



THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE ■



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contrast
Management Consulting



Review of Austria's Social Insurance and Healthcare System

PRESENTATION: POLICY OPTIONS

PREPARED BY THE LONDON SCHOOL OF ECONOMICS AND POLITICAL
SCIENCE (LSE HEALTH)

Review brief

(1 of 2)

- The Ministry of Labour, Social Affairs and Consumer Protection engaged LSE Health to undertake a review of Austria's social insurance and healthcare system
- The review can be broken down into four interconnected reports:
 - Volume 1 Report: International comparisons and policy options **led by LSE Health in partnership with the Institute of Advanced Studies (Vienna)**
 - Volume 2 Report: Legal analysis **led by the University of Salzburg**
 - Volume 3 Report: Stakeholder views (**30 stakeholders** including social security institutions, the Main Association of Austrian Social Security Institutions, social partners, system partners and representatives of health care professions).
 - Volume 4 Report: Situational Analysis **led by Contrast Ernst&Young Management Consulting GmbH (Vienna)**

Review brief

(2 of 2)

- Please note that the review was targeted at the Austrian social insurance system, thus healthcare covered by Federal and Länder governments, were only examined where directly applicable
- This review has chosen to take a pragmatic approach by developing a range of policy options to improve efficiency and equity with minimal to no changes to constitution or legal arrangements

Overview of key findings

- **Perception of the healthcare system**

- High levels of satisfaction within the healthcare system
- One of the lowest levels of unmet medical need in Europe

- **Governance**

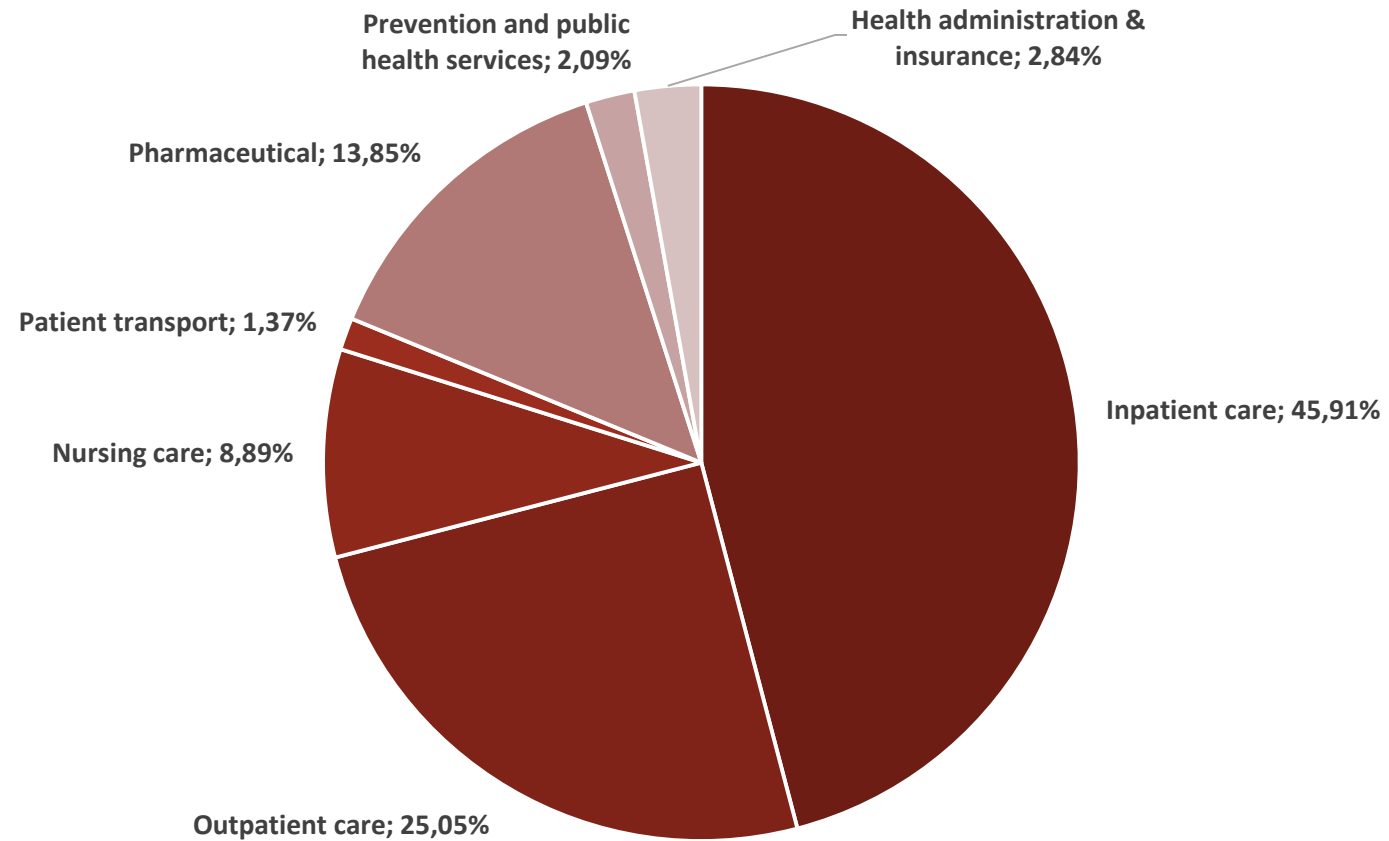
- Despite recent efforts to enhance coordination and align incentives, the system is characterised by its:
 - Multi-layered governance structure (various players)
 - Dual financing arrangement, which may lead to discontinuity of care and potential cost-shifting

- **Risk-adjustment**

- Limited risk-adjustment among social health insurance carriers, and across the spectrum of care (e.g. transfers of funds from Federal Government to Länder is based mostly on historical allocations)
- Limited risk-adjustment inhibits carriers from offering the same benefit packages, despite mostly uniform contribution rates

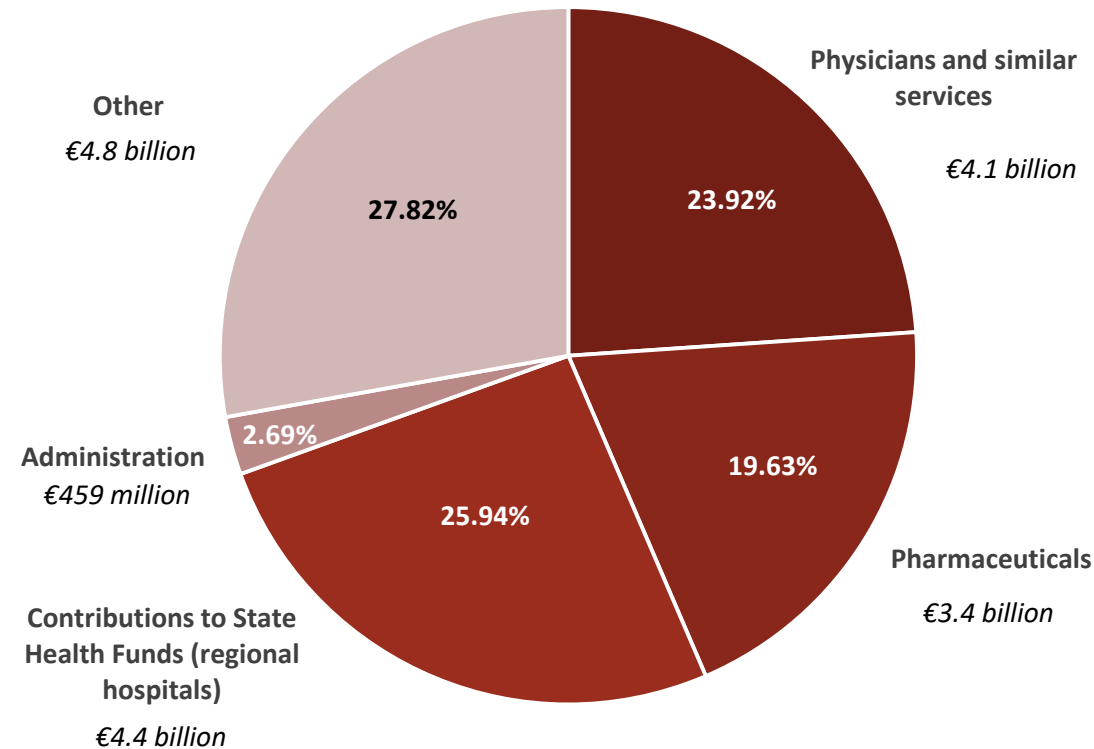
Health expenditure in Austria

Public expenditure (as of 2015)

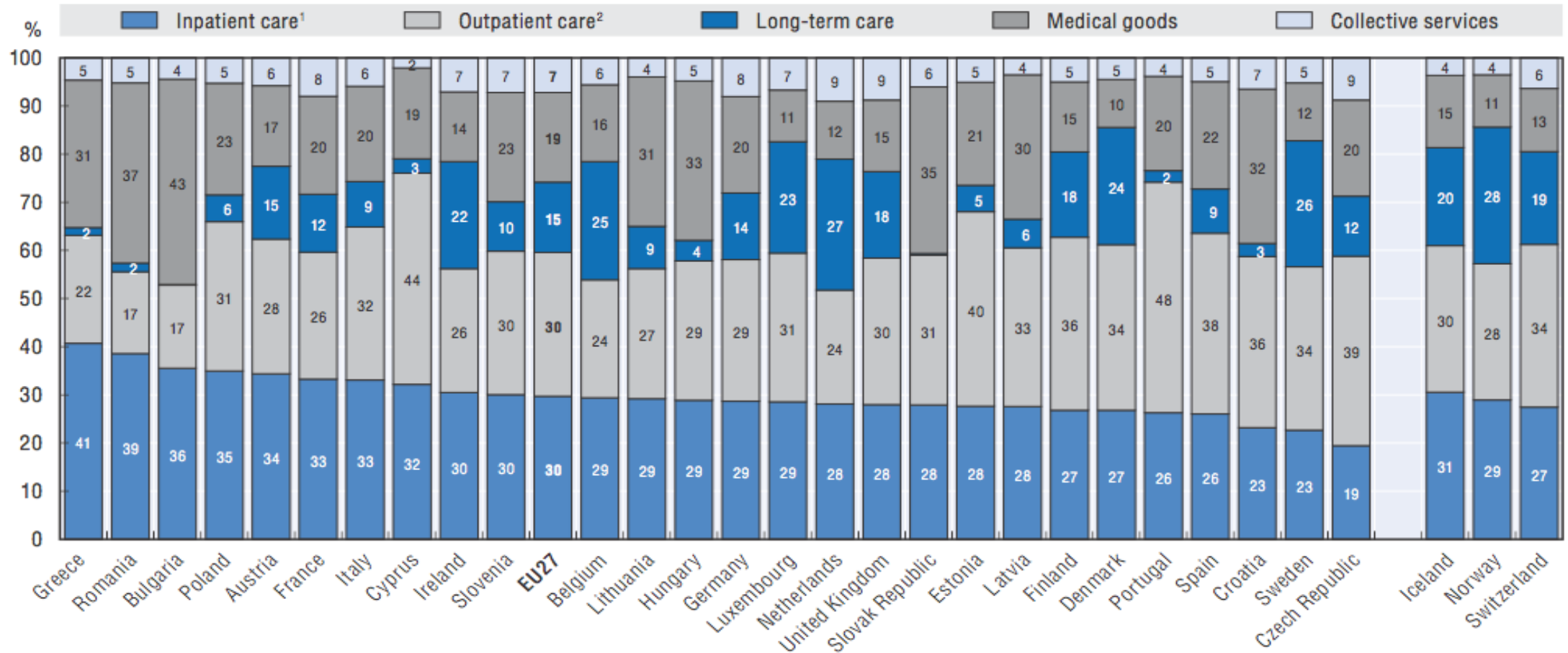


Health expenditure in Austria

Social health insurance expenditure (as of 2015)



5.6. Health expenditure by function of health care, 2014



Note: Countries are ranked by inpatient care as a share of health expenditure.

1. Refers to curative-rehabilitative care in inpatient and day care settings.

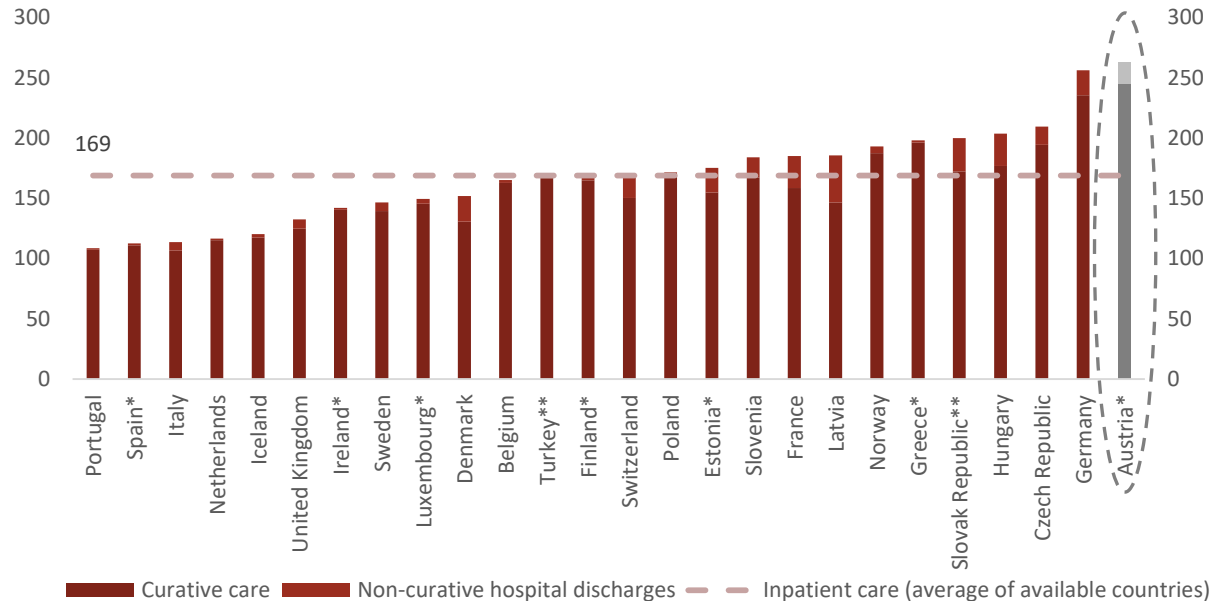
2. Includes home-care and ancillary services.

Source: OECD Health Statistics 2016; Eurostat Database.

Key international comparisons

Healthcare utilisation

*Number of inpatient discharges per 1,000 inhabitants
(2014 or latest available year)*



Key findings

- Austria has the highest number of hospital admissions among countries examined
- Outpatient consultations, however, are only marginally above the average of the countries examined in the figure to the left

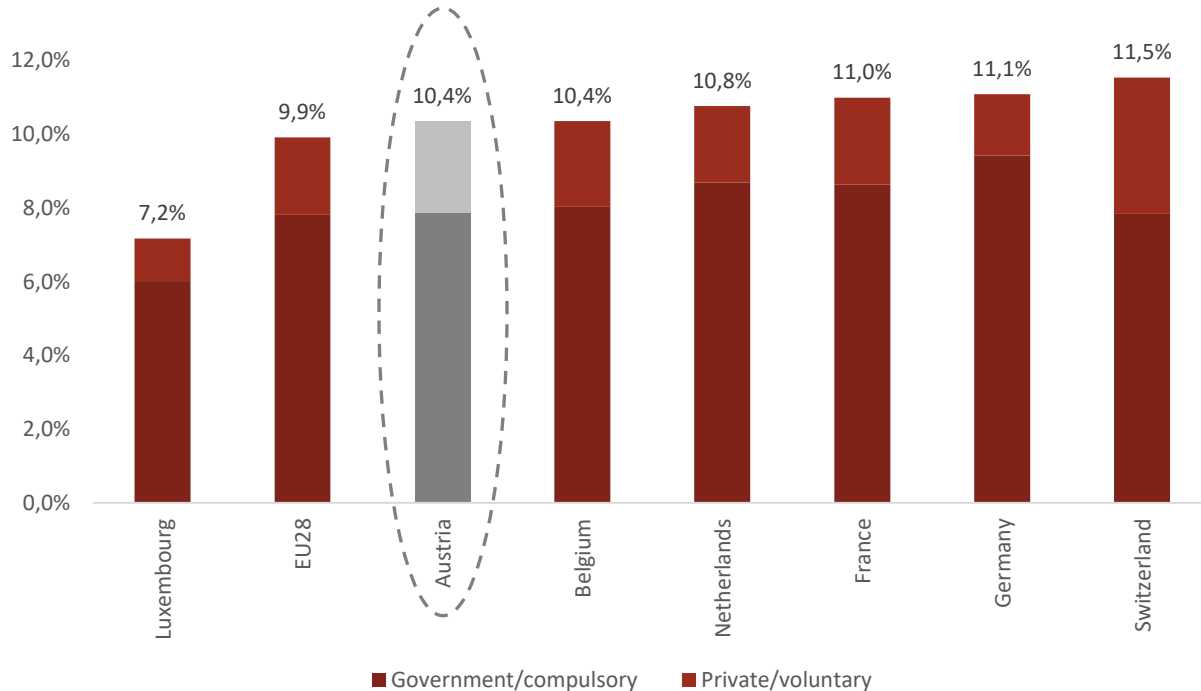
*Excludes discharges of healthy babies born in hospital (between 3-10% of all discharges).

**Includes same-day discharges

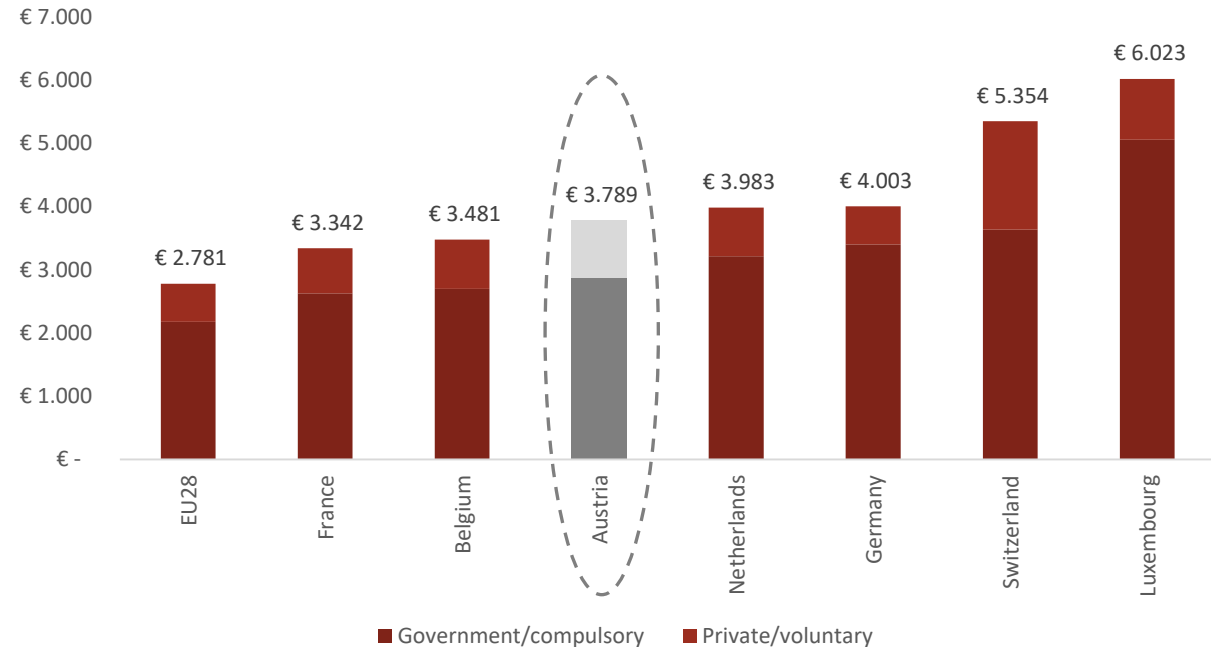
Key international comparisons

Healthcare expenditure

*Health expenditure as a proportion of GDP
(European social insurance systems) (2015)*



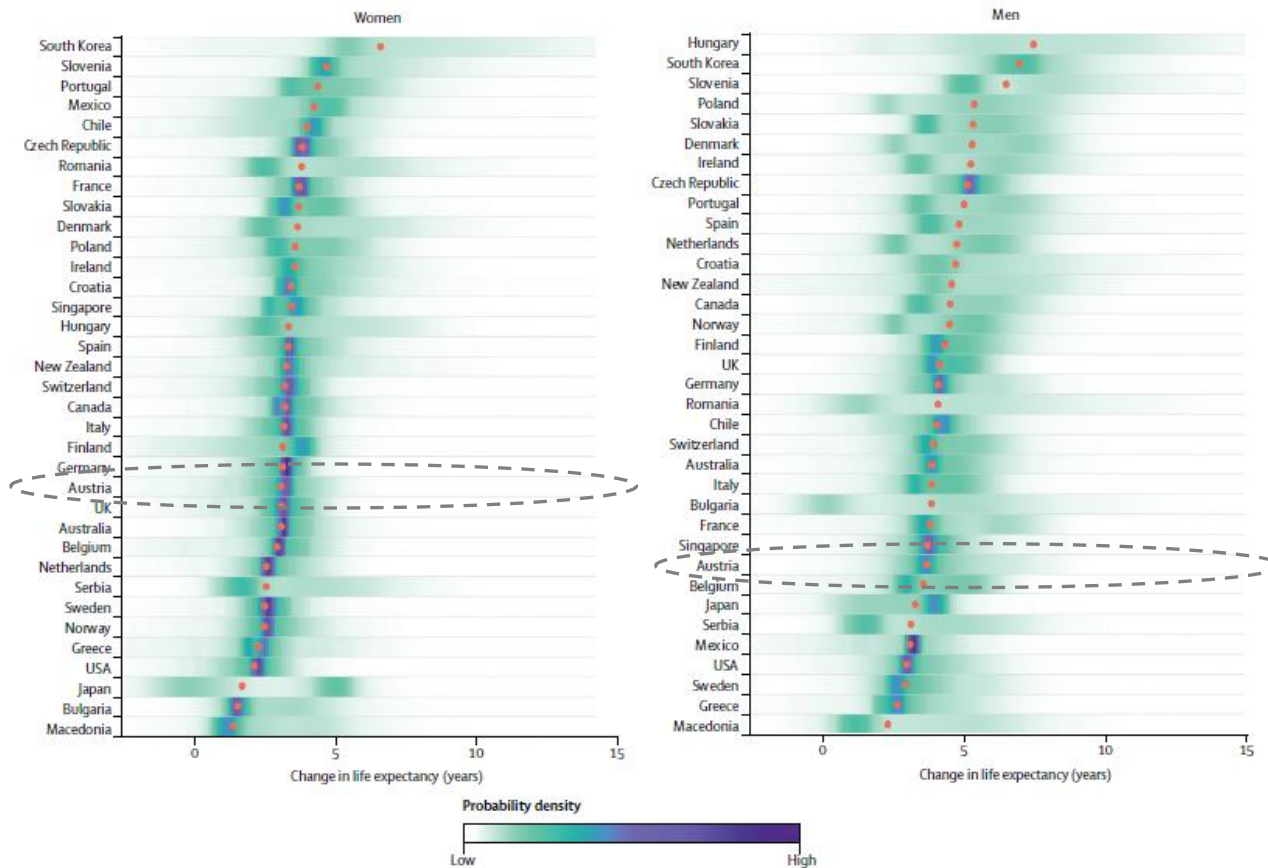
*Total health expenditure per capita
(European social insurance systems) (2015 or nearest year) (€ PPP)*



Despite high rates of hospitalisations and a disproportionate number of doctors, healthcare expenditure is not excessive in international terms.

Key international comparisons

Health outcomes

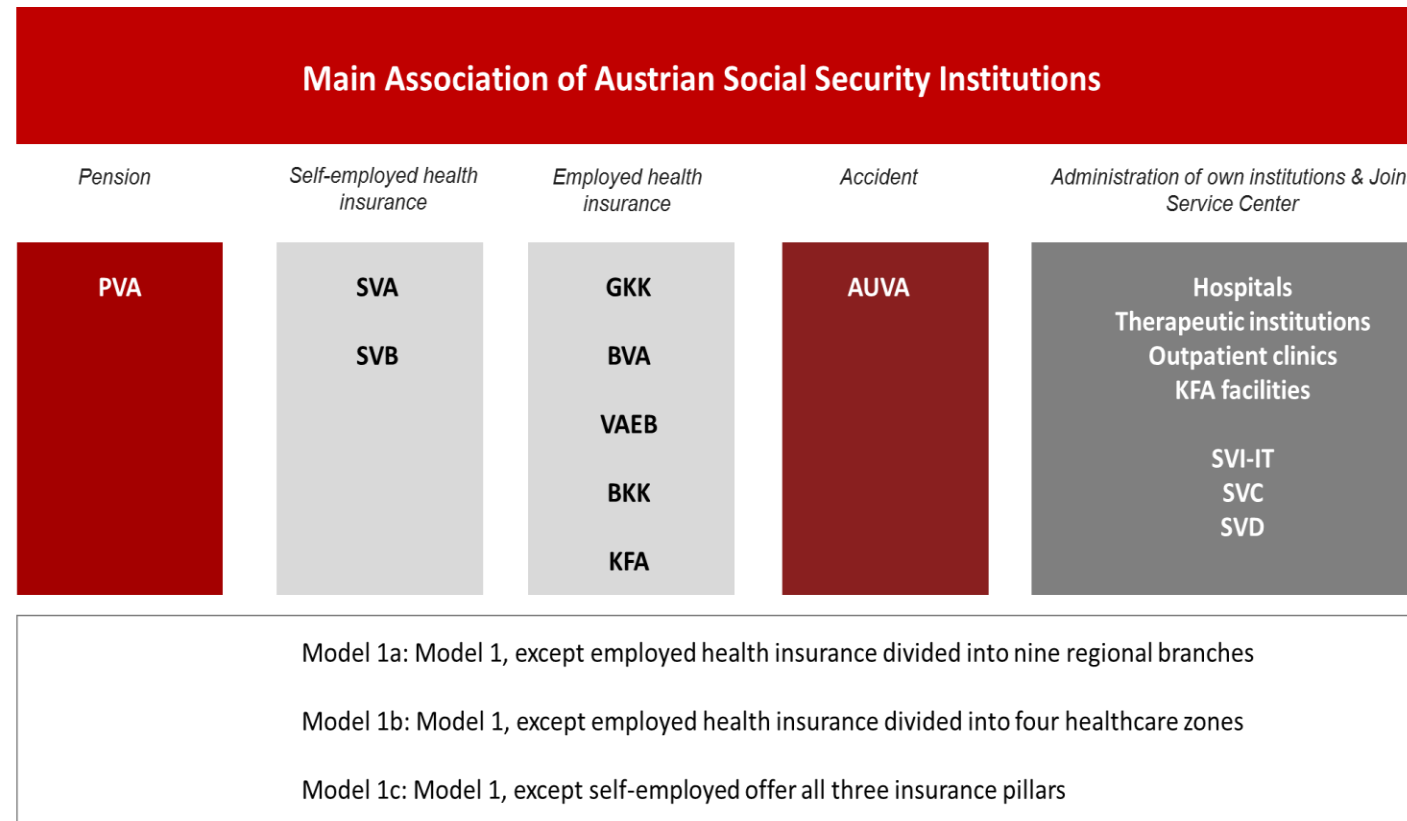


- Kontis *et al.* (2017) found that Austria was in the bottom half of the 35 countries analysed in regard to the median projected change in life expectancy at birth from 2010 to 2030 (for both men and women)

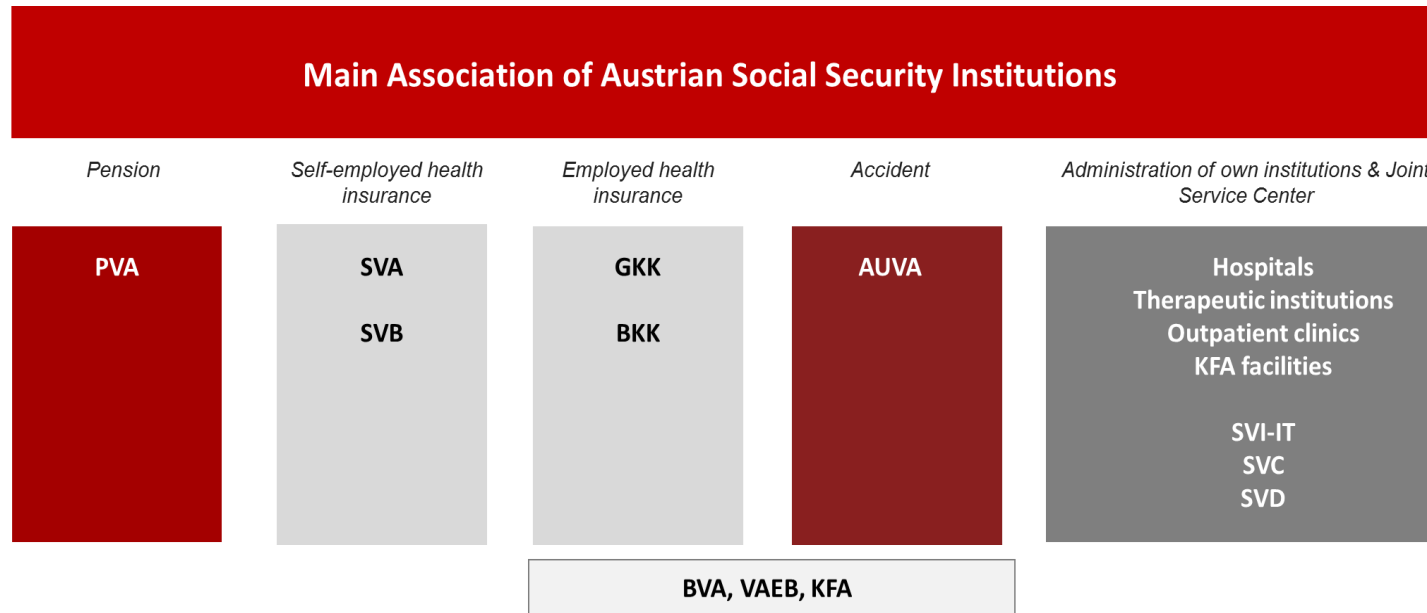
Pre-requisites for consolidating the social insurance system in Austria

- Harmonisation of benefits
- Streamline the contractual system
- Harmonise codification of the tariff system
- Harmonise outpatient consultation codification systems

Model 1



Model 2



Model 2a: Model 2, except employed health insurance divided into nine regional branches

Model 2b: Model 2, except employed health insurance divided into four healthcare zones

Model 2c: Model 2, except self-employed health insurance covering accident and/or pension insurance

Model 3



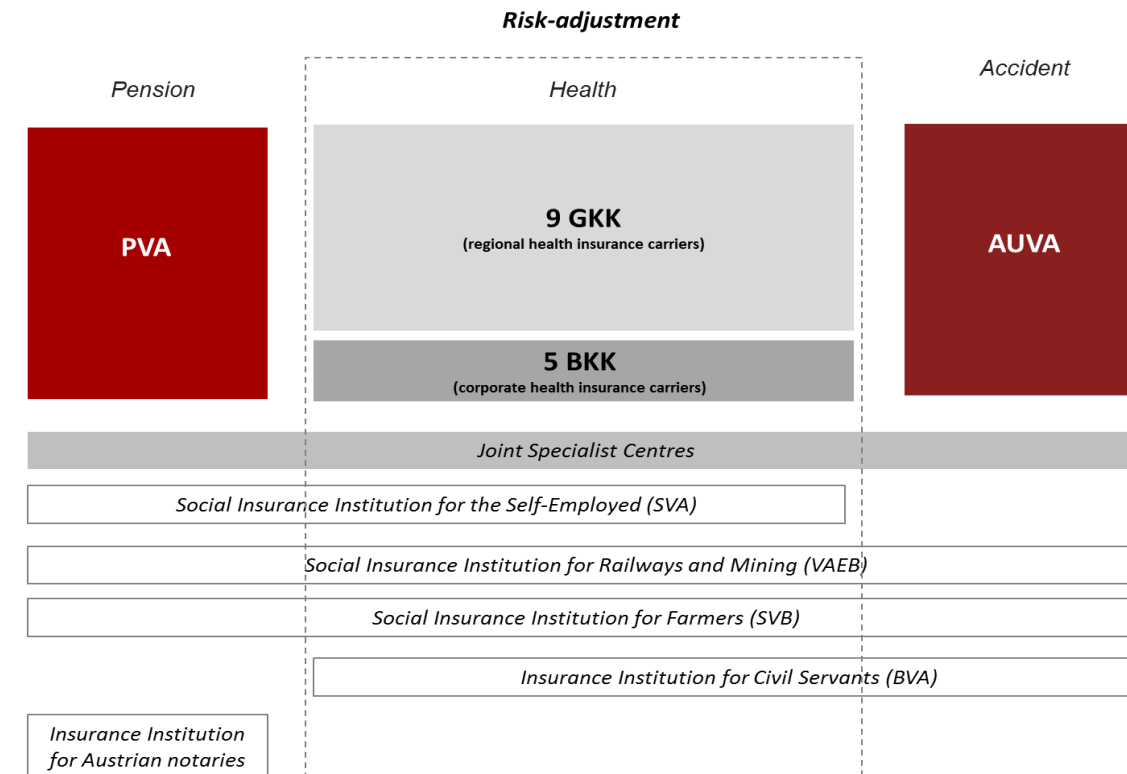
Model 3a: Model 3, except employed health and accident insurance divided into four healthcare zones

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)

Model 4

Main Association of Austrian Social Security Institutions



Policy options

Risk-adjustment options

| Risk-adjustment option | Description | Implementation |
|------------------------|--|--|
| Option 1 (RA1) | All funds received by social health insurance carriers to be risk-adjusted through a central agency (i.e. HVSV). | Mutually exclusive |
| Option 2 (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. | Mutually exclusive |
| Option 3 (RA3) | RA3 would amalgamate existing risk-equalisation schemes into one pool of funds to be used for risk-adjustment purposes. | Could be jointly implemented with RA4 and/or RA5 |
| Option 4 (RA4) | Carriers would subsume responsibility for hospital outpatient departments using an appropriate level of funds from State Health Funds. These funds would be allocated to a central agency (i.e. HVSV) responsible for redistributing monies to carriers based on a range of risk-adjustment factors. | Could be jointly implemented with RA3 and/or RA5 |
| Option 5 (RA5) | 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. | Could be jointly implemented with RA3 and/or RA4 |

Policy options

Estimated costs of harmonising a specific set of benefits (1 of 3)

| <ul style="list-style-type: none"> Medical aids and therapeutic appliances Dentures Health care services: psychotherapy, physiotherapy, logopedics | Floor 1: Increase per capita expenditure (PCE) levels to the average PCE across all carriers | Floor 2: Increase per capita expenditure (PCE) levels to 70% of the highest PCE across all carriers |
|---|---|--|
| Total additional costs per year of harmonising specific benefits across all funds | €171.075.130 | €390.177.440 |
| (Total expenditure for the specified benefits post-harmonisation) | €936.812.053 | €1.155.914.363) |
| Percentage change in expenditure of SHI for the specified benefits | ↑22.3% | ↑50.9% |
| Costs of a partial harmonisation for specific goods and services as a percentage of total expenditure for all SHI benefits | ↑1.1% | ↑2.24% |

Data based on the Income Statements of carriers (2015)

Policy options

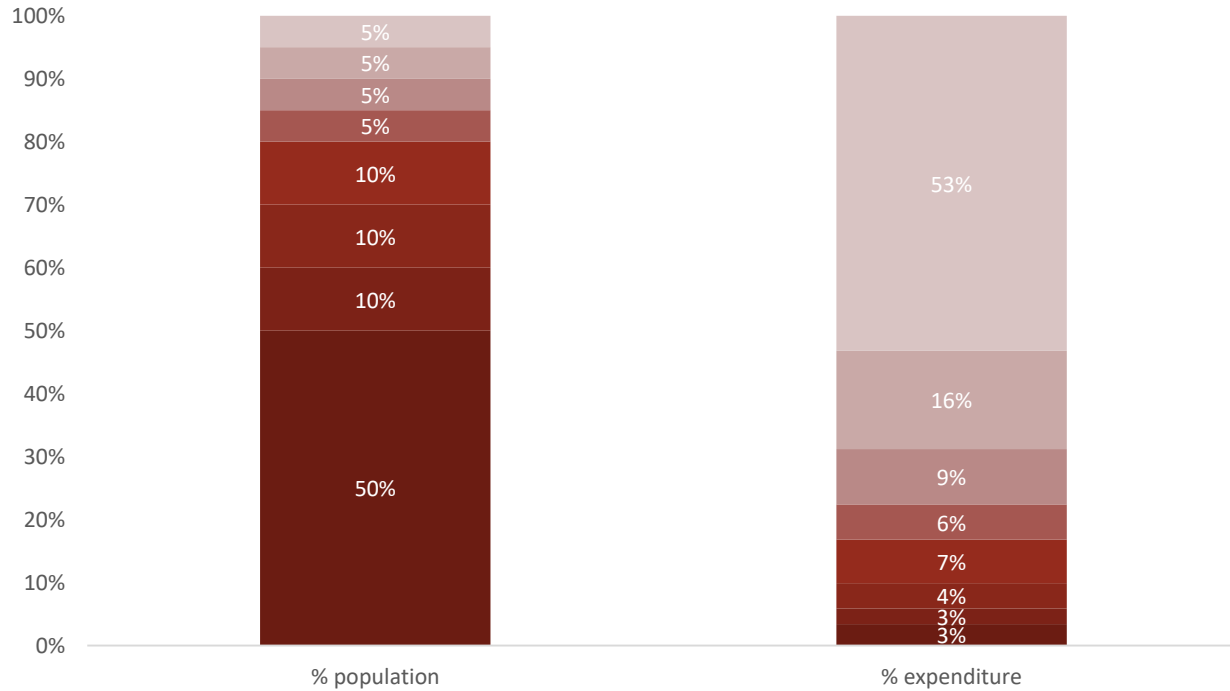
Healthcare quality

| Policy option | Description |
|--|--|
| Role of ÖQMed | Either: a) Retain ÖQMed and create an additional independent quality committee who would hold ultimate responsibility for monitoring the quality of care provided by physicians, or b) Relocate ÖQMed to the Ministry of Health and Women's Affairs. |
| | Maximise the value of quality data collected through, for example, providing physician feedback, sharing best practice principles, and/or in the long-term, linking quality to financial remuneration |
| Data availability and quality indicators | Standardise coding for outpatient diagnoses |
| | Increase focus on outcome and process indicators, and where possible link outcome indicators to aligning process indicators. In addition. link quality indicators across the spectrum of care (e.g. primary, inpatient and long-term care) |

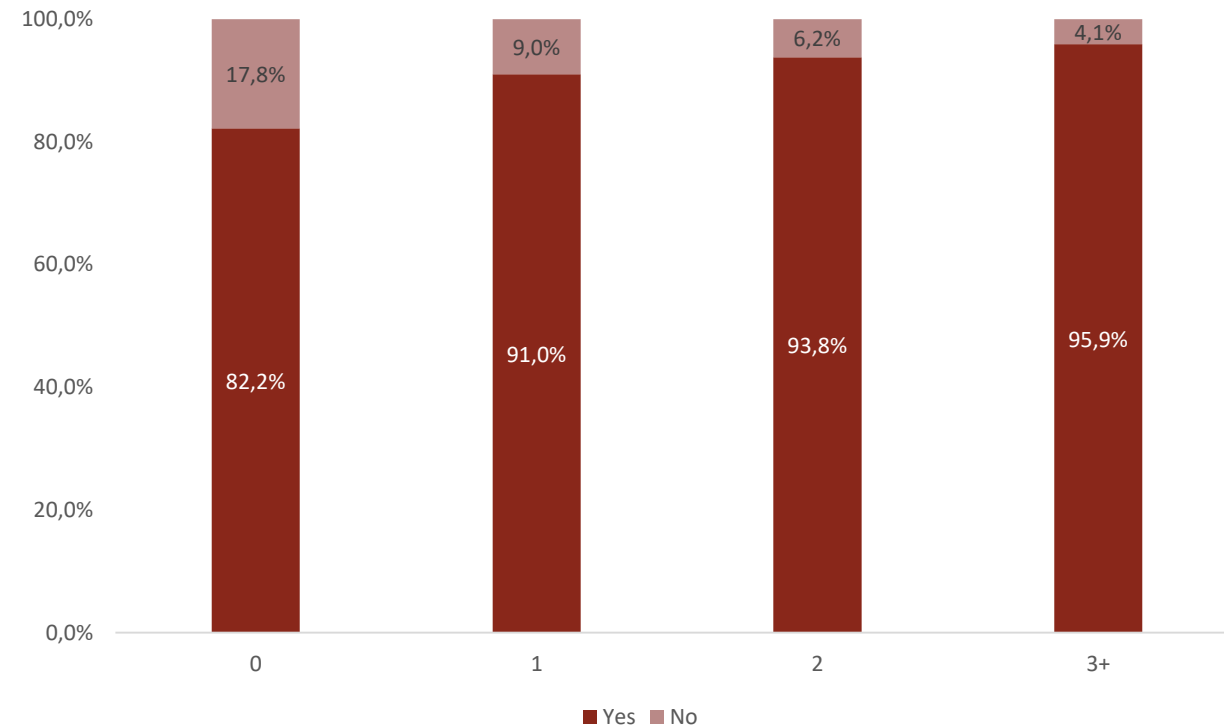
Policy options

User charges (1 of 2)

Distribution of health expenditure for the German population



Frequency of access to doctors associated with number of chronic conditions (Austria, 50+)



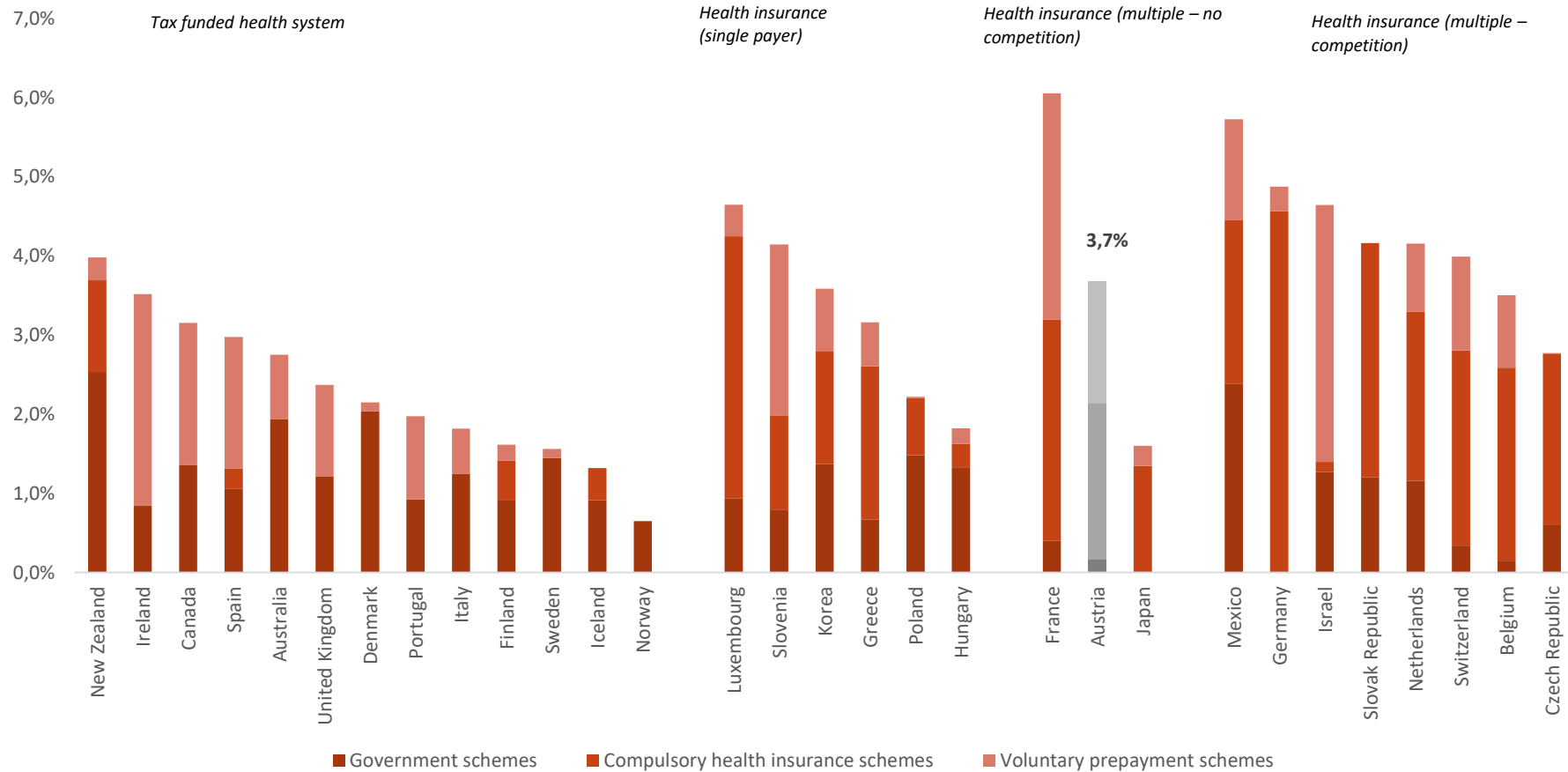
Policy options

User charges (2 of 2)

- Develop a **tiered pharmaceutical expenditure cap** to ease burden on low-income earners:
 - 1.5% net income cap for low-income earners
 - 2.0% net income cap for middle-income earners
 - 2.5% net income cap for high-income earners
 - Potentially extend to all forms of healthcare
- Implement **value-based user charges**, with lower patient costs for products/services deemed to be of high quality/effectiveness by an independent body
- Continue the trend of **converging to lower rates of user charges** across social health insurance carriers

Administrative costs

(International comparisons)



Estimated efficiency gains

| Area | Current expenditure | Lower bound | Upper bound |
|---|---------------------|--|--------------------------------------|
| Administration costs | | Reduction of 10% in (1) 45.9 Mio | Reduction of 10% in (2) 75.2 Mio. |
| (1) Social insurance | 459 Mio. | | |
| (2) Overall government admin. Expenditure (health admin. and insurance) | 752 Mio. | | |
| Inpatient care (total) | 12 bn. | Reduction of 10%: 1.2 bn. *Only 30% of the amount will be saved, as the rest will be redirected to primary care or will fund fixed hospital costs 360 Mio. | *40% 480 Mio. |

| Area | Current expenditure | Lower bound | Upper bound |
|--|--|---|---|
| Inpatient care: Procurement of pharmaceuticals | <p>*Assumption: hospital expenditure on pharma is 10% (1) to 20% (2) of total pharmaceutical expenditure:</p> <p>(1) 277 Mio. (2) 554 Mio.</p> | <p>Reduction of 5% in (1) 13.85 Mio.</p> | <p>Reduction of 5% in (2) 27.7 Mio.</p> |
| <p><i>Generic pharmaceuticals</i></p> <p>Public overall spending on generics</p> | <p>1.3 bn.</p> | <p>Reduction of 5% in public overall spending on generics 65 Mio.</p> | |
| | | <p>Increase consumption of generics by 10%</p> <p>Approx. 65 Mio., depending on the dynamics of the market.</p> | |

| Area | Current expenditure | Lower bound | Upper bound |
|-----------------|---|--|--|
| Fraud and error | <p>1% of insurance benefits (in France)</p> <p>5-8% of total healthcare costs (in Germany)</p> <p>Assumption: 1% of total public expenditure in Austria</p> <p>265 Mio.</p> | <p>Reduction of 30%</p> <p>79.5 Mio.</p> | <p>Reduction of 50%</p> <p>132.6 Mio.</p> |
| Total | | <p>692.3 Mio.</p> <p>2.61% of public expenditure</p> | <p>845.5 Mio.</p> <p>3.19% of public expenditure</p> |

Concluding remarks

- There are no 'magic bullets' to change healthcare systems for the better, given their complexity
- There is an assumption in all countries that other countries are 'doing it better' (not correct!)
- Change, for the better, will not come from doing only one thing well, but doing several things well concurrently
- It is important to build upon successes, which in Austria are low levels of unmet need and high access to services
- To improve quality, it is necessary to reduce unnecessary services, and increase life expectancy and health outcomes.

Acknowledgements

- LSE Health would like to thank:
 - The Institute of Advanced Studies (Vienna), the international evaluation committee, the University of Salzburg, and Ernst&Young Management Consulting (Vienna) for their significant contributions to the review
 - Members of the Ministry of Labour, Social Affairs and Consumer Protection, and the Ministry of Health and Women's Affairs for their assistance in collecting data relevant to the review
 - All stakeholders who participated in the review for providing their feedback and thoughts on how efficiency within the system could be improved

Remaining Policy Options

Policy options

Defining benefits (additional considerations)

Additional considerations:

- **Promote a full HTA for a subset of technologies**
 - Formal evaluations could be introduced across technologies that have important resource implications (high cost/high volume); a threshold for this purpose should be established.
- **Establish clear parameters regarding the conduct of HTA**
 - E.g. type of evidence requirements and the types of evidence that can be admitted into assessment and appraisal.
- **Provide guidance and information on the process**
 - E.g. 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; the monitoring and implementation of decisions; structure and composition of the relevant committee (technology Appraisal Committee – TAC); national-regional-local trade-offs that exist in different circumstances.

Policy options

Public health – Health literacy (1 of 2)

- **Improving health communication between patients and doctors:** Clear health communication between patients and doctors could be further improved by specifying criteria pertaining to the communication process (e.g. ‘teach back’; avoiding jargon) in the medical chamber’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.

Policy options

Public health – Health literacy (2 of 2)

- **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 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.
- **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.

Policy options

Public health – Immunisation (1 of 2)

- **Inclusion of vaccinations in the mother-child passport:** create awareness and incentivize immunisation of children to increase the 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.

Policy options

Public health – Immunisation (2 of 2)

- **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.

Policy options

Public health – Diabetes (1 of 2)

- **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.

Policy options

Public health – Diabetes (2 of 2)

- **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 experienced 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.

Policy options

Collection of contributions for single insured

- **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 and which can be rendered fiscally neutral.
- **Aligning the BVA contribution base with that of regional funds:** 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 to foster equity in the collection of contributions across funds.

Policy options

Investment in 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 the 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

Monitoring and information needs (1 of 3)

- **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.

Policy options

Monitoring and information needs (2 of 3)

- **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.

Policy options

Monitoring and information needs (3 of 3)

- **Expansion of data collection:** a more extensive patient record, which e.g. 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

Healthcare fraud

- **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 instance of healthcare fraud