen Öffentlichkeit der vergangenen 20 Jahre, Soziale Sicherheit 2015, 215; *Kiesl*, Ärztemangel oder Nachbesetzungsprobleme bei Arztstellen: Nur ein semantischer Unterschied?, Soziale Sicherheit 2015, 224; *Frühstück*, Mit großen Schritten in die Zukunft. Interview mit Univ.-Prof. Dr. Markus Müller, Periskop Nr. 73, Februar 2017, 38.

[39] So liegt Österreich im Spitzenfeld der Auswanderungsziele deutscher Ärzte vgl Ärztezeitung vom 26.02.2015 Online Ausgabe <http://www.aerztezeitung.de/praxis_wirtschaft/praxismanagement/praxisfuehrung/article/879124/arbeiten-ausland-oesterreich-zieht-deutsche-aerzte.html> (Datum des letzten Abrufs 14.03.2017); vgl auch die Darstellung von GÖG und BMGF, Bestandaufnahme zum künftigen Ärzteangebot. Überblick über die Datenbestände. Ersteingetragene Turnusärztinnen/-ärzte im Anhang.

Die OÖGKK hat daher bereits – teils in Zusammenarbeit mit den Systempartnern wie Land, Ärztekammer und Spitalsträgern – begonnen, an Konzepten zu arbeiten, die – kurz gefasst – einen besseren Einsatz von Ärzten in der Versorgung gewährleisten sollen und vor allem sicherstellen, dass die Versorgung der Bevölkerung in gewohnt hoher Qualität durch ausreichend, gut ausgebildetes und motiviertes ärztliches Personal erfolgen kann. Solche Initiativen sind aus Sicht der OÖGKK auf bundesweiter Ebene noch nicht ausreichend positioniert.

Redimensionierung des stationären Bereichs – bei gleichzeitiger Anpassung der Finanzierungsströme

Die (geplante und gewollte) Verlagerung von Leistungen zwischen dem intra- und dem extramuralen Bereich scheitert wie o.a. bisher sehr oft an Mechanismen, die es ermöglichen, Mittel im „entlasteten" Bereich frei zu machen und in den Bereich zu verlagern, der die (neuen / verlagerten) Leistungen nun erbringt. Hier braucht es rasch funktionierende und faire Mechanismen, um Patienten gleichzeitig besser und effizienter versorgen zu können.
Zur Illustration der Dringlichkeit dieser Problematik verweist die OÖGKK auf die realen Leistungsentwicklungen im intra- und extramuralen Bereich. So gehen sowohl die stationären als auch die ambulanten (!) Leistungen im oberösterreichischen Spitalsbereich seit 2010 deutlich zurück: 2010-2015 sanken die Belegstage der oberösterreichischen Fondsspitäler um 10,6 Prozent. Die Spitalsambulanzfrequenzen gingen sogar um 5,9 Prozent zurück, was übrigens den öffentlich immer wieder behaupteten Ansturm der Patienten auf die Ambulanzen ins Reich der Mythen verweist. Die gesetzlichen Pauschalzahlungen der OÖGKK als größter Financier im oberösterreichischen Spitalswesen stiegen für diesen Bereich im gleichen Zeitraum um 21,4 Prozent.
Ebenfalls im gleichen Zeitraum stiegen die Fälle der (extramuralen) niedergelassenen Vertragsärzte übrigens um 7,6 Prozent, was zu einer Steigerung der ausbezahlten Honorarsumme von 18,1 Prozent führte.
Die OÖGKK unterstützt explizit das gesundheitspolitische Ziel, den stationären Bereich zu entlasten und auf ein bedarfsgerechtes Maß zu reduzieren, nicht zuletzt auch im Interesse der Patientinnen und Patienten. Dies muss sich aber auch in den Zahlungsströmen widerspiegeln. Ganz besonders im Bereich der Ambulanzen ist aus Sicht der OÖGKK ein differenzierter Blick unter Berücksichtigung des Best Point of Service erforderlich. Da Leistungseinschränkungen in den Ambulanzen noch dazu zu unmittelbaren Substitutionen im niedergelassenen Bereich führen, muss dem Prinzip „Geld folgt Leistung" hier besonders stringent Rechnung getragen werden.

Umsetzung Versorgungsaufträge: Vertragspartner einbinden und Verantwortung einfordern

Ein gemeinsam getragenes Ziel der Gesundheitsreform war und ist die Schaffung von mehr Verbindlichkeit in der Gesundheitsversorgung, etwa im Bereich der Planung. Damit soll der Bevölkerung bzw. den Patienten ermöglicht werden, sich besser im System orientieren zu können, rasch und effektiv zum richtigen Versorgungsangebot in der richtigen Qualität zu kommen usw.
Für die OÖGKK ist es unumgänglich, dass im Zuge dieses Prozesses die Leistungsanbieter in adäquater Form in die Umsetzung mit einbezogen werden. Wesentliche Gründe dafür sind die erforderliche Akzeptanz für die daraus entstehenden Veränderungsprozesse, aber auch die Einbeziehung des praktischen Wissens aus diesen Anbietergruppen. Nicht zuletzt ist aber gerade im Bezug auf die Ärztekammer festzuhalten, dass diese nicht nur als Interessenvertretung konstituiert ist, sondern vom Staat auch mit einer Reihe hoheitlicher Aufgaben beliehen wurde. Im Hinblick auf die gesundheitspolitischen Diskussionen der vergangenen Jahre – von ELGA bis zu PHC – ist aus Sicht der OÖGKK hier auch im Dialog mit der Ärztekammer eine Klärung der Rolle und der Verantwortung herbeizuführen, wenn es um die Erreichung gesamtstaatlicher Interessen in der Gesundheitspolitik geht.

Stärkung der Rolle der Träger gegenüber den Spitälern – dafür ist eine dezentrale Verantwortung wichtig
Die OÖGKK ist mit Abstand der größte Financier im oberösterreichischen Spitalswesen. Durch die Gesundheitsreform ist es – wie erhofft – zu einer deutlich besseren Abstimmung der Planung zwischen intra- und extramuralem Bereich auf Basis gemeinsamer Analysen der realen Versorgungssituation gekommen. Nach wie vor ist die OÖGKK aber von tatsächlichen Steuerungsentscheidungen, die aus ihren Mitteln finanziert werden (!), de facto ausgeschlossen.
Da die Steuerung der Spitäler derzeit praktisch ausschließlich auf Länderebene erfolgt, braucht es auf dieser Ebene auch eine gestärkte Rolle der Gebietskrankenkassen.

3. **Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?**

Große Ungerechtigkeiten bei der Finanzierung (Pro-Kopf-Zahlungen in KH-Finanzierung)
Wie schon unter 3. angeführt, bewirkt die gesetzlich pauschalierte Zahlung der Krankenkassen bei der Krankenanstaltenfinanzierung sehr unterschiedlich hohe Pro-Kopf Belastungen zwischen den Versicherungsträgern. Der Grund dafür ist hauptsächlich im historischen Zustandekommen der Pauschalierung zu suchen. Diese Regelung ist sachlich nur bedingt nachvollziehbar und trifft mehrere Kassen negativ. Unterschiedlichen Angebotsstrukturen in den Bundesländern oder auch in den unterschiedlichen

Beitragsgrundlagen/Leistungsfähigkeiten der verschiedenen Träger spielen dabei eine untergeordnete Rolle.
Berücksichtigt man neben den Zahlungen für stationäre Leistungen auch die Zahlungen an den Spitalsambulanzbereich, weist die OÖGKK die höchste Zahlungsbelastung je Anspruchsberechtigtem auf.[40] Ein Rechenbeispiel zeigt die Bedeutung dieser Ungleichbehandlung: Hätte die OÖGKK im Jahr 2015 den Durchschnittswert aller Kassen für die Spitalsversorgung zu zahlen, so läge ihr Zahlungsbeitrag an den Spitalssektor um rund 115 Millionen Euro pro Jahr niedriger – bzw. könnten diese Mittel sinnvoller anders eingesetzt werden. Eine fairere Verteilung der Mittelaufbringung und Mittelverwendung würde zu gleichen Belastungen führen.

Medikamenteneinkauf bzw. Preisgestaltung

Das Beispiel „Sovaldi" zeigt eine bedrohliche Entwicklung der Gesundheitspolitik in Österreich, Europa aber auch in den USA. Es bedarf in Zukunft europaweiter Anstrengungen und eine konsequente Anwendung der wettbewerbsrechtlichen Grundsätze auch im Medizinprodukte-Sektor, um das Ausnutzen marktbeherrschender Positionen aufgrund (häufig auch noch staatlich geförderter) Innovationen auf Kosten der Beitrags- und Steuerzahler effektiv zu unterbinden.
Ein Blick auf die Umsatzrenditen der betreffenden Anbieterunternehmen, die bis über 50% Gewinn am Umsatz ausweisen,[41] zeigt auch klar auf, dass Grundgesetze des Marktes in diesem Bereich längst außer Kraft gesetzt sind.

Klärung der Rolle und des Auftrags der gesetzlichen Krankenversicherungsträger im Rahmen der Gesundheitsversorgung

Betrachtet man die geltende Rechtslage, so sind die beiden Kernaufgaben der Krankenversicherungsträger zum einen die Mitteleinhebung einschließlich des Versicherungsmanagements, zum anderen die Erfüllung der gesetzlichen Leistungsansprüche der Versicherten, wozu unter anderem der Abschluss von Verträgen mit den Leistungsanbietern einschließlich der Stellenplanung zählt.
Einen Auftrag zur Systemsteuerung, zu einer gesamtwirtschaftlichen Verantwortung oder ähnlichem findet man in den gesetzlichen Grundlagen aber kaum, ebensowenig sind die Befugnisse der Krankenversicherungsträger gegenüber den anderen Akteuren im Gesundheitssystem klar und ausreichend beschrieben.

Nachhaltige Sicherstellung der Finanzierungsbasis

[40] Positionen der Erfolgsrechnungen der GKK, die Bezug zur KH-Finanzierung haben (Ärztliche Hilfe, Zahnbehandlung und Zahnersatz, Anstaltspflege, Mutterschaftsleistungen).
[41] <https://de.statista.com/statistik/daten/studie/471968/umfrage/umsatzrendite-fuehrender-pharmaunternehmen-weltweit/> (Datum des letzten Abrufs 14.03.2017).

Österreichs Krankenversicherung ist – nicht zuletzt aufgrund effektiver politischer Bemühungen – in den vergangenen ca. zehn Jahren aus einer ständigen Finanzproblematik in ein finanziell weitgehend stabilisiertes System übergeführt worden. Eine ganze Reihe an vor allem ausgabenseitigen Maßnahmen ergänzt durch einnahmenseitige Anreizmodelle wie dem Kassenstrukturfonds haben die soziale Krankenversicherung auf einen gesamtstaatlich konsolidierten Ausgabenpfad gebracht. So werden für das Jahr 2016 nahezu alle Gebietskrankenkassen ein positives Reinvermögen aufweisen können. Einzig die WGKK ist knapp im Minus.[42]

Ein Blick in die Zukunft zeigt aber, dass Veränderungen der Wirtschafts- und Arbeitswelt, wie sie aktuell unter den Schlagwörtern „Industrie 4.0", „Künstliche Intelligenz" usw. diskutiert werden, massive Auswirkungen auf die Versicherten-Biografien, auf Erwerbsformen, den Arbeitsmarkt und damit auch auf die Einnahmenstruktur und –situation der Sozialversicherung haben werden.[43] Gleichzeitig werden diese und andere gesellschaftliche Veränderungen auch veränderte Leistungsbedarfe und Handlungsfelder für die Sozialversicherung, insbesondere in der Gesundheitsversorgung, nach sich ziehen.

Auch wenn derzeit noch niemand seriöse Einschätzungen etwa der Auswirkungen dieser Trends auf die Einnahmenseite der Sozialversicherung abgeben kann, bedarf es einer zukunftsorientierten politischen Auseinandersetzung und frühzeitigen Strategieentwicklung, wie Österreichs Sozial- und Gesundheitssystem die neuen Herausforderungen meistern kann.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Ausbau des internationalen Benchmarkings und (inter)nationaler Austausch

Ob WHO, OECD oder European Health Monitor: Werden Gesundheitssysteme einem Benchmark unterzogen, werden im Grunde immer die gleichen Zielgrößen bewertet. Folgende Kenngrößen spielen dabei eine wichtige Rolle:

- die Wirkung auf die Gesundheit der Bevölkerung, also vor allem eine umfassende, hochqualitative medizinische Versorgung von Kranken und wirksame Gesundheitsförderung/Prävention;
- die Patienten- und Bevölkerungsorientierung, also etwa die Zugänglichkeit zum System und Werte wie Menschlichkeit, Einbeziehung und Serviceorientierung sowie
- ein verantwortungsvoller Umgang mit (finanziellen) Ressourcen, Unterbinden von Verschwendung und Korruption.

[42] Vgl die Grafik Entwicklung Reinvermögen im Anhang.
[43] *Schmadlbauer*, Arbeit 4.0 – Auswirkungen auf die Sozialversicherungssysteme, WISO 4/2016, 133.

Dadurch wird auch ein Beitrag zum sozialpolitischen Diskurs geleistet. Wichtig dabei ist jedoch, dass vergleichbare Benchmarks herangezogen werden und die Ergebnisse transparent gestaltet werden.
Durch (inter)nationalen Austausch und Betrachtung der unterschiedlichen Gesundheitssysteme kann das österreichische Sozialversicherungssystem kontinuierlich weiter verbessert werden. Beispielsweise wird in Finnland die medizinische Grundversorgung vorwiegend in Gesundheitszentren erbracht.[44] Seit Anfang 2017 ist nun auch in Österreich das erste voll ausgebaute Primärversorgungszentrum im oberösterreichischen Enns in Betrieb. Reformschritte können im Hinblick auf andere Systemverhältnisse untersucht werden und – wenn möglich – auf hiesige Verhältnisse übertragen werden.
Die OÖGKK hat sich bereits 2006 zur Kooperation mit der deutschen Gesundheitskasse „AOK Bayern" entschlossen. Dabei geht es um eine bilaterale Zusammenarbeit bei der medizinischen Versorgung der Bevölkerung im bayrisch-oberösterreichischen Grenzgebiet. Regelmäßiger Erfahrungsaustausch zwischen den Fachexperten und Führungskräften fördert die zwischenstaatlichen Beziehungen. Auch im nationalen Bereich hat die OÖGKK eine sinnvolle, trägerübergreifende Zusammenarbeit unterstützt: Zum Beispiel gibt es eine gemeinsame österreichweite Vertragspartneranalyse unter Leitung der Leitenden Angestellten der OÖGKK.[45]

Stärkung der Health in All Policies-Strategie

Für eine nachhaltige Gesundheitsentwicklung ist eine Ausrichtung der Gesundheitsversorgung auf eine gesundheitsförderliche Gesamtpolitik unerlässlich. Es zeigt sich außerdem zunehmend, dass die Krankenversicherung für gesellschaftliche Entscheidungen verantwortlich gemacht wird, die im Zusammenhang mit der Gesundheit stehen – zum Beispiel wird im Bereich Ernährung die Zuckerproduktion in der Landwirtschaft gefördert, für die Fettleibigkeit wird jedoch die Krankenversicherung verantwortlich gemacht. Gesundheit sollte aber als gesamtgesellschaftliche Verantwortung angesehen werden. Health in All Policies orientiert sich dabei an den Gesundheitsdeterminanten und berücksichtigt die Auswirkungen politischer Entscheidungen auf die Gesundheit der Bevölkerung. Gerade die Umsetzung einer solchen nachhaltigen Strategie leistet einen wertvollen Beitrag zur Verbesserung der Gesundheitssituation einer Bevölkerung. Eine bessere Vernetzung gerade im Bereich der Gesundheitsförderung und Prävention würde zu einer konsequenten, effektiven Versorgung führen – damit könnten Abstimmungen und Synergien im Hinblick auf

[44] Vgl *Grunenberg* <http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/service/newsletter/iPG-newsletter_archiv/iPG-NL-02-04/Gesundheitssystem_Finnland/index.html> (Datum des letzten Abrufs 14.03.2017)
[45] Vgl *Wesenauer*, Vertragspartner-Analyse: Komplexe Versorgungssysteme mittels Benchmarking optimieren und weiterentwickeln, Soziale Sicherheit 2010, 611.

knappe Ressourcen besser gelingen. Dazu bedarf es nachhaltiger Veränderungen in der gesellschaftspolitischen Auseinandersetzung mit dem Thema Gesundheit.[46] Health in All Policies soll dazu beitragen, die Lebensbereiche der Bevölkerung so zu gestalten, dass sie einen positiven Einfluss auf die Gesundheit haben.
Im österreichischen Sozialversicherungssystem wurden bereits einige Maßnahmen gesetzt, um diese Strategie besser im System zu verankern: Einführung der Rahmen-Gesundheitsziele, ebenso die Entwicklung einer Kindergesundheitsstrategie oder die Gesundheitsziele der einzelnen Bundesländer[47]. Ein einzigartiges Projekt konnte die OÖGKK gemeinsam mit der Wirtschaftskammer OÖ realisieren: „Lebensmittel.G'sund" soll die Gesundheitskompetenz der Beschäftigten im Lebensmittelhandel stärken und so auf die Beratung der Konsumenten einen positiven Einfluss nehmen.[48]
Dennoch besteht in diesem Themenbereich noch erhebliches Entwicklungspotential. Ein weiterer, wesentlicher Schritt in die richtige Richtung wäre etwa, bei Gesetzesentwürfen – analog der Wirkungsorientierten Folgenabschätzung – auch eine Abschätzung der Gesundheitsfolgen zu etablieren.

Dezentrale Verantwortung

Das Gesundheitssystem umfasst rund elf Prozent unserer Volkswirtschaft. Und das noch ohne Pflege. Wenig verwunderlich, dass sowohl auf Ebene der Finanzierung und Steuerung als auch in der Leistungserbringung eine Vielzahl an Akteuren eingebunden ist.
Mag sein, dass andere Gesundheitssysteme etwas weniger komplex aufgestellt sind – aber ein System ohne Schnittstellen, ohne organisationsübergreifende Zuständigkeiten existiert nirgendwo.
Durch professionelle, faire Kooperation können die Potenziale und Chancen genutzt werden, um Innovationen zu ermöglichen. Auf den Punkt gebracht: Was hilft uns das beste theoretische Modell für Primary Health Care, wenn es von den Ärzten bekämpft wird und sich keine Ärzte für ihren Betrieb finden lassen? Es bleibt nutzlose Theorie.[49] Zudem

[46] Vgl *Tuttner*, Health in All Policies: Ansatzmöglichkeiten zur Verankerung einer gesundheitsfördernden sektorenübergreifenden Politik auf kommunaler Ebene, 2013, 10 ff.
[47] Die gesunden Lebensjahre der in Österreich lebenden Bevölkerung sollen in den nächsten 20 Jahren, bis 2032, erhöht werden – dazu mehr unter <http://www.gesundheitsziele-oesterreich.at/> (Datum des letzten Abrufs 08.03.2017). Bereits im Jahr 2012 wurde eine Strategie der österreichischen Sozialversicherung zu bestimmten Aspekten der Kinder- und Jugendgesundheit beschlossen, die nun im Rahmen des BSC-Ziels 2015 „Gesundheit der Kinder und Jugendlichen stärken" überarbeitet wird. Zu den OÖ Gesundheitszielen siehe auch unter <https://www.ooegkk.at/portal27/ooegkkportal/content?contentid=10007.704946&viewmode=content> (Datum des letzten Abrufs 08.03.2017).
[48] OÖGKK medien info service 26/2014.
[49] In OÖ sind die Ergebnisse durch Innovation, Kooperation und dezentrale Verantwortung jedenfalls sehenswert: Beispielsweise wurde 2005 die Chefarztpflicht bei Medikamenten abgeschafft. Das erste PHC im Vollausbau hat im Jänner 2017 sehr erfolgreich den Betrieb aufgenommen (dabei finanziert das Land OÖ mit).

untergräbt beständiger öffentlicher Kampf das Vertrauen der Bevölkerung in die Gesundheitsversorgung.
In Zeiten, in denen auf der einen Seite das Angebot z.B. durch neue Technologien oder Medikamente stetig wächst, gleichzeitig aber die Ressourcen wie Finanzen bzw. Personal begrenzt sind, braucht es ein zielorientiertes System. Grundlage für eine effiziente und effektive Zusammenarbeit ist dabei eine gemeinsame, Outcome-orientierte Zielsetzung.[50] Bei der Umsetzung der gemeinsam festgelegten Ziele steht aber eine dezentrale Verantwortung im Vordergrund. Denn nur so kann die Entwicklung und Pilotierung von innovativen Versorgungs- und/ oder Finanzierungsmodellen[51] vor Ort ermöglicht werden. Durch den Ausbau eines (inter)nationalen Benchmarkings wird das Lernen vom Besten dadurch gezielt gefördert.

Abschließend möchten wir darauf hinweisen, dass sich die OÖGKK in ihrer Strategie an drei zentralen Zielen orientiert: Gesundheit (Outcome), Zufriedenheit und Finanzierbarkeit.[52] An ihnen messen wir auch gesundheitspolitische Vorhaben. Strategien und Maßnahmen müssen in mindestens einem der drei Ziele Verbesserungen für die Menschen bringen – ohne Verschlechterungen in den anderen Zielfeldern. Das Paradoxon: Mehr Qualität bei besseren Kosten bildet im Gesundheitsbereich oft keinen Widerspruch. Im Gegenteil: Überflüssige Medizin wie z.B. unnötige Operationen oder ein „Zuviel" an Medikamenten schafft nicht mehr Gesundheit, sondern schadet den Menschen. Effektive Versorgung führt hingegen nicht nur zu schnellerer Gesundung, sondern stärkt auch die Leistungsfähigkeit der Menschen, macht sie frei von Schmerzen und Pflegebedürftigkeit.
Die richtige Leistung, in der richtigen Qualität, zum richtigen Zeitpunkt: So muss ein Versorgungssystem ausgerichtet sein.[53]

[50] Das Zukunftsbild der österreichischen Sozialversicherung gilt als Basis für das BSC-Zielsteuerungssystem und dient als Ausgangsbasis und Leitbild. Dabei geben definierte Prinzipien/ Leitwerte, den inhaltlichen Rahmen für die gemeinsame Weiterentwicklung des Systems vor.
[51] Weitere Informationen über innovative Modelle der OÖGKK siehe auch im Anhang unter „Starke Selbstverwaltung, kompetentes Management – Beispiele für OÖGKK-Initiativen, -Innovationen und -Beiträge zu österreichweiten Vorhaben".
[52] Vgl *Wesenauer*, Steuerung von Reformpool-Projekten – Systemgrenzen erfolgreich überwinden, Soziale Sicherheit 2007, 460 mit Verweis auf *Hsiao*, International Benchmark Lectures (2001).
[53] *Wesenauer*, Effektive und effiziente Gesundheitsversorgung durch Outcome und Prozessorientierung, SozSi 2010, 530.

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EFFIZIENZANALYSE SOZIALVERSICHERUNGSSYSTEM
AUS SICHT DER DER ÖSTERREICHISCHEN APOTHEKERKAMMER/BEANTWORTUNG FRAGEN

Sehr geehrter Herr Prof. Dr. Elias Mossialos,

herzlichen Dank für die Einladung zur Abgabe einer Stellungnahme und die Möglichkeit der Einbringung unserer Sichtweise in die Studie. Wir begrüßen ausdrücklich diesen Schritt zur Überprüfung des österreichischen Sozialversicherungssystems.

Im Folgenden gehen wir auf die von Ihnen gestellten vier Fragen ein:

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Zu Frage 1:

Die öffentlichen Apotheken erklären sich, wie auch schon gegenüber der Sozialversicherung geäußert, ausdrücklich bereit, einen wesentlichen Beitrag zum Funktionieren einer optimalen Primärversorgung in Österreich zu leisten. Die zentrale Funktion der Apothekerinnen und Apotheker als Arzneimittelfachleute und die zunehmende Bedeutung der Apotheken als Nahversorger definieren die öffentliche Apotheke als Best Point of Service für Beratung und Abgabe von Arzneimitteln.

Von den 5.742 ApothekerInnen in öffentlichen Apotheken sind 4.288 oder rund 75% angestellte Pharmazeuten (Jahr 2015). 87% aller angestellten Apotheker sind Frauen. Durchschnittlich sind rund 4 ApothekerInnen (selbständig und unselbständig) in einer öffentlichen Apotheke tätig (*Österreichische Apothekerkammer*, Apotheke in Zahlen 2016, S 32f).

Eine wichtige Voraussetzung für die Umsetzung einer optimalen Primärversorgung (wie etwa im Rahmen der geplanten PHC-Zentren) ist die multiprofessionelle Zusammenarbeit verschiedener Berufe im Gesundheits- und Sozialbereich, bei der die Leistung der Apotheker als Arzneimittelexperten strukturiert, verbindlich und dokumentiert eingebunden werden sollten.

Darüber hinaus haben wir im Apothekenwesen viele Aspekte, die für eine effiziente Primärversorgung Grundvoraussetzung sind, bereits erfolgreich integriert.

Wahrnehmung von Gesundheitsförderung und Prävention
Öffentliche Apotheken mit ihrem niederschwelligen Zugang, dem hochqualifizierten Personal und der flächendeckenden Verteilung sind als Träger für Präventionsmaßnahmen prädestiniert und können als solche noch viel stärker eingebunden werden.

Die Vorsorgeaktionen in öffentlichen Apotheken sind immer von großem Erfolg geprägt. Beispiele sind die Aktionen zum Thema COPD, Allergie, Sarkopenie oder Raucherentwöhnung, sowie die Screening Aktion „10 Minuten für meine Gesundheit“, im Rahmen dessen Gewicht, Blutdruck, Bauchumfang, Cholesterin und Blutzucker überprüft wurden. Auch durch die regelmäßigen Impfaktionen in Apotheken und die damit verbundene Beratung leisten die öffentlichen Apotheken einen wesentlichen Beitrag zur Gesundheitsförderung und Prävention.
Die öffentlichen Apotheken bieten ein großes Potential, um die Bevölkerung auf dem Gebiet der Vorsorge noch viel intensiver anzusprechen. Das vorhandene Potential wird derzeit viel zu wenig genutzt.

Unterstützung bei der Orientierung – Drehscheibenfunktion der Apotheken

Eine Hilfestellung der Kunden und Patienten bei der Orientierung im Gesundheitsversorgungssystem ist für Apothekerinnen und Apotheker Teil der täglichen Arbeit. Eine Einschätzung des Behandlungsbedarfes (Triage) führt regelmäßig zur Gesundheitsberatung im Rahmen der „Selbstmedikation" oder zum Verweis an den Arzt („Red Flags": Warnsymptome und die Grenzen der Selbstmedikation bilden einen ständigen Schwerpunkt bei unseren Fortbildungen).

Des Weiteren fungieren zahlreiche öffentliche Apotheken – insbesondere im ländlichen Raum - als Stützpunkt und Drehscheibe für Selbsthilfegruppen (Vorträge, Veranstaltungen etc.), mobile Pflegedienste und andere Gesundheitsberufe. Bei Apothekenneu- und -umbauten werden immer öfter extra entsprechende Räumlichkeiten dafür vorgesehen. Es gibt mittlerweile auch eine ganze Reihe von Gesundheitszentren, bei denen neben der öffentlichen Apotheke auch Ärzte und Therapeuten räumlich zusammengefasst sind.

Stärkung der Gesundheitskompetenz inkl. Anleitung zum Selbstmanagement

Bei chronisch kranken Menschen hängt der Behandlungserfolg zum überwiegenden Teil vom Patienten selbst ab und sie sollten deshalb viel stärker in das Management ihrer eigenen Gesundheit einbezogen werden. Die öffentlichen Apotheken setzen schon seit Jahren auf Hilfe zur Selbsthilfe. Beispielsweise haben sich Apothekerinnen und Apotheker zum „Diabetescoach" ausbilden lassen, um Diabetes-Patienten an der Tara begleitend zur Arzneimittelberatung zu einer Verbesserung ihres Lebensstils motivieren zu können. Eine unabhängige Studie zeigte auf, dass sich bei den betreuten Typ II- Diabetikern nach 6 Monaten nicht nur der HbA1c-Wert verbesserte, sondern die Patienten lernten, im Alltag besser mit ihrer Krankheit umzugehen.

Die Apothekerinnen und Apotheker stehen bereit, diese unterstützende Rolle in viele Richtungen auszubauen.

Im täglichen Gespräch leisten die Apothekerinnen und Apotheker zudem einen wichtigen Beitrag, die Gesundheitskompetenz (Health Literacy) zu stärken. Neben der persönlichen Beratung durch die Apothekerinnen und Apotheker gibt es zu den verschiedensten Gesundheitsthemen Folder, die dem Kunden für weiterführende Information ausgehändigt werden können. Die öffentlichen Apotheken sind ideal geeignet, relevantes Wissen verständlich für den Patienten zu kommunizieren.

Entlastung des vollstationären Bereichs
Es gibt zahlreiche Möglichkeiten, durch verstärkte Einbindung der Apothekerinnen und Apotheker den stationären Bereich zu entlasten. Als Beispiel könnten wir uns die Abgabe von Zytostatika und parenteraler Antibiotika in der Apotheke vorstellen.

Mit obigen Ausführungen wird aufgezeigt, in wie vielen Bereichen die Grundsätze der Primärversorgung bei den öffentlichen Apotheken schon umgesetzt sind.

Hinzu kommen weitere Angebote, die den Versorgungsprozess der Patienten im österreichischen Gesundheitswesen optimieren. Im Folgenden nur einige Beispiele:

Apotheken als Sauerstofftankstellen
Die Apotheken eignen sich hervorragend als Sauerstofftankstellen. Die Mitarbeiterinnen und Mitarbeiter sind im Umgang mit medizinischen Gasen gut ausgebildet und die Qualitätsvorschriften der Apotheken unterliegen strengen Regeln, sodass eine hohe Qualität bei der Abgabe des Sauerstoffes gesichert ist. Außerdem sind die Apotheken mit ihren langen Öffnungszeiten und ihrer guten Erreichbarkeit für COPD-Patienten ideale Anlaufstellen.

Zu Frage 2:

Medikationsmanagement
Ein erfolgreiches Medikationsmanagement setzt insbesondere bei chronischen Erkrankungen eine laufende Analyse des Medikationsplans, eine umfassende Dokumentation der Daten sowie eine persönliche Betreuung durch die Apotheker voraus. In Zukunft muss das gesamte Medikationsmanagement in Österreich systematisch verbessert und in Zusammenarbeit aller Partner - vom Arzt bis hin zum Patienten - umgesetzt werden.

Der Fokus des Hauptverbandes der österreichischen Sozialversicherungsträger lag bis dato darauf, die Kosten bei Arzneimitteln zu drücken. Durch öffentliche Diskussionen hat leider das Arzneimittel in der öffentlichen Wahrnehmung einen schlechten Stellenwert bekommen, da es oft nur als Kostenverursacher dargestellt wird. Dabei ist der sinnvolle Einsatz von Arzneimitteln nachweislich ein Kostendämpfer für das Gesundheitswesen.

Beispielsweise betragen die Kosten für chronisch respiratorische Erkrankungen (COPD, Asthma, Emphysema, etc.) in Österreich rund 4-5% der Arzneimittelkosten (ATC-Code: R03), hingegen nur rund 2% der Spitalskosten. Es lässt sich daher sagen, dass die Arzneimitteltherapie eine wichtige Säule der Therapie darstellt. Um eine effektive Anwendung der Arzneimittel durch die Patienten und die entsprechende Adhärenz zu gewährleisten, ist die Patientenbetreuung (zB. Einschulung in die Inhalationstechniken der jeweiligen Inhalativa) sowohl durch Arzt als auch Apotheker wichtig.

Medikationsmanagement ist ein Paradebeispiel für einen vernünftigen Einsatz von Mitteln zur Steigerung der Kosteneffizienz. Erwiesenermaßen werden Folgekosten (vor allem im Spitalsbereich) vermieden und der Einsatz der Arzneimittel (bei Patienten mit Polymedikation) optimiert. Natürlich muss dafür die Leistung der Apotheker honoriert werden. In Zusammenarbeit mit einer privaten Versicherungsanstalt läuft bereits ein erfolgreiches Pilotprojekt („*Medikamente im Griff*").

Disease Management
In der Vergangenheit präsentierte die Österreichische Apothekerkammer mehrere Screening-Aktionen, die von der Bevölkerung gut angenommen wurden. Beispielsweise bestimmten die Apotheker im Rahmen der niederschwelligen Aktion „*10-Minuten für Ihre Gesundheit*" Blutzucker, Cholesterin, Bauchumfang, Raucherstatus, etc. Diese Screening-Aktion deckte viele Fälle von Patienten mit einem relevanten Risiko für Diabetes auf. Diese Patienten wurden zum Arzt weiterverwiesen.

Die Apotheken sind aufgrund des niederschwelligen Zugangs prädestiniert, Funktionen des Disease Managements zu übernehmen („*Diabetes-Coach*").

Zu Frage 3:

Vereinheitlichung der Leistungen
Zu beleuchten ist weiters der Umstand, dass zwar die monatlichen Beitragszahlungen für die Versicherten in allen Bundesländern gleich hoch sind, die Leistungen, Zuschüsse oder Selbstbehalte aber je nach Krankenkasse bzw. Bundesland variieren. Die Österreichische Apothekerkammer spricht sich ausdrücklich für eine Vereinheitlichung in allen Bereichen aus.

Einberechnung der Folgekosten
Dringend notwendig ist eine volkswirtschaftliche Gesamtbetrachtung aller Kosten im Gesundheitswesen. Durch die unterschiedlichen Finanzierungen kommt es immer wieder vor, dass der Fokus auf den Einzelfall gelegt wird und Folgekosten nicht miteinberechnet werden. Eine Bezahlung und Finanzierung aus einem Topf würde klare Impulse in eine gesamtheitliche Betrachtung erzeugen. Sinnvoll wäre in diesem Zusammenhang auch die Implementierung von „*Pay for performance*".

Problematisch ist in diesem Zusammenhang auch die Direktabgabe, beispielsweise von Diabetikerbedarf durch viele Krankenkassen, die ohne ausreichende Beratung/individuelle Betreuung und Versorgung während der Tagesrandzeiten erfolgt. In den Apotheken wird die entsprechende Beratung/Betreuung der Patienten dann kostenlos übernommen. Dieser Beratungsdiebstahl verzerrt naturgemäß jegliche Form von finanzieller Betrachtung.

Korrekte Darstellung der Arzneimittelkosten
Die Darstellung der Kosten im Arzneimittelbereich in der Gebarung der Krankenversicherung ist irreführend: Die Rezeptgebühren – der Selbstbehalt der Patienten, der in der Apotheke bereits einzuheben und an die Krankenkassen abzuführen ist - wird nicht bei den Arzneimittelkosten abgezogen, sondern als Einnahme verbucht. Hierdurch entsteht ein falsches Bild der Arzneimittelkosten für die Sozialversicherung. Weiters wird die Umsatzsteuer bei den Kosten für Arzneimittel ausgewiesen. Dies widerspricht jeglicher üblichen wirtschaftlichen Darstellungsweise, da diese vom Staat fast vollständig refundiert wird.

Es wird in der Gebarung eine Position sonstiger Bezug in Höhe von EUR 67 Mio ausgewiesen, für welche die Krankenversicherungsvertreter in zahlreichen Gesprächen keine Positionen benennen konnten, die den Arzneimittelkosten zugerechnet werden. Auch die Refundierungen der Industrie an die Sozialversicherung (Pharma-Rahmenvertrag, Refaktien) werden nicht mit den Arzneimittelkosten saldiert. In Summe (Mehrwertsteuer, Rezeptgebühren und Zahlungen der Industrie abgezogen) sind daher die in der Realität von den Krankenkassen zu tragenden Arzneimittelkosten um ca. 25% zu hoch ausgewiesen.

Verbesserung der Gebarungsvorschau
Die Prognosen des Hauptverbandes der österreichischen Sozialversicherungsträger hinsichtlich der Kostensteigerungen im Arzneimittelbereich sind in den letzten Jahren viel zu hoch gelegen. Hier ist eine Einbindung der Apothekerschaft dringend geboten. Wir verweisen in diesem Zusammenhang auf einen Bericht des Rechnungshofes: *„Den Instrumenten der Gebarungsvorschau fehlte trotz hohem Aufwand und hohem Detailgrad die erforderliche Glaubwürdigkeit für die Nutzung zur Steuerung."* (*Rechnungshofbericht,* Bund 2016/03, Instrumente zur finanziellen Steuerung der Krankenversicherung, 15).

Arzneimittel-Lieferengpässe und potentielle Versorgungsprobleme
In der Vergangenheit ist es international in einzelnen Fällen zu Lieferengpässen von Arzneimitteln gekommen. Die Gründe dafür sind mannigfaltig: Sei es aufgrund von Produktionsausfällen, Nichtverfügbarkeit von Rohstoffen oder globalen Fusionswellen und damit verbundenem Outsourcing in der Pharmawirtschaft.

Auch Österreich blieb von dieser Entwicklung nicht verschont. Die Lieferfähigkeit von österreichischen Arzneimitteln ist zwar nach wie vor auf hohem Niveau, jedoch ist in jüngster Zeit eine Abnahme zu beobachten. Eine der mannigfaltigen Ursachen dafür ist die Tatsache, dass die österreichischen Erstattungspreise für Arzneimittel unter dem europäischen Durchschnitt liegen (*Österreichische Apothekerkammer*, Apotheke in Zahlen 2016) und österreichische Ware aus dem Markt gezogen wird.

Die Apotheken investieren sehr viel Zeit und Engagement darin, dass aus Lieferengpässen keine Versorgungsengpässe entstehen. In Summe nimmt das Management der Lieferengpässe in den Apotheken bereits bis zu 5 % der Arbeitszeit in Anspruch.

Aufmerksamkeit bedürfen auch die ganz billigen Arzneimittel, bei denen der Deckungsbeitrag für Industrie, pharmazeutischen Großhandel und Apotheken so niedrig ist, dass die Gefahr besteht, dass diese Produkte für die Patienten nicht mehr lange verfügbar sind.

Zu Frage 4:

Effizienzpotentiale durch Vereinheitlichung der Abgabebedingungen
Die organisatorische Abwicklung der Verrechnung von Arzneimittel und Heilbehelfen mit den Krankenkassen funktioniert seitens der Apotheken reibungslos.

Verbesserungspotential bezüglich der Effizienz und Effektivität besteht jedoch in der Vereinheitlichung der Abgabebestimmungen, insbesondere für Wahlarztrezepte sowie Verbandsstoffe und Heilbehelfe.

Privatrezepte, die von Wahlärzten ausgestellt werden, sind grundsätzlich nicht erstattungsfähig und müssen zu diesem Zweck zuerst seitens des jeweiligen Trägers „umgewandelt" bzw. als Kassenrezept anerkannt werden. Die Bedingungen und Modalitäten variieren von Träger zu Träger. Während beispielsweise die Wiener Gebietskrankenkasse („WGKK") die sog. „Pickerl-Lösung" einführte, bei der die bloße Unterschrift der PatientInnen zur formalen Umwandlung ausreicht, müssen Wahlarztrezepte der bei der Niederösterreichischen Gebietskrankenkasse („NÖGKK") versicherten Anspruchsberechtigten zur Umwandlung physisch an den Träger übermittelt werden. Die NÖGKK akzeptiert dabei keine Fernübermittlungen, wie per Fax oder Email. Nach einer etwaigen Umwandlung in ein Kassenrezept, übermittelt die NÖGKK physisch die Wahlarztrezepte zurück an den Patienten, den Wahlarzt oder die Apotheke. Erst nach Einlösen des Rezeptes kann nun die Apotheke mit dem Träger abrechnen. Dieser Prozesslauf ist äußerst ineffizient. Versicherte, Apotheken und Krankenversicherungsträger sehen sich mit vermeidbarem materiellen und zeitlichen Aufwand konfrontiert.

Da sich der für die Abrechnung zuständige Träger nach dem Standort der abrechnenden Apotheke richtet, kommt es zu folgender paradoxen Konstellation: Ein bei der WGKK versicherter Anspruchsberechtigter löst das Wahlarztrezept in einer Apotheke mit Standort in Niederösterreich ein. Da die NÖGKK die „Pickerl-Lösung" der WGKK nicht akzeptiert, ist dieses Wahlarztrezept zwecks Umwandlung in ein Kassenrezept physisch der NÖGKK zu übermitteln. Löst der Anspruchsberechtigte das Wahlarztrezept hingegen in einer Apotheke mit Standort in Wien ein, so ist die „Pickerl-Lösung" anwendbar.

Bei den Heilbehelfen gibt es eine Vielzahl bürokratischer Auflagen für die Apotheken, die dadurch bedingt sind, in welchem Bundesland sich die Apotheke befindet, mit welcher Krankenkasse abzurechnen ist und ob ein Bandagist im Ort ist oder nicht. Insgesamt ergibt sich daraus eine Liste von 144 Seiten (wird halbjährlich neu aufgelegt), die einen erheblichen bürokratischen Aufwand und damit unproduktive Zeit in den Apotheken verursacht. Durch Vereinheitlichung und eine allfällige Reduktion der Krankenkassen, wären auf Seiten der Apotheken und der Krankenkassen Einsparungen im Verwaltungsbereich möglich (Anlage Beispiele für uneinheitliche Abgabebedingungen im Apothekergesamtvertrag).

Effizienzpotential durch Wiederholungsverordnungen

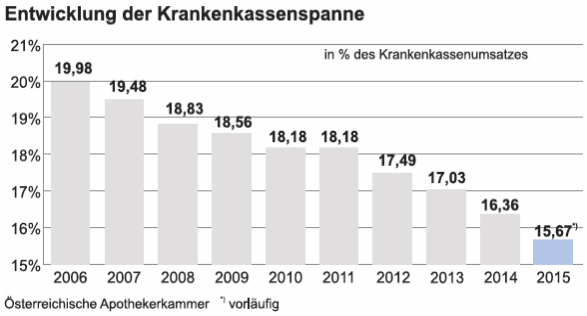
Die Gesundheitssysteme im anglo-amerikanischen Raum ermöglichen den Apothekern, auf Basis einer ärztlichen Initialverordnung Arzneimittel gegen chronische Erkrankungen, beispielsweise für drei Monate, wiederholend zu expedieren und mit den Trägern abzurechnen („*repeated prescriptions*"). Auch in Österreich würde ein solches eingeschränktes Verordnungsrecht helfen, die Kosten im Gesundheitswesen zu senken.

Effizienzpotentiale durch Nutzung des Abrechnungssystems

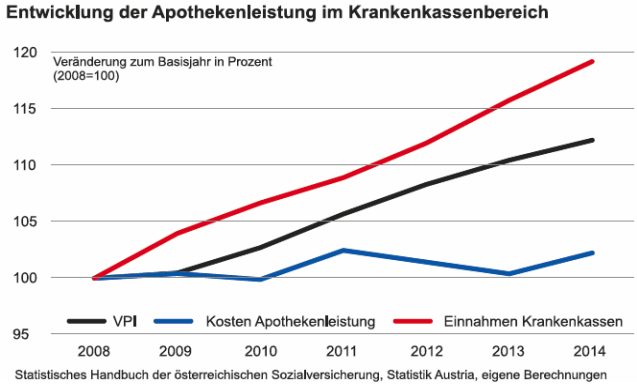
Das perfekt eingespielte und hoch effiziente Abrechnungssystem „öffentliche Apotheken - pharmazeutische Gehaltskasse – Krankenkassen" könnte problemlos auf weitere Bereiche angewendet werden, wie etwa die Versorgung mit Flüssigsauerstoff oder enterale Ernährung. Dadurch käme es zu einem Wegfall von einer Vielzahl von Einzel- und Direktabrechnungen seitens der Krankenkassen mit dem entsprechenden bürokratischen Aufwand. Statt einer Unsumme von Einzelüberweisungen wäre die Bezahlung in der Gesamtabrechnung mit der pharmazeutischen Gehaltskasse inkludiert. Auch für die Patienten wäre die gewohnte Beratung, Abwicklung, Verrechnung der Rezeptgebühr mit der gewohnten Apotheke vor Ort wesentlich einfacher und kosteneffizienter.

Maßnahmen zur Erhaltung der Versorgungsqualität durch die öffentlichen Apotheken

Die Margen und Deckungsbeiträge der Apotheken sinken seit Jahren und erhöhen den Kostendruck. Dies veranschaulichen folgende Tabellen (*Österreichische Apothekerkammer*, Apotheke in Zahlen 2016, S 12, 43):



Wie aus der unteren Grafik ersichtlich, wurde den Apotheken in den letzten Jahren nicht einmal die jährliche Inflation abgegolten. Durch die Nichtvalorisierung der Apothekenleistung haben die öffentlichen Apotheken massiv zur Entschuldung der Krankenkassen beigetragen. Weitere Einsparungen sind den Apotheken ohne Einschränkungen der derzeitigen Leistungen nicht mehr möglich.



Um die qualitativ hochwertigen Dienstleistungen der Apotheker und Apothekerinnen auch in Zukunft gewährleisten zu können, schlagen wir folgende Finanzierungsmaßnahmen vor:

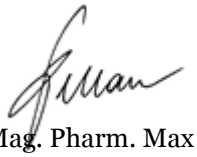
Die **Distributionsmargen** sind alle zwei bis drei Jahre zu valorisieren und den Personal- und Sachkostensteigerungen in den öffentlichen Apotheken anzupassen. Besonders die Vergütungen für **magistrale Anfertigungen** (ad-hoc Rezepturen) sind bei weitem nicht kostendeckend. Die Sozialversicherungsträger vergüten beispielsweise die Arbeit zur ad-hoc Herstellung einer 100g Salbe gemäß Gesamtvertrag mit EUR 2,50. Bei einem Stundensatz eines angestellten Pharmazeuten von EUR 55 entspricht dies einer Herstellungszeit von 2,7 Minuten. Tatsächlich benötigt man 7-10 Minuten zur Herstellung von Salben und Cremen.

Die **Krankenkassen-Aufschläge** zur Deckung der Distributionskosten für Arzneimittel sind in § 3 Abs. 2 Österreichische Arzneitaxe definiert. Bei den sogenannten **Niedrigpreisern** (Apothekeneinkaufspreis AEP bis 10EUR) ergibt sich folgendes Bild:
Der seitens der Krankenversicherungsträger gewährte Aufschlag (exkl. den noch zusätzlich zu gewährenden Sondernachlässen) von 37% auf AEP bis EUR 10,15 schlägt sich bei gängigen Arzneimitteln, wie „Mexalen 500mg 10 Tabletten“ als Deckungsbeitrag mit EUR 0,20 bei den Gebührbefreiten nieder. Im Privatverkauf und Nicht-Gebührenbefreiten sind es EUR 0,49. Aus diesem geringen Deckungsbeitrag lässt sich der Aufwand für Beschaffung, Lagerung, Administration, Beratungsdienstleistung, etc. nicht decken und muss vom Deckungsbeitrag der Mittel-Preiser oder sogar der OTC-Privatverkäufe querfinanziert werden. Die Österreichische Apothekerkammer erachtet daher eine Anpassung der Distributionsmargen bei den Niedrigpreisern hin zu mehr Kostenwahrheit als unumgänglich.

Der Hauptteil der Kosten für die **Pharmakovigilanz** der AGES Medizinmarktaufsicht wird derzeit im Rahmen eines Umlagesystems von den Apotheken eingehoben. Der Nutzen der Pharmakovigilanz kommt jedoch der Allgemeinheit zu gute. Mittelfristig ist zu überlegen, die behördlichen Pharmakovigilanzkosten durch einen geringfügigen Aufschlag auf jede Arzneimittel-Packung zu decken.

Weiters wäre eine Finanzierung der nicht kostendeckenden **Nacht- und Wochenenddienste** der öffentlichen Apotheken, nach deutschem Beispiel, über einen durch einen geringfügigen Aufschlag auf jede Arzneimittel-Packung finanzierten Nachtdienstfonds wünschenswert. Denn bisher werden deren Aufwendungen ausschließlich von den Apotheken finanziert

Mit freundlichen Grüßen
Der Präsident:



(Mag. Pharm. Max Wellan)

Anlagen:

- Beispiele für uneinheitliche Abgabebedingungen im Apothekergesamtvertrag
- Apotheken in Zahlen 2016

ÖSTERREICHISCHE
ÄRZTEKAMMER
Körperschaft öffentlichen Rechts – Mitglied der World Medical Association

Herrn
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Wien, 15.03.2017

Betrifft: Fragen zum österreichischen Sozialversicherungssystem

Sehr geehrter Herr Professor!

In der Beilage übermittelt die Österreichische Ärztekammer ihre Stellungnahme zu den von Ihnen aufgeworfenen Fragestellungen samt weiterer Kommentare.

Mit freundlichen Grüßen

Dr. Artur Wechselberger
Präsident

Anlage

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ÖSTERREICHISCHE ÄRZTEKAMMER

Stellungnahme der Österreichischen Ärztekammer zu den von der London School of Economics aufgeworfenen Fragestellungen

Zur aktuellen Situation der niedergelassenen Ärzteschaft in Österreich

Ärztinnen und Ärzte üben einen **Freien Beruf** aus. Damit haben sie den Grundlagen eines Freien Berufes, zu denen Eigenverantwortlichkeit und Unabhängigkeit, Einhaltung der Berufsethik, persönliche Integrität, fachliche Kompetenz und Qualitätsorientierung sowie Gemeinwohlbezug und Vertraulichkeit gegenüber ihren Patientinnen und Patienten gehören, zu entsprechen.

Ihre Leistungen sind gemeinschaftswichtig und geistig-ideeller Natur. Sie erbringen diese eigenverantwortlich und fachlich unabhängig als persönliche Leistungen, unter Einbindung von Angehörigen anderer Gesundheitsberufe aber auch von Laien, an Individuen aber auch an der Gesellschaft; all dies in wirtschaftlicher Selbständigkeit.

Ärzte sind keine Dienstleister im Sinne der Erbringung eines bestellten Werkes bzw. einer geforderten Dienstleistung. Dies würde dem Sinne eines Freien Berufes ebenso widersprechen wie die Tätigkeit als auftragsgebundene Erfüllungsgehilfen von Sozialversicherungen oder öffentlichen Stellen.

Es entspricht der Grundstruktur des österreichischen Gesundheitswesens, dass die ambulante Patientenversorgung und damit auch die Primärversorgung in der Regel von in Arztpraxen niedergelassenen Ärztinnen und Ärzten erbracht werden. Diese treten dabei, unabhängig, ob als Kassenvertrags- oder Privatärzte, in einer **Doppelfunktion als Angehörig eines Freien Berufs und als Unternehmerinnen und Unternehmer** auf. Damit müssen sie auch den Grundlagen einer korrekten Unternehmensführung entsprechen. Dazu gehören, unter Beachtung der Erfordernisse einer qualitätsvollen Leistungserbringung, der Aufbau von und die Investitionen in die für die Praxis notwendige Infrastruktur ebenso wie die Aufgaben der Mitarbeiterauswahl und Führung, die Definition von Unternehmenszielen sowie die strategische Ausrichtung des Unternehmens sowie die Erfüllung aller Erfordernisse eines pflichtbewussten Kaufmannes und Unternehmers.

Es gilt, den **Wert des Arztes als Unternehmer** zu erkennen und unternehmerische Freiheit zuzulassen und den Ärztinnen und Ärztinnen damit Freiraum für selbstgestaltbare Verantwortung zu erhalten. Bürokratische Auflagen, Genehmigungs- und Berichtspflichten gilt es niedrig zu halten, bedarfsgerechte Unternehmensentscheidungen die Betriebs- und Gesellschaftsform betreffend zu unterstützen, um das Potential kreativer und innovativer Beiträge der Unternehmen Arztpraxis zur Lösung gesundheitspolitischer und gesellschaftlicher Probleme auszuschöpfen.

Die gerade voll einsetzende **Pensionswelle**, entsprechend dem hohen Altersdurchschnitt besonders der Vertragsärzteschaft, bedeutet, sich vermehrt mit den Berufswünschen der nachfolgenden Generation auseinanderzusetzen, um eine möglichst nahtlose Übergabe der Vertragsarztstellen sicher zu stellen. Zudem müssen Maßnahmen getroffen werden, dass die Praxisnachfolger auch willens und in der Lage sind die Versorgungsleistung zu erbringen, die die ausscheidenden bereit waren, zu erbringen. Die Zunahme der Anzahl an Ärztinnen, die geänderten Lebensentwürfe und damit verbundene Einstellung zur Work-Life-Balance erfordern strukturelle Änderungen, um einem Trend zur Arbeit in Krankenanstalten, dem gänzlichen Ausstieg aus den Versorgungssystem oder einer Migration ins Ausland entgegen zu wirken.

Niederlassungs- und Zusammenarbeitsmöglichkeiten in den verschiedensten Varianten, entsprechend den Bedürfnissen der Bevölkerung, der Praxisinhaber und der mitarbeitenden Ärztinnen und Ärzten ist absoluter Vorrang vor den systemtheoretischen Überlegungen zu geben, deren Fokus auf rigide ordnungspolitische und verteilungspolitische sowie ökonomische Interessen abzielt.

Im internationalen Vergleich müssen niedergelassene Ärztinnen und Ärzte in Österreich die durchschnittlich **drei bis fünffache Anzahl an Patienten pro Zeiteinheit** behandeln.

Auf Grundlage der Wesensmerkmale, dem Arbeitsauftrag, der Arbeitsweise, des Arbeitsbereichs, der Arbeitsgrundlagen und der Arbeitsziele der Allgemeinmedizin bieten **Allgemeinmedizinerinnen und Allgemeinmediziner im Rahmen von Primary Health Care** als zentralen Baustein eines jeden Gesundheitswesens ihre Leistungen an. Sie erfüllen dabei die Hauptfunktionen von Primary Care, nämlich die des medizinischen Erstkontaktes (first contact care), der kontinuierlichen Versorgung (continuous care), der umfassenden Versorgung (comprehensive care) sowie der Koordination der Versorgung (coordinated care). Das Arbeitsziel der Allgemeinmedizin ist eine qualitativ hochstehende, möglichst wohnortnahe und niederschwellige Versorgung, die den Schutz des Patienten, aber auch der Gesellschaft vor Fehl-, Unter- oder Überversorgung miteinschließt.

Gerade die allgemeinmedizinische Diagnostik und Therapie baut auf zeitintensive diagnostische und therapeutische Gespräche. Ganz zu schweigen vom Zeitaufwand, den die Behandlung psychisch Kranker oder dementieller Patienten erfordert. Zu den Wesensmerkmalen der Allgemeinmedizin gehört zudem der Kontakt mit den verschiedenen Personengruppen im Behandlungs- und Betreuungsprozess und die Koordination dieses Personenkreises bzw. der Einrichtungen, in denen diese tätig sind.

Zeit gewinnt man durch Steigerung der Zahl der Leistungserbringer (z.B. mehr Vertragsarztstellen), Entlastung von Tätigkeiten, die nicht zu den Kernaufgaben der Ärzte gehören (Hauskrankenpflege, Administration) und durch die Förderung von Kooperation (Zusammenarbeitsformen).

Zeit gewinnt man durch gezielte Zuweisung, Wartezeitenmanagement, raschen Befundtransfer, Nutzung von Telekommunikation, Telemonitoring und Telemedizin.

Zeitschonend ist eine Arbeitssituation, die es möglich macht, einen Diagnose- und Behandlungsprozess ohne Unterbrechung zu Ende zu führen und dabei das gesamte Potential an Wissen und Können des behandelnden Arztes auszuschöpfen. Zudem muss ein Arzt so honoriert werden, dass er neben der Zeit auch einen Anreiz hat, einen Patienten zu Ende zu behandeln.

Mehr Ressourcen (moderne medizinische Leistungen, Abschaffung von kontrollärztlichen Bewilligungssystemen, Ende der Leistungslimitierung über degressive Honorierungssysteme, mehr Ärzte in das System)

Häufig scheitert die Verlagerung von Behandlungsleistungen an den fehlenden Möglichkeiten in der Praxis. Das **Fehlen moderner Leistungen in den Leistungskatalogen der Sozialversicherungen**, die durch Bewilligungssysteme eingeschränkte Verfügbarkeit von Kassenleistungen von der Physiotherapie bis zur Medikation verzögern die Behandlungsabläufe, frustrieren Ärzte wie Patienten und verstärken letztlich den Trend hin zu den Ambulanzen der Krankenhäuser ebenso wie ausgeschöpfte Leistungslimitierungen, die zu Honorarverlusten führen.

Die zeitliche **Verfügbarkeit und der Arbeitseinsatz der niedergelassenen Ärzte** liegen derzeit schon weit über der Normalarbeitszeit von 40 Stunden. Eine Ausdehnung ist nur möglich, wenn es gelingt derzeit brach liegendes ärztliches Arbeitspotential z.B. durch stundenweise Beschäftigung zu mobilisieren. Nur so, und durch die Verbesserung der zeitlichen und räumlichen Abstimmung niedergelassener Ärztinnen und Ärzte, lässt sich das zeitliche Versorgungsangebot verbessern.

Eine Entlastung der niedergelassenen Ärzte durch die Organisation von Bereitschaftsdiensten unter Einbindung von Vertretungsärzten, auch aus dem wohnsitz- und wahlärztlichen Bereich, können die Erreichbarkeit auch in den Nächten und an den Wochenenden verbessern.

Derzeit lassen die Versorgungsnotwendigkeiten und auch die wirtschaftliche Situation der Praxen kaum zu, ausreichend **Zeit für Fortbildung, Supervision und Reflexion des eigenen Handelns und zur Rekreation** zu finden. Ganz zu schweigen von Zeit für persönliche und berufliche Weiterentwicklung, die im angestellten Bereich etwa im Rahmen von Karenz oder Sabbatical möglich sind.

Die beste **organisatorische Unterstützung** bietet ein radikaler Abbau von staatlich und kassenvertraglich vorgeschriebenen Auflagen. Gerade der Trend, Arztpraxen mit Ausstattungs-, Prozess- und Qualitätsnormen zu belasten, die in großen Krankenhäuser ihre Berechtigung haben, in kleinen Versorgungseinrichtungen aber weit überschießend sind, belastet die Ärztinnen und Ärzte zeitlich und finanziell und ist dazu angetan, Praxisübernahmen und Praxisgründungen zu verhindern. Die Angst vor organisatorischen

und administrativen Belastungen sind neben dem auch für kleine Praxen nicht unbedeutendem wirtschaftlichen Risiko wesentliche Gründe, die Jungärztinnen und Jungärzte von einer Niederlassung abhalten.

Der Wunsch am Aufbau größerer Praxiseinheiten scheitert oft am Risiko der Finanzierung und Organisation solcher Einrichtungen. Eine entsprechende **öffentliche Unterstützung** ist dringend geboten.

Gerade die Allgemeinmedizin leidet an einem **Ausbildungsmangel**, den auch die neue Ärzte-Ausbildungsordnung nicht beseitigen können wird. Dieser liegt darin begründet, dass die Allgemeinmediziner an Patienten und in einem Behandlungssetting ausgebildet werden, das ihrer zukünftigen Realität nicht entspricht. Nicht nur, dass so nicht Allgemeinmedizin in ihrer vollen Breite und entsprechend ihren Wesensmerkmalen vermittelt werden kann, bleibt in der krankenhauszentrierten Ausbildung auch das Erlernen der speziellen Arbeitsweise und der Arbeitsziele der Allgemeinmedizin auf der Strecke. Eine intensive Forcierung der Lehrpraxisausbildung und eine rasche Ausdehnung auf ein ganzes Jahr sind wesentlich, um die zukünftige primärärztliche Versorgung qualitativ wie quantitativ sicher zu stellen.

Die ärztliche Versorgung im Bereich der Krankenversicherung

Die Leistungserbringung in der österreichischen Krankenversicherung ist im Bereich der ärztlichen Leistungen im Wesentlichen durch Verträge der Krankenversicherungsträger mit den freiberuflich tätigen Ärzten (Vertragsärzten) organisiert, daneben durch eigene Einrichtungen der Krankenversicherungsträger (z.B. kasseneigene Ambulatorien) sowie durch Verträge mit den Krankenanstalten. Die anfallenden Kosten werden direkt zwischen Krankenversicherungsträger und einzelnen Leistungserbringern verrechnet. Man spricht vom sogenannten *Sachleistungsprinzip*.

Neben den genannten Vertragspartnern in der Leistungserbringung kann jeder Versicherte bzw. Anspruchsberechtigte gemäß dem Grundsatz der freien Arztwahl auch Nichtvertragsärzte, sogenannte Wahlärzte, in Anspruch nehmen. In diesem Fall wird der Versicherte vorleistungspflichtig und es gebührt ihm der Ersatz der Kosten dieser Krankenbehandlung im Ausmaß von 80% jenes Betrages, der bei Inanspruchnahme der entsprechende Vertragspartner des Versicherungsträgers von diesem aufzuwenden gewesen wäre (Kostenerstattung).

Dieses Nebeneinander von Kassenärzten und Wahlärzten ist ein ganz wesentlicher Eckpfeiler der österreichischen Gesundheitsversorgung, der den Patientinnen und Patienten die freie Arztwahl sicherstellt.

Vertragspartnerrecht - Gesamtvertrag

Gemäß dem österreichischen Sozialversicherungsgesetz (ASVG) obliegt es den Krankenversicherungsträgern, für die Krankenbehandlung der Anspruchsberechtigten ausreichend Vorsorge zu treffen. Zur Gewährleistung dieses gesetzlichen Auftrags haben die Krankenversicherungsträger Gesamtverträge zu schließen. Um eine „Übermachtstellung" der Krankenversicherungen gegenüber den einzelnen freiberuflichen Ärzten zu vermeiden, ermächtigt das Sozialversicherungsrecht die örtlich zuständigen Ärztekammern und den Hauptverband (für die Träger der Krankenversicherung) diese Gesamtverträge abzuschließen. Die Österreichische Ärztekammer kann mit Zustimmung der beteiligten Ärztekammern den Gesamtvertrag mit Wirkung für diese abschließen.

Die besondere Bedeutung der Gesamtverträge liegt aber nicht nur in dieser kollektivvertraglichen Funktion für Kassenärztinnen und Kassenärzte. Vielmehr ist der Gesamtvertrag auch das zentrale Instrument zur Sicherstellung einer ausreichenden und flächendeckenden Gesundheitsversorgung im kassenärztlichen Bereich. Im Zusammenspiel zwischen Ärztekammern und Sozialversicherung soll eine flächendeckende Versorgung durch Kassenärzte erreicht werden, die ihre Abbildung im sog. Stellenplan, einem Teil des Gesamtvertrages, findet.

Das Ziel der Ärztekammern hinsichtlich der Ausgestaltung von Stellenplänen ist traditionell die Sicherstellung einer für Patientinnen und Patienten wohnortnahen Medizin. Bedauerlicherweise verfolgen Sozialversicherungsträger im selben Zusammenhang fast ausschließlich ökonomische Überlegungen, weshalb derzeit in Österreich etwa 1400 Kassenstellen fehlen.

Einen weiteren Teil der Gesamtverträge bilden die sog. Honorarordnungen, in denen die kassenärztlichen Leistungen abgebildet und mit Tarifen versehen werden. Eine tatsächliche Abbildung der erbringbaren Leistungen in diesen Honorarkatalogen scheitert jedoch in vielen Fällen wiederum an der mangelnden Finanzierungsbereitschaft der Krankenversicherungsträger.

Die Rechtsbeziehung des freiberuflichen Arztes zum Krankenversicherungsträger entsteht durch den Einzelvertrag. Dieser kann nur im Rahmen des geltenden Gesamtvertrages abgeschlossen werden und sein Inhalt ist weitgehend durch diesen vorgegeben.

Aktuelle gesundheitspolitische Situation

Durch die aktuellen **Artikel 15a-Vereinbarungen** „über die Organisation und die Finanzierung des Gesundheitssystems" sowie über die „Zielsteuerung Gesundheit" kann es zu einer Verschiebung der Kompetenzen innerhalb des dargestellten Systems der

Gesamtverträge zugunsten der Sozialversicherung kommen. Verstärkt könnte dieser Effekt durch das in Umsetzung der Artikel 15a-Vereinbarung erlassene **Vereinbarungsumsetzungsgesetz 2017 (VUG 2017)** werden. Unter bewusstem Ausschluss der Versorgungserfahrung, welche die Ärztekammern in die Versorgungs- und Leistungsplanung bisher eingebracht haben, werden dem Hauptverband der österreichischen Sozialversicherungsträger und den Kassen Kompetenzen eingeräumt, die das jahrzehntelang funktionierende System des „freien Spiels der Kräfte“ zwischen Sozialversicherung und Ärztekammern zu Lasten der niedergelassenen Vertragsärztinnen und Vertragsärzte nachteilig beeinflussen sollen. Bedenkt man, dass es – wie dargestellt – die Ärztekammerseite war, die traditionell für eine Ausweitung der Kassenarztstellen und der Leistungskataloge eingetreten ist, während die Kassen primär ökonomisch begründetet Versorgungsrestriktionen verfolgt haben, so liegt es auf der Hand, dass mit dieser Entwicklung insgesamt eine nachteilige Entwicklung für die Versorgung der Kassenpatientinnen und Kassenpatienten zu erwarten ist.

Diese Intentionen bereiten nicht nur der Ärzteschaft sondern auch der Bevölkerung Sorgen: In der von der Ärztekammer in Auftrag gegebene Patientenbefragung des Hajek Institutes (Patientenbefragung 2016, Dr. Peter Hajek, Public Opinion Strategies), äußerten mehr als die Hälfte der befragten Österreicherinnen und Österreicher aktuell Sorge über die Entwicklungen im österreichischen Gesundheitswesen. Ein Großteil der Befragten macht sich vor allem Sorgen um die Zukunft und befürchtet Einsparungen sowie Leistungskürzungen.

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

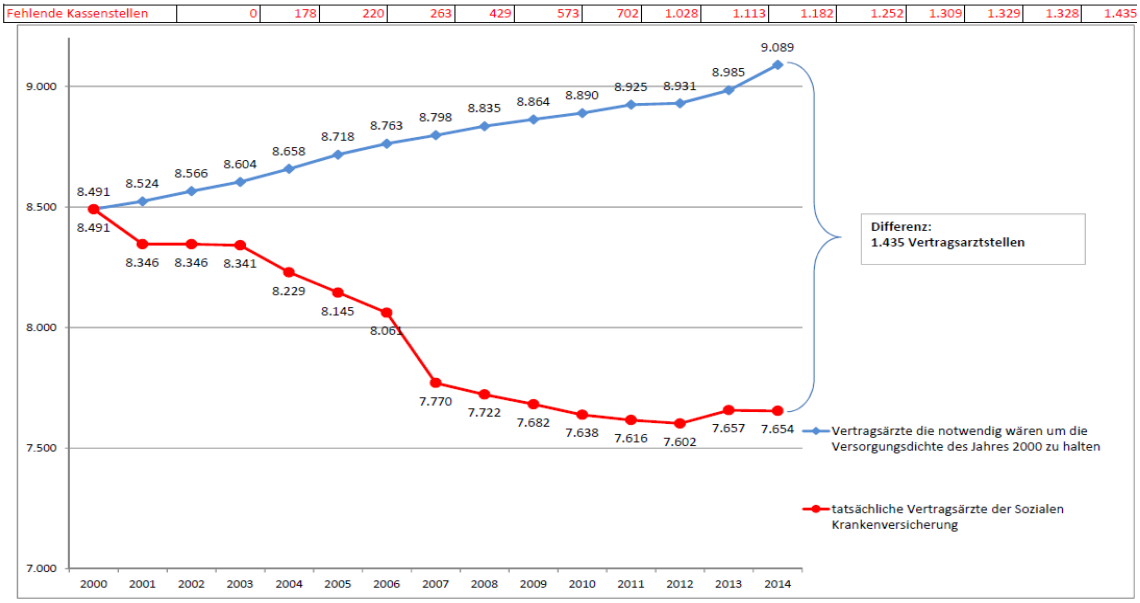
Die erste Priorität stellt die Versorgungssicherheit im niedergelassenen Bereich dar. Die Patientenversorgung ist in Österreich sehr durch seine Krankenhauslastigkeit charakterisiert. Nahezu 2,8 Millionen Spitalsentlassungen pro Jahr bei 8,6 Millionen Einwohnern zeugen ebenso davon wie die fast 60 000 Akutbetten, die zur Verfügung stehen. Zur allgemeinmedizinischen und fachärztlichen Versorgung in Praxen (Einzel- und Gruppenpraxen) niedergelassener Ärztinnen und Ärzte, die über 100 Millionen Patientenkontakte pro Jahr bewältigen kommen noch ca. 17 Millionen ambulante Patientenkontakte in den Krankenhäusern. Eine Doppelgleisigkeit, die auch einem chronischen Ressourcenmangel im niedergelassenen Vertragsärztlichen Bereich und der sektoral getrennten Finanzierung des Gesundheitssystems aber auch aus dem ungesteuerten freien Zugang zu allen Versorgungsebenen resultiert. Effekte, welche die für diese Menge an ambulanten Patienten nicht ausgelegten Krankenhausambulanzen stark überbelasten. Eine Überlastung, die auch der gut ausgebaute ambulante Privatsektor der Wahlärzte nicht auszugleichen vermag.

Prioritäten im Gesundheitswesen

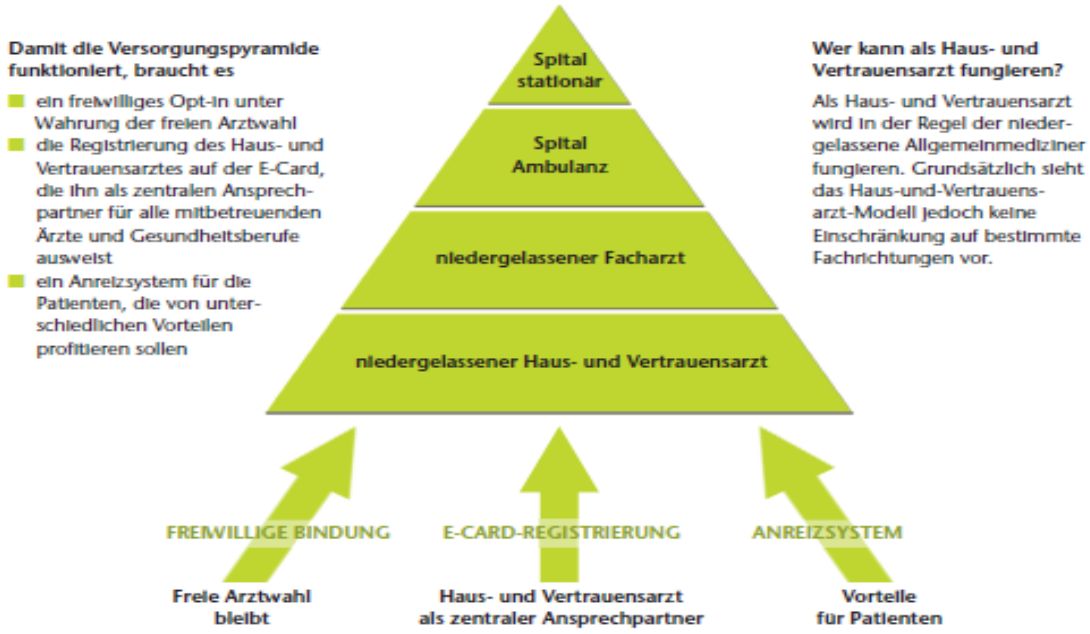
- Bedarfsorientierte, flächendeckende und kosteneffektive ambulante Gesundheitsversorgung unter Berücksichtigung einer immer älter werdenden und stetig wachsenden Bevölkerung.

- Ausbau der niedergelassenen Versorgung zur Entlastung der Ambulanzen und des stationären Bereiches unter Berücksichtigung der bestehenden Strukturen. Dazu sind in etwa 1.400 zusätzliche Kassenstellen notwendig um zumindest die Versorgungsdichte des Jahres 2000 zu erreichen.
  Vgl. dazu die Entwicklung der Bevölkerung und der Vertragsärzte seit dem Jahr 2000:

Jahr	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Einwohner Ö	8.011.566	8.042.293	8.082.121	8.118.245	8.169.441	8.225.278	8.267.948	8.300.954	8.336.549	8.363.040	8.387.742	8.420.900	8.426.311	8.477.230	8.576.149
tatsächliche Vertragsärzte der Sozialen Krankenversicherung	8.491	8.346	8.346	8.341	8.229	8.145	8.061	7.770	7.722	7.682	7.638	7.616	7.602	7.657	7.654
Allgemeinmeidzin	*4.483*	*4.382*	*4.382*	*4.363*	*4.296*	*4.285*	*4.249*	*4.146*	*4.128*	*4.108*	*4.100*	*4.101*	*4.098*	*4.122*	*3.939*
allg. Fachärzte	*3.648*	*3.606*	*3.606*	*3.601*	*3.567*	*3.519*	*3.484*	*3.319*	*3.304*	*3.293*	*3.270*	*3.253*	*3.263*	*3.297*	*3.432*
technische Fächer	*360*	*358*	*358*	*377*	*366*	*341*	*328*	*305*	*290*	*281*	*268*	*262*	*241*	*238*	*283*
Einwohner je Vertragsarzt	**943,5**	963,6	968,4	973,3	992,8	1.009,9	1.025,7	1.068,3	1.079,6	1.088,7	1.098,2	1.105,7	1.108,4	1.107,1	1.120,5
Vertragsärzte die notwendig wären um die Versorgungsdichte des Jahres 2000 zu halten	8.491	8.524	8.566	8.604	8.658	8.718	8.763	8.798	8.835	8.864	8.890	8.925	8.931	8.985	9.089
Fehlende Kassenstellen	0	178	220	263	429	573	702	1.028	1.113	1.182	1.252	1.309	1.329	1.328	1.435



- Strukturierte Steuerung des Patienten durch das Gesundheitssystem: In Österreich kann jeder Patient in jede Ebene des Gesundheitssystems praktisch ohne Auflagen oder Barrieren einsteigen. Die Österreichische Ärztekammer hat dazu auf der folgenden Seite ein Haus- und Vertrauensarztmodells entwickelt:



- Stärkung und Aufwertung des Hausarztes, um den Beruf attraktiver zu machen und dem drohenden Ärztemangel vorzubeugen. Dazu gehört beispielsweise die Verlagerung eines großen Teils der Ausbildung der Ärzte für Allgemeinmedizin in die Lehrpraxen von erfahrenen Ärzten für Allgemeinmedizin sowie eine Sicherung der öffentlichen Finanzierung dieser Lehrpraxis[1].

- Verbesserung der Arbeitsbedingungen im angestellten und niedergelassenen Bereich, um den steigenden Anforderungen und der Arbeitsverdichtung gerecht zu werden. In diesem Zusammenhang soll wiederum die Forderung nach einem gesteuerten Zugang des Patienten durch das Gesundheitssystem festgehalten werden (Priorität der Versorgung in Arztpraxen beziehungsweise ärztlichen Gruppenpraxen vor der Versorgung durch Krankenanstalten). Zusätzliche Forderungen in diesem Zusammenhang sind:
    - Entlastung der Spitalsärzteschaft durch Entlastung von Administrationspflichten, Straffung und Vereinfachung der Abläufe in den Krankenhäusern und kritische Evaluation aller bürokratischer Auflagen mit dem Ziel der Reduktion unnötiger Dokumentation, Reporting- und Kontrollvorgängen.
    - Ebenso die Abschaffung aufwändiger, Kontrollen und Dokumentationsverpflichtungen im niedergelassenen Bereich, die durch die Administration der

[1] **Exkurs: Lehrpraxis**
Die praktische Ausbildung im Rahmen einer anerkannten Lehrpraxis, Lehrgruppenpraxis oder eines Lehrambulatoriums soll den in Ausbildung stehenden Turnusärzten die Möglichkeit geben, einen Teil ihrer Ausbildung unter Anleitung und Aufsicht eines erfahrenen freiberuflich tätigen Arztes zu absolvieren. Damit soll einerseits den Ausbildungsbedürfnissen für eine spätere freiberufliche eigenverantwortliche Ausübung des ärztlichen Berufes im niedergelassenen Bereich Rechnung getragen werden, andererseits soll mit der Möglichkeit der Absolvierung eines Teils der postpromotionellen Ausbildung auch in Lehrpraxen, Lehrgruppenpraxen und in Lehrambulatorien der Tatsache entsprochen werden, dass die in Krankenanstalten vorhandenen Ausbildungsstellen nicht beliebig vermehrt werden können, für die postpromotionelle Ausbildung daher sämtliche Ausbildungsressourcen zu nützen sind. Da die Lehrpraxis seit der ÄAO 2015 gesetzlich verankert ist, muss der Gesetzgeber aus Sicht der Ärztekammer auch für die finanzielle Bedeckung der Lehrpraxis sorgen.

Krankenkassen verursacht werden und deren interner Kostenaufwand in keiner Relation zum erwarteten Einsparungspotential stehen.

- Abbau von konkurrierenden Finanzströmen – Schaffung einer homogenen Finanzierung der Gesundheitssystems und Lösung des Problems der sektoralen Schnittstellen, Finanzierungs- und Organisationsgrenzen. Die Entlastung der Spitalsambulanzen ist solange Theorie, als die Sozialversicherung Leistungen in die Krankenhäuser verlagert und den niedergelassenen Bereich unterfinanziert.

Prioritäten in der Primärversorgung

Österreich ist als 'low primary care'-Land klassifiziert (Ziegler Florian, 2010). Österreich kam in einer Studie von F. Ziegler unter 14 Staaten nur auf Rang 10 und reihte sich mit Belgien, Frankreich, Deutschland und den Vereinigten Staaten in der Gruppe der Staaten ein, welche der Primärversorgung im medizinischen Bereich wenig Platz einräumen. Der Anteil an Allgemeinmedizinern lieg in Österreich unter 20% wogegen international gesehen ein Anteil von 30 Prozent 'moderat', ein Anteil von 50 Prozent empfohlen wäre.

- Steigerung der Zahl der Allgemeinmediziner

- Neue, bedarfs- und situationsgerechte Zusammenarbeitsformen: Erleichterung der Gründung von Gruppenpraxen und anderen Kooperationsformen, Förderung der Anstellung von Ärztinnen und Ärzten in Praxen, Vergesellschaftung mit nichtärztlichen Gesundheits- und Sozialberufen.
    - Sicherung der betriebswirtschaftlichen Rentabilität für die betreibenden Ärztinnen und Ärzte
    - Wegfall degressiver Honorierungsformen, die die Kostendeckung der dort erbrachten Leistungen verhindern (z.B. Honorardegressionen und Deckelungen)
    - Förderung von dislozierten Kooperationsformen durch Vernetzung niedergelassener Versorgungseinrichtungen (Bspw.: Netzwerke – etwa styriamed.net[2])

Die folgende Übersicht zeigt die (sehr zögerliche) Entwicklung von Gruppenpraxen im Vergleich von 2012 zu 2017:

	Ö		B		K		NÖ		OÖ		S		ST		T		V		W	
	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017	2012	2017
Ärzte in Gruppenpraxen	448	778	23	6	8	8	87	236	135	215	10	37	21	29	13	18	0	2	151	227
Gemeldete Gruppenpraxen	170	349	9	3	1	3	27	105	59	105	4	18	8	14	5	7	0	1	57	93
Gruppenpraxen mit §2 Kassa	124	288	5	1			13	104	52*	103*	2	14	8	6		1			44	59
Gruppenpraxen in Form GmbH	6	16								1	1	4							5	11
*zahlreiche "Übergabepraxen"																				

[2] **Exkurs: Ärztenetzwerk styriamed.net:**
„Styriamed.net“ verbindet interessierte und qualifizierte niedergelassene Ärzte und Spitäler zur Verbesserung der Zusammenarbeit im ambulanten Bereich sowie zur Stärkung der Kooperation aller Partner im Gesundheitssystem. Das Zusammenwirken innerhalb des Netzwerkes beruht auf vereinbarten Prozessen, unternehmerischen Organisationsstrukturen und einer gemeinsamen Betreuungskultur. Dadurch ist es möglich, auf die Bedürfnisse der Patienten ausgerichtete, optimale Gesundheitsleistungen zu erbringen.

- Primärversorgung durch Etablierung von Netzwerken, in denen niedergelassene Ärzte mit spezifischen Berufsgruppen des Gesundheits- und Sozialwesens strukturiert zusammenwirken. Berücksichtigung von regionalen Anforderungen als Voraussetzung für die Bildung von Primärversorgungs-Einrichtungen, die an einem Standort konzentriert sind.

- Abbildung einer ärztlichen Primärversorgung im Sozialversicherungsrecht und im ärztlichen Berufsrecht; Primärversorgung muss Teil der gesamtvertraglichen Regelungen zwischen Ärztekammer und Sozialversicherung sein.

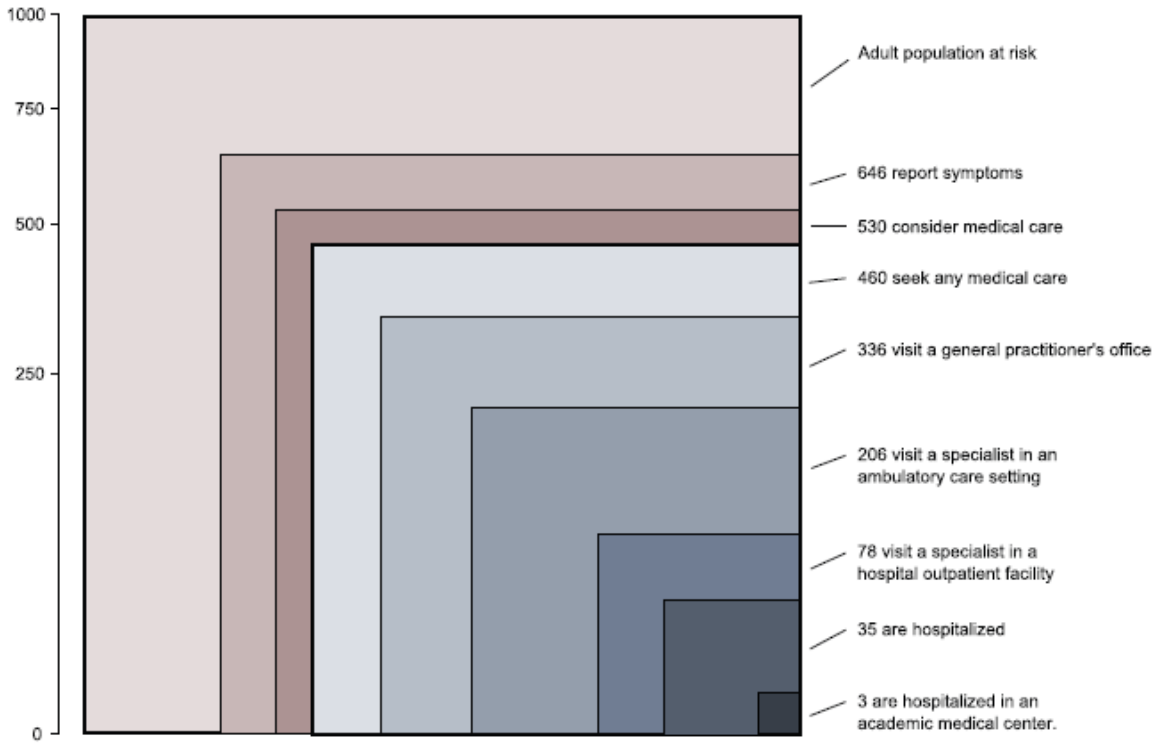
2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Bedarfsabgestimmter und gesteuerter Zugang zu den bestehenden Versorgungsstrukturen, insbesondere zwischen ambulanten und stationären Strukturen.

- Ambulanzentlastung durch Ausbau des niedergelassenen Bereiches

- Patientensteuerung: „lückenlose Primärversorgung“ durch niedergelassene Allgemeinmediziner mit prioritärer Zuweisung von Patienten an niedergelassenen Fachärzte statt unkontrollierte Selbstzuweisung durch die Patienten. Beispiele: Von 419 registrierten Beschwerdebildern könnten mindestens 60 % bei niedergelassenen AllgemeinärztInnen behandelt werden. Bei mindestens 3 % der ausgewerteten Angaben bedürfen die Patienten einer Behandlung im Krankenhaus und bei mindestens 5 % der Behandlung durch Spezialist/innen (Pichlhöfer, O.; Maier, M. (2014): Unregulated access to health-care services is associated with overutilization – lessons from Austria; European Journal of Public Health).

  Vgl. in diesem Zusammenhang die Grafik auf der folgenden Seite:



Haidinger, G.; Eckert-Graf, L.; Wirgler, P. E.; Weber, M.; Csaicich, G.; Meznik, C. (2013): Selbstzuweise im Spital – wie viele könnten im primär-medizinischen Bereich behandelt werden? Zeitschrift für Allgemeinmedizin 2013, 89 (1); S. 41-46

- Ausbau von Präventionsmaßnahmen: Der Gesundheitszustand der Bevölkerung ist durch verstärkte Prävention und mit kontinuierlicher Betreuung zu verbessern. Insbesondere chronisch Kranke und multimorbide Patienten würden von intensiverer ärztlicher Zuwendung profitieren. Diese scheitern oftmals an sehr kurzsichtigen Blickweisen auf die Budgets. Beispielsweise wird derzeit ein flächendeckendes Darmkrebsvorsorgeprogramm trotz des erwiesenen Nutzens nicht eingeführt. Der Mutter-Kind-Pass, der ein sehr wichtiges Vorsorgeinstrument darstellt harrt seit Jahren seiner medizinischen Weiterentwicklung.

Beispiel: Darmkrebsvorsorgeprogramm Vorarlberg

Vor der Einführung der Vorsorgekoloskopie im Bundesland Vorarlberg erfolgte die Diagnose Colorectalkarzinom bei jedem zweiten Patienten bereits im Stadium der Metastasierung. Seit Beginn des Programms im Februar 2007 wurden nur 8,7 Prozent der Fälle im Stadium der Metastasierung diagnostiziert. Die Kosten für eine Behandlung bei Darmkrebs im Stadium IV betragen für die Chemotherapie 235.693 Euro pro Patient. 30 Prozent aller Patienten im Stadium IV haben eine 50-prozentige Chance auf Heilung durch eine Lungen-/Leber-Operation. Die geschätzten Kosten pro Eingriff betragen 7.636 Euro (für eine Lungen-Operation) beziehungsweise 12.280 Euro (für eine Leber-Operation) pro Eingriff. Schon allein aufgrund dieser Zahlen lässt sich ermessen, wieviel menschliches Leid erspart und welche Kosten durch ein Vorsorgeprogramm vermieden werden können.

Die ökonomischen Auswirkungen eines österreichweiten Darmkrebsvorsorgeprogramms wurden im Rahmen einer Studie erarbeitet (Studie „Darmkrebsvorsorge - Ökonomische Evaluation“ von Agnes Streissler-Führer, Daniel Kon im März 2016). Dabei wurden - neben den Kosten für die Behandlung und Pflege – noch weitere

Faktoren berücksichtigt und anhand zweier Modelle berechnet: 1) nach dem Humankapitalansatz mit Einkommens-/Erwerbsverlust der aktiven Bevölkerung und 2) nach dem Zahlungsbereitschaftsansatz: Dieser berücksichtigt auch die Konsumdaten von erwerbsuntätigen Personen – wie beispielsweise Pensionisten.

Der volkswirtschaftliche Nutzen der Darmkrebsvorsorge ist evident. Demnach könnten beim Humankapitalansatz zwischen 736 Millionen und 1,3 Milliarden Euro eingespart werden - davon im Gesundheitsbereich zwischen 265 bis 468 Millionen Euro (= 36 Prozent Einsparung). Beim Zahlungsbereitschaftsansatz wiederum könnten zwischen drei und 4,5 Milliarden Euro eingespart werden; davon zwischen 810 Millionen bis 1,2 Milliarden im Gesundheitsbereich (= 27 Prozent).

Die Kosten für die Koloskopie betragen im zehnten Jahr – auf diesen Zeitraum wurde die Berechnung angelegt – 33 Millionen Euro. Für die in diesem Zeitraum auftretenden Diagnosen und notwendigen therapeutischen Maßnahmen wie etwa Chemotherapie oder Operation sind 25 Millionen Euro zu veranschlagen.

Auf Diagnosen umgelegt heißt das: Nach zehn Jahren Koloskopie-Programm wäre die Prävalenz des Colorectalkarzinoms bei 242 Fällen; ohne Programm bei 1.830. Nach zehn Jahren könnte die jährliche Prävalenz einer Diagnose im Stadium IV um rund 1.600 Betroffene verringert werden. Bei einer längeren Laufzeit des Darmkrebsvorsorgeprogramms – und einer flächendeckenden Umsetzung - ist davon auszugehen, dass jährlich bis zu 2.500 Diagnosen „Colorektalkarzinom“ im Stadium IV weniger erfolgen.

Auswirkungen hätte ein solches Vorsorgeprogramm auch auf die Zahl der Frühpensionierungen: Nach zehn Jahren könnten jährlich zwischen 500 bis 900 darmkrebsbedingte Frühpensionierungen verhindert werden.

- Kompetenzbereinigung: Der Regelungsbereich der Gesundheitsversorgung ist durch eine föderalistische Struktur und die Verankerung unterschiedlichster Kompetenzen für Gesetzgebung und Vollziehung in der österreichischen Bundesverfassung stark zersplittert. So ist beispielsweise der Bund für die Gesetzgebung und Vollziehung in Angelegenheiten des Sozialversicherungswesens (Art 10 Abs. 1 Z 11 B-VG) bzw. Gesundheitswesens (Art 10 Abs. 1 Z 11 B-VG) zuständig, wohingegen im Bereich der Krankenanstalten lediglich die Grundsatzgesetzgebung dem Bund, die Erlassung von Ausführungsgesetzen und die Vollziehung jedoch den jeweiligen Ländern obliegt. Die Länder sind demgegenüber ausschließlich für die Regelungen und Vollziehung in sozialen Angelegenheiten, Pflege- und Wohnheime, sowie das Rettungs-, Leichen- und Bestattungswesen zuständig. Diese Kompetenzzersplitterung stellt das System vor eine Herausforderung, die eine einheitliche und kontinuierliche Gestaltung der Gesundheitsversorgung unmöglich macht. Es wird daher eine Kompetenzbereinigung in der Gesundheitsversorgung gefordert.

- Die Leistungskataloge im niedergelassenen Bereich sind teilweise überaltert. Neue Leistungen zu implementieren ist durch die Zerstreuung der Finanzmittel (Bundesländer = intramural, Sozialversicherung = extramural) mitunter sehr schwierig (siehe das Beispiel Darmkrebsvorsorge).

- Schaffung von zusätzlichen Kassenstellen von bisher nicht berücksichtigten Fachgruppen wie beispielsweise der Nuklearmedizin, Kinder- und Jugendpsychiatrie,

- Rasche Abbildung des medizinischen Fortschrittes in den Honorarkatalogen: Durch den permanenten medizinischen Fortschritt erhöhen sich die Gesundheitsausgaben. Demnach können im OECD Schnitt 37 Prozent des Gesundheitsausgabenanstieges dem technologischen Fortschritt zugerechnet werden, wobei die Autoren dabei zwischen kostensenkenden, schrittweisen Innovationen und kostensteigernden, radikalen Innovationen im Bereich der medizinischen Geräte und Präparate unterscheiden (Machines that go ‚ping': Medical Technology and Health Expenditures in OECD Countries; Health Economics [2015]).

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- Anpassung der Honorarkataloge an moderne Therapieformen.

- Zeitgemäße Weiterentwicklung von Präventionsmaßnahmen:
  - Erhöhung der Durchimpfungsraten
  - Ausbau des Vorsorgeprogramms bzgl. Vorsorge für Schwangere und Kleinkinder (Mutter Kind Pass)
  - Ausbau von Vorsorgeprogrammen (Bspw.: „Junior Check"[3] bei der SVA, Darmkrebsvorsorge, Brustkrebsvorsorge, etc.)
  - Ausbau von ärztlicher Zuwendungsmedizin zur Erhöhung der Patienten-compliance

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Auswertung und Analyse von (bereits vorliegenden) epidemiologischen Daten sowie Evaluierungsdaten aus Vorsorgeprogrammen zur besseren, bedarfsorientierten Versorgungsplanung

- Standardisierte Kommunikation (Bspw.: Arztbriefe, Patient summary, Dokumente die von Ärzten entwickelt werden)

- Qualitätsprogramme

[3] **Exkurs: Junior Check**: Das Vorsorgeprogramm Gesundheits-Check Junior soll die Lücke zwischen den Mutter-Kind-Pass-Untersuchungen und der Vorsorgeuntersuchung (ab dem 18. Geburtstag) schließen. Ziel des Programms ist die Früherkennung von gesundheitlichen Risiken sowie die Förderung der Gesundheitskompetenz. Zudem sollen die Anspruchsberechtigten eine professionelle Unterstützung in wichtigen Entwicklungsphasen wie Einschulung und Pubertät erhalten. Teil des Checks ist auch ein ärztliches Coaching in sensiblen Bereichen wie Ernährung, Medienverhalten und Suchtmittel

ÖGAM
Österreichische Gesellschaft
für Allgemein- und Familienmedizin –
Mitglied der WONCA

ÖGAM Positionen 2017 – Zukunft Allgemeinmedizin

Für die Qualität und die Finanzierbarkeit eines Gesundheitssystems ist nach internationalen vergleichenden Studien eine starke allgemeinmedizinische Ausrichtung entscheidend. Kontinuierliche, integrative und ganzheitlich orientierte Begleitung der Patientinnen und Patienten sowohl in zeitlicher Hinsicht, als auch in Bezug auf die Breite möglicher Anliegen über alle Spezialfächer hinweg, ist eine Voraussetzung für Qualität, und schützt sowohl vor Über- als auch vor Unterversorgung. Dies gilt für Prävention und Akutmedizin ebenso wie für die Betreuung chronisch kranker Menschen, und ist die Domäne der hausärztlichen Allgemein- und Familienmedizin.

Die wissenschaftliche Fachgesellschaft für Allgemein- und Familienmedizin sieht folgende Voraussetzungen für eine erfolgreiche Reform des österreichischen Gesundheitssystems:

1. Grundpfeiler der Gesundheitsversorgung muss ein öffentliches, soziales und solidarisches Gesundheitssystem bleiben, das einkommensunabhängig für jede Mitbürgerin und jeden Mitbürger gleichen und gerechten Zugang zur jeweils optimalen Versorgung gewährleistet.
2. Dies kann unter anderem durch eine durchdachte, gestufte Versorgung erzielt werden, die sicherstellt, dass rasch, zuverlässig und ressourcenschonend der „Best Point of Service“, also die im konkreten Fall sinnvollste Versorgungsebene erreicht werden kann. Die ÖGAM empfiehlt daher freiwillige Einschreibe- oder Listensysteme die den Zutritt ins Gesundheitssystem erleichtern und sichere, strukturierte Begleitung ermöglichen.
3. Die Verbesserung von Zugänglichkeit und Erreichbarkeit der Primärversorgung unter Erhalt der Kontinuität als Qualitätsindikator verlangt nach einer Vielfalt von Organisationsformen im allgemeinmedizinischen, niedergelassenen Bereich als Antwort auf die außerordentliche Heterogenität der regionalen Anforderungen. (Einzelpraxen, Gruppenpraxen, Vernetzungen, Jobsharingpraxen, Zentren etc). Gerechtigkeit hinsichtlich Wertung und Ausstattung der unterschiedlichen Versorgungsformen sehen wir als Voraussetzung.
4. Goldstandard in der modernen allgemeinmedizinischen Versorgung ist die multiprofessionelle Zusammenarbeit mit ärztlichen und nichtärztlichen Gesundheitsberufen in gegenseitigem Respekt, und mit klar geregelten Strukturen und definierten Verantwortungsbereichen. Delegation und Substitution im Sinne einer guten integrierten Gesundheitsversorgung können uns in der hausärztlichen Tätigkeit entlasten und die Qualität der Gesundheitsversorgung steigern.

5. Die selbstständige, eigenverantwortliche Tätigkeit niedergelassener Ärztinnen und Ärzte innerhalb des solidarischen öffentlichen System hat sich als förderlich für Effizienz und Effektivität erwiesen, bei gleichzeitiger Sicherstellung sozialer Ausgewogenheit. Um die dadurch erreichte flächendeckende Versorgungsqualität zu erhalten, ist es erforderlich, die Anzahl tätiger Allgemeinärztinnen und Allgemeinärzte gesetzlich im Verhältnis der zu versorgenden Bevölkerung festzuschreiben, so wie dies durch die derzeitige beschränkte Vergabe von Kassenverträgen geschieht. Hierdurch wird zum einen eine Überversorgung durch angebotsinduzierte Nachfrage („doctorshopping“) minimiert und zum anderen gewährleistet, dass auch in weniger attraktiven Regionen die ärztliche Versorgung sichergestellt bleibt. Zudem wird hierdurch Investitionssicherheit für junge Kollegen geschaffen, die eine Voraussetzung für die Übernahme einer Kassenpraxis ist.
6. Gute Ausbildung einer ausreichenden Zahl von Allgemeinärzten ist eine Voraussetzung für gute Primärversorgung. Dies betrifft selbstverständlich die universitäre Ausbildungen, im gleichen Ausmaß aber auch die spezielle Ausbildung in Allgemeinmedizin, für die die hausärztliche Lehrpraxis unabdingbar und bestimmend ist. Die Finanzierung der Ausbildung ist im öffentlichen Interesse und daher Aufgabe der öffentlichen Hand.
7. Ausbildung und Arbeitsbedingungen für Allgemeinärzte müssen so gestaltet werden, dass die Abwanderung junger Kollegen ins Ausland gestoppt wird, dass eine ausreichend hohe Anzahl geeigneter Ärztinnen und Ärzte sich wieder für das Fachgebiet Allgemeinmedizin entscheidend, und dass diese versorgungswirksam tätig werden und bleiben.
8. Nur so kann eine Mangelsituation verhindert werden, die dazu zwingen würde, auf die Auswahl geeigneter, gut ausgebildeter Ärztinnen und Ärzte zu verzichten.
9. Aufgrund der speziellen Beschaffenheit des Fachgebiets und der erforderlichen spezifischen Qualifikationen muss die Zuerkennung des international üblichen Facharztstatus für Allgemeinärztinnen und Ärzte erfolgen .

Es ist Auftrag von Politik und Sozialversicherung, die Rahmenbedingungen in unserem öffentlichen, sozialen Gesundheitssystem so zu gestalten, dass eine ausreichende Anzahl von Allgemeinmedizinerinnen und Allgemeinmediziner ausgebildet wird, um Versorgungssicherheit auf qualitativ hohem Versorgungsniveau zu gewährleisten.

Die ÖGAM bietet, so wie in den vergangenen Jahren, weiterhin ihre Unterstützung aufgrund ihrer internationalen Erfahrung und ihrer theoretisch-wissenschaftlichen sowie praktischen Expertise an.

Das Präsidium der ÖGAM

Reformvorschläge des Österreichischen Gesundheits- und Krankenpflegeverbandes (ÖGKV)

Laut OECD Zahlen liegen in Österreich die Ausgaben für das Gesundheits- und Sozialwesen im oberen Drittel. Darüber hinaus sind die Ausgaben für die stationäre Versorgung (Akutversorgung und Langzeitpflegebereich) im europäischen Vergleich umfangreich. Ebenso entspricht das Österreichische Gesundheitswesen durch die hohe Anzahl an ÄrztInnen und dem vergleichsweise geringen Anteil an Gesundheits- und Krankenpflegepersonen, nicht den Ansprüchen eines am PatientInnen Bedarf orientierten Systems. Dies zeigt sich insbesondere im Bereich der Versorgung chronisch Kranker in jedem Lebensabschnitt, wo mangels entsprechender fachpflegerischer Struktur im niedergelassenen Bereich das Prinzip ambulant vor stationär nicht umgesetzt werden kann. Ebenso fehlt in Österreich die Nutzung fachpflegerischer Kompetenzen im Rahmen der Familiengesundheit oder aber auch im Rahmen der Schulgesundheit gänzlich. Ein wichtiger Punkt ist auch die Erhaltung der Gesundheits- und Krankenpflegepersonen im erwerbstätigen Berufsleben. Es ist davon auszugehen dass, ähnlich wie in anderen Gesundheitsberufen, für die entsprechenden Jahrgänge altersgerechte berufliche Handlungsfelder zu Verfügung stehen sollten. Als erster wichtiger Schritt in diese Richtung ist die Nutzung der Fachkompetenz der Gesundheits- und Krankenpflegepersonen als GutachterInnen im Rahmen der Antragstellung zum Pflegegeld zu nennen.

Der Österreichische Gesundheits- und Krankenpflegeverband (ÖGKV) erlaubt sich zusammengefasst, folgende Reformvorschläge zu den Fragenkomplexen zu unterbreiten:

- **Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich**

- Bereitstellung bedarfsorientierter Versorgung chronisch Kranker in jedem Lebensabschnitt und in jedem Setting
- Ausbau der Implementierung der Kompetenzen des gehobenen Dienstes für Gesundheits- und Krankenpflege im Rahmen der Primärversorgung
- Klare Rollendefinition der Gesundheits- und Krankenpflege
- Implementierung von Organisationsformen auf Augenhöhe mit allen weiteren Gesundheitsberufen
- Direkte Leistungsverrechnung der Gesundheits- und Krankenpflege mit den jeweiligen Sozialversicherungen

- **Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im Österreichischen Gesundheitssystem enthalten oder implementiert sind**

- Die Nutzung der Kompetenzen des gehobenen Dienstes für Gesundheits- und Krankenpflege im Rahmen der Schulgesundheit
- Die Implementierung eines aufsuchenden Familiengesundheitspflege-Angebotes auf Ebene der Gemeinden

Österreichischer Gesundheits- und Krankenpflegeverband
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- **Welche Bereiche, falls zutreffend, bedürfen weitere Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem**

- Bewertung und Dotierung der fachpflegerischen Leistung, insbesondere hinsichtlich Übernahme der medizinischen Routineversorgung (vgl. § 15 Gesundheits- und Krankenpflegegesetz – GuKG)
- Erstellung von Leistungspaketen für die medizinischen und fachpflegerischen (vgl. §14 Gesundheits- und Krankenpflegegesetz - GuKG) Leistungen insbesondere bei chronisch Kranken in jedem Lebensabschnitt
- Verordnungsermächtigung für den gehobene Dienst für Gesundheits- und Krankenpflege für Medizinprodukte im Zusammenhang mit den Erfordernissen des pflegerischen Versorgungsauftrages (Umsetzung des Pflegeprozesses)
- Reform des Medikament Regimes (z.B. Schmerzmedikamente im Zusammenhang mit der Behandlung von Menschen mit chronischen Schmerzen)

- **Wie können die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden**

- Ausrollung von bereits vorhandenen Projekten zur Qualitätssicherung von Pflegeleistungen
- Entwicklung und Implementierung von Kontrollinstrumenten zur Verwendung von Sachleistungen
- Investition in Fehlermelde- und Lernsysteme und damit Erhöhung der PatientInnensicherheit
- Investition in die Bildung der Gesundheitsberufe insgesamt

Auswahl weiterführender Unterlagen zu konkreten Themen

Österreichisches Gesundheitswesen im internationalen Vergleich (2011 GÖG/ÖBIG)
http://www.bmgf.gv.at/cms/home/attachments/4/8/3/CH1066/CMS1382089784387/das_oesterreichische_gesundheitswesen_im_internationalen_vergleich.pdf

OECD Bericht
http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-en#.WKwR5MszWUk#page1

Primärversorgung, Czypionka & Ulinski, 2014
http://www.hauptverband.at/cdscontent/load?contentid=10008.602001&version=1410347801

Kompetenzmodell des ÖGKV 2010
https://www.oegkv.at/fileadmin/user_upload/Diverses/OEGKV_Handbuch_Abgabeversion.pdf

Gesundheits- und Krankenpflegegesetz – Novelle 2016
https://www.ris.bka.gv.at/Dokumente/BgblAuth/BGBLA_2016_I_75/BGBLA_2016_I_75.pdf

Familiengesundheitspflege in der EU
http://www.euro.who.int/__data/assets/pdf_file/0012/102243/E88841.pdf?ua=1

Schulgesundheit
http://www.bmgf.gv.at/home/Gesundheit/Kinder_und_Jugendgesundheit/Schulgesundheit/Gesundheit_und_Gesundheitsverhalten_oesterreichischer_SchuelerInnen

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die beste Leistung am richtigen Ort für alle PatientInnen

Das österreichische Gesundheitswesen versorgt die gesamte Einwohnerschaft Österreichs. 99,9 Prozent sind krankenversichert. Diese hohe Abdeckung ermöglicht der Bevölkerung den niederschwelligen Zugang zu medizinischer Versorgung. Entsprechend hoch ist auch die Zufriedenheit der Menschen mit dem Gesundheitssystem. Dieses System muss daher erhalten bleiben. Jede/r Patient/in soll die für ihn/sie beste Leistung am richtigen Ort erhalten.

Solidarisches Versicherungssystem sorgt für höchste Zufriedenheit

Das bestehende solidarische, selbstverwaltete Versicherungssystem sorgt für hohe Leistungen und Zufriedenheit bei der Bevölkerung. Das bedeutet, dass allen Vorstellungen von Änderungen des Systems der Pflichtversicherung und den überwiegend beitragsfinanzierten Sozialversicherungsträgern eine Absage erteilt wird. Ein Umbau eines im Prinzip gut funktionierenden und von den Versicherten auch geschätzten Systems etwa in Richtung einer Versicherungspflicht oder gar eines gänzlich staatlichen Gesundheitssystems würde keine Vorteile bringen, sondern nur die Kosten erhöhen.

Gesundheitsreform rasch fortsetzen

Die vorrangige Priorität im österreichischen Gesundheitswesen muss die rasche Fortsetzung der unter dem Titel "Gesundheitsreform" begonnenen vertieften Zusammenarbeit zwischen Bund, Ländern und Sozialversicherung sein. Ziel dieser Reform ist das Prinzip der besten Leistung am besten Ort für jede einzelne Patientin und jeden einzelnen Patienten.
Der in diesem Prozess entwickelte konstruktive Dialog zwischen den beteiligten Partnern muss fortgesetzt werden.

Bedarf planen, Versorgungslücken gar nicht erst entstehen lassen

Dazu gehört auch eine vernünftige vorsorgliche Bedarfsplanung, damit keine Versorgungsengpässe oder gar Versorgungslücken entstehen. Diese Versorgungsplanung muss natürlich sektorenübergreifend sein. Die Beteiligten müssen gemeinsam eine solche Planung entwickeln, die dann für alle Beteiligten und alle Vertragspartner im System verbindlich sein muss. Das bedeutet natürlich auch, dass es für einzelne Berufsgruppen nicht mehr möglich sein darf, durch gesetzlich eingeräumte Zustimmungsrechte die Deckung eines festgestellten Bedarfs durch ein standespolitisches Veto zu verhindern.

Finanzierung nach dem Prinzip „Geld folgt Leistung“

Natürlich kann es in diesem Zusammenhang zu Leistungsverschiebungen kommen, d. h. Versorgungsleistungen, die bisher intramural erbracht wurden, könnten in den niedergelassenen Bereich wandern. Damit eine solche Verschiebung nicht ausschließlich auf Kosten der Sozialversicherungsträger geht, muss natürlich auch die Finanzierung angepasst werden (Stichwort „Geld folgt Leistung“).

Neue Form der Primärversorgung

Um den „best point of service“ in der medizinischen Versorgung effizient verwirklichen zu können, ist in diesem Zusammenhang die rasche Implementierung einer neuen Form der Primärversorgung wichtig. Die bisher hauptsächlich auf Basis von Einzelordinationen sicher gestellte allgemeinmedizinische Versorgung entspricht nicht mehr den Anforderungen der modernen Gesellschaft. Ein Zusammenspiel mehrerer verschiedener Gesundheitsberufe im Team, möglichst an einem Ort, bringt nicht nur für die Patienten klare Vorteile. Auch das Arbeitsumfeld für die dort Beschäftigten sollte sich durch vernünftige Arbeitsteilung verbessern.
Die Einrichtung von Primärversorgungszentren, die als erste Anlaufstelle im Gesundheitssystem fungieren und in weiterer Folge möglichst viele koordinierende Aufgaben für die Patienten übernehmen, ist daher von großer Wichtigkeit.

Neue Honorierungsmodelle für niedergelassene ÄrztInnen

Damit einhergehen muss natürlich auch die Entwicklung neuer Honorierungsmodelle. Bisher stützt sich dieses auf geringe Grundpauschalen und der Bezahlung von Einzelleistungen, was oft zu falschen Anreizen führt und der Qualität der Behandlung oft nicht förderlich ist. Ein Modell einer Abgeltung aus verschiedenen Komponenten, das auch flexibel auf neue Bedürfnisse bei der Behandlung der Bevölkerung (z. B. chronische Krankheiten, höherer Anteil an alten Patienten) adaptiert werden kann.

Sachleistungen vor Geldleistungen

Eine wirksame Primärversorgung würde auch zu einer Sicherstellung und Stärkung des Sachleistungsprinzips führen, zu dem wir uns uneingeschränkt bekennen. Finanzielle Zugangshürden darf es in einem solidarischen Gesundheitssystem nicht geben.

VertragsärztInnen stärken

Dies gilt auch für den Bereich der Flucht aus dem Sozialversicherungs-Vertragsrecht. Besonders spürbar ist diese Problematik im Bereich der ärztlichen Versorgung, Zunehmend mehr Ärzte verzichten auf einen Vertrag mit der zuständigen Krankenkasse und arbeiten auf Wahlarztbasis mit Kostenerstattung für den

Patienten. Für die Patienten mag das im Einzelfall eine als vorteilhaft empfundene Behandlung darstellen, insgesamt stellt eine solche Vorgehensweise allerdings das Sachleistungsprinzip in Frage. Es sollte daher über Regelungen nachgedacht werden, die eine solche Entwicklung verhindern bzw. in Grenzen halten.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Qualitätssicherung ausbauen

Ein Problem im Gesundheitswesen ist sicherlich, dass die Entwicklung eines transparenten Qualitätssicherungssystems vor allem im niedergelassenen Bereich noch am Anfang steht. Hier gilt es, die im Rahmen der Zielsteuerung Gesundheit entwickelten Maßnahmen zügig weiterzuführen. Dazu gehört jedenfalls das Auswerten von verlässlichen Daten, was Ergebnisqualität betrifft. Außerdem müsste der verstärkte Ausbau strukturierter Behandlungsprogramme forciert werden, die sich an Leitlinien orientieren. Andenken sollte man auch eine stärkere Verpflichtung der Gesundheitsberufe zur Teilnahme an solchen Programmen.

Mit Transparenz Wettbewerb zwischen Gesundheitsdienstleistern fördern

Die Auswertung der vorhandenen Qualitätsdaten aus allen Sektoren des Gesundheitssystems sollte auf eine vernünftige Art und Weise auch der Öffentlichkeit zur Verfügung gestellt werden. So können Patienten ihre Wahl eines Gesundheitsdienstleisters auf einer fundierten Basis treffen und der bisher kaum vorhandene Wettbewerb zwischen verschiedenen Gesundheitsdienstleistern könnte damit auch gefördert werden.

Arbeitsbedingungen im Gesundheitsbereich verbessern

Zu einem Problem könnte sich die mangelnde Attraktivität des Gesundheitsbereichs als Arbeitsort auswachsen. Wohl auch wegen unattraktiver Arbeitsbedingungen kommt es an manchen Stellen des Gesundheitssystems zu einem mangelnden Angebot an adäquat ausgebildetem Gesundheitspersonal. Teilweise wurden diese Probleme bereits in Angriff genommen (z. B. Ärzteausbildung neu, Novellierung der Ausbildung der Pflegeberufe), was allein aber nicht ausreichen wird.

Kompetenzen der Berufsgruppen besser nutzen

Vor allem auf dem Gebiet der Arbeitsteilung zwischen den Gesundheitsberufen gibt es noch viel Potenzial. Viele Berufsgruppen absolvieren eine oft langjährige intensive Ausbildung, können bzw. dürfen aber ihre Fähigkeiten dann oft nicht in ausreichendem Ausmaß einsetzen. Im Rahmen einer neuen Arbeitsteilung sind diese Kompetenzen zu nutzen.

Regulierung der Medikamentenpreise andenken

Eine der wichtigsten Aufgaben eines Gesundheitssystems ist die Versorgung der Bevölkerung mit Heilmitteln. Wenn die Preise für Medikamente Höhen erreichen, die von der Sozialversicherung nicht mehr geleistet werden können, ist diese Versorgung in Gefahr. Natürlich müssen auch alle Rationalisierungsmaßnahmen innerhalb des Gesundheitswesens (z. B. gemeinsame Beschaffung aller Sektoren) ausgeschöpft sein. Trotzdem wird es immer wieder Heilmittel geben, die auf Grund einer zeitlichen Monopolstellung bis zur Marktreife allfälliger Konkurrenzprodukte eine Preisdimension erreichen, die das System insgesamt gefährdet. Hier muss möglicherweise auch durch normative Maßnahmen Vorsorge getroffen werden.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Bewährte Organisation nach Sparten und Bundesländern

Die Organisation des Sozialversicherungssystems in den Sparten Kranken-, Unfalls- und Pensionsversicherung hat sich bewährt, ebenso wie die föderale Organisation der Krankenkassen. Eine Zusammenlegung der verschiedenen Sozialversicherungsträger kann die vorhandenen Probleme nicht lösen. Es sei nur daran erinnert, dass die wichtigsten Partner der Sozialversicherungen (wie z. B. Bundesländer, Ärztekammern usw.) ebenfalls föderal organisiert sind.
Vielmehr müssen die aufgetretenen Schwierigkeiten durch andere Maßnahmen, seien sie gesetzlich und/oder strukturell, gelöst werden. Dies gilt sowohl für ein modernes Vertragspartnerrecht als auch für strukturell neue Regelungen, was Risikoausgleich und Rücklagenmanagement betrifft.

Modernere Verträge zwischen Kassen und Gesundheitsdienstleistern

Vor allem auf dem Gebiet des Vertragspartnerrechts ist eine Modernisierung dringend nötig. Das Ziel muss die Sicherung und der Ausbau der Sachleistungsversorgung sein. Es gilt daher, neue Geschäftsmodelle zu entwickeln und zu erlauben, die die Sozialversicherung in die Lage versetzen, flexibel und qualitätsbewusst ihren Versorgungsauftrag erfüllen zu können (z. B. Ausschreibungsmodelle statt Verträgen).

Risiken gerecht auf die einzelnen Kassen verteilen

Ein weiterer Punkt, der gelöst werden muss, ist das Thema Risikostruktur und Rücklagenmanagement. Im derzeitigen, historisch gewachsenen, System, ist die Risikostruktur der verschiedenen Versicherungsgemeinschaften dementsprechend unterschiedlich. Man denke nur an die Unterscheidung zwischen ländlichem Raum und Ballungszentren oder die Unterschiede zwischen industriell starken Regionen und eher kleingewerblich-landwirtschaftlichen Regionen. Diese unterschiedlichen Voraussetzungen führen zu unterschiedlichen finanziellen Spielräumen der einzelnen Sozialversicherungsträger. Solche strukturellen Unterschiede sind daher in Form eines Risikostrukturausgleiches anzupassen.
Wenn auch nach derzeitigem Erkenntnisstand das Einbeziehen aller Träger in den bereits vorhandenen Ausgleichsfonds aus verfassungsrechtlichen Gründen nicht so ohne weiteres möglich ist, sollte die Entwicklung eines Modells des Risikostrukturausgleiches, der zumindest alle unselbstständig Erwerbstätigen umfasst, angestrebt werden.

Rücklagen sollen der Sozialversicherung als Ganzes nutzen

Bis ein solcher erweiterter Strukturausgleich fertiggestellt ist, muss aber auch das derzeit noch vorhandene Ungleichgewicht in der finanziellen Ausstattung der Sozialversicherungsträger ein Thema sein. Auf Grund der Unterschiede in der Struktur der Versichertengemeinschaften kommt es zur ungleichen Verteilung finanzieller Reserven. Ein kluges Rücklagenmanagement, das nicht einfach nur offene Finanzlöcher stopft, muss entwickelt werden. Derzeit noch unproduktiv gehortete Rücklagen müssen einer möglichst großen Versichertengemeinschaft zu Gute kommen. Dabei soll es sich nicht um Maßnahmen handeln, die enteignungsgleiche Wirkung haben, aber für die Sozialversicherung als Ganzes und die Versicherten Nutzen bringen, denkbar wären hier z. B. Investitionshilfen und/oder Anschubfinanzierungen.

Leistungen auf hohem Niveau angleichen

Ein weiterer Bereich, der erwähnt werden soll, ist das Thema Leistungsharmonisierung. Dort, wo unterschiedlichen Leistungen für die Versicherten auch unterschiedliche Beitragssysteme gegenüber stehen (höhere Beiträge, Selbstbehalte usw.), sind solche Unterschiede durchaus argumentierbar, wenngleich auch nicht immer wünschenswert. Aber unter der Gruppe derer, die gleiche Beiträge bezahlen, sind unterschiedliche Leistungen unverständlich. Es sollte der Grundsatz „gleiche Leistungen für gleiche Beiträge“ gelten. Diese Problematik wurde auch erkannt und es gibt Bestrebungen, dieses Thema abzuarbeiten. Eine sofortige Angleichung gestaltet sich aber schwierig, da diese Unterschiede im Leistungsangebot aber oft über lange Jahre gewachsen sind und die finanzielle Ausstattung der Träger unterschiedlich ist.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Gesundheitskompetenz der Menschen stärken

Zur Verbesserung der Effizienz und Effektivität im jetzigen Sozialversicherungssystem wären neben den oben erwähnten Maßnahmen wie ein modernes Vertragspartnerrecht, den Abbau von Veto-Rechten einer einzelnen Berufsgruppe und einer stringenten Bedarfsplanung sicherlich noch Maßnahmen wie die Stärkung der Gesundheitskompetenz der Bevölkerung hilfreich.

Selbsthilfegruppen stärken

Dazu gehören verständlich bereitgestellte Informationen über das Gesundheitssystem ebenso wie die Stärkung der Stellung der PatientInnen im System selbst durch einen Ausbau der unabhängigen Stärkung der Selbsthilfe(gruppen).

Prävention ausbauen

Auch der weitere Ausbau der gezielten Prävention sollte verstärkt werden. Nachdem erstmals im österreichischen Gesundheitswesen nationale Rahmengesundheitsziele beschlossen wurden, sollten an Hand dieser Ziele wirksame Maßnahmen entwickelt und umgesetzt werden.

Faire und nachhaltige Aufteilung der Finanzierung

Alle Maßnahmen und Entwicklungen müssen natürlich unter dem Gesichtspunkt einer fairen und nachhaltigen Finanzierung umgesetzt werden. Zu oft wurde die Diskussion über das Gesundheitswesen in der Vergangenheit unter monetären Gesichtspunkten geführt. Wenn die Weiterführung der Gesundheitsreform mittels Zielsteuerung dazu führen soll, dass der Spitalsbereich entlastet wird, die Aufnahmezahlen sinken und Akutbetten abgebaut werden können, verschiebt sich die Last auf die Sozialversicherung, die den niedergelassenen Bereich zu finanzieren hat. Dazu kommt noch die in den 15a-Vereinbarungen zwischen Bund und Ländern festgelegte Ausgabenobergrenze, die zwar sinnvoll ist, aber den Spielraum einschränkt.
Statt fix vorgegebener Finanzierungsbeiträge sollten finanzielle Mittel als Anreiz- und Steuerungsinstrument eingesetzt werden und damit das Leistungsangebot verbessert werden.

Schnittstellen effizienter verbinden

Besonders augenscheinlich ist das Potenzial zur Effizienzsteigerung im Bereich der Schnittstellen zwischen den Sektoren. Auf Grund der vorgegebenen Kompetenzbereiche kommt es für die Patienten immer wieder zu Übergängen im System, z. B. zwischen stationärer und ambulanter Behandlung, zwischen kurativer Therapie und Pflege bzw. oft auch durch den Wechsel eines Arztes oder zwischen Allgemeinmediziner und Facharzt.
Durch verschiedene Zuständigkeiten und Organisationsformen kommt es dabei zu Problemen an diversen Schnittstellen – Informationen werden unvollständig transferiert oder gehen verloren. Diese Reibungsverluste sind mühsam für PatientInnen und Gesundheitsdienstleister. Außerdem könnten sie weitgehend vermieden werden, was Zeit, Geld und Nerven sparen würde.

ELGA & Co.: Technologie effizient einsetzen

Moderne Informations- und Kommunikationstechnologie könnte hier Abhilfe schaffen, sofern sie konzentriert und flächendeckend eingesetzt würde. Mit ELGA (Elektronische Gesundheitsakte) und TEWEB (Telefon- und webbasiertes Erstkontakt- und Beratungsservice) wurden hier erste Schritte gesetzt, die weiter ausgebaut werden müssen.
Weitere elektronische Möglichkeiten wie etwa eine elektronische Diagnosecodierung oder zusätzliche Funktionen im e-card System gehören auch in diesen Bereich. Da die Umsetzung dieser Projekte meist nur mit Zustimmung der Vertragspartner erreicht werden kann, führt dies oft zu höheren Kosten und verminderter Effizienz. Hier müsste eine Regelung geschaffen werden, die eine Weiterentwicklung im Sinne der Patienten erlaubt, ohne dass sie von einer Seite blockiert bzw. enorm verteuert werden kann.

Flächendeckende Versorgung erhalten

Vorhandene Versorgungsmängel durch zu wenige oder überhaupt fehlende medizinische Versorgung sollten nicht vorkommen. Obwohl Österreich technologisch und ressourcenmäßig insgesamt überversorgt ist, kommt es in manchen Bereichen zu einer punktuellen Unterversorgung. Wenn es eine solche gibt, weil zu wenige Gesundheitsdienstleister vorhanden sind bzw. nicht unter Vertrag genommen werden können, muss darauf reagiert werden.
Weite Wege oder lange Wartezeiten sind den PatientInnen nur in Ausnahmefällen zumutbar, wenn sich dadurch medizinisch kein Nachteil ergibt. In den Bereichen, wo es Aufholbedarf bei der Versorgung gibt, wie z. B. im Bereich der psychischen Störungen und Krankheiten, muss durch den Ausbau der Versorgungsmöglichkeiten gegengesteuert werden.
Dort, wo Wartezeiten aber nicht durch mangelnde Versorgungseinheiten entstehen, sondern durch teilweise ineffiziente Nutzung der vorhandenen Ressourcen, muss energisch gegengesteuert werden. Das Umleiten von PatientInnen in den

lukrativeren privat bezahlten Bereich gefährdet die Sachleistungsversorgung, bevorzugt ökonomisch besser gestellte Versicherte und ist daher abzulehnen.

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Abteilung: HGSE/Obmann Durchwahl: 26000 17. März 2017

Sehr geehrter Herr Prof. Dr. Mossialos,

bezugnehmend auf Ihr Ersuchen vom 27.2.2017 nimmt die Pensionsversicherungsanstalt zu den übermittelten Fragen im Folgenden Stellung und übermittelt Ihnen im Anhang die Informationen, um die im Rahmen der Diskussionsrunde am 21. Februar 2017 ersucht wurde.

Einleitung

Die Pensionsversicherungsanstalt (PVA) merkt zu den aufgeworfenen Fragen vorab an, dass die Beantwortung aus Sicht der PVA als gesetzlich zuständiger Pensionsversicherungsträger für Arbeiter und Angestellte erfolgt und sich weitestgehend auf den der PVA gesetzlich übertragenen Aufgabenbereich beschränkt.

Über die PVA

Im System der österreichischen Sozialversicherungsträger ist die PVA mit rund 3,2 Millionen aktiv Versicherten und rund 1,8 Millionen Pensionsbezieher/-innen sowohl der größte Pensionsversicherungsträger als auch insgesamt der größte Sozialversicherungsträger Österreichs.

Neben dem Bereich Pensionen kommt der PVA auch die Aufgabe zu, ihre Versicherten und Pensionist/-innen mit Leistungen in den Bereichen Rehabilitation (medizinische, berufliche und soziale) und Gesundheitsvorsorge (z.B. Kuren, Gesundheitsvorsorge aktiv) zu versorgen. Als führendes Kompetenzzentrum Österreichs im Bereich der Rehabilitation entwickelt die PVA das Leistungsangebot laufend weiter und führt bei Bedarf auch neue medizinische Leistungen ein.

Die PVA betreibt 17 eigene Rehabilitationseinrichtungen (15 stationär, 2 ambulant) und arbeitet zudem mit zahlreichen Vertragseinrichtungen im Gesundheitsbereich zusammen[1], da die bewilligten Leistungen[2] nur in den Eigenen Einrichtungen allein nicht erbracht werden könnten.

Zu den Fragen:

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Eingangs ist auf die Wichtigkeit der allgemeinen Grundsätze der österreichischen Sozialversicherung zu verweisen, die eine wichtige Basis für das sehr gute Funktionieren des österreichischen Gesundheitswesens bilden: Selbstverwaltung, Pflichtversicherung (und keine Versicherungspflicht), Solidaritätsprinzip, keine Riskenauslese, keine Gewinnorientierung, Schutz von 3 Versicherungszweigen, nämlich Krankenversicherung, Unfallversicherung und Pensionsversicherung. Für den Bereich der Pensionsversicherung ist auch von Bedeutung, dass die Finanzierung auf einem Umlageverfahren und nicht auf einem Kapitaldeckungsverfahren beruht.

Weitere Prioritäten aus Sicht der PVA sind:

Mehr gesunde Lebensjahre und mehr Lebensqualität

Zunächst sollte das Ziel sein, bei allen Menschen die Anzahl der gesunden Lebensjahre zu erhöhen und die Lebensqualität zu steigern.

Erhalt der Arbeitsfähigkeit

Bei aktiven Menschen im Berufsleben soll die Gesundheitsversorgung zudem gewährleisten, dass die Menschen so lange wie möglich und so gesund wie möglich in ihrem angestammten Beruf bleiben können und ihre Arbeitsfähigkeit so lange wie möglich erhalten bleibt. Auch die berufliche Rehabilitation verfolgt dieses Ziel. Denn je mehr dieses Ziel erreicht werden kann, umso selbstbestimmter können die Menschen ihr Leben führen und umso weniger Mittel aus dem Sozialsystem müssen für vorzeitige Pensionierungen wegen Arbeitsunfähigkeit geleistet werden.

Vermeidung von Pflegebedarf

Bei Menschen, die schon eine Leistung aus der Altersversorgung beziehen, muss es Ziel der Gesundheitsversorgung sein, dass die Menschen so lange wie möglich ein selbstständiges Leben führen können und nicht auf fremde Hilfe angewiesen sind. Je mehr dieses Ziel erreicht wird, umso selbstbestimmter können die Menschen ihr Leben führen und umso weniger Pflegegeld muss geleistet werden.

Um diese Ziele zu erreichen, bedarf es umfangreicher Maßnahmen, welche krankheitspräventiv bereits in ganz jungen Jahren beginnen sollten.

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[1] dzt. rd. 90 Vertragspartner für Reha & Kur

[2] 2016 bewilligte die PVA 315.378 medizinisch Maßnahmen, davon waren 226.721 Reha- und Kuraufenthalte (stationär & ambulant)

Ausbau der Krankheitsprävention („Prävention VOR Reha")

Ein gesunder Lebensstil sollte bereits in der Schulausbildung ansetzen und ab diesem Zeitpunkt das ganze Leben lang gefördert werden.

In der Arbeitswelt sind in den Betrieben beispielsweise der Arbeitnehmerschutz und die betriebliche Gesundheitsförderung wichtige Maßnahmen.

Befindet sich ein erwerbstätiger Mensch in Problemlagen, die Beruf und Gesundheit betreffen, sind wirksame Beratungsmaßnahmen für die Menschen und Vernetzungsmaßnahmen zwischen betroffenen Einrichtungen zu befürworten. Ein Beispiel dafür ist das gesetzliche Beratungsangebot fit2work, in welchem Menschen in beruflichen Problemlagen beraten werden und jenen Stellen, die für die benötigte Hilfe zuständig sind, zugewiesen werden. Die PVA ist hier insofern involviert, als dass sie selbst Menschen, bei denen sie eine Problemlage erkennt, dem Programm fit2work zuweist und auch selbst als Rehabilitationsträger Menschen aus fit2work zugewiesen bekommt.

Generell sind auch alle übrigen Maßnahmen, die dazu dienen, bestehende Beschäftigungsverhältnisse zu erhalten, wichtig und sehr zu befürworten. Wie die Erfahrungen der PVA zeigen, streben gerade arbeitslose Menschen viel öfter eine Frühpension an, die ihnen trotz aller Nachteile (v.a. niedrige durchschnittliche Pensionshöhe) aufgrund der Sicherheit des Pensionsbezuges besser scheint, als zu versuchen, wieder eine Beschäftigung zu erlangen.

Ausbau der Rehabilitation („Reha STATT Pension")

Wichtig sind auch Maßnahmen zur Früherkennung von gesundheitlichen Leiden. Denn Früherkennung macht es möglich, bereits in einem frühen Krankheitsstadium zu intervenieren und damit mit einer höheren Erfolgschance zu verhindern, dass sich ein Leiden ausweitet oder gar dauerhaft verfestigt. Maßnahmen wie die kürzlich neu beschlossene gesetzliche Early Intervention bei 28 Krankenstandstagen sind zu begrüßen.

Eine möglichst frühe Intervention erhöht auch im Bereich der Rehabilitation die Wirksamkeit von Reha-Maßnahmen. Verfestigen sich hingegen Krankheiten über einen langen Zeitraum (z.B. psychiatrische Erkrankungen), umso weniger greifen die in der Regel erst spät im Krankheitsverlauf einsetzenden Reha-Maßnahmen.

Ein weiterer wichtiger Faktor im Bereich der medizinischen Rehabilitation ist, dass sie auch auf Anforderungen ausgerichtet ist, die die Arbeitswelt allgemein und der ausgeübte Beruf konkret an die zu rehabilitierende Person stellen. Die PVA hat hier das Projekt IMB (Integrierte medizinisch-berufliche Rehabilitation) ins Leben gerufen. Dieses wird bereits in mehreren PVA-eigenen Sonderkrankenanstalten in einem Pilotprojekt angewendet und soll zukünftig weiter ausgeweitet werden.

Betreuung und Reha bei bereits bestehender oder drohender Invalidität

Hier ist wichtig, dass die Menschen begleitend durch ein Case-Management betreut werden und sie mit diesem den bestmöglichen Weg finden, um wieder arbeitsfähig zu werden und in das Berufsleben zurückkehren zu können.

Qualitätsmessung

Medizinische Leistungen sollen am aktuellen Stand der Wissenschaft gehalten und im Hinblick auf ihre Wirksamkeit und die Erfüllung der sonstigen maßgeblichen Anforderungen laufend evaluiert werden. Dies liefert wesentliche Grundlagen für größtmögliche Effektivität beim Einsatz der Mittel.

Gleicher und gerechter Leistungszugang

Wie bei allen sozialen Leistungen muss auch im Gesundheitsbereich der Zugang zu den Leistungen für alle Menschen gleich und gerecht sein. Daraus folgt, dass bei der Schaffung von Leistungsangeboten darauf zu achten ist, dass diese gleichermaßen auch von allen Menschen in Anspruch genommen werden können, die diese Leistungen benötigen.

Ein Beispiel sind die medizinischen Rehabilitationsleistungen der Phase 2. Diese werden von der PVA seit vielen Jahrzehnten in einer stationären Form, aber seit einigen Jahren immer mehr auch in einer ambulanten Form angeboten. Beide Formen haben grundsätzlich denselben medizinischen Inhalt, jedoch erfolgt die stationäre Form als 3- oder 6-wöchiger Daueraufenthalt in einem – meist wohnortfernen – Rehabilitationszentrum. Die ambulante Form hingegen erfolgt wohnortnah in einem ambulanten Rehabilitationszentrum und die Menschen halten sich dort nur tagsüber auf. Sie bringt damit wesentliche Vorteile für Menschen, die eine ununterbrochene 3-wöchige Absenz von zu Hause aus persönlichen Gründen (Familie oder Beruf) gar nicht oder nur schwer vereinbaren können.

Sozialer Versorgungsauftrag

Das öffentliche Gesundheitswesen soll auch einen sozialen Versorgungsauftrag erfüllen. Insbesondere in medizinisch schweren und komplexen Fällen gibt es von Seiten privater Gesundheitsanbieter kein adäquates Angebot zur optimalen Versorgung, weil diese zu komplex und/oder nicht betriebswirtschaftlich rentabel wäre. Gerade die Träger der Sozialversicherung haben hier die Kompetenzen für entsprechende Versorgungsangebote und müssen diese nicht am Kriterium der betriebswirtschaftlichen Rentabilität ausrichten.

Die PVA bietet in ihren Eigenen Einrichtungen bereits derartige Spezialisierungen an, beispielsweise für Patient/-innen nach Amputationen zur Prothesenversorgung, Patient/-innen mit COPD Stadium Gold IV oder mit schweren Ko-Morbiditäten, Reha-Patient/-innen im Bereich Hämato-Onkologie, Patient/-innen nach Organtransplantationen (Herz, Lunge, Nieren), Patient/-innen mit einem sogenannten Kunstherz, Patient/-innen mit schwerem Übergewicht nach Magenbypass-OP etc.

Die Implementierung derartiger Spezialversorgungen bietet sich in den Eigenen Einrichtungen der PVA auch deshalb an, da diese in die Betriebsorganisation eingegliedert sind und daher eine rasche und direkte Einflussmöglichkeit besteht.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Die Aufrechterhaltung der flächendeckenden niederschwelligen Versorgung muss primäres Ziel bleiben. In der medizinischen Erstversorgung ist der Ausbau der Primärversorgungszentren zu befürworten.

Weiters sollte die integrierte Versorgung weiter ausgebaut werden und Maßnahmen, die der Erreichung der Ziele „Prävention vor Reha", „Reha statt Pension" und Reha bei Invalidität/Berufsunfähigkeit" dienen, sollten noch besser verzahnt werden, um die Effizienz und Wirksamkeit zu erhöhen.

Ein aktuelles Vorhaben in diesem Zusammenhang ist es beispielsweise, das neue Modell in der Gesundheitsvorsorge („Gesundheitsvorsorge Aktiv") bereits in den Betrieben im Bereich der Betrieblichen Gesundheitsförderung zu verankern. Damit würden Menschen, die eine Leistung aus der Gesundheitsvorsorge benötigen, diese früher und damit mit einer höheren Wahrscheinlichkeit einer nachhaltigen Wirksamkeit in Anspruch nehmen können.

Im Bereich der Zuständigkeit für die Rehabilitation für Pensionist/-innen der PVA wäre eine höhere rechtliche Qualität der Kompetenzregelung wünschenswert. Derzeit ist die Zuständigkeit nämlich nicht klar abgegrenzt. Dem Gesetz nach wären die Träger der Krankenversicherung zuständig, de facto wird die Pensionist/-innen-Reha aber aufgrund eines Erlasses des BMASK von der PVA durchgeführt und bezahlt.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Ausbau von hochwertigen, effizienten und effektiven Leistungen

siehe dazu Antworten zu Frage 4

Finanzierung der SV & Digitalisierung der Arbeitswelt (Industrie 4.0)

Dazu ist vorab anzumerken, dass aufgrund von aktuellen Langfristprognosen (z.B. dem EU-Ageing-Report) im System der Altersversorgung von dessen langfristiger Finanzierbarkeit auszugehen ist.

Dennoch ist zu beachten, dass nach einhelliger Einschätzung der Expert/-innen umfassende technologische Entwicklungen bevor stehen bzw. bereits im Gang sind (Industrie 4.0), die enorme Veränderungen in der Arbeitswelt mit sich bringen und der Faktor Arbeit durch digitale Technologien zunehmend verdrängt wird. Da das österreichische System der Sozialversicherung überwiegend aus Beiträgen finanziert wird, welche ihrerseits auf Löhnen und Gehältern basieren, müssen diese Entwicklungen und ihre möglichen Auswirkungen auf das Sozialversicherungssystem im Augen behalten und möglichst gut eingeschätzt werden.

Es ist daher laufend die Frage zu stellen, ob das System der Sozialversicherung zukünftig noch im selben Ausmaß wie bisher finanziert werden kann oder ob man über Alternativen bei der Finanzierung nachdenken muss.

Dies ist insbesondere für das System der Pensionsversicherung wichtig, da diese auf dem Generationenvertrag und dem Umlageverfahren basiert und für dessen Funktionieren das Vertrauen in die Finanzierbarkeit eine maßgebliche Voraussetzung ist.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Allgemeine Vorbemerkung

Nach Ansicht der PVA ist die Effizienz in der Verwaltung in der gesamten SV und konkret in der PVA bereits jetzt sehr hoch.

In der gesamten Sozialversicherung beträgt der eigene Verwaltungs- und Verrechnungsaufwand im Vorjahr rund 2% der Gesamtausgaben und hat sich in den letzten 20 Jahren auch kontinuierlich verringert.

In der PVA ist der eigene Verwaltungs- und Verrechnungsaufwand noch niedriger und lag im Jahr 2016 bei 0,89 % der Gesamtausgaben[3].

Trotz dieser sehr guten Effizienzwerte, setzt die PVA auch im Hinblick auf das stetig weiter wachsende öffentliche Kostenbewusstsein umfangreiche Maßnahmen zur Effizienz- und Effektivitätssteigerung.

Maßnahmen zur Verbesserung bei Leistungserbringung, Effizienz und Effektivität Im Verwaltungsbereich

Weiterentwicklung der IT-Systeme

Auch in der PVA befindet sich die Arbeitswelt mit veränderten Geschäftsabläufen und der zunehmenden EDV-Unterstützung im Umbruch. In wesentlichen Geschäftsbereichen der Verwaltung – z.B. im Pensionsbereich oder im Bereich der Eigenen Einrichtungen - werden Arbeitsabläufe vereinheitlicht, optimiert und durch neue, passend entwickelte EDV-Systeme unterstützt. Dies soll einerseits den Verwaltungsaufwand senken und andererseits mehr Zeit für die Arbeit mit den Versicherten bringen.

Ein aktuelles Beispiel ist das Projekt e-PV (Elektronische Pensionsversicherung, vormals zepta). Hier wird im Pensionsbereich schrittweise ein neues EDV-System eingeführt, das zunächst den Geschäftsprozess bis zur Pensionsgewährung unterstützen wird.
Dabei wurde in einer bereits im Einsatz befindlichen Ausbaustufe der elektronische Akt eingeführt, der Einsatz einer weiteren Ausbaustufe (Release 7) steht unmittelbar bevor.

Bisherige Erfahrungen haben gezeigt, dass Umstellungen, wie z.B. die Einführung des elektronischen Aktes, teilweise mit vorübergehenden Schwierigkeiten verbunden sind.

[3] Vorläufiges Ergebnis 2016, Stand Februar 2017

Gleichzeitig entstehen aber auch Synergien und gewisse Tätigkeiten werden nicht mehr benötigt (wie z.B. manuelle Tätigkeiten mit Papierakten). Auf der anderen Seite kommen manche Tätigkeiten neu dazu (z.B. im elektronischen Posteingang beim Aufbereiten und der Beschlagwortung der digitalisierten Dokumente). Summa summarum sieht die PVA im neuen System aber jedenfalls den zukunftsweisenden Weg, da sich mit zunehmendem Ausbau und steter Weiterentwicklung die Effizienz und die Produktionsgeschwindigkeit sicher weiter erhöhen werden.

An dieser Stelle ist aber auch auf den Umstand hinzuweisen, dass daneben auch die Anforderungen an die Kundenbetreuung steigen werden. Ein Beispiel ist hier der sogenannte zwischenstaatliche Bereich, wo Pensionsverfahren mit internationalen Anknüpfungen zu erledigen sind. Dieser nimmt aufgrund der wachsenden Mobilität der Versicherten insbesondere innerhalb der EU zu. Die Menschen sind zunehmend nicht nur in Österreich, sondern auch in anderen Ländern der EU oder in übrigen Ländern, mit denen Österreich ein Abkommen im Bereich der Sozialen Sicherheit abgeschlossen hat, erwerbstätig.

Ein weiterer Umstand, der in diesem Zusammenhang zu berücksichtigen ist, sind die gesetzlichen Bestimmungen, die die PVA umzusetzen hat. Diese sind teilweise sehr komplex und in ihrer administrativen Umsetzung ressourcenintensiv. Auch für die Zukunft ist hier eine entsprechende Ressourcenbindungen zu erwarten.

Informationsaustausch und Vernetzung zwischen den SV-Trägern fördern und erhöhen

Speziell in der IT machen Kooperationen mit anderen SV-Trägern, die dieselben Anforderungen an EDV-Systeme haben, Sinn.

Ein aktuelles Projekt, das sich aktuell in Umsetzung befindet, ist die Applikation e-PV, die in Kooperation mit der SVA, der SVB und der VAEB entwickelt wird.

Weiters arbeitet die PVA in der IT seit Jahren strategisch mit der AUVA zusammen, um Synergiepotentiale zu heben. Als Ergebnis dieser Zusammenarbeit konnte die Zahl der Rechenzentren der PVA von zwei auf eines reduziert werden.

Auch im Bereich der Begutachtungen sind Verbesserungen möglich. Der gemeinnützige Verein ÖBAK (Österreichische Akademie für ärztliche und pflegerische Begutachtungen), an dem alle Träger, die Begutachtungen durchführen, beteiligt sind, organisiert die gesamte Ausbildung aller Gutachter/-innen. Inhaltlich beschränkt sich Gutachter/-innenausbildung derzeit auf den Bereich Pflegegeld, zukünftig wird auch der Bereich Arbeits-/Erwerbsunfähigkeit übernommen. Der Verein leistet damit auch einen wichtigen Beitrag zur Vereinheitlichung der Begutachtungen über alle beteiligten SV-Träger hinweg.

Maßnahmen zur Steigerung der Qualität der Leistungserbringung, der Effizienz und der Effektivität in den Bereichen Rehabilitation und Gesundheitsvorsorge

Allgemeine Ziele sind hier, den Versicherungsfall der Arbeitsunfähigkeit und einen Bedarf an Pflegehilfsleistungen noch effektiver und effizienter zu verhindern.

Gesundheitsvorsorge Aktiv

Ein wichtiges Projekt der PVA im Bereich der Gesundheitsvorsorge ist in diesem Zusammenhang das neue Modell „Gesundheitsvorsorge Aktiv" (kurz GVA), welches nach und nach die herkömmliche Kur ablösen soll. Die GVA ist ein 22-tägiges stationäres Heilverfahren, welches sich dadurch besonders kennzeichnet, dass es durch mehr Aktivtherapien und besonderer Beachtung der Bewegungsoptimierung, der Bewegungsmotivation und der mentalen Gesundheit, die Menschen nachhaltig zu einem gesünderen Lebensstil bringen soll. Nach einer 3-jährigen Pilotphase wird die GVA nun österreichweit ausgerollt und damit flächendeckend eine moderne und zeitgemäße Gesundheitsvorsorge-Maßnahme eingeführt.

Masterplan Rehabilitation

Für den Bereich Rehabilitation hat der Vorstand der PVA im Oktober 2016 den sogenannten „Masterplan Rehabilitation" beschlossen, welcher die Ziele und Pläne der PVA in diesem Bereich für die nächsten Jahre definiert und damit die Orientierungsgrundlage für das weitere Handeln liefert.

Wichtige Eckpunkte aus dem Masterplan sind:

Ausbau des Grundsatzes „Reha vor Pension"

Dies bedeutet, dass präventive Maßnahmen weiter ausgebaut werden und so weit wie möglich an die Stelle von kurative Maßnahmen treten sollen.

Ausbau der Früherkennung

Weiters gilt es, den Eintritt eines gesundheitlichen Leiden zu verhindern bzw. so früh wie möglich zu erkennen, um einer dauerhaften Verfestigung, die in späterer Folge nicht oder nur mehr sehr schwer rückgängig gemacht werden kann, zuvor zu kommen.

Beispielhaft sind in diesem Zusammenhang die psychiatrischen Erkrankungen zu nennen, welche aktuell die häufigste Ursache bei den Zuerkennungen von BU/IV-Pensionen[4] und Reha-Geld-Zuerkennungen[5] sind. In vielen dieser Fälle hat sich das psychische Leiden bereits stark verfestigt, was die Erfolgschancen auf eine erfolgreiche Rehabilitation wesentlich vermindert. Um die Effektivität zu steigern, baut die PVA die Maßnahmen zur Früherkennung der psychischen Leiden aus, um bereits zu einem viel früheren Zeitpunkt intervenieren zu können.

[4] Psychische Erkrankungen sind in 40% aller BU/IV-Zuerkennungen Ausschlag gebend
[5] Psychische Erkrankungen sind in 60% aller Reha-Gelb-Zuerkennungen Ausschlag gebend

Ein aktuelles Kooperationsprojekt zwischen Wiener Gebietskrankenkasse (WGKK), Stadt Wien und PVA beschäftigt sich mit den Möglichkeiten zur Früherfassung von psychischen Erkrankungen.

Verbesserte Vernetzung aller beteiligten SV-Träger und Institutionen

Auch in allen anderen Bereichen der Rehabilitation und der Gesundheitsvorsorge gilt es, wechselseitige Kooperationen zwischen SV-Trägern und anderen Fachinstitutionen weiter auszubauen und zu verbessern sowie vorhandene Ressourcen zu bündeln. Im Zentrum dieser Zusammenarbeit soll der Patient/die Patientin stehen, der/die bei der Genesung und Wiedererlangung der Arbeitsfähigkeit bestmöglich unterstützt werden muss.

Ein weiteres Projekt, in welchem diese Form der Zusammenarbeit ebenfalls sehr gut funktioniert, ist das Projekt „Alkohol 2020", in welchem die PVA ebenfalls mit der WGKK und der Stadt Wien kooperiert und welches eine integrierte Versorgung für alkoholkranke Menschen in Wien hervorgebracht hat. Aufgrund der bisherigen Erfolge in „Alkohol 2020" arbeitet die PVA daran, dieses Projekt und diese Art der Vernetzung auch in anderen Bundesländern umzusetzen.

Zur Gesundheitsvorsorge Aktiv ist an dieser Stelle nachzutragen, dass die PVA sämtliche Informationen und bisherigen Erkenntnisse zum neuen Modell auch allen anderen SV-Trägern, die Leistungen im Rahmen der Gesundheitsvorsorge erbringen zur Verfügung gestellt und ihnen eine Beteiligung bei den bevorstehenden Ausschreibungen der benötigten Gesundheitsdienstleistungen angeboten hat.

Medizinische Leistungen am neuesten Stand der Wissenschaft halten

Die Vorgaben für die Erbringung der medizinischen Leistungen sind laufend dem aktuellen Stand der Medizin anzupassen. Zu diesem Zweck hält die PVA die Kooperation mit Wissenschaft- und Forschungseinrichtungen für erforderlich.

Weiters sind die medizinische Entwicklungen im Auge zu behalten, z.B. die Fragen, welche gesundheitliche Leiden wie verbreitet sind oder welche Leiden zu- oder abnehmen. Veränderungen führen meist zu neuen Anforderungen an das Versorgungssystem, weshalb darauf entsprechend zu reagieren ist, um den Menschen die benötigten Leistungen anbieten zu können. Die PVA entwickelt aus diesem Grund ihre Leistungen stets weiter und schafft bei Bedarf auch neue Angebote für neue relevante Indikationen. Ein Beispiel aus der Vergangenheit ist die Einführung der onkologischen Rehabilitation als eigener Zweig der Rehabilitation, in dem erstmals die ganz speziellen Bedürfnisse von onkologischen Patient/-innen berücksichtigt wurden.

Aktuelle Krankheitsformen, die im Bereich der Rehabilitation auch immer mehr zu beachten sind, sind z.B. chronischer Schmerz oder die Alkoholkrankheit.

Berücksichtigung individueller Patientenbedürfnisse

Hier gilt es, Angebote derart zu gestalten, dass den betroffenen Menschen so leicht wie möglich gemacht wird, ein Angebot auch anzunehmen.

Als Beispiel ist hier der von der PVA betriebene Ausbau der ambulanten Rehabilitation in der Phase 2 zu nennen, welche als wohnortnahe Reha eine leichtere Einbettung der mehrwöchigen Reha in das persönliche Umfeld ermöglicht und damit besonders jenen Menschen entgegen kommt, denen die Absolvierung eines mehrwöchigen stationären Aufenthalts wegen persönlicher Umstände (Familie, Beruf, etc.) nicht oder nur schwer möglich ist.

Im Bereich der stationären medizinischen Rehabilitation gibt es auch spezielle Angebote, bei denen die besonderen Bedürfnisse von Elternteilen berücksichtigt werden, die für ihre Kinder keine Versorgungsmöglichkeit für die Dauer eines mehrwöchigen stationären Heilverfahrens haben. Betroffene Elternteile erhalten damit die Möglichkeit, ihre Kinder in die Reha-Einrichtung mitzunehmen, wo diese vor Ort speziell untergebracht und betreut werden. Entsprechende Projekte hat die PVA federführend in der onkologischen Rehabilitation am eigenen Standort in Bad Schallerbach sowie im Bereich der psychiatrischen Rehabilitation gemeinsam mit der Vertragseinrichtung Gesundheitstherme Wildbad eingeführt.

Bei der GVA ist vorgesehen, neben einem 22-tägigen dauernden stationären Aufenthalt auch eine wochenweise Inanspruchnahme zu ermöglichen. Voraussetzung für diese Alternative muss sein, dass die medizinische Wirksamkeit dadurch nicht beeinträchtigt wird.

Umsetzung der Integrierten medizinisch-beruflichen Reha

Die medizinische Reha soll auch an die individuelle berufliche Lage des zu rehabilitierenden Menschen ausgerichtet werden. Sie leistet damit einen ganz wichtigen Beitrag, dass den Menschen konkret jene Fertigkeiten erhalten bleiben, die sie zur Fortsetzung der Ausübung ihres Berufs benötigen.

Optimierung des Zuweisungsprozesses zu medizinischen Leistungen

Um die Effizienz einer medizinischen Leistung zu gewährleisten, ist es erforderlich, dass Menschen, die um eine Leistung ansuchen, auch genau die für sie passende Leistung bewilligt bekommen. Die PVA verfolgt hier das Ziel, in Zusammenarbeit mit sämtlichen Stake-Holdern (z.B. Ärztekammer, Hauptverband, Krankenversicherungsträger, Spitäler, etc.) die Treffsicherheit zu erhöhen. Insbesondere sollen mit allen Stellen, die der PVA Fälle zuweisen, einheitliche Standards für die Zuweisung vereinbart werden. Dies soll gewährleisten, dass die PVA umfangreiche Informationen wie möglich erhält, um im Bewilligungs- und Zuweisungsprozess bestmögliche Entscheidungsgrundlagen zu haben.

Weiters sollen im Vorfeld einer Reha-Maßnahme auch mögliche Begleiterkrankungen, die unerkannt den Erfolg der Maßnahme vereiteln könnten (z.B. psychische Störungen, Sucht, chronische Schmerzen, kardio-vaskuläre Risiko-Faktoren) bestmöglich identifiziert werden, um gegebenenfalls rasch darauf reagieren zu können und die Erfolgschancen einer Rehabilitation zu erhöhen.

Verbesserungen bei Antragstellung

Eine weitere Maßnahme, die auch bereits umgesetzt wurde, ist die Modernisierung des Antragsformulars für die Rehabilitation, welches u.a. nun auch erstmals die Möglichkeit einer ambulanten Rehabilitationsmöglichkeit enthält und damit diese Rehabilitationsform in der Öffentlichkeit auch mehr Bekanntheit erlangt.

Es werden auch die Möglichkeiten einer elektronischen Antragstellung ausgebaut. In diesem Bereich verfolgt die PVA aktuell ein Projekt mit dem Wiener Krankenanstaltenverbund und dem Hanusch-Krankenhaus, in welchem die Möglichkeit einer elektronischen Antragstellung für sogenannte Anschlussheilverfahren[6] eingeführt wurde.

Einführung von Patientengruppen

Künftig sollen auch innerhalb einer Reha-Indikation Patientengruppen mit identem oder ähnlichem Behandlungsbedarf geschaffen werden, in welche Reha-Patient/-innen zugewiesen werden und damit eine Reha-Versorgung erhalten können, die noch besser auf ihre individuellen Bedürfnisse ausgerichtet ist.

Mit freundlichen Grüßen

Obmann Generaldirektor

Beilagen

[6] d.s. Rehabilitationsheilverfahren, die unmittelbar oder zeitnah an einen Akutspitalsaufenthalt anschließen

Durchschnittliche Höhe der Pensionen

nach Pensionsarten und Wohnort der Pensionsbezieher

Jänner 2017

Wohnort	BU-/IV-Pensionen	Alle Alters-pensionen	davon		Witwen(r)-pensionen	Waisenpensionen	Durchschnitt alle Pensionen
			Alterspension § 253	Vorzeitige Alterspensionen			
Wien	975,62	1.456,07	1.437,71	1.951,45	815,84	280,88	**1.289,95**
Niederösterreich	1.176,79	1.484,61	1.446,15	1.987,00	835,03	312,28	**1.318,50**
Burgenland	1.238,61	1.398,81	1.351,50	1.908,79	765,71	299,40	**1.238,40**
Oberösterreich	1.119,38	1.419,05	1.371,73	2.013,06	840,68	303,62	**1.262,65**
Steiermark	1.157,57	1.379,02	1.341,07	1.956,26	785,82	287,20	**1.217,30**
Kärnten	1.148,01	1.325,97	1.292,93	1.940,72	763,88	288,77	**1.177,16**
Salzburg	1.115,17	1.399,16	1.362,31	1.968,15	800,99	297,05	**1.258,96**
Tirol	1.094,89	1.315,07	1.281,56	1.978,39	775,55	292,36	**1.186,40**
Vorarlberg	1.040,21	1.260,26	1.221,35	1.971,79	765,53	297,85	**1.144,73**
Ausland	461,15	249,99	247,02	442,88	180,27	148,51	**236,18**
INSGESAMT	**1.079,10**	**1.256,77**	**1.219,89**	**1.915,88**	**692,57**	**280,42**	**1.116,21**

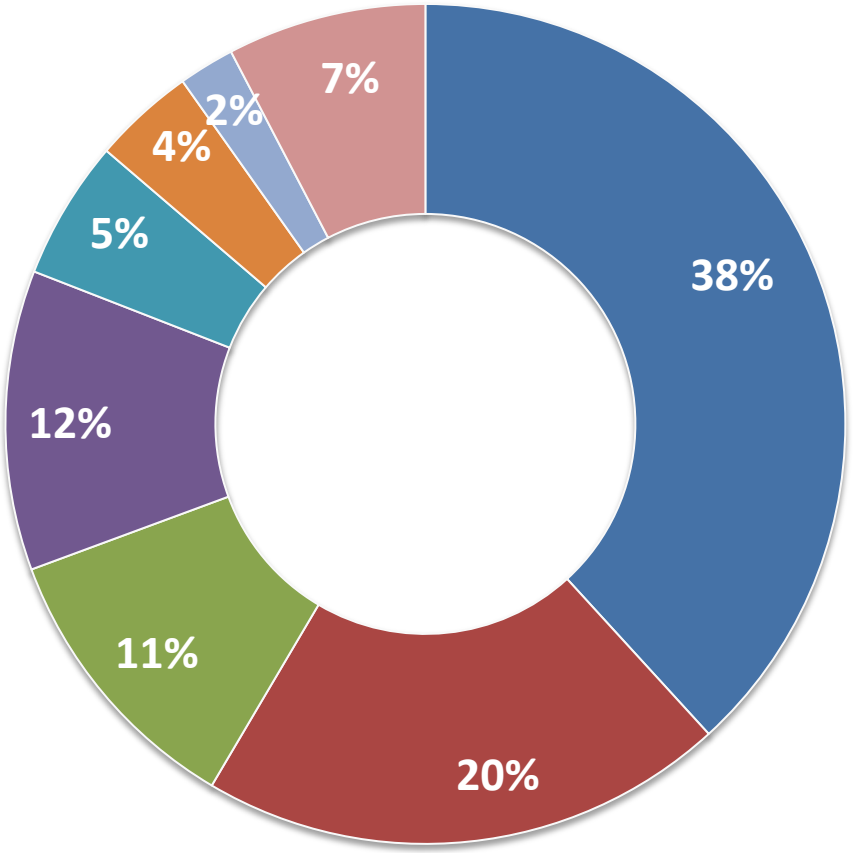
Höhe der Durchschnittspensionen
inklusive Kinderzuschuss, Hilflosenszuschuss
ohne Ausgleichzulage

Ursachen für Invalidität/Berufsunfähigkeit

bei BU/IV-Pensionen

(15.706 Neuzugänge)

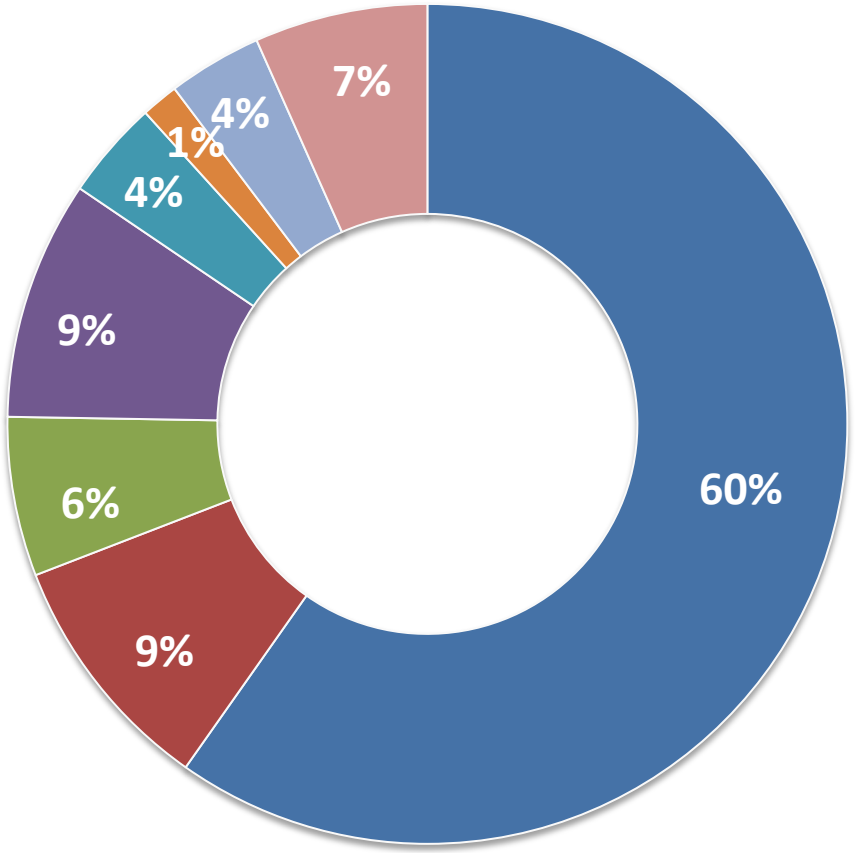
2016



- Psychiatrische
- Bewegungsapparat
- Herz und Kreislauf
- Onkologische
- Neurologische
- Lunge
- Stoffwechsel
- Sonstige

Quelle: PVA/HSCO

Ursachen für Invalidität/Berufsunfähigkeit



beim Reha-Geld

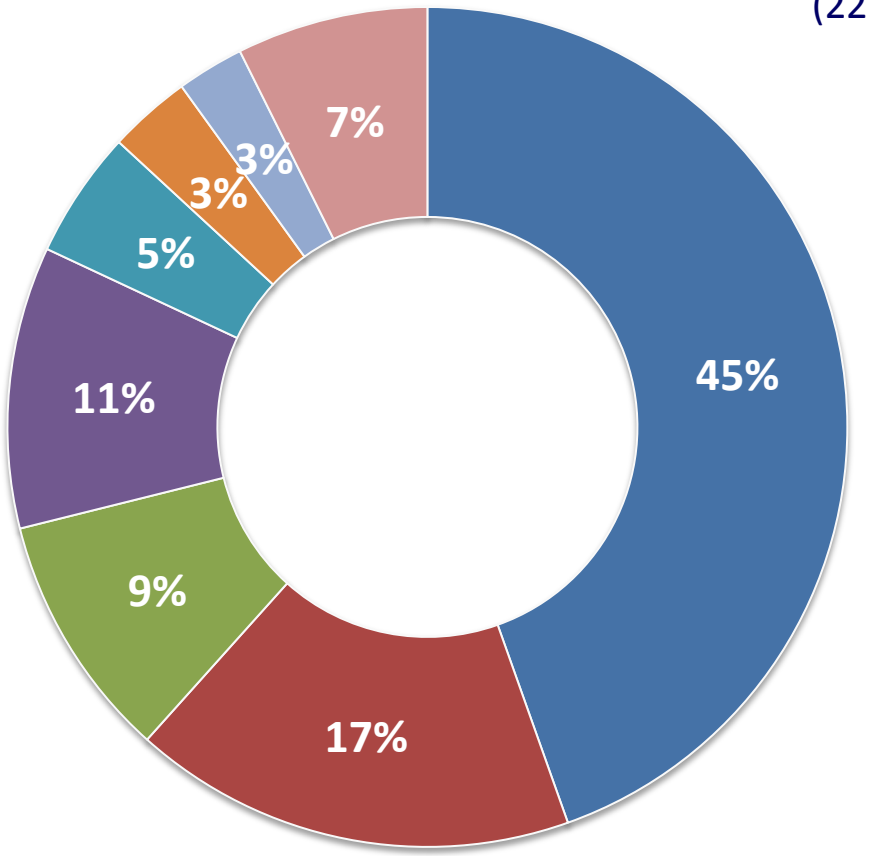
(6.571 Neuzugänge)

2016

- Psychiatrische
- Bewegungsapparat
- Herz und Kreislauf
- Onkologische
- Neurologische
- Lunge
- Stoffwechsel
- Sonstige

Quelle: PVA/HSCO

Fakten zu Invalidität/Berufsunfähigkeit



Ursachen BU/IV gesamt

(22.277 Neuzugänge BU/IV-Pensionen & Reha-Geld)

2016

- Psychiatrische
- Bewegungsapparat
- Herz und Kreislauf
- Onkologische
- Neurologische
- Lunge
- Stoffwechsel
- Sonstige

Quelle: PVA/HSCO

Österreichisches Sozialversicherungssystem / Fragen zur Diskussionsrunde

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Zentrale Priorität hat die Spitalsentlastung in der Primär- und in der Facharztversorgung. Behandlungen und insbesondere Bagatellfälle müssen beim Hausarzt behandelt werden und nicht in Spitalsambulanzen. Dafür muss das System der Primärversorgung weiterentwickelt werden, zum einen mit PHC-Modellen, zum anderen mit Primärversorgungs-Netzwerken im ländlichen Raum.

- Im Zusammenhang mit Primärversorgung müssen vermehrt Modelle zur Anstellung von Ärzten entwickelt werden. Viele (junge) Ärzte wollen keine ganze Kassenstelle, sondern oft nur (Teilzeit) angestellt werden. Es braucht neue Beschäftigungsmodelle.

- Im Zusammenhang mit einer Neuordnung der Primärversorgung hat der Abbau der doppelten Facharztschiene Priorität. Fachärztliche Versorgung wird sowohl niedergelassen als auch in Spezialambulanzen angeboten. Die niedergelassenen Einzelärzte sind eingeschränkt versorgungswirksam (Ursache sind u.a. die eingeschränkten Ordinationszeiten).
  Aus Sicht der SGKK wäre eine Entwicklung sinnvoll, die spezialisierte Fachärzte nur mehr in Zentren bzw. Spezialambulanzen vorsieht, aber nicht mehr als einzelne niedergelassene Ärzte (Ausnahmen sind Fachrichtungen wie z.B. Pädiater, Gynäkologen oder Zahnärzte) .

- Im Bereich der Allgemeinmedizin sieht die SGKK so genannte „gate-keeping-Modelle“ als sinnvoll an. Einschreibemodelle beim Allgemeinmediziner oder im Primärversorgungszentrum mit jährlich möglichem Wechsel müssen geprüft werden. Wechsel in die Facharztebene oder in die Spitalsebene sollen nur nach Überweisung möglich sein (Ausnahme Notfälle und Ausnahme bestimmter Fachrichtungen wie z.B. Zahnarzt, Gynäkologe, Pädiater).

- Der stark wachsende Bereich der Wahlärzte muss in ein Regelsystem eingebunden werden, das sich u.a. an der RÖK und RÖV orientiert (Richtlinien des Hauptverbands über ökonomische Krankenbehandlung und ökonomische Verschreibweise.

Zielführend wäre es, die Kostenerstattung mit der Krankenversicherung ebenso wie das Rezepturrecht an die Einhaltung dieser Regeln zu binden.

- Ausbildung der Ärzte: Um eine qualitativ hochwertige niedergelassene ärztliche Versorgung sicherstellen zu können, braucht es die geeigneten Ärzte. Aus Sicht der SGKK sollten die Auswahlkriterien für die Aufnahme ins Medizinstudium überarbeitet werden, um für die Zukunft nicht nur Spezialisten, sondern auch Basisversorger für die Bevölkerung zur Verfügung stellen zu können.
  Eine Umsetzung der Lehrpraxis wäre sinnvoll, um Ärzte auch dort auszubilden, wo sie einmal arbeiten sollen.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Psychische Gesundheit: Psychisch Kranke sind in Österreich nicht optimal versorgt. Zielführend wäre der Aufbau integrierter Versorgungsmodelle (z.B. rund um Versorgungszentren) für schwer(er) Erkrankte, um den so genannten „Drehtüreffekt", dass psychisch Kranke oft relativ rasch nach Entlassung wieder im Spital landen, zu verringern. Generell ist der Ausbau der Sachleistung in der psychotherapeutischen Versorgung voranzutreiben. Kostenerstattungsmodelle sind nicht zielführend, da sie bei längeren Behandlungen zu Finanzierungsproblemen für den Patienten führen.

- Zahnmedizin: Die zahnmedizinische Versorgung der Krankenversicherung entspricht bekanntermaßen nicht dem Ist-Stand der Zahnmedizin. Die Finanzierung moderner zahnmedizinischer Leistungen speziell im Bereich des Zahnersatzes sprengt allerdings die vorhandenen finanziellen Mittel bei weitem. Konzepte für diesen Bereich wären anzudenken.
  Speziell bei Kindern und Jugendlichen ist zahnmedizinische Prophylaxe („professionelle Mundhygiene") eine wirkungsvolle Methode, um späteren Problemen vorzubeugen. Die Finanzierungsmöglichkeiten der Prophylaxe v.a. für Kinder sind zu prüfen.

- Chronische Erkrankungen: Für chronisch Kranke muss die (Primär-)Versorgung strukturiert und nach evidenzbasierten Kriterien aufgebaut werden. Disease Management Programme sind ein möglicher Ansatzpunkt, der forciert werden sollte (derzeit existiert nur ein DMP für Diabetes; COPD, KHK , Asthma und anderes würden sich für strukturierte Behandlungsprogramme anbieten).

- Pflege: Ausbau der Pflege im stationären Bereich, aber auch in der Hauskrankenpflege, da derzeit viele Pflegebedürftige in den Akutspitälern Betten belegen, weil keine adäquaten Pflegeplätze zu Verfügung stehen.

- Gesundheitskompetenz: Gezielter Ausbau der Gesundheitskompetenz . Health in all policies (v.A. im Bildungsbereich) verankern.
- Geriatrie und Altersmedizin: Ein österreichweit koordinierter Ausbau wäre notwendig. Nicht nur, aber auch im Zusammenhang mit Altersmedizin ist aus unserer Sicht das Thema Palliativversorgung ein zentrales. Die Versorgung in Österreich ist sehr unterschiedlich, die Zuständigkeit samt Finanzierung oft unklar und der Bedarf stark steigend.

- Imfpwesen: Das Impfwesen funktioniert aus Sicht der SGKK nicht zufriedenstellend. Eine Folge ist, dass die Durchimpfungsraten zurückgehen. Eine Neukonzeptionierung durch Bund und Länder, die für diesen Bereich eindeutig zuständig sind, ist aus Sicht der Krankenversicherung notwendig.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- Ausbau des Solidaritätsprinzips: Derzeit sind „gute Risiken" in Sonder-versicherungsträgern, insbes. BVA, VAEB und in den KFAs der Magistrate. Diese Träger sind aber an keinem Ausgleich der Risiken beteiligt.

- Regionale Strukturen müssen berücksichtigt werden: Systempartner im Gesundheitssystem sind die Länder; zentraler Vertragspartner sind die Landesärztekammern sowie die anderen Länderorganisationen der Vertragspartner (Psychotherapeuten, Bandagisten...). Für Verhandlungen sind regionale Krankenversicherungsstrukturen daher von Vorteil.
- Regional organisierte Krankenversicherungsträger sind näher an den Bedürfnissen und Versorgungsnotwendigkeiten vor Ort. Dies erleichtert flexible Planungen.
  Eine bundesweite Großorganisation ist schwerer steuerbar und verleitet zu mehr Ineffizienzen.
- Bei zentralen Organisationsformen wird der Innovationswettbewerb abgeschafft. Derzeit stehen Krankenversicherungsträger in einer Art „Wettbewerb" um innovative Ideen, die oft in Folge auch von anderen umgesetzt werden. Diese Motivation würde bei zentralenOrganisationsformen weitestgehend wegfallen.

- Eigene Einrichtungen: Ausbau der eigenen Einrichtungen von Krankenversicherungsträgern, speziell in unterversorgten Bereichen oder in Bereichen mit hoher finanziellen Belastungen für Versicherte (wie z.B. Zahnmedizin).
  Es ist zu überlegen, ob eigene, von den Trägern geführte PHCs eingerichtet werden können.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Eine österreichweite Leistungsvereinheitlichung ist aus Sicht der SGKK sinnvoll. Das österreichweite Projekt, bei dem die SGKK federführend beteiligt ist, befindet sich im Abschluss der Analysephase. Unterschiedliche Leistungen finden sich sowohl bei satzungsmäßigen Leistungen als auch bei Versorgungsbereichen wie z.B. Psychotherapie. Eine einheitliche, verbindliche Mustersatzung ist aus Sicht der SGKK sinnvoll. Zulässig wären dann nur Mehrleistungen, die finanziell tragbar sind. Selbstbehalte für Versicherte sollten österreichweit auf einheitliche Werte reduziert werden.
- In diesem Zusammenhang scheinen uns bundesweit einheitliche Regelungen in Bereichen sinnvoll, die die Beurteilung der medizinischen Sinnhaftigkeit betreffen. Konkret wäre es zielführend, die Bewilligung von medizinischen Behandlungen nach österreichweit einheitlichen Richtlinien durchzuführen (z.B. Bewilligung von Physiotherpie, MR, etc.). Die Standards der medizinischen Versorgung sollten einheitlich sein.

- Abbau von nachweislicher Spitals-Überversorgung im Bereich der Orthopädie (große Gelenkersätze). Aber auch im Bereich der niedergelassenen Bildgebung (CT und MRI). Österreich hat im OECD Vergleich die höchsten Versorgungszahlen.

- Klarere bundesweite Strukturvorgaben, welche Leistungen wo angeboten werden sollen (stationär oder niedergelassen) und verpflichtende Umsetzung unter der Vorgabe „Geld folgt Leistung“. Ziel muss aus unserer Sicht ein verpflichtender Leistungskatalog sein.

SOZIALVERSICHERUNGSANSTALT
DER BAUERN

www.svb.at

Mag. Franz Ledermüller

Frage 1: Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Längeres selbstbestimmtes Leben bei guter Gesundheit für alle Menschen in Österreich (Zahl der gesunden Lebensjahre erhöhen und Lebensqualität von erkrankten Personen verbessern).
- Gesundheitsversorgung in den ländlichen Regionen sichern (Netzwerk-PHC´s einrichten, Anstellung von Ärzten ermöglichen, Berufsberechtigungen von gehobenen Pflegeberufen ausbauen, Rolle der Spitalsambulanzen von Bezirksspitälern in ländlichen Gebieten für die fachärztliche Versorgung klären).
- Abbau des akutstationären Bereichs bei gleichzeitigem Ausbau der ambulanten Versorgung.

Frage 2: Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Siehe Antwort zu Frage 1: Gesundheitsversorgung im ländlichen Raum sichern.
- Zielgerichtete Gesundheitsförderung und Prävention, Stärkung von evidenzbasierter Früherkennung und Frühintervention (z.B. niederschwellige präventive Maßnahmen durch Hebammen für Schwangere, Leistungen von Wundmanagerinnen, Maßnahmen der Primärprävention, etc.).
- Die Leistungen der gesetzlichen KV sind bei allen Trägern im wesentlichen gleich. Der wichtigste Unterschied sind die Kostenbeteiligungen. Wer die weitere leistungsrechtliche Harmonisierung als Priorität sieht, würde zuerst die die gleiche Versorgungsdichte zw. ländlichen und städtischen Regionen herstellen müssen. Das ist Utopie. Rechtliche Leistungsharmonisierung ist daher logisch keine Priorität, weil sie keine substanzielle Verbesserung für die Versicherten bringt.

Frage 3: Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- Siehe Antwort zu Frage 1: Gesundheitsversorgung im ländlichen Raum sichern.
- Fachärztliche Versorgung: Parallelität von Krankenhausambulanzen zu niedergelassenen Fachärzten.
- Kostenentwicklung im Heilmittelbereich (insbesondere Neuzulassung hochpreisiger Medikamente). Einheitliche EU-Zulassungen nur mit Höchstpreisfestlegung und jährlicher Preisprüfung bei Beibehaltung der nationalen gesetzlichen Regelungen für die Inverkehrbringung.
- Sicherstellung des Strukturausgleichs (durchschnittliche Beitragsgrundlagen, Verhältnis Aktive zu Pensionisten) in der KV aus öffentlichen Mitteln. Strukturausgleich ist sachlich prioritär vor einem Morbiditätsausgleich.

Frage 4: Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität im jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Im Gesundheitssystem gibt es aus unserer Sicht grundsätzlich zwei Wege:
  - Beibehaltung der freien Wahl und des freien Zugangs zu allen Versorgungsleistungen, jedoch mit entsprechenden einkommensbezogenen Kostenbeteiligungen oder
  - Beschränkung der freien Wahl und des Zugangs und administrative Steuerung der Versicherten bei Leistungsinanspruchnahme.

  Der Ausbau von Primärversorgungseinrichtungen ohne gate-keeper-Funktion bei Beibehaltung der freien Arztwahl und des freien Zugangs zu allen Leistungen widerspricht der politisch geforderten Dämpfung der Kostenentwicklung im Gesundheitswesen. Die SVB tritt entschieden für die Beibehaltung der freien Wahl der Versorgungsleistungen ein.

- Strukturveränderungen bei den Sozialversicherungsträgern bringen, wie konkrete Beispiele zeigen, für sich genommen noch keine Verbesserung der Wirtschaftlichkeit (siehe deutsche Krankenkassenzusammenlegungen oder in Österreich die Zusammenlegung von PVArb. und PVAng.) oder der Leistungen für die Versicherten.

  Die SVB ist der Auffassung, dass das historisch gewachsene berufsständische System in der Sozialversicherung beibehalten werden soll. **Kosten oder Leistungsverschlechterungen für die Versicherten aus politisch herbeigeführten strukturellen Änderungen dürfen nicht den Versicherten angelastet werden.**

- Die Strukturfrage wird in Österreich primär aus politischer Sicht diskutiert. Die Frage, was für die Versicherten die geeignetste organisatorische Form ist, wird nachrangig behandelt. Aus Sicht der Versicherten ist wohl die beste Lösung, dass sie bei einem Träger alle Leistungen der gesetzlichen Sozialversicherung in Anspruch nehmen können (one-stop-Shop). Der Allsparten-Träger kann aus dem Wissen und den Daten über die Versicherten in den jeweiligen Bereichen die Leistungen des Trägers für die Versicherten optimieren (z.B. Gesundheitsvorsorge zur Vermeidung von Erwerbsunfähigkeit aus der Pensionsversicherung auf Basis der Daten aus der Krankenversicherung: die SVB bewilligt Rehab-Aufenthalte auf dieser Grundlage ohne Antrag des Versicherten).

Zur Diskussion um die UV: Die UV nach dem BSVG ist zielgerichtet auf die Bedürfnisse der bäuerlichen Berufsgruppe zugeschnitten und weicht daher rechtlich erheblich von der allgemeinen Unfallversicherung ab (Betriebsfortführung als oberstes Ziel, Rentenabfindung bei Pensionsantritt, etc). Grundlage der bäuerlichen UV ist das Solidaritätsprinzip und nicht die Haftungsablöse des Dienstgebers, wie in der UV der Unselbständigen. Die UV nach dem BSVG rechtfertigt daher in besonderer Weise das Bestehen eines berufsbezogenen All-Sparten Trägers.

In der PV ist im Rahmen der politisch angestrebten leistungsrechtlichen Harmonisierung das Thema Erwerbsunfähigkeits- Invaliditäts- und Berufsschutzpensionen unerledigt.

LSE Studie / Fragen SVA

Frage 1: Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Im Rahmen der Gesundheitsreform wurden durch die Einigung von Bund, Ländern und Sozialversicherung auf einen Bundeszielsteuerungsvertrag wichtige Vorgaben für die Qualitätsverbesserung der Gesundheitsversorgung sowie zur Kostendämpfung festgeschrieben. Kernbereich ist das partnerschaftliche Zielsteuerungssystem als Grundlage für eine bessere Abstimmung zwischen den niedergelassenen Ärztinnen/Ärzten und den Spitälern. Die Umsetzung der Gesundheitsreform mit dem Fokus der Qualitätsverbesserung und der Ausgabendämpfung ist zu realisieren. Darüber hinaus muss die Finanzstruktur der Sozialversicherung modernisiert und lukrierte Dämpfungspotentiale in Innovation, Ausbau der Prävention und Gesundheitsförderung, Qualität und die notwendige Abgabensenkung investiert werden. Genau in diesen laut Gesundheitsreform vereinbarten Zielsetzungen – ergänzt durch die rasche Aufstockung von PHC Einheiten zur Verbesserung der Patientenversorgung bei gleichzeitigem Abbau des akutstationären Bereichs - sieht auch die SVA die Prioritäten im österreichischen Gesundheitswesen.

Frage 2: Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Das Gesundheitssystem muss in Zukunft vor allem an der Anzahl der gesunden und beschwerdefreien Lebensjahre (quality adjusted life years) gemessen werden. In dieser Hinsicht ist es wesentlich, vermehrt in präventions- und gesundheitsfördernde Maßnahmen zu investieren, um sowohl die Lebensqualität der Menschen zu erhöhen als auch die damit verbundenen volkswirtschaftlichen Folgekosten (Arbeitsunfähigkeit, Invalidität, etc.) zu senken.

Dazu bräuchte es aber für die Prävention in Österreich beispielsweise eine entscheidende Verbesserung der Transparenz durch Schaffung klarer Informationen über Leistungsangebote, eine Weiterentwicklung eines Kennzahlenvergleichs, die Entwicklung eines Anreizsystems und die Installierung eines Performance Monitoring (Stärkung der Gesundheitseigenverantwortung) als auch weiterer Maßnahmen, die eine zielgerichtete Gesundheitsförderung und evidenzbasierte Prävention ermöglichen.

Frage 3: Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Siehe Frage 2

Frage 4: Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität im jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

a) Chancen der Digitalisierung nutzen: Hier sieht die SVA insbesondere die bestmögliche Nutzung der Digitalisierung als große Chance, um bei immer mehr Dienstleistung und weniger Bürokratie den Kundennutzen weiter zu maximieren.

b) Integrierte Versorgung durch Mehrspartenträger: In Analysen des österreichischen Gesundheitssystems werden immer wieder Forderungen wie Ausbau der Primärversorgung, Ausbau der Prävention, besserer Service für Patienten oder rasche Lösungen für Patienten in den Mittelpunkt gestellt. Zu verstehen sind darunter insbesondere auch der Auf- und Ausbau von integrierten Versorgungsformen und Case Management Strategien. Als bundesweiter Mehrspartenträger hat die SVA bereits jetzt den Vorteil, diesen Forderungen nachkommen und alle Bereiche der sozialen Absicherung von Selbständigen abdecken zu können, indem die Mitglieder der Versichertengemeinschaft alle Leistungen aus der gesetzlichen Kranken- und Pensionsversicherung bei einer Stelle in Anspruch nehmen. Aus Sicht der SVA und ihrer Versichertengemeinschaft stellt gerade dies im Sinne des Dienstleistungs- und Servicegedankens einen Mehrwert dar, der auf Grund der demographischen Entwicklung und den sich daraus ergebenden Konsequenzen einen immer wichtigeren Faktor darstellt, insbesondere aber auch den Maßstäben einer effizienten und effektiven Versorgung genügt (Prävention, Kuration, Reha, Pflege, Altersversorgung – Abdeckung der gesamten „Supply Chain“ im One Stop Shop Prinzip).

c) Qualitätswettbewerb stärken: Im Bereich der Gesundheitseinrichtungen hat die SVA die Erfahrung gemacht, dass Standards in der Leistungserbringung (insbesondere die Versorgungsqualität) sowie Effizienz- und Effektivitätskriterien durch Modelle erhöht werden können, die den Wettbewerb fördern. In Verwirklichung des Grundsatzes „Trennung zwischen Financier und Leistungserbringer“ ist es der SVA durch Führung ihrer Gesundheitseinrichtungen in Form von PPP-Modellen gelungen, sowohl im Leistungsangebot als auch in der Kostenstruktur Marktkonformität zu erreichen.

   Im Sinne der weiteren Stärkung des Qualitätswettbewerbs ist die SVA auch der Ansicht, dass die freie Wahl der Versorgungsleistung (Wahlarztprinzip) unbedingt beibehalten werden soll.

Stadträtin für Soziales, Gesundheit und Frauen der Gemeinde Wien

Fragen LSE:

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

   Österreich verfügt im Gesundheitsbereich über eine hochwertige Angebotspalette, deren Schwerpunkte im Bereich der Versorgung liegen. Der stationäre Bereich ist dabei, das bestätigt der internationale Vergleich, zu stark ausgeprägt, während der ambulante Versorgungsbereich und vor allem Prävention und Früherkennung schwächer priorisiert sind. Diese Prioritäten machen das System teuer und sie entsprechen nicht mehr den aktuellen Anforderungen einer alternden Gesellschaft. Zur Sicherung eines sozialen, qualitativ hochwertigen und nachhaltig finanzierbaren Gesundheitssystems müssen der ambulante und mobile Versorgungsbereich qualitätsgesichert und niederschwellig ausgebaut werden. Die Angebote müssen den Bedürfnissen der BürgerInnen entsprechen und sie serviceorientiert erreichen. Dazu zählen sowohl die Bereiche Prävention, evidenzbasierte Früherkennung und Vorsorge als auch die Akutversorgung und die kontinuierliche Betreuung chronisch Kranker. Der bedarfsgerechte skill-mix, der Einsatz multiprofessioneller Teams sind dabei ebenso relevant wie räumliche, zeitliche und kulturelle Zugänglichkeit.
   Dementsprechend ist der Aufbau einer modernen Primärversorgung für mich ein Schlüsselfaktor. Größere, leistungsstarke Versorgungseinheiten nach den international bewährten Konzepten von Primary Health Care haben das Potential für eine breite und stabile Basisversorgung. Darauf sollte in weiterer Folge eine exzellente zweite Versorgungsebene, sowohl in den Spitälern als auch extramural, aufgesetzt werden, von der aus die abgestimmte Versorgungsprozesse initiiert und koordiniert werden. Rollen und Funktionen in diesen Versorgungsprozessen sind zu definieren und fest zu legen.
   So werden Voraussetzungen für den erforderlichen Abbau des akutstationären Bereichs geschaffen und ein effizienter und effektiver Ressourceneinsatz ermöglicht.
   Für alle Leistungen muss natürlich die Stärkung des Sachleistungsprinzips und eines sozial gerechten Zugangs gelten.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Die Stärkung des ambulanten Bereichs und vor allem der Primärversorgung sollten konzertiert und von allen für die medizinische Versorgung Verantwortlichen gemeinsam vorangetrieben werden. Erst dadurch kann die Kaskade der Entlastung der hochpreisigen stationären Strukturen gänzlich umgesetzt werden.
Die Angebote müssen bedarfsgerecht und qualitätsgesichert sein und unter objektiven Kriterien monitiert und evaluiert werden. Dazu sind transparente Dokumentationssysteme in allen Sektoren sowie verbindliche Prozessstandards erforderlich.

Parallel dazu wären transparente Abgeltungssysteme auszuhandeln, die auch eine Anreizwirkung zur effizienten Leistungserbringung beinhalten. Parallelstrukturen und unnötige Mehrfachleistungen könnten so reduziert werden.

Wir müssen die Patientinnen und Patienten vermehrt in den Mittelpunkt der Behandlungsprozesse stellen und von deren Bedürfnissen ausgehend die Leistungen anbieten, die erforderlich sind, um Krankheit zu verhindern, zu heilen, Lebensqualität aufrecht zu erhalten oder Schmerz zu lindern. Dafür brauchen wir wissenschaftliche Evidenz sowie Empathie und Kommunikationsfähigkeit bei allen Gesundheitsberufen.
Der Erfolg neuer Maßnahmen wird auch davon abhängen, ob es uns gelingt die Betroffenen, sowohl Patientinnen und Patienten als auch MitarbeiterInnen ins Boot zu holen und daran zu beteiligen.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Neben der bereits genannten essentiellen Stärkung der Primärversorgung („Primary Health Care“) ist im Bereich der medizinischen Fachversorgung der Abbau des stationären und ambulanten intramuralen Bereichs in den Reformfokus zu setzen.
Derzeit findet in Österreich, gerade bei der Versorgung chronisch Kranker, zu viel Leistungsgeschehen in den Spitälern statt. Da müssen der medizinische Fortschritt und neue Behandlungsmöglichkeiten viel stärker berücksichtigt werden.
Eine wohnortnahe, ambulante Versorgung ist für Patientinnen und Patienten weniger aufwendig und es kann auch das spitalsimmanente Infektionsrisiko deutlich reduziert werden.
Die „Best Points of Services" sind mittels Versorgungsaufträgen zu definieren und die richtigen Anlauf- und Weiterbehandlungsstellen sind transparent zu machen. Auch müssen

die Voraussetzungen für die Abgeltung und eine etwaige Verschiebung der Finanzmittel geschaffen werden.

4. Wie könnten die Standards der Leistungserbringung und die Effizienz und Effektivität im jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Zum bisher Gesagten ist auch auf die Sicherstellung des erforderlichen Personals zu achten. Dabei sind, ausgehend vom Bedarf der regionalen Bevölkerung, die Aufgabenprofile wenn nötig auch neu zu definieren und die Ausbildungen darauf abzustellen.
Zur Ermittlung des Bedarfs sind die entsprechenden Datengrundlagen zu schaffen und ein intersektoraler Austausch zwischen den Datenbanken zu ermöglichen. Dies ist weiters eine relevante Voraussetzung zur Implementierung eines umfassenden, systematischen und standardisierten Qualitätsmanagements mit umfassender Messung der Ergebnisqualität sowohl im ambulanten als auch im stationären Bereich.

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Ihr Zeichen/Datum	Unser Zeichen	Auskunft	Datum
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Fragen zur Diskussionsrunde über das österreichische Sozialversicherungssystem

Sehr geehrter Herr Professor Mossialos,

gerne kommen wir Ihrem Ersuchen nach, unsere Sichtweisen zum österreichischen Sozialversicherungssystem darzulegen.

Bevor wir auf die Fragen explizit eingehen, möchten wir einige generelle Bemerkungen zu unserem Gesundheitssystem und dessen Grundlagen machen.

Das österreichische Gesundheitssystem basiert auf der Selbstverwaltung, d.h. Repräsentanten der Dienstnehmer und Dienstgeber wurde per Gesetz die Aufgabe übertragen, die Interessen der Versicherten zu vertreten. Durch dieses System wird die Nähe zu den Versicherten garantiert, denn die Mitglieder der Sozialversicherungsgremien (=Versicherungsvertreter) werden von den Interessensvertretungen entsendet und sind daher auch immer am Puls des Geschehens und kennen die Bedürfnisse der Versicherten. Dieses System hat sich sehr bewährt und sollte daher auch nicht angetastet werden.

Feststeht und dies geht aus vielen Studien und internationalen Indizes hervor, dass Österreich eines der besten Gesundheitssysteme der Welt hat. Der niederschwellige Zugang zur Gesundheitsversorgung, der gleiche Zugang, unabhängig von Alter, Geschlecht, sozialer Herkunft und Einkommen, die rasche Zurverfügungstellung neuer innovativer Heilmittel (siehe auch höchste Überlebensrate nach Krebserkrankungen) und eine sehr umfassende Gesundheitsversorgung auf höchstem Niveau zeichnen unser System aus.

Wesentliche Grundlage dafür, dass alle Menschen in den Genuss dieser hochwertigen medizinischen Versorgung kommen können, ist das Sachleistungsprinzip, das daher auch in Zukunft ein unumstößliches Prinzip der Leistungsgewährung sein muss.

Daher ist es auch künftig unser Bestreben, durch eine ausreichende Anzahl von Vertragspartnern den Menschen den gleichen Zugang zur Gesundheitsversorgung zu ermöglichen. Es gibt ja im System bereits eine Vielzahl an Selbstbehalten (Rezeptgebühren, Selbstbehalte bei Heilbehelfen/Hilfsmitteln, bei Aufenthalten in Krankenanstalten, E-Card Gebühr etc.), die Kostenbeteiligungen durch die Versicherten darstellen. Verstärkte Kostenbeteiligungen im Sinne von prozentuellen Beteiligungen an Versicherungsleistungen durch die Versicherten würden a la longue zu einer definitiven Beschränkung des Zugangs all jener zu den medizinischen Leistungen führen, die sich diese nicht leisten können. Letztlich würde dies wirtschafts- und gesellschaftspolitisch zu Problemen führen, weil sich ein verschlechternder Gesundheitszustand einer Bevölkerung natürlich auch auf die wirtschaftliche Leistungsfähigkeit auswirken würde und Ausgrenzungen vom Leistungszugang auch soziale Spannungen zur Folge hätten. Vom damit zusammenhängenden persönlichen Leid der Betroffenen gar nicht zu sprechen. Daher ist für uns das Sachleistungsprinzip unverzichtbar. Innerhalb dessen besteht für die Versicherten die freie Arztwahl und sie sollen auch nicht auf die Inanspruchnahme eines Wahlarztes angewiesen sein. Generell gesprochen sollte daher auch das Vertragspartnerrecht attraktiviert und die Privatmedizin zurückgedrängt werden. In Bezug auf Wahlärzte ist zu sagen, dass diese in der Steiermark keine große Versorgungswirksamkeit haben. Das wird durch folgende Zahlen bewiesen: Bezogen auf das Jahr 2015 beträgt der Aufwand für ärztliche Hilfe durch Vertragsärzte 93,19 % und durch Wahlärzte nur 6,81 %.

Dass jeder Österreicher, jede Österreicherin dieses hohe Leistungsniveau in Anspruch nehmen kann, macht es auch erforderlich, dass möglichst alle Menschen sich an diesem System beteiligen, also pflichtversichert sind. Die Pflichtversicherung stellt sicher, dass die Risiken gut verteilt sind und die Gesunden für die Kranken und die sozial Stärkeren für die sozial Schwächeren einstehen. Würde die Versicherungspflicht Platz greifen, siehe Deutschland, wäre dieser Ausgleich und damit die Versorgung auf diesem hohen Niveau nicht mehr gewährleistet. Als Korrektiv müsste man dann Risikomorbiditätsausgleiche einführen, die wiederum zu ineffizienten Versorgungsstrukturen führen würden.

Schließlich ist zu betonen, dass die Menschen mit unserem Gesundheitssystem sehr zufrieden sind.

Was nun die Debatte um die Zusammenlegung von Versicherungsträgern betrifft, so sind wir davon überzeugt, dass die von manchen als Allheilmittel gesehene Trägerzusammenlegung unsere wesentlichen Herausforderungen, nämlich die Sicherstellung der Leistungen auf hohem, qualitätsgesicherten Niveau und die Finanzierbarkeit des Systems, überhaupt nicht lösen. Durch die Zusammenlegung kommt weder mehr Geld ins System, noch wird die Verwaltung billiger (siehe Deutschland, wo es zu Verteuerungen gekommen ist). Würde es zB nur mehr eine Gebietskrankenkasse geben, müsste diese mit einer Ärztekammer verhandeln, d.h. wenn kein Vertrag zu Stande käme, hätten wir in ganz Österreich einen vertragslosen Zustand. Die Kasse stünde daher stark unter Druck, weil natürlich ein vertragsloser Zustand zu vermeiden ist. Durch das Gebot der Versichertennähe müssen aber auch regionale Strukturen bestehen bleiben und die von vielen gepredigten Einsparungen im Verwaltungsbereich sind sicher nicht zu erzielen.

Die STGKK hat einen Verwaltungsaufwand (netto Personal- und Sachkosten) von lediglich 1,75 % der Gesamtaufwendungen.

Zu bedenken ist auch, dass es im Gesundheitswesen eine verfassungsmäßige Kompetenzverteilung zwischen Bund, Ländern und Sozialversicherung gibt. So lange es die föderale Gliederung der öffentlichen Verwaltung, eine Konzentration der Gesundheitskompetenzen auf Länderebene und eine regionale Struktur der Kammern gibt, ist es für Entscheidungen und Verhandlungen effizient, regionale Krankenversicherungsträger beizubehalten.

Natürlich sind wir innerhalb des bestehenden Systems gefordert, Verbesserungen in der Effektivität und der Effizienz der Versorgung laufend zu erreichen und dort, wo Unzufriedenheiten der Versicherten/PatientInnen bestehen, diesen Rechnung zu tragen.
Das heißt, es wird der Fokus klar auf mehr Outcome-Orientierung in der Versorgung zu richten sein und in jenen Fällen, in welchen nicht erklärbare Leistungsunterschiede bestehen, diese auch zu beseitigen. Wie wohl gesagt werden muss, dass der Großteil der Leistungsgewährung inhaltlich gleichartig ist, aber doch gerade bei den satzungsmäßigen Mehrleistungen Unterschiede bestehen, die für die Versicherten nicht nachvollziehbar sind. Daher unternehmen wir als Träger daher auch gerade Anstrengungen, diese zu harmonisieren.

Worauf auch hinzuweisen ist, ist der gegenwärtige Prozess der Zielsteuerung Gesundheit, wodurch alle zahlenden und daher auch leistungsverantwortlichen Partner im System (Bund, Länder, Sozialversicherungsträger) verstärkt zusammenarbeiten und daher strukturelle, inhaltliche, qualitative Ausrichtungen sichergestellt werden.

Jedenfalls bewähren sich die regionalen Strukturen der Gebietskrankenkassen – also die Zuständigkeit für ein Bundesland – weil es doch auch regionale Spezifika gibt, die zu berücksichtigen sind und daher Versorgung zB in der Steiermark anders sicherzustellen ist als in Wien. Anzusprechen ist letztlich noch die ungleiche Risikoverteilung in der Versichertengemeinschaft, wobei in der BVA, KFA die ungünstigen Risken der GKK's (Mindestsicherungsbezieher, Asylwerber, Arbeitslose, Niedrigverdiener) nicht versichert sind.

Zur Frage 1)
Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Es geht primär um die Sicherstellung einer qualitativ hochstehenden und effizienten Gesundheitsversorgung. Das Augenmerk ist auf die Outcome-Orientierung zu legen. Es müssen verbindliche Versorgungsaufträge für die Ärzte vorhanden sein, nicht wie bisher reine Abrechnungsmöglichkeiten.

Auch in Zukunft müssen das Sachleistungsprinzip und das Solidaritätsprinzip als Grundsätze der Krankenversicherung gewahrt bleiben. Daher ist die Privatmedizin tendenziell durch Attraktivierung des Vertragsarztsystems zurückzudrängen. In diesem Zusammenhang kommt auch dem Ausbau der Primärversorgungseinrichtungen große Bedeutung zu. Daher wird unser verstärktes Augenmerk darauf zu richten sein, ÄrztInnen für Primärversorgungseinheiten zu gewinnen. Die Problematik der wir in diesem Zusammenhang begegnen, ist die stark ablehnende Haltung der Ärztekammer, die diese

neue Versorgungsform weitgehend schlechtredet und daher sehr viel Verunsicherung unter den (Jung)Medizinern bewirkt.

Wichtig ist auch das weitere Forcieren der Gesundheitsförderungs- und Präventionsaktivitäten und auch der Ausbau des TEWEB.

Zu Frage 2)
Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Was bisher in diesem Zusammenhang fehlt, sind Rahmenbedingungen, die den SV-Trägern mehr Spielräume beim Abschluss von Verträgen mit anderen Anbietern als Ärzten ermöglichen. Die Ärztekammer kann derzeit andere Anbieter stark behindern bzw. faktisch verhindern (de facto monopolistische Leistungserbringung) und hat daher eine große Marktdominanz. Das Thema des Leistungseinkaufs generell müsste überarbeitet werden d.h. wie kaufen wir als SV-Träger Leistungen ein. Diese Überlegungen gelten auch für das relativ große Preisdiktat im Bereich der Heilmittel. Die besonders teuren Medikamente stellen alle Gesundheitssysteme vor enorme Herausforderungen.

Im Sinne der Outcome-Orientierung müsste die Evidenzbasierung bzw. HTA wesentlich mehr als Grundlage für die Leistungserbringung und Honorierung herangezogen werden. Auch die abgestimmte gemeinsame Planung durch die Financiers ist zu forcieren, was ja bereits im neu zu erstellenden BZV intendiert ist.

Die Ausweitung von Gesundheitsförderungs- und Präventionsaktivitäten haben wir bereits als Priorität genannt. Diese Themen sollten generell mehr Ausprägung im Gesundheitssystem finden.

Schließlich wäre auch spezielles Augenmerk auf die Versorgung in exponierten Regionen zu fokussieren. Wie können wir Anreize für die Besetzung von Planstellen durch Politik und Systempartner setzen?

Zu Frage 3)
Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Die Finanzierbarkeit der Sozialversicherung muss erhalten bleiben. Der medizinische Fortschritt (technisch, therapeutisch, Heilmittelentwicklung etc.) und eine älter werdende Gesellschaft stellen Herausforderungen ans System dar, weshalb die erforderlichen Rahmenbedingungen und Maßnahmen zu erfolgen haben. Hier sind sicher der Medikamenteneinkauf und die Preispolitik der Pharmawirtschaft anzusprechen. Es braucht gemeinsame Vorgehensweisen der Financiers und auch Regelungen, die Preisexplosionen eindämmen.

Auch das Vertragspartnerrecht und das Krankenanstaltenrecht müssen neu gedacht werden (sprich neue Regelungen der Krankenanstaltenfinanzierung, wenn es um Bettenabbau und die Auslagerungen in den niedergelassenen Bereich geht). Schließlich ist es

auch wichtig, die Beitragseinnahmen für die Leistungsentwicklungen sicherzustellen. Stichwort Industrie 4.0.

Zu Frage 4)
Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Es sollte für alle Leistungserbringer verpflichtend die Diagnosedokumentation eingeführt werden, um eine bessere Grundlage für Bedarfsentwicklungen zu haben. Die Verbindlichkeit der Leistungs- und Kapazitätsplanung für alle Leistungserbringer ist zu fixieren. Der Austausch innerhalb der Träger und der Ausbau von Benchmarking auch international ist zu forcieren. Wichtig für die Systementwicklung ist immer das Lernen vom Besten, das nur durch transparente Ergebnisse möglich ist.

Mit freundlichen Grüßen

Die leitende Angestellte:
Gen. Dir. HR Mag.[a] Andrea Hirschenberger

Die Obfrau:
Mag.[a] Verena Nussbaum


Wir
sorgen
für
Gesundheit

Grundsätzliches und Rahmenbedingungen

Bevor auf die vier gestellten Fragen einzugehen ist, seien einige Vorbemerkungen erlaubt, die für eine korrekte Betrachtung und Bewertung des österreichischen Gesundheitssystems aus Sicht der Tiroler Gebietskrankenkasse von Bedeutung sind:

- „Genetischer Systemdefekt“:
  „Schwächen“ des österreichischen Gesundheitssystems an sich haben ihre Ursachen letztlich nicht bloß in strukturellen Fragen der Sozialversicherung. Die originäre Systemschwäche liegt in der Dualität der Finanzierung und einer letztlich auch damit einhergehenden „Spitalslastigkeit“. Mit den Gesundheitsreformen 2005 und 2013 wurde versucht eine gesamthafte Planung und Steuerung zu etablieren und diesen Systemdefekt zu überwinden, da eine kompetenzrechtliche Einigung zwischen Bund und Länder bisher immer scheiterte. Dieser Prozess ist seit einigen Jahren im Aufbau und noch nicht abgeschlossen.

- Gesamthafte Betrachtung aller Systempartner:
  Die Sozialversicherung sollte jedenfalls als Teil eines Systems mit vielen Verantwortlichen verstanden werden. Im Umkehrschluss bedeutet dies, dass die Anpassung eines Systempartners alleine, ohne auch die anderen Stakeholder „anzupassen“ (z.B. Kompetenzen der Länder, Befugnisse und Rolle der Ärztekammer) bzw. die rahmenrechtlichen Bedingungen nur der Sozialversicherung zu verändern zu kurz greift oder gar dem Gesamtsystem schadet.

- Formen der Verantwortung:
  Wichtig erscheint es auch, die Formen bzw. Grade von Verantwortungen im österreichischen Gesundheitssystem zu berücksichtigen. Zum einen die originären Verantwortungen, die sich aus den unmittelbaren gesetzlichen Anordnungen in den „Stammgesetzen“ der jeweiligen Stakeholder ergeben. Gemeint sind damit die klar umschriebenen Zuständigkeiten der Selbstverwaltung in der Sozialversicherung im ASVG, verbunden mit den entsprechenden Haftungen. Auch die Länder haben ihrerseits ihre Kernverantwortungsbereiche, insbesondere im Krankenanstalten-Bereich. Im Gegensatz dazu stehen jene neu geschaffenen, quasi abgeleiteten Verantwortungen, aus den Gesundheitsreformen. Diese „neuen“ Kommissionen (insbesondere die Bundes-Zielsteuerungskommission, Landesgesundheitsplattform und Landes-Zielsteuerungskommission) sind Beispiele für abgeleitete Kompetenzen – sie lassen die Kernkompetenzen unberührt, können weder die Selbstverwaltung noch eine Landesregierung binden.

- Regionalität als Stärke:
  In Tirol sind fast 80 % der Bevölkerung bereits jetzt schon bei einem Träger gesetzlich krankenversichert. Bedarf und Bedürfnisse können

optimal erfüllt werden. Folgende Argumente sprechen klar für eine regional verantwortete Sozialversicherung bei gleichzeitiger österreichweiter Steuerung:

- Benchmarking: Wettbewerb von Angebot, Effizienz und Dienstleistung zwischen den einzelnen Trägern!
- Länder brauchen starke Partner auf Landesebene:
  Seit der Gesundheitsreform 2005 sowie 2013 sind die je Bundesland eingerichteten Landesgesundheitsfonds relevante Strukturen der Mittelverteilung samt dezentralem Krankenanstalten-Recht. Zentralisierte Gebietskrankenkassen können kein Gegengewicht zu der seither gestärkten Länderrolle bilden.
- Gleichwertiger Systempartner im Leistungseinkauf:
  Wichtige andere Vertragspartner (z.B. Ärztekammer) sind dezentral organisiert – etwa einen Bundes-Gesamtvertrag zu verhandeln wäre angesichts der realpolitischen Verhältnisse wenig weitblickend. Kleinere Strukturen haben hier einen Risikominimierungseffekt.
- Kongruenz von originärer Verantwortung und Gestaltungsmöglichkeit:
  Regionale Repräsentanten haben aufgrund ihrer Funktionen ein starkes Interesse, im Dialog mit der Bevölkerung, eine bedarfs- und bedürfnisgerechte Versorgung sicherzustellen, die Unternehmer optimal zu servicieren und mit den Vertragspartnern im Dialog zu bleiben. Die in der Region lebenden und als gewählte Repräsentanten von Dienstgeber und Dienstnehmer haben selbst das größte Interesse, die bestmögliche Versorgung kostengünstig sicher zu stellen. Sie haben sich auch vor Ort in den regionalen Medien direkt zu rechtfertigen und gestalten ihren eigenen Lebensraum mit. Das Wissen um die regionalen Begebenheiten, den Bedarf und die konkreten Bedürfnisse ist bei der Gesundheitsplanung und Versorgung wesentlich. Dieses Erfolgsrezept der regionalen Verantwortung sollte nicht verworfen werden

Erfolge in der Versorgung der letzten Jahre in Tirol

Die folgende kurze Aufzählung steht stellvertretend für das regionale Engagement für die Tiroler Bevölkerung – die Outcome-Daten in Bezug auf die höchste Zufriedenheit der Tiroler Bevölkerung im Österreichvergleich gibt uns Recht:

- Psychotherapie – Verdoppelung des Angebots auf Basis 2015 bis 2020 um 1000 Plätze; Kinderpaket, verstärkte Angebote in ländlichen Regionen

- Physiotherapie – massive Ausweitung des Sachleistungsangebots mit dem Qualitätsanspruch Integrierter Versorgungszentren in jedem Bezirk
- Integrierte Versorgung von Kindern mit Entwicklungsstörungen
- Rollstuhlversorgung – Anbieternetz erweitert; Zuschüsse erhöht
- Ausbau der Anzahl der Vertragsärztestellen und Attraktivierung der Honorierung
- Neue innovative Zusammenarbeitsformen für Ärzte beschlossen
- CT/MR Bereich: durch flexible Deckelregelung keine bzw. geringe Wartezeiten
- Bodengebundenes Rettungswesen nachhaltig und kostengünstig geregelt
- Ausrollung flächendeckende Palliativ- und Hospizversorgung
- Ausrollung flächendeckende Schlaganfallversorgung und Nachsorge
- Erstaufnahmeeinheit an der Universitätsklinik Innsbruck und Stärkung der ärztlichen Randzeitenversorgung in Innsbruck Stadt

Fragen zur Diskussionsrunde

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Besondere Beachtung der Anforderungen und Möglichkeiten ländlicher Regionen: z.B. in Tirol tendenziell zu wenige Bewerber und Interessenten für Arztstellen; Zentren sind hier schwer bis gar nicht bespielbar

- Krankenhäuser in speziellen Lagen als Primärversorger begreifen und ausrichten

- Alternative Angebotsformen legistisch zulassen: z.B. Netzwerke, Anstellung Arzt bei Arzt, etc.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Paket zur Attraktivierung von Verträgen und der Zusammenarbeit mit der Sozialversicherung, insbesondere Ärzte: z.B. Gründerservice; Customer-Relationship-Management, kurz CRM – vom Studium hin bis zum Vertrag

- Offenes Spannungsfeld: Stärkere staatliche Steuerung durch Verbindlichkeit der Planung bei gleichzeitigem Aufrechterhaltung des „Verhandlungsprinzips“ beim Einkauf von Leistungen.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- (Sozial gestaffelte und für alle gleich gestaltete) Selbstbehalte als ein zentrales Thema

- Die Frage des freien Zugangs in alle Versorgungsebenen an Stelle einer bedarfsgerechten und gesteuerten Inanspruchnahme der Leistungen in der Versorgungspyramide

- Wahlarzt-Thema: steigende Angebote und steigende Nachfrage: Thema nicht ideologisch diskutieren sondern auch die Bedürfnisse des „Marktes“ und der Bevölkerung verstehen und im Gegenzug (siehe oben) die Verträge mit der SV attraktiver gestalten.

- Die stärkere Orientierung an der Zufriedenheit der Versicherten, in Verbindung mit den hohen Erwartungen an Dienstleistungen im Allgemeinen im Rahmen einer „Konsumgesellschaft“.

- Mittelverwendung innerhalb des Sozialversicherungssystems/Prüfung eines Risikostrukturausgleichs

- Einbeziehung der Krankenfürsorgeanstalten (KFA) in das Sozialversicherungssystem

    - Erhöhte Leistungs- und Angebotstransparenz
    - Verstärkte Service-Orientierung
    - Ausbau des Case-Managements und „personalisierte Services“

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Integrierte Versorgungsmodelle zur Betreuung chronisch kranker Menschen entwickeln und verbessern (evidence based, Schnittstellen, …)
- Definition von Versorgungsaufträgen, Qualitätsstandards und Behandlungspfaden
- Governance-Struktur der Sozialversicherung verbessern
- Weitere Bündelung einzelner, in allen Sozialversicherungsträgern gleichartig abgearbeiteter Bereiche (wie z.B. IT, e-health, Nutzbarmachen innovativer Technologie für das Gesundheitswesen
- Modernisierung des Vertragspartner-Rechts
- Beteiligung der BürgerInnen an Entscheidungen im Gesundheitssystem

Diskussionsrunde über das österreichische Sozialversicherungssystem

Interviewtermin Dr. Jan Oliver Huber am 22.2.2017

1. Grundsätzliches

Die Geschichte und Struktur des österreichischen Gesundheitssystems ist durch den föderalistischen Staatsaufbau und durch eine Tradition der Delegation von Kompetenzen an Akteure der Staatsverwaltung geprägt. Dadurch fehlen zentrale Steuerung und Planung in vielen Bereichen, wodurch die mangelhafte Koordination an vielen Stellen sichtbar wird. So bleibt eine wesentliche Schwachstelle im österreichischen Gesundheitswesen, den Eintritt einer Krankheit überhaupt zu verhindern.

Seit Jahrzehnten gibt es Analysen und Studien die sich mit bestehenden Problembereichen des österreichischen Gesundheitswesens und möglichen Verbesserungsvorschlägen beschäftigen. Bereits 1969 wurde durch die WHO festgestellt, woran das Gesundheitssystem noch heute laboriert:

> ***WHO -Regionalbüro für Europa; „Besprechung des Spitalswesen in Österreich mit Empfehlung für künftige Entwicklungen" Oktober 1969, Auszug:***
>
> - *Zwischen intramuralem und extramuralem Bereich besteht eine scharfe Trennlinie. Es gibt Zweigleisigkeiten der Arbeit von Spitälern und Ärzten in der Praxis.*
> - *Es gibt die steigende Tendenz der praktizierenden Ärzte, ihre Patienten in ein Spital einzuweisen - diese Tendenz wird unter anderem durch das Honorierungssystem gefördert.*
> - *Die Vorsorge für die ärztliche Betreuung alter Menschen und chronisch Erkrankter ist im Allgemeinen unzulänglich.*

Dass sich kaum was geändert hat, erkennt man an den Ergebnissen einer Expertengruppe im Auftrag der Bundesregierung[1] aus dem Jahre 2010 (Arbeitsgruppe Verwaltung neu, Bereich „Gesundheit und Pflege"). Damals wurde, unter Bundeskanzler W. Faymann und Vizekanzler J. Pröll, eine Arbeitsgruppe aus fünf regierungsnahen Institutionen gebildet (Rechnungshof, WIFO, IHS, Staatsschuldenausschuss (dem heutigen Fiskalrat) und KDZ – Zentrum für Verwaltungsforschung). Arbeitsauftrag war, eine strukturierte Analyse der bestehenden Probleme und der damit verbundenen Folgewirkungen anzufertigen sowie Lösungsansätze zu erarbeiten. Diese sollten im Nachgang auf politischer Ebene umgesetzt werden. In der Kurzfassung (S. 23ff) steht einleitend:

> *„Prüfungen und Untersuchungen deuten im österreichischen Gesundheits- und Pflegebereich auf grundlegende strukturelle Defizite hin, die zu Ineffizienzen führen und Einsparungs- bzw. Umschichtungsmöglichkeiten nahe legen. Strukturbereinigungen, Effizienzsteigerungen, Synergieeffekte und Qualitätsoptimierungen bleiben durch eine fehlende Leistungsabstimmung zwischen*

[1] (http://www.rechnungshof.gv.at/fileadmin/downloads/2010/beratung/verwaltungsreform/Gesundheit/Problemanalyse_Gesundheit_und_Pflege.pdf

intra- und extramuralen Bereich sowie dem Pflegebereich auch innerhalb der Bereiche ungenützt."

Darüber hinaus:

> *Starre, intransparente Finanzierungsstrukturen: An der Finanzierung des Gesundheitswesens sind insbesondere Gebietskörperschaften, Sozialversicherungsträger, Krankenanstaltenträger und Patienten beteiligt. Die Finanzströme sind verflochten und zeichnen sich durch Parallelität und hohe Komplexität aus. Die Finanzierungsverantwortung von Bund, Ländern, Gemeinden und Sozialversicherungsträgern deckt sich nicht mit ihren Aufgaben- und Ausgabenverantwortungen.*
>
> *Wirtschaftliche und zweckmäßige Leistungsverschiebungen zwischen dem intra- und extramuralen Bereich sowie der Pflege werden verhindert.*
>
> *Als Folge ergeben sich:*
>
> - *parallele und komplexe Finanzströme*
> - *Unterschiedliche Ansichten und Interessen*
> - *Ineffizienzen*
> - *Doppelgleisigkeiten*
> - *Intransparenz*
> - *Zielkonflikte*
> - *Steuerungsdefizite*
>
> *Die strikte Trennung der Kompetenzen und die Pauschalabgeltung der Krankenversicherungsträger für spitalsambulante Leistungen (fehlende Realisierung des Prinzips "Geld folgt Leistung") bewirkt falsche Anreize, und Leistungsverschiebungen aus dem niedergelassenen Bereich in die Spitäler.*

Die Gesundheitsreform (2013-2016) formulierte erstmals konkrete Ziele in wesentlichen Bereichen (Versorgungsstrukturen, Versorgungsprozesse, Ergebnisorientierung, Finanzziele), doch die Zieleerreichung bleibt in manchen Bereichen unerfüllt.

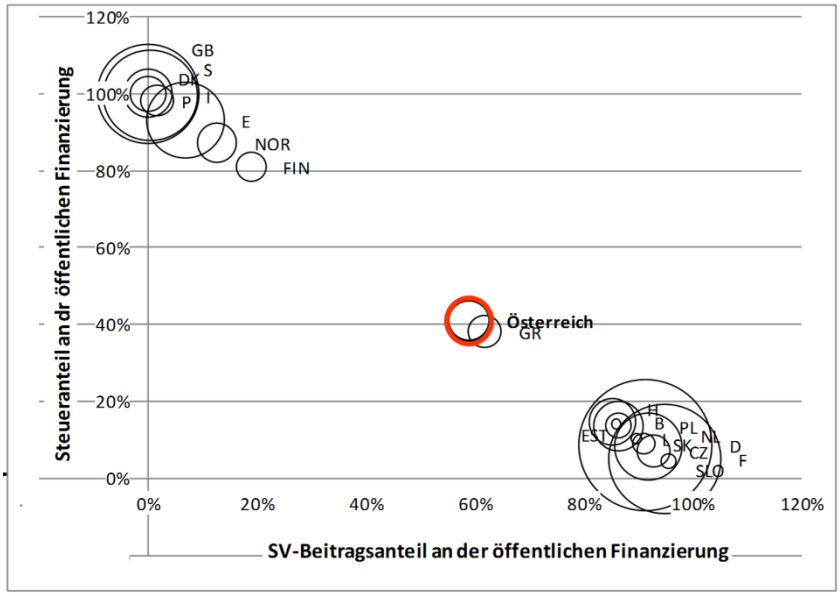
Die EU-Kommission hat im Zuge des European Semester im Country Report für Österreich[2] auch einige Anmerkungen zum Gesundheitswesen gemacht, die zusammengefasst wie folgt lauten:

- Vergleichsweise hohe Ausgaben ua im Gesundheitsbereich (höher als in anderen EU-Mitgliedstaaten) die durch hohe Steuerbelastungen finanziert sind
- Stark zersplitterte Kompetenzen im Gesundheitsbereich gehen zu Lasten der Effektivität und Nachhaltigkeit des Systems (4 Entscheidungsträger im Gesundheitsbereich, dritthöchsten Gesundheitsausgaben in der EU)
- Spitalslastigkeit des österreichischen Systems
- Gesundheitsreform: Ziele zur Verbesserung der Primärversorgung sind nicht sehr ambitioniert (1% der Bevölkerung bis 2016), Ausgabendämpfungspfad ist in Ordnung, bessere und effektivere Kontrollmechanismen greifen, Ziele werden daher auch erreicht, allerdings ist der Prozentanteil am BIP in den letzten 13 Jahren

[2] http://ec.europa.eu/europe2020/pdf/csr2016/cr2016_austria_de.pdf

annähernd gleich geblieben, weshalb eine niedrigere Ausgabendeckelung angedacht werden sollte.

Fakt ist, dass das Gesundheitssystem aufgrund der Vielzahl an Entscheidungsträgern und Finanzierungsquellen. Die Organisation und Steuerung des Gesundheitswesens ist nicht deckungsgleich mit der Finanzierung. Fakt ist, dass die Einnahmen- und Ausgabenzuständigkeit im Bereich der Gesundheitsversorgung nicht aufeinander abgestimmt ist. Österreich hat eine praktisch weltweit einzigartig DUALE Finanzierung (Mischfinanzierung aus Steuer- und Sozialversicherungsmitteln).



OECD Health Statistics 2015; WHO Global Health Expenditure Database. Darstellung: E.Pichlbauer

Die Folge dieser Zersplitterung des Gesundheitssystems ist eben die Unmöglichkeit, eine abgestufte Versorgung zu etablieren mit der Folge, dass wir eine enorme Krankenhaushäufigkeit und Facharztfrequenz haben – und damit bereits seit Jahrzehnten bekannte Schwachstellen bis heute nicht gelöst werden konnten.

2. Fragen

a) Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die Prioritäten ergeben sich aus dem bereits oben gesagten.

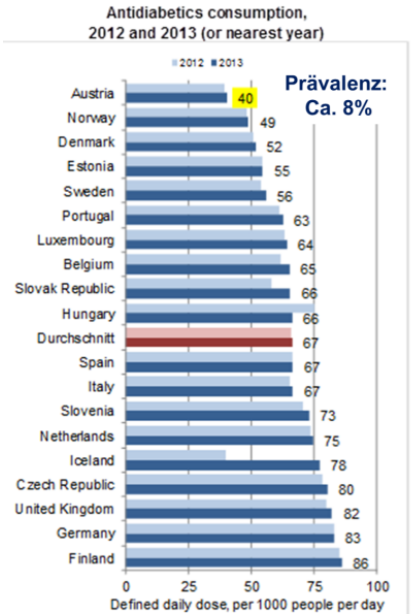
Anzuführen wären nun noch Beispiele, warum eine Verbesserung der Versorgung, insbesondere auch der Primärversorgung besonders wichtig ist:

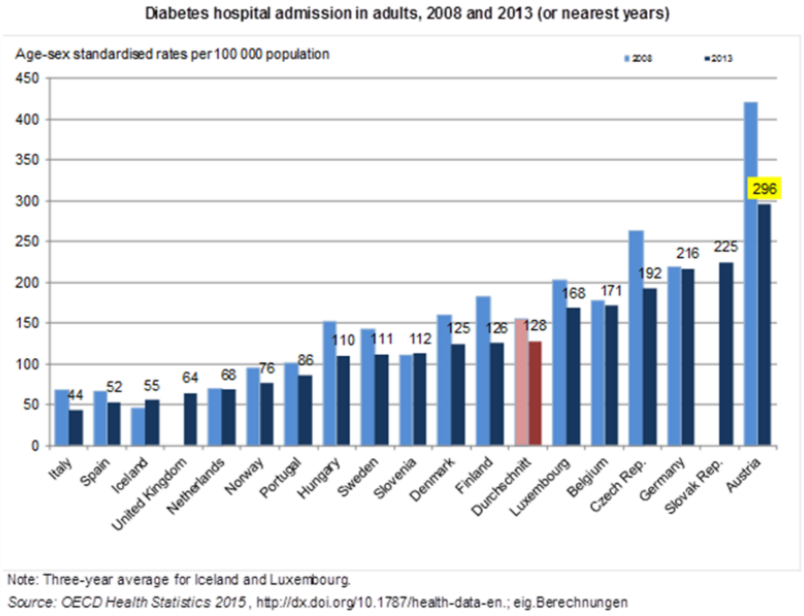
<u>Beispiel:</u>

So sind für die ambulante Aktuversorgung praktisch 37 „Institutionen“ zuständig (i.e. 35 Krankenversicherungsträger, AUVA und „Wahlärzte“ – letztere wurden als 1=Markt gezählt) und 53 Spitalsträger zuständig – die einen durch SV-Beiträge die anderen über Steuern finanziert. Die Kassenbeiträge sind Leistungsunabhängige Pauschalen, die 1997 festgelegt wurden, und nur mehr etwa 20% der Kosten decken – der Rest muss über Steuergelder zugeschossen werden. Seit 1998 wird angekündigt, dass es (1) einen Spitalsambulanzplan in Abstimmung mit den Kassen, (2) einen einehitlichen Leistungskatalog sowie (3) eine eigenständige Finanzierungstangente für Spitalsambulanzen geben soll – es kam jedoch nie dazu. Eine Abstimmung der Versorgung erfolgt nicht, vielmehr agieren die Institutionen jeder für sich bzw „gegeneinander“.

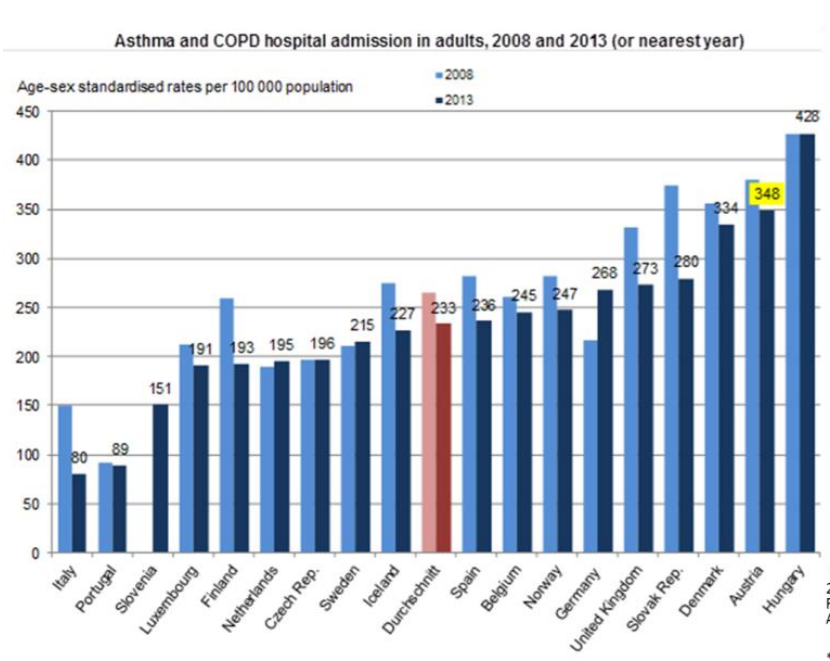
Am Ende ist es, und das ist seit langem bekannt, ist es undenkbar eine integrierte Versorgung, oder wenigstens eine sinnvoll abgestufte Versorgung aufzubauen. Vor allen dort, wo es um die Versorgung chronisch Kranker geht, wird das sehr auffällig.

Obwohl es seit 2007 ein Disease Management Programm (DAS EINZIGE in Ö) gibt, bleibt die Versorgung der Diabetiker insuffizient.



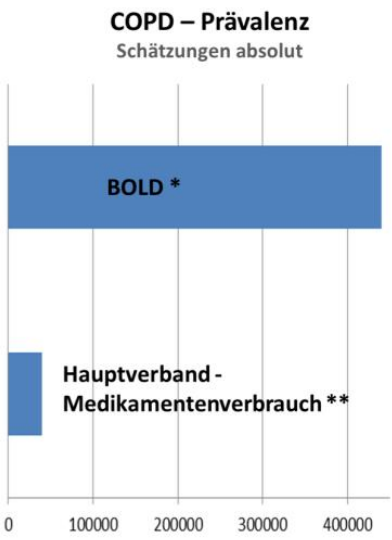


Aber auch andere chronisch Kranke sind schlecht versorgt, etwa Patienten mit COPD:



Note: Three-year average for Luxembourg.

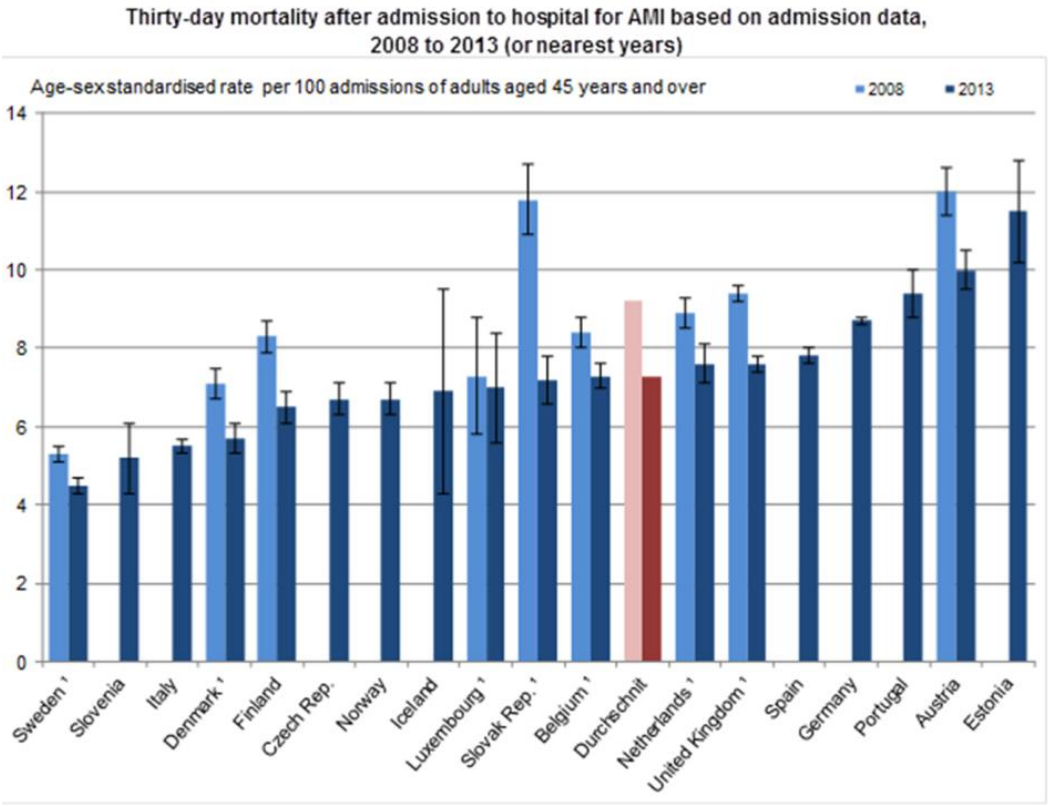
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.; eigene Berechnungen



*Prävalenzschätzung COPD GOLD-2 oder höher nach CHEST; 131/1/ 2007; Schirnhofer et al.;"COPD Prevalence in Salzburg, Austria; Results From the Burden of Obstructive Lung Disease (BOLD) Study"; Statistik Austria: Einwohner 2011 – eigene Berechnungen

**Peter Filzmoser et. al; Statistische Evaluation der Medikamentendaten – Cut-off Bestimmung für COPD: Department of Statistics and Probability Theory; Vienna University of Technology, Austria; 23. August 2012

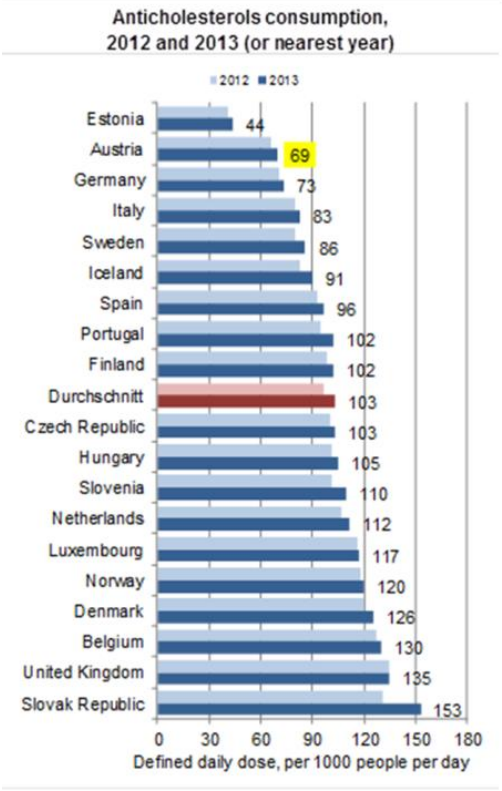
Oder Patienten mit Coronarer Herz Krankheit:

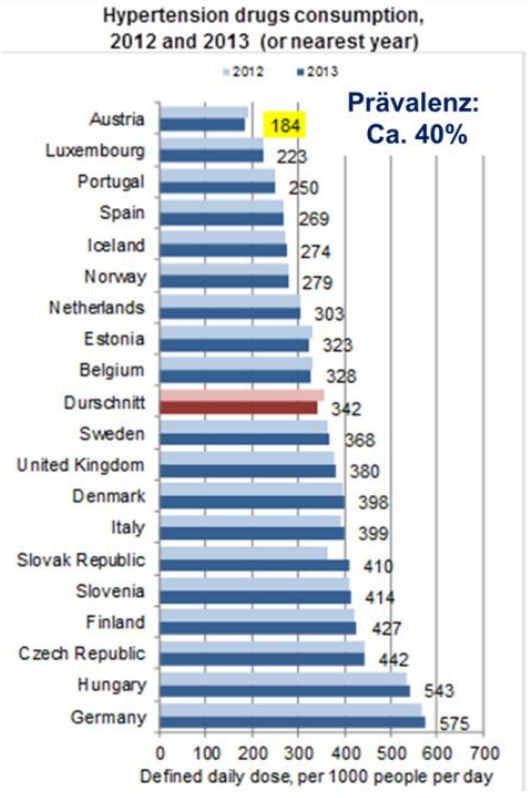


1 Admissions resulting in a transfer are included.

Note: 95% confidence intervals represented by H. Three-year average for Iceland and Luxembourg.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.; eig.Berechnungen





b . Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Um ein modernes, erfolgreiches und nachhaltiges Gesundheitssystem zu implementieren sollte es ein entsprechendes Bewusstsein in der österreichischen Politik als auch in der Bevölkerung zur Relevanz der Prävention geben.

Die Investitionen in das österreichische Gesundheitswesen entsprechen rund 11% des BIP. Wie wohl die Leistungsfähigkeit des Systems in einzelnen Bereichen statistisch belegt[3] ist (Sterblichkeit nach Schlaganfall, Versorgung Krebspatienten/Überlebensraten, geringer Antibiotikaverbrauch, geringe Säuglingssterblichkeit, geringe Rate an HIV-Infektionen….) und die Ausgaben auch konstant bei 10-11% liegen gibt es grobe Defizite[4]:

- Trotz hoher Lebenserwartung leben die Österreich zu kurz gesund (Lebenserwartung vs. gesunde Lebensjahre)
- Hohe COPD-bedingte Sterblichkeit, vor allem bei Kindern, Jugendlichen und Frauen
- Hohe Rate bei Alkoholkonsum/-missbrauch unter Jugendlichen
- Hohe Rate bei Übergewicht unter Jugendlichen
- Schlechte Durchimpfungsraten

Zu verbessern wären einige der oben genannten Defizite durch einfache Maßnahmen, zB: striktes Alkoholverbot unter 18 Jahren, striktes Rauchverbot unter 18 Jahren, strikte Durchsetzung des Rauchverbotes, Bewegungseinheiten und Wissen über gesunde Ernährung bereits im Kindergarten…

Im österreichischen Gesundheitssystem kommt die Ergebnisorientierung (Lebensqualität, gesunde Lebensjahre, Patientensicherheit, Gesundheitskompetenz,…) und die Qualitätssicherung des Systems viel zu kurz. Der Grundsatz „Health in all policies“ sollte einmal mehr als wichtigste Priorität erachtet werden.

c. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

> *(aus dem Bericht der AG Verwaltung neu 2010)*
>
> *Durch mangelnde Vernetzung bestehen zwischen den Krankenversicherungsträgern erhebliche Unterschiede bei den Tarifen und bei den Frequenzen der erbrachten Leistungen. Regelmäßige Vergleiche erfolgen nur sehr eingeschränkt und sind z.B. aufgrund der unterschiedlichen Struktur der Honorarordnungen bzw. der unterschiedlichen Struktur der Leistungserbringer nur eingeschränkt bzw. mit sehr hohem Aufwand möglich.*
>
> *Es besteht wenig Transparenz über die Preise medizinischer Leistungen im niedergelassenen Bereich. Ungerechtfertigte Preisunterschiede können länger bestehen, weil sie nicht auffallen.*

[3] OECD, Health at a Glance Europe, 2016 (S. 63, 131, 71, 77, 131, 115, 117…) und IHE-Report “Comparator Report on patient access to cancer medicines in Europe revisited 2016”
[4] OECD, Health at a Glance Europe, 2016 (S. 57, 67, 95, 97, 145, 147…)

Für die Tarife der einzelnen Leistungen existieren großteils keine exakten Kalkulationen. Bei den Tarifverhandlungen mit der Ärztekammer wird im Wesentlichen über das Gesamthonorarvolumen der Ärztegruppen verhandelt.

Der Zugang von Patienten zu Fachärzten erfolgt idR direkt oder im Wege von Allgemeinmedizinern. Eine Evaluierung des Bedarfes an Allgemeinmedizinern und ihrer Funktion an der Schnittstelle zu den Bereichen Krankenanstalten und Fachärzten unterblieb bisher.

Eine bedarfsgerechte Struktur im niedergelassenen Bereich ist nicht sichergestellt.

Die Anwendung eines einheitlichen Leistungskataloges sowie eine Anpassung der Honorarordnung im österreichischen Sozialversicherungssystem sind unabdingbar. Ergebnisorientierung hinsichtlich Behandlungsqualität sollte im Vordergrund stehen.

d. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Im heutigen österreichischen Sozialversicherungssystem ist die Qualität, Effektivität und Effizienz im Grunde nicht messbar. Zur flächendeckenden Sicherung und Verbesserung der Qualität ist die systematische Qualitätsarbeit zu intensivieren. Dazu wäre ein gesamtösterreichisches einheitliches Qualitätssystem zu entwickeln, zu evaluieren und auch stetig weiter zu entwickeln.

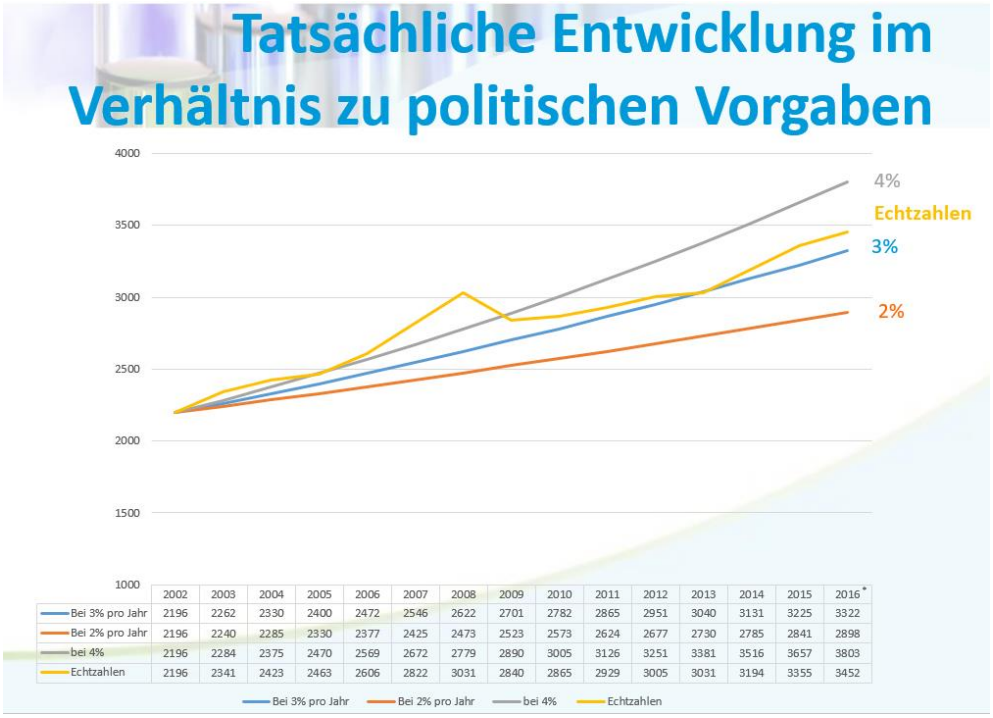
Für Leistungsanbieter auf allen Versorgungsebenen sollte ein Qualitätsmanagement verbindlich vorgesehen werden.

3 Weitere Anmerkungen zum Thema Arzneimittel

Das Wachstum der Arzneimittelausgaben wurde in den letzten Jahren durch viele Bemühungen stark verlangsamt, ua:

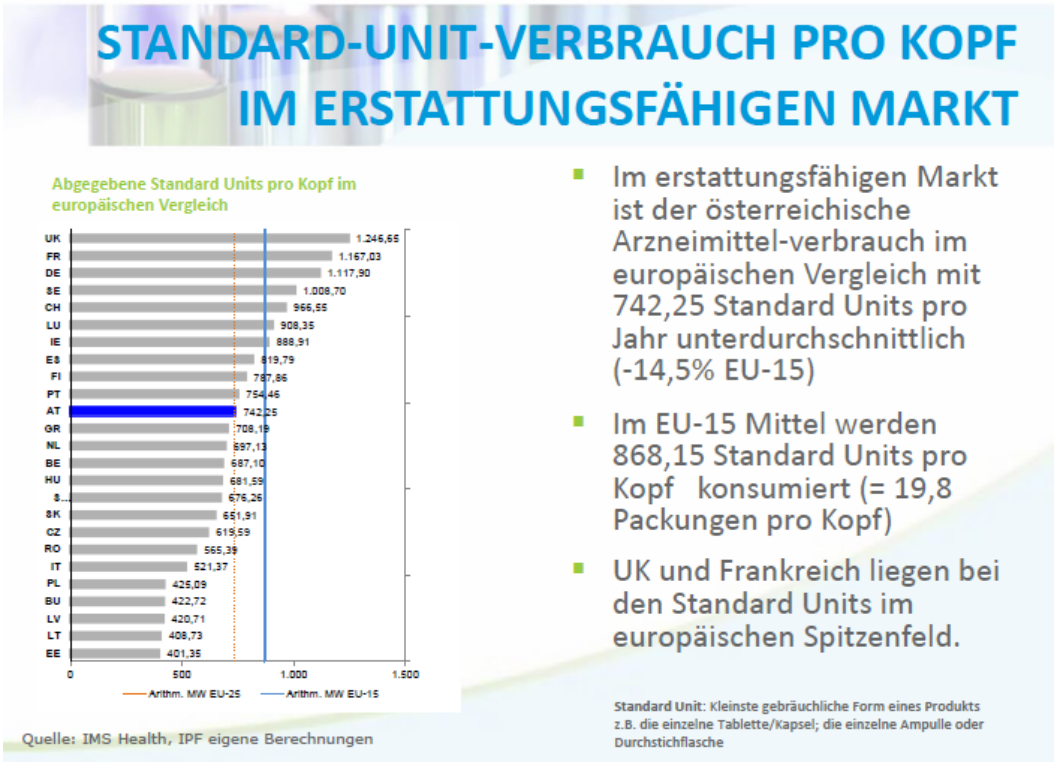
- Einführung des EKO mit Preisregularien für Aufnahme in den Erstattungskodex, insbesondere Generikapreisregel (Stärkung des Preiswettbewerbs)
- Darüber hinaus Preissenkungen und Einsparungen durch Patentabläufe
- Solidarbeiträge seitens der Pharmawirtschaft (seit 2008 – Rahmen-Pharmavertrag)
- Aktivitäten der Krankenversicherungsträger in Bezug auf das Verschreibungsverhalten der Ärzte

Seit der Einführung des Erstattungskodex befindet sich die Entwicklung im politisch akzeptierten Korridor von 3-4%.



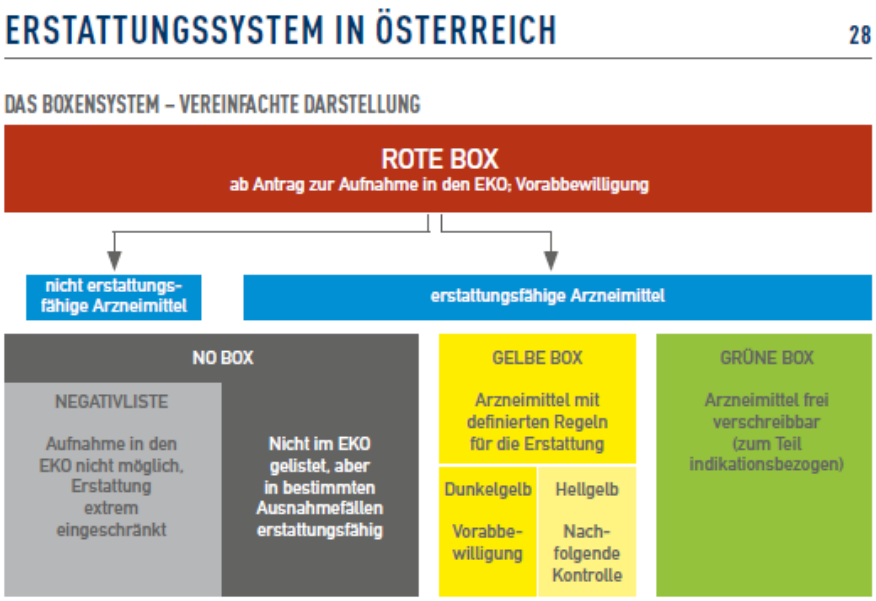
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Bei 3% pro Jahr	2196	2262	2330	2400	2472	2546	2622	2701	2782	2865	2951	3040	3131	3225	3322
Bei 2% pro Jahr	2196	2240	2285	2330	2377	2425	2473	2523	2573	2624	2677	2730	2785	2841	2898
bei 4%	2196	2284	2375	2470	2569	2672	2779	2890	3005	3126	3251	3381	3516	3657	3803
Echtzahlen	2196	2341	2423	2463	2606	2822	3031	2840	2865	2929	3005	3031	3194	3355	3452

Arzneimittelverbrauch in Österreich

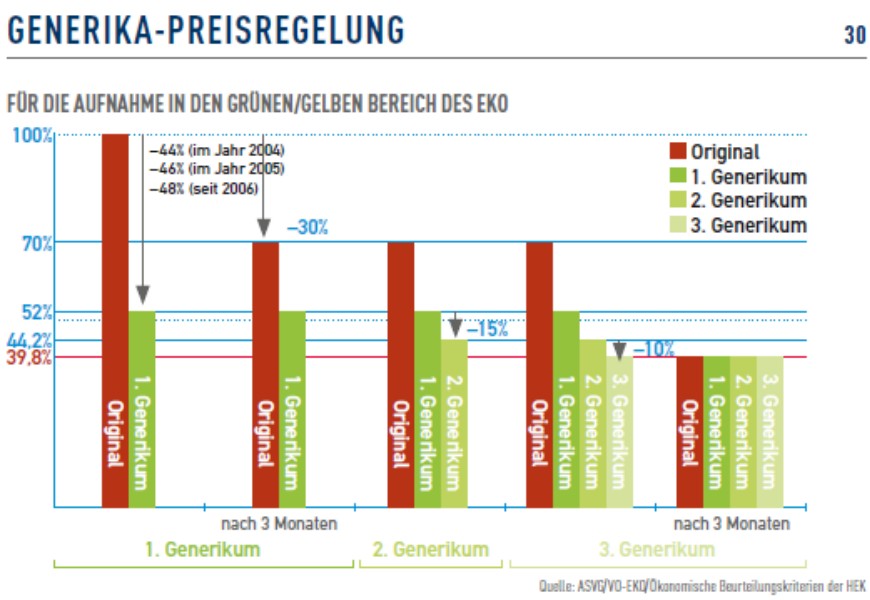


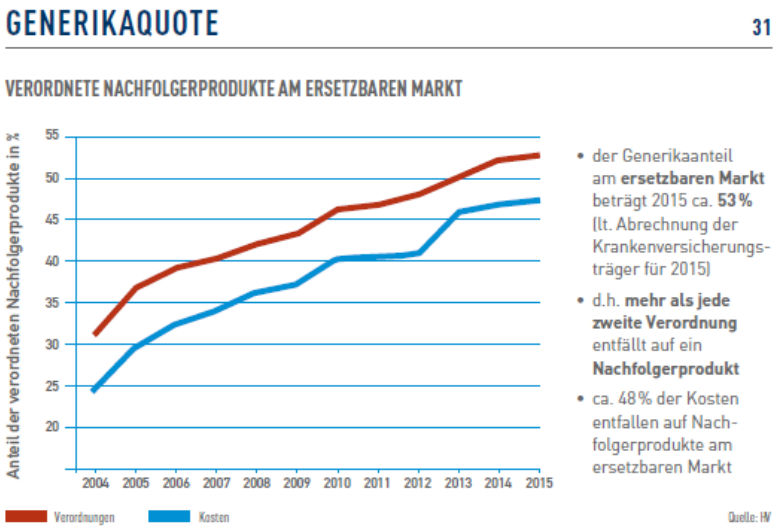
Grundsätzlich zu den bestehenden Preisregularien in Österreich: Arzneimittel, die in den Erstattungskodex aufgenommen werden wollen, haben neben medizinisch-therapeutischen und pharmakologischen Anforderungen, die erfüllt werden müssen, sich auch bestimmten Preisregularien zu unterwerfen (§ 351c ASVG – ua EU-Durchschnittspreis, Sonderbestimmungen für den gelben und grünen Bereich, Preisstufen nach Generikaeintritt,

§ 25 VO-EKO). Anhaltspunkte zur ökonomischen Evaluierung finden sich auch in den Beurteilungskriterien der HEK.



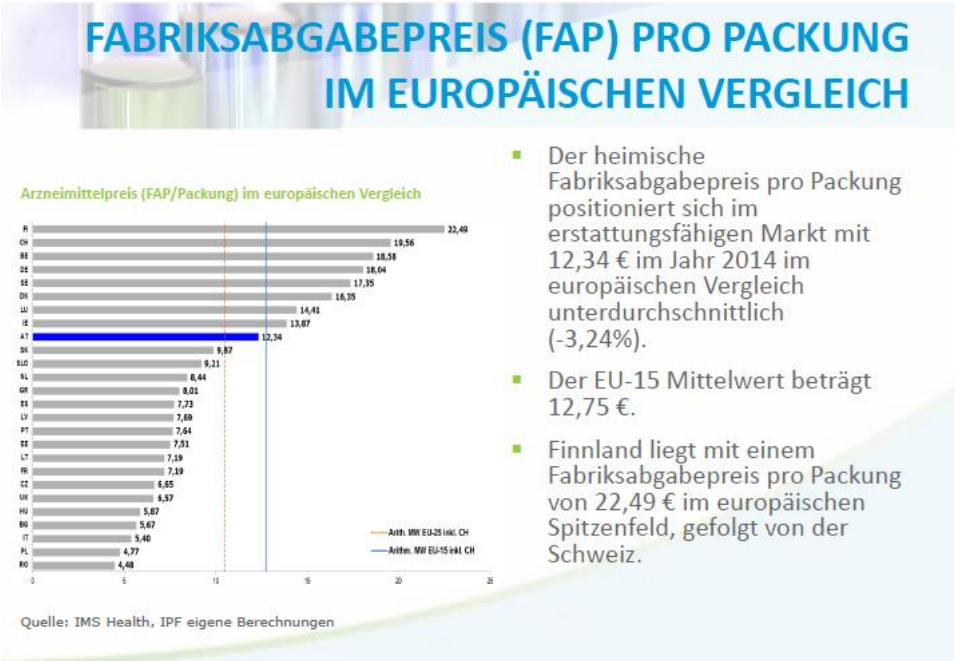
Die Generikapreisregelung (§ 351c Abs 10 ASVG) sieht neben bestimmten Preisabständen eines Generikums zum Original auch gesetzlich festgelegte Preisabstände für das Originalprodukt vor:





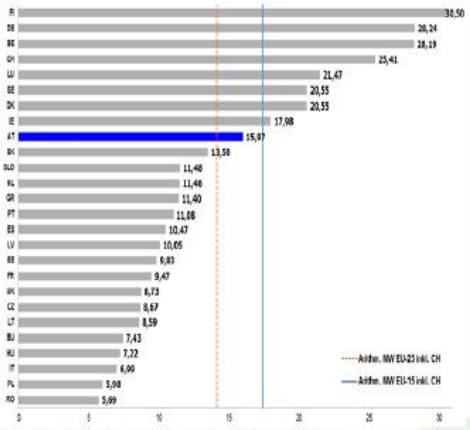
Kritisch anzumerken ist jedoch, dass eine Preisregelung für Biosmilars (Nachbauten von biologischen Arzneimitteln) im österreichischen Rechtsrahmen gänzlich fehlt. Ebenso wie Generika könnten Biosimilars ebenso einen Beitrag zur nachhaltigen Finanzierung des Systems beitragen. Diese Tatsache ist kein Anreiz für Unternehmen, Biosimilars im österreichischen Markt zu etablieren. Hier wird nachweislich auf ein großes Einsparpotenzial verzichtet. Entsprechende Lösungsvorschläge wurden den Entscheidungsträgern bereits vorgelegt.

Grundsätzlich tragen diese Maßnahmen dazu bei, dass die Arzneimittelpreise in Österreich im europäischen Vergleich im Mittelfeld bewegen (erstattungsfähiger Markt, EU-15 – IPF Preisanalyse).



KASSENPREIS (KKP) EXKL. UST PRO PACKUNG IM EUROPÄISCHEN VERGLEICH

Arzneimittelpreis (KKP exkl. USt./Packung) im europäischen Vergleich



Quelle: IMS Health, IPF eigene Berechnungen

- Im erstattungsfähigen Markt beträgt der heimische Kassenpreis exkl. USt pro Packung 15,97 € und ist somit im EU-15 Vergleich unterdurchschnittlich (-8,23%)
- Der EU-15 Mittelwert liegt bei einem Preis pro Packung von 17,41 €.
- Deutschland weist den zweithöchsten Kassenpreis pro Packung auf und verdrängt die Schweiz von Stelle 2.

LSE – The London School of Economics and political Science

FRAGE 1: Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

- Länderübergreifende Planung und Steuerung
- Neue Rechtsformen und Vergütungssysteme für PV
- Fokus auf ausreichende PV im ländlichen Bereich
- Finanzierung des Gesundheitswesens und tragfähige Finanzierungsmechanismen für das Prinzip „Geld folgt Leistung“
- Ausreichende Finanzierung der Rahmengesundheitszielvorgaben bzw. der Gesundheitsförderung und Prävention

FRAGE 2: Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

- Ausrichtung des Gesundheitswesens auf demografische Entwicklungen
- Digitale Gesundheitsversorgungsstrategie (e-Health, m-Health, …)

FRAGE 3: Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

- Selbstverwaltung, Pflichtversicherung (Weiterentwicklung der Selbstverwaltung)
- Sachleistungsprinzip (ausgeprägte Sachleistungsversorgung durch Vertragspartner)
- Doppelstrukturen bei fachärztlicher Versorgung
- Entwicklung der Medikamentenkosten
- Gesundheitskompetenz der Bevölkerung (HLO)

FRAGE 4: Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

- Mehr Orientierung bei der Finanzierung von Gesundheitsleistungen in Richtung „Wirksamkeitsnachweis/evidenzbasierter Medizin“
- Integrierte Versorgungskonzepte, Umsetzung innovativer ländlicher/bevölkerungsnaher Versorgungsmodelle
- Mehr bundesweite Programme in der GFP

Zusammenfassung der BVA zur Diskussionsrunde vom 21.2.2017

1. **Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?**
   Die Themen Public Health und Primärversorgung sind in den Rahmengesundheitszielen und im werdenden B-ZV hinreichend adressiert. Ziel muss sein, die Zahl der gesunden Lebensjahre zu erhöhen und die Lebensqualität von erkrankten Personen zu verbessern. Oberste Priorität hat demzufolge die faktische Etablierung von PHC zwecks Verbesserung der Patientenversorgung, die Sicherung der Gesundheitsversorgung auch in ländlichen Regionen und der Ausbau einer zielgerichteten Gesundheitsförderung und Prävention. Dazu gehört auch die Stärkung von evidenzbasierter Früherkennung und Frühintervention.
   Jede Zielbestimmung und Prioritätensetzung im Gesundheitswesen beruht auf Wertentscheidungen und sollte unter Einbeziehung von Betroffenengruppen im Zusammenwirken mit wissenschaftlichen Expertengremien vorgenommen werden. Eine zielgruppen- und bedarfs- und bedürfnisorientierte Gesundheitspolitik könnte auf dem Konzept der **Gesundheitsdeterminanten** basieren und ginge von der Erkenntnis aus, dass die Gesundheit der Bevölkerung nur durch **gebündelte Anstrengungen in allen Politikfeldern** wirksam und nachhaltig gefördert werden kann. Beabsichtigt wird dabei eine gesundheitsfördernde Gesamtpolitik durch verstärktes Berücksichtigen des Themas Gesundheit in anderen als den unmittelbar dafür zuständigen politischen Sektoren mit ihren jeweils spezifischen Zielen, Zielgruppen und Prioritäten.

2. **Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht in ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?**
   Nicht ausreichend beleuchtet wird aus unserer Sicht derzeit die Sicherung des "Nachwuchses" bei den Leistungserbringern. So ist speziell die ärztliche Versorgung in Österreich mittelfristig als kritisch zu beurteilen. In den nächsten 5-10 Jahren werden allein im Bereich der Allgemeinmediziner rund 2/3 der Ärzte das 65. Lebensjahr vollendet haben.
   Daher sind dringend Maßnahmen zu treffen, um die medizinische Versorgung in Österreich auch pro futuro sicherzustellen (z.B. Gründerservice für Jungärzte, Förderung des Arztes für Allgemeinmedizin in Ausbildung, Teilzeit/Jobsharing für Hausärzte ermöglichen, Anreize für die Tätigkeit als Allgemeinmediziner in der freiberuflichen Praxis setzen...).

3. **Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?**

4. **Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?**

   Der derzeit in Verhandlung stehende B-ZV bildet eine wichtige Grundlage für die Zukunft des österreichischen Gesundheitssystems. Die in dieser Form etablierte Koordinierung zwischen den Systempartnern ist zielführend und weiter umzusetzen. Allerdings: Es gibt zu viele Prioritäten. Der Focus wäre auf den Grundsatz: "Weniger ist mehr" zu setzen. Kernpunkt muss sein, dass die vereinbarten Ziele und Maßnahmen endlich auch für die Patienten wahrnehmbar werden.

Im Bereich der Sozialversicherungsträger ist ein kontinuierlicher Verbesserungsprozess unter der Berücksichtigung der Finanzierbarkeit der einzelnen Maßnahmen anzustreben. Eine Gleichschaltung aller Leistungen ohne Berücksichtigung von unterschiedlichen Finanzierungsgegebenheiten erscheint nicht zielführend. Unterschiedliche Systeme können durchaus befruchtend sein. So sollte dem Grundsatz „Vielfalt statt Eintopf" Rechnung getragen werden.

Im Vordergrund sollte immer der Mensch stehen. Gerade im Bereich der Gesundheit/Sozialversicherung ist schnelle, unbürokratische und umfassende Hilfe unerlässlich.

Die BVA bietet als bundesweiter Mehrspartenträger den Vorteil, dass der Versicherte Leistungen aus allen drei Versicherungszweigen bei einer Stelle in Anspruch nehmen kann.
So ergibt sich nicht nur ein einfacherer Zugang für den Versicherten, sondern auch die Möglichkeit einer ganzheitlichen Sicht auf den Versicherten ohne externe Schnittstellen und damit eine bessere Betreuungsmöglichkeit.

Versicherungsanstalt öffentlich Bediensteter

Obmann

Fritz Neugebauer

Versicherungsanstalt öffentlich Bediensteter Wien

Leitender Angestellter

Dr. Gerhard Vogel

VGKK
Vorarlberger Gebietskrankenkasse

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Ansprechpartnerin
Mag. Christian Weiß

Ihr Zeichen, Datum	Unser Zeichen	Datum
e-mail vom 27.02.2017	**ZDD-O-2017-042**	**13.03.2017**

Fragen zur Diskussionsrunde über das österreichische Sozialversicherungssystem

Sehr geehrter Herr Prof. Dr. Mossialos,

herzlichen Dank für die Einladung zur Teilnahme an der Diskussionsrunde betreffend die Effizienzstudie über das österreichische Sozialversicherungssystem. Nachstehend übermitteln wir unsere schriftliche Stellungnahme zu den von Ihnen aufgeworfenen Fragen in zusammengefasster Form.

Priorität Gesundheitsreform

Auf die soziale Krankenversicherung, die auf den Grundsätzen der Solidarität und der Pflichtversicherung aufbaut und rund 99,9% der hier lebenden Menschen einen Versicherungsschutz und Zugang zu umfassender, qualitativ hochwertiger Gesundheitsversorgung bietet, kann Österreich auch im internationalen Vergleich unseres Erachtens zu Recht stolz sein. Der Großteil der Österreicherinnen und Österreicher sieht dies nach den Umfragen ebenso und ist mit den Leistungen und Angeboten des heimischen Gesundheitswesens sehr zufrieden oder zufrieden.

Probleme sind, wie auch in den Gesundheitssystemen anderer Länder, vorhanden. Es wurden in Österreich jedoch bereits - ausgehend vom „Masterplan Gesundheit" der Sozialversicherung - gemeinsam mit dem Bund und den Ländern Lösungsmaßnahmen eingeleitet. Hauptursache für die Probleme sind anerkannterweise die (verfassungs-)gesetzliche Kompetenzverteilung und Finanzverantwortung im Gesundheitsbereich, die durch eine starke Fragmentierung und Asymmetrien gekennzeichnet sind.

Ziel der seit dem Jahr 2013 laufenden und durch die aktuelle Art. 15a-Vereinbarung (s. Vereinbarung gemäß Art. 15a B-VG Zielsteuerung-Gesundheit) fortgesetzten und weiterentwickelten Ge-

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sundheitsreform ist es daher, diese Fragmentierung und Asymmetrien durch ein gemeinsam von Bund, Ländern und SV vereinbartes Zielsteuerungssystem und eine optimierte sektorenübergreifende Zusammenarbeit in den operativen Bereichen auszugleichen. Zu diesem Zweck wurde eine entsprechende Organisationsstruktur im Bund und in den Ländern geschaffen (s. Vereinbarung gemäß Art. 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens). Durch die Bundeszielsteuerung und die darauf abgestimmte Landeszielsteuerung werden Planung und Steuerung im Gesundheitswesen und die darauf aufsetzenden Maßnahmen gemeinsam abgestimmt und gegebenenfalls gemeinsam finanziert. Zahlreiche Ziele und Maßnahmen, die in diesem Rahmen vereinbart wurden, befinden sich derzeit entweder im Planungsstadium oder bereits in Umsetzung. Ganz aktuell ist hier neben vielen anderen Zielsteuerungsprojekten vor allem der unmittelbar bevorstehende Einsatz der Gesundheitshotline „TEWEB" zu nennen. Absolute **Priorität** hat aus unserer Sicht derzeit daher die weitere **Umsetzung der Gesundheitsreform** und nicht eine neuerliche Strukturdiskussion während laufender und sich positiv entwickelnder Reform.

Strukturdiskussion – was bringen Trägerzusammenlegungen?

Trotz unserer klaren Priorität für die Umsetzung der Gesundheitsreform möchten wir zu diesem Thema auf einige wesentliche Untersuchungsergebnisse bereits vorliegender Studien hinweisen.

1.) Studien und internationale Vergleiche sprechen eindeutig gegen eine Zentralisierung

a.) **Kosten:** Meist wird die Zentralisierung mit dem Argument niedriger Verwaltungskosten gefordert. Dahinter steht die Annahme, dass je größer ein Unternehmen ist, desto niedriger seine Verwaltungskosten sind. Sie baut auf dem betriebswirtschaftlichen Begriff der Skaleneffizienz (economies of scale) auf. Wie Studien zeigen, lässt sich ihre Gültigkeit im Bereich der sozialen KV jedoch nicht bestätigen. Ganz im Gegenteil:

- Deutscher Rechnungshof: In Deutschland gab es in den letzten Jahren unzählige Krankenkassenfusionen (waren im Jahr 1970 noch 1.815 und im Jahr 2000 noch 420 Krankenkassen zu verzeichnen, waren es mit Stichtag 1.1.2016 118). Dadurch sollten Verwaltungskosten gespart werden und auch bei den Leistungsausgaben wurden Einsparungen erwartet. Das tatsächliche Ergebnis ist eindeutig: In den meisten Fällen lagen die Verwaltungskosten nach der Fusion bis zu einem Fünftel über den früheren Werten. Auch bei den Leistungsausgaben wurden keine Einsparungen erzielt.
- Für Österreich weist die jüngste Studie des IHS (Zukunft der Sozialen Krankenversicherung – Entwicklungsmöglichkeiten für Österreich, Studie im Auftrag der Industriellenvereinigung, Jänner 2017) in diesem Zusammenhang auf folgende interessante Zahlen hin:
    - Der tatsächliche Verwaltungs- und Verrechnungsaufwand pro anspruchsberechtigte Person (Bruttoaufwand abzüglich Ersätze) lag 2015 in allen Bundeskassen zum Teil deutlich über den Vergleichswerten der GKK´s. Bemerkenswert ist auch, dass die reale Pro-Kopf-Steigerung seit 2009 ebenfalls bei drei Bundeskassen besonders hoch ausfiel (IHS, 98).
    - Der tatsächliche Verwaltungs- und Verrechnungsaufwand der GKK´s betrug 2015 zwischen 2,12% (GKK Steiermark) und 3,76% (GKK Burgenland) – VGKK: 2,66% - der Beitragseinnahmen. In sämtlichen Bundeskassen liegt der tatsächliche Verwaltungs- und Verrechnungsaufwand über jenem der GKK´s, wobei die Anteile 2015 auch die Vergleichswerte von 2009 übersteigen. Somit unterscheiden sich beiden Kassenarten systematisch nicht nur in der relativen Höhe ihres Verwaltungsaufwandes sondern auch in seiner Dynamik (IHS, 104f).
    - Hinsichtlich des Personalaufwandes wies 2015 zwar die GKK Steiermark die niedrigsten und mit Kärnten und Burgenland gerade GKK´s kleiner Bundesländer die höchsten Kosten pro Kopf auf. Allerdings sind im kleinen Vorarlberg Personalauf-

wendungen vergleichsweise niedrig, was die Bedeutung anderer Determinanten als Größe unterstreicht (IHS, 102).

- Den theoretischen Hintergrund, dass die Verwaltungskosten ab einer gewissen Organisationsgröße nicht kleiner sondern größer werden (diseconomies of scale), hat die Betriebswirtschaft längst nachgewiesen. Speziell für die gesetzliche Krankenversicherung in Deutschland wurde dieser Grundsatz etwa durch Rürup 2006, GKV. Verwaltungskosten und Kassengröße, nachgewiesen.
- Das IHS kommt in erwähnter Studie zum Ergebnis, dass sich im Bereich der Krankenversicherungen sowohl Größenvorteile als auch –nachteile argumentieren lassen. Auch die empirischen Befunde zur Skaleneffizienz bei den Krankenversicherungen sind nicht eindeutig, sie weisen vielmehr darauf hin, dass den jeweiligen Rahmenbedingungen hohe Bedeutung zukommt (IHS, 126).
- Die öffentlichen Verwaltungskosten im österreichischen Gesundheitssystem sind im internationalen Vergleich ohnedies niedrig (siehe liegen z.B. in Deutschland bei rd. 5%, während Österreich dafür rd. 2% bis 3% der laufenden Gesundheitsausgaben verwendet) und bewegen sich im unteren Bereich der westlichen Sozialversicherungsländer (IHS, 121). Eine Optimierung der Verwaltungskosten könnte demnach auch kein größeres Einsparpotential erzielen als einen Bruchteil dieser Ausgaben (IHS, 128).

b.) **Trägeranzahl:** Meist wird im Zusammenhang mit der Zentralisierung auch damit argumentiert, dass es in Österreich überdurchschnittlich viele und kleine KV-Träger gäbe. Dieses Argument ist falsch. Während es in Österreich 19 KV-Träger gibt (davon 6 Betriebskrankenkassen, von denen sich eine in Auflösung befindet), sind 2016 in Deutschland 118, in der Schweiz 57 und in den Niederlanden 25 Krankenkassen zu verzeichnen. Die durchschnittliche Größe der Krankenkassen ist in Deutschland (rd. 606.000 Versicherte) leicht und in der Schweiz (rd. 142.000 Versicherte) deutlich niedriger als in Österreich (rd. 704.000 Versicherte ohne BKK´s). IHS, 127.

c.) **Wettbewerb:** Als weiteres Argument für Zentralisierung wird der fehlende Wettbewerb zwischen den Trägern genannt, der mehrere Träger unnötig mache. Auch dieses Argument ist unrichtig, da man zwischen verschiedenen Formen des Wettbewerbs unterscheiden muss:

- Versicherungswettbewerb (Versicherte können sich „ihre" Krankenkasse aussuchen): Der – in Österreich nicht vorhandene – Versicherungswettbewerb kann zwar Innovationsreize setzen und eine stärkere Kundenorientierung bewirken. Dem steht allerdings gegenüber, dass die Verwaltungskosten durch Marketingaktivitäten und Versichertenwechsel deutlich höher sind. Ebenso zeigt die Evidenz in anderen Ländern, dass die unerwünschte Risikoselektion bisher nicht ausreichend hintangehalten werden kann und Präventionsanreize verlorengehen, da nicht sichergestellt werden kann, dass derjenige Versicherer, der die Präventionsleistung bezahlt, später davon profitiert. Internationale Beispiele zeigen, dass Länder mit ausgeprägter Wettbewerbskultur – Niederlande, Deutschland, Schweiz – in Vergleichsstatistiken durch besonders hohe Gesundheitsausgaben auffallen und Verwaltungskosten nicht gesenkt werden können (IHS, 115f und 123).
- Yardstick Competition: Dabei lässt man bei sich neu stellenden Aufgaben einzelne Versicherungsträger eigene Lösungen entwickeln und einführen. Anhand einer begleitenden Datensammlung kann man dann in weiterer Folge diese Lösungen evaluieren und können andere die jeweils für ihre Bedürfnisse am besten passende Lösung übernehmen, während ungeeignete Lösungen eingestellt werden (IHS, 123f). Ein solcher – auch in der IHS-Studie befürworteter – Wettbewerb setzt mehrere Versicherungsträger voraus, denen sich mehr oder minder die gleichen Aufgaben stellen. Eine Einheitskasse würde sich ungleich schwerer tun, als Organisa-

tion zu lernen als dies mehrere Träger in einer Yardstick Competition können (IHS, 128).

d.) **Einheitliche Leistungen**: Dieses in den Diskussionen immer wieder genannte Argument spricht ebenfalls nicht für eine Zentralisierung. Zum einen kann man eine Vereinheitlichung derzeit ungleicher Leistungen (die ohnehin nur einen kleinen Teil des gesamten Leistungsspektrums ausmachen) auch bei mehreren Trägern erreichen – innerhalb der SV läuft gerade ein entsprechendes Projekt. Zum anderen ist eine absolute Vereinheitlichung bis ins kleinste Detail gar nicht erstrebenswert und widerspricht dem vorhin angeführten Wettbewerbsgedanken im Sinne der Yardstick Competition. Leistungsunterschiede in gewissen Bereichen sind vielmehr Ausdruck von notwendiger Innovationskraft statt Verkrustung. Schon viele gesundheitspolitische Projekte wurden durch die Vorreiterschaft einzelner Träger und den Wettbewerb der Ideen in Folge als einheitliche Leistungen der Sozialversicherung „ausgerollt". Dieser Ausrollprozess sollte zugegebenermaßen in Bereichen sinnvoller gesundheitsrelevanter Projekte beschleunigt werden. Andererseits ist jedoch Einheitlichkeit als oberste Maxime nicht immer anzustreben. Es gibt regional unterschiedliche Umfeldeinflüsse – z.B. strömen auf Grund der Nachbarschaft zur Schweiz, zu Liechtenstein, zu Bayern und Baden-Württemberg auf Vorarlberg ganz andere Einflussfaktoren (Lohnniveau, Leistungsniveau....) auf das Gesundheitssystem ein als z.B. aus den Nachbarländern des Burgenlands. Dies erfordert geradezu unterschiedliche und treffsichere Strategien und Leistungsspektren – wenn man nicht will, dass sich das Gesundheitswesen von derartigen realen Anforderungen kontinuierlich entfernt.

e.) **Kundennähe**: Gerade wenn es darum geht, auf die Bedürfnisse der Kunden – sowohl Versicherte als auch Dienstgeber – optimal einzugehen, sind rasche, unbürokratische und kundennahe Entscheidungen nötig, die in einem bundesweit zentralisierten Träger nicht gewährleistet wären. Vor langer Zeit hat bereits der britische Kolonialbeamte Cyrtil Northcote Parkinson das Problem großer Organisationen erkannt und in seinen Parkinsonschen Gesetzen beschrieben: Große Organisationen neigen dazu, sich selber zu verwalten. Ursache: lange Entscheidungswege, kundenferne Entscheidungen, zusätzliche Hierarchien, Unbeweglichkeiten...
Das heißt jedoch nicht, dass es in Bezug auf Organisation, einheitliche EDV, Mitwirkung in der Bundeszielsteuerung, bundeseinheitliche Projekte und Leistungen nicht auch einer koordinierenden und steuernden Institution auf Bundesebene bedarf (Hauptverband der Sozialversicherungsträger).

f.) **Regionale Finanzierung**: Nur eine dezentrale Struktur stellt sicher, dass die für die optimale Gesundheitsversorgung in der Region benötigten Finanzmittel in ausreichendem Maße zur Verfügung stehen. Ein zentral organisiertes Gesundheitssystem neigt schon allein aufgrund der fehlenden Kenntnis über die regionalen Bedarfe dazu, die vorhandenen Mittel vor allem in die Zentren, d.h. vor allem nach Wien, zu leiten.

g.) **Föderale Struktur**: Nicht zuletzt die föderale Ausrichtung in Österreich - sowohl der allgemeinen staatlichen Verwaltung, der Selbstverwaltung und der wesentlichen Vertragspartner der Krankenversicherungsträger - spricht eindeutig gegen eine bundesweite Zentralisierung. In diesem Punkt ist auch die erwähnte IHS-Studie nicht schlüssig: Sie befürwortet zwar einerseits Trägerzusammenlegungen nach regionalem Gesichtspunkt, wendet sich aber gegen Bundesländerkassen, da diese den Vorteil, nicht an die (engen) geografischen Grenzen der Länder gebunden zu sein, aufheben würden (IHS, 128). Wir sehen ganz im Gegenteil eine Bindung an die Bundesländergrenzen als großen Vorteil: Die Gesprächs- und Verhandlungspartner der KV-Träger sind vor allem in den Ländern situiert, daher macht aus unserer Sicht (dort wo realpolitisch

umsetzbar) eine Verbreiterung der Trägerzuständigkeit auf Ebene der Bundesländer Sinn.

h.) **Reale Machbarkeit**: Bei allen Überlegungen zu Reformen ist in die Entscheidungsfindung auch die Frage der realen Machbarkeit einzubeziehen. Entscheidungen am „grünen Tisch" ohne Berücksichtigung der realen Rahmenbedingungen in den Ländern führen zu Disakzeptanz der Systempartner und Versicherten vor Ort, was einer erfolgreich Umsetzung der Idee diametral entgegen steht. Der Versuch, die Bundesländerebene aufzulösen, wäre eine derartige Entscheidung.

Mit freundlichen Grüßen

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Rückmeldung der

Wiener Gebietskrankenkasse

1.) Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Die Basis des österreichischen Gesundheitssystems sind das **(1) Solidaritätsprinzip**, die Pflichtversicherung und die Selbstverwaltung; Grundpfeiler, die sich seit Jahrzehnten bewähren. Das Solidaritätsprinzip garantiert jeder Versicherten/jedem Versicherten sowie ihren Angehörigen medizinische Versorgung unabhängig vom individuellen Einkommen. Der Zugang zu einer umfangreichen Gesundheitsversorgung steht somit allen offen.

In Österreich ist die freie Arztwahl im niedergelassenen Bereich verankert. Einerseits kann man sich so die behandelnde Ärztin/den behandelnden Arzt aussuchen, andererseits aber auch die Versorgungsebene. Die heimischen Versicherten können somit auswählen, ob sie eine praktische Ärztin/einen praktischen Arzt, eine Fachärztin/einen Facharzt oder die Spitalsambulanz aufsuchen.

Das System der **(2) Selbstverwaltung** gibt es in der heutigen Form seit mehr als 150 Jahren – und es hat sich bewährt. In der Selbstverwaltung werden die Interessen der Versicherten durch Versicherungsvertreterinnen/-vertreter in den Entscheidungsgremien (Vorstand, Generalversammlung, Kontrollversammlung) gewahrt. Die Versicherungsvertreterinnen/-vertreter werden von Dienstnehmerinnen/Dienstnehmer-Vertretungen und Dienstgeberinnen/Dienstgeber-Vertretungen (Arbeiterkammer, Wirtschaftskammer) entsandt. So entsteht zum einen die Nähe zum Versicherten, zum anderen wird die Vertretung demokratisch durch Arbeiterkammer- bzw. Wirtschaftskammer-Wahlen bestimmt. Da die Versicherungsvertreterinnen/-vertreter aus einer Interessensvertretung kommen, wissen sie um die Bedürfnisse ihres Versichertenkreises. Daher ist es auch wichtig, dass die Selbstverwaltung die versicherten Personengruppen widerspiegelt.

Bei Sozialversicherungsträgern, die Dienstnehmerinnen/Dienstnehmer versichern, soll auch künftig gewährleistet sein, dass die Versicherungsvertreterinnen/-vertreter mehrheitlich Arbeitnehmerinnen/-nehmer sind. Gerade für die Gebietskrankenkassen spielt das eine große Rolle. Hier sind ausschließlich Arbeitnehmerinnen/-nehmer versichert.

Die Vorteile der Selbstverwaltung verstärken sich vor allem in Kombination mit regionalen Versicherungsträgern. Gebietskrankenkassen mit einer Selbstverwaltung bestehend aus

regionalen Versichertenvertreterinnen/-vertretern kennen die Interessen der Versicherten in der Region, die regionalen Bedürfnisse ebenso wie regionale Besonderheiten und die Versorgungssituation vor Ort und richten ihre Entscheidungen darauf aus. Dadurch entsteht Versichertennähe in den Entscheidungen aber auch betreffend Gesundheits- und Serviceleistungen (z.B. Regionale Kundencenter und Gesundheitseinrichtungen).

Der Vorteil der **(3) Pflichtversicherung** ist ein geringer Verwaltungsaufwand. Die einzelnen Träger stehen nicht in Konkurrenz zueinander und sparen sich so nicht nur Verwaltungsausgaben sondern auch wettbewerbsbedingte Kosten. Diese Mittel können die einzelnen Träger für Leistungen der Versicherten ausgeben, anstatt sie für die Akquise neuer Versicherter zu verwenden. Kassenwettbewerb führt zum Umwerben guter Risiken. Eine Folge der Versicherungspflicht wäre, dass Krankenkassen für Gutverdiener mit einem breiten Leistungsspektrum entstehen, denen gegenüber Krankenkassen mit weniger Leistungen und günstigeren Beiträgen bzw. Selbstbehalten gegenüberstehen. Das stünde im Gegensatz zu gleichen Leistungen für alle. Einheitliche Leistungen kann es nur dann geben, wenn die Risiken in der Versichertengemeinschaft und somit die Finanzkraft der Träger ausgeglichen sind.

Dass Sozialversicherungsträger in eine finanzielle Schieflage geraten, ist der **(4) Risikostruktur** der Versicherungsgemeinschaft geschuldet. Um das System der Pflichtversicherung möglichst effizient zu gestalten, braucht es annähernd gleiche Strukturen zwischen den Sozialversicherungsträgern. Unterschiedliche Risikostrukturen führen in Folge zu uneinheitlichen finanziellen Lagen und zu Leistungsunterschieden, auch wenn diese Unterschiede im Vergleich zum Gesamtsystem relativ gering sind. Daher müssen die Unterschiede zwischen den einzelnen Trägern möglichst ausgeglichen werden. So könnte man in Folge die Leistungsunterschiede beseitigen und die Finanzierung des Gesamtsystems nachhaltig sicherstellen.

Die Risikostruktur in einem System der Pflichtversicherung ist durch den Träger nicht beeinflussbar. Man hat als Versicherung keinen Einfluss darauf, wie viele Versicherte chronisch krank sind oder sich mit dem Hepatitis-C- oder HI-Virus infiziert haben. Gerade die letztgenannten Beispiele treffen die WGKK im Vergleich mit anderen Kassen stärker – hier hat die WGKK überproportional hohe Kosten zu tragen. Da die WGKK darüber hinaus hauptsächlich in einer Großstadt lebende Versicherte und eine für eine europäische Großstadt typische, hoch spezialisierte und dichte Versorgung bietet, bedarf es eines ausreichenden Ausgleichs zwischen den Trägern. Erforderlich ist aus diesem Grund, dass nicht nur die Gebietskrankenkassen, sondern auch Sonderversicherungsträger mit einer günstigeren Risikostruktur in den Ausgleichsfonds einbezogen werden.

Das österreichische Gesundheitssystem ist durch **(5) Sachleistungsversorgung** geprägt. Im österreichischen System wird unterschieden zwischen Vertragsärztinnen/-ärzten bzw. Vertragseinrichtungen, die einen Vertrag mit den Sozialversicherungsträgern haben, und Privat- bzw. Wahlärztinnen/Wahlärzten und -einrichtungen ohne Vertrag. Für einen guten und gleichen Zugang zum Gesundheitssystem sind Vertragspartnerinnen/Vertragspartner ohne Zuzahlungen und ohne Vorausleistungen von Patientinnen/Patienten ausschlaggebend.

Die Behandlung von Versicherten bei Vertragsärztinnen/-ärzten wird direkt mit dem jeweiligen Träger abgerechnet. An diesem einfachen und unkomplizierten Versorgungszugang soll festgehalten werden. Für einen guten und gleichen Zugang zum Gesundheitssystem sind Vertragsärztinnen/-ärzte zentral in der Planung verankert. Dieses System hat sich auch durch die hohe Zufriedenheit der Bevölkerung mit dem Gesundheitssystem bewährt.

Prinzipiell erfolgt die Versorgungsplanung im Österreichischen Strukturplan Gesundheit (ÖSG), im regionalen Strukturplan Gesundheit (RSG) und den Stellenplänen, die als Bestandteil des Gesamtvertrages zwischen Krankenversicherungsträgern und Ärztekammer verhandelt werden. Der festgestellte Bedarf an niedergelassenen Ärztinnen/Ärzten wird durch Verträge mit den Krankenversicherungsträgern (Vertragsärzte) abgedeckt. Zusätzlich haben freiberufliche Ärztinnen und Ärzte die Freiheit eine Wahlarztordination zu eröffnen – über den festgestellten Bedarf an Vertragsärztinnen und –ärzten hinaus – und Patientinnen/Patienten gegen private Bezahlung zu versorgen. Versicherte können diese Kosten zur Kostenerstattung bei ihrer Krankenversicherung einreichen. In diesem Fall bekommen die Versicherten 80 % des Vertragstarifs einer Vertragsärztin/eines Vertragsarztes ersetzt.

Betrachtenswert ist in diesem Zusammenhang die oftmals erwähnte Zunahme von Wahlärztinnen/-ärzten. Die Versorgungswirksamkeit der Wahlärztinnen/-ärzte ist gering. Oftmals betreiben Spitalsärztinnen/-ärzte eine Wahlordination als Nebentätigkeit. Das belegen auch die Einkommenszahlen der Wahlärztinnen/-ärzte. Rund 80 % der Wahlärztinnen/-ärzte erzielen ein Einkommen von weniger als 10.000 Euro pro Jahr. In Wien liegt der Anteil der Wahlarztleistungen an den Leistungen durch Vertragsärztinnen/-ärzte im letzten Jahrzehnt konstant unter vier Prozent.[1]

[1] Berücksichtigung der SV-relevanten Leistungen: Nur die WA-Kosten die eingereicht und erstattet wurden, können berücksichtigt werden. Leistungen die nicht eingereicht und/ oder nicht erstattet wurden, werden nicht berücksichtigt. Bei Inanspruchnahme von Wahlärzten reichen laut GFK Bevölkerungsstudie – Gesundheit 2016

Berichtsjahr 2011

Fachgebiete	01	03	04	05	06	07	08	09	10
Österreich	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
0-10.000€	91,9%	74,6%	91,0%	78,2%	63,8%	81,4%	74,9%	81,3%	83,2%
10.000€ - 100.000€	7,9%	24,3%	8,8%	21,4%	35,7%	17,4%	24,3%	17,5%	13,9%
>100.000€	0,2%	1,1%	0,1%	0,4%	0,5%	1,2%	0,8%	1,1%	3,0%

Fachgebiete	11	12	15	16	17	19	20	32	Gesamt
Österreich	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
0-10.000€	76,6%	80,1%	90,8%	82,7%	78,8%	74,6%	69,3%	100,0%	**81,2%**
10.000€ - 100.000€	23,2%	18,3%	9,2%	17,3%	20,2%	23,9%	30,2%	0,0%	**18,1%**
>100.000€	0,2%	1,6%	0,0%	0,0%	1,0%	1,5%	0,5%	0,0%	**0,7%**

Quelle: HVB 2016

(6) Keine weiteren Selbstbehalte oder Selbstbehalte beim Arztbesuch

Grundsätzlich ist festzustellen, dass die Selbstbehalte in Österreich im internationalen Vergleich relativ hoch sind. Die heimischen Versicherten sind, bis auf wenige Ausnahmen, bereits mit einer gewissen Anzahl von Zuzahlungen konfrontiert. Hier ein Überblick über die wichtigsten Zuzahlungen:

- Rezeptgebühr: Jede/jeder Versicherte muss für ein rezeptpflichtiges Medikament eine Rezeptgebühr von 5,85 Euro (2017) bezahlen.

- Serviceentgelt für die e-card: Die Versicherten haben jährlich das sogenannte „e-card-Serviceentgelt“ zu entrichten. 2017 beträgt es 11,35 Euro.

- Selbstbehalte für Heilbehelfe und Hilfsmittel: Benötigt eine Versicherte/ein Versicherter beispielsweise orthopädische Schuheinlagen, Krücken oder Brillen, ist ein Selbstbehalt zu leisten. Die Höhe ist jeweils abhängig von den Kosten der bezogenen Leistung.

Bei der Diskussion rund um Selbstbehalte bei Arztbesuchen muss berücksichtigt werden, dass sie finanziell fragliche Auswirkungen hätten und den Zusammenhalt der Solidargemeinschaft in Diskussion stellen. 60 % der Anspruchsberechtigten der WGKK müssten aus sozialen Überlegungen (z.B. geringes Einkommen) von Selbstbehalten bei der Ärztin/dem Arzt ausgenommen werden. Das bedeutet, dass nur jene 40 % der Beitragszahlerinnen und -zahler, die bereits relativ hohe Beiträge bezahlen, auch Selbstbehalte bei Arztbesuchen bezahlen müssten. Das ergab eine vor kurzem für die WGKK erstellte Studie, die als Annahme hatte, dass die Einkommensgrenze für Selbstbehalte bei 1.250 Euro netto pro Monat liegt. Die Studie zeigte, dass Selbstbehalte bei Arztbesuchen keine positiven finanziellen Effekte von Relevanz für die WGKK hätten und

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ca ¾ der Versicherten die Rechnung ein. Die Wahlarztkostenerstattungen der Nicht-§2-Kassen werden nicht berücksichtigt (Grund: Geldleistungsberechtigte der SVA).

das Risiko erhöhen, dass Betroffene notwendige Untersuchungen nicht in Anspruch nehmen – vor allem bei Personen mit niedrigem Einkommen. Die Einhebung der Selbstbehalte bei jedem Arztbesuch inkl. deren Eintreibung lösen einen erheblichen Verwaltungsaufwand aus – zusätzliche kontraproduktive Effekte durch die Verschiebung notwendiger ärztlicher Behandlungen nicht mitberücksichtigt.

(7) Administration des Sozialstaates und öffentliche Gesundheitseinrichtungen

Neben der Zuständigkeit für Kranken-, Unfall- und Pensionsversicherung haben die Sozialversicherungsträger im Laufe der Jahre einen wesentlichen Bestandteil der öffentlichen Administration übernommen. Man kann sagen, dass die Sozialversicherung einen Großteil der Sozialstaatsagenden verwaltet und abwickelt. So kümmern sich die Krankenversicherungsträger etwa um das Melde-, Versicherungs- und Beitragswesen, übernehmen aber auch staatliche Tätigkeitsbereiche und wickeln das Kinderbetreuungsgeld mit Beratung, Berechnung und Auszahlung ab. Mit ihren Kundencentern und Servicestellen leisten die einzelnen SV-Träger ihren Beitrag, um den Staat bei der Verwaltung der Sozialleistungen zu unterstützen.

2.) Gibt es bestimmte wichtige Punkte im Gesundheitswesen, die momentan nicht oder nicht im ausreichenden Ausmaß im österreichischen Gesundheitswesen enthalten oder implementiert sind?

3.) Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Gesundheitssystem und weshalb?

(1) Primärversorgung (PHC)

Die Stärkung der Primärversorgung kommt österreichweit betrachtet nur sehr langsam in die Umsetzung. Die erste Primärversorgungseinrichtung (PHC) Medizin Mariahilf im sechsten Wiener Gemeindebezirk ist sowohl für die Patientinnen/Patienten, als auch für die Ärztinnen/Ärzte ein Gewinn. Die wöchentliche Mindestöffnungszeit beträgt 50 Stunden – somit sind auch die Tagesrandzeiten abgedeckt. Gerade für berufstätige Personen sind Abendöffnungszeiten besonders wichtig. Hinzu kommt, dass im PHC Medizin Mariahilf neben Ärztinnen/Ärzten für Allgemeinmedizin verschiedene weitere Gesundheitsberufe – etwa Psychotherapie, Diätologie sowie Gesundheits- und Krankenpflege – unter einem Dach effizient zusammenarbeiten. Außerdem ist eine umfangreiche und abgestimmte Betreuung

chronisch kranker Menschen gewährleistet. Die Ärztinnen und Ärzte des PHC arbeiten eng mit anderen Gesundheitseinrichtungen in unmittelbarer Nähe zusammen. So können Labor- oder Röntgen-Untersuchungen rasch erbracht werden – viele Untersuchungen, die bisher im Spital erbracht werden mussten. Ein weiterer Vorteil für die Patientinnen/Patienten ist, dass es keine Urlaubssperre gibt. Durch die Arbeit im Team haben die Ärztinnen/Ärzte die Möglichkeit, komplizierte Fälle zusammen zu besprechen. Darüber hinaus bietet das PHC den Gesundheitsberufen die Möglichkeit, Beruf und Familie besser zu vereinbaren. Am Beispiel des PHC Medizin Mariahilf sieht man, dass die Primärversorgung auch entlastend für Spitalsambulanzen und Fachärzte wirkt. 40 % der PHC Patientinnen/Patienten gaben bei einer Befragung an, dass sie in eine Ambulanz oder zu einem Facharzt/Fachärztin gegangen wären, wenn es das PHC Medizin Mariahilf nicht geben würde.

Wenn man die Primärversorgung neu gestaltet, sollte auch ein neues, anreizoptimiertes Honorierungssystem eingeführt werden. Momentan werden die Leistungen der niedergelassenen Vertragsärztinnen/-ärzte großteils über Einzelleistungen und Fallpauschalen honoriert. Dieses System führt dazu, dass die Ärztinnen/Ärzte versuchen, viele Leistungen bei vielen Patientinnen/Patienten zu erbringen und abzurechnen. Für optimale Behandlungsanreize vorteilhaft, wäre eine Honorierung über Grundpauschalen ergänzt um Performance-Honorierungselemente. So könnte die Qualität und die Outcome-Orientierung gesteigert werden.

(2) Telefon- und webbasierte Erstberatung

Ziel des Projektes „TEWEB“ ist eine standardisierte, telefon- und webbasierte Dringlichkeitseinschätzung von Anliegen der Bürgerinnen/Bürger mit gesundheitlichen oder krankheitsbezogenen Fragen rund um die Uhr zur Verfügung zu stellen, welche die Steuerung von Patientenströmen zum bzw. die Leistungserbringung am „Best Point of Service“ unterstützen soll. Gleichzeitig soll dabei die Gesundheitskompetenz der Bevölkerung gestärkt und eine optimierte Navigation im Gesundheitswesen, durch die Reduzierung von vermeidbaren Behandlungen in intramuralen und extramuralen Versorgungsstrukturen, erreicht werden.

TEWEB wird in der Pilotphase in drei Bundesländern (Niederösterreich, Vorarlberg und Wien) mithilfe eines bundesweit einheitlichen, lizenzbasierten und protokollgestützten Expertensystems implementiert. Gemäß der Kooperationsvereinbarung zwischen Bund, Hauptverband der österreichischen Sozialversicherungsträger und den oben genannten Bundesländern, ist das Land Wien gemeinsam mit den Trägern der gesetzlichen

Krankenversicherung für den dezentralen Betrieb des telefon- und webbasierten Erstkontakt- und Beratungsservice in Wien zuständig.

(3) Eigene Einrichtungen der Sozialversicherungsträger

Die eigenen Einrichtungen der Sozialversicherung stellen einen wichtigen Pfeiler der Patientenversorgung in Wien dar. Hier werden Leistungen angeboten, die andere Gesundheitsanbieter nicht oder nicht in ausreichendem Ausmaß erbringen. Aus diesem Grund betreibt die WGKK den Gesundheitsverbund (Hanusch-Krankenhaus, 5 Gesundheitszentren, 8 Zahngesundheitszentren), der eine sinnvolle Ergänzung zum niedergelassenen Bereich darstellt. Das Leistungsangebot im Gesundheitsverbund ist breit gefächert, bietet wohnortnahe Versorgung auf Spezialistenniveau und stationäre Betreuung im Hanusch-Krankenhaus. Durch Spezialambulanzen, z.B in den Bereichen Rheumatologie, Hämatologie und Augenheilkunde gelingt nicht nur eine Reduktion der Wartezeiten für Patientinnen/Patienten, sondern auch eine Einflussnahme auf die Kosten im Bereich der Heilmittel und Heilbehelfe (z.B. Generikaverordnung).
Darüber hinaus verfügen die Mitarbeiterinnen/Mitarbeiter der eigenen Einrichtungen über wichtiges Wissen – Know-How, das für die Erfüllung des Versorgungsauftrages, für die Planung und für Verhandlungen für die WGKK unerlässlich ist.

Öffentliche Gesundheitseinrichtungen müssen ein Teil der Wiener Versorgungslandschaft bleiben, damit der gesetzliche Versorgungsauftrag der WGKK erfüllt werden kann, insbesondere im Falle eines vertragslosen Zustandes oder Ärztestreiks.

(4) Projekte zur Entlastung der Spitäler

Personen, die in Österreich versichert sind, können frei wählen, wo sie sich behandeln lassen möchten. Häufig landen Personen – auch aufgrund unzureichender Informationen – mitunter auf einer Versorgungsebene, die für sie nicht geeignet ist. Um der Überlastung der Spitalsambulanzen entgegenzuwirken, hat die WGKK in Kooperation mit der Stadt Wien im Rahmen der Gesundheitsreform unter anderem zwei Projekte ins Leben gerufen, die beispielhaft für die Gesundheitsreform dargestellt werden.

KiND-Kindernotdienst

Zur Entlastung der Kinderambulanzen in den Wiener Fondskrankenanstalten wurden im Rahmen der Landeszielsteuerung zwei Kindernotdienst-Ordinationen in Spitalsstrukturen

(AKH sowie KFJ) etabliert, welche an Wochenenden und Feiertagen durch die Ärztefunkdienst GmbH mit Kinderfachärztinnen/-fachärzten besetzt werden.

Dabei soll die Wartezeit für spitalpflichtige Patientinnen/Patienten reduziert werden, in dem die hohe Anzahl an Patientinnen/Patienten mit niedrigem Versorgungsbedarf eine Versorgungsalternative geboten wird. Dabei können sich die Eltern der Patientinnen/Patienten selbst für die Behandlung in der Kindernotdienst-Ordination oder in der jeweiligen Notfallambulanz entscheiden. Eine Zuweisung an die Notfallambulanz durch den Kindernotdienst kann bei akutem Bedarf erfolgen.

AMA-Allgemeinmedizinische Akutversorgung im AKH:

Analog zu den KiND Projekten erfolgt gemeinsam mit der Medizinischen Universität Wien am Allgemeinen Krankenhaus Wien die Pilotierung einer Allgemeinmedizinischen Akutversorgung (AMA). Die Allgemeinmedizinische Akutversorgung soll außerhalb der üblichen Ordinationszeiten sowie an Wochenenden und Feiertagen die Wartezeiten für Patientinnen/Patienten in der Spitalsambulanz reduzieren, indem der hohen Anzahl an Patientinnen/Patienten mit niedrigem Versorgungsbedarf, die die Notfallambulanz frequentieren, eine Versorgungsalternative geboten wird. Analog zum Kindernotdienst können sich die Patientinnen/Patienten sowohl vor der Administration an der Notfallambulanz des AKH für die AMA entscheiden als auch nach erfolgter Triage. Patientinnen/Patienten, bei denen nach erfolgter Begutachtung durch die AMA eine weiterführende, nicht akute fachärztliche Behandlung erforderlich ist, werden einer niedergelassenen Fachärztin/einem niedergelassenen Facharzt zugewiesen. Eine Zuweisung an die Notfallambulanz durch die AMA kann bei akutem Bedarf analog zum Kindernotdienst erfolgen. Die Betriebszeit des Pilotprojektes sind Werktags von 16:00 Uhr bis 22:00 Uhr sowie Samstag, Sonntag und Feiertags zw. 10:00 Uhr und 22:00 Uhr.

(5) Ausgeglichene Risikostruktur und Finanzbasis

Um eine drohende Insolvenz der Versicherungsanstalt öffentlich Bediensteter (BVA) abzuwenden, wurde im Zuge der gesetzlichen Änderung der Versicherungszuständigkeit für Vertragsbedienstete ab 1999 Versicherungsverhältnisse von den Gebietskrankenkassen an die BVA sowie div. Krankenfürsorgeanstalten (KFAs) übertragen. Als erster Schritt erfolgte im Jahr 1999 die Eingliederung der neuen Vertragsbediensteten des Bundes in die BVA, im Jahr 2001 wurden die neuen Vertragsbediensteten der Länder und Gemeinden übertragen und 2004 erfolgte die Eingliederung der kündbaren Bediensteten der BVA und der

Dienstnehmerinnen und -nehmer der Universitäten. Dabei handelte es sich um gute Risiken mit entsprechenden Beitragsgrundlagen. Für das Jahr 2015 lässt sich im Vergleich zu 1998 bei der BVA ein Zuwachs des Versichertenstandes von rund 114.600 berechnen, bei den KFAs lt. Berechnungen des Hauptverbandes von rund 29.650. Dementsprechend haben sich dort die Beitragseinnahmen entwickelt. Nach den Berechnungen des Hauptverbandes kann davon ausgegangen werden, dass in dieser Versichertengruppe je Versichertem die Beitragseinnahmen den Leistungsaufwand jährlich um mindestens € 500 übersteigen, woraus sich bei der BVA für das Jahr 2015 Mehreinnahmen von € 57,300.000,00 und bei den KFAs Mehreinnahmen von rund € 14,820.000,00 errechnen. Dies zu Lasten der Gebietskrankenkassen.

In dem mit BGBl I 10/1999 mit Wirksamkeit ab 1.1.1999 in Kraft getretenen § 447i ASVG war dafür ein durch Verordnung des Sozialministeriums nach Bericht des Hauptverbandes festzusetzender Ausgleich vorgesehen. Durch BGBl I 99/2001 wurde diese Bestimmung allerdings mit 31.7.2001 aufgehoben. In den erläuternden Bemerkungen zur Regierungsvorlage wird dies damit begründet, „dass der für die Ermittlung der einschlägigen Werte erforderliche Verwaltungsaufwand in keinem Verhältnis zu deren Aussagekraft“ stünde. Dies umso mehr, als der Veränderung der Versicherungszuständigkeit für die "neuen" Vertragsbediensteten eine Vielzahl von Ausgliederungen von Einrichtungen aus dem Bundesbereich gegenüberstünde, durch die sich ebenfalls laufend Veränderungen in der Versicherungszuständigkeit ergäben, und zwar "in umgekehrter Richtung" (weg von der Versicherungsanstalt öffentlich Bediensteter hin zu den Gebietskrankenkassen). Ausgleichszahlungen in nur eine Richtung wären daher nicht zielführend. Dazu ist allerdings keine zahlenmäßige Erhebung oder Evaluierung der Versichertenströme bekannt geworden.

Aus Sicht der WGKK ist daher die Forderung nach einem entsprechenden finanziellen Ausgleich auch aus diesem Grund zu erheben. Alternativ käme natürlich die Rückübertragung der betroffenen Versicherungsverhältnisse auf die jeweilige, örtlich zuständige GKK in Betracht.

(6) Harmonisierung von Leistungsunterschieden

Neben der Gesundheitsreform gibt es auch Bestrebungen und Maßnahmen der Selbstverwaltung, die in Relation zu den Gesamtleistungen geringfügigen Leistungsunterschiede zwischen den Krankenversicherungsträgern zu harmonisieren. Dabei werden Leistungen der Krankenversicherung auf bestehende Unterschiede hin analysiert. Bei Leistungsangleichungen ist nicht nur die Preiskomponente (z.B. Erhöhung des Kostenzuschusses) sondern auch die Mengenkomponente zu berücksichtigen. Vor allem

aus Sicht der WGKK können sich bei Leistungserhöhungen teilweise beträchtliche Erhöhung der Gesamtausgaben ergeben, da in Wien in vielen Fällen deutlich mehr Versicherte eine Leistung in Anspruch nehmen als in ländlichen Bundesländern. Das liegt nicht nur an der größeren Bevölkerung sondern auch an der Verfügbarkeit und der einfacheren Möglichkeit zur Inanspruchnahme. Für Angleichungen der Leistungen ist daher eine ausgeglichene Finanzierungsbasis zwischen den Trägern eine notwendige Voraussetzung. Diese kann nur durch eine ausgeglichene Risikostruktur oder einem finanziellen Ausgleich unterschiedlicher Risikostrukturen bewirkt werden.

4.) Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

(1) Alternative Leistungserbringung statt eines Verhandlungsmonopols der Ärztekammer

Die Ärztekammer hat bei Verhandlungen aufgrund der aktuellen gesetzlichen Lage und Vertragssituation die Möglichkeit, neue, alternative Versorgungsformen zu blockieren und auch zeitgemäße Honorierungsformen zu verhindern. Und das obwohl der Versorgungsauftrag und damit die Verantwortung für die Versorgung der Bevölkerung den gesetzlichen Krankenversicherungsträgern obliegt.

(2) Wettbewerb zwischen Leistungsanbietern

Die Ärztekammer hat die Möglichkeit andere Leistungsanbieter als freiberufliche Ärztinnen/Ärzte (z.B. neue selbstständige Ambulatorien oder Eigene Einrichtungen der Sozialversicherungsträger) in ihrer Gründung zeitlich zu behindern und so de-facto als alternative Leistungsanbieter zu verhindern. Da sich für die Umsetzung des Versorgungsauftrages für die Krankenversicherung kaum faktische Alternativen als Leistungserbringer anbieten, ist ein Wettbewerb zwischen den Gesundheitsanbietern so gut wie nicht gegeben. Die Ärztekammer nimmt eine Monopolstellung bei der Leistungserbringung ein. Daraus es ergibt sich in der Praxis bei der Erfüllung des Versorgungsauftrages durch die Krankenversicherung eine Abhängigkeit von der Ärztekammer.

(3) Leistungen von Vertragsärztinnen/-ärzten zur Erfüllung des Versorgungsauftrages durch die Krankenversicherungsträger dürfen nicht von der Zustimmung der Ärztekammer abhängig sein.

Ein Beispiel von vielen: Generell längere Öffnungszeiten von Vertragsärztinnen/-ärzten, vor allem zu Tagesrandzeiten, müssen mit der Ärztekammer verhandelt werden (Gesamtvertrag) – ebenso wie sämtliche anderen Leistungen von Vertragsärztinnen/-ärzten – und sind daher nur mit Zustimmung der Ärztekammer möglich. Bis dato ist es in den Vertragsverhandlungen nicht gelungen längere Öffnungszeiten gesamtvertraglich einvernehmlich mit der Ärztekammer zu regeln. Aktuell betragen in Wien die generellen vertraglichen Mindestöffnungszeiten der Vertragsärztinnen/-ärzte daher lediglich 20 Stunden pro Woche. Ausnahmen in Einzelfällen sind nur auf ausdrücklichen Willen einer Ärztin/eines Arztes möglich.

(4) Pauschales Honorierungssystem

Gerade durch eine Honorierungsform anhand von Pauschalen und pay-for-performance Elementen ergeben sich viele Vorteile in der Versorgung aber auch für Ärztinnen/Ärzte. Diese bekämen die oft geforderte Gesprächsleistung mit ihren Patientinnen/Patienten frequenzunabhängig und damit entgegen einer stressigen Massenabfertigung abgegolten und hätten fixe und geregelte Einkommenskomponenten.

Zusätzlich könnten pauschale Kostenerstattungsmöglichkeiten bei der Inanspruchnahme von Wahlärztinnen/-ärzten Vorteile in der Verwaltung bringen. Aktuell müssen sämtliche bei den Versicherungsträgern eingereichte Rechnungen kontrolliert und die Kostenerstattung einzeln berechnet werden. Bei einer pauschalen Vergütung je Inanspruchnahme einer Wahlärztin/eines Wahlarztes würden sich beträchtliche Effizienzsteigerungsmöglichkeiten in der Verwaltung ergeben.

(5) Unabhängige Qualität und Ausbildung

Aktuell erfolgt die Qualitätssicherung der Ärztinnen/Ärzte durch die in der Ärztekammer eingerichteten ÖQMed. Das heißt, die Ärztekammer kontrolliert die Qualität ihrer eigenen Mitglieder, was in Folge zu einem Interessenskonflikt führt. Benötigt werden transparente und verbindliche Qualitätsvorgaben und eine öffentliche, unabhängige Institution, die die Einhaltung kontrolliert.

Die Ärztekammer hat darüber hinaus systembestimmenden Einfluss auf die Ausbildung von Ärztinnen/Ärzte. Im Rahmen der Ausbildung ist die Ärztekammer für die Ausbildungsinhalte von Lehrpraktikantinnen/-praktikanten, den Lehrkatalog für Ausbildungsstellen, für Lehrbücher, Eignungsprüfungen und einiges mehr verantwortlich. Dadurch ergibt sich für die Ärztekammer ein bestimmender Einfluss bereits auf die Anzahl und Qualität der Ärztinnen/Ärzte, die den Versicherungsträgern als Vertragsärztinnen/-ärzte überhaupt zur Erfüllung des Versorgungsauftrages zur Verfügung stehen.

(6) Verträge mit allen Kassen statt gewinnorientierter Selektion

Obwohl kein Wettbewerb zwischen für die Krankenversicherung alternativen Leistungserbringer gegeben ist, besteht teilweise ein Wettbewerb zwischen den Versicherungsträgern über einzelne Vertragsärztinnen/Ärzte. Dies hat zu dem versorgungspolitisch ungewünschten Effekt geführt, dass Vertragsärztinnen/Ärzte – aufgrund privater bzw. ökonomischer Interessen – Kassenverträge mit Sonderversicherungsträgern (z.B. BVA, SVA, KFA) und keine Verträge mit größeren regionalen Gebietskrankenkassen abschließen. Darüber hinaus kommt es von Ärztinnen/Ärzte zu Kündigungen der GKK-Einzelverträge, um nur noch die Versicherten der Sonderversicherungsträger zu betreuen. Hintergrund ist, dass Sonderversicherungsträger teilweise, aufgrund der kleineren Versichertengruppen, der günstigeren Risikostruktur und der dadurch resultierenden besseren Finanzsituation ein höheres Honorar bezahlen.

(7) Bedarfsplanung, Stellenplan und Umsetzung der Planung durch zuständige Krankenversicherungsträger

Die Stellenplanung erfolgt auf Basis des Gesamtvertrags, der mit der örtlich zuständigen Ärztekammer zu verhandeln ist. In manchen Bundesländern ist dieser, ortsdetailliert und nach Fachgruppen aufgegliedert, konkret bestimmt. In Wien besteht der gesamtvertragliche Stellenplan aus zwei Gesamtzahlen - einer für Allgemeinmedizin und einer für Fachärztinnen/-ärzte. Von diesen beiden Gesamtzahlen sind auch die Gruppenpraxenanteile (Stellen für Gesellschafter) umfasst. Innerhalb dieser Gesamtzahl können Kassenstellen über Wien versorgungspolitisch sinnvoll verteilt werden – als Einzelverträge oder Gruppenpraxenstellen – jedoch nur einvernehmlich mit der Ärztekammer

Die Bedarfsplanung für die (Neu-)Ausschreibung von Kassenstellen erfolgt gemeinsam zwischen WGKK und Ärztekammer. Der Stellenplan ist hierfür zwingend zu berücksichtigen.

Am Beispiel Wien erfolgen die Beschlüsse daher innerhalb der festgelegten Gesamtzahlen. Wird eine Stelle frei, wird entschieden, ob diese Stelle am Ort der bisherigen Ordination oder an einer anderen Stelle als Einzelpraxis ausgeschrieben oder ob sie als Gruppenpraxenanteil verwendet wird. Bei Facharztstellen kann die Stelle auch für ein anderes Fachgebiet verwendet werden, wenn dies aus versorgungspolitischen Gründen zweckmäßiger ist.

Seitens der Ärztekammer wird oftmals versucht, Einzelstellen am bisherigen Ort wieder auszuschreiben. Seitens der WGKK wird hingegen angestrebt, vermehrt Gruppenpraxen zu etablieren bzw. bestehende Gruppenpraxen zu erweitern und Stellen in weniger dicht versorgten Gebieten auszuschreiben. Die Beschlüsse, wo und in welcher Art eine Stelle ausgeschrieben wird und somit die Umsetzung der Bedarfsplanung zur Erfüllung des Versorgungsauftrages, hat im derzeitigen System gemeinsam mit der Ärztekammer zu erfolgen.

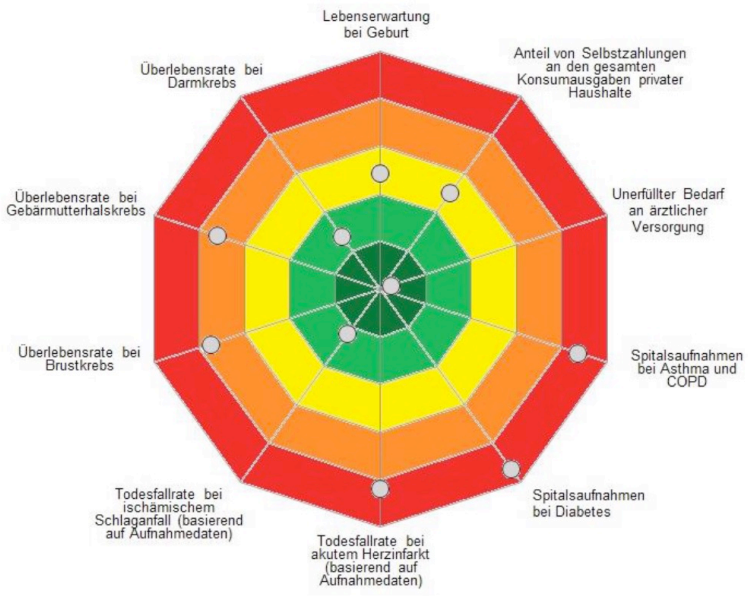
Fragen zur Diskussionsrunde über das österreichische Sozialversicherungssystem

1. Was sind Ihrer Einschätzung nach die Prioritäten im Gesundheitswesen und bei der Primärversorgung in Österreich?

Priorität 1: Die Effizienz des Systems muss verbessert werden
Die Ergebnisse im System entsprechen nicht den hohen Ressourcen, die in das System fließen, siehe etwa den Vergleich der Erwartung gesunder Lebensjahre mit dem hohen Ressourceneinsatz im System.
Laut Daten der Statistik Austria gaben 2014 Staat und Sozialversicherungsträger in Österreich 25,64 Mrd. Euro für die Gesundheit aus, das sind um 873 Mio. Euro bzw. 3,4% mehr als 2013. Die Gesundheitsausgaben insgesamt stiegen zwischen 1990 und 2014 im Schnitt um 5% pro Jahr. Die öffentlichen Gesundheitsausgaben stiegen in diesem Zeitraum von 8,4 auf 11% des Brutto-Inlands-Produkts. Diesen hohen Ausgaben stehen mittelmäßige Ergebnisse gegenüber siehe etwa die Ergebnisse des Euro Health Consumer Index (EHCI) von Health Consumer Powerhouse Ltd.
Hier ist Österreich in den letzten Jahren vom Platz 1 (2007) auf Platz 12 (2015) zurückgefallen.
Außerdem liegt Österreich bei der mittleren Anzahl der zu erwartenden Lebensjahre in Gesundheit international im Mittelfeld.

Wir können uns nur den Ergebnissen von „Gesundheit auf einen Blick 2015 – Wo steht Österreich?“ der OECD anschließen, wo es heißt: „Ein leichter Zugang zur Gesundheitsversorgung ist gewährleistet…“. Ein freier Zugang auf allen Versorgungsebenen bedeutet allerdings nicht automatisch die beste Versorgungsqualität für Patientinnen und Patienten. Denn „…bei der Versorgungsqualität ergibt sich ein gemischtes Bild“ (OECD, „Gesundheit auf einen Blick 2015 – Wo steht Österreich?“):

Wo steht Österreich bei ausgewählten Indikatoren zu Gesundheitszustand, Zugang zur Gesundheitsversorgung und Versorgungsqualität (2013 oder letztes Jahr)



Anmerkung: Je näher sich die jeweiligen Punkte in der Mitte befinden, desto besser schneidet das Land ab. Länder im innersten Kreis sind im obersten Quintil der OECD-Staaten, Länder im äußersten Kreis im untersten Quintil.

Quelle: OECD Gesundheit auf einen Blick 2015 (Grafikdesign: Laboratorio MeS).

Priorität 2: Patientenorientierter Ausbau der Primärversorgung
Diese Schieflage ergibt sich u.a. aus der Kompetenzverteilung die zu ineffizienten Strukturen führen:
Die Verantwortung für Finanzierung und Ausgaben von Bund, Ländern und Gemeinden liegen nicht in derselben Hand (Vorschläge siehe unter Frage 2)

Österreich hat OECD-weit die höchste Zahl an Spitalsentlassungen pro Jahr. Daher gilt es die ambulante Versorgung auszubauen, was insb. durch die Errichtung von Primärversorgungseinheiten zu erreichen ist. Zentrale Punkte bei der Ausgestaltung der Primärversorgung sind: verlängerte Öffnungszeiten, Multidisziplinarität und Zusammenarbeit der beteiligten Berufsgruppen auf Augenhöhe.

Die Niederlande hatten beim European Health Consumer Index (EHCI) immer einen Spitzenplatz; die Begründung dafür sieht EHCI ua darin, dass in den letzten Jahren etwa 160 Primary Health Care Einheiten eingerichtet wurden, die 24 h und 7 Tage die Woche geöffnet haben. Diese Art der Versorgung kommt generell den Patienten und speziell der arbeitenden Bevölkerung zugute, hier ist ein Ausbau dringend notwendig.
Die Gestaltung von Primärversorgungsmodellen muss patienten- und nicht institutionenorientiert unter absoluter **Gleichbehandlung aller Anbieter** sein – im Sinne der besten Versorgung der Patienten muss ein umfassender Ansatz gewählt werden: Etwa müssen Gruppenpraxen und selbständige Ambulatorien gleichbehandelt werden.

2. Gibt es bestimmte wichtige Prioritäten im Gesundheitswesen, die momentan nicht oder nicht im ausreichendem Ausmaß im österreichischen Gesundheitssystem enthalten oder implementiert sind?

Mangelnde Primärversorung siehe unter Frage 1)

Finanzierung aus einem Topf

Die Kompetenzverteilung im Gesundheitsbereich ist stark zersplittert (s. oben): Der Bund ist für die Grundsatzgesetzgebung zuständig. Sowohl Ausführungsgesetzgebung, Vollziehung, Eigentümerschaft und Finanzierung liegen mittel- oder unmittelbar im Einflussbereich der Bundesländer.
Die Bundesregierung kann den Trägern der Krankenanstalten keine verbindlichen Weisungen geben und es gibt daher keine gesamtösterreichische Planung und Steuerung des Versorgungsbedarfs.
Daher kommt es zu umfangreichen Mittelverschiebungen zwischen Gebietskörperschaften, Sozialversicherung, Trägern der Krankenanstalten, Patienten, Landesgesundheitsfonds etc.
Die Komplexität der Finanzierungsströme führt zu Intransparenz und Ineffizienzen und sollte behoben werden.
Um Ineffizienzen entgegenzuwirken sollte das langfristige Ziel die Finanzierung des Gesundheitssystems aus einem Topf sein.

E-Health

Der Einsatz von Informations- und Kommunikationstechnologie ist einer der Hebel, um die im Gesundheitssystem dringend erforderlichen Kostendämpfungen umzusetzen.
Es besteht Reformpotential durch umfassenderen Einsatz moderner Technologien, z.B. in Form von Telemedizin, also Diagnostik und Therapie unter Überbrückung einer räumlichen oder auch zeitlichen Distanz zwischen Arzt/Therapeut und Patienten mittels Telekommunikation. Die Effizienz der Behandlung wird gesteigert, die Behandlungsqualität für Versicherte verbessert und die Kosten reduziert.
BSP: Telerehabilitationsprojekte. Statt stationärer Rehabilitation kann bei gewissen Indikationen auch die Rehabilitation von Zuhause aus unter ärztlicher Aufsicht betrieben werden; etwa nach koronaren Herzerkrankungen ein Training zu Hause am Ergometer, statt in der Reha-Einrichtung. Das spart Kosten und, wie erste Erfahrungen ergeben und geht auch teilweise mit besseren Ergebnissen der Rehabilitation einher.

Um diese Einsparungen auch tatsächlich zu erzielen und Effizienzpotentiale zu heben ist E-Health mit all seinen Aspekten ohne weiteren Verzug umzusetzen, auch über ELGA hinaus. Die Innovations-, Finanz- und Umsetzungskraft der Wirtschaft ist dabei tunlichst zu nutzen.

Unter dem Begriff **Active & Assisted Living** werden Konzepte, Produkte und Dienstleistungen subsummiert, die neue Technologien und soziales Umfeld miteinander verbinden mit dem Ziel, die Lebensqualität für Menschen in allen Lebensabschnitten, vor allem im Alter, zu erhöhen. Solche Lösungen können helfen, die Kostensteigerung im Gesundheitswesen zu senken. Pilotprojekte sollten daher unterstützt werden.

Weg von der Reparaturmedizin hin zu mehr Prävention

Der forcierte Einsatz präventiver Maßnahmen im österreichischen Gesundheitssystem, wie z.B. Gesundheitsprogramme mit Bewegungsschwerpunkten, birgt laut IHS-Studie aus dem Jahr 2004 ein enormes Einsparungspotential von 3,6 Mrd. Euro bzw. 1,7% des BIP. (http://www.ots.at/presseaussendung/OTS_20040630_OTS0120/noegkk-hutter-ihs-studie-bestaetigt-den-weg-der-praevention)

Die Österreicher weisen im internationalen Vergleich ein sehr schlechtes Risikoverhalten auf:
- 2013 rauchten 23,2% der Bevölkerung (OECD 2015).
- Gesundheitsbefragung 2014: 1,76 Mio. Österreicher **ab 15 Jahren** rauchen täglich - 134.000 Personen mehr als bei der letzten Befragung!
- Der Anteil der Fettleibigkeit stieg seit 1991 von 8,5% auf 12,4% = Steigerung von 50%.
- 5% der Österreicher **ab dem 16. Geburtstag** sind als chronische Alkoholiker zu qualifizieren = 350.000 Personen.

Ein wichtiger Bestandteil von Vorsorge ist allerdings ein gesunder Lebensstil.
Die Eigenverantwortung der Bevölkerung muss durch Anreize für ein gesünderes Leben gestärkt werden. Jeder ist dafür selber verantwortlich. Beim Erlernen von Eigenverantwortung beim Lebensstil unterstützen können Anreizsysteme, die in Österreich bisher nur sehr vereinzelt angewendet werden.
So könnte man die Vereinbarung konkreter, individueller **Gesundheitsziele** andenken (etwa Gewichtsverlust, Reduktion des Tabakkonsums, weniger Alkohol, mehr Bewegung…). Bei Erreichung könnte ein Teil des Beitrags zur Krankenversicherung in Form eines Gutscheins erstattet werden.
Die Stärkung der Eigenverantwortung geht schließlich auch mit einem **steigenden Kostenbewusstsein der Patienten** einher (siehe unter Frage 4.)

Chronische Erkrankungen als Herausforderung

Generell muss im System mehr Fokus auf **chronische Erkrankungen** gelegt werden, die in den letzten Jahren massiv zugenommen haben. Nach dem Muster des umfassenden Betreuungsprogrammes für Diabetiker „Therapie aktiv“ sollten entsprechende Programme für weitere Indikationen geschaffen werden.

Bundesweit einheitlicher Wert je LKF-Punkt für alle Krankenanstalten

In Österreich liegt jeder medizinischen Indikation ein sogenannter LKF-Punktewert (LKF: Leistungsorientierte Krankenanstaltenfinanzierung) zu Grunde. Allerdings gibt es Unterschiede in der Bewertung – je nachdem, ob die Leistung von einer öffentlichen oder privaten Krankenanstalt erbracht wird. Da das LKF-System durch unterschiedliche Bepunktung der Leistungen ohnehin eine Differenzierung auf Basis der variablen Kosten vornimmt, ist die unterschiedliche Gestaltung der LKF-Punktewerte diskriminierend und eine Vereinheitlichung anzustreben. Eine Weiterentwicklung des prinzipiell ökonomisch sinnvollen LKF-Systems würde vor allem zu mehr Transparenz führen.

3. Welche Bereiche, falls zutreffend, bedürfen weiterer Aufmerksamkeit im jetzigen österreichischen Sozialversicherungssystem und weshalb?

Das österreichische Sozialversicherungssystem ist gekennzeichnet durch eine große Anzahl an Sozialversicherungsträgern. Dieses System gilt es zu analysieren, weil anzunehmen ist, dass größere Einheiten Effizienzvorteile gegenüber kleineren aufweisen. Überdies wäre im österreichischen System eine Wettbewerbssituation zwischen den Trägern wünschenswert, weil damit mehr Kostenbewusstsein und im Ergebnis eine Effizienzsteigerung verbunden wäre.

Die bestehende Autonomie der Träger führt dazu, dass sich im Laufe der Zeit unterschiedliche Leistungen für die Versicherten entwickeln konnte. Diese Unterschiede bei gleichen Beitragsleistungen sind für die Versicherten nicht nachvollziehbar und stoßen immer wieder auf Unverständnis. Die je nach Träger unterschiedlichen Leistungen erschweren aber auch eine Vergleichbarkeit der Träger untereinander. Eine zentrale Steuerung wäre hier von Vorteil. Im Weiteren sollte die Aufmerksamkeit auf die unterschiedlichen Honorarordnungen gerichtet sein.

Massiver Handlungsbedarf ist bei den Verwaltungskosten zu erkennen. Zu Beginn stellt sich die Frage nach der Höhe der tatsächlichen Verwaltungskosten. In der politischen Diskussion wird die Berechnung immer wieder in Frage gestellt, so dass hier ein dringender Klärungsbedarf besteht.

Für eine fundierte Analyse der Verwaltungskosten ist es erforderlich, dass die Kosten transparent und betriebswirtschaftlichen Grundsätzen entsprechend öffentlich dargestellt werden. Dies ist leider nicht immer und nicht im nötigen Detailgrad der Fall. Auch bestehen wiederum Unterschiede von Träger zu Träger. Abschließend wäre zu prüfen, wie das Kostenbewusstsein der Träger gesteigert werden könnte. Eine Ursache könnte im mangelnden Wettbewerb und in der mangelnden Vergleichbarkeit der Träger und Leistungen untereinander gesehen werden.

Ein großer Faktor der Verwaltungskosten liegt in den Personalkosten. Dazu ist zu bemerken, dass der Personalstand in den Sozialversicherungsträgern laufend ansteigt. Dies lässt den Schluss zu, dass der Bereich Personal Einsparungspotential birgt.

Was den Risikostrukturausgleich betrifft, so sollten die Ausgleichszahlungen nur strukturelle Nachteile entschädigen, nicht aber eine schlechte Gebarung.

Weiterer Handlungsbedarf besteht im Bereich der Lohnnebenkosten. Eine Lohnnebenkostensenkung ist zur Sicherung des Standorts dringend erforderlich.

4. Wie könnten die Standards der Leistungserbringung, die Effizienz und Effektivität in dem jetzigen österreichischen Sozialversicherungssystem weiter verbessert werden?

Die Wirtschaftskammer tritt dafür ein, dass Maßnahmen zur Effizienzsteigerungen getroffen werden, um Maßnahmen für die Versicherten weiter zu verbessern und voranzutreiben. Keinesfalls jedoch dürfen diese Maßnahme auf dem Rücken der Betriebe ausgetragen werden.

Zur Verbesserung der Effizienz kommen, abseits von einer Neugestaltung der Trägerstruktur, eine Reihe von Maßnahmen in Frage. Auch innerhalb des Systems der Pflichtversicherung ist eine Effizienzsteigerung möglich, ein Wettbewerb innerhalb des Systems könnte sinnvoll sein.

Es ist davon auszugehen, dass die derzeitigen Zielsteuerungsprozesse Verbesserungspotential aufweisen. Es ist daher zu hinterfragen, ob das derzeitige System der Zielsteuerung eine wirksame Steuerung und Reduktion der Verwaltungskosten gewährleisten kann. Konkrete Einsparungsziele sind zu verfolgen und umzusetzen.

Um das Ziel der Reduktion der Verwaltungskosten zu erreichen, wäre die Einführung von einheitlichen Kennzahlen in Kombination mit einem wirksamen Kontrollsystem für alle Sozialversicherungsträger ein wesentlicher Schritt. Erst ein System von einheitlichen Kennzahlen ermöglicht die Festlegung von Zielen, deren genaue Planung und Umsetzung wie auch die abschließende Analyse. Ein einheitliches System würde auch die objektive Vergleichbarkeit zwischen den einzelnen Trägern ermöglichen und für eine erhöhte Transparenz sorgen.

Erhöhung der Transparenz: Sämtliche Informationen der Sozialversicherungsträger sollten auf Basis einheitlicher Vorschriften veröffentlicht werden.

Was das Personal der Sozialversicherungsträger betrifft, so bedarf es einer Analyse, inwiefern Unterschiede im Vergleich zur Privatwirtschaft und zum öffentlichen Dienst bestehen. Es wäre zu hinterfragen, ob eine Sonderstellung in Hinblick auf vergleichbare Positionen in der Privatwirtschaft gerechtfertigt ist. Hauptaugenmerk sollte dabei auf den Pensionen, auf einer Modernisierung des Dienstrechts wie auch auf der Gehaltsstruktur liegen.

Weiteres Optimierungspotential ist in den derzeitigen Verwaltungsabläufen zu erkennen. Auch der Bereich IT, Back-Office und Beschaffung beinhaltet Raum für Einsparungen.

Beitragseinhebung: Im Gegensatz zu einer stetigen Ausweitung der Aufgaben der Gebietskrankenkassen wären Entbürokratisierungsmaßnahmen und Entlastungen für Unternehmer dringend zu empfehlen. Eine Möglichkeit wäre die Einhebung von Steuern und Abgaben durch eine Stelle, vorzugsweise durch die Finanzverwaltung. Damit in Zusammenhang steht die Forderung nach einer Vereinheitlichung des Verfahrensrechts für Sozialversicherungsbeiträge und Steuern.

Erhöhung des Kostenbewusstseins des Versicherten: Das derzeitige System führt in manchen Bereichen dazu, dass der Versicherte sich nicht der tatsächlichen Kosten der in Anspruch genommen Leistungen bewusst ist. Die Inanspruchnahme der Leistungen wird als selbstverständlich angesehen. Selbstbehalte können zu einer bewussteren Inanspruchnahme von Leistungen führen und einen kostendämpfenden Effekt aufweisen. Es bedarf daher einer Analyse der bestehenden Zuzahlungen über alle Träger hinweg. Im Anschluss sind die besten Lösungen umzusetzen.

Einheitlicher Leistungskatalog: Zu begrüßen wäre ein einheitlicher Leistungskatalog für alle Versicherten. Ein einheitlicher Leistungskatalog sorgt für eine konkrete Vergleichbarkeit der Leistungen. Überdies könnte damit sowohl eine gezielte Steuerbarkeit der Leistungen wie auch der Kosten ermöglicht werden.

Der Betrieb von eigenen Einrichtungen ist zu hinterfragen und einer eingehenden Analyse zu unterziehen. Anstelle des Betriebs von eigenen Einrichtungen der Sozialversicherungsträger ist die Leistungserbringung durch Private zu bevorzugen. Eine Alternative sind Private-Public-Partnership-Modelle, wie sie seitens der SVA betrieben werden.

Was die Trägerstruktur betrifft, so ist eine Analyse von neuen Modellen zu empfehlen. Die Interessen der Versicherten und die Qualität der Leistungen stehen dabei an oberster Stelle, zusätzlich muss die Effizienz der Verwaltung gewährleistet sein.

Eine Erhöhung der Dienstgeberquote in den Organen der Sozialversicherung könnte einen entscheidenden Impuls zu einem höheren Kostenbewusstsein liefern.

Österreichische Zahnärztekammer

Sehr geehrte [Name wurde entfernt],

Wie gewünscht darf ich Ihnen die Antwort der Österreichischen Zahnärztekammer zu den 4 von Ihnen gestellten Fragen übermitteln:

1 Die wichtigsten Prioritäten im Gesundheitswesen in Österreich liegen aus unser Sicht in der Qualität, in der leichten Zugänglichkeit für die Patienten und in der Kosteneffizienz, wobei wir die Qualität in erster Linie durch eine entsprechend qualitätsvolle Ausbildung der Gesundheitsberufe erfüllt sehen. Unter leichter Zugänglichkeit verstehen wir einerseits die regionale Verteilung von Gesundheitsberufen und die Funktion von Allgemeinmedizinern und Zahnärzten als Erstanlaufstelle für Patienten. Bezüglich der Kosteneffizienz sollte darauf geachtet werden, dass alle Leistungen, die im niedergelassenen Bereich kostengünstiger erbracht werden können, auch dort erbracht werden sollten.

2 Im Prinzip ist das österreichische Gesundheitssystem in der Lage, alle Leistungen zu erbringen, die auf der einen Seite notwendig sind und die auf der anderen Seite auch in anderen vergleichbaren ausländischen System erbracht werden. Diesbezüglich kommt es allenfalls dann zu Problemen, wenn die notwendigen finanziellen Ressourcen nicht gewährleistet sind.

3 Im Bereich der Zahnheilkunde ist es über die Jahre – immerhin stammt der zahnärztliche Gesamtvertrag in weiten Teilen noch aus den 1950er Jahren – dazu gekommen, dass immer größere Teile der modernen Zahnmedizin vom Sozialversicherungsbereich nicht mehr abgedeckt werden. Dies hat dazu geführt, dass im Bereich der Zahnmedizin nur mehr ca. 45% der Gesamtausgaben von der Sozialversicherung geleistet werden. Falls politisch gewünscht ist, diese Entwicklung wieder umzudrehen, sind daher finanzielle Zusatzleistungen hier unumgänglich.

4 Gerade die Zahnheilkunde könnte hier als „role model“ dienen, existieren doch in diesem Bereich ein Österreich weit gültiger Gesamtvertrag und Österreich weit einheitliche Honorartarife. Ähnliches sollte auch bei den anderen Gesundheitsberufen wohl möglich sein. Dieses Beispiel zeigt auch, dass es nicht unbedingt notwendig ist, Sozialversicherungsträger zusammenzulegen oder zu zentralisieren, bei entsprechender Vertragslage ist es auch durchaus möglich, dass auch verschiedene Krankenkassen die gleichen Leistungen für ihre Patienten anbieten können.

Mit freundlichen Grüßen

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Review of Austria's Social Insurance and Healthcare System

Volume 4 – Situational Analysis

Contrast E&Y disclaimer

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Table of Contents

Tables

Figures

1 Introduction

1.1 Review brief

The London School of Economics and Political Science (LSE Health) in collaboration with Contrast Ernst&Young, and the University of Salzburg, have been engaged by the Austrian Ministry of Labour, Social Affairs and Consumer Protection to undertake a study on efficiency potential regarding the Austrian social insurance system.

A four-step methodology has been employed to complete this review, which includes: a) situational analysis (overview of Austria's current social insurance system); b) legal analysis; c) roundtable stakeholder discussions; d) and, a final report outlining a range of policy options for the Austrian social insurance sector.

The situational analysis was led by Contrast E&Y and represents volume 2 within the efficiency review of Austria's social insurance system. The purpose of the situational analysis report was to map out the current healthcare system within Austria in order to identify weaknesses and potential efficiency potentials within the Austrian social insurance system.

1.2 Methodology

In the attempt to review the status-quo of the Austrian Social Security System in a comprehensive manner, various data research methods were utilised, including primary and secondary research: More specifically, primary research methods were applied only in case desk-research did not generate the required depth or breadth of insights, or if the secondary research methods led to inconsistent or contradictory findings, or in case a follow-up analysis which focused on specific topics was essential.

The main sources of information with respect to the situational analysis were: (1) publications and scientific reviews from relevant journals (e.g. HIT, health in transition; or the IHS, i.e. institute for advanced studies), (2) data published by the social insurance carriers, including articles from the HVSV (most of the statistical data was provided by the HVSV), (3) data published by organizations or governmental institutions, such as the GÖG GmbH, the BMGF, the Austrian Chamber of Labour, and the BMASK. Apart from published material, "grey literature" (such as internal working papers, etc.) was also included in the

situational analysis, which was mainly provided by the HVSV and the other aforementioned institutions and organisations.

The primary research was conducted in form of informal expert-interviews and group discussions, which for example involved interviewing experts at the GÖG, and the social insurance carriers, as well as the HVSV. By doing so, a comprehensive assessment of the current situation of the Austrian Social Security System was aimed at.

Consequently, all information and data included in this study originate from sources considered as reliable and trustworthy at the time of creation by the authors. It was taken utmost care to ensure that all underlying data and facts are complete and accurate. Although this situational analysis was undertaken with utmost care, the authors assume no liability for completeness. This report was drafted to serve as solid information basis to conceptualize the policy recommendations, by consolidating data, which resulted from secondary research (publically available data), grey literature (unpublished material, provided by the various stakeholders) and primary research (e.g. interviews and group discussions with the stakeholders involved).

2 Governance and structure

2.1 Self-governance within the Austrian social insurance system[1]

The Austrian social security system is based on the principles of self-governance, which means that the federal state transfers administrative tasks to a certain group of people who have special interest in these tasks[2]. In Austria, this group of people then sends volunteer employee- and employer-representatives, who form self-governing bodies, which manage those administrative tasks. Regarding the carrier for the self-employed, the self-governing bodies are only represented by the self-employed. With respect to the carriers for the employed, the self-governing bodies are represented by both, the employees as well as employers, even though the employers are not covered by the carrier's insurance. They are delegated for five years and do not receive a salary, yet they receive an attendance-fee per meeting day; only chairpeople and their subsidiaries are entitled to an allowance for fulfilling this function (Funktionsgebühr). This joint responsibility of both groups (i.e. employer and employee) ensures a social balance of interests and guarantees that decisions are made and structures are carried equally by both parties. In case of the Austrian social security, the self-governance is responsible for representation of interests and implementation of the law.[3]

2.1.1 Organisation and structure of the health administration

Most of the matters relating to healthcare are the responsibility of the federal state. Yet, the healthcare administration is mostly taken on by the Länder, by means of direct respectively indirect federal administration, or transferred to self-governing social security carriers. However, the federal state carries great responsibility with respect to healthcare, taking in the role of supervisory authority, implementing laws, or in matters of education. Due to self-governance, insured people are indirectly involved in the social security system.

2.1.2 Organisation and structure of the social security system

The Austrian social security is divided into three areas: Health, pension and accident insurance. It is organised as compulsory insurance, ensuring medical care for everyone in case of illness. In addition, it takes care of work accidents and motherhood and provides cash payments as well as benefits in kind. By

[1] Primary sources of data for this section come from: Allgemeines Sozialversicherungsgesetz (ASVG)Hauptverband der österreichischen Sozialversicherungsträger, 'Leistungsbericht 2015'.Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.Maria M. Hofmarcher, Das Österreichische Gesundheitssystem - Akteure, Daten, Analysen.

[2] Hauptverband der österreichischen Sozialversicherungsträger, 'Leistungsbericht 2015'.

[3] Gewerkschaft der Privatangestellten, 'Selbstverwaltung Hintergrundpapier 2015'.

law, all of the social insurance carriers belong to the HVSV.[4] In total, there are 21 social security carriers responsible for health, pension and accident insurance. Health insurances can be organised on a regional level (GKK), on company level (BKK – only very limited number) or by profession (special insurance carriers). Regional health insurances have the general competence to health-insure all people, who do not fall into the responsibility of any other insurer. In addition to the nine GKK and the five BKK, there are four more special health insurance carriers: The Insurance for the Austrian Railways & Mining Industry (VAEB), the Insurance for Trade and Industry (SVA), the Insurance for Farmers (SVB) and the Insurance for Public Service Wage and Salary Earners (BVA). In line with §426 ASVG, the accident insurance AUVA's administrative body is split according to 50% employees and 50% employers. The PVA and the VAEB's administrative bodies comprise 2/3 employees and 1/3 employers. The GKK and the BKK are represented by 4/5 of employees and to 1/5 by the employers. With respect to the control-assembly, the ratios are reversed (for further information, please see §426 ASVG Abs. 2).

Distribution of work between the Federation of Austrian Social Security Carriers and the individual carriers

According to §31 ASVG[5], the Federation of Austrian Social Security Carriers (HVSV) is responsible for:

-Representing the general and public interests in the execution of social security: In general, this includes tasks such as the creation of a mission statement for all social security carriers, observation of the development of social security in the context and interaction with the economy , as well as advising them in order to ensure sustainable performance, taking care of fundamental questions related to social security, representation in common matters, conducting surveys and doing research, granting legal protection, setting regulations for personnel management of the carriers, enter into contracts with public interest groups and contractual partners, defining and setting key performance indicators concerning the cost of the carriers administration expenses and comparing the carriers.

-Provision of services for the social security carriers: This includes the assignment of social insurance numbers and administration of data, running statistics and setting up and keeping a statistics database, developing and managing the documentation of the Austrian social security law, as instructed by the Ministry of Labour, Social Affairs and Consumer Protection (BMASK), regulating standardised forms, data-set records and machine-readable data mediums, establishment and managing the pension accounts.

[4] Maria M. Hofmarcher, *Das Österreichische Gesundheitssystem - Akteure, Daten, Analysen*.
[5] Allgemeines Sozialversicherungsgesetz - § 31 Hauptverband der österreichischen Sozialversicherungsträger.

-Creation of guidelines aiming at the promotion of a sustainable, suitable and standardised implementation and execution of social security: This set of standards includes guidelines for the employment-position plan (Dienstpostenplan), granting of voluntary social contributions to staff of the social security carriers, education and training of this staff, cooperation between the carriers and creation of a common IT system, coordination of the carriers public relations, allocation of benefits through the carriers or the HVSV, a uniform application of contribution groups, consideration of economic principles in medical treatment, allocation of cost reimbursements between the carriers, implementation and documentation of contractual partner inspections, economic prescription of medication and therapeutic products, general collaborations between the carriers and the HVSV, exemptions from the prescription fee, service fees and additional fees, health promotion, prevention and check-ups, rehabilitation, determination of maximum grants to insured persons and coordination of health and accident insurance in case of an accident.

-Creation of a rehabilitation plan for social security carriers

-Support and participation in the execution of regulations relating to the management and financing of health care

In addition to that, the following decisions made by the administrative bodies of the social security institutions need the approval of the HVSV:
- Construction of buildings (for the purpose of administration and various kinds of medical treatments)
- Creation of employment-position plans (in case they relate to higher or leading positions)

In conclusion, it can be said that several decisions made by the carrier's administrative bodies need to be approved by the HSVS, which on the one hand can be seen as an instrument of coordination but on the other hand extends the decision path.

2.1.3 Supervisory authority

The BMASK and the BMF is the supervisory authority of the HVSV and the pension insurance; regarding all other social security carriers, the BMGF acts as the supervising authority.[6] Representatives of the

[6] Allgemeines Sozialversicherungsgesetz - §448 Aufsicht des Bundes Aufsichtsbehörden.

ministries attend social security carriers' meetings in order to supervise all procedures. These representatives can appeal decisions that violate legal regulations, which then have to be resolved by the respective ministry. The supervisory authority monitors the (financial) management in terms of suitability, efficiency, and economy and also observes the compliance with the law. [7]

2.1.4 Allowance for fulfilling a function (Funktionsgebühr)

The allowance for members of the administrative bodies is regulated by law[8]. This regulation states the amount and payment of allowances for the members of the administrative bodies of the carriers and the HVSV, as well as the period of entitlement to these allowances. It also regulates the attendance-fee for administrative bodies and council members. Only functionaries (chairpeople and their subsidiaries) of the administrative bodies are entitled to an allowance. All other members of the administrative bodies only receive an attendance-fee per meeting day. According to §2 Abs. 2 of the Funktionsgebühren-VO[9], the amount of allowances is limited to an annual maximum of 14-times 40% of the basic amount of €7,418.62 (which is the monthly salary for a member of the National Council), which is set in "§ 1 of the Bundesverfassungsgesetz über die Begrenzung von Bezügen öffentlicher Funktionäre".[10]The carriers are divided into groups according to their size and importance. According to the group, the chairmen or chairwoman receives a certain percentage of the annual maximum allowance.

[7] Allgemeines Sozialversicherungsgesetz - §449 Aufgaben der Aufsicht.
[8] Funktionsgebühren- und Sitzungsgeld-Verordnung - §2.
[9] Ibid.
[10] Bundesverfassungsgesetz über die Begrenzung von Bezügen öffentlicher Funktionäre.

Figure 1: Groups of administrative bodies and the amount of allowances for chairmen and presidents, own illustration.

Group	Administrative bodies	Allowance for carrier chairman and president (Percentage of annual maximum)
Group 1	Administrative bodies of the Federation of Social Security Carriers, AUVA, PVA, SVA, SVB, BVA, VAEB and administrative bodies of insurance carriers with annually more than 400.000 insured members on average.	100%
Group 2	Administrative bodies of insurance carriers with annually more than 250.000 insured members on average.	88%
Group 3	Administrative bodies of insurance carriers with annually more than 100.000 insured members on average.	76%
Group 4	Administrative bodies of insurance carriers with annually more than 50.000 insured members on average.	64%
Group 5	Administrative bodies of insurance carriers with annually more than 10.000 insured members on average.	52%
Group 6	Administrative bodies of the Austrian Notaries' Insurance Fund, Administrative bodies of insurance carriers with annually not more than 10.000 insured members on average.	40%

Other functionaries receive a fraction of the allowance mentioned in the figure above, according to their group:

Figure 2: Group of administrative bodies and amount of allowances for other chairmen and management board, own illustration.

Group	Chairman of monitoring conference	Chairman of regional office committee	Chairman of regional service committee	Members of management board (except chairman and his deputies)
Group 1	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$
Group 2	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$
Group 3	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$
Group 4	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$
Group 5	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$
Group 6	$\frac{5}{10}$	$\frac{4}{10}$	$\frac{3}{10}$	$\frac{3}{10}$

Deputies of the functionaries stated above, receive half the allowance of the respective functionary. [11] If a functionary should fill more than one position, he/she is only paid the full amount of the highest allowance. All other allowances are paid out at half. In case the allowances have the same amount, the social security carrier with more insured members has to pay the allowance in full, the other carriers half of it. If a functionary has more than one position at the same social security carrier, the carrier only has to pay the highest allowance. [12] The annual amount of allowances must be equally distributed among the calendar months and is paid afterwards.[13] The entitlement to the allowance lasts for the whole term.[14]
All the other members of the administrative bodies receive an attendance fee for every day, if they attend a meeting of a body of the same social security carrier, or the HVSV. The same applies to members of the councils, when they attend a meeting of the administrative bodies, or a panel meeting. The daily attendance fee is 0.085 % of the annual maximum allowance, according to §2. Persons, who already receive allowances do not receive attendance fees. [15] Overall, those allowances are rather inadequate, especially in view of the responsibilities taken on by the functionaries, who not only have a supply mandate, but who are also responsible for the budget. Given the fact that historically, the corporate insurance carriers were smaller in size, this used to be a part-time job. Considering the responsibilities that come with the size of a GKK nowadays, the workload cannot be dealt with on the side-line, rendering this allowance inadequate.

2.1.5 Human Resource Management and Recruiting

In 2015, the Austrian social security system employed 26.998 persons (full-time equivalent)[16]. The following figure shows the distribution of all employees in the three pillars of the social security and the HVSV:

[11] Gesamte Rechtsvorschrift für Funktionsgebühren- und Sitzungsgeld-Verordnung - §2 Höhe der Funktionsgebühr.
[12] Gesamte Rechtsvorschrift für Funktionsgebühren- und Sitzungsgeld-Verordnung - §3 Höhe der Funktionsgebühr bei Ausübung mehrerer Funktionen.
[13] Gesamte Rechtsvorschrift für Funktionsgebühren- und Sitzungsgeld-Verordnung - §4 Auszahlung der Funktionsgebühr.
[14] Gesamte Rechtsvorschrift für Funktionsgebühren- und Sitzungsgeld-Verordnung - §5 Dauer des Anspruches auf Funktionsgebühr.
[15] Gesamte Rechtsvorschrift für Funktionsgebühren- und Sitzungsgeld-Verordnung - §6 Sitzungsgeld.
[16] Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.

Figure 3: Number of Employees in the Social Security, own illustration, 2015

	Employees
Health insurance	13. 571
Pension insurance	7.878
Accident insurance	5.253
Federation of Austrian Social Security Carriers	296
TOTAL	26.998

The responsibility for the staff is in the hands of the individual social security carrier: It decides on the number and recruitment of personnel and takes care of human resource management. According to §460 ASVG[17], the social security carriers have to make an employment-position plan in relation to their economic situation, which needs to be limited to the necessary. §31 Abs. 5 says, that the plan must be based on the principles of economy, relevance and efficiency. Therefore, it is important to plan according to the absolutely necessary - however, it is not specified what this exactly means. The purpose of this plan is to create an economical personnel plan, however there are no specific consequences in case of exceeding the position plan. Even though, the HVSV is required to authorize these plans, and thus somewhat controls the carriers' HR-management, the system would still benefit from a more profound regulation- and feedback-process, as well as cross-carrier comparisons.

In terms of job advertisements, by law the carriers only have to publicly advertise open positions for senior manager, head physicians and the respective deputies. All other positions can also be regulated internally. In addition, the selection of applicants is not regulated consistently. There is no strict process for the selection, which can influence transparency. The competence of setting general rules is not fully utilized here. The social security carriers do not have a proper process plan concerning this matter, meaning it is neither regulated in the carrier's official regulations nor by guidelines of the HVSV. However, especially for higher positions, an orderly process-cycle and documentation of applications is very important in order to avoid lack of transparency or preferential treatment. Thus, clear guidelines for job advertisements and

[17] Allgemeines Sozialversicherungsgesetz - §460 Bedienstete.

the hiring processes are necessary. This is also important to connect job postings to the content-related job specifications.

The HVSV takes responsibility for the collective agreements and creates guidelines for the regulation of conditions relating to public service law, salary law, and pension law. However, those regulations concentrate more on individual issues, e.g. employment position plan or education, but there are no general guidelines relating to the process instructions for job advertisement and recruitment.

In general, about 20 trainings with approximately 20 participants are undertaken at the carriers and the HVSV, in order to prepare recruitees for the foundation courses. The foundation courses also involve a final exam. Subsequently, there are about 16 intensive seminars per year, which aim at deepening the course contents of the foundation courses

The Austrian Court of Auditors (RH, Rechnungshof) performed an audit of the financial management, concerning the topic compliance in human resources[18]. The audit was performed with data from the AUVA, BVA and PVA. According to this, the carriers were missing a compliance management system that determines relevant data for the area of human resources. In particular, data about process instructions for job advertisement and recruitment, current records of relatives and secondary employment, and documentation of staffing need to be better organised and structured: It was found that documents were missing, or positions were occupied that were not existent beforehand, or applicants were chosen for positions, they did not even apply for. Thus it is recommended to initiate a standardised documentation of all decisions relating to the selection process and an implementation of standardised processes that are transparent and verifiable.

2.1.6 Self-governance in the social security carriers

The administrative bodies of the social security carriers are responsible for a correct process of business operations. There are three main bodies in charge of the different areas of administration: The general meeting, the management board and the monitoring conference.[19]

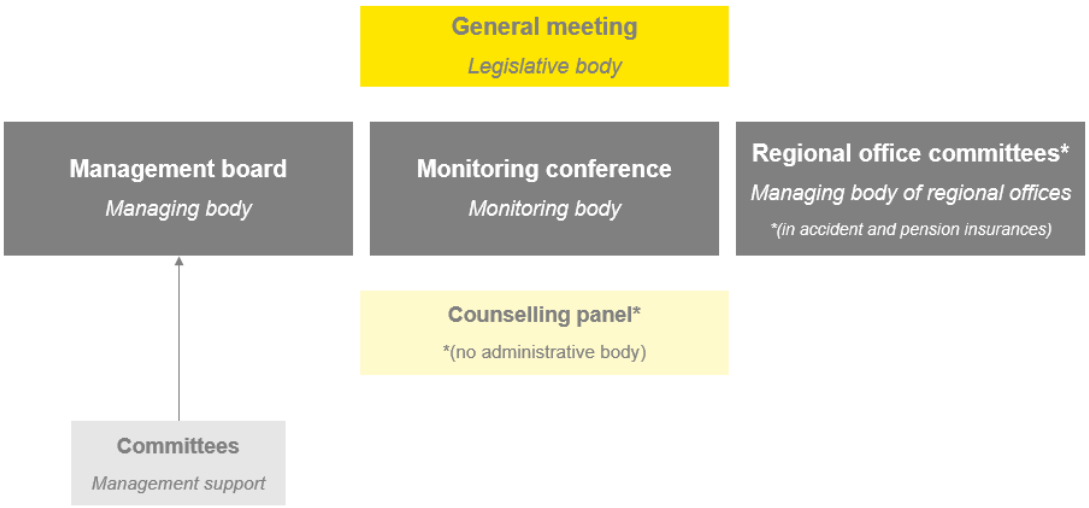
[18] Rechnungshof, 'Bericht Des Rechnungshofes Bund 2017/7 - Compliance Im Vergabe– Und Personalbereich in Der Sozialversicherung'.
[19] Allgemeines Sozialversicherungsgesetz - § 419 Arten der Verwaltungskörper.

The **general** assembly is the legislative body, which is responsible for the statutory law, and has the right to decide on the budget. It can make decisions on financial, as well as legal matters for the social security carriers.[20] The **management board** is the managing body, taking care of the carriers' business. All board members are also members of the general meeting. The board has the general competence to manage every matter that is not specifically assigned to another body. It is responsible for advising on the annual report, or the income statement and manages the relationship of the carrier to its contractual partners. According to § 434 Abs. 1 ASVG[21] the board can transfer responsibilities to a **committee**, i.e. a liability, personnel, service or contribution committee, which then takes care of the assigned operative matters under the authority of the management board. The **monitoring conference** is a body responsible for supervision and auditing of the carrier's management. It constantly monitors the whole (financial) management of the carrier, especially its accounting, cash management, and statement of accounts. The monitoring conference is to be informed about meetings of the general meeting and the presidential board, since it is entitled to a consulting vote and can attend with three representatives.[22] According to § 437 Abs. 1 ASVG[23], some decisions made by the management board need to be approved by the monitoring conference in order to become effective. The **chairman** of a carrier is elected by the management board and plays an important role: He/she is the head of all administrative bodies (except the monitoring conference), and also represents the carrier to the outside world.

In addition to the administrative bodies, carriers have a **counselling panel**, consisting of representatives of insured persons. Two sixth are pensioners, two sixth employees, one sixth employers and one sixth beneficiaries of care allowances. The council is formed by the general meeting on the basis of recommendations by the interest groups. This panel supports the self-governance via counselling and ensures a close connection to the insured persons. However, the counselling panel itself is not an administrative body.

[20] Allgemeines Sozialversicherungsgesetz - §433 Aufgaben der Generalversammlung.
[21] Allgemeines Sozialversicherungsgesetz - § 434 Abs. 1 Aufgaben des Vorstandes und Vertretung des Versicherungsträgers.
[22] Allgemeines Sozialversicherungsgesetz - §436 Aufgaben der Kontrollversammlung.
[23] Allgemeines Sozialversicherungsgesetz - § 437 Zustimmung der Kontrollversammlung.

Figure 4: Structure of the Social Security System, own illustration, based on HVSV Leistungsbericht 2015.



The management board can transfer ongoing tasks to the **office.**[24] This office executes these tasks according to the legislation and statues of the carrier as well as according to decisions and instructions by the administrative bodies. Basically, the office is responsible for the direct implementation and the execution of routine work. It supports decisions of the administrative bodies by executing them, however it is not within its responsibility to replace those decisions in any way.[25] The person responsible (and at the same time supervisor of all employees), is the senior manager. There are specialist departments who deal with the operative management of the different areas of the insurance carrier. In addition, the office takes care of public relations and ombudsman-services of the carrier.

2.1.7 Regional health insurance carrier (Gebietskrankenkasse, GKK)

The governance system of every GKK includes the abovementioned administrative bodies. The general meeting consists of 30, the management board of ten or 15 representatives, and the number of persons sitting on the counselling panel may vary between six and 18 representatives. Here, the counselling panel consists of representatives of pensioners, disabled persons as well as employees and employers. Every GKK has permanent committees and a number of offices throughout the region in order to provide the services in close relation to its insured members.

[24] Allgemeines Sozialversicherungsgesetz - § 434 Abs. 1 Aufgaben des Vorstandes und Vertretung des Versicherungsträgers.
[25] Österreichische Arbeitsgemeinschaft für Rehabilitation, 'Informationstag Für Beiräte Gem. § 440 ASVG'.

Figure 5: Number of Representatives in the Regional Health Insurance Carriers, own illustration.

Insurance carrier	Representatives in				Permanent committees	Headquarter	Number of additional branches
	General Meeting	Management board	Monitoring conference	Counselling panel			
BGKK	30	10	10	12	Liability, Personnel	Eisenstadt	6
KGKK	30	10	10	12	Administration, Personnel, Liability	Klagenfurt	7
NÖGKK	30	15	10	18	Liability, Benefit fund	St. Pölten	24
OÖGKK	30	15	10	12	Administration, Personnel, Service, Liability, Construction	Linz	22
SGKK	30	10	10	6	Administration, Personnel, Benefit fund, Liability,	Salzburg	4
StGKK	30	15	10	18	Administration, Service, Construction, Contribution, Liability, Business	Graz	18
TGKK	30	10	10	6	Administration, Service, Personnel, Construction, IT, Liability	Innsbruck	10
VGKK	30	10	10	12	Service + Contribution + Personnel, Liability,	Dornbirn	6
WGKK	30	15	10	18	Service, Construction, Liability, Cash-Management	Wien	15

2.1.8 Corporate Health Insurance Carriers (Betriebskrankenkasse, BKK)

BKK are health insurances, established by the respective company. By law, new BKK cannot be founded anymore. At present, there are five BKK, which in comparison with GKK have very small numbers of insured persons (please see Table 1 for further information). According to ASVG §445[26], the company has to bear all administrative costs necessary for an orderly administration of the carrier and to compensate any deficits. The number of representatives in the administrative bodies is significantly lower than in the GKK. BKK have ten representatives in the general meeting (except BKK Kapfenberg, which only has five), five on the management board, and five in the monitoring conference.

[26] Allgemeines Sozialversicherungsgesetz - §445 Sondervorschriften für Betriebskrankenkassen.

Figure 6: Number of Representatives in the Corporate Health Insurance Carriers, own illustration.

Insurance carrier	Representatives in			Headquarter
	General Meeting	Management board	Monitoring conference	
BKK Mondi	10	5	5	Wien
BKK voestapline	10	5	5	Leoben
BKK der Wiener Verkehrsbetriebe	10	5	5	Wien
BKK Zeltweg	10	5	5	Zeltweg
BKK Kapfenberg	5	5	5	Kapfenberg

2.1.9 Insurance Institution for the Austrian Railways & Mining Industry (VAEB, Versicherungsanstalt für Eisenbahnen und Bergbau)

The VAEB is a centrally organized insurance and covers all aspects of social security, i.e. health, accident and pension insurance. Its general meeting consists of 60, the management board of 15 and the monitoring board of nine representatives. The VAEB has a counselling panel that includes 18 representatives and serves as connection point for insurer and insured members. Furthermore, the VAEB has several committees, responsible for e.g. pensions and rehabilitation. There are two VAEB offices, one in Vienna and one in Graz. Additionally, the VAEB has formed a prevention committee that is engaged in prevention of work accidents, occupational diseases and health at work. It reports to the BMASK and is the only committee in Austria, which is solely dedicated to this issue.

2.1.10 Good Practice Example

In keeping with the principles of self-governance, the VAEB has launched a council (Versichertenrat), where VAEB insured members can participate and announce their requirements, providing practical and true-to-life input for the insurance and its future development of services. This enables the VAEB to be in close connection with its members and offers a different and 'client-oriented' perspective onto the healthcare needs of the insured. Moreover, this can be considered a type of quality control, as the council

may participate in planning and setting direction with regard to future developments of the VAEB, which also include health promotion, health literacy and disease prevention activities. [27]

2.1.11 Social Security Institution for Farmers (SVB, Sozialversicherungsanstalt der Bauern)

Similar to the VAEB, the SVB covers all social security dimensions. Due to regional service committees (about three to five representatives), which are established in every Land (except Vienna and Lower Austria, who form one unified committee), the SVB provides regional offices, dealing with service matters in all areas. The SVB's administrative body consist of 60 representatives in the general meeting, 14 on the management board and nine in the monitoring conference. Its counselling panel has 18 members, who support the administrative bodies.

2.1.12 Insurance Institution for Public Service Wage and Salary Earners (BVA, Versicherungsanstalt öffentlicher Bediensteter)

The BVA also has regional service committees in every Land, with four representatives per region. Only Vienna, Lower Austria and Burgenland form one united committee, which consists of eight members in total. The management board has 16 representatives, who together with the committee members and 12 additional representatives, form the 60-member general meeting. The monitoring conference has 12, and the counselling panel 18 members.

2.1.13 Social Security Institution for Trade and Industry (SVA, Sozialversicherungsanstalt der gewerblichen Wirtschaft)

The SVA covers two parts of the social security, being the health and pension insurance pillars, yet not the accident insurance. It has 60 representatives in the general meeting, nine are on the managing board and a further nine in the monitoring conference. Its counselling panel has 18 members. In addition to that, the SVA has committees for service, rehabilitation and pensions. Furthermore, there are nine regional service committees with five representatives each, who focus on managing the assigned tasks within the respective Land.

[27] Versicherungsanstalt für Eisenbahnen & Bergbau, 'VAEB Selbstverwatlung: Das Herzstück Der Sozialversicherung'.

2.1.14 Pension insurance institution (PVA)

The administrative bodies of the PVA consist of the following numbers of representatives: 120 in the general meeting, 15 on the management board, and 12 in the monitoring conference. Its counselling panel has 18 members. Again, the PVA also has regional service committees, who perform tasks in their region and consist of six representatives in each Land. Additionally, there are various committees based at the headquarters, who for instance deal with rehabilitation, conflicts, and other services.

2.1.15 Austrian worker's compensation (AUVA)

The AUVA has regional service committees in four Länder, and in addition to that, four service committees and one rehabilitation committee. All of them perform managing tasks, assigned by the management board, which consists of 14 representatives. Sixty members are represented in the general meeting, six in the monitoring conference, and 18 in the counselling panel. It also has a committee focused on rehabilitation, and a further one on service.

Table 1: Number of insured members per insurance carrier, own illustration based on Statistisches Handbuch der österreichischen Sozialversicherung 2016

	Insurance carrier	Insured people including dependents (Anspruchsberechtigte Personen)	Insured people excluding dependents (Beitragsleistende Personen)
Health insurance	GKK Wien	1,644,907	1,218,423
	GKK Niederösterreich	1,195,355	889,872
	GKK Burgenland	207,796	158,931
	GKK Oberösterreich	1,216,485	905,820
	GKK Steiermark	943,210	713,635
	GKK Kärnten	431,930	325,642
	GKK Salzburg	456,768	344,897
	GKK Tirol	579,664	436,873
	GKK Vorarlberg	320,084	236,575
	BKK Austria Tabak	1,912	1,656
	BKK Verkehrsbetriebe	19,650	14,337
	BKK Mondi	2,591	1,729
	BKK VABS	13,034	9,444
	BKK Zeltweg	4,218	2,903
	BKK Kapfenberg	9,967	7,455

	Insurance carrier	Insured people including dependents (Anspruchsberechtigte Personen)	Insured people excluding dependents (Beitragsleistende Personen)
	VAEB	223,251	164,975
	BVA	794,751	549,014
	SVA	779,051	536,619
	SVB	360,903	263,206
	Health insurance total	9,205,527	6,782,006
Pension Insurance	PVA	-	3,194,171
	VAEB	-	47,192
	SVA	-	423,537
	SVB	-	141,828
	VA Austrian Notaries	-	997
	Pension insurance total	-	3,807,725
Accident insurance	AUVA	-	4,856,887
	SVB	-	933,143
	VAEB	-	63,036
	BVA	-	411,336
	Accident insurance total	-	6,264,402

2.1.16 Self-governance of the Federation of Austrian Social Security Institutions (HVSV)

The self-governing bodies of the HSVS represent, in contrast to the carriers' self-governance, not the insured persons, but the carriers.

The carrier conference

According to §441a ASVG[28], the carrier conference consists of the chairmen and their first deputies, representing the 21 social insurance carriers, as well as three representatives for the pensioners, who form the counselling panel. Moreover, the carrier conference elects one president and three deputies for the duration of four years, who represent the carrier conference with respect to the presidential board and the social insurance carriers. The carrier conference is the legislative body of the HVSV and decides on[29]:

[28] Allgemeines Sozialversicherungsgesetz - § 441a Trägerkonferenz.
[29] Allgemeines Sozialversicherungsgesetz - § 441d Aufgaben der Trägerkonferenz.

- annual estimate of the budget,
- annual report,
- statute, model statute, model patient regulation and rules of procedure,
- guidelines,
- system of objectives to coordinate the administrative actions of social security carriers
- General principles of the Federation of Austrian Social Security Institutions.

Presidential Board

In line with § 441b ASVG[30], the presidential board consists of twelve members, delegated by the carrier conference through proposals, made by representations of interest. It consists of:

- Six employee-representatives
  - Five members are proposed by the Federal Chamber of Labour
  - One member is proposed by the Union of Public Services
- Six employer-representatives
  - Five members are proposed by the Austrian Economic Chamber
  - One member is proposed by the presidents of the Austrian Chamber of Agriculture.

Their term in office is four years. The Presidential Board is the managing body of the HVSV and responsible for the execution of all tasks that are not specifically assigned to the any other HVSV body, as well as the representation of the HVSV to the outside world. For the full list of responsibilities with regard to the presidential board, please see §441f ASVG[31].

The management of the HVSV

The HVSV's management is led by the executive manager and three representatives[32]. They are hired for four years by the presidential board via public job advertisement. The management takes care of the day-to-day administration of the office and is bound by instructions of the presidential board.

[30] Allgemeines Sozialversicherungsgesetz - § 441b Verbandsvorstand.
[31] Allgemeines Sozialversicherungsgesetz - § 441f Aufgaben des Verbandsvorstandes.
[32] Allgemeines Sozialversicherungsgesetz - § 441g Verbandsmanagement.

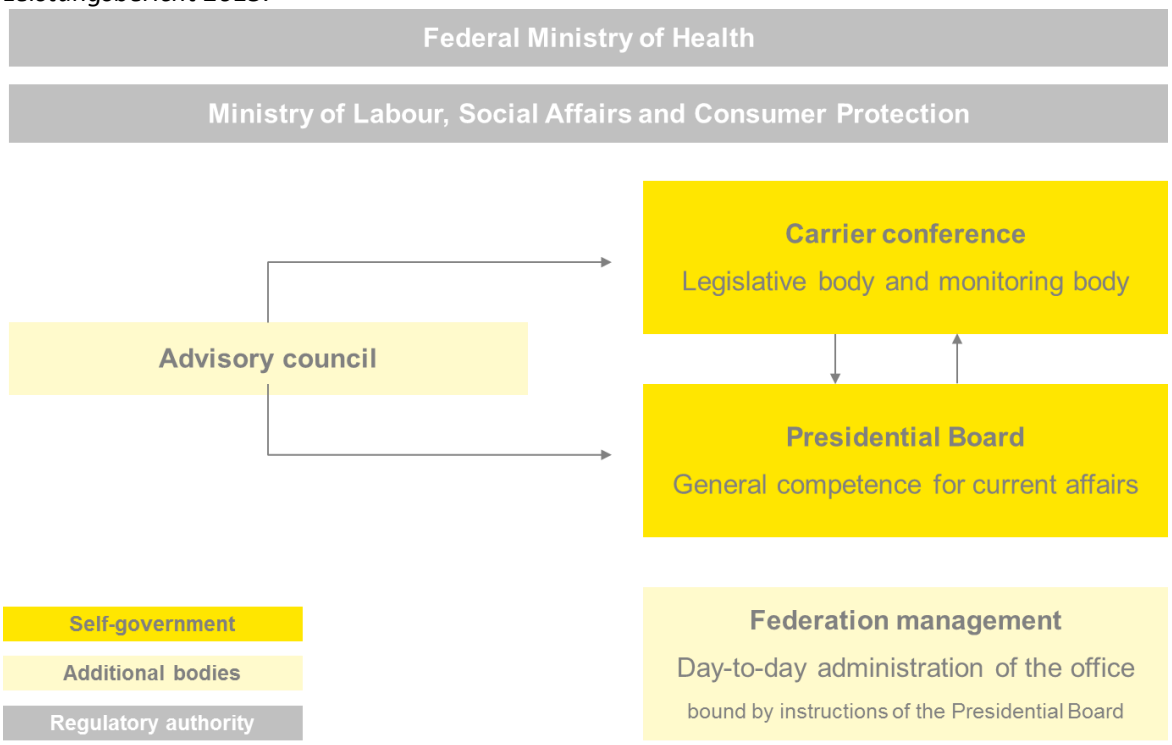
Counselling panel of the HVSV

The advisory council administers requests by the insured community. Through this council, an administration focused on the insured persons may be guaranteed.

The council consists of the following persons: A chairman and two representatives sent by the Minister of the BMASK on the suggestion of the three largest senior citizens' organisations; a chairman representative proposed by the Minister of the BMASK on the suggestion of the Federal Disability Advisory Board and the chairman of the councils of the insurance carriers, represented in the carrier conference.

The council meets at least once a year, and can request a hearing. Its representatives have an advisory vote in the meetings of the administrative bodies.

Figure 7: Self-Governance, additional Bodies, and Regulatory authority, own illustration, based on Leistungsbericht 2015.



2.1.17 Benefit system, insurance sector and contribution system (Leistungs-, Versicherungs- und Beitragswesen, LVB)

The area of responsibility of the LVB includes important issues related to all areas of social security (health, accident and pension insurance), as well as professional support on the topic care allowances, especially analyses of the care-allowance database (PFIF). In more detail, it functions as a coordinating mechanism, which supports the carriers' in implementing legal changes. One example for this is the monthly contribution base notification. Further areas of responsibility of the LVB are combating social fraud, as well as drafting guidelines and regulations on behalf of the HVSV, maintaining the care-allowance database, and updating the interface for businesses regarding the calculation of the social security contributions:

One of the LVB's most important roles is its coordinating function. The goal as coordinating body is to standardise the approach of social security carriers in all areas. Therefore, monthly expert meetings are held, where health insurance carriers submit problems that are discussed and the results incorporated into the E-MVB. The same approach is used for a joint audit of all wage related contributions (GPLA), as well as for issues concerning benefit legislation. Additionally, the LVB coordinated the introduction of the rehabilitation allowance in 2014 and in collaboration with the social security carriers. A special task force is dedicated to the coordination of pension insurance in order to ensure a uniform approach of all pension insurance carriers.

The modification of the payroll method may count as an example for the LVB's coordinating role with regards to the implementation of legal changes. The new monthly contribution base notification is rather complex to implement, since it affects a variety of systems. Thus, a program was initiated in 2015, which is aimed at implementing the new system until 2018. The LVB coordinates several subprojects and contributes to the implementation of this initiative. Furthermore, in early 2016, a law aimed at combating social fraud was introduced in order to approach the challenges in connection with dummy companies. To realize this, the LVB already started in 2015 to coordinate all health insurance carriers with the application of standard products and supported them with the implementation of the legal requirements. This support continued in 2016.

With respect to legal texts and working tools, the LVB also prepares the model statute and model patient regulation, particularly essential guidelines that are to be issued by the HVSV. Additionally, it annually

updates the working tool and forms for businesses in relation to the calculation of social security contributions.

One further area of responsibilities involves the care-allowances, which have the purpose of providing persons in need with help, care and the possibility of living an autonomous life. These payments compensate additional expenses caused by special care. The LVB creates evaluations of this care allowance database that serve to create a statistical analysis of this topic. On top, the LVB handles individual cases, especially health and pension insurance carriers frequently send in written notes or have telephone requests. But also insured persons, tax consultants and contractual partners request advice on individual issues.

2.1.18 Cross-carrier controlling (=Trägerübergreifendes Controlling, TÜC)

This division is responsible for the development of a goal-oriented controlling system, which supports decision-makers of the HVSV in their management tasks. A goal-oriented approach to organize social security, strategically needs target agreements on desired situations, as well as information about achieved current situations and possible deviations. Therefore, the cross-carrier controlling division TÜC was developed. A central instrument is the Balanced Scorecard (BSC). Project coordination plays an important role in this division, especially the set-up of a project office. This office is the central office of the project administration and documentation and offers services related to the execution of social security projects, or projects of the HVSV. Furthermore, the TÜC supports construction projects and establishments of social security carriers, in coordination and participation of e.g. contractual partners or IT issues.

In compliance with the principles of the target identification process, a joint proposal for social security goals for 2016-2020 was developed. Those principles involve active involvement of all parties, and the conception of social security goals. However, as mentioned in the chapter about administration costs, the transparency of the BSC could be improved by e.g. publishing, cross-analysing and explaining the differences in carriers' administration costs. Nevertheless, the newly-developed BSC structure focuses more on the impact of social security services, which still could be improved by e.g. linking the administration costs to specific outcome-oriented targets. The annual targets for 2016-2020 were reviewed critically and adapted to current developments or results if necessary.

The Presidential Board has to submit a proposal concerning the granting of subsidies from the carrier structure fund (=Kassenstrukturfonds) to the Minister of Health and Minister of Finance.[33] Therefore, an evaluation report was developed by TÜC. Additionally, the TÜC performed a monitoring of the social security and the HVSV targets for 2015 in the second quarter of 2015, in order to document developments, results and potential risks.

One of the main tasks of the TÜC's project office is the supervision and development of the project management system (structures, guidelines, standards and methods for the initiation, planning, surveillance and management of projects), administration of the project portfolio database and securing a standardised and harmonized reporting system. A key strategic approach in 2015 was the functional advancement of the project office towards multi-project-management, including the development of the necessary methods and instruments. Based on this initiative, portfolio monitoring and project-overlapping analyses were added to the report about the status of project portfolios of social securities. Since 2015, the project office has been working on establishing a project cockpit in order to support strategic control and decision-making. Last but not least, project management (PM) trainings are held by the project office in order to reflect on PM-standards and decisions made during project simulations.

In order to document the activity of the Competence Centres (CC), therapeutic products/medical aids (HBHI), integrated treatment (IV) and transport (TW), a detailed reporting of the work packages was performed by the TÜC. This includes milestone planning, a diagnosis and a forecast for costs and progress. In addition to this service, the TÜC supports the CC with administrative tasks, like final accounting or modifications of resource planning.

In general, it is necessary that cross-carrier collaboration is fostered, thus the TÜC represents a good initiative. However, there is still room for improvement, i.e. where the joint effort of carriers could go beyond what is now achieved. One such area would be the joint pooling of investments, where carriers could bundle their financial means to jointly provide a better service with e.g. state-of-the art medical equipment, which one carrier taken alone would not be able to fund.

[33] Krankenkassen-Strukturfondsgesetz §3 Verwendung der Mittel.

2.2 Risk-adjustment[34]

The need for compensating risks arises from differences in conditions, which may be caused by a number of reasons[35]: **Regional differences**: the income from contributions differs between the Länder, as there are different economic dynamics and labour markets, leading to varying levels of the populations' income. Concerning the GKK, this results in varying levels of income from contributions. **Demographic differences**: in parallel with the difference in demographic structures in the Länder, there exist dissimilarities within the structure of the regional health carriers. For example, the health insurance carriers demonstrate dissimilar ratios between working persons versus pensioners, or differences in the age of insurance-entitled persons. **Structural differences**: the per capita income from contributions may differ because of structural dissimilarities (e.g. workers, employed persons, pensioners). Connected to this are structural changes regarding the professions of the insured, (for example the number of employed persons is growing, whereas the number of farmers is diminishing).

Besides the Equalization Fund of the GKK, there also exists the Kassenstrukturfonds (KSF)[36], meaning the Insurance Structural Fund, and was established by the BMGF. Between 2011 and 2014, the funds' annual volume accrued to €40 mio, with the objective to reach the set financial targets, and by doing so, receiving the funds to reduce the then extant liabilities of the GKK[37]. Currently, the KSF holds €10 mio and its primary task is to achieve the long-term adjusted and sustainable conduct of all GKK, as well as support each GKK's responsibility with respect to the target-controls. The allocated means are to be used for measures relating to diminishing expenditures, which lie within the responsibility of the GKK, as well as improving care for the insured - in particular the integrated care and quality measures, as well as cross-sectional care-management. The HVSV accounting entity (Rechenkreis Kassenstrukturfonds) suggests the yearly

[34] Primary sources of data for this section are: Data from HVSV Finanzstatistik 2015. Hauptverband der Österreichischen Sozialversicherungsträger, 'Finanzierung: Wahlmodul - Allgemeine Fachausbildung'. Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'. Niederösterreichische GKK, 'Betriebsvergleich Der Gebietskrankenkassen 2015'. Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'. Salzburger Gebietskrankenkasse, 'Ausgleichsfonds Der Gebietskrankenkassen 10 Jahre Strukturausgleich'.

[35] Hauptverband der Österreichischen Sozialversicherungsträger, 'Finanzierung: Wahlmodul - Allgemeine Fachausbildung'.

[36] BGBl. I Nr. 52/2009, Bundesgesetz über einen Kassenstrukturfonds für die Gebietskrankenkassen (Krankenkassen-Strukturfondsgesetz).

[37] Czypionka and Röhrling, 'Zukunft der Gesundheitsausgaben und Gesundheitsfinanzierung in Österreich I: Konsolidierungsszenarien'.

allocation of the financial means in accordance with the BMF to the specific measures, and the consequent distribution of subsidies to the GKK (for further information, please see BGBI I Nr. 52/2009)[38]. Table 2 illustrates the various instruments utilized to achieve the financial compensation within the social security system, in Austria.

Table 2: Financial compensation in the Austrian Social Insurance, sourced from Finanzierung – Wahlmodul – Allgemeine Fachausbildung, 2016

	CAUSE	PARTICIPANTS	INSTRUMENT	TOTAL BUDGET 2016 Estimates in € Mio
1	FUNDS			
1	System of structural equalisation	All regional health funds, i.e. GKKs	Equalisation fund of GKKs (§ 447a ASVG)	311
2	Transfer to a) Länder health care funds b) Federal health care agency	All social security carriers (Exception: Insurance Institution for Austrian Notaries)	Equalisation funds for hospital financing (§ 447f ASVG)	a) 5.138 b) 83,6
3	Transfer to Länder health care funds (Health promotion funds)	All health insurance carriers	Health promotion funds according to § 19 G-ZG (§ 447g ASVG)	13
4	Health promotion and physical health examination	All health insurance carriers	Funds for early detection (physical health) examinations and health promotion (§ 447h ASVG)	4
5	Orthodontic adjustments for children and teenagers	All health insurance carriers	Funds for dental health (§ 447i ASVG)	80
2	ACCOUNTING			
1	Financing of pension insurance	All pensions insurance carriers (Exception: Insurance Institution for Austrian Notaries)	Accounting entity pension insurance	2.303
2	Financial support of goal-oriented regulation	All GKKs	Accounting entity funds for the insurance structure	10

[38] Hauptverband der Österreichischen Sozialversicherungsträger, 'Finanzierung: Wahlmodul - Allgemeine Fachausbildung'.

	CAUSE	PARTICIPANTS	INSTRUMENT	TOTAL BUDGET 2016 Estimates in € Mio
3	OTHER COMPENSATIONS: Claims for compensation and equalisation of burden			
1	Claims for compensation of health insurance towards accident insurance	All GKKs, BKKs and AUVA (Exception: BKK for public transport employees) Compensation by federation	Special flat rate (§ 319a ASVG)	174
2	Claims for compensation for support payments in case of long-lasting sickness (§ 104a GSVG)	SVA and AUVA	Reimbursement of expenses to SVA (§ 319b ASVG)	
3	Non-uniform burden of transfer to Länder health care funds (§ 447f ASVG)	All health insurance carriers Compensation by federation	Equalisation of burden for hospital care expenses (§ 322a ASVG)	
4	Maximum prescription fee 2% of net income	Health insurance carriers according to ASVG, GSVG, BSVG Compensation by federation	Equalisation of burden REGO (§ 322b ASVG)	

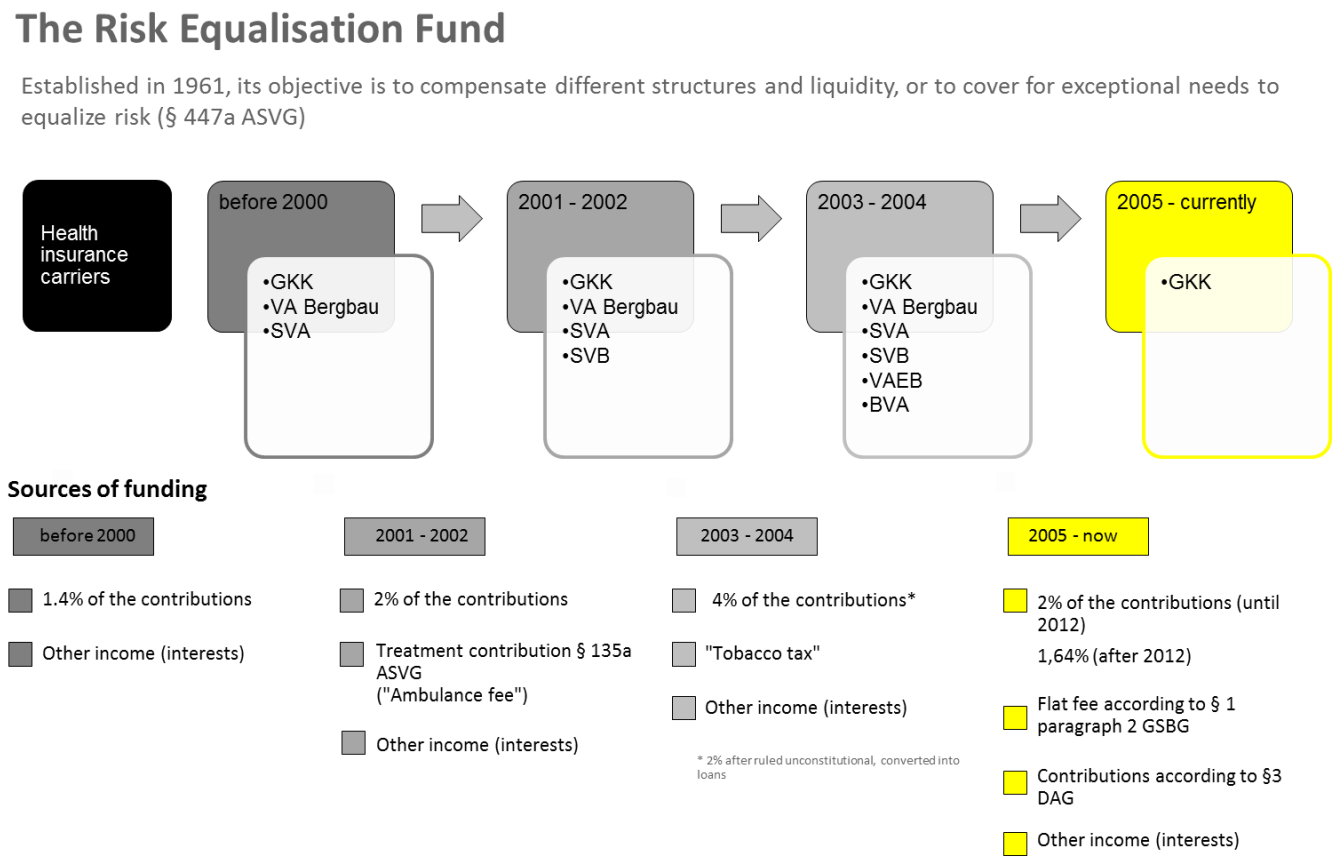
2.2.1 The History of the Risk Equalisation Fund

Since 1961, there has been an Austrian equalisation fund. At present, its main task is to compensate for the regional health carriers' differences in structure (relating to the differences in contribution income, insured persons, and regions) and liquidity, or to support in case of specific needs (§447b ASVG). Yet, the contributing funds have changed over time. Original members were the regional, corporate and agricultural health insurance funds. In 1965, the corporate health insurance funds stopped participating and in 1967, the health insurance fund of the Austrian miners was included. Next, the SVA followed in 1977, and in 2003 the BVA and the VAEB joined the equalisation fund. However, in 2004, the Austrian constitutional court found the transfer of financial resources between the funds unconstitutional, if the equalisation fund was used for different purposes than to balance the different risk structures (e.g. to equalize differences in contributions, or dissimilarities originating from imposing user charges). Moreover, some of the participants were nationwide funds, and others regional funds. Thus, there existed systemic disadvantages for some health insurance carriers, and in result, the VAEB, the SVB and the BVA were segregated from the equalisation fund, meaning the remaining members are the GKK. Also, in order to

set incentives for good conduct, between 2003 and 2004, 55% of the income were bound to achieving set targets (in line with §447c). This paragraph, however ceased to exist in 2005. In 2012, the Hanusch Hospital, an institution, which is owned by the Viennese GKK, was also disengaged from the equalisation fund (and is now financed by all social insurance carriers, less the insurance of the notaries, via means of the equalisation fund for financing hospitals § 447f ASVG[39]). This lead to a discount regarding the contribution payments into the equalisation fund, which was reduced from 2% to 1.64%[40]. Relating to the content of the equalisation, the federation of Austrian Social Security Carriers (HVSV) was asked by the Ministry of Social Affairs (BMASK) to draft recommendations for the reformation of the equalisation fund, in 2001. The aim was to improve the balance of structural differences of the individual regional health insurance funds. As a result thereof, the equalisation fund was regulated anew in 2006, and from then onwards has been based on a scientific structural equalisation model. For an overview on the historical development of the equalization fund, please see Figure 8.

[39] Allgemeines Sozialversicherungsgesetz - § 447f Beiträge der Träger der Sozialversicherung für die Krankenanstaltenfinanzierung; Ausgleichsfonds, n.d.
[40] Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

Figure 8: The History of the Risk Equalisation Fund, own illustration.



The legal foundation for the structural equalisation fund of the regional health insurance carriers, i.e. the GKK, is regulated in §447a[41] (equalisation fund of the GKK) and §447b ASVG[42] (compensating different structures). The change to a standard distribution was aimed at. With this standard distribution, the structural parameters, which cannot be influenced by the carriers (meaning contribution base, insured persons, dependants, age, gender, unemployment, mortality, invalidity, severity of the disease and the morbidity), should be accounted for.

2.2.2 Risk Equalisation Fund sources of revenue

The assets of the Equalisation Fund for the GKK are raised by: [43]

1. Contributions stemming from the GKK, which amount to 1.64% of their contribution income.

[41] Allgemeines Sozialversicherungsgesetz - § 447a Ausgleichsfonds der Gebietskrankenkassen, n.d.
[42] Allgemeines Sozialversicherungsgesetz - § 447b Ausgleich unterschiedlicher Strukturen.
[43] FINANZIERUNG Wahlmodul - Allgemeine Fachausbildung. 2016.

2. A flat rate according to §1a GSBG[44] (€122 Mio per year, which is appreciated annually in line with § 108 Abs. 2 ASVG).
3. The contributions according to §3 DAG (employer's levy): The GKK have to transfer 23.5% of the flat-rate levy, collected from employers of minor employed persons.
4. Income according to §447f Abs. 9 ASVG (i.e. interest earnings of the equalisation fund for hospital financing).
5. Other income, which may include: Interest earnings (of the equalisation fund of the GKKs); Funds stemming from the taxing of tobacco (§ 447a Abs. 10 ASVG): The Federal Minister of Finance transfers € 12,423,759.09, which derive from the taxation of tobacco, to the equalisation fund (happening every September, on an annual basis).

In line with this, the assets and sources of funding, for the structural equalisation fund in 2015 are as depicted by Table 3.

Table 3: Assets and Source of Funding for the Equalization Fund 2015, based on Handbuch der Ö SV, 2016

Assets of the Equalisation Fund, including the Source of Funding, in 2015 (in € mio)	
(1) Contributions of the GKK	167.9
(2) Flat rate payment §1a GSBG	91.9
(3) Contributions according to §3 DAG	27.9
(4) Income according to §447f Abs. 9 ASVG	0
(5) Transfers according to §447a Abs. 10 ASVG	12.4
(5) Interest earnings	0
(5) Other income	0
Total	300.1

The aforementioned transfers (5) according to §447a Abs. 10 ASVG, involve 2/3 of the financial means (i.e. the financial means stemming from the taxing of tobacco) being transferred to the equalisation fund for hospitals (§447f ASVG). The other 1/3 is transferred to the fund for health promotion and prevention (§447h ASVG)[45]. Thus, €287.73 mio remain for the structural equalisation of the regional health carriers.

[44] Gesundheits- und Sozialbereich-Beihilfengesetz - § 1a Pauschalierte Beihilfe.
[45] Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'.

(Also, the flat-rate according to §1a GSBG used to involve paying 24% of the appreciated value of the €122 mio to the SVB, which was stopped in December 2016).

2.2.3 The Risk Adjustment Mechanism and the Asset Allocation of the Equalisation Fund

The structural differences are now indicated in terms of standard costs (= average costs) on the basis of structural parameters such as age, gender, and "cost-intensive entitled beneficiaries" (so-called "expensive cases"). The allocation of funds is based on 3 criteria, (1) the **equalisation of structural differences**, (2) the **balancing of the liquidity** and (3) the **covering in case of a special need for compensation**[46]. The weightings of these may be altered by the carrier conference at the HVSV, currently they are 57% structure, 33% liquidity, and 10% special needs for compensation. Up until 2011 these were divided according to a 45/45/10 rule. From then onward, the criterion liquidity has been annually diminished in favour of compensating for structural differences, with a diminishing factor valued at 3%[47]. For more information, please see Table 4.

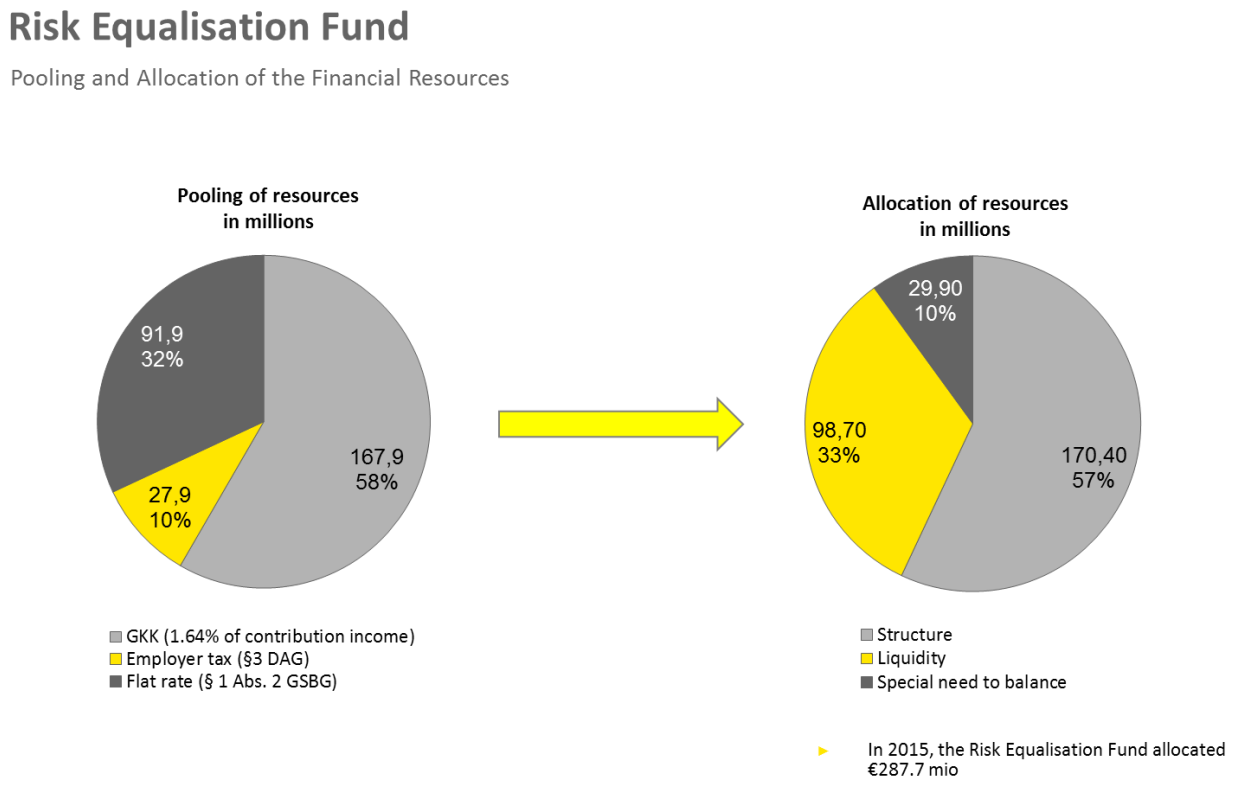
Table 4: The Allocation and Weighting of the Structural Equalization Fund, based on §447a ASVG

Year	Different structures	Different liquidity	Special need for compensation
2005 – 2011	45%	45%	10%
2012 (affecting net income 2013)	48%	42%	10%
2013 (affecting net income 2014)	51%	39%	10%
2014 (affecting net income 2015)	54%	36%	10%
2015 (affecting net income 2016)	57%	33%	10%

In keeping with this, the €287.73 mio assets of the Equalisation Fund were distributed to the individual GKK, to compensate for different structures, to balance the liquidity and to cover for special compensation-needs. As a result, the distribution of assets in 2015 ensued according to Figure 9.

[46] Salzburger Gebietskrankenkasse, 'Ausgleichsfonds Der Gebietskrankenkassen 10 Jahre Strukturausgleich'.
[47] Ibid.

Figure 9: Pooling and Allocation of the Financial Resources of the Risk Equalisation Fund 2015, own illustration, based on data from HVSV.



Please see Table 5 for the preliminary figures for 2015, regarding the Risk Equalisation Fund's allocation of assets and the weightings of the criteria (structure, liquidity and the special need to balance), per carrier in 2015. (Please note that the Rechnungshof reports the financial data for the risk equalisation fund for the year it is reported, whereas the HVSV indicates the year for calculating the allocation of the funds – this means that e.g. the financial figures according to the HVSV are for the year 2013, but according to the HVSV they are 2013). Vienna is the only GKK, which received funds with regards to the criterion liquidity, as it had a negative net-worth of €35.22 per insurance-entitled person (less the uncovered general contingency reserves, Reinvermögen abzüglich ungedeckte allgemeine Rücklage)[48]. The average net assets across all GKK in 2015 accrued to €129.94 per insurance-entitled person, Upper Austria and Salzburg however, had €388.38 and €458.70, in net assets respectively. In case the uncovered general contingency reserve is valued, Vienna shows € -47.86, Upper Austria €188.24 and Salzburg €249.44. For the optional special need to compensate, the GKK Vorarlberg received the overall sum of €945.720, in

[48] Niederösterreichische GKK, 'Betriebsvergleich Der Gebietskrankenkassen 2015'.

order to balance their contributions regarding foreign pensions. Their share of pensioners measured in terms of the overall number of insured person is average, scoring a proportion of 31.83%. The GKK average figured at 31.38% of pensioners in the insurance-pool structure.[49]

Table 5: Allocation of the Financial Means from the Equalisation Fund, in 2015 (preliminary figures), data sourced from HVSV

Versicherungsträger	Struktur (57%)		Liquidität (33%)		Summe Struktur und Liquidität in Euro	Gesamte Verteilungs-option (10%) in Euro (29,900.000 €)	davon		Gesamtmittel in Euro	Gesamtmittel in %
	in %	in Euro	in %	in Euro			Abgeltung VGKK für Beiträge Auslandsrenten	restliche Verteilungsoption (28,954.280,00)		
Insgesamt	**100,00**	**170.400.000,00**	**100,00**	98.700.000,00	***269.100.000,00***	***29.900.000,00***	***945.720,00***	***28.954.280,00***	***299.000.000,00***	***100,00***
Gkk Wien	11,21	19.101.840,00	100,00	98.700.000,00	*117.801.840,00*	*6.500.000,00*	-	6.500.000,00	***124.301.840,00***	***41,57***
Gkk Niederösterreich	10,94	18.641.760,00	-	-	*18.641.760,00*	*7.000.000,00*	-	7.000.000,00	***25.641.760,00***	***8,58***
Gkk Burgenland	6,72	11.450.880,00	-	-	*11.450.880,00*	*2.000.000,00*	-	2.000.000,00	***13.450.880,00***	***4,50***
Gkk Oberösterreich	10,09	17.193.360,00	-	-	*17.193.360,00*	*300.000,00*	-	300.000,00	***17.493.360,00***	***5,85***
Gkk Steiermark	17,62	30.024.480,00	-	-	*30.024.480,00*	*5.900.000,00*	-	5.900.000,00	***35.924.480,00***	***12,01***
Gkk Kärnten	30,75	52.398.000,00	-	-	*52.398.000,00*	*4.000.000,00*	-	4.000.000,00	***56.398.000,00***	***18,86***
Gkk Salzburg	1,11	1.891.440,00	-	-	*1.891.440,00*	*700.000,00*	-	700.000,00	***2.591.440,00***	***0,87***
Gkk Tirol	11,56	19.698.240,00	-	-	*19.698.240,00*	*1.600.000,00*	-	1.600.000,00	***21.298.240,00***	***7,12***
Gkk Vorarlberg	-	-	-	-	-	*1.900.000,00*	*945.720,00*	954.280,00	***1.900.000,00***	***0,64***

As depicted in Table 6 , the need for compensating the criterion liquidity has changed over time. During the period from 2005 until 2015, there are two regional health insurance carriers, which have never needed funds in connection with balancing liquidity, i.e. Upper Austria and Salzburg. Yet, in general, there is a strong trend in requiring less compensation for liquidity, as the historic development shows: In 2008, six GKK carriers needed payments for the imbalances in liquidity, though five years later in 2013, this number has reduced to only two carriers, being Carinthia and Vienna. In 2015, the only remaining GKK, which still needed the funds for liquidity was Vienna, as mentioned before.

[49] Ibid.

Table 6: Balancing Differences in Liquidity, 2005-2015, data sourced from Hauptverband, 2015

GKK	2005	2006	2007	2008	2009	2010	2011	2012 (42%)	2013 (39%)	2014 (36%)	2015 (vorläufig) (33%)
Insgesamt	**56.431.464,12**	**62.342.402,26**	**111.701.168,73**	**125.617.755,46**	**111.445.392,22**	**112.573.268,94**	**114.394.139,02**	**111.143.932,70**	**108.347.268,57**	**103.582.978,98**	**98.700.000,00**
Gkk Wien	18.063.711,66	19.382.252,86	34.080.026,58	40.348.423,05	37.334.206,39	47.066.883,74	67.755.648,54	111.143.932,70	93.666.213,68	74.476.161,89	98.700.000,00
Gkk Niederösterreic	-	-	3.351.035,06	5.841.225,63	5.494.257,84	2.622.957,17	-	-	-	-	-
Gkk Burgenland	8.165.632,86	9.631.901,15	15.325.400,35	13.390.852,73	6.742.446,23	2.285.237,36	-	-	-	-	-
Gkk Oberösterreich	-	-	-	-	-	-	-	-	-	-	-
Gkk Steiermark	8.284.138,93	12.000.912,43	23.010.440,76	27.862.018,16	26.769.183,21	30.124.606,77	26.173.379,01	-	-	-	-
Gkk Kärnten	16.393.340,33	18.135.404,82	29.701.340,77	32.434.504,46	28.307.129,63	30.473.583,90	20.465.111,47	-	14.681.054,89	29.106.817,09	-
Gkk Salzburg	-	-	-	-	-	-	-	-	-	-	-
Gkk Tirol	5.524.640,34	3.191.931,00	6.232.925,21	5.740.731,43	5.828.594,01	-	-	-	-	-	-
Gkk Vorarlberg	-	-	-	-	969.574,91	-	-	-	-	-	-

2.2.4 Determining the Need for Risk Adjustment, due to Structural Differences

In July 2006, the structural equalisation was regulated anew, so that compensating the varying risk structures could be based on a scientific structural equalisation model. The structural parameters, which are utilized in order to calculate and equalize the different structural risks, relate to **age, gender and the cost-intensity of the insured persons**. The data is sourced from the statements of accounts of the regional health insurance carriers and the HVSV is in charge of calculating the structural equalisation model. In more detail, the equalisation of structural differences involves (§447b Abs. 1):

- Balancing **income differences**, which are caused by contribution income and prescription fees (per capita income). Income from the prescription fees are considered as factors, which cannot be influenced. Since 2009, a compensation for the deficit that occurs at the regional health carriers, due to the maximum prescription fee, is provided.
- Calculating the expense-differences concerning the **morbidity**, which are caused by the structure of insurance-entitled persons. This is illustrated by standard costs (= average costs), on the basis of the structural parameters: Age, gender and cost-intensive insurance-entitled persons (including dependents). Cost-intensity applies in case the annual expenses for an insured person's medication

are higher than 99% of all other recipients of benefit (the threshold value for 2014 was €5524 per person[50]).

- Surcharge on top of the standard costs for **other factors**, which relate to expense-differences which can only be influenced in the long-term (for instance, regional differences on the supply side, which go beyond the standard costs described above. Yet, expenses relating to stationary institutional care are not considered).
- **Further factors which cannot be influenced**: Contributions to the equalisation fund, performance-oriented hospital financing payments (LKF Zahlungen), and maternity allowance/according to substitutes (Wochengeld/nach Ersätzen).
- Since 2009, **sick pay** expenses are considered as standard costs.

The figures below give an overview about the age and gender structure of the GKK, as well as the other health insurance carriers for comparison. The largest share of both, men and women above 60 years of age are insured at the GKK Burgenland, being 31% for female and 24.6% for male insured persons. (Put into relation with the non-GKK carriers, the VAEB, the BKK and the SVB, all have more than 45% female insured persons with 60 years or more, with the VAEB having the largest proportion, i.e. 54.9%). The least 60 plus females are found at the GKK Vienna (and the SVA), having 22.5%. The largest proportion of young insured persons in 2015 was insured at the GKK Vienna, having 50% females, and 55.4% males aged 39 or younger.

[50] Salzburger Gebietskrankenkasse, 'Ausgleichsfonds Der Gebietskrankenkassen 10 Jahre Strukturausgleich'.

Figure 10: Gender and Age of Insured Persons per Health Insurance Carrier, 2015 (in %), own illustration, based on data from HVSV and Handbuch der Österreischischen SV 2016

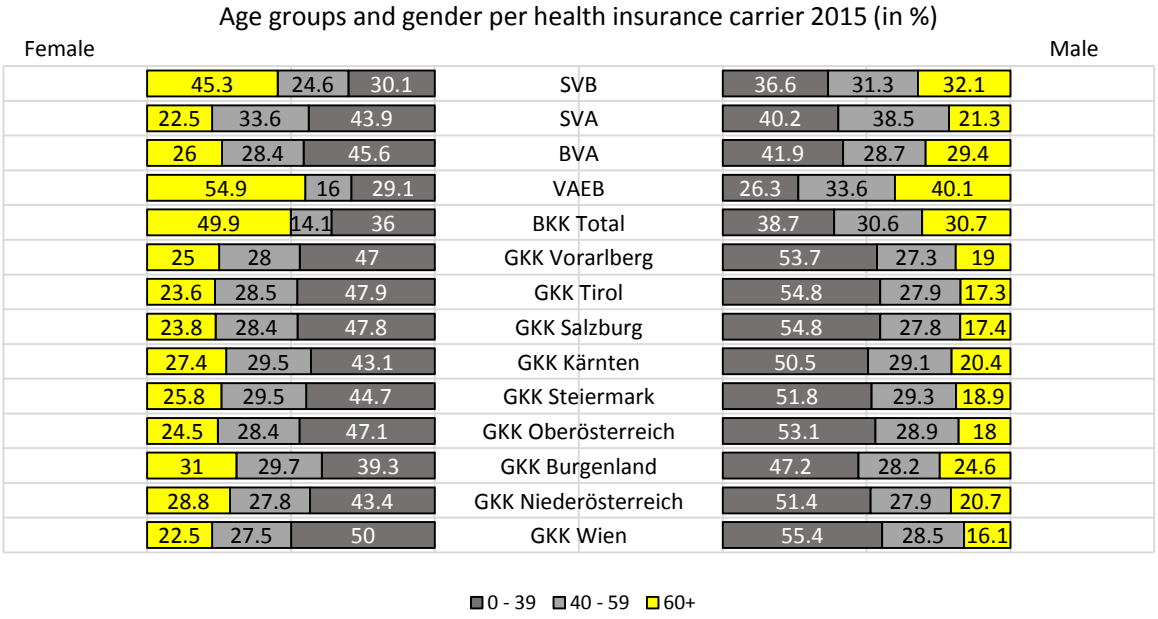
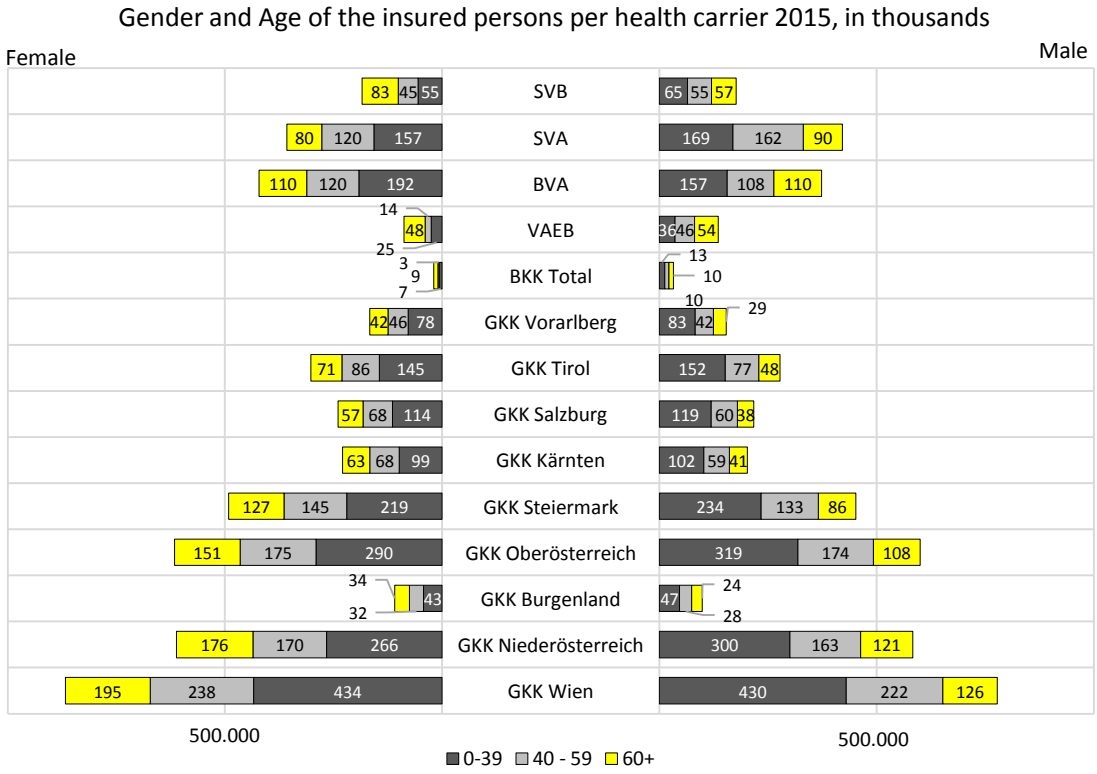


Figure 11: Gender and Age of Insured Persons per Health Insurance Carrier, 2015 (in thousands), own illustration, based on data from HVSV and Handbuch der Österreischischen SV 2016



2.2.5 Determining the Need for Risk Adjustment, due to the Regional Factor

The 'regional factor' is applied to those GKK, whose actual expenses are above those arising from the carrier-individual structure of the insured. The surcharge is adapted according to the carrier-individual difference between actual expenses (taken from the LIVE data, Leistungsinformation für Versicherte) and the expenses due to structural parameters (= standard budget). The regional factor refers to e.g. the supply density and behaviour of contractual partners. It is assumed that these factors can only be influenced by the carrier in the long-term and thus qualifies for compensation. Yet, since the carriers' may eventually influence the regional factors, the surcharge is gradually reduced, by 5% per annum (yet, it just has been decided to discontinue the gradual reduction). The surcharge factor has been reduced by about 37%, since 2005. Although, for Vienna and Lower Austria the gap between actual expenses and standard costs has been growing between 2006 and 2014. Hence, despite having a young pool of insured persons and a high income from contribution (ranking third out of 9 GKK with €1527.64 contribution income per insurance-entitled person[51]), the expenses of the GKK Vienna have to be compensated.

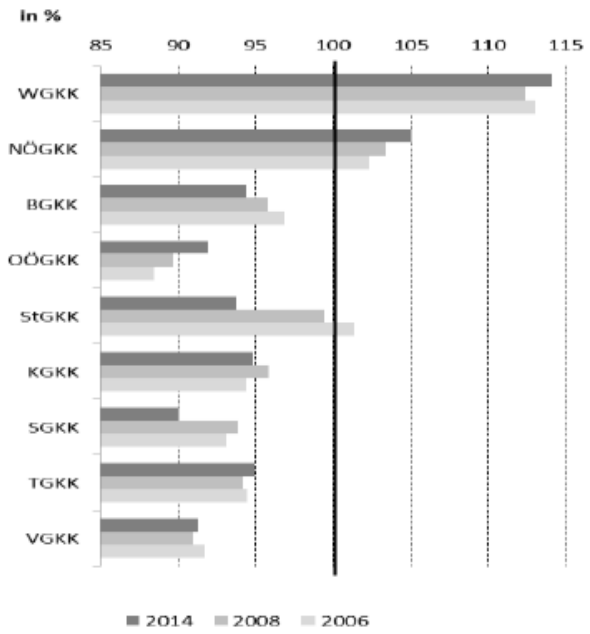
Standard budgets: Age, gender and cost-intensive insured persons are valued according to nationwide average costs. The standard budget (per capita) is determined by the standard budget of the respective GKK divided by its entitled insured persons. For further information, please see Table 7 and Figure 12.

Table 7: Standard Budget per Health-Insurance Entitled Person, 2005-2014.

Standard budget per health-insurance entitled person 2005 – 2014 in €										
	Total	**WGKK**	**NÖGKK**	**BGKK**	**OÖGKK**	**StGKK**	**KGKK**	**SGKK**	**TGKK**	**VGKK**
2005	882.225	908.86	919.06	990.40	846,16	882.64	911.32	830.78	819.90	829,15
2014	1,216.33	1,190.73	1,268.82	1,335.76	1,187.85	1,233.97	1,282.82	1,175.84	1,163.29	1,193.77
Change in %	37.87%	31.01%	38.06%	34.87%	40.38%	39.80%	40.77%	41.53%	41.88%	43.98%

[51] Niederösterreichische GKK, 'Betriebsvergleich Der Gebietskrankenkassen 2015'.

Figure 12: Actual Expenses, in Relation to Standard Costs, source: 10 Jahre Strukturausgleich, 2015



Actual expenses in relation to standard costs (without hospitals) standardised for all GKKs

Explanation:

The 100% line indicates the carrier-individual standard budget (without hospitals). The bars represent the actual expenses, according to the statement of account. If the bars surpass the 100% line, the actual expenses are above the respective carrier-individual standard budget. In this case, this applies to the WGKK and the NÖGKK, in 2014, and the StGKK in 2006.

Based on the current standard cost calculation, it is questionable, whether it is realistic for e.g. Vienna to adapt the actual costs (per health insurance-entitled beneficiary) to align with the nationwide standard costs. The discrepancy is so large that it is likely that relevant factors exist, which are not being considered, and which cannot be influenced by the carrier. Examples for these factors, which cannot be influenced by the carrier are: The density of doctors of choice – without statutory changes these costs cannot be influenced, or persons with drug addictions, HIV, social problems, or the higher health-relevant expenses for persons at risk of poverty or unemployment). [52]

However, as stated in the 10 year-evaluation report of the equalisation fund, a risk structure equalisation mechanism, which takes account of the risks in connection with morbidity is currently not achievable for Austria[53]: 'To what extend the structural parameters age, gender and cost-intensive entitled beneficiaries

[52] Since 2012, the costs for the Hanusch Hospital (part of the WGKK), are compensated by the Equalisation Fund for Hospital-Financing, in line with §447f ASVG, where also the special insurance carriers are contributing.
[53] Salzburger Gebietskrankenkasse, 'Ausgleichsfonds Der Gebietskrankenkassen 10 Jahre Strukturausgleich'.

effectively and sufficiently project the morbidity structure of a carrier cannot be answered at this point. For a morbidity risk balancing equalisation model, we still lack the diagnosis-based data.'

2.2.6 Overview of the Equalisation Fund of the GKK

The following diagrams aim to generate a comprehensive overview about the risk compensation with respect to the Equalisation Fund of the GKK: The financial in- and outflows of the Equalisation Fund of the GKK for 2014 are depicted in Figure 13 (please note that the depicted data, i.e. presenting 2014 values according to the Rechnungshof equals the HVSV data from 2013, as the HVSV calculates the values in advance and the Rechnungshof reports these for the following year). As mentioned before, the taxes stemming from tobacco are directly transferred to the Equalisation Fund for Financing Hospitals (2/3) and the Fund for Health Promotion and Prevention (1/3). Figure 14 explains in more detail, how the mechanism for calculating the standard costs and budget works, which depicts the differences in service structures between the GKK. The figure below visualizes the scheme for determining the differences in GKK's structures. In order to investigate the overall disadvantage (or advantage) per carrier, which triggers the compensation from the Equalisation Fund. For this, the GKK-specific service costs and income from the contribution and the prescription charges are determined. Then, the surplus for disadvantages originating from regional peculiarities is added, which results in the total advantage or disadvantage of the specific GKK. This total will be utilized as basis for compensating the differences between the GKK, by means of the Equalisation Fund of the GKK.

Figure 13: Overview Equalisation Fund of the GKK, In- and Outflows of Financial Means in 2014, own illustrations, based on Rechnungshof 2017/10

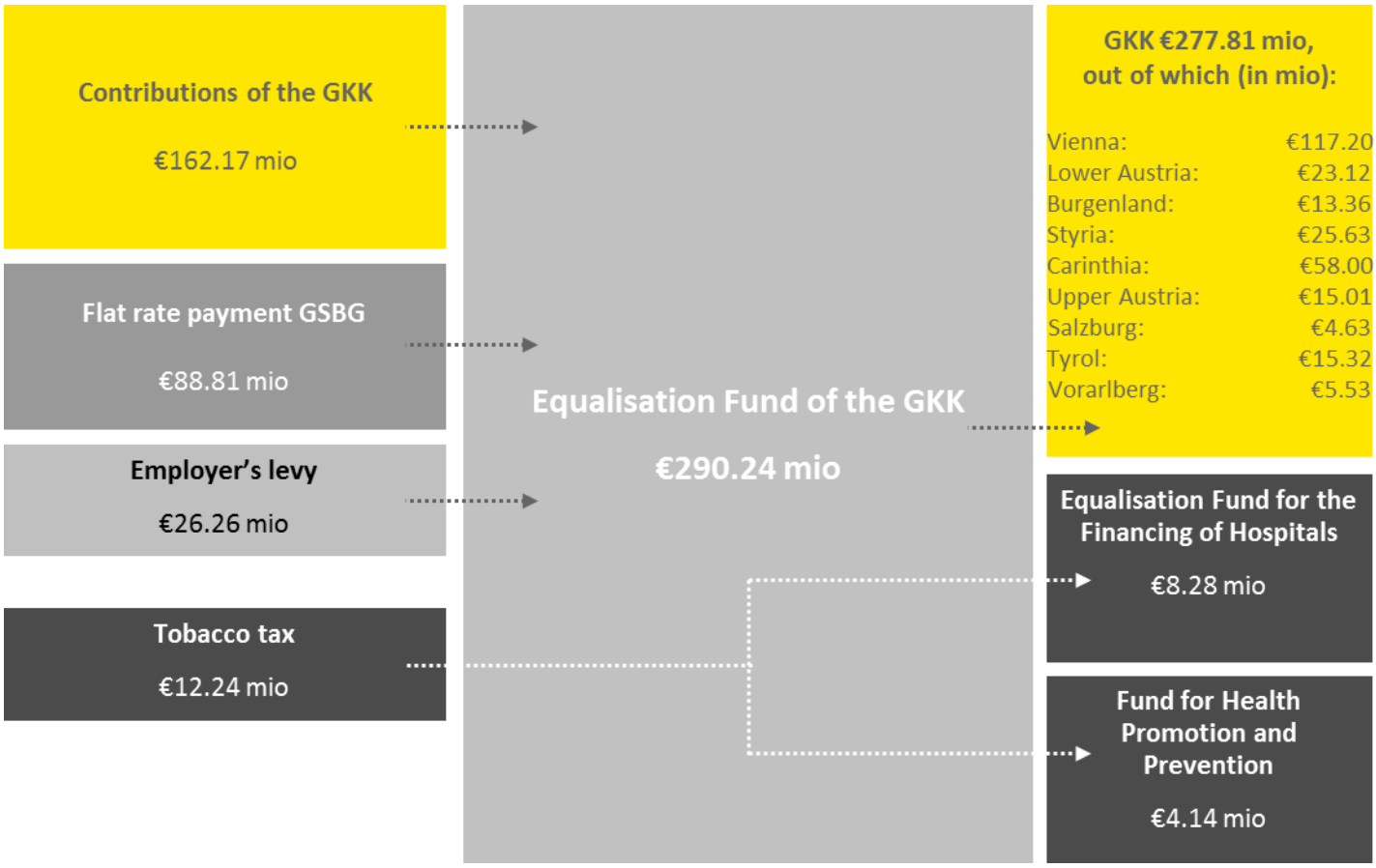


Figure 14: Examining the Differences in Service Structures between the GKK, own illustration, based on 10 Jahre Strukturausgleich, 2015

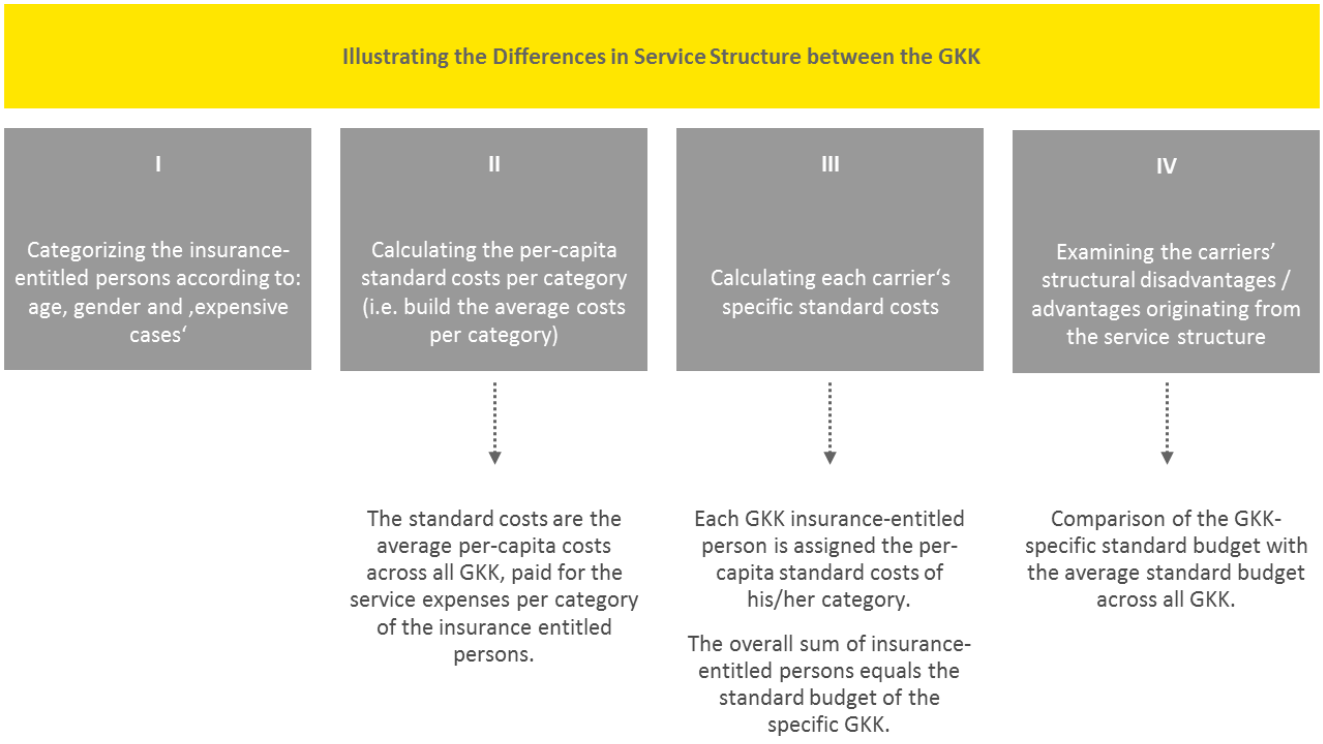
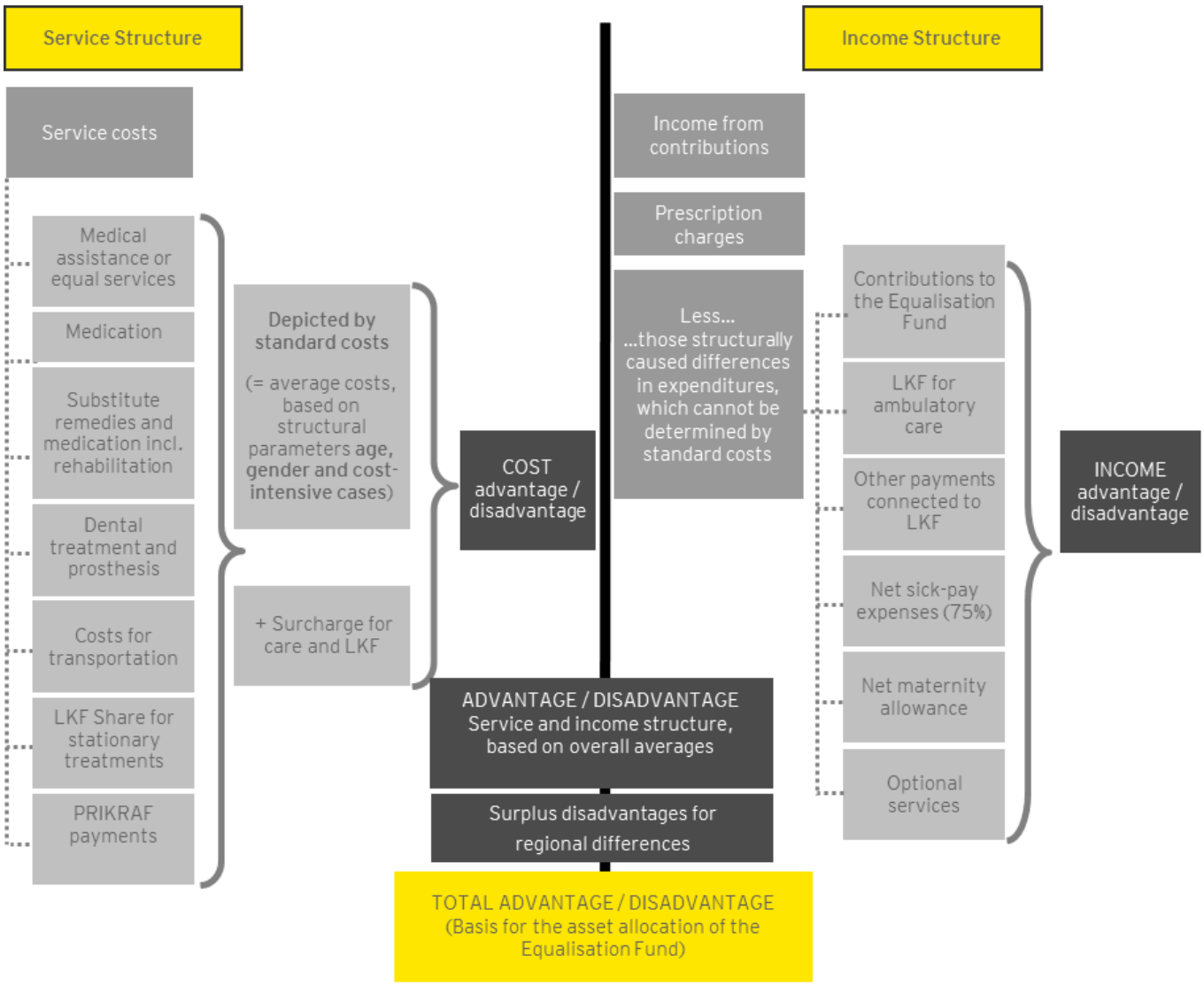


Figure 15: Determining the total Disadvantage per GKK, according to the Service Costs and Income from Contributions, own illustration, based on 10 Jahre Strukturausgleichsfonds, 2015.



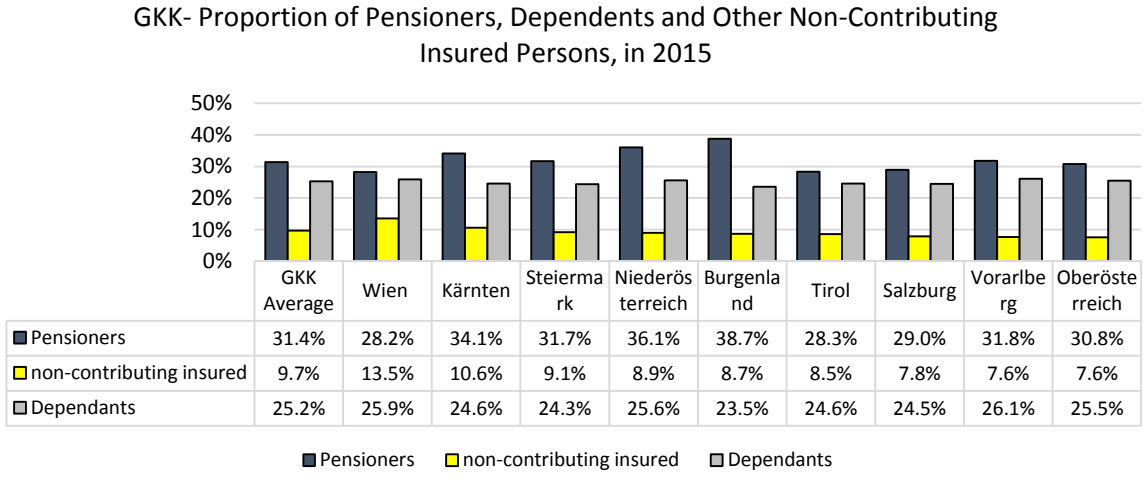
2.2.7 Challenges: Compensation for Burdens caused by the Generalised Hospital Financing

The structural equalisation accounts for the share of the hospital-financing, calculating the serviced days at the hospital in terms of standard costs (average costs). Yet, this may result in disadvantaging those carriers, which are burdened with above average flat rate payments (which also cannot be influenced, currently). The structural equalisation does not account for these disadvantages, which are set for an unlimited period of time and are not reduced.

2.2.8 Proportion of insured pensioners, dependents and non-contributing persons (GKK)

Regarding the regional health carriers, Vorarlberg insured the largest proportion of dependents (26.1%), whereas the Burgenland had the fewest, only reaching 23.5%. The amount of pensioners was also highest in Burgenland, reaching 38.7%, Vienna and Tyrol contrasted this with low proportional numbers for retired insured persons, being 28.2% and 28.3%, respectively. The non-contributing insured persons include unemployed persons, persons receiving childcare benefits, or persons who receive needs-based minimum benefits. The share of non-contributing persons was by far the highest in Vienna, amounting to 13.5%. In comparison, the overall average equalled at 9.7%.[54] The fewest non-contributing persons where found in Vorarlberg and Upper Austria, with 7.36% each (see Figure 16).

Figure 16: GKK - Proportion of Pensioners, Dependents and Other Non-Contributing Insured Persons, in 2015, based on data from Betriebsvergleich 2015.



	GKK Average	Wien	Kärnten	Steiermark	Niederösterreich	Burgenland	Tirol	Salzburg	Vorarlberg	Oberösterreich
Pensioners	31.4%	28.2%	34.1%	31.7%	36.1%	38.7%	28.3%	29.0%	31.8%	30.8%
non-contributing insured	9.7%	13.5%	10.6%	9.1%	8.9%	8.7%	8.5%	7.8%	7.6%	7.6%
Dependants	25.2%	25.9%	24.6%	24.3%	25.6%	23.5%	24.6%	24.5%	26.1%	25.5%

[54] Niederösterreichische GKK, 'Betriebsvergleich Der Gebietskrankenkassen 2015'.

2.2.9 Net subsidies from the Equalisation Fund

Since all GKK pay into the Equalisation Fund, as well as receive payments from it, the analyses should also include the net payments per GKK: Comparing the absolute figures, the GKK Carinthia benefited the most from the equalisation fund, as it received net €70.69 mio, in 2015. Also in relation to the overall expenses, the fund was essential to the GKK Carinthia, covering 8.9% of the expenses. The Viennese GKK, received €60.16 Mio, which covered about 1.9% of the costs. The Burgenland GKK (BGKK) received 2.5% of the expenses from the fund. Contrasting this, GKK Upper Austria paid more financial means into the fund, than it was allocated, having negative net-inflows, i.e. outflows of €21.53 mio. The same applies to GKK Salzburg, which had €7.6 mio net-outflows due to having a better structure of insured persons in relation to the other GKK. For more detailed information on the other GKK, please see figures below.

Figure 17: Equalization Fund: Net-Inflow (Transfer - Subsidies)

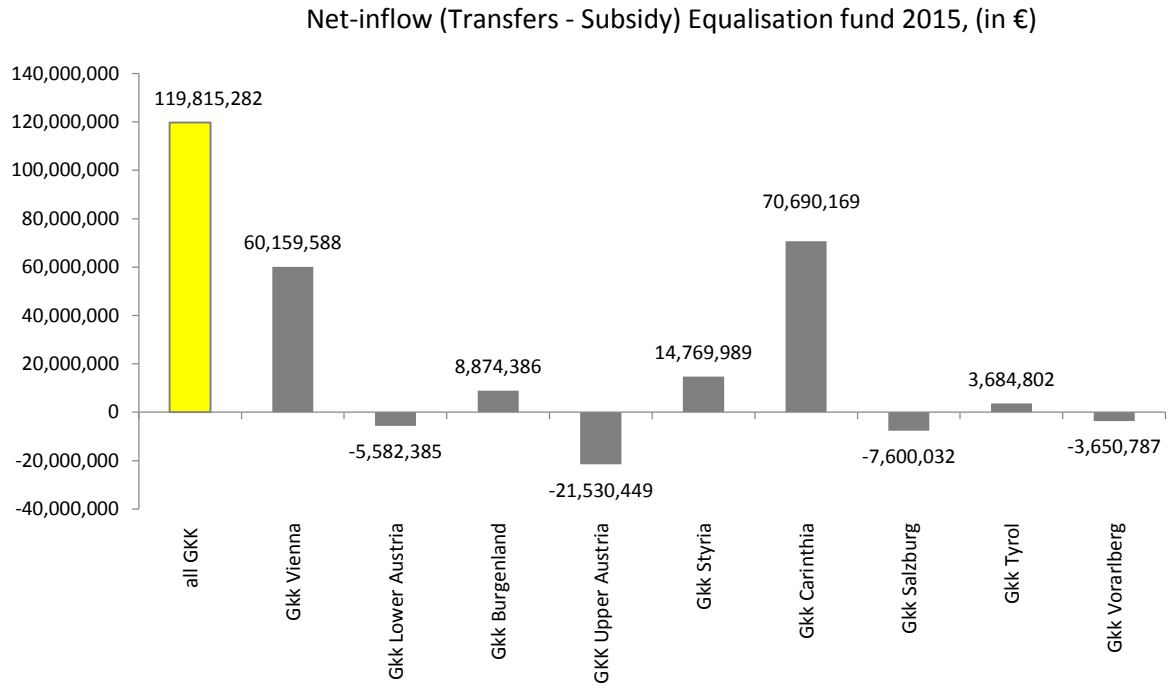
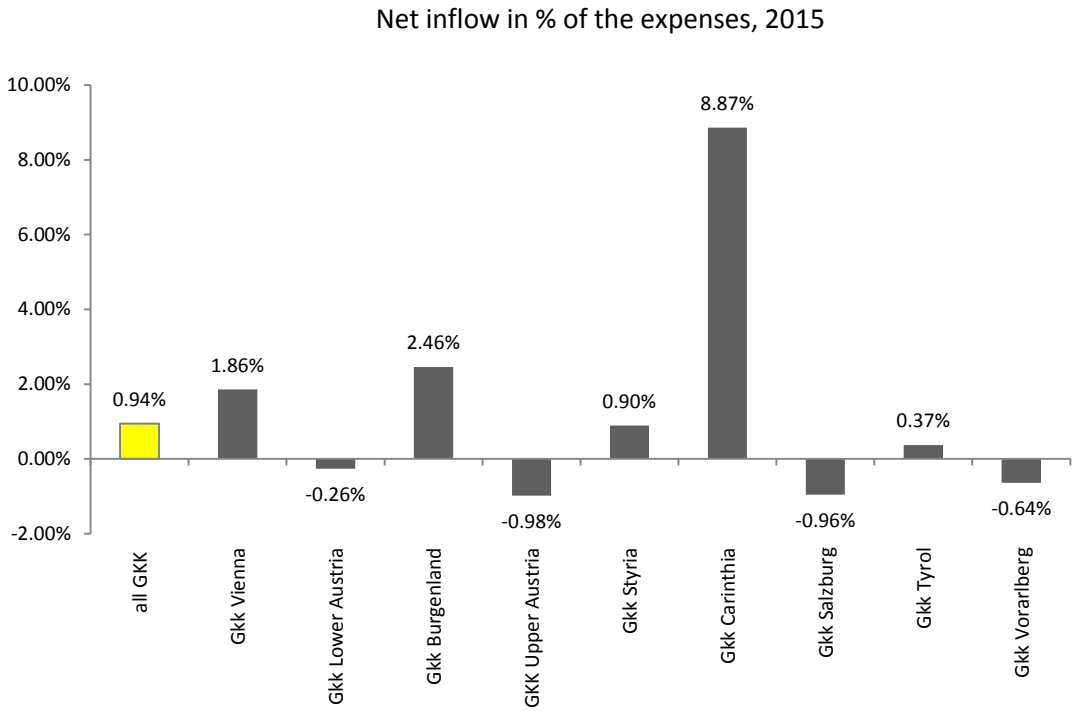


Figure 18: Equalization Fund: Net Inflow in % of the Expenses per GKK



2.2.10 Goal: Comparison of this Structural Equalisation with Other Models

The financial situation of Vienna is accounted for by the equalisation criterion liquidity. However, there is no criterion with concern to the "level of urbanization". The density of physicians and hospitals is higher in urban areas and Vienna is the only Land with just an urban structure. Consequently, it should be considered to replace the factor liquidity by an urbanisation factor, in the mid-term. However, it must be contemplated how this would affect the Carinthian GKK and the Burgenland GKK, as these are net recipient of the equalisation fund. Additionally, the Upper Austrian GKK showed the highest income per capita, amounting to €1.598,05 (stemming from income-contributions and prescription charges), yet for calculating the risk equalization, the Upper Austrian GKK was ranked fifth (after the deductions, the income amounted to €1.270,08). For further information on all carriers' per capita income, used to calculate the structural equalisation, please see the table below.

Table 8: Income per Carrier for calculating the Structural Equalisation, 2015, data sourced from HVSV.

Income per carrier for calculating the structural equalisation

GKK 2015

in Euro

DESCRIPTION	Alle GKK	WIEN	N.OE.	BGLD.	O.OE.	STMK.	KTN.	SLBG.	TIROL	VLBG.
Income from contributions	1.513,10	1.527,64	1.524,79	1.446,14	1.558,29	1.478,58	1.450,56	1.523,41	1.451,49	1.549,48
Prescription charges	44,13	43,41	52,90	56,11	39,75	43,88	42,06	37,23	41,76	41,57
Subtotal	**1.557,23**	**1.571,05**	**1.577,69**	**1.502,24**	**1.598,05**	**1.522,46**	**1.492,62**	**1.560,64**	**1.493,25**	**1.591,05**
minus the contribution to the Equalisation Fund	24,00	24,35	24,16	22,88	24,74	23,36	23,04	24,10	23,05	24,30
plus/minus Compensation for REGO	0,71	1,21	1,22	3,93	- 0,70	1,05	- 0,30	- 0,41	1,58	0,01
minus Optional services medical advice	29,45	20,03	24,28	21,85	32,08	25,51	28,86	42,75	49,75	48,66
plus Compensation for sickness-benefits unemployed persons	25,94	41,16	31,34	28,12	16,94	20,91	22,66	14,46	14,72	16,25
minus Maternity allowance	55,52	62,90	46,26	43,86	54,87	53,71	58,36	57,97	60,09	51,92
plus Compensation Maternity allowance	38,86	44,03	32,38	30,71	38,41	37,60	40,86	40,58	42,06	36,34
minus transfers to the regional health funds (§447 f)	228,43	236,22	198,69	160,82	270,92	212,41	202,91	235,80	228,83	252,18
Income for calculating the structural equalisation	**1.285,36**	**1.313,94**	**1.349,24**	**1.315,59**	**1.270,08**	**1.267,03**	**1.242,68**	**1.254,65**	**1.189,90**	**1.266,58**
Insurance-entitled persons	6.996.199	1.644.907	1.195.355	207.796	1.216.485	943.210	431.930	456.768	579.664	320.084

2.2.11 Structural Differences between all health insurance carriers

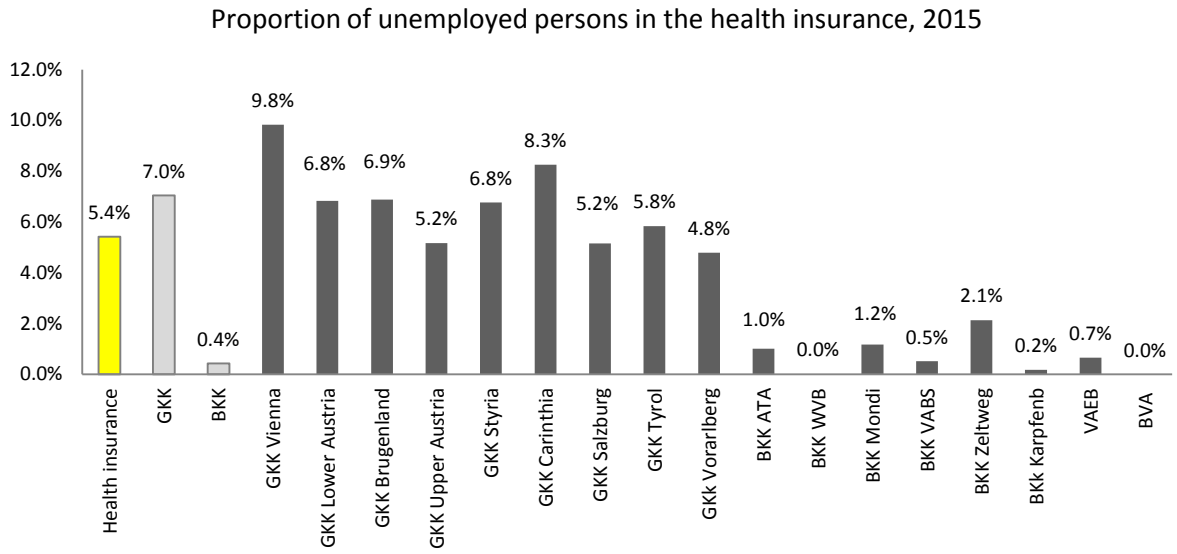
In 2015, there existed 6.891.364 health insurance relationships on annual average. In comparison to this, there were 6.553.415 contribution paying insured persons.[55] Thus, the discrepancy only amounts to 5%. The following three figures illustrate the proportions of unemployed, contribution paying, and pensioners in the insurance relationships of health insurance carriers.

With respect to the amount of unemployed persons, the largest share in 2015 is found at the GKK Vienna with 9.8%, which is followed by the GKK Carinthia (8.3%). The lowest percentage of unemployed persons is insured at the GKK Upper Austria and the GKK Salzburg, both only having 5.2%, which is 1.8% below the average for all GKK (being 7%). With respect to the other health insurance carriers, the BKK Zeltweg

[55] The number of entitled persons was 8.506.925, because dependents are also entitled, but are not counted in the number of insurance relationships ig the y pay no contributions.

figured as the carrier with the highest proportion of unemployed persons with 2.1%, which in comparison with the GKK is diminutive. The SVB as well as the SVA were not included, as they do not have any unemployed persons in their insurance pools. For further information, please see Figure 19.

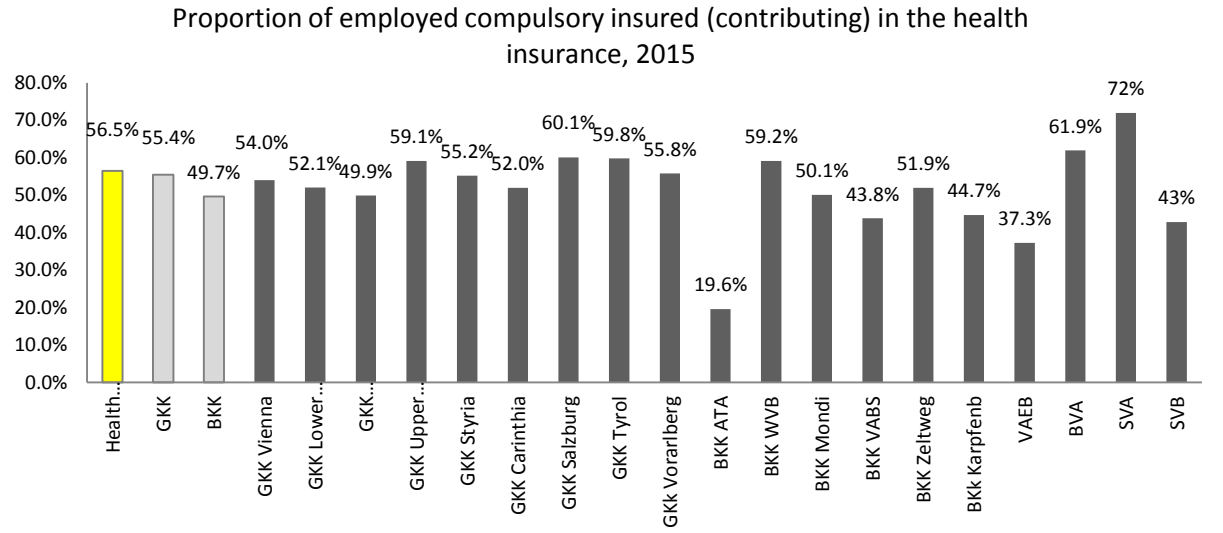
Figure 19: Proportion of Unemployed Persons in the Health Insurance Carriers, own illustration, based on data from Versicherungsverhältnisse 2015.



The average across all health carriers, regarding the contribution paying insured members accumulated to 56.5%. Regarding the GKK, the share of contributing insured persons was the highest at the GKK Salzburg, closely followed by the GKK Tyrol and the GKK Upper Austria, which all had about 60% of contribution paying members (the per capita income from contributions utilized to calculate the allocation of the Equalisation Fund, was the highest in Upper Austria, figuring €1.558,29. The highest overall percentage of any health insurance carrier was achieved by the SVA with 72%. Also, the BVA showed high numbers with 61.9%. The lowest non-GKK health insurance carrier was the BKK ATA with 19.6%, (which for a BKK also showed a comparatively high proportion of unemployed persons, figuring at 1%, whereas the average for BKK's lies at 0.4%). However, the BKK ATA (Austria Tabak) ceased existing in 2017. The lowest GKK was the Burgenland with 49.9%, which is well below the GKK average, which is 55.4%. For further detail, please see

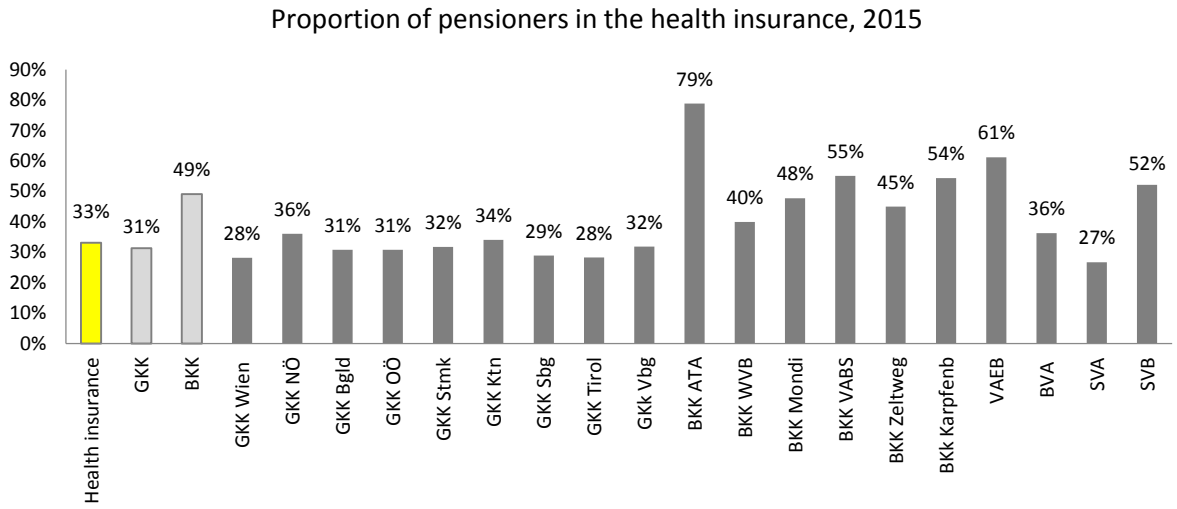
Figure 20the figure below.

Figure 20: Proportion of Employed Compulsory Insured in the Health Insurance Carriers, own illustration, based on data from Versicherungsverhältnisse 2015



The figure below shows, that with respect to the proportion of pensioners, the now closed BKK ATA represented an outlier, with 79% of pensioners in its health insurance pool. This serves as explanation for the low proportions in contribution paying persons. The average across all BKK, however is also relatively high, scoring 59%. In comparison, the average across all health insurance carriers lies at 33%, whereas the GKK have an even lower 31%. The highest pensioners' quota for the special insurances is found at the VAEB with 61%. Contrasting this, is the SVA with less than half of the VAEB, i.e. 27% of pensioners. The highest GKK was as before mentioned the GKK Lower Austria (36%). In comparison, the lowest percentages of pensioners are found at the GKK Vienna and Tyrol, both figuring at 28%.

Figure 21: Proportion of Pensioners in the Health Insurance Carriers, own illustration, based on data from Versicherungsverhälnisse 2015



2.2.12 Proportion of Contributions stemming from Compulsory Insured Persons in Relation to the Overall Health Insurance Carrier's Income

The figure below sets the contributions, stemming from the compulsory insured persons in relation to the income of the health insurance carriers. The differences in the per capita income, are significant between the carriers. These are calculated on the basis of the average total amount of directly insured persons (meaning without co-insured dependents). The per capita income of most of the GKK is around average, which forming the largest part of the health insurance, they highly impact. On the other hand, the majority of the BKK and the BVA are considerably above the average. The SVA and the SVB in contrast, show relatively low per capita incomes. However, the carriers' income is not only characterized by the contributions.

Figure 22: Share of Contributions from active workforce in % of Income, 2015, own illustration, based on Statistisches Handbuch Ö. SV. 2016

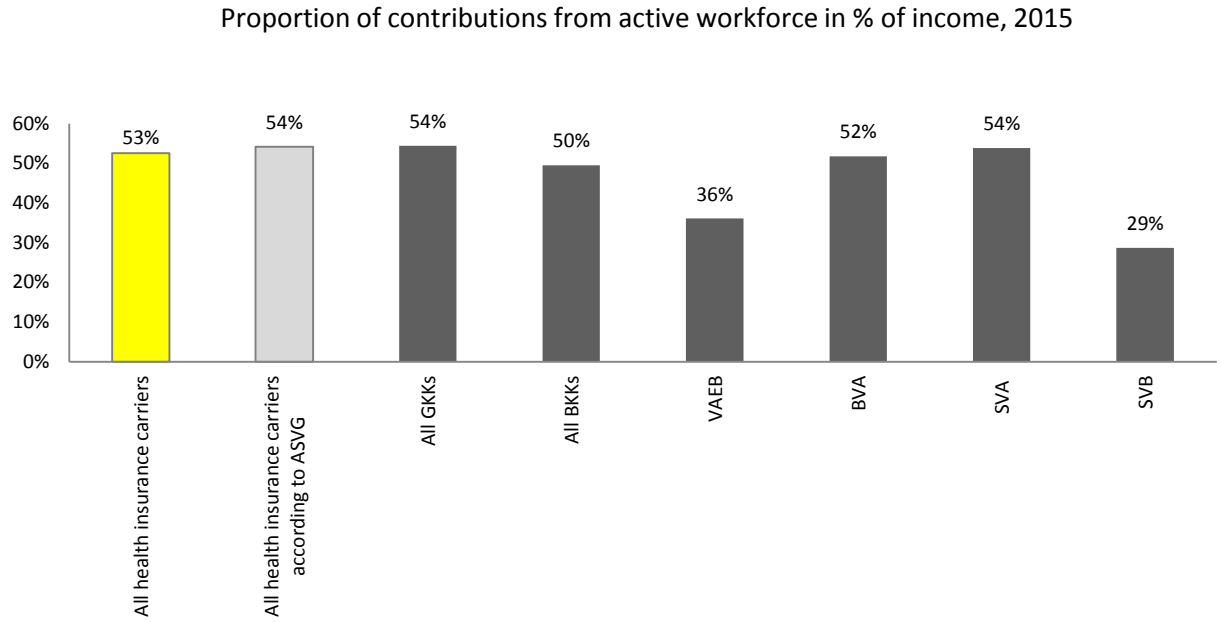


Figure 23: Per Capita Income of all Health Insurance Carriers, own illustration, based on Finanzstatistik 2015

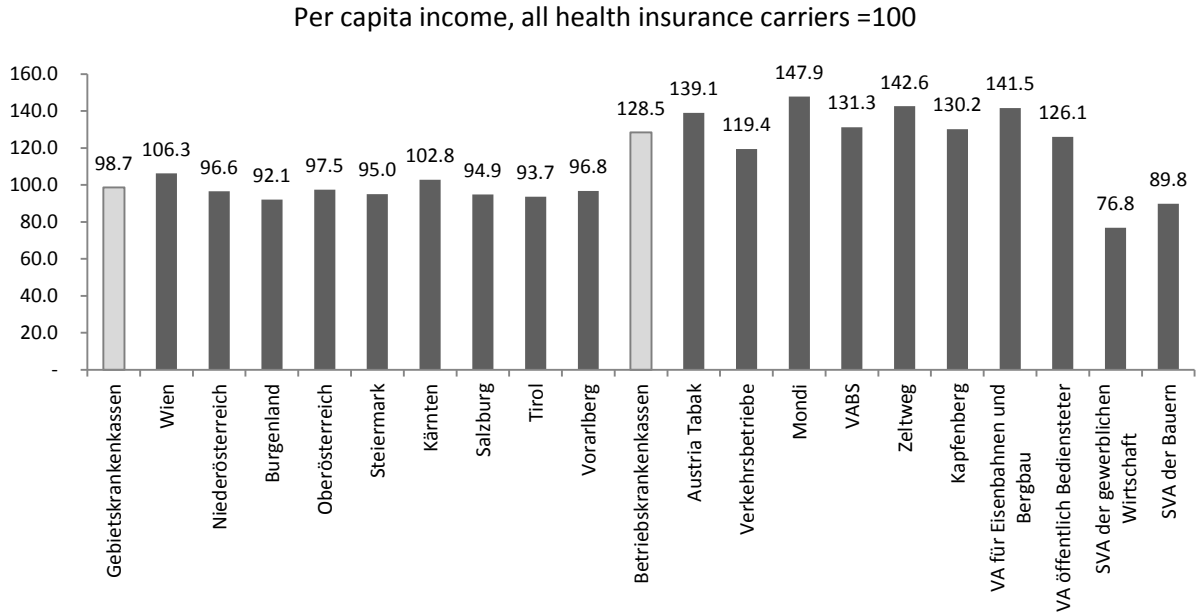
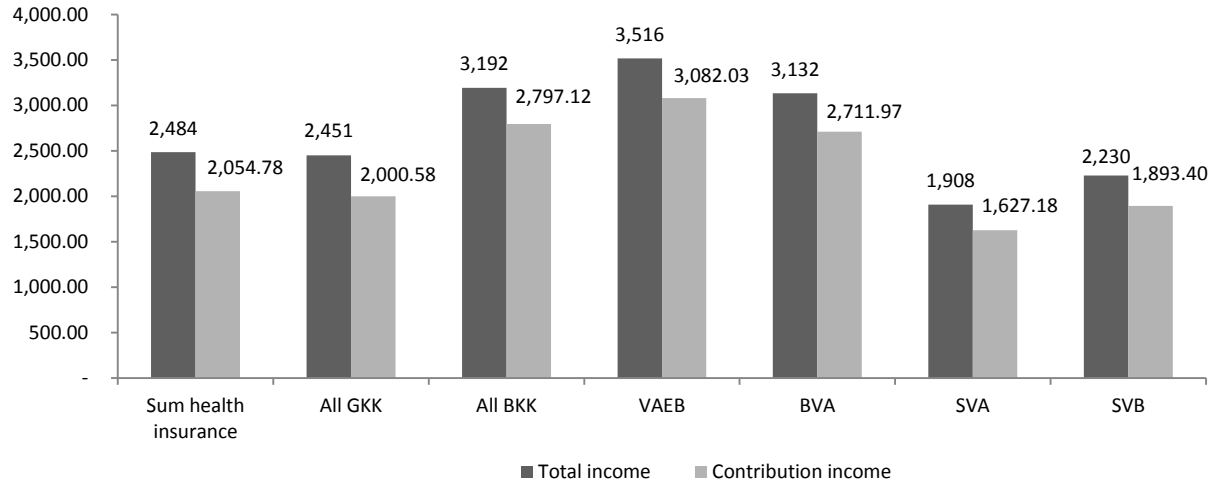


Table 9: Per Capita (excluding Dependents) Income versus Expenses in the Health Insurance, own illustrations, data sourced from Statistisches Handbuch der Ö. Sozialversicherung, 2016

	Per capita rate of income	**Per capita rate of expenses**
All health insurance carriers	**2.484,13**	**2.479,67**
GKKs	2.451,49	2.457,27
Vienna	2.639,48	2.652,98
Lower Austria	2.398,50	2.398,51
Burgenland	2.287,33	2.287,33
Upper Austria	2.420,89	2.436,43
Styria	2.361,09	2.361,09
Carinthia	2.553,95	2.536,83
Salzburg	2.356,29	2.342,88
Tyrol	2.328,00	2.344,06
Vorarlberg	2.404,55	2.416,46
BKK	3.192,19	3.094,36
Austria Tabak	3.454,26	3.341,14
Public transport employees	2.965,88	2.990,29
Mondi	3.674,61	3.443,95
VABS	3.260,52	3.285,33
Zeltweg	3.543,09	3.245,49
Kapfenberg	3.234,74	2.857,15
VAEB	3.515,87	3.487,16
BVA	3.131,98	3.161,66
SVA	1.907,68	1.889,95
SVB	2.230,39	2.018,87

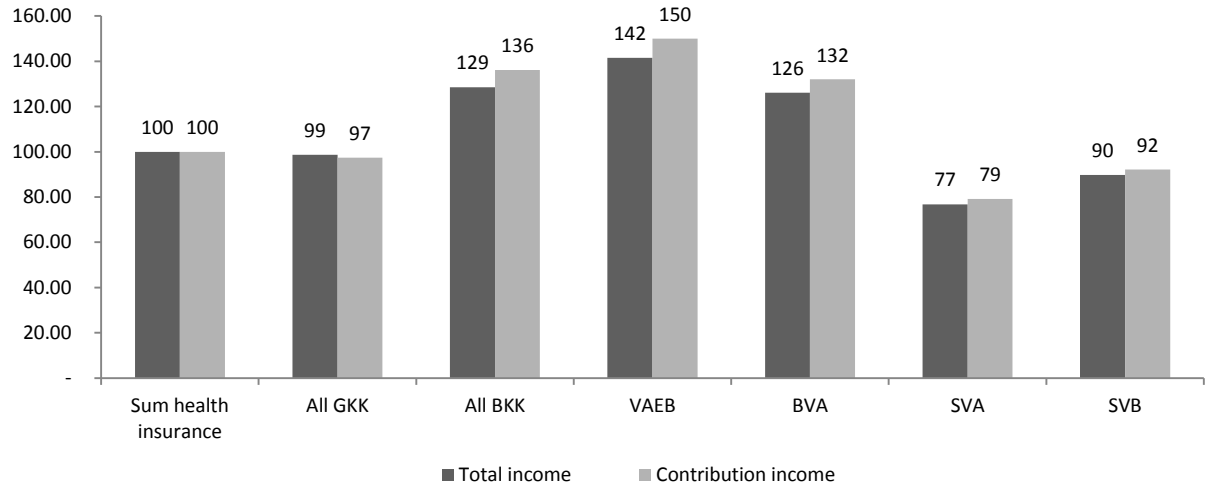
Figure 24: Per Capita Income and Contribution Income, own illustration, based on Finanzstatistik 2015.



2.2.13 Comparison between Income and Contribution Income (per Capita)

The BKK, VAEB and BVA have significantly higher contribution incomes on a per capita basis, than the average of all health insurance carriers. The SVA in contrast, has the lowest income from contributions, (as well as the lowest expenditures). This is likely to be caused by the large share of SVA-insured persons (15% please also see the chapter on multiple insured persons), who count as multiple insured, since they are e.g. self-employed, as well as employed. In case of multiple insurances, the obligation to contribute exists only up to a maximum contribution base. In consequence, the income from contributions is smaller at the SVA. On the expenditure side, multiple insured persons are allowed to choose the insurance carrier, which bears the costs for the provision of services. Resulting from this, the expenditures at the SVA are correspondingly smaller, than the average (also due to the SVA requesting user charges). For more information, please see the figure below (the total average per capita in the health insurance value equals 100).

Figure 25: Comparison between Income and Contribution Income (per Capita), own illustration, based on Finanzstatistik 2015.



2.3 Competencies within the Austrian healthcare system[56]

2.3.1 Federal constitution and division of powers

Provision of care is not only limited on the social insurance providers, but is largely provided by the hospitals. The division of competencies and the division of responsibility for hospitals has developed historically and lies at the core of the Austrian Federal Constitution. The articles 10 to 15 of the Federal Constitutional Law regulate the division of responsibility between the federal and Land level in law-making and execution of laws. Depending on the issue, the division of responsibility differs. There are four main categories of responsibility:

- Art. 10 B-VG: Legislation and execution are a federal responsibility (e.g. federal finances, lending, the monetary and banking systems, civil and criminal law, motoring, business and industry, the military, social insurance, the health-care system and nutrition, including food safety).[57]

[56] Primary sources of data for this section are: Bundes-Verfassungsgesetz (B-VG)Hofmarcher and Quentin, 'Health System Review', 2013.Rechnungshof, 'Verwaltungsreform 2011, Reihe 2011/1'.

[57] Bundes-Verfassungsgesetz (B-VG) – Art. 10 B-VG.

- Art. 11 B-VG: Legislation is a federal matter, execution is the responsibility of the Land (e.g. citizenship, social housing, traffic policing).[58]
- Art. 12 B-VG: Framework legislation is a federal matter, implementing legislation and execution is the responsibility of the Land (e.g. land reform; maternity, infant and children's services; hospitals and nursing homes, and the health spa system).[59]
- Art. 15 B-VG: The general clause in favour of the Länder rules that all unspecified matters of both legislation and execution are the responsibility of the Länder (e.g. farming, tourism, the ambulance service, cinema and other events, kindergartens and crèches, the fire service and matters related to funerals).[6061]
- Art 15a B-VG (1)[62]: Federal State and Länder together can sign agreements on matters related to their respective field of action, e.g. agreement according to Art 15a B-VG[63] on the organization and financing of health care 2016.

The Austrian health-care system is characterized by regionalized provision within a regulatory framework determined at the federal level and delegation of statutory tasks to legally authorized stakeholders in civil society. There are practically no instances of duties being carried out by federal authorities acting on a regional basis (deconcentration). Constitutionally, certain tasks are transferred to the Länder (devolution, regionalization). In all Länder except Vienna, hospital management is outsourced to hospital operating bodies as part of the system of organizational privatization.

In many areas of the responsibility for regulation and financing are separate, meaning that the institution that pays does not necessarily decide on the use of the funds.

The division of competences, particularly within the hospital sector, and the concomitant "dual" financing, are the most significant problems in the Austrian health-care system. In recent years, there has been a trend towards concentrating (centralizing) planning at the federal level through the development of framework plans.

[58] Bundes-Verfassungsgesetz (B-VG) – Art. 11 B-VG.
[59] Bundes-Verfassungsgesetz (B-VG) – Art. 12 B-VG.
[60] Bundes-Verfassungsgesetz (B-VG) – Art. 15 B-VG.
[61] Hofmarcher and Quentin, 'Health System Review', 2013.
[62] Bundes-Verfassungsgesetz (B-VG) – Art. 15 B-VG.
[63] Ibid..

2.3.2 Authorities and competence distribution

Federal State: The administration of health care on the federal level is led by the Minister of Health, who is especially responsible for general health policy and the protection of the population's state of health. The Minister of Health is provided with the Austrian Health Council (Oberster Sanitätsrat, OSR) as consulting body. The council has no jurisdiction, has to be heard in important matters, has a right for requests and provides assessments and statements. It consists of health experts, whereby all relevant professional groups are represented. The consultation takes place in all fundamental medical questions and always complies with current medical science.

Land: The execution of health administration on the Länder level is under the responsibility of the Länder governor or the Länder government, depending on whether it is a federal or Länder matter. As with the federal state, on the Länder level there are also so called Länder Health Councils (Ländessanitätsräte), which support the authorities with consultation.

District: At the district administration authorities (District authority or municipal authority of a city with own statute) own health departments are set up. Physicians, who take on sovereign tasks there, are called medical officers.

Community: The federal constitution says that the local sanitary police, especially in the field of rescue and emergency services as well as funeral services, is to be handled by the communities in their own field of action. The legal framework for these matters is provided by the Länder legislator.

2.3.3 Planning of health care

The requirements for health care (hospitals, medical practitioners, rehabilitation facilities, nursing homes) are constantly changing due to the demographic and epidemiological development. The aim of health planning is to ensure a comprehensive medical care for the population, which is – according to the general principles of the legislator's planning – appropriate, high-quality, effective, efficient and equivalent. Regarding the planning on federal level the Austrian Structural Health Plan (ÖSG) need to be mentioned. The ÖSG is the basis for the planning of the Austrian health care. The plan is coordinated by the Gesundheit Österreich GmbH (GÖG) on behalf of the Federal Health Agency (BGA) and is frequently revised. The ÖSG is a framework plan for a total of 32 care regions throughout Austria and contains

guidelines for detailed planning at the regional level, the so-called Regional Structural Plans for Health (RSG). The RSG are decided upon by the Landes-Zielsteuerungskommission.

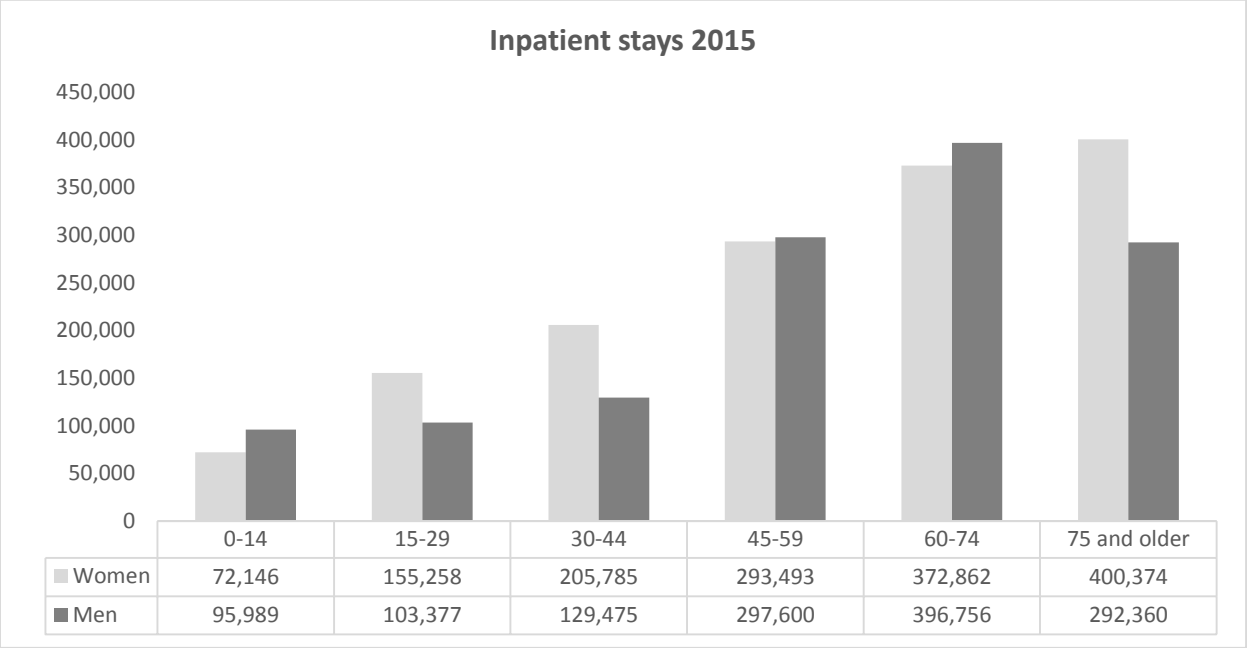
In addition to the inpatient sector (hospitals, accident hospitals and sanatoria), the ÖSG also includes the outpatient sector (medical practitioners, outpatient clinics), rehabilitation and the transition to long-term care. It contains quantitative planning statements (such as number of beds per medical specialty, the availability of a hospital in a timely manner) and qualitative data (e.g. the staffing of a department, minimum equipment for a hospital as a precondition for certain interventions).[64]

2.3.4 Facts and figures hospitals in Austria

In Austria, health care provision in hospitals has a high status. Therefore, in comparison with other European states, there are many and regionally mostly balancing distributed hospital resources. Accordingly, the utilisation of hospitals is high. Austrians are admitted to a hospital inpatient stay more often than in most other European countries. The high and continuously rising number of inpatient hospital stays in Austria and the involved – internationally compared – high "hospital frequency" is for one thing connected with the "hospital load" of the Austrian health care system. Secondly, due to the rapid medical progress and new treatment methods, in Austria day-care hospital treatment is increasingly provided, which is why a former longer stay today can take place in the form of multiple short-term stays. However, eventually billing rules and documentation regulations also lead to a purely statistical increase of inpatient stays and/or to differences between the Länder because of Länder-specific regulations[65].

[64] Gesundheit.gv.at
[65] Ein Service des Bundesministeriums für Frauen und Gesundheit, 'Krankenanstalten in Zahlen'.

Figure 26: Inpatient stays in Austria, own illustration based on Krankenanstalten in Zahlen.

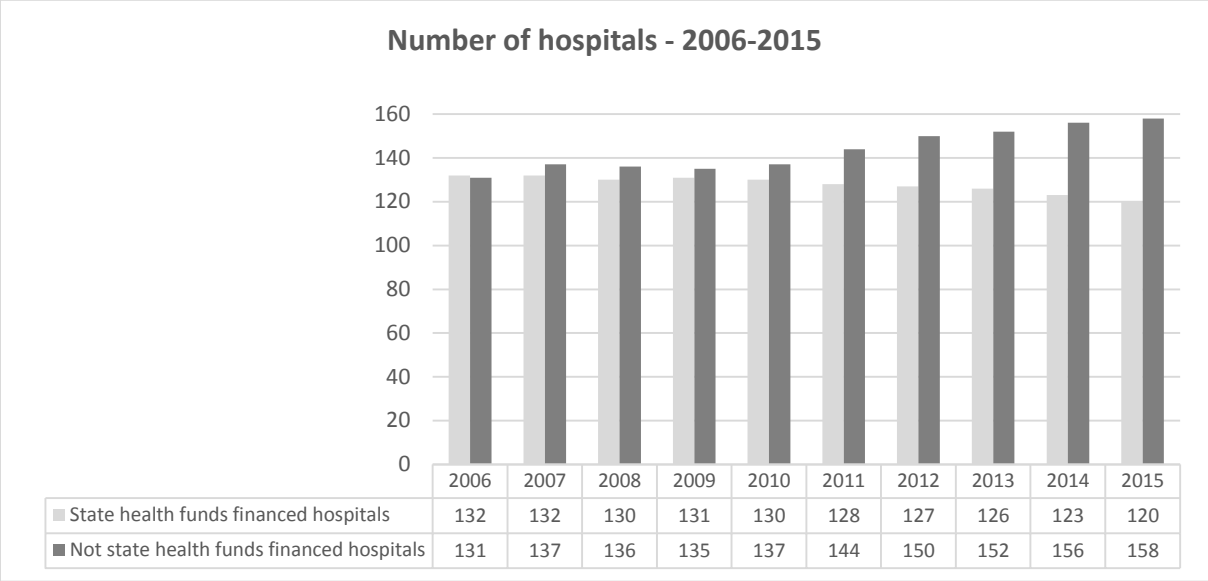


	0-14	15-29	30-44	45-59	60-74	75 and older
Women	72,146	155,258	205,785	293,493	372,862	400,374
Men	95,989	103,377	129,475	297,600	396,756	292,360

The Austrian hospital landscape is diverse and complex. The declining development of the number of hospitals financed by regional health funds, which represent the majority of the inpatient acute care sector, is usually connected to an administrative merging of hospitals. Thereby, in almost every case the individual locations remained, which resulted in de facto almost no reduction of the number of hospital locations.

The increase of hospitals not financed by regional health funds, many of them not providing acute care, is primarily due to the development and expansion of rehabilitation institutions.

Figure 27: Number of hospitals, own illustration based on Krankenanstalten in Zahlen.



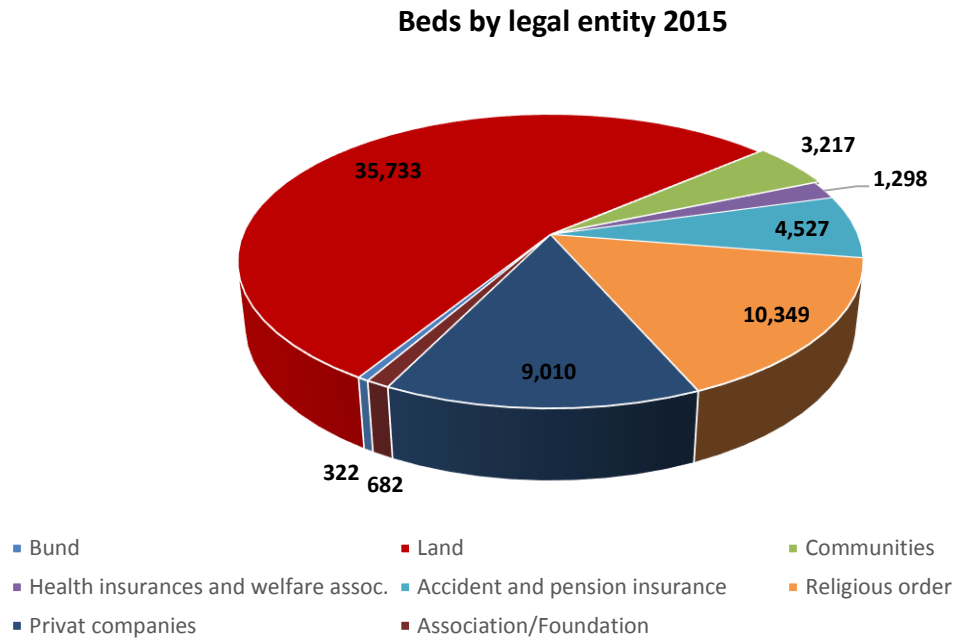
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
State health funds financed hospitals	132	132	130	131	130	128	127	126	123	120
Not state health funds financed hospitals	131	137	136	135	137	144	150	152	156	158

Figure 28: Hospitals in Austria, (www.spitalskompass.at).

Non-profit organization Private institutions

Also the bed development in hospitals financed by regional health funds tends to decrease, despite the increasing number of inpatient stays, because hospital stays in the acute care sector become even shorter. The increase in beds in hospitals not financed by regional health funds, most of them not providing acute care, is primarily connected to the increasing number of these hospitals, especially in the field of rehabilitation.

Figure 29: Beds by legal entity, own illustration based on Krankenanstalten in Zahlen. [66]



2.3.5 Status quo

The current arrangement of the federal structure of the Austrian state is very complex and characterised by interconnected organizational, decision and financing structures. The federal state with ten legislators (1 federal state, 9 Länder) results in an increased (Austria-wide) need for coordination. The evaluation performed by the EU commission in connection with the realisation of internal market regulations shows that the "Factor 10" (ten legislators) can be challenging.

The evaluation shows some minor weaknesses, since it is only a snapshot and only concentrates on the time limits without making a statement about the implementation quality. Concerning this matter, in May 2014 Austria ranked last in timely implementation of inner market regulations in comparison with the EU-28.

With regard to the hospital sector in Austria the Austria-wide performance comparison is complicated by the current competence distribution and the financing of the system becomes very complex (dual financing). Through the existing competence distribution in many fields there are ten laws (e.g. 10 hospital

[66] „tatsächlich aufgestellte Betten, including Rehabilitation centers/clinics ,

laws). Currently a pattern relating to Länder laws can be seen, which shows that the Länder either take over federal legal regulations or implement them by means of own expressions with identical content. Thus, there are ten legislators, administration departments and legal departments employed with identical topics. In this area a bundling of legislation to the federal level would have a high efficiency potential and the laws could be implemented faster. The Austrian Court of Audit identified a lot of potentials in its report "Verwaltungsreform 2011" (Bund 2011/1), e.g. the fragmented constitutional competences in health care, the deficient coordination between the intra- and extramural sector, the overload of the inpatient sector, the high location density, insufficient balance of services and collaborations, the lacking cross-carrier service offer, the service shift between intra- and extramural sector and the absent quality measurement and assurance.[67]

2.3.6 Potential for optimisation

Due to an absent common controlling and financing of the primary care, outpatient and inpatient sector there is a sectoral interface problem. An important issue in this context represents the duplicity in health care services. The switching back and forth of patients in the different care levels (due to dual financing) causes not only costs, but also should be avoided in the interest of a qualitative care of patients.

An additional area that promises efficiency potential is the focus on the best-point-of-service. Patients can choose a care level and therefore often (due to the availability) make use of an expensive infrastructure (e.g. hospital outpatient departments). Through a strong network of intra- and extramural service providers, expensive or unnecessary paths of patients could be reduced. As described in the chapter "Quality", currently there are efforts made also in the outpatient/primary care sector to standardise service documentation (Leistungsdokumentation, KAL und MEL). As long as this is not realised or practiced, due to non-existent cross-carrier data, it will be difficult to evaluate in which care sector the service for the patient would be provided in the most effective and efficient way. [68]

The Austrian Court of Audit suggests that through an adjustment of acute care beds (currently there is an overload in the inpatient care sector) to the European average, funds in the amount of around €2,900 Mio. could be released. A restructuring to the outpatient sector would be possible, which according to

[67] Rechnungshof, 'Verwaltungsreform 2011, Reihe 2011/1'.
[68] Institut für Föderalismus, '36. Bericht Über Den Föderalismus in Österreich (2011)'.

scientific investigations would promise a higher efficiency[69]. One frequently submitted recommendation is the new regulation of existing competences for the Austrian health care through assigning health care, nursing care and sanatorium care to Art. 11 B-VG[70]. This modification of responsibilities in the health care institution sector from Art. 12 B-VG to Art. 11 B-VG (Legislation federal state, execution Länder) on its own would probably cause a little improvement.

So far, the federal state has only defined principles and accordingly left legislative room to move in those areas the state has not set any regulations (e.g. compensation of the special category) or in those where the state left room to move for the Länder legislation on purpose (e.g. arrangement of the ethics committee, medicines commissions, …) In case of a change to Art. 11 B-VG, this room to move would be eliminated. In this context, the change in Art. 11 B-VG would also influence the regional health structure plan, namely that the framework is set on a federal level and the detailed planning takes place on the Länder and regional level in form of regional health structure plans.

To realize the efficiency potentials it is not just about to change the legislation from Art. 12 B-VG to Art. 11 B-VG. To realize the potential it should be a bundle of measures described in this section.

2.4 Administration costs within the current institutional structure[71]

2.4.1 Actual administrative and accounting expenses

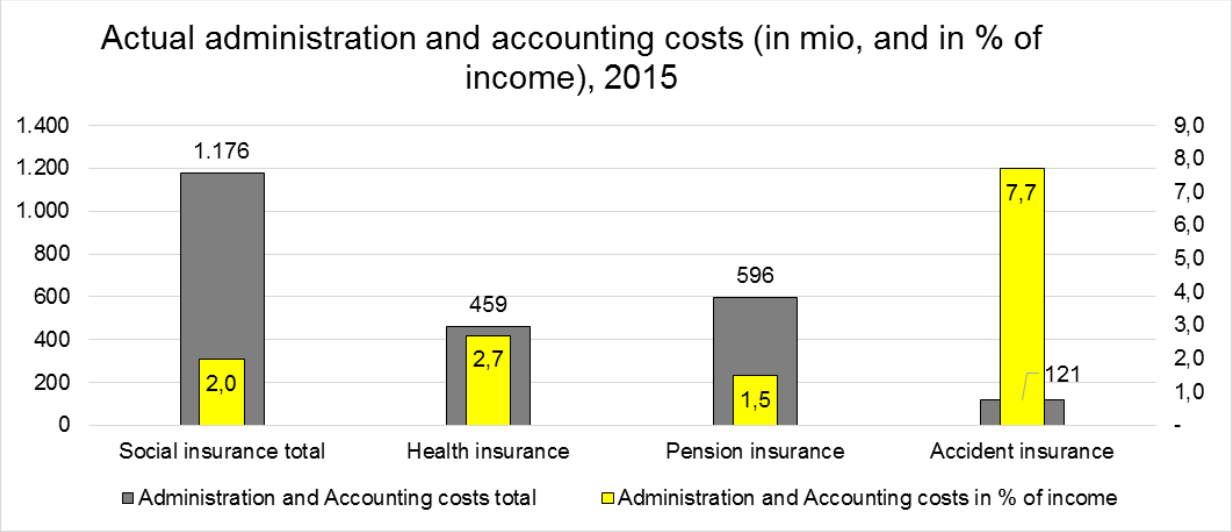
In 2015, the overall administration expenditures, across all social insurance carriers, amounted to €1.176 billion (in 2014, this was €1.161 billion) and averaged at 2% administration and accounting costs in terms of income. The figure below indicates the distribution of the actual administrative expenditures between the health, pension and accident insurances, as well as the ratio between the administration and accounting expenses in terms of the income. Evidently, the pension insurance had the most expenditures with €596 mio and a rather small ratio between administrative expenditures and income, figuring at 1.5%. This was followed by the health insurance with €459 mio and 2.7% administrative costs, whereas the accident insurance had €121 mio of administration cost. The accident insurance showed by far the highest

[69] Rechnungshof, 'Verwaltungsreform 2011, Reihe 2011/1'.
[70] Bundes-Verfassungsgesetz (B-VG) – Art. 11 B-VG.
[71] Primary source of information for this section are: Data from HVSV: Verwaltungsstatistik 2015 and Finanzstatistik 2015Hauptverband der Österreichischen Sozialversicherungsträger, 'Finanzierung: Wahlmodul - Allgemeine Fachausbildung'.Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

administrative costs in relation to its income, reaching 7.7%, in 2015. This may partly be explained by the accident insurance having relatively small volumes of income and expenditures, since accident benefits are comparatively low in relation to pension benefits. Thus, the administrative costs that accrue from handling one case, (which is, compared to the pension insurance, more work-intense) are distributed onto a much smaller amount:

'In comparison to the other pillars of the social security, accident insurance shows the highest administrative costs. However, any report of a work accident or an occupational disease involves a difficult and complex investigation-procedure, assessing the causality between the occupational activity and the accident itself (causing a claim for benefits, provided by the accident insurance).'[72] Contrasting this, the rather low percentage of administrative costs in terms of income for the pension insurance, is likely to be linked to economies of scale, as the pension insurance is denoted by the largest income.

Figure 30: Actual Administration and Accounting Costs (in € Million, and in % of Income), own illustration based on Verwaltungsstatistik, 2015 & Finanzstatistik 2015.The growth in administration and accounting costs



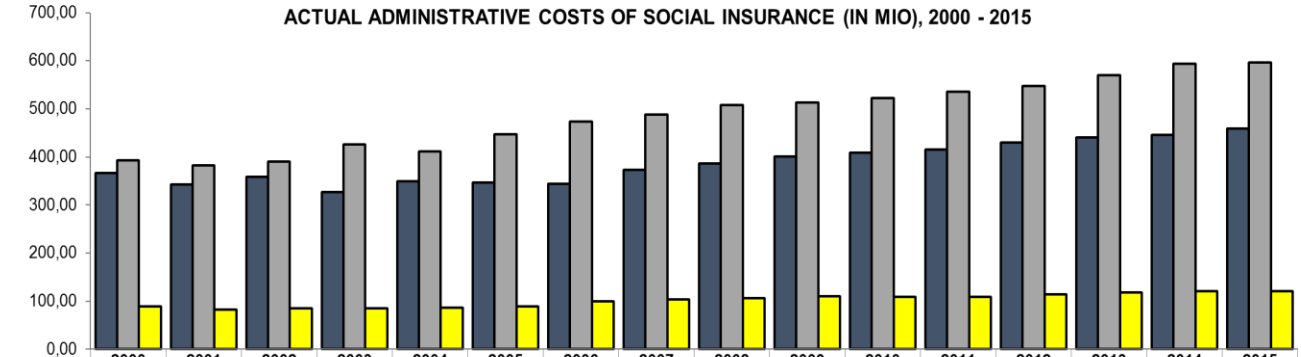
2.4.2 The growth in administration and accounting costs

Besides the ratio between the administration costs and the income, looking at the historical development of the administrative costs may generate a more comprehensive picture. Therefore, Figure 31 shows the development of the actual administration costs for the period 2000-2015, including the distribution

[72] Hauptverband der Österreichischen Sozialversicherungsträger, 'Finanzierung: Wahlmodul - Allgemeine Fachausbildung'.

according to the three pillars of the social insurance system. Accordingly, in 2015 the actual administration costs in connection with the pension insurance amounted to €596.47 mio, followed by €459.25 mio for the health insurance and €120.76 mio for the accident insurance. In addition Figure 31 indicates the annual growth rates of administrative costs, as well as the GDP. When comparing the three pillars' growth rates for this 15 year period, the pension insurance figures 2.9% annual growth on average, followed by the accident insurance with 2.1% and the health insurance with 1.6%. In 2015, however, the growth rates show a different picture, with the health insurance having the largest growth with 2.9%, yet, which still lies below the GDP growth rate of 3.2%, in 2015. In contrast, the pension and accident insurance show comparatively smaller annual growth rates with 0.5% and 0.1%, respectively.

Figure 31: Growth of Actual Administrative Costs of the three Pillars of the Social Insurance, own illustrations, based on Finanzstatistik 2015, Hauptverband and Volkswirtschaftliche Gesamtrechnung 1995-2015, Statistik Austria



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Health	365,95	342,99	358,03	327,25	348,75	346,24	344,64	373,38	386,42	401,34	408,95	414,91	430,37	440,73	446,35	459,25
Pension	392,62	382,87	390,02	425,34	412,02	447,59	473,11	487,61	508,06	513,65	522,60	535,37	547,02	569,78	593,54	596,47
Accident	88,90	83,08	85,63	84,52	86,82	89,52	99,97	103,17	106,20	109,98	108,82	108,58	113,57	118,51	120,65	120,76

Annual growth rate of actual administrative costs & GDP, %

Insurance	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Average
Health	-6.3	4.4	-8.6	6.6	-0.7	-0.5	8.3	3.5	3.9	1.9	1.5	3.7	2.4	1.3	2.9	1.6
Pension	-2.5	1.9	9.1	-3.1	8.6	5.7	3.1	4.2	1.1	1.7	2.4	2.2	4.2	4.2	0.5	2.9
Accident	-6.6	3.1	-1.3	2.7	3.1	11.7	3.2	2.9	3.6	-1.1	-0.2	4.6	4.4	1.8	0.1	2.1
GDP	3.2	2.8	2.1	4.5	4.8	5.3	6.0	3.4	-2.0	2.9	4.8	2.8	1.7	2.4	2.9	3.2

In connection with cost-regression measures, §441e ASVG states that from 2011 onwards, the carrier conference has to establish target controls, which include setting targets for administration cost for the

individual social insurance carriers[73]. Besides hearing the members of the carrier conference, these have to be agreed upon by the minister of the BMASK and the minister of the BMGF. The procedure for setting the targets of the administration costs ensues by calculating the carrier's administrative and accounting costs in terms of the incoming contributions (taking the averages of the financial years 2008-2010). In order to incentivize innovations and investments, the caps for the administration costs are set 0.4 percentage points above the determined historical rate. Yet, there exists no option to adapt this rate, neither in case efficiency potential is identified in the status-quo, nor if there is need for catching-up. Furthermore, the targets do not include any outcome-oriented objectives (e.g. proportion of contribution-payers who need to be checked, or duration of processing approvals/reimbursing costs). In addition, the Court of Auditors (Rechnungshof) criticises that the adherence to the administrative cost targets is neither compared, nor published, nor analysed in detail. [74] The costs are merely checked by establishing that they range below the reference value. Also this may lead to accumulating reserves, as the discrepancy between the targeted cap-value and the actual administrative costs could be enlarged (via drastically lowering the administrative costs)[75]. The current target cap for the administrative cost per carrier is contained in the Balanced Scorecard (BSC) of the HVSV. For 2017, these target caps are depicted in yellow in Figure 32. The grey bars indicate the administrative costs in percentage of the contribution income in 2015, as a reference value. Before the administrative costs targets were set at the BSC, there existed a different cap for the administration costs, from 2001 until 2003. This was based on the historic administration cost values from 1999, adjusted by the changes in the number of insured persons (former §588 ASVG). Subsequently, in 2005 up until 2011, this was changed to target caps for the administrative costs, which were not to be exceeded, as they were linked to the asset allocation of the carrier structure fund (Kassenstrukturfonds), which would not have been paid out in case the caps were not complied with (formerly regulated in §625 Abs. 8 and 9 ASVG). Despite the above explained criticism, the overall moderate growth in administrative costs over the past years demonstrates that on average, the carriers are economically administrating (e.g. since the BSC was installed in 2011, all pillars have been underscoring 4.7% of administration costs). However, it is strongly advised to link the targets with outcome-related objectives, in future. One approach to do so, has recently been undertaken by the NÖGKK in March, 2016, who now defines outcome-oriented strategies in their BSC.

[73] Allgemeines Sozialversicherungsgesetz - §441e Zielsteuerung.
[74] Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.
[75] Ibid.

Figure 32: Discrepancy between Cap and Actual Value of the Administrative Costs 2009-2013, own illustration, based on data from Verwaltungsstatistik 2015 and HVSV BSC 2017

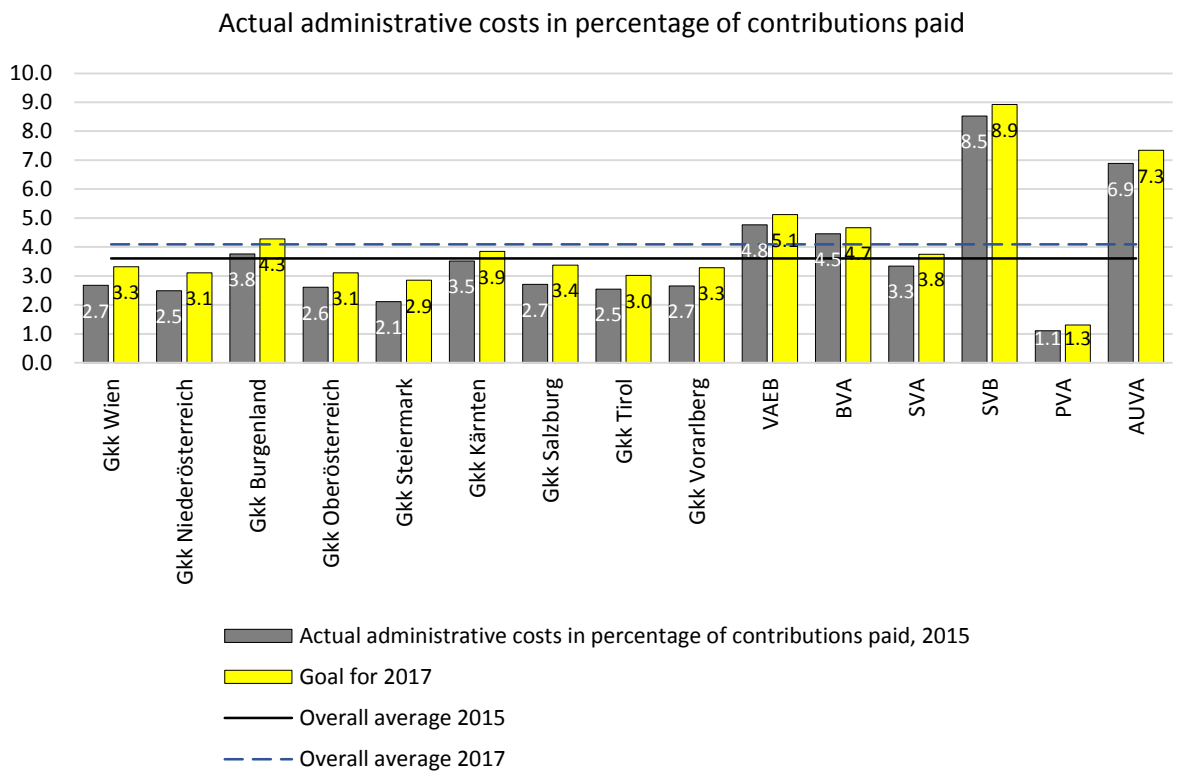
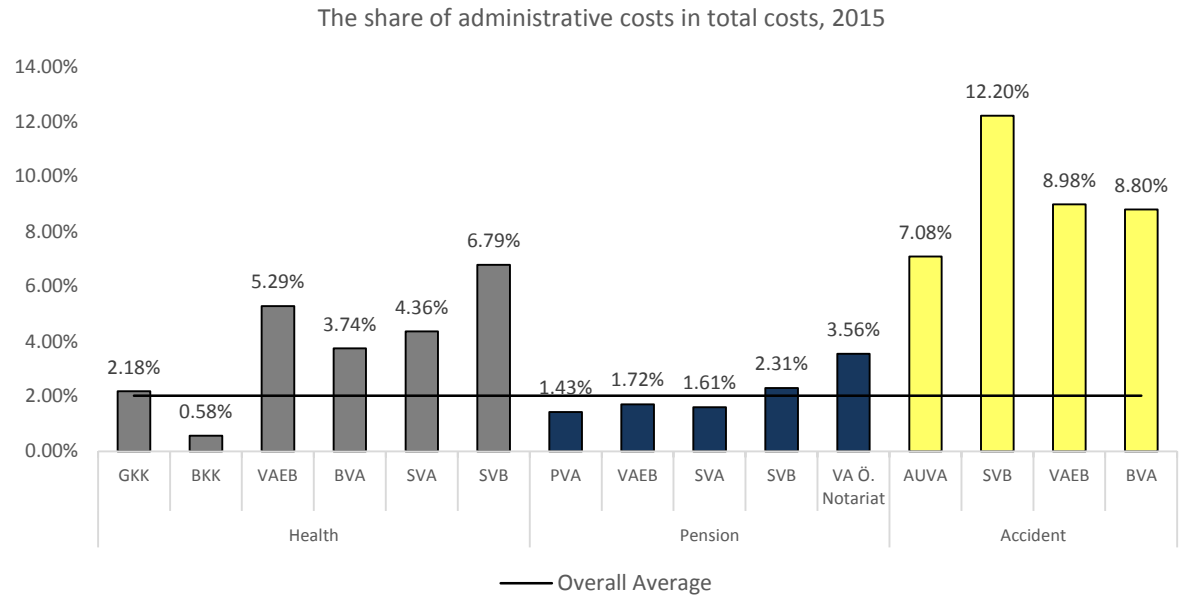


Figure 33 depicts the share of the administrative costs in total costs, per insurance carrier, for all three pillars, in 2015. The total costs equal the overall expenditures, as stated on the income statement, in 2015. The overall expenditures comprise the sum of insurance-services (Versicherungsleistungen), administration and accounting costs, and other operative expenses. In 2015, the total (actual) administrative costs in terms of the overall costs accumulated to 2.7% for the health insurance, regarding the pension insurance this was 1.5%, and 7.5% for the accident insurance.

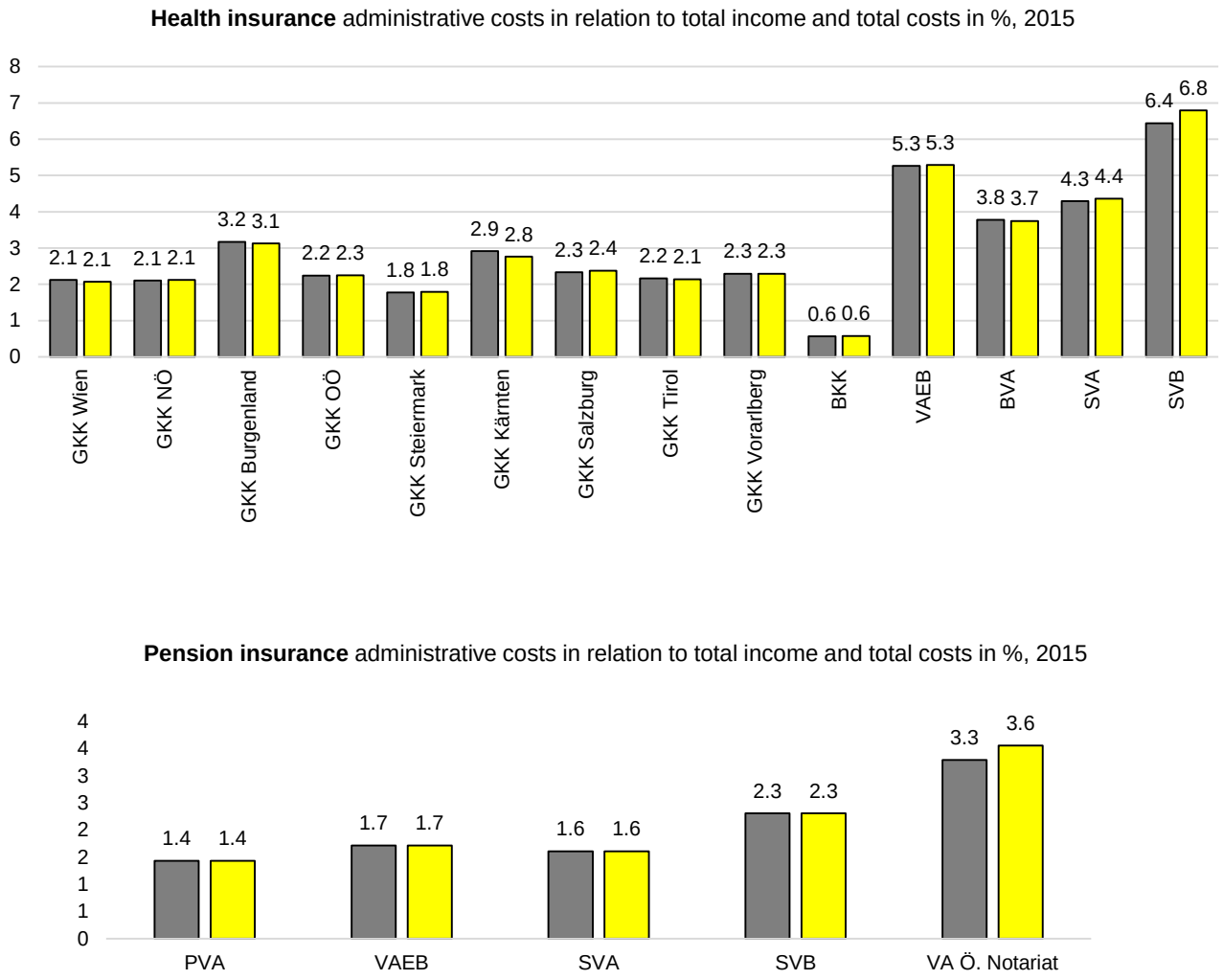
Figure 33: Administrative and Accounting Costs in relation to Total Costs, own illustration based on Finanzstatistik 2015.



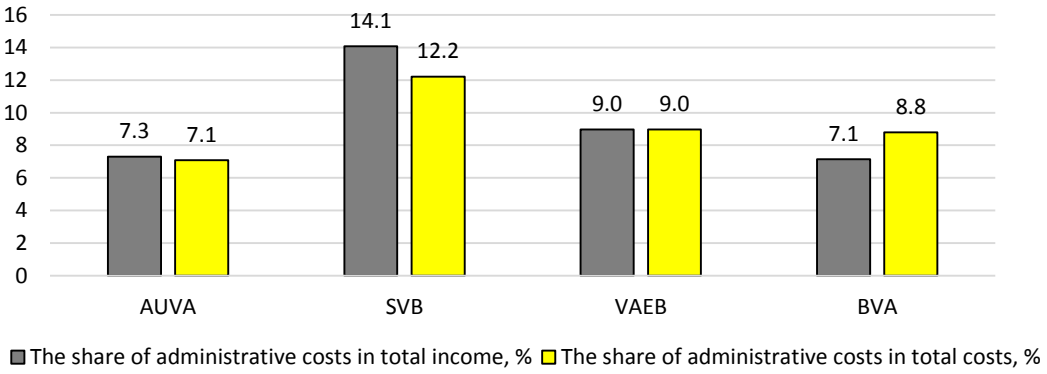
However, a direct comparison between the three pillars cannot be drawn, as the expense items regarding the administrative costs vary (e.g. expenses for own institutions in the accident insurance). Hence, Figure 34 elucidates on the administrative costs in relation to total income and total costs, separately per pillar. Mostly, administrative and accounting costs are either reported in relation to the overall costs, or the total income. In order to draw a more holistic picture, Figure 34 includes both, the administrative costs in relation to the total income as well as the total costs. (This is also relevant, as the target control of the administrative costs, which is decided upon at the carrier conference in agreement with the BMASK and the BMGF, is measured in relation to the contribution income of each insurance carrier). With respect to this target control, setting the upper limits, i.e. the cap for the administrative costs has undergone three phases: between 2001 and 2003, the expenditure limits where based on the historic values for 1999 (accounting for changes in numbers of insured persons; but not including developmental costs in connection with standard products, or ELSY; for more detailed information, please see the now invalid §588 ASVG). After that, §625 Abs. 8 and 9 ASVG defined upper targets for the administrative expenditures, which were not to be surpassed, valid in between 2005 and 2011. These were largely oriented on the rate of inflation, following a rather complex calculation method, based on average per capita quotas (as defined in Abs.9). From 2011 onwards, the current target control of the administrative costs, which is contained in the BSC, has been in effect (see above for the detailed explanation).

Regarding the health insurance, the SVB's ratio between administrative costs and total costs is relatively higher than the administrative cost in terms of the income. This also indicates that the SVB had higher income than total costs, in 2015. If compared to the accident insurance of the SVB, this relation is inverted, as the costs outweigh the income.

Figure 34: Health, Pension and Accident Administrative Costs in Relation to Total Income and Total Costs, 2015, own illustration, based on Finanzstatistik2015.



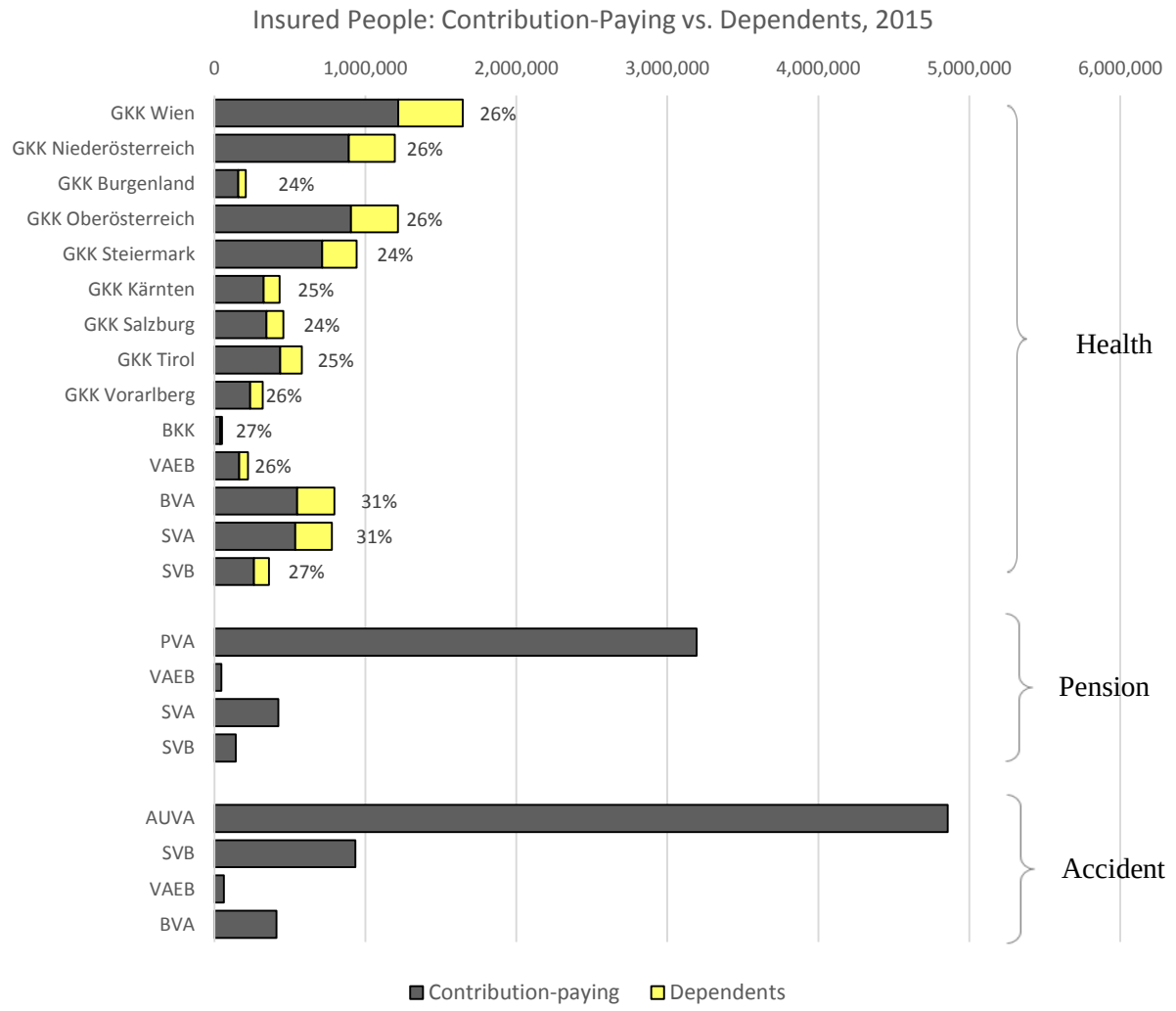
Accident insurance administrative costs in relation to the total income and total costs in %, 2015



2.4.3 Number of persons entitled to insurance versus number of contributing insured persons

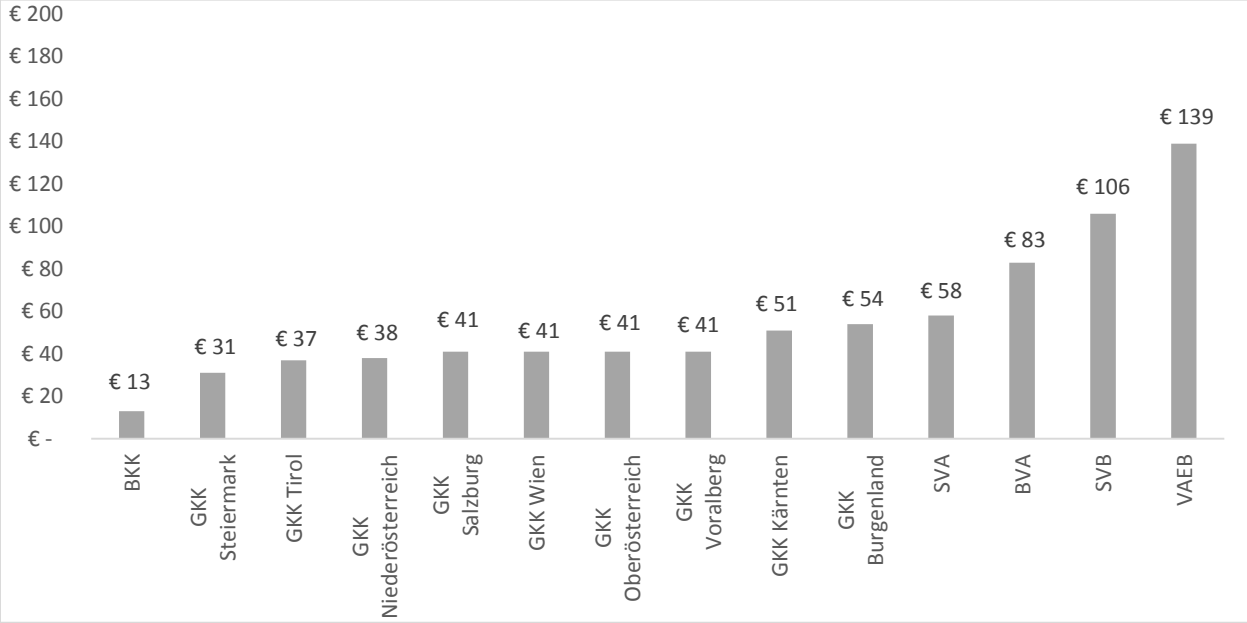
Comparing the administrative costs, it has to be mentioned that for the health insurance, there are insured persons, who do not pay contribution fees (i.e. dependents, who are for instance co-insured spouses or children). Evidently, these dependents also incur administrative costs, which need to be covered. Depending on the health insurance carrier, these vary. In addition, depending on the number of insured persons, economies of scale may be achieved, thus the overall size of the insurance carrier is also important. For an overview about the number of insured persons and the ratio between contribution-paying insured persons versus dependents, please see the below figure. The largest proportion of dependents are to be found within the insurance pool of the BVA and the SVA, amounting to 31%, which can be partly explained by the large number of multiple insured persons at these two carriers. With respect to the size of the overall insurance pool, the AUVA figures the largest, counting more than 4.85 million insured persons. The largest pension insurer, which also figures as the second largest overall insurance carrier, is the PVA, which insures 3.19 million persons. Regarding the health insurance, the GKK Vienna insures the most people, counting 1.64 million persons.

Figure 35: Insured Persons: Contribution-Paying versus Dependents, own illustration, based on data from Handbuch der Österreichischen Sozialversicherung 2016.



The figure below depicts how the administrative costs per carrier vary, if the share of dependents is taken into account. Thus, if the dependents are considered, the administration costs decrease, since the administrative costs are distributed over a larger group of insured persons. The differential amount, by which the administrative costs are reduced (due to taking the dependents into account), is indicated in yellow.

Figure 36: Administration Costs per Insured Person - Hauptverband and Handbuch der Österreichischen Sozialversicherung, 2016



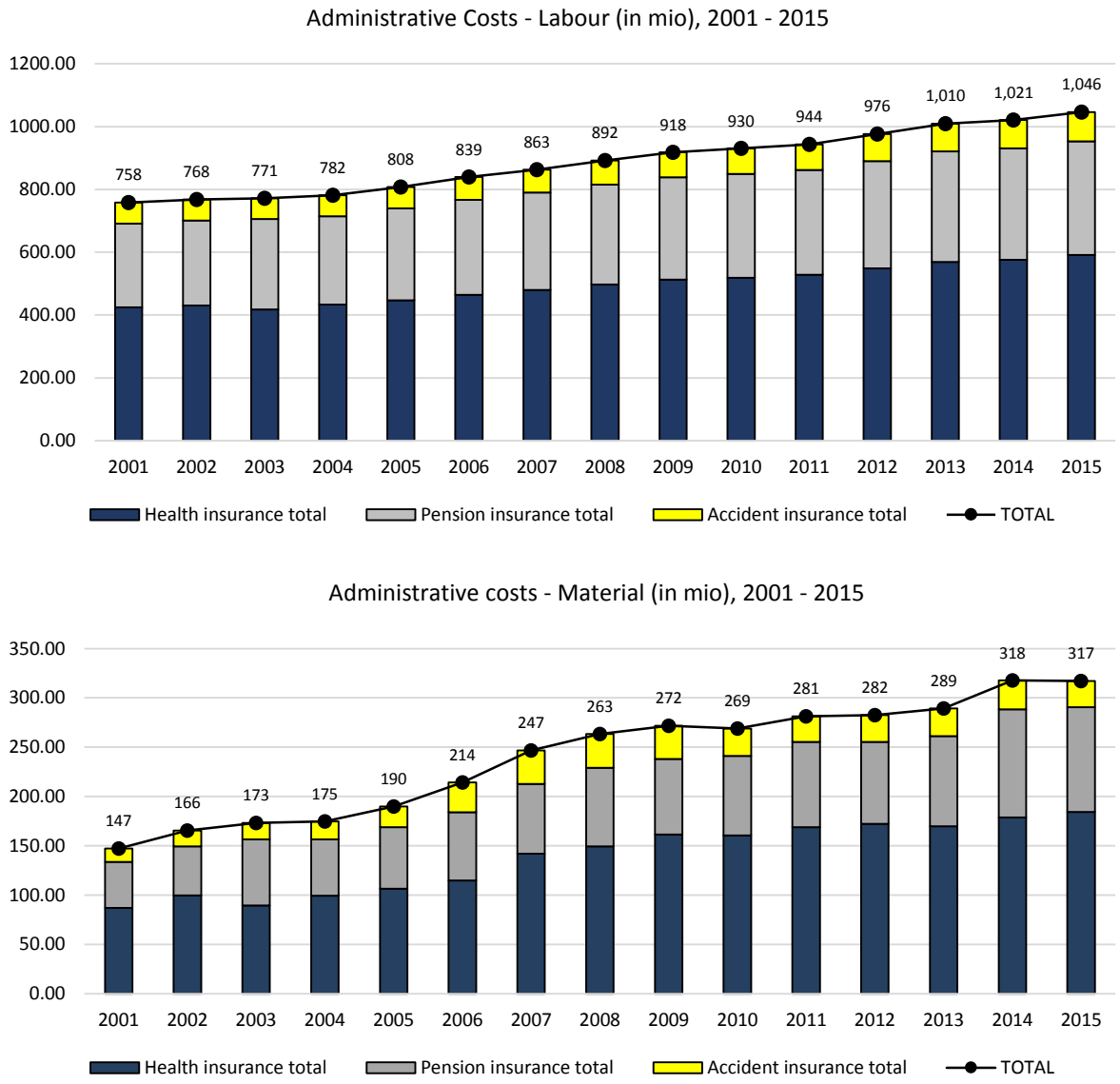
2.4.4 Cost factors for administration and accounting expenditures

The definition of administrative and accounting costs is determined in the accounting standards of the social security, which are classified according to the cost-factors, labour, material, administrative bodies and counselling panel. Accountable are all staff and material expenditures for administration, which relate to the fulfilment of tasks of the insurance carriers.

In keeping with this, the administrative and accounting costs for the social insurance are split into personnel and material costs, as well as costs for administrative bodies and the counselling panel. Personnel costs may accrue in form of administrative personnel, house or other staff, compensations for overtime, voluntary social grants, pensions, severance pay and death grants, as well as statutory wage and salary levies. Material costs involve for instance rent, cleaning, energy, offices, travel expenses, money transfer, court expenses, IT costs, or rented machines. The lion share (i.e. more than 99%) of the gross administrative costs were spent on personnel and material. In more detail, administration costs in connection with personnel accounted for 76.42% and material for 23.17%. The comparatively miniscule remaining 0.41% of gross administration costs were spent on the administrative bodies and the counselling panel. Figure 37 depicts the historical development, regarding the two most costly factors of administrative costs, i.e. the labour and material expenses, split into the three pillars of the social security. Within the analysed period, the material costs more than doubled, starting from €147 mio, in 2001 to

€317 mio in 2015, however the growth in material costs stagnated in 2015. In comparison, the labour administrative costs show a relatively stable growth rate over the analysed period and increased from €758 mio to €1046 mio, in 2015.

Figure 37: Administrative Costs - Labour and Material, own illustrations, based on Verwaltungsstatistik and Finanzstatistik 2015, Hauptverband.



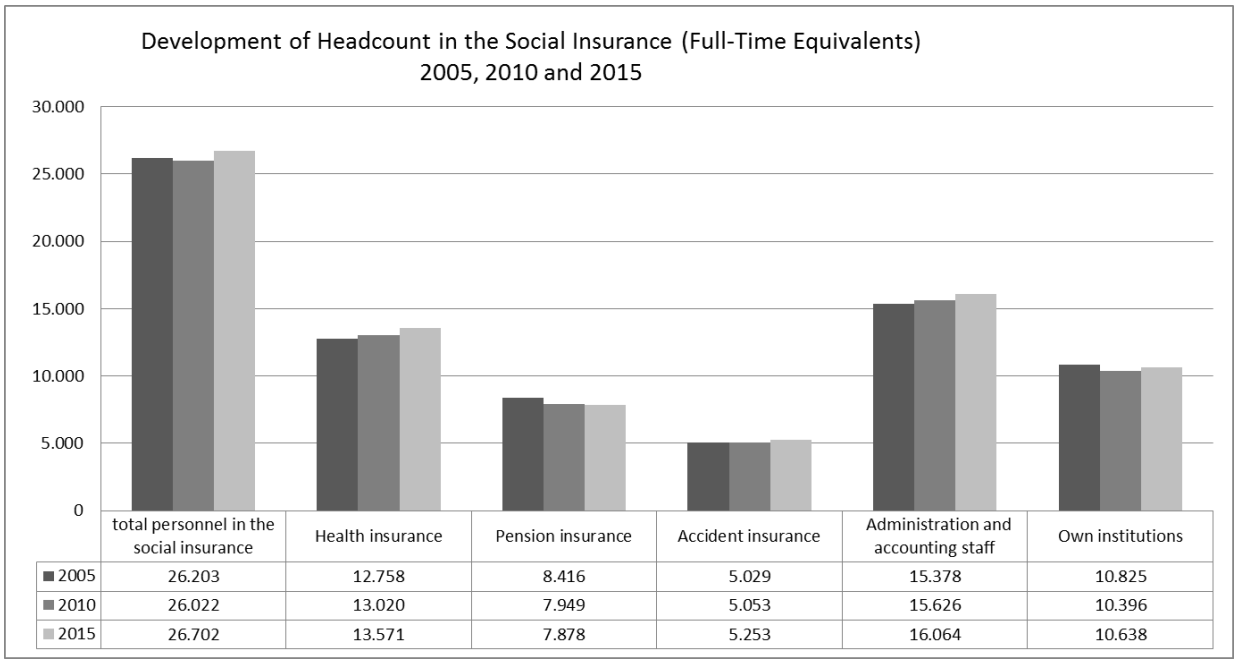
However, there exist costs that could be considered administration and accounting expenditures, but which are not included in the calculations:

- Depreciation: While rent is considered, depreciations are not included. Yet, depreciation (apart from those in connection with own institutions, or those deriving from auxiliary, non-operating assets) should be considered
- Association fees paid to the Federation of Austrian Social Security Institutions (HVSV)
- Chief physician services (possibly)
- In accounting and cost accounting there are divergences in terms of areas that should be assigned to administration

With regard to the number of employees per pillar, the figures have been rather stable since 2005, meaning that in 2005 the annual average number of employees totalled at 26.203 full-time equivalents (FTE). Looking at the development of this figure, the FTE slightly fell to 26.022 in 2010, and was slightly up again in 2015, reaching 26.702 FTE. Out of these 26.702 FTE (2015), 10.638 were employed in own institutions, although the majority of staff worked within the social insurance carriers in the field of administration and accounting and reached 16.604 FTE, in 2015. In general, the majority of the workforce was employed at the health insurance carriers (13.571), which increased over this 10 year period. Similarly, the FTE for the accident insurance rose slightly, starting from 5.029 (2005) to 5.253 (2015), whereas the staff working in the pension insurance carriers fell slightly from 8.416 FTE in 2005 to 7.878 FTE, in 2015. For an overview, stating the development of the annual average number of employees between 2005, 2010, and 2015, please see Figure 38.

It has to be mentioned that these headcounts neither include the persons employed at the HSVS, nor the subsidiaries (i.e. ITSV, SVC, and SVD). The approximate headcounts with respect to 2015 were: The HVSV employed 296 people, the ITSV had a workforce of 613, the SVC figured with 140 employees and the headcount for the SVD equalled 300 people. As a result, the number of employees increases by 1.349 to an approximate total headcount of 28.051 employees. Yet, it has to be taken into consideration that the figures for the HSVS and its subsidiaries are headcounts rather than FTE, thus slight discrepancies may apply. In future, it should be considered to also include the HVSV FTE figures into the administrative costs of personnel.

Figure 38: Development of Headcount (2005, 2010, 2015), own illustrations based on Verwaltungsstatistik 2015, Hauptverband



	total personnel in the social insurance	Health insurance	Pension insurance	Accident insurance	Administration and accounting staff	Own institutions
2005	26.203	12.758	8.416	5.029	15.378	10.825
2010	26.022	13.020	7.949	5.053	15.626	10.396
2015	26.702	13.571	7.878	5.253	16.064	10.638

The development of the workforce per carrier is illustrated in Figure 39. The largest cut in workforce took place at the SVB, which reduced their overall workforce by 28% within ten years (2005-2015). Primarily, this affected staff working within the SVB pension insurance (-39%), followed by the accident insurance (-12%), and then the health insurance (-9%). Yet, looking at the development over a five-year interval (2010-2015) changes the picture, as the overall number of SVB employees was only reduced by 3% and with respect to the health insurance even stayed stable. The other insurance carriers which reduced their number of employees are the BKK, the VAEB, and the SVA (ranked in order of largest decrease). The BKK cut their workforces by 18% (ten-year period) and 13% (calculated over five years). The SVA pension insurance was reduced by 14% over ten years, and -7% over five years. In contrast, their health insurance was increased by 13% (for both periods). Overall, the SVA showed dissimilar developments over the two periods, meaning that over 10 years the number of employees was cut by 4%, whereas within the ten-year interval, the SVA increased their workforce by 1%. The VAEB shows their largest cut in the accident insurance with -9% (over five years), whereas the pension branch was increased by 5% (2010-2015). This

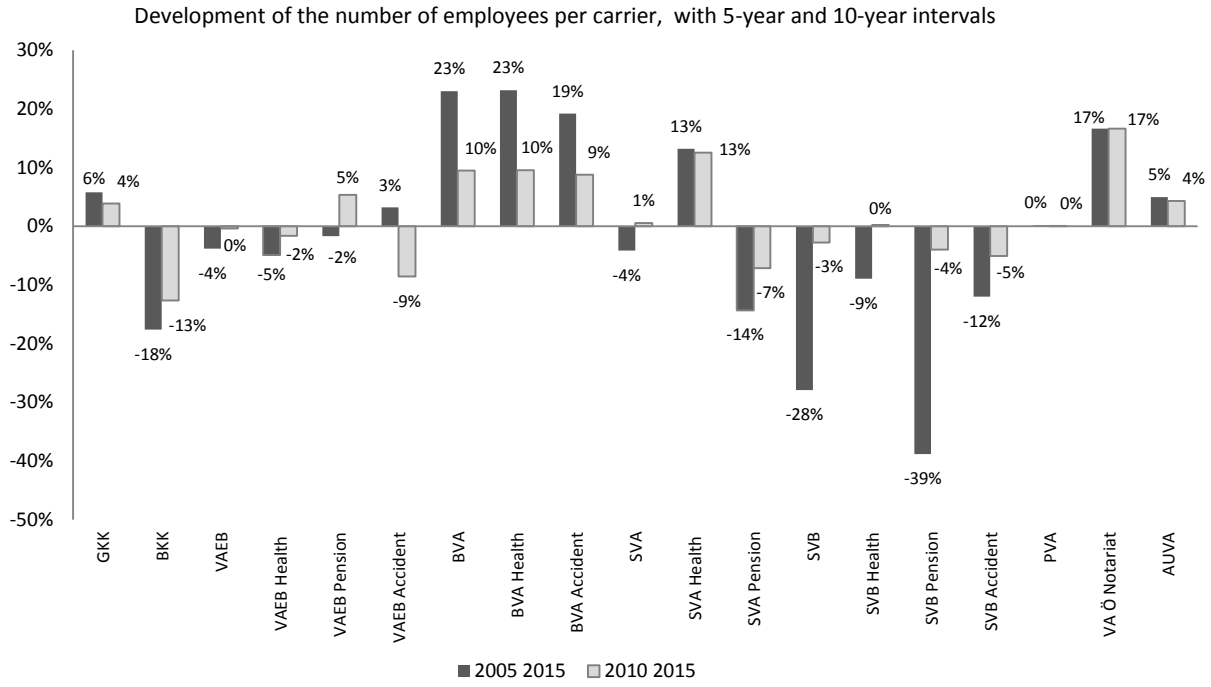
might come as a result of the pool of VAEB insured persons being comparatively aged, i.e. 37% of the overall VAEB insured persons are above 65 years of age[76].

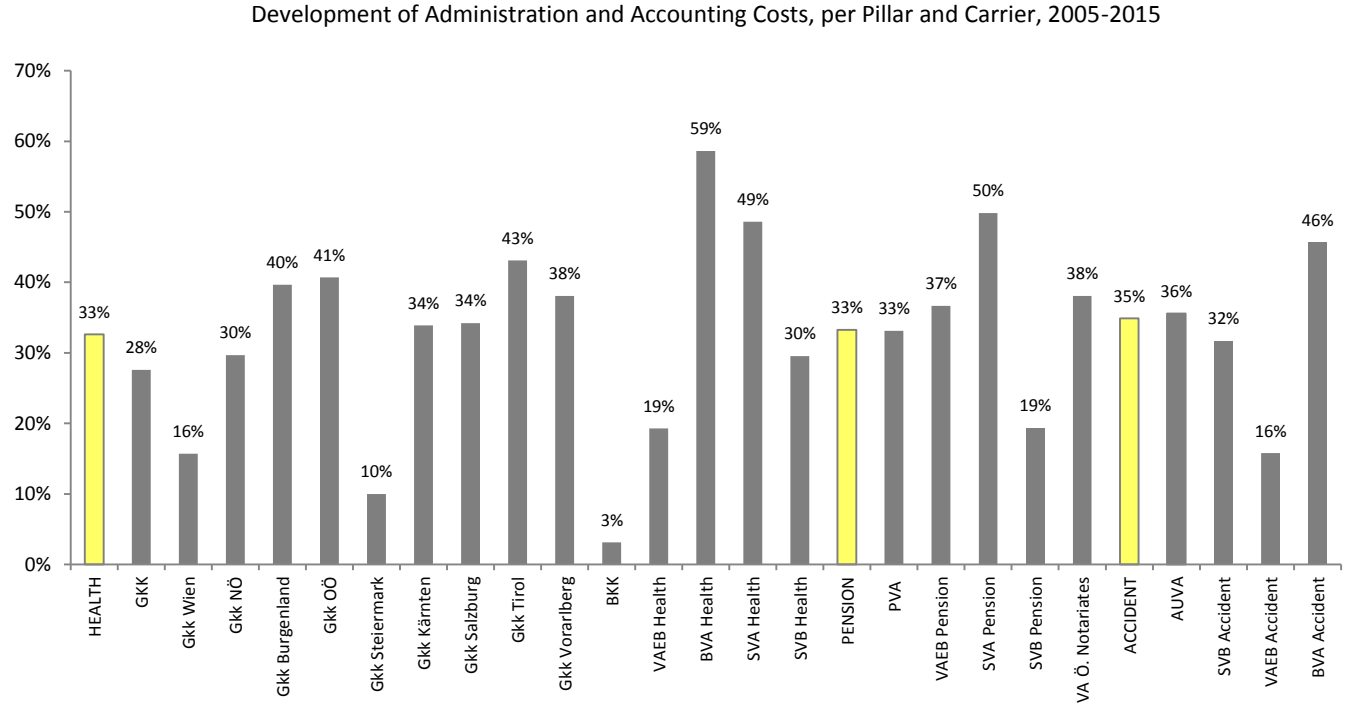
Contrasting this, the BVA increased their staff in both pillars, over both periods. Thus, the BVA increased their health insurance by 23% (ten years, and 10% for five years) and their accident insurance was increased by 19% (ten years, and 9% for five years). The GKK also increased their number of employees, yet to a lesser degree, with 6% and 4% (over 10 and 5 years, respectively). The PVA number of employees stayed stable over both periods and the AUVA indicated roughly the same amount of increase in headcount over both periods, i.e. 5% and 4%.

To complete the picture, the figure below illustrates the development of the overall administration and accounting costs per insurance carrier for the same interval, as analysed before, i.e. 2005-2015. Taken the carriers collectively, the health insurance, the pension insurance and the accident insurance demonstrate rather similar developments, rising by 33%, 33%, and 35% respectively. However, this does not hold, if the individual carriers are examined. The largest growth in administrative costs took place at the BVA health insurance, which witnessed an increase of 59%. Further health insurance carriers where the costs increased by more than 40% were the SVA (49%), the GKK Tyrol (43%), and the GKK Upper Austria. The BKK had a diminutive increase of 3%, however as explained before, this result needs to be interpreted with keeping in mind that the associated firm may bear some of the administrative costs for the corporate health carriers. Furthermore, the GKK Styria showed relatively low growth of administrative costs, reaching 10%, as well as the GKK Vienna, which had 16%. Regarding the individual pension carriers, the SVA showed the highest upsurge with an increase of 50%, and the SVB the lowest, amounting to only 19% growth in ten years. Concerning the accident insurance carriers, the BVA had the highest cost surge with 46% and the VAEB the lowest (16%). Overall, the discrepancies and variations between the carriers were highest in the health insurance, ranging from 10%-59%, followed by the pension insurance (19%-50%), and the accident insurance (16%-46%).

[76] Versicherungsanstalt für Eisenbahnen & Bergbau, 'VAEB Jahresbericht 2015'.

Figure 39: Development in Administration and Accounting Costs per Pillar and per carrier, 2005-2015, in %, own illustration, based on data from Verwaltungsstatistik 2015, Hauptverband.





2.4.5 Adaptation SHA – Administrative costs in health care

In order to be able to internationally compare the Austrian administrative and accounting costs, data sourced by the SHA (System of Health Accounts) is used. Thus, the Austrian administrative costs regarding social security are adapted according to the SHA, which comprises the following alterations:[77]

With respect to the health insurance carriers, the actual administrative and accounting costs (which are reduced by the compensations for collecting contributions, i.e. Verwaltungsersätze) as stated in the financial statistics of the Federation of Austrian Social Security Institutions are used for the SHA calculations. Costs, as well as compensations for pensions are both not considered in the SHA calculations. In the SHA, costs in connection with medical examinations and other support services, as well as the supposed social security contributions are added. For the pension insurances, the SHA only takes account of the health-related administrative costs. In order to calculate this, the share of health-relevant services of the pension insurance carriers is put into relation with the total services of the pension insurance carriers, which then is assigned to the net administrative expenditures.

For the accident insurance the administrative costs are already included in other SHA service categories and hence, these are not separately stated. As a consequence, the HVSV states that these health-relevant or SHA-relevant administrative costs cannot be identified.

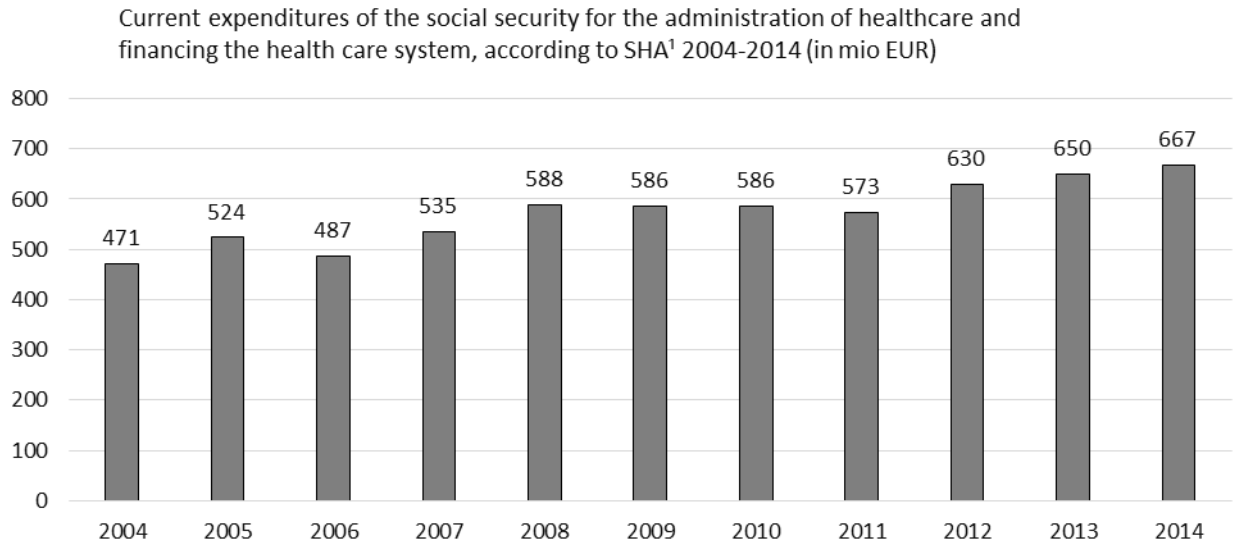
Additionally, administrative costs, which accrue from other social security institutions (such as the IT Services of the SV GmbH, ELGA GmbH, SVC, or the allocation account of ELSY (e-card)), or the health-relevant share of administrative costs of the HVSV are considered. In addition to this, the administrative costs of the KFAs, the PRIKRAFs as well as the depreciation of social security carriers have to be added. As a result, the administrative costs of the Austrian social security carriers according to the SHA calculations amounted to €666.5 mio in 2014, for more information, please see Figure 40.

In comparison, the administrative and accounting costs for all health insurance carriers came to €446.35 mio, in 2014 (as stated in the HVSV Finanzstatistik Tab 6). These two figures cannot be directly compared, since the health-relevant administrative costs of the pension insurance and the accident insurance (in line

[77] Mag. Johannes Schimmerl, BA, Federal agency STATISTICS AUSTRIA

with the HVSV concept), would have to be compared as well, in order to display the discrepancy between these two approaches.

Figure 40: Current expenditures of the Austrian social security for administration and financing of healthcare, own illustration based on SHA and Statistik Austria (2016)

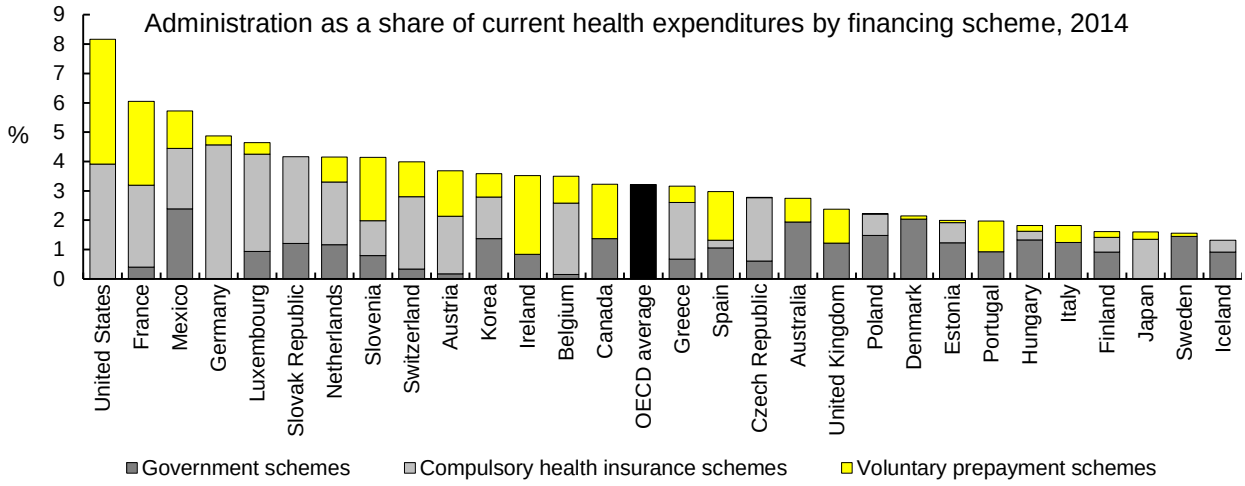


2.4.6 An OECD comparison of administrative costs in connection with health care

For an international comparison of administrative costs, the OECD study, titled "Releasing Health Care System Resources - Tackling Ineffective Spending and Waste", OECD 2016, is helpful.

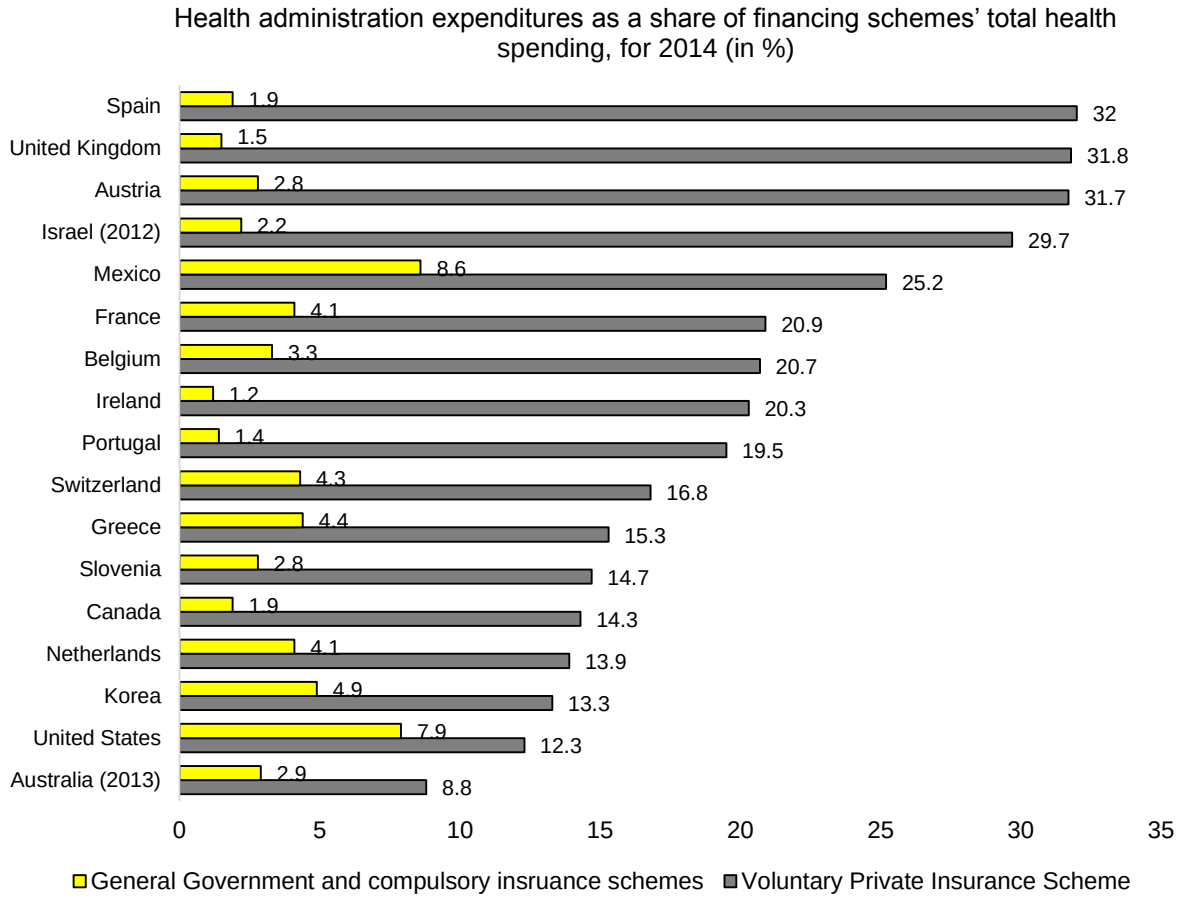
In comparison with the OECD, which on average includes data on 30 countries, the Austrian administrative costs for healthcare are 4%, and thus slightly higher than the OECD average of 3.2%. Taking note of how the administrative costs are calculated, it becomes evident that 1.5 percentage points account for voluntary schemes of private insurers. But only 2% of administrative costs fall into the category of the compulsory health insurance, which nearly covers the entire population, and which finances and performs a substantially larger volume of services. As remarked by the OECD, the compulsory health insurance schemes predominantly refer to social health insurance funds, i.e. the SHI funds, yet may also refer to compulsory health insurance provided by private insurers. Voluntary prepayment schemes mainly refer to voluntary health insurance schemes. Figure 41 displays the ranks regarding the administration costs as share of the healthcare expenditures in 2014, by financing scheme, with Austria scoring the 10th rank.

Figure 41: Administration as a share of current health expenditure by financing scheme, 2014, own illustrations, based on OECD Health Statistics (2016).



In Austria, the share of administrative costs relative to the respective expenditures amounts to 31.7% for private insurance schemes, and 2.8% for public and social security systems, in 2014. For an overview on the other countries contained in the OECD Health Statistics, please see the below figure.

Figure 42: Health administration expenditures as a share of financing schemes' total health spending in 2014, own illustrations, based on OECD Health Statistics 2016, (with data for Australia stemming from 2013)



"Whilst the administration costs are usually higher in multi-payer systems, the distinction between those with choice (i.e. Czech Republic 3.3%, or Germany 5%) and those with automatic affiliation (Austria, France or Japan) is less clear-cut. While Austria and particularly Japan report administrative cost levels below those in countries where insurers do compete, Belgium and France have government administrative costs at a similar level." Additionally, administrative costs for private health insurance are significantly higher than for public schemes. "Health care systems in which coverage is provided by a single entity generally have lower administrative costs than multi-payer systems, partly because they enjoy more economies of scale"[78]. In single-payer schemes, there is only a single accounting and processing system necessary,

[78] Mossialos, 'Funding Health Care: Options for Europe'.

whereas multi-payer systems by their nature multiply the same functions[79]. Due to a high degree of competition in countries where PHI is common, a duplication of processes and lack of economies of scale is likely and therefore more resources are required (i.e. distribution of information, registration of patients, billing or contracting).[80] Additionally, if different countries' administrative costs are contrasted in percentages, one should also consider that these depend on the total reference value. For instance, the German rate of contributions for the health insurance is nearly double the amount of the Austrian, since in Germany, the employee and the employer each pay 7.3%, which, combined equals 14.6%. In consequence, instead of using percentages, the actual amounts of administrative costs per insured person would increase the explanatory power of these comparisons.

2.4.7 Administrative cost expressed in terms of cost-accounting

Via the method of cost accounting one can directly detect the areas, in which the administrative costs accrue, as the costs are assigned to cost centers. This is where the expenditures, which are necessary for the carrier to perform its services, are entered. Cost accounting relates primarily, but not only, to administration - as costs in connection with information services, the medical examiner's office, or the monitoring of sick persons, are also accounted for. Costs associated with e.g. pensions however, are not assigned to individual cost centers, but are added in total as extraordinary expenses. The objective of cost accounting is, to illustrate the expenses, which are necessary to perform a service.

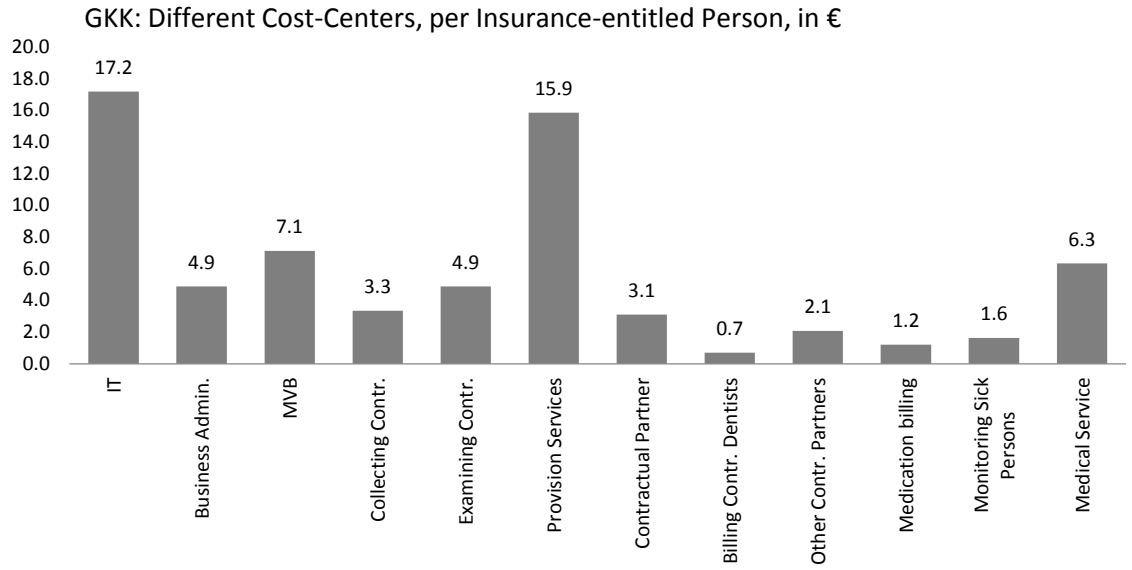
The cost accounting does not involve cost unit accounting. If cost accounting and cost-centre accounting were extended to cost-unit accounting, it would be possible to calculate e.g. the costs of processing one application. Yet, at present, this is not possible. The BMGF is responsible for the accounting standards. With respect to the cost centres of the GKK, the gross costs include expenses for personnel, material, other costs and depreciation (yet neither pensions, nor severance payments. In 2015, these amounted to €590 mio in total, or €84.4 per insurance-entitled person for the regional health carriers.

At the GKK, the lion share was taken by the general cost centre (including for instance IT, management and accounting), the field of contributions (collecting, examining, and registration) and the field of services (billing of contractual partners, provision of services, etc.) Thus the three largest cost centres, calculated

[79] Bentley, 'Waste in the U.S. Health Care System: A Conceptual Framework'.
[80] OECD, *Tackling Wasteful Spending on Health*.

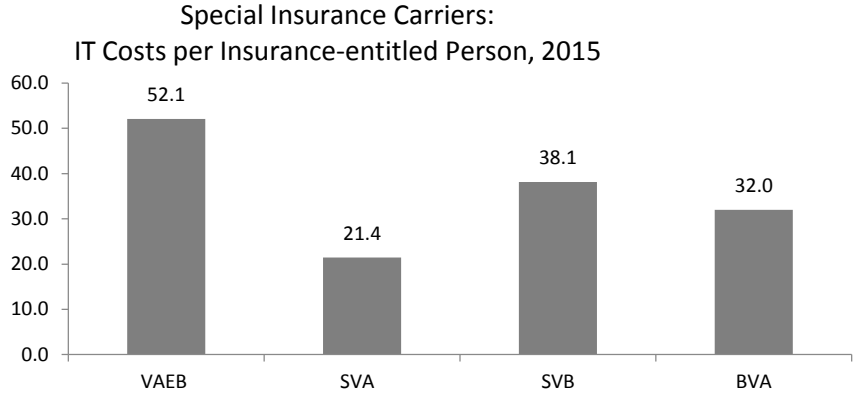
via the methods of cost accounting, amounted to €30.3 per capita for general costs, the costs for providing services was €30.1, and the field of contributions came to €15.3. A more detailed analysis of the cost positions per insurance-entitled person shows that IT (€17.2), the provision of services (e.g. district branches, €15.9), the collection of contributions (€3.3) and the related examinations (€4.9), as well as the medical services (€6.3) are significant cost centres. Yet, the gross expenses per cost centre may vary between the individual regional health carriers. For further information, please view Figure 43.

Figure 43: Regional Health Insurance Carriers: Cost Centres per Insurance-entitled Person, in %, calculated via Cost-Accounting Methods



In comparison with the special insurance carriers, however, there are bigger discrepancies. For example, their IT costs per insurance-entitled person are significantly higher, than the GKK's. Yet, there also exists significant variation in gross costs regarding the special insurance carriers' cost centres. One possible explanation could be that the special insurance carriers do not only provide health insurance, but also pension and in some cases even accident insurance. Another explanatory factor would be their difference in size. Accordingly, the per capita costs per VAEB insured person for IT accrued to €52.1, whereas a SVA insured member only came to IT costs of €21. For further detailed information, please see Figure 44.

Figure 44: Special Insurance Carriers: IT Costs per insurance-entitled Person, in 2015, calculated via Cost-Accounting Methods

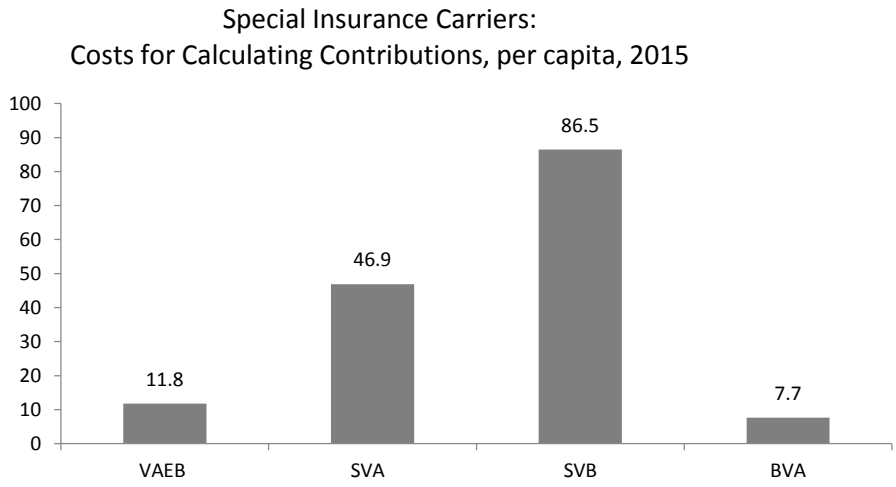


With respect to calculating contributions, there are significant discrepancies in costs between the special insurance carriers. This, however may be explained by the system-endemic higher efforts in connection with setting the contributions for farmers (SVB with €86.5) and self-employed persons (SVA with €46.9). For further information, please see Figure 45. (In contrast to this, at the GKK, the overall costs in connection with contributions per contributing insured person, only came to €20.5).

Also, in connection with the provision of services, the costs at the GKK were relatively small, accounting €15.9, whereas the BVA was the most costly special insurance carrier, accruing costs of €27.7 per insurance entitled person for the provision of services. (The VAEB had €25.4, SVB was €23.2, and the SVA was the cheapest out of the special insurance carriers with €19.2).

The PVA's gross costs according to cost accounting standards for 2015 are in order: Personnel with €250.04 mio, material costs with €104.75 mio, other costs accrued to € 41.99 mio, and calculatory depreciation was €11.74 mio. The three largest cost centres for the AUVA headquarter were the accident prevention with 25%, and IT as well as prevention-advice figured with 15%.

Figure 45: Special Insurance Carriers: Cost for Calculating Contributions, per capita, in 2015, calculated via Cost-Accounting Methods



2.4.8 Challenges and conclusions in connection with administrative and accounting expenses

There exist two different performance indicators with respect to administrative costs, being the administrative and accounting expenses found in the clearance of accounts, and the administrative costs according to the cost accounting (if not explicitly stated otherwise, the figures in this report relate to the administrative and accounting expenses). According to the Court of Auditors, for 2013, the administrative expenses accumulated to €1.129,02 mio, whereas the administration costs according to the cost accounting made out €1.610,81 mio[81]. This difference is due to the cost accounting including administrative costs in connection with rendered services. This contains for example the service items medical examiners' office (Vertrauensärztlicher Dienst), staff and material costs connected to the prevention of diseases and accidents, or rehabilitation. Also, the depreciation is handled differently, as in the administrative costs, the imputed depreciation of real estate and equipment related to the administration is reported. As mentioned before, the Court of Auditors criticized that the upper limits for the administrative expenses referred to the performance indicators of the clearance of accounts, rather than the administrative costs of the cost accounting and thus allowed higher administrative expenditures. Moreover, the administrative expenses should be set into connection with their output, since in some circumstance, higher costs may also effect in higher benefits (as would be the case, if more was spent on

[81] Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

controlling contribution payments, or enhanced consulting for the contractual partners, which may lead to decreasing costs with respect to medication). Publicly relating the administrative expenses to their output, would also assist in explaining the differences between the carriers, and increase transparency.

In general, the administrative costs of the Austrian insurance carriers are, if regarded in comparison to international examples, relatively modest. However, there are indicators for scale economies, e.g. for the health insurance, where the administrative expenses of the larger regional carriers are less expensive than the ones of the special insurance carriers. Relating to this, the most extreme comparison would be GKK Styria with €31 administrative expenses per insured person (including dependents), versus €139 at the VAEB. However, this might also be caused by additional factors, rather than the size of the insurance taken alone. In addition, the largest cost factors, i.e. personnel and material expenses could be reduced, if there was more collaboration between the carriers, particularly in connection with processes every carrier deals with. The ITSV and SVD, for example, are good practices in relation with this. Currently, due to the seniority principle, the administrative costs for personnel strongly depend on the structure of the workforce and their periods of employment[82]. If the remuneration scheme would be modified so that the seniority element would be weakened, this would also imply increasing the starting salaries for new entrants. This would promote mobility and would facilitate job transition between SSI and the overall labour market. Hence, in connection with this, it might be reasonable to install additional incentives s to avoid job fluctuation, as in case the seniority principle would cease to exist, alternative employers would become more attractive. Furthermore task dependent elements in the remuneration scheme could be strengthened.

Moreover, the principles of self-governance are a great benefit of the Austrian system. However, if 21 self-governed bodies coexist, there needs to be one entity creating a shared vision and in line with this, setting the direction. Thus, the HVSV could take on a more directive governing role (to do so, the carriers would need to consent, as due to self-governance, they are part of the HVSV). For some of these responsibilities, the HVSV would already be legally empowered, e.g. §31 Abs. 3 Z. 2 ASVG, where it is stated that the HVSV… ' can suggest and implement measures to sustain the continuous efficiency of the social security, as to not overburden the economy (…) controlling the development of income and expenses across the carriers'. This role could also involve negotiations with contractual partners and thus increase the bargaining power. In connection with this, however, the policies and regulation for the

[82]Ibid.

contractual partners would have to be amended. A further improvement would be more international exchange between the carriers, as is currently already undertaken by the AUVA, who is in close cooperation with international accident insurers, regarding e.g. medical science and development regarding the accident insurance. Besides increasing the base of knowledge, this would also create the opportunity to benchmark, in an otherwise uncompetitive market. In addition, more transparency, e.g. with respect to true costing or benchmarking could be achieved by changing the (international) financial reporting and (cost-) accounting standards, as mentioned previously.

In line with this, the set benchmarks for the administrative costs, should be publicly reported and monitored by a control-committee. A further suggestion could be, to link the allocation of financial means stemming from e.g. the carrier structure fund, to the adherence to the administrative expenditure targets (a similar 'educational' approach was applied already with the carrier structure fund, where financial means where only transferred to the carriers, if the administrative expenditure-caps were not exceeded). To do so, it is also advised to render international key performance indicators (not only in connection with the administrative costs) obligatory for reporting (the implementation of this could be endeavoured as a mutual project, also involving other expert stakeholders, such as Statistic Austria and the GÖG, who at present collaborate in order to collect the SHA data. Yet, connected to this, the accounting standards would need to be altered. For an overview of the current differences in reporting health-related expenses between the SHA and the Austrian Health-Target-Control, please see the table below.

Table 10: Differences in Calculating Health-Expenses – SHA versus ZSG, own illustration, based on Bericht des Rechnungshof 2016/3.

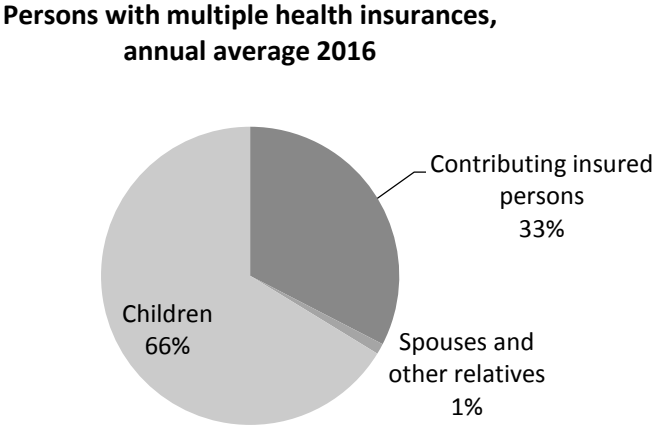
Differences in calculating health-expenses between SHA and 15a agreement health-target-control (ZSG)	
Expenditures in SHA, but not in ZSG	Expenditures in ZSG, but not in SHA
PRIKRAF, Accident hospital (UKH), other hospitals	Prescription charges, cost-sharing, service-fees, pharma-package, other fees
Correction for transfers to the Landes-Fund (Hanusch Hospital)	Governmental subsidies for early detection of diseases
Medical rehabilitation	Transfers abroad
Strengthening physical health (Gesundheitsfestigung)	Loyalty bonus chamber of physicians
Depreciation	Other operating expenses
Clearing reserves (Bereinigung Rücklagen)	Additional administrative expenditures
Other	-

2.5 Multiple insured[83]

2.5.1 Number of cases and types of multiple insurances

On annual average, 717.538 persons were covered by multiple insurances, in 2016. Two thirds of these were dependents: In detail, the multiple insured comprised 66% children and 1% spouses or other relatives (i.e. partner, or civil partners). As a consequence, only about one third out of all multiple insured persons paid contributions to the social security system, i.e. were gainfully employed or pensioners. Therefore, the amount of persons who are covered by multiple insurances and also pay contributions is comparatively small.

Figure 46: Persons with multiple health insurances, annual average in 2016, based on data from HVSV



2.5.2 Multiple insured persons with gainful employment

In 2016, 138.587 persons[84] pursued multiple occupations (meaning two or more occupations). The number of multiple insured working people rose slightly within the past years. However, considering that the total amount of working people has also risen, the share of persons with multiple occupations remained constant. On the 1st of July 2016, 3.5% of the Austrian workforce followed more than one occupation.

[83] Primary sources of data for this section are from: HVSV: Mehrfachversicherte in der Krankenversicherung Haydn, 'Personenbezogene Statistiken 2015'. Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung'.

[84] Remark: This includes persons, who have multiple occupations, yet the same health insurance.

Table 11: Austrian workforce with multiple occupations 2008-2016, as of 1st July 2016

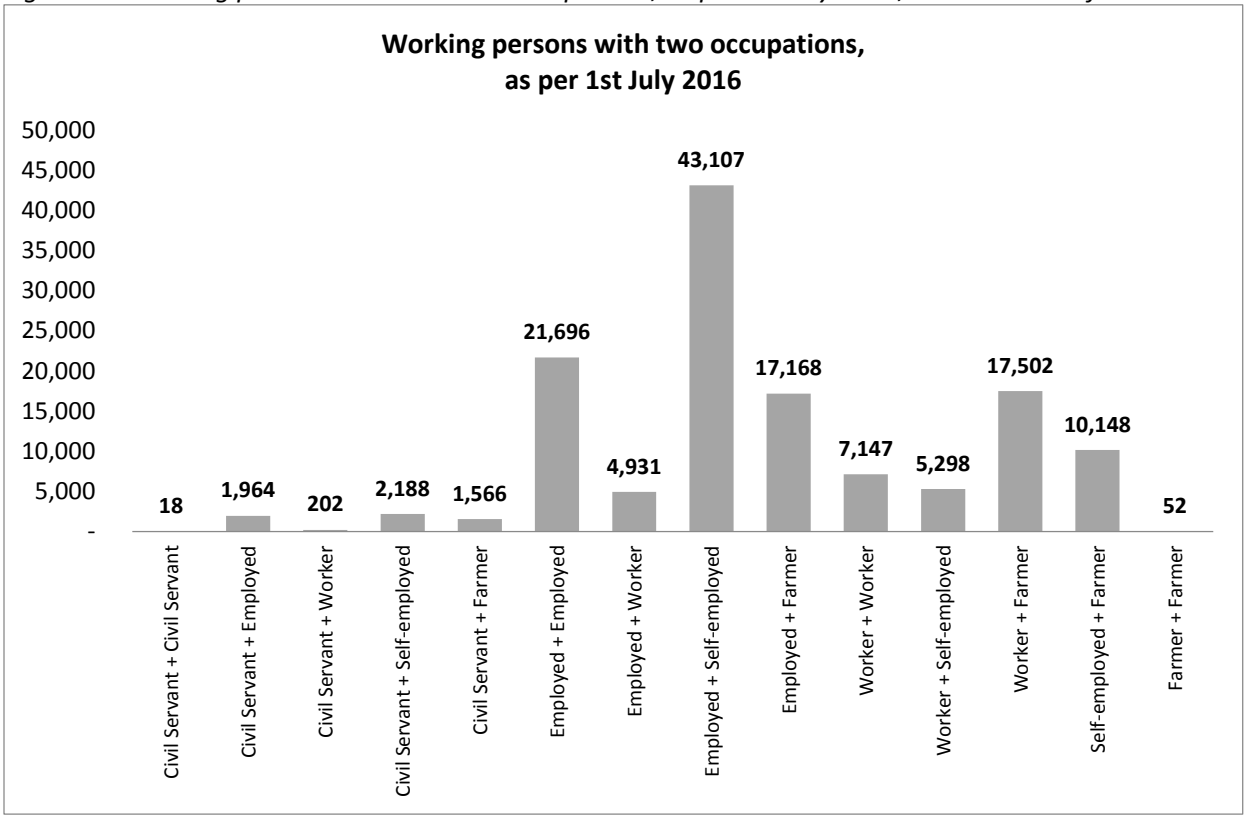
Year	Total	Number of people with one, two or multiple occupation(s)			Total number of Occupations
		one	two	multiple	
2016	3.951.054	3.812.467	132.987	5.600	4.095.791
2015	3.898.605	3.762.696	130.358	5.551	4.040.615
2014	3.876.062	3.741.652	128.910	5.500	4.016.490
2013	3.850.535	3.716.365	128.776	5.394	3.990.625
2012	3.770.318	3.637.643	127.446	5.229	3.908.699
2011	3.733.277	3.601.550	126.589	5.138	3.870.614
2010	3.667.358	3.537.436	124.893	5.029	3.802.780
2009	3.628.881	3.498.613	125.333	4.935	3.764.543
2008	3.700.450	3.567.066	128.360	5.024	3.839.320
2016	100.0%	96.49%	3.37%	0.14%	103.7%
2015	100.0%	96.51%	3.34%	0.14%	103.6%
2014	100.0%	96.53%	3.33%	0.14%	103.6%
2013	100.0%	96.52%	3.34%	0.14%	103.6%
2012	100.0%	96.48%	3.38%	0.14%	103.7%
2011	100.0%	96.47%	3.39%	0.14%	103.7%
2010	100.0%	96.46%	3.41%	0.14%	103.7%
2009	100.0%	96.41%	3.45%	0.14%	103.7%
2008	100.0%	96.40%	3.47%	0.14%	103.8%

In particular, self-employed persons and farmers frequently have multiple occupations. For the self-employed, this applies to 15% of persons and 34% of all farmers (please see the figure below).

Figure 47: Share of persons with multiple occupations in %, as of 2016, based on data from HVSV

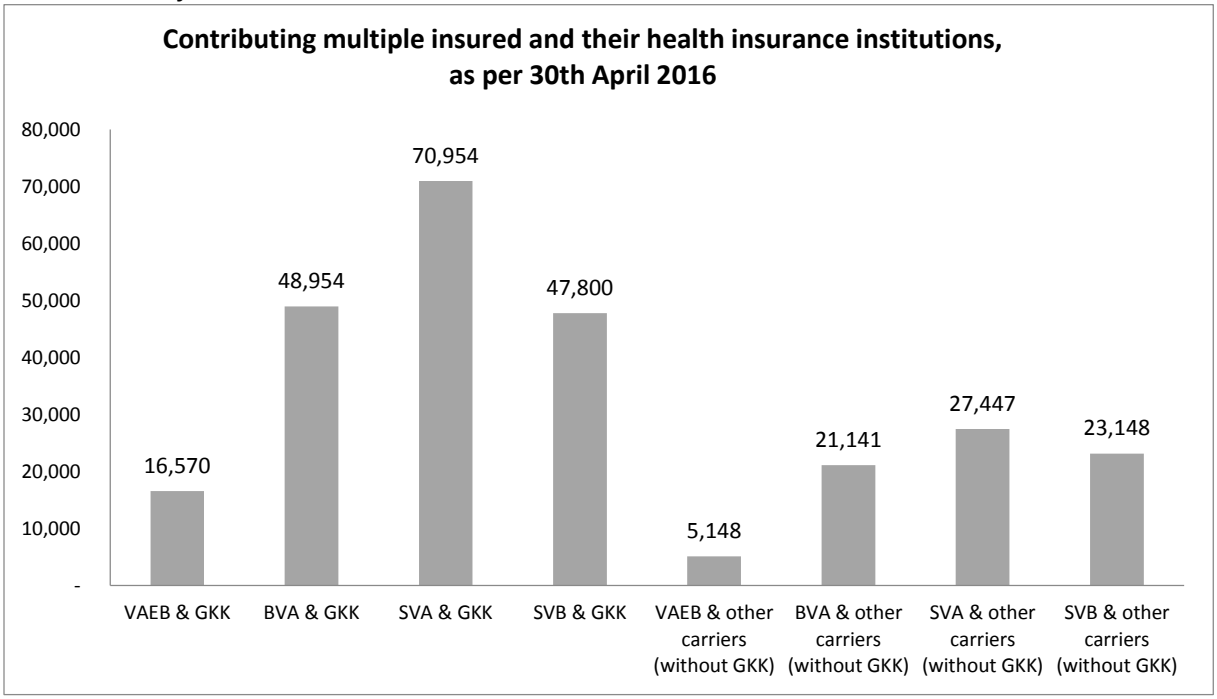
Out of 138.587 persons who had multiple occupations (meaning two or more occupations), 47% were self-employed and 35% were farmers (as of 1st July 2016). For persons with two occupations, the most common combination was being self-employed and employed, which was followed by being in twofold employment, and the combination between farmer and employee/worker (please see the figure below).

Figure 48: Working persons who have two occupations, as per 1st July 2016, based on data from HVSV



Relating to social security carriers, contributing insured persons most commonly had the combination between one of the Regional Health Insurance Institutions (GKK) and the Social Insurance Institution for Commerce and Industry (SVA) (for further information on combinations of insurance carriers, please see Figure 49, which also includes retired persons).

Figure 49: Contributing multiple insured and their health insurance institutions, as per 30th April 2016, based on data from HVSV



2.5.3 Social security legislation for multiple insured persons

The obligation to contribute exists up to a maximum contribution base.[85] If the total sum of contributions exceeds the (annual) maximum contribution base, either the differential assessment claim (in advance) or the refund of contributions (afterwards) can avoid payment of disproportionate amounts (i.e. above the maximum contribution base). A precondition for the refund is that the sum of all contribution bases for the compulsory insurance in the respective year exceeds the 35 times daily amount of the maximum contribution basis for the compulsory insurance (for 2017, this results in 5,810.00 EUR per month).[86]

For the health insurance, 4% of this excess amount (which goes beyond the maximum threshold) of the ASVG contribution gets refunded (since this comprises the employee's as well as the employer's contribution, which for health insurance equals 3.87% and 3.78% respectively[87]). GSVG-/FSVG-/BSVG-contributions (i.e. commercially or free-lancing self-employed persons, or farmers) get refunded in full.[88]

[85] Haydn, 'Personenbezogene Statistiken 2015'.
[86] Bäuerliches Beitragswesen im Überblick
[87] Hauptverband der österreichischen Sozialversicherungsträger, 'Beitragsrechtliche Werte in Der Sozialversicherung 2017'.
[88] SVA Info „Mehrfachversicherung Pensionsversicherung", 2016

However, the respective applications normally have to be actively filed, which not all multiple insured persons will do. The application for refunding the health and- unemployement contributions needs to be submitted to one of the insuring health insurance carriers. This needs to happen until the end of the third calender year, following the respective contribution year. If this application is also filed for the following contribution years, it is valid for as long as the insured person is registered for compulsory insurance with this health insurance carrier.

The occurrence of exceeding contributions may be avoided by applying for the differential assessment claim. Based on the ASVG contribution base, the GSVG-/FSVG- contribution base is set at a level that is likely to eliminate an exceeding contribution; hence, a (partial) exemption from the GSVG obligation to contribute takes place. Furthermore, multiple insured persons secure insurance periods in every pension system of their insurances. However, to claim the pension, insurance months, which were acquired in parallel, can only be claimed once - which means they have to be assigned to one of the pension systems. For this purpose the hierarchy ASVG – GSVG – BSVG applies. 11.4% of the amount which was paid in surplus (above the maximum threshold) gets refunded for the ASVG, for the GSVG/FSVG/BSVG, the full excess contribution (i.e. the employee part) is reimbursed.

Up until now, the so called wage-sum-procedure (Lohnsummenverfahren) has been utilized, where the employer calculates and pays the monthly contribution for all of his/her employees (including both, the employee and the employer contribution fees), without the contributions being allocated to the single person. Hence, the monthly contribution statement is adequate proof, i.e. the names of the employees do not need to be indicated, yet only the wage-sums suffice, which are broken down into contribution- and settlement-groups. Only after the end of the calendar year the pay-slips and the statement of contribution bases have to be created, which comprise the contribution basis for each insured person.
On 1st of January 2019, the monthly contribution base notification (mBGM) will replace this system, for which the legal framework is set by the reporting-obligation Act.[89] The mBGM means a complete system transformation for the employers and the social insurance carriers, enabling high quality and more timely data about monthly contributions. Consequently, in future, data will be available more promptly and not only after the end of the calendar year. More specifically, the mBGM represents a simplification of applications and a decrease in having to report redundant data. In addition, this makes changes in the

[89] Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung'.

insurance history more transparent, errors are avoided due to a clearing system, and the contribution groups are replaced by a new tariff-system.[90]

In consequence, one possible solution could be that the GKK could be obliged to transfer data about multiple insured persons in ASVG or GSVG to the SVA (or vice versa). This would enable the SVA to credit contributions above the maximum contribution base to its insured members in advance without application, or to not even charge this, in the first place. To simplify the process for multiple insured persons, contributions above the maximum contribution base (remaining difference) should get refunded through the official channels and without need for filing applications.

2.5.4 Multiple insured civil servants

For civil servants, the situation is slightly different. Civil servants, who simultaneously engage in a commercial activity, are also compulsory insured in the pension insurance - in accordance with the GSVG. Both, the minimum and the maximum contribution base apply, when establishing the contribution base according to the GSVG. The salary of civil servants do not influence the contribution base compliant with the GSVG.

This is differently dealt with in the health insurance: Besides the B-KUVG, the commercial activity leads to an additional compulsory insurance in line with the GVSG. Since 2006, the contribution base according to B-KUVG is credited to the GSVG minimum contribution base for health insurances. In case the contribution base (in accordance with B-KUVG and GSVG) exceeds the maximum contribution base and an applicable substantiation is available, the contribution base according to GSVG must be set temporarily at most to the difference between B-KUVG and the maximum contribution base. The same applies to the employed persons, who are insured according to ASVG and B-KUVG.

However, if based on regional-law, a sickness insurance claim upon a sickness insurance institution (Krankenfürsorgeanstalt, KFA) exists, neither a crediting on the minimum contribution base according to GSVG, nor a restriction of the maximum contribution base apply[91].

[90] Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung (bMGM) - Fragen-Antworten-Katalog'.
[91] WKO Info: „Beamte als gewerblich Selbständige"; January 2017

Therefore, for civil servants an addition of the contribution bases should be allowed within pension insurance and the KFA, in order to enable an automatic refund of contributions, exceeding the maximum contribution base.

In the work programme of the federal government for 2017/2018, which was decided in a special council of ministers on the 30th January 2017, a simplification of multiple insurances was planned, potentially taking effect from September 2017[92]: 'There exist many possible combinations of occupations. Persons who have multiple occupations that are gainful, i.e. employee and part-time farmer, pay multiple social security contributions and are multiple insured. The obligation to contribute persists up to the maximum contribution base. If the sum of the contribution bases exceeds the maximum contribution base, the exceeding contributions can be avoided by claiming differential assessment (in advance) or a refund of contributions (afterwards). In the future, an automatic difference assessment/refund of contributions through social security will be introduced in case of multiple occupations.'

2.5.5 Allocation of contribution income and costs

Besides the issue of allocating contribution income among multiple insurances, another problem presents the fact that cost allocation is currently not regulated. In fact, the person with multiple insurances, may decide which insurance has to bear the costs of treatment (this may possibly be also influenced by the contractual partner, if he/she partners multiple social security institutions). Thus, distributing the contribution income in relation to the allocation of costs of the different health insurance carriers, would be reasonable and fair.

Currently, if the multiple insurance is based on ASVG and GSVG, the GSVG contribution base is reduced by the differential assessment, independent of where the costs are allocated. In case of multiple insurances of multiple employments according to ASVG, employee contributions exceeding the maximum contribution base can get refunded. This happens at the carrier that receives the filed application for differential assessment.

The current situation is problematic, since numerous incentives that have to be taken into consideration exist. If left uncoordinated, these potentially could influence the cost allocation:

- Scope of service of the respective carrier

[92] „Für Österreich . Arbeitsprogramm der Bundesregierung 2017/2018" January , p.9

- Issue of user charges and cost sharing
- Issue of remunerating physicians providing the same service
- Amount of remuneration, since with physicians-of-choice 80% of the fees a contractual partner would charge, are refunded.

In order to establish equivalence between charged contributions and financed services between the insurance carriers, the following possibilities exist:

Allocation of contribution income according to financed services

Given that any multiple insured person can select which insurance carrier should be charged, the compensation would be very complex. To make matters worse, the remuneration structure implies different fees, as well as different payment terms and tariff models. Besides quarterly flat-rate payments followed by individual service billings, other contracts have all-inclusive prices for clinics with a flat rate per doctor appointment (which gets reduced with every consultation). Some contracts are concluded in advance, others afterwards. Billing and balancing the specific services of individual insured persons, who only occasionally are multiple insured for a short period of time, would cause high administrative efforts. This raises the question whether this effort, considered economically, is in any relation with the balanced net payment flows between the insurance carriers.

Forms of generalized compensation

Through evaluations, or via means of one-time primary research, it could be assessed if the allocation of contributions is conform to the allocation of costs. Divergences can be removed by payments according to the number of multiple insured persons. If certain patterns occur - which group of persons makes use of, or charges, which services to which carrier – thus, the generalized compensation would have a more profound underpinning.

The following basics apply: The better harmonized the catalogue of services, deductibles, cost sharing and remunerations are, the less incentives there are to charge specific services to specific carriers. Moreover, the easier an objective and sound internal financial compensation could be illustrated.

Competence for a carrier

Alternatively, it is possible to determine that with multiple insured persons only one carrier is responsible to provide the service. Priority of law, i.e. the ASVG as fundamental act, could be considered. This could

be reasonable and realistic in many cases, however, not if the income from employment is significantly lower than the income from self-employment. Therefore, in case of multiple insurances, the carrier with whom the insured person was insured first, or to whom more contributions are paid, could be held responsible. This alternative contradicts with the obligatory insurance that is currently regulating employed or self-employed occupations. However, if a person contributes to multiple carriers, but is then assigned to one carrier that is responsible to provide the services, the acceptance of multiple insurances would fall, since a person would be compulsory insured with multiple insurances, yet limited to the catalogue of services of only one insurance carrier.

2.5.6 Conclusion

A simplification via automatic refunding for multiple insured persons and an internal cost allocation is considered a reasonable alternative. The cost allocation should be based on an estimation of payment flows and not on single bills of the individual insured persons. The more services, rates and tariff models are harmonized, the easier it will be to obtain a mechanism that involves all health insurance carriers, who should design such a mechanism.

3 Financial of social security

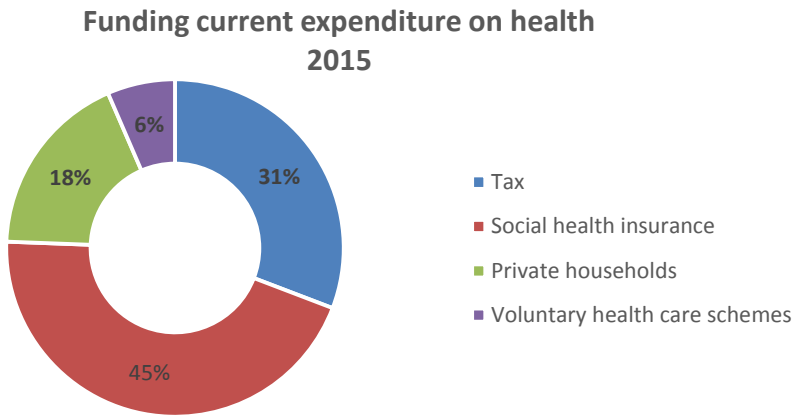
3.1 Financial flows within Austrian healthcare system[93]

3.1.1 Health expenditure in Austria

The health expenditure in Austria are compiled according to the "System of Health Accounts" (SHA). The three SHA-dimensions financing scheme, health care provision and functions of health care establish an accounting framework for health care expenditure.

The current health care expenditure in Austria amounted to €35 077 million in 2015, of which €10 806 million (30.8%) were borne by central, state and local governments and another €15 707 million (44.8%) by social health insurance. Private households spent €6 287 million on health care services and goods, which accounts for 17.9% of Austrian current health expenditure in 2015. 12.0% thereof were cost sharing with social health insurance schemes. In total, 6.5% of current health expenditure was borne by voluntary health care payment schemes[94].

Figure 50: Funding current expenditure on health, own illustration based on Statistics Austria, Health expenditure in Austria



[93] Primary sources of data within this section are: Rechnungshof, 'Bericht Des Rechnungshofes - Mittelflüsse Im Gesundheitswesen'. Hauptverband der österreichischen Sozialversicherungsträger, Finanzstatistik 2015 Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016. Statistik Austria, 'Health Expenditure in Austria'. Statistisches Handbuch der österreichischen Sozialversicherung 2016

[94] Statistik Austria, 'Health Expenditure in Austria'.

By health care provider industries, the largest share of current health expenditure, €13 561 million (38.7%), was spent on services provided by hospitals. These were mainly financed by social health insurance with 47.8% and by government schemes (Bund, Länder, Gemeinden), with a share of 42.5%. The remaining 9.7% were spent mainly by voluntary health insurance schemes or private households. Of the €13 561 million for services provided by hospitals €11 341 million were paid for services of curative and rehabilitative inpatient care, €302 million for day care services and €1 918 million for services of outpatient curative care.

Services by ambulatory health care providers accounted for €7 670 million or 21.9% of current health expenditure. Thereof, €3 314 million were allocated to services provided by physicians and €1 731 million to services by dentists. The remainder of €2 626 million was spent on services provided by other health practitioners, ambulatory health care centres and providers of home health care services.

Ambulatory health care providers were mainly financed by social health insurance, with a share of 52.8% (4 048 million). Private households spent €2 635 million (34.4%) – including 262 million cost sharing with social health insurance schemes – while the remaining 12.9% were borne by government schemes, non-profit institutions serving households financing schemes as well as voluntary health insurance schemes[95].

3.1.2 Current health expenditure - public

Public current health expenditure consists of general government expenditure, which includes expenditure by central, state and local governments as well as social health insurance.

In 2015, the public current expenditure on health amounted to €26 513 million what is equal to a share of 75.6% of all health care spending in Austria. Taking the gross capital formation into account, the public expenditure on health amounted to €27 870 million.

The biggest share of general government expenditure on health (45.9%) in 2015 was spent on inpatient care (incl. long-term care). The other main spending categories were outpatient care (25.1%),

[95] Ibid.

pharmaceutical products, medical durables and non-durables (13.9%) and home-based health care (8.9%)[96].

3.1.3 Current health expenditure – private

Private current health care expenditure consists of household out-of-pocket payments, expenditure by private insurance enterprises, non-profit institutions serving households (NPISHs) as well as expenditure by corporations on occupational health care.

Household out-of-pocket payments and expenditure by private insurance enterprises accounted for the largest share of private current expenditure on health. Their expenditure was spent on inpatient care, outpatient care, pharmaceutical products, medical durables and non-durables and health administration (private health insurance).

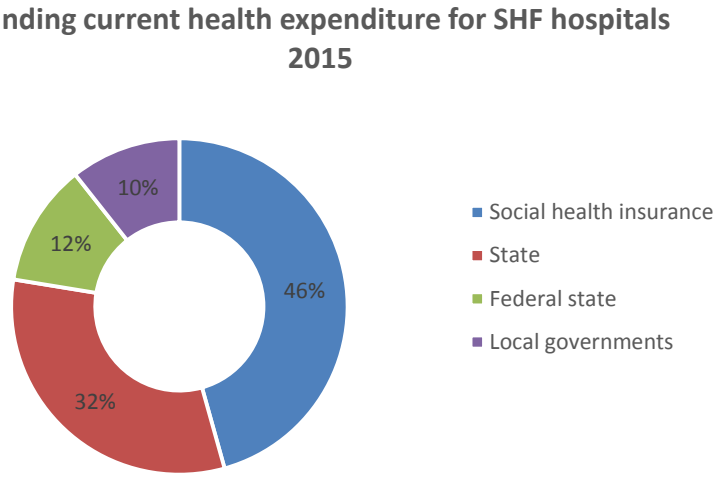
In 2015, private households and private insurance enterprises spent €8 021 million on health care. With a share of 36.8%, the largest expenditure category of private households and private insurance enterprises was outpatient care. Another 28.1% were spent on inpatient care, while the third largest share (27.9%) was allocated to pharmaceutical products, medical durables and non-durables[97].

3.1.4 Current health expenditure – State health funds financed hospitals

The public current expenditure for state health funds financed hospitals (SHF hospitals) amounted to €10 512 million in 2015. This is a growth of 2.7% since 2014. The largest share of expenditure was borne by **social health insurance** schemes adding up to **45.7%** or €4 800 million in 2015, respectively. State, central and local governments spent €3 354 million, €1 239 million and €1 118 million. All in all, **government schemes** were responsible for **54.3%** of the spending.

[96] Ibid.
[97] Ibid.

Figure 51: Funding current expenditure on health for SHF hospitals, own illustration based on Statistics Austria, Health expenditure in Austria.



3.1.5 Gross capital formation

Health care providers allocated €754 million to gross capital formation in 1990. In 2015, the amount had tripled to €2 501 million. This €2 501 million can be divided into a public share of €1.357 million (54.3%, e.g. for hospitals) and a private share of €1 144 million (45.7%, e.g. by medical practitioners, specialists and dentists)[98].

3.1.6 Financial Flows

Financing of the health-care system

The following graphic of financing refers to the, at the time of assignment and creation of the study, applicable agreement according to Art. 15a B-VG on the organisation and financing of health care (BGBl. Nr. 105/2008).

With the completion of the financial equalisation for the period as of 2017, the completion of a new 15a-agreement on the organisation and financing of health care was also made. This agreement ensures the continuous update of determined financing mechanisms of the last period.

[98] Ibid.

Framework of the financing of health care

The Austrian health care system is characterised by the distribution of competences on a variety of actors on a federal, Länder or community level. The distribution of competences is regulated in the federal constitutional law (Bundes-Verfassungsgesetz, B-VG), namely that legislation and execution in the field of health care is the responsibility of the federal government[99], however, the creation of implementation laws and the execution in the field of sanatoriums or nursing homes is the responsibility of the Länder[100]. The distribution of competences significantly contributes to a confusing and for controlling complicating finance architecture of health care[101].

The financing of health care between federal state and Länder is regulated in the agreement according to Art. 15a B-VG on the organisation and financing of health care[102], in the agreement Federal Health-Targets[103] and in the hospitals and sanatorium act (Krankenanstalten-und Kuranstaltengesetz, KAKuG). The social security law (Allgemeines Sozialversicherungsgesetz, ASVG)[104] is an additional important basis for financing of health care. In Article 17 (BGBl. Nr. 105/2008) the funds of the Federal Health Agency and in Article 18 (BGBl. Nr. 105/2008) the funds of regional health funds are regulated. Furthermore, additional regulations are described in the paragraphs 56a to 59j of the KAKuG and in the paragraphs 447a and 447f of the ASVG.

The health and social sector contribution act (Gesundheits- und Sozialbereich-Beihilfegesetz, GSBG) was passed due to Austria's accession to the EU and the associated effects on the turnover tax structure. This affected those health care institution that underlay a non-genuine turnover tax exemption (Social security, health care institutions, hospitals, patient transport, physicians …) This non-genuine tax exemption exists if no turnover tax has to be invoiced but vice versa there is no right to deduct input tax. This results in an added burden for the mentioned institutions in the amount of the non-deductible input tax. The GSBG regulates the compensation of this added burden with funds from the turnover tax revenues[105].

[99] Bundesverfassungsgesetz - Art. 10 Abs. 1 Z 12.
[100] Bundesverfassungsgesetz - Art. 12 Abs. 1 Z 1.
[101] Rechnungshof, 'Bericht Des Rechnungshofes - Mittelflüsse Im Gesundheitswesen'.
[102] VEREINBARUNG gemäß Art. 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens StF: BGBl. I Nr. 105/2008.
[103] Österreichisches Parlament, 'Vereinbarung Gemäß Art. 15a B-VG Zielsteuerung-Gesundheit'.
[104] Allgemeines Sozialversicherungsgesetz, BGBl. Nr. 189/1955.
[105] Rechnungshof, 'Bericht Des Rechnungshofes - Mittelflüsse Im Gesundheitswesen'.

The following table shows the central resources according to the 15a-agreement:

Table 12: Minimum resources according to the 15- agreement, own illustration based on Czypionka et al. 2016.

Source	from	to	Description
15a-VB, Art. 17 (1) Z1	Federal state	BGA	1,416% turnover tax revenue
15a-VB, Art. 17 (1) Z2	Federal state	BGA	258 426 240,71 Euro
15a-VB, Art. 17 (1) Z3	Federal state	BGA	83 573 759,29 Euro
15a-VB, Art. 17 (2)			As from 2009 regulation of valorisation for 15a-VB, Art. 17 (1) Z1 + Z2
15a-VB, Art. 17 (4) Z1	BGA	LGF	Vorweganteil for the Länder NÖ, OÖ, Sbg., Tirol, Stmk.
15a-VB, Art. 17 (4) Z2	BGA	LGF	Deduction of Vorweganteile for projects, planning, transplantation, health promotion and prophylaxis programmes, GÖG, ELGA
15a-VB, Art. 17 (4) Z3	BGA	LGF	1,416% of turnover tax revenue minus Vorweganteile according to Art. 40 (Sanctions intramural sector) to LGF
15a-VB, Art. 21 (1) Z2	Land	LGF	0,949% of turnover tax revenue
15a-VB, Art. 21 (1) Z 3, (6)	SV	LGF	adjusted flat-rate
15a-VB, Art. 21 (1) Z 5	SV	LGF	Fund according to GSBG
15a-VB, Art. 21 (1) Z 6	Communities	LGF	Share of turnover tax revenue
15a-VB, Art. 21 (1) Z 7,8	Carrier, Land, communities	LGF	Arising additional funds, e.g. for operating deficit

The funds of the Federal Health Agency and the social security are transferred through so called Länder quotas (percentage per Land) according to Art. 24 (1), Art. 24 (3), Art. 24 (4) and Art 24 (7) to the regional health funds[106].

[106] VEREINBARUNG gemäß Art. 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens StF: BGBl. I Nr. 105/2008.

Table 13: Länder quotas for the calculation of the mean, own illustration based on RIS 15a BV-G.

	Länder quota (1) according to 15a-VB, Art. 24 (1)	Länder quota (2) according to 15a-VB, Art. 24 (3)	Fully defined (3) key according to 15a-VB, Art. 24 (4)	Number of people 2001
Burgenland	2,572%	2,559%	2,426210014%	3,455%
Carinthia	6,897%	6,867%	7,425630646%	6,963%
Lower Austria	14,451%	14,406%	14,377317701%	19,244%
Upper Austria	13,692%	13,677%	17,448140331%	17,137%
Salzburg	6,429%	6,443%	6,441599507%	6,417%
Styria	12,884%	12,869%	14,549590044%	14,730%
Tyrol	7,982%	8,006%	7,696467182%	8,385%
Vorarlberg	3,717%	3,708%	4,114811946%	4,370%
Vienna	31,376%	31,465%	25,520232629%	19,299%
Total	100%	100%	100%	100%

3.1.7 Income and costs of social security (in total)

The income of Austrian social security amounted to €58.247 Mio. in 2015 in comparison with €56.454 Mio. in 2014. Hence, the total income increased by 3.2%. The costs of social security increased by 3.3%, €56.382 Mio.in 2014 to €58.259 Mio. in 2015. For the most part, funds of social security are raised by contributions of insured members. The contributions for insured members amounted to €44.701 Mio. in 2014 and rose to €46.518 Mio. in 2015. In the area of pension insurance there is a contingent liability of the federal state if contributions do not sufficiently cover the costs. For 2014, the federal state provided €7.715 Mio. for financing of social security. For 2015, this contribution reduced to €7.489 Mio. Compensation for compensatory allowances, other service compensations, prescription fees and cost sharing flow into the social security carriers as additional funds. The income through these mentioned positions amounted to €4.038 Mio. in 2014 and €4.240 Mio. in 2015[107].

Table 14: Income and costs of the Austrian social security, own illustration based on Statistisches Handbuch der österreichischen Sozialversicherung 2016.

Financial management 2014 (total)	Income (in Mio EUR)	Costs (in Mio EUR)	Costs in % of income
Health insurance	16.364	16.275	99,5
Pension insurance	38.527	38.526	100,0

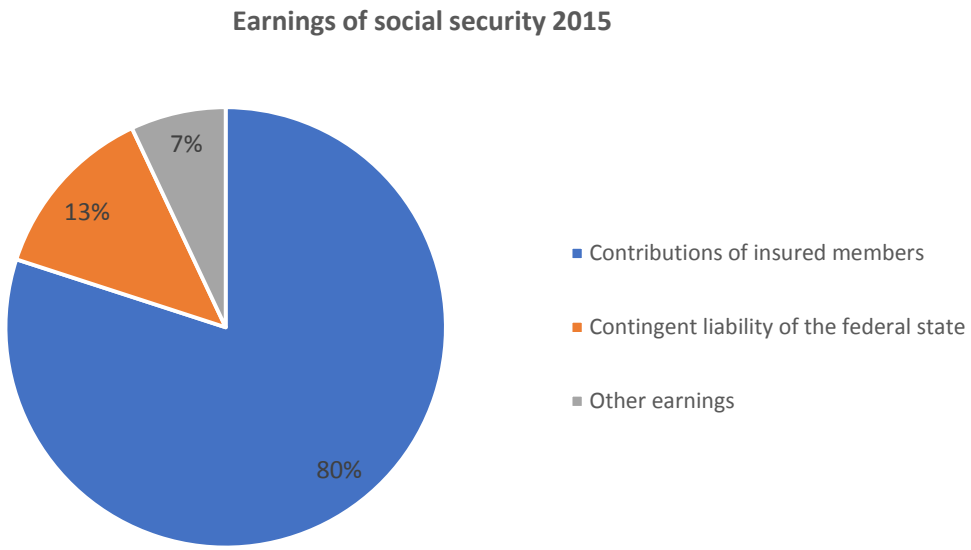
[107] Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.

Financial management 2014 (total)	Income (in Mio EUR)	Costs (in Mio EUR)	Costs in % of income
Accident insurance	1.563	1.581	101,1
Total	56.454	56.382	99,9

Financial management 2015 (total)	Income (in Mio EUR)	Costs (in Mio EUR)	Costs in % of income
Health insurance	17.119	17.088	99,8
Pension insurance	39.567	39.566	100,0
Accident insurance	1.561	1.605	102,8
Total	58.247	58.259	100,0

The figure below shows the total earnings of the Austrian social security. With 80% the contributions of insured members have the largest share, followed by the contingent liability of the federal state with 13%.

Figure 52: Earnings of Austrian social security in 2015, own illustration based on Statistisches Handbuch der österreichischen Sozialversicherung 2016.



3.1.8 Financial management of health, accident and pension insurance

Financial management of health insurance

Table 15: Financial management of health insurance, own illustration based on Finanzstatistik 2015.

Earnings health insurance	in Mio EUR (2014)	in Mio EUR (2015)
Contributions	13.634,4	14.160,2
Prescription fees	381,2	409,1
Service fee	35,5	37,6
Cost sharing	111,5	108,6
Treatment contributions	153,7	152,2
Compensation for service costs	1.422,2	1.667,7
Other	215,0	233,6
Total	15.953	16.769

Expenses health insurance	in Mio EUR (2014)	in Mio EUR (2015)
Insurance benefits	14.170,9	14.757,9
Sick pay	673,5	685,4
Rehabilitation allowance	92,1	248,2
Maternity allowance	460,8	473,8
Social assistance	5,9	8,4
Total	15.398	16.166

Grants by the equalisation fund of the GKK	277,9	287,7
Transfers to the equalisation fund of the GKK	162,8	167,9

Financial management accident insurance

Table 16: Financial management of accident insurance, own illustration based on Finanzstatistik 2015.

Earnings accident insurance	in Mio EUR (2014)	in Mio EUR (2015)
Contributions	1.506,0	1.499,9
Other earnings	50,4	56,1
Total	1.556	1.556

Expenses accident insurance	in Mio EUR (2014)	in Mio EUR (2015)
Insurance benefits	656,2	671,9

Expenditure on accident benefits	622,8	629,8
Grants for continued remuneration	78,6	80,2
Other expenses	220,4	220,7
Total	1.358	1602

Financial management pension insurance

Table 17: Financial management of pension insurance, own illustration based on Finanzstatistik 2015.

Earnings pension insurance	in Mio EUR (2014)	in Mio EUR (2015)
Contributions	29.560.3	30.857,4
Contingent liability of the federal state	7.715,3	7.488,8
Compensatory allowance	1.017.1	987,7
Cost sharing	54.2	55,6
Other earnings	156,9	162,8
Total	38.504	39.552

Expenses pension insurance	in Mio EUR (2014)	in Mio EUR (2015)
Insurance benefits	2.602.6	2.727,4
Pension expenses	33.928,7	34.705,4
Compensatory allowance	1.017.1	987,7
Total	37.548	38.420

3.1.9 Inpatient sector

Earnings and expenses of the Federal Health Agency

The **Federal Health Agency** (Bundesgesundheitsagentur, BGA) was, according to §56a KAKuG[108], a public law fund with own legal entity and the central organ for planning, controlling and financing of health care on the federal level. The management of operations of the BGA is carried out by the Federal Ministry of Health and Women's Affairs.

[108] Krankenanstalten- und Kuranstaltengesetz - §56a Bundesgesundheitsagentur.

Table 18: Earnings and expenses of the Federal Health Agency, own illustration based on Rechnungshof 2017/10, GÖG

Earnings	from	to	in Mio EUR (2014)	in Mio EUR (2015)
Financing according to § 57 (2) Z 1 and Z 2 KAKuG	Federal state	BGA	626,0	640,1
Financing according to § 57 (3) KAKuG	HVSV	BGA	83,6	83,6
Total			709,6	723,7

Expenses	to	in Mio EUR (2014)	in Mio EUR (2015)
Distribution of funds according to KAKuG (§ 57 (4) Z 1, § 57 (4) Z 2, § 57 (4) Z 3 + 4, § 57(4) Z 5, § 57(4) Z 6) to the regional health funds	Burgenland	18,4	19,1
	Carinthia	46,3	48,1
	Lower Austria	106,9	111,2
	Upper Austria	104,7	108,7
	Salzburg	44,7	46,4
	Styria	93,5	97,1
	Tyrol	72,1	74,3
	Vorarlberg	25,7	26,7
	Vienna	184,3	191,5
Total of funds to regional health funds of the Länder		696,5	723,1

The table below shows the exact composition of the total sums for the regional health funds according to the above mentioned paragraphs of the KAKuG.

For the calculation of the contributions according to KAKuG § 57 (4) Z 1, § 57 (4) Z 2 the Länder quota (1) needs to be used. For the contributions according KAKuG § 57 (4) Z 3 + 4 the Länder quota (2) comes to use.

Table 19: Earnings and expenses of the Federal Health Agency, own illustration based on Rechnungshof 2017/10.

Federal State	Total (2015)	Contributions according to KAKuG § 57 (4) Z 1	Contributions according to KAKuG § 57 (4) Z 2	Contributions according to KAKuG § 57 (4) Z 3 + 4	Contributions according to KAKuG § 57(4) Z 5	Contributions according to KAKuG § 57(4) Z 6
	€	€	€	€	€	€
Burgenland	19.140.108	8.825.176	744.802	2.367.584	4.363.697	2.838.849
Carinthia	48.109.641	23.665.334	1.997.239	6.353.342	8.794.333	7.299.393

Federal State	Total (2015)	Contributions according to KAKuG § 57 (4) Z 1	Contributions according to KAKuG § 57 (4) Z 2	Contributions according to KAKuG § 57 (4) Z 3 + 4	Contributions according to KAKuG § 57(4) Z 5	Contributions according to KAKuG § 57(4) Z 6
Lower Austria	111.168.191	49.585.000	4.184.733	13.328.418	24.305.349	19.764.691
Upper Austria	108.728.515	46.980.681	3.964.941	12.653.947	25.274.189	19.854.758
Salzburg	46.381.214	22.059.509	1.861.715	5.961.058	8.104.730	8.394.202
Styria	97.096.024	44.208.230	3.730.959	11.906.387	22.964.125	14.286.322
Tyrol	74.261.322	27.388.241	2.311.434	7.407.144	14.220.332	22.934.172
Vorarlberg	26.739.209	12.753.958	1.076.372	3.430.638	5.519.350	3.958.891
Vienna	191.532.432	107.658.913	9.085.888	29.111.388	24.374.815	21.301.428
Austria	723.156.657	343.125.043	28.958.083	92.519.906	137.920.920	120.632.705

Turnover tax of the Länder and the communities

Table 20: Turnover tax of the Länder

Turnover tax	from	to	in Mio EUR (2014)	in Mio EUR (2015)
Turnover tax of the Länder and the Communities according to 15a-VB, Art. 21 (1) Z2 and 15a-VB, Art. 21 (1) Z 6	Länder	LGF	224,2	228,7
	Communities	LGF	151,7	154,8
Total			375,9	383,5

Deduction of the Vorweganteile

Table 21: Vorweganteile of the Länder, own illustration based on RIS 15a BV-G.

Deduction of the Vorweganteil	from	to	in Mio EUR (2014)	in Mio EUR (2015)
Deduction of the Vorweganteile according to 15a-VB Art. 17 (4) Z1	BGA	LGF Upper Austria	3,63	3,63
	BGA	LGF Styria	4,36	4,36
	BGA	LGF Tyrol	3,63	3,63
	BGA	LGF Lower Austria	2	2
	BGA	LGF Upper Austria	2	2

Deduction of the Vorweganteil	from	to	in Mio EUR (2014)	in Mio EUR (2015)
	BGA	LGF Salzburg	2	2
	BGA	LGF Tyrol	14	14
Total			31,62	31,62

Endowment of regional health funds

The **regional health funds** (Landesgesundheitsfonds, LGF) administer tasks for general planning, controlling and financing of health care on a Länder level. Among other things, these tasks include the presentation of the budget frame for public expenses in health care, the further development of regional structural plans for health, the participation in the realisation of quality specifications for health services or the development of health promotion projects. Furthermore, the funds grant payments to public and private non-profit hospitals on the basis of the performance-oriented hospital financing (leistungsorientierte Krankenanstaltenfinanzierung, LKF) [109].

Table 22: Endowment of regional health funds, own illustration based on Rechnungshof 2017/10, GÖG.

Earnings	from	to	in Mio EUR (2014)
LGF total (2014)	Federal state (GSBG) 656,3 BGA 696,5 Länder (turnover tax) 224,1 Community (turnover tax) 151,7 Social security contributions (§447f ASVG) 4.807,9* Intergovernmental settlement 162,6 Other earnings	LGF - Burgenland	230,3
		LGF - Carinthia	799,0
		LGF – Lower Austria	1.891,2
		LGF – Upper Austria	1.908,7
		LGF - Salzburg	707,9
		LGF - Styria	1.406,3
		LGF - Tyrol	836,3
		LGF - Vorarlberg	449,7

[109] Öffentliches Gesundheitsportal Österreich, 'Bundesgesundheitsagentur'.

Earnings	from	to	in Mio EUR (2014)
	341,2 Funds according to Länder legislation 4.043,6	LGF - Vienna	2.854,6
Total			11.084

The funds of social security listed in the table below are apportioned among the regional health funds according to §447f (3)[110]. From the equalisation fund established for hospital financing, the HVSV transfers 70% of the flat rate amount in 12 equal monthly instalments to the regional health funds.

The funds for the transfers of the equalisation fund are raised through transfers of the social security carriers according to the key stated in §447f (10)[111]. The 30 percent of the flat rate amount are raised by contributions of health insurances in the amount of 0.5% of the general contribution base and the contribution base for special contributions. The funds are transferred in four equal quarterly amounts (§447f (3) 10). If the funds from §447f (3) 1 are not sufficient, health insurance carriers transfer funds according to the following allocation key: [112]

Table 23: Allocation key for transfer of funds, own illustration based on ASVG §447f

Social insurance carrier	Percent
WGKK	18,81319%
NÖGKK	11,47897%
BGKK	1,29897%
OÖGKK	14,33519%
STGKK	8,41037%
KGKK	3,70268%
SGKK	5,23748%
TGKK	5,42572%
VGKK	3,48345%
BKK Austria Tabak	0,06479%
BKK der Wiener Verkehrsbetriebe	0,35058%
BKK Mondi	0,05842%

[110] Allgemeines Sozialversicherungsgesetz - § 447f Beiträge der Träger der Sozialversicherung für die Krankenanstaltenfinanzierung; Ausgleichsfonds, n.d.
[111] Allgemeines Sozialversicherungsgesetz - § 447f (10) Beiträge der Träger der Sozialversicherung für die Krankenanstaltenfinanzierung; Ausgleichsfonds.Ibid.
[112] Ibid.

Social insurance carrier	Percent
BKK voestalpine Bahnsysteme	0,21491%
BKK Zeltweg	0,09834%
BKK Kapfenberg	0,16160%
VAEB, department A (as health insurance carrier)	1,40884%
VAEB, department B (as health insurance carrier)	1,47376%
BVA (as health insurance carrier)	13,60647%
SVA (as health insurance carrier)	7,38738%
SVB (as health insurance carrier)	2,98889%
Sum	100%

The key is newly determined every year in consideration of the development of contribution income of the individual health insurance carriers. For contribution income, the contributions of compulsory insured workforce, voluntary insured members and unemployed persons have to be used. [113]

Funds in the environment of social security

The HVSV established funds for the execution of individual services in health care (especially hospital financing) and the equalisation of structural differences between the regional health insurances. In particular there is the equalisation fund of the regional health insurances (§447a ASVG[114]), the equalisation fund for hospital financing (§447f ASVG[115]) and the fund for medical check-ups, health examinations and health promotion (§447h ASVG[116]). The mentioned funds are managed separately from the remaining capital of social security carriers[117].

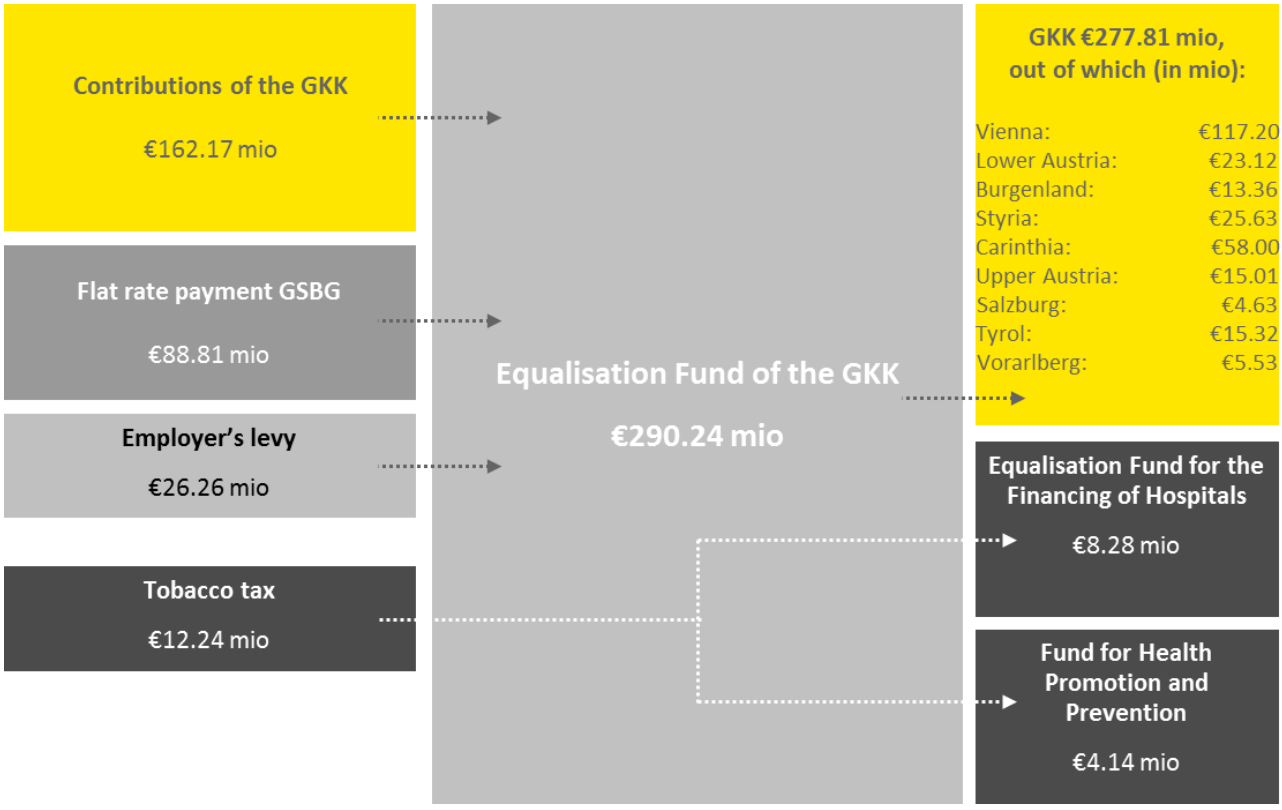
The following graphic shows the equalisation fund of regional health insurances including the corresponding payment flow (please note that the Rechnungshof reports the financial data for the

[113] Allgemeines Sozialversicherungsgesetz - § 447f (11) Beiträge der Träger der Sozialversicherung für die Krankenanstaltenfinanzierung; Ausgleichsfonds.
[114] Allgemeines Sozialversicherungsgesetz - § 447a Ausgleichsfonds der Gebietskrankenkassen, n.d.
[115] Allgemeines Sozialversicherungsgesetz - § 447f Beiträge der Träger der Sozialversicherung für die Krankenanstaltenfinanzierung; Ausgleichsfonds, n.d.
[116] Bundeskanzleramt Rechtsinformationssystem, 'Allgemeines Sozialversicherungsgesetz - §447h Fonds Für Vorsorge(Gesunden)untersuchungen Und Gesundheitsförderung'.
[117] Rechnungshof, 'Bericht Des Rechnungshofes - Mittelflüsse Im Gesundheitswesen'.

equalisation fund for the year it is reported, whereas the HVSV indicates the year for calculating the allocation of the financial means with respect to the risk equalisation fund – regarding this figure, this means that the numbers according to the Rechnungshof are for 2014, according to the HVSV, they are for 2013).

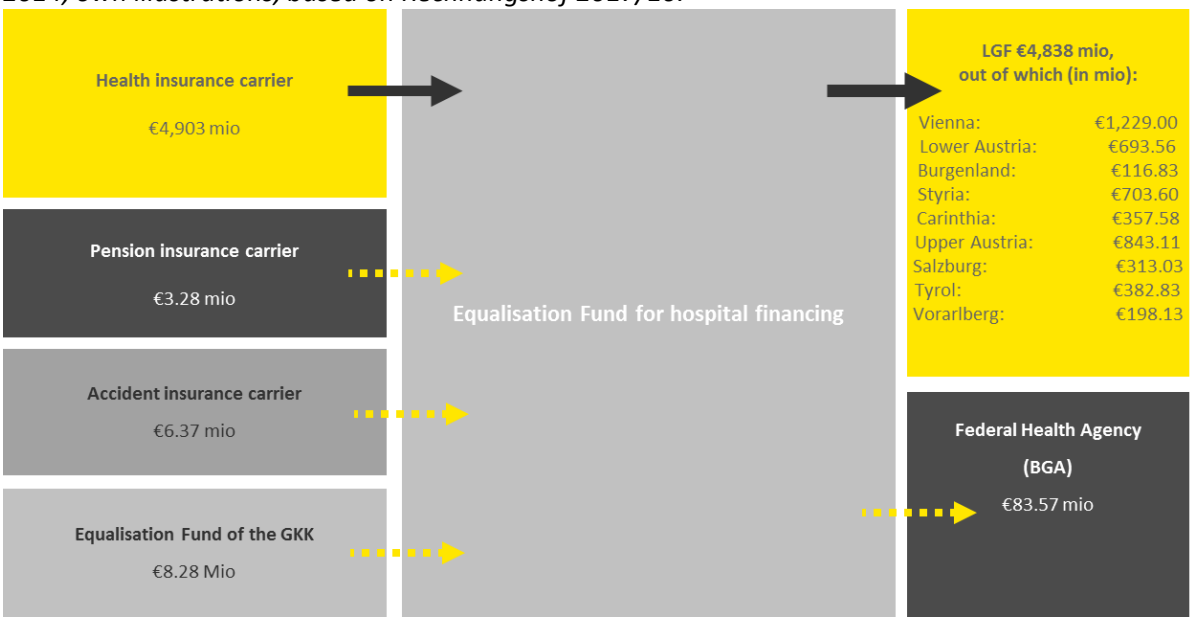
The equalisation fund of the regional health insurances (§447a ASVG)

Figure 53: Overview Equalisation Fund of the GKK, In- and Outflows of Financial Means in 2014, own illustrations, based on Rechnungshof 2017/10.



The equalisation fund for hospital financing (§447f ASVG)

Figure 54: Overview Equalisation Fund for hospital financing, In- and Outflows of Financial Means in 2014, own illustrations, based on Rechnungshof 2017/10.



Private hospitals financing fund (Privatkrankenanstalten Finanzierungsfonds, PRIKRAF)

The PRIKRAF is the compensation office for services performed in private hospitals, for which a service obligation exists for social health insurance. The services performed in private hospitals are reviewed and compensated by the PRIKRAF according to the known rules of performance-oriented hospital financing (leistungsorientierte Krankenanstaltenfinanzierung, LKF). The PRIKRAF is financed by the regional health insurances, company health insurances and special insurance carriers.

In 2015, 44 hospitals were financed through the PRIKRAF. In this year, health insurance carriers contributed a preliminary amount of €112.3 Mio. [118]

3.1.10 Health care institutions for civil servants (Krankenfürsorgeanstalten, KFA)

In Austria, civil servants working for the federal government, most of the Länder, and communities are insured by the Insurance for Public Service Wage and Salary Earners (BVA). In addition to that, on a Länder or community level, there exist health care institutions for civil servants of the Länder or communities,

[118] Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.

called Krankenfürsorgeanstalten (KFA). Therefore, there are 15 additional health (and accident) care institutions for civil servants on a Länder or community level. They are responsible for approximately 200.000 insured members. However, those institutions are not anchored within the social security system, as such. Moreover, the KFA neither belong to the Federation of Social Security Carriers, nor do they operate under the control of the supervisory authorities.[119] The following table shows the expenses (costs) of the KFA in the health sector for the year 2014.

Table 24: Expenses of health care institutions for civil servants (KFA), own illustration based on Rechnungshof 2017/10.

Use of funds	in Mio. EUR (2014)
Sanatoriums and hospitals	171.6
Medical help (including dental treatments)	171.5
Medication and therapeutic products	94.76
Rescue service and patient transportation	4.36
Other health care services (e.g. disease prevention)	0.43
Other (e.g. administrative tasks, cash payments)	65.52

The AUVA

The AUVA is the biggest accident insurance fund and is responsible for the provision of social insurance benefits in the event of an accident to those insured under the ASVG, as well as self-employed people insured by the Social Insurance Institution for the Self-Employed (GSVG). Other insurance providers (BSVG, B-KUVG, Austrian Miners' and Railway Workers' Insurance Fund) combine accident insurance and health insurance in a single policy. The AUVA finances treatment and rehabilitation in the seven emergency hospitals it operates, as well as in other hospitals, and pays sickness benefits in case of accidents.

[119] Pharmig, *Daten & Fakten 2016 - Arzneimittel Und Gesundheitswesen in Österreich*.

AUVA - special flat rate according to §319a ASVG

The special flat rate according to §319a ASVG[120] regulates the mutual claims for compensation between the AUVA and the regional and company health insurances as well as with the VAEB. This amount accounted for €201,450,000.00 in 2015. It is apportioned among the related insurance carriers as follows, whereby this allocation takes place through the HVSV:

§ 319a (2015)		
Health insurances	Special flat rate *) according to § 319a ASVG	
	key *) 2015 in %	Allocation in Euro 2015
§319a-carrier	100.0000	201,450,000.00
Gkk Vienna	21.1771	42,661,267.95
Gkk Lower Austria	16.8832	34,011,206.40
Gkk Burgenland	2.2498	4,532,222.10
Gkk Upper Austria	18.8815	38,036,781.75
Gkk Styria	13.5628	27,322,260.60
Gkk Carinthia	6.3389	12,769,714.05
Gkk Salzburg	7.3228	14,751,780.60
Gkk Tyrol	8.1600	16,438,32.,00
Gkk Vorarlberg	4.7840	9,637,368.00
Bkk Austria Tabak	0.0234	47,139.30
Bkk Mondi	0.0238	47,945.10
Bkk VABS	0.1652	332,795.40
Bkk Zeltweg	0.0540	108,783.00
Bkk Kapfenberg	0.1365	274,979.25
VAEB - Abt.A	0.2370	477,436.50

AUVA - compensation for outpatient services on health insurance patients

The compensation of accident hospitals' (Unfallkrankenhäuser, UKH) services provided for the account of health insurance carriers arises from a share in the amount of 14.5% of the special flat rate. However, this

[120] Allgemeines Sozialversicherungsgesetz - § 319a Besonderer Pauschbetrag.

percentage refers to the total sum. For outpatient services, health insurance carriers do not pay to the same extent as they participate in the flat rate. How much the individual health insurance carriers contribute is set by the HVSV in a so called debit key (Belastungsschlüssel). For 2015, this key is put together as follows:

Outpatient services (2015)		
Amount of compensation (14,5%)		
Debit key *) 2015 in %	Allocation in Euro 2015	
§319a-carrier	100.0000	29,210,250.00
Gkk Vienna	36.6426	10,703,395.07
Gkk Lower Austria	3.7569	1,097,399.88
Gkk Burgenland	0.2156	62,977.30
Gkk Upper Austria	16.1706	4,723,472.69
Gkk Styria	18.7861	5,487,466.77
Gkk Carinthia	13.0586	3,814,449.71
Gkk Salzburg	10.0094	2,923,770.76
Gkk Tyrol	0.1756	51,293.20
Gkk Vorarlberg	0.0824	24,069.25
Bkk Austria Tabak	0.0511	14,926.44
Bkk Mondi	0.0033	963.94
Bkk VABS	0.4379	127,911.68
Bkk Zeltweg	0.0483	14,108.55
Bkk Kapfenberg	0.0422	12,326.72
VAEB - Abt.A	0.5194	151,718.04

A range of other health insurance carriers pay for the outpatient services analogue to the case compensation resulting from the method mentioned above. This is represented as follows:

Other health insurances	7.268.120,00
BKK Wiener Verkehrsbetriebe	174.580,00
BVA	2.751.610,00
VAEB	834.910,00
SVB	500.350,00

Other health insurances	7.268.120,00
SVA	1.888.140,00
KFA Vienna	978.460,00
KFA Graz	140.070,00

In total, the AUVA receives €36,478,370.00 for outpatient treatments of "external" patients.

AUVA - Compensation for inpatient services on health insurance patients

For the treatment of inpatient patients the compensation also happens primarily through flat rate payments. The health insurance carriers who are included in the flat rate regulation (§ 319a ASVG[121]) paid EUR 38,469,339.00 in 2015, whereby the allocation on the individual carriers happens through the HVSV. The allocation is put together as follows:

Inpatient services (2015)	
health insurance carriers	according to HVSV
	Allocation in Euro 2015
§319a-carrier	38,469,339.00
GKK Vienna	13,527,629.00
GKK Lower Austria	1,160,455.00
GKK Burgenland	149,346.00
GKK Upper Austria	5,991,221.00
GKK Styria	8,698,044.00
GKK Carinthia	3,805,739.00
GKK Salzburg	4,418,207.00
GKK Tyrol	67,813.00
GKK Vorarlberg	56,837.00
BKK Austria Tabak	44,884.00
BKK Mondi	2,939.00
BKK voestalp. Bahns.	435,295.00
BKK Zeltweg	58,600.00
BKK Karpfenberg	52,330.00
VAEB - Abt.A	

[121] Ibid.

A range of other health insurance carriers pay analogue to the compensation resulting from the flat rate mentioned above. The relevant sums are as follows:

7.268.120,00	Other health insurance carriers	11.170.259,00
174.580,00	BKK Wiener Verkehrsbetriebe	207.945,00
2.751.610,00	BVA	4.190.074,00
834.910,00	VAEB	2.389.511,00
500.350,00	SVB	1.692.571,00
1.888.140,00	SVA	2.690.158,00
978.460,00	KFA Vienna	
140.070,00	KFA Graz	

In total the AUVA receives EUR 49,639,598.00 (Basis 2015).

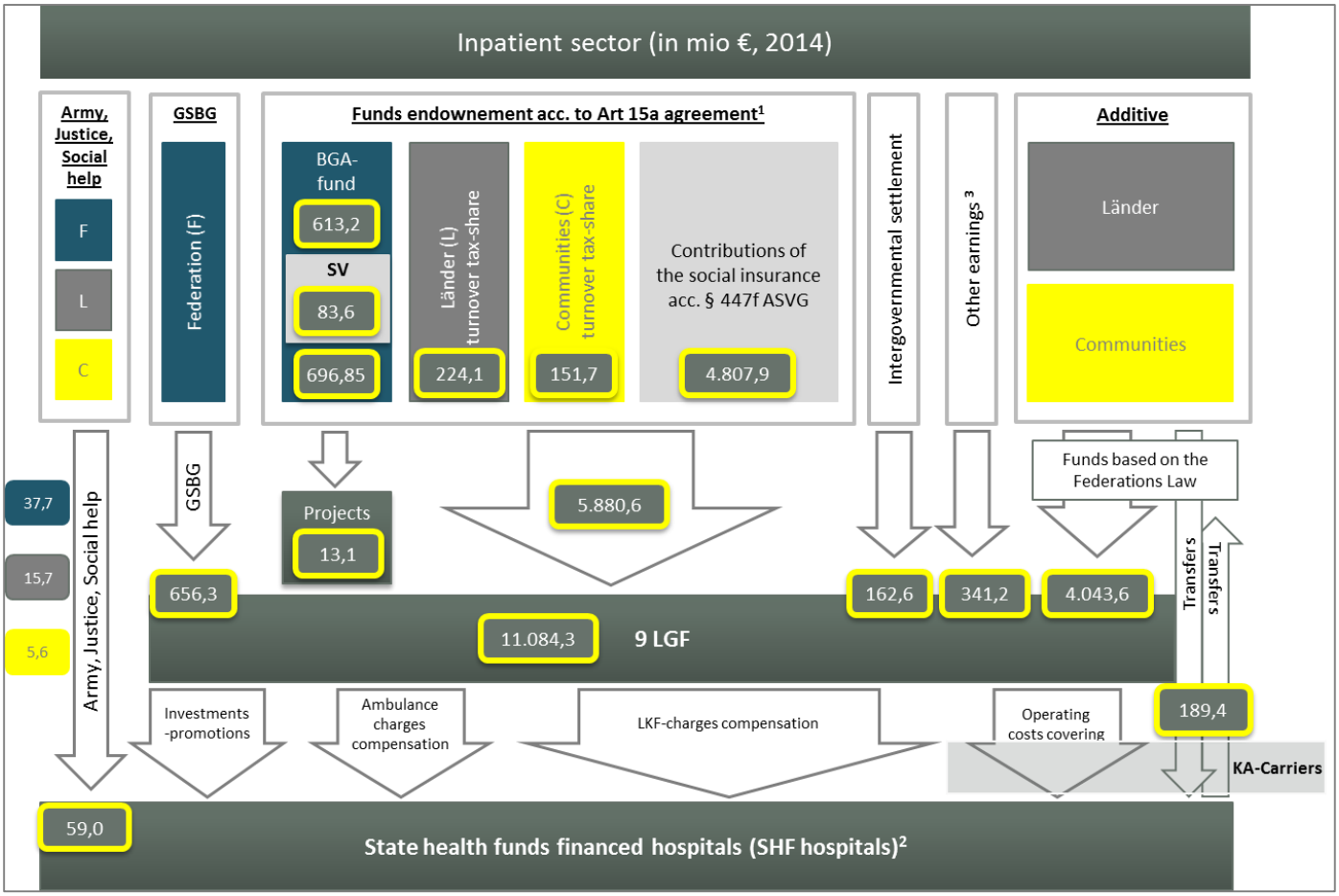
Further important financial flows

Description	from	to	in Mio EUR (2014)	in Mio EUR (2015)
Contributions health insurance of unemployed	Unemployment insurance	Health insurance	343,7	376,5[122]
Replacement for sick pay of unemployed	Unemployment insurance	Health insurance	170,9	181,5[123]
Contributions health insurance of pensioners	Pension insurance	Health insurance	1.519,6	1.613.9[124]
Federal contribution for pension insurance	Federal state	Pension insurance	7.715,2	7.947,2[125]
Compensation allowance	Federal state	Pension insurance	1.017.1	987,7[126]
	Pension insurance	Health Promotion and Rehab	996,7	1.026,8[127]
	Accident insurance	Health Promotion and Rehab	90,5	91,2[128]
	Accident insurance	Curative treatments	429,5	438,3

[122] Statistisches Handbuch der österreichischen Sozialversicherung 2016
[123] Statistisches Handbuch der österreichischen Sozialversicherung 2016
[124] Statistisches Handbuch der österreichischen Sozialversicherung 2016
[125] Bundesrechnungsabschluss für das Jahr 2015
[126] Hauptverband der österreichischen Sozialversicherungsträger, Finanzstatistik 2015
[127] Hauptverband der österreichischen Sozialversicherungsträger, Finanzstatistik 2015
[128] Hauptverband der österreichischen Sozialversicherungsträger, Finanzstatistik 2015

Graphic illustration of the financial flows in the inpatient sector

Figure 55: Overview Financial Flows in the inpatient sector, own illustrations, based on Rechnungshof 2017/10 and GÖG.



[1] Funds according to the allocation key after final statements of the Federation and SV.

[2] Public current health expenditures for state health funds financed hospitals (SHF hospitals) according to SHA do not include investments; additional expenditures on schools, houses, etc.; pensions; expenditures on foreign patients or costs contributions from patients.

[3] e.g. costs contribution, income from regresses, any interests income, KFA contributions and other income of the LGF which cannot be attributed to the above mentioned financial sources; adjusted by the tobacco tax (€75 million), which is part of the other income (as a difference in the contributions between SV according to the final statement of the SV and the amount shown in the RA).

3.1.11 Outpatient sector

The financing of outpatient health care in Austria is mostly happening through social health insurance. Currently, there are 18 health insurance carriers in Austria, which divide into nine regional health insurances, five company health insurances and four national carriers (SVA, SVB, BVA, VAEB). Health

insurances are mainly financed via contributions of insured members (2014: €13,634 Mio., 2015: €14,160 Mio).

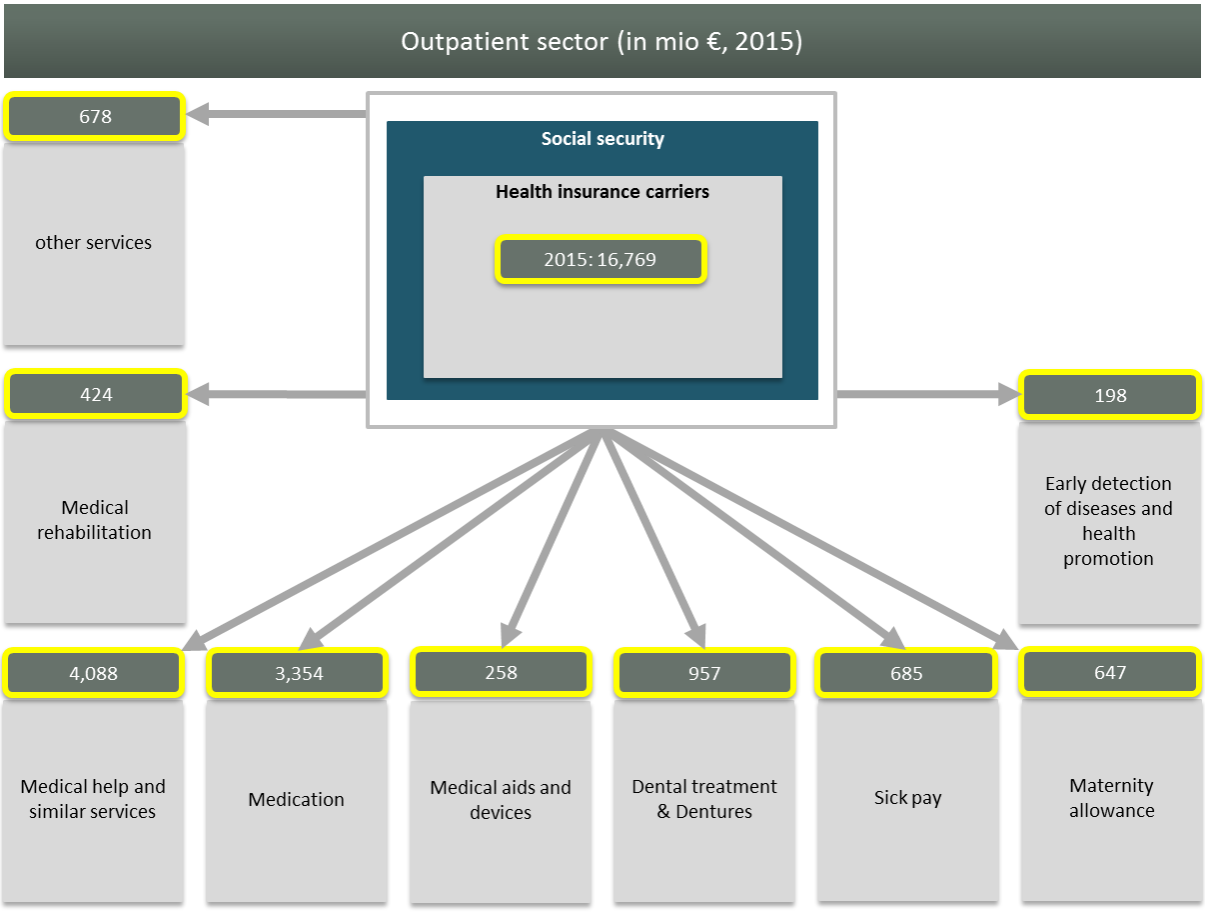
As already mentioned, the responsible health insurance pays all services performed in the extramural area, or under certain conditions provides a reimbursement of costs. A visit to an optional physician is an example for a reimbursement of costs. Health insurances make contracts with the interest groups of the service providers (e.g. Austrian Chamber of Physicians, Austrian Economic Chamber) and negotiate the respective service fees and the framework conditions involved.

The breakdown of expenditures in health insurance for the years 2014 and 2015 is shown in the following table:

Table 25: Expenditures of health insurances, own illustration based on Finanzstatistik 2015.

	in Mio EUR (2014)	in Mio EUR (2015)
Hospital care	4,693	4,875
Medical help and similar services	3,947	4,088
Medication	3,194	3,354
Sick pay	674	685
Dental treatments	657	684
Maternity allowance	627	647
Medical rehabilitation	399	424
Dentures	264	273
Medical help and similar services	252	258
Travel expenses and transportation costs	224	229
Early detection of diseases and health promotion	183	198
Rehabilitation allowance	92	248
Health strengthening and disease prevention	90	96
Medical examiner services	82	86
Medical in-home care	18	19

Figure 56: Overview Financial Flows in the outpatient sector, own illustrations, based on Finanzstatistik 2015.



3.1.12 Hebesätze of pension insurance

Hebesätze of pension insurance are regulated in §73 ASVG[1]. §73 Abs. 1[2] of the ASVG describes that from every payable pension and every special pension payment (with the exception of orphans pension and payable transitional payment) an amount of 5.1% needs to be retained. §73 Abs. 2[3] states that as contributions for the pensioners of the different pension insurances, a defined percentage of the

[1] Allgemeines Sozialversicherungsgesetz - § 73 Beiträge der Krankenversicherung für Pensionisten (Übergangsgeldbezieher)
[2] Allgemeines Sozialversicherungsgesetz - § 73 Abs. 1 Beiträge der Krankenversicherung für Pensionisten (Übergangsgeldbezieher)
[3] Allgemeines Sozialversicherungsgesetz - § 73 Abs. 2 Beiträge der Krankenversicherung für Pensionisten (Übergangsgeldbezieher)

contributions retained according to Abs. 1 must be transferred to the HVSV. An overview on Hebesätze shows Table 26.

To some extent, the Hebesätze generate a paradox redistribution of funds. It is quite conceivable that the SVB could increasingly experience financing problems, since with every farmer who retires, the services grow but the income through contributions declines. However, this is not the case, since the contribution for pensioners that has to be paid to the health insurance carriers according to §26 Abs. 2 BSVG amounts to 387%. Therefore, this Hebesatz is also significantly higher than the comparative values of other insurance carriers (GKK: 178, BVA: 171, VAEB: 308, SVA: 196).

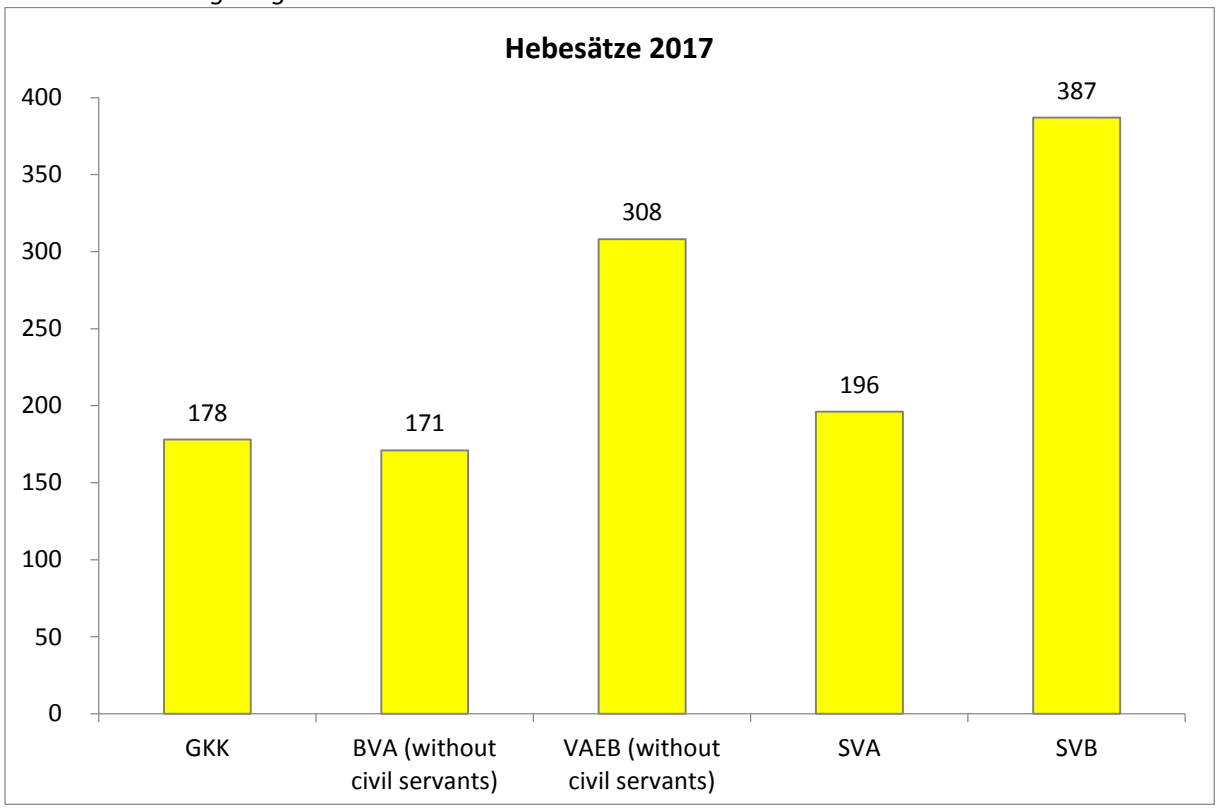
In the health insurance of the SVB, 45% of the income are insurance contributions, 9% other earnings and 46% federal funds. The low own contributions are also explained by the low contribution bases. In the pension insurance of farmers, around 80% of the funds come from the federal state and 20% from insured members. In addition, the change from working life to retirement is related to the change from workplace to residence principle, whereby a paradox allocation of funds is achieved. This affects predominantly person in the GKKn. The working life the insurance mostly generates higher payments of contribution, while during retirement the change to the local health insurance is connected with low payments of contribution and a higher use of service. At retirement age with a relatively high utilisation of services the insured members often do no longer live where they paid their contributions.

Table 26: Hebesätze, own illustration based on Hauptverband der österreichischen Sozialversicherungsträger

Year	Carrier	Contributions health insurance (Pensioners)	Hebesatz (PI-carriers)	Supple-mentary contribution (Pensioners)	Fictional contribution HI	Share Pensioners in %
2015	GKK	5,00	180	0,10	9,1000	56,0
	BVA (without civil servants)	5,00	173	0,10	8,7500	58,3
	VAEB (without civil servants)	5,00	310	0,10	15,6000	32,7
	SVA	5,00	197	0,10	9,9500	51,3
	SVB	5,00	397	0,10	19,9500	25,6
2016	GKK	5,10	178	0,00	9,0780	56,2

Year	Carrier	Contributions health insurance (Pensioners)	Hebesatz (PI-carriers)	Supple-mentary contribution (Pensioners)	Fictional contribution HI	Share Pensioners in %
	BVA (without civil servants)	5,10	171	0,00	8,7210	58,5
	VAEB (without civil servants)	5,10	305	0,00	15,5550	32,8
	SVA	5,10	192	0,00	9,7920	52,1
	SVB	5,10	387	0,00	19,7370	25,8
2017	GKK	5,10	178	0,00	9,0780	56,2
	BVA (without civil servants)	5,10	171	0,00	8,7210	58,5
	VAEB (without civil servants)	5,10	308	0,00	15,7080	32,5
	SVA	5,10	196	0,00	9,9960	51,0
	SVB	5,10	387	0,00	19,7370	25,8

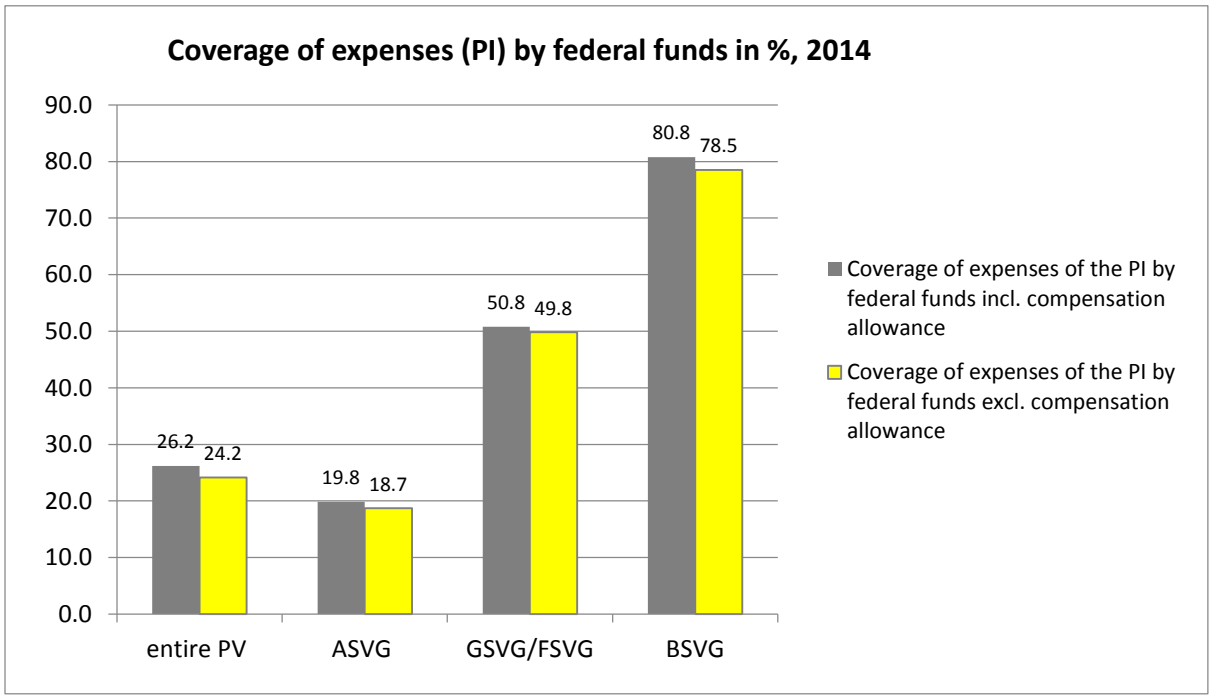
Table 27: Hebesätze, own illustration based on Hauptverband der österreichischen Sozialversicherungsträger



Funding ratios of the pension insurance

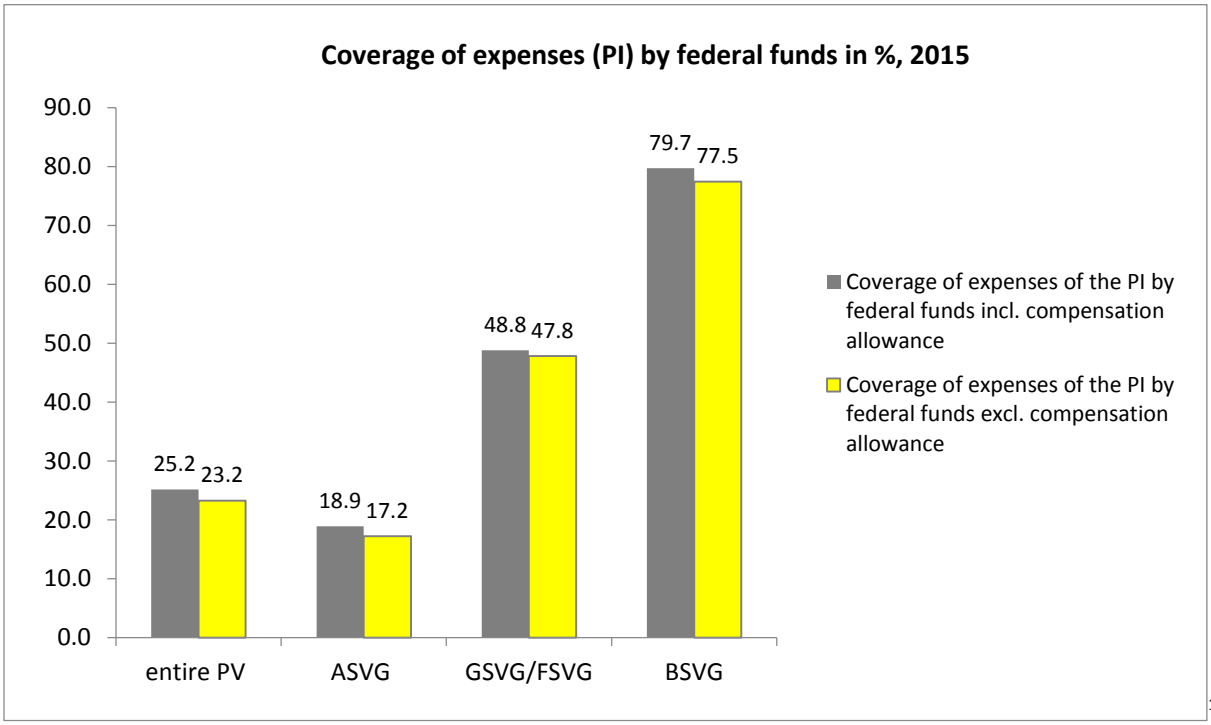
The following graphics show the coverage rate of expenses of the pension insurances according to ASVG, GSVG / FSVG and BSVG for 2014 and 2015. Illustrated are the coverage rates of the expenses once including and once excluding the equalisation allowance. For all pension insurance carriers the federal contribution to pension insurance covered around 24.2% of the incurred expenses of €37,470 Mio. in 2014. In the ASVG, the share varies around 18.7%, in the GSVG/GSVG 49.8% and in the BSVG 78.5%. In 2015, this overall share reduced to 23.2% for all pension insurance carriers, in the ASVG to 17.2%, GSVG/FSVG to 47.6% and in the BSVG to 77.5%. If all shares are shown including the equalisation allowance, the values are around 1-2% higher. With regard to the equalisation allowance it has to be mentioned that the federal state replaces the total expenses for the equalisation allowance to the pension insurance carriers. Therefore, the expenses for the equalisation allowance are transitory items in the budget of the pension insurances.

Figure 57: Share of expenditure by federal funds 2014, own illustrations, based on Gutachten Pensionskommission.[129]



[129] Gutachten der Kommission zur langfristigen Pensionssicherung für das Jahr 2017

Figure 58: Share of expenditure by federal funds 2015, own illustrations, based on Gutachten Pensionskommission.[130]



[131]

Comparison of the statutory pension insurance and the civil servants

The following graphics show the development of the statutory pension insurance and the pension insurance of the civil servants. Illustrated are the total income, contributions of insured people and employers as well as the number of pensioners and the general tax funds per pensioner.

In the statutory pension insurance the total income increased since 2005 by 47% compared to the pension insurance of the civil servants with 28%. The contributions of the insured and employers of the civil servants developed relatively stable (+3%) since 2005 compared to the statutory pension insurance with an increase of 42%/41%. The general tax funds per pensioner in the statutory pension insurance

[130] Gutachten der Kommission zur langfristigen Pensionssicherung für das Jahr 2017

[131] It has to be remarked that there are certain effects, which cause insured persons to change their carriers: for instance, if an insured person changes the type of work, e.g. after several years of being employed and paying contributions to one carrier, the person could become self-employed and with this, the insurance carrier would also change, due to the compulsory insurance, (in this example to the insurance fund of the self-employed). Yet, with increasing age, the insured person is also likely to need more health services and in addition the insurance fund, which last covered the health insurance before retiring is responsible for financing the entire pension payments.

amounted to €4,874 (+37% since 2005) in 2014 compared to €19,974 (+55% since 2005) for the civil servants. The part of pensions financed out of general tax revenues is much higher in the system of civil servants even if fictitious contribution payments by the employers were assumed.

Table 28: Gesetzliche Pensionsversicherung (ASVG, GSVG, FSVG, BSVG), own illustration based on BMASK / Statistik Austria, Essos-Datenbank

Year	Statutory pension insurance (ASVG, GSVG, FSVG, BSVG)							
	Total income in mio Euro	thereof				General tax revenue as a % of the income	Number of pensioners (Persons)	General tax funds per pensioner in €
		Contribution insured	Contributionemployer	General tax funds (including compensation allowance)	Transfers, other			
2005	26.224	9.042	9.350	6.569	1.263	25,0	1.846.754	3.557
2006	27.355	9.458	9.750	6.745	1.402	24,7	1.871.520	3.604
2007	28.618	9.927	10.260	6.925	1.506	24,2	1.900.338	3.644
2008	30.199	10.437	10.828	7.467	1.467	24,7	1.920.526	3.888
2009	31.733	10.611	10.932	8.560	1.630	27,0	1.960.066	4.367
2010	32.963	10.851	11.243	8.758	2.111	26,6	1.983.749	4.415
2011	34.038	11.414	11.767	8.858	1.999	26,0	2.011.154	4.404
2012	35.643	11.883	12.253	9.574	1.933	26,9	2.032.544	4.710
2013	37.077	12.384	12.713	9.664	2.316	26,1	2.055.613	4.701
2014	38.472	12.861	13.144	10.055	2.412	26,1	2.062.966	4.874
Increase 2005 - 2014 in %	+ 47	+ 42	+ 41	+ 53	+ 91		+ 12	+ 37

Table 29: Öffentliche Rechtsträger (Bund, Länder, Gemeinden und Pensionsübernahmen (ÖBB, POST usw.)), own illustration based on BMASK / Statistik Austria, Essos-Datenbank

Year	Public legal entities (Bund, Länder, Gemeinden und Pensionsübernahmen (ÖBB, POST usw.))							
	Total income in mio Euro	thereof				General tax revenue as a % of the income	Number of pensioners (Persons)	General tax funds per pensioner in €
		Contribution insured	Contribution employer; assumed relationship ASVG)	General tax funds	Transfers, other			
2005	9.132	2.289	2.802	3.990	51	43,7	308.858	12.919
2006	9.360	2.317	2.836	4.165	42	44,5	308.506	13.501
2007	9.558	2.340	2.864	4.306	48	45,1	311.966	13.803
2008	9.864	2.374	2.906	4.543	41	46,1	312.534	14.536
2009	10.197	2.409	2.944	4.816	28	47,2	313.464	15.364
2010	10.494	2.400	2.937	5.122	35	48,8	314.415	16.291
2011	10.677	2.378	2.911	5.351	37	50,1	315.324	16.970
2012	11.025	2.353	2.880	5.754	38	52,2	316.254	18.194
2013	11.343	2.403	2.942	5.953	45	52,5	320.638	18.566
2014	11.661	2.364	2.894	6.366	37	54,6	318.715	19.974
Increase 2005 - 2014 in %	+ 28	+ 3	+ 3	+ 60	- 27		+ 3	+ 55

3.2 Collection of contributions[132]

3.2.1 Self-employed persons engaged in commercial activity, insured at SVA

The contribution rate is based on the self-employed person's income, which is subject to compulsory insurance, as stated by the income tax statement. In addition to this income, compulsory pension and health insurance contributions, (which were paid in advance) for the respective calendar year, are added.[133]

The contribution base for health insurance is limited with the maximum base of €69,720.00 and a minimum base of €5,108.40, which for the pension insurance amounts to €8,682.00. Since the income tax statement is only issued at the end of the year, a preliminary calculation of contributions is required.

In 2016, the monthly minimum contribution base for health insurance was lowered to the level of the monthly ASVG marginal earnings threshold (Geringfügigkeitsgrenze). The monthly minimum contribution base for pension insurance will also be lowered (i12 times) to the marginal earnings threshold until 2022.[134] Yet, it needs to be taken into account that the minimum contribution base in the GSVG is due 12 times. In the SVA, the rate of contribution for pension insurance is 18.50% and for health insurance 7.65%. The contribution for accident insurance is fixed and independent of the amount of income and amounts to €9.33 per month, in 2017.[135] In the FSVG, the rate of contribution for the pension insurance is 20%.[136]

3.2.2 Farmers, insured at SVB

The contribution base, according to the BSVG, is the insured value of the farmer's agricultural/forestry business, which is derived from the standard value for the agricultural/forestry areas.[137] The derived contribution base is specified in a contributions table.

[132] Primary source of data for this section are: Hauptverband der österreichischen Sozialversicherungsträger, 'Beitragsrechtliche Werte in Der Sozialversicherung 2017'.Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung'.

[133] Sozialversicherungsanstalt der gewerblichen Wirtschaft, 'Vorläufige Berechnung Der Beiträge'.

[134] Sozialversicherungsanstalt der gewerblichen Wirtschaft, 'Bundesregierung Beschließt Senkung Der Mindestbeiträge Für Selbstständige'.

[135] Sozialversicherungsanstalt der gewerblichen Wirtschaft, 'Mindestbeiträge Und Höchstbeiträge'.

[136] Sozialversicherungsanstalt der gewerblichen Wirtschaft, 'Endgültige Berechnung Der Beiträge'.

[137] Sozialversicherungsanstalt der Bauern, "Beitragsgrundlage Vom Einheitswert."

The rate of contribution for health insurance is 7.65%, for pension insurance 17% and for accident insurance 1.9%. In 2017, the minimum contribution base in the flat-rate system amounts to €785.56 for health and accident insurance and €425.70 for pension insurance.

In case of the contribution foundation option (Beitragsgrundlagenoption, i.e. instead of the insured value of the agricultural business, the income, as indicated on the income statement, is used for setting the contribution base), the minimum contribution bases are higher: Health and accident insurance €1,476.16, pension insurance €785.56.[138] Thus, with this option, the operating manager/farmer of an agricultural/forestry business can apply to use the income shown in the income tax statement for the contribution assessment, instead of utilizing the insured value as basis.

3.2.3 Workers and employees

For workers and employees the ASVG §44 specifies that the "due earned income during the contribution period" serves as the contribution base. §49 also defines remuneration as "monetary and in-kind earnings, which the compulsory insured employee is entitled to, owing to his/her employment". Thus, the ASVG follows the principle of entitlement-to-remuneration (Anspruchslohnprinzip), rather than the inflow-principle, which is usually dominant in tax law. With respect to the principle of entitlement-to-remuneration, the minimum for the contribution base is the civil claim for payment (zivilrechtlicher Entgeltanspruch), as regulated by collective agreements, employment contracts etc. However, this does not depend on whether the payment was actually paid out to this extend. The claim to a certain amount is sufficient.[139] The maximum contribution rate for workers and employees for 2017 is set at €4980 (monthly), which on a daily basis amounts to €166 and the wage for the marginal employment (Grenzbetrag für Geringfügigkeit) is currently €425.70.

The contribution rates according to the ASVG (and thus applicable to workers, employees, freelancers, agricultural workers, and miners) amount to: 1.3% for the accident insurance (paid by the employer), 3.87% and 3.78% for the health insurance, (paid by the employee and the employer, respectively), and

[138] Sozialversicherungsanstalt der Bauern, 'Beitragsgrundlagenoption - Gesamtbetrieb'.
[139] NÖDIS - Das Dienstgebertportal der NÖGKK, 'Entgelt - Beitragspflichtig'.

22.8% for pension insurance (which is split into 10.25% for the employee and 12.55% for the employer).[140] For a detailed list of the contribution rates for workers and employees, please see below[141]:

Figure 59: Beitragsstäze (in Prozent), HVSV: Beitragsrechtliche Werte in der Sozialversicherung, 2017

3. Beitragssätze (in Prozent)

Bezeichnung	Arbeiter[1]			Landarbeiter			Angestellte			Freie Dienstnehmer		
	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber-anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber-anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber anteil	ins-gesamt	Dienst-nehmer-anteil	Dienst-geber anteil
Krankenversicherung, § 51 ASVG	7,65	3,87	3,78	7,65	3,87	3,78	7,65	3,87	3,78	7,65	3,87	3,78
Unfallversicherung, § 51 ASVG	1,30	0,00	1,30	1,30	0,00	1,30	1,30	0,00	1,30	1,30	0,00	1,30
Pensionsversicherung, § 51 ASVG [10]	22,80	10,25	12,55	22,80	10,25	12,55	22,80	10,25	12,55	22,80	10,25	12,55
Knappschaftliche Pensionsversicherung, §§ 51,51a ASVG	28,30	10,25	18,05	-	-	-	28,30	10,25	18,05	-	-	-
Arbeitslosenversicherung (AV) [8]	6,00	3,00	3,00	6,00	3,00	3,00	6,00	3,00	3,00	6,00	3,00	3,00
IESG-Zuschlag	0,35	0,00	0,35	0,35	0,00	0,35	0,35	0,00	0,35	0,35	0,00	0,35
Arbeiterkammerumlage [2]	0,50	0,50	0,00	0,75	0,75	0,00	0,50	0,50	0,00	0,50	0,50	0,00
Wohnbauförderungsbeitrag	1,00	0,50	0,50	-	-	-	1,00	0,50	0,50	-	-	-
Schlechtwetterentschädigungsbeitrag [3]	1,40	0,70	0,70	-	-	-	-	-	-	-	-	-
Nachtschwerarbeits-Beitrag [4]	3,40	0,00	3,40	3,40	0,00	3,40	3,40	0,00	3,40	-	-	-
Dienstgeberabgabe [5]	16,40	0,00	16,40	16,40	0,00	16,40	16,40	0,00	16,40	16,40	0,00	16,40
Beitrag für Versicherte in geringfügigen Beschäftigungsverhältnissen gemäß § 53a ASVG [6]	14,12	14,12	0,00	14,12	14,12	0,00	14,12	14,12	0,00	14,12	14,12	0,00
Beitrag zur Betrieblichen Vorsorge (BV) [7]	1,53	0,00	1,53	1,53	0,00	1,53	1,53	0,00	1,53	1,53	0,00	1,53
Sozial- und Weiterbildungsfonds-Beitrag (SO)[9]	0,80	0,00	0,80	-	-	-	0,80	0,00	0,80	-	-	-

3.2.4 Civil servants and public employees

With respect to the social security of the civil service, there exists a maximum contribution base for health insurance (€4980 in 2017), but not for the accident insurance. With respect to the pension insurance, only new contractual civil servants are insured with the PVA according to the ASVG. These new are charged 10.25% and the employer pays 12.55%, which in total accrues to 22.8%. The contribution for the health insurance for active civil servants amounts to 7.635% (which is split into 4.1% for the civil servant and 3.535% for the employer). For accident insurance, the contribution comes to 0.47%, however as mentioned before there exists no maximum contribution base. Regarding pension insurance, there is a maximum contribution base for contractual civil servants and employees at universities. For every employee, who is subject to the Pension Act, the contribution for pension insurance is levied by the employer, without a maximum contribution base.

[140] Hauptverband der österreichischen Sozialversicherungsträger, 'Beitragsrechtliche Werte in Der Sozialversicherung 2017'.
[141] Ibid.

3.2.5 Conclusion and Outlook

The contribution bases are to be judged by taking the different allocations of income of the various social security carriers into consideration. Setting the contribution bases and rates of contribution results in differently high levels of self-funding, and thus, varying ratios between own contributions and funds provided by federal tax. However, this may be partly explained by the lower rates of contribution for pension insurance and setting the base for contributions.

As mentioned in the section about multiple insurances, the monthly contribution base notification (mBGM) system will replace the current wage-sum-procedure (Lohnsummenverfahren). In the current system, the employer is responsible for computing and paying both, the employee and the employer monthly contribution rates, for all of the employees, who work in the firm. However, so far, the contributions cannot be allocated to the individual, as the monthly contribution statement is adequate proof, which does not show the individual employee's name, but only the overall sum of wages, which are broken down into contribution- and settlement-groups[142]. This includes information about the scope of the insurance, the category of the employee (e.g. worker), the percentages of the employee and employer shares, as well as the allocation according to the three pillars of the social insurance. In addition, the supplementary costs need to be calculated for every employee (these are for instance for the chamber of labour, or the public housing contribution) and corporate prevention. In order to simplify the system, the mBGM will be a modular tariff system, which aims to be less complex. This tariff system comprises three elements[143]:

1. Group or category of employee (Beschäftigtengruppe)
2. Supplements (Ergänzung)
3. Additions or deductions (Abschläge/Zuschläge)

Ad 1: The category of employee specifies: The scope of the insurance, i.e. the applicable branches of the social insurance. Furthermore, the category, which can be either worker or employee, and the compulsory contribution and the rates of contributions for the social insurance branches (split into employee and employer shares), as well as the compulsory contributions and percentages for the Chamber of Labor or the Chamber of Agricultural Workers (Arbeiter-, or Landarbeiterkammerumlage), public housing

[142] Hauptverband der österreichischen Sozialversicherungsträger, 'Arbeitsbehelf Für Dienstgeberinnen Und Dienstgeber Sowie Lohnverrechnerinnen Und Lohnverrechner - Stand: 1.1.2017'.
[143] Sozialversicherung, *Monatliche Beitragsgrundlagenmeldung - Tarifsystem*.

contribution and the supplementary fee related to the insolvency-wage-security-Act (Insolvenz-Entgeltsicherungsgesetz). Consequently, the category of employee comprises all information about one specific group of ensured persons, e.g. for all workers, hence for the majority of employees reporting this information is sufficient. (For further information, please refer to the BRG-Schema)[144].

Ad 2: The supplements are only applicable for special cases, i.e. if there is a liability to pay the night-heavy-labor-contribution and/or the contribution for adverse weather conditions, or if the employee belongs to a specific category of profession (e.g. social-development worker), or if there exists an irregularity regarding the employees membership in a chamber.

Ad 3: The third element of the mBGM refers to individual particularities with respect to the settlement, and includes either additions or deductions, which may apply for workers and employees, alike. These could happen, in form of income-related deductions of the unemployment contribution, a deduced contribution for founders, service-contributions, age-related deductions or the complete concession of the unemployment insurance. Below illustrates what the employer had to report in the old system (on the left-hand side) versus the simplifications of the new mBGM system (on the right), for a 'normal worker':

1) Contribution group = A1	Worker (1)
2) Contribution for the Chamber of Labour = J	
3) Contribution for Housing Subsidy = J	
4) IE-Addition = J	
5) Contribution for adverse weather conditions = N	
6) Contribution for night heavy labour	

The mBGM is likely to take effect from January 2019. The legal framework for the mBGM is set by the reporting-obligation Act.[145] The mBGM means a complete system transformation affecting the employers and the social insurance carriers, enabling high quality and more timely data about monthly contributions. Consequently, in future, data will be available more promptly and not only after the end of the calendar

[144] Hauptverband der österreichischen Sozialversicherungsträger, 'Beitragsgruppenschema Und Übersicht Für DienstgeberInnen Und LohnverrechnerInnen Stand: 1.1.2017'.
[145] Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung'.

year. More specifically, the mBGM represents a simplification of applications and a decrease in having to report redundant data. In addition, this makes changes in the insurance history more transparent, errors are avoided due to a clearing system, and the contribution groups are replaced by this new tariff-system.[146]

To better align the GSVG with the BSVG and the ASVG, there were several amendments within the past years, which clearly aim to unify the value-limits (Wertgrenzen) regarding the obligation to contribute. Nevertheless, there exist substantial differences in setting the contribution bases with respect to the different social insurance laws: put into simple terms, whilst self-employed persons are assessed according to their profits, farmers are assessed according to the standard value for the agricultural/forestry areas and employed persons are assessed in terms of their salaries. Since each system follows its own logic, the reporting and examination can be different in the carriers. In particular with respect to the self-insured persons, this leads to increased examination expenditures per capita.

In comparison to the ASVG/GSVG, the BSVG involves two options to assess the contributions: on the one hand a flat-rate system according to the standard value (calculated in line with the insured value for the agricultural/forestry areas), and on the other hand, there is the option to assess via the farmer's income (in line with the income statement, which is the same method of assessment as used in line with the GSVG). According to the SVB annual report 2015[147], out of an overall 120.253 contribution assessments according to the BSVG, 106.249 were calculated in terms of the standard value (i.e. 88%), 8.972 were set via individual contribution basis (in particular, this applies to multiple insured persons with Differenzbeitragsgrundlagenbildung, i.e. setting the differential contribution basis), 3.400 were assessed via the income statements, i.e. BGT-Option, and 1.732 with the little option (i.e. Einkommensbetriebe und Betriebe mit Kleiner Option, where setting the contribution is not or not purely based on the standard value, but depends on the earnings as indicated in the income statement). [148]

The insurance value (as base for setting the contribution basis) is calculated in accordance with the tax unit value of the agricultural area. By doing so, the value is to be rounded down to the next full hundred Euro, meaning this could lead to an average reduction of €50 (of the unit value). Further, the insurance value is formed according to the unit value and the so called income factor.

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[146] Österreichische Sozialversicherung, 'Monatliche Beitragsgrundlagenmeldung (bMGM) - Fragen-Antworten-Katalog'.

[147] SVB Jahresbericht 2015, S. 105

[148] SVB Jahresbericht 2015, S. 105

The actual insurance value itself is based on a percentage which decreases with rising unit-values. Thus, in 2017, between €5,100 and €8,700, this value accounts for 21.30 % and from 43,700 EUR upwards, for only 3.06 %. Using the example of a farming business, which ranges above the maximum contribution base, the insurance value would be calculated in accordance with the following table:

Table 30: Unit values for calculating contribution basis at SVB

Unit value (Einheitswert)				Percentage considered for contribution base (fließt in BGL ein)
from	- EUR	to	5,000 EUR	19.17 %
from	5,100 EUR	to	8,700 EUR	21.30 %
from	8,800 EUR	to	10,900 EUR	17.31 %
from	11,000 EUR	to	14,500 EUR	11.98 %
from	14,600 EUR	to	21,800 EUR	9.72 %
from	21,900 EUR	to	29,000 EUR	7.19 %
from	29,100 EUR	to	36,300 EUR	5.33 %
from	36,400 EUR	to	43,600 EUR	3.99 %
from	43,700 EUR	to	87,500 EUR	3.06 %

There also exist differences with respect to the minimum contribution basis between the BSVG and the ASVG and the GSVG. For farming businesses, which are operated by partners, who are married, the minimum contribution basis for the farmers' pension insurance is € 212.85, and for the health insurance € 392.78 (in 2017). However, the ASVG low income threshold (Geringfügikeitsgrenze) is set at € 425.70 EUR. If a BSVG insured person would receive a pension, calculated according to the € 212.85 over a period of 45 years, this would account for approximately € 170 in today's monetary value; Hence, farmers (especially in case of a farming business which is operated by married partners) are at a higher risk of old-age poverty. The same low contribution basis with respect to the pension and health insurance is also used for children, who work on the farm, or the farmer's parents after they have passed on the ownership of the farm to their child.

For farming businesses operated by married partners, the maximum contribution basis is reached with a unit value of € 277,200 EUR-which is more than 3- times higher than that for a business operated by a single operator (Betriebsführer) (87,500 EUR). [149]

In conclusion, calculating and setting the contribution bases for self-employed and employed persons differs massively. Self-employed persons can – via tax law (or in the case of farmers via the effect of the flat rate model) – control their contribution basis to a certain degree (additionally, in the GSVG, there are deductions for capital and restructuring gains). Contrasting this, the employees underlie a fixed allocation of their income through the synchronization with the tax law with regard to the exemption from the concept of remuneration.

3.3 User charges[150]

A user charge is the amount an insured person has to contribute as share to the costs of the carrier (= cost sharing). In the Austrian social security system, certain services are based on cost sharing. Most of the cost sharing and user charges cover the same service areas, however there are many differences between the insurances in terms of the level of contribution. The following is an overview of possible areas where cost sharing and user charges are present in Austria:

- Service fee as access to ambulatory physicians
- Dental treatments
- Orthodontic treatments
- Dentures
- Hospital care
- Medication
- Therapeutic appliances
- Rehabilitation

[149] Sozialversicherungsanstalt der Bauern, 'Beitragstabelle Der Bäuerlichen Sozialversicherung Gültig Ab 1. Jänner 2017'.

[150] Primary sources of data for this section are: Hofmarcher-Holzhacker, 'Unbeliebt Aber Zunehmend: Private Gesundheitsausgaben, Selbstbehalte Stagnieren'. Hofmarcher and Quentin, 'Austria'. Hofmarcher-Holzhacker, 'Fast Track: Private Gesundheitsausgaben 2014'. Streissler-Führer, Friedl, and Pichler, 'Selbstbehalte Im Gesundheitswesen'. Data from HVSV Finanzstatistik 2015

There are two prime reasons to apply user charges in social security: At first, they can avoid over-use of services by the insured persons which can cause unnecessary expenses for the carrier. When an insured person has to pay a certain share of the costs, he/she is less likely to use this service more than necessary since this would involve additional expenses for him/her, as well. Second, user charges serve as income for the carrier as it represents relief to the budget.[151] However, this is not always the case, since cost sharing in some cases, can also cause high administrative costs and therefore potentially results in only a minimum increase in income.

In general, the share of user charges (17%) in total costs in the Austrian social security system are relatively high in comparison to the OECD. On average, an Austrian household spends approximately €100 per month on medication, cost sharing, user charges or health services, which are not covered by the insurance. [152]

3.3.1 Differences between the health insurance funds

As stated above, there are differences between the individual insurance funds, in terms of cost sharing and user charges in certain areas:

A prescription fee of €5.85 applies per package (Status 2017) to all insured persons, independent of their insurance status. In general, the prescription charges are capped, i.e. they may not exceed 2% of the annual net income, which is the limit for the prescription charges (Rezeptgebührenobergrenze). There are exemptions for specific group of persons, e.g. people with infectious diseases, pensioners with compensatory allowance, men and women in civilian service, children covered under a parent's policy or "people requiring social protection". [153] Single persons with a net income of €889.84 or lower, as well as married couples with an income of €1,334.17 or lower, are exempted from this fee. Persons with health expenditures higher than the average (due to chronic diseases), who have net incomes of no more than €1,023.32 (single person) or €1,534.30 (married couples) can also apply for an exemption of the prescription fee. Every additional child raises the calculation basis by €137.30. [154]

[151] Hofmarcher-Holzhacker, 'Unbeliebt Aber Zunehmend: Private Gesundheitsausgaben, Selbstbehalte Stagnieren'.
[152] Streissler-Führer, Friedl, and Pichler, 'Selbstbehalte Im Gesundheitswesen'.
[153] Hofmarcher and Quentin, 'Austria'.
[154] Hauptverband der Österreichischen Sozialversicherungsträger, '2017: Neue Beträge in Der Sozialversicherung'.

Explicitly, only the ASVG carriers charge the service fee for the e-card (which in 2017 amounted to €11 per year), yet they do not levy general user charges. The e-card gives insured persons access to ambulatory physicians or dental treatment. For the other carriers, instead of the service fee for the e-card, they compensate this service fee by levying user charges. These user charges may vary between quarterly contributions (in line with the BSVG, the SVB charges €9.61 per quarter, but only in case health services are used). The other carriers levy percentage shares between 10% and 20%. Orthodontic treatment and denture user charges are based on the statues of the insurance carrier according to the ASVG, but include cost sharing between 20% and 50% for all other insurances.

Since July 2015, severe orthodontic misalignments on level 4 or 5 of the IOTN-Index of children until the age of 18 are excluded from cost sharing. This initiative is called "Gratis-Zahnspange" (= free braces") and was introduced by health insurances in order to prevent follow-up problems in the adult age. All misalignments that are only on level 1-3 do not urgently require treatment, therefore treatments of these lighter misalignments usually imply a contribution towards the costs by the insured person.[155] Regardless of insurance, therapeutic appliances require a 10% cost sharing, but at least €33.20. For visual aids, the cost sharing is at least €99.60 (Status 2017). Children under 15, severely disabled children or persons, who do not have to pay a prescription fee due to special need for protection, are exempted from sharing those costs. [156]

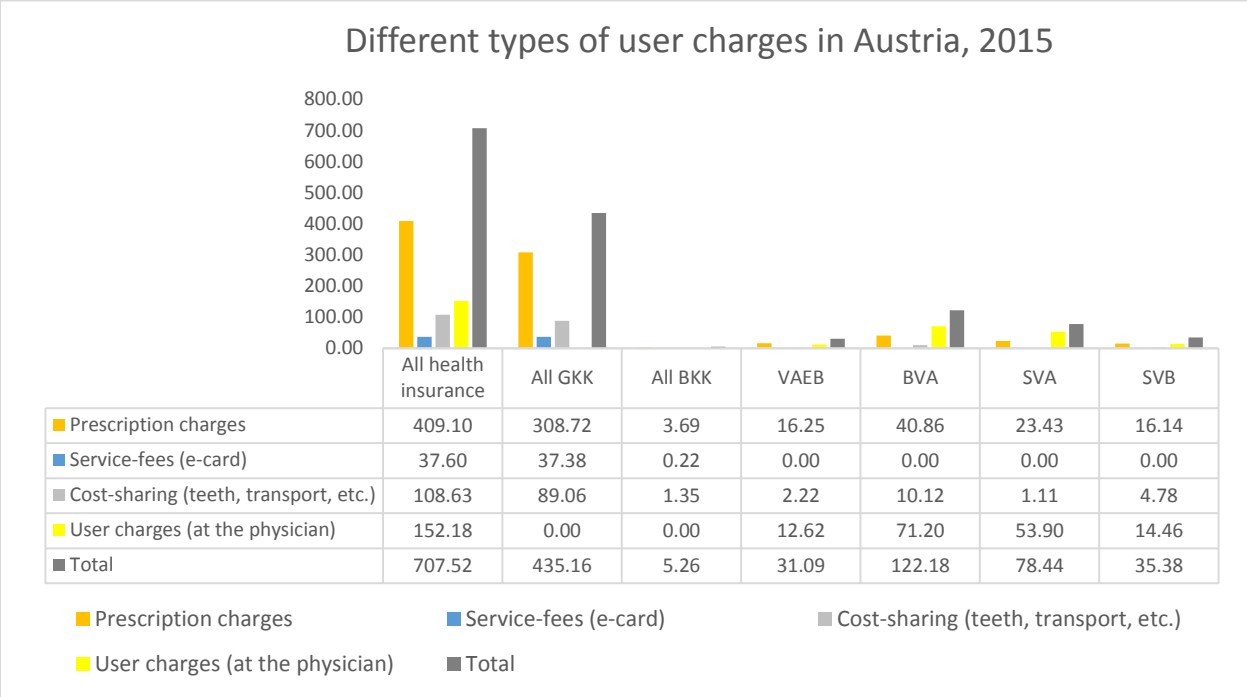
3.3.2 Financial situation

In 2015, the overall total for all types of user charges amounted to €707.52 mio. Out of these, the prescription charges represented the highest share, amounting to €409.10 mio. In relation to the overall income of the health insurance carriers, this signified 2.4%[157]. The second largest share were the user charges, which e.g. are charged to the patient at medical practices (this neither applies to the GKK, nor the BKK). These amounted to €152.18 mio, which in relation to the overall income of the health insurance is 0.9%. The cost-sharing, which can be imposed for e.g. transportation costs or dental treatments accounted for €108.63 mio. The smallest amount was charged for the services in connection with the e-card, which in total came to €37.6 mio. However, the special insurance carriers (i.e. VAEB, BVA, SVA and

[155] 'Start Für Gratis-Zahnspange in Österreich'.
[156] Hauptverband der Österreichischen Sozialversicherungsträger, '2017: Neue Beträge in Der Sozialversicherung'.
[157] Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.

SVB) do not incur any direct charges with respect to the e-card. The highest proportion of total charges and fees in relation to the overall insurance service payments happened at the SVA, reaching 8.1%, followed by the BVA with 7.3%. The GKK Salzburg showed the lowest total charges and fees, amounting to only 2.9% in terms of the overall insurance service payments. For further information on the different types of user charges, please see Figure 60.

Figure 60: Types of user charges in Austria, 2015, own illustration based on Finanzstatistik 2015.



	All health insurance	All GKK	All BKK	VAEB	BVA	SVA	SVB
Prescription charges	409.10	308.72	3.69	16.25	40.86	23.43	16.14
Service-fees (e-card)	37.60	37.38	0.22	0.00	0.00	0.00	0.00
Cost-sharing (teeth, transport, etc.)	108.63	89.06	1.35	2.22	10.12	1.11	4.78
User charges (at the physician)	152.18	0.00	0.00	12.62	71.20	53.90	14.46
Total	707.52	435.16	5.26	31.09	122.18	78.44	35.38

In relation to the total income of the carriers, the treatment contributions (i.e. user charges) for the SVA and the BVA appeared comparatively high, with 5.1% and 4.1%, respectively. With respect to the other two special insurance carriers (Sonderversicherungsträger), i.e. the SVB and VAEB, the treatment contributions represented 2.4% and 2.1% of the overall income for 2015. If calculated across all health carriers, the share of treatment contributions in terms of the total income amounts to merely 0.9%. This is largely due to neither the GKK, nor the BKK really having user charges. For further information on the user charges per carrier in relation to the total income, in 2015, please view figure below.

Figure 61: Share of User Charges in terms of Income 2015, own illustration based on data from HVSV

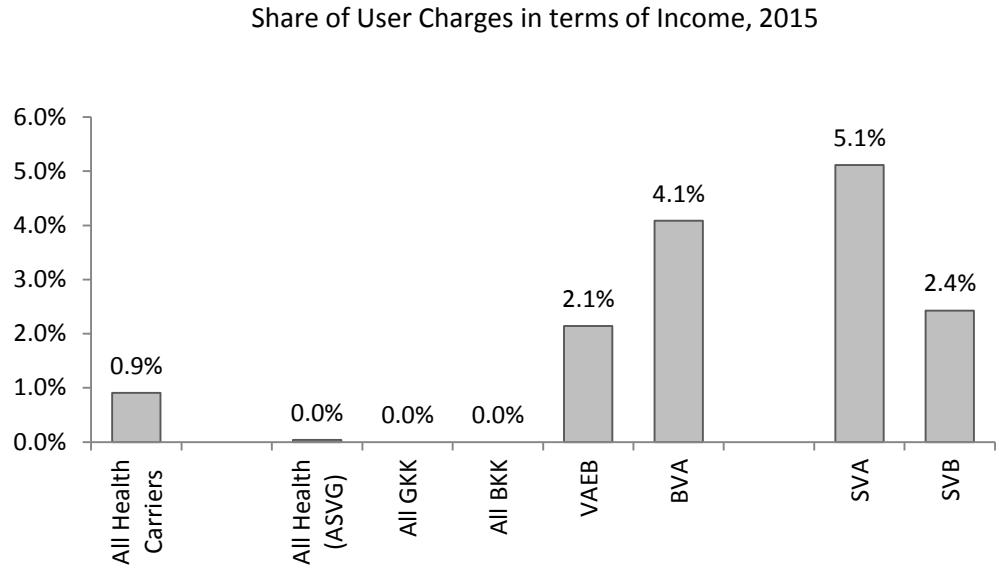
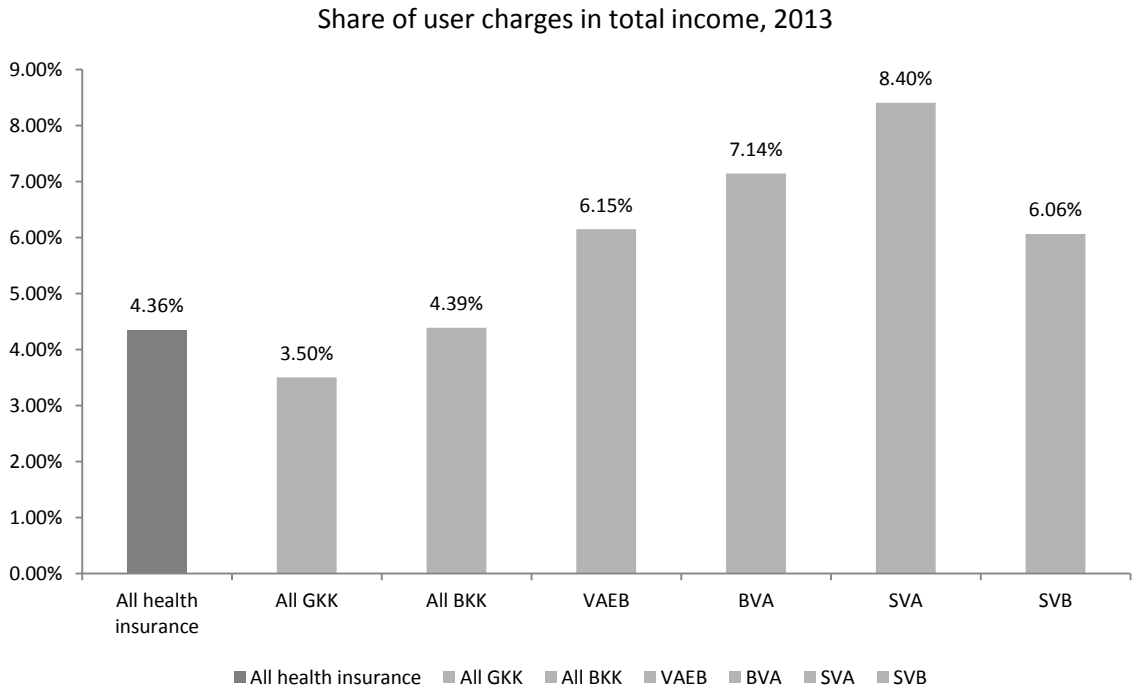
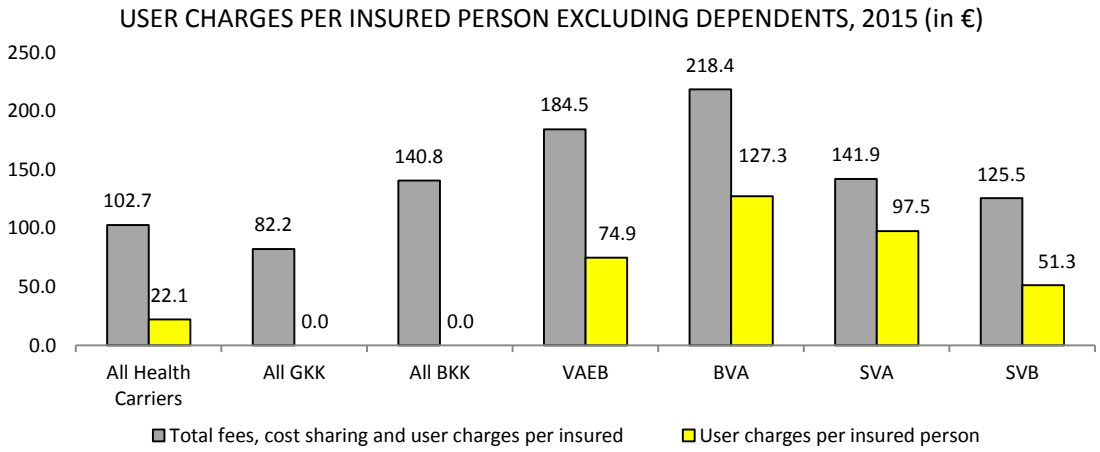


Figure 62: Share of Total fees (cost-sharing and user charges) in Total Income 2013, own illustration based on data from HVSV



The figure below illustrates the financial differences per capita between the total fees (cost-sharing, and user charges) versus the user charges (indicated in yellow): The first diagram shows the annual charges per head, including dependents, whereas the second diagram demonstrates the per capita value, if dependents are excluded. In both cases, the BVA indicates the highest per-capita values. In case the dependents are excluded, the BVA total fees are more than twice the average of all health insurance carriers (€218.4 versus €102.7). The GKK and the BKK, which both do not have user charges, had rather dissimilar results, as the BKK showed a comparatively high €102.4 in total fees, contrasted by the GKK, which only charged €62.2. In addition to this, the BKK showed higher total fees than the SVB and the SVA, despite not incurring user charges (although, in case the dependents are included the SVA-value is slightly higher). The largest discrepancy between total fees and user charges per capita is witnessed at the VAEB and the SVB, where the user charges represent less than half of the total fees (this applies in both cases, including and excluding dependents).

Figure 63: User charges per insured person, own illustration based on Finanzstatistik 2015



3.3.3 Advantages and disadvantages in connection with user charges

An increase in user charges for doctor appointments would not represent the principles of social security and could potentially result in a de-solidarization[158]. Furthermore, the user charges in Austria are higher than the user charges levied in many other European countries, like e.g. Germany or France.

[158] Streissler-Führer, Friedl, and Pichler, 'Selbstbehalte Im Gesundheitswesen'.

Another argument is the failing of a policy that was present in Germany from 2004-2012: Due to the "Praxisgebühr" (=consultation fee) of €10 per quarter, especially people with lower incomes did not attend regular check-ups in order to avoid the fee. However, this can result in follow-up problems and therefore cause costs in the long term higher than the income earned by the fees. In general, research shows that high user charges affect people with low-income, who generally have a higher health risk, and older people the most, since higher cost sharing would cause an even higher burden on their health expenditures. Therefore, they try to avoid going to a doctor, which only results in follow-up costs due to late treatments. In addition to that, the higher administrative costs as a result of additional user charges is an argument against the introduction of more user charges. Therefore, in the past years, they tended to decrease.

Especially for an insurance fund like the WGKK, where contributions are only indirectly collected from the insured person, a user charge causes high administrative costs. Furthermore, many exemptions would have to be considered for e.g. children, people with minimum income, employees on leave and many more. Therefore, a raise of user charges would only cause a comparatively small increase in income for the WGKK.

On the other hand, the user charges may serve as control and steering mechanisms, incentivizing the insured person to stay healthy. In connection with this, the SVA offers a health check-up, where patients determine health goals together with their physician. Those goals are related to blood pressure, weight, sport, tobacco and alcohol. If patients reach those goals, they can apply for a reduction of their user charge from 20% to 10%. In addition to that, in 2013 the SVA introduced a maximum limit of user charges per person which is based on 5% of the individual annual income.

Besides the SVA, the VAEB, the SVB and the BVA also have user charges: The VAEB lowered its treatment user charges from 14% to 7% in 2015 until 2018. These user charges apply e.g. to doctor appointments, other medical care, or laboratory tests. Children until the age of 18 (until 27 in case of continuing education or studies), or persons with disabilities are exempted from these user charges. In addition to that, VAEB offers a project called "Best-Price-Euro", which means that the insurance repays 1€ per package of medication to its insured members, if they decide to buy cheaper products with an equivalent

quality.[159] Persons insured with the SVB have to pay a flat-rate payment of €9.61 per quarter (Status 2017) in case they require medical treatment.[160] Only if the insured member visits a dentist an additional payment of €9.61 is required for the same quarter. These flat-rate payments are invoiced at the end of each quarter, or automatically retained from pensions. Children, until the age of 18, or maximum 27 in case they pursue further education, do not have to pay user charges. Per quarter, one general practitioner, one specialist and one dentist can be visited.[161] In 2016, the BVA also lowered its user charges for medical treatments from 20% to 10%. Only removable orthodontic treatments still require a 20% cost sharing. [162]

Internationally, the trend goes towards a reduction in user charges, as in most of the OECD countries the share of "out-of-pocket" payments in total costs has been decreasing. In keeping with this, this stagnating development of user charges can also be observed, here. In Austria, the stagnating development of user charges and cost-sharing, are to large extents due to the prescription drug expense-cap and ongoing bonus programs. Since 2010 self-payments have been significantly rising, in particular in connection with direct payments to medical providers. In 2014, the direct payments to doctors-of choice amounted to approximately €500 mio. About €390 mio of these direct payments were charged by private specialists[163]. Yet, these represent informal payments, i.e. hidden cost-sharing, as the patient's choice is limited by the social health insurance system: In principle, physicians may be consulted free-of choice, however the incurred fees may only be partially refunded, depending on the health insurance carrier. The pricing for private physicians' and non-medical providers is not really regulated, but fundamentally left to market forces. The usual reimbursement for consulting a private physician or a doctor-of-choice is pegged to approximately 80% of the fees a contractual physician would receive[164].

[159] Versicherungsanstalt für Eisenbahnen und Bergbau, '2015-01-01 - Behandlungsbeiträge Werden Halbiert'.
[160] Sozialversicherungsanstalt der Bauern, 'Krankenversicherung'.
[161] Sozialversicherungsanstalt der Bauern, *Leitfaden Der Bäuerlichen Sozialversicherung*, 2016.
[162] Versicherungsanstalt öffentlich Bediensteter, 'Was Ist Der Behandlungsbeitrag?'
[163] Hofmarcher-Holzhacker, 'Fast Track: Private Gesundheitsausgaben 2014'.
[164] Ibid.

3.4 Austria's social welfare base[165]

3.4.1 Overview

The key interest of a welfare state is to provide secure living conditions for all citizens. Depending on the phase or situation they are in, the welfare state supports eligible beneficiaries with targeted benefits to enable them to lead a self-determined life. Social policy in Austria not only makes a major contribution to preventing and avoiding poverty, but it also creates the basis for social cohesion, social security and helps to manage social, demographic and economic change. The description of social expenditure is based on the ESSPROS methodology (European System of integrated Social Protection Statistics) agreed between Eurostat and the EU Member States in the late 1970's. ESSPROS is built on the concept of social protection, or the coverage of precisely defined risks and needs including health, disability (invalidity), old age, family and unemployment. It records the receipts and the expenditure of the organizations or schemes involved in social protection interventions[166].

The registration of social spending within the EU is carried out standardized by structuring social spending according to social risks (see table below).

Table 64: Functions of social protection, own illustration based on Social Affairs Ministry – The Austrian welfare state 2016.

Situation in life	Benefits and examples
Old age	All social benefits in cash and in kind (save spending on healthcare and survivors' pensions) for persons above statutory retirement age (60 years for women and 65 years for men).[167]
Survivors	Survivors' pensions (benefits for widows/widowers and [half-] orphans) of various social systems for all age groups (also for those above statutory retirement age).
Health	Public spending on healthcare for all age groups.
Invalidity	Invalidity-related social benefits for persons below statutory retirement age (the corresponding benefits for persons above statutory retirement age are described in the 'old-age' function).

[165] Primary source of data for this section are: Österreichische Sozialversicherung, 'Sozialversicherung Österreich - Pflichtversicherung'. Sozialministerium, 'THE AUSTRIAN WELFARE STATE - Benefits, Expenditure and Financing 2016'.Statistik Austria, 'Social Expenditure'.

[166] Sozialministerium, 'THE AUSTRIAN WELFARE STATE - Benefits, Expenditure and Financing 2016'.

[167] Österreichische Sozialversicherung, 'Regelpensionsalter'.
The regular retirement age: for women the completed 60th year of life, for men the completed 65th year of life. The regular retirement age of women will gradually be adapted to the men's one as of 1st of January 2024.

Situation in life	Benefits and examples
Family/Children	Social benefits in cash and in kind for children and young people (save health- and education-related benefits) and family benefits for parents and/or guardians.
Unemployment	Social benefits awarded in the context of actual and pending unemployment (not only Unemployment Insurance-based benefits).
Others	Part of the expenditure used to combat social exclusion, e.g. housing assistance, means-tested minimum income benefits and other benefits provided for social reasons; a large portion of means-tested benefits, such as equalisation supplements under statutory pension insurance schemes or unemployment assistance is described in the old-age and unemployment functions.

3.4.2 Social expenditure by functions in Austria 2015

A large proportion of expenditure on social benefits in Austria is in respect of the old age function. In 2015, around €44.226 million were spent on old age benefits, equating to 44.3% of total social benefit expenditure. Expenditure on benefits in the context of the sickness/health care function, at a level of around €25.417 million, was in second place with a share of 25.4%. Almost 70% of social expenditure was thus in respect of old age and health care benefits. Significantly lower proportions of expenditure were accounted for by the following functions (stages of life or social risks): 9.6% family/children, 6.7% disability, 6% survivors, 5.6% unemployment and 2.3% housing and social exclusion.

69% of social expenditure (without taking into account transfers and other expenditure) consisted of cash benefits and 31% of benefits in kind. Benefits in kind (31%) are dominated by out-patient and in-patient health care benefits[168]. For further information, please see
Figure 65.

Figure 65: Social expenditure by function in Austria 2015, own illustration based on Statistics Austria, ESSPROS. Compiled on 6 December 2016

	Sickness / health care	Disability	Old age	Survivors	Family/ children	Un-employment	Housing and social exclusion[169]	Total

[168] Statistik Austria, 'Social Expenditure'.
[169] This function summarises housing assistance, rent and rental cost support, benefits in cash and in kind under the minimum income benefit scheme, tax credits, etc.

€ Mio	25.417	6.703	44.226	6.046	9.621	5.636	2.290	99.940
%	25.4	6.7	44.3	6.0	9.6	5.6	2.3	100

The mentioned cash benefits mainly serve to provide income substitution during periods of inactivity or incapacity to work. Their crucial importance is mainly reflected in old-age, invalidity, etc. and support during periods of additional financial burden (e.g. for parents or for persons in need of nursing care). Benefits in kind are primarily intended to provide support through programs and services (e.g. in case of sickness, long-term care needs and disability, childcare, etc.). Benefits in kind are dominated by out-patient and in-patient health care benefits[170]. For an overview on social expenditures, by functions, please see the figure below.

[170] Sozialministerium, 'THE AUSTRIAN WELFARE STATE - Benefits, Expenditure and Financing 2016'.

Figure 66: Social expenditure by functions 2015, own illustration based on Statistics Austria, ESSPROS. Compiled on 6 December 2016

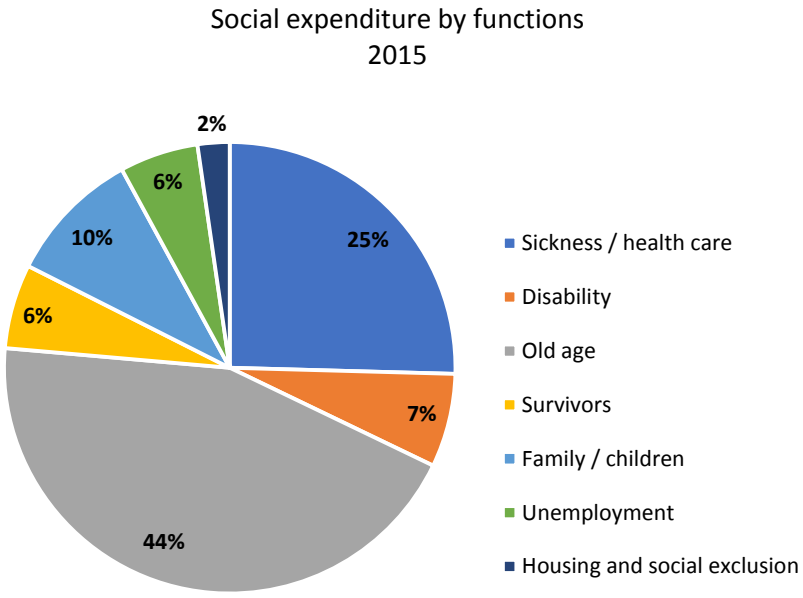
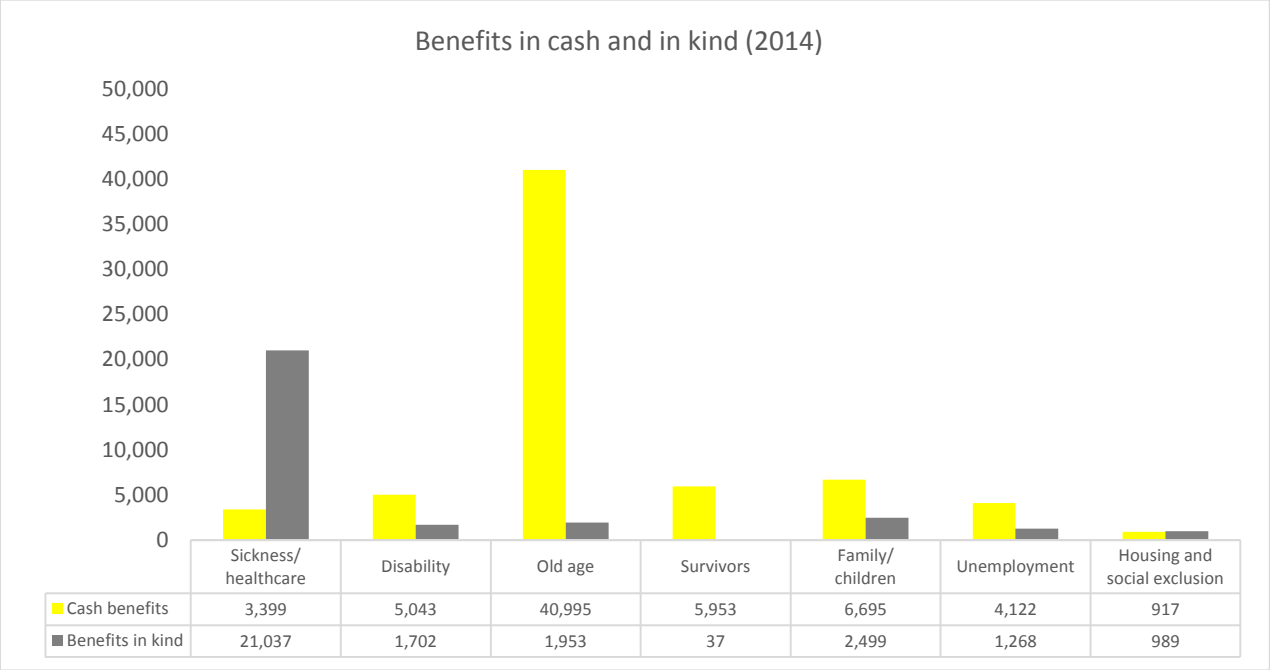


Figure 67 shows that the proportion of in-kind benefits greatly varies by social area, ranging from 86% in healthcare benefits (outpatient and inpatient services) and 5% in old-age and survivors benefits[171].

The level of social expenditure according to the European System of Integrated Social Protection Statistics (ESSPROS) as a percentage of gross domestic product (GDP) was 30.2% (please view Figure 68). In 2015, the rise of the ratio in the last years was affected by the crisis and slow economic growth. Therefore, in 2008 and 2009 as well as since 2012, the increase in social expenditure has been higher than economic growth. Social Expenditures play an important role as automatic stabilisers.

[171] Ibid.

Figure 67: Benefits in cash and in kind by life situation, own illustration, based on The Austrian Welfare State 2016



	Sickness/ healthcare	Disability	Old age	Survivors	Family/ children	Unemployment	Housing and social exclusion
Cash benefits	3,399	5,043	40,995	5,953	6,695	4,122	917
Benefits in kind	21,037	1,702	1,953	37	2,499	1,268	989

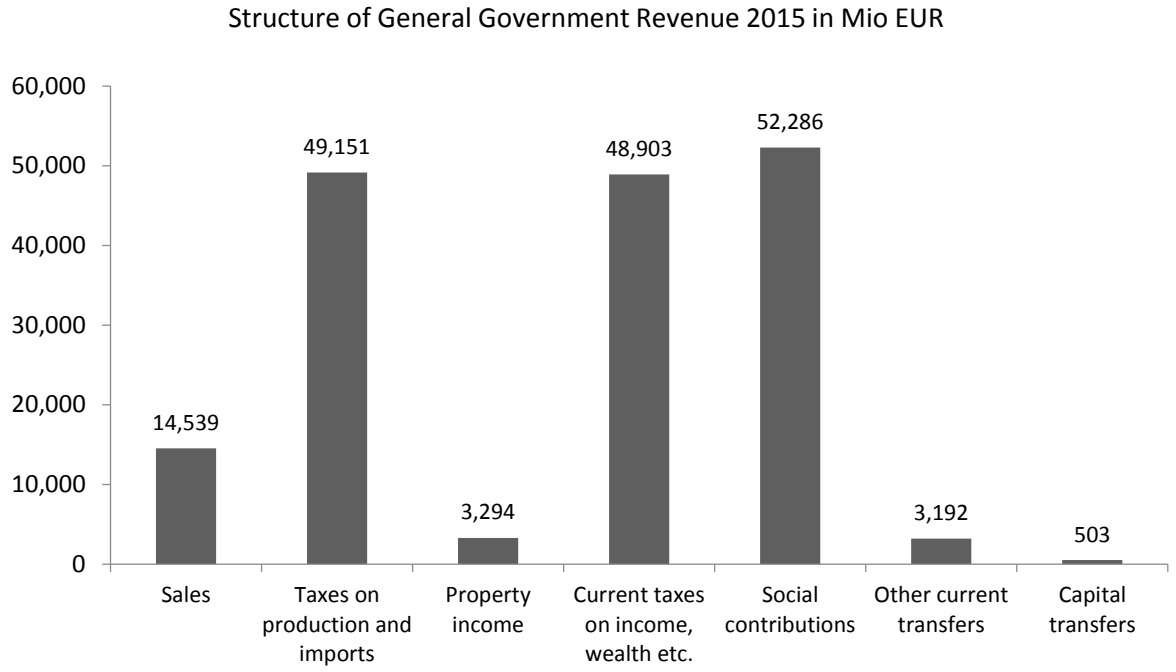
Figure 68: Social Expenditure to GDP Ratio 1980 – 2015, own illustration, based on data from Statistik Austria, 2015[172]

3.4.3 Financing of social expenditure

The welfare state does not produce the required financial resources for the provision of social contribution by itself, but draws on different financing sources like taxes and contributions on income earned in the economic process. For a full outline of the structure with regards to the general government revenues in 2015, please see Figure 69.

[172] Statistik Austria, 'Social Expenditure-to-GDP Ratio'.

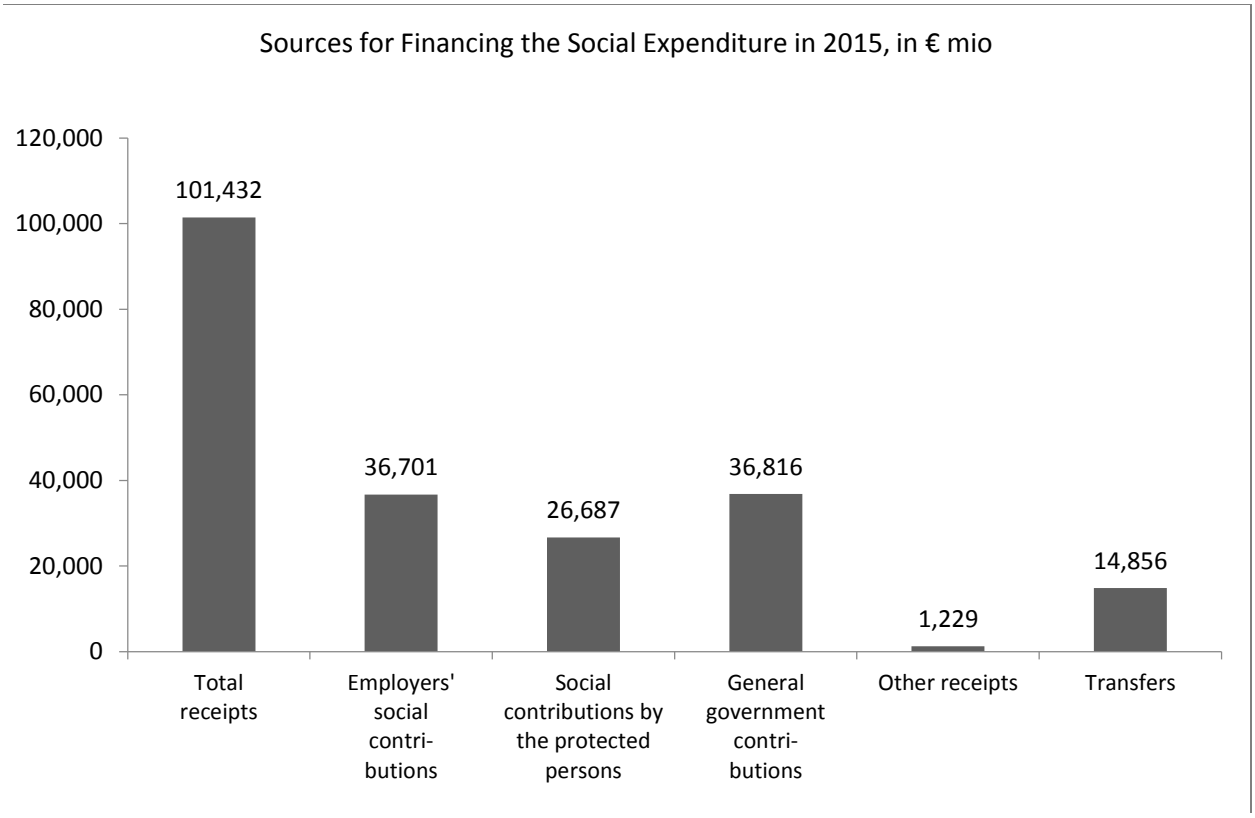
Figure 69: Structure of General Government Revenues, 2015 in € mio, own illustration based on Statistik Austria[173]



In Austria, the state is predominantly financed by levying the earned income and indirect taxes. The prime share of this is imposed in form of social security contributions, followed by income-taxes and the taxation of wealth. Yet, in Austria, wealth is hardly taxed, and only the earned income is subject to the progressive tax tariff, which also represents a taxation of the income from labour. Thus, the financing of the state heavily depends on the volume of gainful employment. Figure 70 displays the sources for financing the social expenditures.

[173] Statistik Austria, 'Structure of General Government Revenue and Expenditure'.

Figure 70: Sources for Financing the Social Expenditures in 2015, own illustration, based on Statistik Austria[174]



According to the European System of Integrated Social Protection Statistics (ESSPROS), more than one third of social expenditure is financed via employers' social contributions (2015: 36%) and via general revenues from the federal government, by the Länder (federal provinces) and municipalities (36%), while more than one quarter is funded by social contributions from the protected persons themselves (26%)[175]. For more information upon the financing via contributions, please see the chapter about collecting distributions.

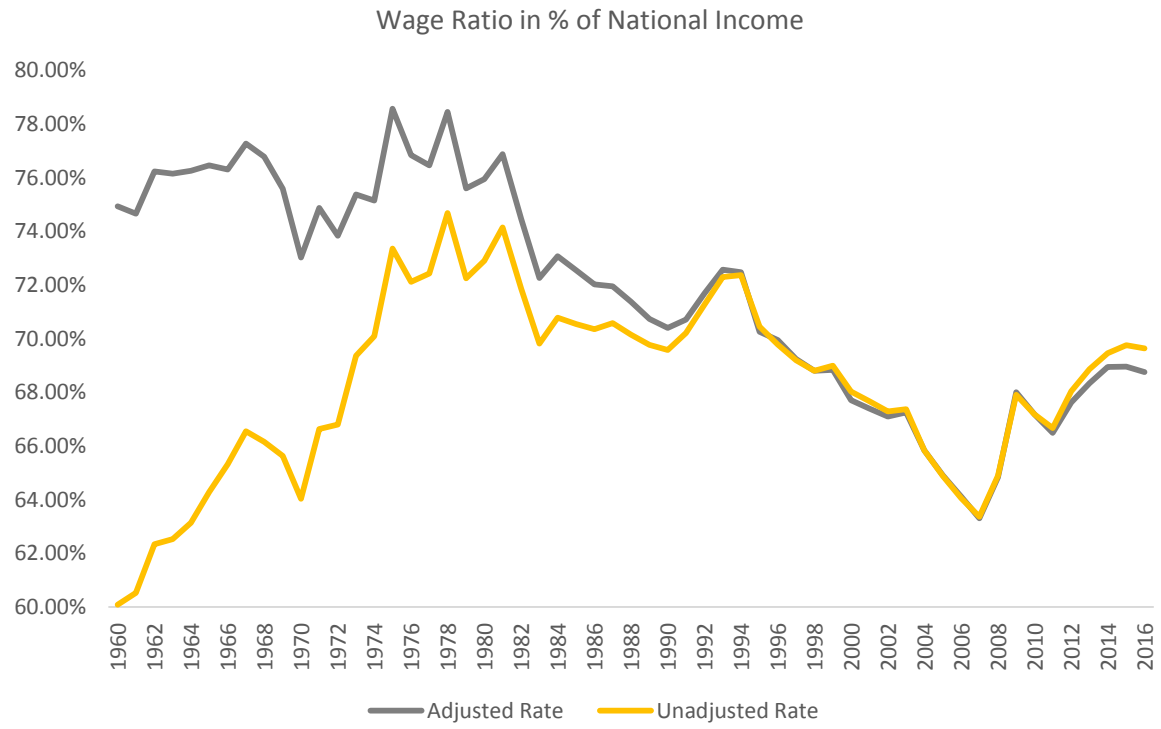
Noteworthy in this context is that a series of social protection systems exists. Individual social protection systems show a nature of welfare, others a nature of provision.

[174] Statistik Austria, 'Financing of Social Expenditure'.
[175] Statistik Austria, 'Social Expenditure'.

A crucial importance plays the social security which is based on compulsory insurance[176], solidarity principle[177] and self-governance[178] and financed by contributions.

In Austria, up to the financial crisis, the functional distribution has shifted in disfavour of the income from wages. On the other hand, the tax- and contribution-ratio on the earned income increased. For further information, please view Figure 71, in which the wage ratio in terms of % of the national income is displayed (the adjusted rate corrects for the change in proportion of employed persons in all gainful working persons, with reference to the base-year (2010).

Figure 71: Wage Ratio (in % of the National Income), data source: AMECO and INEQ



[176] Österreichische Sozialversicherung, 'Sozialversicherung Österreich - Pflichtversicherung'.
The Austrian social security is based on a compulsory insurance system. This means that insurance comes into effect by law independently of an individual's will.

[177] The solidarity principle refers to the equalisation between healthy and sick persons, young and old persons, families with many children and singles, persons with high and low income, employed persons and pensioners. There is no risk selection, no age limit and no termination of insurance coverage due to overuse of services.

[178] Österreichische Sozialversicherung, 'Selbstverwaltung - Verwaltungskörper'.
Self-governance is part of the public administration. The federal state resigns from its responsibility to manage this area of administration. The administrative tasks are transferred to self-governing bodies by law. Those bodies consist of representatives of interest groups affected by this issue. They are not bound to instructions but underlie the supervisory law of federal authorities.

The overview table below shows further social protection systems, which are mostly financed by budget funds of public authorities (Social security Carriers, Federal state, Länder, communities).

Table 31: Social protection systems in Austria, own illustration based on Social Affairs Ministry – The Austrian welfare state 2016

Social protection system	Features and examples
Social Insurance	Eligibility and assessment criteria for monetary social benefits for old age and invalidity are primarily linked to an individual's (previous) activity and income status; insurance rights go beyond this framework (e.g. co-insurance in social health insurance schemes).
Unemployment insurance (UI)	Covers benefits awarded (by the public employment service) in the context of pending or existing unemployment; e.g. unemployment benefits, unemployment assistance and active labor market policies.
Universal systems	Benefits awarded to the entire resident population irrespective of the current or former income and activity status; e.g. family allowance and tax credit for children, childcare allowance, long-term care system and the benefits in kind offered by the healthcare system.
Means-tested benefits	Benefits involving a means test on income; these cash benefits are only available to those in need; the claimants' existing income and, in part, their assets are used to determine eligibility. Examples of these benefits primarily include minimum income levels under the statutory pension insurance scheme (equalization supplements), unemployment assistance under unemployment insurance, the means-tested minimum income scheme and grants to pupils and students.
Social protection for civil servants	Set out in civil service law; civil servants have their own pension law.
Social compensation systems	Special laws on cash-income support; benefits for victims of war, military service, crime and vaccinations;
Protection under labor law	Entitlements under labor law (e.g. continued payment of wages in case of sickness);
Occupational pension schemes	e.g. defined pension funds, direct defined benefit programs;
Social services	Includes a range of social services in different fields, e.g. counselling (violence, drugs, homelessness, etc.), child- and family-related services, homes for the elderly and nursing homes, housing or employment schemes for people with special needs, etc.

The Austrian social security system is, as already mentioned, based on the principles of mandatory insurance, solidarity and autonomy. Social insurance is primarily financed by employers and employees

contributions (see chapter about collecting contributions) under the so called pay-as-you-go system (for Health insurance, work accident insurance, pension insurance)[179]. In this model, received contributions of insured members are not saved for the long-term for every payer (like in the funding method), but used immediately to finance services for other insured members. Thus, all contributing employees finance current pensions in confidence that future generations will do the same for them. This procedure is also described with the keyword "intergenerational contract"[180].

3.5 Make or buy healthcare services (social health insurers)[181]

3.5.1 Overview

In 2015, Austrian social security carriers operated 120 independent outpatient clinics, 28 other independent institutions, as well as 48 own institutions for inpatient treatments. This amounts to a total number of 196 own institutions.[182] The health insurance carriers own the most outpatient clinics, as well as rehabilitation centres. Own hospitals are almost exclusively operated by the AUVA (accident hospitals), with the exception of one general hospital, the Hanusch Krankenhaus, which is owned by the Viennese GKK.[183]

According to the statistical handbook of the Austrian social security, in 2015 own institutions employed 10.638 employees (full-time equivalent), which equals 2.5% growth in 5 years. Only taking account of the hospitals, outpatient clinics and rehabilitation centres (resulting in 141 institutions), the total expenses for own institutions amounted to €1.195 billion, in 2015. Personnel costs accounted for 74% (€865.14 Mio), material expenses, e.g. rent, energy or inventory, accounted for 15% (€174.81 Mio) and medical expenses, e.g. physician's fees, examination material or food, accounted for 11% (€124.72 Mio) of the total costs. From 2014 to 2015, the total expenses for own institutions grew by 3.3%, material expenses

[179] Statistik Austria, 'Social Expenditure'.
[180] Öffentliches Gesundheitsportal Österreich, 'Sozialversicherung'.
[181] Primary sources of data for this section are: Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'. Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016. Parmigiani, 'Why Do Firms Make and Buy? An Investigation of Concurrent Sourcing'. Stakeholder Interviews with carriers, which have own institutions

[182] Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'.
[183] Wirtschaftskammer Österreich, 'Effizienzpotentiale in Der Sozialversicherung'.

increased by 4.2%, personnel costs rose by 3.0%, and medical expenses by 5.6%[184]. The reimbursement of costs for the own institutions derived largely from the carriers themselves. In 2015, this accrued to €178.12 Mio, followed by cost-sharing of the insured persons and their dependents (€31.30 Mio). The amount stemming from self-paying patients added up to €19.05 Mio. The highest income was achieved by services in connection with rehabilitation €185.94 Mio, followed by inpatient accident treatments (€165.48 Mio), and €136.25 Mio from fees to cover the costs of the institution (Anstaltspflege).This fee is charged by the institution to the insured person, for the first 28 days (per year) of staying in the hospital. The amount varies between the Länder, in Vienna the charge is currently €11.94 per day (in 2017). In comparison, the income from dental treatments and dental prosthesis only came to €89.29 Mio. With respect to human resources, the largest share of costs was accumulated by the salaries for care- and medical assistants with €259.38 Mio. Physicians, dentists and pharmacists salaries amounted to €154.68 Mio, whereas the labour costs for administrative personnel summed up to €70.04 Mio. Real estate investment accrued to €201.56 Mio (including depreciation, this equalled €260.71 Mio)[185]. However, it needs to be remarked that due to the own institutions mostly operating at cost, these expenditures are economic in comparison with the contractual partners' prices in the outpatient sector, which otherwise would have to be recompensed by the insurance carriers. For an overview about the own institutions, please see the figure below.

[184] Hauptverband der österreichischen Sozialversicherungsträger, 'Statistisches Handbuch der österreichischen Sozialversicherung 2016', 2016.
[185] Ibid.

Figure 72: Own institutions of social security carriers, own illustration, based on Handbuch der österreichischen Sozialversicherung 2016

120	**Independent outpatient clinics**
38	General outpatient clinics with 115 ambulances or specialist wards
80	Dental outpatient clinics with 326 chairs
2	Centres for outpatient rehabilitation
28	**Other independent institutions**
28	Other independent institutions for the execution of youth, health or other medical examinations
48	**Own institutions for inpatient treatments**
1	General hospital with 455 beds and 38 ambulances
7	Accident hospitals with 985 beds
28	Special hospitals (rehabilitation centres) with 3,875 beds
7	Sanatoriums or health spas with 638 beds
5	Recreation homes, convalescent homes with 514 beds
15	***Health care institutions for civil servants (Krankenfürsorgeanstalt, KFA)****
-	** Data not available*

3.5.2 Own Institutions' General Function and Core Competence

In order to be able to comprehensively assess the advantages and disadvantages in connection with own institutions, several carriers were invited to provide a first-hand picture of their situation[186]. The participating representatives included both, persons with medical as well as organisational expertise on the subject of own institutions. By doing so, queries with respect to the strategic future, challenges, contractual partners and provision of services could be answered.

Besides the core competencies and details listed in the table at the end of this chapter, there exist some more general aspects, which relate to all own institutions of the individual carriers. First and foremost, all insurance carriers stressed the importance of the own institutions, with respect to being able to offer health services, even in case the contractual partners could not be signed, which would effect in an unregulated situation (vertragsloser Zustand). Moreover, cost aspects play a role, as the own institutions are able to offer cheaper services than the contractual partners (e.g. dental surgery at the ZGZ). Another

[186] OÖGKK, WGKK, PVA, BVA, VAEB, SVA, VAEB, AUVA

important aspect is that benchmarks in relation to the contractual partners' prices and quality are more easily set (e.g. dental clinics). Accordingly, operating own institutions holds the possibility to generate first-hand knowledge, which may be applied to either negotiate contracts with partners, or with respect to setting standards and quality control measures.

In line with these aspects, the OÖGKK moreover focuses on certain niche-healthcare offerings at fair prices, in particular with respect to necessary dental and orthodontic treatments, which are warranted for independent of the patient's financial status. These include for instance treatments for hearing-impaired persons, since staff is able to communicate in sign language, dental treatments for old persons in retirement homes, or underwater-water-therapy at the GZ, which effectively benefits the insured persons, yet includes a rather costly large appliance and thus could not be obtained on the market, elsewhere. With the multi-professional provision of services (Gesundheitsverbund), the WGKK offers a variety of services in health care (Hanusch Krankenhaus and 5 health centres). Through this network of services, the WGKK can ensure a consistent quality level in all six locations which are all electronically connected. Therefore, the focus is on efficiency and economy, not on making profit. The own institutions are needs-oriented, which is implemented e.g. in specialist physicians having extended opening hours. Own institutions also ensure independent service provision without being bound to contractual partners. In addition, the own institutions serve as means for medical education, scientific research and training staff. Also, in the WGKK specialised services are offered, including treatments againstrheumatism, diabetes or haematology.

The VAEB states that their own institutions focus more on health policy and health targets than making profit (in contrast to private institutions). They ensure quality standards, which are higher than those of contractual partners. This goes in line with the BVA's as well as the PVA´s perspective. There is more room for innovation and a stronger focus on prevention, which also includes testing pilot projects. The service profile can be designed less standardied and more individualised.

Moreover, the core competency of the AUVA is traumatology, for which it is internationally distinguished (90% of the treatments occur in UKHs). In connection with this, all of the own UKH have highly specialized centres, which undertake scientific research as well as train medical staff. They are very strong in relation to offering integrated services as well as setting quality standards.

3.5.3 Strategy and Innovation

VAEB's strategy is to focus on profession-oriented health in line with the Austrian health targets, which they implement via means of their own institutions. There is a strong focus on health promotion and prevention (e.g. developing HLO organisations). Moreover, the VAEB has innovative projects planned for the following years: Outpatient aftercare, e-health projects, info centre terminals, development of treatment standards (e.g. sports, nutrition, and smoking), therapeutic aftercare (post physiotherapy), implementation of new forms of management, prevention weeks and the introduction of implant operations in one of their service centres. A further aspect, which does not only apply to the VAEB's 11 dental clinics, but to all carriers offering dental services, is that in comparison with the dentists in the outpatient area, the prices for dental treatments have negligible margins, and often only cover the costs, whilst up-keeping the same standard of quality. In consequence thereof, patients with lower income may also afford dental treatments, which are not fully covered by the insurance claim. The accident insurance AUVA has a strong focus on research in the field of accident surgery and rehabilitation and provides the latest and best service for accident patients. In addition, an IT connection of all service areas ensures a standardised documentation and accessibility of information. Instead of offering a broad service spectrum, the OÖGKK specialized its healthcare provision, by focussing on services, which otherwise could not be obtained (this includes a children's dental clinic, or a dental hygiene service, where the OÖGKK visits retirement homes). The PVA has a similar approach and does not undertake any standard services in relation to cure anymore, but has been outsourcing curative services, since 2012. This allows to set the focus on its core competencies in the area of rehabilitation. The BVA started oncological rehabilitation already in 2005

3.5.4 Redundant services / stopped activities

The WGKK bundled its endoscopy units in the Hanusch Krankenhaus and health centres and reduced these from five to three. At the VAEB, the number of own institutions was significantly reduced within the last 15 years. The OÖGKK also reduced some areas (e.g. physical medicine) and instead concentrates more on dental treatments and niche healthcare services. In addition, they want to set the focus on larger institutions and abolish centres with only one dental chair. The PVA and BVA reported that they outsourced cure and now focus on rehabilitation in their own institutions, where they show experience and willingness to innovate.

3.5.5 Benefits and added value

As in the case of the other carriers, the WGKK's own institutions have trained specialists, expertise, and a knowledge bargaining power. They are not oriented on making profit – the only goal is to be efficient and to cover the costs. The multiprovision of services ensures knowledge transfer, support, and economic reasonable distribution of services, security, and availability of different services at the same location. Through this cooperation between GZ, ZGZ and HKH they can take advantage of synergy effects. Moreover, due to training own medical staff e.g. at the HKH or the ZGZ, the WGKK is often able to retain physicians, who hand in their notice, as contractual partners in the outpatient area. Due to the medical standards and regulations regarding the treatment and prevention concept of the VAEB, the own institutions are considered to have a higher standard than the contractual partners. In addition, there is more room for innovation and a focus on sustainable health interventions.

AUVA's own institutions ensure a direct and uncomplicated implementation of service standards, and especially its accident hospitals have a high reputation in the field of accident surgery, as well as a high rates of survival in international comparison. The principle of accident insurance is to cover all areas from prevention to accident treatment until rehabilitation. Through covering all of these areas with the own institutions of the AUVA, it is able to ensure a simple ongoing treatment, safeguarding a holistic treatment and recovery process, which is also profited by synergy effects. Like all carriers, which operate own institutions, the ÖOGKK sees one of the primary benefits in the added autonomy, which enables to provide medical services in case the contractual negotiations remain unresolved. For example, even if the partners could not be contracted, the OÖGKK would be able to cover approximately 20% of the preservative surgical care in Upper Austria. Additionally, the OÖGKK calculated that the cost-savings amounted to about €3.7 mio in 2015 – owing to the fact that the dentists in the established sector did not need to be compensated.

Also services are provided to all insured persons of the SSIs, as the own institutions are open to everyone, i.e. they treat patients independent of their insurance coverage (e.g. in exchange for self-payments), age, health status, sex, etc. and thus serve an important socio-political mission. Furthermore, innovative services can be tested and implemented faster and with less complications.

3.5.6 Cooperation activities of the own institutions

The WGKK cooperates with the Competence Centre Therapeutic products / Medical aids, and has a cooperation with PVA in the laboratory environment. Moreover, it works together with the AUVA in regard to research. The VAEB has a subsidiary called “IfgGP” which supports in the field of prevention and promotion research, consultation and evaluations. Their subsidiary wellcon operates in the field of health prevention and work medicine. They also have a cooperation with AIT or EVOCare GmbH, which is related to e-health. In the field of cross-carrier cooperation, which happens mostly through HVSV, the VAEB also has some bilateral agreements, mostly with the PVA (rehabilitation). Its own institutions are open to all insured persons, but prevention services only apply for VAEB members. The AUVA also cooperates with colleges, universities, and the Ludwig Boltzmann Institute. In addition, it cooperates with specialists of other carriers for special and rare injury cases. AUVA accident hospitals also provide treatment of severely injured insured members of other carriers. Moreover, the UKH cooperate with rehabilitation centres and hospitals (for example the rehab centre and the UKH in Meidling, or other specialist hospitals)

3.5.7 Challenges

In spite of the health centres and dental health centres of the WGKK not having sick-beds, there are more statutory requirements stipulated in the Hospital Act (which also applies to ambulatories) than in the outpatient sector. This challenge involves substantial surplus costs (e.g. sanitary regulations) and applies to all own institutions. A further challenge is represented by § 339 ASVG, which stipulates that the insurance carriers are obliged to obtain the approval of the local Chamber of Physicians, in case they want to construct, modify or purchase property for the own institutions. If, however, this should not be possible, an economic needs test (Bedarfsprüfungsverfahren) has to ensue, which in any case will lead to delays. According to the VAEB, many private institutions do not meet their requirements and high quality standards, since they are focused on making profit, which sometimes does not correlate with health policy developments. Therefore, it is hard to find contractual partners offering the same quality. In the case of the AUVA, it is generally difficult to compare their own institutions with others, since AUVA does not have explicit contractual partners except in the field of health cures.

3.5.8 Future

In the future, the WGKK is planning to open a paediatric emergency unit and potentially an endocrinology unit, depending on future demands within this field. The VAEB plans a cooperation with the Land Styria

and Krankenanstalten GmbH (KAGES) and an expansion and connection of its IT system. The AUVA wants to research on the effectivity of connecting the acute trauma care with the rehabilitation care.

3.5.9 PPP-Models (Public-Private-Partnerships)

The social security carriers SVA and SVB operate their own institutions as PPP-models (Public-Private-Partnership), which means that part of the institution is privatized and the other part remains within the ownership of the carrier. The SVA operates four institutions, one outpatient clinic and three rehabilitation centres. All of these are run in collaboration with the same private partner, who holds 49% of the shares, thus SVA holds the majority with 51%.

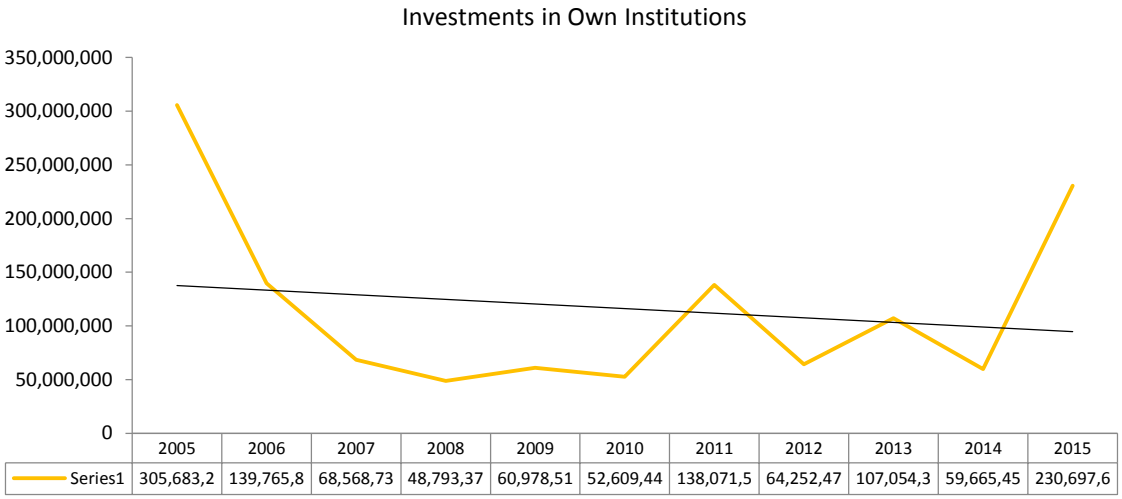
The SVB operates five rehabilitations centres, yet in contrast to the SVA, the SVB only holds 26% ownership in each of its five PPP-models - thus holding the minority share, though with a blocking minority (Sperrminorität). When creating the PPP-models in 2010, the main objective was to secure the high quality standards of medical care for their insured members. First, this was realized by involving private partners, who invested in updating the rehabilitation centres (in particular renovating the building structure), and second, by treating non-SVB patients, so that despite the declining number of SVB insured persons, the capacity of the own institutions would be improved[187].

3.5.10 Investments in Own Institutions

As illustrated by the black trend-line in the figure below, the investments in the own institutions have been declining in total over the ten year period from 2005 until 2015. However, the year-to-year variation ranges from €305.68 mio in 2005 to €48.79 mio in 2008. This development can be explained by the large investments undertaken by the AUVA. These involved the new-construction of the accident hospital, which was opened in 2005, in Linz. Further, extensive renovation and reconstruction works took place, which effected in the re-opening of the-state-of-the-art intensive care units, in Meidling, in 2012. This may serve as explanation for the upsurge in investments in 2011. In addition to this, the AUVA's rehabilitation centre in Häring was re-opened in December 2014, causing the larger investment sums in the previous year.

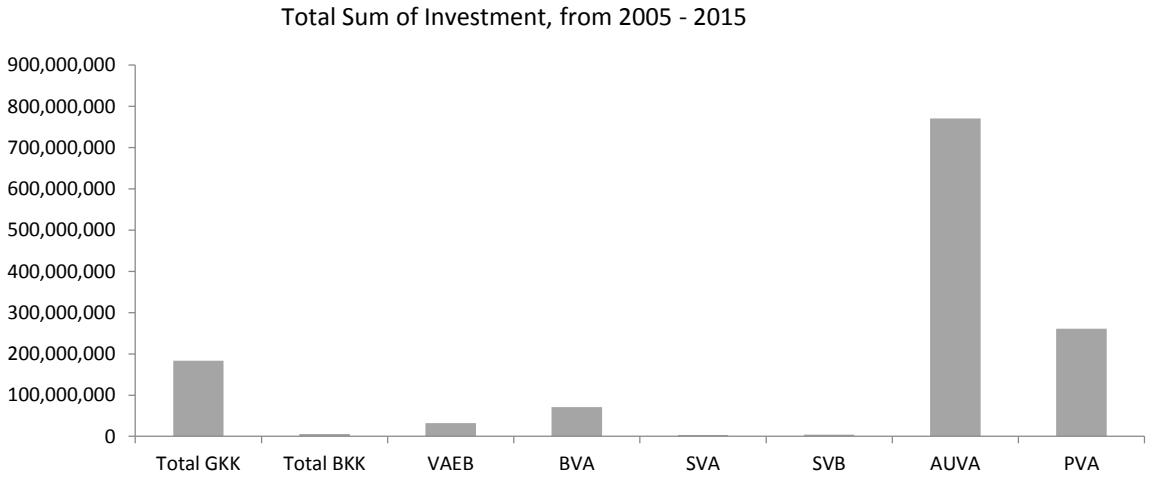
[187] Sozialversicherungsanstalt der Bauern, *Leitfaden Der Bäuerlichen Sozialversicherung*, 2016.

Figure 73: Investments in Own Institutions from 2005 until 2015 in €, own illustration



A further explanatory factor for the difference in total sums of investments are the size discrepancies between the carriers: the PVA and the AUVA are the largest social security carriers, covering a market share of 84% and 78% respectively, whereas the largest health insurer is the WGKK with a market share of (only) 18% (for further information, please refer to the chapter about size and economies of scale). Another logical reason for the comparatively high investment sums of the AUVA are the renovation works for their accident hospitals, which were described before. The figure below displays the total sum of investments from 2005 up until 2015.

Figure 74: Total Sum of Investment, from 2005-2015 in €, own illustration



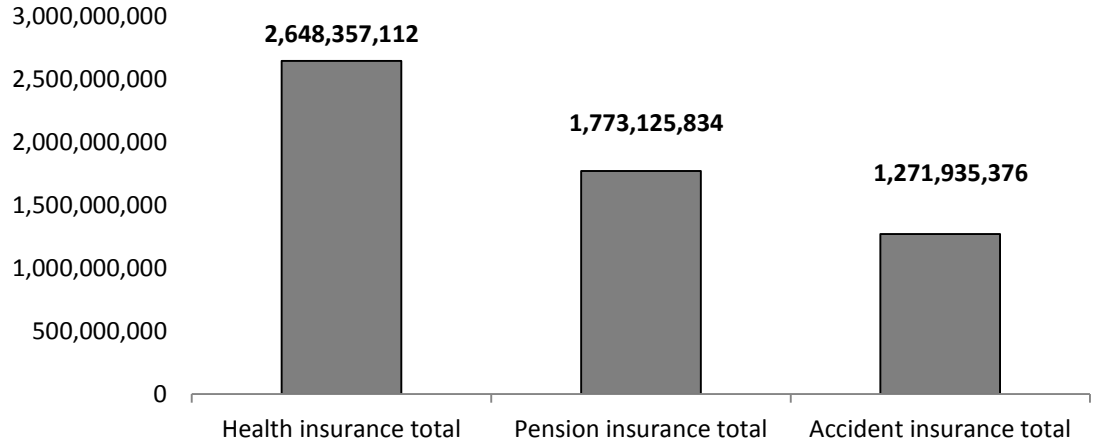
Carrier	Number and Type	Function / USP	Key activity / Core competencies	Strategy / Innovation	Target groups	Redundant services / stopped activities	Benefits / added value	Cooperation	Finances / additional Costs	Challenges	Future
PVA	17 rehabilitation centres	- longtime experience in rehabilitation services and continuity (80% market share in rehabilitation) - high willingness to innovate	- illnesses of the supporting and movement system - neurological diseases - cardiovascual diseases - Diabetes mellitus and other methabolic diseases - respiratory diseases - illnesses of the digestive tract	- Tele-Reha - new rehab indication oncologic reha. - rehabilitation for patients with mucoviscidosis /transplants /artificial hearts - treatments to quit smoking / obese patients /amputations /bariatric patients - electronic allocation of patients to institutions - gender medicine - outpatient project for chronic pain patients - education of minors with diabetes - food management system in all own institutions - central purchasing of all own institutions		- no more cure treatments in own institutions, only rehabilitation	- flexible, rapid adaptation to changes in regulations - not dependent on contractual partners (easier implementation and execution of new treatment methods) - no focus on making profit	- formal and factural obligation to cooperate with other social security carriers		- few possibitlities for development due to legal basis - PVA does not receive medical records for incoming rehabilitation patients - rehabilitation services for dependants need to be regulated - create legal foundation for treating pensioners (current basis is 1999) - seperate field of study for prevention -legally accept rehabilitation as preventive activity -enable scientific research for rehabilitation	- Reha-App Cardio - implementation of ICF into neurology- and orthopaedics-SKA (to all own institutions until 2018) - update of electronic appointment system, new orientation in planning of time - imlementation of the electronic reha information system (RIS) - implementation and certification of quality management system "Easy living"
AUVA	7 accident hospitals (UKH)	- ensure accident treatment according to § 189 (1) ASVG	- acute treatment	- connect UKH with Traumanetzwerke (as in Germany)	Accident patients		- high education of staff and good equipment - high service quality - high repuation - high survival rate	-Trauma Registry of the German Trauma Society (DGU)	- different financing system (compared to public hospitals - accident surgery is a cost-intensive field, therefore inpatient stays are more expensive than in other institutions (however, the difference is not unreasonably high, even though costs are higher for the UKH) - costs for one day in a UKH: 835 EUR	- comparison between costs for treatments in UKH and private institutions is difficult (only flat rate payments + no clear documentation about hospital stays caused by work accident)	- reorganise consulting examinations - cooperation with specialist hospitals or AKH - expansion of orthopaedic services
	4 rehabilitation centres (RZ)	- medical reahbilitation only in AUVA institutions (no contractual partners, only in case of health cures) - special education of staff	- traumatic brain injury - occupational diseases - treatment of injury consequences - paralysis - apalcic syndrome - polytrauma - nerve injuries - complex hand injuries - amputations - burnings	- standardised registration of comorbidities and early treatment ensures better rehabilitation outcome	Patients with follow-up problems / diseases		- department for treatment of work diseases is unique in Austria		- difficult to compare due to different service offers (than other institutions) - costs for one day in a RZ: 446 EUR		

Carrier	Number and Type	Function / USP	Key activity / Core competencies	Strategy / Innovation	Target groups	Redundant services / stopped activities	Benefits / added value	Cooperation	Finances / additional Costs	Challenges	Future
OÖGKK	15 Outpatient dental clinics	- tailoring necessary medical services to people with special needs (e.g. elderly, or deaf persons) - offering affordable dental treatment (providing medical care, independent of the patient's financial status)	- offering a portfolio of dental services (e.g. preservative, prosthetic, prohylactic, and orthodontic segments)	- offering niche services - medical autonomy (own institutions account for 20% of preservative surgical care in Upper Austria) - cost savings compared to established dentists (in 2015, these amounted to about €3.7 mio)	- vulnerable and impaired persons (e.g. deaf persons) - socially deprived and marginalised persons, often with high health-risks - financially less fortunate persons - children and adolescents (ZGZ) - oncological patients (rehab centre)	- gradual closure of "one-chair-dental ambulatories"	- not profit-oriented - counteract monopoly on supplier side - cost cutting due to lower costs per treatment (lower than contractual partners) - cost savings due to networking of dental clinics (e.g. radiographs)	- service for patients who are only treatable under anaesthesia: Cooperation with Länder hospital Vöcklabrück and Medical Campus IV Linz - cross-carrier cooperation (e.g. orthodontics)	- contractual partners may charge higher fees (according to the guidelines a 45 min. dental prophylaxis is charged with €80 at contractual partners, whereas the own institutions cost €60.20)	- patients lacking the medical indication usually consult established doctors , which results in a loss of income for the own institutions	- close/merge one-chair ambulatories to create larger entitites in order to profit from synergy effects - introduction of ELGA until 2022
	4 Outpatient clinics phsysical medicine and ambulatory rehab (GZ PMR)	- more comprehensive services than contractual partners' physio-institutes (inc. ergotherapy, speech therapy, clinical psychology, dietology)	- physical medicine - rehab of the movement and supporting apparatus /neurological/pain rehab - integrative care inc. neurologist, dietician and clinical phsychologists	- multi-modal treatment concepts - reestablish the patient's participation (professional and social context) - services not provided elsewhere (e.g. underwater therapy)		- closing diagnostic departments (laboratories/ radiology) - shift from passive therapy (medical massages) to active therapy (physiotherapy)		- cooperation with "Netzwerk-Hilfe" counselors - cross-carrier cooperations (e.g. work group "Medical rehab")			- reconstruction/ modernisation of service centre (e.g. GZ PMR Vöcklabruck) - new group services (e.g. medical training therapy groups) - introduction of ELGA until 2017
	3 Rehab centres		- post oncological rehab - cure for deaf patients - geriatrics: movement and supporting apparatus - burnout prophylaxis - chronic widespread pain - metabolic diseases - light neurological diseases					- Caritas/EMMA: child care by Caritas, financed by OÖGKK - Barmherzige Brüder Hospital collaboration treating deaf patients - external expertise for the stationary stop smoking project			- introduction of ELGA until 2017 recently added: - "ANNA" - stay for nursing relatives - "EMMA" - stay for parents with disabled children

3.6 Reserve finances among social health insurers

According to the terms of the accounting regulations of the social security, (analogous to equity capital), the reserves result from the sum of asset items less the liabilities. Thus, the reserves are equivalent to the net assets of the social security. In the end of 2015, these amounted to €5.69 billion in total.[188] Therefore, the reserves or net assets are not to be put on one level with liquid or disposable assets, since the active side of the balance sheet does not only consist of financial assets, but also comprises assets in terms of real estate, property etc., which are necessary for operating and administering the own institutions. For an overview about the reserves per pillar of the social insurance, please view the figure below.

Figure 75: Net assets of social security carriers, own illustration, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015



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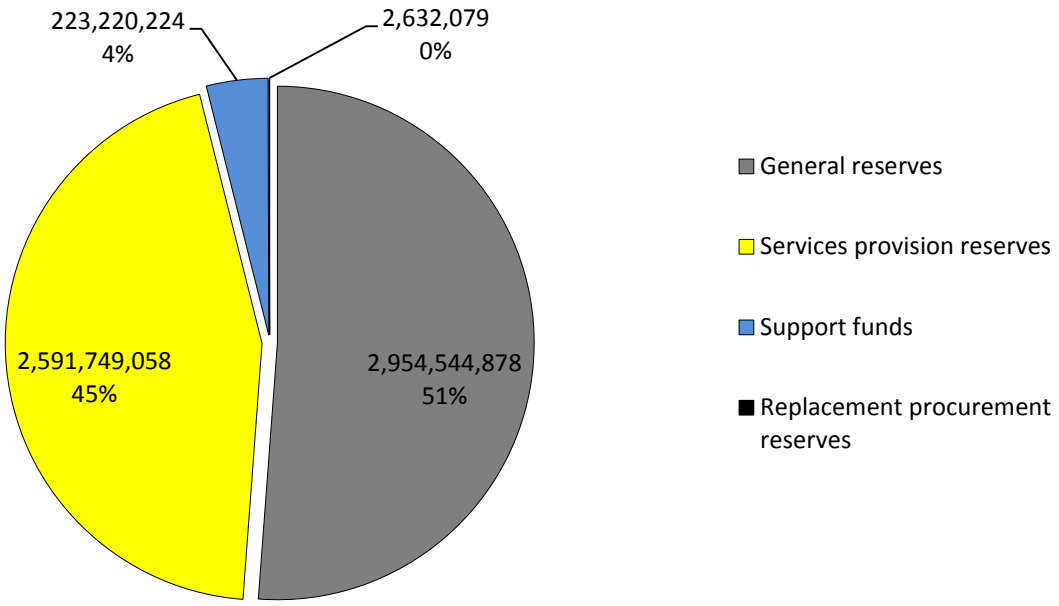
The net assets (reserves) can be divided into the general reserves, the service provision reserves (Leistungssicherungsrücklage) and the smaller special reserves (support funds and replacement procurement reserves). The carriers are required to build up a service provision reserve, in order to balance fluctuations in connection with contribution income and benefit payments, and to assure the fulfilment of service obligations. This should amount to a twelfth of the service expenditures of one year (=target amount). The general reserves may also serve the purpose of funding future construction projects and investments. Hence, by accumulating general reserves, carriers can provide the financial means to renew or renovate their institutions. Therefore, it cannot be assumed that these reserves are freely available. For this, the medium-term plan and the investment needs of the carriers would need to be

[188] Hauptverband der Österreichischen Sozialversicherungsträger. Zusammenstellung der Schlussbilanzen 2015. 2017.

known. Furthermore, due to the fixed targets on the spending limit, the carriers cannot rapidly reduce their reserves, since they should develop their expenses within the agreed framework. The figure below depicts the types of reserves and the distribution of assets.

Figure 76: Net assets structure of social security carriers, own illustrations, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"



3.6.1 Allocation of reserves

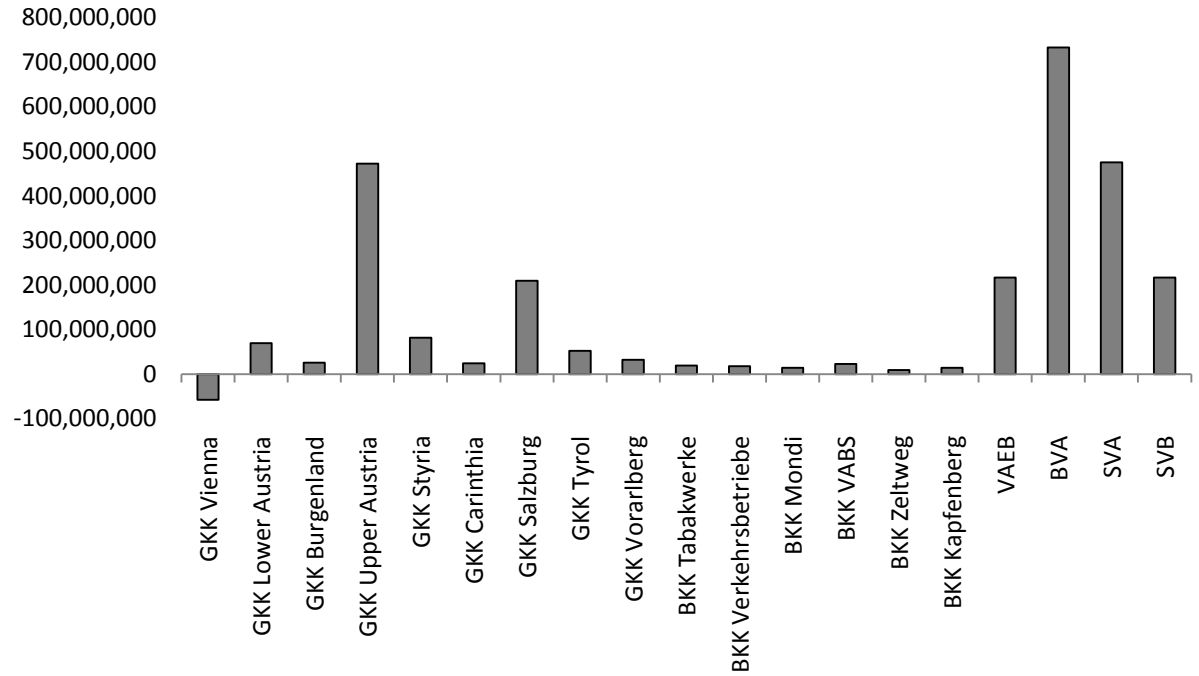
Within the health insurance, the reserves are not equally allocated. Especially nationwide carriers have high reserves. With €733 mio, the BVA has the highest amount of net assets, followed by the SVA with €475 mio and the SVB and VAEB with €217 mio, each. Among the regional health insurance funds the OÖGKK has the highest amount of net assets, worth €472 mio, followed by the SGKK with €209 mio. Other carriers have comparatively low amounts of net assets and the WGKK still has a negative total of net assets, however, this has been reduced significantly within the past years.[189] For an overview about the net assets of the health insurance carriers, in 2015, please see the table and figure below.

[189] Hauptverband der Österreichischen Sozialversicherungsträger. Zusammenstellung der Schlussbilanzen 2015. 2017.

Table 32: Distribution of reserves per carrier, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"

GKK Vienna	- 57.942.474
GKK Lower Austria	+ 69.120.920
GKK Burgenland	+ 25.813.978
GKK Upper Austria	+ 472.457.205
GKK Styria	+ 81.618.476
GKK Carinthia	+ 24.419.343
GKK Salzburg	+ 209.518.651
GKK Tyrol	+ 51.879.451
GKK Vorarlberg	+ 32.129.286
BKK Tabakwerke	+ 19.112.982
BKK Verkehrsbetriebe	+ 17.552.084
BKK Mondi	+ 14.426.356
BKK VABS	+ 22.699.386
BKK Zeltweg	+ 8.884.603
BKK Kapfenberg	+ 14.324.793
VAEB	+ 216.872.622
BVA	+ 733.472.873
SVA	+ 475.260.115
SVB	+ 216.736.462

Figure 77: Net assets of health insurance carriers, own illustration, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"



3.6.2 Development of net assets of regional health insurance funds

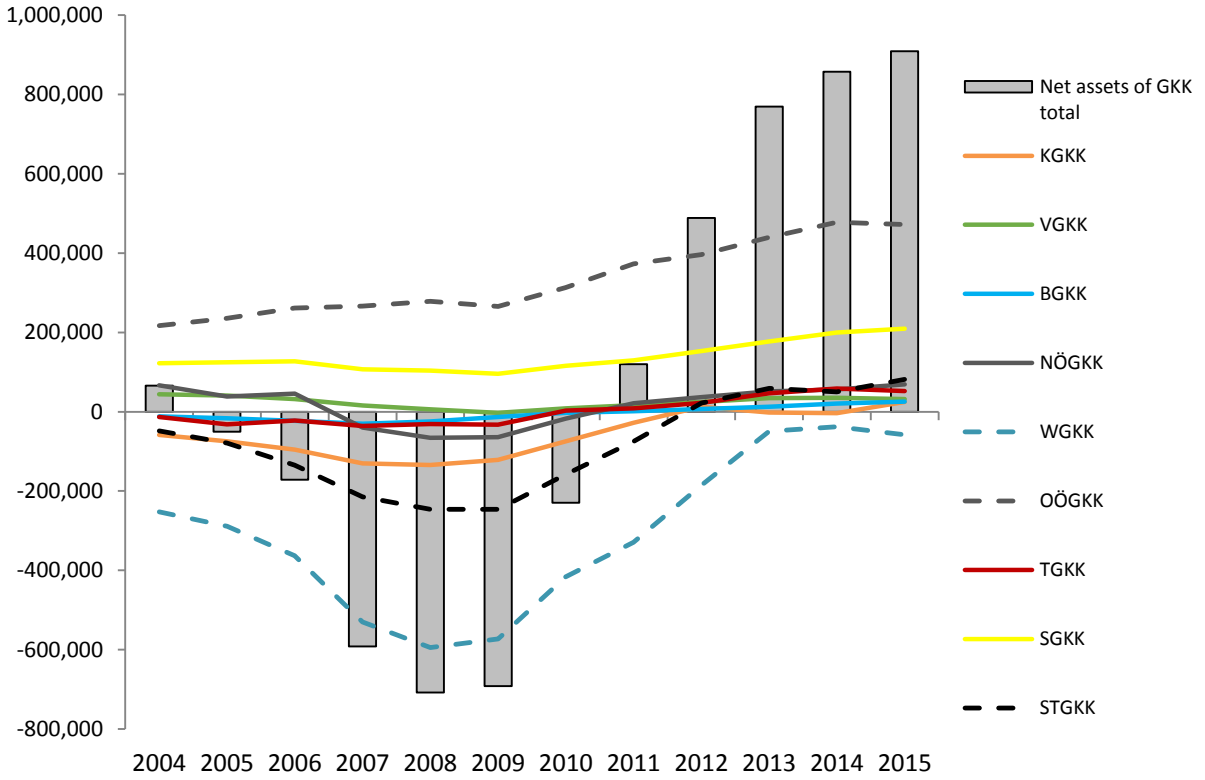
Between 2007 and 2009, generally, the regional health insurance funds (GKK) were heavily indebted. Yet, since then, the GKK succeeded in obtaining total positive net assets again, which partially result from setting appropriate political measures. These political measures included for example the carrier rescue package (Kassensanierungspaket), which was concluded by the ministerial council in 2009:[190] This package was based on the agreement between the social insurance carriers and the federal government. It specified that the (regional) carriers had to aim at a stepwise reduction of their debts up until 2013, and consequently, to reach an overall balanced conduct (Gebarung) of the social health insurance system. In return, the federal government agreed to provide additional financial resources. The main points regarding the income-side included: Debt-waiving regarding the GKK (overall €450 mio for the period between 2010 and 2012), reducing the VAT-rate for medication, or additional financial means from the Health and Social Sector Contribution Act (GSBG) (overall about €498.39 mio for the period between 2009

[190] Rechnungshof. Rechnungshofbericht Reihe Bund 2016/3 [Internet]. 2016 p. 1–543. Available from: http://www.rechnungshof.gv.at/fileadmin/downloads/_jahre/2016/berichte/berichte_bund/Bund_2016_03.pdf

and 2013), the carrier structure fund (Kassenstrukturfonds) for the GKK, (from 2010 until 2014 in sum about €260 mio), a one-time amount to secure the liquidity (instant relief) of €45 mio.[191]

The figure below illustrates the development of the regional health insurance funds, for the period between 2004 and 2015.

Figure 78: Net assets of regional health insurance funds, 2004 – 2015, own illustrations based on data from HVSV: "Zusammenstellung der Schlussbilanzen", for 2004-2015



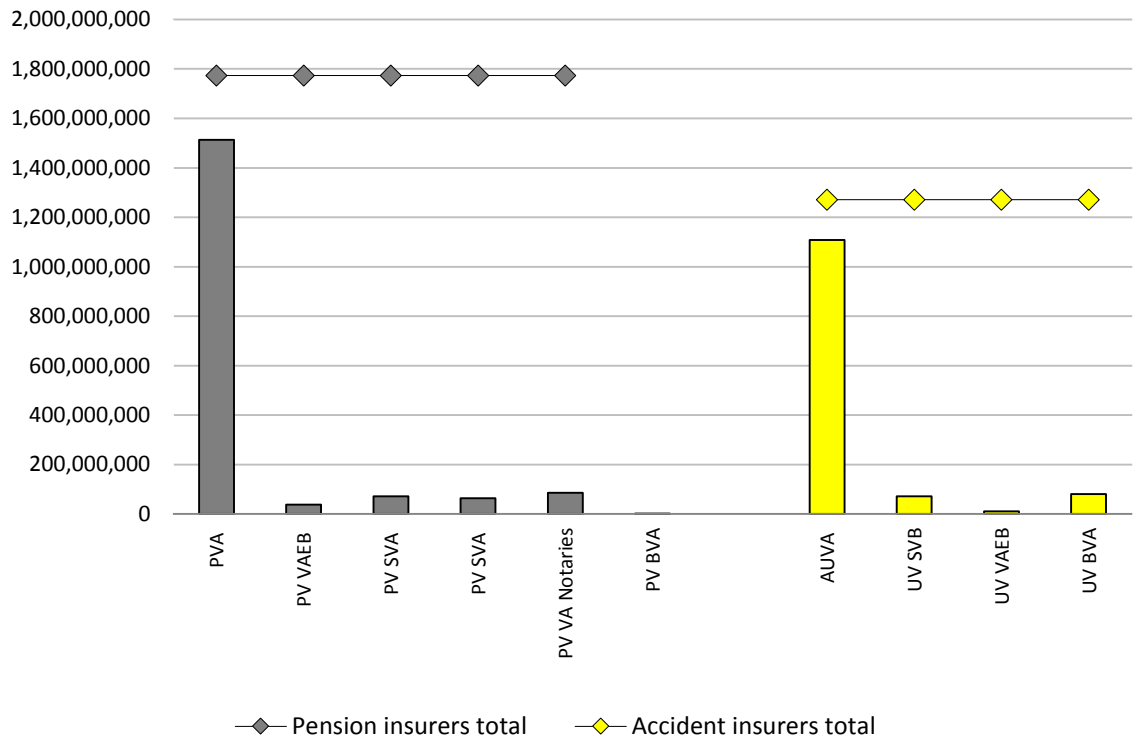
3.6.3 Net assets of pension insurance and accident insurance carriers

Amongst the pension insurance and accident insurance carriers, the PVA and AUVA show the highest amount of net assets, which is also owing to their assets in terms of real estate and own institutions. The

[191] Rechnungshof. Rechnungshofbericht Reihe Bund 2016/3 [Internet]. 2016 p. 1–543. Available from: http://www.rechnungshof.gv.at/fileadmin/downloads/_jahre/2016/berichte/berichte_bund/Bund_2016_03.pdf

figure below illustrates the net assets for the pension and accident insurance carriers, which in 2015, as mentioned above, totalled €1.77 and €1.27 billion, respectively.[192]

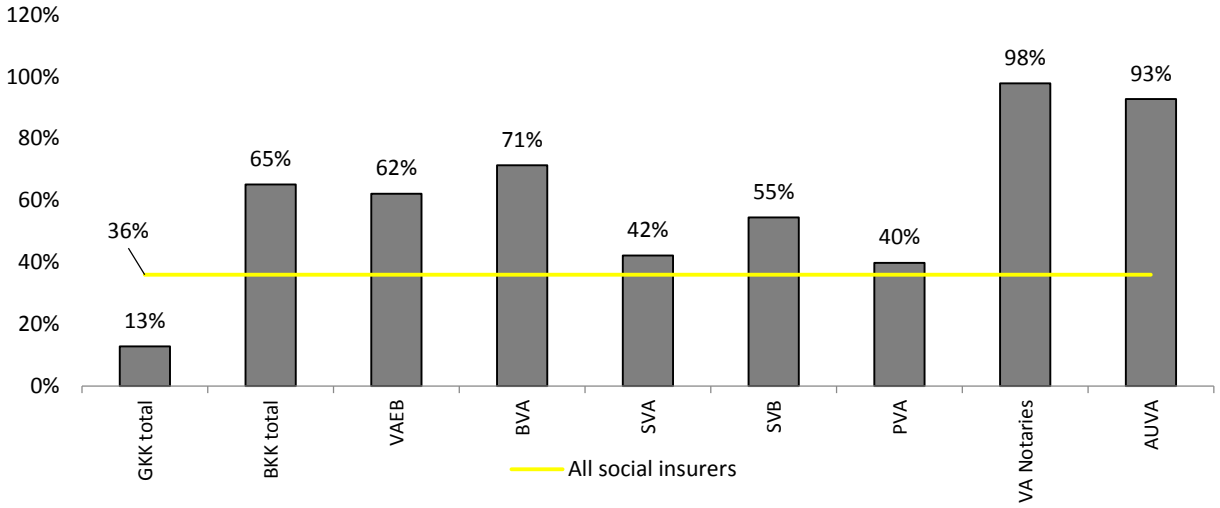
Figure 79: Net assets of pension and accident insurances, own illustration, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"



In 2015, the overall social security was indicated by a 36% share of net assets in total assets. The GKK had a significantly lower value, whereas the VAEB, BVA, SVB and AUVA showed in comparison very high values.[193] For an overview about the carriers net assets in proportion to total assets, please see the figure below.

[192] Hauptverband der Österreichischen Sozialversicherungsträger. Zusammenstellung der Schlussbilanzen 2015. 2017.
[193] Ibid.

Figure 80: Share of net assets in total assets, with weighted average of all social insurers,, own illustration, based on data from HVSV "Zusammenstellung der Schlussbilanzen 2015"

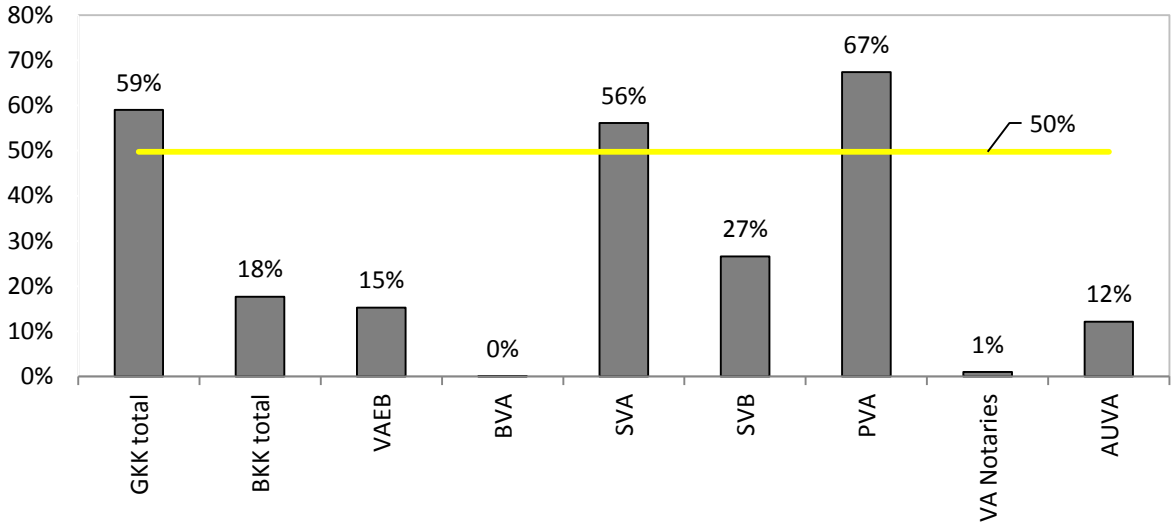


3.6.4 Structure of assets

In many social security carriers, a very large share of assets are represented by contribution receivables (Beitragsforderungen). In relation to all assets, they account for a total of 50%. The GKK, SVA and PVA have high values, which are more than 50%. The figure below depicts the share of contribution receivables in total assets.[194]

[194] Ibid.

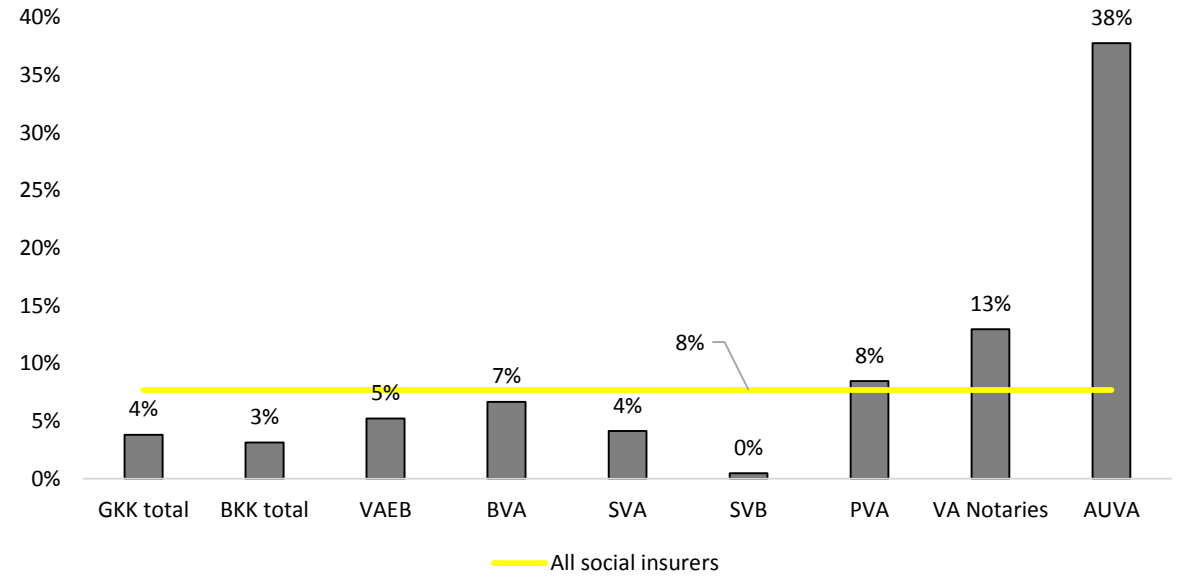
Figure 81: Share of contribution claims in total assets, own illustration, based on HVSV: " Zusammenstellung der Schlussbilanzen 2015



The share of real estate in total assets is unequally distributed among the social security carriers. The share of real estate across all social security carriers' amounts to 8%, the GKK have 4%, the PVA 8% and the AUVA 38%.[195] This results as consequence from the AUVA operating seven accident hospitals (UKH) and four rehabilitation centres, which explain the large percentage of real estate in assets -these represent operating assets. Figure 82 depicts the share of real estate of all social insurers in terms of total asset, in 2015. Figure 83 illustrates the share of securities, loans and tied deposits in total assets, for the year 2015.

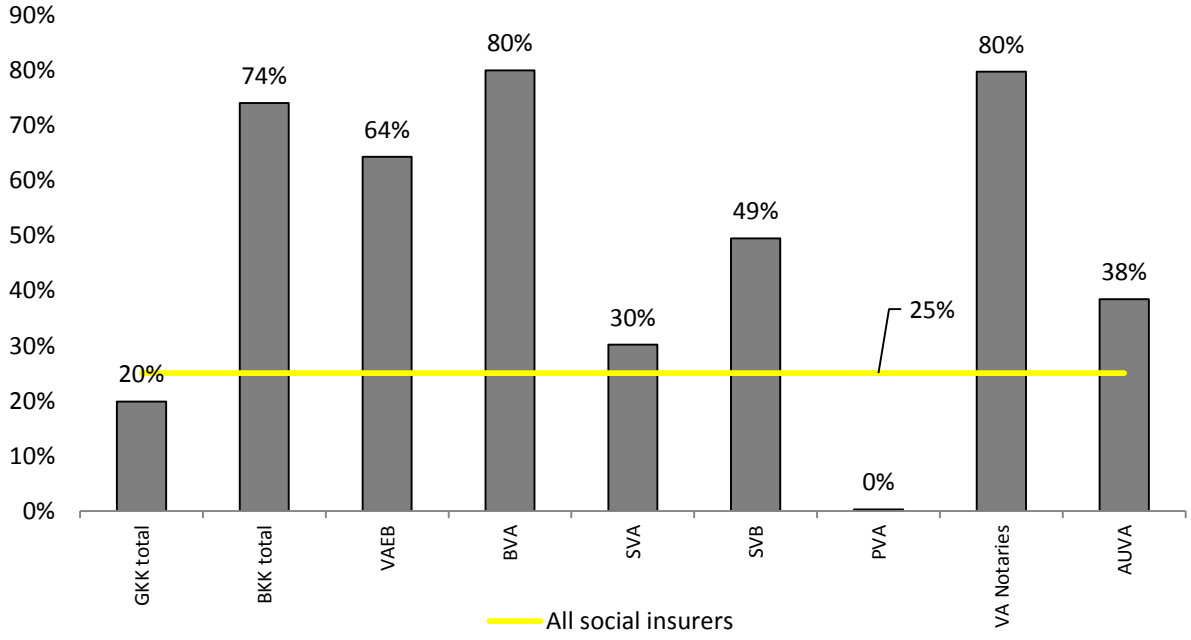
[195] Hauptverband der Österreichischen Sozialversicherungsträger. Zusammenstellung der Schlussbilanzen 2015. 2017.

Figure 82: Share of real estates in total assets, own illustration, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"



The sum comprised of fixed-income securities, loans, fixed and short-term deposits was in proportion to total assets 25% across all social security carriers. The BKK, VAEB and BVA show comparatively high values.

Figure 83: Share of securities, loans and deposits in total assets, own illustration, based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015"

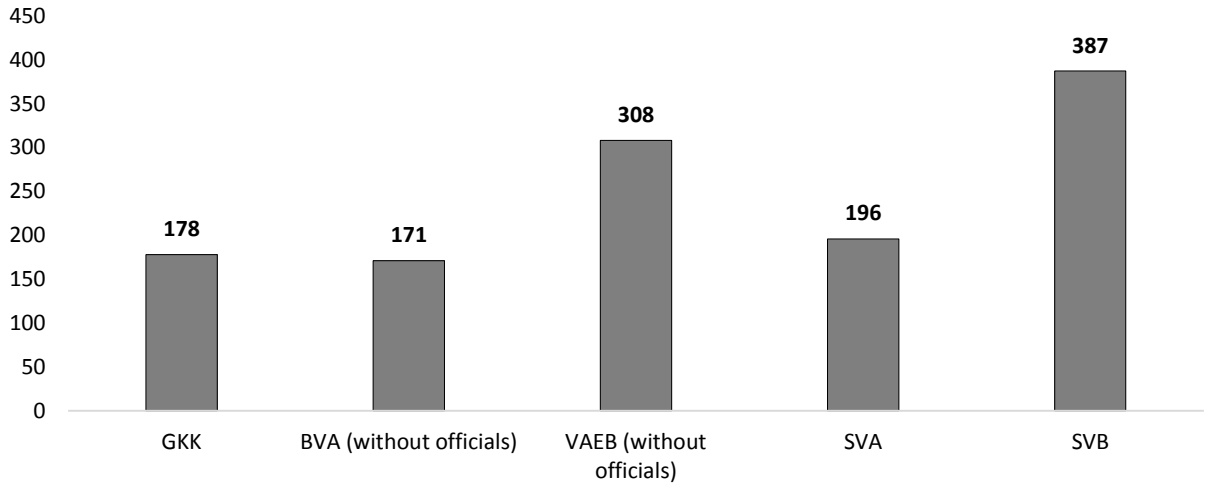


However, the short-term deposits (kurzfristige Einlagen) are to be interpreted with caution, since they only show the value on the reporting date and this may vary strongly. In comparison, the fixed deposits (gebundene Einlagen) have a minimum tie of one year.

3.6.5 Hebesätze (rate of assessment) for pensioners

It has to be noted that reserves are also contingent on political measures, which can be modified: Besides the different distribution of insured members to the carriers, which causes that predominantly the regional health insurance funds cover the unemployed persons, and persons at risk of poverty, there also are different subsidies for the insured communities. The figure below depicts the Hebesätze in percentage, which serve to top-up the contributions for the health insurance of pensioners (i.e. the fictional employers' contributions).

Figure 84: Hebesätze 2017 in percent, own illustration, based on data from HVSV: "Hebesätze 2015 -2017"



It can be assumed that the Hebesätze for pensioners advantage the VAEB and the SVB, since for these carriers, the Hebesatz is significantly higher (in percentages as well as absolute terms) than for e.g. the regional health insurance funds.[196] The Hebesatz in the health insurance is the fictional employer's contribution for pensioners. This Hebesatz is significantly higher in the SVB and the VAEB than at other carriers. This can be justified by the fact that both carriers insure a high proportion of pensioners and that with rising age, the health expenditures are also expected to increase. In addition to this, the SVB has relatively low pensions, which are caused by calculating the contributions via the assessed value

[196] Hauptverband der Österreichischen Sozialversicherungsträger. Hebesätze 2015 -2017. 2017.

(Einheitswert). This also renders a higher percentage necessary. However, the particularly high Hebesätze at the SVB and the VAEB effect in the health insurance carriers receiving significantly higher income for a retiring insured person, meaning that with an increasing proportion of pensioners, the carrier's financial situation improves. In line with this, the GKK received €696 per pensioner in Hebesätze per year, whereas the special health insurance carriers received €858.90, in 2015. The table below demonstrates the annual income at the health insurance carriers with respect to the Hebesätze per pensioner, for the year 2015.[197]

Table 33: Income from Hebesätze per pensioner, own illustration, based on data from HVSV: "Hebesätze 2015-2017"

Insurance carrier	Income from Hebesätze per pensioner
GKK	€696.3
BVA [198]	€1,043.07
SVB	€1,716.25
VAEB	€1,816.42
SVA	€912.48

Since it can be assumed that older persons cause higher health expenditures regardless of the amount of their pension, it would be useful to change the Hebesätze (currently calculated on the basis of a percentage of the pension) to age-dependent flat rate payments. The high Hebesätze serve as explanatory factor for the VAEB and the SVB showing clear positive net assets despite the high share of pensioners in their pools of insured persons.

3.6.6 Unemployed insured members

The reserves also depend on the structure of the insured members. The advantageous financial situation of the nationwide carriers is also due to the fact that these carriers do not have to insure unemployed persons, as 99.7% of all unemployed persons are insured at the regional health insurance funds.[199] The table below shows the share of unemployed persons per carrier.

[197] Ibid.

[198] Estimate: No separation between officials and contractual employees (no Hebesätze for officials but employer share)

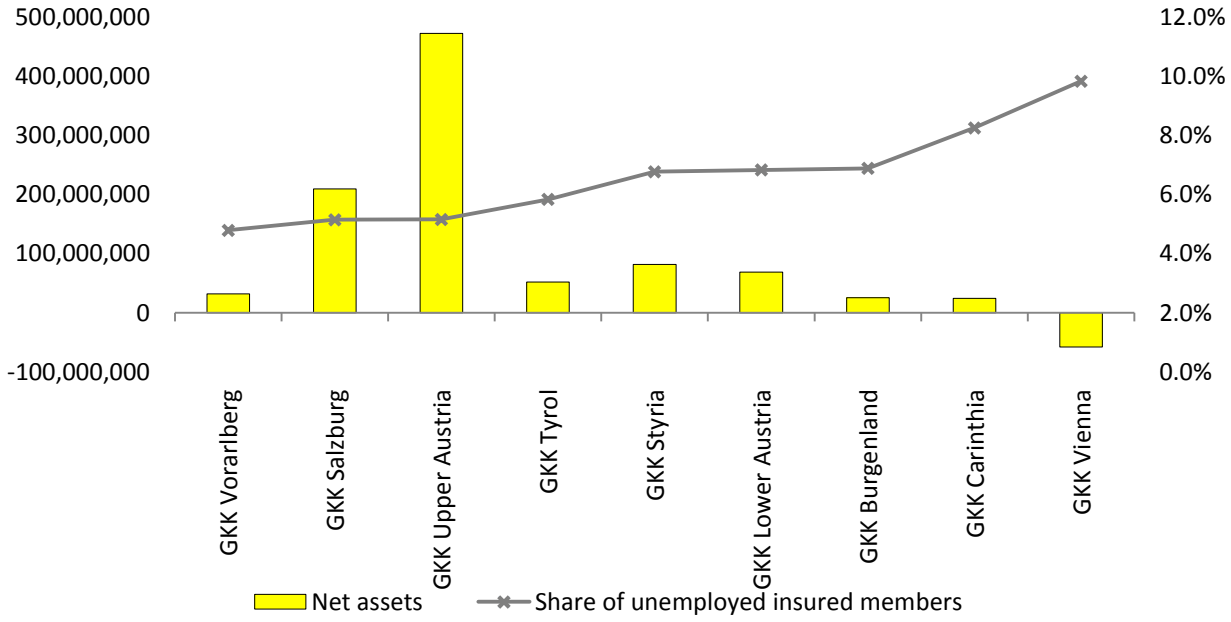
[199] Hauptverband der Österreichischen Sozialversicherungsträger. Versicherungsverhältnisse 2015. 2017.

Table 34: Unemployed persons in health insurance, based on data from HVSV: "Versicherungsverhältnisse 2015"

Insurance carrier	Unemployed persons in health insurance	Share of unemployed persons according to carriers
Health insurance total	373,772	100.00%
GKK	372,513	99.66%
BKK	160	0.04%
VAEB	1,099	0.29%
BVA	0	0.00%

Additionally, also among the GKK exist differences in reserves: the OÖGKK and the SGKK have comparatively high reserves and a relatively low share of unemployed insured members. In contrast, carriers with the highest share of unemployed members have the lowest net assets. Of course, there exist various other influencing factors, yet the structure of insured members evidently seems to impact the net assets.[200] The figure below depicts the connection between the share of unemployed insured members and the net assets per carrier, in 2015.

Figure 85: Net assets and share of unemployed insured members in the regional health insurance carriers, own illustration based on data from HVSV: "Zusammenstellung der Schlussbilanzen 2015" & "Versicherungsverhältnisse 2015"



[200] Hauptverband der Österreichischen Sozialversicherungsträger. Zusammenstellung der Schlussbilanzen 2015. 2017.

4 Contracts and purchasing

4.1 Contractual arrangements[201]

Social security institutions organize their own contracts with service providers (except hospitals). The HVSV is influencing those negotiations with e.g. templates for fee agreements and generally supports negotiations between contractual partners and social security carriers. The involvement of the HVSV ensures the establishment of contracts on the same basis for all health insurance institutions. For hospital provision, the contracts and fee agreements vary between the social security institutions and Länder. All health care professions are only allowed to practice if they have the appropriate permission. Many of them (e.g. physicians, pharmacists, dentists, midwives, clinical psychologists etc.) need an entry in a public register, which is run by professional bodies, chambers or the Federal Ministry of Health. Health professions like qualified nursing staff, therapeutic masseurs, paramedics or specialist medical technicians do require compulsory registration for those and other health professionsstarting with 1.7.2018 is [202].

The following paragraphs will take a closer look at the various contractual partners of social security institutions:

4.1.1 Physicians

The Austrian Chamber of Physicians is the legal representative body of physicians. There are nine physician's chambers in the Länder, which are all member of the Austrian Chamber of Physicians. All physicians must be part of the chamber, which is responsible for contracting relations between physicians and social security carriers. On a regular basis, the bodies and social security institutions have negotiations about tariffs, services and the like. In 2006, dentists and tooth, mouth or jaw specialists left the Austrian Chamber of Physicians and formed their own chamber, the Austrian Dentists' Chamber. There are also regional dentists' chambers who are all members of the Austrian Dentists' Chamber. It is also responsible for contracting with health insurances and making professional, social and economic demands on behalf

[201] Primary sources of data within this section are: Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'. Hofmarcher and Quentin, 'Health System Review', 2013.

[202] https://www.arbeiterkammer.at/interessenvertretung/arbeitsmarkt/gesundheitsberufe/Registrierung_fuer_Gesundheitsberufe.html; 21.6.2017

of its members. In addition, there are the Austrian Pharmacists' Association, the Pharmaceutical Salary Fund and the Austrian Midwives' Committee[203].

The social insurance carriers, as well as the HVSV have special divisions concentrating on contractual physicians:

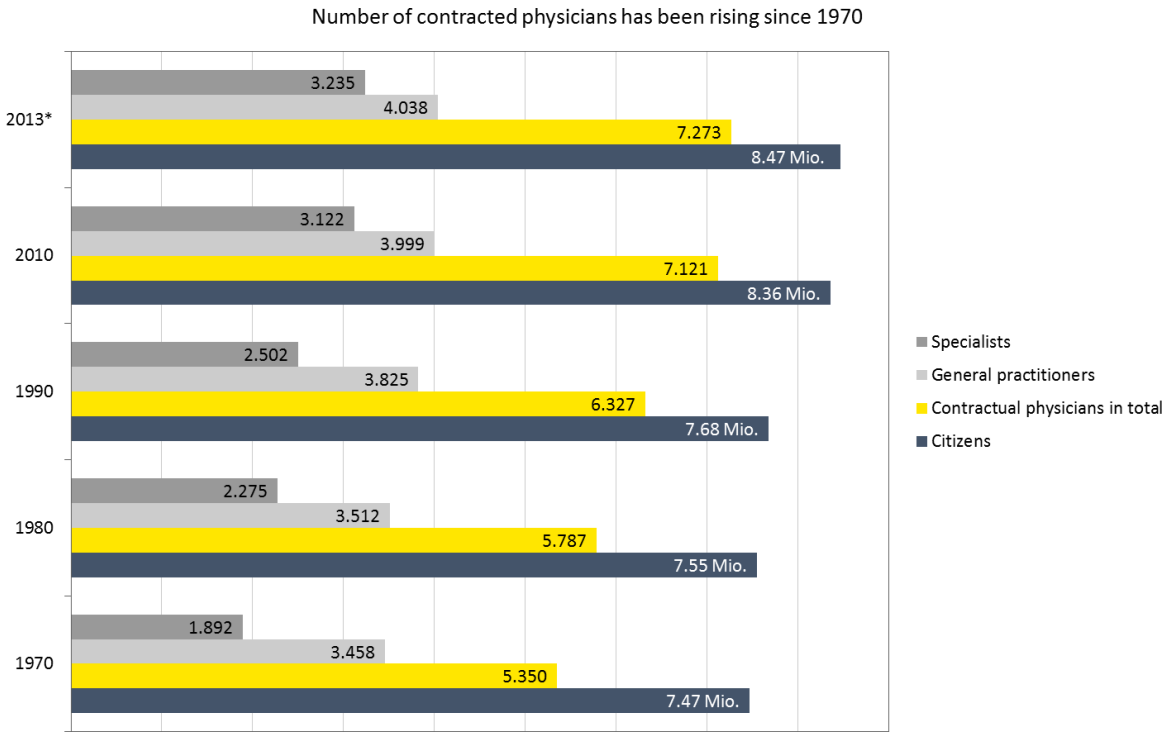
- Assisting with contractual relationships to established physicians, clinical psychologists and psychotherapists:
  - The division VPA supports insurance carriers in contract negotiations with the Austrian Chamber of Physicians. It also reports on e.g. financial assessments and compliance of financial targets.
  - Recently, several agreements decided on advancing electronical settlements with health insurance carriers.
- Related health topics and issues relating to professional rights:
  - Health insurance carriers are supported by the VPA (Vertragspartner Ärzte) in legal affairs, if necessary, via consultation, granting of legal protection by the Federation of Austrian Social Security Institutions or implementation of legal task forces.
- Fee-structure administration online (Honorarordnungsverwaltung-online) is an essential element of data transfer, as it enables a nationwide and uniform visualization of the fee-structures and contractual items with respect to all health insurance carriers.

Besides the primary responsibilities, the contractual physicians are dedicated to the following matters:

- Health of Children and Adolescents: One example is the work on a regulation catalogue, aimed at therapies for children and adolescents that is continuously progressed and further developed. The catalogue deals with specific applications of therapies and is already implemented as pilot project in several parts of Austria.
- Mental health: Since 2012, the Austrian social security has been operating a program, focused on the promotion and prevention of, as well as healthcare provision for, mental health issues.
- Dental health: During the past years, stronger financial support for children's dental healthcare was introduced, because early treatment of misalignments can prevent orthodontic problems in the adult age.

[203] Ibid Hofmarcher and Quentin, 'Health System Review', 2013.

Figure 86: Number of Contracted Physicians, own illustration, based on Leistungsbericht 2015, Hauptverband der Österreichischen Sozialversicherungsträger.



Furthermore, in 2005, a special task force formed by the Austrian Chamber of Physicians and the HVSV worked on a modernisation and improvement of medical check-ups. This reformation enabled to provide a nationwide check-up that is based on scientific knowledge. In Austria, every citizen (even those who are not insured) from the age of 18 on is entitled to a free annual health check-up which is based on the individual needs of the patients.

In addition to that, in 2011 and 2012, the Austrian Chamber of Physicians and the HVSV conducted negotiations on early breast cancer detection based on key points set by the Federal Health Commission. In 2012, limited to five years, they introduced a new screening program. For the first time, standardised quality criteria defined on a high level for an important area of early diagnosis of diseases were agreed on (e.g. equal opportunities for all women, low-threshold access, target-group-oriented approach, high quality standards etc.) and a as part of this program a regular recertification of radiologist was contracted.-

In 1995, the HVSV entered into an overall contract with the professional association of Austrian psychologists (Berufsverband österreichischer Psychologinnen und Psychologen, BÖP) which allows to make use of clinical-psychological diagnosis as benefit in kind. For social security, this contract was another step towards a modernisation of the contractual partner structures.

4.1.2 Medication (Vertragspartner Medikamente,)

The provision of medication is regulated by a contract between the Austrian Chamber of Pharmacists and the HVSV.

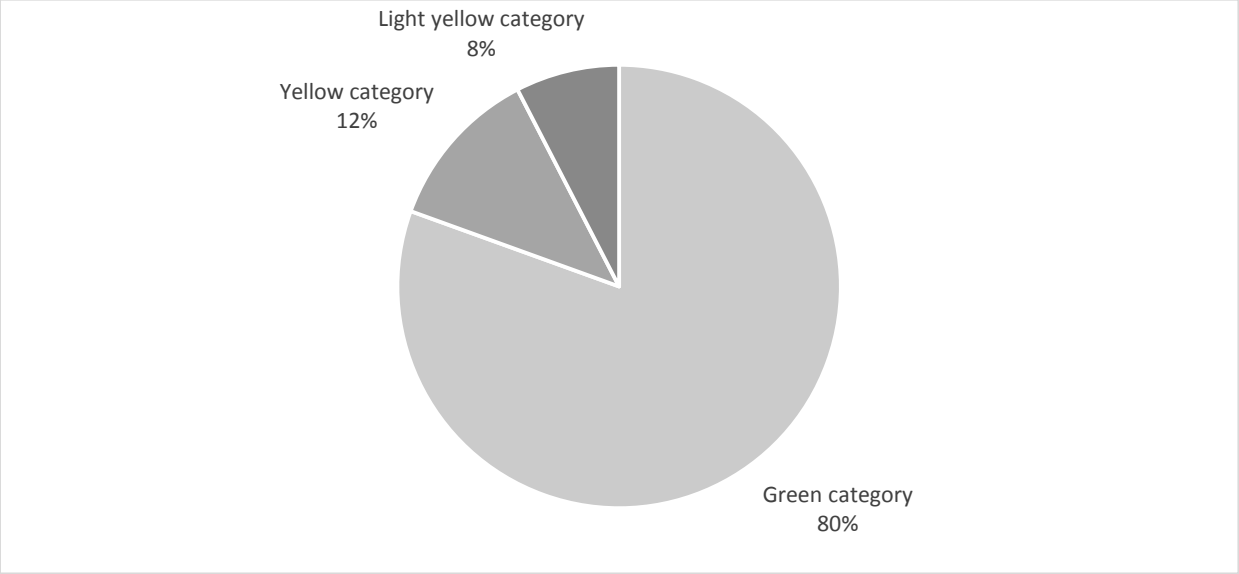
In 2015, Austrian health insurances recorded 122 Mio. boxes of medication, which amounts to expenses of €2.93 billion for medication (excluding sales tax). This means that on average every beneficiary received 14.29 pharmaceutical packages worth €24.09 each.

4.1.3 The Reimbursement Code (Erstattungskodex, EKO) (please visit: *www.erstattungskodex.at*)

The reimbursement code (EKO) is a regular publication, published by the Federation of Austrian Social Security Carriers. It includes approved, available and refundable pharmaceutical products that are assumed to have a therapeutic effect and use for patients in terms of medical treatment. In 2016, 5.017 pharmaceutical products were listed in the EKO, 89 of them in the red category (i.e. all medicines that applied for inclusion into the EKO are listed)[204].

[204] Ibid.

Figure 87: Erstattungskodex, own illustration, based on Leistungsbericht 2015, Hauptverband der Österreichischen Sozialversicherungsträger.



The following requests by pharmaceutical companies were submitted to the Federation of Austrian Social Security Institutions in 2015:

- 293 requests for inclusion in the EKO
- 17 requests for change of usage of pharmaceutical products already included in the EKO
- 14 requests for change of packaging size of pharmaceutical products already included in the EKO
- 31 requests for exclusion from the EKO
- 10 requests for price elevation of pharmaceutical products already included in the EKO.

An additional 266 proceedings were initiated by the Federation of Austrian Social Security Institutions.

The drug-evaluation-commission (Heilmittel-Evaluierungs-Kommission) recommends inclusion and exclusion as well as change of prescription of pharmaceutical products to the general management. For 1.012 pharmaceutical products, the commission was able to negotiate price reductions that amounted in savings of € 51.68 Mio. (Basis: retail price).

The following requests/proceedings according to VO-EKO were presented to the drug-evaluation-commission. In the red box, all medicines that applied for inclusion into the EKO are listed. The decision on inclusion in the green or yellow boxes is taken within 90 or 180 days (in case of pricing and

reimbursement). In case of a negative decision, the medicine will be delisted from the red box. The yellow box includes medicines, which fulfil certain criteria (e.g. specific disease or age group). For medicines in the red and the yellow boxes, an ex-ante approval of a sickness fund 'chief physician' has to be sought by the prescribing doctor. In the subgroup of the light yellow box, an ex-post volume control of the prescribing doctor might take place (instead of an ex-ante approval). The green box includes medicines, qualifying for automatic reimbursement; when prescribed by a contractual physician.

Table 35: Number of Products presented in 2015 per EKO-Category, own illustration, based on Leistungsbericht 2015, Hauptverband der Österreichischen Sozialversicherungsträger.

Number of products	Group
5 products	Red category
237 products	Green category
116 products	Yellow category
55 products	Proceeding initiated by federation – change of prescription or exclusion

Provision of the population with pharmacies

In 2015, there were 1.328 public pharmacies and 854 physicians with in-house pharmacies providing Austria with medication. Moreover, there are projects, which focus on educating patients, one of these is Arznei & Vernunft (="Medication & reasoning"). The initiative "Arznei & Vernunft" is a project initiated by the Federation of Austrian Social Security Institutions, Pharmig, Austrian Chamber of Physicians and the Austrian Chamber of Pharmacists. The main goal of this project is to inform about the wise handling of medication (*www.arzneiundvernunft.at*).

Polypharmacy

The Austrian Social Security supports the further improvement of therapy quality as well as prevention of overmedication (polypharmacy) and its negative effects.

One approach to combat this issue is the campaign "Vorsicht, Wechselwirkung!" (="Attention, pharmacological interaction!"). This campaign was initiated by the regional health insurance carriers in Vienna and Salzburg, together with medical companies and addresses both, physicians and insured persons. Its goal is to draw attention to the issue of polypharmacy. Health insurance carriers distribute information material to physicians, patients and insured persons and the back of the EKO also contains information about this campaign. Another approach is the annual "Polyquote" (="Polyquota"), a quota which serves general practitioners as source of information with respect to the overmedication of patients.

4.1.4 Relationship with other partners

Hospitals, sanatoriums and rehabilitation centres

In 2014, Austria had 279 hospitals with a total of 64.792 beds. 123 hospitals (44%), where 89% of all inpatient stays took place, are financed by regional health funds. The basis for the relationship with those financed hospitals are the agreements „About the organisation and financing of the health care system"(BGBl. I 2013/199) as well as „System of objectives related to health"(BGBl. I 2013/200). In the course of the equalisation fund established by the HVSV, social security carriers preliminarily spent €5.061,997,386.39 for hospital financing. Hospitals not financed by regional health funds are financed by a private hospital financing fund called PRIKRAF (Privatkrankenanstalten-Finanzierungsfonds). Currently there are 44 hospitals financed by this fund. In 2015, health insurance carriers preliminarily contributed €112,335 Mio. PRIKRAF applied control mechanisms to ensure an effective and appropriate application of its funds.

Electronic data exchange with health institutions

In 2004, a task force with representatives of the federal state, the Länder, social security carriers and the HVSV was formed to take on the issue of data exchange with health institutions. In 2015, the groundwork for an implementation of the e-Card infrastructure in health institutions was done[205].

[205] Ibid.

Various other partners

In 2015, the HVSV provided a single valorisation contribution of €1.25 mio. to orthopaedic shoemaker businesses, which was distributed according to the share of submitted expenses for orthopaedic shoes and shoe finishing in 2014. This contribution corresponded with 4.2% of the submitted fees. However, the professional group still insists on tariff adaptations plus a valorisation of tariffs[206].

Moreover, the hearing system specialists are further partners. The working group hearing aids developed a new overall contract, which includes, besides various updates, an adaptation of minimum technical requirements for devices of all categories. However, negotiations are still in progress. Additionally, discussions about the establishment of independent information centres are in process as well. Those centres should consult insured persons to avoid high payments for additional features that, from a medical point of view, are not necessary[207].

Further partners are In-vitro-Fertilisation centres, according to § 5 Abs. 1 IVF-FondsG[208]. The HVSV concludes contracts with In-vitro-Fertilisation centres for the IVF fund. Contracts with private and public centres were concluded[209].

As a further contractual partner, the operators of Austrian emergency rescue helicopters are affiliated in an interest group. A direct charging agreement was completed, which includes a nationwide assessment of all operators, no financial burden on insured persons, or the establishment of a clearing-office to deal with controversial cases.

[206] Ibid.
[207] Ibid.
[208] IVF-Fonds-Gesetz - §5 Vertragskrankenanstalten; Qualitätssicherung.
[209] Hauptverband der österreichischen Sozialversicherungsträger, 'Handbuch der österreichischen Sozialversicherung 2016'.

4.2 Quality of care within the Austrian healthcare system[210]

The aim of the quality work in the health care system is to optimise the quality of patient care and to implement appropriate measures of quality assurance on the basis of existing resources. In this context, quality stands for the degree of achievement of patient-centred, transparent, effective and efficient provision of services in all health care sectors. Thus, quality is the degree of conformity of treatment outcomes and previously framed goals of good treatment.

4.2.1 General framework

Besides occupational laws or other legal guidelines (ASVG, KAKuG, etc.) that include quality-related regulations, the Health Care Quality Act (Gesundheitsqualitätsgesetz, GQG) forms the legal basis. The GQG outlines the essential basis for a nationwide assurance of quality in health care. It defines definitions and foundations for a common understanding of quality in health care and allows the development and implementation of nationwide recommendations or specifications for health care services. The guiding principles of the law are patient orientation, transparency, effectiveness and efficiency.

With the agreements according to Art.15a B-VG[211] about the organisation and financing of the health care system and the Federal Health-Targets, the federal state and the Länder implement the law, on the basis of which the "quality strategy" was also developed. The quality strategy aims at optimal and equivalent care in terms of quality for all patients with coordinated measures in the areas of patient safety, structural, process and output quality, risk management, as well as education and training.

On an institutional level, the Federal Ministry of Health and Women's Affairs (BMGF), the Federal Institute for Quality in Health Care (Bundesinstitut für Qualität im Gesundheitswesen, BIQG), the Gesundheit Österreich GmbH (GÖG), the social security carriers as well as the Austrian Chamber of Physicians

[210] Primary sources of data for this section are: Hauptverband der Österreichischen Sozialversicherungsträger, 'Qualitätsmanagement Im Österreichischen Gesundheitssystem'. Maria M. Hofmarcher, *Das Österreichische Gesundheitssystem - Akteure, Daten, Analysen*. Ministerium für Frauen und Gesundheit, 'Bundeseinheitliche Ergebnisqualitätsmessung Aus Routinedaten: Austrian Inpatient Quality Indicators (A-IQI)'. Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

[211] Gesamte Rechtsvorschrift für Grundversorgungsvereinbarung - Art. 15a B-VG.

(Österreichische Ärztekammer, ÖÄK) are instructed by law to engage in the topic quality in health care on a national level.

Various activities are set nationwide on the basis of the Health Care Quality Act. With regard to the structural quality, essential amounts and quality of personnel and material organisation of institutions (e.g. number of specialists, beds or medical devices in a care region or in a hospital) are collected, evaluated and developed on a regular basis. Standards for the hospital area are defined by the Austrian Health Care Structure Plan (Österreichischer Strukturplan Gesundheit, ÖSG). Guidelines for the outpatient sector are going to be included in the ÖSG, appearing in 2017.

In the area of process quality, treatment and working processes are described in the form of quality standards, or recommended as application of federal quality guidelines, based on the current state of scientific knowledge. Examples are the federal quality guideline for admission and release management (2012), the federal quality standard early detection of breast cancer through mammography (2012) and the federal quality standard organisation and strategy of hospital hygiene (2015).

Output quality is about measuring, documenting and evaluating changes of the state of health and the quality of life. Furthermore, data about patient satisfaction and their experiences with the health care system is collected cross-sectoral on a regular basis (in the form of Austria-wide patient surveys). By comparing the results, quality of medical care can be observed and improved. In this context, it is important to mention the A-IGI (Austrian Inpatient Quality Indicators) and the quality register (electronic database for medical treatments).

An additional quality-related topic is the available information. To improve transparency in health care, information about health and quality topics are provided to the public (*www.spitalskompass.at*, *https://rehakompass.goeg.at, www.kliniksuche.at*). [212]

4.2.2 Quality in the inpatient sector

The quality work and the involved requirements for Austrian hospitals are regulated by e.g. the hospital and sanatorium law (Krankenanstalten- und Kuranstaltengesetz, KAKuG) or the physician's law. According

[212] 'Qualität Im Gesundheitswesen'.

to §5b KAKuG[213], hospitals with patient beds are obliged to employ a commission for quality assurance. The commission has to initiate, coordinate and support quality assurance measures.

All Austrian emergency hospitals and inpatient rehabilitation centres report on the current status of quality work in their periodic quality reporting. The reporting is made via a web-based platform (*www.qualitaetsplattform.de*), where questions are asked about: Quality strategy, quality models, patient and staff surveys and complaint management. The output quality measurement is made via the above mentioned system A-IQI (Austrian Inpatient Quality Indicators).

As a part of the health care reform in 2013, a nationally standardized measurement of output quality was implemented. This measurement is based on routine data which is aggregated into Austrian Inpatient Quality Indicators (A-IQI) and does also include a peer-review process. The indicators are based on the invoice data of the performance oriented hospital funding (Leistungsorientierte Krankenanstaltenfinanzierung, LKF). The measurement and analysis is standardized and uses a tool called QDok. Quality indicators are based on diseases or surgeries and cover a vast spectrum from routine procedures all the way to highly specialized treatments. In total, A-IQI consists of 52 indicator groups with a total of 278 indicators, which are subject to a yearly review and improvement. The indicators cover deaths, frequency of ICU-treatment, complications, aggregated numbers, surgery techniques, process data and additional information. However, it is important to notice that these indicators do not constitute an accurate display of the clinical reality, nor is it possible to reach scientific conclusions, based solely on these indicators, and the measurement itself does not improve quality.

The A-IQI organization is made up of two bodies: the operative or controlling group and the scientific council. The operative group consists of members of the BMGF, all 10 funds (9 Landesgesundheitsfonds, 1 Privatkrankenanstalten-Finanzierungsfond) and the HVSV. This group is tasked with choosing the yearly focus areas and peer-review process, the adaption and development of the indicators and the peer-review process, the production of a yearly report and forwarding analysis-based recommendations to relevant committees. The scientific council consists of members of the same institutions as the operative group, plus members of hospital carriers and hospitals and supports the development and adaptation of the indicators as well as the content-wise discussion of the indicators.

[213] Krankenanstalten- und Kuranstaltengesetz - § 5b Qualitätssicherung.

The peer review process takes one day and takes place at the hospital. The peer-review team consists of three to four peers, which are experienced and well trained chief physicians of at least two different specialisations. This team analyses around 20 cases, based on pre-defined criteria. At the heart of this process is the final discussion of the results with the local physicians-in-chief and the following definition of measures of improvement. Goals of this process include the optimization of the whole treatment-process, showing local peculiarities, establishing an open error culture, the sustainability of the improvement process and the control of the indicators. [214]

Furthermore A-IQI allows for IQI comparisons between Austria, Germany and Switzerland.

4.2.3 Quality in the outpatient sector

In light of the agreement according to Art. 15a B.VG[215] Federal Health-Targets (Zielsteuerung Gesundheit) and the Federal Health-Target Contract (Bundes-Zielsteuerungsvertrag, B-ZV), quality measurement continues to increase in importance within the Austrian health care system. As mentioned above, one of the focus areas is the measurement of output quality (Ergebnisqualität, EQ) across all sectors of the health care system.

While the measurement of quality is already well established in the inpatient sector, especially considering A-IQI, there is a lack of such a measurement system for the outpatient sector. However, the development of such a system is part of the Federal Health-Target Contract (B-ZV) and in the annual working program, which is derived from the B-ZV. Currently, there are only pilot projects in the area of cross-sector output measurement in some states, but there is no nationally comparable system. As a result and according to BZ-V, indicators, fit to show cross-sector output quality, should be defined and integrated into national output quality measurement systems.

The Austrian Chamber of Physicians (Österreichische Ärztekammer, ÖÄK) is obliged to publish a quality assurance order for the outpatient sector every five years. Quality assurance in outpatient facilities (ärztliche Ordinationen) is carried out by ÖQMed (Austrian Society for Quality Assurance & Quality

[214] Ministerium für Frauen und Gesundheit, 'Bundeseinheitliche Ergebnisqualitätsmessung Aus Routinedaten: Austrian Inpatient Quality Indicators (A-IQI)'.
[215] Gesamte Rechtsvorschrift für Grundversorgungsvereinbarung - Art. 15a B-VG.

Management in Medicine GmbH), a subsidiary of ÖÄK. The ÖQMed performs quality assurance in Austrian outpatient facilities by elaborating specialist quality criteria. The quality control is perfomed by the ÖQMed, based on checks of compliance with the criteria. The ÖQMed was restructured by the federal law for strengthening the provision of outpatient public health care. The bodies of the ÖQMed are the scientific council, presided by the Gesundheit Österreich GmbH, and the evaluation council.[216]
In accordance with §118c[217] an order for quality assurance was published by the ÖAK. Correspondingly, ÖQMed checked the structural quality, e.g. the equipment, as well as some basic processes. However, there was no analysis of the treatment processes (process quality) or the treatment results (output quality).[218]

4.2.4 From the Austrian Inpatient Quality Indicators (A-IQI) to the Austrian Outpatient Quality Indicators (A-OQI)

Due to the lack of a system comparable to A-IQI in the outpatient sector, there is currently a move towards a comparable system called A-OQI (Austrian Outpatient Quality Indicators), which aims at providing information comparable to A-IQI for the outpatient sector and to allow for cross-sector comparability and cross-sector quality management. A-OQI will focus on four areas: chronic diseases, interventions, patient safety, patient satisfaction (see patient satisfaction survey). The data used for A-OQI is, in general, based on already available data.

The collected data will be made anonymous, evaluated and submitted to the steering group. After that, non-anonymous data and evaluations are transmitted to ÖÄK which forwards it to the corresponding health care service providers (Gesundheitsdiensteanbieter, GDA). The BMG is in charge of making the data anonymous and reversing the anonymity before the submission to the ÖÄK.

The concept is based on regional variability. If regional variability exists and this variability can be explained through sources and indicators which are within the scope of regional GDAs, best practices will be used in order to transform the outpatient sector into a learning organization. These regional variations will be dealt with by so called quality circles (Qualitätszirkel, QZ). The steering group (see A-IQI) will choose the region, moderators and invite members (experts and GDAs) to the QZ. In a second step, the QZ

[216] Maria M. Hofmarcher, *Das Österreichische Gesundheitssystem - Akteure, Daten, Analysen*.
[217] Ärztegesetz 1998 - §118c Verordnung zur Qualitätssicherung der ärztlichen Versorgung.
[218] Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

formulates the problem, looks for reasons, formulates goals, plans actions, carries them out and publishes reports regularly. Then, in cooperation with the steering group, these results are evaluated and a final report consisting of an in depth analysis and derived recommendations is published.

The development of A-OQI happens currently in pilot regions, which were chosen based mainly on their willingness to cooperate. Before the roll-out to the rest of Austria can be planned, an evaluation of experiences will be conducted. Sustainable results can only be expected after a considerable period of time after the roll-out, evaluation and improvements have taken place. [219]

4.2.5 Perceved quality in the Austrian healthcare system

The Federal Health-Target Contract determines as operational objective (objective 8.4.1) to survey the satisfaction of the general public with the health care system, and to measure the subjective state of health of the population on a regular basis. Based on the mentioned goal in 2015 a patient survey was conducted on the perceived quality and patients' experience of the Austrian health care system. More than 20.000 participants were surveyed, all of which had received some kind of treatment in the previous quarter. While 82% percent reported, that their health improved following a treatment, 98% were satisfied with the general outpatient sector and 97% were satisfied with the treatment they received. These figures were slightly lower for the inpatient sector, 95% and 96% respectively. In total 96% of respondents in the outpatient sector reported that they were included in the decisions of the treatment and 99% said that they were thoroughly informed about the treatment by the doctor, compared to 90% and 96% in the inpatient sector. Roughly one fifth of all patients reported a lack of communication in one way or another. This might be between health care providers or between them and doctors / pharmacists. Furthermore, there is a strong desire (89%) for receiving medical reports digitally or at least for doctors to be able to access them digitally. [220]

[219] Hauptverband der Österreichischen Sozialversicherungsträger, 'Qualitätsmanagement Im Österreichischen Gesundheitssystem'.
[220] 'Sektorübergreifende Patientenbefragung - Ergebnisbericht 2015'.

Table 36: Own illustration, based on Patientenbefragung 2015

Results of the patient survey 2015		
Improved health as a result of treatment	82%	
	Outpatient	Inpatient
General satisfaction	98%	95%
Satisfaction with treatment	97%	96%
Patients were included in treatment decisions	96%	90%
Doctor informed patients thoroughly	99%	96%
Reported lack of cooperation of different health care providers	13%	
Lack of information transfer between different health care providers	17%	
Contradicting information about best treatment	17%	
Lack of information about drugs (dosage, side effects,…)	20%	
No information when to contact doctor again in case of deteriorating symptoms	24%	
Wish for electronic results / medical reports	89%	

4.2.6 Potential for development

In Austria, an outstanding number of persons uses the medical care units making structural, process and output quality of the provided treatments more and more important. It can be assumed that the population, physicians and social security are similarly interested in the evaluation, discussion and improvement of the output quality referring to suitable quality indicators.

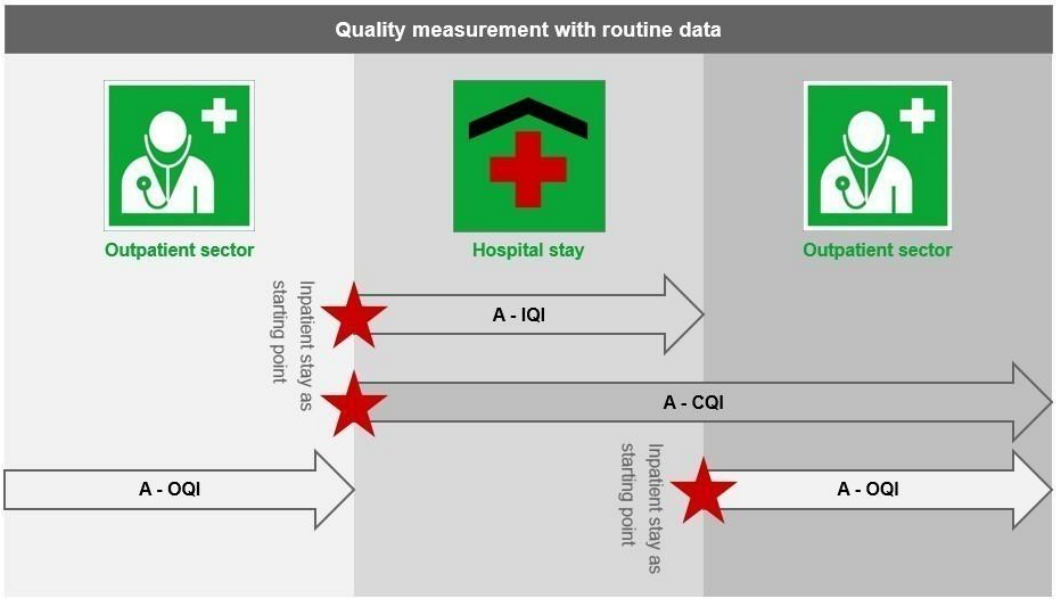
As mentioned, there is a lack of quality assurance systems across the inpatient and outpatient sector, and while there are some developments taking place at the moment, this is still one of the most pressing issues when it comes to reaching the goal of high-quality health care for all patients, as stated in the national health care quality strategy.

As already described, thanks to A-IQI there is a nationwide standardized instrument to measure output quality in the hospital sector, however, currently there is no Austria-wide implemented concept for quality measurement in the outpatient sector or cross-sector area. With the described concept A-OQI there is a concept for the outpatient sector, which is tested via pilot projects.

The result of the patient surveys in 2015 showed that 13% of the respondents are missing a functioning cooperation between the different health care providers. A cross-sector quality assurance would be a possibility to optimize this issue, since influences on the overall treatment result, e.g. late complications, could capture the effectiveness of the care chain and the quality of care in the outpatient sector. In order to evaluate the treatment success in the overall health care system, it is indispensable to be able to keep track of the further path of patients after their release from the hospital. In order to gain this overview, the data of hospitals needs to be merged with the data of the social security. Regarding this, in Lower Austria, a research project (December 2012), named "Cross-sectoral quality assurance by means of A-CQI (Austrian Cross Sectoral Quality Indicators)" (Sektorübergreifende Qualitätssicherung mittels A-CQI) was carried out.

For the A-CQI method, as a first step 12 symptoms or service areas were selected according to the criteria: frequency of the symptom in the population, high-risk operations and very expensive methods. A-CQI enables to make care and output quality measurable during a patient career. [221]

Figure 88: Quality measurement with routine data, own illustration, based on Ergebnisqualitätsmessung im Gesundheitswesen[222]



[221] NÖ Patienten- und Pflegeanwaltschaft, 'Qualitätsmessung in Der Medizin'.
[222] Hauptverband der Österreichischen Sozialversicherungsträger, 'Ergebnisqualitätsmessung Im Gesundheitswesen'.

The Austrian health care system consists of a myriad of different actors and institutions which already offer a vast potential for development of the quality of health care services. One part of this potential could be leveraged by broadening the scope of the checks and controls conducted by ÖQMed, the ÖÄK subsidiary in charge of structural quality in outpatient facilities. As of now, ÖQMed is only carrying out checks of the (infra-) structural quality, but not on the quality of the processes, the results or outputs. Furthermore, it could be put in charge of checking the compliance with further education duties. Currently, checks are only undertaken online, without inspecting the doctor's clinic. Also, the provision of services is not inspected, but only the health and safety standards of the clinic. In addition, ÖQMED is a direct subsidiary of the Austrian Chamber of Physicians.

Plenty of legislation already exists, giving the BMGF a vast array of possibilities when it comes to defining standards and guidelines. This opportunity could be seized in order to further the development of quality assurance systems and measures. The same is true, albeit to a different extent, for health insurance carriers, since their cooperation with doctors and health care providers is based upon overall contracts. Health insurance carriers should use the possibility of including quality assurance arrangements in these contracts, in order to further the comparability of quality measures.[223]

4.3 Procurement of medicines[224]

4.3.1 Pharmaceutical regulatory system

In Austria, the health care system, including the pharmaceutical system, is characterised by the interplay of a number of actors: The main competent authority at federal level is the Federal Ministry of Health and Woman's Affairs (BMGF), which is responsible for drafting legislation and for strategic matters in the field of medication. The advisory councils and commissions in the pharmaceutical sector are also based at the Ministry. Another important public entity related to medication is the Austrian Federal Office for Safety in Health Care (Bundesamt für Sicherheit im Gesundheitswesen, BASG) which is responsible for granting market authorisations and for the vigilance of human and veterinary medicines, as well as of medical

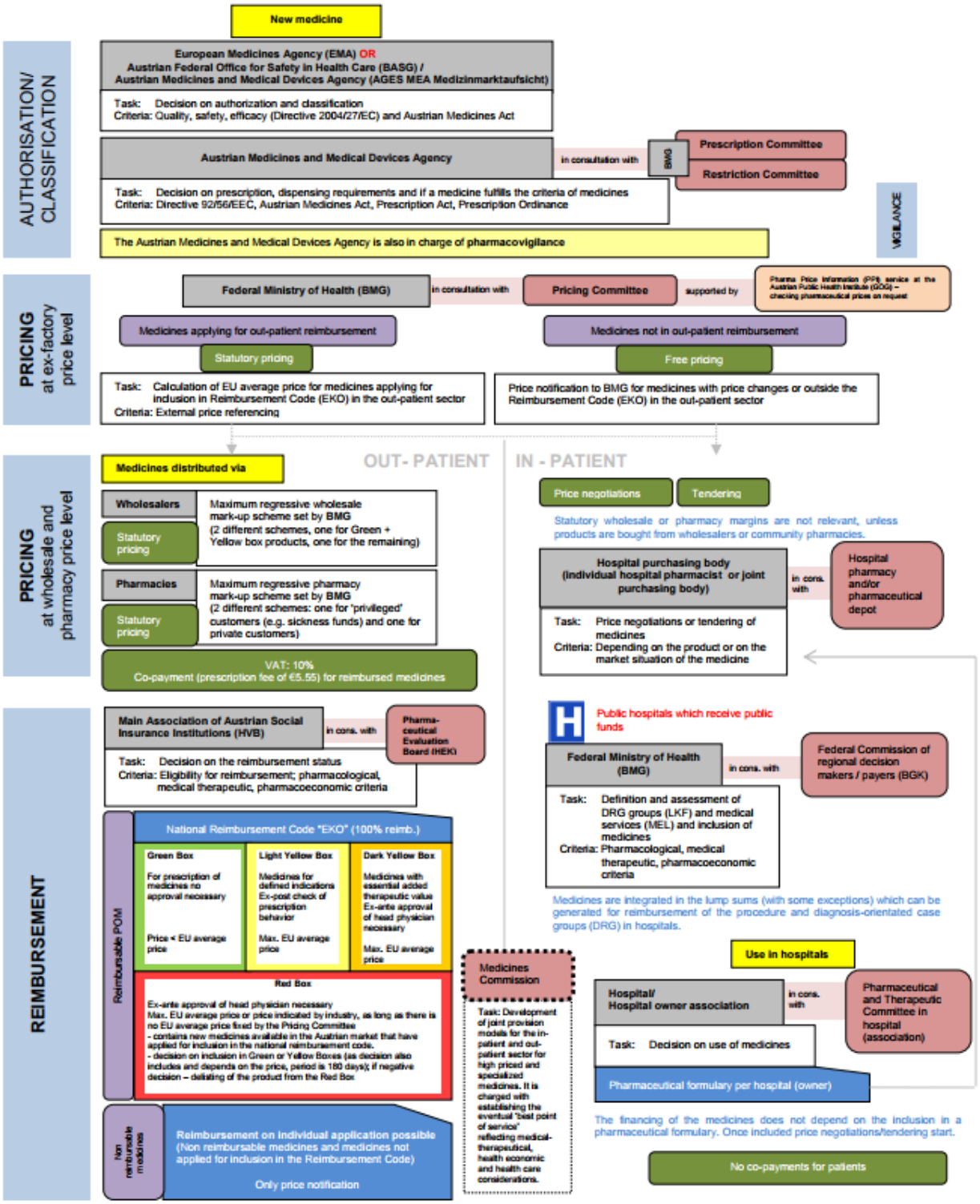
[223] Rechnungshof, 'Rechnungshofbericht Reihe Bund 2016/3'.

[224] Primary sources of data for this section are: Hofmarcher and Quentin, 'Health System Review', 2013. Hauptverband der österreichischen Sozialversicherungsträger, 'Leistungsbericht 2015'. Hauptverband der Österreichischen Sozialversicherungsträger, 'Dürfen Lebenswichtige Medikamente so Teuer Sein?', n.d Pharmig, *Daten & Fakten 2016 - Arzneimittel Und Gesundheitswesen in Österreich*. WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, 'Short PPRI / PHIS Pharma Profile'.

devices. The BASG, which is subordinate to the Federal Ministry of Health and Woman's Affairs (BMGF), acts as a Medication Agency. A limited liability company owned by the Republic of Austria, the Austrian Agency for Health and Food Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit GmbH, AGES), supports the BASG in its work. AGES Medizinmarktaufsicht (Austrian Medicines and Medical Devices Agency), which is a subdivision of this Agency, takes care of the pharmaceutical agenda. Pricing activities fall into the field of responsibilities of the Federal Ministry of Health and Woman's Affairs, which is assisted by the Pricing Committee (PK), especially in terms of the EU average pricing system, introduced in 2004, for reimbursed medication in the out-patient sector. Decisions on the inclusion of medicines into reimbursement in the out-patient sector are taken by the Federation of Austrian Social Security Institutions (HVSV) on the basis of the recommendations of the Pharmaceutical Evaluation Board (Heilmittel-Evaluierungs-Kommission, HEK)[225].The figure below provides an overview of the pharmaceutical system in Austria, covering the in-patient and the out-patient sector.

[225] WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, "Short PPRI / PHIS Pharma Profile."

Figure 89: Flowchart of the pharmaceutical system in Austria, illustration from Health Systems in Transition – Austria



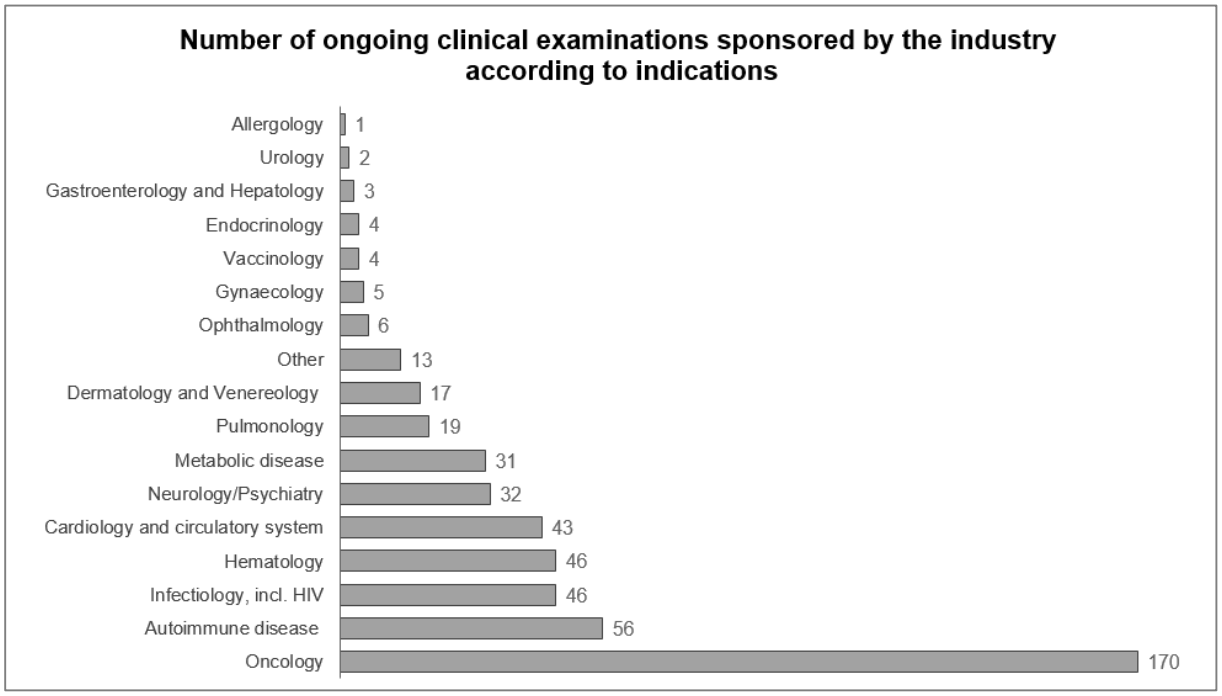
4.3.2 Medicines

In 2015, the social health insurances covered the cost for around 122 million prescribed packages of medication, which amounts to expenses of €2.93 billion (excluding sales tax). This means that on average every beneficiary received 14.29 pharmaceutical packages, worth €24.09 each.[226]

According to §133 ASVG[227], medical treatment includes medical help, medication and therapeutic products. Medical treatment should be adequate and appropriate, yet not exceed the necessary. The services offered for medical treatment are provided as benefits in kind (except if stated otherwise in the law). Access to relevant medical advance is to be granted to patients, provided that according to the current state of science, a relevant value can be assumed. Medication expenses of the Austrian social security rose by 5% from 2014 to 2015. These increased expenditures are particularly caused by high-priced, specialised medication (e.g. oncology products, or orphan drugs). This is supported by the number of ongoing sponsored clinical examinations, which are undertaken in order to get admitted. Please see Figure 90 for the various clinical examinations, listed according to the indications, and including the all examinations in 2014 (i.e. holistically displaying all started, current, and finished clinical examinations in 2014). The prime share of clinical examinations was undertaken in connection with oncology (170 clinical examinations), which was followed by autoimmune diseases with 56 examinations. [228]

[226] Hauptverband der österreichischen Sozialversicherungsträger, 'Leistungsbericht 2015'.
[227] Allgemeines Sozialversicherungsgesetz - § 133 Umfang der Krankenbehandlung, n.d.
[228] Pharmig, *Daten & Fakten 2016 - Arzneimittel Und Gesundheitswesen in Österreich*.

Figure 90: Number of ongoing clinical examinations to get admission, sponsored by the industry according to indications



Relating to the increase in expenditures, the most significant driving force is the Hepatitis C treatment. Despite the fact that the total number of prescriptions is relatively stable, there is an increase in costs for high-cost medication. [229] In 2009, expensive medication had a share of 14.11% in the total costs. In 2015, this share rose to 28.62% of all costs, whilst the number of prescriptions increased by only 0.41%.[230] According to HVSV, besides cancer and hepatitis drugs, medication for autoimmune diseases (i.e. rheumatoid arthritis, chronic inflammatory bowel diseases) will be the main driving force of costs in the next few years. According to an IMS Institute study, this trend will be ongoing: The prognosis for this is an increase in medication costs of around 30% worldwide, up until 2020. [231]

[229] in 2009, there were around 120,91 Mio. prescriptions ,Prescriptions, in 2015 around 121,56 Mio. Prescriptions. This corresponds with an increase of 0.5% in five years. Drugs with a retail price above €700 per box are considered as high-priced medication.

[230] Hauptverband der Österreichischen Sozialversicherungsträger, 'Dürfen Lebenswichtige Medikamente so Teuer Sein?', n.d.

[231] IMS Institute for Healthcare Informatics, 'The Global Use of Medicines: Outlook through 2016'.

4.3.3 Providing the population with medication

In 2015, there were approximately 220 pharmaceutical companies, in Austria. The pharmaceutical industry is characterized by small- and medium-sized enterprises. Most deliveries are handled via pharmaceutical wholesalers. There exist eight wholesalers in Austria, who provide a full range of medicines on the market (full-line wholesalers). The pharmaceutical wholesale is organized as a multi-channel system: The wholesaler delivers the medication to the pharmacies, for example three times a day, and in case of emergency, an immediate delivery is also possible. In the out-patient sector medicines are mainly dispensed by public pharmacies, or in-house pharmacies from physicians. 2015 there were 1.328 public pharmacies and 854 dispensing physicians with in-house pharmacies providing medicines.

Also, there are 46 hospital pharmacies, thus 16.5% of all hospitals (278 in 2015) have a pharmacy. The remaining hospitals are without pharmacy, yet pharmaceutical provision is delivered by so-called "pharmaceutical depots", which are served by the hospital pharmacy of another hospital or a public pharmacy.[232]

Generally, the establishment of a new pharmacy in Austria is statutorily regulated in the Pharmacy Act. The process of establishing a new pharmacy is based on the geographic criteria (the minimum distance between the new pharmacy and the nearest existing pharmacy has to be at least 500 meters) and demographic criteria (the number of people who continue to be supplied by adjoining pharmacies must not fall below 5.500 as a result of establishing a new pharmacy).

4.3.4 Pricing of medication

In Austria the pricing of medicine is regulated by law and falls into the responsibility of the Federal Ministry of Health and Women (BMGF), who collaborates with the Pricing Committee. The Pricing Committee's activities are based on the Price Act (Preisgesetz 1992 i.d.g.F.), which, in fact, does not apply to medication only, but also to other society-related products, such as raw materials. According to the Price Act, the Ministry of Health and Women is entitled and obliged to determine a national price, justified in terms of the national economy. Prices are either calculated by the Ministry of Health and Women, advised by the Pricing Committee (via the method of the European Union (EU) average price) or notified by companies

[232] WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, 'Short PPRI / PHIS Pharma Profile'.

(price notification at manufacturer price level). These prices are maximum prices; accordingly, medicines may be priced lower. According to the Price Act, if a notified price is deemed too high from the perspective of the Austrian economy, the Ministry of Health and Women has the opportunity to start an official price-fixing process. If such a process is not started within six weeks, the proposed price will be automatically granted.

By amending the relevant provisions of the ASVG as of 1 May 2017 (not yet published), it is established that the price commission has to determine the EU average price six months after the application for inclusion in the EKO for the first time. After another 18 months, further 24 and optionally after 18 months again the EU average price needs to be determined.

There are specific pricing rules for medications, whose manufacturers apply for the inclusion in the positive list (Erstattungskodex, EKO). Medication which is included in the EKO has to be priced either according to the EU average price (as established by the Pricing Committee), or below this price. Decisions on the reimbursement status are taken by the HVSV, on the basis of recommendations of the Pharmaceutical Evaluation Board (HEK). The HVSV decides in accordance with the Transparency Directive[233] within 90 days (180 days in the case of pricing and reimbursement), counted from the date it receives the recommendation of HEK. The external price-referencing tool, called 'European Union average price system', was introduced in Austria in 2004. Starting 2018 the EU average price system is not only set for medicines applying for inclusion into the EKO but also for those which are not listed in the EKO, if they caused sales of 750.000 EUR which were born by health insurance in the last 12 months. The relevant legal basis is the Regulation on Procedural Rules for Calculation of the EU average price, which was published on 1 October 2005.[234]

The regulation states that the market authorisation holder, who applies for inclusion of a medicine into the EKO, has to provide information, e.g. whether the product is on the market in any other EU Member State. If this is the case, the ex-factory and wholesale prices of the medicine in all EU Member States have to be submitted. To do this, pharmaceutical companies have to use a standard form, which was developed by the Pricing Committee (PK).[235]

[233] Amtsblatt der Europäischen Gemeinschaft, 'Richtlinie Des Rates'.
[234] Allgemeines Sozialversicherungsgesetz, EU-Durchschnittspreise laut ASVG.
[235] Ministerium für Frauen und Gesundheit, 'Arzneimittelpreise'.

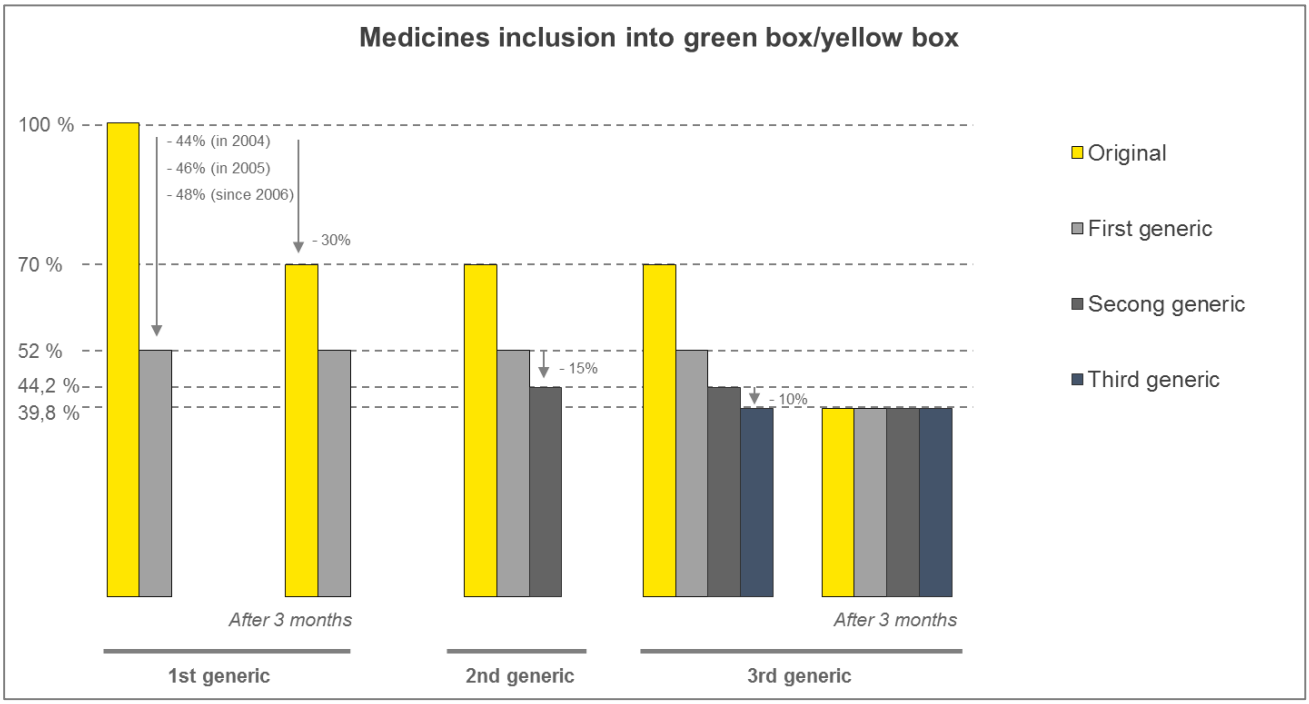
According to the General Social Insurance Law (ASVG), the Gesundheit Österreich GmbH (GÖG) may be asked at random by the Pricing Committee to check the prices, submitted by the industry. The Pricing Committee calculates the EU average price of the medication, which apply for inclusion into reimbursement code (EKO). The prices are compared per unit to presentations of the same strength, the same package size and the same dosage. The EU average price can be determined, in case that the on-patent medicine is marketed in at least half of the European Union Member States and for generics in at least two Member States. Otherwise, the EU average price cannot be determined, and a price evaluation will be carried out every six months. If the criteria are not met at the second re-evaluation, the EU average price will be determined on the basis of the information available, i.e. the available countries.

In addition to the common price setting method of the EU average price, price negotiations may take place in case of reimbursable medicines. Therefore, starting from the determined EU average price at the manufacturer price level, the HVSV can further negotiate the price. The legal framework for the price negotiations is provided by the Procedural Rules for the publication of the EKO. As soon as an agreement is reached, negotiations end, and the ex-factory price is ruled to be binding. Internal price referencing is applied for so-called 'follower' medicines, such as generics, which apply for inclusion in the EKO. According to the Procedural Rules for publication of the EKO, the first generic product or other 'follower', is priced at least 48% below the price of the original brand, which went off-patent. From 1 May 2017, the first generic product is priced 50% below the price of the original brand and 38% for biosimilars.

The second and each subsequent 'followers' are required to have a price difference related to the previously included generic: The price of the second 'follower' has to be 15% lower than the one of the first 'follower', and the price of the third 'follower' has to be 10% lower than the price of the second 'follower'. The price of the original product has to be reduced by at least 30% within three months after the inclusion of the first generic into the EKO.[236] With the fourth 'follower' the original product has to reduce the price on the level of the third 'follower' or it has to be removed from the EKO. The new regulation (effective from 1. May 2017) foresees a price reduction for generics of 18% respectively 15% and for biosimilars a reduction of 15% respectively 10%.

[236] WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, 'Short PPRI / PHIS Pharma Profile'.

Figure 91: Medicines inclusion into green box/yellow box, own illustration, based on Pharmig Zahlen & Fakten Kompakt 2016.



4.3.5 Mark-ups

With respect to the wholesale, the pricing is (as already mentioned) regulated by law and characterized by a regressive mark-up scheme, which is applies to all medicines. There exist two different schemes – one for reimbursable medicines (green and yellow boxes) and one for the remaining medication.[237]

- Ex-factory price plus wholesale mark-ups: for reimbursable medicine, based on the EU average price (between 7% and 15.5%), and for not reimbursable medicine (between 9% and 17.5%).
- Pharmacy purchasing price plus pharmacy mark-ups: depending on the price level the mark-ups are in between 3.9% and 37% for reimbursable medicines, and 12.5% to 55% for not reimbursable medicines (including a 15% surcharge for private customers).
- Price for health insurance carriers: for reimbursable medicines

[237] Bundesministerin für Gesundheit und Frauen, Verordnung der Bundesministerin für Gesundheit und Frauen über Höchstaufschläge im Arzneimittelgroßhandel 2004.

- Pharmacy sales price plus VAT: ten percent. The value-added tax rate on medicines is 10%. The VAT-rate was reduced from 20% to 10% in 2009. With this mark-up and the VAT it is possible to calculate the final customer price.[238]

4.3.6 Pharma Framework Contract (Rahmen-Pharmavertrag)

The pharma framework contract is unique in Europe and has been in existence, since 2008. On a contractual basis, the pharmaceutical industry and social health insurance are working together to support the performance of the statutory health insurance funds, in particular for the patient.

For the framework contract 2018 (2016 to 31.12.2018), pharmaceutical companies and wholesalers are transferring €125 million to the health insurance funds. 2017 and 2018 will depend on the actual increase in expenditures (per % €10 million), but with a total of up to €160 million.[239]

4.3.7 Reimbursement of medicines

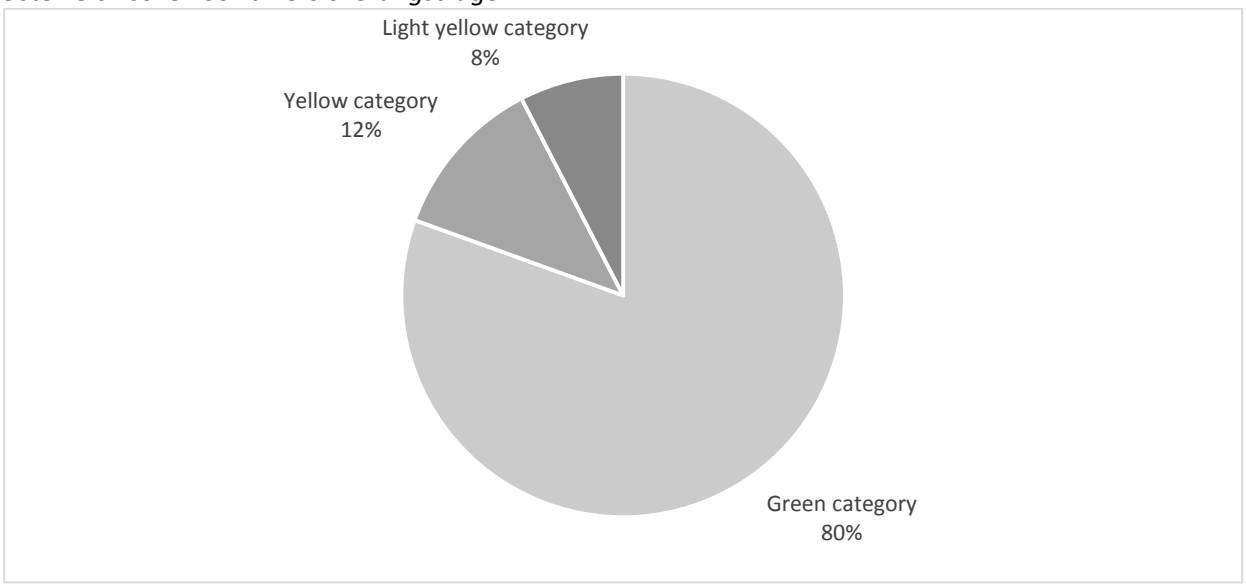
In Austria, medicines are granted in kind to the insured. The legal basis for the reimbursement scheme is §31 (3) section 12 of the ASVG and the procedural rules for the publication of the reimbursement code (EKO).

The reimbursement code (EKO) is an annual publication, published by the HVSV. Monthly changes of the EKO are published in the Internet. The EKO includes approved, available and refundable pharmaceutical products, which are assumed to have a therapeutic effect on and use for patients in terms of medical treatments. The EKO is a positive list of medications in Austria, with different conditions regarding the prescription. The EKO has three main segments, the green box (§31 Abs. 3 Z. 12 lit. c ASVG), the yellow box (§31 Abs. 3 Z. 12 lit. b ASVG) and the red box (§31 Abs. 3 Z. 12 lit. a ASVG). In the red box, all medicines that applied for inclusion into the EKO are listed. The decision on inclusion in the green or yellow boxes is taken within 90 or 180 days (in case of pricing and reimbursement). In case of a negative decision, the medicine will be delisted from the red box. The yellow box includes medicines, which fulfil certain criteria (e.g. specific disease or age group). For medicines in the red and the yellow boxes, an ex-ante approval of a sickness fund 'chief physician' has to be sought by the prescribing doctor. In the subgroup of the light

[238] 'Wie Arzneimittelpreise Gebildet Werden'.
[239] Pharmig, 'Rahmen-Pharmavertrag'.

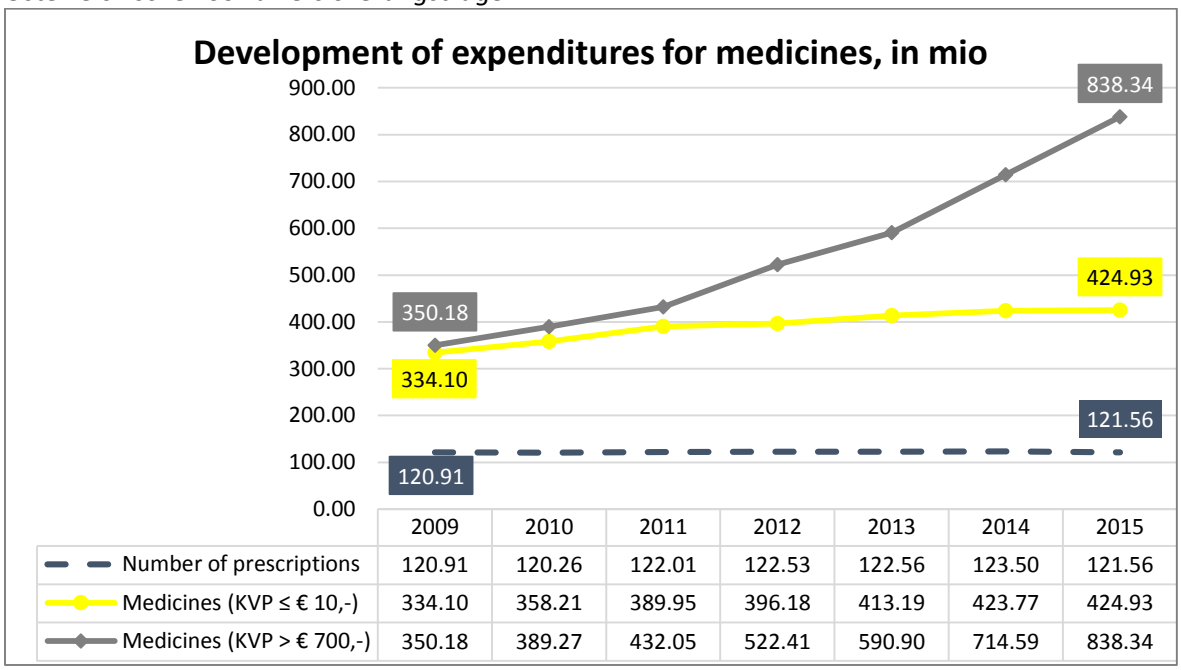
yellow box, an ex-post volume control of the prescribing doctor might take place (instead of an ex-ante approval). The green box includes medicines, qualifying for automatic reimbursement; when prescribed by a contractual physician. Inclusion is based on certain criteria, relating to medicine usage, such as disease group or mode of application. In addition to the positive list, there is a further list, which includes medicines, which are in general not eligible for reimbursement. In 2015, 5.002 pharmaceutical products were listed in the EKO. Figure 92 indicates the green and yellow categories of the EKO.

Figure 92: Erstattungskodex, own illustration, based on Leistungsbericht 2015, Hauptverband der Österreichischen Sozialversicherungsträger.



In addition to the aforementioned boxes, it is important to explain the so called No-Box medicines. These are medicines where the pharmaceutical company does not ask for inclusion in the EKO, or the medicine has not been included or deleted from the EKO. By doing so, the companies are not bound to the specific rules for the inclusion in the positive list of the EKO. The companies are thus allowed to charge market prices. This could be one reason for the cost increase in the last years. With regard to the new price regulation, reference is made to the comments under 17.1.4.

Figure 93: Development of expenditures for medicines, own illustration, based on Hauptverband der Österreichischen Sozialversicherungsträger.



	2009	2010	2011	2012	2013	2014	2015
Number of prescriptions	120.91	120.26	122.01	122.53	122.56	123.50	121.56
Medicines (KVP ≤ € 10,-)	334.10	358.21	389.95	396.18	413.19	423.77	424.93
Medicines (KVP > € 700,-)	350.18	389.27	432.05	522.41	590.90	714.59	838.34

Figure 93 shows the development of expenditures for medicines in Austria since 2009. The growth rate for medicines with a KVP under €10 is 27.19% compared to medicines with a KVP over €700 with a growth rate from 139.40%.

Referring the reimbursement of medicines in Austria, medicines are either fully reimbursed, or not reimbursed at all. If medicines are reimbursed, patients have to pay a fixed prescription fee out-of pocket, amounting to € 5.85 (01.01.2017) per package. In 2008, the prescription fee has been statutorily capped. This means that all beneficiaries spend no more than 2% of their net annual income on medication. Vulnerable groups (e.g. people with infectious diseases, pensioners with compensatory allowance, civil servants, and children who are covered under a parent's policy) are exempt from the prescription fee.

The volume control, the prescription volume, and the pattern of general practitioners and specialists are monitored by the individual sickness funds, with view on their compliance with the HVSV's Guidelines on the economic prescription of medicines and therapeutic aids (RöV). The RöV encourages doctors to prescribe the most economic medicine out of several therapeutically similar alternatives.[240]

[240] WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, 'Short PPRI / PHIS Pharma Profile'.

In 2015, the following requests by pharmaceutical companies were submitted to the HVSV:

- 293 requests for inclusion in the EKO
- 17 requests to change the usage of pharmaceutical products, already included in the EKO
- 14 requests to change the packaging size of pharmaceutical products, already included in the EKO
- 31 requests for exclusion from the EKO
- 10 requests for price elevation of pharmaceutical products, already included in the EKO.

An additional 266 proceedings were initiated by the HVSV. The drug-evaluation-commission (=Heilmittel-Evaluierungs-Kommission) recommends inclusion and exclusion, as well as change of prescription of pharmaceutical products to the general management. For 1.012 pharmaceutical products, the commission was able to negotiate price reductions that amounted in savings of € 51.68 Mio (based on retail prices).[241] The following requests/proceedings, according to VO-EKO were presented to the drug-evaluation-commission:

Table 37: Number of Products per EKO-Category, own illustration, based on Leistungsbericht 2015, Hauptverband der Österreichischen Sozialversicherungsträger.

Number of products	Group
5	Red category
237	Green category
116	Yellow category
55	Proceeding initiated by federation – change of prescription or exclusion

Outpatient medicine expenditures, in Austria

At present, rising medicine costs are a worldwide concern, and Austria has to deal with this issue, too. A study from the HVSV describes the dynamics of drug expenditures in the out-patient sector, since the introduction of the current reimbursement system, in 2005 (important: at the first ATC level).

While outpatient drug expenditures increased significantly from 2006 to 2008, only a moderate rise occurred from 2009 to 2013. In 2014, the expenses started to rise again considerably, with the ATC levels J (antiinfectives), L (antineoplastics and immuno-modulators) and B (blood and blood forming organs)

[241] Hauptverband der österreichischen Sozialversicherungsträger, 'Leistungsbericht 2015'.

being the main cost drivers. Apart from that, one notices that the expenditures for the ATC group L have been growing steadily for the past 10 years, increasing 33% alone from 2011 to 2014. ATC group N - being the second largest cost driver - was responsible for increasing drug expenditures up until 2011. This changed after 2011. A further major cost driver with increasingly high expenditures, since 2012, is ATC group B. A significant decrease in expenditures (for example by loss of exclusivity) has recently not occurred, except in 2013 (ATC group C – cardiovascular system). The current rise is strongly dominated by the new drugs to treat hepatitis C (part of group J), followed by direct oral anticoagulants.

Due to this high-priced medicines, pharmaceutical expenditures in the out-patient sector are recently increasing. In 2014, 0.4% of the prescriptions were responsible for almost 26% of the total costs. This in combination with a weak economic growth, has been stressing the health care budgets in Austria, as well as high-priced medicines, which are in the pipelines of the pharmaceutical companies.[242]

4.3.8 BeNeLuxA – collaboration on procurement of pharmaceuticals for rare diseases

Facing the mentioned concern, this initiative is planning to jointly negotiate prices for medicines for rare diseases which was initiated by Belgium and the Netherlands (April 2015), and was later joined by Luxembourg (September 2015) and Austria (June 2016).

This group of countries, known as 'BeNeLuxA', intends to collaborate more closely across a range of areas: health technology assessment (HTA); horizon scanning; exchange of information on pharmaceutical markets, prices and disease-specific cross-border registries; and pricing and reimbursement, including joint negotiation. The ultimate aim is to ensure access to innovative drugs, initially orphan drugs, at affordable prices for the respective population. By being able to present a bigger patient pool to pharmaceutical companies, it is hoped to increase purchasing power. For the future it is envisaged that even more countries will join the initiative.

This pilot-project followed the difficult national negotiations over certain high-priced drugs, such as for instance, the Hepatitis C drug sofosbuvir. Through better sharing of information and closer collaboration, it is believed that governments could obtain reduced, but fair prices. For the pharmaceutical industry the

[242] Hauptverband der Österreichischen Sozialversicherungsträger, 'Dynamics of Public Outpatient Drug Expenditures in Austria, 2005-2015'.

benefit is direct access to a larger patient population and more streamlined market access, as they only need to provide one dossier, not one per country, managed in a coordinated decision process. This coordinated procurement relies on a set of principles: setting clear, common goals; being clear on the mutual benefits; a pragmatic approach, focusing on the desired outcomes, and having a lean organizational structure; understanding that cooperation is not the solution to all problems; voluntary participation; and a strong political will. The project has no fixed 'roadmap': the degree of collaboration depends on what is required with a stepwise approach to participation.[243]

4.3.9 Outlook

In order to counteract the trend of overpriced medication, the rules need to be changed on all levels in favour of a solidarity-based financed health system (applying to Austria, Europe, and internationally). In particular, an effective purchasing role on behalf of the contributors must be granted to social security, in the future. Above all, more transparency has to be provided. Through the project "European Integrated Price Information Database", the HVSV uses the possibility to exchange list-prices of involved member states. The average price is only a theoretical price, since individually negotiated discounts are not considered and the real prices paid by the states, are significantly lower than the list prices. To evaluate EU average prices at frequent intervals would be a benefit to profit from price reductions. One step towards a joint purchase on the European level was made with the „Joint Procurement Agreement". Through this agreement, in case of a cross-border health risk, synergy effects can be used, and therefore the negotiating power vis-à-vis the pharmaceutical industry can be increased.

[243] World Health Organization, 'How Can Voluntary Cross-Border Collaboration in Public Procurement Improve Access to Health Technologies in Europe?'

The following table shows the list of countries, who have signed the Joint Procurement Agreement.[244]

Table 38: Countries who have signed the Joint Procurement Agreement

Date	Country
18. April 2016	Germany
19. February 2016	Austria
22. September 2015	France
19. June 2015	Ireland
10. December 2014	Denmark, Lithuania
12. November 2014	Hungary
16. October 2014	Italy
23. September 2014	Romania
26. June 2014	Luxembourg
20. June 2014	Belgium, Croatia, Czech Republic, Cyprus, Estonia, Greece, Latvia, Malta, Netherlands, Portugal, Slovakia, Slovenia, Spain, United Kingdom

Another good-practice project is the described cooperation of the Benelux countries and Austria in the field of medication for rare diseases, where joint negotiations with the pharmaceutical industry are conducted.

[244] European Commission, 'Joint Procurement Agreement - List of EU Countries - European Commission'.

5 Public health and disease management

5.1 Prevention, promotion and health literacy[245]

Health promotion and prevention in Austria ensues in accordance with the WHO model, i.e. is designed to promote health first and foremost via self-determination, aiming to engage the individual to improve their own health by living healthily[246]. Moreover, a holistic approach in line with Health in all Policies is being undertaken. For instance, the intersectional project "Healthy Schools" represents a joint health-promotion-measure, which is supported by the Federal Ministry of Health and Women's Affairs, the Federal Ministry for Education, the Arts and Culture and the Federation of Austrian Social Security Institutions (for more information, please visit *www.gesundeschule.at*).

In general, prevention is aimed at averting illnesses and counteracting the spreading of disease. There exist three types of prevention, which are differentiated according to the point in time when the preventive intervention takes place: Primary prevention takes place prior to the disease, i.e. it assists in eliminating health-damaging factors, and includes for example measures in connection with hygiene, vaccinations, or preventive measures during pregnancy[247]. In comparison, secondary prevention is focused on intervening existing health-damaging situations. Procedures in the area of secondary prevention include for example the detection and treatment of pre-clinical pathological changes. Tertiary prevention concentrates on restoring health after the medical condition occurred and hence refers to the management of long-term or ongoing illnesses to avoid re-hospitalization. As a result of tertiary prevention, consequential health-damages may be prevented and the rehabilitation of patients facilitated[248].

With regard to health promotion, one distinguishes between two levels of interventions: The first focusses on individuals' health-enhancing behaviors and the second aims to create external conditions that are

[245][245] Primary sources of data for this section are: Bundesministerium für Gesundheit und Frauen, 'Gesundheitsförderungsstrategie Im Rahmen Des Bundes-Zielsteuerungsvertrags'. Bundesministerium für Gesundheit und Frauen, 'Öffentliche Ausgaben für Gesundheitsförderung und Prävention in Österreich 2012'. Gesundheit Österreich GmbH, 'Menschen Mit Migrationshintergrund Besser Erreichen'. Hofmarcher and Quentin, 'Health System Review', 2013. Rohrauer-Näf and Waldherr, Leitbegriffe Der Gesundheitsförderung Und Prävention: Gesundheitsförderung in Österreich.

[246] Hofmarcher and Quentin, 'Health System Review', 2013.

[247] Hurrelmann, Klotz, and Haisch, *Lehrbuch Prävention Und Gesundheitsförderung*.

[248] Sindler, 'Kann die medizinische Vorsorgeuntersuchung durch verhaltensorientierte Angebote der Gesundheitsförderung ergänzt und verbessert werden?'

health-promoting on a broader spectrum[249]. Measures taken to improve the conditions in terms of second level promotion are for example creating and implementing infrastructure for exercise programs, whereas an example for level-one promotion would be nutrition counseling[250].

5.1.1 The governance of promotion and prevention: The role of ministries and health institutions

In Austria, the essential stakeholders for promoting health are, the Federal Ministry of Health and Women's Affairs (BMGF, *http://www.bmgf.gv.at/*), the social security institutions directed by the Federation of Austrian Social Security Institutions (HVSV, *http://www.hauptverband.at/),* the Fonds Gesundes Österreich (i.e. Healthy Austria Fund, FGÖ, *http://www.fgoe.org/)* which forms part of the Gesundheit Österreich GmbH (i.e. GÖG *http://www.goeg.at),* AGES (Austrian Agency for Health and Food Safety) *(https://www.ages.at/),* civil society organizations, church bodies, the Austrian Network on Workplace Health Promotion *(http://www.netzwerk-bgf.at),* as well as several research institutes[252].

As the highest federal authority with respect to healthcare, the *Federal Ministry of Health and Women's Affairs* (BMGF, which took over the agenda on Women's affairs, in 2016) is in charge of liaising with the social security funds and professional bodies alike, and controls the adherence to laws which protect the healthcare in Austria. The BMGF orchestrates the Federal Health Agency (Bundesgesundheitsagentur, BGA), which is established as a public-law fund with separate legal entity and builds the central structure for planning, steering and financing the Austrian healthcare sector on the federal level. Besides, there are several advisory boards and commissions at the BMGF's disposal, which are relevant for prevention of disease and promotion of healthcare, for instance the National Nutrition Commission. The BMGF's main funding focus in 2017 is set upon supporting measures for children and adolescents, preventing and fighting infectious diseases (e.g. HIV, Aids, Hepatitis A and B), as well as intercultural, female and gender-specific health promotion and prevention[253]. To fulfill its tasks, the BMGF is subdivided into four departments, with activities in Section I referring to the healthcare system and its central coordination[254]. This also includes coordinating international healthcare policies, collaborating with the WHO and the

[249] Hurrelmann, Klotz, and Haisch, *Lehrbuch Prävention Und Gesundheitsförderung*.
[250] Sindler, 'Kann die medizinische Vorsorgeuntersuchung durch verhaltensorientierte Angebote der Gesundheitsförderung ergänzt und verbessert werden?'
[251] Hofmarcher and Quentin, 'Health System Review', 2013.
[252] Ibid.
[253] Bundesministerium für Gesundheit und Frauen, 'BMGF Förderung Für Gesundheitsförderung'.
[254] Hofmarcher and Quentin, 'Health System Review', 2013.

European Parliament. A further area of responsibility for Section I is to develop guidelines for the allocation of resources, in order to reform pools, and to realize healthcare-related projects. This means the BMGF's Section I is responsible for determining the finances of preventive and promotive healthcare projects. Section II is mainly concerned with legal matters and consumer health protection, which relating to promotion and prevention is particularly important with respect to legislation on tobacco, alcohol and substance-independent addiction, as well as food safety. In addition, the Section III concentrates on public health service and medical issues, and Section IV centers on female affairs and gender equality. Within Section III, Department 6 focuses on health promotion and disease prevention. In line with this, there have been several target-specific undertakings on the federal level, which emphasize health-promotion with respect to subgroups; for instance measures explicitly aimed at women, socially disadvantaged groups, or children, such as 'Eat right from the start' (*http://www.richtigessenvonanfangan.at/home/)*, which is a joint initiative between AGES, BMGF and the HVSV. The multilingual internet platform combines detailed information and advice on nutrition for pregnant or breast-feeding women, babies and toddlers. In detail Section III, Department 6 includes the following fields of responsibilities[255]:

- Matters relating to health-promotion and primary prevention
- Coordination, strengthening and development of inter-policy collaborations in the sense of Health in All Policies (HiAP), which has been applied, for instance, in connection with the 'National Nutrition Action Plan', or the 'Child Health Research' initiative[256].
- Coordination of the National Health Goals (Gesundheitsziele Österreich); health-promotion and prevention in relation to the agenda of the Health Targets (including expert-groups on Public Health/Health Promotion, and the Health Promotion Strategy)
- Health competency (including the platform *www.oepgk.at*)
- Health impact assessment
- Matters relating to sports and exercise, including the national action plan exercise
- Accident prevention
- Matters relating to dental health
- Occupational health promotion
- Health promotion in schools

[255] Bundesministerium für Gesundheit und Frauen, 'BMGF Geschäftseinteilung'.
[256] Hofmarcher and Quentin, 'Health System Review', 2013.

- HBSC-Study
- National and international network for health-promoting hospitals and healthcare institutions including the WHO-cooperation center for health promotion in hospitals and healthcare
- Coordination-unit for prevention-funding of the Federal Health Agency.

With respect to the *social security institutions*, the General Social Security Act (Allgemeines Sozialversicherungsgesetz, ASVG) constitutes in §116 that the promotion of health is an obligatory responsibility for Austrian social security carriers[257]. In addition, there are statutory regulations for voluntary promotion- and prevention-actions, which may be undertaken by the social security carriers, depending on their financial capacity. Social insurance carriers play an important role in health promotion and prevention by performing health check-ups, structured treatment programs and programs to reduce tobacco consumption. The social security carriers are represented by an umbrella organisation, the *Federation of Austrian Social Security Institutions* (HVSV), which also undertakes numerous tasks in health prevention. In 2012, 3.1 % of the total expenditures for healthcare in Austria accounted for promotion and prevention, resulting in approximate costs of €750 million (excluding tertiary prevention). 72.5% of these costs were covered by social security carriers, 15.9% by the federal government (including the FGÖ), 9.3% by the Länder, and 2.3% by the municipalities. If tertiary prevention is included, these proportions vary slightly in that the overall €2.019 billion were funded to 87.1% by the social security carriers, 5.9% by the federal government, 6.1% by the Länder, and the municipalities had a stake of 0.9%[258].

The *Healthy Austria Fund* (FGÖ) forms part of the national research and planning institute *Gesundheit Österreich GmbH* (GÖG), and undertakes numerous tasks related to health promotion and prevention. It operates information campaigns about such topics as exercising, nutrition and psychological or cardiovascular health. The predominant target groups are children and young people in their extracurricular hours, working people in small and medium-sized businesses and older people. The FGÖ is partly funded by financial means deriving from VAT and has an annual budget of €7.25 million[259]. The GÖG's sole proprietor is the federal government; its field of activities is subdivided into three divisions, the aforementioned *FGÖ, ÖBIG* and the *BIQG*. The ÖBIG (i.e. Austrian Federal Institute for Health)

[257] Allgemeines Sozialversicherungsgesetz - §116 Aufgaben.
[258] Bundesministerium für Gesundheit und Frauen, 'Öffentliche Ausgaben für Gesundheitsförderung und Prävention in Österreich 2012'.
[259] Hofmarcher and Quentin, 'Health System Review', 2013.

performs scientific research and planning, exclusively on behalf of the federal government. The BIQG's (i.e. the Federal Institute for Quality in the Health Service) field of responsibilities involves the development, implementation and continuous evaluation of the quality regarding the Austrian health-system. By doing so, the BIQG monitors the adherence to the main principles patient-orientation, transparency, effectivity and efficiency. Furthermore, the GÖG has two subsidiaries, the GÖG FP which undertakes scientific research and planning and is organized as a not for profit unit. The second subsidiary is GÖG B, which is as a for profit consultancy. Additionally, the GÖG also works within the area of the BGA-funds (Bundesgesundheitsagentur/BGA-Mittel), where the BMGF solely represents the place of business, rather than holding the directive authority over GÖG.

AGES is the Austrian Agency for Food and Health Safety with more than 1400 experts working on various tasks in the field of food safety. Its research and work is based on the Food Hygiene and Consumer Protection Act. AGES is separated into five strategic areas (food security, food hygiene, animal health, public health, monitoring of the medicines market) and three applicable fields (data, statistics & integrative risk assessment; radiation protection; knowledge transfer & applied research)[260].

Civil society organizations and church bodies bear high responsibilities related to healthcare in Austria. In fact, many hospitals belong to either the Catholic or Evangelical church. Healthcare is one out of six areas of services, which the Austrian church is involved in. Also, the church employs a significant amount of full-time staff in this area.

The Austrian Network on Workplace Health Promotion is dedicated to raising awareness of workplace health promotion through centres of expertise in the Länder and constitutes a very important actor in the current development of occupational health. The network is formed by a combination of federal institutions, social security institutions, the FGÖ and further social partners.

[260] Ibid.

5.1.2 The framework for health promotion and prevention

In 1998, the Health Promotion Act (Gesundheitsförderungsgesetz, 1998) was passed, which was guided by the Ottawa Charta of the WHO[261]. In order to implement the Health Promotion Act 1998, the Fonds Gesundes Österreich, FGÖ was initiated by the joint efforts of the federal government, the Länder, and the municipalities. The FGÖ represents the national competence centre and central funding office for health promotion and prevention, and figures as one of three business units of the Gesundheit Österreich GmbH (GÖG).

On the federal level, the BMGF's health promotion and prevention department, as well as the social insurance institutions play major roles in setting the strategic framework[262]. On a regional level, the prevention- and health-promotion institutions of the Länder impact the settings of healthy schools and healthy municipalities. Beyond this, there exists a complex structure of organisations and persons fostering promotion and prevention. Moreover, the *Healthcare Reform 2013* strengthened the promotion of health and the collaboration between the actors (in particular regarding the interaction between federal and regional levels), and assisted in achieving a more comprehensive implementation of health-centred policies. In accordance with this, the *National Health Goals* (Gesundheitsziele Österreich, which were formerly known as the Rahmengesundheitsziele) were established, which are meant to set the guidelines for a health-political orientation, valid for the next 20 years. Their envisaged objective is to raise life-expectancy by two healthy years by 2030[263]. In specific terms, the ten targets of the National Health Goals are:

1. To provide health-promoting living and working conditions for all population groups through cooperation of all societal and political areas.
2. To promote fair and equal opportunities in health, irrespective of gender, socio-economic group, ethnic origin and age.
3. To enhance health literacy in the population.
4. To secure sustainable natural resources such as air, water and soil and healthy environments for future generations.
5. To strengthen social cohesion as a health enhancer.

[261] WHO, 'Ottawa Charta Zur Gesundheitsförderung'.
[262] Rohrauer-Näf and Waldherr, *Leitbegriffe Der Gesundheitsförderung Und Prävention: Gesundheitsförderung in Österreich*.
[263] Hofmarcher and Quentin, 'Health System Review', 2013.

6. To ensure conditions under which children and young people can grow up as healthy as possible.
7. To provide access to a healthy diet for all.
8. To promote healthy, safe exercise and activity in everyday life through appropriate environments.
9. To promote psychosocial health in all population group.
10. To secure sustainable and efficient healthcare services of high quality for all[264].

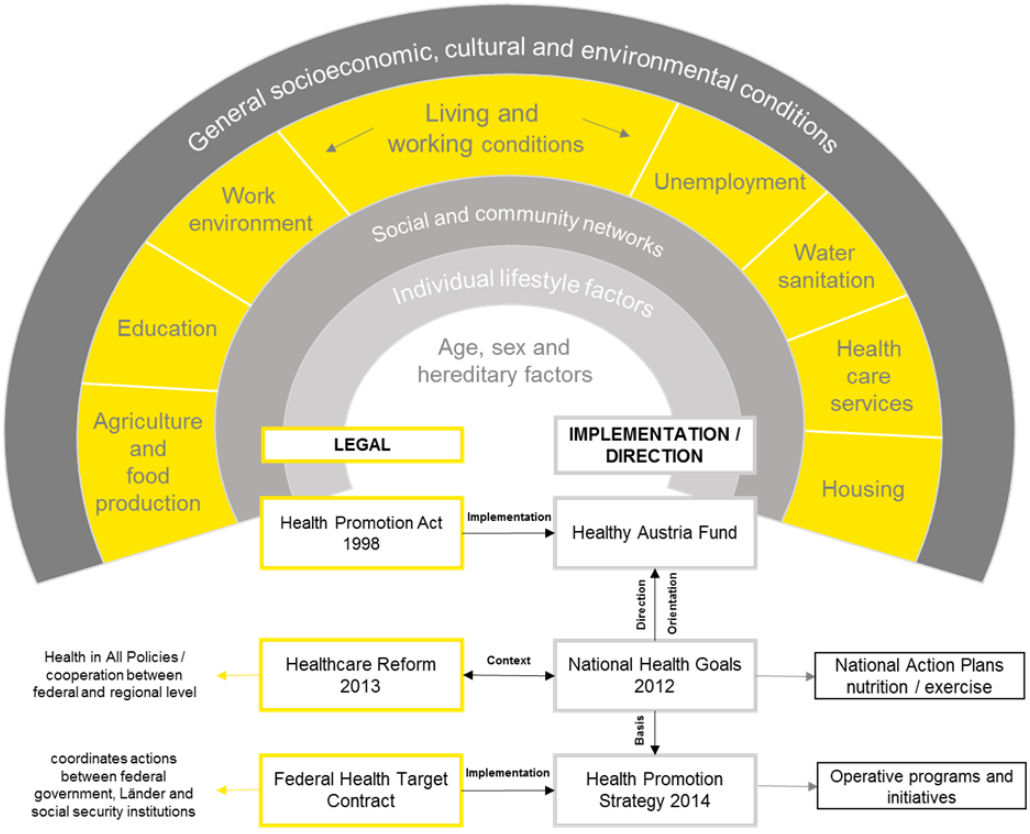
In addition, the National Health Goals served as basis for the Health Promotion Strategy, which forms part of the *Federal Health-Target Contract* (Bundes-Zielsteuerungsvertrag). One of its main objectives is to align actions between the federal government, the Länder and the social insurance institutions[265]. In March 2014, the *Health Promotion Strategy* was created, in order to strengthen health-promotion and primary prevention, to enable cooperative lines-of-action between the federal government, the Länder and the social insurance carriers. Thus, the Health Promotion Strategy aims at building a framework, which aligns goal- and impact-driven, as well as quality-assured actions. Its content is based on the National Health Goals, the health goals of the Länder (Landesgesundheitsziele), as well as the Federal Health-Targets (Zielsteuerung Gesundheit), putting emphasis on inter-disciplinarity and thus the adherence to the principles of "Health in All Policies"[266]. It defines all fields of intervention, in which health-promotion and primary prevention shell be implemented and for which the financial means of the *Länder Health Promotion Funds* (i.e. Landesgesundheitsförderungsfonds, LGFF) and the financial means for prevention of the Federal Health Agency (Bundesgesundheitsagentur, BGA) are to be spent during the period between 2013 and 2022. The strategy's scope is thus twofold: on the one hand it serves as basic guideline for contractual partners regarding health-promotion activities in Austria. On the other hand, it defines mandatory targets for the allocation of financial resources[267]. Its overall objective is to contribute to a longer, self-determined, healthy life for all people in Austria. In more detail, the objectives are as follows:

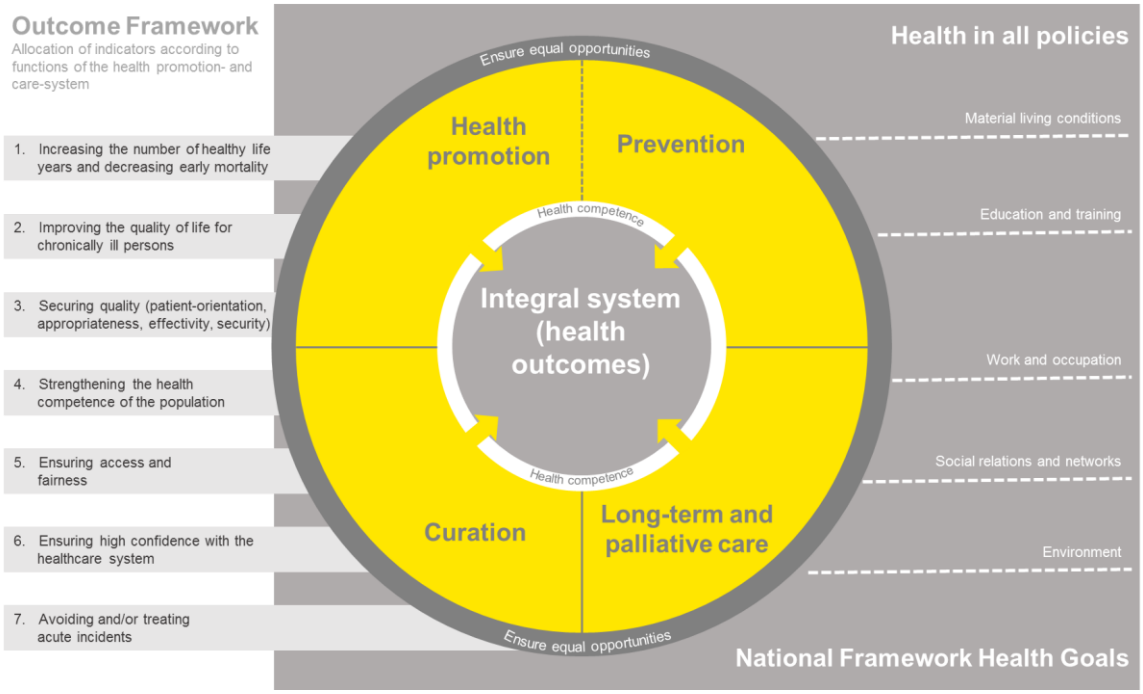
- Supporting the implementation of the National Health Goals, the health goals of the Länder, as well as the topics regarding the promotion of health, found in the Federal Health-Targets.
- Strengthening and developing the over-arching political collaboration with respect to "Health in All Policies".

[264] Bundesministerium für Gesundheit und Frauen, 'Health Targets Austria'.
[265] Rohrauer-Näf and Waldherr, *Leitbegriffe Der Gesundheitsförderung Und Prävention: Gesundheitsförderung in Österreich*.
[266] Bundesministerium für Gesundheit und Frauen, 'Gesundheitsförderungsstrategie Im Rahmen Des Bundes-Zielsteuerungsvertrags'.
[267] Ibid.

- Supporting a broad and aligned approach in the area of health-promotion
- Contributing to the quality development in the area of health-promotion
- Contributing to the capacity building in the area of health-promotion
- Spreading best practice examples.

Figure 94: The Framework for Health-Promotion and Disease Prevention in Austria, own illustrations, based on Whitehead and Dahlgren (1992) and GÖG.





5.1.3 The Austrian situation regarding health promotion, prevention and literacy

In 1974, the *Preventive Screening Program* was initiated in Austria, aimed at reducing health-related risk factors (i.e. primary prevention), as well as detecting diseases early (i.e. secondary prevention). This may count as one of the factors that led to an average increase in the life expectancy of women and men by seven and eight years, respectively. Due to this initiative, every person living in Austria has access to annual basic check-ups free of charge, irrelevant whether the person is insured or not (in case the person is not insured, the local regional-health-insurance carrier bears the costs).

The contents for these preventive check-ups were developed in collaboration between the Federation of Austrian Social Security Institutions and the Austrian Medical Chamber, have been in place since 2005 and contain the following gender-specific medical program-points[268]: Anamnesis, a comprehensive physical health examination, blood pressure & Body-Mass-Index, blood tests (including blood sugar level, cholesterol, triglyzerides, gamma-gt) & urine analysis (leukocytes, protein, glucose, nitrites, urobilinogen, blood), haemoccult-test, for women a smear test and for men a prostate examination, and a final discussion of the health results and consequences[269]. A more recent addition to the preventive screenings

[268] Federal Ministry of Health and Women's Affairs, 'BMGF Preventive Check-Ups'.
[269] 'Öffentliches Gesundheitsportal Österreich'.

are for instance periodontal examinations, colonoscopy, and the introduction of lifestyle-medicines.[270] These novel features were developed in collaboration between the HVSV, the BMGF and the Austrian Medical Association and comprising support with respect to changing to a form of lifestyle that endorses health-benefits, including the key-topics nutrition, exercise and smoking. In order to analyze these, the parameters Body-Mass-Index, the total and HDL-cholesterol levels are measured. Modifications of the screening program also involve the emphasis of the GP's role as consultant; and an invitation system which contacts groups of insured persons, who are at risk, below 40 years of age every three and above 40, every two years; as well as a new systematic and standardized approach to documenting and evaluating the check-ups, also in connection with recognizing health-risks, especially with regard to the cardiovascular system, cancer or diabetes. Consequently, the anamnesis and structured documentation are essential[271].

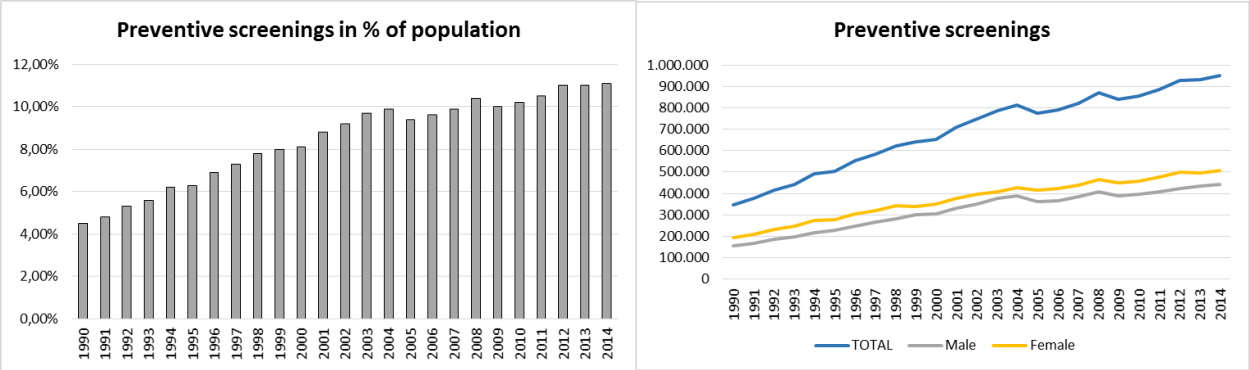
Connected to this, a report published in 2014 emphasizes that setting varied and non-monetary incentives for physicians may be advantageous. These non-monetary incentives might take place in form of quality improvement measures, creating new learning cultures, improved support due to service coordination and extended IT equipment, or via establishing a strong brand, based on professional reputation and transparency.[272] In relation to setting incentives to advocate promotion and prevention, the Diabetes disease management program 'Therapy Active' (*http://diabetes.therapie-aktiv.at*) successfully incentivizes hospital staff by offering administrative software- and program-trainings. Besides, the partaking physician is perceived as an expert within the field of counselling patients with Diabetes and therefore may enhance his public image considerably.

Figure 95 shows the growth in preventive screenings over the past 25 years. This demonstrates that there has been an improvement, starting from about 4% in 1990 to approximately 11% in 2014. However, growth has been stagnating since 2012, levelling at around 11% for three years in a row. Moreover, on average the Austrian population undergoes preventive screenings only every three years, reaching a total

[270] Laut Hauptverband der österreichischen Sozialversicherungsträger hat die Lebensstilmedizin zum Ziel, Menschen über einen gesundheitsfördernden Lebensstil aufzuklären und sie bei der Umsetzung zu unterstützen. Diese Fachrichtung fokussiert hauptsächlich auf Themen wie Ernährung, Bewegung und Rauchen.
[271] Hauptverband der österreichischen Sozialversicherungsträger, 'Vorsorgeuntersuchung Neu'.
[272] Hauptverband der österreichischen Sozialversicherungsträger, 'Gutachten Zur Gestaltung Nicht-Monetärer Anreize Für Ärztinnen Und Ärzte'.

of only about 40% of the population[273]. In addition, there is a gender-related trend in that more females are making use of preventive screenings. To increase participation regarding the screening program, an invitation system has been installed, which in particular is aimed at addressing people with increased health-risks. The screenings evaluated in Figure 95 are the before mentioned screening-points, not accounting for the gender-specific tests[274]:

Figure 95: Utilization of Preventive Screenings in Austria from 1990 - 2014. Own illustration, based on datafrom HVSV.



The most recent comprehensive calculations regarding *public expenditures on promotion and prevention* were undertaken by the GÖG, in 2016, based on data derived for 2012[275]. This report indicates that the overall combined expenditures on health promotion and prevention of the national public bodies and competent authorities (being the federal state incl. the FGÖ, the Länder, the municipalities and social insurance institutions) amounted to a total sum of €2.019 billion. Taken on a per-capita level, this amounts to €239.65 and represents a share of 8.3% of all current expenditures on health, undertaken by the Austrian federal government[276].

This sum includes expenditures on all levels, that is, promotion (2.7%), primary- (12.4%), secondary- (12.4%), as well as tertiary-prevention (72%) and capacity building (0.3%), i.e. progressing the infrastructure for promotion and prevention. Further findings of this report include that the lion share of these expenditures was covered by the social insurance which contributed with 87.1%. In comparison, the

[273] 'Hauptverband'.
[274] Ibid.
[275] Bundesministerium für Gesundheit und Frauen, 'Öffentliche Ausgaben für Gesundheitsförderung und Prävention in Österreich 2012'.
[276] Ibid.

federal state (including the FGÖ) covered 5.9% of expenses, whereas the Länder spent 6.1% and the municipalities 0.9%[277].

In more detail, expenditures on *health promotion* were found to be predominantly spent on informing, including the topics communication and education, followed by health promotion activities within the setting 'healthy schools' and the setting of municipalities. Within *primary prevention*, the topics avoidance of illness and accidents and activities for a healthier lifestyle received the prime attention; further, the prevention of addictions and the prevention of communicable diseases were attended to. In more specific terms, the top positions of primary prevention were: oral health promotion and preventive dental care, immunizations, and accident prevention at work / prevention of work-related illnesses. The expenditures within the area of *secondary prevention* were allocated to: first, preventive medical-check-ups according to social insurance law; second, the national Mother-Child-Health Program (examinations for pregnant women and their children); and third, expenditures on school health (also comprising medical screenings). Expenditures on *tertiary prevention* received the largest share, out of which the lion part was spent on medical rehabilitation, followed by medical cures. In comparison with the last comprehensive calculations in 2001, which recorded €1.03 billion public expenditures within promotion and prevention, the expenditures have approximately doubled, by 2012[278]. This exceeds the general development of current Austrian health expenditures by far, which increased by an in comparison more modest 59.4%[279]. For a detailed outline of the level of intervention and associated definition of topics with respect to health-promotion and prevention, please see Figure 96.

Figure 96: Definitions and Topics regarding Promotion and Prevention, own illustration based on BMGF/GÖG, 2016.

Level of intervention	Definition	Topic
Core area		
Health promotion	a target group specific approach which starts at certain settings (living environments) and targets health promotional changes both	• family/ home environment • healthy kindergarten and healthy nursery • healthy schools and other education institutions • workplace health promotion • healthy Commune / City • leisure and consumer world

[277] Ibid.
[278] Ibid.
[279] Statistik Austria, 'Gesundheitsausgaben nach System of Health Accounts für Österreich'.

Level of intervention	Definition	Topic
	at the behavioural and the relational level	• health promotion in public institutions • health information/ health literacy • opportunities for participation and self-help • other
Primary prevention	is directed, within the meaning of a disease prevention, to prevent, reduce the likelihood or delay certain health damages, diseases or accidents trough targeted activities	
Primary prevention 1	promotion of a healthy lifestyle or prevention of diseases and accidents	• dental health • health of parents and children • psychosocial health • accident prevention (leisure/ household) • prevention of accidents at work and work-related illnesses • occupational medicine/ organisational health promotion measures of employers • nutrition and exercise for disease prevention • substitute or respite care • other
Primary prevention 2	avoidance of the emergence of addictions	no thematic subdivision
Primary prevention 3	prevention of communicable diseases	• vaccinations • TB-prevention • HIV/ hepatitis C • Other
Primary prevention 4	health protection	• hygiene • monitoring of medical products • radiation protection • food and drinking water inspection • other
Secondary prevention	early detection of existing illnesses or risks of illnesses and early intervention to contain disease progression / chronification	• mother-and child-passport • new-born-screening • infant examinations • school doctor examinations • adolescents examinations • eye and hearing test • early detection of cancer • preventive examinations according to the social security act • other preventive examinations • smoking cessation • weight reduction programs • measures and programs to prevent/ delay work-related illnesses • programs to prevent/ delay the need for care • disease-management programs (DMP) • other

Level of intervention	Definition	Topic
Tertiary prevention	delay of the course of a disease (after manifestation or treatment), avoidance of relapses and reduction of consequential damages	• (medical) rehabilitation • stabilization of health, treatment at a health resort or health prevention (especially of retirement pension insurances) • short-term-care / rehabilitation / transitional care • other
Capacity building	expenses used for the implementation and improvement of structures for health promotion and prevention	• further development of practitioner's knowledge and skills • expansion of the support and the infrastructure for health promotion and prevention in organisation • execution of health effects assessments • other
Supplementary survey – HiAP measures		
HiAP	measures with different principal objectives but which also pursue health promotion and prevention, as one of more or secondary targets within the meaning of a health promotional general policy (Health-in-all-Policies-Approach)	• classification by policy areas

As an example for promotion of health and prevention of disease within the realm of a social insurance carrier, the approach '*Independently healthy*' was undertaken by the SVA (Social Insurance Institution for Commerce and Industry, *http://www.sva-gesundheitsversicherung.at/).* This project's guiding principle is that prevention is better than cure, ascribing a new role to GPs, who are not only caring for their patients in case of illness, but also support their patients with staying healthy. Patients are encouraged to actively participate in this program, with financial incentives being set. In more specific terms, this bonus program means that patients, who achieve all of the health-objectives set in cooperation with the GP, will only have to pay a 10% co-insurance rate instead of 20% for medical and dental treatments. The parameters which define the health-objectives are: Blood-pressure, weight, exercise, tobacco, and alcohol[280].

[280] Sozialversicherungsanstalt der gewerblichen Wirtschaft, 'Selbstständig Gesund: Das Programm - Die Fünf Gesundheitsziele'.

In more general terms, the social insurance institutions predominantly focus on the settings school and companies. To a less significant degree, prevention measures are targeted at the communal and individual level, yet. At this level, the main focus lies on supporting measures - relating to nutrition, exercise, stress, oral health, and reducing tobacco consumption via e.g. the 'smoker quitting hotline', which was set up in 2006 in cooperation between the federal authorities and the social security institutions[281]. In addition, preventive occupational health provision in Austrian companies is defined by the Employee Protection Act, which outlines the extent of safety requirements at the workplace. This includes measures like the nomination of a corporate health-and-safety representative, and the deployment of medical personnel, depending on the size of the firm. In order to comply with this act, small businesses (i.e. up to a maximum of 50 employees; or if the workforce includes apprentices or disabled people up to 53 employees) are offered visits from occupational health physicians and safety personnel, free-of charge by the AUVA (accident insurance institution, *https://www.auva.at/*)[282]. A more general aim of AUVA with respect to health promotion and prevention is to anchor a positive prevention culture at the very core of Austrian companies, which involves partnering with management and staff alike, which is also supported by the work of occupational health physicians. Their fields of responsibilities are defined in the 7th Section of the ASchG (in particular in §§ 81 and 82), which in very broad terms are preventive measures with regard to occupational illnesses, as well as health & safety within the working environment. In order to become an occupational physician, one has to fulfil at least a 12-week specialist training after having finished the medical studies[283].

The tables below give an overview of the allocation of financial assets regarding the Länder Health Promotion Funds (Table 39) and the funds for prevention (Table 40). In 2014, €15 million were spent on the promotion of health by means of the LGFF - Länder Health Promotion Funds. In accordance with §19 G-ZG, aimed at strengthening health-promotion, the funds volume is fixed with €150 million for the period 2013 - 2022, and annually split between the Länder (i.e. receiving in total the combined annual sum of €2 million) and the regional health funds (€13 million per year, in total)[284].

[281] Rohrauer-Näf and Waldherr, *Leitbegriffe Der Gesundheitsförderung Und Prävention: Gesundheitsförderung in Österreich*.
[282] Hofmarcher and Quentin, 'Health System Review', 2013.
[283] Schenk et al., 'AUVA - Basiswissen Arbeitnehmerschutz'.
[284] § 19 G-ZG Stärkung der Gesundheitsförderung, 19.

Within the 15a B-VG-agreement, which contains the organization and financing of the healthcare service (BGBl I 2008/105), it is stated that an annual sum of €3.5 million will be provided for super-regionally significant programs in connection with prevention and treatment measures. In 2010, the ÖBIG was assigned the task to develop a strategy for the allocation of these financial resources with respect to increasing prevention. This strategy was developed in collaboration with experts from the task force Public Health/Health Promotion (which is directed by the BMGF's Section III), and contains the principles for allocating financial means, the criteria for selecting the focal topics regarding prevention, as well as setting quality criteria for eligible measures. Accordingly, for the years 2015 and 2016, €3.5 million (per annum) were distributed. The split of financial resources between the federal government, the Länder and the regional health insurance carriers ensued according to 1/5, 2/5, and 2/5, respectively[285]. These resources were mainly spent on the implementation of primary-prevention measures, including e.g. the joint-financing of breast cancer-screening.

Table 39: LGFF - Länder Health Promotion Funds, own illustration based on BMGF Gesundheitsförderungsstrategie im Rahmen des Bundes-Zielsteuerungsvertrags, 2014.

Annual assets for the LGFF-Länder Health Promotion Funds from 2013 – 2022; (according to Art. 15a B-VG Health-Targets, Art.23)			
Health promotion funds for 2014 (rounded)			
Länder	Total	Funding per Land	Funding per Social insurance**
• Austria	15.000.000	2.000.000	13.000.000
• Burgenland	509.240	67.834	441.406
• Carinthia	1.011.447	131.551	879.896
• Lower Austria	2.911.264	383.221	2.528.043
• Upper Austria	2.490.322	335.732	2.154.590
• Salzburg	961.254	125.945	835.309
• Styria	2.177.007	286.715	1.890.292
• Tyrol	1.266.527	169.193	1.097.333
• Vorarlberg	660.851	88.145	572.705
• Vienna	3.012.088	411.663	2.600.425
** as per resolution of the carrier conference			

[285] Bundesministerium für Gesundheit und Frauen, 'Gesundheitsförderungsstrategie Im Rahmen Des Bundes-Zielsteuerungsvertrags'.

Table 40: Distribution-key for Prevention Funds, own illustration based on BMGF Gesundheitsförderungsstrategie im Rahmen des Bundes-Zielsteuerungsvertrags, 2014.

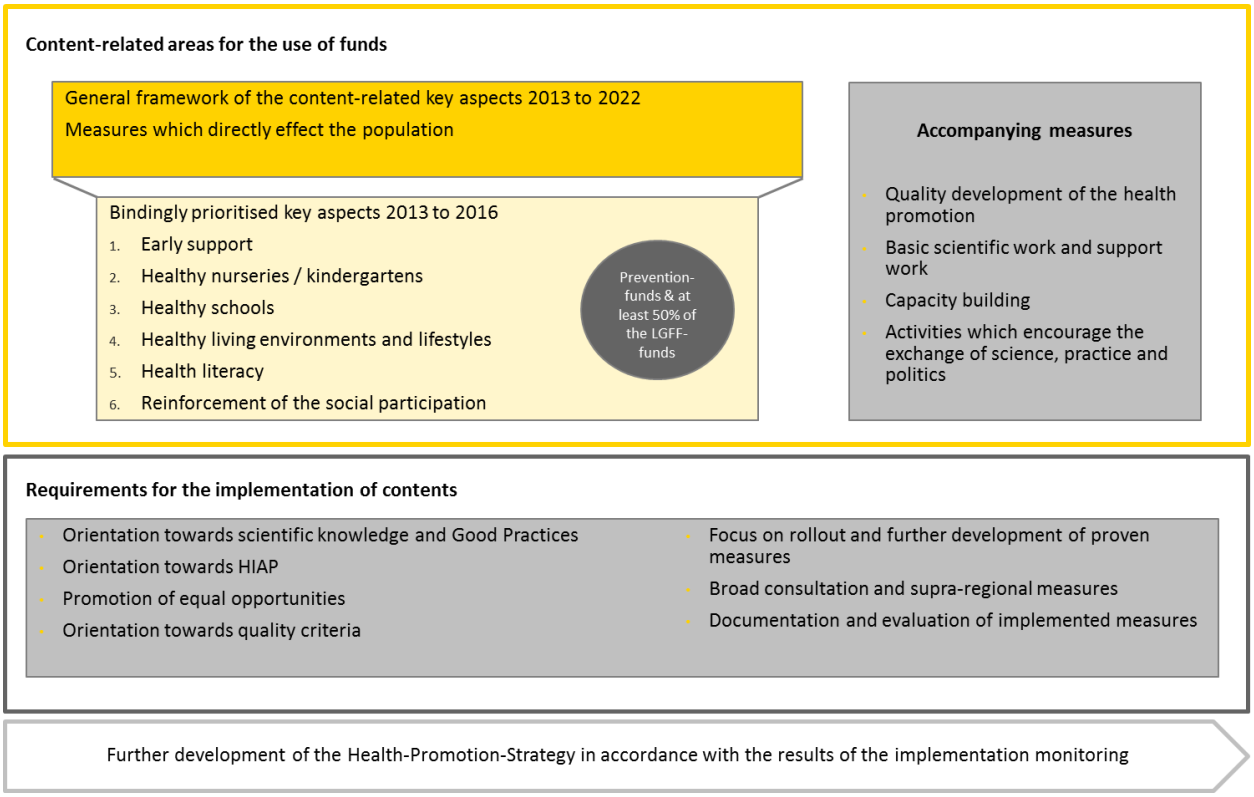
Distribution-key for Prevention Funds; (according to Art. 15a B-VG Organization and Financing of Healthcare, Art. 24, Abs. 65)		
Recipient of funds	Share per curia of the prevention funds	Distribution of funds as defined in article 15a B-VG
federal government	1/5 of funds	
Burgenland	2/5 of funds	0,034
Carinthia		0.068
Lower Austria		0,192
Upper Austria		0.17
Salzburg		0,063
Styria		0.145
Tyrol		0,084
Vorarlberg		0.044
Viennna		0,201
BGKK	2/5 of funds	0.034
KGKK		0,068
NÖGKK		0.192
OÖGKK		0,17
SGKK		0.063
STGKK		0,145
TGKK		0.084
VGKK		0,044
WGKK		0.201

The following six fields of intervention were prioritized for the period between 2013-2016, meaning the financial means of prevention and at least 50% of the health-promotion-fund had to be spent on: early support, healthy nurseries & kindergartens, healthy schools, healthy lifestyle and living environments (for adolescents and working-age persons), health literacy (for adolescents, working-age persons and the elderly), and social participation and psychosocial health (in particular for elderly persons)[286]. For an

[286] Ibid.

overview about the guidelines for allocating resources, please view the content-related guidelines for the use of funds, depicted in Figure 97.

Figure 97: Guidelines for the use of funds, own illustration based on BMGF Health Promotion Strategy-Overview on Principles for Funding, 2014.



In addition, the FGÖ publishes a comprehensive list of current and previous projects which have been funded and undertaken in connection with promoting health and preventing disease (*http://www.fgoe.org/projektfoerderung/gefoerderte-projekte*). These projects can be categorized according to Table 3, with the FGÖ supporting the categories health promotion and primary prevention[287].

A project, which is supported by the GÖG (ÖBIG and FGÖ), is *Early Support* (i.e Frühe Hilfen *http://www.fruehehilfen.at/*). Early Support is an all-inclusive and supra-regional concept for health promotion and early intervention, which offers support to families - in particular during childhood (commencing with

[287] Fonds Gesundes Österreich, 'Leitfaden Zur Projektförderung Des Fonds Gesundes Österreich'.

pregnancy and lasting up until the start of schooling). The interventions take the specific circumstances of the participating families into consideration. The objective is to sustainably improve development and health-related opportunities for children, parents and families, as well as the larger society. Besides offering support in everyday situations or promoting parental skills, the prevention (or reduction) of developmental disorders are important fields of interaction for the project. Furthermore, it safeguards children's right for security, health-promotion and participation, by putting emphasis on an easy and intuitive access. Although multi-professional cooperation is one of the central pillars of this concept, volunteers also play an important role. Due to close collaboration and team-working efforts between supporters, a successful realization of the project objectives can be ensured. Collaboration ensues for example with institutions from the areas of healthcare, pregnancy counselling, interdisciplinary early support, child and youth welfare, as well as parental education. Early Support's objective is to not only improve its nationwide offerings but also the quality of its supply-network. A number of international strategy documents applaud early support measures, as they show high potential for improving health-aspects, as well as health equality. Moreover, international surveys evaluate the project to have a high cost-value ratio. Also, practitioners regard the project highly: In some regions (e.g. in Vorarlberg, initiated by the regional VGKK) contractual physicians may charge fees for referring patients to the Early Support Network. Despite showing increasing referral figures, many contractual physicians will not invoice their referral service, as they appreciate being able to transfer their patients/families into a competent support-system.

Table 41: FGÖ Healthy Austria Fund, own illustration based on Fonds Gesundes Österreich.

	1. Health promotion	2. Primary prevention	3. Secondary prevention	4. Tertiary prevention
Starting point	to increase health potentials without a reference to risks and diseases in settings	to reduce the risks before the disease onsets	during the disease stage	after the acute disease treatment
Health term	broad health term (physical – mental – social)	A) broad health term (physical – mental – social)	biomedical health term	biomedical health term
		B) biomedical health term		
Target group	population groups (social groups)	A) individuals	individuals (patients)	individuals (rehabilitand)
		B) population groups (social groups)		
Measure orientation	resource-increasing ratio-changing behaviour-changing	risk-reducing ratio-changing behaviour-changing	curative	relapse-preventive rehabilitativ palliative

Within the jurisdiction of the fund „Gesundes Österreich"

Beyond the jurisdiction of the fund „Gesundes Österreich"

Generally, the FGÖ-supported projects focus on a comprehensive understanding of physical, psychological, and social health. Projects focusing on bio-medical primary prevention do not fall into the responsibility of the FGÖ. Furthermore, projects which center on individuals or projects from the secondary or tertiary prevention category are also excluded from funding by the FGÖ.

Financial support is granted for projects emphasizing: practice-orientation (in various settings), corporate health promotion (separately for small & medium-sized enterprises, and larger corporations), projects focusing on education & training and networking, communal projects aiming to jointly achieve better health, and international projects. Usually, the maximum value of support amounts to 1/3 up to 50 percent of the acknowledged overall project costs.

Until the year 2020, the following contents have been prioritized in connection with health-promotion in Austria[288]:

[288] Bundesministerium für Gesundheit und Frauen, 'Gesundheitsförderungsstrategie Im Rahmen Des Bundes-Zielsteuerungsvertrags'.

Table 42: General framework for the content-related key aspects 2013 to 2022, own illustrations based on BMGF Gesundheitsförderungsstrategie.

areas of inter-vention	Target groups	Birth, early childhood 0-3 years	Childhood 4-12 years	Adolescence 13-20 years	Working age 25-65 years	Seniority 65 years and older
Family		· early support · health promotion for families with small children and pregnant woman				
Kindergarten		· healthy nurseries and kindergartens · transfer of health literacy in childcare facilities				
School			· healthy schools · transfer of health literacy in schools/ childcare facilities			
Company				· workplace health promotion		
Commune/ district		· participation: children and adolescence · Promotion of health literacy of medically disadvantaged population groups · Implementation of key aspects, in accordance with local settings			· healthy aging	
Leisure / consumer world		· Development of health promotion approaches for leisure settings · health literacy promoting consumer information and service companies & manufacturing firms				
Public services		· Hospitals and healthcare providers with healthy literacy · Promotion of health literacy in self-help groups and patient representatives · Health promotion measures in nursing homes				
Society		· Assessments of health impacts · Capacity building for an intersectoral health promotion · Development of a network of health promotion actors · Creation of participation possibilities in living environments trough network-settings				

A recent monitoring-report, published in 2016 by the BMGF evaluated the various initiatives and measures, which have been undertaken in connection with the Health Promotion Strategy, and came to the following conclusions: Most measures are based on scientific research. Health in All Policies has been developed successfully with respect to sharing information and setting joint objectives. Equal opportunities concerning health are still to be improved, in particular with respect to target-groups that are difficult to access. The settings for measures are varied, with the classic settings featuring predominantly (i.e. school, company, municipality and family). However, the settings 'spare-time & world of consumption' and 'social policy & media' have to be more focused on. The target groups, which are primarily addressed are: pupils, children & adolescents, as well as teachers, parents and elderly persons. With respect to groups characterized by worse health-chances, it has to be seen, how these can be more successfully accessed.[289]

[289] '1. Bundes- Monitoringbericht Zur Gesundheitsförderungsstrategie'.

5.1.4 Health literacy in Austria

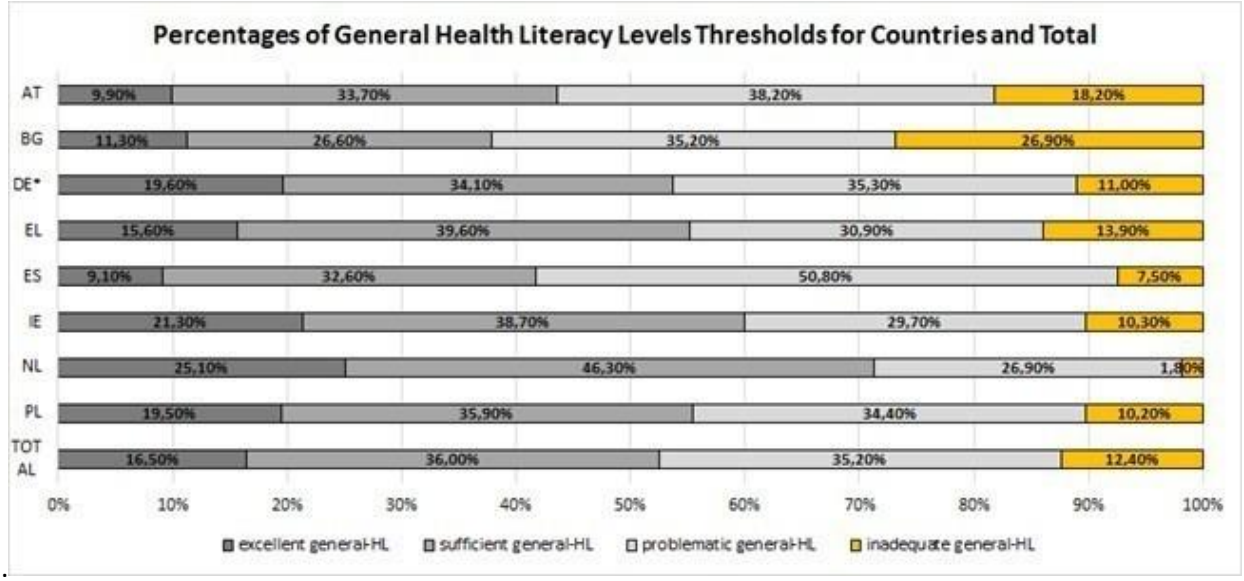
The results of a comparative report on health literacy in eight EU Member States illustrate how Austria performs with respect to health literacy[290]: Austria scores worse than the average results of eight other European countries on general health literacy, with more than half of the surveyed population showing problematic or inadequate general health literacy (for a comparison of the Austrian general health literacy level)[291]. Additionally, the proportion of people with excellent general health literacy in Austria only reaches 9.9% in comparison to 16.5% on European average. On the other end of the spectrum, 18.2% have an inadequate general health literacy, which again is worse than the European average which lies at 12.4%.

Alarmingly, Austria underscores on all three health literacy indices, being healthcare, disease prevention and health promotion when compared to the European average, by showcasing fewer people with excellent health literacy and an increased proportion with inadequate levels of health literacy. Also, there exist strong regional variations in health literacy, with merely 36% showing limited health literacy in Vorarlberg, yet 63.3% in Styria[292]. Moreover, Austria showed the strongest link between the health literacy results and the socio-demographic variables income, age and gender. However, the health literacy results for adolescents only differed slightly from the ones obtained for adults, with adolescents scoring better in questions relating to health promotion.

As a consequence of inadequate health literacy, health behaviours, health risks, health outcomes and healthcare use, as well as costs may be negatively impacted: The physical exercising patterns in Austria are comparatively poor, with only 11.5% exercising almost every day (European average: 26.2%), whereas alcohol drinking and smoking behaviours roughly coincide with the European averages. With respect to the average Austrian Body-Mass-Index the results are pleasing, as the largest proportion is within the normal range (45.5% compared to 38.8% in Europe) and moreover, Austria has the smallest percentage of obese people (20.2% compared to 25.7% in Europe). In addition, it was demonstrated that the relatively poor Austrian health literacy negatively effects on the frequency of hospital stays[293].

[290] 'Comparative Report on Health Literacy in Eight EU Member States. The European Health Literacy Survey HLS-EU'.
[291] Kickbusch et al., 'Gesundheitskompetenz. Die Fakten'.
[292] Ibid.
[293] 'Comparative Report on Health Literacy in Eight EU Member States. The European Health Literacy Survey HLS-EU'.

Figure 98: Comparison of General Health Literacy Levels for Eight EU Member States; own depiction based on HLS-EU



In keeping with the National Health Goals and the Health Promotion Strategy, *the Austrian Platform for Health Competence, ÖPGK* was initiated by the Federal Health Commission, in 2014 *(https://oepgk.at)*. The primary objective of the ÖPGK is to support the nationwide and sustainable attainment with respect to the third National Health Goal. Specifically, this entails to increase the health competency by (1) rendering the system, including its stakeholders and institutions more health-competent, (2) to reinforce the individual's health-literacy, also by taking vulnerable groups into consideration and (3) to anchor health-competence in the service and production industries, where health-services are 'consumed'[294]. Consequently, health-competency is understood as a relational concept which involves improving the individual's health competence, as well as the framework conditions and information offerings. This also involves taking the social settings and organizations into consideration[295]. The five functions of the ÖPGK are defined as follows: First, to support the long-term development and establishment of health competence in Austria; Second, to foster joint learning and the development of network structures, collaboration and the exchange of knowledge; Third, to enable and to align measures between politics

[294] Österreichische Plattform Gesundheitskompetenz, 'ÖPGK - Rahmen Gesundheitsziel 3'.

[295] Gutknecht-Gmeiner, M. and Capellaro, M., 'Externe Evaluation Der Österreichischen Plattform Gesundheitskompetenz (ÖPGK) - Endbericht'.

and society; Fourth, to increase comprehension, knowledge transfer and innovation; Fifth, to develop fundamental measures for monitoring, reporting, transparency and quality control[296].

5.1.5 Migrant population - measures taken by the government, insurers and other actors for people with migratory backgrounds

In comparison to the native Austrian population, persons with foreign origins less frequently use the offerings of prevention and health-promotion[297]. In general, persons with migration background are more likely to take curative, rather than preventive measures (which is also evident in the increased number of visits in ambulatory care) and evaluate their state of health relatively poorer (75% of people with foreign backgrounds stated their health to be excellent or good, versus 78% of native Austrians). In particular, persons with Turkish or ex-Yugoslavian backgrounds differ strongly in that only 57% evaluated their health status to be excellent/good.[298] Moreover, the ATHIS study 2006/7 shows that people with Turkish or ex-Yugoslavian backgrounds less frequently use preventative measures and screenings (e.g. mammography, a pap-smear test, PSA-test for prostate, bowel cancer screenings).

Additionally, the HSBC report investigated the health behavior in school aged children and asked pupils aged 11, 13, 15, and 17 to evaluate their health. Juveniles with migratory backgrounds (i.e. parents were born abroad) evaluated their health more negatively, than pupils without migratory background. However, the financial situation of the family also played an essential role in how positive the status of health was evaluated.

Nevertheless, the life-expectancy of persons born abroad in 2014 is very similar to the one of the native Austrian population, which reaches 78.5 years of age for male and 83.6 years for female Austrian citizens, showing a slightly increased life-expectancy for foreign-born men with 79.3 years and marginally decreased life-expectancy of 83.3 years for foreign-born women in 2014. These surprisingly indifferent results are not yet adequately explained, but may be partly due to statistical effects/errors which may

[296] Bundesministerium für Gesundheit, 'Empfehlungen Zur Einrichtung Der "Österreichischen Plattform Gesundheitskompetenz" (ÖPGK)'.
[297] Ibid.
[298] Statistik Austria, 'Migration & Integration - Zahlen.daten.indikatoren 2016'.

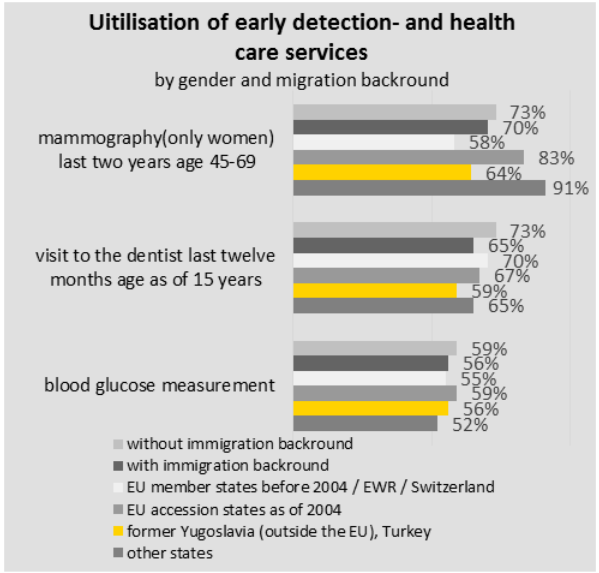
underrepresent the number of foreign deaths, or alternatively be due to the selective immigration of persons with exceptionally good health status[299].

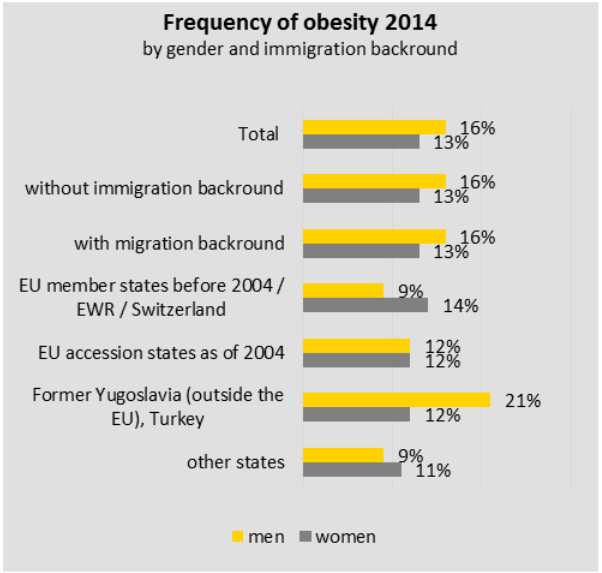
This tendency continues, as persons with migration background are still less likely to use preventive measures (for comparison, the percentages for native Austrians are quoted in brackets): only 64% undertook mammography-screening (versus 73%), regular visits to the dentist 59% (versus 73%). Strongly diverging results were also discovered for vaccinations, where only 46% had completed the tick-vaccine (versus 70%), tetanus 64% (versus 76%), diphtheria 32% (versus 50%), and polio 34% (versus 47%)[300]. With respect to testing the blood-sugar-level, there were no significant differences between persons with or without migratory background.

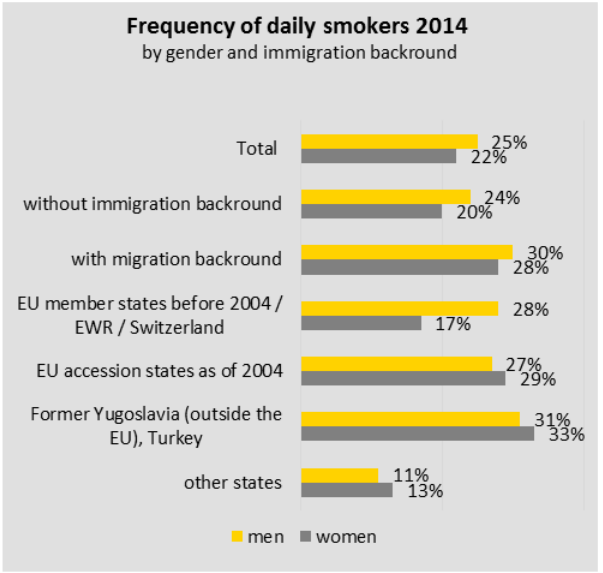
In addition, persons with migration background are less likely to see GPs or specialists, but instead use hospital ambulatory services. Possible explanations for this are missing knowledge about the Austrian health-system and access to primary care, language barriers, fear of discrimination, lack of social networks, or little contentment/confidence.

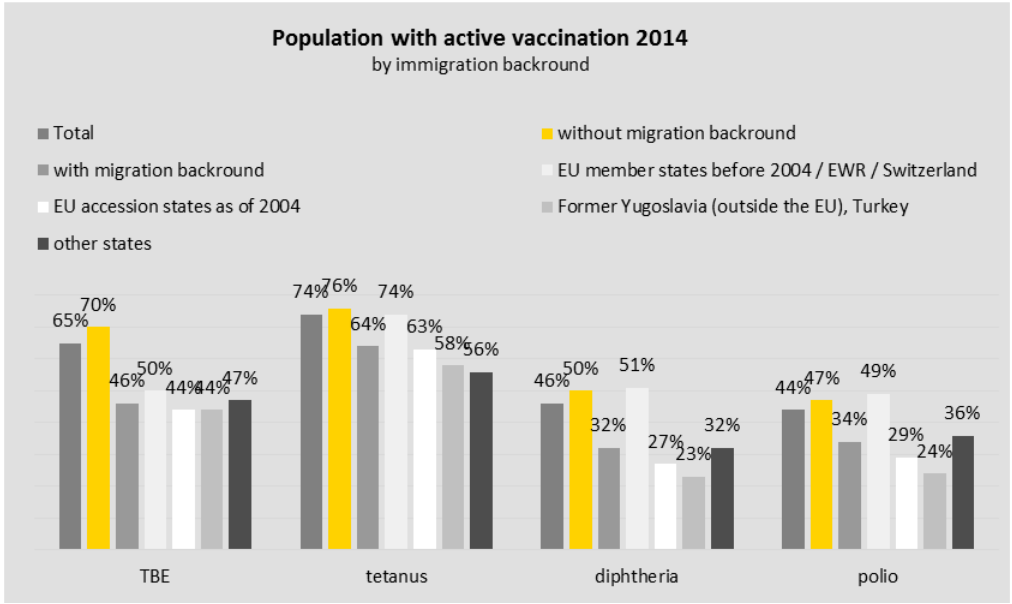
[299] Ibid.
[300] Ibid.

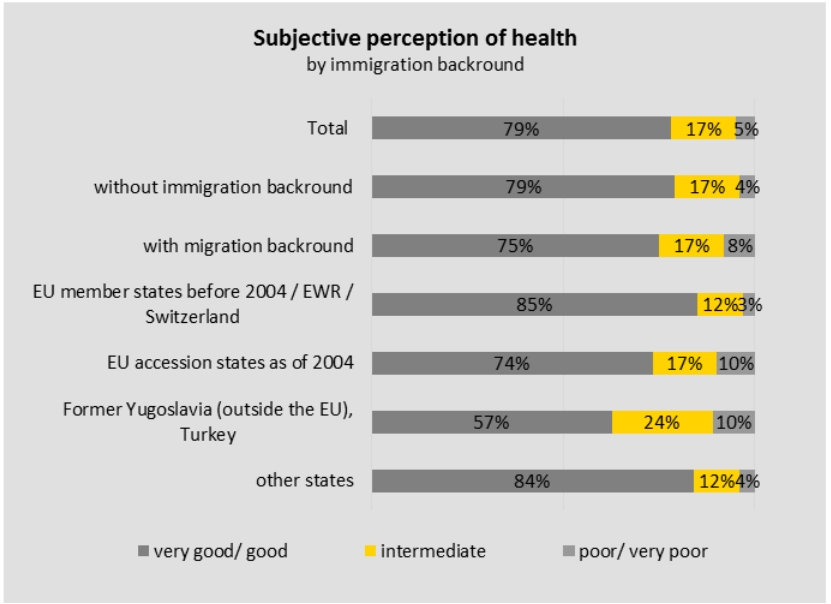
Figure 99: Comparison of Health Indicators, own illustrations, based on Statistik Austria: Austrian Health Service, 2014.











5.1.6 Projects aimed at strengthening prevention and promotion for persons with migration background

The socio-cultural background has (indirect) effects on health and disease - it shapes the awareness and description of symptoms, the expectations regarding the treatments, and health-related behavior. In cases where the doctor and the patient stem from the same cultural/social context, their health and disease-related theories are likely to be similar, leading to a better mutual understanding, adequate use of health systems, higher compliance and an overall better result. The more these attitudes differ, the more likely misunderstandings occur, which might influence the success-rate of the treatments[301]. Analogous to this, the National Health Goal's objective 10 is aimed at "ensuring qualitatively high and efficient healthcare provision for everybody in a sustainable manner". In more detail, this means to prioritize the strengthening of prevention and primary healthcare, as well as ensuring target-group-specific and anti-discriminatory access, in particular for disadvantaged demographic groups.

Taking this into account, a guideline was developed on behalf of the combined efforts of AK Wien, BMG, FGÖ, Stadt Wien and the WGKK, in 2016. The main objective is to advice on how to overcome barriers-to-entry regarding the healthcare system in Austria for socio-economically disadvantaged persons with migratory background. Content-wise, this guideline puts emphasis on the topics nutrition and exercise, adiposity and diabetes, whilst accounting for cultural diverse backgrounds, differences in age, gender and education. It is aimed at informing healthcare practitioners from the areas of promotion, prevention and curation by providing recommendations for action and implementation.

To eliminate language barriers, this guideline produces instructions for communicating well with persons with migratory background according to their socio-cultural context. For instance, it is recommended to keep sentences short with clear-cut messages, to rather use images than long phrases, to abstain from using cultural-symbolic messages, to convert medical jargon into everyday or colloquial language. Additionally, information should be interactive and provided in multiple languages.

Moreover, the Migrant Integration Policy Index, i.e. MIPEX study, which is co-funded by the European Commission, found that particularly with respect to the healthcare sector, Austria's system is rather responsive to immigrants' needs[302]. In comparison to the other participating countries, Austria's migrant health-score is ranked 8th out of 38. Explicitly, the two urban settings of Salzburg and Vienna

[301] Gesundheit Österreich GmbH, 'Menschen Mit Migrationshintergrund Besser Erreichen'.
[302] Migrant Integration Policy Index, 'Austria Policy Indicatiors'.

are reported to score relatively higher in all dimensions than most EU countries evaluated. However, regional differences apply. The dimensions, which were assessed are entitlements, access policies, responsive services, and mechanisms for change. Concerning entitlements, legal migrants receive the same treatment as Austrian citizen, i.e. the conditions of the insurance-based healthcare system apply. Moreover, asylum-seekers are guaranteed equal entitlements on condition that they remain within their designated area of residence. Undocumented migrants in contrast only receive emergency care, TB treatments and prenatal care, yet may face complications with documentation and clinical discretion. Regarding the second dimension, access policies, Austria scores rather well, as healthcare services are reasonably easy to access. Further, legal migrants and asylum-seekers are provided information in several languages via online sources, brochures, campaigns or face-to-face services. Nevertheless, intercultural mediators are only rarely supplied (for instance Turkish native speakers in Vienna). With respect to the dimension responsive services, the services are reported to be responsive to migrants' healthcare requirements, mostly as part of local integration strategies. Due to healthcare staff often being multilingual and trained in diversity/sensitivity standards, feedback from migrant patients is taken on board. The fourth dimension, mechanism for change evaluates the health policies and concluded that Austria is somewhat more responsive than the average. The design and implementation of novel migrant health services have emerged on an ad-hoc basis from specific programs (for instance women's health), or leading specialists (e.g. the 'migrant-friendly hospital' Kaiser-Franz-Josef in Vienna) [303]. For an overview of projects focusing on improving health-aspects with regard to the migrant population, in Austria, please view Figure 100.

[303] Ibid.

Figure 100: Topic, Target Groups and Type of Measure regarding Projects focusing on Migration and Health in Austria; own illustration, based on GÖG/ÖBIG

Topic	Number
• health promotion	**34**
• health literacy	24
• sensibilisation	23
• empowerment	20
• prevention	19
• mental health	13
• health behaviour (exercise behaviour)	6
• training and support of multiplier	6
• equal opportunities	6
• advisory and Information related to health topics	6
• addiction	5
• improvement of health	5
• concrete health topics (breast cancer, dental health, HIV/Aids	4
• reinforcement of resources	3
Target group	**Number**
• no concrete target group	22
• concrete target groups	65
• examples for target groups (overlap possible)	
• people who deal with migrants (e.g. teachers, health personnel	24
• women	15
• children and adolescents	13
• parents	10
• asylum seekers / asylees / persons enjoying subsidiary protection	5
• multipliers or key personalities of communities	4
• witnesses or victims of slave trade / violence	2
Type of measure	**Number**
• workshops / courses / trainings / programs / seminars / continuing education	63
• information / events / talks	42
• counselling	17
• networking	16
• excursions	9
• round tables	9
• translation work	9
• psychological / psychotherapeutic offering	4

5.2 Case and care management[304]

5.2.1 Overview

In general, the concept of case management (CM) represents an integrated and thus holistic approach to healthcare management by individually and continuously accompanying patients on their way to recovery. This also involves accounting for their physical and psychological conditions, and to consider their social environment. Case managers accordingly coordinate the interplay of different interfaces within the healthcare system. Up until now, it has not been scientifically proven that case management is capable to significantly reduce healthcare-costs (which may be partly due to insufficient availability of longitudinal data)[305]. However, case management has been associated with positive effects regarding the quality of care[306]. Particularly in Austria, discharge management is essential in order to connect the gap between inpatient and outpatient care and thus enables the flow of information. Moreover, case management may reduce the length of hospital stays, by comprehensively planning the care-pathways in advance. At large, case management involves three purposes: advocating, brokering and gate-keeping[307]. The advocacy function targets health-impaired or socially disadvantaged persons (for instance unemployed, homeless, HIV-patients, or people with psychiatric disorders), by enabling them to pursue and to realize their personal interests and requirements. The broker function provides objective mediation between demand and supply regarding health services and support with organizing the processes involved. The gate-keeper function serves as restrictive measure to control the otherwise unhindered access to the healthcare system.

In addition, a standard intervention in case management is discharge management, where the aim is to cross-disciplinary organize the nursing, medical and social needs of patients with multiple care-requirements after being discharged from the hospital. It can either be undertaken by the general care personnel of the hospital, i.e. direct discharge management, or by a person who is employed to coordinate dischargement, i.e. the case manager. With respect to case management, the patient's discharge is undertaken with focus on coordinating processes with the aim to recover and reintegrate the affected person into the working world. The phases which are common in case-management are:

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[304] Primary sources of data for this section are: Bundesministerium für Gesundheit und Frauen, 'Analyse Regionaler Pilotprojekte Zum Aufnahme- Und Entlassungsmanagement'. Czypionka et al., 'Health System Watch Ausgabe I - Case Management in Österreich Und Europa - Gesundheitsökonomische Evaluation: Politische Implikationen Und Nutzentheoretischer Outcome'. fit2work, 'Jahresbericht 2015 - Information für die Steuerungsgruppe'. Interview with AMS.

[305] Murphy et al., 'Calculating Cost Savings for Care Management Programs'.

[306] Czypionka et al., 'Health System Watch Ausgabe I - Case Management in Österreich Und Europa - Gesundheitsökonomische Evaluation: Politische Implikationen Und Nutzentheoretischer Outcome'.

[307] Ibid.

Assessment of problems, resources and care requirements, planning and coordinating the implementation[308].

5.2.2 Case Management in Austria: Legal specifications and responsibilities

As specified in ASVG (§ 143 b)[309], case management in the social security system is established for the group of persons, who receive the rehabilitation allowance. Thus, this includes individuals, who are not permanently, but only temporarily disabled to fulfill their occupation. This ensues irrespective of their current state of employment, i.e. both are covered, employed and unemployed persons. The objective of this type of case management is to achieve occupational recovery, which, for instance, is undertaken by the initiatives fit2work, Early Interventions, the part-time reintegration, occupational retraining, as well as the rehabilitation allowance-.

Consequently, in Austria, the legal interpretation of case management is closely linked to medical rehabilitation. As manifested by the General Social Security Act §143b about case management, it is the health insurance institutions' responsibility to comprehensively support the insured during the transition between being discharged from medical treatment and being fully recovered, and to regain the capacity to work[310]. Furthermore, medical rehabilitation demands the active participation of the patient and follows the concept of a holistic model by viewing the patient as part of the larger society (bio-psychological model)[311].

In general, the aim of rehabilitation is to enable the patient in the best possible way to lead life independently, to participate in professional life, or to finish education. In order to qualify for medical rehabilitation, the following three criteria apply in accordance with the Work and Health Act:
In need of rehabilitation: The patient's capabilities are reduced, limiting normal activities in a non-temporary manner. To improve capabilities and to overcome functional restrictions, supplementary measures, which go beyond curative care, are deemed necessary.
Suitability for rehabilitation measures: The patient exhibits the psychological and physical ability to partake in the rehabilitation measure, i.e. motivation and ability to undergo the rehabilitation measures.

[308] Bundesministerium für Gesundheit und Frauen, 'Analyse Regionaler Pilotprojekte Zum Aufnahme- Und Entlassungsmanagement'.
[309] Allgemeines Sozialversicherungsgesetz - § 143b Case Management .
[310] Allgemeines Sozialversicherungsgesetz - §143b Case Management, 143.
[311] Hofmarcher and Quentin, 'Health System Review', 2013.

Rehabilitation prognosis: The target of the rehabilitation measure can be met within the specified time-frame.

Rehabilitation measures may be offered in either inpatient or ambulatory rehabilitation[312]. Consequently, this involves the assessment of needs and the step-by-step coordination of individual care-pathways, which consecutively have to be implemented by the appropriate healthcare providers. Legislation determines which branch of the social insurance is responsible for covering the costs involved in rehabilitation measures: In general terms, reestablishing health after workplace accidents and work-related illnesses falls within the responsibility of the accident insurance. In comparison, the pension insurance is liable, if either the avoidance of early retirement because of ill-health is needed (forming part of the compulsory benefit package of pension insurance), or the avoidance of requiring long-term care is aimed at (non-compulsory, however covered as health-promotion). Health insurance institutions account for the costs in cases where the comprehensive restoration of health is involved, in order to preserve the capability to self-help. To clearly determine the accountability for rehabilitation measures, the social insurance institutions are ranked according to their liability, by the following order: First, accident insurance institutions (in case the reason for needing rehabilitation is work-related), second pension insurance institutions (if it is likely that the patient would become, or already has become invalid or incapable to work without rehabilitation measures); third, health insurance institutions offer supplementary responsibility, so that inpatient medical rehabilitation may be provided to persons who are not (or no longer) entitled to pension insurance, or co-insured dependents[313].

5.2.3 Case Management and Rehabilitation in Austria

In line with the rehabilitation-centered interpretation of case management, §307g stipulates that the insured person has to partake in continuous examinations provided by an assessment competence-center, which has been established as part of the pension insurance institution[314]. In this competence-center an interdisciplinary team of experts assesses the insured person's medical, professional and labor-market related condition[315]. To render the swift recovery to work possible, the pension and health insurance institutions have to closely cooperate with the *Public Employment Service Austria* (AMS). In case the assessment report determines that full occupational recovery is expected to be

[312] Ibid.
[313] Gesundheit Österreich GmbH, 'Österreichischer Rehabilitationskompass'.
[314] Allgemeines Sozialversicherungsgesetz - §307g Kompetenzzentrum Begutachtung.
[315] Pensionsversicherungsanstalt, 'Masterplan Rehabilitation'.

impossible, the insured person may be eligible to claim incapacity to work[316] or invalidity pensions[317] (besides the likely permanent incapacity to work, there exist some further criteria for entitlement)[318].

5.2.4 Options for case management and rehabilitation measures in Austria

If however, the impairment of health is unlikely to be permanent and the patient has only been temporarily incapable to work, or invalid for the duration of at least six months, and the affected person was below 50 years of age on 1st January 2014, then the health insurance will pay *rehabilitation allowance*[319]. This also applies in cases where the occupational measures of rehabilitation are neither reasonable nor appropriate, as assessed by the pension insurance[320]. During the period of receiving rehabilitation allowances, the patient is covered by the health insurance and is also entitled to receive medical rehabilitation, if necessary in order to recuperate the capacity to work. Furthermore, the health insurance institution assigns a case manager to the patient, who provides assistance on the way to convalescence, during the entire period of receiving rehabilitation allowance. The guiding principles for the case manager are offering 'assistance for self-help', which involves for example setting individual health-targets to stabilize or improve the health-status. For patients, this service is free-of-charge, however they are obliged to cooperate in order to enable the swift occupational recovery. Otherwise, the rehabilitation allowance may be withheld[321]. Usually, the rehabilitation allowance is paid monthly and equals 60% of the final salary, yet in any case, has to amount to at least €889.84 per month, in 2017 (for single persons, pegged to the equalization supplement)[322]. The health insurance institution has to reassess the level of impairment after one year, at the latest, in order to determine, whether the rehabilitation allowance is to be continued. To do so, the health insurance institution may rely on the evaluations of the case manager and assessment competence center[323]. For an overview on rehabilitation allowances and further options and alternatives, please view table at the end of this chapter.

To foster the reintegration of persons, who have been taken ill for more than six weeks, the option of *reintegration part-time* will be offered, taking legal effect from 1st July 2017. As detailed in ASVG §143d,

[316] Allgemeines Sozialversicherungsgestz -§271 Berufsunfähigkeitspension.
[317] Allgemeines Sozialversicherungsgesetz - §254 Invaliditätspension.
[318] Pensionsversicherungsanstalt, 'Invaliditäts- Bzw. Berufsunfähigkeitspension'.
[319] Allgemeines Sozialversicherungsgesetz - §143a Rehabilitationsgeld.
[320] Pensionsversicherungsanstalt, 'Invaliditäts- Bzw. Berufsunfähigkeitspension'.
[321] Wiener Gebietskrankenkasse, 'Case Management Bei Bezug von Rehabilitationsgeld'.
[322] Pensionsversicherungsanstalt, 'Information Für Bezieher/Innen Einer Invaliditäts- Bzw. Berufsunfähigkeitspension'.
[323] Allgemeines Sozialversicherungsgesetz - §143a Rehabilitationsgeld.

this provides[324]: The step-by-step return of employees to the professional world, which is jointly agreed upon between the employer and employee and ensues according to a reintegration plan (which should be specified in consultation with occupational physicians or fit2work case managers). With this, the weekly working time is reduced to in between 25%-50% and the employer pays the salary in aliquot terms, whereas the (regional) health insurance institution pays the proportional surplus, i.e. up to a maximum of 50% based on the increased rate of sickness benefits. The reintegration part-time is available from one up to six months, but may in special cases be extended to a maximum of 9 months. However, this is only possible, if the senior physician gives his repeated medical approval. Moreover, to be eligible for reintegration part-time, the following requirements have to be fulfilled: at least six weeks of sick leave, the confirmation that the person affected is capable to work within the means of the reintegration part-time, a plan which specifies the terms of the reintegration and which is medically approved by the occupational physician, or medical service or the fit2work case management[325].

If the status of impaired health is not permanent, but lasts to the extent of at least six months and the affected person is thus only temporarily disabled or incapable to work, *occupational retraining* might be an alternative to either stay on the job market, or to be reintegrated in the working world[326]. During the period of occupational retraining, the AMS will pay retraining allowances, if certain conditions apply: First, if the pension insurance institution has assessed that the affected person's occupational disability or invalidity is not permanent, yet temporary, and has lasted for at least six months. Moreover, the occupational measures regarding the rehabilitation need to be appropriate and reasonable. In any case, the allowance is only paid, if the affected person actively participates in the selection, planning and execution of retraining. The same applies to impending disablement or occupational disability. Additionally, the new profession needs to be on the same qualification-level as the former occupation. The allowance paid increases in line with the phase of retraining, meaning that during the selection and planning phases the retraining allowance equals the amount of unemployment benefits, yet is raised during the retraining phase and at that point amounts to the unemployment rate and the surplus of 22%.[327]

As the key-objective is the swift recovery of working & earning capacity, the case manager's task is to organize the continuous and integrated support throughout the medical rehabilitation process. This

[324] Allgemeines Sozialversicherungsgesetz - 143d Wiedereingliederungsgeld.
[325] Wirtschaftskammer Österreich, 'Wiedereingliederungsteilzeitgesetz - Besserer Arbeitseinstieg Nach Langem Krankenstand'.
[326] Portal der Arbeiterkammer, 'Rehabilitations- Und Umschulungsgeld'.
[327] Arbeitsmarktservice Österreich, 'Umschulungsgeld'.

implies that the insured person's profession and employer have to be taken into consideration, too, as the rehabilitation measures ought to effect in permanently restoring the affected person's professional and economic situation and adequate place within society, and to re-establish the person's autonomy. In order to achieve this, the intervention measures have to be undertaken as early as possible, which is regulated in the fifth amendment of RRK 2005, i.e. the directive about the 'delivery of rehabilitation services and services in connection with the strengthening of health and health-promotion', which will take effect in April 2017. Provided that the three aforementioned criteria of the Work and Health Act apply, the §32 RRK 2005 defines ten categories of disease-diagnoses following surgical procedures and medical treatments, which validate the early detection of persons in need of rehabilitation measures. These diagnoses comprise injuries and damages relating to the musculoskeletal system, cardiovascular disorders, diseases of the central and peripheral nervous system, endocrine and metabolic diseases, disorders of the lung and respiratory tract, gastro-intestinal diseases, craniocerebral trauma, disorders of the lymphatic system, oncological diseases, and psychiatric disorders. If one of these diseases is attested, the health insurance has to submit the details of the affected insured person to the pension or accident insurance institution, so the medical rehabilitation treatment may be started without further delay. An additional requirement is laid down in §33, which stipulates that the medical assessment, determining the occupational disability, needs to be established by a chief physician. Additionally, in case an insured person has been unable to work for more than 40 days during the past 365 days (resulting from one of the above specified diseases), the chief physician has to assess the preconditions for early detection. Moreover, the health insurance only needs to report the insured person's details to the accident insurance, if the reason for the occupational disability is likely to be a work-related accident, or an occupational disease.

One rehabilitation project, which follows the principles of early detection and also is closely linked to case management, is *fit2work* (*http://www.fit2work.at/home/*). This project is regulated in the Work and Health Act, as well as in §33a RRK 2005 and predominantly targets persons, who show more than 40 sick-days within a year. Its key-objective is to sustainably secure the affected person's ability to work and thus increase their self-respect, as well as social integration within the working environment. In more general terms, fit2work counteracts the systemic out-casting from professional life, which may be caused by an impaired health-status. The program has been initiated by the Austrian Federal Government in 2011 for individuals, and since 2012 also includes services for companies. Fit2work is financed by the Public Employment Service Austria (AMS), the Regional Health Insurance Funds (GKK), the Austrian Federal Pension Fund (PV), the General Accident Insurance Institution (AUVA), the Ministry of Social Affairs (BMASK) and since 2015, also by the European Social Fund.

Since fit2work is designed to offer advisory services for individuals, who may, due to their impaired health-status find it difficult to either find work (i.e. unemployed), or to upkeep their current employment (i.e. employed), potential participants are targeted in different ways: First, the potential clients may be 'detected early' according to the aforementioned disease diagnoses (less the categories of gastro-intestinal and oncological diseases, and craniocerebral trauma), who are then contacted by one of the regional health insurance institutions (GKK), in case they were sick for more than 40 days during the past 365 days. Also, the Public Employment Service (AMS) invites persons, who have been unemployed due to ill health and may benefit from the program (in 2016 approximately 60% of the participants were unemployed), and in some cases individuals may even act autonomously and register themselves. For a figurative depiction of the case management process regarding the personal counselling, please view fihure at the end of this chapter.

The service for companies is called "fit2work organizational counselling", which targets public as well as private organizations and supports the retention and reintegration process of employees with impaired health. In 2015, 50% of the participating organizations were medium-sized and employed in between 50 to 250 persons, 27% had more than 250 members of staff and 23% were small enterprises, employing fewer than 50 persons[328]. Due to the free-of-charge services the organization's sickness-figures may be decreased and the retention-rate improved, which in turn assists in preserving the stock of know-how within the company. A special feature of the fit2work organizational counselling is that it develops individual solutions, in consultation with the respective organization. The mentoring process is divided into five phases, namely the information phase, the status-quo-survey, the analysis and development of improvement measures, the implementation- and the evaluation-phase. Managers and other internal representatives, who are trained by fit2work, function as contact persons for employees. For more information on the process involved in organizational counselling, please view figure at the end of this chapter.

The cornerstones of the fit2work program are: Participation is voluntary (for all participants, i.e. there are no sanctions if one decides to not partake), provided information is kept anonymous, the service is offered to everyone. It represents a one-stop shop by presenting expert advice, and a comprehensive overview of all available measures and grants[329]. Currently, there are more than 40 drop-in centers nationwide, offering comprehensive information-, advisory and support services. Up until December 2016, approximately 17,000 persons have participated in fit2work and more than 680 companies have

[328] fit2work, 'Jahresbericht 2015 - Information für die Steuerungsgruppe'.
[329] Pensionsversicherungsanstalt, 'fit2work', 2.

been supported by the advisory services[330]. In 2015, nearly 5,500 individuals received counselling and intensive advisory from fit2work-case managers[331]. Approximately 70% of the participants were between the age of 40-59 years, and the share of female participants outweighed male clients, reaching 57%. The majority of disease diagnoses related to either psychological disorders (about 40%), or injuries and damages relating to the musculoskeletal system (also, about 40%). Furthermore, the psychological disorders can be subdivided into diagnoses with multiple disorders (56%), affective disorders (22%), neurotic, stress & somatoform disorders (19%), and difficulties to organize life and burn-out syndrome (6%). Due to the increased psychological and psychotherapeutically demand, fit2work has started a further pilot project in 2013, which ensues in collaboration with the professional association of psychologists (BPÖ) and is jointly financed by the PVA and the AMS (by GAMP-means). Up until September 2016, more than 4,300 clients were treated - either individually or in groups. In consequence of the clinic-psychological and psychotherapeutic treatments, the capacity of fit2work participants was significantly increased: in 81% of participants, who were diagnosed with psychic disorders, and 79% of cases where the musculoskeletal system was impaired. Moreover, the number of medical consultations and hospital stays were reduced, in 83% and 76% of cases, respectively. As a result of this pilot project, 43% of individuals, who were formerly unemployed, could be re-integrated into the working world. As clinic-psychological treatments are not covered by the ASVG and thus have to be paid by the individual, it is particularly important that the integrated support of the case management offers this function (free-of-charge), as otherwise many persons might not be able to afford psychological and psychotherapeutic treatments[332]. Moreover, a study evaluating the program's effectiveness demonstrates that participants were able to increase their working days following the case management by 5.7 days, whereas the control group, which did not receive such treatment, could not achieve this, yet instead decreased their working days by 8.6 days (yet, they started at a higher level)[333]. This positive trend also holds if the observation time is increased to the medium to long-term (i.e. 6 and 12 months), meaning that participants were able to improve their working days in the long-term[334]. Despite the success of fit2work, the invitation system could still be improved, as only about 4% of persons who are invited, participate in fit2work[335]. In contrast to fit2work, the project *early interventions* already intervenes in case a person has been incapable to work for more than 28 consecutive days, due to one of the disease diagnoses as defined in §33a RRK 2005 (which are the same categories of diseases that also apply to fit2work). However, this excludes time spent in hospital

[330] Hauptverband der Österreichischen Sozialversicherungsträger, 'Fünf Jahre fit2work-Beratung - Eine Bilanz'.
[331] fit2work, 'Jahresbericht 2015 - Information für die Steuerungsgruppe'.
[332] Hauptverband der Österreichischen Sozialversicherungsträger, 'Fünf Jahre fit2work-Beratung - Eine Bilanz'.
[333] Statistik Austria, 'fit2work Auswertungen 2014 - Evaluierung der Personenberatung'.
[334] fit2work, 'Jahresbericht 2015 - Information für die Steuerungsgruppe'.
[335] Statistik Austria, 'fit2work Auswertungen 2014 - Evaluierung der Personenberatung'.

care, inpatient or ambulatory rehabilitation, measures for health promotion undertaken by the pension insurance institutions, or any other measures to strengthen the health, as well as time spent for medical measures of rehabilitation in the accident insurance institutions). In §34a RRK 2005, it is outlined that the GKK is responsible to invite these persons to a voluntary consultation, in order to analyze the disease process and healing progress. This consultation is usually led by a case manager and should be used to inform about existing prevention and rehabilitation measures, including fit2work and early intervention. Thus, the case manager is the first point of contact and can, if better suited, also transfers the affected person to fit2work. In general the project early intervention emphasizes the principle 'rehabilitation and reintegration into the working environment, in advance of pensions', by aiming to raise the actual age of retirement and setting the rehabilitation initiatives at an earlier stage, where rehabilitation might be more effective, still. Thus, early intervention's objective is to avoid invalidity, already on the level of the health insurance institutions - by targeting persons, who are likely to become invalid or incapable to work, soon[336]. By doing so, the medical rehabilitation measures have to be coordinated in keeping with the individual's occupational situation, hence also taking the affected person's professional situation into account. In addition, § 198 ASVG specifies several work-related support measures, including for instance advice on career choices, or retraining.[337]

5.2.5 Case Management challenges in Austria

The monitoring and evaluating, which forms part of the phases in case management, is complicated in Austria, as the outpatient and inpatient sectors are insufficiently linked. Thus, hospitals only have limited access to and control of extramural health-providers and their decisions, and vice versa[338]. Given this situation, the challenges envisaged by case managers become clear, emphasizing the mediating role of the case manager, who aims to act as the point of intersection in the system, on behalf of the affected person. Because of this, it becomes even more essential that in future, the stakeholders act jointly and that an integrated and united network is created, where knowledge is shared and the affected person is supported holistically, at the best point of service, and the earliest point in time[339]. In addition, another limitation of this type of rehabilitation-centered case management, which predominantly aims at occupational recovery, is that it is not expedient to solve the health issues of persons, whose health-status is too poor to be recovered to working capacity.

[336] Sozialversicherungs-Änderungsgesetz 2017 – SVÄG 2017.
[337] Allgemeines Sozialversicherungsgesetz - §198 Berufliche Maßnahmen der Rehabilitation.
[338] Bundesministerium für Gesundheit und Frauen, 'Analyse Regionaler Pilotprojekte Zum Aufnahme- Und Entlassungsmanagement'.
[339] Bundeskanzleramt Österreich, 'Reformpfad Pensionen'.

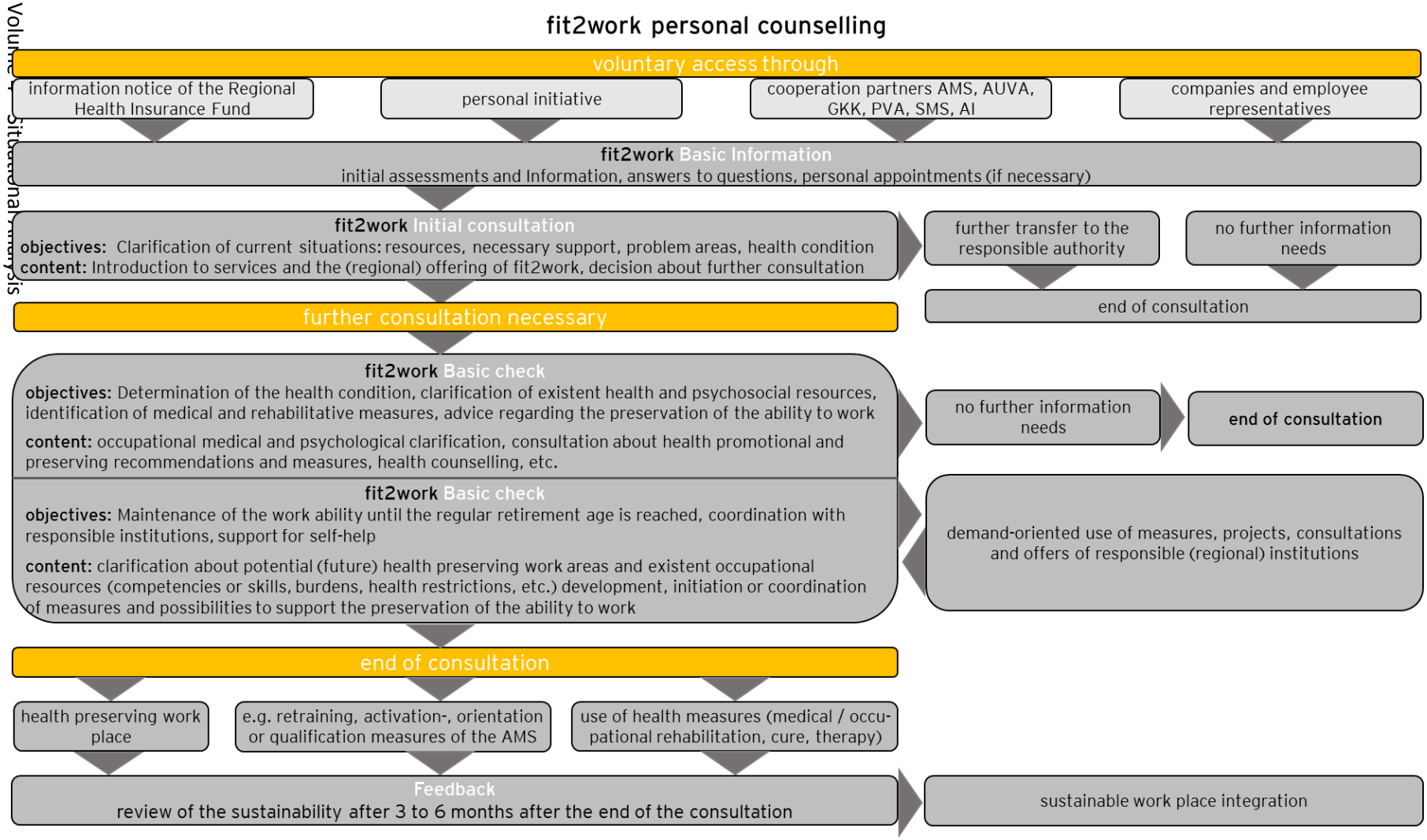
	Early Intervention	fit2work	Reintegration part-time	Occupational retraining	Rehabilitation allowance
Target group / Requirements	> 28 consecutive sick days (depending on disease diagnosis)	• gainfully employed person with at least 40 sick days during the past year • gainfully employed person who is likely to become unemployed or disabled due to ill-health • working persons or unemployed persons with long-term diseases or health issues • companies and employee-representatives	• at least six weeks of sick leave • confirmed capacity to work (in line with the reintegration) • preparation of a reintegration plan in consultation with an occupational physician / occupational health service or fit2work • agreement between the employee and employer according to the Work and Health Act (AGG)	• If due to an impaired health one is not permanently, but to the extent of at least six months (temporarily) disabled or incapable to work, and occupational retraining is reasonable and appropriate, one will receive an allowance for occupational retraining from the AMS. However, this only ensues in case the affected person actively participates in the selection, planning and execution of retraining. The same applies to impending disablement or occupational disability. • retraining for other occupations (maintaining the level of qualification)	• If due to ill-health one is not permanently, but to the extent of at least six months (temporarily) disabled or incapable to work, one receives rehabilitation allowances instead of invalidity- or occupational disability pension from the responsible GKK. • If occupational arrangements of rehabilitation are not appropriate or not reasonable.
More details / responsible party	CM GKK invitation depends on disease diagnosis	fit2work *http://www.fit2work.at/home/*	Draft of Act §143d ASVG, which will be effective from 1st July 2017: *https://www.google.de/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiv88WuvpLSAhUHWCwKHSMNB7sQFggcMAA&url=https%3A%2F%2Fwww.ris.bka.gv.at%2FDokumente%2FBegut%2FBEGUT_COO_2026_100_2_1286107%2FBEGUT_COO_2026_100_2_1286107.rtf&usg=AFQjCNEXazlMhdNiNsrnmS3BwJw4IlcmIA&sig2=xfxxnhKeLOzVLF05FLAwlA&cad=rja*	AMS *https://www.arbeiterkammer.at/beratung/arbeitundrecht/pension/pensionsformen/Rehabilitations-_und_Umschulungsgeld.html*	CM GKK *http://www.pensionsversicherung.at/portal27/pvaportal/content?contentid=10007.707671&viewmode=content*
Range of services offered	CM initiates the first contact and if applicable transfers the affected person to fit2work	CM, group therapies; individual therapies	• reintegration part-time allowance for up to six months, with the weekly working time being reduced by 25%-50%; • the employer pays the salary in aliquot terms, the health insurance institution covers the remaining proportion (based on the increased rate of sick-pay) • part-time allowance is usually offered for up to 6 months, but may be extended to a maximum of	The allowance sum for occupational retraining is paid out 12x per year. During the selection and planning phase, the money paid equals the amount of unemployment benefits. During retraining the allowance sum paid accrues to the amount of unemployment benefits plus an extra 22%, yet, in any case needs to be at least €34.60 per day (in 2017).	• rehabilitation money is paid out 12x a year, in the amount of sick-pay (generally 60% of last wage/salary), however, at least in the amount of compensatory allowances for single persons (2017: € 889,84) • if one receives rehabilitation money, the person is health-insured and is entitled to medical rehabilitation if this is necessary to restore the capacity to work

	Early Intervention	fit2work	Reintegration part-time	Occupational retraining	Rehabilitation allowance
			9 months, if the senior physician gives his renewed medical approval		• rehabilitation money / money for occupational retraining, medical and/or occupational rehabilitation
Actors involved	GKK, fit2work	Federal agencies, social security carriers, Federation of Austrian Social Security Institutions and AMS determined by law	GKK, fit2work	AMS	GKK: Rehabilitation allowance PVA: Application and assessment
Legal basis	SVÄG 2017	Work and Health Act (AGG)	§143d ASVG, §13a AVRAG	§ 39b AlVG	CM - §143b ASVG, Rehabilitation allowance - §143 a ASVG

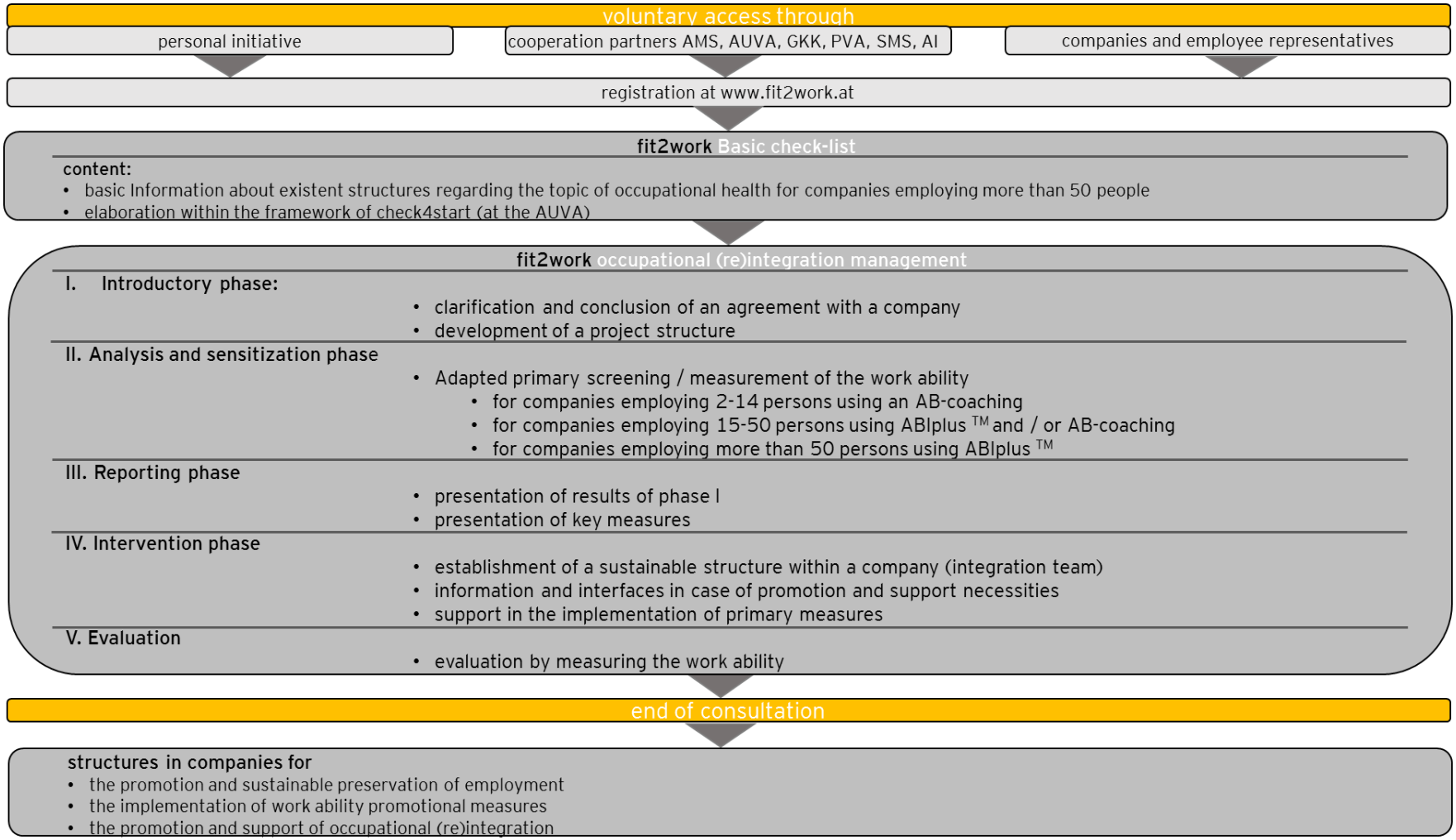
Table 43: Measures involving Case Management, own illustration.

The following two figures below represent:

- *Figure 101: fit2work: Personal Counselling, illustration based on fit2work - Ablauf Personenberatung*
- *Figure 102: fit2work: Occupational Counselling, illustration based on fit2work - Ablauf Betriebsberatung.*


fit2work personal counselling
voluntary access through
information notice of the Regional Health Insurance Fund
personal initiative
cooperation partners AMS, AUVA, GKK, PVA, SMS, AI
companies and employee representatives
fit2work Basic Information
initial assessments and Information, answers to questions, personal appointments (if necessary)
fit2work Initial consultation
objectives: Clarification of current situations: resources, necessary support, problem areas, health condition
content: Introduction to services and the (regional) offering of fit2work, decision about further consultation
further transfer to the responsible authority
no further information needs
end of consultation
further consultation necessary
fit2work Basic check
objectives: Determination of the health condition, clarification of existent health and psychosocial resources, identification of medical and rehabilitative measures, advice regarding the preservation of the ability to work
content: occupational medical and psychological clarification, consultation about health promotional and preserving recommendations and measures, health counselling, etc.
no further information needs
end of consultation
fit2work Basic check
objectives: Maintenance of the work ability until the regular retirement age is reached, coordination with responsible institutions, support for self-help
content: clarification about potential (future) health preserving work areas and existent occupational resources (competencies or skills, burdens, health restrictions, etc.) development, initiation or coordination of measures and possibilities to support the preservation of the ability to work
demand-oriented use of measures, projects, consultations and offers of responsible (regional) institutions
end of consultation
health preserving work place
e.g. retraining, activation-, orientation or qualification measures of the AMS
use of health measures (medical / occupational rehabilitation, cure, therapy)
Feedback
review of the sustainability after 3 to 6 months after the end of the consultation
sustainable work place integration

fit2work occupational counselling



6 Monitoring report

The common Federal Health-Targets played an essential role in the Healthcare-Reform 2013: In the course of this reform, the system partners (combining the federal government, the Länder and the social security carriers) jointly acknowledged common health targets, which were to be continuously monitored with respect to the realized progress.

In the period between 2013 and 2016, the financial- and content-related target achievements were evaluated according to pre-defined parameters and target values, which were published in the bi-annual monitoring reports. With regard to this, 60% out of an overall total of 106 target values could be achieved. For the subsequent period, lasting from 2017 until 2021, a new Federal Health-Target Contract was signed and in line with this, the monitoring was also significantly modified: In future, the monitoring will almost exclusively focus on quantitative parameters and target-values. Moreover, these were reduced to 22.