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Sector Inquiry Health Part II: Healthcare in Rural Areas

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The present report does not contain any trade secrets. Any confidential information has been deleted. This is to prevent any sensitive corporate information provided by market participants being made known to their competitors.

The present report has been drawn up to the best of the authors' knowledge and with the greatest possible care on the basis of discussions with stakeholders, data and information that have been communicated to the BWB, and publicly available sources.

All terms used in the present report to refer to persons include men and women equally, and are to be understood as gender-neutral.

Executive summary

The Federal Competition Authority (BWB) has been analysing the Austrian healthcare sector since the beginning of 2017. In this sector inquiry, the BWB has evaluated the competitive environment in certain submarkets of the healthcare market. The inquiry is based on information requested from market participants, academic literature, and field reports and surveys provided by national competition authorities. In addition to this, in-depth discussions have been held with undertakings, interest groups and other institutions active in the healthcare market. The goal is to identify possible distortions of competition and highlight options for liberalisation that will provide undertakings with greater scope for action and deliver benefits for consumers. Studies have demonstrated that a certain amount of competition on the healthcare market can lead to better provision, and improve the quality of products and services.

The report on the first part of the inquiry, *The Austrian Pharmacy Market*, was published on 18 May 2018. It analyses possible restraints on competition on the market for community pharmacies, in particular with regard to market entry for pharmacies (needs assessment), the ownership of pharmacies (including the prohibition of third-party ownership, wholesalers and branch pharmacies) and the rules on the operation of pharmacies (including opening hours, the provision of services, online sales and the prerogative of pharmacies to sell OTC medicines).

In the past few years, there has been increasing evidence of a partial deterioration of basic medical care in rural areas, in particular due to growing problems filling vacant permanent posts for general practitioners under contract to health insurance funds. The age structure of the general practitioners in private practice and the retirements it implies are to be expected in the years to come, as well as the modest levels of interest shown by young doctors in taking up the posts that will be vacated suggest that the situation may be expected to deteriorate further in the near future. In view of how these developments have recently been intensifying, the BWB has therefore decided to focus its next report on the above-mentioned aspect of healthcare in rural areas from a competition perspective.

Chapter I gives a survey of medical and pharmaceutical provision in Austria. It is apparent that in small municipalities a great deal of medical and pharmaceutical care is provided by general practitioners with their own practice dispensaries. Especially in rural areas, however, there are also municipalities that rely on services provided from neighbouring municipalities. In the years 2009–2018, 155 new community pharmacies were opened, mostly in municipalities with growing populations. Particularly in municipalities with 1,000 to 5,000 inhabitants, existing practice dispensaries have been driven out of the market as a result of the opening of new community pharmacies.

Chapter II addresses public health policies and measures taken by regional authorities, social insurance institutions and interest groups in order to maintain the healthcare provided by the public health insurance funds. The variety of support measures ranges from different monetary and non-monetary incentive models to ideas about central planning that would, for instance, prohibit the provision of medical services by private doctors *("… if you are not willing to do what we want, we will force you to*"). It goes without saying that the BWB does not regard approaches of this kind as likely to achieve the goals that are being pursued.

Chapter III pays particular attention to the question of whether and to what extent regulatory restrictions on practice dispensaries might impair the attractiveness of rural doctors' practices, and whether such restrictions are justified from a healthcare perspective. While conducting its investigations, the BWB soon realised that operating a practice dispensary is an essential factor in the attractiveness of a rural health insurance fund doctor's practice, and may consequently be considered a vital building block for universal healthcare provision in rural areas. Doctors operating their own practice dispensaries compete to a certain extent with private community pharmacies, and are currently faced with very restrictive regulations laid down in the Austrian Pharmacies Act (ApothekenG). The report therefore analyses the existing situation, the applicable legal provisions and their impact on the supply of medicinal products in rural areas. As the conclusion of the inquiry, it may be stated that community pharmacies and practice dispensaries do not necessarily have to be treated differently under competition law, either in order to improve security of supply or in order to ensure a certain level of quality when it comes to the dispensing of medicines. Unlike in the past, the vast majority of products sold in community pharmacies are no longer produced at these pharmacies. This means one reason for the largely exclusive distribution of medicines by community pharmacies has ceased to be relevant. The deregulation of the provisions in the Pharmacies Act on practice dispensaries is therefore recommended.

Chapter IV deals in greater detail with the new primary healthcare units ("PVEs"), the establishment of which is being driven ahead primarily in order to reduce the burdens on hospital outpatient departments. It also examines what impacts these primary healthcare

units might have on healthcare provision in rural areas. Furthermore, this chapter looks at the option that now exists for doctors to be employed and training placements for general practitioners.

Chapter V analyses the proposals put forward by the Austrian Chamber of Pharmacists on 25 April 2019 for the modernisation of the Austrian Pharmacies Act, and relates them to the recommendations published in the report on the first part of the sector inquiry, *The Austrian Pharmacy Market*. It is apparent that several of the proposals made by the Chamber of Pharmacists clearly correlate with the BWB's recommendations, a fact that is to be welcomed from the BWB's point of view.

In compliance with Section 2 para. 1 of the Austrian Competition Act, all investigations and analyses contained in the present report are based on the BWB's fundamental understanding that patients' freedom of choice, the comparability of medical services and the removal of artificial barriers to competition must be seen as the main pillars of competition in the healthcare sector.

Approach and methodology: This report is based on discussions with interest groups that represent both doctors and pharmacists, as well as the Main Association of Austrian Social Security Institutions. Furthermore, documents and statistical data provided by these organisations have been analysed. Building on the data provided by the Austrian Medical Chamber, the Austrian Chamber of Pharmacists and the Main Association of Austrian Social Security Institutions, a map has been drawn up that shows health insurance fund posts with practice dispensaries (both geographically and over time). Moreover, academic publications, court rulings, and reports and studies have been analysed, and the BWB has also participated in various discussion events on the topic with stakeholders and market participants.

Recommendations

- More rapid creation of across-the-board funding schemes and financial incentives for health insurance fund posts for general practitioners in rural areas.
- Intensified, across-the-board action to enhance the status of general practice in the theoretical and practical parts of university courses in human medicine.
- Further flexibilisation and expansion of the opportunities for development open to doctors in private practice with contracts under section 2 of one of the master contracts that govern doctors' conditions ("section 2 contract doctors").
- Awareness-raising measures (for instance through an information campaign) with the goals of boosting the esteem in which section 2 contract doctors are held and enhancing their status in the field of general practice.

- Deletion without replacement of the minimum distances set in Section 29 ApothekenG for the authorisation of a practice dispensary in a municipality without a community pharmacy.
- Deletion of the special provisions on the minimum distance practice dispensaries have to be away from community pharmacies pursuant to Section 28 para. 3 ApothekenG in municipalities with just one health insurance fund post for a doctor and one license issued for a community pharmacy. Instead of this, community pharmacies and doctors' dispensaries are to be given equal legal treatment on the basis of Section 10 ApothekenG.
- Consideration of the specific structural peculiarities of rural areas when the needs assessment under Section 10 ApothekenG is carried out.
- Permanent posts for primary healthcare units are not to be allocated at the expense of health insurance fund posts for doctors in rural areas. Instead, it is proposed that permanent posts should be managed systematically using a transparent catalogue of criteria.
- Authorisation for primary healthcare units to also operate their own practice dispensaries.
- Measures to ensure freedom of choice in non-acute cases by organising opening hours appropriately at primary healthcare units where patients may be treated by a variety of doctors.
- (Minimum) criteria for the needs assessment that will be carried out by the Austrian Chamber of Pharmacists for mobile dispensing services subject to mandatory authorisation are to be regulated in legislation. Alternatively, it would be conceivable for such a service to be authorised automatically where there was no mobile dispensing service in the catchment area, unless the Austrian Chamber of Pharmacists demonstrated an absence of demand.
- Provided there are no compelling reasons that stand in the way of this in individual cases, branch pharmacies should be established permanently. The period for which a branch pharmacy is protected should run in parallel to the term of the main pharmacy's licence.

I. Survey of regional provision with pharmacies and general practitioners in Austria

In the course of the investigations carried out by the BWB, the Austrian Chamber of Pharmacists and the Austrian Medical Chamber were asked to provide information about the locations of community pharmacies, practice dispensaries and health insurance fund posts for general practitioners in Austria. These data have been correlated by the BWB with population data from Statistics Austria.

Section I.1 gives an overview of the current provision with pharmacies and general practitioners in Austria. Section I.2 looks at the density of provision relative to population size, as well as the distances to the closest pharmacy/practice dispensary and the closest doctor. Section I.3 deals with the changes that have taken place in the healthcare situation during the years 2008–2019.

1. Regional distribution

Figures for 2019: Table 1 lists the numbers of pharmacies and health insurance fund posts for doctors by province. In total, there are at present 1,438 pharmacies operated by pharmacists in Austria, of which twenty-nine are branch pharmacies and thirty-seven are hospital pharmacies without an associated community pharmacy. By contrast to this, there are 794 practice dispensaries operated by public health insurance fund doctors.[1] In total, there are therefore 2,232 community pharmacies and practice dispensaries.

It is evident from Table 2 that pharmacy services are overwhelmingly provided by practice dispensaries in municipalities of up to 5,000 inhabitants. In total, about 21% of general practitioners with health insurance fund contracts operate practice dispensaries. In municipalities with populations of up to 1,000, 74% of contracted general practitioners operate practice dispensaries, while the figure is 44% in municipalities with between 1,000 and 5,000 inhabitants.

At present, there are 3,757 general practitioners with regional social health insurance fund contracts in Austria. General practitioners contracted to smaller health insurance

[1] Pursuant to Section 29 para. 1 no. 1 Pharmacies Act (ApothekenG), authorisation to operate a practice dispensary is conditional in particular upon the existence of a contractual relationship pursuant to Section 342 para. 1 General Social Insurance Act (ASVG), i.e. a post financed by a regional social health insurance fund.

funds usually have a contract with the relevant regional social health insurance fund as well. The authorisation of a practice dispensary is conditional upon the doctor having a regional social health insurance fund contract. However, there are another fifty-two general practitioners who operate a practice dispensary although they do not have a regional social health insurance fund contract, but just a contract with a smaller health insurance fund. In total, there are therefore 3,809 general practitioners with regional social health insurance fund contracts and/or authorisation to operate practice dispensaries in Austria.[2]

Figure 1 and Figure 2 show the spatial distribution of community pharmacies, practice dispensaries (which are always assigned to a health insurance fund doctor's post) and other health insurance fund doctors (general practitioners under contract to regional social health insurance funds) in Austria. It is apparent that pharmacies and health insurance fund posts are distributed very unevenly across Austria in ways that reflect the country's topography and population density.

Table 1 Pharmacies and public health insurance fund doctors by province

	Apotheken				Allgemeinmediziner mit Kassenvertrag**		
Bundesland	gesamt	öffentliche	Filialen	Krankenhaus*	gesamt	mit Hausapotheke	ohne Hausapotheke
Burgenland	45	40	4	1	145	43	102
Kärnten	105	100	2	3	259	60	199
Niederösterreich	250	239	6	5	792	231	561
Oberösterreich	215	204	2	9	627	200	427
Salzburg	94	90	3	1	231	30	201
Steiermark	207	200	3	4	571	151	420
Tirol	129	120	8	1	320	60	260
Vorarlberg	53	51	1	1	156	19	137
Wien	340	328	0	12	708	0	708
GESAMT	1.438	1.372	29	37	3.809	794	3.015

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, Auswertungen der RWR, Stand: Q2/2019. *Krankenhausapotheken ohne angeschlossene öffentliche Apotheke; **Allgemeinmediziner mit GKK-Kassenvertrag und/oder mit Hausapotheke.

[2] Figures for Q2/2019. Minor inconsistencies in the numbers of posts for doctors may result *inter alia* from the assignment of practice dispensaries to health insurance fund posts on the basis of contact details.

Table 2 Pharmacies and public health insurance fund doctors by municipality size classes

Gemeindegrößenklasse	Apotheken				Allgemeinmediziner mit Kassenvertrag**		
Einwohner	gesamt	öffentliche	Filialen	Krankenhaus*	gesamt	mit Hausapotheke	ohne Hausapotheke
≤1.000	4	3	1	0	125	92	33
1.000-5.000	368	343	24	1	1.553	688	865
5.000-10.000	231	225	4	2	509	10	499
10.000-50.000	256	246	0	10	519	4	515
>50.000	579	555	0	24	1.103	0	1.103
GESAMT	1.438	1.372	29	37	3.809	794	3.015

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, Auswertungen der BWB, Stand: Q2/2019. *Krankenhausapotheken ohne angeschlossene öffentliche Apotheke; **Allgemeinmediziner mit GKK-Kassenvertrag und/oder mit Hausapotheke.

2. Density of provision

Municipalities without pharmacy provision are found above all in rural areas: Table 3 shows that about 38% of Austrian municipalities have neither a pharmacy nor a practice dispensary. About 26% of municipalities do not have a health insurance fund doctor. As is evident from Table 4, municipalities without pharmacies and doctors are found overwhelmingly, but not exclusively, in rural areas.[3] About 61% of municipalities without a community pharmacy or practice dispensary are located in rural areas, 30% in rural areas surrounding urban centres (outer zones), 2% in regional centres and 8% in urban centres. This imbalance is even more pronounced when it comes to health insurance fund doctors: 66% of municipalities without a health insurance fund doctor are located in rural areas, 28% in rural areas surrounding centres, 1% in regional centres and 5% in urban centres.

Density of provision relative to population: On average, Austria has about 15.8 community pharmacies (incl. branch pharmacies) per 100,000 inhabitants. This is well below the average of 24.7 pharmacies per 100,000 inhabitants for the OECD states.[4] If practice dispensaries are also taken into consideration, the level of provision rises to 24.8 pharmacies/dispensaries per 100,000 inhabitants. Especially in municipalities with fewer than 5,000 inhabitants, services are overwhelmingly provided by practice dispensaries. When community pharmacies and practice dispensaries are looked at together, there is a higher density of provision per 100,000 inhabitants in small municipalities than in large municipalities. This picture is also apparent when it comes to public health insurance fund doctors (cf. Table 5). By contrast, the distances to the closest pharmacy/practice dispensary and the closest doctor are longer in small municipalities (see below).

[3] Localities have been classified into rural and urban areas on the basis of Statistics Austria's urban-rural typology; cf. https://www.statistik.at/web_en/classifications/regional_breakdown/urban_rural/index.html, accessed 5 November 2019.

[4] Cf. OECD (2017), "Pharmacists and pharmacies", in *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris, 189, Table 10.5.

Table 3 Municipalities without medical/pharmacy provision (municipality size classes)

Gemeindegrößenklasse	Gemeinden		
Einwohner	Anzahl	ohne Arzt*	ohne Apo/Hapo**
≤1.000	419	299	326
1.000-5.000	1.423	249	462
5.000-10.000	168	0	2
10.000-50.000	77	0	0
>50.000	9	0	0
GESAMT	2.096	548	790

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, Auswertungen der RWR, Stand: Q2/2019. *Allgemeinmediziner mit GKK-Kassenvertrag und/oder mit Hausapotheke, **Öffentliche Apotheken und Hausapotheken;

Table 4 Municipalities without medical/pharmacy provision (urban-rural typology)

		Gemeinden		
Urban-Rural-Typologie		Anzahl	ohne Arzt*	ohne (Haus-)Apotheke**
Urbane Zentren	städtisch	231	26	60
Regionale Zentren	ländlich	78	8	15
Umland	ländlich	555	153	237
Ländlicher Raum	ländlich	1.232	361	478
GESAMT		2.096	548	790

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, Auswertungen der RWR, Stand: Q2/2019. *Allgemeinmediziner mit GKK-Kassenvertrag und/oder mit Hausapotheke, **Öffentliche Apotheken und Hausapotheken;

Table 5 Inhabitants per pharmacy and per doctor

Gemeindegrößenklasse	Gemeinden	Apotheken*	Apo/Hapo**	Ärzte***
Einwohner	Anzahl	pro 100.000 Einwohner		
≤1.000	419	1,5	35,0	45,6
1.000-5.000	1.423	11,5	33,0	48,6
5.000-10.000	168	20,0	20,8	44,4
10.000-50.000	77	19,2	19,5	40,4
>50.000	9	18,8	18,8	37,3
GESAMT	2.096	15,8	24,8	43,0

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, Auswertungen der RWR, Stand: Q2/2019.

*Öffentliche Apotheken (inkl) Filialapotheken, **Öffentliche Apotheken (inkl Filialen) und Hausapotheken, ***Allgemeinmediziner mit GKK-Kassenarztstelle und/oder Hausapotheke.

Figure 1 Community pharmacies and practice dispensaries in Austria

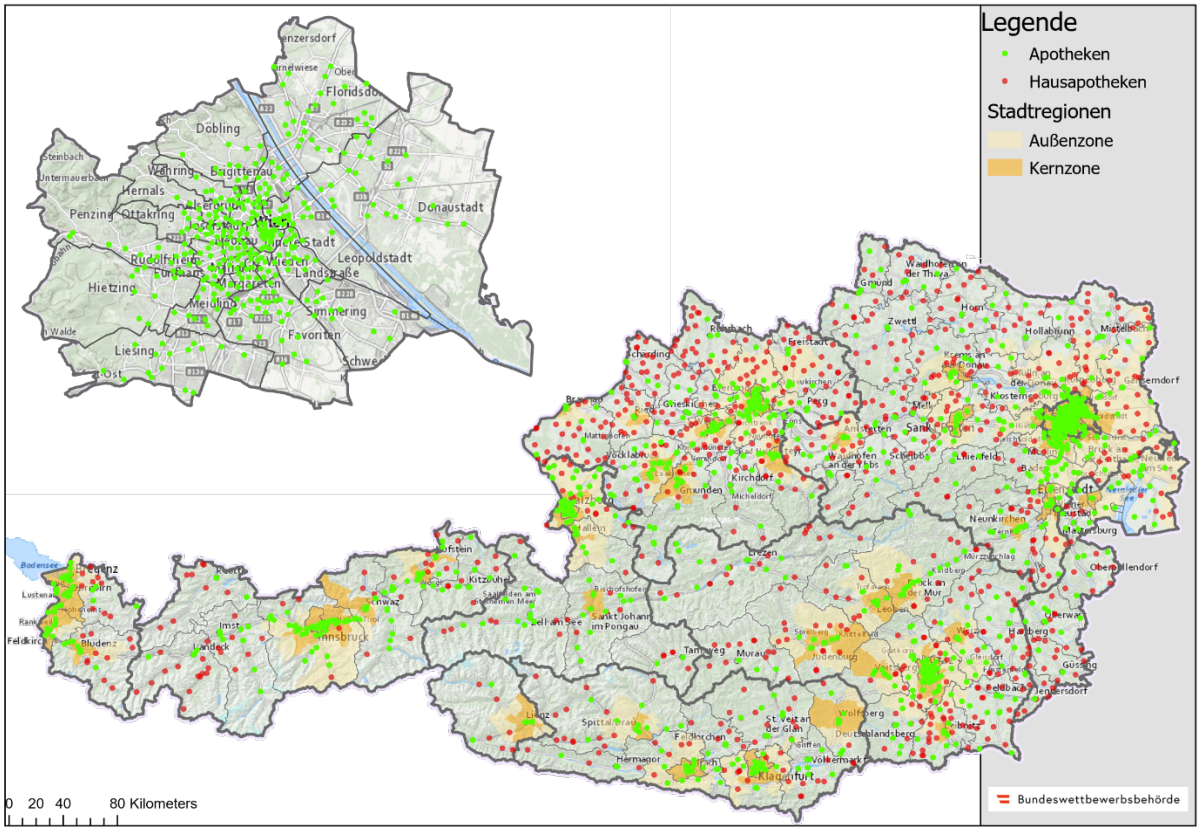
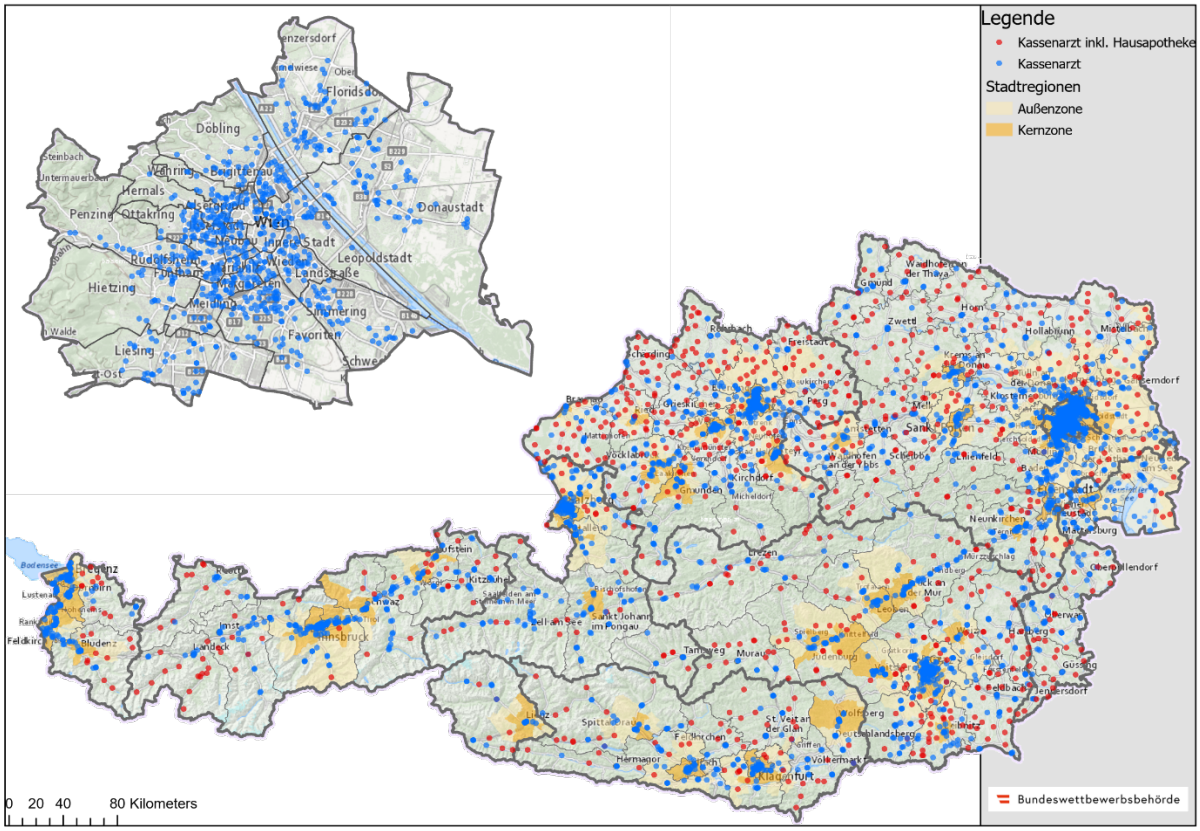


Figure 2 Health insurance fund doctors with/without practice dispensaries in Austria



Distances to the closest pharmacy and closest doctor: While there are more municipalities without medical and pharmacy provision in total in rural areas, it also has to be taken into consideration that the distance to the closest doctor or pharmacy may be much longer in extensive rural municipalities than in conurbations. The distribution of inhabitants within a municipality may also be very heterogeneous. These differences are depicted in Statistics Austria's regional statistical grid units.[5] The highest resolution gives the numbers of inhabitants on the basis of a 100 x 100 metre grid. The distances (in kilometres by road) to the closest pharmacy and closest doctor have been calculated on the basis of these data.

[5] Cf. https://www.statistik.at/web_en/classifications/regional_breakdown/grid/index.html, accessed 5 November 2019.

Figure 3 Distance to the closest pharmacy/practice dispensary by municipality size class

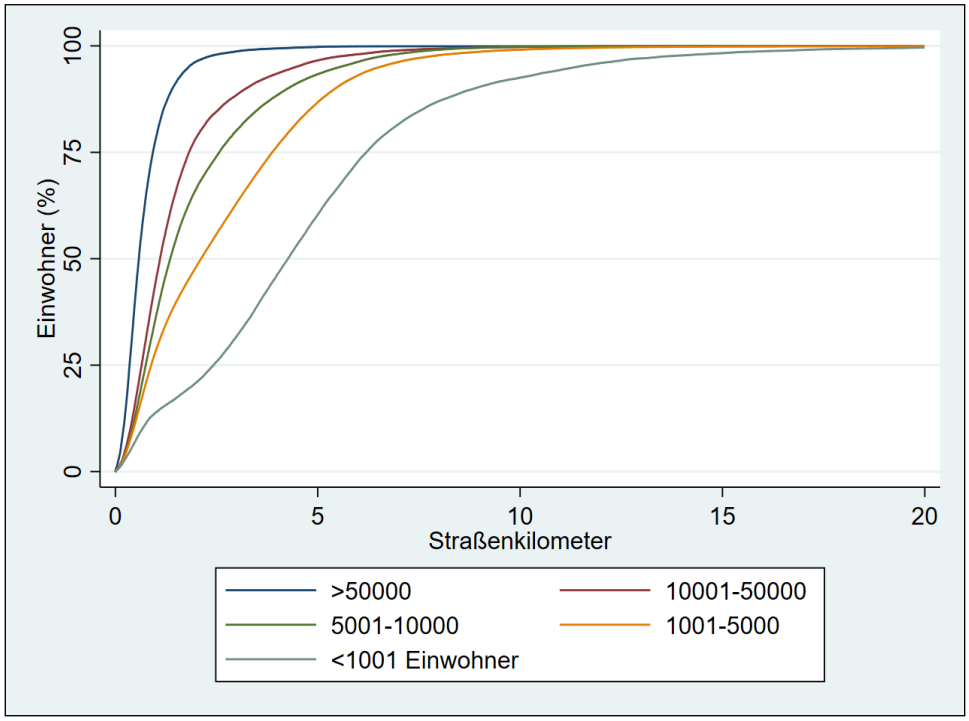


Figure 3 and the upper part of Table 6 show the distance to the closest community pharmacy or practice dispensary. For instance, 50% of inhabitants (above the median) in these municipalities have to make a journey of more than 4.3 kilometres by road. 25% of inhabitants (above the 75th percentile) have to make a journey of more than 6.2 kilometres by road, and 10% (above the 90th percentile) have a journey of more than 8.9 kilometres by road. A large proportion of the population have to cover long distances to reach their closest pharmacy/practice dispensary in municipalities with between 1,000 and 5,000 inhabitants too. The distances are considerably shorter in larger municipalities and urban areas.

As is evident from Table 2, pharmacy services are overwhelmingly provided by practice dispensaries in municipalities with fewer than 5,000 inhabitants. The lower part of Table 6 shows the additional distance that has to be covered if the closest community pharmacy is visited rather than the closest practice dispensary. In municipalities with fewer than 1,000 inhabitants, 25% of the population have to travel an additional distance of at least 8 kilometres by road, and 10% of the population have an additional distance of 12.8 kilometres by road. In municipalities with between 1,000 and 5,000 inhabitants, 25% of the population have to travel an additional distance of at least 5.3 kilometres by road, and 10% have an additional distance of at least 9 kilometres by road.

The upper part of Table 7 shows that the populations of municipalities with low numbers of inhabitants have to travel considerably longer distances in order to reach the closest health insurance fund doctor. It is evident from the lower part of Table 7 that significant additional distances have to be covered in municipalities with fewer than 5,000 inhabitants in order to visit a health insurance fund doctor without a practice dispensary. Medical and pharmacy services in municipalities with between 1,000 and 5,000 inhabitants, and in particular in municipalities with fewer than 1,000 inhabitants, are therefore built essentially on public health insurance fund doctors with practice dispensaries.

Table 6 Distance to the closest pharmacy/practice dispensary by municipality size class

Gemeindegrößenklasse	Entfernung der Einwohner zur nächsten öffentlichen Apotheke oder Hausapotheke (Straßenkilometer)				
Einwohner	25. Perzentil	Median	75. Perzentil	90. Perzentil	99. Perzentil
≤1.000	2,4	4,3	6,2	8,9	16,9
1.000-5.000	0,9	2,1	3,9	5,4	9,7
5.000-10.000	0,8	1,4	2,6	4,3	7,9
10.000-50.000	0,6	1,1	1,8	3,2	7,1
>50.000	0,4	0,6	0,9	1,4	3,3
Gemeindegrößenklasse	Mehrweg zur nächsten öffentlichen Apotheke (Straßenkilometer)				
Einwohner	25. Perzentil	Median	75. Perzentil	90. Perzentil	99. Perzentil
≤1.000	0,0	3,2	8,0	12,8	34,1
1.000-5.000	0,0	0,0	5,3	9,0	19,5
5.000-10.000	0,0	0,0	0,0	0,0	6,8
10.000-50.000	0,0	0,0	0,0	0,0	1,8
>50.000	0,0	0,0	0,0	0,0	0,0

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, WiGeoGis, Berechnungen der BWB. Stand: Q2/2019.

Table 7 Distance to the closest health insurance fund doctor by municipality size class

Gemeindegrößenklasse	Entfernung der Einwohner zum nächsten Kassenarzt* mit oder ohne Hausapotheke (Straßenkilometer)				
Einwohner	25. Perzentil	Median	75. Perzentil	90. Perzentil	99. Perzentil
≤1.000	1,8	3,7	5,6	8,0	16,1
1.000-5.000	0,7	1,5	3,2	4,9	9,1
5.000-10.000	0,6	1,1	2,2	3,8	7,2
10.000-50.000	0,5	0,9	1,5	2,7	6,6
>50.000	0,3	0,4	0,7	1,1	3,0
Gemeindegrößenklasse	Mehrweg zum nächsten Kassenarzt* ohne Hausapotheke (Straßenkilometer)				
Einwohner	25. Perzentil	Median	75. Perzentil	90. Perzentil	99. Perzentil
≤1.000	0,0	1,2	6,9	12,3	33,5
1.000-5.000	0,0	0,0	4,2	7,8	17,4
5.000-10.000	0,0	0,0	0,0	0,0	4,3
10.000-50.000	0,0	0,0	0,0	0,0	1,4
>50.000	0,0	0,0	0,0	0,0	0,0

Quelle: Apothekerkammer, Ärztekammer, Statistik Austria, WiGeoGis, Berechnungen der BWB. Stand: Q2/2019.

*Allgemeinmediziner mit GKK Kassenvertrag und/oder Hausapotheke.

3. Development of provision during the years 2009–2018

Figure 4 shows spatially where pharmacies and practice dispensaries have opened and closed. It is evident once again that these developments are very unevenly distributed in Austria. As Table 8 and Table 9 show, 155 community pharmacies were opened and three community pharmacies closed in Austria during the period from 2009 to 2018.[6] No new pharmacies were opened in municipalities with fewer than 1,000 inhabitants. 46% of the new pharmacies opened were in municipalities with between 1,000 and 5,000 inhabitants, 17% in municipalities with between 5,000 and 10,000 inhabitants, 12% in municipalities with between 10,000 and 50,000 inhabitants, and 25% in municipalities with more than 50,000 inhabitants.

Especially in the 1,000–5,000-inhabitants size class, existing practice dispensaries have been driven out of the market as a result of the opening of new community pharmacies. In total, the opening of thirty-seven community pharmacies led to the closure of sixty-two practice dispensaries on regulatory grounds.[7] Styria and Upper Austria, in particular, were affected by the closure of practice dispensaries (cf. Table 8).

No statistics on the development of health insurance fund posts for doctors in Austria are available to the BWB. According to the Austrian Medical Chamber, however, it has been increasingly common in recent years for health insurance fund posts for doctors to go unfilled.[8] In the second quarter of 2019, ninety-four posts for general practitioners and fifty-nine posts for specialised doctors were vacant (cf. Table 10).

6 During the period from 2009 to 2019, one branch pharmacy was closed (without replacement) in Murau, and one community pharmacy was closed in each of Innsbruck and Preding (Styria).

7 Figures on the revocation of authorisations to operate a practice dispensary when a new community pharmacy is established under Section 29 para. 3 ApothekenG provided by the Austrian Chamber of Pharmacists.

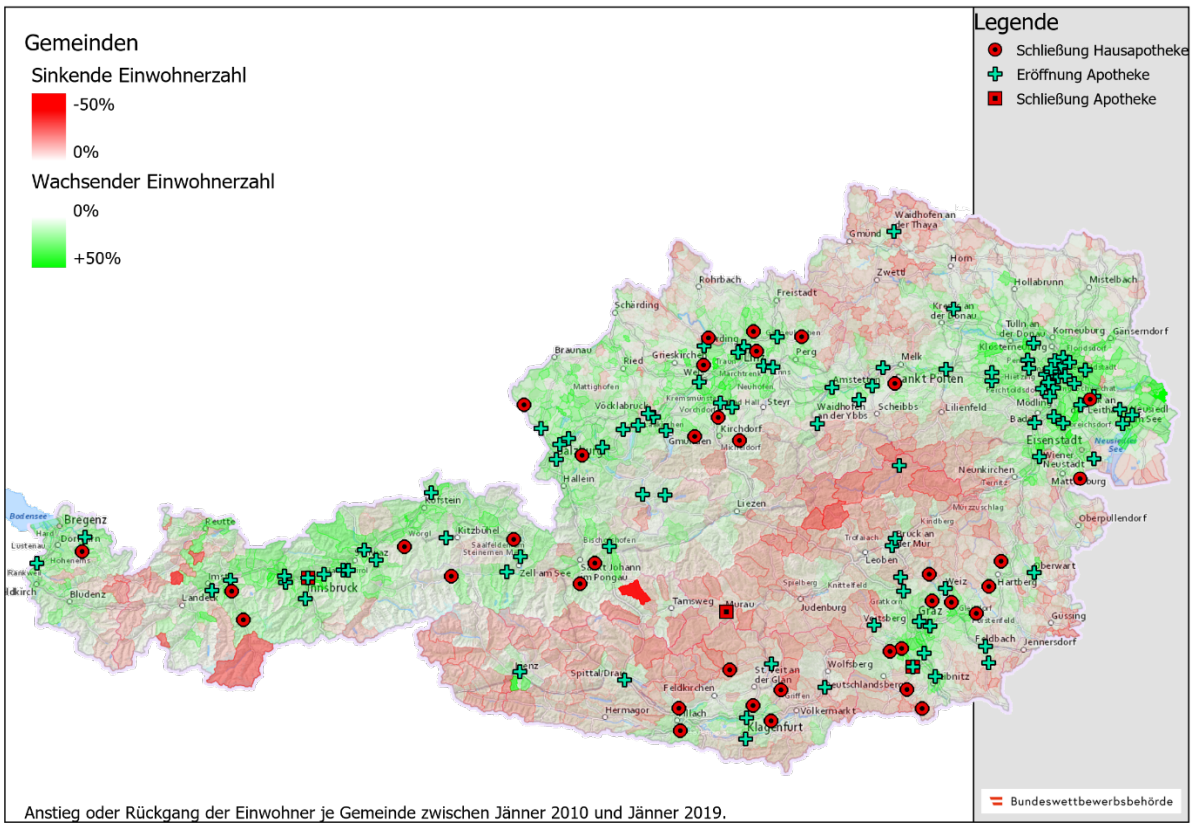
8 Information communicated orally by the Austrian Medical Chamber.

Table 8 Pharmacies opened and closed by province (2009–2018)

Bundesland	öffentliche Apotheken*		Hausapotheken	Bevölkerungswachstum
	Eröffnungen	Schließungen	Schließungen**	1/2009-1/2019
Burgenland	4	0	1	3,8%
Kärnten	13	0	8	0,3%
Niederösterreich	26	0	3	4,7%
Oberösterreich	29	0	16	5,2%
Salzburg	14	0	9	5,4%
Steiermark	26	2	19	3,2%
Tirol	17	1	5	7,4%
Vorarlberg	3	0	1	7,4%
Wien	23	0	0	12,9%
GESAMT	155	3	62	6,3%

Quelle: Ärztekammer, Statistik Austria, Auswertungen der RWR, Stand: Q2/2019 *Allgemeinmediziner mit GKK-Kassenvertrag und/oder mit Hausapotheke.

Figure 4 Pharmacies and practice dispensaries opened and closed (2009–2018)



Anstieg oder Rückgang der Einwohner je Gemeinde zwischen Jänner 2010 und Jänner 2019.

Table 9 Pharmacies opened and closed by municipality size classes (2009–2018)

Gemeindegrößenklasse	öffentliche Apotheken*		Hausapotheken	Bevölkerungswachstum
Einwohner	Eröffnungen	Schließungen	Schließungen**	1/2009-1/2019
≤1.000	0	0	0	0%
1.000-5.000	71	2	56	3%
5.000-10.000	27	0	6	4%
10.000-50.000	19	0	0	6%
>50.000	38	1	0	11%
GESAMT	155	3	62	6%

Quelle: Apothekerkammer, Statistik Austria, Stand: Q2/2019. *Öffentliche Apotheken, inkl. Filial- und Krankenhausapotheken.
**Schließungen wegen der Eröffnung öffentlicher Apotheken.

Table 10 Vacant health insurance fund posts for doctors

Bundesland	Offene Kassenstellen		
	Allgemeinmediziner	Fachärzte	Gesamt
Burgenland*	1	3	4
Kärnten	1	2	3
Niederösterreich	22	10	32
Oberösterreich	28	7	35
Salzburg*	1	7	8
Steiermark	13	7	20
Tirol	4	9	13
Vorarlberg*	2	5	7
Wien	22	9	31
GESAMT	94	59	153

Quelle: Ärztekammer, Stand: Q2/2019. *Darunter auch neu geschaffene Stellen.

II. Shortages of doctors in rural areas and health policy measures

International studies regularly attest that, comparatively, Austria has one of the highest densities of doctors.[9] On the basis of data provided by the Austrian Medical Chamber, however, it is apparent that there is a tendency towards shortages of doctors (in various disciplines) in private practice in Austria, in particular in permanent posts financed by the health insurance funds. According to the data, fifty-nine permanent health insurance fund posts for specialised doctors and ninety-four permanent health insurance fund posts in general practice were vacant across Austria at the end of the second quarter of 2019.[10]

This development will continue to intensify in future. Rural areas will be affected by it in particular. This situation is due firstly to the age structure of doctors in private practice, and secondly to the practical conditions and future prospects for young doctors starting out in private practice.

1. Legal framework

With a view to standardisation and to ensure a level playing field for the negotiating parties, master contracts are agreed at the regional level between the Main Association of Austrian Social Security Institutions (**Main Association**) on behalf of the health insurance funds and, as a rule, the medical chamber responsible for each province as the statutory body that represents the interests of doctors there.[11] Pursuant to Section 342 ASVG, fees, procedural processes, and rights and duties are regulated in these master contracts, among other matters. In this connection, under Section 342 para. 1 no. 10 ASVG, provision is made in principle for an age limit that requires doctors under contract to retire when they reach the age of 70. This fixed age limit may be extended if there is an impending shortage of doctors.[12]

Under Section 341 para. 3 ASVG, the substantive content of these master contracts is also the substantive content of the individual contracts, as they are known, that are to be concluded between the health insurance funds and self-employed doctors.[13]

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9 Cf. for instance OECD, "Doctors: Total, Per 1 000 inhabitants, 2018 or latest available", OECD Health Statistics, https://data.oecd.org/chart/5E5P.

10 Austrian Medical Chamber, "Unbesetzte Kassenstellen Ende Q2 2019".

11 Kneihs and Mosler (2012), "§ 341 ASVG", in Mosler, Müller and Pfeil, *Der SV-Komm*, para. 9.

12 Kneihs and Mosler (2012), "§ 342 ASVG", in Mosler, Müller and Pfeil, *Der SV-Komm*, para. 44.

13 Mayrhofer, "Gesamtverträge und EU-Recht", *Recht der Medizin*, 2018/133, 204.

Health insurance funds are obliged by Section 23 para. 5 ASVG[14] in particular to make sufficient provision for the medical treatment of insurance holders and their family members. The health insurance funds comply with this obligation, for instance, by making contractual arrangements under Section 338 para. 1 ASVG with self-employed doctors, alongside other groups of medical professionals.[15] This is intended to ensure the provision of what are known as benefits in kind, as part of which the health insurance funds primarily guarantee medical assistance within the meaning of Section 135 ASVG that is delivered by self-employed doctors who have contractual relationships with the health insurance funds.[16]

Section 2 of each of these master contracts lists the health insurance funds that fall within the scope of the master contract. Against this background, self-employed doctors who have a contractual relationship with a health insurance fund are generally known as "section 2 contract doctors".[17]

2. Reasons for the shortages of doctors

With regard to the shortages of section 2 contract doctors in general practice, the discussion that follows will in particular examine the age structure of section 2 contract doctors in general practice, and the practical conditions and future prospects for young doctors who are starting out as general practitioners in private practice.

2.1. Age structure

In view of the age limit fixed in principle at the age of 70 (cf. section II.1) and the possibility of early retirement, particular significance attaches to the age structure of section 2 contract doctors in general practice.

As far as can be ascertained, there was a total of 3,937 section 2 contract doctors in general practice in Austria in 2018.[18] Of these section 2 contract doctors in general practice, 2,009 will reach the age of 65 within the next ten years, which represents a proportion of 51.03%.[19] Furthermore, 1,183 of the section 2 contract doctors in general practice will reach the age of 65 within the next five years, which represents a proportion

[14] Federal Act of 9 September 1955 on General Social Insurance (**ASVG**), first published in *Bundesgesetzblatt* (*Federal Law Gazette*, *BGBl.*) No. 189/1955, most recently amended by *Federal Law Gazette* I No. 84/2019.

[15] Mayrhofer, "Gesamtverträge und EU-Recht", *Recht der Medizin*, 2018/133, 203.

[16] Stöger (2012), "§ 23 ASVG", in Mosler, Müller and Pfeil, *Der SV-Komm*, para. 22; Mayrhofer, "Gesamtverträge und EU-Recht", *Recht der Medizin*, 2018/133, 203–204.

[17] Cf. on this topic http://www.hauptverband.at/cdscontent/?contentid=10007.693774.

[18] Austrian Medical Chamber (18 December 2018), "Pressekonferenz Ärztemangel in Österreich".

[19] Austrian Medical Chamber (18 December 2018), "Pressekonferenz Ärztemangel in Österreich".

of 30.05%.[20] The number of practising section 2 contract doctors in general practice aged between 65 and 70 is 254, which represents a proportion of 6.45%.

As far as the provisions that allow exemptions from the 70-year age limit are concerned (cf. section II.1), the statistics for 2018 indicate that fifty-three section 2 contract doctors were working in general practice in Austria beyond the age of 70, which represents a proportion of 1.35%.[21]

This makes it clear that at present the overwhelming majority of section 2 contract doctors in general practice have already passed the age of 55. Furthermore, it is also clear that only a small fraction of section 2 contract doctors in general practice carry on practising after they reach the age of 65.

2.2. Practical conditions and future prospects

On the basis of available studies, it is apparent that a large proportion of students of human medicine in Austria do not wish to subsequently work as general practitioners in private practice.[22] The reasons that are given for this include, in particular, salaries that are not equivalent to those for specialised doctors, too little time for patients, the excessively strict performance targets set by the health insurance funds and the various services that cannot be charged for. Another aspect is work-life balance, which may be affected negatively by the constant availability of general practitioners in private practice. Furthermore, mention is also made in this connection of the lack of esteem in which general practitioners are held, in particular by their colleagues who work as specialised doctors.

Attention is centred particularly on rural areas in this respect. As far as these issues are concerned, it may be concluded that financial incentives could have a positive influence on whether human medicine students decide to subsequently practise as general practitioners in rural areas.[23] Furthermore, it has been found in this connection that students of human medicine who originally come from rural areas are comparatively more likely to work in rural areas later as well.[24]

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20 Austrian Medical Chamber (18 December 2018), "Pressekonferenz Ärztemangel in Österreich".

21 Austrian Medical Chamber (18 December 2018), "Pressekonferenz Ärztemangel in Österreich".

22 Medical University of Graz (5 December 2017), *Erhebung der Berufsmotivation zur Allgemeinmedizin von Studierenden und jungen Ärzten in Österreich und Deutschland*, 48 et seq.

23 Medical University of Graz (5 December 2017), *Erhebung der Berufsmotivation zur Allgemeinmedizin von Studierenden und jungen Ärzten in Österreich und Deutschland*, 48, with further citations.

24 Cf. Medical University of Graz (5 December 2017), *Erhebung der Berufsmotivation zur Allgemeinmedizin von Studierenden und jungen Ärzten in Österreich und Deutschland*, 48; cf. also World Health Organisation (**WHO**) (2010), *Increasing access to health workers in remote and rural areas through improved retention*, 18, https://apps.who.int/iris/bitstream/handle/10665/44369/9789241564014_eng.pdf;jsessionid=E7008DCB72071595936639AF19988025?sequence=1.

Against this background, various funding measures focussed on different facets of the problem have also been adopted at the provincial level in order to bolster the position of doctors in private practice, in particular in rural areas.[25]

- In Burgenland, it has been decided to put in place a funding scheme for rural doctors.[26] Furthermore, there are extensive grants and funding opportunities for human medicine students and graduates in Burgenland who, for instance, commit to take up a permanent health insurance fund post in general practice there for a period of five years.[27]
- In Carinthia, a sliding hardship allowance for section 2 contract doctors has been created for rural areas.[28]
- In Lower Austria, a Lower Austrian Rural Doctor Initiative has been set up under which locum practice arrangements have been put in place, for instance for vacant permanent health insurance fund posts in rural areas, while funding measures for the modernisation of general practitioners' practices are provided for.[29]
- In Styria, a graduated start-up financing scheme for section 2 contract doctors has been launched.[30]
- In Vienna, funding measures have been put in place for doctors who take over and/or establish practices.[31]
- In Vorarlberg, apart from a private practice bonus for section 2 contract doctors, various job-sharing models have also been introduced.[32]

Another significant aspect with regard to choice of career is the kind of setting in which doctors collaborate with other professionals. A majority of students of human medicine

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25 The list that follows is in alphabetical order.

26 Cf. on this topic http://www.aekbgld.at/landarztforderung.

27 Cf. the 91st Directive of the Provincial Government of Burgenland on the Award of Grants to Medicine Students to Improve General Practice Provision in the Province of Burgenland, Decision of the Provincial Government of Burgenland of 20 March 2018, *Landesblatt für das Burgenland* (*Provincial Gazette for Burgenland*, *Labl.*) 13, 30 March 2018.

28 Cf. the relevant Scale of Fees, in the Version Adopted pursuant to Section 30 Para. 1 of the Master Contract of 1 August 1972 between the Medical Chamber for Carinthia and the Main Association of Austrian Social Security Institutions on behalf of the Carinthian Health Insurance Funds Listed in Section 2 of the Master Contract, H 29, http://www.aekktn.at/documents/10745/22851937/KGKK+Gesamtvertrag+2019+-+Honorarordnung/e9eb7ef6-d1a6-45f6-bbf7-7b795afffbf2?version=1.0&t=1554884724000.

29 Cf. on this topic Province of Lower Austria, "Initiative Landarzt Niederösterreich" (2 January 2018), http://www.noel.gv.at/noe/LH_Mikl-Leitner_startet__Initiative_Landarzt_Niederoester.html.

30 Cf. on this topic for instance https://www.aekstmk.or.at/186?articleId=240.

31 Cf. the Master Contract of 1 January 2011, Concluded pursuant to Sections 338, 341 and 342 of the General Social Insurance Act, *Federal Law Gazette* No. 189/1955, as Amended from Time to Time, and pursuant to Section 66a Para. 1 No. 1 of the Doctors Act, *Federal Law Gazette* I 1998/169, as Amended from Time to Time, between the Medical Chamber for Vienna, Chapter of Doctors in Private Practice and the Main Association of Austrian Social Security Institutions on Behalf of the Health Insurance Funds Specified in Section 2, section 5 para. 12, https://www.wgkk.at/cdscontent/load?contentid=10008.595922&version=1454315488.

32 On job-sharing models in Vorarlberg, cf. https://www.arztinvorarlberg.at/aek/servlet/AttachmentServlet?action=show&id=3603.

would prefer the way in which they collaborate with other professionals to offer the broadest possible opportunities for development, for instance in the setting of a community practice where a number of doctors work independently from one another under a single roof.[33]

In addition to this, first steps have been taken to enhance the status of general practice in higher education by establishing dedicated departments[34] and institutes[35] at medical universities. In this connection, there have also been calls for additional action to anchor general practice in both the theoretical and practical parts of human medicine courses.[36]

3. Competition assessment

From a competition perspective too, it is to be noted that the most universal possible healthcare provision in the field of general practice constitutes an essential cornerstone for a functioning healthcare system in Austria.[37]

In view of the constant rises in expenditure at hospitals,[38] particular significance is attached to having a sufficient number of section 2 contract doctors in general practice. In many instances, they act as the initial point of contact for patients and therefore perform a "gatekeeper function" when individuals are first treated.

The argument that there is a high density of doctors in Austria is not convincing from a competition perspective. While the number of section 2 contract doctors in general practice has been stagnating for a long time, patient numbers have been rising markedly on account of the growing population.[39] In view of this, precarious situations can arise when medical treatment is sought and given, from the perspectives of both patients and doctors.

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33 Medical University of Graz (5 December 2017), *Erhebung der Berufsmotivation zur Allgemeinmedizin von Studierenden und jungen Ärzten in Österreich und Deutschland*, 30.

34 Center for Public Heath, Medical University of Vienna, Department of General Practice/Family Medicine, cf. https://allgmed.meduniwien.ac.at/.

35 Institute of General Practice and Evidence-Based Health Services Research, Medical University of Graz, cf. https://allgemeinmedizin.medunigraz.at/en/unser-institut/; Institute of General Practice, Family Medicine and Preventive Medicine, Paracelsus Medical University, cf. https://www.pmu.ac.at/allgemeinmedizin.html.

36 Cf. Austrian Society for General Practice/Family Medicine, *Masterplan Allgemeinmedizin*, 21 et seq. and 28 et seq.

37 This point is also discussed in Austrian Society for General Practice/Family Medicine, *Masterplan Allgemeinmedizin*, 2.

38 Cf. for instance ORF, "Fachleute warnen: Spitalsausgaben vor rasantem Anstieg" (20 August 2019), https://orf.at/stories/3134286/; cf. Hofmarcher and Singhuber (2019), *Leistungskraft regionaler Gesundheitssysteme*, with further citations.

39 Medical University of Graz (5 December 2017), *Erhebung der Berufsmotivation zur Allgemeinmedizin von Studierenden und jungen Ärzten in Österreich und Deutschland*, 10; cf. Sinnbell, "Allgemeinmedizin in Österreich – harte Fakten und Mutmaßungen", *Zeitschrift für Gesundheitspolitik*, 2016/2, 32–33, with further citations.

With regard to doctors' age structure, it is apparent that, viewed statistically, a large proportion of section 2 contract doctors in general practice will cease practising in the medium-to-long term. At the same time, the numbers of graduates completing courses in human medicine make it clear[40] that nowhere near as many young doctors will be coming through to take the older generation's places in general practice. This is why measures to manage supply with funding opportunities for general practitioners who hold permanent health insurance fund posts in rural areas are to be welcomed from a competition perspective.

In addition to this, the trends towards flexibilisation and the funding of opportunities for development are meeting the expectations of doctors who have just embarked upon careers in private practice.[41] From a competition point of view as well, the further development of opportunities to practice the profession could result in permanent health insurance fund posts for general practitioners in rural areas becoming more attractive.

One issue that is not to be underestimated is the overarching, multifaceted topic of esteem as a motivating factor for those who work in general practice. The measures already implemented in this connection, at universities for instance, are to be acknowledged as first approaches to a solution.

Nonetheless, yet further steps need to be taken to raise the esteem in which general practitioners with section 2 contract posts are held and enhance their status, among the medical community and in society, as well as in economic terms (cf. also on this topic section I.2.2).[42] In the light of this, the practice dispensary represents a decisive instrument with which to tackle the problem from competition points of view, in particular in rural areas (cf. on this topic the detailed discussion in chapter III).

4. Recommendations

- Across-the-board funding schemes and financial incentives for permanent health insurance fund posts for general practitioners in rural areas.
- Intensified, across-the-board action to enhance the status of general practice in the theoretical and practical parts of university courses in human medicine.
- Further flexibilisation and expansion of the opportunities for development open to Section 2 contract doctors in private practice.

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40 The number of graduates from (degree and master's) courses in human medicine at public and private universities in Austria in 2017/2018 was 1,361.

41 This point is also discussed in Austrian Society for General Practice/Family Medicine, *Masterplan Allgemeinmedizin*, 67 et seq.

42 Cf. also on this topic Austrian Society for General Practice/Family Medicine, *Masterplan Allgemeinmedizin*, 94 et seq.

- Awareness-raising measures (for instance through an information campaign) with the goals of boosting the esteem in which section 2 contract general practitioners are held and enhancing their status.

III. Practice dispensaries

With regard to the shortages of doctors discussed in chapter II, practice dispensaries can be viewed as a significant option for action to enhance the status of permanent health insurance fund posts for general practitioners, and so make it possible to ensure the most universal possible healthcare provision for the population, in particular in rural areas.

1. Legal framework conditions

The relevant legal provisions concerning practice dispensaries are found above all in the Pharmacies Act (ApothekenG).[43]

1.1. Authorisation of a practice dispensary

Pursuant to Section 29 para. 1 ApothekenG, authorisation for the operation of a practice dispensary is to be granted to a general practitioner by the district administration authority if the general practitioner

(i) has a contractual relationship within the meaning of Section 342 para. 1 ASVG (Section 29 para. 1 no. 1);
(ii) there is no community pharmacy located in the municipality where the doctor has their practice (Section 29 para. 1 no. 2); and
(iii) the doctor's practice is more than six kilometres by road from the premises of the community pharmacy (Section 29 para. 1 no. 3).

Against this background, a general practitioner within the meaning of Section 7 and Section 31 para. 1 ÄrzteG[44] (also known colloquially as a "**GP**" or "**family doctor**") or, where applicable, a group practice within the meaning of Section 52a ÄrzteG in which the general practitioner is a partner, will as a rule have a contractual relationship under Section 342 para. 1 ASVG (also known colloquially as a "**major health insurance fund contract**"), which forms the legal basis for dealings between the general practitioner (or where applicable the group practice) and the health insurance fund.[45]

With regard to the requirement of a minimum distance of more than six kilometres by road between the doctor's practice and the premises of the (closest) community

[43] Act of 18 December 1906 pertaining to the Regulation of Pharmacies (**ApothekenG**), first published in *Reichsgesetzblatt* (*Imperial Law Gazette*, *RGBl.*) No. 5/1907, most recently amended by *Federal Law Gazette* I No. 59/2018.

[44] Federal Act concerning the Practice of the Medical Profession and the Professional Representation of Doctors (**ÄrzteG**), first published in *Federal Law Gazette* I No. 169/1998, most recently amended by *Federal Law Gazette* I No. 28/2019.

[45] Voglmair, "Ärztliche Hausapotheke: Fragestellungen aus der Praxis – Antworten für die Praxis (Teil II)", *Recht der Medizin*, 2016, 105.

pharmacy, account is to be taken of whether the roads are open for road traffic all year round under normal conditions.[46]

1.2. Granting of licences for new community pharmacies

The objective prerequisites for the granting of a licence for a new community pharmacy are regulated in Section 10 ApothekenG. Furthermore, while the necessary positive conditions set out in Section 10 para. 1 ApothekenG that confirm the need for such a new community pharmacy have to be satisfied, none of the negative conditions that would rule out the need for a pharmacy under Section 10 para. 2 ApothekenG may be met.

1.3. One contract doctor municipalities

Where a licence has been definitively granted to a community pharmacy, authorisation to operate a practice dispensary may be granted in what is known as a "one contract doctor municipality" pursuant to Section 28 para. 3 ApothekenG, if the distance between the dispensing doctor's practice and the premises of the closest community pharmacy is more than six kilometres by road.

The negative criteria that rule out the granting of licences for new community pharmacies in one contract doctor municipalities override to a certain extent the requirement set out in Section 29 para. 1 no. 1 ApothekenG. In this special situation, pursuant to Section 10 para. 2 and para. 3 no. 2 ApothekenG, there is accordingly no need for a new public pharmacy to be established in a municipality where

(i) there is a practice dispensary; and

(ii) there are fewer than two health insurance fund posts for general practitioners under Section 342 para. 1 ASVG, or there is a group practice contracted to a health insurance fund that, at most, is equivalent to one-and-a-half full-time posts for contract doctors, and there is no further post for a health insurance fund general practitioner under Section 342 para. 1 ASVG in the municipality (one contract doctor municipality).[47]

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[46] Cf. N. Raschauer (2016), "§ 29 ApothekenG", in Neumayr, Resch and Wallner (eds.), *Gmundner Kommentar zum Gesundheitsrecht*, paras. 14 et seq., with further citations; Potacs and Scholz (2011), "Apothekenrecht", in Resch and Wallner (eds.), *Handbuch Medizinrecht*, paras. 109 et seq., with further citations; Voglmair, "Ärztliche Hausapotheke: Fragestellungen aus der Praxis – Antworten für die Praxis (Teil II)", *Recht der Medizin*, 2016, 104, with further citations.

[47] In the interests of completeness, it should also be noted that, pursuant to Section 10 para. 2 nos. 2–3, there is no need to license a new community pharmacy if

(i) the distance between the prospective premises of the new community pharmacy that is to be established and the premises of the closest existing community pharmacy is less than 500 metres; or

(ii) the number of persons who will continue to be served from the premises of one of the existing community pharmacies in the surrounding area will be reduced as a consequence of the establishment of the new pharmacy, and will be less than 5,500.

In view of this, the rigid kilometres-by-road rules set out in Section 29 para. 1 no. 1, and para. 3 no. 1 ApothekenG are not applied directly when it come to the granting of licences for new community pharmacies in one contract doctor municipalities (cf. section III.1.1).

1.4. Revocation of authorisation to operate a practice dispensary

Regardless of the special situation for practice dispensaries in one contract doctor municipalities, authorisation to operate a practice dispensary is to be revoked by the district administration authority when a new community pharmacy is established if

(i) the route between the doctor's practice and the premises of the new community pharmacy is no more than four kilometres by road;[48] and
(ii) the practice dispensary is not located either in a municipality covered by Section 10 para. 2 no. 1 ApothekenG or in a municipality covered by Section 10 para. 3 ApothekenG (one contract doctor municipality, cf. section III.1.3).

Furthermore, under Section 10 para. 2 no. 4 ApothekenG, in cases of this kind the district administration authority is required to adopt a decision ordering that the practice dispensary has to close down three years subsequent to the granting of the licence for the new community pharmacy.

2. Competition assessment

From a competition perspective on healthcare provision, attention centres above all on the removal of artificial barriers to competition, freedom of choice for patients and the comparability of medical services. As far as these considerations are concerned, practice dispensaries may contribute decisively to the most universal possible healthcare provision for the population, in particular in rural areas.

2.1. Interpretation of the ApothekenG and conclusions from the case law

The original version of the ApothekenG, which entered into force in 1907, featured corresponding provisions concerning both community pharmacies and practice dispensaries. The statutory coexistence of community pharmacies and practice dispensaries was already laid down in the original ApothekenG. It may be deduced from this that the historic legislators who first drafted the ApothekenG were conscious that, on the one hand, community pharmacies serve conurbations above all and, on the other

[48] With regard to the distance requirement, reference is made *mutatis mutandis* to section III.1.1.

hand, practice dispensaries are primarily intended to ensure security of supply in rural areas.[49]

Even though the ApothekenG has been the subject of numerous revisions, some of which have also been prompted by judgments handed down by the Austrian Constitutional Court (**VfGH**), fundamental inferences can be drawn from it with regard to the relationship of community pharmacies and practice dispensaries. During the legislative procedure, for instance, reference was also made to the significance of practice dispensaries in rural areas.[50] Furthermore, one recent VfGH judgment states that the separation of doctors' activities and the supply of the population with medicines (in other words: the mere presence of community pharmacies) does not make sense in particular rural areas on economic grounds, and is detrimental to health policy objectives.[51]

The definitive case law of the Austrian Supreme Administrative Court (**VwGH**) on the relevant provisions of the ApothekenG about practice dispensaries, some of it delivered very recently, also underlines how legally controversial the relationship of community pharmacies and practice dispensaries has always been.[52]

2.2. Patient choice

From a competition perspective, greater patient choice is to be welcomed. The restrictive provisions on community pharmacies' opening hours, the liberalisation of which would also be welcome from a competition perspective (cf. section V.1), no longer adequately accommodate many people's contemporary lifestyles (in particular their work and their private living circumstances). Against this background, the current arrangements sometimes make it considerably more difficult for patients to obtain the prescription-only medicinal products they need.

Greater choice is undoubtedly created by the additional provision of practice dispensaries. In contrast to community pharmacies, general practitioners in private practice usually have more flexible opening hours. This puts the patient in a position to

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49 Cf. Wallner, "Vorschläge für ein neues System der Hausapothekenbewilligung", *Zeitschrift für Gesundheitspolitik*, 2016/1, 12, which refers to the longer distances patients have to travel (to community pharmacies) in rural areas .

50 Cf. Khol, Westenthaler et al., Private Members' Motion concerning a Federal Act to Amend the Pharmacies Act, 341/A XXIGP; cf. also on this topic the amendment to the Pharmacies Act, *Federal Law Gazette* I No. 16/2001; cf. also Wallner, "Vorschläge für ein neues System der Hausapothekenbewilligung", *Zeitschrift für Gesundheitspolitik*, 2016/1, 18.

51 Cf. VfGH, 26 June 2008, G12/08, paras 4.3.1–4.3.2; cf. also the reference to the materials relating to the revision of the ApothekenG, in *Federal Law Gazette* I 41/2006, AA-202 XXII GP, 4; cf. also Wallner, "Vorschläge für ein neues System der Hausapothekenbewilligung", *Zeitschrift für Gesundheitspolitik*, 2016/1, 18–19.

52 Cf. for instance VwGH, 25 June 2019, Ra 2019/10/0012; VwGH, 27 March 2019, Ra 2018/10/0034; VwGH, 24 October 2018, Ro 2017/10/0010.

obtain the prescription-only medicines they need from an additional source of supply (which may be advantageous in individual cases, both in terms of time and geography).

In particular in rural areas, it is not comprehensible within a competition framework why a patient diagnosed with a condition by the general practitioner who is treating them then has to travel several kilometres to the closest community pharmacy that dispenses the prescription-only medicines they require, even in an area where there may not be reliable public transport services. From a competition perspective, it would therefore also be desirable in the interests of patient choice if the rigid provisions on the four or six kilometres by road were to be liberalised in favour of practice dispensaries.

2.3. Complementary provision

The breadth of the range of products offered by community pharmacies and practice dispensaries differs fundamentally. While an average community pharmacy in Austria has about 6,000 different medicinal products and a total of about 24,000 packets of medicine in stock,[53] it is to be assumed that a practice dispensary will only be able to offer a far smaller selection. As a matter of principle, on account of the different range and depth of the medicinal products provided, it is therefore to be assumed that, in quantitative terms, the overwhelming majority of medicinal products will also be dispensed by community pharmacies in future.

A large proportion of community pharmacies' turnover is generated at present from the dispensing of prescription-only medicines.[54] At the same time, the range of services provided by community pharmacies has (also) developed in recent years towards that of a "*modern local provider and important health centre*".[55]

The overlaps between their product ranges are relevant in particular when it comes to medicinal products that, under Section 1 para. 1 and Section 2 para. 1 Federal Act on the Dispensing of Prescription-only Medicines (RezeptpflichtG),[56] have been designated as prescription-only by the Federal Minister of Health and Women's Affairs[57] or the Austrian Federal Office for Safety in Health Care (**BASG**).[58] In this connection, it is to be noted that, pursuant to Section 1 para. 1 RezeptpflichtG, it is incumbent upon doctors to prescribe such medicinal products – irrespective whether they are dispensed by a community

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53 Cf. Austrian Chamber of Pharmacists, *Apotheke in Zahlen 2019*, 8.

54 Cf. Austrian Chamber of Pharmacists, *Apotheke in Zahlen 2019*, 8.

55 Cf. Austrian Chamber of Pharmacists, *Apotheke in Zahlen 2019*, 16.

56 Federal Act of 25 October 1972 on the Dispensing of Prescription-only Medicines (**RezeptpflichtG**), first published in *Federal Law Gazette* No. 413/1972, most recently amended by *Federal Law Gazette* I No. 30/2019.

57 Now the Federal Minister of Labour, Social Affairs, Health and Consumer Protection.

58 Cf. Königshofer (2011), "Arzneimittelrecht", in Resch and Wallner (eds.), *Handbuch Medizinrecht*, paras. 119 et seq., with further citations

pharmacy or a practice dispensary. On account of the expertise a general practitioner may be presumed to possess, it is to be assumed that, even when a prescription-only medicine is dispensed directly by a practice dispensary, the duties to inform the patient about how to take the medicine, its applications and any side effects will be complied with appropriately.[59]

Further to this, in the light of the current bottlenecks in the supply of medicines,[60] an additional option for patients to obtain them from practice dispensaries is certainly to be assessed positively from a competition perspective as well.

2.4. Tension between treatment and dispensing

At least at first sight, it is not to be denied that a certain tension may be inherent in the operation of practice dispensaries because the general practitioner who treats the patient and prescribes them medicinal products is the very same person who dispenses those medicinal products. In this respect, the literature talks of what is known as the countervalence principle. This means that the medical service provider (in other words: the general practitioner who treats the patient) is fundamentally not supposed to derive any income or other pecuniary benefits from services (provided by their practice dispensary) when they are themselves able to influence the demand for those services.[61]

2.4.1. Approaches to prescribing

There could theoretically be an incentive for general practitioners with practice dispensaries to prescribe and dispense medicines that tended to be more expensive or larger quantities of medicines on which they earned high margins.[62]

In this connection, it is to be noted firstly that the pricing of medicines is regulated by statute in Austria.[63] Against this background, general practitioners with practice dispensaries are also subject to price capping that applies to the dispensing of prescription-only medicines, in particular on the basis of the Reimbursement Codex (**EKO**) issued by the Main Association pursuant to Section 31 para. 3 no. 12 ASVG.[64] Secondly, the conclusions reached by the study cited in footnote 62 about the approaches to prescribing taken by general practitioners with practice dispensaries are based exclusively

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59 Cf. Austrian Chamber of Pharmacists, *Apotheke in Zahlen 2019*, 16, which refers to these duties in relation to community pharmacies.

60 See for instance ORF, "Lieferengpässe bei Medikamenten häufen sich" (2 July 2019), https://help.orf.at/stories/2987772/.

61 Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 101.

62 This point is discussed for instance in Müller, Meyer and Stummer, "Das Verschreibeverhalten von Allgemeinmedizinern am Beispiel der Arzneimittelverordnungen in Österreich", *Gesundheitswesen,* 2011, 443 et seq.

63 Cf. Austrian Chamber of Pharmacists, *Apotheke in Zahlen 2019*, 9.

64 Online: http://www.hauptverband.at/cdscontent/?contentid=10007.694354&viewmode=content.

on medicine costs.[65] This study therefore fails to take account of the patient's diagnosis, the form of therapy or the patient's disease burden. As a rule, the patient's age especially constitutes a significant factor in the costs of medicinal products.[66]

As a matter of principle, the general practitioner who is treating the individual patient decides which medicine is most suitable for that person. Despite this, general practitioners with contractual relationships under Section 342 para. 1 ASVG (cf. Section III.1.1) are subject to certain restrictions on the choices they make imposed by the Main Association, which has issued Guidelines on Economical Prescribing (also known as the "**Ökotool**").[67]

The expediency and cost-effectiveness of a prescription are therefore determined by a general practitioner who has a contractual relationship of this kind. Such judgements are based firstly on its effectiveness and the well-being of the patient, and secondly on the costs that are incurred. This is why the most economical option is to be prescribed where medicines are equivalent in their value for the patient's treatment. When the Guidelines on Economical Prescribing are contravened by a general practitioner with a practice dispensary, their contractual relationship under Section 342 para. 1 ASVG (cf. section III.1.1) may be terminated. Furthermore, in this case they may also find themselves threatened with professional misconduct proceedings.

Nor have studies of the issue conducted in Upper Austria succeeded in finding any outright uneconomic behaviour on the part of general practitioners with practice dispensaries in comparison to the average Upper Austrian doctor.[68,69]

2.4.2. International comparison

Although national health systems are organised in very different ways, international comparisons are also worthwhile when it comes to this matter. Apart from Austria, the system of practice dispensaries is found elsewhere in Europe as well, for instance in Switzerland, Lichtenstein, the Netherlands, the United Kingdom, Hungary, and

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65 Müller, Meyer and Stummer, "Das Verschreibeverhalten von Allgemeinmedizinern am Beispiel der Arzneimittelverordnungen in Österreich", *Gesundheitswesen*, 2011, 443 (449).

66 Schablegger (2006), *Schluß mit heilmittelökonomischen Mythen und Märchen über Hausapotheken führende Ärzte*, 2.

67 Main Association of Austrian Social Security Institutions (2005), Guidelines on Economical Prescribing of Medicinal Products and Medical Aids (**Guidelines on Economical Prescribing**), Announcement No. 5/2005, most recently amended by the 2nd Amendment to the Guidelines on Economical Prescribing, Announcement No. 29/2006.

68 On the systematic approach taken in the research and the conclusions drawn from it, cf. Schablegger (2006), *Schluß mit heilmittelökonomischen Mythen und Märchen über Hausapotheken führende Ärzte*, 5.

69 Cf. also a comprehensive analysis published in 2016 that comes to the same conclusion as the publication cited in footnote 68: Schablegger, "Hausapotheken in Oberösterreich – Schluss mit dem Wirbel, her mit den Fakten!", *Zeitschrift für Gesundheitspolitik*, 2016/1, 50 et seq., with further citations.

sporadically in Greece, France, Spain and Belgium.[70] Medicinal products are (sometimes) dispensed directly by doctors outside Europe as well, for instance in the USA, New Zealand, South Africa, Canada, Australia, and numerous countries in Africa and Asia.[71]

Switzerland offers an illuminating comparison with regard to practice dispensaries, and not just on account of its geographical proximity. In Switzerland, practice dispensaries are run by "self-dispensing doctors" and regulated at the cantonal level.[72] In particular in the cantons of German-speaking Switzerland, there has been a liberalisation of the rules on self-dispensing doctors. An extensive study published in 2014 comes to the conclusion that patients who obtain their medicines directly from a self-dispensing doctor in Switzerland incur comparatively lower amounts of expenditure on medicinal products.[73,74,75]

Furthermore, as far as the relationship between community pharmacies and practice dispensaries is concerned, it is possible to draw the conclusion that the liberalisation of the rules on self-dispensing doctors experienced in Switzerland over the last few years has not led to any reduction in the numbers of public pharmacies in the cantons where it has been implemented.[76,77] This fact is also partly to be attributed to the attitude found in 2014 in the Canton of Zurich, where two-thirds of doctors had decided not to bother operating a practice dispensary on account of the amount of effort that would be involved.[78]

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70 Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 101.

71 Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 101.

72 Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 101.

73 Cf. Trottmann, Früh, Reich and Telser (2014), *Auswirkungen der Medikamentenabgabe durch die Ärzteschaft (Selbstdispensation) auf den Arzneimittelkonsum und die Kosten zu Lasten der obligatorischen Krankenpflegeversicherung ("**OKP**")*, 9 et seq.; in the interests of completeness, however, it should be noted firstly as far as the situation in Switzerland is concerned that expenditure on medical services is higher there and the number of consultations is rising. Secondly, what is know as "service-based remuneration" (**LOA**) is also payable at community pharmacies in Switzerland for prescription-only medicines as a kind of consultation fee.

74 In the interests of balance, it should be noted that the academic response to the study cited in footnote 73 in Switzerland has also seen contrary conclusions reached; cf. Rischatsch, "Lead me not into temptation: drug price regulation and dispensing physicians in Switzerland", *European Journal of Health Economics*, 2014/15, 697–708; Kaiser and Schmid, "Does physician dispensing increase drug expenditures? Empirical evidence from Switzerland", *Health Economics*, 2016/25, 71–90.

75 On the critical debate about the work done by Rischatsch, and Kaiser and Schmid, cf. Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 110.

76 Cf. Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 104 on the Canton of Zurich, and 112 on the general situation; with regard to the general situation, a slight rise in the number of community pharmacies has even been recorded; for what is in some respects a critical account of the impact of liberalisation on the pharmacy market, cf. Vogler, Habimana and Arts, "Does deregulation in community pharmacy impact accessibility of medicines, quality of pharmacy services and costs? Evidence from nine European countries", *Health Policy*, 2014/117, 311–327.

77 Cf. also on this topic Federal Competition Authority (BWB) (2018), *Sector Inquiry Health: Part I: The Austrian Pharmacy Market*, 12.

78 Bergmair, "Selbstdispension in der Schweiz", *Zeitschrift für Gesundheitspolitik*, 2016/1, 104.

3. Recommendations

- Deletion without replacement of the minimum distances set in Section 29 ApothekenG for the authorisation of a practice dispensary in a municipality without a community pharmacy.
- Deletion of the special provisions on the minimum distance practice dispensaries have to be away from community pharmacies pursuant to Section 28 para. 3 ApothekenG in municipalities with just one health insurance fund post for a doctor and one licence issued for a community pharmacy. Instead of this, community pharmacies and doctor's dispensaries are to be given equal legal treatment on the basis of Section 10 ApothekenG.
- Consideration of the specific structural peculiarities of rural areas when the needs assessment under Section 10 ApothekenG is carried out.

IV. Primary healthcare units (PVEs), employment of doctors and training placements

1. Primary healthcare units

1.1. General remarks

The idea of a reform of primary healthcare goes back to the Federal Health Conference that was held in March 2014.[79]

It is intended to deliver advantages for patients in terms of holistic, continuous care, a reduction in the burdens on hospital outpatient departments and an enhancement of the status of general practice as a career.[80]

The possibility of the establishment of primary healthcare units (**PVEs**) was then regulated in federal legislation in 2017 with the Primary Health Care Act (PrimVG).[81]

According to the Act, a primary healthcare unit must have a legal personality of its own and be included in the relevant Regional Structural Plan for Healthcare **(RSG)** .

The basis for cooperation with the health insurance funds is a primary healthcare contract, to which the regional social health insurance fund responsible for provision in the province always has to be a party.[82]

A primary healthcare unit established at one location can only be operated in the organisational form of a group practice under the ÄrzteG or as an independent outpatient facility under the Federal Hospitals Act.[83] In addition to this, it is possible to form a

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79 Cf. Federal Ministry of Labour, Social Affairs, Health and Consumer Protection (BMASGK), "Das Konzept zur Primärversorgung", https://www.sozialministerium.at/site/Gesundheit/Gesundheitssystem/Gesundheitsreform/Das_Konzept_zur_Primaerversorgung.

80 Cf. Federal Ministry of Health (BMG), *"Das Team rund um den Hausarzt": Konzept zur multiprofessionellen und interdisziplinären Primärversorgung in Österreich*, 5, https://www.sozialministerium.at/cms/site/attachments/1/2/6/CH3973/CMS1404305722379/primaerversorgung.pdf .

81 Federal Act on Primary Healthcare in Primary Healthcare Units (**PrimVG**), *Federal Law Gazette* I No. 131/2017, https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20009948.

82 Cf. Wallner, "Organisationsvorschriften für Primärversorgungseinheiten", *Recht der Medizin*, 2018, 6, 269.

83 Federal Act on Hospitals and Clinics (KAKuG), most recently amended by *Federal Law Gazette* I No. 13/2019.

network that may consist of self-employed doctors, group practices, and members of other health and welfare professions or their professional organisations.

The freedom of choice of doctor enshrined in Austrian social insurance legislation remains upheld in its previous form.

1.2. Goals of primary healthcare units

The establishment of the primary healthcare units is intended to put in place comprehensive healthcare provision under one roof, close to where people live and with patient-friendly opening hours.[84]

Primary healthcare units have to consist of a core team of general practitioners, as well as healthcare and nursing staff. Depending on demand, paediatricians and members of other health and welfare professions (midwives and psychologists, for example) may also be involved in a structured fashion. By the end of 2021, seventy-five primary healthcare units are to be established in Austria (there are eighteen at the moment; for greater detail on this topic, see section IV.1.4 below).[85]

1.3. Organisation of primary healthcare units

Pursuant to Section 2 para. 1 PrimVG, a primary healthcare unit constitutes a first point of contact in the healthcare system for the public, above all the population in its catchment area, functioning as a setting for mandatory, structured collaboration of the kind intended by the healthcare concept set out in Section 6 PrimVG.

According to Section 2 para. 4 PrimVG, a primary healthcare unit has to be incorporated with a legal personality of its own. However, the primary healthcare unit itself it not a legal form under company law, but a form of operational organisation within which medical services are provided. The prerequisite of legal personality therefore relates to the operator of the primary healthcare unit. [86]

Primary healthcare units have to make available services for the promotion of health and the prevention of diseases, as well as the comprehensive treatment of acute and chronic conditions. In addition to this, primary healthcare units are intended to coordinate the measures required for holistic, continuous healthcare provision and medical care.

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84 Cf. Main Association of Austrian Social Security Institutions, "Die neue Primärversorgung ist Schlüssel zur Verbesserung der Gesundheitsversorgung", http://www.hauptverband.at/cdscontent/?contentid=10007.782526.

85 Cf. Main Association of Austrian Social Security Institutions, "Die neue Primärversorgung ist Schlüssel zur Verbesserung der Gesundheitsversorgung".

86 Cf. Wallner, "Organisationsvorschriften für Primärversorgungseinheiten", *Recht der Medizin*, 2018, 6, 269.

Depending on the location and demand, members of other health and welfare professions, and institutions in which such individuals are employed may be involved by a primary healthcare unit.

In this context, Section 2 para. 3 PrimVG makes mention in particular of midwives, psychologists, psychotherapists, members of the healthcare and nursing professions that are regulated in the Act on Medical Assistant Professions and the Medical and Therapeutic Massage Act, and the higher clinical-technical professions.

Furthermore, there is the possibility of cooperation with community pharmacies (cf. Section 2 paras. 2–3 PrimVG).

1.4. Numbers and locations of primary healthcare units

At present, there are eighteen primary healthcare units in total:[87]

Vienna (3):

1. Primary Healthcare Center Medicine Mariahilf
2. Donaustadt Primary Health Care
3. Meidling Primary Healthcare Unit – Regional Medical Centre

Lower Austria (3):

4. Schwechat Primary Healthcare Centre
5. St. Pölten Primary Healthcare Centre
6. Böheimkirchen Primary Healthcare Unit – Centre for Local Medical and Welfare Provision

Burgenland (1):

7. Raabtal Primary Healthcare Network

Upper Austria (4):

8. Haslach Primary Healthcare Centre
9. Marchtrenk Primary Healthcare Centre
10. The Family Doctors – Enns Primary Healthcare Centre
11. Sierning-Neuzeug Primary Healthcare Network

Salzburg (1):

12. Tennengau Healthcare Network

[87] Austrian Forum for Primary Healthcare, "Versorgungskarte", https://primaerversorgung.org/versorgungskarte/; Main Association of Austrian Social Security Institutions, "teambasierte Primärversorgung: PVE Pilotprojekte", https://www.sv-primaerversorgung.at/cdscontent/?contentid=10007.796755&viewmode=content.

Styria (6):

13. Liebenau Social Medical Centre
14. MEDIUS – Centre for Health
15. Weiz Health Centre
16. Joglland Health Centre
17. Mariazell Health Centre
18. Eisenerz Health Centre

A total of seventy-five primary healthcare units are to be established in Austria by the end of 2021.

1.5. Financing

Strengthening primary healthcare services was pursued as an aim in the agreement concluded in 2017 pursuant to Art. 15a Federal Constitutional Act on the Organisation and Financing of the Health Sector,[88] in the agreement pursuant to Art. 15a Federal Constitutional Act on Target-Based Governance in the Health Sector[89] and in the Target-Based Healthcare Governance Act.

€200m is being made available for the expansion of primary healthcare under the PrimVG.

1.6. Master Contract

On 2 April 2019, agreement was reached by the Austrian Medical Chamber and the Main Association of Austrian Social Security Institutions on a master contract for primary healthcare units, which stipulates the services to be provided and the fees payable to doctors.[90]

The Master Contract prescribes the parameters for the new, team-based approach to primary healthcare that is to be implemented throughout Austria, but also leaves scope for regional arrangements that make it possible to respond to the needs of patients and the professional groups who work in the primary healthcare units.

Provision is made for an obligatory healthcare mandate for each primary healthcare unit across Austria (based on the Austrian Structural Plan for Healthcare (**ÖSG**) drawn up by

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88 Accessible online via the Legal Information System of the Republic of Austria: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=LrVbg&Gesetzesnummer=20001137.

89 Accessible online via the Legal Information System of the Republic of Austria: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=LrW&Gesetzesnummer=20000543.

90 Austrian Medical Chamber, "Primärversorgung: Bundesweiter Gesamtvertrag für Primärversorgungseinheiten abgeschlossen" (3 April 2019), OTS, https://www.ots.at/presseaussendung/OTS_20190403_OTS0066/primaerversorgung-bundesweiter-gesamtvertrag-fuer-primaerversorgungseinheiten-abgeschlossen.

the Austrian Federation, the provinces and the social security institutions). The planning of posts is integrated with the RSG.

Demand-responsive opening hours within the meaning of Section 4 no. 2 PrimVG are provided for from Monday to Friday at least, including early and late opening hours. These minimum opening hours must be agreed within a corridor of forty to fifty hours a week where there are three posts for doctors.[91]

The impact of the healthcare services provided is to be clearly tangible for patients. Depending on size, the existing primary healthcare units treat between 3,000 and 7,000 patients a quarter.

The aim is for the seventy-five primary healthcare units planned throughout Austria to provide healthcare services to 10% of the population, and further expansion is foreseen. On average, between three and five doctors work at a primary healthcare unit. If there are to be seventy-five primary healthcare units, this implies there will be 300–400 general practitioners, although the paediatricians who may be involved have not been included in these figures.

1.7. Competition assessment

In principle, the BWB welcomes the establishment of primary medical services as a way of enabling patients to benefit from more easily accessible, wider-ranging healthcare provision. The reduction in the burdens on hospital outpatient departments this is intended to bring about is also to be viewed as positive.

With regard to the organisation of the primary healthcare units, however, it is to be considered that, above all as far as healthcare in rural areas is concerned, such newly created facilities can only be regarded as expedient if universal medical provision for patients is ensured.

Accordingly, the development towards centralised provision should not be pursued at the expense of the permanent posts that are already budgeted for rural doctors. In this respect, there could be a risk of the services provided by rural doctors being thinned out (even further).

A systematic approach to the utilisation of permanent health insurance fund posts for primary healthcare units is not clearly in evidence. It is not currently envisaged that

[91] Cf. Master Contract for Primary Healthcare Units Concluded pursuant to Section 342b General Social Insurance Act (ASVG), *Federal Law Gazette* No. 189/1955, as Amended from Time to Time, and pursuant to Section 117b Para. 1 No. 1 Doctors Act 1998, *Federal Law Gazette* I 1998/169, as Amended from Time to Time, between the Federal Chapter of Doctors in Private Practice of the Austrian Medical Chamber (Hereinafter the Medical Chamber) on Its Own Behalf and on Behalf of the Assemblies of the Chapters of Doctors in Private Practice of the Provincial Medical Chambers Specified in Section 2, and the Main Association of Austrian Social Security Institutions (Hereinafter the Main Association) on Behalf of the Social Security Institutions Specified in Section 2, section 10 para. 1 no. i.

additional health insurance fund posts will be created for the primary healthcare units. The health insurance fund posts that are required will have to be drawn from among the permanent posts that already exist. There are no particular catchment areas for health insurance fund posts defined in geographical terms. They are allocated individually according to the needs of the region in question. There is a risk here that, if nothing is done to protect against this, the redistribution of permanent posts may cause local shortages of health insurance fund posts in rural areas. This would run counter to the intention behind the primary healthcare concept, which is to provide for the delivery of universal services to the whole population.

Patients' ability to freely choose the general practitioner who treats them is also provided for at the primary healthcare units. On account of their regulated opening hours, attention is to be paid to ensuring freedom of choice.

The operation of practice dispensaries is currently not regulated at primary healthcare units. Section 2 para. 3 PrimVG merely provides for the possibility of cooperation with community pharmacies. In the interests of comprehensive medical provision for patients, above all in rural areas, the BWB would certainly regard it as sensible for primary healthcare units themselves to be able to operate practice dispensaries in addition to the option they have of cooperating with community pharmacies. Within the context of holistic healthcare services, this could contribute to the efforts to make the primary healthcare units and general practice careers in rural areas yet more attractive, while at the same time ensuring the local supply of necessary medicines.

1.8. Recommendations

- Permanent posts: The BWB recommends a system be developed for the utilisation of permanent posts for primary healthcare units, since such a system is currently not in evidence. In particular, a catalogue of criteria could be elaborated here that would explain comprehensibly why a particular location had been selected for the funding of a permanent post and, in addition to this, would be intended to prevent the allocation of permanent posts to the primary healthcare units weakening rural doctor's practices.
- Freedom of choice: Patients' freedom to choose which doctor they are treated by could be constrained by the opening hours that are adopted. The BWB therefore recommends action be taken to ensure freedom of choice in non-acute cases, for instance by dividing up a practice's opening hours between doctors so that they are all available at different times of day in the course of the week.
- Practice dispensaries: In addition to the provision on primary healthcare units' cooperation with community pharmacies that is already in place today, the BWB recommends that provision be made for an option that would allow practice

dispensaries to be operated at primary healthcare units as well. This would add value to the delivery of holistic health services, above all in rural areas.

2. Employment of doctors

2.1. General remarks

In connection with the primary healthcare units, attention is also to be paid to the employment of doctors by doctors. Thanks to the recent amendment of the ÄrzteG,[92] Section 47a of the Act makes it possible for doctors to be employed at practices and/or group practices.

Doctors who hold a licence to practice (i.e. general practitioners and specialised doctors) are accordingly able to employ other doctors (Section 47 para. 1). They may only be employed in the same specialism as the doctor who employs them. Despite the fact that they are employees, these doctors have a fundamental duty to practise their profession in a personal capacity (Section 47 para. 3).

2.2. Working times

In principle, a maximum of two doctors may be employed for hours equivalent to one full-time post (forty hours a week) at a practice, while a maximum of four doctors may be employed for hours equivalent to two full-time posts (eighty hours a week) at a group practice. Pursuant to Section 47a para. 2, exceptions are possible at primary healthcare units. Overtime is not expressly regulated, but is probably possible within the limits set by the Working Time Act (**AZG**).[93]

2.3. Liability

When treatment errors occur at a hospital, the hospital is liable, but to date treatment errors at medical practices have been the liability of the practice owner. Under the new wording of Section 47a para. 3 ÄrzteG, which constitutes a special provision under the law of liability, the employed doctor who bears the ultimate medical responsibility is liable for such errors rather than the practice owner.[94]

2.4. Delimitation between employment and locum practice

A further clarification was concerned with the delimitation of employment and locum practice. Accordingly, pursuant to Section 47a paras. 4–5 ÄrzteG, "ad hoc and regular

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92 *Federal Law Gazette* I No. 20/2019, https://www.ris.bka.gv.at/eli/bgbl/I/2019/20.

93 Cf. Holzgruber, "Ärztegesetz: Regelung zur Anstellung von Ärztinnen und Ärzten" (23 January 2019), medinlive, https://www.medinlive.at/gesundheitspolitik/regelung-zur-anstellung-von-aerztinnen-und-aerzten.

94 Cf. Holzgruber, "Ärztegesetz: Regelung zur Anstellung von Ärztinnen und Ärzten", medinlive.

cover for a practice owner or a partner in a group practice" is categorised as self-employed work. An employment relationship only exists if the practice owner and the locum doctor work simultaneously in the practice or group practice.[95]

3. Training placements for general practitioners

3.1. General remarks

The training of general practitioners in training practices has also been affected by the establishment of the primary healthcare units.[96] The current Medical Training Regulation (**ÄAO 2015**) accordingly provides for all foundation doctors to be trained on an obligatory basis for six months at a (group) training practice following the end of their specialist training in general practice.[97]

The aims are firstly to expand the provision for patients, and secondly to familiarise young doctors with private practice as a career and guarantee they are better prepared for the challenges they will encounter.

3.2. Forms of training placement

The following two models are provided for when trainees undertake training placements under the ÄAO 2015:

- employment at a (group) training practice of general practitioners or
- continued employment at the "training hospital" where the trainee has been working hitherto and secondment to a (group) training practice.

3.3. Financing and funding

The costs for the financing of training placements are borne by the Austrian Federation (25%), the provinces (32.5%), the social insurance institutions (32.5%) and (group) training practice owners (10%).

Trainees are employed for thirty hours a week. The funding provided is based on this working time. No funding is granted for longer hours of employment or any overtime that may be done.

Part-time employment is possible as of a minimum of fifteen hours a week, and results in the length of the training period being extended.

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95 Cf. also Holzgruber, "Ärztegesetz: Regelung zur Anstellung von Ärztinnen und Ärzten", medinlive.

96 Main Association of Austrian Social Security Institutions, "Sozialversicherung bekennt sich bei der Ärzteausbildung in Lehrpraxen zur Mitfinanzierung", http://www.hauptverband.at/cdscontent/?contentid=10007.764533.

97 Recognised (group) training practices are listed in the Austrian Medical Chamber's register of training settings: https://www.aerztekammer.at/en/ausbildungsstaettenverzeichnis.

The salary prescribed by the current collective agreement for training placements is equivalent to the sum to which the foundation doctor would be entitled under the Vienna Hospital Association's salary structure, subject to additional consideration of their previous service after nine months of basic training and a twenty-seven-month hospital foundation placement.

There is an entitlement to funding if the (group) training practice holds a valid training licence in general practice under the ÄAO 2015, and the foundation doctor has not previously received any funding.

3.4. Competition assessment

The BWB favours both training placements as such and the initiatives taken to fund them. These allow targeted measures to be taken to increase the attractiveness of working in general practice. This may in turn lead to the future of general practice as a career being secured, above all in rural areas.

Note: For further information on primary healthcare units, the employment of doctors and training placements, please see the websites of the Austrian Medical Chamber and the Main Association of Austrian Social Security Institutions.

V. Proposals made by the Austrian Chamber of Pharmacists (öApK) for the modernisation of the Pharmacies Act

A draft bill for the revision of the Pharmacies Act has been forwarded to the BWB by the öApK. The most significant amendments from a competition perspective are picked out below, with the existing provisions being compared briefly to the revisions proposed by the öApK. Each comparison is followed by a commentary that explains the BWB's view of the planned amendments, and discusses the extent to which consideration has been given to any calls for more competition made in the first part of the BWB's Sector Inquiry Health (May 2018).

The aims of the öApK draft are to modernise and update the ApothekenG, and achieve a far-reaching improvement in the supply of medicinal products to the population. No proposals have been made concerning practice dispensaries (Sections 28 et seq.), in view of which reference is made to the ideas discussed in chapter III.

1. Opening hours and emergency out-of-hours rotas (Section 8)

Existing provisions: At present, pharmacies' opening hours are set by the district administration authority, while a maximum weekly opening time of forty-eight hours and daily lunchtime closing for about two hours are to be complied with. All pharmacies in a locality have to abide by the same opening hours.

öApK proposals: In future, all pharmacies in a locality are to keep uniform core opening hours of at least thirty-six hours, which are to be set by the district administration authority in an ordinance. In addition to this, individual, optional opening hours that go beyond this up to a maximum of seventy-two hours (analogous to the hours kept in the retail trade) are to be possible. Account is to be taken of the consulting hours of the local public health insurance fund general practitioners. Individual pharmacy opening hours are to be notified one year in advance for the purpose of allocating out-of-hours duties.

Commentary: The BWB is very strongly in favour of this step because restricted opening hours have been one of consumers' biggest criticisms in the past, and were consequently

addressed in the first part of the Sector Inquiry (see *Sector Inquiry Health: Part 1*, 22, section VII.1).

The current draft bill draws on the general shop opening hours applied in the retail trade. The (two-hour) lunchtime closing that is still provided for has been deleted from the draft bill without replacement, as a result of which pharmacists will be free in future to either open at times that permit consumers to purchase medicinal products during their lunch breaks, or to schedule lunchtime closing at their pharmacy. The new provisions on the set opening hours, according to which every pharmacy can voluntarily stay open for longer than a minimum core time of thirty-six hours and, by so doing, position itself more attractively than other pharmacies in terms of opening hours, are also positive. Coordination with the local general public health insurance fund doctors seems sensible, because this will ideally make it possible for patients to go straight from their doctor to a pharmacy on the same day. The notification of opening hours one year in advance appears acceptable for planning purposes, without encroaching all too much on pharmacists' freedom.

2. Delivery of medicinal products (Section 8a)

Existing provisions: "Within a radius of six kilometres by road from the premises of the existing community pharmacy, urgently needed medicinal products may be delivered to patients by the pharmacy's own delivery service."

öApK proposals: The pharmacy's current in-house delivery service is to be replaced with a demand-responsive "mobile dispensing service" located in its catchment area, which will require authorisation and may also be operated jointly by several pharmacies. The maximum distance of six kilometres by road that currently applies will be deleted without replacement, and would be replaced by the term "catchment area". A new duty to deliver urgently required medicinal products in the catchment area in justified individual cases will be added. It will also be allowed for non-prescription medicinal products to (continue to) be delivered outside the pharmacy's catchment area without authorisation by means of distance selling pursuant to Section 59 para. 10 no. 1 Medicinal Products Act (ArzneimittelG).

Commentary: The maximum distance of six kilometres by road and the criterion of "urgently needed medicinal products" will cease to apply as restrictions, which is to be advocated in competition terms and satisfies a demand put forward by the BWB (*Sector Inquiry Health: Part I*, 28, section VII.4). However, the planned new provisions now include a needs assessment carried out by the öApK, although the draft bill does not offer any criteria that would allow this assessment procedure to be scrutinised.

In its explanatory notes on the proposed revision, the öApK states that the old provisions were too rigid. Thanks to the reference now made to the catchment area, an assessment could concentrate more on the circumstances of the individual case. Situations would be possible in which there might be overlaps with other pharmacies' catchment areas: several pharmacies could operate a mobile dispensing service jointly or in alternation, or a pharmacy could cover an additional catchment area on account of the demand for this provision and the simultaneous absence of a local mobile dispensing service.

Provided the öApK puts the approach set out in the explanatory notes summarised above into practice in this fashion, both better provision of medicinal products and an increase in (regional) competition would have to be anticipated. However, since the draft bill does not include any criteria for the potential blank check of the "needs assessment by the öApK", there is a danger that – like the limitations that have been in place to date – the revised provisions on delivery could effectively impose territorial restrictions. In this context, therefore, only practical experience will reveal the extent to which the öApK is going to permit free competition when it comes to the delivery of medicinal products.

This contrasts with the fact that non-prescription medicines can already be delivered outside pharmacies' own catchment areas today by means of distance selling. No amendments are planned on this point, and such changes are not necessary from a competition perspective either.

3. Licensing of, and legal form for, the operation of community pharmacies (Section 12)

Current provisions: The current general provisions concerning licensing say that the licence holder has to own a holding of more than half the entire pharmacy undertaking. It is possible to deviate from this if the licence holder owns a holding of at least one-quarter, and is entitled and obliged to increase their holding to a total of more than half of the entire pharmacy undertaking, either through transfer upon death or at the latest within ten years by transfer *inter vivos*. In any event, the licence holder must have the sole power to manage and represent the undertaking.

öApK proposals: In future, at least 51% of newly established and (subject to transitional provisions) existing pharmacies (of which at least 25% must be held directly) are to be owned by the licence holder, who is to control the undertaking (legally and economically). This requirement will apply to existing partnerships the next time there is a change of licence holder, but at the latest ten years following the revised provisions' entry into force. Additionally, persons or undertakings may directly or indirectly hold more than 25% of the shares in a maximum of 3% of community pharmacies (Section 12 para. 6).

Commentary: These provisions address a set of problems that were dealt with comprehensively in the first part of the Sector Inquiry (see *Sector Health Inquiry: Part 1*, 18, section VI.2.b). Under the current provisions, it would be possible for a pharmacy's business to be conducted by the licence holder alone, but the (economic) power of disposition to be exercised by a pharmaceutical company with a holding of more than 50% that stayed in the background. Thanks to the reference now made to the competition law concept of control by the licence holder, it is guaranteed that the influence exerted by pharmaceutical companies over individual pharmacies will decline. The selection of products they stock and the advice they offer can therefore be oriented more strongly towards what is beneficial to customers.

The newly drafted Section 12 para. 6 takes the same approach. The threshold of a maximum of 3% implements the critical limit that was highlighted by the Cartel Court in 2003. While the new provisions on "control" that are discussed above relate to individual pharmacies, this "market share cap" will ensure that the influence of individual wholesalers on Austria's entire pharmacy market will decline and/or cease to be a competition concern, and that this development will not be reversed in future either.

4. Relocation of pharmacies (Section 14)

Current provisions: The relocation of a pharmacy within the locality designated in the licensing decision will require approval by the öApK. Relocation to another locality is to be authorised by the district administration authority if the prerequisites for the granting of a licence pursuant to Section 10 are satisfied and, in addition to this, the area's needs can be satisfied better from the new location.

öApK proposals: The öApK will have to authorise the relocation of a pharmacy within a locality in future, provided a minimum distance of 500 metres to the closest community pharmacy is complied with and/or an existing distance of less than 500 metres is not further reduced. Alternatively, the district administration authority may authorise such a relocation, provided that at least 5,500 people will remain as a potential customer base for each of the surrounding pharmacies. Relocation to a different locality is regulated in specific terms to the extent that such a relocation has to be authorised through a licensing procedure. The same is true for relocation to an "expanded locality" (i.e. elsewhere within the same municipality) while, in addition to this, better provision must be guaranteed from the new location.

Commentary: In contrast to earlier, the licensing criterion of a minimum distance to the closest community pharmacy will be applied to relocation within a locality. These new provisions and the alternative option of authorisation by the district administration authority are intended to prevent relocation within a locality having disadvantageous impacts on other pharmacies and/or security of supply. This also appears justifiable from

a competition perspective, because it does not impose any additional impediments compared to the new authorisation procedure.

The revised provisions on relocation to another locality or elsewhere in the municipality mean these two cases now fall under the general licensing procedure, and enable the öApK to assess security of supply in the individual case. At the same time, they allow pharmacists who do not find suitable shop premises within their designated locality or, for example, have to give up their premises on business grounds because the street layout has been altered to relocate their pharmacy within a municipality or outside it. In this way, pharmacies' economic operation can be ensured, even in cases where there are external problems, and competition between them can be upheld.

5. Branch pharmacies (Section 24)

Current provisions: For localities without a community pharmacy or practice dispensary, the owner of a community pharmacy may be authorised to operate one branch pharmacy if this locality is no more than four kilometres by road away from their main pharmacy and there is need for an outlet to dispense medicinal products. The branch pharmacy may only be operated in conjunction with the main pharmacy. According to the third sentence of Section 47 para. 2, an application for the granting of a licence is to be rejected without further proceedings if authorisation for the establishment of a branch pharmacy has been granted less than five years previously in the municipality of the location for which the application has been submitted.

öApK proposals: The distance of four kilometres by road is no longer to be crucial in future where new branch pharmacies are to be established, but the main pharmacy must be one of the three closest pharmacies to the new branch pharmacy. Pharmacists will be allowed to operate a maximum of three branch pharmacies rather than just one. Existing pharmacies must continue to have a potential customer base of at least 5,500 people. Branch pharmacies will have to be opened within two years – otherwise their approval will expire. In compensation, the period for which branch pharmacies are protected under Section 47 ApothekenG is to be raised from five to seven years. A separate authorised responsible pharmacist who does not operate or manage any other pharmacy will have to be appointed for each branch pharmacy.

Commentary: These provisions implement a proposal made by the BWB for the number of permissible branch pharmacies to be increased, and for their establishment to be made easier (see *Sector Inquiry Health: Part 1*, 21, section VI.3).

Instead of the rigid measure of kilometres, the revised legislation will allow greater distances between a new branch pharmacy and the main pharmacy. Together with the possibility of now operating up to three branch pharmacies, the new provisions will open

up additional fields of business activity for pharmacists. This provision harmonises in particular with the revised wording of Section 12. It will only be possible to push back pharmaceutical companies out of the pharmacy market if pharmacies' survival is guaranteed on a solid economic basis.

In contrast to this, thanks to the minimum potential customer base for the closest two pharmacies in third-party ownership and the branch's compulsory management by a freely available pharmacist, security of supply and the safety of the advice provided will be guaranteed, as a result of which it is not only from a competition perspective that the new provisions set out in Section 12 can be described as well-targeted and successful.

Nevertheless, there is a negative side: since the establishment and opening of a (branch) pharmacy is associated with high costs, the – also increased – period of protection of seven years could have a deterrent effect. As future branch pharmacies are without exception to be managed by a separate authorised pharmacist who does not operate or manage any other pharmacy, the branch pharmacies will effectively amount to fully fledged pharmacies. It is to be questioned why an application for the granting of a licence should lead to the closure of a branch pharmacy in this case after it has been trading for seven years. Provided there are no serious reasons for a new replacement pharmacy to be established in a branch pharmacy's catchment area, the branch pharmacy should be allowed to operate permanently.

6. Competition assessment

The most elementary changes made in the revised version of the Act are concerned firstly with tightening up the rules on holdings in pharmacies, and secondly with liberalising opening hours, deliveries of medicinal products and the establishment of branch pharmacies.

These four steps go in the right direction from a competition perspective: in future, it is to be expected that pharmacists will (have to) show they have both economic and *de facto* control over their pharmacies. It appears within the bounds of the possible that pharmaceutical companies will lose influence on the pharmacy market. From an economic perspective, the most important guarantee for this should above all be the new provisions on the establishment of branch pharmacies. Whereas, up until now, a pharmacist has been able to own and operate a maximum of two pharmacies, following the implementation of the revised legislation they will be allowed to run twice as many outlets. This will spread the economic risk across several locations and, at the same time, strengthen the pharmacist's position as a customer in their dealings with the pharmaceutical companies. It certainly appears conceivable that, as a result of this, it will be possible to ensure purchasing conditions become more favourable over the long term.

An improvement in competition is to be anticipated on the sales side as well. Complementing the already liberalised delivery of non-prescription medicinal products, a newly established mobile dispensing service could not only cater for patients who were in need of nursing care or immobile, but possibly represent a competitive advantage over other pharmacies. Together with up to three branch pharmacies, a considerably larger catchment area than hitherto could be served in this way by one pharmacist. The new provisions on opening hours, which are modeled on those for the retail trade, may also result in more competition between neighbouring pharmacies, and are likely to be greeted positively by consumers and patients.

7. Recommendations

- (Minimum) criteria for the needs assessment that will be carried out by the öApK for mobile dispensing services subject to mandatory authorisation are to be regulated in legislation. Alternatively, it would be conceivable for such a service to be authorised automatically where there was no mobile dispensing service in the catchment area, unless the öApK demonstrated an absence of demand.
- Provided there are no compelling reasons that stand in the way of this in individual cases, branch pharmacies should be established permanently. The period for which a branch pharmacy is protected should run in parallel to the term of the main pharmacy's licence.

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