recommendation
Austrian Council for Research and Technology Development

18 September 2014

Recommendation on cooperation of medical universities and university clinics

Background

Since the introduction of the Austrian University Act 2002 (UG) and divestment of the medical universities in 2004, the framework conditions for the cooperation of the medical universities with the university clinics have been controversially discussed again and again. At the three existing medical university locations – Vienna, Graz and Innsbruck – there were various developments and reform efforts during this period, which are intended to regulate the cooperation between hospital operators and universities. A sustainable solution for all three existing locations has not been found yet. The landscape of Austrian medicine at universities has also been expanded by the decision to set up a new medical faculty at the University of Linz. The underlying financing model will present a long-term solution for this location. It is, however, not fully applicable at the existing locations of Vienna, Graz and Innsbruck.

A university clinic can be defined as a hospital whose operation serves entirely or partially the teaching and research purpose of a medical university. As a "centralized provider" they are also an indispensable partner for patient care. This distribution of tasks is also reflected in the distribution of competencies in Austrian Federal Constitutional Law, whereby the federal government is responsible for science, research and teaching, but the federal states are responsible for patient care.

This varying assignment of competencies and the interests connected with it resulted with different transition and intermediate solutions at the three established locations in different situations. The multifarious interface problems this creates are manifested in the daily operation of the university clinics, but especially in the following areas:

- **Strategy**: The different responsibility and mandate areas of the two regional administrative bodies result in different objectives and prevent or impede a joint strategic orientation of the medical university and the hospital operators for a university clinic. In extreme cases, the talk is even of "conflicting goals".
- **HR management**: The various legal employment contracts and the rigid public services law prevent and exacerbate strategic and operative HR management with the goal of resource-friendly HR deployment.

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- **Organization**: The legally prescribed separate structures between medical universities and hospital operators create duplicated management and administration structures, which reveal optimization requirement with regard to both effectiveness and efficiency.
- **Financing**: The medical universities must, by law, perform their teaching and research tasks in the clinical area in interaction with public hospitals. For the performance of teaching and research tasks as part of the public hospitals, the federal government refunds the additional costs for the hospital operators as "additional clinical expenditure", which are incurred with the set-up, design, expansion and operation of these hospitals. With regard to the financing of the university clinics, this is complicated by the terms of employment of the doctors in the federal states being regulated differently and infrastructure investments in the federal states being distributed differently at federal and state level.

The special provision stipulated in the Austrian University Act for medical universities to conclude an agreement on cooperation with the operation of the individual organizational units belonging to the clinical area of the medical university and medical faculty and simultaneously forming a part of the public hospital has to date[1] only been implemented at the Graz location to such a degree that would enable and realise the joint structures for managing the organizations. Agreements on cooperation have also recently been made between Vienna Medical University and the City of Vienna and the Medical University of Innsbruck in acc. With TILAK. Planning for the future financing and management of the medical universities and university clinics can now be implemented on this basis.

From the Austrian Council for Research and Technology Development's point of view these cooperation agreements between the hospital operators and the medical universities now enable cooperation reforms, despite different starting situations at the different locations. This long-term process must, of course, be accompanied by suitable transitional provisions[2].

At the centre of the definition of the respective competencies at both the federal side and the state side, there should at any rate be an increase in the performance of university medicine in Austria, which can be supported by increased transparency in financing.

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[1] Universitätsgesetz (Austrian University Act) 2002, § 29 Z 5.

[2] An adjusted form of the payment of the ACE can be negotiated at the earliest with the performance agreement period 2016-18 and prepared for implementation in the following period. Until then patient care in particular, clinic operation and the defined amount of equalization payments within the scope of the ACE must be guaranteed by the federal government for the entire period with suitable transitional provisions. In this period, the required structures for this must be modified and adapted within the scope of the cooperation agreements between the medical universities and university clinics.

Recommendations

Principle of a three-tier model for determining and paying additional clinical expenditure:

The medical universities must, by law, perform their teaching and research tasks in the clinical area in interaction with public hospitals. The federal government reimburses the legal entities of the hospitals in acc. with § 55 KAKuG for those additional costs that are incurred with the set-up, design and expansion of the public hospitals that also serve to provide teaching at medical universities and faculties because of the requirements of the teaching. This includes the costs, among others, of the people, medical equipment, service and maintenance (of buildings), investments and higher running costs in the operation of a university clinic used for this purpose. It should also still be possible to negotiate investment costs for new clinic buildings and conversions between the federal government and state and the legal entities of the hospitals.

To coordinate the financing and payment of the ACE the Council recommends a specific sequence of negotiations and agreement of results, which enable the timely and predictable implementation of the tasks in research and teaching, and for patient care as well.

Definition of research and teaching scope and HR planning at federal government level

First step:

Negotiation of the budgetary framework for payment of the ACE.

Responsibility: BMF – BMWFW

The Council recommends the amount of the budget for additional clinical expenditure at the medical universities be negotiated and defined by the ministries in advance for the next two performance agreement periods.

> The content-relevant basis for the negotiations is formed by the development plans (and/or medical master plans) of the medical universities as the basis for strategic orientation of research (clinic), teaching and patient care, which define the scope and volume of the research and teaching activities at the respective locations in conjunction with the university clinics.
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> The budget available for this can be determined in the cycle of the performance agreement negotiations for a period of at least three years. It defines the budgetary framework for the negotiations and planning between the medical universities and the responsible federal ministry.

Second step:

Negotiation of the teaching and research priorities (clinic area) and the scientific staff scheduled for this

Responsibility: BMWFW – medical universities

The Council recommends the number of scientific staff deployed for research, science and teaching be defined, as well as the definition of groups of people with different research and teaching expenditure.

The scope of research connected with the university clinic and the personnel available for this can be defined based on the development plan (master plan) and the performance agreements of the medical universities together with the responsible ministry in the magnitude of the budgetary framework available for this. On the basis of the varying usage and research performance of the doctors connected with it at a university clinic, the Council proposes three usage groups for calculating the additional costs be defined – (i) Doctors with higher levels of research/teaching activity, (ii) Doctors with lower levels of research/teaching activity and (iii) Doctors without special research/teaching tasks. The scope of research and teaching in relation to normal working time must be negotiated for the respective groups. Regulation in the Austrian University Act[3] can offer a basis for this. The defined usage groups and the associated research and teaching expenditure consequently provide a direct reference for payment of the ACE (see model for payment of the Additional Clinical Expenditure). The number of scientific employees in the defined groups (i and ii) is essentially specified here by the amount of research and teaching; the affiliation of the employees (doctors), however, enables a flexible, somewhat project-dependent allocation. The basis for this is formed by the development plan and the performance agreements of the medical universities with the responsible ministry.

Third step:

Negotiation of the medical staff additionally required for patient care.

Responsibility: State/hospital

The Council recommends the additional requirement for medical staff for patient care be determined based on the number of doctors in acc. with their usage groups.

The state defines the required staff volume for patient care based on the constitutional mandate. The number of doctors required for this can now be calculated based on the capacity made available by the

[3] § 29 (5) The medical university or the university at which a medical faculty is set up must reach an agreement with the legal entity of the hospital following approval by the federal minister while considering the performance agreement in acc. with § 13 on the cooperation with the operation of the individual organizational units that belong to the clinical area of the medical university or medical faculty and are at the same time a part of the public hospital, which also contains the reciprocal performances and their evaluation. This agreement must also specify that university affiliates in acc. with § 94 Para. 1 Z 4 in doctor or dentist use, who are commissioned with assistance in the performance of tasks of the organizational units of the clinical area as facilities of the hospital, in a recalculation period of 26 weeks use at least 30% of the normal working time of these university affiliates, applied to the respective organizational unit, for university research and teaching.

medical universities (federal government). The proportion of university staff for research and teaching defined in step 2 now also defines the proportion that is available for patient care (difference between research part and normal working time). The capacity available for patient care is therefore oriented towards the defined research volume and average research requirement, as well as the teaching expenditure for doctors. Joint HR management of the medical universities and the hospitals planned in the cooperation contracts can form the basis to fund both, patient care and research and teaching as a joint task in the development of university clinics.

A transparent staffing structure must be created here as a prerequisite for a flexible staffing policy.

A performance agreement period (currently three years) can be applied as a planning period for the necessary medical requirements to properly maintain patient care in the competency area of Austria's "Länder".

In its statement and recommendation on additional clinical expenditure (2012), the Austrian Science Council (ÖWR) also specifies that, among other elements, "the service offering for hospitals must be discussed and coordinated with the medical university, so that the state hospitals and university clinics dual function is satisfied. The ÖWR specifies further that an appropriate agreement can be used to define what the hospitals can expect of the university employees in patient care and what room to manoeuvre will be provided for research and teaching in relation to the state doctors." With regard to the different staffing situation and the use of the medical staff at the three existing medical universities, the Council recommends the implementation of joint executive committees and joint HR management, as intended in the already concluded agreements on cooperation between the medical universities and the hospital operators. In the future this should enable (i) the definition of joint objectives in research and teaching, (ii) the development of a transparent HR structure and (iii) the creation of a joint development plan, which incorporates research, teaching and patient care on an equal footing.

Payment of the HR expenditure for health care and nursing and technical infrastructure

Similar to the recommended definition of the research and teaching expenditure in the three-tier model illustrated above, the Council recommends a coupling of the payment and calculation of the ACE to groups of people that have been defined for a specific amount of research and teaching.

Research, science and teaching are very closely connected with patient care. A complete separation calculation across all areas of the running costs can only, if at all, be produced with unjustifiable administration expenditure and is therefore not viable in many areas. The payment of

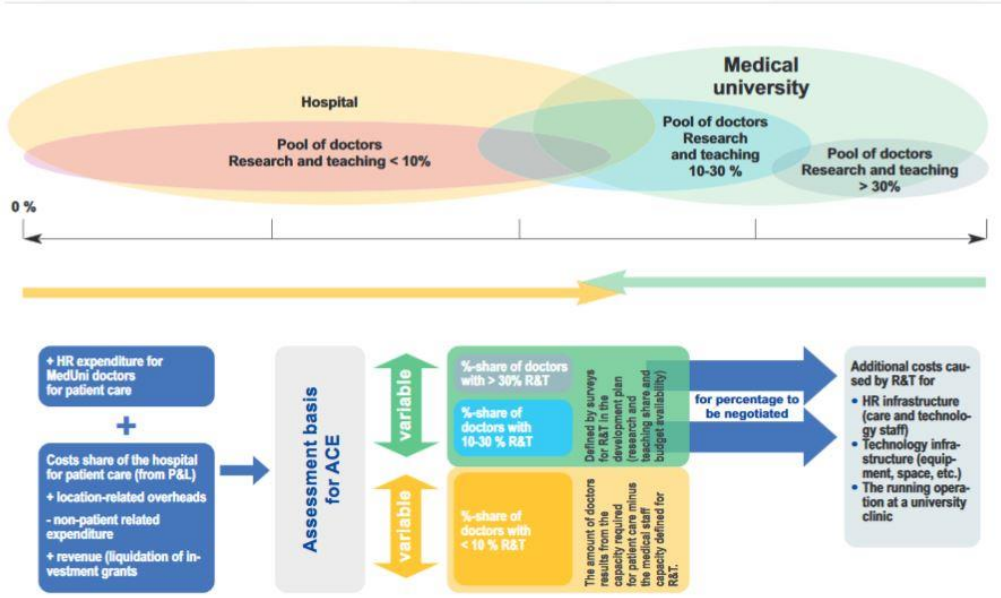
the additional clinical expenditure should represent the clearest possible agreement and regulation, which covers the costs for the additional HR expenditure (health care and nursing staff, staff for technology and administration), caused by research and teaching and the provision of a technical infrastructure (space, medical-technical equipment, etc.).

Priority should therefore be given to flat rates and standard rates where applicable on the basis of model calculations.[4] [5] [6] Calculations at the university clinics are also available, which can serve as the basis for defining and paying the ACE.

Model for paying additional clinical expenditure

The amount of the costs reimbursement, incurred for additional services in patient care, for research and medical-technical equipment, consumables or in administration, is specified by the research share defined in the preliminary stage – number of doctors with specific amount of research and teaching activities.

Figure 4: Model for paying additional clinical expenditure to medical universities and university clinics



The assessment basis for the ACE essentially results from the overall costs of the university hospital, which can be determined according to the P&L account and specific surcharges and deductions.

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[4] Güntert, B., et al. (2004): Final report on the project to create an appropriate model to determine and handle the additional clinical expenditure with the operation of Vienna's general hospital from 2004 on the basis of the comparison of 12/2000, long version August 30, 2004.

[5] Perception report of Audit Court; RH ZI 001.509/038-Pr/6/00, pp. 21–29.

[6] Kriegel, J. (2005): *Finanzmanagement im Universitätskrankenhaus: Klinischer Mehraufwand für Forschung und Lehre.*

The percentage of doctors with higher and medium research and teaching activity is defined in the development planning and strategy of the medical universities and forms a variable percentage of the doctors that perform research and teaching, and therefore is relevant for determining the (absolute) ACE. The resources available at this doctor pool for patient care are also defined by this.

A respectively fixed percentage of the assessment basis must be negotiated for these groups, which incorporates the proportional additional costs caused by R&T for HR infrastructure and other costs for the running operation. The percentage of doctors who are predominantly (more than 90%) responsible for patient care is not used for determining the (absolute) ACE.

If the research volume (number of people with defined research percentage) increases, this cost share also increases proportionally. If, on the other hand, the percentage of services for patient care increases, then the proportional additional expenditure falls relative to the overall costs. The requirement for doctors, who are required (additionally) for patient care, is also determined. The framework conditions provide specific percentages of HR costs for the medical staff, which are carried by the federal government or the state and which can be billed reciprocally according to the proportion of research and teaching expenditure or expenditure for patient care. As an example, three "doctor pools" with different teaching and research percentages were defined in the model for paying the ACE. Doctors/scientists with a share of more than 30 percent for research and teaching (predominantly research and teaching), for example, could be rated with a higher percentage (share up to 100%) for the calculation of additional costs. Doctors/scientists with a share of 10 to 30 percent for research and teaching (low level of research and teaching) could, on the other hand, be rated with a lower percentage for calculating the (absolute) ACE. The number of doctors that are not active in research and teaching is not relevant for payment of the ACE.

Further recommendations on strategic planning and coordination between the university locations

As part of a study commissioned and performed on behalf of the Austrian Council for Research and Technology Development[7], in numerous interviews, discussions and meetings on the future possibilities for payment of the ACE and the cooperation of the medical universities with the university clinics, arguments were also gathered, and taken on board by the Council and directed as recommendations to the different stakeholders for the future development of the medical universities.

The Austrian Council recommends:

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[7] Austin Pock + Partners GmbH: *Befunde und Handlungsansätze zur Weiterentwicklung der Universitätsmedizin in Österreich.*
Der Klinische Mehraufwand und die Zusammenarbeit im Rahmen der Universitätskliniken, May 2014 (commissioned by the Austrian Council).

- **The set-up of joint structures in the administration and organization of the university clinics (hospital operators) with the medical universities.** The legal framework conditions for this must be created.

- **creation of service level agreements of the medical universities**

  Joint service level and target agreements of the medical universities with the responsible ministry should be provided for improved and efficient use of resources, e.g. for expanding and modernising the research infrastructure at the medical universities.

- **the development of a joint strategy for research and teaching at the medical universities – priority**

  Joint and special research strategies at the medical universities in coordination with one another should be planned in research in particular to promote research priorities with the most efficient possible use of resources.

- **the investment costs for research infrastructure and for construction and renovation work at the university clinics in terms of Austria as a medical research location must be negotiated between the federal government and the "Länder"**

  According to Austrian Federal Constitutional Law, the hospital operator is responsible for maintaining the infrastructure by matter of principle. Devices/equipment that are mainly used for research purposes are the responsibility of the medical universities and therefore of the federal government. Optimum financing is indispensable for securing high medical quality at Austrian university clinics. As unavoidable overlaps between research and health care mandates occur here, negotiations on the percentage of new constructions and modernisation of infrastructures between the federal government and states must be held. Financial resources, which are assigned here to research and teaching, should be exclusively available to the medical universities as research infrastructure and not used for financing equipment that is primarily required for patient care.

- **an efficient coordination of the strategic priorities of the university clinics with superordinate structure plans (Austrian Health Care Structure Plan, ÖSG, Regional Health Care Structure Plans, RSG)**

  The size of the care region and the corresponding "case numbers" to be expected at the locations are an essential factor for the successful operation of medical centres of excellence. A nationwide coordination is therefore critical for optimum planning. In urban areas and regions with low population density, additional strategies must be developed (decentralisation and priority setting in urban regions and centralisation in rural regions).

Duplicate structures that have formed at university clinic locations should (with little effect on capacity) be removed with increased cooperation with surrounding hospital centres.

Addendum to recommendation of the Council, "Cooperation between medical universities and university clinics in Austria"

Open discussion points and questions on political implementation

While working out the recommendation, statements and documents were provided by the rectors of the medical universities, which are intended to refer to requirements and open discussion points with regard to political implementation.

- Patient care, research and teaching are inseparably connected in the university hospital.
- The special feature of a medical university manifests itself in the fact that researchers care for patients and train students. There is an essential difference with other research organizations in additional patient care.
- An adjusted method for financing the additional clinical expenditure (ACE) must not result in a reduction of clinic research in Austria.
- Current ACE and ACE for investments for construction purposes and for equipment must continue to be considered separately. The costs for procurement, operation and maintenance should be assigned proportionally and evaluated at periodic intervals.
- The agreements must guarantee that the ACE is not applied for cross-financing the patient care by the federal government/the medical university, which falls to the hospital operators.
- The agreements and regulations should at least apply for three service level agreement periods.
- On the basis of the function of the university hospital as a central medical institution in full operation, the financing of the existing ACE must be guaranteed with appropriate transitional regulations and periods.
- For areas that overlap between the medical universities and the university clinics, the establishment of joint management (MedUni – hospital) for the strategic and operative management of the university hospital should be endeavoured.