Diploma Thesis

(In)equity of Health Care Services Provision - Comparing Austria, Finland, Germany and Norway

submitted by

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Declaration of Authorship

I, Mathias-Maximilian LINDERMUTH, hereby certify that this thesis has been composed by me and is based on my own work, unless stated otherwise. No other person's work has been used without due acknowledgement in this thesis. All references and verbatim extracts have been quoted, and all sources of information, including graphs and data sets, have been specifically acknowledged.

Jerusalem, am 01.06.2016 Mathias-Maximilian Lindermuth eh.

Preface

After a period of peace and prosperity after the Second World War, since Europe has chosen cooperation over confrontation, a new generation of young professionals is facing new challenges.

The financial crisis of 2008 has shown the weakness of an interconnected global economy relying too heavily on the financial market. In the aftermath of bailing-out institutions of the financial market and key-institutions of our society (pension funds and insurance companies, e.g.), public debt has risen significantly throughout the world but especially in the Western Countries.

To face the challenges of growing public debt, governments throughout Europe have implemented diversely strict austerity policies, which are affecting all government sectors, including the health care sector.

Therefore, I wish to compare the affects of a variety of health care policies implemented in Austria, Germany, Finland and Norway since the financial crisis, analyzing whether they have boosted or lowered equality within their respective populations.

By putting implemented ideas and reforms to a test, this diploma thesis shall contribute to a conclusion how the health care sector can react to precarious funding and what measures need to be undertaken to reform the social welfare state, built after the Second World War.

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Zusammenfassung

Problemstellung: Der öffentliche Haushalt ist in ganz Europa seit den wirtschaftlichen Entwicklungen ab 2007 unter Druck geraten. Einsparungen und Kosteneffizienz sind das Thema – auch im Gesundheitsbereich. Es gilt Strategien zu finden, trotz Einsparungen, ein solidarisches Gesundheitssystem aufrechtzuerhalten und den Bedürfnissen der modernen Medizin anzupassen.

Ziele und Forschungsfragen: Das Ziel der Arbeit ist die Evaluierung von Reformen und Strategien, die die Regierungen der Fokusländer (AUT, GER, NOR, FIN) seit 2007 unternommen haben, um der prekären finanziellen Situation zu entsprechen. Darüber hinaus werden die Herausforderungen der verschiedenen Gesundheitssysteme so herausgearbeitet, dass sich die LeserInnen selbst eine Meinung über die jüngsten Entwicklungen in den Gesundheitsbereichen oben genannter Staaten bilden können. Abschließend werden weitere Reformansätze in einem hypothetischen Gesundheitssystem mit dem administrativen Charakter des Österreichischen Gesundheitssystems aufgezeigt.

Methoden: Literaturrecherche. Als Einleitung wird der Begriff von Gerechtigkeit im Gesundheitssystem definiert – darauf aufbauend werden die Gesundheitssysteme genannter Staaten und kürzliche Reformen anhand der Definitionen: Bedarfsgerechtigkeit, Chancengleichheit im Zugang, Finanzielle Viabilität, Leistung und Effizienz, mit ökonomischen Variablen (zB Ärztedichte) aufgearbeitet.

Ergebnisse: In allen Fokusstaaten sind Reformen im Gesundheitswesen im Gange, welche sich in dreien dieser Staaten aus der prekären Budgetsituation seit 2007 ergeben. Österreich begann eine Reform 2005 und 2013, die vor allem eine Stärkung der Primärversorgung zum Ziel hat (zB. Gruppenpraxen etc.). Dennoch zeigen sich Ineffizienzen, beispielsweise durch die Parallelität an Anbietern im Gesundheitsbereich, dem Fehlen eines universellen Datenaustauschsystems (ELGA wird vielfach abgelehnt und zahlreiche PatientInnen nehmen daran nicht teil) uvm. Deutschland will mittels "Medizinischer Versorgungszentren" ein gatekeeping-System im Primärversorgungsbereich etablieren. Problematisch stellt sich die Tatsache dar, dass 10% der Bevölkerung privatversichert sind, und diese dem öffentlichen Sozialversicherungssystem abhanden kommen. Finnland steht vor geographischen Herausforderungen. Der Mangel an Fachkräften im Gesundheitsbereich in abgelegenen Gebieten führt dort zur Ungleichheit im Angebot von Gesundheitsleistungen. Diesen Herausforderungen wird durch das Schaffen einer neuen, einheitlichen Administration sowie durch Attraktivierung dieser abgelegenen Regionen für Fachkräfte des Gesundheitswesens, begegnet. Norwegen hat als einziges Schwerpunktland keine prekäre Finanzsituation und finanziert das Gesundheitssystem aus seinen Erdöleinnahmen. Da aber mit einem zur Neige gehen der Erdölvorkommen zu rechnen ist, wurde jüngst eine Reform eingeleitet, welche verschiedene "national priority areas" definierte (zB. Ausbau der psychiatrischen Krankenpflege etc.), in die verstärkt investiert werden soll.

Alle Schwerpunktländer sind aber mit einer Kosten-intensiven demographischen Entwicklung konfrontiert.

Schlussfolgerungen: Augenmerk dieser Arbeit liegt auf dem Vergleich der Gesundheitssysteme der Fokusländer mit dem Ziel der Herausarbeitung wie ein möglichst solidarischer Zugang zu einem hypothetischen Gesundheitssystem, das die administrative Basis des österreichischen Gesundheitssystem hat. Für dieses hypothetische Gesundheitssystem werden Präventionsstrategien, bspw. Reformansätze der Verhältnis- und Verhaltensprävention, präsentiert, Vorschläge zur Verkürzung der Arbeitszeiten von Ärzten, eingebracht, die Eigenständigkeit der Gemeinden in der Primärversorgung (community based health care system), betont, welche in Modellregionen getestet werden könnte. Die Reform der Langzeitpflege wird ebenso angeregt (Niederländisches Modell), wie auch Projekte zur Förderung von health literacy vorgeschlagen werden (kanadische Projekte).

Schlüsselwörter: Verteilungsgerechtigkeit im Gesundheitssystem, Finanzkrise, Österreichische Gesundheitsreform 2013, health literacy, health promotion.

Abstract

Background: Due to the economic developments since 2007 there are financial restraints on budgets throughout Europe. Therefore, the public health care sector has to contribute the necessary savings. Strategies have to be developed to ensure that health care institutions are better able to raiserevenue with out the fundamental solidary principle of European health care systems at stake.

Aims and objectives: This diploma thesis aims to evaluate recent implemented policies or reforms in regard to whether these have lead to more or less equity in health care services provision in the focus countries Austria, Germany, Finland and Norway. Challenges of the current systems shallfurther more be presented to discuss these recent developments. Gained information shall then be used to propose amendments to a hypothetical health care system with the administrative framework oft he Austrian one.

Methods: Presented work is based on a literature review. First, literature is reviewed due to whether it defines equity within the health care sector, followed by assessing the afore mentioned reforms based on the following variables: equity in service provision (the provider'sinfluences on thedemand), equal opportunities (access to health care services), financial viability (pricing and usage of services), performance (fast and effective treatment) and efficiency (ratio of costs to benefits). To assist in this assessment further economical variables are introduced (e.g. density of doctors).

Results: Research has shown that the health care systems of the focus countries are currently under reform, which is mainly due to afore mentioned financial restrains on state budgets. With the health care sector reform of 2013 (e.g. "Gruppenpraxen" or "reform pool" projects), Austria is expecting a higher number of patients in the primary health care sector. Inefficiencies arise from a multitude of low-threshold health care providers, the lack of a universal data sharing system (ELGA does not include all health care users), and an unresolved Long Term Care problem. Germany's health care system is trying a similar approach - with "Medizinischen Versorgungszentren" hospital owners are employing general practicioners and specialized doctors to redirect patient flows. However, 10% of Germans currentlyopt-out of public insurance, and for private insurance. These health care users can be considered mainly as contributers. Both Germany and Austria are willing to strengthen the Primary Health care Sector within the current reform frame works - a key aspect of these reform approaches will be the assignment of a gatekeeper function to the general practicioners. Finland is facing challenges providing health care in remote areas, due to the fact that the number of health care professionals in these areas are low. A current reform is trying to steer health care professionals to remote areas via certain incentives. Another key objective is the implementation of one administrative body. However, the Finnish health care system in general succeeded in improving public health by implementing certain preventive and curative policies. Norway faces fewer limitations in providing health care due to its high tax base and ist oil revenues but is in need of structural reform to keep up with innovation in the health care sector as well as implement a value-for-money approach and proper cost-effectiveness for the post-oil-revenue future. A recent reform aims to improve patient rights by guaranteeing waiting times through implementation of prioritization systems. Furthermore, "national priority areas" have been defined, which shall lead to more funding allocated to psychiatric, preventive, rehabilitation andcomprehensive nursing care. All countries have in common that they are facing increasing health care costs due to the current demographic trend.

Conclusions: One of the focuses in this literature review is how the Austrian health care sector can build on the reforms of 2013. The importance of prevention is stressed, and combined condition as well as behaviour oriented prevention policies are suggested. A general lowering of working hours for physicians and a community based health care system for testing in model regions are recommended. The reform of Long Term Care is brought up and the Dutch System for Long Term Care is presented as an example. Finally, projects to further health literacy among patients, especially the elderly, are mentioned and practical examples from Canada introduced.

Keywords: equity of health care services provision, financial crisis, Austrian health care system reform 2013, health literacy, health promotion.

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Abbreviations

WHO **W**orld **H**ealth **O**rganization
GAVI **G**lobal **A**lliance for **V**accinations and **I**mmunization
GDR **G**erman **D**emocratic **R**epublic
FCIC **F**inancial **C**risis **I**nquiring **C**omission
IMF **I**nternational **M**onetary **F**und
US **U**nited **S**tates
NHI **N**ational **H**ealth care **I**nsurance

For my family, especially my grandmothers who have wished to see me finish my studies

Either write something worth reading or do something worth writing.

Benjamin Franklin

Chapter 1

Introduction

1.1 What is equity?

”Equity“ has a multitude of meanings, defined by the context we use it in. According to an Oxford English Dictionary, the word equity is defined as “the quality of being fair and impartial“, whereas “equality“ – a word, in literature widely linked to “equity“ – is defined as “the state of being equal, especially in status, rights, or opportunities“. These two terms are very much intertwined and shall help to compare countries in this diploma thesis. On the other hand, “inequity“ is defined as a “lack of fairness“ or even “justice“. “Inequality“ is defined as “the difference in size, degree, circumstances, etc.“ or as “lack of equality“ [1].

The meaning of “equity“ also varies with one's very own profession and the field of science one works in:

Philology, for example, may have particular interest in the origin of the word ”equity“: ”equity“ derives from ancient greek, where the term's meaning can be specified as a reasonable and moderate exercise of one's rights. As typical for stoic philosophy it shall be avoided to insist on one's own rights too firmly. By being self-moderate the problems of living together in a society shall be overcome.

In the science of psychology, Equity Theory [2], which was developed in 1963 by J. Stacy Adams who was a behavioral psychologist, offers an own equation in which one's own inputs and outcomes are compared to a partner's ones:

$$\frac{\text{individual's outcomes}}{\text{individual's own inputs}} = \frac{\text{relational partner's outcomes}}{\text{relational partner's inputs}}$$

This multitude of meanings make it much more necessary to define one meaning as a basis for this diploma thesis. As a health care professional, the author understands "equity" in the wider context of Health Equity, which means fairness and justice in the provision of health care services. Therefore, this term shall be assessed based on the following variables[1]:

- Equity of demand (influences of the providers on the demand)
- Equal opportunities (access to health care regardless of income or status)
- Financial viability (pricing and usage of services)
- Performance (fast and effective treatment)
- Efficiency (ratio of costs and benefits)

To better understand these rather abstract terms, the author will interpret equity of demand by assessing whether it is easy for patients to access health care services (gatekeeper function vs. free choice to attend a registered doctor or go to the hospital directly) or not so. Equal opportuinties will be discussed by showing how many of a focus countries‘ population are insured via the public system, and how many have additional private insurance as well as for which health care services patient's have to pay contributions. Financial viability of health care systems has been an issue since the economic developments of 2007 and therefore reforms are under way. These reforms are focusing on the Primary Health Care sector[2] and day-clinic treatment as hospital beds are reduced due to them being cost-intensive. This is why the Primary Health Care sector of the focus countries will be presented alongside the general presentation of the health care systems in Chapter 2. Throughout Chapter 3 and 4, the financial viability of certain reforms or reform policies (such as the Dutch system of Long Term Care) will be presented to show cost-saving approaches in the focus countries and how they push or lower equality in the health care sector. Presented diploma thesis will further discuss performance of the health care systems of the focus countries, thereby evaluating waiting times, especially between publicly insured and private insured patients. Finally, questions of efficiency shall be raised and discussed whether prevention measures and registered doctors help saving costs by providing quality, low-threshold health care.

Additionally, economical variables of the OECD (Organisation for Co-operation and Economical Development) shall be used to outline health equity during the course of

[1] See Online Resource: "Principles of health economics (including the notions of scarcity, supply and demand, marginal analysis, distinctions between need and demand, opportunity cost, margins, efficiency and equity)", Link: http://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4d-health-economics/principles-he

[2] See for further information: The World Health report 2008" – http://www.who.int/whr/2008/whr08_en.pdf

this diploma thesis. Equity of demand and equal opportunities are also a matter of the availability of doctors in a certain region, thereby the denisty of doctors and the number of hospital beds per inhabitants shall be shown further on.

As reforms are still under way in almost all example countries, financial viability shall be outlined through comparison, thereby opposing how much is spent on the public health care sector, to what in turn is covered for through public payments [3, 4].

1.2 Defining equity in Health Care and its provision

Having defined how variable equity may be seen by a variety of different sciences, the focus shall turn in more detail to the question what equity means in the context of health, health care and its services provision. In the following chapters the health care systems of Austria, Finland, Germany as well as Norway and services provision in the mentioned countries shall be described in more detail.

Equity in the context of health, may define health itself as of extreme (market) value to our economic system: As a healthy individual one is able to work and therefore provide for yourself and others, e.g. your children. Being healthy offers one the possibility to better one's life circumstances by working, and through paying one's contributions to the sickness funds (or via taxes to a National Health Care System, as in Finland and Norway) providing for possible injuries or illnesses. A healthy individual has a higher market value for his/her employer as the employer does not have to cover for possible sickness leaves often.

If health care services are defined as an elementary need provided by the state, sickness funds or a tax-financed system can be considered equitable, as these institutions/systems eleviate the individual from covering the total of their health care costs [5], thereby promoting equality among one country's population.

As one's genetical predisposition differs, as one's risk behaviour (lifestyle, nutrition, substance abusing behaviour) and one's individual development, as well as our perception of being sick or being healthy differs, equity in regard to health be defined by one's current health status - but by the access to diagnostics and treatment. Health related inequity occurs if one's state of health mostly depending on your socio-economic status, this indicates health related inequity. Such inequity is perceived as unfair, as higher morbidity and mortality related to social factors (distribution of wealth and income for example) is considered avoidable, compared to personal dispositions (such as predisposition or risk behaviour) [6][3].

[3]See: Mielck 1994, page 14

Nevertheless: One's life expectancy is lower if you are a member of a population group with a lower socio-economic status - mainly defined by one's income, one's education and one's job -, showing - together with one's cultural background - a clear impact on the development of health related inequity. Having mentioned life expectancy and one's socio-economic status as clear indicators of health equity, surely sickness leaves can also be mentioned as indicators for health related life expectancy calculations in countries.

A report conducted by the World Bank in 1993 analyzing a variety of countries and their development between 1900 and 1990[4] clearly shows their interdependencies [7]:

- Income and life expectancy correlate. Especially in the first half of the last century, they increased exponentially.
- The marginal improvement in life expectancy per dollar increase of income is low and nearly non-existant for high-income people.
- In countries with a high level of income, a significant correlation between further increase of life expectancy and an even higher income can hardly be found.

This leads to further conclusions:

In addition, as wealth and a higher level of education do correlate, this has led to a better understanding of how health and illness are intertwined. This also leads to a more health-centered lifestyle. On the other hand, people with low income hardly consult medical specialists and show a higher risk behaviour, leading to a mortality which is twice as high as the mortality in academics[5]. Also sickness leave days were twice as high among early school leavers and secondary school graduates than among academics[6].

Focusing on people of one country or region, studies are showing a correlation between and individual's socio-economic status and his/her state of health [8, 9][7]. As an example for such a study, the "Whitehall Study" shall be mentioned: This study among 17000 public servants in London, showed a 3 times higher increase in life expectancy in higher pay grades than in lower ones - while the study of Kolsterhuis and Müller-Fahrnow among men between the ages of 30 and 59 years, insured by a German employees sickness fund, showed a double as high increase in life expectancy among the better incomes in comparison to the lower incomes.

However, above an income per capita of approximately 5000 USD[8], the increase of life expectancy is slowly leveling out, as shown in Figure 2, in the appendix. The

[4]See: World Bank 1993, https://openknowledge.worldbank.org/handle/10986/5976, page 34
[5]See: Siegrist, Möller-Leimkühler 1998, page 96
[6]See: Bormann, Schröder 1994, page 210ff
[7]See: Marmot et al. 1991, page 1387ff - Klosterhuis, Müller-Fahrnow 1993, page 319ff
[8]as shown in mentioned World Bank report from 1993

epidemiological threshold has been reached, where the gain in years due to the treatment of infectious diseases plateaued due to chronic sickness such as diabetes or cardiovascular diseases (so-called "diseases of affluence")[9].

This may lead one to defining a statement: The lower the income, the lower one's life expectancy. However, it is interesting to see, that differences of the level of income between countries does not as much affect life expectancy as a difference among the population of one and the same country: In 2001, Switzerland had a life expectancy of 79.9 years, and Germany one of 78.2 - but Greece with only 1/3 of the GDP per Capita of Germany, one of 78.1 years [10][10]. Thus, social cohesion within a population seems to be of importance.

Summarizing, life expectancy is determined by the socio-economic status of an individual. Health inequity, therefore, has social and economic "roots", a phenomenon that can be labeled as avoidable in a welfare state. Hoewever, total equality can not be reached, given the initially stated individual diversity with regard to genetical predespositions, risk behaviour, relationships and the development of an individual. In order to balance the impact of socio-economic status, it is possible to define, understand and change pathogenic factors.

Having shown the importance of socio-economic status, also other aspects of equity in the health sector are to be considered.

Therefore, over the course of the following chapters, the health care systems of the focus countries with regard to how they push equality among population groups of a different socio-economic status shall be compared. The social and economic factors of health equity shall be discussed in more detail, thereby proposing answers to questions such as: How equal is the access to good health if your socio-economic status is low? How "better off" are privately insured patients in comparison to those "only" covered by public insurance? How is access to health care provided in private hospitals, or medical practices? Can we take the provision of private health care as an indicator for a 2-class-medical care-system, with one "class" waiting for appointments and the others just skipping the queue to get ahead because they pay extra?

However, the presented work is mainly intended to help readers to accumulate enough knowledge to give their own answers to the questions raised, as these questions are still debated by the scientific community.

[9]See Reference 5 - Gesundheitsökonomie: Strukturen - Methoden - Praxisbeispiele, 2007
[10]See: WHO 2002, Annex Table 1, page 178ff

At this point in this diploma thesis, mainly two key questions arise: How efficient is our health care system and what does it provide? And secondly, can we continue to have it funded by the public?

To answer these questions, we have to define health as a good, that can be achieved through health care services, thereby defining a market for health as a good first (as Kessel (1958), Mushkin (1958) and Arrow (1963) have done it).

Economically, the health care sector is one of the main expenses of the GDP in modern industrialized countries. On the other hand, being in good health is essential for individual productivity. Where good health is lost, public health care insurance covers costs, itself funded by a solidarity priniciple, as is the case in the focus countries [11][11]. As previously stated, such solidary public health care coverage is perceived as essential to achieve the goal of maximizing equity, or better, equal opportunities.

With gallopping costs due to demographical developments in Western Countries, the question of how limited (funding) resources shall be efficiently allocated, has not yet been answered satisfactorily. As an "intangible good" a true market price has not been found, so different definitions were necessary to clarify how health is to be measured.

One of these is the individual production of health, which can be achieved through behaviour manipulation via the consumption of health-promoting goods. Simply stated, health increases individual human capital. This puts health as a good an individual is able to obtain.

Health care as another factor of determining health, is on the other hand a very heterogenous good. Basically, health care is obtained to improve an individual's health status. Nevertheless, its consumption is not only decided by the patient himself, but rather through an "agent", such as a physician and/or the hospital itself providing a (probably) limited range of services [12, 13][12].

Directly related to consumption are supply and demand which are key issues regarding the aforementioned questions. With regard to health as a good, the importance of supply-induced demand for health care services needs to be stressed. Such a demand can be steered through organizing a health care system, which itself influences its own efficiency and sustainability (Honorierungsstruktur - reward system). In conclusion, benefits of health care can on the individual level be subsummized as: access to the system, information in regard to diagnosis and therapy, and as being able to choose between therapy options [14, 15][13].

[11] See: Seidl (1994), pages 365ff
[12] See: Levinthal (1988) and Rogerson (1985)
[13] See: McGuire et al (1988), pages 46 - 51 and Harsanyi (1982), pages 60ff

1.2.1 Focusing on health care systems - financially viable pushing equity or are they themselves sick?

Equity is also a question of financial means. Ethically, health and the life of the individual have no price. But do the current health care systems in our focus countries truly save all those lifes that they could save? Do we really support and care effectively for everyone sick?

Looking into the future, one key question is funding. Just to give an example on how much funding is needed: IMS Health, a market research institute, found a 3.5 % increase in revenue in the pharmaceautical market for 2009, which would equal a top revenue of 550 billion euros in absolute numbers. Even in economically hard times, the market for pharmaceuticals seems to be developing just fine. This means, the public hand spent an increasing amount on pharmaceuticals as Europe is mainly relying on a solicaric principle to finance the health care costs of an individual. If one looks at Germany, in 2013 revenue on selling pharmaceuticals were at 43,37 billion euros[14]. Austria spent 32.5 billion euros on health care in 2013, 3.3 billion of these 32.5 on pharmaceuticals. Not much? 32.5 billion euros are almost a tenth of the country's GDP[15]. With such revenue no one wonders that fusions between big pharmaceutical companies between 2008 and 2009 had a volume of 200 billion euros. In the same year, Austria's GDP reached 280 billion euros.

The previous paragraphs have identified public health care as important for a society to see itself as a society of equal opportunities and of being (rather) equal. As money has been growing scarce since the economic developments of 2007 and special circumstances (such as e.g. the establishment of a bad bank for irrevocable debts of the Hypo Alpe Adria Bank in Carinthia, Austria) have put budgets under pressure, terms such as "efficiency" have been used to cover clear austerity policies in the sector: One of them is cutting jobs – with the intelligent approach that more and more work is done by fewer and fewer people leading to less personal treating more and more patients in less time, leading to longer working hours, overworking, stress and – who is wondering? – errors.

A study conducted in the local hospital in Steyr (Austria) has shown in 2002, how working hours of up to 100 hours are affecting quality, thereby looking at patients that had to be operated on a second time. If the working hours of the surgeon had been between 13 and 24 hours a day, one third of the patients had to be operated a second time. If the surgeon worked over 24 hours, around 70 percent [16]. It is common

[14]See: "Arzneimittelumsatz (in Mrd. Euro und in Mio. Packungseinheiten) in Apotheken, Drogerie- und Verbrauchermärkten" – Online Resource: Link

[15]See: Health care spending – Statistics Austria Link) and: GDP Austria Link

[16]See: "Burnout gefährdet Patienten" – Online Resource: Link

knowledge, that 24 hours of sleep depriviation have the same impact on conciousness as 1 per mill blood alcohol concentration. As long as "opt-out"-contracts work around the 48 working hours per week regulation of the EU, such happenings will occur daily.

Having picked out a few burning questions in regard to equity in the health care sector, to focus on concerns more detailed, the next chapter will introduce the health care systems of the focus countries Austria, Finland, Germany and Norway, so that recent challenges can be presented via those example states and possible approaches of solving them may be discussed.

Over the course of the following chapters, presented work aims to have a closer look at recently implemented policies or reforms in the focus countries and whether these have lead to more or less equity in health care services provision in Austria, Germany, Finland and Norway. Furthermore, upcoming and present challenges of the current systems (such as demographics) shall be outlined to discuss these recent developments. In the last chapter, gained information will then be used to propose additional amendments to policies of the current Austrian health care reform of 2013.

1.2.2 The global dimension of Health Equity – an Excursus

Health Equity is of global importance as millions of people worldwide are still striving for better or even just access to health care. As funding is growing short for international organizations such as the WHO, just recently, Philanthrocapitalism has been discussed as a possiblity to redistribute fair access to health from rich to poor. Therefore, in the course of recent events around the Ebola pandemic in Western Africa, Bill Gates has announced in September 2014 that - via the Bill & Melinda Gates foundation - he will contribute 50 Mill. USD to support the efforts of the international community to confine the outbreak to the area and treat all infected swiftly and efficiently.

The Bill & Melina Gates Foundation is with assets worth 42.3 billion dollars [16][17] surely one of the biggest world-wide operating organizations, dedicated to improve life circumstances of people in Developing Countries, their access to Health Care and proper education including.

Apart from its own projects, which they organize via a donation and grant system, they are also contributing to the budget of the WHO. As all 194 member states of this international organization are cutting back on their contributions, nowadays, 80% of the funding derives from free contributions or donations. As such contributions are depending on the good will of donors, they can not be counted on for sure. This affects

[17] As of 30th September 2014 - see link to their statistics in the bibliography

the possibility to react to an outbreak such as the one of Ebola drastically: The etat for emergencies was halfed: from 469 million Dollar in 2012/2013 down to 228 million Dollar in 2014/2015 [17]. This makes any contribution of a big donor all the more important.

Linsey McGoey, professor for sociology at the University of Essex, states in an interview: *"Do we then support and salute the growing role of philanthropic actors in this space? The answer, for a number of reasons, may be no. We need to start looking at why States are retracting their commitments to aid spending at the international level in today's climate. One of the reasons stems from very complex but observable changes that have happened in the space of global economic governance, and particularly in the space of increased financialisation. We observe very high rates of inequality at the national and international level. We have seen an incredible enrichment of the wealthiest individuals on a global level, and there is a direct correlation between increased wealth accumulation, regressive tax measures, and funding towards philanthropic activities."* [18], thereby outlining the source of a growing possibility of philantrocapitalism as a replacement to governments engaging in international aid and relief services. Professor McGoey states further, *"Philanthropy may be growing, but only in the context of rampant inequality. Many people suggest that we need to reconsider how we can increase political measures to help ensure more distribution of wealth at the level of taxation and at the level of increasing government resources for spending on health, rather than assume that the needs of various marginalised populations can be met through hoping that private philanthropic players will spend their fortunes in a socially just way."* [18, 19][18], thereby outlining the basic problem: Philantropy relies on the good will of a philantropist, whereas governments or (inter)national organizations have clear policies, clear duties, defined by laws or international treaties which are shaped by elected officials, whose work is continiously financed by taxes. Such institutions outweigh the defined "hope" for good will clearly, as these instiutions on the one hand are comprised by a multitude of people which are put in these positions by democratic election or - if public servants - via a selection processes. On the other hand we are facing just a small group of philantropists - which raises a burning question: Can there ever be enough philantropists for the people in need of a proper access to health care? Insitutions, on the other hand, have defined obligations and tasks - and therefore outweigh good will, however honourable it may be.

If the "outsourcing" of international aid and relief services to private foundations continues, an international public health policy is replaced by an uncoordinated variety of individual projects, which are defined by clear cost-benefit-ratios, as Bill Gates puts it himself: *"I have been sharing my idea of catalytic philanthropy for a while now. It works*

[18]See Online Resource - hinnovic.org - "Philanthrocapitalism, the Gates Foundation and global health – an interview with Linsey McGoey"

a lot like the private markets: You invest for big returns" [20][19]. But "big returns" do not apply that well to Ebola, as Ebola outbreaks tend to happen in rural and remote areas. To battle such a disease, a whole treatment infrastructure will then have to be implemented, training for health care professionals caried out and more.

Public-private partnerships offer an opportunity to keep health care budgets in balance in these financially precarious situations in many donor countries. But to promote and push Health Equity worldwide, it has to be organized as a balanced partnership - not only oriented at a cost-benefit-ratio or economy-oriented thinking. The contributions of the private sector can therefore be an addition but never a replacement, as then the fate and well-being of humanity would be lying in the hand of a few donors with very individual - and individually different - agendas, beliefs or interests. After all, a foundation does not need to render an account to anyone about anything. Governments, on the other hand, get (re)elected. Accountability is a cornerstone of their work life and work process.

Even though the good doing of several individuals is a honourable thing, it leaves one with a shallow taste - as Jeremy Youde, lecturer at Minnesota Duluth University, puts it: *"There is no public debate about the granting of [their] funds"* [17][20], [21].

This excursus has shown the global importance of health equity and possible hazards of replacing public funding with private investors. Public-private partnerships can function, if policies are conducted on a broad basis of principles and are not allocated in regard to individual interests. Furthermore, the innovative capacity of the private sector and their additional control function is included and that may proof a viable basis for health care reform approaches.

1.2.3 Health Care Systems under pressure – Developments in Europe since 2007 [21]

Though reforms of the health care sector started to take place in the focus countries in the early 2000s, a main stimulus for continuous reform has been given by the economic crisis of 2007 onwards.

Since then, health care budgets have been under considerable strain as bank bailouts increased spending by simultainiously plummetting tax revenues. This was followed by austerity policies in all departments of national governments and so have struck in the

[19] See Online Resource in bibliography - "Bill Gates: Here's My Plan to Improve Our World - And How You Can Help" - 11.12.2013

[20] See, Die Zeit, Nr. 44, "Der Weltgesundheitspapostel", Online Resource in Bibliography - 23.10.2014

[21] [16]

health sector as well: Cost reduction shall be reached by pushing for more efficiency, but also by implementing or raising user charges (Finland, Norway), cutting bonuses and benefits (transportation coverage, dental health care...), by removing services from benefit packages and freezing salaries of health care professionals. Some countries elevated taxes on alcohol (Finland) or tobacco (Austria, Germany) but also imposed new taxation such as for soft drinks (Finland) or sparkling wine (Austria).

The various causes for the economic developments since 2007 are still not fully understood and currently focus of research in many disciplines. However, to understand why the focus countries have not been as severely affected by budget cuts in the health care sector as in the Southern Economies (e.g. Spain, Greece, Portugal...), it is important to present the findings of the Financial Crisis Inquiring Commission, set up by the US Government: The FCIC stated in its final report that an abundance of investments in mortgage-backed securities including high-risk debts, which were in addition poorly administered can be considered the origin of the crisis. These packages led to a rise of interest which in turn led to borrower defaults as paying back loan and increasing interest rates was simply to much to handle for many households. As loans defaulted, banks, contractors and insurances (which insured debts for a possible default) came under pressure until some had to file for bankruptcy, sending the housing and stock markets in a week-long free fall.

Ireland, Spain or Italy - just to give examples - had banks mostly investing in such mortgage-backed securities and additionally supporting the building of huge housing complexes, thereby developing so-called "property bubbles". These were at first similarly fuelled by loans with low interest for the private sector until the market turned and interest rates increased. Then, debts could not be paid back anymore - and the whole charade began anew, this time, in Europe.

Other countries, such as Austria, were hit later on in the crisis as its population hardly invested in such mortgage-backed-securities, but more in gold, housing or just keeping savings with their local bank. To use economic terms: Austrians invested more "conservatively", instead of at the stock market.

This is why the economic crisis hit those countries without huge "property bubbles" at a later stage, when recession followed after the almost collapse of the European banking sector. Even though Austria (also because of its tight economic links to Germany) did rather well during the crisis, one has to wait for the budgetary affects of the execution of the bad loans of the Hypo Alpe Adria Bank - as well as the economic development of Finland (after a deficit of 239 million Euros in 2014, Nokia generated a profit of

177 million Euros in the first quarter of 2015[22]), to see how health care budgets will develop over the following years. On the other hand, Norway, as of now, has hardly been affected by the crisis and therefore did not report any direct affects on the health care sector[23] - while Germany implemented reform measures already lined out in the previous chapter[24].

1.2.3.1 Effects of the economical developments since 2007 on the Health Care Systems in the EU

The effects on the health care systems in the EU are as diverse as its member states [22]. Some countries were better prepared as they adopted fiscal measures already in the early 2000s (e.g. by setting aside financial reserves for health care investments), other countries protected their health budgets from any cuts (Belgium or Denmark, which subsidized the health care budget with funds from the educational budget) and many - such as Austria - used the stimulus of the crisis to strengthen their negotiation position with other stakeholders in the sector (such as the pharmaceutical companies, regarding drug prices - or the doctors association, regarding service reimbursment).

Austria used the crisis to speed up reform by introducing the Austrian Health Fund Law in September 2009. Measures of mentioned law include an annual government subsidy to the sickness funds but require them in turn to cut costs. In 2009, the subsidy was set at 100 million Euros but plummeted over the years to 40 million Euros since 2011 due to budget consolidations. Furthermore, a Debt Forgiveness Law was introduced, writing off debts of the sickness funds, between 2010 and 2012. To offer relief to low-income policy holders of the sickness funds, as of 1st January 2008, a ceiling was implemented for prescription fees. This ceiling sets a limit of 2 % of a policy holder's annual net income to be spent on prescribed drugs, after which the person is exempted from all further charges occurring from prescribed drugs for the rest of the calendar year. The sickness funds predicted a number of approxiamtely 300 000 people to be benefiting from this new law but as the economic downturn continues, it is yet unclear who will pay for the revenue losses due to this new law.

Finland decreased the extent of coverage by increasing user charges for many health services (by 10% in 2010[25]) - a measure taken, which may cause concern as households

[22]See Online Resource: "Nokia überraschte mit starkem Umsatzwachstum im ersten Quartal", Link:http://derstandard.at/2000015096550/Nokia-ueberraschte-mit-starkem-Umsatzwachstum-im-ersten-Quartal

[23]See Reference 32 - page 23

[24]See Chapter 2 - "The Health Care Systems of the focus countries", subsection "The German Health Care System"

[25]See Reference 32 - page 59

are burdened more financially and probably reduce the willingness of low-income policy holders to obtain care when they are sick.

Finnish municipalities have also introduced a service voucher which shall increase the freedom of choice of users of public services. Currently, those are mainly used for social services but an introduction for use in health care services was planned for 2011. Additionally, Finland increased alcohol taxes in 2012 and introduced a special tax on soft drinks.

Having shown example policies on how the focus countries have reacted, the outcome of these measures taken cannot yet be fully assessed. However, looking at previous economic crises may help to understand how societies have dealt with such extraordinary circumstances. Generally, societies see a correlation between unemployment on the one side - and suicides and murders on the other [23][26], whereas a rise of 3 or more % in unemployment lead to an increasing number of alcohol related deaths[27]. Finland and Sweden have shown to be exceptional in that regard as in the early 1990s, though unemployment rose, suicides dropped. Social cohesion and a vast public social support network might be the key to understanding this phenomenon. Apart from suicides, unemployed people also face a higher possibility to be in the need of psychological support.

But to further understand impacts of major economic crises, one has to find major historic events relating to an economic disturbance such as the crisis from 2007 onwards. Both the Great Depression of the early 1930s and the break-up of the Soviet Union proof to be suitable for such a task: With both events, a rapid fall in life expectancy can be observed, when people had to face privatisations that were undertaken with great haste or when cheap alcohol was widely available (such as in many successor states of the former Soviet Union). However, such a rapid fall was mitigated in countries with strong markers of social capital, where people were to a large number members of religious groups or trade unions. Also when cheap alcohol was not available - such as during Prohibition - people's life expectancy did not fall that quickly. A study looking at data from the OECD countries during 25 years[24], showed that a 100 USD increase in social welfare spending per person per year led to a 1.19% decrease in mortality of all causes. In countries which spent less than 70 USD per person per year (e.g. Spain) an economic downturn led to more suicides while an expenditure of at least 300 USD led to no negative short term effect on the overall population's health (e.g. Finland spent as much).

[26] As shown by Martikainen and Valkonen, See Reference 23
[27] See Reference 31 - page 1325

Being unemployed or fearing being unemployed showed adverse effects on mental health while income reduction, growing health care costs for the individual and cuts in health care services provisions prevented patients to ask for care in time, thereby leading to negative effects on overall population's health as already notable in Greece, Spain or Portugal[28].

This shows that a strong social cohesion and wide provision for access to health and social care services for the most vulnerable members of society are of highest importance especially in times of a deteriorating economy.

Such reforms are due to the financial burdens that many European countries have to face since the economic developments of 2008. Though Iceland is not one of the focus countries of this diploma thesis, its reactions to the collapse of the Icelandic banking sector also triggered structural reform in their health care sector, which may proof as a thought-provoking impulse for further discussions:

The Icelandic government deregulated the banking sector in the mid 1990ies, leading to small Icelandic banks investing big on the US subprime mortgage market - and as it collapsed, these banks suddenly faced gigantic losses.

The IMF immediately offered a rescue package, asking the Icelandic government to take over the banks' losses, having the Icelandic people pay 50% of their national income to private and public entities in the UK and the Netherlands between 2016 and 2023. Due to massive protests following this announcement, a referendum was held in which 93 % of the voters rejected the rescue package proposed by the IMF.

Though the UK government quickly invoked anti-terrorist legislation to freeze Icelandic assets, Iceland invested further in social protection and reregulated the banking sector which gave the Icelandic people a feeling of unity. Health improved also as Icelanders turned to cooking at home and started eating more traditionally again (as imports became more expensive due to the drop of value of the króna), going so far as forcing Mc Donalds to pull out of Iceland. Iceland also retained its restricted policies towards alcohol consumption [25].

Well done, Iceland? Even though this statement may be debatable, future statistics will shows how structural reforms like above mentioned may affect the health of the Icelandic population positively.

However, recent data of the WHO shows that deaths due to ischaemic heart diseases or stroke further declined, which may be already considered an effect of these structural reforms.

[28] See Reference 22 and 32

Such structural reforms can be considered key elements of condition oriented prevention. In opposition to this concept, a variety of measures of behavioural oriented prevention policies – such as a boni-mali-system – could have also been implemented. Both concepts shall be presented in the last chapter of this diploma thesis [23].

1.2.4 Outlining current reform approaches in regard to financial viability of health care systems

In all focus countries, reforms are under way. One such reform to level costs and make them more transparent, has been the implementation of DRGs - or Diagnosis Related Groups. Such DRGs offer a fixed amount paid to a department / the hospital per each diagnosis. This development lead to a significant reduction in the amount of days a patient is admitted to a hospital, furthering the reduction of available hospital beds, increasing in turn readmission rates[29] [26]. A focus on minimal-invasive-procedures can be seen as well.

The reorganisation of hospital financing via DRGs has shifted the focus of a hospital centered public health care system to an ambulatory one - with cost transparency increasing, comparising of hospitals made easier and furthered competition among hospitals. However, it shall be stated that mainly private and profit orientated hospitals were able to increase their market share due to this development[30]. This shift to day hospital procedures shall also be discussed at a later stage in this thesis.

However reform approaches may look like – and a few will be discussed during the course of this diploma thesis, it is essential, that a publicly financed health care system providing for a country's population survives any cost-cutting-measure. A final report of the commission on Social Determinants of Health has shown that publicly funded health care systems are evidently more effective in promotion redistributions in countries where these are financed through general taxation and/or mandatory universal insurance[31].

This statement as well as the impact of user fees on health outcomes shall be discussed in the later stages of these diploma thesis. In this report, the importance of Primary Health Care is stressed as well: A model focusing on prevention and its promotion in balance with investment in curative intervention with adequate referral to secondary and tertiary care, which is why, over the course of the following chapter, the primary health care sector of the focus countries shall be presented.

[29] See Geissler et al., 2011

[30] See Reference 26 - Rothgang et al, 2010

[31] See: "Closing the gap in a generation" - Final Report by the Commission on Social Determinants of Health - http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703$_e$*ng.pdf*

In the focus countries, primary care is largely exercised by general practicioners, to whom people attend to in case they are sick. These general practicioners may work solo or in group practice, and are reimbursed either from social insurance or public funds. Any form of disease prevention or health promotion is not at the centre of such a system, focused on dealing with already occured sicknesses.

To encourage reform and implement public health elements into primary health care systems has been discussed since the beginning of the 2000s, including the following approaches:

- promoting the establishment of group practices (Germany, Austria);
- promotion of teamwork between different health professionals – reorganisation of tasks between physician and other health care professionals;
- introduction of additional payment for certain services (e.g. immunization) and partial capitation payment to supplement fee-for-service;
- increase in the range of services provided by general practicioners (e.g., community-based mental health services and minor surgery - Norway);
- strengthening of the gate-keeping role (e.g., by limiting budgets for certain procedures, thereby making primary care providers budget holders directly responsible for providing services for their patients, or restricting access to secondary and tertiary care without referral).

Primary care continues to be physician-centred and oriented towards curative services. Group practices and teamwork are emerging, but most GPs still work alone. They often compete with specialists for patients. Their gatekeeping role is limited if patients can go freely and without additional financial cost directly to a specialist or to a hospital outpatient department (Austria or Germany). A general trend has been to introduce market elements (for example in Germany, Greece, the Netherlands), along with elements of integrated care. Traditionally, the trade-off between equity, efficiency and choice in these countries is bent towards more choice and efficiency and less equity[32].

This chapter has defined an interpretation of equity and variables to approximate this abstract term. Additionally, recent European (structural reforms in e.g. Iceland) and global developments (Private-Public-Partnerships) in the health care sector have been shown. The final paragraph of this chapter shall outline the further structuring of this diploma thesis:

[32]See Online Resource – Primary Health Care“, Link: http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care

- Chapter 2 presents the health care systems of the focus countries. As their primary health care sectors will play a key role in future reforms in these countries, they will be discussed in depth. To structure this chapter, Michael Moran's typology of health care states is used[33].
- Chapter 3 will assess how the current status of the health care systems presented in the previous chapters pushes equity, which shortcomings have come to the attention of the author and what challenges these systems are facing. Current reform approaches in the various countries are also outlined.
- Chapter 4 will summarize drawn conclusions of the previous chapters, suggesting a reform of a utopian health care system with the administrative framework of the Austrian health care system, whose reform of 2013 is introduced at the beginning.

A health care system combines approaches from prevention, over health care services provision in hospitals and with doctors in private praxis, to rehabilitation and Long Term Care. This diploma thesis will focus on health care services provision in hospitals and with registered doctors in the Primary Health Care sector, assessing specialized doctors only where necessary for comprehension (e.g. with waiting times in regard to assessing performance and equal opportunities). However, as possible improvements to boost equality in health care systems shall be discussed in this diploma thesis, questions of prevention measures as elements of health care reform will be discussed and a concept of Long Term Care will be presented in the conclusions, where suggestions for possible adaptions to health care systems to push equality in these systems are made on the basis of the administrative framework of the Austrian health care system. Therefore, these topics will be covered in more depth with the focus country Austria.

[33] Regarding Michael Moran, see introductional statements of chapter 2, and Reference 34

Chapter 2

Health Care Services Provision in Austria, Germany, Finland and Norway - Present Status

2.1 The health care systems of the focus countries

Having raised a variety of concerncs with health care systems in Austria and Germany, this section shall have a closer look at the health care systems of the focus countries Austria, Finland, Germany and Norway, followed by present challenges in more detail and concluding with showing possible approaches to finding solutions to these challenges at hand.

2.1.1 Countries with a social insurance system - focusing on Austria and Germany

In a country with a social insurance system, any service - from diagnostics, drugs or treatment - derives from being a member of one of the sickness funds and paying one's insurance contribution. Through one's contribution, each insured person is entitled to the insurer's performance in case one is in need of it. That is why, an insured person is allowed to go to the hospital or the general practitioner with only (in Austria) an "e card" to pay for the treatment. In regard to equity of demand, mentioned in the previous chapter, this is a very low-threshold provision of health care services, as no gatekeeper steers patient flows: Whenever a patient is sick, he can choose freely to go to a hospital's outpatient department, a general practicioner or a specialized doctor, even though appointments at specialized doctors do have longer waiting times. Apart

from one's own contribution, one's employer pays a certain amount for each employee to the sickness funds as a contribution to his employee's health insurance policy. Support from the government via taxes is also necessary to cover the health care costs. It is striking that, though the government supports the sickness funds via its tax income, it offers the sickness funds more room for manoeuvering in conducting their daily business. Only framework legislation is provided by the government. Austria for example has 19 different sickness funds[1], each of them has its own scope of services rendered to its own insured - as well as its own type of forms. This diversity of services rendered, as well as whether and how much patient contributions are asked for, vary with each sickness fund. This may cause inequality among patients insured via the public system. However, this issue will not be discussed in presented diploma thesis, as only access to the health care system as a whole shall be the focus of this work in regard to equity of demand.

2.1.1.1 The Austrian Health Care System [28]

The Austrian social insurance system was implemented in 1889 - and its services provision has grown ever since. Putting it in exact numbers on who is not a member of the social insurance system is hardly possible - one newspaper article puts forth a number: Approximately 100 000 people are not members of the social insurance system in Austria[2]. In 2009 a support fund was set up for those sickness funds with low contributions, called "Kassenstrukturfond".

One's membership depends on one's profession: There are seperate sickness funds for workers and employees, for self-employed, farmers, railway employees and miners, as well as public servants. An insured person will be assigned automatically to one of the sickness funds in regard to one's profession and in which federal state one works, as the sickness funds are regionally organised. Pensioners, people without work and students are obligatorily insured by means of a different system. If one earns below 405.98 Euros a month, one may choose to become a member - while self-employed persons are obliged to be insured, but may stay self-insured through a private insurance company and therefore are not obligatory a member of the social insurance system. Children, relatives in need of care and non-working spouses are insured by the working parent or spouse with no extra contribution to be paid.

[1] See Online Resource - Link: https://www.help.gv.at/Portal.Node/hlpd/public/content/289/Seite.2893001.html

[2] See Online Resource: Kurier, Print Issue: 11.09.2013: "100 000 Österreicher haben keine Versicherung" - Link: http://kurier.at/chronik/oesterreich/100-000-oesterreicher-haben-keine-versicherung/26.201.959

2.1.1.1.1 Financing of the Health Care Sector in Austria

In 2013 Austria spent 9.8 % of its GDP for its health care system[3] - which equals in absolute numbers a total of 20.441 billion Euros. In comparison to other OECD countries, Austria spends 3842.4 Euros - adjusted to purchasing power and per capita - only being topped among EU member states by the Netherlands with 4252 Euros[4]. Even though this number includes private spending too, a total of 75.2 % of health care costs were paid by the public hand in 2013[5].

Contributions to the sickness funds are equal to every sickness fund and every profession (since 2003) and are calculated with 7.65 % of one's monthly income. However, this is limited to being calculated from a monthly income of 4650 Euros[6]. As a worker/employee, approximately half of the 7.65 % are paid by the employer (it varies with one's legal profession status). Even though most treatments and drug costs are covered by this contribution, additional contributions and patient contributions ("Selbstbehalte") vary with each sickness fund. Generally, each insured has to pay for each prescription with a fee of 5.55 Euros [7] and a fee of 12 to 28 Euros per day, a maximum of up to 28 days a year, for staying in the hospital[8]. There are exceptions to this fee for being admitted to the hospital: e.g. if one delivers a child, or donates organs. If one has a very low income or pension, one can apply for being freed of mentioned fees.

The "e card", which indicates one's membership to a sickness fund and one's public insurance status, does also come with a yearly "service contribution" of 10.83 Euros (for 2015) will need to be paid by the 15th of November[9].

2.1.1.1.2 Organisational Structure of the Health Care System in Austria

The system is here divided in "mural" and "extramural" health care service provision. Under "mural" health care services one may understand all services provided to a patient in a hospital during his admission to one. Hospitals are members of a managment cooperation (such as e.g. the KAGES in Styria), which are individual for each federal

[3]See Online Resource: "Gesundheitsausgaben in Österreich laut System of Health Accounts (OECD) 1) 1990 - 2013, in Mio. EUR", Link: http://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/gesundheit/gesundheitsausgaben/019701.html

[4]Numbers of 2013 - See Online Resource: "Health expenditure and financing - Measure: per capita, current prices" - Link: http://stats.oecd.org/index.aspx?DataSetCode=SHA

[5]See: Link, footnote 3 in this chapter

[6]See Online Resource: "Beitragsrechtliche Werte 2015 - Link: https://www.sozialversicherung.at/portal27/sec/portal/esvportal/content/contentWindow?contentid=10007.683724&action=2

[7]See Online Resource: "Rezeptgebühr" - Link: https://www.help.gv.at/Portal.Node/hlpd/public/content/169/Seite.1693902.html

[8]See Online Resource: "Was kostet der Spitalsaufenthalt?", Link:https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/Was_kostet_der_Spitalsaufenthalt_HK.html

[9]See Online Resource: "e-card Service Entgelt", Link: http://www.chipkarte.at/portal27/portal/ecardportal/content/contentWindow?contentid=10007.678600&action=2"

state in Austria. By the law, it is the obligation of each Austrian federal state individually to cover both all necessary investment as well as the running costs, which is done via reimbursement on the basis of generalised DRGs (diagnosis related groups). The rest of the occurring costs will be reimbursed by the sickness funds, which come up for the above mentioned costs. Though many hospitals are offering more and more day-clinic-procedures, Austria still provides a high number of hospital beds per 1000 inhabitants: 7.65 in 2013[10].

"Extramural" health care services are provided by both general practitioners and specialized doctors, hospital policlinics and dentists. With these mentioned providers each sickness fund concludes a contract about what services are considered to be covered by the sickness fund as well as how much they will be paid for exercising these services. If a doctor has a contract with the sickness fund, a 100 % of the doctor's reimbursement is paid by the sickness fund. If the doctor is "just" a "doctor of one's free choosing" (Wahlarzt), only 80 % are refunded. Generally, in comparison to other OECD countries 4.97 doctors per 1000 inhabitants is quite a high number of "extramural" health care provision[11]. A sickness fund can also offer to refund a 100 %, if there are not enough doctors in the area, who have a contract with the individual patient's sickness fund.

2.1.1.1.3 Excursus: The 2013 health care system reform in Austria

In regard to inpatient care (care for patients admitted to the hospital), Austria utilizes 35% of its current health care spending, while only 25% is used for ambulatory care, which is lower than in other OECD-countries [29]. The spending on inpatient care even increased over the last years in comparison to other expenditure in the health care sector, showing that all planning and reform attempts had little influence on balancing the scales between inpatient and outpatient care. Some success has been achieved between 2005 and 2011 through capacity building initiatives such as "reform pools"-funds (via such a pool fund, the above mentioned AEE is financed) and "Ärzte GmbHs".

With the recession of 2009 onwards, Austria's budget deficit reached 2.18% of GDP in 2012, with public debt increasing to 92% of GDP in 2012 and public spending to 51% of GDP[12]. To tackle these developments and to achieve a balanced budget by 2016, a consolidation plan was implemented, which should save 26 billion Euros. In order to support this consolidation plan, a budget cap, gradually leveling public health

[10] See Online Resource: "Health Care Resources - Hospital Beds" - Link: http://stats.oecd.org/index.aspx?DataSetCode=SHA#

[11] See Online Resource: "Ärzte und Ärztinnen 2013 absolut und auf 100.000 Einwohner nach Bundesländern", Link: http://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/gesundheit/gesundheitsversorgung/personal_im_gesundheitswesen/022351.html

[12] See OECD Data on Austria - Link: https://data.oecd.org/austria.htm and https://data.oecd.org/gga/general-government-spending.html

expenditure growth was introduced, thereby trying to lower an average growth rate of 5% between 1990 and 2010 (currently at 3.6% p.a.) - which would equal to 3.4 billion Euros in absolute numbers[13]. This amount shall be covered by the federal states to an amount of 60%, while the federal government will cover 40%[14].

Generally speaking, the health care sector is contributing 13% to the total consolidation sum of 26 billion Euros.

The various stakeholders agreed on enhancing primary health care models to an extent that at least 1 % of the population are cared for via these, on establishing two multi-disciplinary ambulatory outpatient care centers and increasing day case approaches for various interventions such as hernia or cataract surgery by 2016. Moreover, regional ambulatory care providers shall accordate opening hours in the evening and on weekends to eleveate pressure on hospital ambulatory units as well as hospital admissions and average length of stay shall be reduced. This shall reduce in turn the general number of available hospital beds. These initiatives to improve primary care capacities shall set clear cooperation standards among all stakeholders and thereby making this reform a success where previous ones got stuck in debates on responsibility issues.

With a standardized managment of hospital admissions and discharge, the implementation of disease management programs for chronic disesases, the establishment of coordinated care networks, the promotion of rational use of pharmaceuticals and the set-up of a telephone-health-advisory-service by the end of 2015, corner stones of the reform have been outlined. Especially the focus on chronic diseases shall diminuish health care costs on the long run, by improving quality of life as well as lowering mortality rates (Austria intends to improve population health by gaining two healthy life years by 2020, a commitment to the EU 2020 agenda). The implementation of central electronic health records (ELGA) is still under way and widely oppposed, both by physicians and patients.

2.1.1.1.4 Health Care Services Provision in Austria

As a member, one's sickness fund will cover the cost for ambulant treatment both with extramural doctors and in hospitals, any costs that occur with dental (except dental prosthesis - which is only covered in certain cases for children with dental braces, since 2015), psychological, physio-, ergo, and logotherapeutical treatment, any costs that occur with prescribed drugs, medical care at one's home, rehabilitation costs, costs that occur during hospital admission and costs for treatment at a health resort. This will be considered as "non-cash benefit". As "Cash benefits", that are provided by the sickness

[13]See Appendix: Figure 3

[14]See: "The Austrian consolidation plan 2012 – 2016", Link at www.oebfa.at

funds, can be considered the money one earns while one is on a sickness leave as well as the coverage of one's maternity allowance.

Mentioned services are considered as legal obligations of the sickness funds, as they are part of the legal framework provided by the government. In addition, each sickness fund offers certain benefits, e.g. services for preventional treatment or contribution exemptions.

A tendency to hospital admission can still be seen in Austria, as a high number of hospital beds is still available.

2.1.1.1.5 The Primary Health Care Sector in Austria – and its reform approach

Austria's health care system has a dual system of ambulatory care both in hospitals as with general practicioners and specialised doctors. This leads to frequent visits to the hospital, especially at times when praxis are closed, leading to longer waiting times for patients with appointments and less time for patients admitted to the hospital.

To relieve hospital doctors from extra work with non-hospitalized patients, the LKH Bregenz has started a pilot project in 2012, which is called "Ambulante Erstversorgungseinheit" - or short AEE. Goals of this AEE are mainly to relieve ambulatory care provided by specialised doctors within the hospital, using a prioritization system regarding neediness of patients to distinguish real emergencies. Additionally it aims to inform patients about the health care services provision system in Austria, from general practicioners via specialized doctors in private practice to specialized ambulatory care in hospitals, to hospital admission.

In this AEE general practicioners, which are employees of the hospital, assess all patients, who seek treatment in the hospital, with the only exception of accident patients and women being over 12 weeks pregnant. At the entrance desk those patients are rated regarding their neediness by schooled nurses through an internationally approved system - the Manchester triage system - , which classifies patients after mentioned neediness in regard to waiting time allocated to them. Patients in need of immediate care will not be waiting at all, while patients who are not desperately in need of immediate attention may wait up to 120 minutes. Having been assessed, patients will be seen by the doctor according to their neediness. The general practicioner then decides upon further diagnostic measures or treatment needed - and if the patient shall be referred to a specialised doctor / general practicioner outside of the hospital or if the patient shall be seen by a specialized doctor within the hospital or needs to be sent to a hospital with certain specializations.

Possible diagnostics with the AEE are urine tests, pregnancy tests, thoracic x-ray, sonography, ECG, §8-examiniations (psychiatric assessment if the patient needs to be sent to a locked psychiatric ward). A laboratory provides information regarding electrolytes, kidney and liver parameters, bilirubin, CRP, Troponin T, blood sugar, C2-levels. Due to its location within the hospital, further diagnostics are possible if the patient is admitted.

Treatment mainly comprises of drug treatment, including anti-emetics, anti-pyretic and analgesic drugs, but also clysters and small surgical interventions are provided for. To stress the fact that the Austrian health care system actually does not allow self-hospitilization, no sickness leaves are granted to or control appointments with the patients are offered by the AEE.

With this concept, 12.546 patients have been provided with immediate care in the AEE since 2012, with 32.4% having been treated completely with their visit in the AEE, 29.4% of the patients have been sent to general practicioners and specialized doctors outside of the hospital, while 37.9% have been cared for within the hospital by specialized doctors.

In general, of mentioned 12. 546 patients, 62.3% could actually have been adequately cared for by a general practicioner or a specialized doctor in private praxis instead of coming to the hospital for treatment[15].

These 12.546 patients had to wait approximately 49 minutes on average - with a doctor-patient-time of 11 minutes to follow. These patients mainly seeked treatment of diseases of the internal medicine spectrum (27%), followed by 15% in need of surgical treatment, 12 % of pediatric cases, 10% which could be allocated to both orthopedical issues and urological ones, followed by 8% of dermatological and 6% of ENT-cases. Any emergencies are either treated at the AEE - or are transferred to specialized ambulatory care units.

In october 2014, an evaluation among hospital employees of the different departments was conducted, showing great acceptance of the implementation of the AEE-project, hardly any time loss with emergency patients and a significant relieve in patient numbers with the specialized ambulatory care.

But why was such an implementation even necessesary? Does the Austrian health care system not anyhow forbid self-admission to the hospitals? It does, but does anybody know about that? And is it sanctioned? In Vorarlberg alone, 25% of all 125.000 ambulatory care patients admit themselves to the hospital. As above quoted study shows, more than 60% of these could have been cared for outside of the hospital. And the LKH Bregenz even faced 26.000 self-admitted patients for ambulatory care per year, surpassing the average of 25% each year, with a 36% total. With the implementation of

[15] See Online Resource: "Präsentation der Ergebnisse der Vorarlberger Spitalsambulanzstudie 2010" - Link: http://presse.vorarlberg.at/land/servlet/AttachmentServlet?action=show&id=13809

the AEE, any patient coming to the hospital without having an appointment, is assessed regarding his neediness and then transferred to a specialized ambulatory care unit - or is referred to a general practicioner for further care, if a treatment and diagnostics in the hospital are not necessary. This leads to gated access to specialized ambulatory care units within the hospital, and less waiting time for patients with appointments – in turn, assuring less over-time for doctors and other health care professionals. Personell fluctuations have been declining since the implementation of the AEE as well.

The success of the AEE since its implementation has lead to the establishment of the Manchester Triage System in all departments of the hospital. Furthermore, from 01. January 2016 onwards, an interdisciplinary emergency unit including first-aid for accident patients shall be implemented. However, there is still a lack of general practicioners working in the AEE - which leads to limited working hours (Monday to Friday from 8am to 9pm - Saturday and Sunday from 8am to 8pm).

Having achieved a better organization of self-admitting patients, a relieve of specialized ambulatory care units in hospitals, thereby decreasing waiting time for patients with appointments and preventing redundant diagnostics, lead to increased public awareness in the region regarding better health care services provision at the LKH Bregenz.

Could this be a model project for organizational reform in hospitals throughout Austria?[16]

2.1.1.2 The German Health Care System [28]

Germany can be called the inventor of the health insurance system via sickness funds, which was implemented by Chancellor Bismarck in 1883, when this insurance was obligatory for industrial workers. Similar to the Austrian System, the German Federal Government is responsible for framework legislation for the health care sector, federal states are responsible for planning and financing the health care services provision in hospitals. The sickness funds are reimbursing the self-administrating partners - the doctors - for exercising "extramural" health care services. They are defining reimbursement of the doctors and covered services (and their amount - e.g. how many ECGs a doctor may write in a quarter).

Germany has 124 sickness funds (as of January 2015[17]). Among those the insured may choose freely, where they want to be insured. They HAVE to be insured, but can choose

[16]All statistics are assessed by the LKH Bregenz and are owned and generously provided by Dr. med. univ. Verena Elsensohn.

[17]See Online Resource:"Anzahl der Krankenkassen" - Link: https://www.gkv-spitzenverband.de/presse/zahlen_und_grafiken/zahlen_und_grafiken.jsp#lightbox

WHERE they want to be insured (since 1996). Only some sickness funds have limitations regarding their membership due to different reasons: some are just regional, others only for employees and workers of a certain company.

If one earns less than 54 900 Euros a year, one is obliged to be insured. Apart from that, pensioners, people without work and other retrievers of social support need to be insured as well. If one earns more than 54 900 Euros, as an employee, public servant or self-employed, one is able to choose whether to remain with the public sickness funds or change to a private one. This is why only 90 % of the working population are insured via the public system - half of the remaining, not-publicly insured working population are public servants, who are partly supported by the government for their sickness costs (50% of the costs for active public servants, 70% for pensioners) and partly privately insured. This private insurance has to cover at least ambulatory costs and costs occurring while admitted to the hospital (up to a self-coverage contribution of at most 5000 Euros).

Non-working spouses and children are insured with the paying member, but don't have to contribute. This additional benefit comes only with the public sickness funds. Furthermore, until 2009, private sickness funds were able to decline membership to an interested person or ask for additional risk contributions and service exclusions if the interested was seriously/chronically sick. Even though since 2009 private sickness funds are obliged to offer everyone who may insure him- or herself with them a certain "basic contribution fee", morbidity ratings are still better with the private ones then the public ones.

2.1.1.2.1 Financing of the Health Care Sector in Germany

Germany spent 11.3% of its GDP on health in 2012 and 2013[18] - with its per capita expenditure rising to a total of 3825.2 Euros[19] in 2013.

Turning to the individual contribution to the health costs, 2015's actuarial basis for the contribution to the sickness funds is 2835 Euros per month in the western federal states and 2415 Euros in the federal states of the former GDR[20] - with the contribution rate being lowered from 15.5 % to 14.6% (This nationwide uniform percentage has been implemented with 1st January 2009 - before then, sickness funds could decide upon their rate individually, within a given legal framework).

[18]See Online Resource - Worldbank Data Pool: Health expenditure, total (% of GDP), Link: http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

[19]Numbers of 2013 - See Online Resource: "Health expenditure and financing - Measure: per capita, current prices" - Link: http://stats.oecd.org/index.aspx?DataSetCode=SHA

[20]See Online Resource - "Bezugsgröße in der Sozialversicherung neu festgelegt" - Link: http://www.bundesregierung.de/Content/DE/Artikel/2014/10/2014-10-15-rechengroessen-sozialversicherung.html

Germany changed the parietary system of contribution rates, divided between employer and employee, and rearranged it to a 54:46 ratio in favor of the employer. This was one of the policy measures to stimulate the economy by lowering ancillary wage costs.

Since a health reform in 2007, the central government itself allocates money to the sickness funds, depending on their number of members and what sicknesses their members have. If those allocations are not enough, sickness funds have to ask for further contributions from their members - on the other hand, if a sickness fund does not spend all its money in one fiscal year, a bonus may be awarded to its members. In Germany's compulsory coverage system (but not compulsory insurance system, like in Austria) this led to an increased competition among the sickness funds, with sickness funds, which asked additional contributions, losing members[21].

Germany tried to ask an additional contribution for ambulatory visits to the doctor or to the hospital, but canceled that legislation with January 2013. Since then, one has to pay 10 Euros a day for the first 4 weeks one spends in the hospital a year.

For prescribed drugs, 10 % have to be covered by the individual, with at least 5 Euros and at most 10 Euros per drug. However, children and pregnant women are excluded from this obligatory contributions - as well as all contributions are not allowed to cost more than 2 % of the income of one's whole household, or 1 % in case of a chronically sick person being a member of the household.

Private sickness funds orientate their fees according to age, gender and health risk when a contract is signed with an interested future member. Once signed, only part of the fee is used for the actual health costs of the individual member - most of the fee are invested to cover costs in the later life stages of the (new) member. Though private sickness funds are interesting to the young, with further aging, fees are increasing, posing a problem with the newly retired as their income changes with retirement abruptly.

Concluding, it shall be stated, that as the government sickness funds, Germany's private insurance companies have hardly any capital reserves. Even though a part is invested, a major share of the payments of each cohort is used for the needs of the elderly clients. It shall be further stated that with both the public and the private health care insurance system, a patient has hardly ever to pay the health care services provider directly - which leads to them not being aware of what these services actually costs, furthering the little understanding of responsibility - and so hardly motivating one individual to economize.

[21]See Pressel 2012 [30])

2.1.1.2.2 Organisational Structure of the Health Care System in Germany

Germany's health care system is "currently under construction". Though ambulatory health care is mainly offered by general practitioners and specialized registered doctors, the government pushes for health care centers (Medizinische Versorgungszentren), which are also supported financially. Such centers are mainly founded and managed by hospital operators. Via these centres, general practitioners shall be assigned with the role of gatekeepers - and members of sickness funds shall be encouraged to attend to these gatekeeping doctors (Hausarzt-System) with a variety of boni such as shorter waiting time until one gets an appointment or no contributions for prescribed drugs etc. However, generally, the old system of "freedom of choosing" one's doctor or hospital is still in place, thereby providing a high equity of demand, as any patient can choose freely whether to attend to a registered doctor or an outpatient department at the hospital.

As ambulatory health care is mainly exercised by the registered doctors (both spezialised doctors or general practicioners), a patient can only be referred to a hospital in case of emergency or for a treatment that needs hospital admission. A shift towards a gatekeeping system can therefore be seen in these developments.There are a few exceptions with some hospitals, but in general, this is a nationwide understanding.

As in Austria, federal states are responsible for planning and exercising health care services offered via hospitals - this seems to be done thoroughly as Germany still offers a high amount of hospital beds per 1000 inhabitants: 8.3 in 2013.

2.1.1.2.3 Health Care Services Provision in Germany

The German sickness funds cover prevention, health promotion, ambulatory and hospital admission costs, dental health care (to a certain extent), drug costs, medical aid costs, home care, rehabilitation costs, therapies, corrective lenses and transportation costs (the two latter under certain conditions). Sickness and maternity leave are also covered by the public funds.

Private sickness funds however usually care for additional services, such as being treated by the head doctor or having a one- or two-bed room in the hospital. Generally, members have to pay for these services in advance and then later are reimbursed.

As in Austria, Germany still provides a high number of hospital beds, which is why a focus on hospital care can still be seen. However, a shift towards day-clinic surgery and treatment and a strengthening of the Primary Health Care Sector is happening both in Austria and Germany.

2.1.1.2.4 The Primary Health Care sector in Germany

Almost all ambulatory care is caried out by general practicioners. The majority of these physicians have a solo practice. Their local, equipment and staff is financed by the physicians themselves who are in turn reimbursed for all diagnostics and treatment rendered to the patient via the sickness fund system.

Mainly, physicians transfer their patients for cases they can not deal with (e.g. surgeries) to hospital physicians for inpatient treatment and receive them back after discharge. Therefore, post-surgical care is mainly done by general practicioners and only short check-ups with the hospital surgeons are arranged, if necessary.

Germany has no gatekeeping system, but reform towards such a one is under way. Currently, patients are still free to select a sickness-fund-affiliated doctor of their own choosing. Principally, according to the Social Code Book (§ 76 SGB V), sickness fund members select one family practitioner, with no possibility to choose during one (financial) quarter. Even though this ist he law, no mechanism of control or reinforce this self-gatekeeping are outlined in the law.

Family practitioners are general practicioners, general internists and paediatricians may choose whether they either work as such family practitioners or as specialists (§ 73 SGB V). Since specialists and family practitioners have different profiles of service reimbursement, this choosing is necessary.

The federal government tries to strengthen the stand of family practice in the ambulatory care sector, but despite all efforts undertaken, the number of office-based specialists has increased more rapidly than those of general practitioners in recent years[22].

2.1.2 Countries with a communal-based system - focusing on Finland and Norway [28]

Traditionally health care services are provided and rather freely organised on the regional and communal level, with the central government only providing framework legislation and general recommendations for health policies. This means that regions and communities are able to define independent goals and organise their health care services provision according to their special needs. Nowadays, this changes and the central government takes over more and more responsibilities (See Saltmann et al. 2012) [31].

[22]See Online Resource – Health Care Systems in Transition – Germany“ – Link: http://www.euro.who.int/__data/assets/pdf_file/0010/80776/E68952.pdf

2.1.2.1 The Finnish Health Care System

Finland still offers community-based health centers that are run by the communities in regard to their needs. Additionally, every Finn is insured via a national health insurance, which also finances certain health care services. Centralization is in Finland still on the way, but the fusion of communities has not happened as thoroughly as it has, for example, in Denmark.

2.1.2.1.1 Financing of the Health Care Sector in Finland

Finland spent 8.7% of its GDP on its health care sector in 2014. Per Capita, compared to other OECD countries, the OECD estimates an expenditure of 3268.9 Euros for 2014[23].

The Finnish health care system is mainly publicly funded, whereas 74.9 % of the overall health care costs were paid by the public hand. Compared to the other Scandinavian countries, Finland's private hand is covering almost 10 % more of the overall costs. Generally, the communal health care services are paid for via taxes. Hereby, the central government pays each community a certain amount, which varies with the necessities of the health care services provided by the specific community (e.g. Kuopio with one university hospital and a few local health centres will be allocated more than Utsjoki, a small community of 1263 inhabitants in the far North of the country). The rest is financed by communal taxes, which are collected by the municipalities themselves.

The National Health Insurance is with 1.24 % of the income for the working population and 1.41 % for pensioners lower than in Austria or Germany. Additionally, each jobholder pays 0.67 % of his/her income for a possible loss of income due to a longer period of sickness - this is topped by additional 1.97% of the income, which is paid by the employer (numbers from 2008[24]). All those contributions are deducted from the salary every month.

However, the Finnish health care system does not rely on these small percentages. In fact, further contributions in the day-to-day patient-doctor-relation are quite common: As the communities decide on their services individually, those additional contributions vary quite a bit. For a visit with a doctor in a communal health care center one may pay 11 Euros, but only 3 times a year, or 22 Euros as a generalized fee for one year. In the emergency room, if you come there between 8pm and 8 am weekdays or on weekends and public holidays during the whole day, you will have to pay 15 Euros - for dental health issues, 7 Euros. Depending on further, necessary treatment during a visit to the

[23] See Online Resource: "Health Expenditure and Financing - Measure: per capita, current prices", Link: http://stats.oecd.org/index.aspx?DataSetCode=SHA

[24] See Reference 15 in the bibliography, pages 48 - 50

Emergency Room, contributions up to 130 Euros are possible. Children up to the age of 18 are free of those extra contributions.

If you attend the ambulatory at the hospital, you have to pay 22 to 72 Euros, depending on which treatment you get. If you are admitted to the hospital, each day is charged with 32.60 Euros - in total all extra contributions have to be paid up to a yearly total of 636 Euros. Higher costs are covered by the community.

The impact of such patient contributions on equity of demand and equal opportunities in accessing health care services shall be discussed at a later stage in this diploma thesis.

All drug treatment is co-financed via the National Health Insurance. In general, 42% of the price of prescribed drugs are covered - with chronic diseases between 72 and 100% of the costs are paid by the insurance, if they are more expensive than 3 Euros a piece. Again, there is a yearly total of 636 Euros an insured person has to pay for one's prescribed drugs, over which limit all costs are covered by the National Health Insurance - but only if the drugs one has to buy, when he/she has reached this maximum, costs more than 1.50 Euros per prescribed drug.

2.1.2.1.2 Organisational Structure of the Health Care System in Finland

Services of a general practitioner is offered to the public via communal health care centers, where such doctors are employed. Those centers are the backbone of Finnish primary care - and they are not just offering medical support. Furthermore, measures of prevention and health promotion, psycho-social support, counseling in regard to family planning and many other services are offered via these centres [32][25]. The general practitioner functions as a gatekeeper, referring patients to either the hospital or a specialized doctor. There is no freedom of choice for the patients in regard to their general practitioner - and general practitioners are paid for by the government.

Hospitals are mainly paid for by the communities - and patients are referred to hospitals according to their place of residence. It is interesting that Finland has a high rate of hospital beds per 1000 inhabitants: 5.5 instead of 4.8 OECD-average.

If you go to a spezialised doctor without a referral or choose to go to another general practitioner, part of the costs may be covered by the National Health Insurance - but mainly, one is on one's own.

[25] See Hämel/Schäffer 2014

2.1.2.1.3 Health Care Services Provision in Finland

All communal health services can be summarized as all services provided by general and specialized doctors, during ambulatory visits and services rendered to the patient when admitted to the hospital. In addition, rehabilitation services and general prevention are also decided upon via the local municipalities. The National Health Insurance covers sickness leaves and maternity allowances as well as services in relation to workplace health promotion. Furthermore, costs occurring for drug treatment or for moving a patient, are covered by it. There are many exemptions and additional benefits rendered to the public via those two systems - only eyesight tests, glasses, methods of alternative medicine and dental services need to be paid in full privately.

Though an above average number of hospital beds is provided for, a tendency on communal, extramural“ health services can be seen in Finland.

2.1.2.1.4 The Primary Health Care System in Finland

The current law delivering municipal primary health services originates from the Primary Health Care Act in 1972. This major milestone in providing health care in Finland adopted a broader perspective, in which municipalities were obliged to provide general medical treatment, primary medical care and public health in form of a new provider at that time, a health centre“. Such a functional unit named health centre“ shall provide primary curative, preventive and public health services to its population, thereby not necessary being obliged to work from a single location. In larger cities such activities are usually organized at several different stations. These centres are either owned by one municipality alone or by several (small) communities together. They are non-profit and publicly owned as well as run. Finland offered in 2007 237 health centres to its population. The size of these centres varies according tot he area it serves. Such areas are greater in the less populated areas of the North, but are smaller in the South. At the moment, about one in four health centres has a population base of 20 000 inhabitants or more. The number of inhabitants per health centre physician varies, approximately between 1500–2000. These health centres offer a wide variety of services: inpatient care in inpatient wards, outpatient medical care, preventive services, dental care, maternity care, child health care, school health care, care for older people, family planning, physiotherapy and occupational health care. Legislation gives municipalities a rather free hand on how these services shall be provided, but there are national guidelines, e.g. for maternity and child health, school health care and screening. The health centres are usually equipped with physicians' and nurses' consulting rooms, there are normally X-ray facilities, a clinical laboratory, facilities for minor surgery and endoscopic examinations

as well as special equipment such as electrocardiogram and ultrasound. The personnel consists normally of a variety of health professionals: apart from medical doctors, nurses and public health nurses, social workers, dentists, physiotherapists, psychologists and midwives can be found on the payroll. The main work of the health centre's physician is to provide office-based general medical care to patients of all ages – additionally elements of maternal and child health care, school health services, family planning, home visits (mainly done by nurses though), consultations at municipal nursing homes and forensic activities (declaring somebody dead) can be added to the daily activities of a general practicioner. Some health centres have arranged for regular consultations from specialists. In remote, less populated areas, however, health centres are also responsible to provide comprehensive emergency and short-term curative inpatient services. The GP-run inpatient department of such a health centre works very much like a hospital department and has on average between 30 and 60 beds. The majority oft he inpatients are elderly people with chronic diseases. Furthermore, nurses play an essential role in Finnish primary health care. Some nurses do not only assist general practicioners, they have their own consulting hours, give injections, remove sutures and monitor blood pressure. New qualifications such as acute care and assessing new patients are more and more added to the current curriculum. Nurses are not formally gate-keepers to physicians, but it has become a widespread practice that one sees a nurse first before going to a physician's appointment. Maternal and child care are mainly the responsibility of public health nurses who have been educated in delivering preventive services. They are also engaged in family planning, occupational health care, home nursing, health promotion activities and school health care[26].

2.1.2.2 The Norwegian Health Care System

Norway also has a dual system, in which - since 2002 - the central government is responsible for providing hospital care, while communities care for ambulatory needs of their inhabitants. Any health care provided by private insurance companies can only be considered as additional as only 5 % of the population holds such insurance policies for extra support, accounting for only 1 % of the nationwide health care costs. Health care coverage is obligatory and covering every inhabitant.

[26]See Online Resource – Primary Health Care – Data and statistics, Finland", Link: http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/data-and-statistics/a-selection-of-country-profiles/finland-2008

2.1.2.2.1 Financing of the Health Care Sector in Norway [33]

Norway covers 85.5% of its health care costs publicly, with a per capita expenditure of 6760.95 Euros[27] in 2013[28]. The public funding for the health care sector derives from non allocated tax revenues (both from the central government and the communities) and the individual's social security contribution (Norway has one social security contribution, it is not split in a rate for pension funds, health care and other service separately.). Each year in October, the government provides parliament with a health care budget for the next fiscal year which is then decided upon in December. This maximum spending limit can be worked around by the communities via their own tax revenue. The social security contribution is a split one like in all other focus countries: both employee and employer contribute, with the employer providing the major part. There is no maximum calculation basis - it is just calculated from one's salary. Sickness and maternity leave are partly paid via one's social security contribution and the tax system. The crisis of 2007 onwards hardly affected the health care budget, as Norway has reported substantial oil revenues ever since.

Only upon admission to the hospital, one does not have to pay extra for health care. If one attends to one's general practitioner, one has to pay 18 Euros - or 30 Euros after 10pm. If a specialized doctor needs to be seen, 40 Euros are charged. For any prescribed drug, one has to contribute 36% of the costs up to a maximum of 65 Euros per quarter. Any additional contributions have a limit which is set by parliament each year anew. Exceptions consider low-pensioners, children up to 16 years - and patients with certain diseases (e.g., such as HIV).

2.1.2.2.2 Organisational Structure of the Health Care System in Norway

General practitioners have a gatekeeping function and work either for the communities or self-dependent. Each Norwegian may choose his/her general practitioner freely but only twice a year at most. If you don't choose "your" general practitioner, you have to pay higher ambulatory fees. A specialised doctor can only be seen (if covered for by the public) via referral of a general practitioner. However, primary health care is lacking personal: In 2012, 2.1 specialized doctors came on every general practitioner.

Most hospitals are run by the public hand - and are since 2002 the responsibility of the central government. 4 regional offices oversee the hospitals within their respective regions, but hospitals are still rather independent in their usage of means. Patients

[27] Calculated of 53 956.4 NOK, with the average exchange rate of 2013 - See: https://www.oanda.com/currency/average

[28] See Online Resource: "Health expenditure and financing - Measure: per capita, current prices" - Link: http://stats.oecd.org/index.aspx?DataSetCode=SHA

can choose freely between the hospitals. There seems to be a greater visible shift towards ambulatory care as Norway only provides a constant number of 3.3 beds per 1000 inhabitants since 2009[29]

2.1.2.2.3 Health Care Services Provision in Norway

Almost all health care is provided for - including dental health care up to the age of 20 years (for above 20 years, exceptions can be made). Costs for dental care and physiotherapy are partly supported - corrective lenses and therapies based on alternative medicine have to be paid individually.

With a low number of hospital beds, a tendency to registered, but specialized doctors can be observed.

2.1.2.2.4 The Primary Health Care System in Norway

The 431 municipalities are responsible for providing their citizens with quality primary health care and social services as well as advocating patient's rights. The catalogue of responsibilities comprises of a variety of preventive and curative treatment such as:

- Health promotion and prevention, including school health services and child health care, thereby having health centres offer check-ups for pregnant women and vaccination programmes for (school) children
- Diagnosis, general medical treatment and rehabilitation (including nursing and physiotherapy)
- Nursing care within and outside institutions

There are around 4000 general practicioners in Norway and they act as gatekeepers for patients to the health care system. Currently, almost all Norwegians are a member of the regular general practicioner list system, in which the patients may choose their general practicioner[30].

[29] See Online Resource: "Hospital beds per 1000 people", Link: http://data.worldbank.org/indicator/SH.MED.BEDS.ZS

[30] See Online Resource – Health Systems in Transition – Norway“ – Link: http://www.euro.who.int/__data/assets/pdf_file/0005/95144/E88821.pdf

Chapter 3

Assessing equity of the health care systems of the focus countries

This section shall have a closer look at the health care systems of the focus countries Austria, Finland, Germany and Norway and how health equity in these countries is developing under present challenges – so both present inequalities as well as counter-measures by the respective governments are outlined, thereby defining how they effect the variables equity of demand (access to health care services), equal opportunities (what is offered to the publicly insured) and performance (waiting times in relation to whether one patient is privately, additionally privately or publicly insured).

Therefore, over the course of the following chapter, the health care systems of the focus countries shall be compared by assessing equity of demand through consumption (under which circumstances is it possible for a sick person to obtain low-threshold health care services without or only partly private payment), equal opportunities through health care services provision (in regard to waiting times and preferential treatment by rendering these services provided in hospitals and by spezialised doctors in private praxis) and the availability of health care professionals (density of doctors). The issues of financing and regulation (governance) have been discussed in the previous chapter and shall only be mentioned as necessary for comprehension[1] [34].

The general typisations of the countries in two main policy systems (Corporate Health Care States and Command and Control States)[2], as done in Chapter 2, are important to study inequality in access and health care services provisions for patients in various

[1]See Reference 33 - Moran 1999
[2]See Reference 33 - Moran, 1999

countries and to collect data to evaluate the populations happiness with one country's health care system. Therefore, pro and contra of those two types of systems shall be discussed now following, thereby including all variables stated in Chapter 1.

3.1 Health Care Systems in Corporate Health Care States - An assessment of equity of access

Before Germany implemented a nationwide contribution percentage to the sickness funds in 2009, health care costs (in percentage of the GDP) were at a higher level then in Austria[3]. The freedom of choice among public sickness funds in Germany has led to increased competition among sickness funds regarding their service provision with additional restraint from the central government which allocates financing due to membership numbers. This freedom of choice offers a patient the possibility to choose which coverage and benefit plan of a social sickness fund suits him/her best. Such a system pushes for more equal opportunities, as the patient can choose free, even though the choice is limited to what is offered, then the Austrian system, where your profession and where you exercise this proffession decides for you.

However, analyses have shown that, though the expenditure is high in both countries, the service niveau is too - which is true for Finland as well[4] [35].

3.1.1 Equity of Access to Health Care Services Provision in Austria

There is only 2% of the population, who report difficulty accessing services, of which again a small percentage indiquate barriers resulting from costs[5] [36]. Second, the ratio of physicians, who have a contract with the sickness funds, to inhabitants seem to be balanced throughout the country. Additionally, inequality in access to general practicioners, due to a low income, is below the OECD average[6]. Finally, it has been possible to maintain such a high level of equity in access to health care despite the fact that user charges and direct payments are increasing. This is mainly due to many payment exemptions, e.g. through a cap on prescription fees. The implementation of the European Health Care insurance card, better known in Austria as e-card", plays an important part in securing low-threshold provision of basic health care, because, since 2010, needbased minimum income (formerly welfare) recipients receive comprehensive insurance coverage.

[3] See OECD Health Data 2012
[4] See Reference 34 - Wendt & Kohl 2010
[5] See Reference 35 - Allin & Masseria, 2009
[6] See Online Resource: OECD Health Working Paper No. 58

However, recently, there seems to be a growing inequity in access to health care services within the Austrian health care system, resulting from imbalances in the provision system. Inquiries of the Ministry of Health indiquate these imbalances as follows: steadily increasing long waiting times, a general lack of time of health care professionals when treating patients, the perception of a two-tier health care system, pharmaceuticals that need to be paid privately and the bureaucracy of sickness funds. All these issues contribute to the perception of an increasing inequality in the provision system.

Studies also show that disadvantaged groups use services either late or not at all – especially, certain preventive services such as immunization and dentistry[7]. This is shown by a recent study, indicating a 40% higher likelihood of patients in the highest income decile to visit a dentist than those in the lowest income decile[8] – which also placed Austria high in EU-rankings in regard to inequality in dental care services provision [37]. It is yet unclear whether new legislation concerning coverage of dental braclets for children will shift numbers in favor of equality.

Concerning waiting times for treatments financed by the sickness fund system, there is a widespread concern that private payments to physicians and/or private insurance policies shorten waiting times for patients or even avoid them at all, thereby both effecting the variables equal opportunities and performance. However, waiting times have fallen for elective interventions generally since the introduction of a waiting list management system (such as the Manchester Triage System) within hospitals in some federal states. But then again, the speed of access to care and a patient's membership of a private health insurance scheme are linked as an international study shows [38]: In Ireland, Portugal and the United Kingdom, but also in Austria and Germany physicians are allowed to work both in the public and private sector. Private health insurance fees or private payments are an important source of income for these physicians.

When indicating having private health insurance, a service user expects to avoid waiting times - therefore the perception of inequities, or a two-tier health-care system, can be observed as a result. This is mainly due to the issue that the number diagnostic methods offered to patients (such as a CT or an EKG) is limited by the sickness funds for each quarter. As the Oekonsult study "Gesundheit 2010" shows, 90% of respondents have the impression that patients with a higher income enjoy better medical care. Furthermore, it has also been criticised by the Court of Auditors, that patients with (supplementary) private insurance coverage sometimes receive too many services, including extensive

[7]See Online Resource: "Das österreichische Gesundheitswesen im internationalen Vergleich", Ladruner et al., 2012 - Link: http://www.bmg.gv.at/cms/home/attachments/4/8/3/CH1066/CMS1382089784387/gesundheitswesen_2012.pdf

[8]See Online Resource mentioned above - OCED Paper No.58

laboratory tests or stay longer in hospitals[9]. Overall, a study by van Doorslaer et al. from 2006 has confirmed that higher income individuals receive a preferential and more extensive treatment in Austria as well as in other countries [39]. This seems contradictory, as one of the esteemed key aims of the Austrian health care system is to ensure any access to care on the basis of neediness only. As current government policies reassured this statement, regulations for organizing waiting times have been introduced in 2011.

In regard to the availability of health care services, ambulatory rehabilitation – and in particular ambulatory neurorehabilitation – as well as palliative care are not developed equally in all federal states. The psychosocial and psychotherapy care sector is also characterized by a wide ranged regional variation in regard to access and affordability. This poses as a future challenge as recent OECD reports show a growing prevalence of mental illness[10]. Even though efforts have been made to increase psychiatric, psychological and psychosocial care provision by increasing their ambulatory provision, in several federal states (e.g. Lower Austria) a combination of financial restraints and regional diversities has still not widened the access to such particular care.

A regional variation also occurs with the availability of health care services in general: While Vienna and Upper Austria offer a wide range of services, federal states with lower per capita incomes do less so - and there is still a considerable variation amng the regional sickness funds what additional ("voluntary") services they provide. This concerns especially the Long Term Care sector: In 2007's Eurobarometer, 41% of the participants in the survey stated that care services were not always fully availabe, and 56% believing they could not afford Long Term Care services in general at all..

3.1.2 Equity of Access to Health Care Services Provision in Germany

Surveys of the Commonwealth Fund – as well as other studies (e.g. Schölkopf, 2010) – show Germany on top in regard to access to medical care [40][41]. In mentioned Commonwealth Fund survey 83% of the respondents had to wait less than four weeks to get an appointment with a specialized doctor - and 78% had to wait also less than a month for an elective surgery. Even though these numbers show the good state the German health care system seems to be in - doubtlessly, there is another side to it: In 2011, 6% did not take their drugs regularly as they wanted to avoid payment for a new package or the prescription fee. Then, 16% did not visit a doctor even though they had

[9] See Online Resource: Working Group Report "Gesundheit und Pflege": Link: http://www.rechnungshof.gv.at/fileadmin/downloads/2010/beratung/verwaltungsreform/Gesundheit/Problemanalyse_Gesundheit_und_Pflege.pdf

[10] See Online Resource: "Mental healthcare under-resourced in too many countries" - Link: http://www.oecd.org/newsroom/mental-healthcare-under-resourced-in-too-many-countries.html

a medical issue a doctor should have attended too – and: only 70% of the asked stated, that they were confident to be able to afford the care needed in case they got seriously ill [41].

If we look at data from the OECD from 2011, Germany is placed second from the bottom after the United States regarding the issue that costs associated with receiving treatment, prevent people in need of medical care to see a physician: 17% of above-average income and 27% with below-average income interviewed stated, that they had not consulted with a physician or restrained themselves from treatment or a recommended medical examination.

In regard to the variables equal opportunities and equity of demand, user charges of any nature may prevent patients from accessing health care services. Even though patients of a low socio-economic status may be exempted from it, these extra costs can target average income patients who will not receive such a support, which may in turn increase financial pressure on their households.

As a low-threshold access to health care services also depends on whether a general practicioner or a specialized doctor to consult is even available in a patient's region, the opportunity to make use of such services is also depending on where one lives. Thus, German physicians are more evenly distributed regionally[11]. Even so, large regional differences can be found and a lack of specialists is obvious in many rural areas, primarily in the federal states of the former GDR. This comprehensive shortage of physicians in both the ambulatory and hospital sectors are shown by Kopetsch, 2010 [42].

So where lies then the major problem of inequity in access to health care? Mainly with the different reimbursement plans of health care services providers in the public and the private health care insurance system, particularly in ambulatory care. For patients, covered by the public sickness funds, a doctor receives a combination of flat rates and payments for any diagnostics and treatments he administers on the patient - up to a maximum quantity. On the other hand, privately insured patients do not have such a maximum limit. This may explain why - if we look at the Catalogue of Tariffs for Phsycians of the private health care insurance corporations, physicians may charge 1.7 or 2.3 times the basic rate of a publicly insured patient - in addition to no maximum limits.

Such differing reimbursement systems lead to physicians treating privately insured patients with preference. On the other hand, patients ensured with the public sickness funds, stay shorter with the doctor during consultations, feel less advised and even more

[11] See OECD Database, numbers of 2013 - Link: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

kept out of the process of decision-making in regard to their treatment[43] – and not to forget: Private patients have shorter waiting time to expect additionally [44]. This shifts equality of opportunities in favor of privately or additionally private insured patients.

An indicator in regard to performance of a health care system is the waiting time for an appointment with a physician. The 2007 Health Monitor (Gesundheitsmonitor) has shown that general practicioners have not distinguished between publicly and privately insured patients when allocating appointments - while specialized doctors offer shorter waiting time for an appointment to the privately insured: In fact, privately insured patients get an appointment two and a half days earlier, and have to wait nine minutes less for the physician to attend to them [45].

But to see these developments as differences in service provision and convenience only, might be to narrow-sighted: It clearly shows an abundance of care for private patients - meanwhile the risk evolves that inadequate, too little and incorrect care is rendered to publicly insured patients in the Germany Health Care System [46]. As mentioned in Chapter 2, Germany offers people of a certain (high) level of income the opportunity to be insured via a private health care insurance company, thereby offering the possibility to leave the public health care insurance system which is based on a solidaric principle. But for whom is such a membership highly beneficial? One can say, that young, healthy singles with a high income are both attracted by the benefits of private insurance as well as they are the target group of such corporations. Exactly those members are important for the public health care insurance system as they mainly pay membership fees but hardly make use of health care services.

3.2 Health Care Systems in Command and Control States - An assessment of equity of access

Finland and Norway, though having a municipality oriented health care system, could not be more diverse. Norway, a potent oil-drilling nation, is still relying on a vast income that helps the country through the current recession. Even though this might not be considered sustainable by all economists, Norway is investing its oil revenues via its "Government Pension Fund" worldwide, having reached a value of almost 7 trillion Norwegian Krone, or 755 874 000 000 Euros in July 2015[12].

Finland on the other hand is suffering under the recession since the economic crisis of 2007. For three years in a row, Finland's economic output levels are well behind 2008's -

[12] See Online Resource: Website of the Government Pension Fund of Norway - Link: http://www.nbim.no/en/

causes can be found with its two main export partners: The euro zone is struggling with its debt crisis and Russia's economy is for a while now on a slowdown. Furthermore, core businesses such as Nokia have been on a decline, reporting a plus in revenues only in 2015 after facing big losses in the year before. 2015 statistics show a further decline of 0.4 % in the second-quarter GDP, after a decline of 0.1% in the first. Latest forecasts put Finland's GDP growth in a range of -0.1 to 0.5% by the end of 2015 and estimate a growth of 1.0 to 1.6% in 2016. Before these developments, Finland was known for pursuing a strict fiscal policy - however, countermeasure policies by the government have increased public debt and the budget deficit - even so far, that a warning has been issued by the European Commission.

With such diverse countries at hand, how may have these recent developments affected health care services provision in Finland and Norway?

3.2.1 Equity of Access to Health Care Services Provision in Finland

As in Chapter 2 stated, Finland has a National Health Care Insurance system (NHI), which is mainly financed via two types of taxes: a progressive income tax of the state and a flat percentage, income tax of municipalities. The insurance premium for tax payers is proportional, being a flat percentage of income. Furthermore, the employer pays a certain percentage for each employee as well. Any shortcomings are co-financed by the state budget. As the progressive source of financing the health care system has decreased since the mid 1990ies, more regressive forms of financing have been implemented, putting strain on low-income social groups thereby shifting the variable of equal opportunities in disfavor to them.

One of these measures taken, and probably the most regressive one for low-income groups, are the user charges. On a municipal level, for any services rendered to a patient, legislation limits the user charge to a maximum for each visit / treatment obtained with an additional annual ceiling to all health care costs paid by one individual. With this measurement, almost 7% of health care costs in municipalities are covered. Outpatient drugs are covered by the NHI. On average, 63% of the costs of outpatient prescription drugs are reimbursed to the patient[13]. Even though user charges put strains on Finnish households, social assistance for individuals and families, whose income is too low, is available.

[13] See: Finnish statistics on medicines 2006, issued by the National Agency of Medicines and Social Insurance Institute, 2007

If private health care services are frequented by a patient, the patient can apply for a reimbursment of a third of the costs. People with a lower-income are thereby easier excluded from the private health care services than their wealthier counterparts, but they do have the chance to use health care services rendered to the public by the communities. Statistics on this matter show, that the unemployed are less likely to use private health care services because of the low reimbursement rate[14]. What can be considered furthermore as inequitable, may be the issue that the NHI pays partly for private health care costs, even though considerable parts of the population are not being able to obtain private health care services - either because they can not pay for such services or because they live in rural areas where hardly any are offered.

To bring it to a point, the Finnish health care system is struggling with two major problems: Geographical inequities, influencing mainly equity of demand, and inequities among the various socio-economic groups of its population, influencing mainly the equality of opportunities. Further, the ability to provide own language and culturally sensitive health services to ethnic minorities will proof challenging, as increasing immigration can be expected [47], thereby putting further strain on those variables.

Focusing on municipal health care, significant differences in health care services provision and waiting times occur, thereby influencing the variable performance. The number of in-patient cases and surgical procedures per capita varies among hospital districts and with procedures (e.g. orthopaedic operations) [48] - a variation that also occurs with out-patient care at the five university hospital regions of the country [49]. Also in regard to investments in municipal health care, differences between the municipalities occur, as such investments may be neglected as financial means are scarce due to the ongoing recession. As statistics are scarce, there is one example worth mentioning: The number of granted sickness allowances varies between 7% and 18% among municipalities, leading to the assumption that there are significant differences in morbidity between municipalities[15].

To understand all these differences in utilization and service delivery, it shall be stated that the Finnish health care system is still rather decentral organized, and reforms - as in Denmark or Norway - are not yet fully underway. All these variations may also be due to certain co-factors as age structure of municipalities, physician shortage (especially in rural areas) and the access to private health care services and occupational ones, if such are even available. Especially due to geographical inequities, quality and scope of municipal services is difficult to assess adjusted to these variables and will therefore be left aside in this diploma thesis.

[14]See: Sosaali - ja terveydenhuollon kansallinen kehittämisohjelma [National Development Programme for Social Welfare and Health Care], by the Ministry of Social Affairs and Health, Selvityksiä 2008:6

[15]See Online Resource: SOTKAnet Indicator Bank - Link: http://www.sotkanet.fi/

To strengthen equal opportunities for its publicly insured population, in 2005, the Finnish government implemented a new law (Primary Health Care Act and Act on Specialized Medical Care), which set a maximum to waiting times, issued national treatment and quality guidelines to further standardize health care practices and also defined limits to the access of non-urgent specialized care (elective) procedures.

Turning towards the significant socio-economic differences in the use of health care services[16], one may state that an imbalance towards the wealthier population is one of the highest among OECD countries, alongside with the United States and Portugal[17]. This imbalance can especially be seen with screening diagnostics, dental care, need-related coronary revascularizations and with a few elective specialized care operations (e.g. prostatectomy or a lumbar disc operation) [47]. In general, it can be stated that employees are healthier than workers, employed are healthier than unemployed - and citizens with a high income and a high educational level are healthier than those of low-income and a basic educational level [50].

To understand these developments, a focus on the use of private health care services as well as occupational health care is necessary: Private health care services offer better access to services (in regard to waiting times for example) than the municipal sector and are less accessible to the low-income groups due to the issue that only a third of their costs are covered by the NHI. Additionally, the NHI does not set any limits to private health care providers - on the contrary, with municipal services there occurs a rationing. Furthermore, these private services are funded by the NHI without ever controlling them in regard to need or efficiency. On the other hand, municipalities do have strict health care budgets. This imbalance between private health care services provision and the municipal one is further aggreavated by geographical inequalities: Even if municipalities would cover, for example, dental services or psychotherapy - it is again a matter of whether these services are even available in the municipality.

Another issue to further inequitiy, is the fact that occupational health care - paid for by the employer - is free for patients, while municipal health care charges the user. That these developments are also lucrative for health care professionals shows the following development: Between 1996 and 2006 the number of physicians in occupational health care increased by 69%, in private health care by 62%, but in municipal health centres only been 9%[51]. As private outpatient services are an important pathway to specialized care in municipal health services (e.g. for cataract operations) a favouring of those with better income may occur. Better access for private patients may also occur due to the issue that private health care services have no gatekeeping function.

[16]See Reference 51
[17]See Reference 37 - pages 177 - 180

3.2.2 Equity of Access to Health Care Services Provision in Norway

Norway considers the provision and assuring of universal and equitable access to health care as an important health policy aim. To demonstrate its commitment, the Norwegian government passed the Public Health Act in 2011, defining the responsibility for public health work and reducing health inequalities as key efforts on all levels of government. In the long run, it shall promote health by acting on social determinants (such as the ones stated in the introduction to this diploma thesis) of health through involving other sectors of civil society.

Although Norway has one of the highest numbers of working physicians in Europe, it struggles with the vastness of its own country and the therein scattered population, especially those living in rural and remote areas. Even with a rather fair distribution of skilled general practicioners across the country, specialized doctors are rather concentrated in the capital and other urban areas – a fact that pushes general practicioners in remote communities to their limits as they have to treat medical conditions which are normally dealt with in hopsitals. The Norwegian Statistic Centre also shows geographical inequalities in access to dental care. Almost all large hospitals are located in urban areas and all tertiary care hospitals are located in the biggest cities of Norway, forcing urban residents from smaller cities to commute for long distances in order to obtain special care, thereby increasing service use by citizens of the big cities[52]. As in Finland, the central government tries to balance these geographical problems and the inequal distribution of hospitals with a vast network of ambulance transportation services. Furthermore, Norway is using several strategies to attract health care workers to Northern Norway and battle its geographical challenges - one of the most successful has been the establishment of a new medical faculty in Tromsø in the early 1970s. Another is the development and use of telemedicine applications.

The use of primary health care services in Norway is fairly equal among different socio-economic groups - while the use of specialized health care services is more frequent among people of a higher socio-economic status [53]. Jensen (2009) further showed that social inequalities in access to care are the highest among the elderly population[54]. Moreover, the study confirms the importance of one's individual education and income if one chooses to use services of specialized doctors.

Additionally, the hospital choice reform seems to affect equity. Patients reporting to have chosen a hospital face, on the other hand, shorter average waiting times than patients staying at the local hospital [55].

3.3 Facing challenges - Pushing for more equality in the health care systems of the focus countries

Having looked at shortcomings in the provision of health care in the focus countries, the following section shall outline current reform approaches in the different countries and how they affect the variables outlined in Chapter 1.

General issues of the Austrian health care sector are: too many patients in inpatient care, skyrocketing health care spending, and a general growing of public debt[18]. That is why in 2010 talks were initiated by the Ministry of Health with all the stakeholders, developing an agenda of a health care system reform from 2013 onwards.

Additionally, Austria's health care system faces a progressive ageing of the Austrian population, which is slightly higher than in many other European countries. Furthermore, a shift towards chronic disorders can be seen, which makes Long Term Care and investment in preventive measures a pressing issue.

With the aging of the population and the steady increase in Long Term Care costs, the new financing system of DRGs aims to stabilize expenditure in the Austrian hospital sector, increase efficiency by decreasing long-term hopsital stays and improve quality of health care services provided in hospitals. Additionally, 'Quality strategies' are tested in a number of model hospitals, which shall increase competition between hospital services providers. However, coordination between hospital and primary care services faces still challenges. There is tension between the sickness funds and the chamber of doctors, regarding the establishment of new reimbursement structures. To further level costs in health care expenditure, a tendency to strengthen the role of primary care in relation to secondary care and to increase prevention services and health promotion can be seen, as shown by the idea to establish 'District Social Services and Health Units' to coordinate medical and social services available. Long Term Care is still being extended, as a shortage of such facilities has led to patients no longer in the need of acute care, occupying hospital beds intended for such patients.

Germany's health care system shows one big aspect, promoting inequality - the issue that almost 10 % have opted out of the public sickness funds. But why have they opted out? If they insure themselves at a very young age, the lower both the five-year-cohort of which his or her premium is calculated and the risk evaluation are - as well as the lower the premium to pay will be. This premium can only be raised if the general health care costs affecting all of the age group is rising too. This means, that the insurance premium

[18]See: Hofmarcher, M.M. Das Österreichische Gesundheitssystem, Akteure, Daten, Analysen. Medizinisch Wissenschaftliche Verlagsgesellschaft, Berlin; 2013

is only adapted to the average health risk of the cohort's age group the individual has first joined in - never with the individual's health risk.

The general increase in longevity and expensive new medical technology will put further strain on the health care budget. Another challenge arises with deficits in providing adequate Long Term Care, which leads to many supplementary private health care insurance policy holders, what in turn is defying principles of equal access to health care. In general, private health care companies show adverse selection, as healthier individuals with higher incomes mostly enroll with them, putting further pressure on the public health care system staying with the remaining population[19]. Additional inefficiencies arise with the multitude of health care providers, a missing universal data sharing system and a high demand for health care professionals as the system is of an all-inclusive nature, leading to lengthy waiting times. One of the concepts in discussion is an income-independent per capita contribution that is risk scheme adjusted and offers tax compensation mechanisms to the contributer. If health care services rendered to the patient would only be reliing on such income-independent per capita contributions, this suggestion to replace the existing social health care insurance contribution system has to involve tax financed subsidy protocols to ensure the support for low income contributers[20].

Summarizing, it can be said, that the German health care system generally offers adequate care of highly skilled health care professionals to its population of all socio-economic statuses, it faces financial pressure and a cost-intensive demographic trend leading to a questionable, longterm sustainability of the system if it does not amend.

A current issue in the Finnish health care system is the public funding system which leads to service inefficiencies, overlapping capacities and waiting lists. Additionally, due to the vastness of the country, an inequitable distribution among the population, is taking place, therefore influencing equal opportunities and equity of demand. On the other hand, costs are increasing with the aging of the population as in other EU-countries, thereby raising voices in favor of more competition among health care providers and how patient-awareness can be increased in regard to health care costs. With prevention being key to preserve health in an aging population, funding will be a hot topic as increased spending for curative care and for chronic disease management will be pressing in the upcoming years. A harsh competition for professional staff is further an issue, one should not underestimate. As the other focus countries, Finland is working on a health care reform. The current proposal indicates as a key objective the creation of overseeing

[19] See: Sekhri N., Savedoff W., Thripathi S. - Regulating Private Health Insurance To Serve The Public Interest - Policy Issues For Developing Countries, Nr. 3, 2005

[20] See: Bäumler M., Sundmacher L., Zander B. - Major reform of German SHI contributions, Survey Nr. 16, 2010, University of Technology Berlin - Link: http://hpm.org/en/Surveys/TU_Berlin_-_D/16/Major_reform_of_German_SHI_contributions.html

regions responsible for the social, welfare and health care services provision. In an example, this means that if an elderly person breaks a leg, any service, from surgery, over in-patient follow-up care, to home care and rehabilitation, would be planned and organized by one administrative body avoiding unnecessary confusion of where to go and apply for further care.

This way, the government is trying to level the rising costs in the Finnish social welfare and health care sector to guarantee its aging population continious provision of these services in the future. Through this approach of ensuring strong incentives for result-oriented health care services provision, which itself orients at key principles to improve both access to and obtainment of better health, available resources shall be used more efficiently by the Finnish population. Socially marginalised groups shall be reached through labour force service centers and an initative to implement occupational health services for the unemployed is still underway. The payment ceilings mentioned in the previous chapter are surely eleviating low-income households, but not all of them. Additionally, it is questionable whether the highly indebted municipalities are able to hold at the current level of user fees or whether they will rise, posing a further threat to equal access to public health care.

All these challenges have not prevented the Finnish health care system from improving public health by introducing preventive and curative policy measures. Also, infant and maternal mortality is low and life expectancy continiously improving, pushing cancer survival rates up and holding communicable diseases on an ongoing low level.

As in all OECD countries, Norway faces an aging population putting pressure on health care services provision, and with hospitals shortening the length of hospital admissions, the necessity of care for the discharged will be felt by the municipal care services. These challenges shall be met with the 2012 Coordination Reform (e.g. the reform includes direct investments to areas where care was weakly provided such as mental health care and low-threshold care) and though there is a consensus on the need of this reform, the coordination among the key stakeholders has yet to proof sustainable to implement the reform. There is still a lack of facilitated negotiation between all providers and the use and collection of information even in regard to what the population expects from service delivery (e.g. national standards or workforce requirements for primary health care units). To achieve this, Norway is still in the need of a proper data infrastructure to provide modern health care services.

Though Norway is not facing financing problems in the health care sector yet, a value-for-money approach and proper cost-effectiveness measures are recommendable. Even though investments made have brought positive changes, the focus shall be on using

exisiting infrastructre (promoting efficiency in the health care services provision or implementing incentive policies for providers).

However, a number of problems remain with the above mentioned reform: In the primary care sector, general practicioners payment shall be comprised of a combination of capitation funding and fees for services, which should strengthen their role as gatekeepers. However, this reform leads to changes in resource allocation and payment contracts, as it urges municipalities to attract additional general practicioners, which in turn leads then to declining patient numbers with the incumbent general practicioners, who are depending on the payment of municipalities which is rendered to them by the number of patients treated. To cover their living expenses, it is likely that they will then increase or implement further fees for services provided. Additionally, the capitation of fees may not fully attend to a patient's health needs, as such a cap limits payments for visits to the doctor, who in turn may then decide disfavorably to attend to the patient (longer).

The legislation concerning patient rights aims to improve both access to the public health care system but also information about what it offers to the public. The reform contains the implementation of prioritization (e.g. with the Manchester Triage system) through guranteed waiting times. As acitivity-based financing is introduced to hospital treatment, the incentive for assigning a high priority leading to (maybe unnecessary) admission may be high for hospitals. With hospitals competing for financing on the basis of admission numbers, this reform may lead to a debridment of funds towards the psychiatric, preventive, rehabilitation and comprehensive nursing care – all areas which have been outlined as "national priority areas" by the government. However, competition among hospitals may lead to pushing quality in the hospitals, additionally furthered through strengthening the patient's right to more freedom of choice among hospitals both within and outside their home region[21].

[21]For further information - See the OECD report on the reform of the health care sector in Norway: http://www.oecd.org/norway/1864965.pdf

Chapter 4

Drawing conclusions - Improving health care systems

Having presented health care systems of 4 focus countries and having shown their advantages and disadvantages, the remaining chapter of this diploma thesis shall take up all collected information about the advantages of the health care systems in the focus countries, thereby forming suggestions how a utopian health care system may look like, which is based on the administrative framework of the current Austrian health care system. As introduction, current approaches to improve performance of and efficiency in health care systems are presented and conclusions on the Austrian health care reform of 2013 are drawn.

4.0.0.1 Thinking about Performance and Efficiency in health care systems – New approaches

In presented diploma thesis, variables have been defined of which three have been attended to extensively, while the variables of preformance and questions of efficiency in health care systems, are of a more abstract nature, and shall therefore be discussed in a more general approach, now following. Having presented one way to assess performance of a health care system through waiting times, another one is pay-for-performance – the formula is simple: A criteria catalogue of quality measures is defined and clinicians can then earn a bonus if their preformance is in accordance with the aforesaid criteria. There are still studies under way but one example for such a programme is the Bridge

to Excellence“ [1]initiative, which offers criteria catalogues for many different chronic diseases. One of those is Diabetes Mellitus type 2 in which participating doctors have to meet certain benchmarks on the following parameters:

- Blood pressure
- LDL levels
- HgBA1c levels
- Ophtalmologic and podiatry exams
- Nephropathy assessment

The range of incentives are diverse, but also include cash payouts to the participating health care professionals. These payouts are paid for by insuring companies and employers, as healthier employees or insured persons help saving costs and increase productivity due to fewer sickness leaves[2]. Efficiency in the context of health care can be understood as using the least possible input for a defined output. This could be for example keeping hospital stays to a minimum length, by avoiding on the other hand high readmission rates. A widely discussed term in this regard is 'allocative efficiency', which sets outcomes of health care services provision in relation to how these are distributed among a population. In these discussions, the mix of services provided to maximize a broad distribution, both in regard to diseases (prevention and treatment strategies, e.g. for HIV/AIDS) and in a broader context (health improvement of a population as a whole). With cost-effectiveness analysis, a connection to financial viability is formed, as health inputs (in monetary terms) are put in touch with health outcomes (e.g. disability-adjusted life years). Such an analysis then may show inefficiencies, such as needlessly high costs of intervention (excessive hospitalization – or for wrong reasons: Long Term Care patients in acute care wards) or reliances on brand-name health care products, for example[3].

4.0.0.2 Conclusions on the 2013 reform of the Austrian Health Care sector

The 2013 health reform framework defines specific data needs and data collection as key instruments to forecast health expenditure in the future. This will centralize reporting, thereby helping to monitor health care system preformance.

[1]See Online Resource: Bridges to Excellence“ – Link: http://www.hci3.org/programs-efforts/bridges-to-excellence

[2]See for further information: http://www.hci3.org/

[3]See for further information: Improving health system efficiency as a means of moving towards universal coverage“, World Health Report 2010, Background paper 28 - http://www.who.int/healthsystems/topics/financing/healthreport/28UCefficiency.pdf

Furthermore, spending for federal states is capped by fiscal targets imposed by the EU which are linked to sanctions if a federal state, or a region is non-compliant.

The main aim of the reform is to ensure the right supply of safe care in adequate settings, not having acute-care beds in hospitals occupied by long-term-care patients who shall be cared for in appropriate homes, with again having hospital ambulatory units just attended by emergency patients. Patients in need of non-emergency care are treated by a general practicioner, or an extramural specialized doctor.

However, certain flaws come with the implementation of the reform: The comission, comprised of representatives of all stakeholders, implements another admistrative body, which shall oversee the "governance by objectives"-approach - if it is truly accepted by the administration is yet to be seen. Additionally, violations of prior fiscal pacts between the federal government and the federal states have not been sanctioned - e.g. when targets in regard to a reduction of hospital beds have not been met.

However, instead of rationalizing task sharing and distributing clear competences between the federal government and the federal states, another body has been formed, with all key stakeholders participating. Instead of harmonizing public sickness funds by replacing a variety of benefit packages and payment plans with one, funding pools to further targeted stakeholder cooperation have been implemented. A vague approach via sanctions shall move all stakeholders to meet set performance goals.

With a variety of different payments systems, coverage and benefit packages at hand, health care services provision is imbalanced among the Austrian population, leading to a confuse crossover of inpatient and ambulatory care, Long Term Care and an incoherent coordination between hospital care and annexed rehabilitation.

Austria could have gone further by setting standards for cross-stakeholder pooling of funds and standardized purchasing policies in all federal states. Concluding, a comprehensive administrative reform, overcoming federalistic fragmentation both in administration as with the sickness funds, targeting overcapacity in some areas by shifting these to the primary health care sector, and generally promoting cost-efficiency and public awareness to health care costs, could have been key targets of the reform package to ensure the solidaric nature of the health care system.

4.0.1 A fair and solidaric future for the Austrian health care system

After having shown in Chapter 3 how equity in the health care systems of the focus countries is developing also because of recent reforms, this section shall suggest how certain approaches of the 3 other focus countries and new ideas from Canada and the

US could be implemented in the administrative framework of the Austrian health care system, thereby pushing for more quality in it:

Austria profits from its population's high trust in the availability and quality of the health care system, providing up-to-date medical care. However, their is a lack of understanding on the costs of this system by the population which needs to change in order to keep the system afloat - while on the side of health care services providers the shift to primary care and prevention measures needs to be a number one priority. The country may also profit from its federalistic structure, offering the possiblity to try out different models to provide health care services (such as with the AEE at the LKH Bregenz).

In specifics, Austria could improve its high standards in health care services provision by implementing a gateway system using the Norwegian gatekeeping approach by giving each Austrian the opportunity to choose his or her general practicioner freely twice a year. If one does not choose a general practicioner, any visit to any general practicioner shall result in an additional fee. A specialized doctor, however, can only bee seen if referred to by the general practicioner - no exceptions to be made. This way, a patient becomes familiar to the treating GP, which should improve compliance. Even though such an implementation will effect the variable equity of demand, it may proof necessary to limit both costs from hospital admissions and outpatient departments and errors occuring from overworked health care professionals in hospitals.

General practicioners shall have the opportunity to either work independently or organize in health care centers like in Germany (Medizinische Versorgungszentren), which are supported by hospital operators, thereby improving access to health care services especially in remote areas. These health care centers shall be organized by the communities according to their needs, which can be assessed through statistics of the regional hospital. Also opening hours shall be organized differently as especially on weekends and at night the majority of general practicioners are not available. Generally, health care centers with paid psychotherapists, physio- and ergotherapists may level costs for sickness funds but also provide better preventive care, as depression and vertebral column related issues such as prolapses are high cost generating diseases as they also lead to people drop out of the workforce. Furthermore chronic diseases, such as Diabetes Mellitus type 2, are putting strains on the health care system. With such chronic diseases, an approach as stated in Chapter 1 could be applied: Methods of behaviour oriented prevention could be offered by such health care centers, e.g. through financial incentives or boni (shorter waiting times or reduced receipe fees for prescribed drugs) for patients being compliant to preventive measures, and who are also complying to yearly health checks. It shall be stressed that any treatment or diagnostics rendered to a patient

compliant to preventive measures and health promoting lifestyles shall be free of charge and even encouraged through a variety of incentives.

Depending on one's commitment to preventive measures and one's own health promotion, a boni and mali-system shall encourage compliance - while, in case of then getting sick with a chronic disease, prescripted drugs shall be covered to either full price if compliant with further therapy, or a declining percentage of coverage if a patient does not comply to his or her individual health plan for dealing with the disease.

In comparison to the behaviour oriented approach, the concept of condition oriented prevention shall be outlined at this point: Simply speaking, all policies that direct to prevent or diminuish the number of sufferers of a certain disease, can be considered condition oriented prevention. To give an example: As a condition oriented prevention approach, the German Alliance of Non-communicable Diseases suggested to implement an obligatory one hour of physical activity at school, the promotion of healthier food through taxing their unhealthy counterparties, to set minimum quality standards for meals provided in kindergarten or school cafeterias as well as banning all advertisment promoting unhealthy food choices which are directed at children as primary target population.

Additionally, overworked health care professionals are a key problem to ensure quality provision of health care services. Therefore, the Finnish approach to gating patients to attend the hospital at hours where many health care professionals are available, shall be implemented: If you come to the hospital or a regional health care center between 8pm and 7am on weekdays or if you come on weekends and public holidays without an appointment, you shall pay a general fee of 35 euros. Depending on further diagnostics or treatment which the patient wishes to obtain in the hospital at those hours but could be obtained at night pharmacies or with the general practicioner the next day, shall be paid for as well up to an amount of 200 euros. A yearly cap for such payments shall be discussed - and certainly ANY emergency is not charged at all. Once again it shall be stressed, that these measures are intended to steer patient flows for sicknesses and injuries that are shall be dealt with in the Primary Health Care sector to these registered doctors, who in turn need to be provided with the necessary means to handle the increasing number of patients.

It shall be further stressed that reduced fees for the less-income population shall be available - however, not fully discarded, as non-compliance is shown high with this population segment but is seen to be a cause of lack of knowledge which in turn can be dealt with through health education and prevention measures at previously mentioned regional health care centers.

In a transitional period, until enough regional health care centers are established, projects like the AEE, also informing patients about the structure of the Austrian health care system (e.g. in regard to self-admission), are recommended. Moreover, a decentrialization to communities having the possibility to decide upon health care services provision independently would need a new interpretation of the meaning of federalism. This can not go without taking responsibility by implementing legislation giving taxation and tax collection rights to the regions and communities.

4.0.1.1 Conclusions

Stated suggestions are additive to the reforms already on the way in the Austrian health care sector. These approaches shall strengthen the approach to shift more and more competences and responsibilities to primary health care services, but these health care services need to be available free of charge to the public to promote equality among the population through health care. However, as budgets are limited such an approach needs to be co-financed by saving costs on the long run, preventing over-treatment of privately insured patients and generation of costs in hospitals where any care rendered to the patient is cost-intensive, especially upon admission. A steering of patient flows through the implementation of (minor) fees may proof necessary on the long run, as cost-awareness is still not sufficient, even though sickness funds inform their insured upon treatment costs once a year. Additionally, more health care professionals are available during normal workday hours and on weekdays, which makes team decisions easier. A general re-thinking of working hours of physicians (limiting working hours to 12 or at most 16 a day) shall be discussed too, but needs more physicians first to even think about such a reform.

Generally, a triangle system like in the Scandinavian countries may be interesting to try out in a model region: municipalities, responsible for their own health care centers which they can set up according to their needs, regions continuing to be responsible for the hospitals and the federal government evaluating public efforts to improve its population's health and setting goals for achieving better health nationwide.

Also in regard to Long Term Care, new approaches on how to deal with an increasing demand for care for patients with chronic diseases and the elderly population need to be found: Over the last years, the Dutch system for Long Term Care has received much praise and shall be presented as a possible model system for reform in the sector: It generally covers at-home and institutional care for the elderly, chronic psychiatry patients and mentally and physically handicapped, thereby offering personal care, nursing, treatment, daily-life-assistance and the stay in an institution to mentioned people in

need. Assistance at home is covered and organized by the municipalities for which they receive a limited grant - an incentive to organise mentioned assistance efficiently. Co-payments to the system exist and vary in regard to what assistance is needed and are income dependent - in general the system is tax-financed. Any request for care obtained via mentioned system needs to be assessed, which is done by deciding which services of the above mentioned are the most fitting for the requesting person. However, any person living with the requesting person in the same household is obliged to "supportive care" that one family member renders to another.

If you are choosing an organization to care for you, you may choose one via the regional care offices, which is run by a health insuring company. This is called in-kind care. Their budgets are provided via the Long Term Care system but they are obliged to keep the costs within the national and regional budget maximums. If these targets are not met, another health insurer may be assigned to the regional care office. If you are not choosing an organiation to care for you, you receive a budget, which is 25% lower than the current costs of mentioned in-kind care. The person in need of care can then choose who should be the one caring for him or her - and just has to report back and give proof that the money was actually used for care services. The sector is regulated by th Dutch Health Authority (Nederlandse Zorgautoriteit, NZa).

With homebased care however, the NZa ensures competition and sets maximum tariffs. These are paid in hourly wages, with the only exception of day care groups.

Institutional care is also regulated by the NZa, which sets guidelines for care thereby regulating delivery as tariffs can only be collected by compliant providers. Mentioned tariffs are based on payments allocated to so-called "severity-of-care-packages" which combine a variety of care actions rendered to the patient.

A regulation and coordination of Long Term Care under one institutional overhead may offer Austria the possibility to regulated prices, as it is done in negotitations in regard to pharmaceuticals or via the sickness funds with the doctors in private praxis. A cost-efficient approach, with a hearty commitment to preventive measures and providing the best possible care to the public as one's better health pushes equality, may be an approach to push for more equity in Austrian society. If high quality health care and Long Term Care services can be rendered to the people cost-efficiently, some more equity in the world could be achieved.

Moreover, funding – and in that regard, the variable of financial viability is touched - will be the issue for any intended reform. With the concept of Generational Accounting, a government may evaluate whether its fiscal policies are sustainable, if all net tax income that comes from all living and expected future generations plus the official public

debt add up to zero or even a plus. If that is not the case, a "fiscal gap" residues. Even though this may give you a general outlook on future budgetary means, it is still sensitive to growth, both economical and population wise - but it may help to adjust the level of employer contribution over the next years, estimate the coverage of health benefit packages required per generation, and the percentage of both the contributions to the sickness funds as well as the overall payroll tax. In addition, an individual's risk assessment may proof of assistance to calculate lifetime health care costs - such an assessment could be done through standardized guidelines with the annual health check already implemented in the Austrian health care system.

With private health care insurance, though mainly of an additional nature, the public often speaks of a "2-class-system", which in turn is hard to verify. In general, physicians are not treating private insured patients in hospitals very different from other patients. They are, however, often considered to be funding contributers: The unlimited earnings of their treatment offer the possibility to render additional services to patients who are only insured via the public sector. As physicians in the hospitals are not principally driven by a market principle - as they earn a salary - such behaviour of redistribution can be broadly observed. Further legislation and regulation for the private health care sector especially for patients attending to physicians in private praxis shall be considered even though it may affect earnings of extramural physicians. If the government would consider compensation measures for such losses - e.g. by increasing the social sickness funds' limits for certain diagnostics or examinations - preference, given to privately insured patients, could be balanced. As one's health can be considered an asset to better one's living conditions, a "one class" health care system offering everyone the same services would support equal opportunities for a country's population to strive for a better socio-economic status. However, it shall be stated that hardly anyone is fully privately insured in Austria and the number of additionally insured patients is also rather low, even declining over the last years.

A major issue to overcome is the diffuse distribution of competences between the federal government, the federal states and the communities, thereby detoriating federalism from a multi-view-angle to newspaper articles about day-to-day quarels among different levels of federal administraion. If federal states can spend tax money, they can also collect taxes. Checks-and-balances, a rather old but functioning approach.

Concluding, current approaches of European governments turning towards condition oriented and behaviour oriented prevention shall be discussed. To have such policies turn out a success, the health literacy of an individual has to be high – rather contrary to condition oriented prevention approaches, which (re)set the framework of a society through law changes.

A health literate person offers enough cognitive and social understanding to be motivated and able to gain access to and understand to use available information promoting the maintainance of good health. To train and educate a person to be health literate, is a matter of empowerment, not only influencing the individual's lifestyle conditions and decisions, but raising further awareness to determinants of health, leading to actions in favor of maintaining good health. And as outlined in chapter 1 – good health means a higher contribution to the increase of social capital.

As shown by a paper of the Canadian Public Health Association, the aim of a policy promoting health literacy is that the individual is able to[4]:

- *"understand and carry out instructions for self-care, including administering complex daily medical regimens,*
- *plan and achieve the lifestyle adjustments required for improved health*
- *make informed positive healthrelated decisions,*
- *know how and when to access health care,*
- *share health promoting activities with others,*
- *address health issues in the community and society."*

In a practical example, the association managed to match a physician with a literacy learner so that they together conduct user-friendly signage in a trial hospital, or bringing a nurse and a local First nation member together, helping them to produce a video explaining the First Nation's customs to health care professionals. Furthermore, they implemented a teach-back strategy (the patient repeats what he/she believed to have understood after having been informed by a health care professional) to evaluate whether patients understood diabetes self-managment instructions. Thereby, the patient becomes an expert in regard to his own health, which may boost compliance significantly. Together with a pay-for-performance approach for health care professionals, this could proof a highly motivating angle to implement a variety of prevention plans.

However, also nurses inquiring a few days after the visit with the patient via telephone whether they are doing better or come by with the given instructions may proof a simple, but highly benefitial innovation in the primary health care setting.

Preventive policies and policies of improving health literacy especially among the elderly, may be another corner stone of a health care reform targeting to strengthen the primary health care sector, as the current reform is aiming to do.

[4]See: http://www.cpha.ca/uploads/progs/literacy/examples$_e$*.pdf*

Ending, it shall be stressed that any reform shall have the preservation or even improvement of a solidarity based health care system as its main aim. Such a health care system may not succeed to achieve true equity due to many factors outlined in the first three chapters, but equality of opportunities is possible – if our health care system remains a public and one-class one. To ensure such a future development of the Austrian health care system, the informed citizen has to remain vigilant to any new policies or intended law changes – as well as the government has to be called upon to ensure a financially viable future through structural reforms spiked with elements of behaviour oriented prevention measures.

Suggestions for such additional elements to the current reform have been outlined throughout this last chapter, leaving the reader an opportunity to form his / her own opinion. Presented work also tried to distinguish between "equity" and "equality", but both meanings are very much intertwined in the literature available for this diploma thesis. Therefore, they have been used alongside as the goal of any society should always be equity in health, even though a solidaric health care system may in a realistic way only achieve better equality through the various, presented pathways. In the end, being born into a "better family" which can pay for education and for health care services out-of-pocket, will still achieve a better health than families of a lower socio-economic status. And even if we would overcome this obstacle, our genes would still have an influence on our health as well.

Therefore, one can only encourage further discussion on the matter and possibilities of reform as a solidaric, public health care system does balance the scales a little more and improves equality of opportunities in a society. In the end, however, just talking about reform can not be the only thing that is done – as US-president Lyndon B. Johnson once put it: *"We have talked long enough in this country about equal rights. It is time now to write the next chapter - and to write it in the books of law."*

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Appendix A

Appendix A

Figure 2 - Life expectancy and income per capita for selected countries and periods

From: The World Bank report of 1990

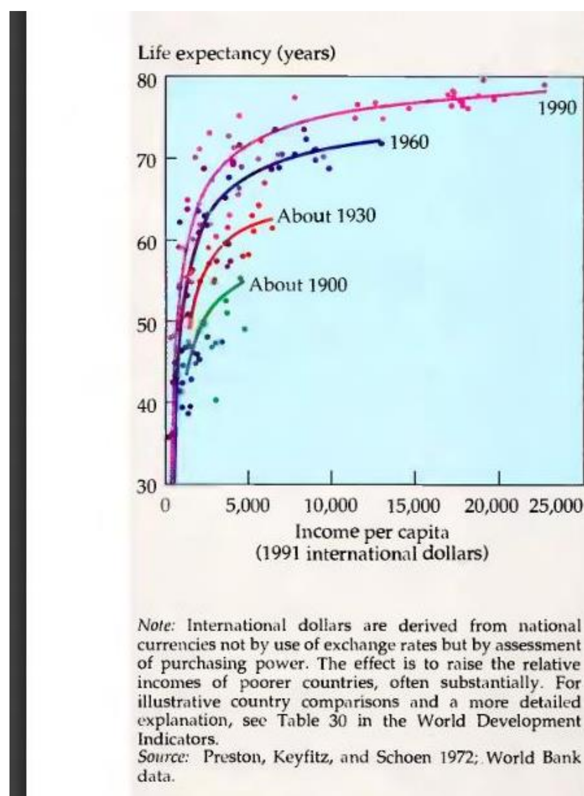
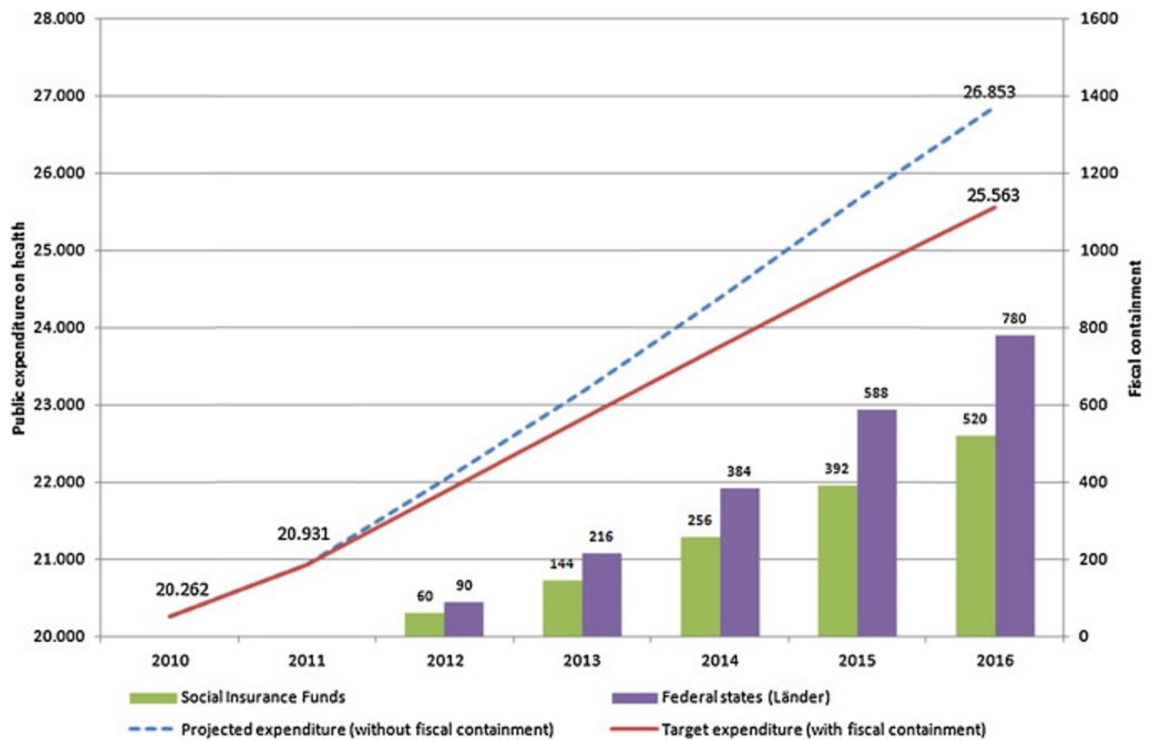


Figure 3 - Budget cap on public expenditure on health and contribution to cost containment according to main financing agents (excluding public expenditure on long-term care), in million EURO (nominal).

From: The Austrian health reform 2013 is promising but requires continuous political ambition, by Maria M. Hofmarcher. See: http://www.healthpolicyjrnl.com/article/S0168-8510



Bibliography

[1] Oxford english dictionary - Online Version via Karl-Franzens-university library online portal, Accessed in 03/2015. URL https://unikat.uni-graz.at

[2] Cook K. Messick D. Equity theory: psychological and sociological perspectives. Praeger, 1983.

[3] Nollert M.; Budowski M. Soziale Gerechtigkeiten. Seismo Verlag - Sozialwissenschaften und Gesellschaftsfragen, 2008.

[4] Koller P. Gerechtigkeit im politischen Diskurs der Gegenwart. Passagen-Verlag, Wien, 2001.

[5] Schumacher H. Hajen L., Paetow H. Gesundheitsökonomie: Strukturen - Methoden - Praxisbeispiele. Verlag W. Kohlhammer, 3. Auflage, 2007. ISBN 3-17-019394-5.

[6] Mielck A., editor. Krankheit und soziale Ungleichheit, Ergebnisse der sozialepidemiologischen Forschung in Deutschland, Opladen. Verlag Leske + Budrich, 1994. ISBN 978-3-322-95904-1.

[7] World Bank. World Development Report 1993 - Investing in Health. pp. 34. Report, 1993.

[8] Smith D. Patel C. North F. Marmot M.G., Stansfield S. Health inequalities among British servants: The Whitehall study. *The Lancet*, 337(8754):1387–1393, 1991.

[9] Müller-Fahrnow W. Klosterhuis H. Sozialschicht und Sterblichkeit bei männlichen Angestellten aus den alten Bundesländern, pages 319–330. in: *Krankheit und soziale Ungleichheit Ergebnisse der sozialepidemiologischen Forschung in Deutschland*. VS Verlag für Sozialwissenschaften / Leske + Budrich, 1993.

[10] WHO. The World Health Report 2000 - Reducing Risks, Promoting Healthy Life. Report, 2000.

[11] Seidl C. Marktgerechte versus kollektivistische Sozialpolitik, *Marktwirtschaft als Aufgabe - Wirtschaft und Gesellschaft im Übergang vom Plan zum Markt*, 3:363–376. Verlag Gustav Fischer, 1994.

[12] Levinthal D. A survey of agency models of organizations. *Journal of Economic Behavior and Organization*, 9(2):153–185, 1988.

[13] Rogerson W. The first-order approach to principal-agent problems. *Econometrica*, 53:1357–1368, 1985.

[14] G. Mooney McGuire A., Henderson J. The Economics of Health Care. Routledge Chapman & Hall, London, 2005 - New Edition, First Edition: 1988.

[15] J. C. Harsanyi. Morality and the Theory of Rational Behaviour, *Utilitarianism and Beyond*, 53:39–63. Cambridge University Press, 1982.

[16] The Bill & Belinda Gates Foundation - Online Ressource - fact sheet and statistics, 2014. Accessed in 04/2015. URL http://www.gatesfoundation.org/who-we-are/general-information/foundation-factsheet.

[17] Ross J. Der Weltgesundheitsapostel, 10/2014. Die Zeit 44:23. Accessed in 05/2015. URL http://www.zeit.de/2014/44/bill-gates-stiftung-gesundheit-spenden.

[18] McGoey L. Philanthrocapitalism, the Gates foundation and Global Health - an interview with Linsey Mcgoey, 2013. Accessed in 06/2015. URL http://www.hinnovic.org/philanthrocapitalism-gates-foundation-global-health-with-linsey-mcgoey/.

[19] McGoey L. Philanthrocapitalism and its critics. *Poetics*, 40(2):185–199, 2012.

[20] Gates B. Bill Gates: Here's my plan to improve our world - and how you can help, 12/2013. Accessed in 06/2015. URL http://www.wired.com/2013/11/bill-gates-wired-essay/all/.

[21] Cyclus J. Thomson S. Basu S. Stuckler D. Mackenbach J. P. McKee M. Karanikolos M., Mladovsky P. Financial crisis, austerity, and health in Europe. *The Lancet*, 11/2015, 381(9874):1323–1331. URL http://dx.doi.org/10.1016/S0140-6736(13)60102-6. doi: 10.1016/S0140-6736(13)60102-6; 11.

[22] Cyclus J. Karanikolos M. Evetovits T. Thomson S. McKee M. Mladovsky P., Srivastava D. Health policy responses to the financial crisis in Europe (policy summary 5). Report 5, World Health Organization, 2012.

[23] Valkonen T. Martikainen P. T. Excess mortaility of unemployed men and women during a period of rapidly increasing unemployment. *The Lancet*, 348(9032):909–912, 1996.

[24] McKee M. Stuckler D., Basu S. Budget crises, health, and social welfare programmes. *BMJ*, 340, 06/24, 2010. URL http://www.bmj.com/content/340/bmj.c3311.abstract.

[25] Gudmundsdottir D. The impact of economic crisis on happiness. *Social Indicators Research*, 110(3):1083–1101, 2013.

[26] Frisina L. Grimmeisen S. Schmid A. Wendt C. Rothgang H., Cacace M. The State and Health Care. Comparing OECD Countries, *The European Legacy: Toward New Paradigms*, 17:410ff. Basingstoke: Palgrave Macmillan, 2012.

[27] Wendt C. Mapping European health care systems. A comparative analysis of financing, service provision, and access to health care. *Journal of European Social Policy*, 19(5):432–445, 2009.

[28] Pressel H. Schölkopf M. Das Gesundheitswesen im internationalen Vergleich. Medizinische Wissenschaftliche Verlagsgesellschaft, Berlin, 2. Auflage, 2014.

[29] Wörgötter A. Gönenc R., Hofmarcher M.M. Reforming austria's highly regarded but costly health system, *OECD Economics Department Working Paper*, 895, 2011. Accessed in 11/2015. URL http://www.oecd-ilibrary.org/economics/reforming-austria-s-highly-regarded-but-costly-health-system_5kg51mbntk7j-en.

[30] Pressel H. Der Gesundheitsfond: Enstehung - Einführung - Weiterentwicklung - Folgen. Verlag für Sozialwissenschaften / Springer Verlag, 2012.

[31] Lehto J. Winblad U. Saltmann R.B., Vrangbaek K. Consolidating national authority in Nordic health systems. *Eurohealth*, 18(3):21–24, 2012.

[32] Schaeffer D. Haemel K. Kommunale Gesundheitszentren in Finnland - Entwicklung und aktuelle Herausforderungen in der ländlichen Primärversorgung. *Jahrbuch für kritische Medizin und Gesundheitswissenschaften*, 50:11–29, 2014.

[33] Ringard A. Lindahl A. K. The Norwegian Health Care System. Report 1717, 2013. The Common Wealth Fund (Ed.).

[34] Moran M. Lowe R. (review) Governing the health care state. a comparative study of the United Kingdom, the United States and Germany. *Medical History*, 44(4): 562–563, 2000.

[35] Kohl J. Wendt C. Translating monetary inputs into health care services - the influence of different modes of public policy in a comparative perspective. *Journal of Comparative Policy Analysis: Research and Practice*, 12(1-2):11–31, 2010.

[36] Mossialos E. Allin S., Maseria C. Measuring socioeconomic differences in use of health care services by wealth versus by income. *American Journal of Public Health*, 99(10):1849–1855, 2009.

[37] Listl S. Income-related inequalities in dental service utilization by Europeans aged 50+. *Journal of Dental Research*, 90(6):717–723, 2011.

[38] Puffer F.. Van Doorslaer E., Koolman X. Equity in the Use of Physician Visits in OECD Countries: Has Equal Treatment for Equal Need been Achieved?, pages 225–242. in: *Measuring Up: Improving Health Systems Performance in OECD Countries*. OECD, Paris, 2002.

[39] Koolman X. Van Doorslaer E., Masseria C. Inequalities in access to medical care by income in developed countries. *Canadian Medical Association Journal*, 174(2): 177–183, 2006.

[40] Schoen C. et al. How health insurance design affects access to care and costs, by income, in eleven countries. *Health Affairs (Millwood)*, 29(12):2323–2334, 2010.

[41] Schoen C. et al. New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. *Health Affairs (Millwood)*, 30 (12):2437–2448, 2011.

[42] Kopetsch T. Dem deutschen Gesundheitswesen gehen die Ärzte aus! : Studie zur Altersstruktur- und Arztzahlenentwicklung. Köln : KBV, 2003. in: *Früher u.d.T.: Gehen dem deutschen Gesundheitswesen die Ärzte aus?*; [Hauptbd., 3. aktualis. u. überarb. Aufl.:] Berlin : Bundesärztekammer u. Kassenärtzl. Bundesvereinigung.

[43] Helmert U. Mielck A. Das Arzt-Patienten-Verhältnis in der ambulanten Versorgung: Unterschiede zwischen GKV- und PKV-Versicherten, pages 114–132. in: *Gesundheitsmonitor 2007: Gesundheitsversorgung und Gestaltungsoptionen aus der Perspektive von Bevölkerung und Ärzten*. Bertelsmann Stiftung, 1. Edition, 2007.

[44] Lüngen M. et al. Waiting times for elective treatments according to insurance status: a randomized empirical study in Germany. *International Journal for Equity in Health*, 7(1):1–7, 2008.

[45] Schellhorn M. Vergleich der Wartezeiten von gesetzlich und privat versicherten in der ambulanten ärztlichen Versorgung, pages 95–113. in: *Gesundheitsmonitor 2007: Gesundheitsversorgung und Gestaltungsoptionen aus der Perspektive von Bevölkerung und Ärzten*. Bertelsmann Stiftung, 1. Edition, 2010.

[46] Greß S. Mit gleichen Rahmenbedingungen zu einem fairen Wettbewerb im Gesundheitssystem. Zur Notwendigkeit einer einheitlichen Wettbewerbsordnung auf dem deutschen Krankenversicherungsmarkt. *WISO direkt*, 4(1):1–4, 2009.

[47] Teperi J. et al. Sufficient services for all. Perspectives on equity in social and health care. 2006. Accessed in 08/2015, URL http://www.stakes.fi/verkkojulkaisut/raportit/M233--VERKKO.pdf.

[48] Mikkola H. et al. Orthopedic surgeries in Finland 1987 to 2002. Number of surgeries according to the geographic waiting time and centralization. *Duodecim - lääketietellinen aikakauskirja*, 121(8):861–871, 2005.

[49] Health service utilization and its socioeconomic determinants. Health 2000 survey. Report 10, National Public Health Institute, 2006. Accessed in 10/2015. URL http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2006/2006b10.pdf.

[50] Lahelma E. Martelin T., Koskinen S. Health disparities between population groups. *Health in Finland*, pages 102–105, 2006.

[51] Suomen Lääkäriliitto. Physician survey 2015. Statistics. Accessed in 10/2015. URL http://www.laakariliitto.fi/site/assets/files/1011/vuositilastot_2015_en.pdf;.

[52] Lafkiri K. Municipality level accessibility to specialized health care in Norway. Report, 2010. Accessed in 10/2015. URL https://www.med.uio.no/helsam/forskning/nettverk/hero/publikasjoner/skriftserie/2010/2010_7.pdf.

[53] Stirbu I. et al. Inequalities in utilisation of general practicioner and specialist services in 9 European countries. 2011. *BMC Health Services Research*. Accessed in 09/2015, URL http://www.biomedcentral.com/1472--6963/11/288 .

[54] Jensen A. Tannlegetjenester: internasjonale sammenligninger, nasjonale analyser. 2013. Accessed in 07/2015. URL http://helsedirektoratet.no/Om/kurs-konferanser/Documents/Arne%20Jensen,%20SSB%20-%20seminar%206.7.2013.pdf.

[55] Hagen T.P. Ringard A. Are waiting times for hospital admissions affected by patients' choice and mobility? 2011. Accessed in 09/2015. *BMC Health Services Research*, 11(170), URL http://www.biomedcentral.com/1472-6963/11/170.