Republic of Austria

Answer to the questionnaire on Health and Long-Term Care for the Elderly

(Document SPC/2002/APR/01 DE/Rev. 1)

Access

1.1 Health care

1.1.1 Mechanisms for guaranteeing access

In Austria the provision of health care services to the population and the management of the health care system are considered to be primarily responsibilities of the state. The state-managed health care system has the task of providing health care services accessible to the whole population and evenly distributed over the Austrian territory. In Austria these services are provided by public, private non-profit and private organisations and individuals.

Austria has a well-functioning health care system with qualitatively and quantitatively adequate facilities. An important element characterising the quality of the Austrian health care system is the fact that all persons insured have access to adequate health care services.

A strategic policy paper of the Austrian federal government lays down the principles that basically all persons have equal access to all medical services in conformity with professionally defined quality standards and that services are not allotted based on specific criteria, such as age, gender, income, social status, religion and the like.

In view of this general consensus among the Austrian population, all reforms of the health care system do not only aim at guaranteeing the financial viability of the health care system but also strive to maintain the unrestricted access to any form of necessary medical services.

The core of this system is the **social health insurance,** which is based on **compulsory insurance**. 99% of the Austrian population are insured under this system. All persons employed in Austria, their dependants but also the unemployed and retired are covered by this compulsory insurance. In Austria a policy of balancing risks based on a concept of social solidarity is pursued, which implies the redistribution of wealth (e.g. from the rich to the poor) and consequently contributes to the eradication of poverty.

The social health insurance benefits are predominantly financed through insurance contributions. The contributors are employees covered by compulsory insurance,

their employers paying 50% of the total contribution as well as the insured self-employed (farmers, other persons carrying on a trade or business in their own name and for their own account, the liberal professions). Affiliation to a social health insurance institution cannot be selected freely (compulsory insurance) but is dependent on the profession exercised. The rates of contribution range from 3.55% and 3.95% of the gross income up the maximum basis for contribution assessment per employee and employer.

The social health insurance system covers all benefits relating to medical treatment; they are not limited in any way. The social health insurance is organised on the basis of the **principle of in-kind benefits** (but also offers cash benefits, e.g. sickness benefits). Specific health services require co-payments by the insured, e.g. charge for health insurance tickets (€ 3.63 per quarter), prescription charge (€ 4.14 per medication), contribution to the cost of hospital care (€ 7.6 per day; € 12.—for dependants) and charge for outpatient treatment by hospitals (between € 10.90 and € 18.17, up to a maximum of € 72.67 annually). Self-employed persons, civil servants and farmers have to pay 20% of the cost of benefits in kind themselves.

To ensure the social compatibility of the system of co-payments, persons with a low income (current threshold € 630.92 for single persons, € 900.13 for married couples/cohabitees) or persons who furnish evidence of extraordinary expenditure due to sickness are in general exempted from prescription charge and consequently all other co-payments (principle of guaranteeing social protection to the needy).

1.1.2 Assessment

As mentioned under 1.1.1., the compulsory insurance system provides free access to both inpatient and outpatient health care services. For persons not covered by health insurance protection, the costs are borne by the social assistance system ("Sozialhilfe") of the *Länder* governments. Asylum seekers who qualified for the Welfare Programme for Asylum Seekers ("Bundesbetreuung") of the federal government are covered by health insurance. In Austria there are no long waiting lists, problems or unequal treatment of specific groups with regard to medical care.

1.1.3 Challenges
1.1.4 Planned policy changes

The federal government (incl. social health insurance) and the *Länder* governments – the main responsible players in the health system – conclude so-called "Agreements pursuant to Art. 15a B-VG (Federal Constitutional Law)", i.e. a kind of "state agreements", at regular intervals. In the most recent Agreement the parties pledged that also in the future a high-quality, effective, efficient and universally accessible health care system free from inequalities will be guaranteed in Austria. Another objective is to analyse and promote the entire health system as well as specific sectors at a supraregional level in line with the demographic trends and requirements and by taking into account the different conditions in the *Länder* of Austria (see 3.1.3.).

Since 1997 accessibility of all areas of inpatient acute care in public and private non-profit hospitals has been guaranteed in particular by mandatory provisions included in the **Austrian Hospital and Major Equipment Plan** (*Österreichischer*

*Krankenanstalten- und Großgeräteplan **(ÖKAP/GGP)***. This plan lays down hospital locations, specialist structures and the number of beds per hospital, the number of beds per specialisation and *Land*, the number and type of large medico-technical equipment as well as locations and capacities for selected medical services. Therefore this plan is also a tool for ensuring the structural quality of hospitals and of the hospital network. It is updated/revised at regular intervals and gradually developed into a service-provision plan (*Leistungsangebotsplan*, see 2.1.1.). In the current version of the 2001 ÖKAP/GGP some sectors were already planned by applying the new planning strategy.

The subject of free access of the population to the health system and the regional health services is also addressed in the " **2001 – 2003 National Action Plan against Poverty and Social Exclusion**". In chapter 1.2.3. ("Health Care and Long-Term Care") an even regional distribution of access to health care services is established as an objective due to a varying density of supply with doctors on the federal territory (urban/rural disparities). By realising this goal, unimpeded access to health care services will be enhanced.

Since 1 August 2001 health care services may be provided by so-called "group practices", i.e. several doctors specialised in the same or different branches of medicine are located on the same premises. These group practices offer patients the advantage of longer opening hours and/or the possibility of undergoing different treatments at the same place. This is considered another important step towards improving the supply with medical services and facilitating access to them. Furthermore, in this context mention should be made of the fact that the law requires such group practices to ensure accessibility to the disabled in accordance with ÖNORM standards ("barrier-free access").

The "e-card" shall be introduced nationwide in 2004. This chip card will put an end to about 42 million health insurance tickets annually. This does not only mean a reduction of the administrative burden (of enterprises, the social insurance institutions and doctors) but also facilitates access of the insured to doctors.

1.2 Long-term care

1.2.1 Access to long-term care

On 1 July 1993 a new and comprehensive system of long-term care became effective in Austria, closing the last gap in the national social protection system.

Before the Federal Long-Term Care Allowance Act [**Bundespflegegeldgesetz (BPGG)**] and the 9 corresponding **Long-Term Care Allowance Acts of the *Länder*** entered into force, numerous cash benefits were granted in cases of long-term care. These cash benefits varied considerably both in terms of amounts and eligibility criteria. In most cases the cash benefits did not respond to the concrete needs. As a result, people heavily depending on care services provided by others and the severely disabled did not receive adequate care. This was particularly true for the major part of the social insurance system, under which no less than approximately 235,000 persons were entitled to a supplementary pay due their need for long-term care ("Hilflosenzuschuss") in 1993.

When **the long-term care system** was subject to **reform**, about 10% of the dependent persons were taken care of in homes for the elderly and nursing homes. Between 80% and 85% of the demand for care was met by family members or other private care providers, while social service institutions accounted only for a minor percentage. Therefore the reform of the long-term care system first of all introduced a uniform nationwide care allowance and secondly focused on improving the offer of social service institutions.

With the entering into force of the **Federal Long-Term Care Allowance Act,** a needs-based care allowance system comprising seven levels was introduced. People have a legal claim to this allowance regardless of their income, personal assets and the cause of their long-term care requirements. This care allowance replaces the care-related cash benefits existing prior to 1 July 1993. The Care Allowance Acts of the *Länder* cover persons not entitled to benefits under the BPGG. These care allowances of the *Länder* are of the same amount and granted by applying the same criteria as the BPGG.

In accordance with the **Long-Term Care Agreement,** the *Länder* agreed to adopt legislation based on uniform principles and objectives. The required harmonisation of the care allowance legislation particularly refers to the levels, needs-orientation and amounts, eligibility regardless of income and personal assets as well as legal enforceability.

The following principles are applied in legislation on long-term care allowances:

- All groups of people who are disabled and in need of long-term care, i.e. the elderly but also physically and mentally disabled people and handicapped children, are eligible under the long-term care allowance acts.
- The benefits are based on principles of finality. Equal benefits are provided for equal need for care, irrespective of the cause of this need for long-term care.
- The care allowance is calculated on the basis of the actual need. The concrete requirements of care and assistance will exclusively determine the amount of care allowance.
- This care allowance aims at covering care-related additional expenses and takes the form of a single lump-sum payment.
- The care allowance aims at improving the options of those affected for a self-determined life, e.g. by remaining in their familiar environment.
- People affected have a legal claim to care allowance.
- The competent courts for legal disputes, which are social law cases by nature, are the courts for labour, social security and related matters.
- The care allowance is granted irrespective of the income and personal assets.
- The care allowance expenditure is borne by the federal government and the *Länder* in the framework of the responsibilities delegated to them under the Constitutional Law.
- The care allowance is basically financed from the general budget.

The care allowance is paid 12 times a year; the following table shows the 7 care allowance levels and the respective number of recipients (see also Annex 1):

	Amount in €	Amount in ATS	Recipients under the Federal Act	Share	Recipients under the *Länder* Acts	Share
Level 1	145.40	2,000.-	54,164	19.36%	9,608	18.76%
Level 2	268.00	3,688.-	104,398	37.31%	15,602	30.47%
Level 3	413.50	5,690.-	47,709	17.05%	10,601	20.70%
Level 4	620.30	8,535.-	41,512	14.84%	6,516	12.72%
Level 5	842.40	11,591.-	21,825	7.80%	4,579	8.94%
Level 6	1,148.70	15,806.-	6,204	2.22%	2,866	5.60%
Level 7	1,531.50	21,074.-	4,000	1.43%	1,440	2.81%
Total			**!Syntax Error,)**	**!Syntax Error,)**	**!Syntax Error,)**	**!Syntax Error,)**

State: federal government data April 2002, *Länder* data December 2000
Source: Main Association of the Austrian Social Insurance Institutions, Report of the Working Group on Long-Term Care, 2000

The amount of time spent on care services is the decisive criterion for the levels 1 – 4. It is determined on the basis of a medical expert opinion. To qualify for the levels 5 – 7, an additional criterion has to be met. The care allowance is a contribution to care-related additional expenses that takes the form of a lump-sum payment. Therefore the actual costs of care incurred in the individual case are not taken into account in assigning the level.

The specific provisions regarding the assessment of the need of care are laid down in the **Ordinance on Care Allowance Levels pursuant to the Federal Care Allowance Act** ("**Einstufungsverordnung zum BPGG" [EinstV])**. This ordinance defines "care" and "assistance" and the time allotted to individual tasks, e.g. dressing and undressing, care of the body, preparation of food, feeding as well as mobility assistance.

The ordinance (EinstV) also stipulates that decisions regarding the care allowance level have to be based on a **medical expert opinion.** In individual cases it may be necessary to consult other health professionals (e.g. nurses) to ensure a comprehensive evaluation of the care requirements. Expert opinions are usually based on medial examinations during house calls.

The ordinance (EinstV) takes account of the **specific requirements of persons with mental or psychic disabilities:** Guidance and supervision is equated with care and assistance and a specific amount of time spent on motivating the disabled person is recognised as well.

The Austrian care allowance system covers all persons in need of care, i.e. elderly people requiring care (the largest group), handicapped children, physically,

psychically and mentally handicapped people. As a rule the care allowance level is assigned based on the functional disablement. The minimum levels laid down in the law for persons with high-grade impairment of sight, blind persons, deaf and blind persons as well persons predominantly using wheelchairs to be able to manage their lives independently have the purpose of guaranteeing that the care-relevant needs of these persons are satisfied.

To improve the **situation of family members providing care,** with effect 1 January 1998 a preferential scheme for continued old-age insurance was created for persons who provide care to close relatives receiving level 5, 6 or 7 allowances and who therefore had to give up gainful employment. These care providers were given preferential treatment by financing the fictitious employer's contribution from the federal budget. Thus they have to pay a contribution of only 10.25% of the basis for contribution assessment (instead of 22.8%).
With effect of 1 January 2001, this preferential treatment was also given to family members providing care to recipients of level 4 allowances. With effect of 1 September 2002 the preferential treatment will also include level 3 allowances.

The position of care providers within the family was strengthened by an additional measure. The reform of the scheme of **non-contributory co-insurance in the health insurance,** which took effect on 1 January 2001, ensures that family members receiving a care allowance of at least level 4 or family members providing care to insured persons entitled to care allowance of at least level 4 continue to be co-insured without having to pay contributions.

Since January 1998 the Federal Ministry for Social Security and Generations has offered a **counselling service for care providers**. This service addresses all private care providers and all persons affected by care-related problems. This counselling service was conceived as an information platform and guidance centre providing assistance to those seeking advice. In addition, information is provided in brochures and on the Internet. The **database "Handynet-Österreich"** serves as an Internet information pool about technical aids and organisations for people with handicaps.

The legislation regarding the long-term care system is adjusted on an ongoing basis to practical experience and the relevant court rulings.

The long-time care system is a **combination of cash benefits and benefits in kind**. First of all, a uniform care allowance was introduced throughout Austria. The second main innovation was the **enhancement of social services**, a task which falls within the purview of the *Länder.*
In the Agreement pursuant to Art. 15a of the Federal Constitutional Law (B-VG) concluded between the federal government and the *Länder* on measures for persons requiring care the *Länder* undertook to ensure that decentralised community, semi-institutional and institutional services will be established/enhanced throughout the entire Austrian territory. For this purpose a **catalogue of services and quality criteria** for social services was included in the Agreement. The *Länder* are also responsible for interlinking the services offered at the organisational level and guaranteeing information and counselling.
The objectives of the system are as follows:

- Persons in need of care should have a **free choice** between the services offered.

- The improvement of the **community long-term care system** has to take clear priority over institutional facilities.
- The **nursing homes** should be small, decentralised and integrated in residential communities.
- The establishment of new nursing structures has to contribute to **reducing the strain on the family members providing care**. The range of assistance offered is of crucial importance (e.g. daily care, short-term care, care during holidays).

The individual **laws on social assistance of the *Länder*** do not only cover assistance to secure daily needs and aid in specific situations but also **social services**. Social service organisations aim at providing assistance in managing social problems regularly occurring in the entire population in specific situations and which cannot be solved (only) by material aid. The main forms of social services are home help, home nursing service, family help, meals on wheels services, counselling services, measures to enhance social contacts and participation in the cultural life as well as homes for the elderly and nursing homes. These services are provided in the *Länder* of Austria by entities established under private law. Hence, there is no legal claim to these measures.

The above-mentioned Agreement stipulates that the persons in need of care may be requested to make **contributions to the cost** of the care services but that social aspects have to be taken into consideration in assessing the share to be borne by them.

These social services will never be able to replace care within the family but they are an indispensable means to reduce the strain on and to support **care providers within the family.**

In their study analysing the effects of the long-term care system Badelt et al. looked into the question how many care allowance recipients make use of social services (see Annex 1: “Care Allowance Recipients and the **Use of Social Services**“).
A total of 56% of the persons surveyed make use of one or several services (47% use services in their own homes and 22% use services outside). About one third of all care allowance recipients can now use more social services than before the introduction of the care allowance. The use of services depends mainly on the care allowance level, the total income of the person in need of care (income plus care allowance) and the existing range of services.

The 2000 Report of the Working Group on Long-term Care states that an increasing tendency of using **out-patient services** has been recorded since 1993 (see Annex 1: “**Community Services** from 1993 – 2000“).

1.2.2 Assessment

Since services are offered above all at the regional/local level, significant **differences between the individual *Länder*** may be recorded. While there has been a long-standing tradition of providing social services in some *Länder*, e.g. in Vorarlberg and Vienna, regional gaps in the coverage with care services have to be closed in others, e.g. in Carinthia and Burgenland (see Annex “Use of Social Services in the Individual *Länder*”).

Waiting periods for admission to a nursing home - the example of the *Land* Vienna:

For a direct transfer from a hospital to institutional care the average waiting period is 2 months. Before admission to a care facility, the patient is provided care in the hospital.

In 2001 the waiting periods for transfers to institutional care facilities of persons previously using community care services were as follows: 41% of the persons were admitted immediately or within 7 days after applying for admission, 59% of the persons had to wait between 8 and 90 days.

According to the information provided by private care institutions, admission to private institutional care facilities involves a waiting period between 14 days and 6 months.

1.2.3 Challenges

In the study of Badelt et.al. on the **analysis of the effects of the long-term care system** the question was asked: “Do you need more help than you currently receive?” One fourth of the persons answered “yes”. Very frequently the need for services for accompanying the persons affected to participate in social activities and to medical-therapeutic institutions was expressed. 12% of the respondents answered the question why no social services were used by stating that no such services were offered in their proximity. For 16% of the care allowance recipients the social services offered were too expensive. Other problems criticised by many respondents were frequent staff changes, lacking flexibility and organisational rigidities.

The study of Badelt et.al. confirmed that the situation of the persons in need of care and their care providers had considerably been improved by the care allowance acts and accompanying measures. Nevertheless, there are still **problems** in the overall long-term care system which were not solved by introducing the care allowance. The most pressing needs are more far-reaching social protection and support of the care providers, measures to make gainful employment and informal care services more compatible as well as to enhance and achieve a better integration of social services.

1.2.4 Planned policy changes

In conformity with the above-mentioned Agreement, the **range of social services offered in all *Länder* is widened.** To realise this goal, long-term planning is necessary. To this end, the *Länder* prepared demand and development plans between 1996 and 1998. Gradual implementation will be completed by the year 2010. The *Länder* adjust their planning to current developments on an ongoing basis. Since the medium term of the planning horizon has been reached, an **interim evaluation of the progress made** based on the demand and development plans of the *Länder* will be prepared in 2002/2003. The aim of this evaluation is to identify and systematically assess the implementation steps taken in the *Länder* and the respective results. Hence, it will also be possible to appraise the effects of the Agreement.

2 Quality

2.1 Health care

2.1.1 Standards

In the context of developing the **Austrian Hospital and Major Equipment Plan** (see also 1.1.3/1.1.4) into a service-provision plan, structural quality criteria were developed for inpatient acute care in hospitals financed through public resources from the funds of the nine *Länder.* These public general and specialised hospitals and the private non-profit general hospitals are referred to as “fund hospitals”. Based on the concept of **service-provision planning,** the quality of the services provided is contingent on the structural quality and the performance volume. Service-provision planning means a step forward from the traditional approach of planning the number of beds towards capacity planning (turnover, length of occupancy). Moreover, the planning recommendations are more quality-oriented. The aspect of quality is integrated into planning by defining structural quality criteria and a performance spectrum graded by specialisation. The structural criteria basically comprise definitions regarding staff size and qualifications as well as infrastructural requirements. Partly they also define minimum turnover ratios required in terms of quality assurance and/or the necessary range of services offered.

To date **structural quality criteria** have been developed for intensive care, selected expensive and resource-intensive health services (e.g. cardiosurgery, transplantation surgery) and for fledgling forms of health care (e.g. palliative medicine, psychosomatic medicine). Moreover, additional intramural care levels have been defined on the basis of structural quality criteria to achieve a graduation of care levels (e.g. full departments, minor departments, day clinics), and their location is laid down in the plan. Corresponding to the graduated care levels graduated performance spectra were laid down for selected areas of specialised medicine.

The above structural quality criteria and graduated performance spectra for specialised medicine were defined and adopted by the Structural Commission (*Strukturkommission*) on behalf of the federal government and the *Länder* in 2001. To some extent their application has already become mandatory, while an agreement has to be reached on some specific details regarding their implementation still in 2002. The Austrian Hospital and Major Equipment Plan 2001 (version 1 January 2002), including the structural quality criteria and graduated performance spectra for specialised medicine is available on the homepage of the Federal Ministry for Social Security and Generations (www.bmsg.gv.at).

With regard to the **process quality standards,** the federal government focuses on implementing benchmarking projects in the framework of its quality strategy. These projects are subject to scientific project management monitoring and involve a maximum number of professionals of the practice. The participation of local cooperation partners is a sine qua non to ensure the recognition and acceptance of the best practice tools proposed and to guarantee and promote their sustainable use in practice. The benchmarking projects aim at developing best practice tools on the one hand and their sustainable use throughout Austria on the other hand. Benchmarking projects were inter alia implemented with regard to patient-orientation, interface management (admission to and discharge from hospital), OP organisation,

cooperation between internal service providers in hospitals and wards with beds as well as the optimised administration of antibiotics and avoidance of nosocomial infections in hospitals. Guides and quality instruments were developed for many projects. They were published as brochures and made available to the players of the practice (see 2.1.5.4: List of Brochures of the Structural Commission and the Federal Ministry for Social Security and Generations). These activities are an important contribution to the development of standards and guidelines in defined areas.

The assessment of the **quality of results** is considered the most difficult task. In this context, the Federal Ministry for Social Security and Generations supported pilot projects, such as the participation of Austrian hospitals in the international "Quality Indicator Project" of the Maryland Hospital Association/USA and the study "Quality of Results in Hospitals" (see 2.1.5.4 : List of Brochures of the Structural Commission and the Federal Ministry for Social Security and Generations). According to the plans of the Federal Ministry for Social Security and Generations, these activities will be continued at the national level and the exchange of experience will be intensified at the international level.

The Main Association of Austrian Social Insurance Institutions, acting as a self-governing entity, and the Austrian Medical Association (Österreichische Ärztekammer) and its specialists' associations were responsible for developing the standards for the **extramural sector.** These requirements include clinical standards, provisions regarding the cost-effective prescription of medication and therapeutic aids as well as structural criteria (opening hours of practices, etc.). An amended act, which recently took effect, stipulates that the Austrian Medical Association has to develop quality standards regarding practising doctors.

The patients' rights were defined in the Hospital Act (see Annex 2).

2.1.2 Assessment

The quality of care provided by practising doctors and inpatient facilities is currently not measured and assessed in accreditation procedures. Certification in accordance with recognised quality management models (ISO, EFQM, etc.) is voluntary. The federal government is committed to disseminate and promote knowledge about the different quality management instruments but has not made these procedures a mandatory requirement.

As parties to the Agreement pursuant to Art. 15a B-VG, the federal government and the *Länder* agreed with regard to the inpatient acute care provided by the Fund Hospitals to develop the **Austrian Hospital and Major Equipment Plan** into a service-provision plan. In this context mandatory structural quality criteria and graduated performance spectra for specialised medicine are laid down, which will be issued as guidelines by the Structural Commission (regarding the status quo see 2.1.1). This is a **binding commitment** by the relevant political forces to **support** the development, regular evaluation and updating of structural quality criteria.

As far as process quality criteria are concerned, the federal government currently considers voluntary participation appropriate to ensure that the **benchmarking projects** will meet with universal acceptance and to raise awareness of quality in practical everyday life.

Furthermore, the **medical officers of health** conduct checks in health facilities in the framework of the **public sanitary inspection scheme** by increasingly applying uniform procedures throughout Austria.

The quality of health care provided by doctors in their own **practices** is ensured by professional supervision of the Austrian Medical Association (de facto by means of clinical standards laid down in medical-clinical guidelines of the specialists' associations) and by organisational standards issued by the Main Association of the Social Insurance Institutions (opening hours, cost-effective prescription of medication and medical devices).

2.1.3 Promoting quality enhancements

The **efficient cooperation of all relevant players** (service providers, fund providers, patients, administration) is indispensable for promoting the quality of health services. These key players have to be convinced of the common objective of enhanced quality. An important step towards joint action is the general promotion of quality awareness in health institutions.

In this context a **legal-organisational framework** providing defined objectives and creating binding requirements is helpful. The necessary steps were taken under the Agreement pursuant to Art. 15a B-VG, in which the federal government and the *Länder* agreed on an article on quality stipulating that jointly adopted quality initiatives will be organised for the entire term of the Agreement pursuant to Art. 15a B-VG (period 2001 - 2004).

An important pillar with a view to implementing a quality system is the promotion and support of those **professionals** ultimately providing health services *in situ*. For this reason it is highly important to ensure that the staff is involved as intensively as possible in implementing quality projects. It is hardly possible to pursue quality enhancement strategies in health institutions against the will of the staff.

A second important pillar in implementing quality strategies consists in **raising the awareness of patients** since the increased empowerment of patients may considerably support convalescence. To promote this idea, the federal government commissioned a project titled "Co-Production by Empowerment – Quality Improvements with Regard to the Care of Patients and Postoperative Convalescence in Surgery" (see 2.1.5.4 : List of Projects).

It is important to **involve the providers of funds** in quality programmes since the long-term target may not only consist in cutting health budgets and in launching excessive austerity programmes but in developing instruments combining quality-related efficacy and cost-efficiency requirements in a beneficial way.

Transparency is another key element promoting the establishment of a quality system. The federal government therefore assumed the responsibility of financing the introduction of a specific information platform on quality management in the health sector: The "forumQat" (www.forumQ.at) aims at providing information about projects and activities, advanced training courses and events in the area of quality management to all players. Transparency is also ensured by plans dealing with the

implementation of a comprehensive quality reporting system. In the medium term all relevant players are to receive an annual “federal quality report” (based on the quality reports of the *Länder*). Moreover, in the framework of the sanitary inspection scheme the governments of the *Länder* submit reports to the federal government on an ongoing basis.

2.1.4 Challenges

One of the quality-related challenges is the necessity to combine quality and economic efficiency in an advantageous way. Carefully planned activities in the quality area may cause higher costs in the short run but will have positive effects on the budgets of those funding health care in the medium and long run. Therefore quality management and other aspects of the health system will necessarily overlap. The **Agreement pursuant to 15a B-VG** adopted by the federal government and the *Länder* responds to these general challenges by defining the key action fields for the term of the agreement (2001-2004) as follows:

- developing the Austrian Hospital and Major Equipment Plan into a service-provision plan
- improvement and further development of the system of performance-related hospital financing (similar to a diagnosis-related group [DRG] system)
- introduction of a quality system throughout Austria
- improvement of the interface management
- increased use of new information technologies and adoption of a law on health telematics

The establishment of a nationwide quality system is an important pillar of the overall strategy under the Agreement pursuant to Art. 15a B-VG.

In addition to its quality-based mandate derived from the Agreement pursuant to Art. 15a B-VG, the Federal Ministry for Social Security and Generations will place emphasis on quality-related aspects in the area of medical care and nursing in hospitals. The focus is on developing

- an antibiotics culture (optimisation of the use of antibiotics),
- a fault culture (“no blame culture“ in the event of undesired results),
- a strategy to avoid and observe nosocomial infections,
- a palliative culture (by making relevant training and advanced training programmes for the health professions a mandatory requirement under the applicable legislation as well as by implementing the structural quality criteria defined in the Austrian hospital plan in palliative medicine),
- a state-of-the-art inspection system for medical officers of health.

Another future task area consists in developing concepts for the **empowerment of patients**. In addition to laying down patients’ rights in the Hospital Act (see Annex 2) and establishing the patients’ ombudsman, a patients’ charter was defined. Moreover, self-help groups have strengthened their position over the last years by founding an umbrella organisation, which permits them to promote their interests

more efficiently. Based on previous projects successfully concluded, the federal government initiated a multi-annual quality project titled “Patient-Orientation in Hospitals“ (see 2.1.5.4: List of Projects).

2.1.5 Planned policy changes – quality strategy of the Austrian federal government in the health sector

2.1.5.1 Introduction

In Austria, like in all other Western European countries, increasing importance has been attached to the concept of quality over the last years.

The basic principles of the quality strategy of the federal government are patient-orientation, transparency in terms of systematic further development and economic efficiency.

In this context, quality work is not perceived to be in contradiction to economic efficiency. A good quality of performance means that the resources are used effectively, i.e. a high degree of goal performance is achieved. Action based on economic efficiency implies that a service is performed efficiently, i.e. guarantees the optimum input-output relation. Each individual strategy has to aim at developing innovative instruments and good procedures to ensure that both principles are combined.

2.1.5.2. Chronology of the quality strategy in the Austrian health sector and institutional framework

In Austria, like in most European countries, it became necessary to formulate objectives and implementation strategies with regard to quality assurance in the 90s. These measures were a consequence of the changed quality awareness of the population, the shortage of resources, fiercer competition and greater competitive pressure.

The more exacting requirements were taken into account in the 1993 **amendment of the Federal Hospital Act (Bundes-Krankenanstaltengesetz)**. In essence, the amendment laid down patients’ rights (see Annex 2), increased the competencies of the hospital hygienists and included a special paragraph on quality assurance in hospitals. The aim of this amendment was to incorporate quality assurance at the institutional level in Austrian hospitals.

The next step to promote the development of the health system consisted in strengthening the quality pillar under the **Agreement pursuant to Article 15a B-VG on the reform of the health sector and hospital financing (1997 - 2000)** concluded between the federal government and the *Länder*. Based on this Agreement, a so-called Structural Commission was set up at the federal level, in which the key partners of the Austrian health sector are represented. Since then, quality assurance has been a task of the Structural Commission explicitly mentioned in the Agreement.

The Austrian Hospital and Major Equipment Plan (ÖKAP/GGP) was another integral part of this Agreement. In accordance with the Agreement, the system of performance-related hospital financing (*Leistungsorientierte Krankenanstaltenfinanzierung, LKF*) – similar to the DRG system – was introduced throughout Austria with effect 1 January 1997. Both instruments have made an important contribution to quality work all over Austria. By transforming the ÖKAP/GGP into a service-provision plan, the structural quality of Austrian hospitals is to be guaranteed and improved. The LKF-system has been crucial to improving the quality of documentation and thus the transparency of performance in Austrian hospitals.

The most recent and most important step in the field of institutional development was the conclusion of **another four-year Agreement pursuant to Article 15a B-VG on the restructuring of the health sector and hospital financing from 2001 to 2004** (see homepage of the Federal Ministry for Social Security and Generations: www.bmsg.gv.at). This new Agreement stipulates that the ÖKAP/GGP has to be revised and the LKF-system has to be continued and further developed. Since it includes a more comprehensive article on quality, attention is focused on the significance of quality in the health sector. Moreover, the federal government and *Länder* agreed to cooperate in key areas, such as health telematics and interface management (two areas which are a sine qua non for effective quality work).

As experience has shown, quality work in a strict sense does not only require the incorporation of this concept at the institutional level but makes it indispensable to define quality targets at the federal level, the necessary activities and concrete projects in more detail. Therefore, **Article 6 of the current Agreement** provides a comprehensive definition of the **subject of quality**:

(1) In order to guarantee and improve the quality of the Austrian health sector throughout the federal territory, systematic quality work in the health sector has to be intensified. For this purpose an **Austria-wide quality system** has to be developed, implemented, regularly evaluated and further developed based on the unanimous consent of the parties to the Agreement. This quality system has to be founded on the principles of patient-orientation, transparency, efficiency and cost control.

(2) The parties to the Agreement represented in the Structural Commission have to **define uniform principles throughout Austria** and lay down by unanimous consent and with binding force **requirements regarding implementation procedures** as well as a time schedule for implementation. The Structural Commission is in particular responsible for ensuring that the necessary measures will be taken with respect to:
    1. information and quality reporting,
    2. promotion measures and incentive mechanisms,
    3. guidelines, directives and standards,
    4. quality measuring and quality evaluation (ongoing standardised quality monitoring),
    5. quality-oriented interface management.

(3) During the term of the Agreement particularly **projects in the below areas have to be supported** and subject to ongoing economic evaluation:

1. improvement of the quality of patient referral, admission and discharge,
2. development of best-practice models,
3. quality measures in blood management,
4. appropriate use of medicines taking account of aggregate economic factors,
5. infections/hygiene in hospitals,
6. development of treatment paths and minimum standards,
7. scientific documentation of health services,
8. quality of results in the intramural and extramural areas,
9. interface management,
10. health telematics,
11. quality of documentation,
12. structural quality criteria for service-provision planning.

(4) A **mechanism of sanctions** has to be established. It will be applied if the structural requirements agreed by unanimous consent and with binding force by the parties to the Agreement and the framework conditions for ensuring systematic quality work are not fulfilled.

In addition to its mandate under the Agreement pursuant to Art. 15a B-VG, the Federal Ministry for Social Security and Generations focuses on quality-related aspects and activities in the area of medical care. The main objectives is to develop an antibiotics culture (optimisation of the antibiotics use) and a fault culture ("no blame culture" in the event of undesired results), to formulate a strategy to avoid and monitor nosocomial infections and to develop a palliative culture. Palliative care is a relatively new medical discipline and has been gaining increasing importance in medical care. The aim is to make the palliative culture a central element of quality work in inpatient and outpatient care. With regard to promoting the palliative culture, the federal government considers it imperative to make training and advanced training programmes for the health professions an integral part of the relevant legislation and to implement the structural quality criteria defined in the hospital plan in palliative medicine.

The training and advanced training of medical officers of health is considered crucial to empower and qualify them to conduct hospital inspections in the framework of the public sanitary inspection scheme. This should facilitate the development of a state-of-the-art inspection system in health institutions.

A specific working group on "quality in the health sector" supported by external experts was set up in the framework of the annual Austrian health conference.

As the above description shows, in the beginning health-specific quality initiatives of the federal government were predominantly launched in the inpatient (hospital) sector. Due to the independent financing of this sector, quality assurance in the extramural area (established practices of doctors) was considered to fall within the purview of the social security institutions and the Austrian Medical Association acting as a self-governing entity as well as its specialists' associations. However, all players involved have become aware of the need for more coordination between the intramural and the extramural sectors in the last years. In the context of improving the interface management, increasing efforts are made to apply the catalogue of diagnoses and services of the inpatient sector to outpatient hospital departments. Subsequently, a comparable methodology should be used for doctors' practices.

An important step towards enhanced quality standards for doctors' practices was recently taken by enacting legislation according to which the Austrian Medical Association has to develop quality standards for practices and – once the Main Association of the Social Insurance Institutions exercised its right of examination – to submit them for approval to the Federal Minister of Social Security and Generations.

2.1.5.3 Main activities at the international level

At the international level, Austria made quality assurance a centre of activity during its EU presidency in 1998. The diverging quality strategies in the health sector of the EU Member States and the activities of the European Commission were discussed for the first time at an expert meeting and a conference at the level of health ministers. The results of these talks were made available to the international public in a publication (see 2.1.5.4 List of Brochures "Quality in the Health Sector"). To gain in-depth knowledge about the health systems of the candidate countries, a study was commissioned in 1999, which used an analogous approach to analyse the importance attributed to quality policy in the health sector of the candidate countries. This study was also published (see 2.1.5.4 List of Brochures).

At the international level Austria will be faced with the challenge of participating in quality initiatives of international organisations with existing resources and to integrate the results appropriately into national activities. One of the tasks of Austria is to answer and further develop this questionnaire of the European Commission. In addition, the federal government agreed with the OECD to participate in working groups on the development of quality indicators in the framework of the multi-annual "OECD Health Project". Furthermore, the Federal Ministry maintains contacts with WHO bodies analysing the quality strategies of the member states. By way of conclusion, it should be stated that it seems imperative to coordinate the activities of the various international players dealing with quality work in the health sector. This would certainly facilitate the participation of the member states.

2.1.5.4 Quality-related activities and projects as well as publications of the Federal Ministry for Social Security and Generations

The Federal Ministry for Social Security and Generations proactively promoted quality-related project work and activities even before concluding the recent Agreement pursuant to Article 15a B-VG. In implementing the projects it was considered highly important to involve key players and professional groups from the practice to ensure maximum acceptance and practical relevance of the project results.

A specific quality logo was developed to present the intensified quality-related efforts of the Federal Ministry for Social Security and Generations to an interested public. This logo has been printed on all relevant publications of the Ministry since 2001.

Projects/activities concluded:

- antibiotics strategy (ABS) project in hospitals with bed wards
- antibiotics strategy (ABS) project: implementation counselling in 5 hospitals
- co-production by empowerment: quality improvements in patient care and postoperative convalescence in surgery

- pilot project: measuring the quality of results in hospitals
- evaluation of quality-assurance measures in hospitals
- development of a guide on quality assurance
- development of a guide on patient-orientation
- quality in hospitals
- national quality-assurance institutions in the health sector of selected countries, conference of the EU health ministers: quality in the health sectors – opportunities and limits of cooperation at the EU level to achieve a high level of health protection in the Member States
- quality policy in the health sector of the candidate countries, drafting of a directive on quality assurance in microbiological diagnostics
- the Austrian Hospital and Major Equipment Plan (ÖKAP/GGP) as an instrument of structural quality assurance
- programmatic definition of structural quality criteria and graduated performance spectra of specialised medicine in the framework of the ÖKAP/GGP

Ongoing projects/activities:

- checklists for hospital inspection by public authorities
- DDD project regarding antibiotics recording in hospitals with bed wards
- evaluation of the antibiotics (ABS) strategy in hospitals 2001/2002
- preliminary study: evaluation of quality-assurance measures in independent outpatient clinics
- forumQ.at
- organisation and strategy of hospital hygiene – “Pro-Hyg“
- MRSA questionnaires in hospitals with bed wards
- Austrian Network of Health-Promoting Hospitals
- patient-orientation in Austrian hospitals
- pilot project regarding the establishment of an Austria-wide quality reporting system
- quality indicator project
- revision of the Austrian Hospital and Major Equipment Plan (ÖKAP/GGP) as of 1 January 2003
- definition of the methods for implementing the structural quality criteria and graduated performance spectra of specialised medicine previously defined in the framework of the ÖKAP/GGP

Planned projects/activities:

- measures to reduce the blood transfusion rate in Austrian hospitals
- 2nd evaluation of quality-assurance measures in hospitals in 2002/2003
- optimisation of the use of medication in Austrian hospitals
- improvement of the interface management between outpatient and inpatient care
- implementation counselling regarding the antibiotics strategy in 30 hospitals from 2002 - 2004
- revision and re-issuing the quality assurance guide
- development of the Austrian Hospital and Major Equipment Plan into a comprehensive service-provision plan, including the evaluation and updating of structural quality criteria and graduated performance spectra for

specialised medicine as well as extending the range of care services and areas covered by the plan

The following brochures of the Structural Commission/Federal Ministry for Social Security and Generations were published in the past years:

- Quality Assurance Guide (1995) in German, English and French
- Patient-Orientation Guide (1998) in German, English and French
- Guidelines regarding the Promotion of the Antibiotics Culture in Hospitals (1998) German, English
- Quality in the Health Sector (1998) in German, English and French
- Interface Management – Medical Services (2001)
- Hospital Admission and Discharge Management (2001)
- OP Organisation (2001)
- Patient-Oriented Ward Organisation (2001)
- Measuring the Quality of Results in Hospitals (2001)
- Quality Policy in the EU Candidate Countries (2001) in English, German
- Guidelines "Standardisation and Quality Assurance in Microbiological Laboratory Diagnostics" 2001 Microbiology
- Checklist "Inspection of Hospital Hygiene" 2000 for medical officers of health (www.dgs.at/krankenhaus)
- Austrian Hospital and Major Equipment Plan (ÖKAP/GGP) 2001, version of 1 January 2002, incl. structural quality criteria and graduated performance spectra for specialised medicine (www.gesundheit.bmsg.gv.at)

2.2 Long-term care

2.2.1 Standards

The *Länder* assumed the responsibility for adequate **professional quality assurance and control of social services**. If the *Länder* do not perform the respective services themselves they have to ensure that performance by other providers fulfils all quality and demand requirements and is based on the principles of suitability and operational efficiency.

Annex A of the Article 15a-Agreement between the federal government and the *Länder* defines the **minimum standards** social services have to meet. Regarding the **community service sector** attention is drawn to the following aspects:

- free choice among the services offered
- a comprehensive and integrated range of services and interconnection of services
- availability on Sundays and holidays
- quality assurance and control by the *Länder*

Minimum standards are defined for the **institutional sector** as well. In particular the following requirements are listed:

- small, manageable homes

- integration of homes into the community
- minimum equipment of rooms
- minimum offer of rooms and services
- unlimited visiting time
- free choice of doctor
- legal protection of the residents of homes
- enacting of legislation on supervision by the *Länder*

In the meantime most provincial governments adopted legislation on the supervision of homes for the elderly and nursing homes, guaranteeing inter alia the **legal protection of residents**.

2.2.2 Monitoring and promoting quality

Although the experience of the last years has shown that the care provided is of high quality, also within families, and that there is only a small number of cases of inadequate care, data regarding the **status quo and quality of care** in Austria were collected and evaluated in a 6-months pilot project commissioned by the Federal Ministry for Labour, Health and Social Affairs.

In the framework of this pilot project, de-personalised data of care allowance recipients provided by the decision makers of the federal government were gathered for the period 1 September 1996 to 28 February 1997. For the purpose of this survey a form was developed, which doctors had to fill in during medical examinations for issuing their expert opinions.

With this form data regarding the following subjects were gathered:

- personal data
- proposed assignation of care allowance level
- living situation
- care situation
- use of professional services
- quality of domestic care

As regards data on the quality of care, only care within the family was subject to **evaluation**. In 96.6% of all cases adequate care was provided and only 3.4% were found to be inadequate.

A specific section **of the Federal Long-term Care Allowance Act** was dedicated to **quality assurance**, which took effect on 1 July 2001, to ensure that more importance will be attached to this area in the future. For this purpose the decision makers will inter alia be able to take measures to intensify quality assurance. Checks on the quality of care in the form of house visits will be an important instrument. However these house visits will not be limited to checking the care provided. Equal importance will be attached to offering the persons involved in the actual care information and counselling on this occasion. In this spirit the planned house visits are intended to provide support to the care providers within families.

Since **social services** fall within the purview of the individual *Länder***,** there is no uniform and binding definition of quality and quality assurance regarding social services.

The requirements of persons in need of care cannot be met unless there is sufficient **staff providing care**. The federal government and the *Länder* therefore agreed to improve the working and training conditions of staff and to make work and the family life for professional care providers more compatible.

The federal government is responsible for legislation regarding the professional activity description and the training of **nursing staff** holding diplomas and the **nursing support staff**. The federal government is also competent for enacting provisions regarding training facilities qualifying as a "school" in accordance with Art. 14 B-VG (e.g. special schools for the social professions in accordance with the School Organisation Act or schools for health care and nursing in accordance with the Health Care and Nursing Act). Legislation regarding the professional activity description and the training of **care providers to the elderly**, **family helps** and **home helps** falls however within the purview of the *Länder*. To date, four *Länder* have adopted laws in this area.

2.2.3 Challenges

Currently there are numerous problems in the context of the **nursing/care professions**:

- Legislation on training programmes and professional activity descriptions lacks uniformity, is incoherent and overlapping. In some *Länder* these areas are not covered by legal provisions.
- The narrow definitions of the activities and powers are problematic in daily work, above all between medical and non-medical professions.
- Mutual recognition of training is possible only in countries with the appropriate legislation.

2.2.4 Planned policy changes

In cooperation with the Austrian Federal Health Institute (Österreichisches Bundesinstitut für Gesundheitswesen/ÖBIG) as well as two pension insurance institutions (in their capacity as decision makers), the Federal Ministry for Social Security and Generations carried out **another pilot project** to transpose the legal measures.

In the framework of this project conducted in the beginning of 2002, about 1,000 care allowance recipients of the two pension insurance institutions were counselled during house visits by care professionals. The aim of this project was to gather data about the concrete status quo of care and care deficits and to provide care-related information and counselling.

The results of the house visits were entered in standardised forms, summarised in a report and subject to evaluation by the Federal Ministry for Social Security and Generations and the ÖBIG. The aim is to apply this procedure on a large scale if this pilot project proves successful and a feasible method to carry out the statutory mandate of quality assurance.

In 2001 a working group on "**professional activity descriptions and training in health care and the care of the handicapped"** was set up under the lead of the Federal Ministry for Social Security and Generations. It was tasked with developing a uniform, graded and modular system of training programmes and professional activity descriptions for the care of the elderly and of handicapped persons. The objective is to arrive at an agreement between the federal government and the *Länder*, which lays down the central elements of this system. Details on the implementation would then be defined in laws of the *Länder*.

3 Sustainability

3.1 Health care

3.1.1 Expenditure and financing

The design of the Austrian health system (in particular the concepts of social protection and freedom of choice within a wide range of health services) as well as the high quality of health services is reflected in the expenditure on health care.

In Austria there is a general consensus on "mixed financing". About half of the expenditure on the health sector in Austria is financed from health insurance contributions, about one fifth is raised by tax receipts and about one fourth by private households (incl. private health insurance).

In 2000 the health expenditure amounted to € 16.487 billion. The share of the health expenditure in the gross domestic product is an important indicator for health expenditure comparisons. In 2000 the share of the health expenditure in the GDP was 8.0%. The public health expenditure was approximately 5.6% of the GDP.

The trend of the health expenditure between 1995 and 2000 is shown in the Annex 3.

3.1.2 Expenditure trends

As the table "Health Expenditure Trends" in the Annex shows, the **public health expenditure** declined below the 70% threshold of the entire health expenditure in 2000. The public per capita health expenditure increased by 1% in 1999 and 2.5% in 2000, (basis 1995) and thus considerably less than the economic performance. In the same period the real per capita expenditure increased continuously and significantly faster than the GDP. After the health expenditure quota has constantly corresponded to approximately 8% of the BIP since 1997, the dynamic analysis of the expenditure shows a **shift of the financing burden,** a trend that has already been noticeable in the last years.

The health expenditure of the **public and private households** has increased significantly over the last decades and consumes an ever increasing share of the aggregate income. This upward tendency of the health expenditure is due to the medico-technical progress and the demographic development.

In the framework of the EU project "**Forecasting the Effects of Ageing on Health Expenditure in Austria**" the public health expenditure was assessed based on the following assumptions:

Public health expenditure on acute care:

The public health expenditure stated in this report is made up by the expenditure of the public hospitals, the expenditure of the health insurance institutions on medical assistance and medications. In total these three expenditure categories amounted to 4.9% of the GDP in 2000. As mentioned under 3.1.1., the public health expenditure stood at 5.6% of the GDP in the same period. This difference results from expenditure items for which no data on age distribution are available (see Annex 4: Public Health Expenditure).

Depending on the demographic development assumed, the public health expenditure is expected to increase to 6.40% / 5.97% / 6.65% of the GDP until the year 2050. The gap between the three demographic models computed will widen only in about twenty years; until then the three models show a relatively similar trend. Since the scenario assuming a *numerous population* is based on higher fertility and increased immigration, the share of the elderly is not as significant as in the other two scenarios. Therefore the share of the elderly in the GDP is rising less sharply and the health expenditure is borne by a greater number of gainfully employed persons: in relation to the GDP the health expenditure seems to be lower than in scenarios assuming smaller rates of immigration or fertility.

The forecasts are based on the assumption that public health expenditure will be subject to the same estimated price increases as the overall economy. In the above forecast the price increases in the health sector correspond to the per capita GDP growth. This is a rather conservative assumption since in the past in most countries more significant price increases were observed in the health sector than in the overall economy. However there are signs that the statistically recorded price increases in the health sector are systematically overestimated since quality increases are considered only inadequately. Since this forecast focuses on the trend of expenditure, it is only of minor relevance if these expenditure increases are paralleled by qualitative performance improvements. A priori it is not clear whether in the future the health sector will record an exponential upsurge in prices similar to that in the past. Since efforts to control price hikes can be observed in almost all countries, price increases are likely to be less pronounced in the future than in the past.

Health services are used by more older than younger people. Currently the percentage of the health costs spent on the age group 80+ is two and a half times higher than the share of this group in the population (see below table). The age group 0-64 corresponds to 84% of the population and consumes 61% of the health resources.

Age groups and their share in the health expenditure, 2000

Age group	Percentage of population	Percentage of expenditure
0 to 64	84%	61%
65 to 79	12%	28%
80+	4%	11%
Total	100%	100%

Source: IHS HealthEcon 2002.

In other words, currently 3 percentage points of the 4.9% health expenditure correspond to the age group below 65 and only approximately half a percentage point of the GDP to the age group 80+. In line with the changes in the population structure, the relative weight of the expenditure will shift between the age groups: Based on the assumption of a constant age-expenditure profile and the demographic trend underlying the main scenario, in 2050 2.7% of the GDP will still be spent on the age group below 65 and no less than 1.6% of the GDP on the age group 80+. Therefore the increase of the public health expenditure from 4.9% of the GDP to 6.4% is not only the result of the growth of the two older age groups but also sets off the (small) decrease of expenditure on the age group 0-64 (see Chart in the Annex 4: Distribution of the Public Health Expenditure).

3.1.3 Cost control mechanisms

Due to challenges in the area of health policy combined with sustainable consolidation efforts, the sector of health and social affairs is a continuous target of reform.

Austria is pursuing the approach of “improving the existing” and aims at strengthening the health sector by making maximum use of efficiency potentials and coordinating the health care supply, without calling into question the principle of social solidarity.

At the beginning of 1997 a comprehensive reform of the health sector took effect, which was based on the political principles of equal access to health services, a health insurance system founded on social solidarity, mixed financing from insurance contributions and general taxes as well as the public provision of health services.

Since 1997 the federal government and the *Länder* have regularly concluded agreements, in which they express their intention to guarantee a high-quality, effective, efficient, universally accessible and undiscriminating health care system in Austria and to ensure the financial viability of the Austrian health sector by taking into account the financial framework conditions and possible cost savings. Another aim is to continuously analyse and promote the entire health system and its individual branches on a supraregional basis in line with the demographic trends and demands and by giving consideration to the different conditions in the *Länder*. For this purpose, the parties to the Agreement undertake to devote their best efforts to meet the following objectives (including the intramural and extramural areas):

- to achieve an integrated, coordinated planning in all areas of the health sector,
- to introduce a mandatory quality system aiming at efficiency gains in the Austrian health sector,
- to create the necessary conditions for an effective and efficient use of information technologies in the health sector,
- to improve the interface management by mandatory cooperation procedures among the health providers, and
- to develop the Austrian Hospital and Major Equipment Plan into a service-provision plan.

In 1997 the financing system of the public and private non-profit hospitals was reformed. The new **system of performance-related hospital financing** (LKF) is based on lump sum payments on a case-by-case basis and provides the necessary framework for ensuring that the segment of the health sector with the highest expenditure is subject to general budgetary control and integrating all providers of funds of the health sector. The establishment of the so-called "*Länder Fund*" (a financing fund) implies the restructuring of financial flows, decision-making procedures and incentives for the biggest sector of the health system, i.e. the hospital sector. The combined system of budgeting and performance-based accounting aims at enhancing the transparency of services and expenditure in the hospital sector. As experience shows, this target has been met. As all governmental units and the health insurance institutions are affected by the changeover of the financing system due to the possible activation of consultation and sanction mechanisms, the hospital sector is subject to a global budgetary control in each *Land*.

In the wake of establishing the Financing Fund for Private Hospitals in 2001, private hospitals also changed over to an accounting system based on the performance-related hospital financing system.

Since the introduction of the LKF-system the average length of bed occupancy in public hospitals recorded further decreases. The trend towards more efficiency in providing services and curbing the increases in costs has continued also in the last years.

Another cornerstone of this Agreement is the **Austrian Hospital and Major Equipment Plan:** it provides for the restructuring of a number of hospitals and defines future-oriented health care mandates (with the year 2005 as a planning horizon). To adjust hospital provision to the needs of an increasing number of elderly people, the parties agreed to ensure a nationwide supply of facilities for **acute geriatrics and remobilisation** in acute hospitals. This will be done by changing the designated use of existing bed capacities by 2005. The objective is to remobilise older patients to avoid the necessity of permanent care. Furthermore **palliative care units** are being established in acute hospitals to provide care to the terminally ill and dying. Due to the high incidence of acute apoplectic fits recorded in Austria, hospitals are provided with an increasing number of **stroke units**.

In spring 2001 another measure was taken to reduce the burden on the inpatient sector. One reason for introducing a "contribution to outpatient clinical treatment" was to induce patients to use the services provided by the extramural sector instead of outpatient hospital departments. Redirecting patient flows to the extramural sector is justified both by medical reasons and overall economic goals.

3.1.4 Challenges

A major challenge is the tense **financial situation of the social health insurance system**, which is due to the declining wage increase (to which the contribution revenue is linked) on the one hand and the progress of medicine and the demographic development on the other hand.

In 2001 the social health insurance system recorded receipts amounting to € 10.3 billion and an expenditure of € 10.4 billion. This results in a balance of € - 148.6 million. A clearly negative result is forecast also for the year 2002.

To consolidate the social health insurance system, measures regarding the income (e.g. stepping up the receipts by a general increase of insurance contributions, increased co-payments by the patients) and targeted at the expenditure (e.g. by cutting the cost of pharmaceutical products) are considered.

While the rate of contribution to the social health insurance has not been increased, in the past years various co-payments have been introduced to control the costs (e.g. for cures and rehabilitation, charge for health insurance tickets, increases of prescription charges, contribution for outpatient hospital treatment). Exemptions are granted to persons in need of specific social protection (see 1.1.1). Furthermore, the health insurance contributions of old-age pensioners were slightly increased.

With effect 1 January 2003, the equalisation fund of the health insurance institutions will be restructured to ensure a more effective system of financial transfers among the health insurance funds.

To cut the cost of pharmaceutical products, the prices and margins (wholesale margin and pharmacy margin) were decreased and agreements on mechanisms to control the cost of medications were concluded with the medical associations. Furthermore, the Austrian social insurance system was subject to a legal obligation of taking cost control measures in administration.

3.1.5 Planned policy changes

The policy changes introduced into the Austrian health sector in the past years reflect an important motivation to reform the health sector, i.e. to take preventive measures to relieve the cost pressure resulting from an ageing population. This will make it possible to cover the additional financial burden caused by an ageing population partly by efficiency gains.

In view of the demographic change of our society, the transdisciplinary **working group "The Elderly in Austria"** was set up in the framework of the Austrian health conference. It is developing proposals for innovations, changes and reforms in the health and social system regarding the supply of services to the elderly, which may be put directly into practice. A concrete set of measures with regard to the "interface management between the outpatient and inpatient sector for the chronically ill and people very advanced in years" has already been prepared.

In the framework of the annual Austrian health conference the working group **"Health Economics and Financing"** was set up, in which external experts participate.

It should be stressed once more that the necessary structural adjustments have already been initiated by taking the measures described under 3.1.3. These far-reaching structural measures ensure that the system will keep pace with medical progress and will increasingly be tailored to patients' needs. Moreover, they will make it possible to achieve efficiency gains in the Austrian health care system also in the next years.

3.2 Long-term care

3.2.1 Expenditure and financing

The **care allowance** is an **independent social benefit**. The care allowance is not a benefit under the statutory social insurance system, especially since it is not financed through contributions of the insured but from the budgets of the federal government and the *Länder.*

The below table shows the **expenditure of the federal government** for benefits in accordance with the Federal Long-Term Care Allowance Act in 2001:

Sector	Expenditure 2001 (in € million)	Expenditure 2001 (in ATS million)
Social insurance system	1,289.9	17,750
Federal Old-Age Pension Authority	40.6	559
Austrian Railways	44.5	613
Austrian Mail Services	26.4	363
Federal Welfare Agencies	12.1	166
Benefits to victims of the NS regime ("Opferfürsorge")	0.8	11
Teachers employed by the *Länder*	12.6	173
Total	**1,426.9**	**19,635**

The expenditure for benefits under the Long-Term Care Allowance Acts of the ***Länder*** amounted to approximately € 269 million (about ATS 3.7 billion) in 2000.

The expenditure for **social services** is financed from the budgets of the *Länder* (social assistance). The expenditure for benefits in kind amounted to roughly ATS 3.7 billion (EUR 270 million) in 1999. In addition, the *Länder* made co-payments on accommodation cost in homes for the elderly and nursing homes totalling approximately ATS 11 billion (EUR 800 million).

3.2.2 Cost control mechanisms

In Austria there are currently about **500,000 persons in need of care** (out of a population of 8 million), of whom about 315,000 are eligible to care allowance. The remaining number does not require a level of care which would qualify them to receive care allowance.

About 80% - 85% of the care allowance recipients are provided care by family members or within a neighbourhood assistance scheme and about 5% - 10% by social service organisations at home. About 15% live in residential homes.

Considering the fact that the care allowance usually covers only about 15% - 20% of the professional care services actually required by those affected, an enormous additional budgetary expenditure would be caused if the total demand for care services provided by care professionals had to be financed.

The care services covered by the Austrian long-term care system are defined in the law as well as the pertaining ordinances on care allowance levels. They cover basic hygiene, such as daily care of the body, and household tasks, e.g. cleaning and heating of the home. Care covered by this scheme does not include medical care, which is definitely a service covered by the health insurance. As a rule, medical services, such as treatment or diagnostic services, must therefore be performed under the health insurance scheme.

Another cost control mechanism applied by the *Länder* in the area of social services are **cost contributions** by the affected. The persons in need of care are required to make cost contributions when using care services. The financial situation of the person (income and assets) is however taken into consideration.

There is no comparative assessment of different approaches.

3.2.3 Challenges

The most important challenges regarding the sustained financial viability of long-term care are first of all the **demographic development and the ageing population.** In this context it should however be stressed that given the progress of medicine ageing does not necessarily mean an increased need for care.

Thanks to the medical-technical progress, an increasing number of people reach an advanced age with more need for care. In Austria the number of those aged 65+ will increase by almost one third in the next 25 years, the number of those 85+ will almost double. The social networks which have provided the main share of care services in the past are subject to fundamental changes.
Between 1981 and 1999

- the employment rate of women aged between 15 and 60 years increased from 57% to 63%,
- the total divorce rate increased from 26.5% to 40.5%,
- the number of one-person households increased from 782,000 to 986,000 and will continue to increase by approximately another 200,000 in the next 20 years.

The declining care capacities within families resulting from this trend will step up an increasing demand for professional service providers.

Secondly, these challenges affect also **budgetary performance targets**, in particular since the Austrian long-term care system is a budget-financed system.

3.2.4 Planned policy changes

It is an objective of the Austrian long-term care system that persons in need of care are provided care services in their homes (with the support of professional mobile service providers), in particular since this is also more cost-effective than institutional care (see 1.2.1).

There are no planned policy changes.