Health Service Planning in Austria

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Overview

- Main characteristics of the Austrian health care system
- “Austria in the world”
- “The world in Austria”
- What has been achieved?
- The way forward
<table>
<thead>
<tr>
<th>Degree of Centralisation</th>
<th>Level of Government</th>
<th>Governing tasks</th>
<th>Characteristics</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High</td>
<td>Central</td>
<td>Provision of national public goods</td>
<td>National scope</td>
<td>National defense</td>
</tr>
<tr>
<td>High</td>
<td>Local Authorities</td>
<td>Economic stability</td>
<td>National scope, involvement of all government levels</td>
<td>Monetary and fiscal policy</td>
</tr>
<tr>
<td>Medium</td>
<td>Local authorities, Social Security</td>
<td>Income and wealth distribution</td>
<td>National scope, involvement of all government levels</td>
<td>Basic level of social protection</td>
</tr>
<tr>
<td>Low</td>
<td>Federal States and Municipalities</td>
<td>Urban, suburban and rural tasks</td>
<td>Local scope with spill-overs</td>
<td>Hospitals, Secondary Schools, Theaters</td>
</tr>
<tr>
<td>Very Low</td>
<td>Municipalities</td>
<td>Basic tasks, Rural tasks</td>
<td>Local scope with spill-overs</td>
<td>City cleaning and operational services, Kindergarten</td>
</tr>
</tbody>
</table>

Source: Handler 2007, from Wegener (2003), own adaption
Austria has potential for regulated competition on the supply side

- Compulsory contributions and taxes

- Decentralized selective contracting in primary care based on regional plans with some central guidelines
  - Unrestricted access and choice of primary care providers

- Decentralized inpatient care provision based on coordinated plans between central and regional governments
  - Unrestricted access and choice for inpatient care

- Mostly benefits in kind
  - Entitlements for some benefits differ across regions

- Provider reimbursement prevails
  - Payment schemes within and across care sectors are not aligned and differ also across regions
Health expenditure level is high and growth is largely driven by high and rising use of hospital capacity

Total health expenditure as a share of GDP, 1995-2008

Source: OECD Health Data 2009, Statistik Austria 2010.
Performance-based financing in Austria increased hospital activity and enhanced the ability to regulate by volume.

Source: WHO Health for all database, June 2010, own calculations.
There is excess capacity of hospitals but only when viewed in isolation

Current health expenditure by function of health care, 2007

* Refers to curative-rehabilitative care in in-patient and day-care settings.
** Includes home-care and ancillary services

Source: OECD Health Data 2009.
What is the right mix of labour and capital in the health sector?

Data refer to 2007
Sources: LFS-EUROSTAT Database 2009, OECD Health Data 2009, own calculations
Mainly „capital costs“ drive spending growth in hospital care

<table>
<thead>
<tr>
<th>In € at current prices</th>
<th>Total Operating Cost</th>
<th>Total Operating Cost without imputed additive cost*</th>
<th>Imputed additive cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008 per capita</td>
<td>AAGR** 98-08</td>
<td>2008 per capita</td>
</tr>
<tr>
<td>Burgenland</td>
<td>708</td>
<td>4,9</td>
<td>649</td>
</tr>
<tr>
<td>Kärnten</td>
<td>1.220</td>
<td>3,5</td>
<td>1073</td>
</tr>
<tr>
<td>Niederösterreich</td>
<td>957</td>
<td>5,4</td>
<td>867</td>
</tr>
<tr>
<td>Oberösterreich</td>
<td>1.205</td>
<td>5,3</td>
<td>1020</td>
</tr>
<tr>
<td>Salzburg</td>
<td>1.196</td>
<td>4,5</td>
<td>1062</td>
</tr>
<tr>
<td>Steiermark</td>
<td>1.172</td>
<td>4,7</td>
<td>1041</td>
</tr>
<tr>
<td>Tirol</td>
<td>1.155</td>
<td>3,9</td>
<td>972</td>
</tr>
<tr>
<td>Vorarlberg</td>
<td>920</td>
<td>3,4</td>
<td>840</td>
</tr>
<tr>
<td>Wien</td>
<td>1.830</td>
<td>2,5</td>
<td>1580</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.245</strong></td>
<td><strong>4,1</strong></td>
<td><strong>1088</strong></td>
</tr>
</tbody>
</table>

**Memorandum item**

| Total expenditure on health | 3,543 | 4,2 |
| Capital Stock per health employee*** | 89.365 | 2,4 |
| Gross Domestic Product     | 33,833 | 3,7 |

*Imputed additive cost: "Kalkulatorische Zusatzkosten", Kostenartengruppe 08
**AAGR: Average Annual Growth Rate
***Net capital stock (ÖNACE Rev. 1.1) at current prices per health and social care employee
Sources: BMG, Statistik Austria, OECD Health Data, June 2009, own calculations
Austrian health reforms since the mid 90`s

- Focused on supply side and cost containment measures designed to achieve fiscal stability
  - concentrated on the hospital sector & pharmaceutical spending
- Introduced initiatives with greater emphasis on quality of care and e-health
- Largely preserved the institutional structure of finance and care delivery
  - Stimulated cooperation between financing agents and providers on a regional level, e.g. „reform pool“
- Recent discussions have considered some form of single payer model
- New draft legislation envisages improvements in capacity in ambulatory care
Despite reforms, care delivery remains fragmented

- Many different actors determine resource usage in health and social care
- All of them seek to ensure cost control and efficiency in their specific area.
- But lack of oversight and good governance impedes economic efficiency
- 2005 legislation intensified efforts to centrally regulate decentralized supply
  - by volume-based framework plans (OSG)
  - details to be determined on regional levels (RSG) where all care sectors are to be incorporated
Planning aims to align fragmented and overlapping responsibilities in health care.
Planning seeks to balance supply across care sectors and regions but also pushes for greater mobility of providers and patients.

"Integrated Regional Health Care Planning" based on 32 "HC Regions" / 4 "HC Zones"
Based on a national framework plan (OSG), regional planning (RSG) aims to:

- Ensure needs-based provision of effective services, equally accessible and applicable to the whole range of services available in the supply region at stake
- Improve coordinated care delivery for patients across care sectors and in navigating the system
- Better align planning in all areas to regional supply levels
- Inform supra-regional coordination through the national plan (OSG)
- Mandate minimum levels of supply of services
- Ensure re-allocation of capacity to accommodate changing need, e.g. build capacity outside hospitals where pertinent
Overall regional capacity needs are framed in three matrices covering:

- **Capacity**: “Planungsmatrix”
  - classifies number of beds according to defined medical profiles for acute inpatient care
  - recommends capacity for other care sectors, e.g. the number of ambulatory care providers outside hospitals

- **Scope**: “Versorgungsmatrix”
  - advises number of cases per LDF groups (DRG-groups) per region to be treated in target year
    - Expert-driven, mostly medical experts on the basis of historic time series data
  - uses upper and lower thresholds for target case loads (+/-25% deviation from the national average)

- **Quality**: “Leistungsmatrix”
  - prescribes minimum levels of service delivery for specific surgical procedures
  - defines hospital profiles
End-point in regional plans:
Estimate of inpatient care bed demand based on a version of the Hill-Burton Formula (HBF)

- HBF (year, specialty) = \( \frac{(ALOS \times AD \times PoP)}{(tOcc \times 365)} \)
  - ALOS: Average Length of Stay
  - AD: Admissions
  - Pop: Population
  - tOcc: target Occupancy Rate

- includes
  - Criteria of availability by using measures of spatial distribution of hospital providers
  - Population benchmarks, also for high-tech equipment plan, e.g. 50 000-90 000 inhabitants for low profile hospitals
Compliance with OSG prescriptions is monitored and reported back to federal and regional levels.

Austrian Health Information System (ÖGIS)

Hospital admission rate 1992-2007 (cataract surgery, MEL15.05)
Hospital admission rate 1992-2007 (acute care hospitals; MEL15.05) - admissions per 100,000 population

Remark: Thin Line = values on national level; bold line = values on provincial level; triangles in graphs mark significance levels.

*) age standardized (European Standard Population)

What has been achieved?

- Ability to plan on the basis of case loads allows for better targeting of care needs.
- All acute care sectors are integrated in federal supply planning efforts although there is ample scope for regions to neglect target supply of providers including hospital providers.
- Planning on the regional level made requirements for better data collection obvious and transparent, e.g. ambulatory care outside hospitals.
- Implementation of regional plans is monitored through feedback loops with stakeholders.
- Federal oversight is increased but at the same time regional decision making is strengthened.
- This is consistent with overall attempts in other policy areas to better align fiscal responsibilities with regional and local preferences.
The way forward

- Link target volumes to cost-(effectiveness) and more comprehensively to quality measures
- More intelligence is needed to develop incentives for regions to adhere to target provisions
- Built-in framework of early alerts identifying non-compliant regional authorities and providers
- Address fragmentation of governance on regional levels
Thank you for your attention

Further reading:

Maria M. Hofmarcher, Bernadette Hawel. "Ambulatory care reforms fail to face the facts?". Health Policy Monitor, April 2010. Available at http://www.hpm.org/survey/at/a15/1