Maria M. Hofmarcher
HealthSystemIntelligence

April 2015

Health system performance in Austria has improved but it needs more effort[1]

Summary

Health spending limits as stipulated in the Austrian health reform legislation 2013 are met in 2013 and likely also in 2014. Throughout 2018 it will be increasingly difficult to adhere to the requested budgetary framework as economic conditions have weakened. To gradually adjust the financial performance of the health system to overall economic conditions would require containing about 1,7 billion Euros additionally in 2016. Supply performance has somewhat improved by increasing day care up to thresholds and by reducing bed-days as demanded. However, structural change in care delivery through building improved primary care capacity is slow and targets set in this area are meagre. Also, quality management across care sectors appears below targets and the implementation of electronic health records is stalled. Sustainability is somewhat at risk. Cost is likely pushed through renewed wage settlements across the country for hospital doctors in response to the implementation of EU working-time directive. Further, price pressures coming from new and innovative drugs might accelerate, also in light of yet unmet chronic care needs. Thus far health reform failed to establish a commission, which was proposed to optimize high price drug use across care sectors.

Background

Health reform 2013 envisages significant changes in healthcare, introducing a more evidence-based and coordinated approach to the planning and delivery of services. It is expected that the reform will lead to a substantial shift from in-patient to out-patient and ambulatory care through targets. Reiterated in the 2013 government coalition programme Health reform 2013 introduced a global budget cap for public spending on health aiming at (1) leveraging the achievement of supply targets and (2) supporting consolidation (Gesundheitsreformgesetz, 2013; Hofmarcher, 2014). The budget cap defines a ceiling on public health spending that should not exceed predicted annual GDP growth. This should be achieved by adherence to the limits stipulated in the 2011 federal budgetary framework. It is expected that with this measure the health sector will contain spending growth in the order of about 3.4 billion Euros until 2016, for details see Janger et al. 2014, Table 1. Targets agreed to date are likely not sufficiently ambitious to achieve reform goals. Both adjustments of the current federal budgetary framework as well as enhanced supply targets are likely needed.

A monitoring scheme has been set up with biannual reporting obligations. In June 2014 the first monitoring report was published which details the degree of target achievements related to 1) supply and outcome performance and 2) financial performance of the health system (Gesundheit Österreich GmbH, 2014). In February 2015 the second monitoring report was available. Financial performance is monitored by comparing public expenditure on health

[1] Paper is published in Janger J. et.al. Monitoring of Austria´s efforts within the Europe 2020 strategy. Up-date 2014/15. Austrian Institute of Economic Research - WIFO, Wien 2015, April.

excluding public spending on long-term care, calculated according to OECD System of Health Accounts standards with expenditure caps for all payers' involved.

- Public health expenditure was projected using average growth rates over a period of 10 years, which has been 5 percent on average annually.
- Spending caps were defined by employing upper spending limits as stated in the federal financial framework legislation (Bundesfinanzrahmengesetz 2011)[2]. These caps are used for monitoring the achievement of spending targets of social health insurance and of federal states ("Länder") separately[3].

Overall in 2012 public health expenditure were below caps by 133 Mio. Euro. Consolidated across payers cost containment could be realized in the order of 284 Mio. Euro (Gesundheit Österreich GmbH, 2014 and 2015), which is about double the amount foreseen in projections (155 Mio. Euro), see also Figure 22 in Janger et al. 2014. The below target performance was achieved fairly equal by federal states as well as within social health insurance. Also financial targets appear to be achieved in 2013 (Gesundheit Österreich GmbH 2015). Year on year nominal public health spending growth was at 1,4 % while nominal GDP growth was at 1,7 % (Statistik Austria 2015).

While these results are promising to meet agreed targets they may not hold when up-dated benchmarks are applied. First, the economy has been growing gloomier than expected in 2011. Second, the government has reinforced the commitment to achieve a balanced budget in 2016. Third, upper expenditure limits as applied have become unsustainable in light of retarded economic conditions. Finally, in the near future the health system is faced with both cost-push factors, e.g. increased wage cost and demand pull factors e.g. high price drugs and chronic care needs.

The aim of this section is (1) to provide an overview of expenditure growth scenarios by employing recently published expenditure caps including a simulation of the distance between expenditure caps and current GDP growth projections until 2018 and (2) to give an overview of the target achievement for key areas proposed by the health reform 2013[4].

Cost effectiveness has improved but sustainability is at risk

Figure 1 shows the development of public health expenditure (excluding long-term care) for the period 2014 to 2018, see Table 1 for details. The health system has met spending targets in 2013 and likely meets 2014 targets as stipulated in the health reform legislation 2013. In particular, spending targets appear in line with an adjusted path, which applies recently

[2] This legislation foresees spending caps for total public expenditure of the federal government and is up-dated annually by adjusting these caps on the basis of medium term economic forecasts (Mittelfristige Prognosen).

[3] For this exercise health reform legislation defines accounting standards for federal states and social health insurance separately on the basis of current sources. This implies that certain expenditure items are excluded so that total public health spending across payers is somewhat lower than public health expenditure as reported according to the System of Health Accounts methodology; see Figure 2.2 in GÖG 2014.

[4] This overview is restricted to measures, which are subject to impact assessment in 2017, see Table 2. For more details on measures employed by the health reform and target achievement see GÖG 2014 and 2015.

published growth rates of the social insurance budget in the health system throughout 2016. However, this path is quite optimistic as it was derived from the social insurance budget which is only about half of total public expenditure on health. Officially published spending figures of hospital care on the level of the "Länder" for the year 2014 will only become available at the end of February 2016[5]. However, preliminary results presented in the second monitoring report point to an above target achievement in 2014 (Gesundheit Österreich GmbH 2015).

Table 1: Scenarios for public health expenditure growth, % nominal change

		2014	2015	2016	2017	2018
Expected	Status quo#, no reform	5,2	5,2	4,6	4,5	4,5
Likely	Status quo, adjusted*	4,9	5,4	4,1	4,3	4,3
Bench-marks	1) Federal budgetary framework§	4,1	3,9	4,5+	3,7	2,5
	2) GDP forecast&	2,2	2,3	2,5	2,9	3,0
	3) Public expenditure forecast&	5,6	1,5	2,3	2,4	2,5

+ this figure is derived from average annual change of total federal spending as the corresponding figure in the chapter "Health" is biased (+9,1%) in 2016. In this year additional federal monies for a dental health funds will be phased in (BMF 2014, WKÖ 2014).

Sources:

Gesundheitsreformgesetz 2013; 2017-2018: Health System Intelligence estimates
* Hauptverband der Sozialversicherungsträger: 2014: final; 2015-2016: forecasts; 2017-2018: Health System Intelligence estimates
§2013-2015: Bundesfinanzrahmen 2013; 2016-2018: Bundesfinanzrahmen 2014: Gesundheit
& Mittelfristige Prognose WIFO -Monatsberichte, 1/2015: 2014-2019

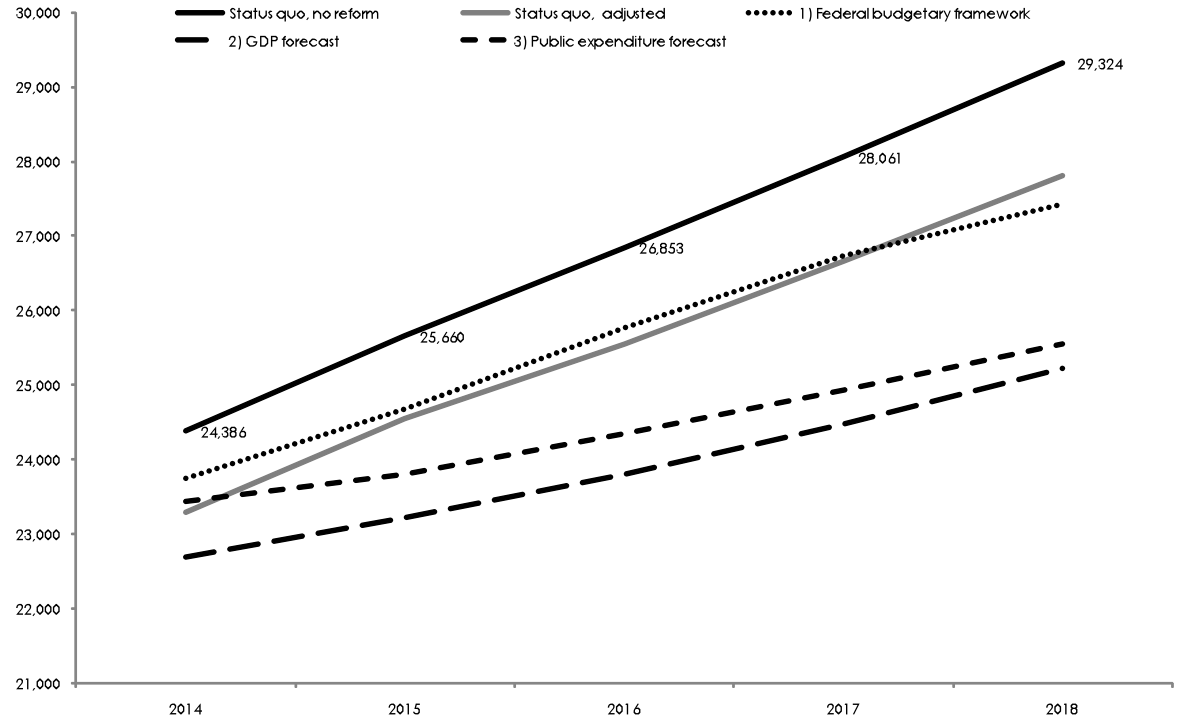
Scenarios were built to 1) present expenditure development as stated in the legislation 2013 ("expected") and 2) to take more recent developments into account ("likely"). Both Scenarios are compared with three benchmark forecasts (1) "Federal budgetary framework " (2)"GDP growth" and (3) "public expenditure growth". The benchmark "Federal budgetary framework" uses up-dated growth assumptions of the framework 2013 for the years 2014 and 2015. For the years 2016 to 2018 it uses predicted developments of the federal budget as it was stated in 2014 in the chapter health. Figure 1 shows the evolution of the public spending on health in these two scenarios. In addition it displays the development until 2018 when benchmark growth rates are applied.

Figure 2 uses scenarios as developed in Table 1 and shows spending gaps until 2018 (excluding the benchmark "public expenditure forecast") by estimating in both scenarios the difference between the legally requested cost containment path and the evolution of public expenditure on health if they followed GDP growth forecasts. For example, in 2014 the health system may have not only met spending targets as requested but may also out-perform targets (-455 Mio. Euro). As a consequence the health system would have contained cost in the order of about 1 billion Euros, i.e. 638 Mio. Euros as foreseen ("Expected": blue bar) and 455 Mio. Euros in excess to this amount ("Likely": green bar).

[5] Currently the Ministry of Health has an agreement with Statistik Austria to report health expenditure with a delay of 2 years, i.e. in February 2015 expenditure data of 2013 have been reported. In the future it will be essential to close this reporting gap. In particular as health reform 2013 foresees bi-annual monitoring of financial performance. Health expenditure reporting and the monitoring of target achievement are not aligned.

Health reform 2013 anticipates the gradual adjustment of public health spending performance to GDP growth through adherence to the spending path stipulated in the federal budgetary framework. However, when taking recent GDP forecasts into account the gap between the health sectors cost containment paths and GDP growth is widening (Table 1). This implies that permitted expenditure growth stipulated in the current federal budgetary framework is a rather soft benchmark and would need to be adjusted to weaker than expected economic performance as assumed in 2011.

Figure 1: Scenarios of the development of public health expenditure (without long-term care), in 1000 Euros.



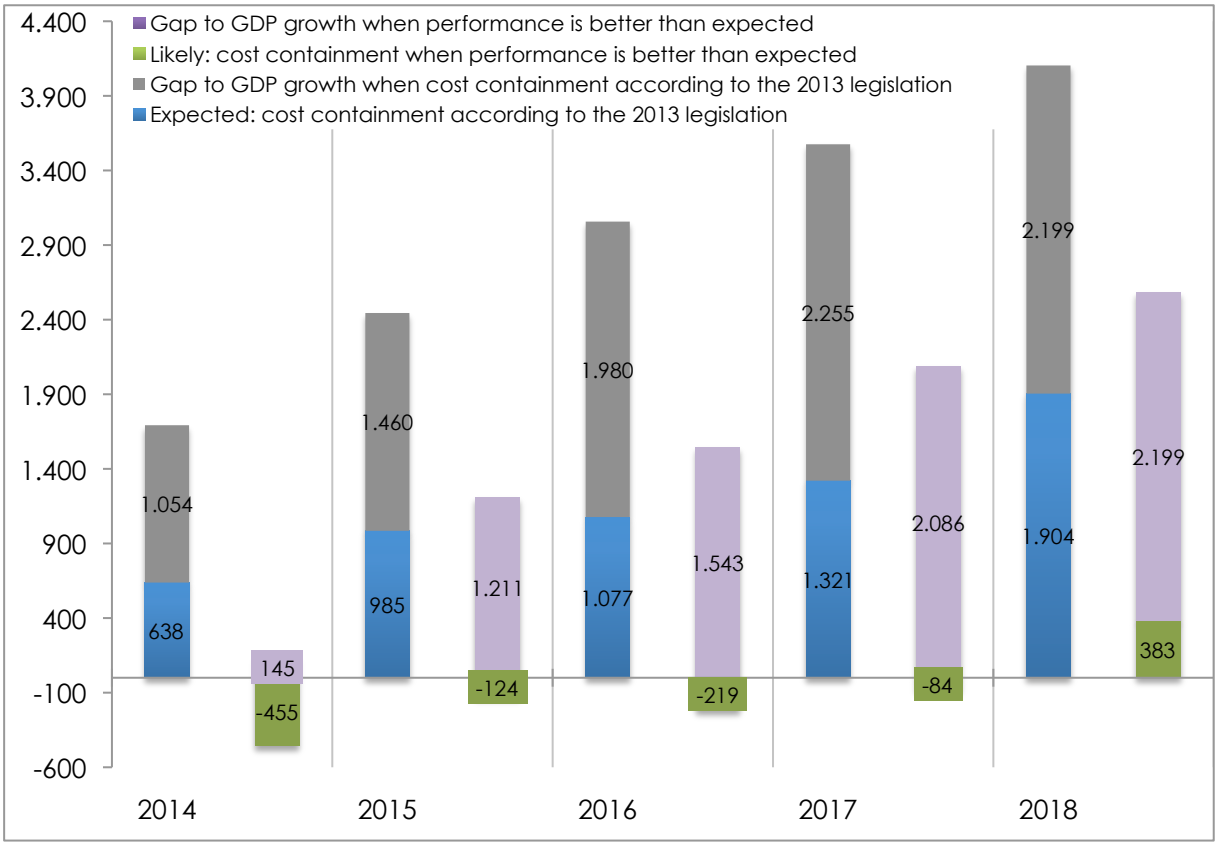
Source: Health System Intelligence compilation, see Table 1 for details.

For example, in 2014 the health sector is requested to contain spending growth by about 640 Mio. Euro when it performs according to the path stipulated in the legislation ("Expected"). If the health sector grew in line with GDP performance in 2014 an additional amount of about 1 billion Euros would be required. By looking at the scenario "likely" simulations show that the health sector would have additional cost containment requirements in the order of 145 Mio. Euro if it grew according to predicted GDP performance.

While the scenario „likely" clearly points to a favourable financal performance of the health systems when compared to the status quo („expected") it is visible that in both scenarios cost containment requirements intensify. For example, in 2016 the health sector may achieve spending limits but has increasing pressure from the benchmark GDP growth. Additional cost containment would be necessary in the order of 1.5 and 1.9 billion Euros even though

spending targets according to the benchmark "federal budgtary framework" are likely met. This implies that on average the health sector would need to curb an additional amount of about 1,7 billion Euros in 2016 if GDP growth was the benchmark. In 2017 cost containment requirements may rise to about 2,1 billion Euros, in 2018 to 2,5 billion on average.

Figure 2: The spending gap is increasing but likely less strong than expected, in 1000 Euros



Source: Health System Intelligence compilation, see Table 1 for details.

Supply performance has slightly improved

Table 2 summarizes measuers proposed by health reform 2013 which are subject to impact assessment in 2017 (Gesundheitsreformgesetz 2013). Expert assessment is made to estimate the likelyhood of target achievement. Targets for 3 out of 6 measures will be likely achieved in 2017. Notably, hospitals likely perform more cost effective by increasing day care according to targets but also by reducing bed-days. However targets for reduced average length of stay may be failed. This is probably caused by high and increasing demand (admissions) while at the same time bed-days have been declining but at a lower pace than a rise in admissions occurred. While this development reflects productivity improvements in this area it also points to the lack of adequate capacity outside acute hospital care. Such capacities are needed to absorb patients in intermediary settings or horizontally integrated ambulatory care entities in hospitals with broader and higher skill mix. In this area health reform appears

slow and targets set are insufficient. The robust growth of health labor everywhere requires to enhance the productivity of this incrasing work force in particular through structural change of delivey models (Hofmarcher et al, 2015).

Also better coordinated pharmaceutical care failed thus far, see Table 2. In light of an increasing number of effective but high price drugs on the market it would be essential to improve coordination in this area. Coordination is key to safeguard equal access to such drugs for all patients in need and to ensure sustainablitiy of drugs spending through renewed reimbursement schemes for high price drugs.

Sustainability risks need to be addressed

Even though the performance of the health system seems to have improved in recent years and likely out-performs targets maybe well into 2016 in some important areas sustainability is at risk.

- First, the health system will be faced with higher labour costs through renewed wage settlements of hospital doctors across the country in response to the implemenation of the EU-working time directive. Close monitoring of cost increases is required. In this context the timing of publically available health expenditure reporting needs to become more adequate, and aligned with monitoring requirements of financial performance. Further, rolling adjustments of the spending limits to overall economic conditions is required. In particular, spending limits of the federal budgetary framework used for the evaluation of the financial performance of health sector may need to become more strict.
- Second, demand for high price drugs will increase. This is also reflected in recent forecasts of this spending item (Hauptverband, 2014). In concert with yet unmet chronic care needs drug costs likely accelerate. Health reform failed to implement a commission to better oversee the use of high priced drugs across care sectors. Drug cost management likely needs improvment.
- Third, progress in structural change of care delivery to improve primary care capacity is slow even though supply performance has improved in important areas of hosptial care. Targets in this area need to be made more ambitious to speed-up capacity building outside hospitals or transformed hospitals. This includes more efforts to implement electronic health records as foreseen.
- Finally structural reform of the institutional make-up of the health system is not (yet) adequately addressed (Baumgartner – Pitlik – Kaniovski, 2015). While this is largely a matter of adminstrative reform of the state it should involve the governance model of the health system, e.g. consolidation of the social health insurance landscape. Further improvements are needed on the level of pooling funds to make purchasing of services across care sectors more effective, e.g. joint pooling and purchasing of ambulatory care (Janger et. al, 2014; Hofmarcher, 2014).

Table 2: Summary of measures proposed by health reform 2013 which are subject to impact assessment in 2017

		Likelihood of achievement in 2017	Remarks
Measure 1	Ensure best point of service		
	• Increase day care 4.2 pp. to 25 per cent of all hospital admission	****	Average length of stay targets expected to be failed
	• Reduce bed-days	****	
Measure 2	Build capacity for innovative, multidisciplinary care models		
	• Increase the number of such models • Make existing ambulatory care more responsive to patient needs, e.g. opening hours	**	Target is conservative: 1% of the population should be cared in such models
Measure 3	Enhance targeted health promotion and prevention		
	• Definition of unified principals for newly established funds on the regional level • 150 Mio. Euros between 2013-2022	**	Funds will operate in parallel with other funding and governance sources
Measure 4	Enhance quality with focus on outcome quality		
	• Establish outcome measurement comparable across sectors by 2014	--	Largely devolved to the regional level
Measure 5	Establish a monitoring system to enable evaluation of objectives and to promote transparency		
	• Establish a monitoring framework in 2013 • Provide annual monitoring reports per „Land“, first 2014 for the year 2013	****	1. Monitoring report: June 2014; 2. Report: February 2015
Measure 6	Warrant effective and efficient use of drugs		
	• Establish a commission in 2013 which recommends the use of high price drugs used across sectors and recommend which reimbursement mode is to apply	--	Will not be implemented

Note , *low likelihood, *****very high likelihood, expert assessment

Source: Gesundheitsreformgesetz 2013, Gesundheit Österreich GmbH 2014/2015, Health System Intelligence compilation

References

BGBLA 2014_I_37: Bundesgesetz, mit dem das Bundesfinanzrahmengesetz 2014 bis 2017 geändert und das Bundesfinanzrahmengesetz 2015 bis 2018 erlassen wird

BMF (2014) Strategiebericht 2015 - 2018 Bericht der Bundesregierung gemäß § 14 BHG 2013, Wien, April

BMF (2014) Übersicht über die österreichische Haushaltsplanung 2015, Wien, Oktober

Gesundheitsreformgesetz 2013: Bundesgesetzblatt I/ Nr. 81/2013.

GÖG (2014): Monitoring nach Vereinbarung gem. Art. 15a B-VG Zielsteuerung-Gesundheit und Bundes-Zielsteuerungsvertrag, I/2014, Wien, Juni

GÖG (2015): Monitoring nach Vereinbarung gem. Art. 15a B-VG Zielsteuerung-Gesundheit und Bundes-Zielsteuerungsvertrag, II/2014, Wien, Februar

Hauptverband der Österreichischen Sozialversicherungsträger (2014): Aktualisierte Voranschläge Krankenversicherung 2014, und Gebarungsvorschaurechnung Krankenversicherung 2015/2016, Stand: 15. November 2014, Wien

Hofmarcher M.M. (2014) The Austrian health reform 2013 is promising but requires continuous political ambition, Health Policy, October 2014, Volume 118, Issue 1, Pages 8–13: http://dx.doi.org/10.1016/j.healthpol.2014.09.001

Hofmarcher, M.M, L. Tarver, E. Festl (2015) On health employment growth and structural change in care delivery, submitted to Health Policy

Janger, J. et al. (2014) Monitoring of Austria's Efforts Within the Europe 2020 Strategy Update 2013-14, Austrian Institute of Economic Research, Health System Intelligence, commissioned by the Federal Chancellery, Wien, June

WIFO (2014): Mittelfristige Prognose der österreichischen Wirtschaft bis 2018, WIFO-Monatsberichte, 2014, 87(2), S. 117-131

Baumgartner, J., Kaniovski, S., Pitlik, H., "Wirtschaftswachstum weiterhin verhalten, Arbeitslosigkeit bleibt hoch. Mittelfristige Prognose der österreichischen Wirtschaft bis 2019", WIFO -Monatsberichte, 2015, 88(1), pp. 51–66.

WKÖ (2014), Bundesbudget 2014 und 2015 Bundesfinanzrahmen 2015-2018, Wien, Juli