

Financing inpatient health care in Austria

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Health care in Austria is organized via statutory health insurance that covers almost 99% of inhabitants. The revenue sources for the health care budget are complex. They consist of the combined payments of employers and employees to the social health insurance funds, which amount to 46% of total expenditure on health. A further 30% is provided by taxes and the remaining 24% consist of co-payments paid out-of-pocket by patients themselves or covered by additional private health insurance.¹ While the federal government is responsible for enacting basic laws in health care, implementation falls under the remit of the country's nine provinces. However, actual implementation is carried out by the so-called 'health platforms'* at the federal and province level. As part of health care reforms in 2005, State Health Funds were set up in each province to finance inpatient care and to implement regulations concerning health care in general.² There are 183 acute care hospitals in Austria (2006) providing 52,894 beds.³ Of these hospitals, 140 (92% of beds in acute care hospitals) are public or private not-for-profit hospitals financed mainly by the State Health Funds. The budgets of the State Health Funds consist of resources from the federal government, the provinces and the municipalities based on fixed percentages of value-added taxes. Furthermore, social insurance funds pay a flat fee. In most provinces, contributions by municipalities and provinces covering hospitals' operational deficits are also added to the State Health Funds. The private for-profit hospitals are mainly financed by direct patient contributions or private health insurance. Additionally, for health services covered by the social insurance funds, these private hospitals are reimbursed by the Private Hospitals Financing Fund (PRIKRAF). While the average length of stay has been decreasing constantly, admission rates remain at a high level. However, comparisons with other countries are problematic because outpatient health services performed in hospitals (ie. 0-day stays), which is very common among Austrian hospitals, require a formal hospital admission for reimbursement purposes.

The Austrian DRG system

Until 1996 hospital financing was implemented on a per diem basis and there were no incentives for cost efficiency or transparency. Therefore, after years of development and reforms of the legal framework, a performance-orientated hospital financing system, called *Leistungsorientierte Krankenanstaltenfinanzierung* (LKF), was introduced and made compulsory in 1997 for all hospitals financed by today's State Health Funds. Moreover, LKF became compulsory even for private for-profit hospitals that provide services covered by the social health insurance scheme. LKF is neither an adoption nor a further development of existing DRG systems. It was developed and still is administered by a group of experts at the Ministry of Health. Detailed information and grouping software is freely available at www.bmg.gv.at.

Goals

The main goals connected to the introduction of a case-based financing system were⁴: – higher transparency of costs and activities; – reduction of the frequency of hospitalization; – reduction of annual cost increases and the average length of stay; – to shift from inpatient care to ambulatory care; – reduction of hospital beds; and – implementation of an easy-to-use steering and planning instrument.

System characteristics

Today, LKF primarily serves as a reimbursement framework. Together with the Austrian Structural Plan for Health it is also used for steering and planning purposes by defining minimum requirements for certain health services to be reimbursed. LKF is a two-part system, with a core area and a 'steering' area. Patient classification and the allocation of corresponding scores are performed in the core area, and are administered by the Ministry of Health at the federal level uniformly for all provinces and hospitals. The steering area, located at the province level, regulates how hospitals are reimbursed within the LKF scheme. Patient classification is based on whether or not patients have received one of the expensive or very frequently used services in the Austrian catalogue of procedures (list of all inpatient services covered by the social health insurance system). They are classified either into one of the 204 single medical procedure groups (MEL groups) or into one of the 219 main diagnosis groups (HDG groups). These groups have been

defined to pool medically similar hospital cases into economically homogeneous groups. In each of these groups a decision tree classifies patients into one of the 979 performance-orientated (procedure or diagnosis orientated) case groups, called LDF groups. The information used in determining a LDF group is related to hospital stay (e.g. diagnoses according to ICD-10 BMSG 2001 or medical services) or patient characteristics (e.g. age classes).

Each LDF group has a certain score that consists of a performance component (e.g. treatments, diagnostic procedures) and a day component (e.g. nursing, hotel costs). Outlier reductions or surcharges are applied to the day component. For stays in intensive care units or special departments (e.g. psychiatric or acute geriatric/ remobilization departments) extra scores are allocated on a per diem basis.⁵ Originally, the steering area was introduced to ensure a smooth transition to the new case-based financing system and to create incentives to achieve high quality health care. However, the provinces, which are relatively free to implement the steering area according to their needs, use it to distribute their resources according to certain criteria. Two provinces (Lower and Upper Austria) do not, or just marginally, use the area for resource allocation. However, most provinces use it to allocate either a fixed percentage of the budget according to hospital or personnel factors (Vorarlberg, Tyrol, Burgenland) or by weighting the LKF scores directly by hospital or personnel factors (Carinthia, Styria, Vienna). In Salzburg a mixture of both is used.⁶

Concluding remarks

After the introduction of LKF a shift from outpatient to inpatient care was observed although the contrary was desired. This is partly due to the lack of interfaces between these two sectors. Currently, there are efforts towards achieving integrated health care and the development of a joint catalogue of procedures for inpatient and outpatient care is ongoing. With better integration of care, the necessity of hospital admissions, especially 0-day stays, decreases and the implementation of episodes of care, including inpatient and outpatient care, is possible. However, the current outpatient financing system differs enormously from the one used for inpatient services delivered in hospitals. It is therefore also necessary to discuss how integrated care should be reimbursed.

REFERENCES

1. Thomson S et al. *Financing health care in the European Union. Challenges and Policy Responses*. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2009
2. Hofmarcher MM, Rack H-M. *Health Systems in Transition: Austria*. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006;8(3):1–247.
3. BMGFJ. *Krankenanstalten in Österreich-Hospitals in Austria 2008*. Bundesministerium für Gesundheit, Familie und Jugend, 2008.
4. Olensky E. *Die Funktionsweise des österreichischen LKF-Systems*. Bundesministerium für Gesundheit und Frauen, 2004.
5. BMGFJ. *Leistungsorientierte Krankenanstaltenfinanzierung – LKF – Systembeschreibung 2009*. Bundesministerium für Gesundheit, Familie und Jugend, 2008.
6. Hofmarcher MM, Riedel M. Gesundheitsausgaben in der EU: Ohne Privat kein Staat, Schwerpunktthema. Das österreichische Krankenanstaltenwesen – eines oder neun Systeme? *Health System Watch* 2001;1/Frühjahr.

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