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Distribution of Healthcare Providers and Health Workforce in Slovenia

The institutional framework –The case of Austria

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Workshop 2, Ljubljana, 19 January 2018

Institutional framework in Austria

- Health care system is highly **segregated**
- The **responsibility** for financing, planning and controlling is strictly parted between
  - the federal level (esp. MoH),
  - 9 provinces,
  - 22 public social insurances as well as
  - cities and municipalities
- The **Federal Government** has a **central role** (eg. legislation), but **many competences are delegated**
- **Joint responsibility** for **structural policies** and **planning** (agreements under Art. 15a of Austria's Constitutional Act)
- Need for **cooperation** of **a large number of actors**

Health Reform 2006

- **Strengthen integrated health care** – measures **to overcome the strict separation** of health care sectors and **improvement of coordination** of planning, financing and governance
  - Reform of Institutions on **federal** and **regional** level (*Federal Health Care Agency, Regional Health Care Funds*)
  - Integrated Health Care Structure Plans for the **federal** level (*Austrian Health Care Structure Plan – **ÖSG***) and for the **regional** level (*Regional Health Care Structure Plans – **RSG***)
- **Improve quality of health care** – measures to built up a uniform **nationwide system** of **quality measurement** and **quality management** as well as **quality assurance** (*Act on Health Care Quality, Federal Institute for Quality Assurance in Health Care – business unit of GÖG)*
- **Ensure economic stability** –**sustainable financial security** of the health care system

Health Reform 2013 – period 1 (2013–2016)

- Is a **deepening concretization** of the **health reform 2005**
  → **sustainable financial security** of the health care system
- **Gradually reducing growth of public health expenditure** in relation to projected growth of GDP → definition of **health expenditure targets**
- **Governance by objectives**, via targets in the areas of
  - health care **structures**
  - health care **processes**
  - health **outcome**
  - **financial** development
- **Equal partnership** between **federal authority, 9 regional authorities (provinces) and public health insurances** under the condition of **unchanged responsibilities**
- **Federal and 9 regional 4-year contracts** (2013–2016) and **yearly working programs**
- **Monitoring** of health care **reform progress** in the **9 provinces**

Health Reform – period 2 (2017–2021)
Consolidation in targets

- » Focussing the efforts
- » Reduction of strategic and operative targets
- » and operationalisation via target dimensions
  - » Better health service provision
    - » Demand-oriented provider structure
    - » The right care (*also HWF*)
  - » Better quality
    - » Better coordination of care
    - » Treatment when you need it
  - » Healthier population
    - » Staying healthy
    - » Healthier lifestyle
  - » Better value
    - » Ensuring financials sustainability

Strategische Dimension Strategische Ziele		Operative Dimension Operative Ziele		Messgrößen	Zielwerte/ -vorgaben
Bessere Versorgung	S1: Stärkung der ambulanten Versorgung bei gleichzeitiger Entlastung des akutstationären Bereichs und Optimierung des Ressourceneinsatzes	Bedarfs-gerechte Versorgungs-strukturen	1: Verbesserung der integrativen Versorgung durch gemeinsame abgestimmte verbindliche Planung und Umsetzung der folgenden Ziele (1.1 bis 1.3)	*Messgrößen und Zielwerte/Zielvorgaben sind direkt den operativen Zielen 1.1. bis 1.3 zugeordnet. Diese sind in der Analyse gemeinsam zu betrachten.*	
			1.1: Primärversorgungsmodelle auf- und ausbauen	(1) Umgesetzte PV-Einheiten (2) In PV-Einheiten versorgte Bevölkerung *Zusätzlich noch zu entwickelnde Messgröße:* *Anteil von Fällen mit abgeschlossener Behandlung*	75 ↑
			1.2: Bedarfsgerechte Gestaltung, Abstimmung und Weiterentwicklung der ambulanten Fachversorgung	(3) Anzahl multiprofessioneller und/oder interdisziplinärer Versorgungsformen im ambulanten Fachbereich mit Versorgungsauftrag *Zusätzlich noch zu entwickelnde Messgröße zur Versorgungs-wirksamkeit von multiprofessionellen und/oder interdisziplinären ambulanten Versorgungsformen*	↑
			1.3: Bedarfsgerechte Anpassung der stationären Versorgungsstrukturen	(4) Krankenhaushäufigkeit in FKA (5) Belagstagedichte in FKA (6) Ausgewählte TK-Leistungsbündel, die tagesklinisch-stationär oder ambulant erbracht werden	-2 % jährl. -2 % jährl. pro Leistungs-bündel definiert
		Die richtige Versorgung („The right care")	2: Verfügbarkeit und Einsatz des für die qualitätsvolle Versorgung erforderlichen Gesundheitspersonals (Skill-Mix, Nachwuchssicherung, demographische Entwicklung) sicherstellen	(7) Anzahl der besetzten und genehmigten Ausbildungsstellen AM/FA (8) Ärztliche Versorgungsdichte (9) Relation DGKP und PFA zu ÄrztInnen in FKA („Nurse to Physician Ratio")	Beobachtungswert Beobachtungswert Beobachtungswert
			3: Stärkere Ausrichtung des Vertragswesens und der Honorierungssysteme am Versorgungsbedarf bei gleichzeitiger Unterstützung der Zielsetzungen der ZS-G (insbesondere Versorgung am „Best Point of Service") und der Anforderungen an die Versorgungsformen	*Messgrößen siehe op. Ziele 1.1 bis 1.3.*	
			4: Optimierung der Versorgung von Kindern und Jugendlichen in ausgewählten Bereichen	(10) Masern/Mumps/Röteln - Durchimpfungsrate Kinder (11) Ambulante KJP-Angebote	↑ ↑
Bessere Qualität	S2: Sicherstellen der Zufriedenheit der Bevölkerung durch Optimierung der Versorgungs- und Behandlungsprozesse	Besser koordinierte Versorgung	5: Gezielter Einsatz von IKT zur Patientenversorgung, Systemsteuerung und Innovation	(12) Umsetzungsgrad ELGA (13) Polypharmazie Prävalenz (14) Potentiell inadäquate Medikation (PIM) bei Älteren *Zusätzlich noch zu entwickelnde Messgröße zu TEWEB auf Basis der Evaluierung der Pilotprojekte*	↑ ↓ ↓
			6: Verbesserung der integrierten Versorgung	(15) Aufenthalte mit kurzer präop. VWD in FKA (16) In Therapie Aktiv versorgte PatientInnen und teilnehmende ÄrztInnen (AM und IM)	94 % ↑
			7: Medikamentenversorgung sektorenübergreifend gemeinsam optimieren	(17) Anzahl der gemeinsamen Medikamentenbeschaffungen	↑
			8: Sicherstellung der Ergebnisqualität im gesamten ambulanten Bereich	*Messgrößen im Zusammenhang mit den weiterführenden Arbeiten zur Qualitätsmessung im ambulanten Bereich noch zu entwickeln*	
		Behandlung, zum richtigen Zeitpunkt	9: Zur Stärkung der Sachleistungsversorgung örtliche, zeitliche und soziale Zugangsbarrieren abbauen	(18) Zufriedenheit mit der medizinischen Versorgung in Österreich	→↑
Gesündere Bevölkerung	S3: Gesundheitsförderung und Prävention: Erhöhung der Zahl der gesunden Lebensjahre und Verbesserung der Lebensqualität von erkrankten Personen	Gesund bleiben	10: Stärkung der Gesundheitskompetenz der Bevölkerung	(19) Exzellente und ausreichende Gesundheitskompetenz	↑
		Gesünder leben	11: Stärkung von zielgerichteter Gesundheitsförderung und Prävention	(20) Gesunde Lebensjahre bei der Geburt (21) Täglich Rauchende (22) Kariesfreie Kinder	↑ ↓ ↑
„Better value"	S4: Gewährleistung einer nachhaltigen Finanzierbarkeit der öffentlichen Gesundheitsausgaben	Nachhaltigkeit sichern	Messgrößen und Zielwerte siehe Finanzzielsteuerung bzw. Einhaltung der Ausgabenobergrenzen Art. 7		

The future of HWFP

- Integrated view on HWFP **high on the agenda**
  - Key issue in the **new "contract on health targets" (2017–2021)** between federal government, regional government and sickness funds
    - **joint supraregional** planning and governance, development of competence-profiles, establishing a new skill-mix
    - involvement of additional stakeholders is challenging

Operatives Ziel 2	Verfügbarkeit und Einsatz des für die qualitätsvolle Versorgung erforderlichen Gesundheitspersonals (Skill-Mix, Nachwuchssicherung, demographische Entwicklung) sicherstellen
Messgrößen und Zielwerte	(7) Anzahl der besetzten und genehmigten Ausbildungsstellen AM/FÄ *Keine Zielvorgabe (Beobachtungswert)* (8) Ärztliche Versorgungsdichte *Keine Zielvorgabe (Beobachtungswert)* (9) Relation DGKP und PFA zu ÄrztInnen in FKA („Nurse to Physician Ratio") *Keine Zielvorgabe (Beobachtungswert)*

- Data issues are persisting; health professionals register is set up for Nurses, Assistant Nurses and Higher medical-technical Professions
- New methodological approach → from static modelling to microsimulations-based models ("IT-Tool")
- Implementing a nation-wide monitoring

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Institutional Framework
Federal level: Commission – Training of physicians

- Agreement between federal and regional governments on the organisation and financing of the healthcare system (2013)
- Article 44 "**Training of physicians**"
  - setting up a commission
  - including regional governments, social insurance funds, medical chamber, medical universities, hospital management
  - chaired by the MoH
- **Task**: **giving advice** concerning training of physicians
  1. Planning
  2. Governance
  3. Quality management
  4. Development

Medical education and training system – Physicians

Restricted capacities (and EMS-test) for public universities

Basic medical education at **university** (6 years)

Post-graduate training as a **specialist** (6 years) or **generalist** (3.5 years) in teaching hospitals and practices (GP)

Exam and/or approval as physician by medical chamber

Contract with SHI and/or Salaried in hospital and/or Non-contracted in private practice

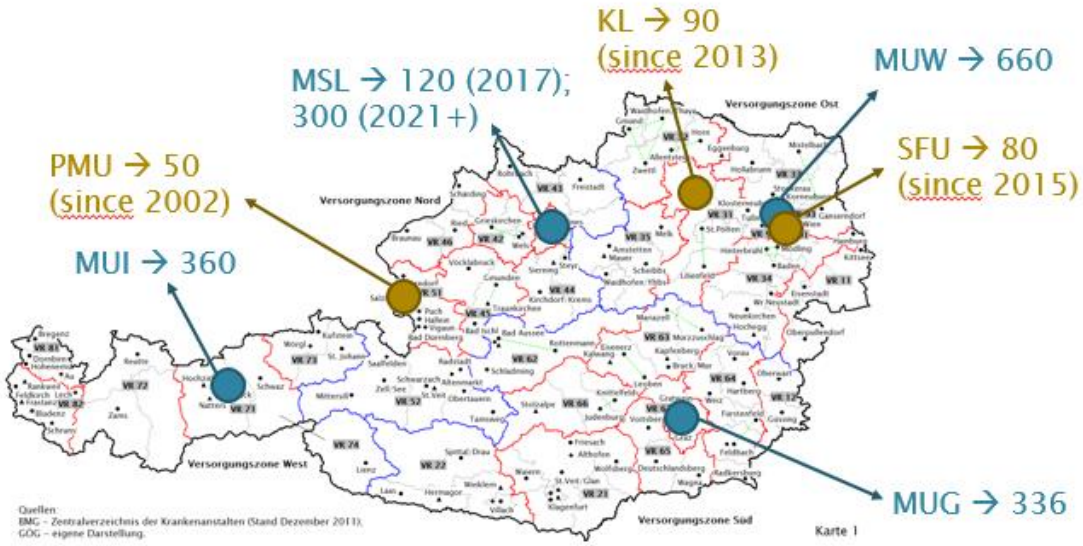
Joint responsibility for **education of physicians** (legislation)

University: Federal Ministry of Science, Research and Economy

Post-graduate training: Federal Ministry of Health (MoH) + Medical Chamber

Medical education – university – current capacities

- **Institutional setting**
  - 3 public medical universities (Vienna, Graz, Innsbruck) + 1 public medical school (as part of the University of Linz, since 2014) run by the federal government
  - 3 private universities offering medical education



Physicians: Access to medical education

- **Until 2002**
  Unlimited access for Austrians, South Tyrol + LUX;
  Access for EU member states only if access was granted in country of origin
- **2002 onwards**
  First attempt to regulate number of students by the implementation of "integrated tests" at the end of year 1
- **2005**
  Decision of European Court of Justice that same access criteria have to apply to all EU residents → Massive **inflow of German students**
- **2006 onwards**
  Introduction of **standardized EMS-test** as access criteria +
  introduction of **quota**:
  - 95% of study places for EU (in total)
  - 75% for A, South Tyrol & LUX

  Treaty violation proceedings (EC) and subsequent moratorium ended 2017.

Physicians: Post-graduate training

- **Reform** of the education of physicians (2015)
  - improvement of **quality** and **attractiveness**
  - introducing **common basic training**
  - and compulsory **GP training in ambulatory setting** (GP teaching practices)

- **Institutional setting**
  - **Residency places** offered **by (public) hospitals**
    - based on **quality criteria** (e.g. sufficient number of procedures performed)
    - places **approved** and monitored by **medical chamber**
  - **Access** organised by **training institutions**, applications by medical graduates
  - for **GP** a minimum numbers of graduates per year and province is stipulated by the "Art.44 commission"
  - for **specialists** no regulation

Physicians: Licensing and contracting

- Licensing
  - Entry into **physicians' register** (run by medical chamber) after GP/specialty exam or approval
    - Exams for GP and specialists organised and held by medical chamber
    - Approval of foreign-trained doctors organised by medical chamber
  - Continuous training organised by medical chamber
- Contracting with **sickness funds**
  - Number of contracts contracted between SHI and medical chamber (restricted number)
  - Applicants are put on a "waiting list" run by the medical chamber
    - MoH/parliament can define ranking criteria
- Contracting not essential to open up private practice
  - Constitutional right to practice for every physician (1867)
  - Patients are reimbursed 80% of the regular fee if consulting a non-contracted physician → number is increasing

HCP in Austria – Overview (1): Higher Education on Academic Level

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Condition for Practice

- **Doctor of Medicine**
  - General Practititioner
  - Specialised doctor – medical specialties
- **Dental Practitioner**
- **Healthcare Psychologist**
- **Clinical Psychologist**
- **Pharmacist**
- **Veterinary Surgeon**
- **Exercise Therapist(*)**

→ University:
- Academic Grade varies between Bachelor/Master/Dr./PhD,
- followed by education and training in clinical setting, except (*).

- **Midwife**
- **Higher medical-technical Professions**
  - Physiotherapist
  - Biomedical Analyst
  - Radiological Technologist
  - Dietitian
  - Occupational Therapist
  - Speech Therapist/Logopedist
  - Orthoptist
- **Qualified Nurse(**)**

→ University of Applied Sciences:
- Academic Grade: Bachelor
- in combination with education and training in clinical setting.
- (**) Partly!

- **Music Therapist**
- **Psychotherapist**

→ Different and variable!

Source: Federal Ministry of Health, Healthcare Professions in Austria, 2016; Illustration: Gesundheit Österreich GmbH.

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HCP in Austria – Overview (2): Other Types of Education

Condition for Practice

- Qualified Nurse (*)
- Qualified Nursing Assistant
- Nursing Assistant
- Qualified Cardio-technician
- Medical Assistant Professions
  - Disinfection Assistant
  - Plastering Assistant
  - Laboratory Assistant
  - Assistant Prosector
  - Operating theatre Assistant
  - Doctor's surgery Assistant
  - Radiology assistant
  - Qualified medical Assistant

(*) School of Nursing (until 2023): 3 Years

School/Course: 2 Years

Course: 1 Year

Training within framework of employment: 18 Months
- Professional requirements for admission to training:
  - Radiological Technologist
  - Biomedical Analyst
  - Nurse Specialist: Intensive care or anaesthetic care

School of medical assistant professions or course: 650 to 2500 (Qualified medical Assistant) hrs

Source: Federal Ministry of Health, Healthcare Professions in Austria, 2016; Illustration: Gesundheit Österreich GmbH. Regina Aistleithner, GÖG

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HCP in Austria – Overview (3): Other Types of Education

Condition for Practice

- Medical Masseur
- Therapeutic Masseur

Training:
- Medical Masseur: two modules, 1690 hrs
- Therapeutic Masseur: +800 hrs

- Emergency Medical Technician (Paramedic)
  - First-level Emergency Medical Technician
  - Second-level Emergency Medical Technician
  - Second-level Emergency Medical Technician with special emergency qualifications

Training:
- First-level: 1260 hrs
- Second-level: 2480 hrs
- Special emergency qualifications:
  - Pharmacology: 50 hrs
  - Venous access and infusion: 50 hrs
  - Artificial respiration and intubation: 110 hrs

- Dental Assistance

Course and within framework of training employment: 3 Years, 3600 hrs
– Specialization in prophylaxis assistance: + 144 hrs

Source: Federal Ministry of Health, Healthcare Professions in Austria, 2016; Illustration: Gesundheit Österreich GmbH.

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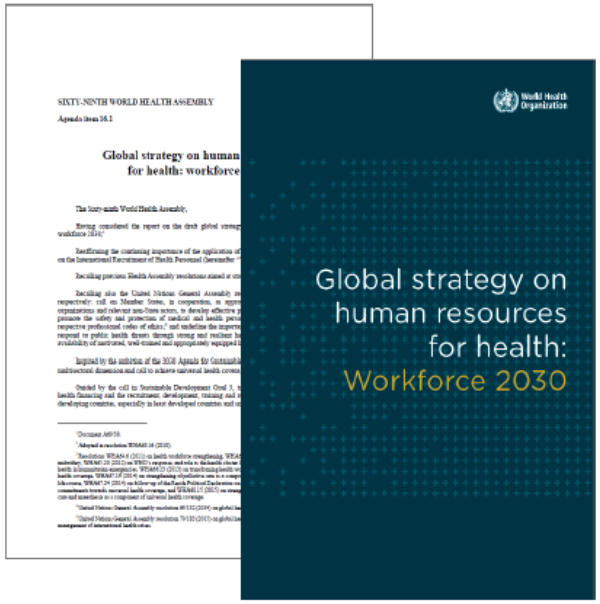
International context – WHO/Global strategy

Global strategy on human resources for health

Unanimously adopted by Member States at the 69th WHA in May 2016



1. **Optimize the existing workforce** in pursuit of the Sustainable Development Goals and UHC (e.g. education, employment, retention)

2. **Anticipate future workforce** requirements by 2030 and plan the necessary changes (e.g. a fit for purpose, needs-based workforce)

3. **Strengthen individual and institutional capacity** to manage HRH policy, planning and implementation (e.g. migration and regulation)

4. **Strengthen** the **data, evidence and knowledge** for cost-effective policy decisions

http://who.int/hrh/resources/pub_globstrathrh-2030/en/

WHO – Global strategy – deeper look

Objective 3

Build the capacity of institutions at subnational, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health

Milestones:

- 3.1 By 2020, all countries will have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.
- 3.2 By 2020, all countries will have an HRH unit with responsibility to develop and monitor policies and plans.
- 3.3 By 2020, all countries will have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.

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