Healthcare & Life Sciences - Austria

Ministry of Health proposes bill on healthcare reform

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Introduction

The Austrian healthcare system is characterised by the federal structure of the country, the delegation of competences to self-governing bodies in the social security system and cross-stakeholder structures at federal and provincial level, which possess competences in cooperative planning, coordination and financing. Whereas almost all areas of the healthcare system are primarily the regulatory responsibility of the federal authorities, in the hospital sector, the federal legislature is responsible for enacting only basic law. Legislation on implementation and enforcement is the responsibility of the nine federal provinces.

Public spending on healthcare is approximately €20 billion; this corresponds to approximately 7% of gross domestic product (GDP). Austrian healthcare expenditure appears above average in comparison with that of other EU member states. Hospitals that are listed in the hospitals plan of a federal province (ie, fund hospitals) are subject to public law and have a statutory requirement to provide care and admit patients. They are entitled to legally prescribed subsidies from public sources for investment, maintenance and operating costs. The ratio of six beds for each 1,000 persons is clearly above the EU average. Furthermore, the admission rate of 27.9 for each 100 inhabitants is one of the highest in the European Union.

In recent years the average annual growth of public healthcare expenditure was consistently above the nominal growth of GDP (5.2% as compared to 3.6%). The federal and provincial governments reached an agreement on the organisation and financing of healthcare in 2008 and the Federal Health Commission established a structure plan on healthcare that has been amended several times.

The Ministry of Health has produced a draft bill that aims to bring the growth of public health expenditure into line with the growth in GDP, so that the share of public health expenditure remains stable at approximately 7%.

Draft bill

According to the announcements, the bill intends to achieve cost containment through six measures:

- curative care at 'best point of service', in particular relief of the inpatient sector;
- enforcement of innovative outpatient care and development of existing possibilities for interdisciplinary cooperation in the outpatient sector;
- targeted health promotion and prevention, development of evidence-based early diagnosis and early intervention;
- nationwide workmanship on the levels of structure, process and result quality;
- establishment of a monitoring system; and
- effective and efficient application of medicines.

To achieve these aims, the Federal Health Commission (comprising representatives of the federal government, the provincial governments, the Fund of Social Security Institutions and various stakeholders) will:

- develop efficiency-oriented financing models for hospitals;
- establish financing guidelines;

- define health aims and indicators for monitoring; and
- develop a documentation and information system.

A federal steering committee will coordinate these various tasks, monitor the results and impose penalties to avoid double tracks in planning. The committee will also draft agreements between the federal government and the Fund of Social Security Institutions on a revolving basis, with a validity of four years each. The first of these agreements will apply as of June 30 2013. To implement these agreements at provincial level, the corresponding institutions (ie, healthcare platforms and provincial steering committees) must draft provincial agreements between the province and the local social security institutions. The first agreements will apply as of September 30 2013. The agreements will be based on the Structural Healthcare Plan and aim to:

- improve allocation of outpatient and inpatient facilities;
- improve comparability; and
- establish efficient quality control.

The bill also provides for the implementation of a joint commission on medicines for the inpatient and outpatient sector, in particular for recommendations for high-priced and specialised medicines. On the basis of the recommendations issued by this commission, the federal steering committee will be able to determine which high-priced and specialised medicines may be administered in which healthcare sector. The commission's recommendations must consider the 'best point of service' and the medical-therapeutic, health-economic and supply engineering aspects, in particular.

As a first step, the annual growth of public healthcare expenditure will be reduced to 3.6% until 2016. Thereafter, the annual growth will be capped at the average annual growth of GDP. Although the federal government and the provinces have already agreed on the values for the first period (ie, until 2016), an agreement on future periods has yet to be reached on a fair partnership basis.

The social security institutions must subsidise the provinces with €13 million a year for health promotion and prevention activities.

The commissions provided for by the draft are equally represented by the federal government, the provincial governments, the Fund of Social Security Institutions and various stakeholders (these include physicians, pharmacists and patients, but not industry members). Their decisions require a three-quarters majority. The aims defined in the revolving agreements will be monitored continuously and penalties will be imposed where appropriate. The penalties provided for by the bill include public reports and the setting of a final deadline to achieve the aims. In case of non-compliance, each party to the agreement may seek the decision of an arbitration commission (also equally represented by the stakeholders), which may decide by a simple majority.

Comment

In theory, the draft bill is well suited to achieve the aim of cost containment. However, in practice, its results are likely to be limited. The composition of the commissions is such that the 'payers' (ie, federal government and social security) have only a simple majority over the 'spenders' (ie, provinces, municipalities, hospitals and doctors). Therefore, the three-quarters majority required for resolutions on the aspired aims on cost containment will be unachievable for measures that affect local interests. Furthermore, non-compliance will be enforceable only once an agreement has been reached, because the arbitration commission may decide by simple majority.

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