ABSTRACT

Focusing on key principles and objectives of the health care reform in Austria, financing, planning, and decision-making within the new structures are discussed. The executive body of the Styrian State Health Fund, the Health Platform, has diverse tasks. The Platform is supported by two advisory bodies, one preparing decision-making, the other - unique within the German speaking countries – consulting on women’s health issues. “Health Care” as a subject in the medical curriculum has been integrated in the course units of social medicine at the Medical University Graz. The subject focuses on social security issues and health care services. The extent of training, however, does not qualify medical students for management functions in health care.

Key words: Austria, Styria, health care, reform

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THE AUSTRIAN HEALTH CARE REFORM 2005 AND THE NEW STRUCTURES IN STYRIA

Health care in Austria is a public sector responsibility. Essentially, health care provision is regulated federally by law and lies within regional authorities’ responsibility, as health care is organized locally in each state.

In the last decades, the lack of coordination of service provision primarily concerning medical care, which has led to the neglect of health promotion and rehabilitation, was brought up in every public discussion on Austrian health care. There was a consensus on the importance of general access. This target in health care has been nearly met, with the exception of undocumented migrants. In Austria, compulsory health insurance covers 98% of the population. Reforms should therefore focus on reorientation, reorganization of the services, and sustainability of financing health care. An increase in life expectancy at birth and at later ages, the increasing number of chronic diseases, new technologies, as well as rising health care expenditures provide strong arguments for an urgent reform.

In Styria, the population comprises 1,182,003 people, 573,132 being males and 608,871 females (2001). The sex ratio in 2001 was 943 males per 1,000 females. Concerning age distribution, the percentage of people above 60 in 2001 was 18.4% (male 16%, female 20.6%). Life expectancy at birth (1999-2003) is 75.4 for males and 81.7 for females. Focusing on mortality and morbidity, heart and vascular diseases are the dominant chronic diseases. The health care budget amounted to 9.6% of the gross domestic product in 2004 corresponding to 23 billion Euros.

Initiating and organizing social and administrative changes Austria has a long-lasting tradition of a top-down strategy: the authorities are the main agents of change. Starting with the introduction of the “medical police” (medicinische Polizey) as a controlling body of population’s health; Johann Peter Frank first described this model of structuring public health via a top-down strategy (1, 2).

The above mentioned challenges to health care in Austria prompted the previous conservative government to pass legislation in 2004 with the objective of coordinating health services more adequately and more efficiently while also enhancing the quality of the health care services and securing financial resources for health care of the population.

The reform targeted the following objectives: centralising the coordination of health care planning and financing; improving integration of services, especially between inpatient and outpatient sectors; developing interfaces between in- and outpatient care, acute and long-term care, nursing and medical care, home care providers and outpatient services; coordinating services from health promotion to prevention, medical care and rehabilitation.

Centralising coordination of planning and financing in health care and preserving the autonomy of the states (Länder) as provided in the constitution, these new structures at federal and state levels were stipulated by the law. The legal entity at the federal level is now the Federal Health Agency (Bundesgesundheitsagentur), with the Federal Health Commission (Bundesgesundheitskommission) as its executive body. At the state level, the legal entities are the State Health Funds (Landesgesundheitsfonds), with the Health Platforms (Gesundheitsplattform) as their executive bodies. This article concentrates on these regional bodies, their members and their tasks.

The executive bodies of the Styrian Health Fund are the Styrian Health Platform, with its general management (Geschäftsstelle) headed by two executive directors (representing the regional health insurance and the State of Styria), and as an advisory board, the health conference: experts and actors in health care convening biannually. The first meeting was focused on women’s health issues, thus emphasising the importance the new health governor wished to express on these issues and resulting in the establishment of a women’s health advisory board within the Platform. The second conference held in March 2007 was focused on health targets for
Styria, starting their intended broad discussion with health actors.

The Styrian Health Platform consists of 21 members representing the regional government, the social health insurance, the federal authority, the physicians’ chamber, the local and regional communities, private and public hospital owners and a patients’ ombudsperson.

The State Health Platform has the following steering, controlling and financing responsibilities (Austrian Federal Law Gazette, BGBl I, No 73/2005) as agreed upon according to the Federal Constitution Article 15a regarding the organization and financing of the health care system (Styrian Health Fund Act, Austrian State Law Gazette, LGBl, No 6/2006): cooperating in implementation and monitoring of quality guidelines for provision of health services; budgeting public expenditure for inpatient and outpatient services; cooperating in planning and providing services; implementing performance-oriented reimbursement standards for all health care sectors based on appropriate documentation systems; analysing the developments in the Austrian health care system, with particular attention to gender-specific differentiation; interface management between various sectors of the health care system; cooperation in the health telematics sector, in market monitoring and price information; developing projects for health promotion; developing and implementing specific measures to shift health care provision from inpatient to outpatient services; realising models of good practice, integrating planning, implementation and financing of specialist medical care in hospital outpatient care and private practice; coordinated planning between (medical) health care and nursing.

These broad tasks are very challenging, encompassing documentation by gathering adequate data on quality assurance, the management of services, and the development of innovative good practice models. Organisational and management capacities need to be built, bodies installed, qualified staff taken in. Filling the gap between passing legislation and implementing it, both organisation and management will be a challenge to authorities, politicians, health insurance companies and interest groups. Negotiations and consensus-reaching between the various interest groups is a predominant issue in the Platform. Coordinating their health services is challenging for providers. Interest groups and beneficiaries of health services should be taken into account if empowerment and participation as guiding principles are to be taken seriously.

The Advisory Board of the Styrian Health Platform has been established. Its members are State representatives, representatives of the social health insurances (Austrian Federal Law Gazette, BGBl. I, No 73/2005), representatives of local and regional communities (2), and a representative of the physicians’ chamber (1). With the exception of the physicians’ chamber, these institutions are the financing bodies of health care in Austria, as well as in Styria. The physicians’ chamber is the only interest group represented in the Advisory Board.

The Health Governor of Styria entrusted the Women’s Health Center with the task of conceptualising an Advisory Board for the Styrian Health Platform on Women’s Health. It has been devised as an interprofessional board of health, gender and legal experts with eight members. Its task is to advise the Platform on women’s health issues. All proposals to the Platform are discussed in the Advisory Board, which formulates recommendations for the Platform. All proposals are thus gendered, outlining gender specific objectives, interventions, gendered evaluation indicators and controlling. It has been recommended that all bodies build up gender competent staff resources to enable women’s health specific projects aimed at improving women’s health in Styria. This advisory board is unique among German speaking countries.

This new Health Reform Act 2005 (Health Reform Act 2005, BGBl I No 179/2004) emphasises the importance of health promotion and the implementation of interfaces in the health care sectors. There is hope that this act will encourage institutions to carry out health promotion and the implementation of interfaces at a more signifi-
cantly level. Since only the Chamber of Physicians has been involved so far, to the neglect of other interest groups such as nurses’ associations, non-governmental organisations or self-help groups, other relevant interest groups have not been represented yet. Implementing gender specific aspects and women’s health care has been started.

As scientific research has recently confirmed, health is essentially gender-related, taking sex and gender into account is seen as a quality indicator for health care provision. This fact has major implications on health policies. Women are structurally disadvantaged in our society and have health needs different from those of men. To improve women’s health, action is needed on various levels. Structural changes have to be implemented at all planning and intervention levels for a sustainable development of women’s health. Both health politicians and decision-makers should consider women’s health as a cross-sectional issue. Public institutions and private providers will have to change their largely implicit and often traditional concepts of women’s health and modify their intervention strategies to meet the World Health Organisation’s targets (3). Individual, organizational and interventional strategies, as well as the promotion of women’s health research, are to be embraced by women’s health policy. It is vital that the work in all these areas should be undertaken concurrently.

PITFALLS AND CHALLENGES

For the purpose of health care reform in Styria, but also generally in Austria, a variety of policy instruments are being used: advisory boards and state health conferences focusing on various topics relevant for health care and health promotion in the region; compulsory regional health plans comprising all areas of care provision; service provision planning (Leistungsangebotsplanung) in accordance with the Austrian framework of the states defining their demand and supply in health care; and budgeting through the “Reformpool” (€ 150 million, 1% of the total budget for the inpatient and outpatient sector), with the intention of shifting health care from the inpatient to the outpatient sector by agreement between the State of Styria and the social insurance institutions both benefiting from these shifts. Traditionally Austria change is organised mostly from the top-down, so the Advisory Boards and the state health conferences are not yet centrally involved in decision-making processes. Taking into account that civil society will be developing continually in Austria, participatory policies will need strengthening as well. Advisory Boards will gain momentum and more power within this process.

Steering by means of the Styrian Health Plan (Regionaler Strukturplan Gesundheit/RSG), as well as service provision planning will be real challenges. The federal framework has mostly provided planning data on hospital care. Data on outpatient care and rehabilitation has so far been lacking. The methodological approach for regional service provision planning is not an easy task, particularly specifying service amounts (at all supply levels) in order to provide fair access to care, at the same time ensuring the efficient provision of effective services. The specifics will have to be negotiated between the regional authorities, the social health insurance, and the service providers.

The cooperation and budgeting instrument, the “Reformpool” has been designed to promote efficient allocation of funding to where it is most useful. It provides stakeholders with the opportunity to compensate for shifts in services which may arise, for example, by reducing inpatient capacities. Whether and in which way cooperation between financing agents and providers within the Health Platform will take place is too early to predict. Projects are often ambiguous, not yet concrete and only loosely address the main objective of this reform - facilitating the shift of service provision from inpatient care to the outpatient care sector or vice versa, as appropriate (4). A balanced division of service provision between inpatient and outpatient care may only occur if the Health Sector Master Plan (Österreichischer Strukturplan Gesundheit) is implemented and capacities are adequately assessed based
on current and future estimation of care needs in hospital facilities and outside.

Currently service provision in ambulatory care is largely financed and organised by social health insurance. The financing of hospital expenditures by the social health insurance is capped, restricted to a defined percentage whereas the rest is financed by the state and the federal level (4).

"HEALTH CARE" AS A SUBJECT IN THE MEDICAL CURRICULUM AT THE MEDICAL UNIVERSITY OF GRAZ

The subjects Health Care and Social Security™ are parts of the course Social Medicine. Social Security focuses on financing, structures and provision of care.

The subject Health Care Services includes the following topics: overview of the history of health care provision, the health care structure – inpatient, outpatient care and public health, the providers, mainly doctors, pharmacists and nurses, the contributions to health care, benefits, patients’ rights, and social networks supporting health (5).

These required subjects are taught in lectures. Both Health Care and Social Security encompass four teaching lessons of 45 minutes each. A written assessment is given at the end of the lecture period.

In addition, two elective courses with about 100 teaching hours focusing on management and health economics are offered once a year. Only twenty students are accepted per course. As compared with the total cohort of around 260 students, this is not as inclusive as one would want it to be.

Implementing new structures in health care provision is challenging, since management resources for steering and providing health care need to be built and gender competency enhanced. The new generation of medical doctors will not fulfill the needed professional qualifications, as their training does not encompass necessary management skills. At the moment, the three medical universities in Austria have no joint action in the area of management qualifications of their students. However, universities providing a great deal of continuing education programmes in management qualification. In Austria, certified management training is compulsory for chief physician personnel. Offering opportunities for other health professionals enhancing management qualifications generally in health care could be a solution, too (6).

REFERENCES