

# Issues, Claims, and Concerns of Different Stakeholders of Healthcare Systems

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## INTRODUCTION

Adopting a holistic sociotechnical perspective, healthcare systems do not merely exhibit complex structures and functionalities but are also affected by the differing expectations, claims, and concerns of the systems' stakeholders (Guba & Lincoln, 1989; Haux, Winter, & Ammenwerth, 2004). Furthermore, the issues addressed at healthcare systems are not limited to the concerns and requirements of health service providers, whose primary and most fundamental concerns in general terms represent the assurance of their own economic well-being and ability to proactively operate as well as the development of sustainable strategies in order to realize their own interests whatever they may be (Carsten, Hankeln, & Lohmann, 2004; Kappler, 1994). Furthermore, the objectives of other health systems stakeholders such as hospital operators and financiers as well as (health) politicians, which may well be in contradiction to the objectives of mere health service providers, have to be incorporated when systematically analyzing healthcare systems (Horev & Babad, 2005; Peltier, Kleimenhagen, & Neidu, 1996; Staudinger, 2004a ).

If one now considers the capability of various stakeholders to implement their varying concerns, one may first assume that the political sphere in conjunction with hospital as well as healthcare operators and financiers has exclusive rights on organizing the system because of the common aptitude for developing and executing norms and directives in a way that allows the system's functionality to correspond to their own objectives. However, it has to be noted that in the

case of health service providers delivering respective services within these system specifications, the subsequent adoption mechanism may have a reversing effect as compared to the original intentions and objectives of, for example, the legislators (Lim, Lee, & Taehun, 2005; Puxty, 1994).

In this context of potentially competing (and even conflicting) stakeholders' interests, the quality and availability of process data is of particular importance for all affected system participants. When considering the questions of system transparency and functionality, process data which are valid and, more importantly, able to be evaluated, provide the basis for judging whether certain system objectives are actually able to be implemented and have been implemented and whether deviations have taken place or not. However, as the process data is again acquired by different stakeholders themselves, conflicts may arise with regard to different perceived levels of process support and data management may well become an essential part of the conflict due to different data management objectives of the system's participants (Lim et al., 2005; Power, 1999).

## BACKGROUND

The challenges involved with the potential conflict of competing issues, claims, and concerns of healthcare systems' stakeholders are currently being analyzed and observed on an international scale with a substantial amount of research focusing on the concept that participative models contribute to the solving of

this conflict (Byrne & Sahay, 2007; Chaulagai et al., 2005). However, opposing this popular presumption of participative models are the health service providers' fundamental interests in being involved in the—particularly financial—health resource allocation processes in a manner which is conducive to allowing the greatest range of possible actions as well as reactive capability for themselves (Robinson, 2000; Robinson, 2004).

Playing an important role here is the fact that it is not only the health service providers, operators, financiers, and politicians striving for the realization of their concerns. Patients as well as tax payers also have an important say in this potential conflict and wish to incorporate their interests, too. Moreover, conflict-laden moments may also take place within different groups of stakeholders themselves. If one regards the general public, for instance, one may well realize competing multistakeholder interests when taking the stance of tax payers, where people may be less inclined to pay higher taxes on the one hand, and considering the interests of tax paying patients, who expect an adequately financed healthcare system, on the other (Staudinger, 2004a).

Hence, this resource-based approach to the implementation and evaluation of healthcare systems outlined above may serve as an appropriate tool for maintaining an overview of the development of the cost-service ratio (Webster, 2006; WHO, 2000). This approach, however, appears to be fairly inadequate because of two reasons: First, and more generally, healthcare systems do not necessarily adhere to market economy criteria. Second, the resource-based approach only considers non-monetary phenomena such as the local provision of healthcare structures when actual services are provided at this level and parameters such as service-quality ratio as well as the necessity for the provision of certain medical services can be taken into account (Berger, Honig, & Spatz, 2006). This problem of incorporating relevant phenomena is more intensified by the fact that, through the formation of (virtual) medical networks, the analysis of the individual health service providers from a strategic perspective is no longer sufficient (Waitzkin, Jasso-Aguilar, Landwehr, & Mountain, 2005).

Beyond pure cost considerations, analyses of the effectiveness of medical facilities and national healthcare systems therefore have to be carried out on the basis of input and output analyses, quality analyses, and associated process analyses. This in turn has to be done on the basis of process data which are (1) comparable

and hence able to be analyzed on the one hand and (2) represent an integrative part of data management within the healthcare system on the other (Kaushal, Bates, Poon, Jha, & Blumenthal, 2005).

The challenges involved with the incorporation (and sometimes also unilateral resolution) of different stakeholders' issues, claims, and concerns into health systems shall be presented using the example of healthcare reforms in Austria.

## **ISSUES, CLAIMS, AND CONCERNS OF DIFFERENT STAKEHOLDERS OF HEALTHCARE SYSTEMS**

### **Trade-Offs between Interdependent Stakeholders' Objectives in Austria**

The Austrian healthcare systems can be first and foremost characterized by its decentralized and mostly federal nature in terms of decision-making as well as service-provision (Hofmarcher & Rack, 2006). As in other social insurance countries, virtually the entire national population is obliged to be health insured (save for a few exceptions such as soldiers, claimers of social benefits or prisoners) and people are bound by legislation to membership of a particular insurance association depending on the individual profession. The financing of hospitals and doctors, again, is in principle thought to be provided by social insurance associations too, even though the members' insurance premiums are not sufficient to finance the entire system. For this reason, federal government taxes are also incorporated in order to maintain a stable system (Hofmarcher & Rack, 2006).

In principle, each insured person is able to freely choose his or her hospital and physicians irrespective of whether these healthcare providers have contracts with the relevant insurance association or not. Financial compensation between different (in particular federal) insurance associations is only granted up to a certain extent, and in the past this has led to strong competition between the healthcare providers—and also between the insurance associations themselves (Hofmarcher & Rack, 2006).

Currently, the Austrian healthcare system is still lacking a reasonable amount of data exchange between healthcare providers as well as financiers, and neither central patient records nor process requirements or

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