

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

Degree of Centralisation

high: revenues

low: expenditure

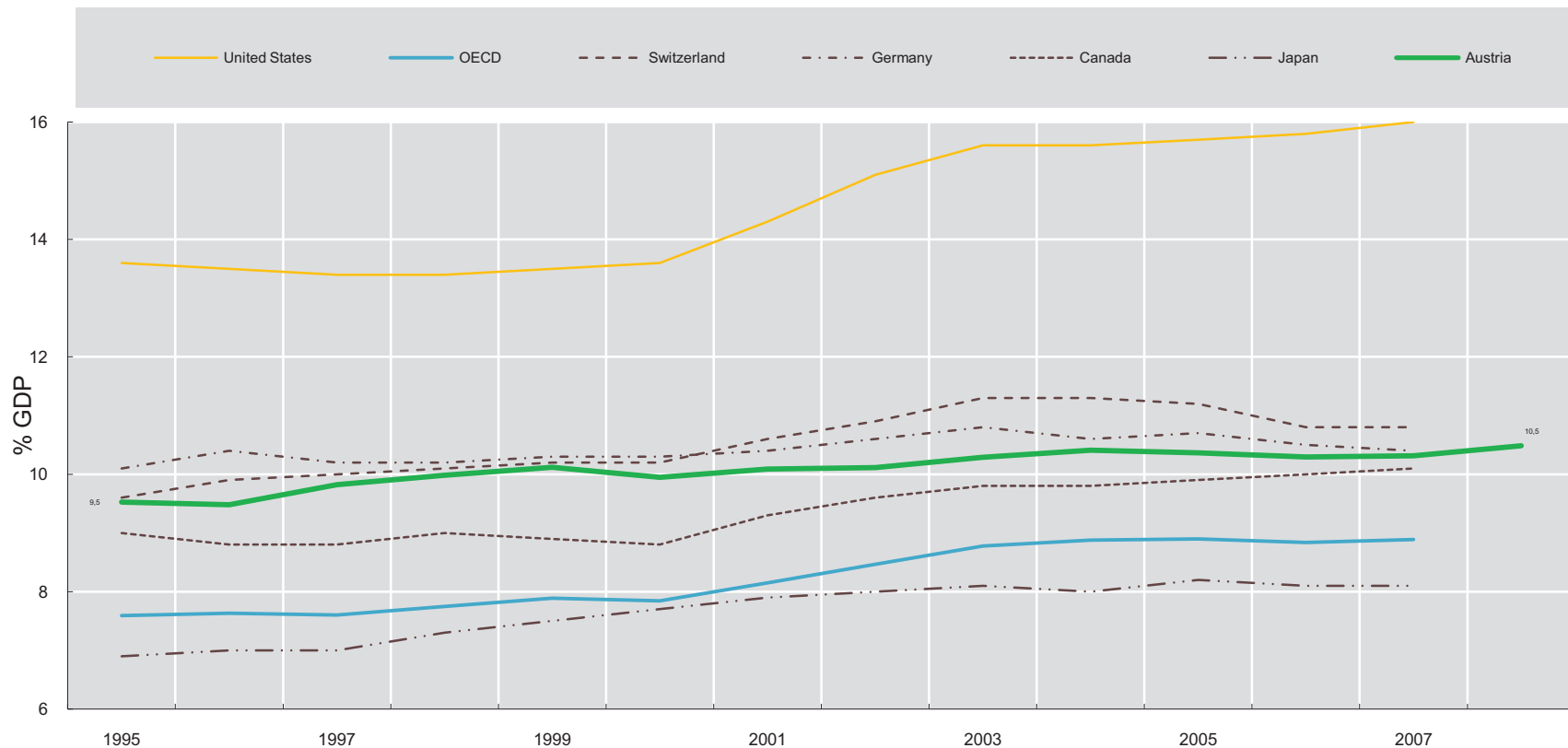
Degree of Centralisation	Level of Government	Governing tasks	Characteristics	Example
Very High	Central	Provision of national public goods	National scope	National defense
High	Local Authorities	Economic stability	National scope, involvement of all government levels	Monetary and fiscal policy
Medium	Local authorities, Social Security	Income and wealth distribution	National scope, involvement of all government levels	Basic level of social protection
Low	Federal States and Municipalities	Urban, suburban and rural tasks	Local scope with spill-overs	Hospitals, Secondary Schools, Theaters
Very Low	Municipalities	Basic tasks, Rural tasks	Local scope with spill-overs	City cleaning and operational services, Kindergarten

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

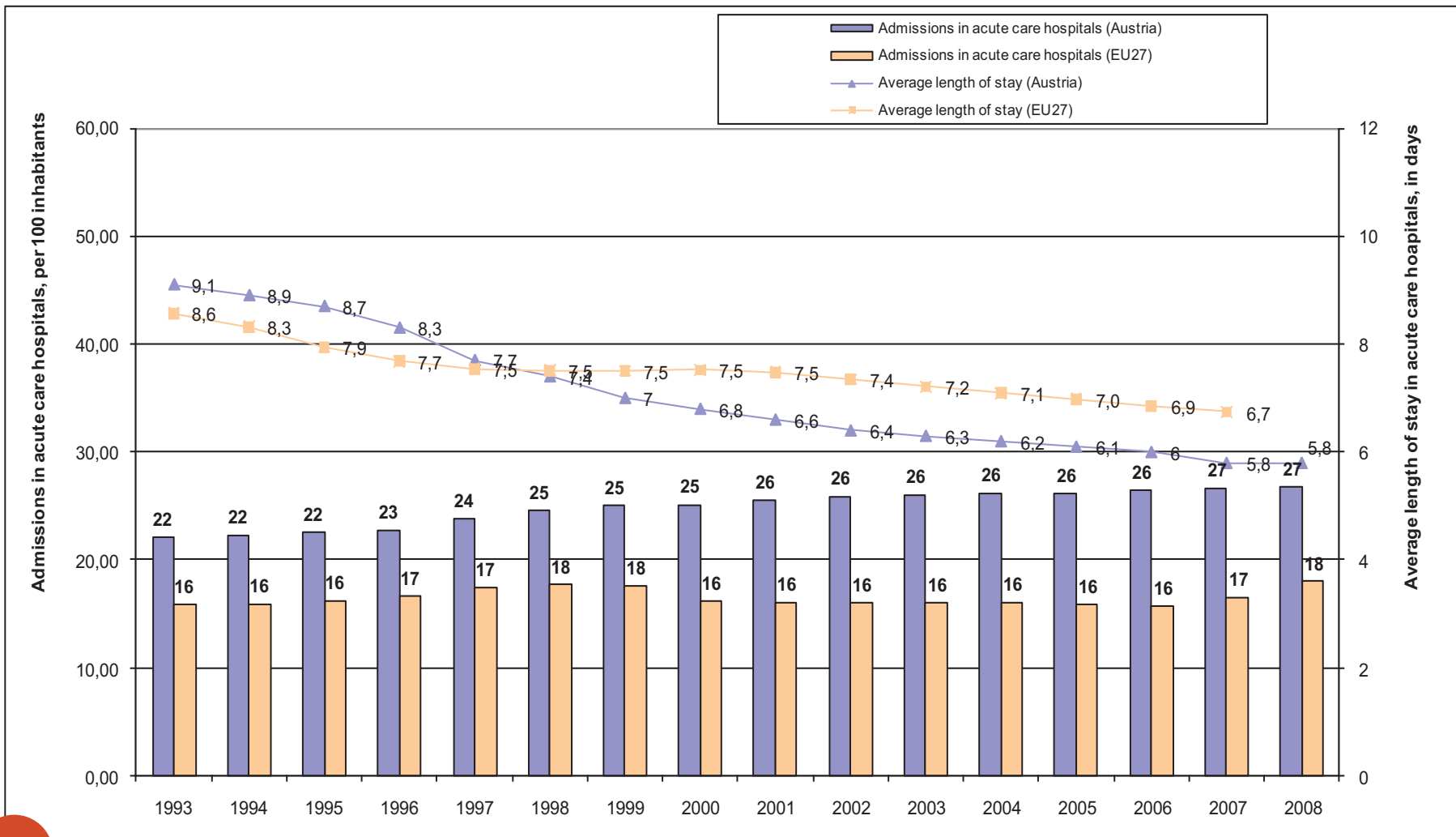
Health expenditure level is high and growth is largely driven by high and rising use of hospital capacity

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



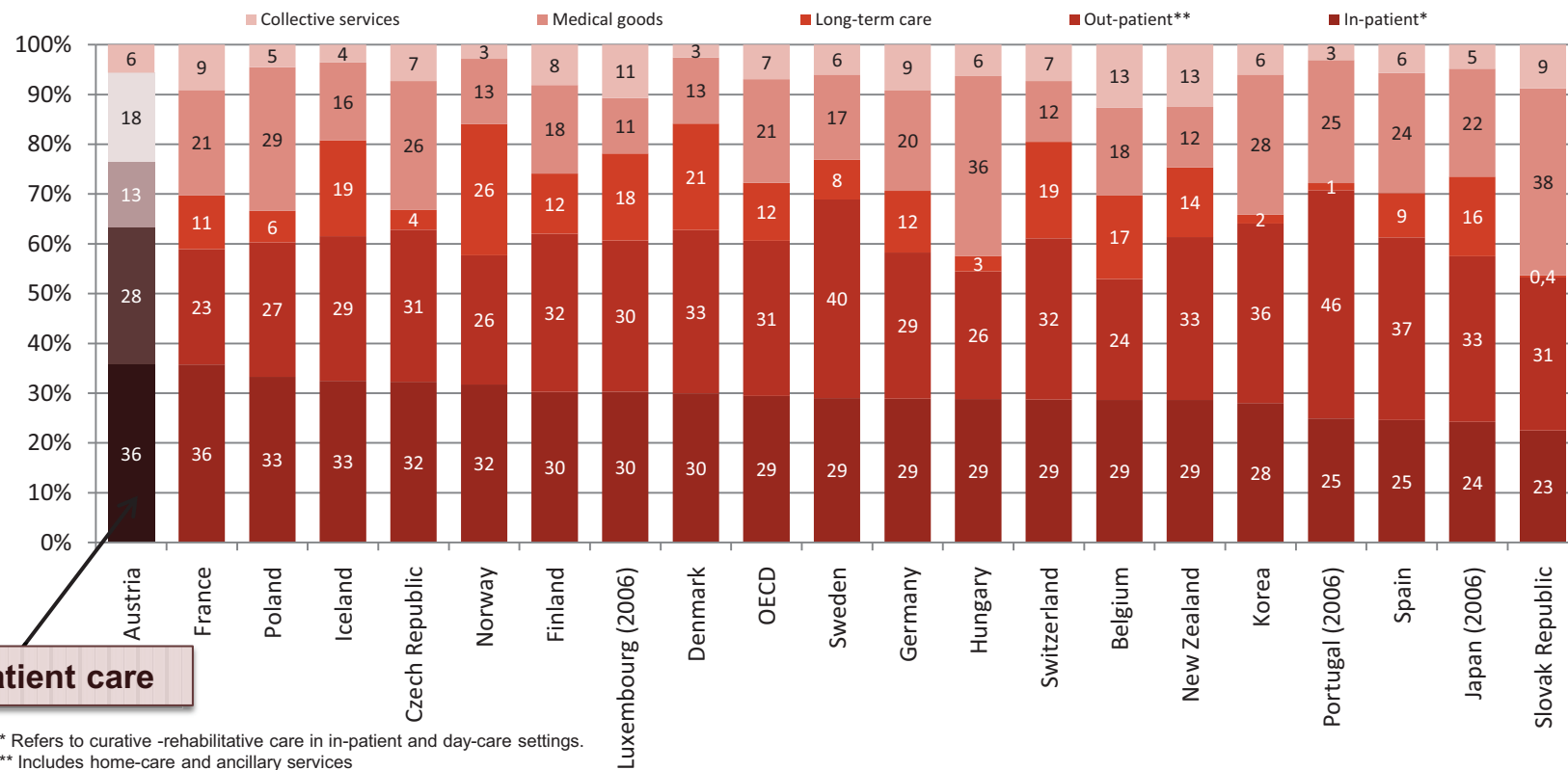
Source: OECD Health Data 2009, Statistik Austria 2010.

Performance-based financing in Austria increased hospital activity and enhanced the ability to regulate by volume



There is excess capacity of hospitals but only when viewed in isolation

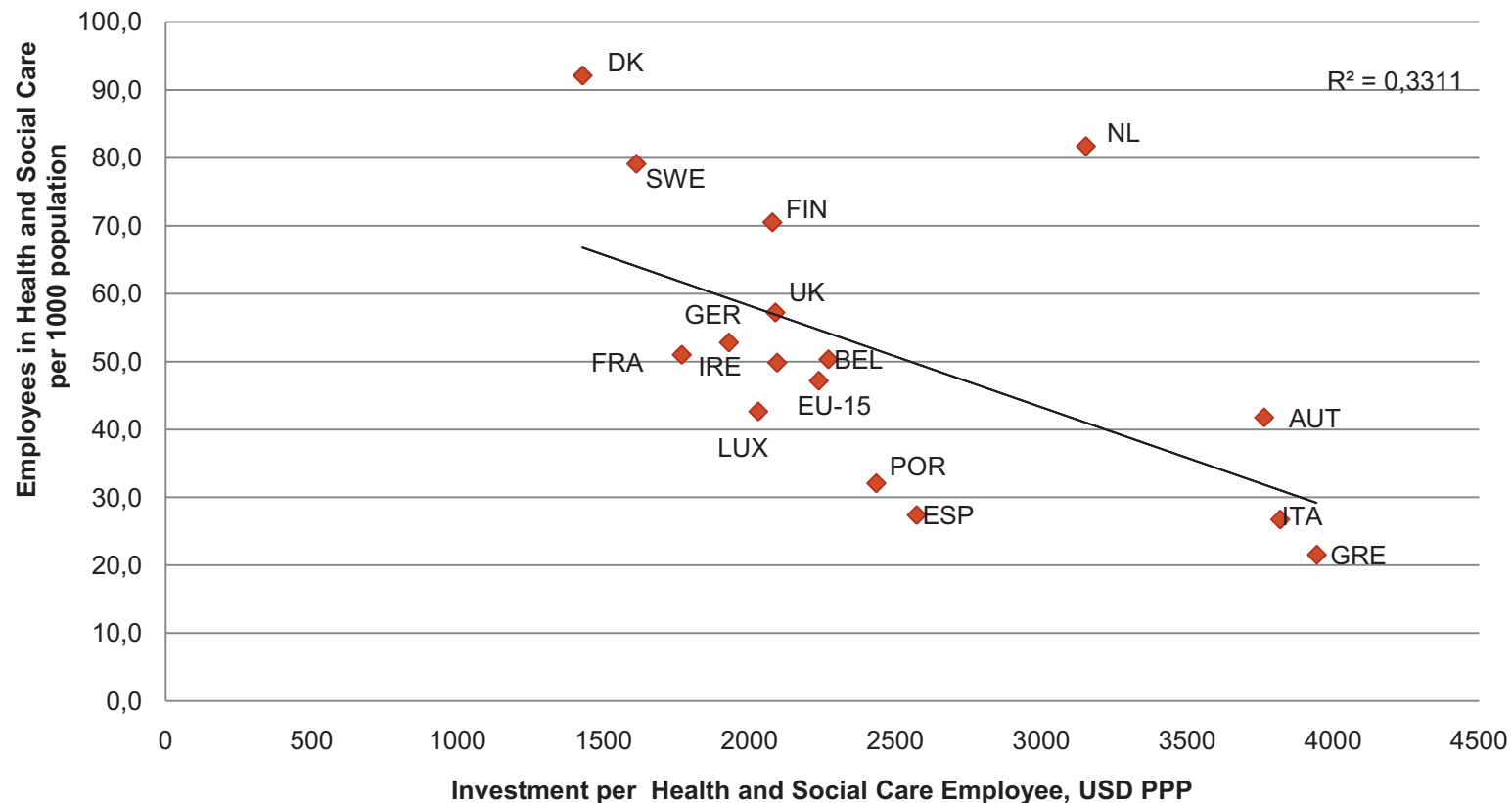
Current health expenditure by function of health care, 2007



In-patient care

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

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

In € at current prices	Total Operating Cost		Total Operating Cost without imputed additive cost*		Imputed additive cost*	
	2008 per capita	AAGR** 98-08	2008 per capita	AAGR** 98-08	2008 per capita	AAGR** 98-08
Burgenland	708	4,9	649	4,6	59	8,7
Kärnten	1.220	3,5	1073	3,2	147	6,6
Niederösterreich	957	5,4	867	5,2	90	8,1
Oberösterreich	1.205	5,3	1020	4,6	185	10,2
Salzburg	1.196	4,5	1062	4,1	134	7,9
Steiermark	1.172	4,7	1041	4,5	130	6,5
Tirol	1.155	3,9	972	3,4	182	7,4
Vorarlberg	920	3,4	840	3,4	80	4,1
Wien	1.830	2,5	1580	2,3	250	4,0
<i>Total</i>	<i>1.245</i>	<i>4,1</i>	<i>1088</i>	<i>3,7</i>	<i>157</i>	<i>6,6</i>
<i>Memorandum item</i>						
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

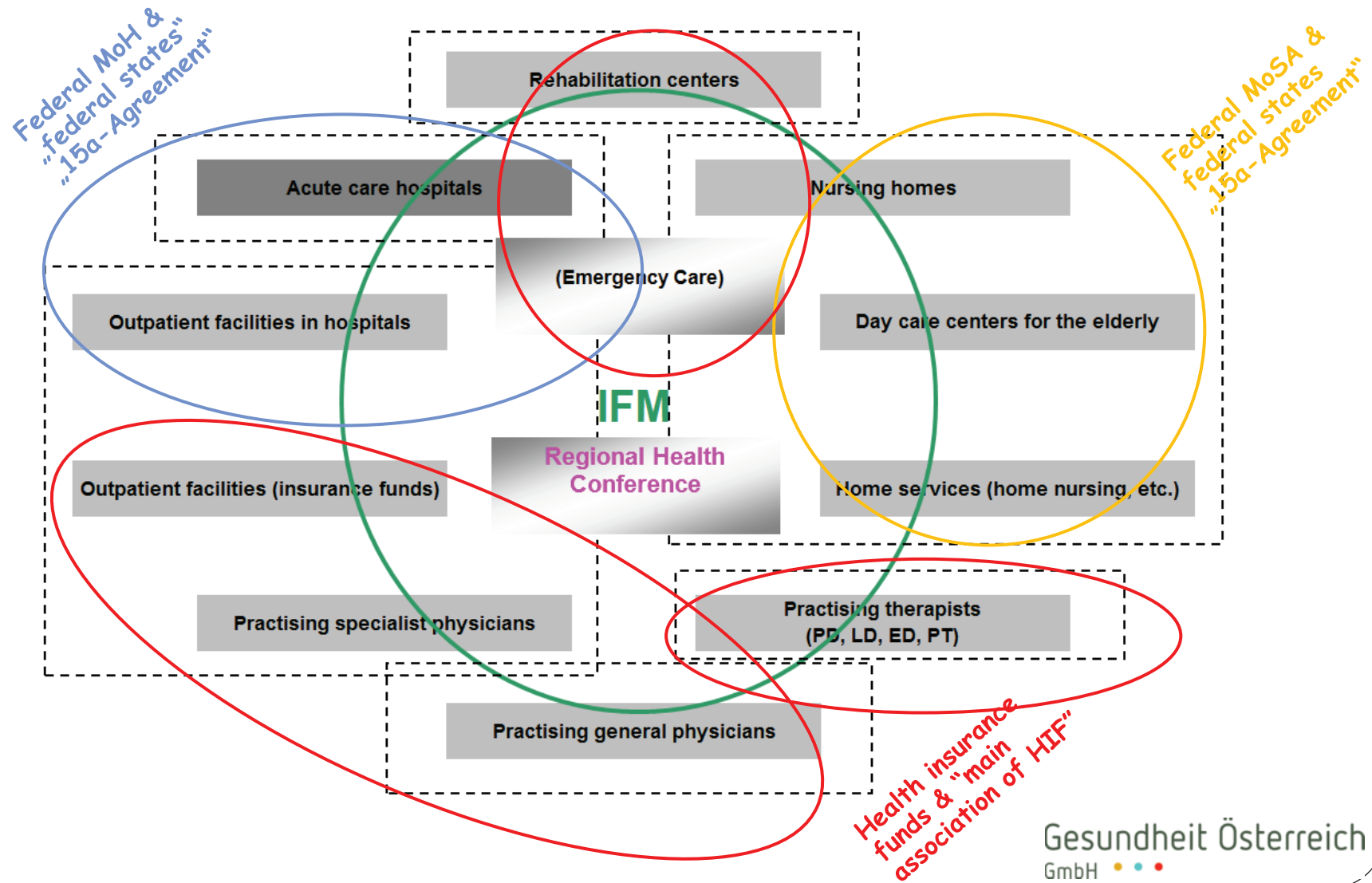
Austrian health reforms since the mid 90`s

- 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

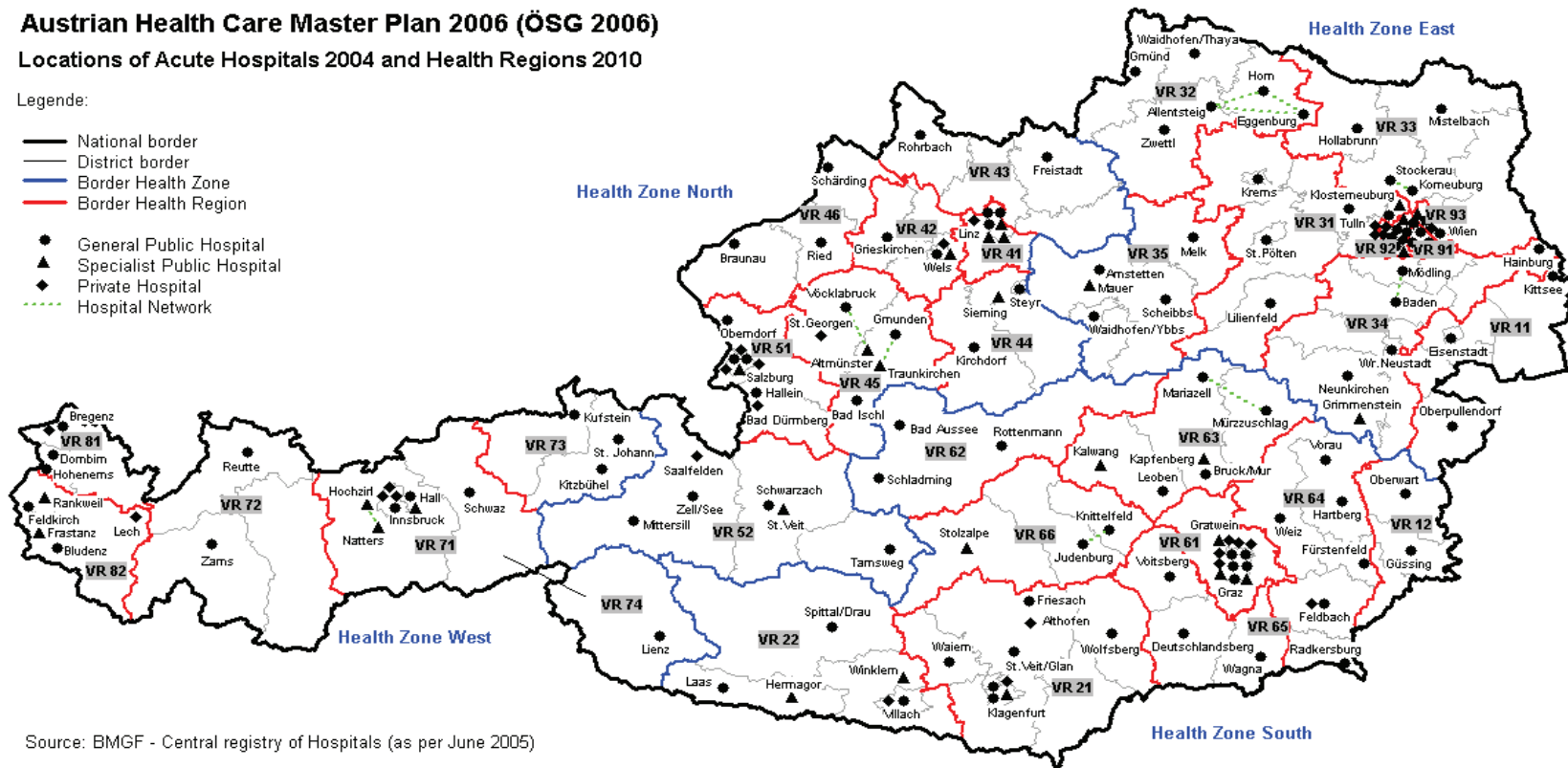
„Integrated Regional Health Care Planning“ based on **32 “HC Regions”** / **4 “HC Zones”**

Austrian Health Care Master Plan 2006 (ÖSG 2006)

Locations of Acute Hospitals 2004 and Health Regions 2010

Legende:

- National border
- District border
- Border Health Zone
- Border Health Region
- General Public Hospital
- ▲ Specialist Public Hospital
- ◆ Private Hospital
- Hospital Network



Source: BMGF - Central registry of Hospitals (as per June 2005)

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)

- $HBF(\text{year, specialty}) = (ALOS \times AD \times PoP) / (tOcc \times 365)$
 - 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

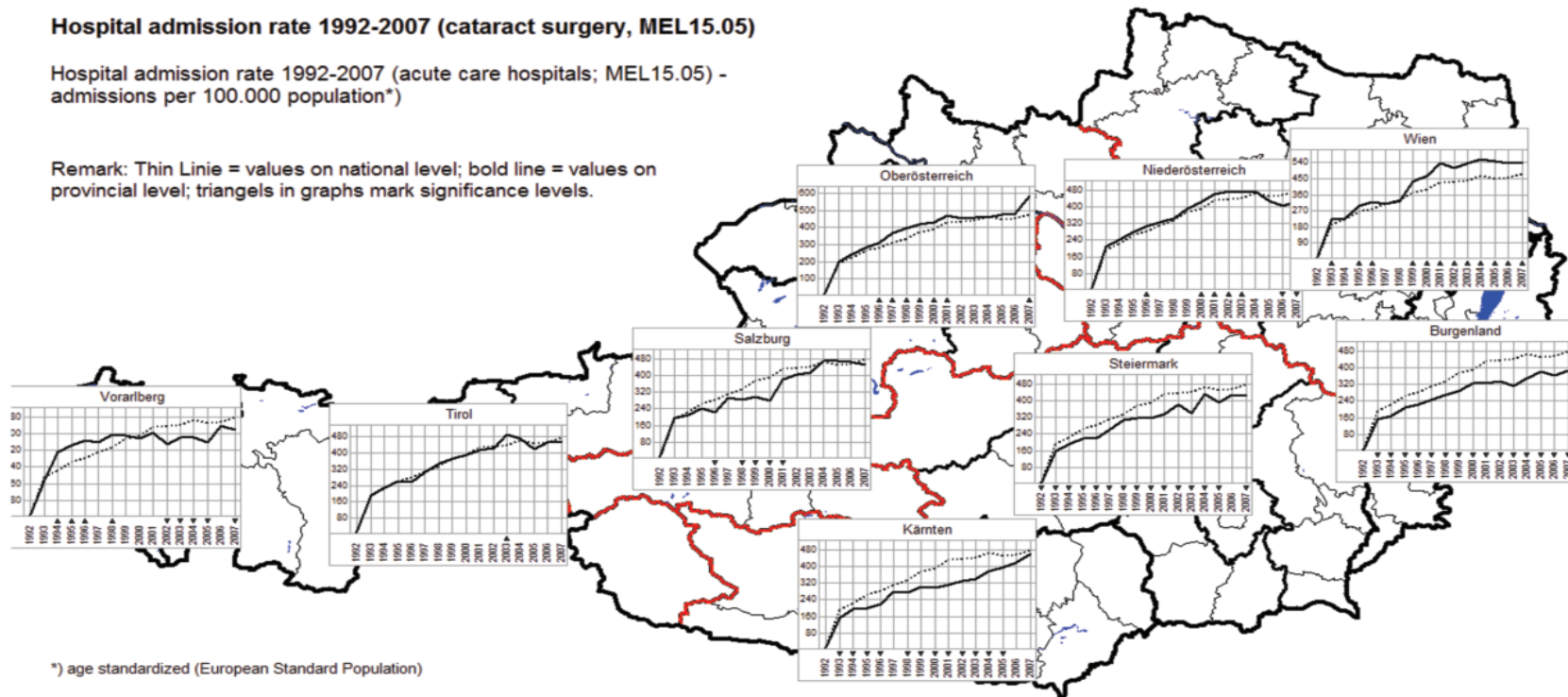
Austrian Health Information System (ÖGIS)



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 Linie = 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 feed-back 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. "Excess Capacity and Planning: Kain tortures Abel". Health Policy Monitor, April 2010. Available at <http://www.hpm.org/survey/at/a15/2>

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>