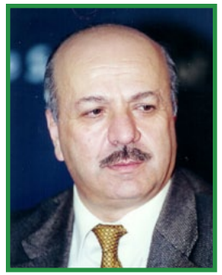
Healthcare in Austria: “Everyone Should Get the Opportunity for Medical Treatment in Austria”



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Summary

The Austrian health system provides universal coverage for a wide range of benefits and high-quality care. Free choice of providers and unrestricted access to all care levels are characteristic features of the system. Unsurprisingly, population satisfaction is well above EU average. The health-care system has been shaped by both the federal structure of the state and a tradition of delegating responsibilities to self-governing stakeholders. As in any health system, a number of challenges remain. The costs of the health-care system are well above the EU15 average, both in absolute terms and as a percentage of GDP. There are important structural imbalances in healthcare provision, with an oversized hospital sector and insufficient resources available for ambulatory care and preventive medicine.
Spending on preventive medicine, at 2% of total health spending, is significantly lower than the EU15 and OECD average (both 3%), and also shows a below-average rate of growth. Now, the focus is on health promotion and prevention in the “framework health goals” approved in 2012. This would be likely to improve the health of the Austrian population and would help to reduce costs associated with preventable diseases.

Background

The confederation of Austria is made up of nine regions (the Länder). Each region (Land), except the capital city, Vienna, is divided into districts (administrative regions), which are themselves divided into local authorities. The 8.4 million inhabitants of Austria are among the wealthiest in the EU, with a GDP per capita of about €35 800. The majority of the country is in the Alps and only a third of its landmass lies lower than 550 m above sea level. Like the rest of the Eurozone, the Austrian economy experienced a recession in 2009, from which it swiftly recovered in 2010 and 2011.
The Austrian health system has been shaped by three important institutional characteristics: (1) The constitutional make-up of the state with health-care responsibilities being shared between the federal level and the Länder; (2) a high degree of delegation of responsibility to self-governing bodies; and (3) a mixed model of financing, to which the state and social health insurance contribute almost equal shares.
Since 1980 life expectancy at birth has risen by 8 years, and in 2010 stood at 78 years for men and 83 years for women (above the EU27 averages of 75.3 and 81.7 respectively). Circulatory illnesses and cancer are the most common causes of death and together are responsible for more than two thirds of deaths. However, age-standardized mortality rates for circulatory illnesses, particularly ischaemic heart disease and cerebrovascular accidents (strokes) have fallen more than 40 per cent since 1995. In 2010 just under 70 per cent of all Austrians assessed their own state of health as “very good” or “good” (again somewhat higher than the EU average of 67%). Income-related inequality in states of health has increased since 2005, though it remains relatively low when compared internationally.

Organization and Governance of the Health-Care System

Almost all areas of the health-care system except inpatient care are constitutionally a federal responsibility, overseen by the Federal Ministry of Health assisted by a range of national institutions. However, in practice the Austrian health-care system is highly decentralized and involves multiple actors. It is characterized by regionalized provision within a regulatory framework determined at the federal level, delegation of statutory tasks to legally authorized stakeholders in civil society, and a wide degree of consensus required for decision-taking.
Implementation of health insurance and ambulatory care has been delegated to social security institutions, which are managed as self-governing bodies, brought together in a national Federation of Austrian Social Security Institutions (HVSV). The hospital sector is treated differently, with only the basics defined at federal level, the specifics of legislation and implementation being the responsibility of the Länder. There is an overall national structural plan for the health system (the ÖSG), which sets the parameters for regional and local provision. Planning in the Austrian health-care system is largely input-oriented. The medium-term goal for planning in the health sector is “needs-based planning”, where need is calculated according to morbidity statistics.

Ambulatory Care

In the ambulatory and rehabilitation sectors, as well as in the field of medication, health-care is organized through negotiations between the social security institutions and the Chambers of Physicians and Pharmacy Boards together with the representatives of other health-care professions. The annual collective contracts encompass payment regulations, service volumes, and a location-based capacity plan, which sets out the local distribution of contracted physicians and group practices.

Hospital Care

For hospital (inpatient) care, the Länder are obliged to provide sufficient facilities for their population. In principle, they do this in compliance with federal requirements and in cooperation with the social security institutions. However, there are only limited sanctions if Länder do not comply with federal requirements. Länder also license health-care providers (except independent physicians and group practices). The Federal Health Agency (BGA) is the central facility for supra-regional and cross-sector planning, governance and finance of the health-care system. The BGA also channels federal resources to nine regional health funds, which pool resources for the financing of inpatient care at the Länder level.

Governance

The Federal Health Agency’s governing body brings together a wide range of stakeholders, and decisions generally require agreement between the federal government, the Länder and the social security institutions. The regional funds similarly have a broad range of stakeholder involvement and require a broad consensus to make decisions; this is intended to improve cooperation between social security and the Länder, in order to make cross-sector improvements to care and to the health-care system as a whole.
Management of public hospitals is outsourced to private hospital management companies in every Land except Vienna. Church institutions are also important in the health system. In particular, there are numerous hospitals run by catholic orders or by the social welfare branch of the evangelical church, and these play an important role in supporting the severely ill and in providing palliative care.
Public health services (ÖGD) are generally coordinated and supervised at federal level but implementation is mostly delegated to local and Länder authorities, as well as social security institutions.

Financing

Total health expenditure in Austria in 2010 amounted to €31.4 billion or approximately €3750 per resident. It was higher than the EU15 average, at approximately 11% of GDP (the EU15 average is 10.6%). The proportion of public health expenditure (taxes and social insurance contributions) within that total expenditure was 77.5%, which is slightly above the EU15 average of 77.3%.
Social insurance funds are the largest source of finance, accounting for approximately 52% (€13.3 billion) of current health expenditure (though only 0.7% of long-

term care expenditure) in 2010. The federal level, Länder and local authorities covered approximately 24% (€6.1 billion) of expenditure on healthcare and 81% (€3.6 billion) of expenditure on long-term care. Debt has also been a significant source of financing in Länder. These debts have often been "outsourced" from Länder (the owners of hospitals) to hospital management companies. Consequently, the national growth and stability pact agreed in 2012 has had an important influence on hospital financing as hospital debts now had to be included in regional accounts. In 2009, the total debt of hospitals or their owners to the capital markets was approximately €3.3 billion, and had doubledsince 2006.

Insurance Coverage and Payments to Providers

Almost the entire population (99.9%) had health insurance coverage in 2011. Membership of a health insurance scheme is determined by place of residence and/or occupation, so there is no competition between funds. Social insurance contributions are determined at federal level by parliament. In recent years, they have been fixed at 7.65% of income for most of the population, but individualsearning more than €4110 per month do not have to pay contributions for income exceeding this threshold.Any person insured by a social insurance fund has a legal entitlement to a broad range of in-kind and financial benefits. The guiding principle behind the system is that the provision of treatment must be sufficient and appropriate, but should not exceed what is necessary.

Payment of providers differs depending on the source of financing and the type of provider. Public and non-profit hospitals providing statutory services receive a 'Diagnosis-Related Group' (DRG)-based budget from the regional health fund. Most health insurance funds pay for ambulatory services using a mixed payment system, combining flat-rate payments (per patient, per quarter–basic service compensation) and fee-for-service payments. The allocation of these payment elements varies by specialty and Land. While overall remuneration for staff within the public system is perceived as relatively low, income for GPs is around the average for OECD countries, and the income of specialist physicians is amongst the highest in the OECD (although behind that in Germany and the Netherlands).

Physical and Human Resources

The level of investment in health-care infrastructure is high by international standards. Also, compared to other OECD countries, the Austrian population enjoys above-average access to major medical-technical equipment, particularly in the area of computed tomography and magnetic resonance imaging.

There are around 270 hospitals in Austria, of which 178 provide acute inpatient care. One of the stated aims of Austrian health-care planning has been to reduce the number of hospital beds. Between 2000 and 2010, the average reduction in bed numbers across Austria was 10%, though with much variation between Länder. However, compared to the rest of the EU, bed numbers per head in Austria are still amongst the highest, though approximately level with Germany.

Use of information and communication technologies within the health-care system is generally good, though more so in hospitals than in the ambulatory sector. An electronic social insurance card was introduced throughout the country in 2005; piloting is underway to introduce an electronic health file. At 4.8 physicians per 1000 residents, Austria has the second highest physician-to-population ratio in the EU, after Greece. Austria trains an above-EU-average number of medical students, and (unusually for a west-European country) is a net exporter of physicians; there is concern within Austria about the potential risks from such migration. The number of nurses per 1000 residents, however, is slightly below the EU-27 average. This means that Switzerland, Germany and many northern European nations have significantly more healthcare staff overall per head.

Provision of Services

Although there is a national public health service (ÖGD), preventive activities are not well coordinated and both implementation and financing remain heavily fragmented. One example is vaccination: by the age of two, one-fifth of children have not had their standard vaccinations. Compared across the OECD, Austria's vaccination rate is very low at 74 per cent for measles and 83 per cent for pertussis (whooping cough).

In the ambulatory sector, patients can choose between single-doctor practices, hospital outpatient clinics, freestanding outpatient clinics and, since 2010, group practices of doctors; just under half of all active physicians in Austria work in independent practice. An exact division between primary care and secondary care is not possible, as hospital outpatient clinics also provide a lot of primary care. Treatment by specialist physicians is also available at individual practicesas well as at freestanding and hospital-based ambulatory clinics.

In 2011, patients consulted a general practitioner, specialist physician or other social security contracted service provider an average of 14 times. However, about 44% of independently practising physicians were not contracted to any health insurance fund. If patients go to one of these physicians, they have to pay the fee directly but will be reimbursed up to 80% of the fee that would havebeen paid to contracted physicians for equivalent services.

For inpatient care "standard" (basic secondary care services), and "specialist" (eg orthopaedic surgery) hospitals as well as highly developed "central" (full secondary and tertiary services, eg university) hospitals are available. Attempts have been made over many years to replace inpatient with ambulatory care, where appropriate. The main point of conflict in this process is how to compensate social security institutions for an increase in ambulatory care costs if inpatient care (the responsibility of the Länder) is scaled down. In general, the coordination of primary and secondary care as well as of acute and long-term care suffers from fragmented responsibilities.

Pharmaceuticals

The Federation of Austrian Social Security Institutions provides a positive list of pharmaceuticals, the so-called Reimbursement Codex (EKO). Of the approximately 9,800 permitted medications in Austria (variations in form and dosage counted separately, but not variations in pack size), around 4200 were contained in the reimbursement codex at the start of 2010. All insured patients in Austria have free access to any physician-prescribed medication listed in the reimbursement codex upon payment of a prescription fee (€5.15 in 2012). New patent-protected medications included in the reimbursement codex are not permitted to be above the average price for the EU; generics are subject tosubstantial compulsory price reductions.

Long-term care policy is rooted in the goals and values of the current social welfare model, where family responsibility for care of dependents comes before that of the state (principle of subsidiarity). A needs-oriented long-term care allowance enables people in need of long-term care to organize and direct their own care provision as required. Patients have a right to claim long-term care allowance payments irrespective of their income if care is expected to be needed for at least six months. At the end of 2010, 443 395 persons or almost 30% of the population above 65 received long-term care allowances. Up to three-quarters of all older people who require care are cared for chiefly by family members, 80% of whom are women; there is provision for financial support as well as respite care.

Principal Health Reforms

Health reforms between 2005 and 2012 can be ordered into the following broad thematic areas:

(1) Improvement in coordination and governance of the health-care system

(2) Securing financing for the health insurance funds and for long-term care

(3) Expansion of health insurance protection and limitation of financial burden

(4) Unification of responsibilities for medications and medical devices, opening up of the pharmaceutical market, slowing of growth in costs

(5) Other principal reforms concern the new scheme of group practices (Ärzte-GmbHs), promotion of care at home, the planned introduction of electronic health files, the expansion of quality assurance in hospitals, linking the amount of subsidy to hospitals from public budgets to a proportion of the total level of taxation income, expansion of prevention through screening measures, a National Nutrition Action Plan, a Children's Health Strategy and the development of framework health goals for Austria.

Conclusions

The history and structure of the Austrian health-care system has been shaped by both the federal structure of the state and a tradition of delegating responsibilities to self-governing stakeholders. On the one hand, this enables decentralized planning and governance, adjusted to local norms and preferences. On the other hand, it also leads to fragmentation of responsibilities and frequently results in inadequate coordination. For this reason, efforts have been made for several years (particularly following the 2005 health-care reform) to achieve more joint planning, governance and financing of the health-care system at the federal and regional level.

Together with health insurance, the tax system makes a considerable contribution to the financing of the Austrian health-care system. This mixed financing model ensures that the health-care system is financed in a way that is relatively fair through progressive taxation.

Efficiency may be improved by shifting inpatient care provision towards the ambulatory care sector. Also, continuity of care needs improvement, in particular for chronic diseases and improvements in preventive medicine.