

Work Package 2 Report

Austria



Work Package 2: Thick descriptions of

- Health Network Tennengau
- Sociomedical Centre Liebenau

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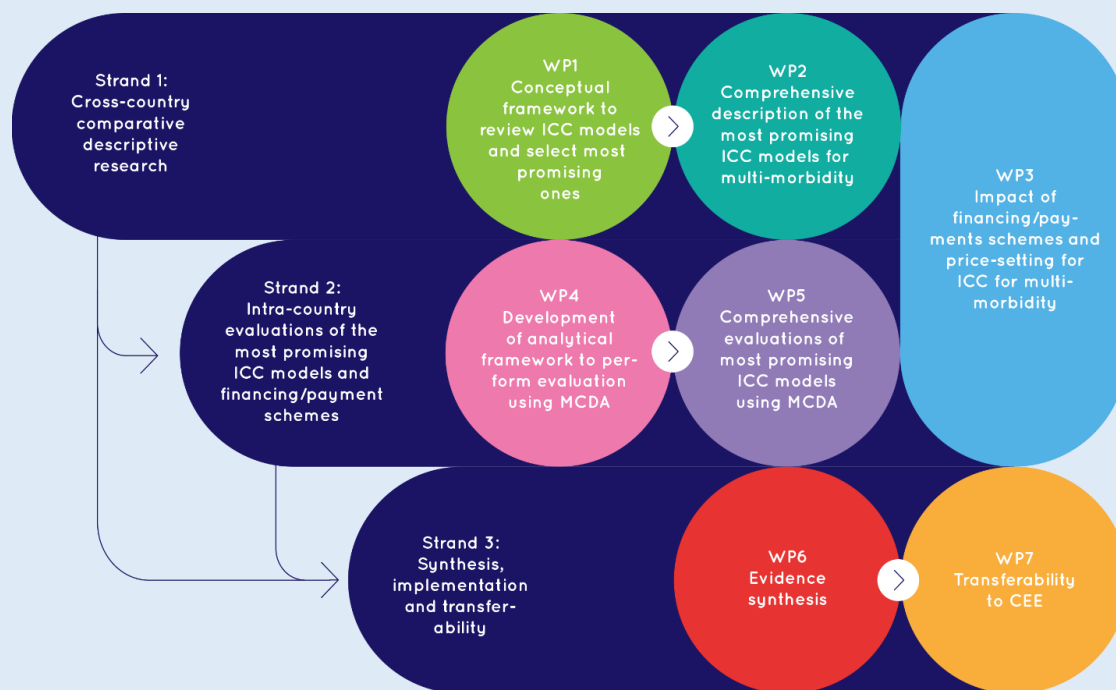
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The SELFIE project

SELFIE (Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, FInancing, and performancE) is a Horizon2020 funded EU project that aims to contribute to the improvement of person-centred care for persons with multi-morbidity by proposing evidence-based, economically sustainable, integrated care programmes that stimulate cooperation across health and social care and are supported by appropriate financing and payment schemes. More specifically, SELFIE aims to:

- Develop a taxonomy of promising integrated care programmes for persons with multi-morbidity;
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives to implement integrated care;
- Provide empirical evidence of the impact of promising integrated care on a wide range of outcomes using Multi-Criteria Decision Analysis;
- Develop implementation and change strategies tailored to different care settings and contexts in Europe, especially Central and Eastern Europe.

SELFIE strands of research and work package (WP) overview



The SELFIE consortium includes eight countries: the Netherlands (coordinator), Austria, Croatia, Germany, Hungary, Norway, Spain, and the UK.

Executive Summary

The **Health Network Tennengau (HNT)** is a bottom-up network comprised of social and health service providers and voluntary organisations. The Tennengau region is a rural area in the state of Salzburg. The HNT has its origin in a pilot project for medical home nursing care introduced in 1995 and has since gradually evolved into a comprehensive network. Since 2003, it has been organised as a not-for-profit cooperative that currently has 29 member institutions.

Service delivery within the programme is divided into 6 modules: (1) the core of the network which coordinates the entire programme, (2) a counselling service for the elderly in municipalities, (3) GPs and specialists, (4) geriatric remobilisation in the hospital Abtenau, (5) inpatient care for the elderly and social and psychological services, and (6) discharge management and transition care in the public hospital Hallein.

The governance structure of the HNT is characterised by a climate of equitable cooperation between the small and large network members. A high communication effort is required to uphold the contacts between the involved partners. Several new professional roles have developed as part of the programme: A senior citizen counsellor, who has a background as a nurse, assesses the patients' needs, provides information and coordinates social and nursing care. A discharge manager, who also has a background as a nurse, works in the hospital and performs a Discharge Risk Screening and organises the discharge. Furthermore, the role of a mobile specialised nurse is planned to be introduced soon.

The HNT uses a secure data network for patient data that has been established between the hospital and approx. 100 regional GPs. This data network is being well-accepted by all involved partners. Specific ICT applications to be used by patients are not part of the programme – the network rather stresses the importance of personal relationships.

The HNT receives annual funding from the Salzburg health fund as well as project-based funding from various sources. Financing problems are omnipresent within the programme, resulting in limited compensation of the involved partners, a lack of resources for public relations, as well as a lack of funding at the start of pilot projects. In consequence, the HNT relies to a high degree on voluntary work.

Several key findings can be derived from the thick description of the Health Network Tennengau. Shared decision-making as well as a culture of communication and trust are perceived as important features in

the programme. While there is high appreciation of the non-hierarchical structure, there is also a wish for further professionalization of the network. Sustainability of the network's financing is questionable, which is mostly due to structural financial barriers in the Austrian system.

The **Sociomedical Centre Liebenau (SMC)** is a bottom-up pioneer model providing health and social care predominantly to vulnerable and disadvantaged groups. It is situated in the socially deprived Liebenau district in the Austrian city of Graz and was founded by three physicians in 1984. It is currently organised as a collaboration of a group practice with the Association for Practical Social Medicine.

All activities of the SMC are based on a "social health and medicine approach" with a focus on inequality with respect to health and social status. It targets persons with physical and mental disorders and/or social problems. The SMC is operated by a multidisciplinary team including physicians, social workers and social pedagogues. This team offers both medical care (e.g. primary medical care, psychotherapy, addiction treatment, health promotion) and social care (e.g. various counselling services, community work). A continuous holistic assessment of the patient with an emphasis on social aspects is central to the SMC's work, as well as target group appropriate communication and joint case conferences.

The SMC is characterised by a flat hierarchy in the cooperation between physicians, assistants and social workers. It employs personnel with multiple qualifications in all positions and the entire team participates in hiring decisions. Within the programme, new roles have been assumed by "old" professions, in particular the responsible participation of all staff in joint case analyses and the assumption of wound management duties by assistants.

The SMC uses a specifically developed electronic data gathering and processing system. Patient-used ICT applications are viewed critically due to considerations of equitable access. However, there is a positive attitude towards EMRs, as they can be used to monitor patients' medication use and thereby avoid prescription medication addiction.

The SMC receives annual funding from the regional health insurance fund as well as project-based funding from various sources. Some of the work within the programme is also done on a voluntary basis. Financing is a central problem due to a missing financing framework for group practices in Austria. There are currently negotiations on its future funding.

Some of the key findings to be derived from the thick description of the Sociomedical Centre Liebenau are the following. Its focus on the combination of health and social problems particularly of low-income groups makes it one of the most innovative care models in Austria. Its central aspect is the collaboration of different healthcare and social care professionals. Sustainability of the programme, however, depends on future financing structures.

1. Methodological approach

This report is part of WP2 of the project SELFIE. The WP leader is the *Institute for Advanced Studies (IHS)* in Vienna, the WP co-leader is the *August Pi i Sunyer Biomedical Research Institute (IDIBAPS)* in Barcelona. The stated objective of WP2 is to comprehensively describe the 17 integrated chronic care (ICC) programmes selected in the course of WP1, covering the following features:

- **Barriers to and facilitators of implementation:** how were the most promising ICC models implemented and what were the barriers and facilitators during the implementation phase?
- **Patient centeredness:** how is the delivery of care designed around the patient?
- **Use of modern ICT:** which ICT (information and communications technology) applications are used in the most promising ICC models to support the care process and what are the requirements for implementing them successfully in the treatment of patients with multi-morbidity?
- **Use of self-management interventions:** which self-management interventions are used in the ICC models and how are they adapted to patients from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation?
- **Involvement of new professional roles:** are there new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC models and what are the barriers and facilitators in their successful introduction?
- **Existing evidence:** what is the existing evidence of the impact of the most promising ICC models?

The methodological approach chosen to achieve this objective is that of a “thick description”. For each of the eight countries participating in SELFIE, this report contains at least two¹ thick descriptions of the programmes selected in the respective country, resulting in a total of 17 thick descriptions.

The method of thick description is a well-established qualitative empirical approach. The basic idea was first introduced by the philosopher Gilbert Ryle (Ryle, 1949). In the 1970s, it was established as a qualitative method to investigate implicit social practices in their specific contexts by the anthropologist Clifford Geertz (Geertz, 1973). Geertz himself does not provide an explicit definition of this scientific approach. Studying thick descriptions by Geertz himself as well as other scholars, however, makes it

¹ Three in the case of the Netherlands.

possible to deduce the main aspects of the method. In the following quote, Geertz outlines the aims of the method:

“Setting down the meaning particular social actions have for the actors whose actions they are, and stating, as explicitly as we can manage, what the knowledge thus attained demonstrates about the society in which it is found and, beyond that, about social life as such. Our double task is to uncover the conceptual structures that inform our subjects’ acts, the ‘said’ of social discourse, and to construct a system of analysis in whose terms what is generic to those structures, what belongs to them because they are what they are, will stand out against the other determinants of human behavior. [...] provide a vocabulary in which what symbolic action has to say about [...] the role of culture in human life can be expressed.” (Geertz, 1973: 22)

In recent decades, Geertz’ methodological and conceptual work has influenced empirical research in several disciplines (McCloskey, 1988). In sociology, it is widely used in a variety of research fields, including research of care practices (Maloney-Krichmar and Preece, 2005).

As shown in Figure 1, a thick description covers several levels of depth of analysis. The starting point is a formal description, which provides information on the surface of the studied phenomenon.

Figure 1: Levels of the programme description



Source: IHS (2015)

In the specific context of the SELFIE project, this formal description pertains to the general organisational structure of the programme and formal relations of the involved stakeholders. The formal

description is valuable in itself, because it gives an overview of the domains and levels of integration, the individuals and organisations involved, the tools used and the processes employed. In particular, the formal description includes the following information:

- Name of the programme
- Contact details of the programme management
- Starting date of the programme
- Geographical scope of the programme
- Target group of the programme (type of individuals/scope/included combinations of morbidities)
- Number of persons treated in the programme (total and development over time)
- Aim of the programme
- Definition/understanding of “integrated care” (as far as described in documents)
- Definition/understanding of “multi-morbidity” (as far as described in documents)
- Definition/understanding of “person centredness” (as far as described in documents)
- Definition/understanding of “self-management” (as far as described in documents)
- Organisational form and ownership of the programme (including legal form)
- Involved partner organisations (payer(s), medical and social service providers), including subdivisions (e.g. departments of a hospital)
- Involved disciplines and professions

The formal description is mainly based on available literature, a variety of documents (e.g. official documents of the programme, grey literature) and expert information. A document analysis was performed on these materials, which comprise the first source of information and the basis for obtaining “hard facts” on the respective programme.

However, written documents are in general not suitable to give a deeper understanding of what actually constitutes the programme below its surface when put into practice. These substructures are, however, essential for the functioning of the programme. In addition to the formal description, the method of thick description therefore aims to gain insights on what lies beneath the surface of the studied phenomenon (see Figure 1).

For the purpose of gathering the necessary information, interviews were conducted with different stakeholders involved in the programme. These served as the second source of information. While the interviews were also used to complement the “hard facts” gathered in the course of the document analysis, their main aim was to obtain “soft facts” about the substructure of the programmes. Therefore, questions of “how” and “why” were at the centre of the interviews and the subsequent analysis of their contents. This comprehensive approach allows for a deeper understanding of what daily practice in the programme looks like and in which way multi-morbidity is addressed in the specific context of the programme.

A set of stakeholder types to be interviewed was defined in advance. This set consisted of the following stakeholder types:

A. Manager(s) of the programme

B. Initiator(s) of the programme: individuals or representatives of institutions that participated in initiating, conceptualising and planning the programme (e.g. representatives of sickness funds, physicians, etc...)

C. Representative(s) of sponsor/payer organisations: individuals or representatives of institutions that fund the programme on a project basis or on a regular basis (e.g. representatives of sickness funds, representatives of municipalities, representatives of associations, etc...)

D. Medical and social staff

D1: physician(s)

D2: non-physician medical staff (e.g. nurses), social staff, new professional groups (if applicable)

E. Informal caregivers (e.g. relatives, neighbours, volunteers)

F. Clients or their representatives (e.g. clients or persons in their close environment, representatives of self-help groups)

G. Other stakeholder(s): individuals or representatives of institutions, who turn out to be of specific relevance for the respective programme and do not fit in the categories A.-F.

For each stakeholder type, the WP leader set a minimum number of persons to be interviewed. However, considering that the 17 selected programmes involve very different kinds of stakeholders, a specific sample of interviewees was developed for each individual programme. The partners discussed these samples with the WP leader, in order to ensure a balanced sample structure in each programme.

For each of these stakeholder types, thematic focus areas were defined. Based on these focus areas, a set of interview protocols was prepared by the WP leader. The protocols accounted for the different backgrounds and relevant themes of the individual stakeholder types. This served the purpose of gaining insights into the programme from various perspectives. The included questions concerned, for example, the stakeholders' perceptions of delivery of care for persons with multiple chronic conditions, their roles and relationships in the programme, their specific problems and their personal views.

In general, all interview protocols were structured according to the following outline:

- A Brief introduction about SELFIE and the interviewer as well as clear information about the goal of the interview
- Signing and exchanging the anonymity agreement and the declaration of consent for recording
- First question: Regarding the person's qualification and position in the programme
- Next question: Regarding the main work of the interviewee and his/her specific role in the programme
- 1-2 main questions: Regarding the work in the programme (covering selected focus area of respective stakeholder type)
- (Direct and indirect follow-up questions)
- Last question: valuation of an important aspect of the programme

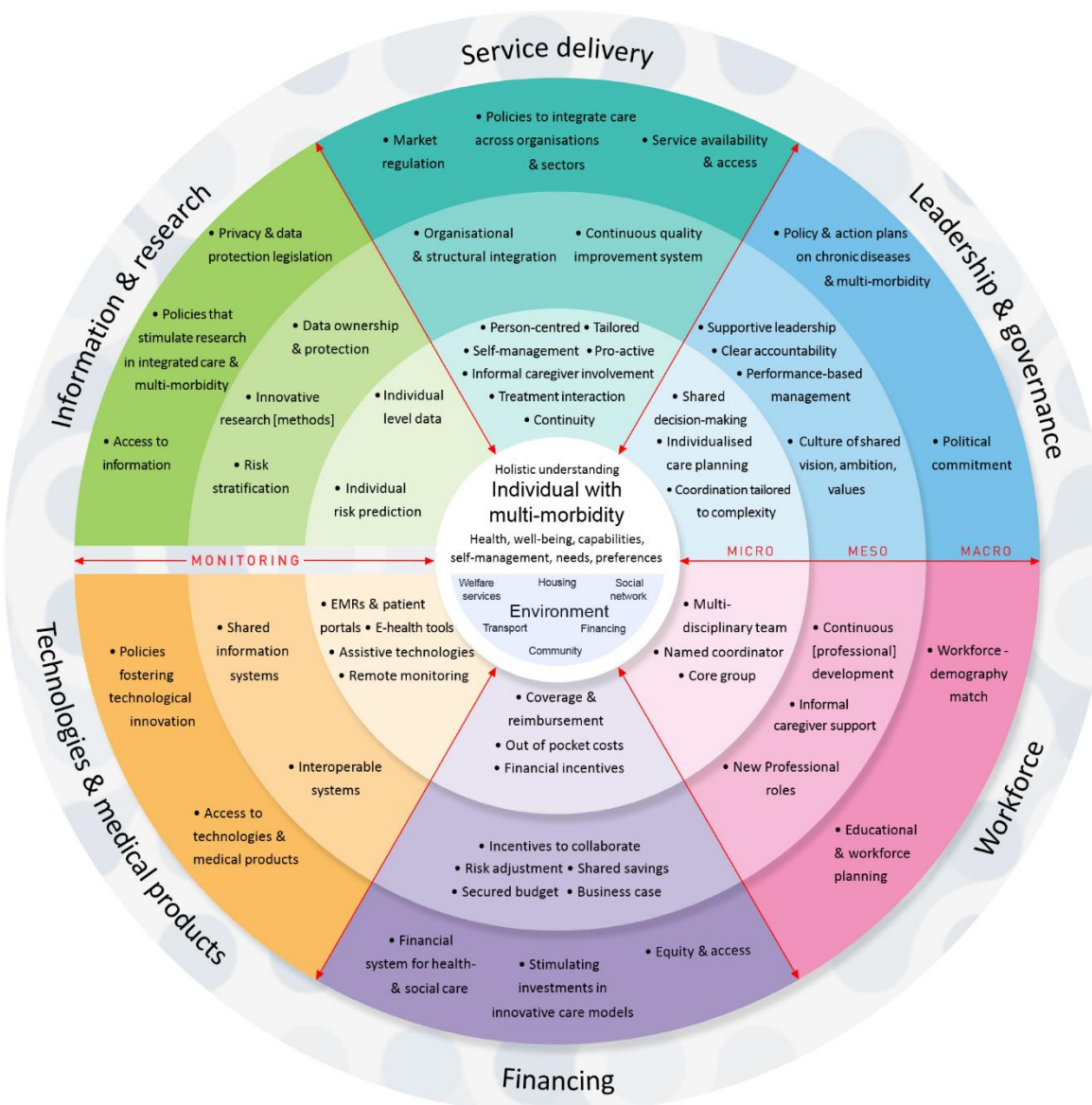
The interview protocols were adapted by the partners according to the specific context of each programme and interviewee, using prior knowledge obtained from the document analysis and from previous interviews. The interviews were carried out face-to-face and the interview duration was between 30 and 90 minutes. The interviews were recorded and transcribed. The resulting transcripts were analysed using the method of content analysis developed by Mayring (Mayring, 2001). This method involves the following steps of abductive interpretation²:

- Selecting units of analysis
- Paraphrasing these units of analysis
- Transforming the paraphrases to short forms
- Constructing categories, where possible

² Timmermans and Tavory (2012) define abduction as a "creative inferential process aimed at producing new hypotheses and theories based on surprising research evidence."

The thick descriptions are structured according to the elements of the conceptual framework developed in the course of WP1. The model is depicted in Figure 2.

Figure 2: Conceptual framework for the delivery of care for persons with multiple chronic conditions



Source: Leijten et al. (submitted manuscript, 2016)

Simultaneously, each thick description covers the eight tasks of WP2 set out in the SELFIE proposal, as well as one supplementary task (denoted by TS), which was agreed on by the project consortium at the kick-off meeting and actually belonging to WP3:

- **Task 1:** To develop the approach for the qualitative analysis of ICC programmes

- **Task 2:** To investigate how the most promising ICC programmes were implemented as well as to identify barriers and facilitators during the implementation phase
- **Task 3:** To analyse how the delivery of care is designed around the patient in the most promising ICC programmes
- **Task 4:** To analyse the relationship with long term care, social care and other partners beyond the healthcare system
- **Task 5:** To investigate which ICT applications are used in the most promising ICC programmes to support the care process as well as to explore the requirements for implementing them successfully in the treatment of patients with multi-morbidity
- **Task 6:** To analyse which self-management interventions are used in the most promising ICC programmes and how they were adapted to patients with multi-morbidity from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation
- **Task 7:** To explore new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC programmes as well as to identify barriers and facilitators in their successful introduction
- **Task 8:** To review existing evidence on the impact of the most promising ICC programmes
- **Task TS:** To explore the experiences of the stakeholders regarding financing and payment schemes

The WP leader provided the partners with continuous guidance in order to ensure that all partners are able to follow the methodological approach described above. This guidance mainly consisted in three parts. First, in the preparatory phase of WP2, methodological guidance materials were developed by the WP leader for all partners. These materials were presented to the partners in the course of the 2nd steering committee meeting in Vienna on January 25th and 26th 2016. Second, a special training course was held at IHS Vienna for researchers directly involved in the thick description on April 14th 2016. Third, all 17 thick descriptions were reviewed in order to ensure that they are harmonised to a certain degree. In this third part, the WP leader received support from the WP co-leader. The review process was divided as follows:

- **WP leader:** Germany, Netherlands, Norway and Spain
- **WP co-leader:** Austria, Croatia, Hungary and United Kingdom

However, it is part of the method that thick descriptions are not standardized but instead should be guided by what the prominent features of the individual studied phenomenon are. Therefore, the diversity in the thick descriptions reflects different topicalities, approaches, challenges and solutions.

As mentioned above, the method of thick description allows for a deep understanding of the implicit structures of the investigated programmes. This is of utmost importance also as a basis for further work packages of the SELFIE project. In the context of WP3, this deep knowledge can help to understand incentives of payment methods better and thus help to develop a comprehensive guide to financial and payment schemes that facilitate the provision of ICC to multi-morbid patients, as well as a guide to pricing of ICC programmes. In the context of WP4, this knowledge it can help to identify the relevant indicators to measure outcomes of ICC programmes. In the context of WP5, it can help to gain ideas regarding how to set up a suitable empirical evaluation of these programmes. Furthermore, it may help to better understand and explain the outcomes of the empirical evaluation.

Each report is structured in the following way: After the methods chapter, chapter 2 provides general information on the national health and social care system with a special focus on integrated chronic care for persons with multi-morbidity. This chapter covers the macro level of the conceptual framework and has the purpose of giving insight into the specific context the two selected programmes are embedded in. The programmes are subsequently described in detail in chapters 3 and 4, respectively. The descriptions present important findings obtained from the document analyses as well as the interview analyses. After a short overview of basic information about the programme, the findings are structured according to the six segments of the conceptual framework: service delivery, leadership and governance, workforce, technologies and medical products, information and research/monitoring and financing. Furthermore, the implementation process is described in an additional section. The descriptions conclude with a discussion of the respective programme. The discussion summarises the distinctive features of the programme and puts the empirical findings in context of the conceptual framework.

The report includes several quotations from the interviews. These are intended to present the stakeholders' perspectives in their own words. They were selected in the process of "abduction" and are used as a source of, e.g., typical forms of care practices, cooperation forms and motivations for participating in the programme. All quotations are anonymised and translated into English. In the appendix, however, they can be found in the respective original language.

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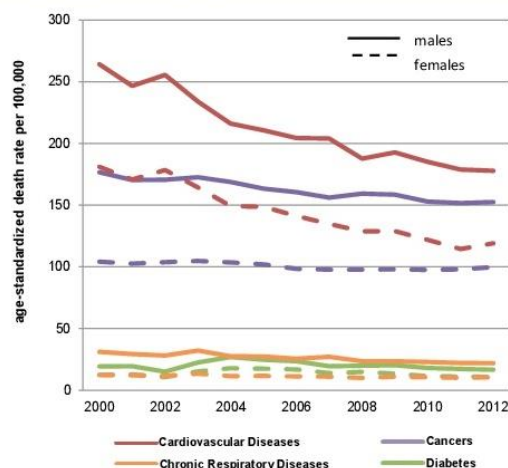
2. Macro level

Austria

Total population: 8 464 000

Income Group: High

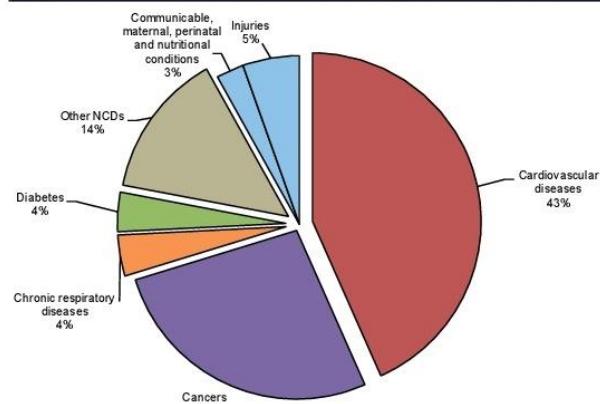
Age-standardized death rates



Percentage of population living in urban areas: 67.7%

Population proportion between ages 30 and 70 years: 54.0%

Proportional mortality (% of total deaths, all ages, both sexes)



Total deaths: 78,000
NCDs are estimated to account for 92% of total deaths.

Adult risk factors

	males	females	total
Current tobacco smoking (2011)	46%	47%	46%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	15.4	6.3	10.3
Raised blood pressure (2008)	31.4%	25.5%	28.4%
Obesity (2008)	21.0%	20.9%	20.9%

National systems response to NCDs

Has an operational NCD unit/branch or department within the Ministry of Health, or equivalent	No
Has an operational multisectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors	No
Has an operational policy, strategy or action plan to reduce the harmful use of alcohol	No
Has an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity	No
Has an operational policy, strategy or action plan to reduce the burden of tobacco use	No
Has an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets	Yes
Has evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach	No
Has an NCD surveillance and monitoring system in place to enable reporting against the nine global NCD targets	No
Has a national, population-based cancer registry	Yes

Source: WHO (2014)

Table 1: Key facts and figures of the Austrian healthcare system

	Austria
Key facts and figures	
Model of care	Bismarck
Demographic indicators	
Population	8,629,519 (2015)
Population ≥ 64 yrs (%)	18.5% (2015)
Life expectancy (yrs)	at birth: male: 78.6 yrs (2015) at birth: female: 83.6 yrs (2015)
Birth rate	life births per 1,000: 9.8 (2015)
Gross mortality rate	deaths per 1,000: 9.6 (2015)
Leading cause for mortality: SDR, diseases of the circulatory system SDR, malignant neoplasms	ICD-10: I00-I99: 411.8 deaths per 100,000 (2015) C00-C97: 235.8 deaths per 100,000 (2015)
Infant mortality	infant deaths per 1,000: 3.1 (2015)
Maternal mortality	deaths per 100,000: 4.7 (2015)
Healthcare expenditure	
Healthcare expenditure % GDP	total expenditure: 11.0% (2014) current expenditure: 10.3% (2014)
Healthcare expenditure per capita PPP \$/year	4,896 (current expenditure, 2014)*
Coverage (% population) (paid by taxes)	99.9% (2015)**
Public Payer	government, social health insurance
Subst. private insurance (% population)	34% (2010)***
Healthcare provision	
Number of physicians per 100,000 population	505.7 (2015)
Number of hospital beds per 1,000 population	7.55 (2015)

Sources: Statistics Austria. *OECD Health Statistics. ** Federation of Social Insurance Institutions. *** Hofmarcher MM (2013): Health Systems in Transition: Austria.

2.1. Service delivery

Description of the main policies and regulations shaping the health and social care system

The Austrian healthcare system is characterised by three important aspects:

- the constitutional make-up of the federal state with healthcare competences being shared between the federal level and the regional level (“Länder”)
- a high degree of delegation of responsibility to self-governing bodies
- a mixed model of financing, where state (federal state, “Länder”, municipalities) and social health insurance contribute almost equal shares

The Federal Constitutional Law regulates that responsibility for regulation of most areas of the healthcare system lies primarily with the federal government. However, an important exemption was made in regard to the hospital sector. For hospitals only the basic requirements are defined at the federal level, while the “Länder” are in charge of the specifics of legislation and implementation. Furthermore, the “Länder” have to ensure the availability of sufficient hospital capacity for inpatient care.

The inpatient sector is organized as follows: Every “Land” has its own State Health Fund, which receives funding from the federal authorities, the “Länder”, the municipalities and social security institutions. The state health funds are responsible for the implementation of federal guidelines and use the means at their disposal to finance inpatient care. In addition, every “Land” has its own State Health Platform, the governing body of its State Health Fund. In this platform the “Land” and social security institutions are equally represented and furthermore federal authorities and other relevant stakeholders (municipal authorities, chambers of physicians, hospital operating companies, etc.).

The outpatient sector is organized as follows: It is organized through negotiations between the 22 social security institutions³ or the Federation of Austrian Social Security Institutions on the one hand, and the chambers of physicians and pharmacy boards (which are organized as public law bodies), and the statutory professional associations of healthcare professions on the other. This cooperation works

³ The 22 social security institutions consist of 19 social health insurance funds, one accident insurance fund and two pension insurance funds.

within a legally defined framework to safeguard care and the financing of care. In some fields, social health insurers fulfil their obligation to ensure care provision by running own facilities.

Description of clear and well-designed national/regional policies/plans and programmes supporting integrated care for chronic patients with multi-morbid condition/complex care needs.

In 2005 the Austrian healthcare system was reformed. The aim of this reform was to overcome sectoral boundaries and to improve the coordination of planning, controlling and financing. One of its main measures was the policy tool called “*Reformpool*”. It was considered to be a significant step towards more coordinated care by providing a platform at regional level for both, “*Länder*” and social health insurances to jointly organize and fund lighthouse projects. These projects were expected to overcome the fragmentation of the healthcare system, to foster integrated care, to ultimately shift health services to the most adequate sector, to improve allocative efficiency and/or quality of care.

The phase-out of the “*Reformpool*” has officially started with the end of 2013. Although progress was made through some lighthouse projects, most of the challenges the “*Reformpool*” was meant to tackle and overcome are still in place. One reason for this was the absence of a mechanism to automatically introduce successful lighthouse projects into regular funding and to secure a nationwide roll-out. (Czypionka et al., unpublished manuscript, 2016)

In 2006, a “*Competence Center Integrierte Versorgung*” (CCIV) was founded in order to elaborate necessary foundations for provision of integrated care and has been in operation since then (see 2.6).

Description of specific policies for integration of social and healthcare programmes for management of patients with multi-morbidity with current or potential social needs?

In 2012, 10 health targets for Austria were launched. They aim to prolong the healthy life years of all people living in Austria in the coming 20 years (until 2032), irrespective of their level of education, income or personal living condition. Health target 10 reads as follows: “To secure sustainable and efficient healthcare services of high quality for all.” It fosters integrated care unspecifically by stating: “It is important in terms of quality, effectiveness and efficiency to have integrated, multi-professional and health promoting care systems and networks. Effective early diagnosis, early intervention, integrated

care services and enhancing patients' skills with regard to responding to their diseases are factors of key relevance.” (Federal Ministry of Health, 2012)

However, there are still important and difficult aspects like financing and the fields of competences between the federal government and the “Länder” which have not been completely resolved yet. Therefore, concrete policy measures were not implemented yet.

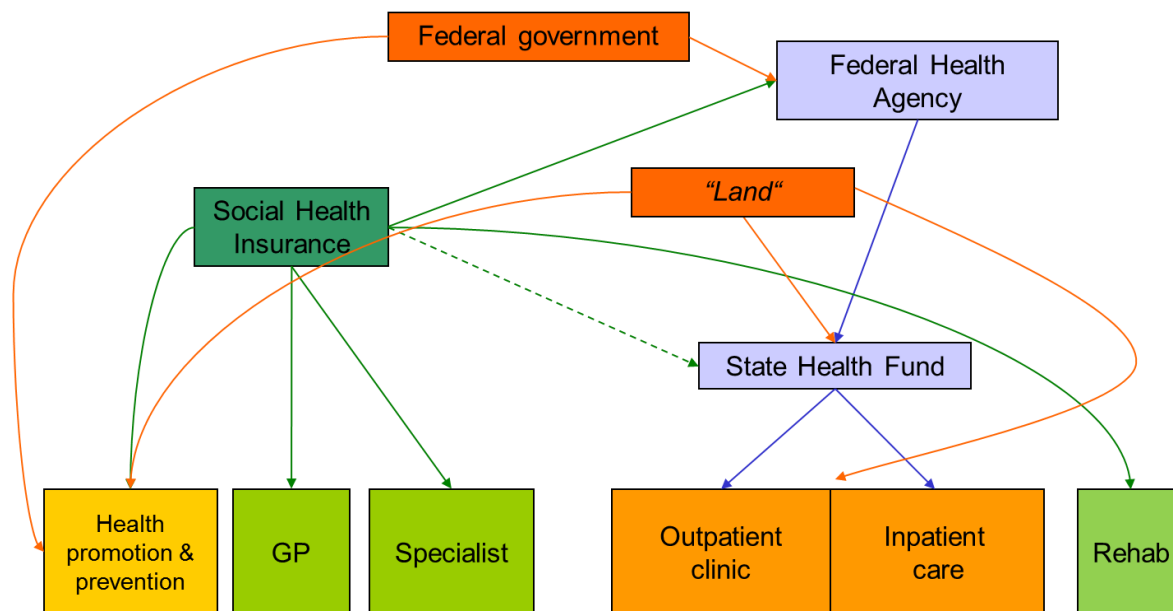
2.2. Leadership & governance

Briefly describe how governance of the health and social care system is structured at national/regional level and who the main actors are

The Austrian healthcare system is based on a social health insurance (SHI) model following a Bismarckian tradition. It is mainly funded by income-dependent contributions of the insured. Membership is compulsory, covering 99% of the population, who are allocated to one of the 19 social health insurance funds based on their “Land” and type of employment. Patients have free and easy access to most services and can freely choose their doctors and points of entry into the system due to the absence of gatekeeping. This contributes to a strong secondary care oriented and hospital centered system, featuring 278 hospitals with inpatient beds for 8.5 million inhabitants in 2015.

The Austrian healthcare system is governed by many cooperating actors, including the federal government, the Ministry of Health, the Ministry of Labour, Social Affairs and Consumer Protection, the “Länder”, the social security institutions and advocacy groups such as employers’ and employees organizations (the Federal Economic Chamber, the Federal Chamber of Labour) and professional associations. Nearly all expenses in the outpatient sector are borne by SHI. In the inpatient sector, SHI co-finances about 47 of total costs incurred by patients through a lump sum payment to the State Health Funds. The federal, regional and municipal levels contribute the residual funds. Despite its mandatory payment, SHI has no discretionary power in the inpatient sector and vice versa.

The organisation of Austrian healthcare system is illustrated in the figure below:



Briefly describe how governance of the integrated care initiatives/programmes at national/regional level is structured and who the main actors are

The Austrian healthcare system uses mainly two tools to govern integrated care initiatives/programmes: Article 15a B-VG about the organization and financing of the healthcare system (*“Artikel 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens”*) and the Austrian Structural Plan Health (*“Österreichischer Strukturplan Gesundheit”*)

Article 15aB-VG about the organization and financing of the healthcare system establishes a framework for financial relations between the federal government, the *“Länder”* and the local authorities. Although it states to aim at fostering integrated care, among others, it does not specify at all how to achieve this aim.

The Austrian Structural Plan Health is an overall national structural plan for the healthcare system. It plans the whole structure of provision – inpatient care, outpatient clinics and rehabilitation. Based on the Austrian Structural Plan Health, each *“Land”* develops its regional structural plan health. The Austrian Structural Plan Health as well as the regional structural plans health intend to improve the coordination between inpatient and outpatient sectors and to foster integrated care. However, no explicit measures how to foster integrated care are mentioned in any of these plans.

2.3. Workforce

How is the workforce prepared for and involved in the transitions and scale-up of integrated care?

In the Austrian healthcare system, integrated care has not explicitly been part of/a module in the curricula of physicians, nursing staff and other medical staff so far. Currently, however, the curriculum of nurses is about to be reformed in order to improve and diversify the care system. As there is hardly any information available on the design and content of the new curriculum, it is not clear, whether and if yes, which aspects of integrated care will be considered in it.

Describe the occurrence of new professional roles and occupations involved in integrated care

In course of fostering integrated care in the Austrian healthcare system two new professions have been created:

- senior citizen counsellors (*“Seniorenberater“*):

The senior citizen counsellors are competent in health, social, care, legal and financial matters. The core task of the senior citizen counsellors is to provide independent and impartial information and to coordinate professional relationships concerning social/nursing care, legal and financial matters.

- discharge manager (*“Entlassungsmanager“*):

The discharge manager is a registered nurse with several years of professional experience. He/she needs knowledge of medicine, nursing and social work as well as the skill for empathetic handling of patients and socio-psychological de-escalation. The discharge manager performs needs assessment and management tasks in the hospital, but no medical or care tasks. Moreover, it is the duty of the discharge management to perform a Discharge Risk Screening (DRS) with four dimensions (self-care deficit, living alone, provision of care for relatives, prior use of home care services).

2.4. Financing

Brief description of the funding system for the health and social care sector in general and integrated care specifically

Total healthcare expenditures/current healthcare expenditures in Austria amounted to 36.3 billion € /33.8 billion € in 2014. 77% of the current healthcare expenditures were financed through public funds. The social insurance funds were the most important source of finance, accounting for approximately 45% (€ 15.1 billion) of current health expenditure. The Federation, Länder and local authorities covered approximately 31% (€ 10.5 billion) of current expenditure on healthcare.

When it comes to integrated care there is no defined funding system. Usually regional authorities and funds, like regional social health insurance funds and municipalities, provide some financial means. Additional funding is requested from organisations related to individual projects, in order to enable their implementation.

Are financial policies aligned with large scale implementation of integrated care?

Currently, financial policies are not aligned with large scale implementation of integrated care in the Austrian healthcare system. The “Reformpool” was a financial policy tool to foster large scale implementation of integrated care. However, as mentioned above, the “Reformpool” does not exist anymore.

How is sustainability of funding for integrated care ensured?

Currently, no budget is explicitly designated for integrated care in the Austria healthcare system. Thus, the sustainability of funding for integrated care/integrated care projects is not ensured per se. Rather, it always depends on individual projects and related negotiations.

2.5. Technologies & medical products

Describe national/regional policies to promote the use of ICT to support integrated care?

Currently, there are no policies to promote the use of ICT to support integrated care in the Austrian healthcare system.

Describe national/regional policies stimulating e-health applications and assistive devices?

ELGA (electronic health files) is being introduced gradually since the end of 2015. First, it was launched in public hospitals. Step-by-step ELGA will also be rolled-out to GPs, specialists and pharmacies. In May 2016, ELGA has been introduced in two pilot regions. ELGA enables easier access to health data for patients, doctors and pharmacists. E-medication, which is an important part of ELGA, has started in one testing region (Deutschlandsberg in Styria) in May 2016. The nationwide roll-out of E-medication will start in the beginning of 2017. It provides all concerned parties with information about prescribed and bought medication. ELGA is the most comprehensive e-health initiative in Austria and has been pursued since 2010.

2.6. Information & research

Describe legislative framework on data privacy with respect to integrated care? Does it follow the current EU directive? Is it constraining implementation of integrated care?

No information available.

Describe specific national/regional research programmes for integrated care and/or multi-morbidity

The most important research (programme) regarding integrated care in Austria is currently conducted by the “*Competence Center Integrierte Versorgung*” (CCIV). It was established by the social health insurance funds and serves as a central point for capacity building and concentration of expertise and operating experience in the field of integrated care. The CCIV refers to scientific principles of integrated care.

The CCIV functions as central department where expertise and experience regarding integrated care is collected and generated. Therefore, it is not only a research institution but also a point of contact for patients and health facilities.

The CCIV especially focuses on integrated care for children and teenagers, breast cancer prevention, diabetes mellitus type II and multi-morbidity. Additionally, it promotes the exchange of knowledge and

information among social health insurance funds and health facilities in order to improve the treatment of patients.

Describe if and how they are embedded in larger (European-wide) innovation & research platforms for integrated care?

No information available.

2.7. References

Czypionka, T., Röhring, G., Ulinski, S., Berger, M. (2016): Analysis of the “Reformpool”-activity in Austria: Has the challenge been met? Manuscript, unpublished.

Federal Ministry of Health (2012): Health Targets for Austria. Relevance – Options – Contexts.

World Health Organization (WHO) (2014). Noncommunicable Diseases (NCD) Country Profiles.
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3. Programme 1: Health Network Tennengau (*Gesundheitsnetzwerk Tennengau*)

3.1. Basic information

The thick description of the Health Network Tennengau (HNT) is based on an analysis of 13 documents and 16 interviews with a total of 23 representatives of all stakeholder groups. Table 2 gives an overview of the structure of the interview sample.

Table 2: Sample structure for the Health Network Tennengau case study

	Stakeholder type	Interviews	Interviewees
A	Managers	2	2
B	Initiators	2	2
C	Representatives of payer organisations	3	3
D1	Physicians	2	2
D2	Non-physician medical staff, new roles	4	8
E	Informal caregivers	2	3
F	Clients or their representatives	2	2
G	Other (regional association)	Together with D2	1
	Total	17	23

The high number of interviews with non-physician medical staff (and their representatives) is due to the fact that these professionals play a central role in the HNT. Three interviewees brought a second or third person to the interviews at short notice, which resulted in an unexpectedly high total number of interviewees. However, this was welcomed by the research team, as these persons added valuable additional perspectives to the analysis.

The interviews were carried out by either one or two researchers and lasted between 40 and 60 minutes each. They were held either on the premises of the respective interviewee's organisation or, in the case of the clients, at home. A second interview was conducted with one interviewee due to his special role in the network both as an initiator and as a physician. The interviews were recorded and professionally transcribed. The data was analysed using a content analysis approach based on Mayring. In the analysis process, additional information was repeatedly sought and provided by e-mail and phone by the HNT's managing director.

Table 3 gives an overview of basic information about the HNT.

Table 3: Basic information about the programme

Information category	Description
Programme name	Gesundheitsnetzwerk.at
Contact details, programme management	Mag. Gabriela Pichler, Tennengauhaus, Mauttorpromenade 8 5400 Hallein/Pernerinsel, Tel. 06245/70 05 020, Mobile 0664/4114646
Starting date of the programme	1995 as pilot programme, since 2002 as cooperative
Geographical scope	Tennengau
Target group of the programme	All inhabitants of the region Tennengau. Although all inhabitants of the Tennengau are the target group, the activities are especially geared towards senior citizens who require social care. The HNT does not distinguish between persons with multiple chronic conditions and persons who are generally healthy but require care services due to limitations in old age.
Number of patients treated in the programme	The region has 54,000 inhabitants.
Aim of the programme	On patient level: ensure that healthy population remains healthy; facilitate the recovery of ill patients; provide relief to chronically ill; preserve the dignity of dying patients; On system level: improved cooperation between intra- and extramural health services for more efficient patient care.
Definition/understanding of “integrated care”	No definition of integrated care was found; the programme has grown over decades.
Definition/understanding of “multi-morbidity”	No definition of multi-morbidity was found.
Definition/understanding of “patient centredness”	No definition of patient centredness was found.
Definition/understanding of “self-management”	No definition of self-management was found.
Organisational form and ownership	Not-for-profit cooperative association with limited liability (Gemeinnützige Genossenschaft m.b.H. im Revisionsverband des Raiffeisenverbandes Salzburg), it is owned by 29 members of the cooperative*
Involved partner organisations	29 partner organisations collaborate within the programme, including the majority of social and health service providers and voluntary organisations in the region* Moreover, payer organisations are involved, such as the regional municipalities (Regionalverband Tennengau)
Involved disciplines and professions	Primary, secondary and social care services, including the fields of inpatient care, medical therapy, preventive healthcare and self-help, social and home nursing services, an insurance, a mediator and a lawyer *

Source: Gesundheitsnetzwerk.at, 2016, Gesundheitsnetzwerk.at, o.J.a, Schwaiger, 2008.

*The Health Network Tennengau is organised as a not-for-profit cooperative and it is owned by 29 individuals and member organisations. These members include the majority of social and health service providers and voluntary organisations in the region. Each member has one vote in the cooperative. The cooperative comprises of partners within and beyond the healthcare system: two hospitals (in the cities of Hallein and Abtenau), physicians (Dr. Christoph Dachs, Prim. Univ.-Doz. Dr. Karl Miller,

other district doctors in the Tennengau), a hospital nursing director (Mag. Karl Schwaiger), nursing homes (Abtenau, Kuchl, Hallein), voluntary organisations providing long-term and social care services (Austrian Red Cross, Hilfswerk Salzburg, Arbeiter-Samariterbund, Caritas, Diakonie.mobil Salzburg, Pflegewerk Austria and Volkshilfe Salzburg), professional groups (state association of psychotherapy, national association of psychologists, AVOS- working group for preventive medicine), hospice care (Hospiz Bewegung Salzburg), a senior center, self-help groups, a counselling organisation for chronic illnesses, a spa hotel, a pharmacy, an insurance company, a memory psychologist, a mediator and lawyers. (Gesundheitsnetzwerk.at 2016)

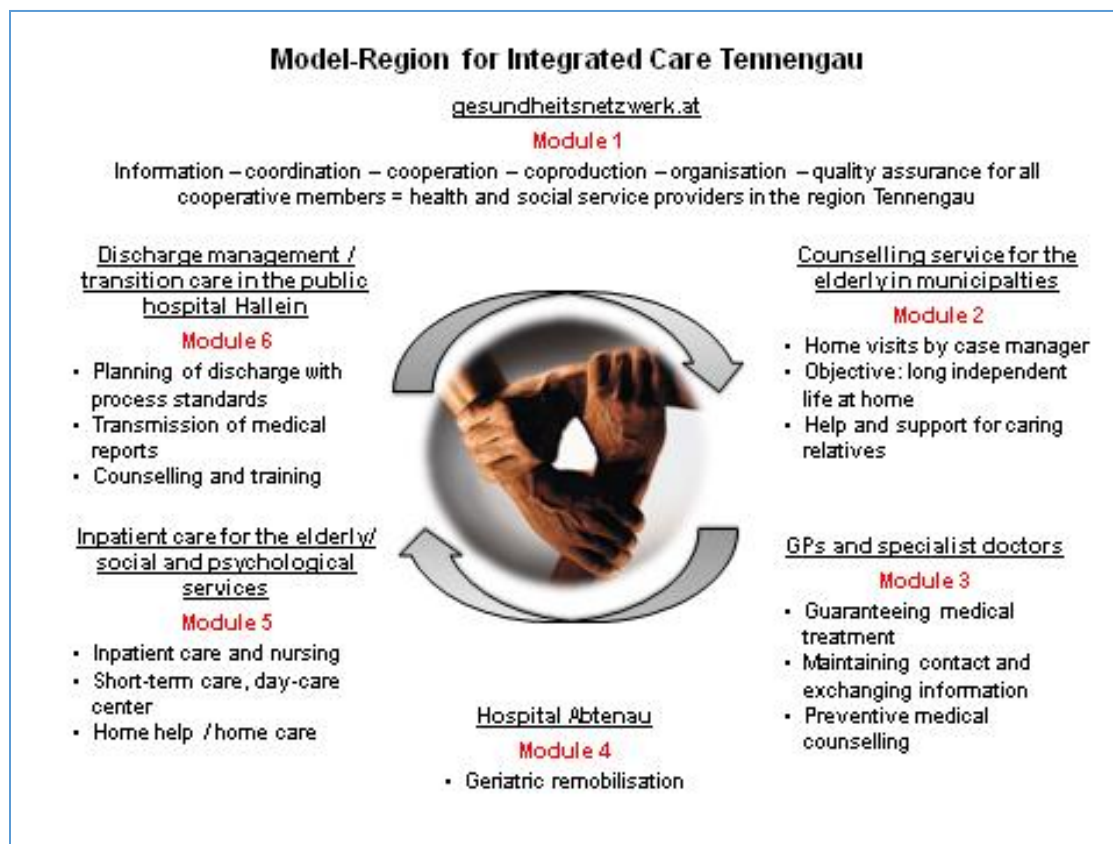
3.2. Service delivery

3.2.1. Design of delivery of care

The Health Network Tennengau puts the patient at the centre of the care process. Its aim is to facilitate integrated care around the patient, namely to provide information, counselling, coordination and interface management through case and care management and the optimisation of procedures through improved communication. (Schwaiger, 2008) The interconnectedness with non-medical service providers is a central concern for all stakeholder of the HNT. All persons involved view an effective cooperation between medical and non-medical actors as a constitutive condition for integrated care, equally concerning doctors (GPs and specialists), health managers, social workers and new professions (P1-1, P6_1, P10-1). Thus, the HNT is at its core not a medical programme, but a network between doctors, hospitals, care facilities and diverse social institutions (P3_1, P5_1). The activities of the health network are embedded in the healthcare system and should improve the care process (P16_1). The governance structures of the HNT include all major players of the healthcare system and the network has continuously received political support and promotion (P12_1, P15).

Figure 3 shows how integrated care is established in the region and how the programme is embedded in the healthcare system. Within 6 modules, an integrated care process is organised around the mostly elderly patient. Module 1, the health network, provides information, coordination, cooperation, coproduction, organisation and quality assurance for all cooperative members. Module 2 is the counselling service for the elderly, which advises both patients and relatives through home visits. Module 3 comprises of GPs and specialists. Module 4 consists of activities at the hospital Abtenau, which provides geriatric remobilisation. Module 5 includes inpatient care for the elderly and social and psychological services. Module 6 is the hospital discharge management.

Figure 3: Tennengau as model region for Integrated Care



Source: Translated from Schwaiger, 2008: 31.

Initiatives of the Health Network Tennengau

The HNT is not a single programme, but consists of several activities that aim at patient-centred care. These initiatives are usually set up as projects around problems that arise in the Tennengau population. The initiatives include (Gesundheitsnetzwerk.at, o.J.a):

1. The introduction of a handover and takeover consultation in the hospital for patients whose health status or care needs require increased support. Home care nurse, hospital nurses and relatives together compile a report for the transfer.
2. The transmission of the doctor's letter and the diagnostic findings directly from the hospital to the resident doctors via a proprietary IT-solution. About 100 physicians are part of this network.
3. Establishment of the hospice initiative Tennengau
4. Internet portal to inform the population about all health services in the region www.gesundheitsnetzwerk.at

5. Organisation of training sessions and panel discussions concerning topics of medicine, care and social affairs.
6. Project “Pfündiges Abnehmen” to lose weight; the network organised, financed, quality-controlled and evaluated the project and 30 obese patients reduced weight with the medical control of the hospital Hallein.
7. Dementia project: Development of a concept for an early diagnose and treatment of dementia, including a training for relatives.
8. Counselling services for the elderly: Two senior counsellors visit senior citizens free of charge in Tennengau at home. They advise on all questions concerning the health and social sector, coordinate the need for care and optimise organisational procedures. The aim is to enable senior citizens to stay at home as long as possible.
9. Reformpool project “Case- und Care management Tennengau”: Hospital patients without a sufficient social network at home are provided with discharge management that organises care within the network. Moreover, patients who were suspected to have unmet needs for care and their relatives were offered guidance on and contact with all available care services.
10. Targeted interface management: Weekly information on the homepage about available beds in nursing homes in the state of Salzburg as a service and to avoid “bed-blockers”.
11. Development of recommendations for Salzburg to reduce avoidable transports from nursing homes to hospitals.
12. SAVE HIP: Research project to determine the factors that can lead to a re-admission of previously hospitalised fall-prone patients.

Counselling services for the elderly

The counselling services of module 2 emphasise their prophylactic character and outreach services, providing telephone consultation and home visits. The project is implemented in 9 of the 13 municipalities in Tennengau for all inhabitants who are older than 80. Initially, more age groups were supposed to be included, but this turned out to be financially infeasible.

The senior counsellors first call the potential clients to arrange a home visit. This lowers the barrier to participate and provides the possibility to assess the senior citizen in his or her natural environment. Informal caregivers are also invited to attend. During the visit, the counsellors assess the care needs of the clients, their capabilities and environment holistically. At the centre of the conversation is the

personal discussion about the current health situation of the clients and expected changes. In this way, the counsellors can tie up on the individual capabilities, resources and wishes of the patient for an independent life. (P1_1)

Furthermore, they provide information material and contact details on how the required care can be obtained. Thereby, they inform both the senior citizens and their relatives and informal carers. Moreover, they provide help with diverse applications, the procurement of aids, the prevention of trip hazards, dementia counselling, preventive counselling and health promotion, how to remain independent and with information on insurance for caring relatives. Moreover, they support relatives if they are overly challenged by the care of the senior citizen. If the senior citizen's situation is complex, the nurse sets up case management. 67.4% of the senior citizens were visited once and the remainder received up to a maximum of 7 home visits. On average, there were 4 telephone contacts per senior citizen. Political support comes from the mayors of the region, as they personally invite senior citizens to participate in the counselling services when they turn 80 years old. (Gesundheitsnetzwerk.at, o.J.b) Moreover, the mayors provide the lists with all inhabitants who are eligible for the project.

Discharge Management

The project "Case and Care management Tennengau" is located in the hospital Hallein, but combines inpatient and home care. Already when a patient is admitted to hospital, an assessment is conducted whether the patient could be confronted with special problems when discharged. Whenever this is the case, a centrally organised discharge management takes over responsibility. The discharge management unit assesses the care needs of hospital patients when they are discharged. The discharge manager assesses four dimensions

- self-care deficits
- living situation
- patient as carer for others
- whether home care services were used before.

Following on from this Discharge Risk Screening (DRS), the patients and their relatives are offered tailored advice and contact with all available care services. (Göbel and Schwaiger, 2010) The discharge manager distinguishes between patients who wish help with contacting care services, who need

information but the relatives organise everything and who do not need care or do not like information. This choice is documented and submitted to the attending physician.

If the patients wish to be assisted, the discharge manager calls the most suited care organisations. She informs them about the patient's individual care needs. This is possible, as the hospital and the care organisations have good and lasting relationships due to good prior experience. Thus, the care organisations often accept difficult cases that would not receive a place at all or not as fast without this trusting relationship.

The interviews show that the clients are very satisfied with this form of communication. They appreciate the tone and the freedom for their own decision:

IP: I mean, I could go, of course, but I was very weak. I should – I should now go regularly, but the diarrhoea prevents me. (...) In the hospital, I think it was Miss H., she gave me good advice. She would also have helped me to get some kind of 24-hour care. But in the end, my sons arranged it, because at first I refused to have the 24-hour care because I said that I can't afford it, because it's not cheap. I basically refused and said that I would manage somehow. (...) My sons then talked me into it. (P14_1, 374-384, 399)⁴

SAVE HIP

The project "SAVE HIP – Posthospitaler Verlauf von SturzpatientInnen" (post-hospital development of fall patients) is a new project of the HNT and combines inpatient and home care. Fall prone patients and their relatives are informed during their hospital stay about the advantages and usage of hip protectors. If they are interested they are given two such protector pants free of charge for the use at home. The HNT has secured a sponsor who covers the cost of 140€ per patient.

IP: In the hospital, when this project is started and the client agrees to take part, a basic dementia assessment is first carried out so we know if the person is also able to understand what it's all about. Then the patient and their relatives are interviewed and a month later a questionnaire is filled out at home about the carrying, but also about the household situation, tripping hazards, etc. (P4_1, 370-375)

⁴ All quotes are taken from the interviews with the various stakeholders. They have all been anonymised. I, I2 stand for interviewer, IP, IP2 for Interview Partner. Square brackets [Dr. X] are used to indicate anonymised names or not fully understandable text passages or to explain the word before it. Any words that are underlined are words that were emphasised by the interviewees. (...) indicates the omission of a passage that was not relevant to the statement. The interview and line numbers are given at the end of each quote.

The pants shall not only mitigate the consequences of a fall, but also reduce the number of falls. Experience has shown this is the case. Patients that wear the protectors have less fear to move alone at home. The professional carer confirms that she cannot think of a patient who used these trousers and fell. This should be confirmed by an evaluation of the project. The aim of the project is to prove the effectiveness of the offer and thus motivate the health insurance to partly cover the financing.

Characteristics of the design of integrated care in the HNT

The design of integrated care for chronically ill is based on the following characteristics in the HNT:

- A medical and care oriented problem understanding and a corresponding definition of the target group of multi-morbid people.
- It is practically put into effect on a network level as gradual innovate project formulation, proposal and project securement.
- The generated effects are manifold and are reflected in a long-lasting willingness to cooperate, a high patient satisfaction and a measurable hospital relief.

Medical and care oriented problem understanding and target group definition

According to their own understanding, the integrated care of multi-morbid patients plays an important role in the work of professional stakeholder of the HNT, and was the main reason for its inception. Thereby it is notable that the term multi-morbid is not actively used, but only in reaction to matching questions by the interviewer. Often, simply the term chronically ill patients or chronically ill clients is used, but in the meaning of people with multiple chronic conditions. Throughout all interviews, multi-morbid patients are not considered separately from chronically ill patients with a singular disease. Multi-morbid patients are rather absorbed within the target group of chronically ill. A reason for this can be found in the population orientation of the programme. The programme is not focused on special disease patterns or therapeutic pathways, but on the health and care problems of the aging population in this rural region and especially on the individual aptitude of care due to many years of care deficiencies. Thus, “multiple” is understood as the overlap of medical, nursing and social problems and their integrated provision. The consideration of medical problems of various illnesses is a part of this field of activity. The analysis of the interviews shows a complex understanding of “(multi-morbid) chronically ill persons”, which can be shown in the statements of a doctor, a carer, a health manager and a health politician. The following understanding reflects a medical perspective:

I: Do multi-morbid, chronically ill patients play a special role in your work or are they just one part of what you do and not worth a particular mention? What experience do you have here? (...)

IP: Chronically ill patients naturally play a special role nowadays, because they need special attention. These are the patients we see frequently. Those for whom we often also have to adapt the treatment. Such patients are very different to acute patients with the flu or some form of acute pain. They come on time, get treated and then leave, and I don't have to give them any further thought. Nowadays, of course, the number of chronically ill patients is on the rise, because people are living longer, and treating these patients is a particular challenge, and I think that integrated care really does of course play a big role here. What are the challenges in treating the chronically ill? The challenge is making sure that you treat them correctly throughout their illness. And that brings us to this somato-psycho-social model, which is very, very important: seeing the patient in his or her entirety. A patient with chronic diabetes, for example, whose illness is also caused by an unhealthy lifestyle. The big challenge in such a case lies in motivating such people to change something in their lives, and then looking closely at what their life, their family situation is like? Can I trust the patient to change their lifestyle? Or are they not going to change at all, and I will just have to treat the illness in a way that accommodates their lifestyle? Those are the challenges we GPs face, and I think that we are probably better at this than the consultants, who naturally only sees a particular aspect, and that's why I'm for doing this in very clear cooperation with the consultants, who we need with great regularity, but I believe that this care, this ongoing care is the key aspect in treating and supporting a chronically ill patient. (P16_1, 12-39)

Chronically ill patients are a permanent part of the system and need a holistic and long-term treatment. It is important to frequently adapt treatments and this requires the cooperation with specialists. The illnesses of these patients need to be "accompanied" and this requires analysing the illness in its complexity and with its interdependencies with social problems. The doctor cannot only address the patient's disease, but needs to address the whole person. Moreover, it is often necessary to motivate patients to change something in their life and take the family context into account. A judgement has to be passed, whether the person can achieve such a change or whether the doctor has to accept a potentially changeable progression of the disease. Thus, self-management is not achievable by all patients, and the proper assessment demands social competence and clear communication from the

doctors. The focus is here on a cooperative and flexible accompaniment and guidance of patients that systematically exceeds the medical system.

A mobile carer summarises her understanding of multi-morbid patients:

IP: Particularly in the case of such multi-morbid or other clients [who have social or mental problems, it is difficult. But]⁵ I wouldn't often describe it as 'difficult', because we don't see it as so difficult at all, but: they are different. They need a different kind of care, but that's when, for example, all these counselling sessions or the support that goes with it come into play, it's not the actual treatment that's more complex, it's what goes with it that becomes more complex. That's my experience from the care perspective. I see it happening [with my own eyes]. Like with Mister X. I wouldn't have been able to treat him [once on a specific day] because I first had to make sure that all the things were covered. During the consultation alone, I had to talk to him [about how he was feeling and that he should get dressed] for a quarter of an hour until I had him at the stage that he would even get out of bed, because someone was there and I think he suffers from hallucinations on top of everything else. So there's definitely a lot to it. (P10_1, 580-590)

The quotation shows that multi-morbid patients are different for professional carers than patients with simple diagnoses and therapy plans. Mrs. U mentioned an alcoholic patient with behavioural problems, but not even this patient should be discriminated against by being called "difficult". She emphasised that not the care is more challenging for patients with social problems, but the work surrounding it, e.g., getting the patient to dress. However, this work around is often a prerequisite for performing the actual care. This time consuming tasks constitute a considerable burden, as financing for care and for GP consultations is already tight, and the time is then lacking either for medical care or the GPs are not fully paid for their time.

The health manager further explains:

IP: Patients who are multi-morbid and chronically ill [are those] who are not easy or problematic to accommodate or care for, people who are released from hospital, i.e. elderly, multi-imorbid people. (P5_1, 42-44)

⁵ The [explanation in brackets] should help to understand the word said before by the interviewee e.g.: "multi-morbid ore other clients".

The quotation shows that the stakeholders of the HNT are aware of the problems that multi-morbid patients bring along. At first, there is a challenge for care, a proper “accommodation”. Thus, the hospital focuses on discharge management. Secondly, the medical care is also perceived as „not easy“, because integrated medical interventions are not directly accessible for the hospital alone and difficult to organise on the countryside. Thus, interface management between inpatient care, care at home, home nursing care and social care is “problematic” and a challenge for all involved.

The federal state government also has a problem oriented view of multi-morbid patients, but its interest to save costs by integrated care dominates:

IP: Why do we need these facilities [like the health network Tennengau and the PHC-centres that are planned in Austria]? Because we can't have all the people with chronic illnesses or multiple chronic illnesses permanently in the outpatient departments [of hospitals], because that is the most expensive form of care and is also not the best point of service. And we need the PHC-centres for these chronically ill cases in particular. (P15_1, 171-174)

The quotation reflects that multi-morbid patients are often used as a synonym for all long-lasting and expensive cases of illness. Local health policy is concerned with the integrated care of all chronically ill and does not highlight the subgroup of multi-morbid patients. A best point of service as the ideal point in the system to receive medical treatment should be realized for all chronically ill.

Network level as gradual innovate project development

The cooperative and especially the yearly general meeting of the HNT are used by all stakeholders as regional information exchange for integrated care. People report from their own work, share interests and build trust. This can eliminate misunderstandings and facilitate cooperation. The network also informs outside doctors in cooperation with the regional doctor's association or association for general practice, as only a few outpatient doctors are members of the network (P6_1).

When a new project is developed, not all members participate, but only a core team (doctors, hospital manager, manager of the health network) that reports to other interested stakeholders. The project is then developed in regular project meetings. The manager of the HNT is responsible for lobbying the payer organisations [P6, P8].

One of the most important (innovate) tasks at network level is adapting the financing structures of new projects to the framework conditions. One standard solution is the transfer of ownership of a project to

other entities. For example, the discharge management was integrated in the hospital in order to secure financing. Now, the discharge management is primarily used to reach the goals of regional health policy, namely to reduce hospital admissions (P5_1).

The interview statements concerning the concrete care work show for both the medical and the non-medical staff a strong orientation on individual health problems of clients [P1, P4, P10]. The cooperation between doctors proceeds in traditional forms, as GPs call specialists for their expertise regarding difficult cases (P16_1). However, this communication has gained quality through a long participation in the network. The responses are faster, less bureaucratic and more cooperative. There is mutual trust and a joint interest in the therapy plan. However, the development of therapy plans between GPs and inpatient doctors does not yet follow institutionalised rules. The hospital develops therapy plans and sends them to the attending GP. For this the information network DAME is used, which is described section 3.5. (P4_1)

The longer the doctors have participated in projects of the HNT, the better the exchange is. Similarly, employees in the care sector report that the quality of communication and cooperation is positively influenced by the HNT. A doctor explains:

IP: I got the maximum benefit out of the health network because I know everyone. I get on well with everyone. That means I don't need it [the HNT] as much perhaps as others [doctors], who don't know the people as well yet. (P16_1, 230-232)

Manifold effects

The professionals involved see manifold effects of their cooperative work. The clients and informal caregivers positively experience the services offered, especially the seamless transition from inpatient to outpatient and home care and the holistic care. This became evident in the statements of doctors and the management, but also the statement of an informal caregiver supports this:

IP: Yes, this lady looks after people's interests. I felt it first hand, my God, at last there is now someone in the hospital who wants to help, who helps to make sure that everything works. I think now, I was there too for client Y. There are people who have no one, and then it's good that there's such a network. Or are being exploited by someone, even financially. That brings us back to human dignity, and there I find it so important that there's something like that, an organisation like that. So I think it is really important that there's something like that, that help is provided. (P7_1, 549-557)

Despite the successes of the HNT, the participating stakeholders have new ideas to integrate care requirements in treatment plans. More integrative measures can certainly be expected in the future.

Patient wishes

The interviewed patient and their relatives appreciate the HTN's delivery of care. However, chronically ill patients wish for a more intensive cooperation between medical and non-medical service providers which facilitates their already complex medical-psychological-social problems. This cooperation is capable of development. A patient remarks that he has too many contact persons and would like to have one contact point that oversees all of his therapies, checks, care assistance, etc. It is an enormous burden for multi-morbid patients to follow all diagnoses, therapies, drugs and appointments and find new service providers if new complications arise. Moreover, more contact persons are usually more costly. Many patients are overburdened and can only arrange themselves with the help of relatives. A multi-morbid patient explains:

IP: I have problems with my legs, both of them. Both. I had this operation on my left leg, a number of operations, and still have an open wound that has now healed relatively well, but is still open. That means I have to dress it every two days. On the right leg, I have problems with my hip (sighs), it could be better. So I'm pretty lame.

I: Yes, the open wound. You said that you're not having home nursing care for that,

IP: the Red Cross.

I: Does that mean your 24-hour carer has been trained to do that, she can do it?

IP: No. I've been doing that now since 2006, I dress it myself, I do it, I dress it myself. No, I've been having it dressed since 2002. It's now 2016. 14 years. In the meantime, I know myself how it needs to be dressed. Yes, I've had it dressed often enough in the hospital in Salzburg, I still go to the Derma [Dermatology Ward] for check-ups. I haven't been there for ages now. I should go back soon. Yes. So I know how I need to be dressed and what to dress it with. And I told my carer that and she is now [able to do it] following my instructions.

I: And do you also have the right bandaging materials?

IP: Yes, yes, yes, yes.

I: Because it is sometimes the case that you get high quality bandages in hospital, and a GP is no longer allowed to prescribe them.

IP: No, no. No.

I: Do you have this problem?

IP: No. No problem. Everything that I saw in practice in the hospital, what they used to dress me, I get all that on prescription from my GP and- Yes. No problem. (P14_1, 458-474)

Patient often can't express their gratitude or wishes to the HNT. They have a specific perspective to the services provided by the HNT. Although many patients use services of the HNT, they are often not aware of the HNT itself. Many patients know the case and care manager of the hospital and the senior counsellors by name and appreciate their support in a situation of need. Others name the mobile carer Mrs. U. with her professional, patient and friendly manner. The patients are always surprised that these persons are part of the HNT and that different organisations collaborate in the background. The clients often do not notice the contacts between medical and care organisations. If they notice that stakeholders exchange information about them, they perceive it as helpful and it deepens their trust in the regional healthcare system.

Almost all patient representatives neither knew the name of the network nor its intentions. However, all patients remembered the names of the people that represent the HNT, even if their contact was some time ago. Moreover, all interviewees positively commented on the work of these persons, on their professionalism and the integrated manner of the received services.

Mrs. B mirrors the problem of missing public relations work from a client's perspective:

IP: Such a nice lady, she takes care of things and helps you now and she works for this, it's coming to me, this network? I didn't even know that it's a network, but it felt to me like a net, a net that had been spun. (...) Everything ran like clockwork, but only because of this woman, Miss H., I had the impression. Otherwise, it would never been like that. For me, that was like a miracle (...).

I: You said that for you, this Frau H. was the embodiment of this support. You said it was seamless: everything was prepared.

IP: Yes. Totally.

I: And you said you didn't even realise that this help came from the health network Tennengau, that the health network existed?

IP: No, I had never heard of it.

I: But you did, so to say, feel the effect of this health network?

IP: Yes, and how. (...) Yes, also the friendliness and the fact that someone would be there to help [after the stay in hospital], that they looked after the person. I think it's great that there's something like that. The organisation is just great. There should be something like that in all areas. (P7_1, 566-577)

3.2.2. Self-management interventions

The improvement of self-management is an important topic in the HNT. The interviews showed manifold problems that are opposed to an enhanced independent dealing of chronically ill with their health. The providers distinguish on the one hand between present, eligible and insufficient abilities to actively contribute to one's health and on the other hand between present, eligible and insufficient willingness to do so.

The documents indicate that the counselling services for the elderly are the only institutionalised HNT programme to provide self-management interventions. The target group consists of the senior citizens of nine municipalities in the Tennengau who should be enabled to live as long in their own home as possible. Two senior counsellors, advise the senior citizens on ways to stay healthy at home and on what care arrangements are possible. However, there is no information available that these interventions are adapted to multi-morbid patients or to different cultural and socio-demographic groups. Indeed, the region Tennengau appears to be a rather homogenous rural area. The visits are free of charge for the senior citizens. The local mayors support the intervention by personally inviting every senior citizen to a home visit on their 80th birthday⁶. (Schwaiger, 2008) There is no information available on the rate of eligible senior citizens making use of home visits. However, 99% felt to be better informed after the counselling (Schwaiger, 2009).

Care providers emphasise in the interviews that many patients are willing to take responsibility for successful therapies by changing selective living habits, e.g., by giving up smoking or more exercise. Both patients and informal carers acknowledge the importance of their own health responsibility and ability. One multi-morbid patient specified that his sons wrote him a daily to do list, ranging from meals, his drug intake, which he prepares weekly with his carer, to daily exercises. In addition, the patient takes part in the documentation of his health values:

⁶ In rural Austria, it is customary that the mayor visits each senior citizen on their 80th birthday.

I: Other than operating the oxygen tank yourself, are there any other technical devices that you use and have to operate on a day-to-day basis? To measure your blood pressure or other things?

IP: I measure my blood pressure, my blood sugar, yes. I've also got diabetes. But I've got that fairly well under control, the diabetes, with the tablet. I don't need to inject as well or do anything else. (P14_1, 304-312)

Later, the patient describes that he already participated in training during his hospital stay. This verifies his self-responsible behaviour:

IP: I'm well-known at the hospital in the Diabetes department, have already done some training courses, everything. They are quite active in the hospital in Hallein, and I am going on [date] for my next check-up in the Diabetes department. You show them the records you've been keeping. (...)

I: You just mentioned another keyword: training. You've done some courses. What courses have you done?

IP: Diabetes courses.

I: What does that mean? What did you do in the course?

IP: It was a course that lasted a week. Two hours in the afternoons, every afternoon for two hours. Well, the trainer essentially explained everything there was to know about diabetes. What it is. What you're allowed to eat, how you can monitor it, your blood sugar, etc. (...)

I: That means you really did get general training. And did you need additional training to learn how to measure your blood sugar?

IP: We did that as well, because I got the measuring device from the hospital. So we did it there once ourselves, and they showed us how to change the needles, how to change the test strips, etc. Yes. (P14_1, 318-337)

According to the views of doctors and carers, the ability for self-management is not solely depending on age. They estimate that also a small percentage of persons 80 years old and above is able to take on certain tasks after corresponding instructions. The care management explains:

IP: It depends on the person. I see 86-year-olds who are top fit, have all their faculties, are communicative, receptive and can see well and I also see people where I look at their date of birth and think, that can't be – he's only 68, but already biologically so old and tired. So it depends on the person. There are definitely clients who are willing and able, and others who you

definitely wouldn't get through to in such training courses. So there are both. It differs from case to case. Compliance is the issue. Who has compliance, who doesn't. [You also can't get through to the latter.] (P4_1, 411-416)

At the same time, the interviewees report a wide spread interest for health related lectures and trainings. However, the resources of the HNT are not sufficient to provide these offers and it is planned to offer lectures and trainings if the submitted PHC-network concept is funded.

As has been outlined in the previous citation, the ability for self-management can only be trained if the patients are truly interested in it. The conversations proved that the successful promotion of self-management for multi-morbid patients requires a certain social and mental context. In the interviews, problems that prevent chronically ill patients from taking self-responsibility were addressed:

- they have lost their cognitive abilities to do so
- they cannot meet the requirements due to addiction
- certain care services are too expensive for them and thus they use them sporadically or not at all
- they lack social contacts at home and thus are more likely to visit the hospital in order to be cared for and talked to.

This points to the complexity of the environment that doctors and carers face when aiming to increase self-responsibility of the chronically ill. In addition, the social environment is often more important than the medical environment, or a lack of self-management can lead to a suboptimal medical treatment.

IP: So many people still believe that the doctor is responsible for their health, and I always say, no, if they have the cognitive ability, they are responsible for 80 %. The doctor can only diagnose and prescribe treatment and make recommendations, but what they [the clients] actually do with all that is no longer in their [doctors, nurses, caregivers] control. Losing weight, stopping smoking. We have many COPD patients, who would need – exactly, that's a good example – who would need an oxygen tank at home. But they don't get one because they smoke. Yes. (P4_1, 283-289)

3.3. Leadership & governance

The HNT is organised as a not for profit cooperative and it is owned by 29 individuals and member organisations. These members include the majority of social and health service providers and voluntary organisations in the region. Each member has one vote in the cooperative. The cooperative comprises of

partners within and beyond the healthcare system. (Gesundheitsnetzwerk.at, 2016) It is noteworthy that over the whole period the members of the network remained stable and no one left after the first period of enthusiasm. As our interviews show, this is probably due to the trustful communication, the distribution of benefits and the dismantling of reservations.

The main motivation behind the partnership is to improve the care process for patients and to create a model region of integrated care (Pichler, 2013). The interviews show that the stakeholders are very proud of their network and the diverse projects and aim to develop it further. Thereby, the long-time experience of teamwork, the originality of various projects, jointly tackled obstacles, new partners, the gratitude of patients and the respect of community politicians and regional politics act as a resource for activities. The HNT members assess the HNT structures as reasonable and helpful, which is also expressed emotionally:

IP: Sensationally, all the social and welfare services are members. There are none that are not members. (P6_1, 259)

Furthermore, the interviews revealed a double structure of the HNT. On the one hand, the active centre of the cooperative members acts on a structured and law-regulated basis relatively regularly. On the other hand, stakeholders of single projects concentrate on their special tasks and limited circle of participants, but also benefit from the loose ties of all network partners. Also the documents show that depending on the initiative, a members' subsample works together to design and lead the project. Although many of these service providers are competitors, they are cooperating and are regularly able to exploit synergies. The climate of equitable cooperation between large and small network members, e.g., the hospital Hallein and doctors, is of special value. The communication is characterised by mutual appreciation and an argumentative discourse. Moreover, the initiatives are designed not to favour certain service providers, but encourage the patients to choose for themselves. (Schwaiger, 2008) This is very important for the clients, as the counsellors do not try to sell them a service, but leave all decisions for the commissioning of care with the clients. Also the initial scepticism, whether certain care providers might be favoured by the counselling, has changed to a positive assessment. This is reflected in the following problem description:

IP: There was also fear among the social services that they would lose clients as a result. Their fear was: Will the advisors for senior citizens be neutral in their advice? Will they have all the brochures with them? No one could know that for certain. No one could influence whether the advisors then showed preference for a particular service when talking to a client – and that was

what the social services feared, that the advisors [could] say: 'But why don't you take [supplier X instead of Y]. That was what was behind the fears. They naturally also wanted statistics on which client was transferred to whom, so that they could compare the results. It then transpired that it hadn't been a problem at all, that they were indeed neutral and that the criteria used to select a care service often also depended on things like a neighbour using them too, because if the vehicle from one particular care service had been seen in front of the house next door, she said: 'Well, if they're already going there, then they can look after me as well'. That was really the reason why a particular service was chosen. Aside from that, the distribution was very correct and equal, and it was everyone's experience in the end that they could trust that the advice was neutral and that they had gained additional clients. And then the situation calmed down again. (P6_1, 334-349)

The HNT emphasized its regional roots from the beginning onwards. Thus, the regional association Tennengau and the city of Hallein play a special role as external partners. They are themselves not members of the cooperation, but closely linked with the HNT and support the network ideally and organisationally. For example, the counselling for the elderly was transferred to the ownership of the regional association Tennengau in order to secure financing. Although the HNT would like to keep its projects, they value the work of the regional association and vice versa the mayors and regional association values the commitment of the HNT. The municipality of Hallein explains:

IP: Many ideas and networks then came into being, like the discharge management and the like, and they naturally in turn bring benefits for the local authorities, and so we didn't only expect these benefits, we also saw them in reality, e.g. the cooperation between the old people's homes and the hospital. (...) So this network on the one hand supplied the people with information about what was available – where to go if they had this or that health profile or these symptoms and would like more information – and on the other hand there were clear lines in place for what to do with a patient, what to do with patients when they are discharged from hospital. (P15_1, 83-97)

The professional service providers made it clear in the interviews that time is essential for building trusting and objective communication. The different stakeholders find a common language by meeting repeatedly in different circumstances. Also the new project to establish a connected system of PHC-centres, which is currently in development, emphasises the importance of cooperation with providers outside of the healthcare system. The interviewees talk about a hub, which is easily accessible for

doctors, providers and patients around the clock. Moreover, it is aimed for a permanent basic funding of this hub. A doctor explains:

IP: And in Hallein, there are now plans to build up a structure via the health network as integrated care hub, which vice versa works well, where we can call up, if needed, a dietician, a care service, wound management, a physiotherapist, I need that a lot, an occupational therapist, a pharmacist, and who knows what else. Those are the concepts that are being developed at the moment. (P16_1, 85-90)

The starting point of this project is the medical experience that the characteristics of patients have changed in the past and are further changing. The percentage of chronically ill and multi-morbid is growing and the requirements for doctors as well. Thus, an effective cooperation between medical and non-medical actors should lead to an easing of the burden of non-medical tasks and change structures of responsibility. In particular GPs feel burdened by complex problems of chronically ill patients and they are also left with social problems of patients. Moreover, multi-morbidities require diverse treatment offers, which a single doctor cannot provide alone:

IP: In other healthcare centres, most – or a part of – the non-medical health professions are employed by the PHC-centre. But I think that that is not the right way, because it involves a lot of administrative effort. (...) That means that I can no longer afford it as a doctor, I then really need an additional manager, but if I have the manager in the health network Tennengau hub, then he manages where the people can get it. For example, at the moment I have only one chronic wound, and for that I don't need to employ a wound manager. Of course, I need a physiotherapist relatively often. I could possibly employ one, but the physiotherapists don't want that. I rarely need a speech therapist. I also rarely need an occupational therapist. I also rarely need a dietician. I need social workers more often, but not often enough to keep one employed full time. (P16_1, 534-549)

The care facilities also value the increasing collaboration with outpatient doctors and the hospital, as information barriers are lowered in the general meeting of the HNT and the cooperation within projects surpassing professional boundaries.

In the same way, the cooperation with the two senior counsellors happens informally and in a trusting way. They call care facilities at a short notice and make arrangements for their clients. Or they give the contact details to patients and pre-inform the potential care services. The cooperation between the

discharge manager of the hospital and the care facilities is also not only conducted in writing, but often via telephone calls and informal contacts. This allows exchanging detailed information, which is necessary for a seamless transition to home care.

IP: The cooperation with the senior citizens advisors is great, there is Frau X, Nurse Y, and our contacts with them are excellent. (P10_1, 99-100)

Despite the achieved success, both the management and the care providers see a capacity for development. They report that there is no participation of the mobile home care in concrete projects of the HNT, because the operative centre passes on manifold tasks and it has to pay off to participate in a project. However, repeated individual contacts with the network manager revive the interest to actively participate in the future. The management also clearly states that much communication effort is needed to uphold the contact on the different organizational levels: Centre, head of departments and carers. A successful project work requires such communication practices, but resources to do so are currently missing.

3.4. Workforce

The document analysis and the interviews confirm that the HNT has introduced new professions in the socio-medical sector in Austria, including:

- Manager of the health network
- Senior citizen counsellors
- Discharge manager

In addition, it is planned to employ a

- Mobile specialised nurse

Two new professional roles – senior citizen counsellor and discharge manager – reflect that traditionally, the Austrian healthcare system does not offer support to guide patients through their care options and legal and financial matters. Moreover, as was mentioned by a carer, social, psychological and medical challenges demand from both nurses and doctors to initiate the willingness for care and the assistance of relatives. Situative social-communicative, psychological and medical competencies need to be developed through trainings, which are offered by the HNT. For example, the “day of nursing 2016” addressed problems in care for patients with a migrant background.

Manager of the health network

The manager of the health network is employed with a service contract at the cooperative, but she acts like a managing director and has overall responsibility. The service contract is a temporary solution, as there is no adequate form of financing available for a permanent contract. From the point of view of the members and of the payers, she is underpaid for her work. The manager has a qualification in business management, an extensive experience with project management and beyond that she acquired specific knowledge in health policy, medicine, nursing and social psychology.

Furthermore she successfully manages the communication and cooperation between the various stakeholders, submits project proposals and directs their execution. In addition, she is responsible for lobbying concerning the HNT as well as for public relations. Although there are currently no available resources for it, an education in public health management would be advantageous for the manager.

Senior citizen counsellors

The two senior citizen counsellors are both registered nurses with several years of experience and are competent in health, social, care, legal and financial matters. Regular team meetings, case supervision and the opportunity for psycho-therapeutical support should ensure the service quality of the senior citizen counsellors. (Schwaiger, 2008)

The core task of the senior citizen counsellors is to provide independent and impartial information and to coordinate professional relationships concerning social/nursing care, legal and financial matters. Senior citizen consultants need to have the ability to inform frequently in an individual way about the existing care institutions and their offers or possible bottlenecks (P1_1). They must be empathic towards the chronically ill and elderly as well as towards their relatives, in order to understand their complex problem situations. Senior citizen counsellors also assess the care needs of the patients and the living environment. Their duties include support with applications for care allowances, for increases of care allowances and for remissions of telephone charges. They advise concerning diet and drinking patterns, healthy behaviour, the provision of aids and information on how falls can be prevented. Moreover, they organise care services, e.g. home care services, meals on wheels or the move to a nursing home. They do not perform any caring tasks themselves. (Gesundheitsnetzwerk.at, 2016; Them and Schulc, 2008) Apart from their specific knowledge in nursing they also have to have psychological skills, as they need to be able to develop sufficient influence on their patients and to create the best possible solutions in

emotionally strained situations. As senior counsellors needs the ability to inform people of different educational background and age groups about alternative offers and, if desired, arrange contacts. They need to be organized and mobile, as they work in an outreach capacity (P1_1).

Discharge manager

Case- and care management or discharge management is a new profession within the HNT. The discharge manager is a registered nurse with several years of professional experience. The discharge manager needs knowledge of medicine, nursing and social work as well as the skill for empathetic handling of patients and socio-psychological de-escalation. The discharge manager performs a needs assessment and management tasks in the hospital, but no medical or care tasks. It was the task of the discharge manager to develop a guideline that includes all steps and process standards for the discharge. Moreover, it is the duty of the discharge management to perform a Discharge Risk Screening (DRS) with four dimensions (self-care deficit, living alone, provider of care for relatives, prior use of home care services). In addition, the manager is not only expected to know the whole regional care offers and all GPs in the region, but also should be familiar with the competence structures, the processes and working time patterns in hospitals (P5_1). She has to be used to reading of patient-related data systems and the use of IT applications. Furthermore, dealing with doctors, the health management, heads of nursing and social services as well as chronically ill persons is part of the requirements. After detailed consultation, they have to leave their clients and their relatives enough space to make their own individual decisions. Paternalistic behaviour would be obstructive and was not observed. In total, the new professional role was perceived as an easing of a burden for the hospital care teams. Also the relatives and extramural partners appreciated the availability of one central contact person. (Göbel and Schwaiger, 2010)

Mobile specialised nurse

Currently, under the new PHC-network application, the position of a new mobile wound nurse is in planning (P3_1). Although exact parameters are not determined until now, it is planned that this mobile nurse should be employed at the HNT and should be available for all participating doctors and their clients when needed. Therefore, not only a nursing education will be required, but also a professional experience in wound care. Mobile wound care demands also an enormous flexibility and the ability to deal with several doctors rapidly and appropriately (P6_1).

Also the doctors need to adapt if the wound nurse is not under their authority. Coordination is necessary among possible competing demands from the patients and their care rhythms. Therefore, all persons concerned have to deal with each other respectfully and patient-oriented (P16_1).

3.5. Technologies & medical products

ICT applications are on the one hand used to inform the target group of the HNT, the population of Tennengau, about all health services in the region and on the other hand, they facilitate interface management between health service providers. The internet portal www.gesundheitsnetzwerk.at was established to inform the inhabitants of Tennengau about events, legal aspects, service providers and government departments and nursing homes in the region. Moreover, the homepage provides a weekly update of available beds in nursing homes in Salzburg to facilitate the search process for institutional care for both relatives and senior citizens. (Gesundheitsnetzwerk.at, 2016; Gesundheitsnetzwerk.at, o.J.b)

Due to the initiative of the HNT and the hospital, a secure data network was established between hospitals and the regional doctors more than 15 years ago. About 100 doctors are part of this computer network. (Gesundheitsnetzwerk.at, o.J.a) The project is named “DAME – Data Network of Medicine”⁷. It transmits the doctor’s letter and the diagnostic findings directly from the hospital to the resident doctors by encoding patient’s data based on EDIFACT. The server was bought by the HNT and was placed into the hospital of Hallein. What is not possible until now is the backflow of data from the doctors to hospitals. This would be a desirable additional feature.

The starting point of this initiative was that the HNT rarely dealt with day-to-day needs of doctors but focused on social and care responsibilities. The board of the network acknowledged this problem and developed a project that specifically addressed an acute problem of doctors: The burden of a time lag if doctors’ letters are only sent by post from hospitals to attending physician. Following from the problem analysis, a secure data connection was developed, which accelerated not only the information transfer from hospitals to local doctors but also relieved the doctors from their documenting tasks.

IP: “DAME” was a product where we said: ‘How do we get the GPs even more on board’? Because that was also always a bit latent, that doctors said: ‘Well as a doctor, you don’t really need that [what the HNT has offered so far]’. We had meetings where the medical fraternity

⁷ The German word “Dame” also means “lady”

said: 'Those are all social issues, we're not responsible for social issues, we're responsible for health'. And then we [Dr. X and myself] had a supervision workshop organised under the framework of the ONGKG, the "Network of Health-Promoting Hospitals" ["Netzwerk Gesundheitsfördender Krankenhäuser"]. We put that to good use. Dr. X, I'll never forget that, said: 'If you don't provide any benefits for the participants, it will never succeed. So put yourselves in their shoes and think about what a GP needs to continue a treatment well.' At that time, a GP had to wait a very long time, up to three weeks, for a doctor's letter. He only got the handwritten short version of the doctor's letter from the patient, and that didn't contain much. And the long version of the doctor's letter, well it just took a long time for it to be posted and delivered to the GP, and then you had to read it and then you had to archive it, it was all very complicated. And we then managed at the beginning of 2000 to offer a secure data connection via Telekom to over 100 GPs. That's standard practice nowadays, with ELGA in any case, but the precursor at that time was our "DAME" project. (P5_1, 174-190)

According to participants, the use of this electronical data path is part of the everyday relationship between the hospital and doctors and is no longer debated, as it is working fine:

IP: We are not working on it [this topic] directly. Or are working on it indirectly. We've done a lot of preliminary work, but it's not a particularly hot topic at the moment, but it (...) is a part of the health network. (P16_1, 379-380)

The interviewed patients are also aware of the fast delivery of data. One of them is Mr. N. Although he does not know how the system works in detail due to his age, he is pleased with the collaboration between the hospital and his doctor to facilitate his "seamless care". This is probably even more so because he suffers from multiple diseases such as asthma, diabetes, vessel occlusion, high blood pressure etc. He has been ill for over ten years and was repeatedly admitted to hospital, e.g. for unexplained diarrhoea. Thus, he depends on a fast and faultless exchange of data between the hospital and doctors. This fast data exchange process in particular makes sense out of a patient's perspective, if it is accompanied by personal consultations between the doctors in order to eliminate information gaps.

IP: The GP gets the doctor's letter that I, for example, got on discharge, practically hot off the press from the hospital. This doctor's letter is faxed immediately to the GP. In other words, the GP knows sooner than I do what it contains. (laughs)

I: Yes. Okay. It is good when the doctors work together.

IP: Yes, yes. And the doctor [his GP] knows all the doctors and in particular those from the Internal Medicine department and he will definitely ring up if there is something in it that is not clear and needs to be clarified. (P14_1, 290-297)

In contrast to this information technology solution of a concrete organisational problem, the utilisation of ICT applications by patients is not in the centre of attention of the HNT. Even the terminology is only used by the interview partners after asking and even then with a limited interpretation.

IP: What do you mean by ICT applications? Tele-medicine? We don't have the geographical need for that [the unconditional use of ITCs] like, for example, other States in Austria. The State of Lower Austria has that need, Lower Austria covers a large area. You have to travel a long distance there to get to a doctor. Here, everything is really close together. Your home and the nearest doctor are, so to speak, so near to each other geographically that this tele-medicine is almost never used. (P19_1, 71-74)

The relationship of providers in the network towards patient-related ICT applications is strongly focused on current needs of the chronically ill patients and the consequent needs of medical work. The older cohorts have experience with a medical care with basic use of ICT, but have little experience with the self-application of new technical applications beyond traditional blood pressure or insulin analysers or self-injections.

These historical and regional characteristics of care provision shape older client's expectations towards an integrated "care by the GP", or by their clinicians and care services. These expectations limit the scope for autonomous use of ICT applications. Therefore the introduction of new ICT applications requires motivation, instruction and training specifically in rural areas. The relationship of stakeholders to ICT applications is guided by the communication between firstly doctors and patients and secondly between carers and clients. All aids are subordinate to these relationships. They have to solve a concrete problem and need to be operable for doctors and patients. The attitude of service providers in the HNT towards new ICT applications seems to be very objective and not euphoric, as is demonstrated by the quotation below:

IP: So this electronic data exchange is naturally important today and is standard practice nowadays, no question of that. In the very beginning [of the "DAME" project], we were the inductor for this. (...) I believe that the data exchange between the hospital and GP surgeries is almost at its limit, whereby we only have a one-way data line at the moment. I think that in

future we will also send our data to the hospital. (...) We generally don't have a Send module, although that would also be important, or you really do set up one of those clouds where everyone can have access to the information. That is the one thing. The other is that when it comes in particular to integrated care, electronic data transfer will also play a role, e.g. with blood sugar measurements or blood pressure readings that can be sent back and forward as it were. That can all be done electronically nowadays. (P16_1, 363-374)

The quotation illustrates that the expansion of ICT utilisation currently is a rather secondary task for the HNT.

3.6. Information & research/monitoring

There is consensus between the HNT and the payer organisations that an evaluation of the integrated care services of the network is reasonable in principle. Accordingly, two initiatives of the HNT have been evaluated up to date, namely the counselling for the elderly and the discharge management. Moreover, the interviewees mentioned that the evaluation has to be affordable, accurate and methodologically correct. It has to be specifically targeted to the project in order to avoid data graveyards which cannot be used for health policy making. (P6_1, P13_1)

The payers are sceptical, whether effects of intervening health programmes compared to a defined prior state can be determined. To do so, sufficiently defined parameters would have to be available in order to observe effects over a fixed period of time. However, some effects occur indirectly and only over a long time period, causing problems for the evaluation. Thus, a payer mentions:

IP: The positive effect is difficult to prove, in any case. (...) They did that very well in the health network. That was a very good result. I can't tell them there how they should do things. As far as I am concerned, it has to be appropriate and comprehensible, only two or three parameters. [We don't share] This obsession with evaluation [which some do] because how should I evaluate a measure if I don't even have a point to start from. To be able to evaluate, I at least need a status quo, and if I don't have a status quo, then what should I evaluate for heaven's sake? What should I use to measure the change? If you ask me, that's always the most difficult part of evaluating, determining the status quo. I have to be able to say that is the basic assumption, that is what we are starting from and that is what has changed after three years. (P12_1, 266, 454-465)

The payer organisations have specific demands concerning evaluation. In addition, evaluations are often not conceptualized enough due to data issues or difficulties in financing.

The founders of the HNT have lobbied for evaluation from the beginning onwards, as they were convinced of the positive effects of the programme and as they want to see their work accredited in public. In addition, they are forced to demonstrate the effects of their work due to their project related form of financing.

The main factor of justifying the financing is to relieve hospitals, as the funding of the HNT is provided under this health policy goal. Stakeholders of the network monitor this policy goal, but they acknowledge manifold effects. It is their target to improve integrated care of all patients, in particular a seamless transition between hospitals and home care, in order to ultimately improve patient's health, patient's satisfaction and their quality of life as a whole. In addition, the burden of outpatient doctors should be reduced and savings are expected in several other sectors. The HNT would like to frequently evaluate these effects in a comprehensive and professional manner.

However, the financial resources of the payer organisations do not allow for such complex evaluations. Still more, they cannot even finance a simple evaluation of all projects. So it is stated from a payer organisation:

IP: Let's put it this way, we can't always afford that [a comprehensive evaluation of innovative projects]. (P13_1, 435-436)

A positive example for a successful evaluation is the case and care management project. This evaluation not only confirmed the positive expectations of the founders but also the concerns of the social insurance disappeared.

It is worth considering that each individual payer organisation has specific interests in its area of responsibility. Therefore, the health fund was interested in a relief of hospitals, whereas the social insurance had a specific interest in cost reducing effects in the outpatient sector. The different meanings of the knowledge production of evaluations are emphasised:

IP: The Reform Pool project ran for several years. It was initially run for one year as a kind of pre-project study to determine whether it also fitted into the Reform Pool projects programme. Then, after a year, the group that was working on it determined that it "fitted very nicely". And it then ran for several years and was then evaluated by Professor X. The evaluation showed it to have

been very successful, despite the initial doubts on the part of the social security provider, who thought it would be worth doing for the hospital, but not for GPs, It then later transpired that GPs had also profited from the Reform Pool project. So it was, as it were, ultimately a win-win situation for all, the Reform Pool project. (P13_1, 50-58)

Evaluation outcomes

Two initiatives of the HNT were evaluated, namely the counselling for the elderly and the discharge management. Karl Schwaiger, who is not only one of the founders of the HNT, but also the nursing director in the hospital Hallein, analysed both initiatives during his studies.

Counselling for the elderly in Tennengau

The counselling services for the elderly were first evaluated by Schwaiger (2008) and the findings were further used by Schwaiger (2008) and by Schwaiger and Populorum (2008). Due to the double role Schwaiger inhabits both as an evaluator and as leading figure in the HNT, the counselling services were later re-evaluated by them and Schulc from the Health & Life Sciences University UMIT in Tirol. However, the analyses are a snapshot in time of the needs and characteristics of elderly patients in the programme and no assertions can be made whether the programme leads to less institutional care, better quality of life, etc. Neither a monitoring nor quality insurance system was mentioned in the available documents.

Schwaiger asked the senior counsellors to collect data for a questionnaire with 125 questions and 168 variables through questioning, observing and assessing the elderly during their home visits. Out of 588 participating 80+ elderly, 179 (30.4%) were included in the survey between September 2007 and May 2008. The survey analysed the bio-psycho-social factors concerning the activities of daily life (ADL) and the instrumental activities of daily living (IADL), the composition of household and the state of health in general, the frequency of falls, as well as the need for counselling by descriptive statistics. Findings concerning ADL and IADL proved that vision, hearing and mobility deteriorate with age.

100% of the elderly are satisfied with their current living situation, and 93.5% would be willing to receive home care from service providers. However, 43.6% could not imagine a life in a nursing home even if it is necessary. 65.0% of the observed receive care by a family member.

Concerning the impact of the counselling services, 74.0% reported that they were made aware of hazards, 99.0% felt to be better informed after the counselling, 84.0% have improved knowledges about local services, 47.0% use the counselling in order to change (e.g. way of living) and 24.0% would like to have a second home visit.

Them and Schulc evaluated the acceptance of and need for counselling services for seniors living at home along the same dimensions as Schwaiger. They used a questionnaire of 68 factors concerning the bio-psycho-social health status of the participants between the years 2007 and 2009. (Them and Schulc, 2008) In sum, 516 persons have participated in the programme over all age groups, and 484 home visits were made. (Them and Schulc 2010) Out of the 362 surveyed persons of 80 years and plus, 47.5% receive a care allowance. Most of these seniors are classified in care groups two (36.6%) and three (25.3%) followed by care group one (16.3%), on a scale from 1-7. The survey shows that out of 362 elderly living at home, 274 are supported by their families and in all age groups, the majority of elderly does not receive external help. Moreover, they found that motor abilities and the capacity to self-supply deteriorate with age and accordingly the need for assistance increases. As their health deteriorates, more than one quarter of seniors in each case become afraid of having to move into a nursing home, of being alone or that they might have an accident. Almost 20.0% fear that they might be a burden for their relatives.

The counselling services for seniors help them with legal issues such as care applications (35.0%), increase of care allowances (23.0%) and applications for remission of telephone charges. 98.0% receive counselling concerning their diet and drinking pattern, 91.0% concerning the provision of aids, 86.0% concerning healthy behaviour and 76.0% concerning financial support. The counsellors organised for 46.0% acute management, for 38.0% home care services, for 17.0% meals on wheels and for 13.0% the move to a nursing home. (Them and Schulc, 2008)

Thus, both evaluations by Schwaiger and by Them and Schulc show the wish and capacity of elderly to live independently at home. The results show that relatives, professional carers and community nurses can provide targeted support. If people wish to live at home during old age, they require a well-organised caring system.

Discharge management – case and care management

The discharge management, which was implemented in the hospitals Hallein and Abtenau, was evaluated by Klassen (2010) and discussed by Müller and Klassen (2011) and Göbel and Schwaiger (2010). The evaluation aimed to determine whether the re-hospitalisation rate could be lowered, whether the length of stay was shortened and whether extramural expenditures for doctors and drugs could be decreased or were at least not increasing. The observed population is divided into the age cohorts “more than 80 years” (61.0%), “between 70 and 80 years” (23.0%), “under 70 years” (16.0%). A majority of these patients suffer from multi-morbidity. About half of these patients continue to live at home after their hospital discharge, a quarter are transferred into institutional care, and the remainder passes away, is transferred to another hospital, etc. The evaluation was performed through a descriptive data analysis, the comparison of a trial (N=194) and control group (N=1,537) and a pre- and post-measuring. The project was monitored between June 2008 and February 2010. During this period, 492 cases representing 432 patients were included in the discharge management.

The re-hospitalisation rate of 432 patients receiving discharge management (of whom 32 died during the discharge management) was 14.8%. Moreover, if patients were additionally looked after by network partners of the discharge management after their discharge, the re-hospitalisation rate decreased to 6.9%. By contrast, 17.7% of the 1,537 patients with the same age structure who were not included in the discharge management were re-hospitalised during the same period. The pre- and post-measurement showed that the number of hospital stays was, with 238 stays, higher three months before than three months after the discharge management with 196 stays, in all age groups. However, in the hospital Hallein, the re-hospitalisation rate for 80-years-old and above remains constant pre and post the measurement. Klassen concludes that the aim of the project, decreasing the rate of hospitalisation, is attained.

The analysis of the length of stay in the hospital Hallein showed that more than 80-year-old discharge management patients (68.0%) caused 68.9% of days of in hospital. By comparison, in the control group 42.8% of patients above 80 years were responsible for 48.5% of hospitalisations. Klassen thus claims that an effect of decreased days of hospitalisation can be demonstrated for this age group. The pre and post comparison showed that 2,310 days of hospitalisation were needed three months before the discharge management, compared to 2,079 days after. However, the length of hospitalisation increased for the age group between 70 and 80 after the discharge management and in the hospital Hallein, the

length of hospitalisation increases post for all age groups. Thus, the aim of decreasing the length of stay is only partially fulfilled. The highest values regarding both re-hospitalisation and length of stay are observed with patients who did not participate in the discharge management due to non-compliance. Indeed, patient compliance seems to be the most critical factor of success for the discharge management.

Concerning extramural costs, the study shows that three months after the EM the number and costs of performed services by extramural doctors decreased for all age groups compared to three months before. Moreover, the age group between 70 and 80 used fewer and less expensive drugs three months after the discharge management. Patients under the age of 70 use more drugs at lower costs after the discharge management, whereas the quantity and costs for 80-year-old and older patients increase. Thus, Klassen concludes that one aim of the project, decreasing costs, is partially attained. (Klassen, 2010; Müller and Klassen, 2011)

In addition to these evaluations, the discharge manager records her activities and their effects in order to legitimise her position (P4_1). The HNT also self-evaluates the project HIP (P6_1). This should show that the investment is reasonable and the health insurance should be informed that it leads to a cost reduction due to fewer falls of patients.

3.7. Financing

The HNT was founded by a team of doctors and a healthcare manager of the local hospital on a voluntary basis and initially received a support of 20,000 € from the municipality Hallein for the first eight years. This public sponsorship had to be requested from the social committee on a yearly basis. After the HNT demonstrated a hospital relieving function, the funds for hospital relieving measures “SAGRAF” in Salzburg (precursor of the Salzburg health fund “SAGES”, financed by the state of Salzburg and the regional health insurance fund) provided a low basic funding. This allowed partly financing a manager on the basis of a service contract, stabilising the work within the network. Furthermore, it led to the design and implementation of more individual projects. Still, the financial means remain limited and the manager explains accordingly:

IP: My agency sends one invoice a month and that's that. But my way of working is such that I really like to get my teeth into things. That was probably why I didn't just work the hours we got paid but much more, but that doesn't matter. I saw this health network construct as a chance, as a unique opportunity to have all the social services provided by the State under one roof. There's

nothing like that anywhere in Austria, and I was so fascinated by it that I fell totally in love with the idea and then it in turn kept growing and growing and growing. (P6_1, 85-92)

Funding for individual projects is either requested from the health fund or from current framework programmes such as the reformpool programme⁸. The discharge management programme was initially submitted to the health fund for support, which enabled the network to distribute a small remuneration to the persons involved. The project counselling for the elderly was initially financed by the state of Salzburg during 2007 – 2009. Additionally, participating municipalities contributed 1 € per inhabitant per year to support the work of the two senior counsellors. The remainder of the costs was paid by the state of Salzburg. The problem of finding sustainable financing for successful projects had to be repeatedly resolved.

Financing problems and activities to ensure the financing of the HNT as well as its individual projects are an important issue for all professional stakeholders. “Financial security” includes several aspects:

- Limited amount of basic funding and thus limited possibilities for action (e.g., appropriate fees, public relations activities, allowances for project developments)
- Yearly securement of basic funding for the cooperative by delivering a proof of success to the regional health fund in the course of the current regional healthcare strategy (e.g. focus on hospital relieving measures)
- Timely acquisition of financial means for individual projects (e.g. adjourned grants due to delayed statutory basis)
- Assurance of medium term funding for pilot projects by transferring administration (e.g. to hospitals or to regional authorities)
- Criticism of Austrian political framework conditions including Salzburg’s financing problems for integrated care

Financing problems are a key issue of the core team. Thereby, it has to be distinguished between the funding of the network activities (project development, network communication and coordination etc.) and the funding of services within individual projects (medical cooperation, social counselling for patients etc.). The funding of care services within projects is usually perceived as appropriate during the

⁸ As part of the healthcare reform 2005, the policy tool “reformpool” was established as a significant step towards more coordinated care by providing a platform at regional level for both SHI and the federal states to jointly organise and fund lighthouse projects. These projects were expected to overcome the fragmentation of the healthcare system and ultimately shift health services to the most adequate sector, improving allocative efficiency and/or quality of care

pilot stage as well as after a successful incorporation into routine care. However, the public goods oriented services of network members are not fully funded. This implies that the communicative and cooperative work among stakeholders themselves is structurally limited. As a result, many activities are carried out by the core team, which occasionally involves additional service providers and regional stakeholders. Other service providers in the network react pragmatically by participating in the design and implementation of projects that correspond to their specific interests or have secured funding. As a consequence, other projects that are equally important to the development of integrated care are left out.

This behaviour is rational as all professional stakeholders have to be economical with their resources. Potential partners expect a specific benefit from their contribution to the network or to an individual project. These benefits also include information yields or solutions to complex problems in their own area of responsibility. However, financial gains through customer acquisition or savings of resources are finally the basis for decision making. This is true for hospitals, doctors and social service providers. The situation for hospitals is described as follows:

IP: But hospitals do have one incentive to participate, because if they do so they could raise the quality of their work. If a hospital becomes more efficient, if it can save resources in some area, then it could become better from a quality perspective. That would be possible then, because quality assurance is always a matter of resources. (P13_1, 344-348)

The situation from a physician perspective:

IP: Why do so few doctors take part? If you ask me, it's a money issue. If there was payment involved, they would be on board. (...)

If, for example, the State government talks to representatives of the network who are self-employed, it would need to pay them for this. Because if someone who works for the health insurance participates, they are paid by health insurance. (...) Doctors have a double negative effect, because they have to pay someone or close their practice and so they effectively have a loss in income. (P16_1, 501-516)

Social service providers are also looking for their benefits. It was reported that each organisation of social services was concerned that they might lose some of their clients due to the programme counselling for the elderly and therefore might suffer from financial losses. Overall, the payment structures for network stakeholders are considered as in need for development.

If people are sceptical about their payment, they reduce their willingness for cooperation. However, the interviews revealed that benefits are defined more broadly: Besides resolving complex care supply problems, a positive public opinion is explicitly included as a benefit. A positive public opinion leads to more interest in integrated care. In addition, the advance in knowledge through communication within the network is appreciated and the involved organisations inform each other about their activities and interests to profile their services. However, financial compensation of communication and cooperation services is still seen as a key aspect. Like all stakeholders, the core team of the HNT wishes for a stronger recognition of its public goods provision by appropriate compensation for their development, communication and coordination activities. A limitation on the share of unpaid work would surely lead to a collaboration of further interested parties and ensure the activities of the core team in the long term. In many interviews a high share of voluntary work was reported:

IP: We have always done very good work with very modest means, but of course 80 % of the work was also voluntary. (P4_1, 279-280)

An increase in basic funding is therefore regarded as necessary, although the stakeholders do not believe this is going to happen. The state already made clear that no financial means can be provided to increase basic funding. Moreover, it also has been indicated that there are no means available for the dissemination of the structures of the HNT to other regions within Salzburg or to other Austrian states.

IP: Difficult. Difficult. Difficult. The entire State funding situation for hospitals, it's already dependent on subsidies and that's getting more and more critical. It doesn't get easier, doesn't let up. Instead, it's increasingly becoming a crisis, and it's getting harder to get funding for it. (P13_1, 302-305)

Another important financing gap named by stakeholders is the lack of available funding for target group specific public relations work in order to inform the regional population about the services offered by the HNT. Services of the HNT are not sufficiently publicly known, although clients do appreciate them. Additionally, the population is not aware of the complexity of care services, wherefore no additional pressure is put on the financing organisations in order to systemically expand the promotion of such integrated care programmes.

In contrast to the desired increase of basic funding, the mode of the annual accounting of services is accepted by the persons involved. In general, the current basic funding of the HNT by the health fund Salzburg is perceived as good and reasonable. Additionally, it is not thought to be at risk, as the annually

required evidence of savings in the hospital sector is repeatedly achieved. The financing organisation values the services provided by the HNT as positive and sustainable and therefore does not principally question future funding.

In this context it is notable that all persons concerned perceive the funding criterion “hospital relief”, which follows from the policy framework of the state of Salzburg, as a given, although the intentions and provisions of the HNT go further.

IP: The funding comes from the State of Salzburg’s SAKRAF fund for measures to reduce the pressure on hospitals. Which basically means: we have to demonstrate each year that we are working on measures and projects for measures to reduce the pressure on hospitals, and for that the State currently gives us 20,600 euros a year and that has to cover everything from office to management right through to all that is needed to coordinate these projects. (P6_1, 98-102)

From the stakeholders’ point of view, financing problems arise in particular at the start of pilot projects as well as during the transition period to a regular funding. Concerning the initial phase of pilot projects, the stakeholders refer to the fact that they had to meet the spirit of national and regional framework programmes for funding and the development of individual projects. It was mentioned with regret that it is hard to be ahead of time. This implies that from an innovation perspective, Austria lacks funding structures for pilot projects beyond current strategic priorities.

IP: We were always too early with our projects (laughs). (P13_1, 193)

As a recent example, the delay of the amendment to the health reform law was pointed out. This delays the funding and therefore the start of a new project of the HNT to develop PHC-network structures.

The HNT also gained experience with the transition from the pilot phase of innovative integrated projects to permanent financing. Thereby, multiple problems play a role which can hardly be influenced by stakeholders. In such emergency situations, the programme ownership was successfully transferred two times from the HNT to other regional organisations. Those two projects are firstly the counselling for the elderly where the ownership was given to the regional association Tennengau and it is now financed by the social department of the state of Salzburg and secondly the project case and care management, which was taken over by the hospital association of Hallein and is therefore financed by the regional health insurance fund. The change of ownership was only possible as regional stakeholders had an interest in both projects from the very beginning onwards. It is notable that the hospital

association is a member of the cooperative, while the regional association is not. This proves that the change of project ownership with the aim to ensure the sustainability of the integrated pilot projects is not only positively influenced by a long-lasting network of formal members but also by informal relationships with members of other regional organisations.

IP2: For the mayor, it very quickly became clear that an advice system for senior citizens was something that the local authorities would like to have. Because the focus was on keeping the elderly at home in their own four walls for as long as possible, because as soon as they use the other healthcare system it costs money – and not an insignificant amount – and that’s why there was such a strong focus on saying we want to have the advisors for senior citizens in our local authorities. The local authorities also contributed financially to this in the beginning. So it was indeed also co-financed by the local authorities in the beginning. In the meantime it is financed totally by the State social services department. (P1_1, 375-381)

Originating from concrete financing problems of the network, all stakeholders criticize Austrian framework conditions of healthcare financing from their specific point of view. Their criticism especially concerns the split in competencies and funding between the Ministry of Health (healthcare) and the Ministry of Labour, Social Affairs and Consumer Protection (social care). As a result, the funding of integrated services is further complicated, as it is often moved between financiers or entirely dropped. Stakeholders on all levels agree that a successful integrated care for all patients, including multi-morbid patients, requires an integrated organisation of health and social competencies and of funding. However, there is a broad pessimism that this integrated organization will be achieved in the foreseeable future. Despite these drawbacks, the HNT is currently applying to develop a regional network of PHC-centres. (P5_1, P6_1, P12_1, P16_1)

3.8. Implementation process

3.8.1. Historical information

The HNT evolved gradually over time. It first started with a pilot project on medical home nursing care of the Ludwig Boltzmann Institute in 1995. Afterwards, the ARGE (working group) network “Patientenbetreuung Tennengau” started in 1997, which was renamed health network Tennengau in 2001. At its beginning stood the problem what to do when discharging persons with multiple chronic conditions from the hospital (P3_1, P5_1). In 2003 the cooperative was started. (Gesundheitsnetzwerk.at, o.J.b) The main goal of the cooperative is to create a model region of

integrated care (Pichler, 2013). The project gradually widened its scope by establishing more initiatives, increasing to currently 12 (Gesundheitsnetzwerk.at, o.J.a). By 2015, all essential providers of care in the region Tennengau were members of the Network. (Gesundheitsnetzwerk.at, o.J.a)

Depending on the initiative, different stakeholders were involved in the implementation process and included all those in the region concerned with possible changes. These stakeholders include also political actors.

Different Narratives of the history of implementation

The history of the implementation of the HNT is told in various narratives, namely:

- as a history of a pilot project and its protagonists
- as a shared history of problem realisation and of a learning process
- as a history of innovation and decision making and as a success story⁹

A history of a pilot project and its protagonists

The participants see themselves as pioneers of an integrated health system for every individual patient, whereby particular attention is dedicated to the holistic support of the multi-morbid. One of the initiators phrased it as follows:

IP: As far as its origins are concerned, we had had a pilot project, a study, launched by the Ludwig Boltzmann Institute: Why is nursing care at home received so badly. (...) And had arranged for the first time several meetings in this context with GPs. And had then noticed in the course of this new form of cooperation, which hadn't existed before, that it is in fact really sensible for the hospital and the GPs to talk to each other and that there are indeed information deficits. Then it all went quiet for a while (...) but what did remain was the realisation: talking to one another is good and networking is even better. A few months later, we began to convene this group again here in the hospital (...) and we then decided in this group that we would make it a regular meeting, that we would meet every quarter to exchange information and discuss multiply chronically ill cases, patients who are not easy or even problematic to place and care for, and make sure that we worked together here, so that we were not going in opposite directions but instead working together in a coordinated manner. We then saw relatively quickly

⁹ Notwithstanding that failures and structural barriers became a subject of discussion too, but they do not dominate the intention of the team irrespective of the many risks existing.

that this was sensible, that it worked, and so we then founded the new “ARGE Patientennetzwerk Tennengau” [“Tennengau Patient Network Working Group”]. That was, as it were, the original version, and the “Gesundheitsnetzwerk Tennengau” [“health network Tennengau”] ultimately grew from that and started various projects, the majority of which were fortunately also successfully completed. And so it progressed from there. (...) I think two aspects were key. The key aspect was to guide patients through the healthcare and welfare system, and to do so together. And since everywhere you go the stakeholders are different, a coordinated approach was needed: first through meetings and discussions, second through joint projects, and third we then recognised that it would be good if other additional parties were involved, i.e. old people’s homes, home nursing care associations. That was then the next step. The next step after that was to encourage social networking among the providers. In other words, if you know each other better, if you also know and can gauge the services you each provide better, then you can also communicate better with each other and share information well on a professional level. That was the second thing I came to realise. We linked and strengthened this by holding joint meetings, setting common goals, initiating joint education events throughout the year. Those were essentially the key points, and I think a certain culture has since developed over the years in the Tennengau region. Nowadays, there are no borders between the different participants. If I contact someone, that contact is basically friendly and positive from the start, even if I were perhaps on occasion to voice criticism. (...) That is seen as a matter of course. In other areas, I’ve heard that in other areas that can often cause tensions, that people are in competition with each other. We try to act in line with this culture here, I sense it and I notice that we support and encourage each other and that’s what I find good and is what, I think, has established itself over the course of time. (P5_1, 21-86)

The same story is told by a different initiator in different words:

IP: Over 20 years ago, there was a pilot project initiated by the Ludwig Boltzmann Institute that was intended to push measures that replaced hospitals. So you see, what is very in today, was already on the table more than 20 years ago. We sat down then with the experts. At that time, I was still a young practitioner. And we thought about what we could do. And we came to the conclusion that it would in fact make sense when people are discharged from hospital, elderly, multi-morbid people in particular. In our experience, if such people are discharged on a Friday into an infrastructure that doesn’t meet their needs, they end up back in hospital again the next

day, because the family can't cope, the patient can't cope, the system can't cope. And we said that we wanted to create something that would reduce this revolving door effect, and out of that the "Discharge Visit" ["Entlassungsvisite"] project was born, which was also paid for at that time by the State and is still, I think, paid for today. In other words, we were given the possibility to collect the patient directly from hospital and also for organising the care, that the patient is handed over directly to the caregiver, that checks are made that the necessary infrastructure is in place at home, that there is a nursing bed, that there is a toilet seat, that there is a bath lift and everything a person needs when they come home from hospital after a stroke or some other illness – and we also had that evaluated at that time. (...) That was all 20 years ago, and then the pilot project finished, and we said to ourselves, what are we going to do now with all this? Now we've created the network, now we've done all the preparatory work, it really would be a problem to let it die. So we then linked up with the health network and tried, in addition to all the hospital visits, to bring all the care associations together, all the caregiver associations. Then we tried to get the social services department on board. We got the pension association on board, etc. etc. etc. We extended the network further and further, because we told ourselves that this really was a good integrated care project that we wanted to continue and extend to provide better care and support for the patients. We were then, as in now transpires, just way ahead of our time, because the notion of integrated healthcare provision in Austria was not really one that had been thought through and was also being put into practice, and the hospital associations let us know that they would help us because we were nice, but that they didn't really see any other sense in it and that as long as they didn't do more business, they didn't see any sense in it. That was their statement at that time. (...) We are now in the situation that as a result of the whole national debate on integrated care, PHC-centers (...) we are slowly but surely reaching the situation where people are taking note of the health network again (...) and we plan, in a future project, to now really turn the health network into an integrated health hub like the politicians want (P3_1, 41-90).

Both exemplary statements show that the initiators followed a holistic aim during the implementation of the HNT. It connects three different aspects: efficiency improvements of hospitalisations (budget relief), better treatments of chronically ill (patient satisfaction) and a better cooperation between medicine and care (relief of doctors involved). For more than 20 years initiators of the programme have

devoted themselves to new projects with a growing number of partners, always with respect to this tripartite structure of the understanding of care.

The project “Case and Care Management” (=discharge management) was implemented on behalf of the health platform of Salzburg. (Schwaiger, 2008) According to Austrian law, a standardised discharge management had to be implemented until 2013. Following on from this, the Health Platform Salzburg commissioned the reformpool project Case- and Care-Management Tennengau. The project was financed by the Health Fund Salzburg, which is in turn financed by the regional state and social health insurance.

The case and care management changed the tasks of the involved staff members. The nursing staff of the ward is no longer responsible for discharge, but discharge management is done centrally in the hospital. Thus, explicit working time is reserved for consulting and organising discharge. The hospital took on an experienced new member of staff, a qualified caregiver, as new discharge manager. The nurse also works with GPs in the region. Moreover, she collaborates with case managers from social health insurance. The discharge manager developed a guideline that includes all steps in the process. The project was then presented in the hospital to doctors, nurses and physiotherapist and to extramural partners in order to increase their awareness and cooperation. (Schwaiger and Klassen, 2011)

The two main barriers of the discharge management were firstly, that patients could not be discharged due to a lack of care for them, as all capacities of carers and nursing homes were used. Second, many patients did not understand that they required help and could no longer live independently, or, the patients expected to be cared for by relatives, who were not able or willing to do so. (Schwaiger and Klassen, 2011)

An important facilitator during the implementation for the network was the establishment of the counselling for the elderly and the case and care management Tennengau as “reformpool” project in Austria. As part of the health reform 2005, the policy tool “reformpool” was established as a significant step towards more coordinated care by providing a platform at regional level for both SHI and the federal states to jointly organise and fund lighthouse projects. These projects were expected to overcome the fragmentation of the healthcare system and ultimately shift health services to the most adequate sector, improving allocative efficiency and/or quality of care. Between 2007 and 2009 the counselling services were part of the reformpool. In 2010, the project was adapted into the routine care

system. The social resort of Salzburg currently funds the counselling services, but they are only implemented in 9 of 13 municipalities.

An additional important facilitator for the counselling for the elderly and the discharge management Tennengau was the personal union, as Karl Schwaiger, the chairman of the Health Network Tennengau, is at the same time the director of nursing at the hospital Hallein. (Schwaiger, 2008)

A shared history of problem realisation and of a learning process

The history of implementation, which was presented by the participants, shows no linearly temporary characteristics. There is no linear way from objective to determination of means and further to realisation to end the programme or to change it into a new structure. The history of implementation of the HNT is still not fully completed. Because the network participants have always seen their activities as a special form of an innovation platform for new projects, the health network itself is steadily being improved.

In addition, both quotations point out that the HNT is not a strategy-driven project and not based on a mellow concept of multi-morbidity and on respective legal conditions, like in some other countries. It is not a medicine-driven programme either, optimising therapies and treatments.

The HNT is rather seen by its organisers as an experiential and learning project that started from a holistic aim and developed from project to project, by analysing the experiences of each specific initial problem. Afterwards the network group develops and determines together an innovative project, which is then submitted for financing/financial support and eventually started in an appropriate team. The specific outcomes of the project get analysed internally and externally evaluated after a predetermined period. If there appears any supply gaps new successor projects need to be developed. The initiators work step-by-step, always saying “the next step was...” or “then we have...done and afterwards...”. Even the federal province mentioned the following: “From my understanding the health network is a learning organisation.” (P13_1, 97 – 98) This also implies the processing of rejections of finances and other problem situations. Therefore the HNT seems to be a long chain of experiential and innovative individual projects, which are initiated by the network and are controlled or rather passed on to regional providers. This is the reason why it is not possible to fully separate the history of implementation and the current design of care. In conclusion, it is important to understand that the participants see themselves as innovators who are developing new projects.

Exemplary is the start of the project counselling for the elderly. It traces back to a meeting of the network in 2005, where the members of the cooperative and the municipalities in Tennengau (“Regionalverband”) agreed that the Network should increasingly work in the field of case and care management. They found a big gap of knowledge in the population concerning available care support. Although there is much on offer, it is difficult for patients and relatives to overview the various services. Following on from this, two strategy meetings with the heads of social service providers were held and the cooperation for a joint project was established. In further meetings, they agreed on a strategy (Schwaiger, 2008):

- The project does not decrease the autonomy of the participating organisation
- The welfare of the client is at the centre and he or she can choose the service provider freely. The core question is: What does the customer need?
- Networking is positive and synergies should be exploited
- Constructive dialogue is required, despite the competition between service providers
- The project team needs to be powerful. Thus, representatives of all organisations are part and received decision making power
- The project team reports to a steering committee that consists of the heads of the organisations and financiers
- The Network pays for additional expertise
- All involved organisations agree to the start of project development.

Building on this strategy, a multidisciplinary team developed the counselling for the elderly. Starting in 2007, it was implemented in 6 municipalities in Tennengau. (Gesundheitsnetzwerk.at, o.J.b)

According to the two statements above and some other interviews it can be seen that the HNT can be considered as a care induced programme, which emanates from gaps of the Austrian healthcare system, in specific for the chronically ill and the unnecessary burdens for patients, hospitals and attending physicians. Participating doctors and managers of hospitals suffered for years from the so called “revolving door effect” and therefore were unsatisfied with the limited possibilities of care for their patients. Moreover, the foundation of the HNT happened during a political window of opportunity when start-up financing became possible.

Thus, the development of the whole network started because of increased hospital admissions caused by insufficient home care offers and the indignation of professionals to close these gaps with joint efforts. The several different interviewees pointed out that this problem still exists and is of great importance, whereas other aspects as for example shared benefit plans or strained self-management play only a minor role.

In addition, both statements show that a shared history with separated storylines and meaning priorities developed. The shared history of implementation is used by the participants to ensure themselves in risky situations or towards the public again and again of their separated targets and of the meaningfulness of their common actions. This is necessary, because the network is exposed to three different inventory risks. One of these is that the health network is unique in Austria, so there is no way to invoke on the experience of others. Another problem is that the HNT is a partially subsidised bottom-up programme and therefore a lot of voluntary commitment is demanded from the participants. Lastly mentioned, there is a financial problem, namely that every year the individual projects must apply for funding.

A history of innovation and decision making and a success story

Irrespective of these many different risks the participants get their motivation to continue from the already gained success of the network and their pride in their own achievements. But beside this history of success, it is not to overhear that they had to and still have to struggle with some difficulties while trying to improve care. There is an example from the quotation above: „We were then, as in now transpires, just way ahead of our time, because the notion of integrated healthcare provision in Austria was not really one that had been thought through.“ [Some examples followed like medical transports or hospitals, acting over years “against their financial interests“, because the dominating financing system did not reward any form of cooperation]. In another part of the interview one of the participants mentioned „we were always starting our projects too early “. Consequently, financing problems during the whole period of implementation occurred for which there had to be repeatedly found solutions. A termination of the activities did never come into question.

There are some interviews where barriers of the network activities play a greater role. One of the biggest problems mentioned is that there are only finite resources for professional public relations. The following quotation from a doctor draws a picture of the problems:

IP: The funding is very tight and limited. That's the reality we have faced over the last 20 years: that we haven't been able to do optimal PR work. We didn't have the financial resources to do anything major. In my opinion, the lack of professional PR work has, for example, been one of our biggest shortcomings in the last 20 years. This also led to the fact that our real intention didn't quite have its intended effect. Our intention was that the health network Tennengau would also be seen externally as the point of contact for health and social matters here in the region for the region, for the people, for all those interested and for the policymakers. That would have been our intention. We members of the network have always, of course, provided our expertise on a voluntary basis. But it never got as far that a "health centre" was set up with surgery hours and information that we could have provided. That keeps us back. (P8_1, 203-218)

From the point of view of the care providers the problem is the absence of good visibility due to the lack of public relations. The network does not get enough acceptance from payer organisations and the public, because they are unaware of the peculiarity of the network's offers.

3.8.2. Present information

Information for this section is provided throughout the previous sections.

3.8.3. Future implementation/development

Building on the previous success of the HNT, there will be lots of new projects focused around the implementation of regionally connected PHC-centres. Furthermore, current estimations – from participants as well as on a national level and from payer organisations – expect that the model of the HNT has transfer potential, meaning that it could be possible that the model spreads out to other regions. This is due to the practicability of several different individual projects and due to the functionality of a network of integrated care, which brings its participants some benefit and improves medical treatments and increases patient's satisfaction. A partner of one of the payer organisations explained in a nutshell:

IP: The Tennengau network is an optimal structure in my view. (P13_1, 148)

At the country level, the scalability of this programme is considered to be only partly possible. Interview partners think that the model of the health network can only be implemented in regions where comparable parameters exist. They further mention that there are some areas, where the players in the healthcare industry do not enjoy such a good communication climate. Therefore, it is important to bring

possible cooperation partners together in a first step. In addition, they advise to combine the model of the HNT with supply centres in more densely populated areas.

Referring to the currently much discussed issue of PHC-centres in Austria, they distinguish two different types of models at state level. Although for participants of the HNT such individual projects are just one piece of the whole model, from the view of the state these projects are attributed with greater importance due to their national relevance for health. So there is a kind of a trade-off between bottom-up models and top-down demands of current models of national health policy. Which approach is going to prevail is still to be determined.

A positive scalability condition is the enormous knowledge of the HNT that has been accumulated over the years. This might be an advantage for the dissemination of the model. In addition, stakeholders are willing to participate in communication activities which again can be used to diffuse knowledge.

But internal as well as external stakeholders indicate that the diffusion of the HNT model underlies certain conditions which are not fulfilled at the moment. On the one hand it cannot be taken for granted that there are people who will voluntarily work for the network, because there is not enough remuneration that would secure active participation of professionals and of non-physicians. On the other hand there is a lack of funding instruments, not only at the financial side but also in form of missing instruments for a systematic programme processing, which impedes the diffusion of knowledge.

The HNT was also acknowledged in politics and by policy makers. The Austrian Federal Institute for the Health System (ÖBIG) recommends in the structural plan for “Health Salzburg 2010” that the project Tennengau should be implemented in the whole federal state. Moreover, the intergovernmental agreement in Salzburg specifies that the existing care consultation in Salzburg should be based on the model of the visiting care consultations in Tennengau. (Gesundheitsnetzwerk.at, o.J.b) Despite the successful pilot project of the HNT and its appraisal, its individual projects have not been placed sufficiently on the agenda of health policy until now. Although the people in Tennengau try to support other regions with the implementation of a similar programme, they focus on the internal development of the project, as the HNT is currently applying to develop a regional network of PHC-centres.

3.9. Discussion

3.9.1. General discussion

Although the HNT targets the whole population in a rural area, it specially focuses on the chronically ill. At its core is the seamless care between hospital and home care in a unity of care and medical attention. The HNT has been successful for more than 20 years due to voluntary work and a culture of respect between all stakeholders. However, this also constitutes a weakness of the HNT, as it is not easily generalisable. In other regions, not only the culture, but also voluntary stakeholders are lacking to build up integrated care without proper payment. Thus, the HNT offers manifold points for development that can only be spread by securing a sustainable financing.

The information obtained from involved doctors and interviewed patients concerning the health status show the following results:

- Multi-morbid patients play a big role within the HNT.
- As the HNT is a population oriented network, many different illnesses are cared for.
- Multi-morbid patients are not treated differently from other chronically ill, but are treated as a part of the large group of chronically ill by doctors and carers.

Based on the empirical findings in previous sections, the theoretical model of selfie is discussed. The model sectors include:

- Holistic Assessment
- Governance and Leadership
- Delivery system
- Health and social care financing
- Health workforce
- Technologies and pharmaceuticals
- Information and Research

3.9.2. Discussion of the programme in the context of the conceptual framework

Holistic Assessment

According to doctors and carers, clients can be distinguished based on two dimensions:

1. Willingness for or refusal of active participation.

2. Psychological, physical, cognitive and social capabilities or lacking capability for active participation.

Both dimensions constitute a continuum on which patients can be placed. In order to assess the continuum, a trustful relationship and sufficient time is needed. This is often not the case. According to service providers, the willingness of patients is hardly possible to influence, but often changes during times of need. The state of patients on the second dimension is reduced as patients become older. However, there is no direct connection with e.g. the age of 80 and an inability for self-management.

The communication of the medical and non-medical staff, type-adjusted trainings and personal training are necessary for patients to acquire the skills for their illnesses and therapies. If a person is not willing or able to do so, another solution has to be found.

A holistic assessment is done project based within the HNT. This is primarily done by nursing staff or doctors and nursing staff. Thus, a holistic assessment does not develop a joint medical diagnostic but should ensure a seamless care of chronically ill between hospital, GP and nursing care.

a) Governance and Leadership

Shared decision making is a part of the work in the HNT and is done on different levels. For example, patients choose their care providers or organise their own care in the case and care management after receiving broad information. They are also free to choose an entirely different solution and their GP is informed about their case in all situations. The senior counselling functions in a similar way, as patients are encouraged to choose their own care providers.

The exchange between GPs and specialists is rather traditional and done via telephone calls and doctors' letters. According to doctors, this exchange has potential for improvement, e.g., by a data exchange from regional doctors back to the hospital. Patients and informal caregivers did not express wishes, as they are not aware of alternatives. For them, a trusting relationship with the GP and a fast information of the doctor by the hospital are important.

In a few interviews, the special culture in the HNT is emphasised. The culture includes good mutual knowledge of the senior staff in the institutions, a good knowledge between cooperating medical and non-medical staff and a trustful relationship. This facilitates the regulation of conflicts and the solving of mistakes between partners. By comparison, the HNT does not have strong hierarchies. However, the

persons involved repeatedly pointed out that the trustful relationships and the voluntary engagement need to be complemented by a professional network management. Bottom-up programmes are successful, but they need professionalisation after the initial pilot stage. This vice versa depends on the regulatory framework.

The HNT is a cooperative and organised around long-lasting and temporary single projects. This organisational form is due to the lack of corresponding models in regular health policy. The regional health policy positively assesses the HNT and provides a small basic funding and support for individual projects. However, on a national and regional level, adequate structural conditions for a systematic support of such projects are missing.

b) Delivery system

On a micro level, the HNT shows a clear person centred integrated care. A special emphasis is put on the continuity of care between hospital and home care. Moreover, the HNT pays attention to the treatment of chronically ill patients. Thus, it is noticeable that the term “multi-morbid” is usually not actively used, but only in reaction to the question. Usually, it is referred to chronically ill patients or clients. The particularity of multi-morbid patients is seen as the need for special attendance. This long-term attendance is understood as holistic, medical and non-medical care by both doctors and carers.

Based on this understanding, the family situation and the cognitive abilities are as well assessed as the individual illnesses and the development and constant check of the therapy plan. According to the caregivers, multi-morbid patients have often cognitive limitations or are socially deprived. This requires the staff to quickly comprehend the personal situation of the ill, to be flexible and the work plans need continuity.

Quality assurance concerning care is done according to set parameters. Quality assurance concerning medical care has so far not been institutionalised and is subject to various medical initiatives. A reason for this gap in systematic quality assurance for medical treatment in general and the integrated care for multi-morbid patients in particular in Austria is a missing legal framework.

c) Health and social care financing

The access to the HNT is low-threshold not only due to its patient-centeredness, but also due its services free of charge. Clients are offered these services directly by the hospital, the attending doctors and senior counsellors or they can find information online.

The patients do not receive incentives for their self-management, but they also do not expect to do so. If they are compliant, they aim to do it as good as they can. They are aware that they save money for fall-trousers by participating in the project HIP and that they make an important contribution when they answer a survey, as the health insurance may cover costs in the future. There are no additional costs for the patients.

On the network level, the principal problem of only project financing has persisted for more than 20 years. Although this situation is frustrating, the stakeholders are again and again willing to find new solutions for the lack of regular funding. It is not predictable how long this willingness will last for. Doctors and care institutions would be more involved if they received payment for their additional work.

The case study HNT shows that Austria has structural financial barriers for the development, permanent securement and spread of innovative models for integrated care on both national and regional level.

d) Workforce

The HNT introduced three new professional roles in the socio-medical sector, including:

- Manager of the health network
- Senior counsellors
- Case and care manager (discharge manager)

In addition, it is planned to employ a

- Mobile specialized nurse

The new professional roles require skills for case related communication with patients, doctors, nurses and social workers. The communication is very flexible, often over the telephone and sometimes via the data network DAME. All new professions know each other personally and share a trustful relationship.

Besides their education in nursing and sometimes additional trainings, all new professions are very committed and open for complex medical, psychic and social challenges. Although there is not yet a system for role-specific training, the HNT organises together with regional politics trainings for doctors and nurses concerning the integrated care for all patients. The staff in the new professional roles mentioned interest for different trainings, which however are not specific for multi-morbid patients.

On a national level, a study programme for “healthcare” is being discussed. However, many practical initiatives are thereby not taken into account.

e) Technologies and pharmaceuticals

The cooperation between specialists in hospitals ensures the important safety of individual polypharmacy. A seamless transition between the hospital and home care is secured by the case and care manager and the data transfer system DAME. However, the doctors and professional caregivers attribute a high burden to the requirements of monitoring. All stakeholders wish to be unburdened. The usage of DAME is judged as helpful for the medical work. It is expected that the new PHC law will make further relief possible. A further burden by documenting work of doctors is rejected.

Patient-centred ICT applications have so far not been in the centre of attention of the HNT. The resources for innovative projects are consumed by the PHC-application. It has to be taken into account that the stakeholders of each integrated care programme have their own history and development focus. What is in the focus of some programmes of integrated care at the moment, can be insignificant in other projects.

f) Information and Research

Patient data are documented by the attending physicians and by nursing services. After the hospital stay, case data and a clinical course about home care necessities are electronically sent to the outpatient doctors and sometimes care institutions are contacted. This exchange of information is valued by all stakeholders involved. However, so far there is no electronical exchange between all inpatient and outpatient doctors, which is criticised by GPs. Nevertheless, it is pointed out that the doctors’ involvement depends on their age. Often, they do not want to change long-term behaviour.

The starting point of the HNT was the participation in a medical research project. Thus, the stakeholders of the HNT value the knowledge generation of research and the contacts with researchers as input for their practical work. Overall, they value a knowledge exchange with external stakeholders.

Specific patient data are routinely submitted to the social insurance and collected and systematised there. An evaluation of HNT project has only be done in selected cases, because a separate financing is lacking. Moreover, the regional level values a slim data collection in order not to create data cemeteries.

The regional level prefers few but meaningful data with high methodological standards. Thus, a project-based evaluation and data gathering are preferred.

3.10. Appendix – Original Quotes from Health Network Tennengau Interviews

IP: Da sind dann viele Ideen und Vernetzungen entstanden wie das Entlassungsmanagement und solche Dinge und die bringen natürlich wieder den Gemeinden Vorteile, und diese Vorteile haben wir uns nicht nur erwartet, sondern haben wir dann auch gesehen, z.B. die Zusammenarbeit der Seniorenheime mit dem Krankenhaus. (...) So hat dieses Netzwerk einfach einerseits die Menschen mit Information versorgt, was gibt es, wo wende ich mich hin, wenn ich das oder jenes Gesundheitsbild oder Krankheitsbild habe und mich informieren möchte und andererseits für die handelnden Personen einfach klare Linien da waren, was machen wir mit dem Patienten, was machen wir mit der Patientin, wenn sie aus dem Krankenhaus entlassen wird. (P15_1, 83-97)

IP: Von den Ursprüngen her hat es bei uns ein Pilotprojekt, eine Untersuchung gegeben, gestartet vom Ludwig Boltzmann Institut: Warum wird die medizinische Hauskrankenpflege in Österreich so schlecht angenommen. (...) Und haben dann erstmalig in diesem Zusammenhang mehrere Treffen mit niedergelassener Ärzteschaft vereinbart. Und haben dann im Zuge dieser neuen Form der Zusammenarbeit, die es vorher nicht gab, bemerkt, dass das eigentlich ganz gescheit ist, wenn man miteinander spricht, das Krankenhaus mit niedergelassener Ärzteschaft und dass es da eigentlich Informationsdefizite gibt. Dann war einige Zeit ein bisschen Ruhe, (...) aber übrig geblieben ist diese Erkenntnis: Miteinander reden ist gut und vernetzen ist doch besser. Wir haben einige Monate später begonnen, diese Gruppe noch einmal einzuberufen hier im Krankenhaus (...) und wir haben dann in diesem Kreis beschlossen, das machen wir zu einer regelmäßigen Runde, dass wir uns vierteljährlich austauschen und Fallbesprechungen machen zu Patienten, die eben multimorbid und chronisch krank sind, die eben in der Unterbringung und Versorgung nicht einfach sind oder problematisch sind, und schauen, dass wir hier gemeinsame Wege gehen, damit nicht einer an dem Strang zieht und der andere in die Gegenrichtung, sondern dass wir hier koordiniert vorgehen können. Wir haben dann relativ bald gesehen, das ist sinnvoll, das funktioniert und haben dann erstmalig die „ARGE Patientennetzwerk Tennengau“ gegründet. Das war sozusagen die Ursprungsversion und aus dem raus ist dann schlussendlich das „Gesundheitsnetzwerk Tennengau“ entstanden mit verschiedenen Projekten, die dann eben gestartet wurden und zum Glück auch größtenteils erfolgreich abgeschlossen werden konnten. So hat das einfach seinen Lauf genommen. (...) Aus meiner Wahrnehmung waren zwei Aspekte ganz

wesentlich. Der wesentliche Aspekt war, Patienten durch das System des Gesundheits- und Sozialwesens zu führen, gemeinsam zu führen. Und nachdem überall unterschiedliche Stakeholder sitzen, war es einfach notwendig, eine Koordination zu schaffen: in erster Linie mit Gesprächen, in zweiter Linie mit gemeinsamen Projekten, in dritter Linie haben wir dann gemerkt, es ist gut, wenn auch andere, weitere Teilnehmer dazukommen, eben Seniorenheime, Hauskrankenpflegevereine. Das war dann nächste Schritt. Dann der nächste Schritt war, dass wir eine soziale Vernetzung unter den Anbietern erreichen wollten. Das heißt, wenn man sich besser kennt, wenn man auch gegenseitig die Leistungen besser kennt und einschätzen lernt, dann kann man auch besser miteinander kommunizieren und sich auf fachlicher Ebene gut austauschen. Das war dann die weitere Erkenntnis. Das haben wir dann auch verknüpft und verstärkt mit der Abhaltung von gemeinsamen Klausuren, gemeinsame Ziele festzulegen, gemeinsame Fortbildungsveranstaltungen zu initiieren über das Jahr. Das waren so die ganz wesentlichen Punkte und da hat sich eigentlich dann in dem Bezirk Tennengau über diese Jahre, glaube ich, eine gewisse Kultur herangebildet. Es gibt heute keine Grenzen zwischen den Beteiligten. Wenn ich einfach mit jemand Kontakt aufnehmen möchte, dann ist das gleich ein grundsätzlich freundschaftlicher positiver Kontakt, auch wenn ich vielleicht einmal Kritik äußern sollte. (...) Das ist eine Selbstverständlichkeit. In anderen Bereichen höre ich, dass sich das oft sehr reibt dann, dass man da in Konkurrenz tritt und bei uns versucht man eben im Sinne dieser Kultur, die ich schon spüre und merke, dass man sich gegenseitig unterstützt und fördert und das finde ich das Schöne und das ist, glaube ich, auch das, was sich im Zeitverlauf so eingebürgert hat. (P5_1, 21-86)

IP: Es hat vor über 20 Jahren vom Ludwig Boltzmann Institut ausgehend ein Pilotprojekt gegeben, das Krankenhaus ersetzende Maßnahmen forcieren sollte. Sie sehen, dass das, was heute sehr modern ist, vor über 20 Jahren schon am Tablett gestanden ist. Wir sind da zusammengesessen mit Fachleuten. Ich war damals noch ein junger Praktiker. Und wir haben überlegt, was wir machen können. Und wir sind draufgekommen, dass es eigentlich einen Sinn machen würde, die Leute, die im Krankenhaus entlassen werden, eben alte, multimorbide Leute. Wir haben die Erfahrung gehabt, dass die Leute, wenn sie am Freitag entlassen werden und sie kommen in eine Infrastruktur, die ihnen nicht gerecht wird, dass sie am nächsten Tag gleich wieder eingewiesen werden, weil die Familie überfordert ist, der Patient ist überfordert, das System ist überfordert. Und wir haben gesagt, wir wollen etwas kreieren, was diesen Drehtüreffekt vermindert und aus dem Ganzen wurde das Projekt „Entlassungsvisite“ kreiert, das damals auch vom Land bezahlt wurde und heute, glaube ich, noch bezahlt wird. Das heißt, wir haben die Möglichkeit bekommen, den Patienten direkt aus dem Krankenhaus abzuholen bzw. auch für die Pflege,

dass die Pflege den Patienten direkt übergeben bekommt, dass geschaut worden ist, dass eine Infrastruktur zuhause ist, dass ein Pflegebett da ist, dass, ein Toilettensitz da ist, dass ein Badewannenlift da ist und was man immer so braucht, wenn einer halt aus dem Krankenhaus zurückkommt, nach einem Schlaganfall oder sonst irgendeiner Erkrankung und wir haben das damals auch evaluieren lassen. (...) Das Ganze ist 20 Jahre zurück und dann ist das Pilotprojekt ausgelaufen und dann haben wir gesagt, was tun wir jetzt mit der ganzen Geschichte. Jetzt sind wir vernetzt, jetzt haben wir eine Vorarbeit geleistet, eigentlich wäre es ein Problem, das sterben zu lassen und haben dann an der Idee des Gesundheitsnetzwerkes geknüpft und haben versucht, eben neben dieser ganzen Krankenhausvisite einmal die ganzen Pflegevereine zusammenzuholen, die ganzen Betreuungsvereine. Dann haben wir das Sozialamt mit ins Boot geholt. Wir haben den Vorsorgeverein ins Boot geholt und, und, und. Wir haben immer weiter geknüpft, weil wir gesagt haben, eigentlich ist das so ein gutes integriertes Gesundheitsprojekt, das wollen wir weiterführen und uns weiter knüpfen im Sinne einer besseren Versorgung des Patienten. Wir waren damals, wie sich heute herausgestellt hat, einfach viel zu früh dran, weil dieser Gedanke der integrierten Gesundheitsversorgung in Österreich noch nicht wirklich ein durchgedachter und auch gelebter gewesen ist und uns die Krankenhausvereine signalisiert haben, ja, weil ihr nett seid, sind wir gerne dabei, aber sonst sehen wir wirklich keinen Sinn, solange wir nicht mehr Geschäft machen, sehen wir da keinen Sinn darin. Das war damals so die Aussage. (...) Wir sind jetzt in der Situation, dass wir aufgrund der ganzen nationalen Diskussion über eine integrierte Gesundheitsversorgung, PHC's (...) schön langsam in die Situation kommen, dass man wieder auf das Gesundheitsnetzwerk aufmerksam wird (.) und wir haben ja vor, das ist unser Zukunftsprojekt, das Gesundheitsnetzwerk jetzt wirklich ganz konsequent zu einer Drehscheibe integrierte Gesundheitsversorgung zu machen, wie es auch die Politik will. (3_1, 41-90)

IP: Die Finanzierung hält sich sehr in engen Grenzen. Das sind die Realitäten, mit denen wir auch in den letzten 20 Jahren konfrontiert waren: dass wir keine optimale PR-Arbeit machen konnten. Die finanziellen Möglichkeiten waren nicht in dem Ausmaß gegeben, dass wir irgendwelche großen Schritte machen konnten. Also z.B. aus meiner Sicht ist eins der größten Mankos in den letzten 20 Jahren gewesen die fehlende professionelle PR-Arbeit. Das hat auch dazu geführt hat, dass unsere Intension, nicht ganz gewirkt hat. Unsere Intension war, dass das Gesundheitsnetzwerk Tennengau auch von außen gesehen der Ansprechpartner in Gesundheits- und in Sozialfragen hier in der Region für die Region ist, für die Bevölkerung, für alle Interessierten und auch für die Politik der Ansprechpartner. Das wäre unsere Intension gewesen. Wir Netzwerkteilnehmer haben uns mit unserer Expertise natürlich

auch auf ehrenamtlicher Ebene eingebracht. Aber es ist nicht so weit gekommen, dass wirklich ein „Gesundheitshaus“ mit Sprechstunden und mit Informationsmöglichkeiten entstanden ist, die wir weitergeben hätten können. Das hemmt u(P8_1, 203-218)

IP: So eine liebe Dame, na die kümmert sich ja und die hilft dir jetzt und die arbeitet für dieses, jetzt sage ich, das Netzwerk? Ich habe gar nicht gewusst, dass es ein Netzwerk ist aber es ist mir vorgekommen, wie ein Netz, wie ein gesponnenes Netz (...) Es ist alles gelaufen wie am Schnürchen, aber nur durch diese Frau Mag. H, ist mir vorgekommen. Sonst wäre das nicht so gewesen. Das war für mich wie ein Wunder (...)

I: Sie haben gesagt, für Sie ist die Frau H. der Inbegriff dieser Hilfe gewesen. Sie haben gesagt, es war nahtlos: alles war vorbereitet.

IP: Ja. Total.

I: Und Sie haben gesagt, Sie haben gar nicht gewusst, dass diese Hilfe vom Gesundheitsnetzwerk Tennengau kommt, dass es das Gesundheitsnetzwerk gibt?

IP: Nein, war mir ja ganz fremd.

I: Aber Sie haben sozusagen die Auswirkung dieses Gesundheitsnetzwerkes gespürt?

IP: Ja, aber wie. (...) Ja, auch die Liebenswürdigkeit und dass da jemand helfen wird [nach dem Krankenhausaufenthalt], dass sich der um den Menschen kümmert. Ich finde das so toll, dass es das gibt. Die Organisation ist einfach super. Die sollte es viel mehr in allen Sparten geben, so was. (P7_1, 566-577)

IP: Das Netzwerk Tennengau ist so eine Optimalstruktur aus meiner Sicht. (P13_1, 148)

I: Spielen multimorbid chronisch kranke PatientInnen in Ihrer Arbeit eine besondere Rolle oder sind diese ein Teil des Ganzen und sind gar nicht so hervorzuheben? Wie sind Ihre Erfahrungen? (...)

IP: Natürlich spielen heute chronisch Kranke eine besondere Rolle, weil sie eben besondere Zuwendung brauchen. Das sind die Patienten, die wir häufig sehen. Die, wo wir immer wieder auch die Therapie anpassen müssen. Das ist etwas ganz anderes als beim akuten Patienten, der eine Grippe hat oder irgendeinen akuten Schmerz. Der kommt punktuell, der wird behandelt und ist dann wieder draußen und ich muss mir keine weiteren Gedanken machen. Heute ist es natürlich so, dass die chronisch Kranken immer mehr werden, weil die Leute auch immer älter werden und das ist eine besondere Herausforderung, die Begleitung des Patienten und da denke ich mir, da spielt natürlich wirklich die integrierte Gesundheitsversorgung eine große Rolle. Was sind die Herausforderungen für den chronisch

Kranken? Die Herausforderung ist, dass man ihn ordentlich begleitet in seiner ganzen Krankheit. Da sind wir jetzt bei diesem somato-psycho-sozialen Modell, das ganz, ganz wichtig ist: Den Patienten und seine Gesamtheit zu sehen. Zum Beispiel, wenn ich an chronisch kranke Diabetiker denke, deren Krankheiten ja auch durch einen falschen Lebensstil verursacht sind. Da sind die Herausforderungen groß, die Leute zu motivieren, etwas zu verändern im Leben und da genau schauen, wie steht der da, in welchem Familienkontext steht der da? Kann ich dem das überhaupt zutrauen, dass sich den Lebensstil zu verändern? Oder wird sich der nicht verändern und ich muss ihn einfach in seiner Krankheit so begleiten, dass es für ihn passt. Das sind einfach die Herausforderungen, die wir als Allgemeinmediziner haben und da glaube ich, da sind wir durchaus besser als die Fachärzte, die natürlich nur diese Teilaspekte sehen und drum bin ich ein Verfechter, dass schon in einer ganz klaren Zusammenarbeit mit den Fachärzten zu machen, die wir nicht so selten brauchen, aber ich glaube, dass diese Begleitung, diese kontinuierliche Begleitung das Wesentliche ist in der Betreuung des chronisch kranken Patienten. (P16_1, 12-39)

IP: Gerade bei so Multimorbiden oder bei anderen Klienten [die soziale oder psychische Probleme haben, ist es schwierig. Aber] ich will es gar nicht oft als ‚schwierig‘ bezeichnen, weil wir sehen es gar nicht als so schwierig an, sondern: Sie sind anders. Sie brauchen eine andere Betreuung, aber gerade da fallen z.B. diese Beratungsgespräche an oder diese Betreuung rundherum an, es ist gar nicht die Pflege, die aufwändiger wird, sondern das Rundherum wird aufwendiger. Das ist also die Erfahrung, jetzt meine, aus der Pflege. Ich sehe es ja [mit eigenen Augen]. So wie bei dem Herrn X. Ich hätte den [einmal an einem bestimmten Tag] gar nicht pflegen können, weil, zuerst einmal muss ich ja schauen, dass das Rundherum abgedeckt ist. Das Gespräch allein schon [darüber, wie es ihm geht und dass er sich anziehen soll] war eine viertel Stunde, bis ich den soweit gehabt habe, dass er überhaupt einmal aus dem Bett rauskommt, weil irgendwer war ja da und ich meine, der hat Wahnvorstellungen auch noch dazu. Also das ist ja gar nicht so ohne. (P10_1, 580-590)

IP: Patienten, die multimorbid und chronisch krank sind, [sind solche] die in der Unterbringung und Versorgung nicht einfach sind oder problematisch sind, Leute, die im Krankenhaus entlassen werden, eben alte, multimorbide Leute. (P5_1, 42-44)

IP: Warum brauchen wir diese Einrichtungen [wie das Gesundheitsnetzwerk Tennengau sowie die in Österreich geplanten PHCs]? Weil wir nicht alle chronisch Kranken oder auch mehrfach chronisch Kranken ständig in den Ambulanzen [der Krankenhäuser] haben möchten, weil das ist die teuerste

Versorgung und ist auch nicht Best Point of Service und gerade für diese chronischen Fälle braucht man die PHCs. (P15_1, 171-174)

IP: Ich habe ja aus dem Gesundheitsnetzwerk einen maximalen Benefit herausgezogen, weil ich kenne alle. Ich bin mit allen gut. Das heißt, ich brauche es [das GNT] eh nicht mehr so, wie vielleicht andere [ÄrztInnen], die die Leute noch nicht so kennen. (P16_1, 230-232)

IP: Es gab auch zwischen den sozialen Diensten die Befürchtung, dadurch Kunden zu verlieren. Es gab die Befürchtung: Werden die Seniorenberaterinnen neutral anbieten? Haben die alle Prospekte mit? Niemand wusste das sicher. Niemand kann das beeinflussen, ob die Beraterinnen nicht doch im Gespräch dann einen präferieren – und das war die Befürchtung der sozialen Dienste, dass die Beraterinnen, wenn die rausgehen, sagen [könnten]: ‚Aber nehmen sie lieber [den Anbieter X statt Y]. Das war die Befürchtung dahinter. Sie wollten natürlich auch Statistiken, welche Kunden wurden zu wem übermittelt, damit man vergleichen konnte. Was sich dann herausgestellt hat, war, dass es kein Problem war, dass sie sehr wohl neutral geblieben sind und dass die Kriterien, einen Hilfsdienst zu wählen, oftmals auch abhängig gewesen sind von dem, dass die Nachbarin schon den hatte, weil, wenn die das Auto von diesem Hilfsdienst dort vor der Haustür gesehen hat, hat sie gesagt: ‚Ah, die kommen da schon hin, können sie mich auch mit betreuen.‘ So war eigentlich eher der Zusammenhang, warum man bestimmte Sachen wählt. Ansonsten war die Verteilung eine sehr korrekte und gleichmäßige und alle hatten dann die Erfahrung am Schluss, sie können sich darauf verlassen: Es wird neutral beraten und sie haben zusätzliche Kunden und dann war die Sache wieder beruhigt. (P6_1, 334-349)

IP: Ich meine, ich konnte gehen, ja, aber ich war sehr schwach. Ich sollte- Ich sollte jetzt regelmäßig gehen, der Durchfall hindert mich aber. (...) Im Krankenhaus, ich glaube, die Frau H., die hat mich gut beraten. Die hätte auch geholfen, dass ich irgendeine 24 Stunden Pflege kriege. Im Endeffekt haben das aber dann meine Söhne in die Hand genommen, weil ich mich zuerst einmal gewehrt habe, dass wegen der 24 Stunden Pflege, weil ich gesagt habe, ich kann mir das nicht leisten, weil das ist ja doch nicht billig. Da habe mich eigentlich gewehrt, habe gesagt, ich komm’ schon über die Runden (...) Meine Söhne haben mich dann überredet dazu. (P14_1, 374-384, 399)

IP: Im Krankenhaus wird das erste Mal, wenn dieses Projekt gestartet ist und die Klientel sich bereit erklärt, da mitzumachen, bereits ein Basis Assessment zum Thema Demenz gemacht, damit man weiß ob die Person auch in der Lage ist zu verstehen, um was es da geht. Dann wird eine Befragung des Patienten und der Angehörigen durchgeführt und dann einen Monat später wird zuhause ein

Fragebogen ausgefüllt über das Tragen, aber auch über die häusliche Situation, Stolperfallen etc. (P4_1, 370-375)

IP: Ja, diese Frau kümmert sich um die Menschen. Da habe ich es spüren dürfen, mein Gott, jetzt ist da endlich einmal im Krankenhaus ein Mensch, der helfen will, der hilft, dass alles gut läuft. Ich denke mir jetzt, da war ich da auch für die Klientin Y. Es gibt ja Menschen, die niemanden dann haben, da ist es ja gut, wenn so ein Netzwerk da ist. Oder dass sie von jemand ausgenutzt werden, finanziell auch. Da sind wir wieder bei der Menschenwürde und da finde ich so wichtig, dass es so was gibt, so eine Organisation gibt. Also ich finde das höchstbrisant, dass es so was gibt, dass geholfen wird. (P7_1, 549-557)

IP: Meine Beine machen Probleme, beide. Beide. Am linken Fuß habe ich diese OP, eine Summe von Operationen und nach wie vor eine offene Wunde, die also zwar jetzt schon relativ gut verheilt ist, aber immer noch offen ist. Das heißt, ich muss alle zwei Tage verbinden. Am rechten Fuß habe ich das mit der Hüfte (seufzt), es könnte besser sein. Also ich hatsch anständig.

I: Ja. Die offene Wunde, da haben Sie gesagt, die da sparen Sie sich jetzt die ambulante Pflegehilfe,
IP: das Rote Kreuz.

I: heißt das, Ihre 24-Stundenpflegerin ist dafür ausgebildet, sie kann das?

IP: Nein. Ich mache das jetzt seit 2006, tu ich mich selber verbinden, tu ich-, werde ich verbunden. Nein, seit 2002 werde ich verbunden. Jetzt haben wir 2016. 14 Jahre. In der Zwischenzeit weiß ich selber, wie ich zu verbinden bin, ja. Ich bin oft genug im Krankenhaus in Salzburg verbunden worden, bin auch immer noch auf der Dermat [dermatologischen Station] zur Kontrolle. Jetzt war ich schon lange nicht mehr. Ich müsste wieder hinschauen. Ja. Also ich weiß, wie ich zu verbinden bin und mit was ich zu verbinden bin. Und das habe ich meiner Betreuerin gesagt und die ist in der Zwischenzeit [in der Lage], nach meiner Anweisung, ja.

I: Und haben Sie auch das richtige Verbandsmaterial?

IP: Ja, ja. Ja, ja.

I: Weil, es ist ja manchmal so, dass man im Krankenhaus eine hohe Qualität an Verbandsmaterial bekommt und der Hausarzt darf es nicht mehr verschreiben.

IP: Nein, nein. Nein.

I: Haben Sie dieses Problem?

IP: Nein. Kein Problem. All das, was ich praktisch im Krankenhaus gesehen habe, mit was ich verbunden worden bin, das kriege ich über den Hausarzt verschrieben und- Ja. Kein Problem. (P14_1, 458-474)

IP: Und in Hallein, jetzt angedacht dass wir über das Gesundheitsnetzwerk als Drehscheibe der integrierten Versorgung eine Struktur aufbauen, die vice versa gut funktioniert, wo wir abrufen können, wenn es sein sollte, einen Ernährungsberater, eine Pflege, Wundmanagement, eine Physiotherapie, die brauche ich öfter, Ergotherapie, Apotheke, was weiß ich alles. Das sind so die Konzepte, die im Moment entwickelt werden. (P16_1, 85-90)

IP: In anderen Gesundheitszentren sind die meisten- oder ein Teil der nicht ärztlichen Gesundheitsberufe beim PHC angestellt. Ich glaube aber, dass das nicht der richtige Weg ist, weil es unheimlich viel Verwaltungsaufwand ist. (...) Das heißt, das kann ich als Arzt nicht mehr leisten, da brauche ich dann wirklich einen zusätzlichen Manager. Wenn ich den Manager aber in die Drehscheibe Gesundheitsnetzwerk Tennengau habe, dann verwaltet der das, wo die Leute es abrufen können. Zum Beispiel: Ich habe im Moment eine einzige chronische Wunde, dafür brauche ich keinen Wundmanager anstellen. Ich brauche natürlich relativ häufig einen Physiotherapeuten. Den könnte ich möglicherweise noch anstellen, das wollen aber die Physiotherapeuten nicht. Logopäden brauche ich selten. Ergotherapeuten brauche ich auch selten. Diätassistentin brauche ich auch selten. Sozialarbeiter bräuchte ich häufiger, aber auch nicht so, dass ich den zu 100 % auslaste. (P16_1, 534-549)

IP: Die Zusammenarbeit mit den Seniorenberaterinnen ist super, also da ist die Frau X., Diplomgesundheitskrankenschwester Y, also mit denen haben wir die besten Kontakte. (P10_1, 99-100)

IP: Das „DAME“ war ein Produkt, wo wir gesagt haben: ‚Wie bringen wir die niedergelassene Ärzteschaft noch mehr ins Boot.‘ Weil das war auch immer ein bisschen latent, dass Ärzte gesagt haben: Naja, das, [was das GNT bisher angeboten hat], braucht man als Arzt nicht. Wir haben Sitzungen gehabt, wo die Ärzteschaft gesagt hat: ‚Das sind alles soziale Fragen, wir sind nicht für soziale Fragen zuständig, sondern für die Gesundheit zuständig. Und dann haben wir [Dr. X und ich] so einen Supervisionsworkshop gehabt im Rahmen des „Netzwerks Gesundheitsfördernder Krankenhäuser“ ONGKG. Das haben wir gut genützt. Der Dr. X, das vergesse ich nie, hat gesagt: ‚Wenn ihr keinen Nutzen für alle Beteiligten schafft, dann gelingt es nicht. Also versetzt euch in die Lage, was braucht ein niedergelassener Arzt, dass er eine Behandlung gut fortsetzen kann. Ein niedergelassener Arzt musste damals sehr lange, bis zu drei Wochen, auf einen Arztbrief warten. Er hat nur die handgeschriebenen Kurzarztbriefe vom Patienten mitbekommen und das war sehr wenig und die langen Arztbriefe, die haben einfach eine lange Zeit gedauert, bis die versendet waren und dann beim Arzt in der Post waren und dann musst‘ das lesen und dann musst‘ das archivieren, das ist alles kompliziert und wir haben damals eben Anfang 2000 mit der

Telekom, glaube ich, das geschafft, dass wir eine datensichere Leitung zu über 100 niedergelassenen Ärzten angeboten haben. Das ist heute eine Selbstverständlichkeit, mit ELGA sowieso, aber der Vorläufer war unser DAME-Projekt damals. (P5_1, 174-190)

IP: Wir sind nicht unmittelbar dran [an diesem Thema]. Oder sind mittelbar dran. Wir haben schon einiges an Vorarbeiten geleistet, aber das ist jetzt im Moment nicht ganz so aktuell, aber es (...) ist ein Teil des Gesundheitsnetzwerkes. (P16_1, 379-380)

IP: Der Hausarzt kriegt ja praktisch ganz druckfrisch den Arztbrief vom Krankenhaus, den ich z.B. bei der Entlassung bekommen habe. Diesen Arztbrief kriegt der Hausarzt sofort am Tisch per Fax. Ja. Das heißt, der Hausarzt weiß das noch schneller als ich, was da drin steht. (lacht)

I: Ja. Okay. Es ist gut, wenn die Ärzte miteinander arbeiten.

IP: Ja, ja. Und der Dr. [sein Hausarzt], kennt halt alle Ärzte und speziell die von der inneren Abteilung und der ruft sicher an, wenn da irgendwas drin steht, was nicht ganz klar ist, was zu hinterfragen wäre. (P14_1, 290-297)

IP: Was meinen Sie mit ICT-Applikationen? Telemedizin? Wir haben von der Geografie her ja nicht die Notwendigkeit dazu [ITC unbedingt zu nutzen] wie z.B. in anderen Bundesländern Österreichs. Das Bundesland Niederösterreich hat diese Notwendigkeit, Niederösterreich ist sehr weitläufig. Da muss man ganz weit fahren, bis man zu einem Arzt kommt. Bei uns ist das ganz knapp beisammen. Sozusagen der Wohnort und der nächste Arzt ist so nahe geographisch gelegen, dass diese Telemedizin fast nie zum Einsatz kommt. (P19_1, 71-74)

IP: Also dieser elektronische Austausch ist natürlich heute wichtig und ist heute Standard, da braucht man überhaupt nicht drüber reden. Ganz am Anfang des [Projektes DAME] waren wir der Induktor für diese Geschichte. (...) Ich glaube, dass der Datenaustausch schon ziemlich ausgereizt ist zwischen Krankenhaus und Arztpraxen, wobei wir im Moment nur One Way Datenleitung haben. Ich glaube, dass wir in Zukunft auch unsere Daten ins Krankenhaus schicken. (...) In der Regel haben wir kein Versandmodul, obwohl das auch wichtig wäre, oder man macht wirklich so eine Cloud, wo sich jeder die Informationen abholen kann. Das ist das eine. Das andere ist, gerade wenn es um integrierte Gesundheitsversorgung geht, werden elektronische Datenübertragungen auch eine Rolle spielen, z.B. über Blutzuckermessungen Blutdruck, die man sozusagen hin und her sendet, das geht ja heute alles elektronisch. (P16_1, 363-374)

IP: Gibt es außer der eigenständigen Bedienung der Sauerstoffflasche noch andere Technik, die Sie benutzen und im Alltag bedienen müssen? Blutdruck messen oder irgendwelche anderen Dinge?

IP: Blutdruck messen, Blutzucker messen, ja. Diabetes habe ich auch. Die habe ich aber relativ gut im Griff, die Diabetes, mit der Tablette. Ich brauche nicht zusätzlich spritzen oder sonst irgendwas. (P14_1, 304-312)

IP: Ich bin im Krankenhaus bekannt in der Diabetikerabteilung, habe schon Schulungen mitgemacht, alles. Die sind also da recht aktiv im Krankenhaus Hallein und ich bin am [soundsovielten] zur nächsten Kontrolle praktisch in der Diabetes Abteilung. Da legt man praktisch seine Aufzeichnungen vor. (...)

I: Sie haben mir jetzt wieder ein Stichwort gegeben: Schulungen. Sie haben Schulungen gemacht. Was haben Sie denn für Schulungen gemacht?

IP: Ja, Diabetes-Schulung, ja.

I: Was heißt das? Wie ist das abgelaufen?

IP: Das ist eine Schulung gewesen, die hat eine Woche gedauert. Nachmittags zwei Stunden, jeweils Nachmittag zwei Stunden. Naja, da hat also der Vortragende praktisch durchgemacht das ganze Thema Diabetes. Was ist das, was darf man essen, wie kann man es überprüfen, seinen Blutzucker usw. (...)

I: Das heißt, da haben Sie wirklich eine Allgemeinbildung bekommen. Und für das Messen des Blutzuckers brauchten Sie keine Extraschulung?

IP: Das haben wir zwar auch gemacht, weil das Messgerät, das habe ich praktisch vom Krankenhaus bekommen. Ja, da haben wir es selber einmal gemacht, ja, und wie man die Nadeln austauscht, wie man die Teststreifen austauscht usw. Ja. (P14_1, 318-337)

IP: Es ist ganz individuell. Also ich erlebe top fitte 86-jährige, die in allen Qualitäten orientiert sind, die gut hören, die aufgeschlossen sind, die gut sehen und ich erlebe also Menschen, da schaue ich auf das Geburtsdatum und denke ich mir, kann nicht sein, der ist erst 68, aber biologisch so alt und so angeschlagen. Also es ist individuell. Es gibt sicher Klientel, das da bereit ist und ein anderes, das man sicher nicht erreichen kann mit solchen Schulungen. Also es gibt beides. Es ist individuell verschieden. Compliance ist das Thema. Also wer Compliance hat, ja, wer es nicht hat, [den kann man auch nicht erreichen] (P4_1, 411-416)

IP: Es glauben so viele Leute immer noch, der Arzt ist verantwortlich für ihre Gesundheit und ich sage immer, nein, wenn sie kognitiv auf der Höhe sind, sind sie zu 80 % verantwortlich. Der Arzt kann nur

Diagnostik und Therapie und Empfehlungen erstellen, aber was sie [die KlientInnen] umsetzen, hat man [Ärzte, Pflegekräfte] meist nicht in der Hand. Gewichtsreduktion, Rauchen aufhören. Wir haben ja viele COPD'ler, die bräuchten – genau, das ist ein gutes Beispiel – die bräuchten Heimsauerstoff. Sie kriegen aber keinen, weil sie rauchen. Ja. (P4_1, 283-289)

IP: Der positive Effekt ist schwierig nachzuweisen, auf alle Fälle. (...) Beim Gesundheitsnetzwerk haben sie das ganz gut gemacht. Das war ein ganz gutes Ergebnis. Da kann ich keine Vorgaben geben, wie sie es tun haben. Es muss nur in meinen Augen im Rahmen sein und verständlich, einfach zwei/drei Parameter. Diese [teilweise vertretene] Evaluierungswut [teilen wir nicht], weil, wie soll ich eine Maßnahme evaluieren, wenn ich nicht einmal einen Ausgangspunkt habe. Um evaluieren zu können, brauche ich einmal einen Status Quo und wenn ich keinen Status Quo habe, ja, was evaluiere ich denn dann, um Gottes Willen. Woran will ich denn die Veränderung messen? Und das finde ich in meinen Augen immer das Schwierigste, den Status Quo beim Evaluieren herzustellen. Ich muss ja sagen, das- ist die Grundannahme, das ist das, wovon wir ausgehen und das ist die Veränderung nach drei Jahren. (P12_1, 266, 454-465)

IP Das [eine umfassende Evaluierung von innovativen Projekten] können wir uns nicht überall leisten, sagen wir es so. (P13_1, 435-436)

IP: Das Reformpoolprojekt ist über mehrere Jahre gelaufen. Es war zunächst ein Jahr vorgeschaltet als Art Vorprojektstudie, ob das Reformpoolprojekt auch ins Programm passt der Reformpoolprojekte. Dann, nach dem einen Jahr ist festgestellt worden von der Gruppe, die damit befasst war: ‚Passt sehr gut.‘ Und das wurde dann mehrere Jahre lang durchgeführt und von Prof. X dann evaluiert. Das Projekt wurde sehr erfolgreich evaluiert trotz anfänglicher Vorbedenken seitens der Sozialversicherung, die ja gemeint hat, es wird sich für das Krankenhaus auszahlen, für den niedergelassenen Bereich aber nicht. Es hat sich dann hinterher herausgestellt, auch der niedergelassene Bereich hat vom Reformpoolprojekt profitiert. Also es war sozusagen für alle eine gewinnende Situation letztlich, das Reformpoolprojekt. (P13_1, 50-58)

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4. Programme 2: Sociomedical Centre Liebenau (*Sozialmedizinisches Zentrum Liebenau*)

4.1. Basic information

To produce the thick description of the Sociomedical Centre Liebenau (SMC), 15 comprehensive documents provided by participants in the SMC and about the health centre were analysed and interviews held with representatives of all stakeholder groups. As Table 4 shows, 12 interviews were held, and a total of 13 people were interviewed. The structure of the sample was as follows:

Table 4: Sample structure for the SMC Liebenau case study

	Stakeholder	Interviews	Interviewees
A	Managers	1	1
B	Initiators	1	1
C	Representatives of payer organisations	1	2
D1	Physicians	3	3
D2	Non-physician medical staff, new roles	3	3
E	Informal caregivers	2	2
F	Clients or their representatives	1	1
	Total	12	13

Only two physicians currently work at SMC Liebenau, both of whom were interviewed. One of the former medical residents was also interviewed. Two further interviews were conducted with the doctor who initiated and served for many years as manager of the SMC in order to discuss all the aspects mentioned. Moreover, in addition to details of their medical roles, the two other physicians also provided information, albeit only to a limited extent, on the centre's history and management. The number of interviews with non-doctor medical staff/holders of new roles was deliberately high, because the SMC depends strongly on their active collaboration and because new roles have been created here. Given the centre's clientele (many alcoholics and mentally ill patients), it was very difficult to find patients who would agree to be interviewed. The two informal caregivers are, however, both themselves SMC patients. The interviews were carried out by one or two researchers and each lasted between 30 and 90 minutes. They were conducted either in the SMC or, in the case of the patients or caregivers, at home. In the analysis process, additional information was repeatedly sought and provided by e-mail and phone by the initiator of the SMC, which proved a great help.

The following table gives an overview about the basic information about the SMC Liebenau.

Table 5: Basic information about SMC Liebenau

Information category	Description
Programme name	Sozialmedizinisches Zentrum Liebenau – Sociomedical Centre Liebenau
Contact details, programme management	Dr. Rainer Possert, SMC Liebenau, Liebenauer Hauptstraße 141, 8041 Graz, Austria
Starting date of the programme	October 1984
Geographical scope	The city districts of Graz Liebenau and Jakomini. Liebenau has 13,766 inhabitants and Jakomini 32,393 inhabitants.
Target group of the programme	The SMC caters towards disadvantaged citizens in the districts of Liebenau and Jakomini. The area is home to migrants, socially disadvantaged people and pensioners and is often referred to as a problem district. Moreover, the SMC focuses on drug addicts.
Number of patients treated in the programme	As said in the interview (1), the SMC is visited by 1,500 patients per quarter, about 800-1,000 patients use the social counselling service, 100 drug addicts are treated, about 200 clients use the social work service, and 500 persons use the community work option.
Aim of the programme	To establish comprehensive medical and psycho-social care.
Definition/understanding of “integrated care”	No definition of integrated care was found. However, they define themselves as a centre for integrative care, seemingly due to the cooperation between professions and the holistic assessment of patients.
Definition/understanding of “multi-morbidity”	No definition of multi-morbidity was found.
Definition/understanding of “patient centredness”	No definition of patient-centredness was found.
Definition/understanding of “self-management”	No definition of self-management was found.
Organisational form and ownership	The SMC consists of a medical group practice owned by the two physicians and a not-for-profit association (Verein für praktische Sozialmedizin), which forms the legal basis for the SMC.
Involved partner organisations	In 2011, the SMC network partners included associations that promote health: club WIKI, club Pro-Health – Health initiative for Africans, Vivid – society for addiction prevention, club INPUT, club “Adults protect children”; medical entities such as pharmacies, outpatient physicians and home nursing care services; two police stations; two schools and three youth centres; political administrative entities such as the housing office and youth welfare office; churches, a market garden, a property management organisation and an art initiative
Involved disciplines and professions	Within the SMC, two physicians, two administrative assistants, two social workers, two health promoters, a music therapist, a psychotherapist and a lawyer work together

Sources: Sozialmedizinisches Zentrum Liebenau, 2016a; Urlsberger, 2012; Sozialmedizinisches Zentrum Liebenau, 2015a; Pammer, 2013

4.2. Service delivery

4.2.1. Design of delivery of care

All activities of the SMC team are carried out on the basis of a “social health and medicine” approach. The participants stress – both in their concepts and in the interviews – that health is not “made” through medical treatment, it emerges – or is endangered – in the process of social life. They further stress that the chances of enjoying a healthy life are unequally distributed among the population, and see it as their task to also reach those “who otherwise would not be reached”. From this perspective, “integrated care” means recognising the social causes of illnesses and/or recovery and promoting health on a cross-sector basis. One of the physicians formulated this as follows:

IP: That means, I have to recognise that someone who is, for example, psychologically disturbed, doesn't need a psychiatrist, but someone to lend an ear and listen. That means, I have to understand that keeping an apartment is essential to the health (smiles) of my patients and that that is more important than prescribing some pill, for example. If I [as a doctor] have not understood that the social situation is very important in an individual case, if someone doesn't know how he is going to finance his everyday needs, then coping, for instance, with his diabetes or his multiple illnesses is probably the least of his worries, because he'll say: 'Okay, that's an organic illness that I have, but I don't know if I can keep the apartment or I don't know if the youth welfare office is going to take my children away or something. As a doctor, I then have the responsibility to also help resolve these problems, because only then will the medicine prescribed work. (...) I don't have the impression that, for example, the badly adjusted patients with diabetes are the ones who now get too little medical advice, they (...) are the ones who have extreme psycho-social problems, and that doesn't even need to be migration and language barriers, it could also be illiteracy or something like that, i.e. really serious problems that are simply not recognised (P4_2, 303-319) ¹⁰

Following this approach, the SMC Liebenau was ahead of its time concerning its governance and delivery of care structures, and its work-sharing and holistic care delivery did not fit into the Austrian healthcare system (Sozialmedizinisches Zentrum Liebenau, 2016b). Thus, the delivery of care is very much shaped by the ideas of the SMC's three founding physicians. As the physicians outlined in the interviews, they

¹⁰ All quotes are taken from the interviews with the various stakeholders. They have all been anonymised. I, I2 stand for interviewer, IP, IP2 for Interview Partner. Square brackets [Dr. X] are used to indicate anonymised names or not fully understandable text passages or to explain the word before it. Any words that are underlined are words that were emphasised by the interviewees. (...) indicates the omission of a passage that was not relevant to the statement. The interview and line numbers are given at the end of each quote.

perceive patients and illness in a fundamentally different way to standard medicine. They see patients not only as biological entities, but as “*zoon politicon*”. It is important for them not to deny patients control of their illnesses, but to encourage them to voice their values and preferences. They emphasise a conversation-based medicine, where the physicians take time to talk with the patients. They are also prepared to take patients’ criticism into account (Possert, 1989).

It is the policy of the SMC to promote equal opportunities in health, especially for the disadvantaged, to strengthen self-confidence and agency, and to promote sustainable projects. Thus, their areas of work include: the environment (living conditions, noise prevention, speed limits, promotion of social networks (schools, senior citizens, single parents)); medical factors (physician’s practice, social services, physiotherapy, psychotherapy, logotherapy, social work, counselling); socio-economic themes (employee training, supervision, multiplier education, informing the population) and individual factors (health awareness, health behaviour, health knowledge, lifestyle) (Sozialmedizinisches Zentrum Liebenau, 2015a). One of the physicians formulated this as follows:

IP: I have to start from where the patient is, namely with his [psychosocial] problems, not with the fact that he needs better training to cope with his diabetes, but rather he has to see that it is linked, his psychosocial situation. But he also has to know that I [as a doctor] am perhaps the right person for that. He has to actually accept that because otherwise he’ll say: ‘Yes Doctor, I know, I should lose weight and I need to count calories’. And so on. But he naturally says nothing like: ‘But I can’t because I have other problems’. He lacks this perception and that’s why the doctor doesn’t ask him, and it gets lost in the rest. (P4_2, 323-230)

The SMC team focus on specific target groups, which run the risk of remaining untreated. These comprise people who are drug dependent, people who are already receiving opioid substitution treatment and people who are legally required to undergo therapy, as they have previously been in conflict with the law. Most of these clients, and a large number of the SMC’s other clients, are people with multiple chronic diseases. Combinations of physical with mental disorders and/or social problems are most frequent. The SMC offers a wide range of opioid substitution and dependency treatment therapy including reduction treatment, permanent substitution, bridging therapies and outpatient drug withdrawal. A central part of the treatment is psychotherapeutic support. Therefore, the physicians work closely in a multidisciplinary team with social workers and social pedagogues (Huber, 2006).

In addition to this cooperation, the two current physicians at the SMC are allowed to provide general practice, psychosocial, psychosomatic, psychotherapeutical and environmental medicine, psychotherapy, supervision and acupuncture (Sozialmedizinisches Zentrum Liebenau, 2016a). The physicians act as a form of gatekeeper, as they refer patients to care services within the SMC (Urlesberger, 2012). A large part of their work is substitution therapy for opiate-dependent patients, which they have offered since 1993. In 2004, the SMC became a registered institution pursuant to §15 of the Narcotic Substances Act (*Suchtmittelgesetz*). The treatment of large numbers of opiate-dependent patients at the start of the programme was also the result of the lack of available treatment services for these patients, as “difficult” patients were even declined by psychiatrists (Sozialmedizinisches Zentrum Liebenau, 2015a; Huber, 2006).

In addition to medical care, the SMC offers a wide range of social care and health promotion services for its patients and the inhabitants of the regions. These include (Sozialmedizinisches Zentrum Liebenau, 2016a):

1. Anonymous and free of charge social care
2. Health promotion and community work
3. Culture of Remembrance
4. Counselling Centre
5. Music therapy (currently not offered)

The counselling centre offers counselling in a wide range of topics (Sozialmedizinisches Zentrum Liebenau, 2016a):

- Mental and family problems: Marriage conflicts, education problems, antenatal care, violence in and outside the family, professional problems, suicidal thoughts, traumatic experiences, etc.
- Sexual counselling: Conflicts in relationships, sexuality, sexual violence, a change in sexuality, homosexuality and sexual orientation, pregnancy and abortion, sexual education, etc.
- Medical counselling: Alcoholism, drug addiction, other addictions, mental illness, psychosomatic problems, violence, illness, desire to have children, suicidal danger, fear, contact problems, traumatic experiences, etc.
- Social work and care: Social challenges, addiction, care, mental problems and support in contacts with administrative authorities, etc.
- Legal counselling

In addition, the SMC also promotes a culture of remembrance and advocates a historical reappraisal of the National Socialist regime in Austria. To achieve this, it organises events and exhibitions (Sozialmedizinisches Zentrum Liebenau, 2016a).

Health promotion and community work comprises of the following projects (Sozialmedizinisches Zentrum Liebenau, 2016a):

- District centres Grünanger and Jakomini: The district centre Grünanger offers walking, brunch, counselling by social workers, gardening, music and an open bookshelf. The district centre Jakomini is very involved in neighbourhood initiatives. It supports the organisation of neighbourhood meetings, resolves conflicts between neighbours, organises neighbourhood parties and joint outings. It offers a parent-child group, music for small children, a band cafe, a single parent cafe, a joint daily lunch, an open bookshelf, a health forum and career counselling.
- Community gardens Schönau and Grünanger: Volunteers take care of the gardens and jointly plan the design.
- Panel for socio-medical practice (Sozialmedizinische Praxis): An event series that discusses current medical, health science and health policy topics.
- Health platform Liebenau: The platform is a regular meeting point for local health policy issues. It should empower residents and spread knowledge of health relevant topics, discuss local political issues and develop solutions and strategies.
- Health promotion with senior citizens: The senior citizens' platform offers events for senior citizens, and the SMC is member of the senior citizens' association Liebenau. The SMC team visits various organisations for senior citizens and answers questions about care, health and nutrition in old age, medical care, etc.
- Brunch at Grünanger: Once a week, a healthy breakfast is provided at Grünanger, which is an important social event for the participants. After the brunch, the social worker is available for consultations.
- Walk with us: The SMC offers two weekly Nordic walking groups.
- Music at Grünanger: On Sundays, everyone is invited to play music and to sing together.
- Musi and Musi star: Musi offers music education for children, which is otherwise not affordable for disadvantaged groups. Musi star offers music afternoons for parents and children.

- Plunge and fall: This project trains boys and girls in schools in how to fall safely and how to defend themselves in dangerous situations.
- Round table Grünanger: Four times a year, employees of the SMC and other organisations in the area, politicians and residents meet to discuss local problems.
- Stages district health for all (2008 - 2011): This project was financed for three years by the Fund for a Healthy Austria and the State of Styria. The main aim was to enable locals to actively promote their health and to build social networks. The project established the district centres and initiatives in their current form.

Over the last thirty years, various studies examined the needs of the population in Liebenau, and the SMC always endeavoured to organise its services around these needs. In 1987, a psychologist wrote a report on the living conditions of the inhabitants in Liebenau (Scheucher et al., 1987). As a response to the report, the SMC widened its scope and introduced social work in its portfolio (Brunner, 2013). A health survey followed in 1999 (Possert, 2000) and in 2001, the SMC co-produced a report together with the institute of social medicine on “how healthy is Liebenau?”. A report on the situation of youth in Liebenau in 2002 led to the establishment of the event series “Youth in Liebenau” (Brunner, 2013).

In the Interviews for the present study, it became clear that scientific work and analysis of the social structures and the state of health of the population in Liebenau play an important part in the work of the SMC physicians. They take a lot of time to develop research issues, to organise research projects, to cooperate with medical scientists and to guide interested PhDs. (P1_2, P4_2, P10_2) The interview with one physician indicates how closely the physicians’ sociomedical motivation is tied to their scientific engagement:

IP: We went to this district because it was a working class area and because at that time it was also underserved. There were positions vacant. And to get to know the field we wanted to work in in more depth, you need take actions that are at least to some extent objective. This applies to the social structure and other aspects. (P9_2, 28-31)

Consequently, the services offered by the SMC include not only a rich integrated care and information service for their clients, but also contributions to the medical discourse on healthcare. As the interviews with partners in the Styrian Health Policy sector and payer organisations show, the SMC’s practices and research are well known, valued and have influenced the debate on integrated care. The following assessment comes from one of the state health insurance funds:

IP: I often go to these health events. The SMC organises round tables on specific topics in the centre every one to two months, and I've been going to these regularly for 30 years. I realised early on that this inter-sector, this interdisciplinary work makes sense. (...) You have to give the doctors a chance as well, because they have to work closely together, closer that they have up to now and the chemistry between them has to work too. (P12_2, 828-838)

In the interviews with the SMC team, it is evident that they do practice integrated care on an everyday basis through their specific work routines, in particular for their chronically ill focus target groups:

- a) Target group appropriate communication and “working together in close proximity” on an everyday basis to implement low-threshold access to integrated care.
- b) Cross-sector cooperation in SMC outreaches social projects to realise low-threshold access to integrated care.
- c) Regular joint case conferences for quality assurance purposes.

a) Target group appropriate communication and “working together in close proximity” on an everyday basis to implement low-threshold access to integrated care.

As the interviews show, all staff at the SMC embrace the policy of treating clients with care and respect and work in close proximity and cooperation on an everyday basis, with physicians, medical residents, medical assistants and social workers all contacting each other directly and personally when a complex problem arises. (P2_2, P3_2, P5_2).

The assistants endeavour to use colloquial language when admitting an patient and taking details of their history and help older and impaired clients in filling out the patient history form. At the same time, individual clients are told about the house regulations if they have behavioural issues. The participatory observation showed that from a coordination and appropriate communication perspective the demands on the assistants during normal surgery hours are huge. They not only have to register the client, they also have to coordinate with the social workers, provide real-time information to the physicians, complete preparatory tasks like measuring blood pressure, answer the phone, call the health insurance fund if there are any problems with the client's card, etc. Nonetheless, they still strive to deal attentively with all patient groups.

The policy of “working together in close proximity” can be further seen, for example, in the fact that the assistant enters the doctor's room as a matter of course at the end of a consultation to give/get

information about a client who has just come from social counselling. The assistant, in turn, is spoken to by the social worker directly at her desk and before a client leaves the SMC, he/she stops at the information counter to tell the assistant she is doing so. This serves in the patients' interests to break down barriers and avoid the delays that are common in written information exchange. It also means that the professionals involved receive a lot of information in real-time.

The observation of this way of working shows this is only possible because there is a very close relationship of trust between the professionals at the SMC and all staff are empowered and competent in focused verbal communication. It also requires an enormous ability to concentrate because, in addition to their "normal work", the staff have to take in additional information or make decisions quickly, e.g. to arrange appointments, several times a day. This additional load is only accepted because all the professionals at the SMC are convinced that this approach makes sense and is in the patients' best interests.

This flexible, face-to-face communication is also supported by the current physical layout of the SMC. The information counter, physicians' rooms, lab rooms and social counselling rooms are all located on one level and are accessed from a central, light and modern waiting room, which one enters directly from the stairs. In the early years of the SMC, the physicians' and social counselling rooms were located in two adjacent buildings, which meant that the staff often had to phone each other. The clients, in turn, had to walk from the "front building" to the "back building" for medical care or counselling. Nowadays, there is no longer any visual barrier: when someone enters the SMC, it is already a holistic experience – patients and professionals quite literally have no further threshold to cross between medical and social care.

b) Cross-sector cooperation in SMC outreaches social projects to realise low-threshold access to integrated care.

The low-threshold access to integrated sociomedical care is also realised through the systematic cooperation between the physicians and social workers in the health promotion and social counselling outreach projects. The outreach projects are important for all patients, but are particularly important for clients in the socially disadvantaged target groups.

In this regard, one social worker at the SMC reports that she systematically divides her working day between very different health-related and social projects. These include first of all the social counselling

service at the SMC, which the physicians can call upon on a flexible basis. This means that a social worker works at the SMC three mornings a week, in order to be available at the physicians' request to see clients who need counselling or to take part in a health promotion project. The same social worker also reports that she works directly in the community to promote health. She organises a regular brunch for the socially disadvantaged. She also makes house calls to isolated clients, co-organises district events that also address health topics and arranges education events for all citizens. But she also provides social counselling to SMC patients, helps them with care applications, etc. and provides family counselling on a phone and face-to-face basis. One social worker reports in this context:

IP: On Monday, Tuesday and Friday, I am always in the practice from eight to twelve. That's a permanent arrangement. If a patient sees one of the physicians, and he notices that the patient could also do with the support of a social worker, he can simply call me over there, and I can go over on the spur of the moment, introduce myself to the person right away and, if the person has the time and inclination, can start working on the matter at once. There was one instance last week, for example, when a patient didn't know how to apply for an attendance allowance. Dr. Y. rang me up, and I took her over to the counselling room right after her consultation with the doctor, and we filled in the form together there and then. (...) What's so special about my work at the SMC is that I work together with other health professionals under one roof, e.g. with the physicians. And I think the big difference is that for many, this removes the psychological barrier a little. It's quite possible for people to go to their GP, and for him to ask: 'Have you talked to a social worker about that?' And for them to say: 'No, I haven't, but I'll think about it.' But then there's usually a psychological barrier. But if the doctor says: 'Wait a moment, we have a social worker here, you can meet them right away.' When the people then see me, and I start talking to them and building a relationship at once, it's easier for many people, and they can come to one and the same place for different problems, don't need to go to yet another place, partly don't need to repeat their whole life history again, because I talk to the doctor and vice versa, and then I already know a bit about the case. At the same time, we also have appropriate health promotion projects like, for instance, Nordic Walking, the brunch (...). And it works the other way round too, that I meet someone, for example at the lunch, who otherwise has nothing to do with the surgery, for instance, and we get talking, and it transpires that he has had some physical problem or other for ages, but hasn't been to the doctor for years. And that helps then of course in the other direction when you say: 'Why don't you come over, I'll be there too, I'll accompany

you to the doctor at the start if you like and will introduce you.’ That also helps a lot of people.
(P2_2, 120-162)

This flexibility in distributing one’s own work requires a great deal of internal coordination within the SMC, work which was done directly for many years by the two physicians and the chairman of the association. This work is done for the main part on a voluntary basis. When one of the two initiators retired, a managing director was appointed for a short time to ease the burden on the team. However, this was faced with problems of an organisational nature. One of the reason for these problems are the shortcomings in Austrian healthcare funding, whereby all employees of the association – including the managing director – can only be employed on a fix-term contract basis. In the case of a management position like that of the managing director, this can lead to identification issues.

c) Regular joint case conferences for quality assurance purposes.

The regular joint case conferences are a core element of the cooperation between medical and non-medical staff (P1_2, P2_2, P4_2, P5_2). The number of such conferences has evidently reduced in comparison to the early days of the SMC, possibly because this model as a whole necessitates additional work that everyone concerned needs to have the time to do. The interviews indicate that these case conferences are currently held about once a month. What sets the SMC case conferences apart is that they cover not just patients with multiple medical ailments, but rather clients with medical and social issues. As a consequence, the participation of medical and social work personnel is seen as imperative or, to put it better, “normal”. Also of note is the fact that assistants contribute on equal terms with the physicians and are even encouraged by the latter to prepare cases for discussion. One assistant talks about this as follows:

IP: We meet once a month at lunchtime on a Monday, and each of us selects a case which was interesting or striking in that month and presents it briefly based on the following points: Why is this case important for the SMC? Who were all involved in to? What illnesses were involved? Is there a solution? Etc. And the case is then discussed, sometimes only one case is discussed.

I: How long does such a meeting last?

IP: One to one-and-a-half hours.

I: Do only the doctors propose such cases?

IP: No. Also community services, social workers. Everyone has their turn. Assistants, doctors. (...) I also have to occasionally prepare something about a long-term patient. (...) Because she rings up

every day. She is very demanding, is scared of everything. So she's got, among other things, an eye disease, and she is extremely scared about that, and I think she is just lonely and simply wants to talk to someone every day and that's why she calls us and then calls the pharmacy.

I: And did you find a solution?

IP: Yes, yes. We drew the patient's attention to the fact that she should speak to the social worker, because, we arrange a brunch on Thursdays, that she should go to that or go Nordic Walking, etc. (...)

I: Do you talk more about social problems there or are medical things discussed to an equal extent?

IP: Equally, yes to an equal extent. (P52_2, 65-94)

The two initiators of the SMC emphasise that they couldn't imagine working in a different way and reject the widespread form of cooperation that is restricted solely to doctors and is only conducted by phone:

IP: The integrated approach is certainly difficult, because de facto integration is usually seen as follows: 'You know each other, you ring each other up, you refer patients to one another, that's cooperation, but it's not working together with a patient. So meetings for helpers, where everyone who is working with or for a patient sit down at one table, those are rare, they're not the norm. (...) Joint case analysis is somehow just part of what we do here. In any case, I'd find it difficult to imagine doing anything other than ringing the social worker or saying 'Come here, let's talk with this difficult patient together'. Or if I find out that our team is working with a patient, e.g. an addict, and then suddenly three or four people are working on a client, then I'll say to them: 'Can I also take a look, because perhaps something will come to me as a doctor'. (P4_2, 284-296)

A former medical resident reports that he found it very instructive to be allowed to experience such joint case conferences in practice and understand based on a concrete example the meaning of "integrated care" and the content of a sociomedical approach to care. The assistants likewise stress the learning function of these conferences and the fact that they gain competence in dealing with patients through them.

IP: I hadn't experienced anything like that before. Where do you find doctors and social workers working together on one patient? I really learned a lot during this period, things I hadn't learned

in the hospital. I enjoyed this type of medical work, I could imagine working like that in future. But it is difficult to get such a job. (P3_2, 150-153)

The interviews with the participants from different professions show that these joint case conferences are valued by everyone concerned. Working together in this way had a positive influence on the work atmosphere and helped to break down hierarchies and the distinctions between fields as well as to create relationships of trust. A shared language emerged, which facilitates effective communication. The joint case studies also resulted in enormous sociomedical knowledge gains for all concerned. Patients with multiple chronic illnesses profit from the fact that complicated problems can be treated more effectively or resolved.

The patients of the SMC appreciate the SMC service delivery and use the care that is offered. Urlesberger described the utilisation of SMC services by 60 persons between the ages of 21 and 70 in 2012. He found that 90% of those surveyed visit the GP practice and 43% make use of the physiotherapy service. 42% of the SMC clients surveyed participated in health promotion activities (walking, brunch, yoga, summer party, etc.), 62% read the magazine *SMC info* and 38% attended events organised by the panel for socio-medical practice. Social workers are consulted by 12%, while the counselling services for family and legal aspects are used by 13%. Moreover, Urlesberger noted that people in the age group 61-71 years in particular consider the SMC as a central contact point and location for comprehensive care (Urlesberger, 2012).

Huber (2006) interviewed substitution patients in 2005. Of the 78 substitution patients cared for by the SMC in 2005, 28% were female and 72% male, which corresponds to the estimated distribution of addiction in society. The patients were very satisfied with the services of the SMC and emphasised the comprehensive care it provided. They mentioned aspects of care that are important for them and which they found encountered at the SMC: not being treated as inferior; a relationship of trust with the doctor; individualised treatment; and demarcation to other patients. On the other hand, some patients criticized the longer waiting times (Huber, 2006).

In the interviews conducted with patients and caregiving relatives for the present study, it becomes evident that clients with multiple chronic illnesses and their relatives appreciate the integrated care provided by the SMC (see also 4.2.2 and 4.5). One informal caregiver for a seriously ill multiple sclerosis patient reports that he is very glad to have the SMC, because he always received help there. Concerning the SMC, he says:

IP: I am very satisfied. Yes, yes.

I: What are you satisfied with? What is good at the SMC?

IP: In the first instance with Dr. Y. I can ask him about anything. He's really open. Yes.

I: Okay. Have you been with him for many years?

IP: Yes, for 20 years. Since I came to live here, yes. (...)

I: The social support the SMC offers, is any of that useful to you – other than the fact that your doctor is a good doctor?

IP: I have occasionally made enquiries in that direction, but it is not really something that – because I do everything myself, you know. Yes. (...) What I did try once, that was great, really really good, but then it [the project] was stopped. It was with the high school over there, the young people did a kind of visiting service. They come over and sit with here for half an hour. (...) That didn't take the burden off me. It's more work for me. I have to get everything ready, because she usually otherwise lies in bed naked during the day as well. I couldn't have that. So I had to put some clothes on her. It's more work for me, but it's better for her. (P8_2, 285-289; 369-374)

The statements by the carer show that the integrated form of medical and social care provided by the SMC had already helped him. Since the visit project was not continued due to lack of finance, this help also has its limits. In addition, the carer encounters problems that the SMC cannot solve at all – as a result of the framework in Austria. This applies in particular to the lack of paid mobile instant support for acute care problems. To date, a patient has to be taken into hospital to have a catheter that has become detached during a spasm replaced or must have a standing order with one of the mobile care providers.

4.2.2. Self-management interventions

From the beginning, the empowerment of patients and local residents was a core concern for the physicians and an integral part of the work of the SMC. The physicians believe in emancipatory medicine, where it is the right of the patient, and not a favour on the part of the doctor, to be taken seriously and to be well informed (Sozialmedizinisches Zentrum Liebenau, 2015a).

Based on this approach, the assistants repeatedly encourage all patients who are able to do so to actively participate in their own recovery. This includes activities like measuring blood pressure daily for patients with high blood pressure or measuring blood sugar levels. It also includes more complicated

tasks like self-injecting. One patient explained in this context that she would “of course be having training next week” and was fully confident she would learn everything she needed to know in the process. If necessary, she could always ask again and get help. (P7_2) The patient described the information she had received from the medical staff as follows: she was given personalised instructions, which were repeated if necessary. Training courses are thus not seen as one-off events with the clients subsequently left to their own devices.

Moreover, the physicians follow the Ottawa Charta and aim to enable patients to regain control over their health and their social living environment. They acknowledge that health is not only determined by bio-medical factors, but that wealth, education, political participation and social integration also contribute to the health status (Sozialmedizinisches Zentrum Liebenau, 2016a). Thus, the SMC actively encourages citizens to take ownership of political processes and to influence communal decisions that impact their health and social life. The physicians initiated or have taken part in various citizens’ participatory projects, lobbying for clean groundwater, the survival of the local Puch company, primary care, the preservation of the Grünanger housing estate, and against atomic threats, noise pollution, etc. (Brunner, 2013).

The SMC encourages patients to promote their own physical and psychological health with the services it offers. These include Nordic walking and social activities such as cooking, gardening, playing music and counselling services. Furthermore, the SMC provides education and information and thereby seeks to enable patients to exert more influence on their health and social living environment. The SMC believes that well-being and health can only be subjectively defined by the patients, and not predetermined by the doctor, yet acknowledges the importance of intervention by professionals at the same time. The SMC offers a programme of events and publishes its own magazine, *SMZ Info*. The topics for the events can be suggested by the participants. *SMZ Info* is published quarterly and informs the public about SMC services, medical issues and citizens’ initiatives. It is sent to about 1,300 people free of charge (Sozialmedizinisches Zentrum Liebenau, 2015a).

It was also made apparent in the interviews that the staff at the SMC take a specific social approach to the topic of self-management. This applies equally to physicians, assistants and social workers. The following response was given in this regard by one assistant:

I: Is there also a group of patients who are chronically ill and who do some things for themselves? Self-inject, measure their blood pressure, etc.

IP: There are patients who have their feet firmly on the ground and can do so, and there are others where it is difficult. So it went like this when a patient came in: If someone came in and just wanted a prescription, e.g. an antihypertensive, then we'd say: 'Let's measure your blood pressure first. (...) Only the physicians can sign prescriptions.' Then, after measuring, I'd go in [to the doctor] and say: 'A prescription please, and the patient's blood pressure today is, e.g. 220/100'. Then he'd immediately say: 'Leave it there, we need to talk about it, because there's no point in writing a prescription. If he really has taken his medicine, his blood pressure can't be that high.' Diabetics are, e.g., also fairly undisciplined. (Sighs) You can see when someone's Body-Mass-Index is already this or that, and we'll say: 'Have you already measured your sugar?' Answer: 'Yes, yes. It's great, it's really good.' Then we'll say: 'Fine, do you mind if we do it too?' That immediately met with defence. Of course you have to prick them and it hurts. (...) And then the values are bad. Or you say: 'You haven't got a HbA1c value, that's a long-term measure of your blood sugar, can you go to the lab first, then we can give you another prescription. Sometimes, they got angry about this, but really we were only reflecting their own bad conscience, in other words, I should be ashamed of myself a bit.

I: And do these problems occur often?

IP: Often, because there are a lot of people like that. (..) But if you ask me, those who were a bit more difficult to handle were the diabetics. Those are, I would say, the most difficult, because there you have people who are insulin dependent. (...) They don't stop eating and say instead: 'Okay, a slice of chocolate cake with whipped cream, four extra units.' (...) They don't even think about what it will do to them afterwards: when it comes to ulcerated legs, when it comes to the risk of a stroke, when it comes to I can't see anymore. You have to repeatedly remind and coach them. They don't think about it and pay less attention to what the doctor says than the substitution patients. That's right, when you think about it. (P10_2, 422-454)

As this quote and many others show, the staff at the SMC take particular account of the knowledge, resources, circumstances and scope of the SMC's various client groups. For this reason, it is repeatedly stressed that the term "self-management" may not be used from an assumed better informed position by the professionals, but rather that the patients are the ones who know their own health needs best, since they live with them each and every day in their own particular circumstances. Accordingly, the SMC does not use the term "self-management" either in its daily work language or in its concepts, preferring instead to use the term "empowerment". According to the people interviewed, physicians,

carers and counsellors carry particular responsibility in this respect. At the same time, they refer very consciously to the limits of self-management. The physicians at the SMC stress, for example, the great importance of the doctor as a contact person, so that health promoting treatment of patients is possible. And they also consider themselves responsible for continually providing a push and not just prescribing medicine, even in cases of behaviour that is detrimental to health.

IP: So, I would describe “self-management more as a problematic approach. I mean, I’m a doctor myself, yes, and when you’re ill, you’d like to believe that a doctor can self-manage himself, but it doesn’t work like that. You need contact people. You need a person on the outside to communicate with about it. That doesn’t work at all from a communication perspective. You need someone, an outsider, who helps you to manage it. So one of our most important tasks is to help patients manage their health, because they can’t do it on their own. (P1_2, 806-812)

The limits of self-management are also raised from the informal carers’ perspective. Herr O, reports, for example, that he has been caring for his brother, who is an alcoholic, suffers from dementia and is handicapped, for many years. He is now retired himself and is no longer physically capable of caring for his brother. So he hired a round-the-clock carer. But he is not very satisfied with her; she is not a trained carer, she doesn’t speak enough German, and she doesn’t do the necessary physiotherapy activation exercises to the required depth. Given this background, it doesn’t seem surprising that the patient “doesn’t really participate”. However, it becomes apparent in the course of the interview that the ill brother already could not be activated adequately after a stay in a hospital rehabilitation clinic. He cannot determine himself to what extent this is the result of his brother’s cognitive deficiencies or a lack adequate attention. He just sees that his brother is becoming less and less active. Herr O. is, however, happy with the medical support he gets at the SMC. He talks frequently to his brother’s doctor and can even use his own doctor’s appointments to do so. They have a relationship of trust that goes back decades. The interview with the professional carer also confirms that the doctor is very familiar not only with both men’s illnesses, but also with their family history and personal problems. He also makes regular house calls to chronically ill patients.

4.3. Leadership & governance

The SMC Liebenau consists of a medical group practice owned by two physicians and a not-for-profit association (Verein für praktische Sozialmedizin), which is the legal basis for the SMC and its social and medical care projects. The physicians work on the association’s board and inspire its decisions. The

board conceptualizes all SMC projects and discusses all problems. For this purpose, it meets several times a year. The board also communicates with external partners and payer organizations.

The SMC is a pilot model for integrated medical and social care in Styria, a State in the south of Austria. It combines cooperation beyond the healthcare system as well as with external partners. Over the last 3 decades, 1-3 physicians, 1-2 social workers, 1-2 health promoters, a music therapist, a psychotherapist, a physiotherapist and a lawyer have all worked together in the SMC (Sozialmedizinisches Zentrum Liebenau, 2016a, P1). The SMC currently has no psychotherapist, physiotherapist or music therapist in its team, but does work with an external music therapist. In the past, the SMC also had a sociologist and a group for long-term care and domestic services. The former found another job, and to date the SMC has not been able to hire a replacement. The latter had to be disbanded following changes to the law. The physicians also regularly collaborate well with specialists. Its contacts with other GPs in the area is poor, and there are communication difficulties with hospitals, but these are not specified further in its official documents. On the GP side, there has always been a sense of competition between the “individual GPs” and the “big SMC”, while there were clear differences between the non-hierarchical culture in the SMC and the culture in several Austrian hospitals.

In the interviews with the participating physicians it becomes clear that there have been substantial differences between the mainstream understanding of “integrated medical care” and the traditional structures in this sector on one hand and the understanding of “integrated socio-medical care” and the cross-sectional practices in the SMC on the other. The sociomedical and societal point of view of the physicians involved is paraphrased in the following interview passage:

IP: Having social workers and other professionals working in the SMC eases the burden. I no longer have to do everything myself. I know what it's like for colleagues who work in the country or who work alone. And then they want to help someone, but how?! They have to phone the authorities at social services and call this person and that person. That's all work. But if I can say to the patient: 'Please [talk] to the social worker or something like that, you can arrange a psychotherapy appointment or the like with them, it won't take long, you can do it immediately. So they get help more quickly and that's a relief. I don't have to organise as much for the patients as other doctors have to do. We also do supervisions with patients with drug problems, where doctors come in and treat these patients. These are abstruse cases. Another doctor would have to ring up all over the place until he found a social worker for a patient with a drug problem, and then he'd have to go through some very complicated meetings. That's not a

problem here, because first it can all always be done informally on site and second we have our case conferences, which happen all the time in any case, because you do become blinded by routine when you're always caught up in it. You no longer even see it [the problem] in all its clarity. But there, we're in the care field, but not so much the health field, with this community building field or local district health work. You could naturally ask: 'What does local district work have to do with health and with the SMC?'

I: And what answer would you give?

IP: Well, you can read in WHO documents that health is an inter-sectoral matter and an interdisciplinary matter. And health for all would also mean that different departments are involved, like the social services department, the health department through to town planning. It goes as far as town planning. Health is also linked with town planning. For example, in that district over there, where a relatively large number of poor people live in shacks, if you were to build a power plant around the corner and they were confronted with heavy-duty traffic for five years, what would that mean for their health? If people can no longer sleep, if they have no peace any more in their gardens because heavy lorries are making a noise all day and construction machines are running.

I: Is that a practical example?

IP: Yes, that is planned. That is a practical example. (P1_2, 618-649)

The physicians of the SMC cannot and will not separate their professional work as physicians from their civic engagement and try to realize their integrated care model in the SMC. However, most of the problems they have been confronted with came from the Medical Association. In other words, these problems came (and come) from their own professional association, since their representatives do not support or endorse group practices and sociomedical cooperative projects.

IP: There was of course resistance from the Medical Association, they never wanted it. They are still not interested in PHC. (...) It's happening again, like 30 years ago. (P1_2, 241-244)

The initiators of the SMC noticed that good relationships with external partners ensure the continuity of the relationship (Possert, 1989). The SMC cooperates with various partners beyond the healthcare system depending on the needs of its current activities. In order to retain the Grünanger barracks, for example, round table meetings were held with local pharmacies, the Sigmund Freud Clinic in Graz, youth

care institutions, the city mayor, the police, architects and the housing officer (Sozialmedizinisches Zentrum Liebenau, 2015a).

As already pointed out in 4.2, integrated care from medical and non-medical professionals forms the core of the SMC-model. The physicians aim for collegial and equal cooperation with all health workers, free from the professional hierarchies that are engrained in the Austrian healthcare system (Possert, 1989). Documents from the initial years of the SMC describe team meetings two times a week over lunch to reach consensus decisions. After discussing organisational aspects, the team then discussed patient issues. Despite its aim of equal cooperation, hierarchical problems were evident during these meetings. This hierarchy stems from the leading role of the physicians during the founding of the SMC and their medical and financial liability. In addition to these meetings, all team members have access to supervision once a month (Possert, 1989). Urlsberger (2012) explains that the network between the different areas of work and the outside world is a core competency of the SMC. The communication culture remains a basis in its daily work, and the coordination of therapy plans distinguishes the SMC from the other physicians' practices commonly found in Austria.

Behind the interdisciplinary teamwork lies on the one hand a political motivation to treat all professions as equals and on the other hand the conviction that a holistic treatment is an advantage for the patient and eases the work of the doctor (Brunner, 2013). One doctor admits that he does have a medicine-centred view and regards other areas as helpful support in improving his own work as doctor. For patients, the access to both physicians and counselling services is low threshold, as they have frequently already used one service and know the SMC infrastructure and its existing networks (Brunner, 2013)

At the start of the SMC, the team was governed by the visions of the physicians. There was not much room for the ideas of other professions, and multi-professional cooperation was not achieved in the beginning. The members of the team of physicians remained constant for years, but the members of the team from other professions changed regularly. Often, employees only stayed with the SMC for one year due to the lack of sustainable financing. This was difficult, as they had to learn anew and integrate new team members again from year to year (Possert, 1991).

The physicians' willingness to cooperate with other professions and to adapt their language, especially when it comes to psychosomatic and social issues, is particularly profound in the SMC. However, education differences and professional socialisation make it a challenge for interdisciplinary cooperation to find a common language (Brunner, 2013). Another problem has been the distribution of

responsibilities. Psychologists, for instance, wanted to provide treatment and not just to do community work (Possert, 1991).

In all interviews with members of staff at the SMC, it is confirmed that the cross-sector model of communication and cooperation between physicians, medical and non-medical personnel described above has now been achieved in practice for several decades. Three aspects play a decisive role here from an organisational perspective, namely:

- a) Use of the benefits of a group practice for informal exchange between the physicians on innovative project ideas,
- b) Use of the Association for Practical Social Medicine for project development and controlling, and
- c) Voluntary commitment to participate in the SMC-specific forms of cooperation and communication.

a) Use of the benefits of a group practice for informal exchange between the physicians on innovative project ideas

As becomes clear in the interviews with the physicians, the physicians in the group practice discuss current aspects of sociomedical care on a quasi-daily basis. This exchange takes place regularly in the breaks between surgeries or after the SMC closes for the day. This intense informal communication is facilitated by the fact that the participating physicians work in adjacent offices, but above all by the fact that they share the same approach to care, trust each other and enjoy a close working relationship. In the interviews, the physicians always use the word “we” and refer to the direct personal contact with patients and the team when they talk about their work in the SMC:

IP: And as approach (...), we have always focused on dialogue-based medicine. (P4_2, 25-29)

IP: There are hardly any doctor's practices at present which cooperate directly with social workers, face-to-face. That's still relatively new (...). Our concept was always one of cooperation. I.e., a single doctor, who works on his own, is antagonistic, because the quality's not there. When doctors cooperate with each other, you always get higher quality in cooperations. (...) And cooperation outside the medical profession, away from the god in the white coat, to [direct cooperation] with other health professions. (P1_2, 165-179)

This type of direct communication is also extended to medical residents working in the SMC on a temporary basis. In other words, the medical hierarchies are kept deliberately flat – in a system that in Austria tends to be very hierarchical. As one of the medical residents reports:

IP: That was new to me, that the communication in the SMC is so direct. That's unusual. I had to get used to it first. Dr. X and Dr. Y repeatedly address you. You have to react directly. That's also hard. (...) But that's what's so interesting. The work in the SMC is just that, special. (P3_2, 250-254)

The physicians discuss complicated care cases, among which patients with multiple chronic illnesses play an important role. They swap experiences and support each other on the basis of their respective specialisations. If it appears sensible for their treatment, individual patients will be swapped between the physicians. In this way, the specific qualifications of the physicians can be put to optimal use in the interests of the patients. Patients themselves can also ask – and be allowed – to change physicians in the group practice. For example, when one of the physicians retired, many of his patients switched to a doctor in the SMC, without any loss of trust or confidence.

The physicians in the SMC also regularly discuss ideas for new projects in the same informal manner described above. The physical and intellectual proximity of the physicians in the group practice is also beneficial for the emergence of ideas for new projects and for the discussion of problems in realising them. It becomes evident in the interviews that this dual informal exchange between the physicians in the group practice is a main pillar of this model.

b) Use of the Association for Practical Social Medicine for project development and controlling

The work of the Association for Practical Social Medicine is of similar importance. The physicians and other members (past and present) of the SMC team are actively involved in this association. At the centre lie the regular board meetings and annual general meetings. Like the Health Network Tennengau, its work is regulated by the provisions of the Austrian Law on Associations (*Vereinsgesetz*). Its long-standing chairman is one of the initiators of the SMC, who after several decades of activity in this role would now like to pass on the chair to an equally active successor. The association is currently undergoing a generation change, since the second doctor at the SMC will also be retiring in the foreseeable future. As a result, intense discussions are currently taking place on the topics of generation change in the medical fraternity and the structural development of the SMC. As the association's board notes:

IP: We are currently in a transition phase as far as the people who do our work are concerned, and we have to make sure that we achieve this generation change in practical terms, and that is not so easy. (...) The difficulty is that much of the organisation work that we have done somehow

seems to be too complex. There is great enthusiasm, I know, among the 30-35 year-olds, who have some projects, ideas, etc., but if they come to nothing, they simply go in another direction. In other words, they have the enthusiasm, are open to psychosocial ideas, etc. but actually sticking at it and championing it quasi for years is not their [the new generation] thing, because the young ones set something up and say: 'Okay, if it doesn't work like that, then I'll do something totally different.' And they then turn round, jump into the Volkswagen bus and drive somewhere for two months and say: 'Then I'll do something totally different.' (P4_2, 136-144)

At the same time, and for some years now, the physicians at the SMC have been checking the medical residents who come to work in the group practice on a temporary basis with regard to their interest in working in the group practice and/or with the association. It transpires that only one of these residents expressed interest in the challenging and time-consuming work of the SMC and, thus, also the association. Since the association is, however, an important pillar of the sociomedical work of the SMC, its members are currently looking for a structural solution to influence the replacements for the upcoming vacancies. This is proving very difficult under the existing framework in Austria, since it falls under the competences of the Medical Association, thus implying a complicated points system in which group practices and cross-sector care do not play a central role.

c) Voluntary commitment to participate in the SMC-specific forms of cooperation and communication.

Without exception, all staff at the SMC support and feel committed to the sociomedical approach insofar as they actively participate in all the above mentioned innovative forms of cooperation and, in part, also in voluntary activities. All the professionals are in this sense intrinsically motivated. They happily do additional work for two reasons. First, they feel an obligation to the clients of the SMC and also to the residents of the district. They all share a special sensibility for the SMC's particular target groups. At the same time, they view the additional demands, for instance, of the work with addicts, the joint case conferences or the health promotion activities in the local area as opportunities for personal career development. In addition, the physicians and staff at the SMC value each other's dedication and work and feel that they are also recognised by the clients as part of a unique healthcare offering. One assistant provides various examples of how patients welcome the commitment of the SMC staff and, in this way, also give them something back. For one assistant, one of many such examples is the great joy the patients express when they are admitted to the SMC youth visit programme:

IP: So the patients literally blossom. (...) So the doctors asked us: 'Who do you think would like that and who would also need someone to visit?' Then we suggested people. Then we asked the patients. They were naturally, how should I say it, they were delighted, and the youth volunteers were also delighted, because some of them continued visiting long after the project ended. That gives you a good feeling. (P6_2, 627-632)

4.4. Workforce

While various professions collaborate within the SMC Liebenau, only the physicians fulfil new professional roles in an old profession. The documents do not indicate that other members of staff, such as the social workers, health promoters, psychologist and lawyer; perform different tasks to those performed by their industry colleagues in other settings.

The initially three, and now two, physicians practice “dialogue-based medicine” (Possert, 1991). It was their intention to set an example against “speechless”, instrument- and drug-based medicine by actively listening to the patients. Moreover, it was crucial for the founders to critique the psychiatric practices of the day with their way of practice (Sozialmedizinisches Zentrum Liebenau, 2015a). The physicians reject both a patriarchal medical system, where the doctor deprives the patients of their health competencies, and an authoritarian and hierarchical cooperation between different professions in the health sector. They are further prepared to accept criticism from the patients (Possert, 1989). They acknowledge that health is determined not only by bio-medical factors, but also that wealth, education, political participation and social integration contribute to the health status (Sozialmedizinisches Zentrum Liebenau, 2016a). This prompted the physicians to participate in many various local initiatives, e.g. against noise pollution, against atomic threats or in remembrance of holocaust victims (Sozialmedizinisches Zentrum Liebenau, 2015a).

As the physicians are self-employed and were the founders of the SMC, they were free to define their own roles from the outset. There was continuity in the team of physicians for many years, and they adapted the work environment to their individual needs (Possert, 1991). Possert (ibid.) also notes that the physicians could not fall back on established care models and did not receive the requisite know-how during their education. Over time, they developed areas of specialisation, also in line with their prior education. One doctor partly completed the paediatrics course and offered gynaecological examinations, while another doctor offered acupuncture. As they referred patients to each other, and

patients became increasingly aware of their areas of specialisation, this division of tasks was strengthened (Possert, 1991).

One barrier to the practice of “dialogue-based medicine” was the fact that the Austrian healthcare funds do not remunerate physicians for talking to patients. The physicians tried to alleviate this problem by pooling their incomes, in order to cross-finance the working time needed to talk to patients through the other (private) services they offered (Possert, 1991). Moreover, as Possert outlined in 1989, barriers for the promotion of psycho-social medicine include the perseverance of the regional health insurance funds with old care models, the Medical Association’s inability to look beyond narrow professional and status interests, the disinterest of politicians in social issues, the economic fetishism and the marginalisation of so-called fringe groups.

It becomes clear in the interviews that the SMC quasi attracts staff with multiple qualifications through its good reputation and uses specific recruiting activities to actively select them. The physicians’ multiple qualifications have already been mentioned. But the assistants, for instance, also report that they not only have college degrees, but are also trained paramedics. The situation is similar for other members of staff. Furthermore, all interviewees knew and valued the special nature of the SMC before they applied to work there. The SMC is also known in Graz through media reports.

In line with the flat hierarchies, the entire team is involved in the selection of staff who are competent and motivated in integrated care. As one of the medical residents reports, he found it a very unusual experience that assistants co-determine whether he fits into the team as a doctor and will be given a job or not. Vice versa, one social worker reports that this ensures that the cross-sector requirements can be successfully met even at the selection stage. One assistant recounts:

IP: First of all, when someone new came on board, we could always already have some say in who was selected. It wasn’t like you were just told that someone would be starting tomorrow, it was always a bit of a team decision. With the assistants, for example, we could say if we wanted someone or not, or that we thought those were the ones who should go on the shortlist, and I can honestly say, our opinions were always taken into consideration. And for the others, it was the same in their areas. For example, the social workers changed relatively often for various reasons. There were some who went on to further education, others who came from different parts of Austria and had studied here, but then wanted to go home again after all, and they could nonetheless also make suggestions or propose someone or perhaps knew someone who

had studied with them and then also always brought someone on board. Naturally, the physicians still had the final say, but in principle the team was always asked. It always worked, the replacements always fitted into the team. I can't recall anyone joining, where we would have said: 'No, that's not going to work, that a reason for me to leave or feel uncomfortable or something.' That was really never the case. (P10_2, 243-258)

The assistants and social workers further report that they take on a range of new roles through the SMC's integrated approach. They refer in this context to forms of cooperative addiction treatment in which, in addition to the attending physicians, the assistants and social workers also worked with the patients. The afore-mentioned joint cases conferences also play a central role here in providing them with psychosocial knowledge.

It is also reported that the social workers serve as health coaches to the district. This means that they not only advise and support direct clients, through various SMC projects (e.g. the regular brunch) they also advise house caretakers and other active citizens, who themselves form part of health promotion in the district. So they have to acquire and apply communication competences on multiple levels.

According to the interviewees, these new and unusual demands make "the job fascinating". One assistant underscores that she not only expanded her view of her work at the SMC, she also learned many practical skills that had not formed part of her original training. These include how to bandage wounds correctly, which the assistants learned from the qualified nurses in the nursing care service. Or the instruction she received from a co-worker in how to calculate budgets, a task she subsequently also took over in the future. Or learning how to deal with addicts in situations of acute crisis, as the following quote indicates:

IP: When dealing with addicts, you learn things like: a dog can be so important for someone. (...) And what do we do now [the man had to go into hospital, and the dog was to be put down]. Who could we call, what could we do, ask the social worker, who else could we ask what we needed to consider. That was really hard, and we all also benefited a lot from the social worker. (...) We had a social worker then who had worked in Vienna for that – what's it called now? (...) There's a low threshold facility there where people who are not in the right substitution programme can go along and still get something and perhaps even get a shower, and she was there and she also told us that [everything that is important for addicts]. That was a big asset for us, because you have your channels, your network, and that was amazing. (...) And those were

fantastic inputs really. Then we had another social worker, who had previously worked in a prison (...) and- there you also hear totally different things and the like. We expanded our horizons, I think, somehow, amazing (chuckles), and that was great and also, of course, because so many different people work in such a project I think, other people (...), other people come on board somehow. Even in the team (...) and that was also somehow exciting, and then it got more with the association, this scientific work and so. (P6_2, 120-140)

The assumption of new professional roles is thus seen by all interviewees as positive and handled well. At its core, it is basically learning by doing.

4.5. Technologies & medical products

The documents relating to the SMC Liebenau did not describe any use of ICT applications. This is not a coincidence, since the SMC team orients itself for one thing on the “dialogue-based medicine” concept and questions all usable new technologies with respect to their functionality for this concept. New technologies are thus not a priori assessed to be positive. Likewise, the SMC team concentrates on target groups that can only handle new ICTs to a limited extent and thus gives preference to technologies that are easy to use. And, ultimately, the SMC has for decades been involuntarily pushed into a kind of island existence, so that external communication is largely conducted in person, with ITC support restricted to eCard transactions.

From the inequality-sensitive dialogue-based medicine perspective, a critical attitude is also taken to the various disease management programmes in which the use of new technologies is being tested without due consideration of social structures and the limits these place on the use of such technologies. As one doctor puts it:

IP: A colleague visited me and tried to enlist me for the disease management programme in Styria, and I tried to explain to her: ‘It’s common practice to check nerves once a year and request the results from the optician or do blood tests every three months and give the patient a pass and so on, and if this electronic disease management programme helps me to do this, then that’s good. Then I’ll sit at the computer a bit longer and get 50€ per patient.’ But, then I said: ‘Are you aware that the patients have psychosocial problems? Because this category isn’t on your form. It is not taken into consideration in the training course, never mind included in the written material you hand out. Did you check that 15 % - as studies for Austria indicate – of the participants really weren’t practically illiterate?’ Then she looked at me with wide eyes and said:

'No we didn't, that's not our task.' So then I said: 'If you come to me with a programme like that, I'll sign up on the spot, but otherwise I don't see it as necessary. (...) When you're dealing with simple folk, you perhaps have to see things in a completely different way, use totally different tools and so on. That's a dilemma, and there are few good examples. It's why, if you ask me, disease management programmes don't work well either, because they just don't look at things from this psychosocial perspective. (P4_2, 332-360)

This quote confirms that the doctor is indeed interested in quality management for integrated care, but that in his opinion there is a blind spot when it comes to socially-related health problems. Implicit here is also the criticism of an unfair distribution of healthcare resources across different groups in society. As far as the physicians at the SMC are concerned, it is not a question of a decision in favour of technology-assisted programmes, but a decision in favour of programmes with a medical-social-psychological focus, which could in part require completely different technologies.

Opinions of the introduction of the electronic health card are, however, basically positive, since it will contribute to uncovering prescription medicine abuse in the population, bring this to the attention of physicians and help previously unrecognised addicts enter into treatment.

These opinions are also shared by all staff at the SMC. This is confirmed by the following statement by an assistant, who works on a daily basis with clients among whom some have basically no affinity for technology and can only accomplish even simple everyday tasks to a limited extent. This problem is evidently much more widespread in some urban districts and regions than in others, so it is significant that is specifically referred to, as in this case, by medical personnel:

IP: We also have alcoholics, and we also have a not so small group, above all women, old, older, who are totally dependent on Benzodiazepine, i.e. sleeping pills. So I mean, if a young substitution patient goes on the rampage once because he doesn't get something, then okay. But these were old women, who began to cry in front of us when we told them they couldn't even have Rohypnol. And that's really something, I mean when you yourself, when you are much younger, when you're trying to help them and end up saying: 'My god, I made a poor old lady cry.' But she was really actually also terrible; They don't go away and they get much more insistent and say: 'I want it, I need it, I have to have it.' And they go round several doctors. We didn't realise this until the eCard came along. You didn't notice it before, because they just go from one doctor to another and say: 'My doctor is on holiday.' Who questions that when they

only have a first aid certificate! And they get it from more than one doctor. When the card came along [eCard], that was the group that was most surprised that that no longer worked. I say [after inserting the card]: ‘You’ve already been to a GP, I’m sorry, you’re blocked for us, namely for three months by the health insurance fund.’ And she says: ‘No, I haven’t been anywhere at all.’ Then we call up the health insurance and say: ‘Sorry, I can’t insert the card, but the patient says she hasn’t been anywhere.’ Then you hear the list of doctors that have been visited with this eCard. So you call them: ‘We prescribed her Rohypnol because you were on holiday.’ ‘We were not on holiday.’ That doesn’t work anymore, or is harder. (P4_2, 473-489)

The payer organisations likewise ascribe great relevance to the introduction of the electronic patient card. With ELGA, as the system is known in Austria, comes the hope that overmedication in the case of people with multiple chronic illnesses will, in particular, reduce. This should reduce costs significantly.

4.6. Information & research/monitoring

The impact of the SMC Liebenau has not been studied in a systematic manner. However, several Master’s theses have studied different parts of the SMC. In his thesis, Urlesberger (2012) examined whether the SMC qualifies as a centre for integrated care. He compared national and international health goals to the aims and work of the SMC and interviewed patients and experts, concluding that the SMC is a prime example of integrated care. Nestelberger (2014) studied the brunch that is held at the Grünanger. She compared her qualitative research findings regarding this project with criteria in literature and concluded that the brunch qualifies as a health promotion measure. Brunner (2013) likewise described the SMC in her thesis and explored the question of whether it is a useful care model according to the WHO recommendations for the health and social challenges of the 21st century. In doing so, she conducted a comprehensive literature review, on-site research and structured interviews with healthcare providers and concluded that the SMC is a living model of comprehensive primary care. Finally, Gruber (2002) looked at the path to professionalisation of a non-profit cooperation using the SMC as an example.

It was made clear in the interviews that the cooperative work in the SMC is not based solely on the constant exchange between the professionals, but also on an internal electronic database. Patient data are stored and encrypted in an SMC database by the attending physicians and other staff. The database contains not only data on the patient’s health, data, but also from social counselling and other sociomedical projects. The minutes of the case conferences are thus also available to all staff. In conflict

situations, when enrolling a client in a new project or when family or other social circumstances change, the physicians, assistants and social workers can thus read up on the development of a case in a quick and uncomplicated manner. The cooperatively acquired knowledge is accessible for various care tasks (P1_2, P2_2). The integrated care thus obtains a database that can be accessed flexibly yet is also secure.

It also emerged in the interviews that the physicians at the SMC have continually encouraged thematic research since the centre was founded and organised this through cooperation activities or by procuring their own research funding. They have also tutored multiple doctorate candidates. This research has focused on two themes, firstly the analysis of the health status and care requirements of Liebenau residents, i.e. the SMC's target groups, and secondly the analysis of its own work. The findings have been used to develop concepts for new projects or improve the work of the SMC. They have also been used for health education purposes by presenting the findings at events for local residents. As one of the initiators reports:

IP: At the start of this process [the drafting of a study into the health status of the residents of Liebenau], we involved the local population in these so-called health conferences, because we also told them that public funding was being used here, and that the people who live here have a right to know what happens with this study. (...) Health conferences are events where patients and local residents come together and where health and illness topics are discussed based on concrete problems, e.g. environmental factors that influence health or traffic noise or something else.

I: And where did you hold these conferences? In the SMC, or somewhere else?

IP: At the time these studies were published, we still didn't have a room, so they were held in public spaces like the parish hall or the hospital. (P9_2, 45-58)

Annual reports were also written on the projects acquired, which could, however, only offer a brief overview of the patients involved and the activities carried out. The team had no means available to conduct a detailed output evaluation.

IP: In this sense, we had no evaluation. We wanted to do that right at the start, because there were ICD-10 diagnoses and the like around in our set-up phase. We said to the healthcare fund: 'We write precise diagnoses on the referral slips and on the sick notes. (...) You still filled out referral slips and sick notes by hand in those days. (...) And we wanted to see at that time if

something could be improved. (...) I'll never forget how we asked the then head [X] of the regional healthcare fund if they would be willing to fill out our sick notes exactly. At that time, there was still no ICD, but at least the precise diagnoses, and we were willing to work together with the healthcare fund. The answer: 'Yes, if the Minister for Social Affairs [Y] pays.' So much to the atmosphere, and we had absolutely no internal resources for evaluations. (...) We would have had absolutely no problem in doing an evaluation, but of course you can't look up the ICD again every day and check and do that really exactly or check multiple diagnoses. The amount of work involved explodes. It would have become too much work to document it, and we didn't have the resources. What we did do for a long time – and still do – in our health promotion work were keep good records. We produced loads and loads of minutes of team meetings and procedures, etc. Why I really encouraged, so that we could at least do such a process evaluation if it push came to shove. But no one was interested except for the FPÖ project. (P9_2, 607-632)

The payer organisations accepted these short reports, because the annual application process required enormous administrative effort on both sides, but, above all, because the services provided by the SMC have been known to those responsible for years, and there is a tried and tested relationship of trust between the SMC and the payer organisations. The special integrated care services provided by the SMC in an area of the city with diverse health and social problems was emphasised by all representatives of the payer organisations who were interviewed.

Furthermore, evaluations tend to be seen in terms of their practical benefit to state politics. As the state representatives note:

IP: Annual subsidies cause an enormous amount of admin on both sides, and if I then also require them to submit a comprehensive report each year, even though I already know what they're doing, because they've been doing it for 20 years, then I just create admin for both parties, for the state as well. I have to free up those resources again as well. (...) In this respect, I'm sceptical of evaluations, because I always say, before I even begin a project, right at the very start, I want to a) know the goal and b) also know in advance what decision will be made if the goal is a) achieved or not achieved, because otherwise it's basically redundant. That was another problem with those Reform Pool projects. They were all pushed, and they were also evaluated, but no one knew what we were then going to do at the end, and it really was like that. (...) So I'm not saying that every project has to work, otherwise I wouldn't need to run it as a pilot. I would just like to know in advance what the goal is and if it is reached, and if it is reached, I also need to know

what I'm going to do in three years' time, because I then either have to reserve funding or have to make a law. But I can't just say, let's wait and see. (...) And with evaluations, I also have the problem that I have read many evaluation reports. They seem to me a bit like everyone was happy, it was all very good. (P11_2, 531-561)

As this quote shows, evaluations are regarded critically when they incur costs, yet are of no direct use in health policy decisions. The example of the Reform Pool projects is used here to show that the quality of the applications should be such that they already include clearly formulated output goals, whose achievement will then be demonstrated by the applicant. The payer organisations tend to prefer clear, easy-to-manage success criteria over comprehensive and cost-intensive evaluations. Likewise, the quality of the application should also allow an element of scale. As a rule, the only projects funded are those that are not restricted to a singular context, but rather have a chance of being extended elsewhere. The decision makers preferably already want to know when they approve a pilot project what is to be done if it is successfully concluded.

The SMC meets the first condition, but – due to the barriers in Austrian funding structures – not the second. Nonetheless, its work is valued to such an extent that project funding was always granted, with the centre only required to submit simple annual reports. Evaluations are not regarded as expedient here. They do not deliver the solution to the real structural problem. The physicians at the SMC would, in contrast, be quite willing to evaluate the results of their work or let these be evaluated, because they have a direct link to science and research. However, they lack the means to do so.

4.7. Financing

The group practice is mainly financed through payments by the regional health insurance fund, and, until about 1990, all the physicians' incomes were pooled and distributed according to a time-revenue key. This should ensure a balance between medical treatments covered by the health insurance and private income, as some services, like talking to patients, are time intensive and not remunerated (Sozialmedizinisches Zentrum Liebenau, 2015a; Possert, 1989; Possert, 1991). Later, the system was changed to divide the earnings into thirds (Possert, 1991). After Dr. Fritsch left in 1994, the costs for rent and overheads could no longer be divided in three, but had to be borne by the two remaining physicians (Sozialmedizinisches Zentrum Liebenau, 2015a). Employee salaries are above the collective wage agreement and jointly agreed (Possert, 1989). In the early years, the SMC Liebenau was organised on a voluntary basis, and, in the 1990s, public core funding was obtained (Brunner, 2013). There is conflicting

information about the co-payments of patients. The various initiatives of the SMC are largely financed by various public entities (e.g. earmarked funding from the Ministry of Families, a one-off subsidy from the city of Graz, the provision of human resources from the public employment service) and by deductible of the patients (Brunner, 2013). By way of contrast, Possert (2000) states that all services of the SMC are free of charge for patients.

In the interviews with the physicians and representatives of the payer organisations, the structural funding problems are a central topic. In many respects, it appears that the funding and remuneration system at the SMC works to a large extent on the basis of a number of social preconditions. In other words, the interviewees reckon that, in actual practice, the following factors play an effective role:

- strong voluntary engagement on the part of the initiators
- the commitment from the payer organisations
- intensive communication with diverse payer organisations
- the intrinsic motivation of staff.

The initiators of the SMC are in agreement with the regional payer organisations that Austria lacks an appropriate funding framework for integrated care health centres like the SMC. Both sides criticise this in principle. As one of the representatives of the payer side notes:

IP: That is in principle the basic problem for the SMC too, and was only concealed there by this private initiative, which was then at some stage just good [well-positioned], but the basic problem is that there is no framework for it. (...) I'm not saying that the money is not there, because it is in fact there, , there is money there for all the areas they cover in the SMC, and it is spent as well, and has also always been spent.

I2: And who's to blame that there is no such framework? After all, the funding could have been amalgamated.

IP: The distribution of competences in Austria. (P11_2, 103-111)

For their part, the organisers of the SMC note:

IP: Yes, that's a catastrophe. We waste, I think, one and a half months each year on that. If you receive grants from six [payers], you have to submit six claims, write six reports. I mean, the state government was of course generous; in principle it was like a basic subsidy: then you only wrote down what was necessary. But despite that, you have still have to submit the claims – and

do so exactly, 2 euros 25, right down to the last cent. In other words, the organisational requirements are extremely unfavourable. (P9_2, 427-433)

Nevertheless, both sides endeavour to work as best they can with the existing options and safeguard the funding for the SMC each year. They have done so successfully for three decades, firstly because the potential payers value the sociomedical approach. As the regional health insurance fund notes:

IP: I know the people [from the SMC] personally very well, and this sociomedical idea is one I also in some way support, because in my opinion health requires a bit more than just treatment. This concept of health goes a bit further – I also see that – and they were, of course, the pioneers more than 30 years ago. (P13_2, 59-63)

Secondly, funding has so far been successfully obtained because the SMC not only repeatedly came up with new and innovative integrated care projects, but also actively communicated this and discussed them with the state government, the health insurance fund, the city of Graz and the local council. Through these talks, special forms of funding were found for the individual projects.

The following quote from one of the organisers makes two things clear: first, how many different payers contribute to funding the SMC and, second, the amount of context knowledge that has to flow into funding-related communication in order to successfully maintain a roughly coherent level of funding for the SMC:

IP: The social services department in Graz pays a part of the social activities in the individual districts, but primarily also the social workers. The city health council pays for some of our health projects, but those are small amounts, a few thousand euros. And the housing office, which is now the housing department, is run at political level by the KPÖ [Communist Party of Austria]. That's a special constellation in Graz, where the Deputy Mayoress is from the Communist Party. This department also runs the district community centres, and we get a fairly large chunk there, where we run two small community centres, one in a vulnerable district, the so-called Grünanger district, and one in the so-called Schöner Viertel ["Nicer District"]. Our staff work there. We've been there practically from the outset and said: 'We want to safeguard precisely this kind of care.' (P4_2, 81-92)

The intensive communication with all these payer organisation has become problematic in recent times, since one of the physicians retired, and the assignment structures that are in place for doctor positions

mean there is a risk that the vacancy will not be filled by someone who is suitable and able to successfully handle all the necessary unpaid communication work.

Recently, however, the possibility has also arisen that a completely new funding structure might be agreed between the Styrian health fund, the regional health insurance fund and the SMC, which would safeguard the SMC at least for four years and open up a new option for the future. A solution is being sought on the basis of the Hospitals Act [*Krankenanstaltengesetz*], which would simultaneously factor in the SMC's unique selling point and establish in detail the need for such a centre. The negotiations are currently underway. The participants are working intensely on this, are highly motivated and are optimistic that a solution for the SMC can be found, as the following statement from a health fund representative shows:

IP: The SMC is unique in its sociomedical form, and we want to secure this integrated care status for the SMC. We want to bring it into the institutional form in this framework, because the settlement mechanisms at the health insurance funds are simply not suitable for this type of activity [that of the SMC]. We face two challenges here. One is that we are looking to found this institute without the support of the Medical Council. And we thus have to look very precisely from the legal and content perspectives at the SMC's unique selling point, because we have now begun to develop a needs assessment procedure for precisely this mix of services. (P12_2, 74-81)

With regard to appropriate remuneration for their work in the SMC, the participating physicians stress that they do a lot of this work on a voluntary basis via the association. They do it with pleasure, because integrated care is very important to them. Nonetheless, they would welcome structurally appropriate funding, so that physicians who are not prepared to make such a strong commitment also still get involved. This is not least a generation issue, since young medical residents do not consider the high amount of time they would need to work and the high share of unpaid work at the SMC to be attractive, even if integrated care does interest them. An appropriate remuneration solution for participating physicians will thus be essential for the continued existence of the SMC beyond the approaching generation change.

As far as the non-doctor staff at the SMC are concerned, they feel they receive adequate remuneration for their work in integrated care. It was noted, for instance, that surgery assistants are also partly paid via the association, since they do work for the addiction and family counselling services or other projects. As one assistant reports:

IP: And this was a special grant from the state to the association, and we were always also, at least I was also, employed by the association for a few hours. Because this work, e.g. the work with substitution patients, did take up a great deal of time, sometimes even during surgery hours. (P10_2, 265-268)

The cumulative salary calculation for SMC staff has no negative consequences for them, since they all feel they are paid adequately. There are risks, however, for the chairman of the association and the physicians, who have in the past also on occasion paid themselves late in order to be able to pay the staff their salaries on time. This again demonstrates that the funding system at the SMC works under social preconditions.

The positive perceptions of remuneration are influenced not just by the salary amounts but also by the high level of intrinsic motivation on the part of SMC staff. The interviewees do not view their special tasks in the SMC as an extra service on top of their “normal” assistant, social counselling and health promotion. Instead, they view their complex job profiles as “normal”. These are thus perceived by internalised common basic understanding not as a burden but as a bonus: they enjoy the work, they learn extraordinary things, they are viewed by the patients as part of a special services centre. If they move to another establishment, they can demonstrate additional qualifications. The problems lie, therefore, on a different level, not in the adequate remuneration and recognition of the SMC staff.

From the client perspective, it should also be noted that the care services offered by the SMC are free of charge to patients. This is particularly important to the physicians, since it means they can also ensure low-threshold access to integrated sociomedical care for low-income groups as well.

4.8. Implementation process

4.8.1. Historical information

The SMC Liebenau was founded by three young physicians, Diego Fritsch, Gustav Mittelbach and Rainer Possert. Their main intention behind the initiative was to change the prevailing medical practices of the time and to offer qualitative medical and psycho-social care in a disadvantaged area. All three were members of critical student groups in the 1970s, where they actively discussed alternatives to the prevailing medicine (Sozialmedizinisches Zentrum Liebenau, 2015a). Within the critical medicine movement at universities, they questioned the role of medicine as a neutral science. Instead, critical

medicine addressed the division between statutory insurance patients and patients with additional private insurance (which guarantees nicer rooms and a free choice of physicians, potentially leading to faster treatment) in hospitals, social inequalities and health, and the role of medicine during the National Socialist era (Possert, 2000).

The SMC itself is built on four core principles (Sozialmedizinisches Zentrum Liebenau, 2015a):

- Firstly, it follows a “critical medicine” approach, which is responsible for and connected with individual patients and not the pharmaceutical industry.
- Secondly, it follows a medicine grounded in both the natural and the social sciences.
- Thirdly, it supports a solidary care system without class differences in medical care.
- Fourthly, the continuous reminder that health is not only produced by medical factors and that social inequality leads to ill health.

The implementation process was prepared by the three physicians and proved rather lengthy due to various opposition forces. The initial negotiations began in 1981, with the SMC ultimately founded in 1984. The physicians soon realized that they could not implement their vision of comprehensive primary healthcare within the existing healthcare institutions and aimed for three individual physicians’ posts. Thus, the negotiations concentrated on the Medical Association and the regional health insurance fund (Possert, 1989). A particular barrier during the implementation process was the fact that the SMC was the first group practice in Austria, thus raising institutional resistance. After Fritsch, Mittelbach and Possert had obtained the three posts as physicians in 1984, other physicians in the region protested. The latter claimed that the SMC would threaten the existence of individual physicians, as they could share work and did not have to carry the burden of holiday replacement, thus creating a competitive advantage over single practices. More than 70 physicians in the region signed a petition against the SMC and used their influence with the Medical Association to prevent the SMC by all means possible. The SMC threatened to sue the Medical Association and go public, which eventually broke the resistance (Possert, 1989). Despite this resistance, the SMC also received political support from the regional health insurance fund in Styria and the Minister for Social Affairs (Possert, 2000).

The SMC began as the first Austrian group practice with physiotherapy. In the same year (1984), the Verein für praktische Sozialmedizin (“Association for Practical Social Medicine”) and the family counselling service Graz-Süd (“Graz-South”) were established. The association should ensure a democratic cooperation with other health workers (Sozialmedizinisches Zentrum Liebenau, 2015a). All

parts of the SMC operate in the same building complex. The legal holder of the SMC is the not-for-profit Verein für praktische Sozialmedizin, which is also the holder of the family counselling service. It is governed by a board made up of three members, who are elected every three years. The group practice and physiotherapy service remain autonomous economic bodies (Brunner, 2013). Rainer Possert is the chairman of the Verein für praktische Sozialmedizin and acts as managing director. He finds it a burden to be responsible for human resources, controlling, concept development, etc. This management task requires maintaining relationships with politicians, setting new strategic directions and acquiring grant money, and it would be beneficial for the SMC to be part of a healthcare facility and regular healthcare (Brunner, 2013). Until 1997, no long-term planning was possible, as new applications for funding had to be submitted every year. The funding for the activities of the SMC was then spontaneously decided and was often in conflict with the interests of lobbyists and bureaucracy (Possert, 2000). For example, after the physicians and others protested against the building of a new street that would have generated a lot of traffic, the employment contract of a social worker who was financed by the local council was not prolonged (Sozialmedizinisches Zentrum Liebenau, 2015a).

Since its establishment in 1984, the SMC has expanded to offer psychotherapy, social work and home care services, and has subsequently integrated health promotion and prevention into its portfolio. At the height of its activities, the SMC had 45 employees (Urlesberger, 2012). In 1994, one doctor left the group practice for personal and health reasons and went on to work in single practice in the neighbourhood. This led to the loss of the third doctor's post, as the contract was tied to his person and not to the SMC (Sozialmedizinisches Zentrum Liebenau, 2015a). Moreover, when funding structures for home nursing care and home care were changed in Styria, the SMC had to cooperate with a regional nursing service to deliver its care services. However, in 2010, this cooperation stopped, as the SMC demanded qualitative criteria that the regional nursing service was not willing to accept. The SMC thus no longer provides nursing care services (Brunner, 2013). Table 6 shows the development of the SMC over the course of time.

Table 6: Development of SMC services and initiatives over time

Year	Events
1984	Foundation of the group practice, the family counselling centre and the Association for Practical Social Medicine
1985	Introduction of individual psychotherapy free of charge District Study "Liebenau"
1986	Social work added to portfolio Launch of a patient magazine

	Initiative to rescue a local production facility, "Puch-Zweiradwerk" Information desk about radiation exposure from Chernobyl
1987	Establishment of a psychotherapy practice "Muscular dystrophy" self-help group founded
1988	Citizens committee prevents a 4-lane road in the district
1990	Start of home nursing care with one nurse
1992	Start of home care services
1994	Start of care for the elderly, courses and counselling for caregiving relatives
1995	Social and health conference Liebenau Start of drug substitution therapy
1997	Grünanger: Successful preservation of the housing estate Healthcare conference with representatives from Sweden Start of antenatal classes in the SMC
1998	Start of project work and events in the health promotion area Regional health conference Liebenau Education in health promotion by Univ.-Prof. Dr. Noack Health platform Liebenau is established Introduction of a running group Relaunch of the patient magazine SMC Info Regular case conferences for SMC employees Introduction of a monthly group for substitution patients
1999	Start of the Grünanger round table International symposium First event series panel for social and medical practice
2000	Start of plunge and fall Introduction of speech correction and movement with music Signature campaign against contract-free employment (medical association and regional health insurance fund) Presentation of the SMC at the World Organization of Family Doctors Congress
2001	Presentation of report "How healthy is Liebenau?" Foundation of the senior citizens organisation Liebenau Open letter against the introduction of control nurses in home care
2002	Introduction of sexual counselling and mediation Study on youth in Liebenau Safety training for elderly women Workshop and leaflet on (mis-)management of health
2003	Start of Youth Liebenau event series Health promotion through empowerment at local school Congress presentation on "Gender makes care" Employment of civil servants
2004	Campaign against call for bids for home care services is successful Registration of the institution according to §15 of the Narcotic Substances Act

Source: Sozialmedizinisches Zentrum Liebenau, 2005.

The SMC's history is recounted in the interviews as told in the analysed documents, since the initiators have written down their own accounts of the history for various purposes over the years. The main

problems that are emphasised are the inhibiting Austrian parameters for group practices and for single-source sociomedical all-round care (P4_2). The support from the Austrian Ministry of Health and officials in the city of Graz are mentioned, in contrast, as positive aspects. This support allowed the initiators of the SMC to familiarise them quickly with the general set-up. A further positive aspect throughout the entire lifespan of the SMC has been the interest to cooperate from medically trained personal, which meant that the SMC was always able to hire qualified and committed staff (P4_2). Successors for the physicians were sought by taking on medical residents. These, however, have so far only shown limited interest, not because of the sociomedical approach, but because of the voluntary work that is also required (P3_2). In contrast to these surmountable problems, the initiators refer to the resistance to the group practice from the Medical Association, which they characterise as at times even “hostile” (P1_2, P4_2). But this did not stop those involved from doggedly following their chosen path. One of the initiators describes the beginnings of the SMC as follows:

IP: Originally, five GPs applied to the health insurance funds, etc. for such a project and also to the Medical Association, and of those three [doctors] ultimately joined the group practice. And the approach we had at that time, with “dialogue-based medicine” and wanting to operate more like a walk-in clinic, that ironically is precisely the project that’s now being negotiated [with the Styrian health insurance fund] in that form. And to realise our staff-friendly, evidence-oriented medicine against profit interests and against their eminences, we also immediately founded a counselling service as well, a family counselling service, so that we would also get paid for this counselling activity, these talks with patients. That was basically how we got started, and we also founded an association pretty much at the same time as the medical practice. And the association was then the hub for the hiring of further personnel in a non-doctor capacity. Initially, it was a prerequisite for us to be recognised as a counselling service under the provisions of the [Austrian] Family Support Act [Familienförderungsgesetz]. That was essentially a law for counselling centres – to cushion the abortion clauses, and as a concession to the church authorities, so they could set up such counselling centres and have staff, etc. We were one of the counselling centres that were not linked to any particular religion. We started with that relatively soon, there were [also] requirements [in the conditions] for graduates, to hire psychologists, psychotherapists, social workers via the association. That gave us a really good organisational basis for expansion, without knowing at the time that we wanted to do something like we are doing now. At that time, we just wanted to work as a team and not just as doctors. (P4_2, 22-43)

A further problem only emerged after 30 years, when one of the initiators retired. The first solution to this, taking on a managing director for the SMC, led to various organisational problems, and the association parted company with him again. The second solution, the re-assumption of the primary responsibility and work by the original initiators, implied a heavy burden that could only be carried as an interim solution. The pressure on the SMC to find a long-term solution is thus growing.

4.8.2. Present information

It became evident in the interviews that the SMC Liebenau currently finds itself in an important new phase in its development. The physicians at the SMC and the Association for Practical Social Medicine are presently in negotiations with the Styrian health fund to agree a forward-looking organisational form for the SMC in line with the PHC Act that is expected to be passed in the near future. The aim is to have the SMC recognised as a PHC Centre. The negotiations are ongoing, and the results are still open.

4.8.3. Future implementation/development

While the SMC Liebenau had to build its own structures when it was founded, the Austrian healthcare system has evolved over time and adapted to promote primary healthcare. A decision has been taken in principle by the Styrian Counsellor for Health, the President of the Medical Association and the Chairwoman of the Styrian regional health insurance fund that the SMC should be the first Primary Healthcare Centre in Styria (Sozialmedizinisches Zentrum Liebenau 2016b).

4.9. Discussion

4.9.1. General discussion

The SMC Liebenau has several distinctive features. It is one of the few pioneer models in Austria and has been a success story for more than three decades. It is a bottom-up model.

Its organisational structure is unique in Austria. It combines a medical group practice with the work of an association. The latter organises diverse health promotion and social work projects and works closely with the group practice. Funding for the project work is acquired from and settled with a range of payer organisations on an annual basis. The physicians and some of the non-doctor personnel also contribute a great deal of their time to the projects on a voluntary basis. All core facilities of the SMC are located in one building. It also organises and holds health-related events at other public venues in the district.

The SMC's goal is to safeguard access to high quality integrated healthcare for all social groups in the Liebenau district of Graz. Accordingly, it is a community-oriented care model. Given the particular social structure in the district, its clients and target groups include an above-average number of people with low incomes and an above-average number of people with multiple chronic illnesses. The disorders treated are many and varied.

From a health status perspective, a particularly high share of the SMC's clients are patients with psychological and other illnesses or addicts with other illnesses. Multi-morbid patients with chronic illnesses are not treated by the physicians and other members of staff as a separate group, but rather as part of their chronically ill patients.

The work culture at the SMC is one of flat hierarchies, whereby the final responsibility ultimately lies with the physicians. The physicians, assistants and social workers view and treat each other with mutual professional respect.

The model cannot be easily generalised, because the Austrian healthcare system so far does not provide regular funding for either group practices or integrated health centres like the SMC. It is currently treated both by the payer organisations and by the initiators perforce as a special model, although both sides support and value the centre's sociomedical approach.

4.9.2. Discussion of the programme in the context of the conceptual framework

In the following section, the model that was previously developed in theory will now be applied to the empirical findings regarding the SMC Liebenau outlined in this document. The model sectors

- a) Holistic Assessment
- b) Governance and Leadership
- c) Delivery System
- d) Health and Social Care Financing
- e) Health Workforce
- f) Technologies and Pharmaceuticals
- g) Information and Research

will be discussed in sequence, starting in each case from the micro-level. The starting point is the discussion of the empirically documented health situation of multi-morbid chronically ill people, their surroundings and a corresponding holistic assessment.

a) Holistic Assessment

Holistic assessment is a core concern for all staff at the SMC. In the interviews, two particular aspects emerged in this case study with regard to the understanding of holistic assessment in the SMC and its specific forms of implementation.

First, holistic assessment is not seen as something temporary or concludable that is then followed by an optimal treatment plan. Instead, it is seen as a process. Holistic assessment accompanies the respective patient throughout the course of their life and illness. The physicians and staff at the SMC have known many of their patients for decades, and they know them not just as “medical cases” but are also familiar with many of the social and psychological aspects of their histories. They see this as a crucial basis for successful holistic assessment. Changes in the social and work environment are repeatedly noted, and treatment paths adapted to the changing subjective circumstances.

Second, this shows that a “holistic” assessment in the SMC also takes particular account of a client’s circumstances and possibilities/capabilities. All health analyses and assessments in the SMC thus follow a sociomedical approach. Through this approach, it differs from many other programmes, which also target integrated care.

At the SMC, holistic assessment is a task that is realised as far as possible within the centre itself. The multiple qualifications of almost all members of staff form an important basis here. It is realised above all through case-specific, intensive communication between all professions and through the SMC’s projects. Direct, regular contact with the physicians in combination with the benefits of the group practice form the basis.

The cross-sector case analyses are perceived by all participants as a further important element of this work. These are held monthly, and all physicians and staff are involved in the preparation, implementation and realisation of the results. It is important to the physicians to bring together and include the professional knowledge and expertise of all medical and non-medical personnel in these case analysis and the subsequent treatment measures.

Concentrating the cross-sector assessment within the SMC leads to short paths for patients and provides low threshold access to integrated care for socially deprived and vulnerable groups as well. But it also has its limits: according to the physicians, cooperation with hospitals and other GPs has so far not been adequately developed due to the historical reservations towards the SMC approach. Treatment paths for certain multiple clinical pictures could also be improved if this cooperation could be systematically developed further.

b) Governance and Leadership

Joint decision making is an important aspect in the healthcare work at the SMC and is put into effect both in the medical group practice as well as in all projects organised by the association.

The physicians repeatedly emphasise that “sensible” doctor’s orders are of little use when treatment paths are not/cannot be followed by patients for a multitude of different social and psychological reasons. Decisive for successful health outcomes is rather that the physicians listen to the patients and that they work out together using “dialogue-based medicine” what things are crucial to health from the client’s subjective perspective. Not infrequently, social circumstances play a more decisive role here than, for example, adhering to medicinal treatment plans or the regular monitoring of health data. For this reason, medical recommendations are frequently discussed with the social workers. Use is made here of the close cooperation that is possible due to the physical proximity between the group practice and the social workers (both are located in one building).

The involving of clients is also extended to the various health promotion, community work and social work projects. For example, the regular brunch offers residents an opportunity not only to overcome social isolation, but also to talk about their health problems and issues at a time they themselves have chosen. They then receive accompanied access to medical care, socio-psychological support or counselling by a social worker.

It does, however, also become clear in the interviews that this outreaching and involving sociomedical concept takes a very long time, requires a great deal of communication legwork and places heavy demands on the professionals involved.

The quality of the communication with clients that is thereby required has been developed jointly by the SMC team over many years and is still being developed to the present day. It is facilitated by a culture of

respect for all clients as well as a strived-for culture of non-hierarchical communication between doctor and non-doctor and medical and non-medical staff at the SMC.

This type of communication is socially very demanding, since in Austria clear hierarchical relationships generally prevail between physicians and nursing/care staff. People therefore have to “get used to” this non-hierarchical professional culture. At the same time, they also need a special sensibility for the complex health problems of socially deprived and vulnerable groups. According to the physicians at the SMC, this is an aspect that is currently neglected in medical training.

From its organisational structure, the SMC is a combination of a group practice and an association for practical social medicine. The association designs health promotion, community work and social work projects. Every year, it raises the funding, organises these projects, hires the staff and settles the projects with the various payer organisations.

From an organisational perspective, the SMC thus pushes at the limits of the fragmented Austrian healthcare and social system. As a result, even after 30 years it has still not succeeded in securing guaranteed core funding, even though its work is held in high esteem by the payer organisations.

c) Delivery System

The design of the SMC’s delivery of care is based on a clear sociomedical approach. Integrated care at the SMC centres on helping clients with their individual socio-psychological and sociomedical problems. Many of these clients have multiple chronic illnesses. They are frequently people from low income groups or who are unemployed or socially isolated. Their clinical pictures often contain combinations with mental illnesses or addictions. As a consequence, the SMC offers a variety of substitution therapies including psychological support. The direct access to social counselling is also of particular importance.

From the patient perspective, the SMC is thus a place where they can discuss complex sociomedical problems with an interdisciplinary team from different angles, without having to leave the building, without the need for extensive prior knowledge of medical and social institutions, and without fear that they will be turned away. The SMC has thus realised what is referred to in other sectors as a “one-stop-shop” for integrated sociomedical care for clients in this district.

This benefits all clients, but especially those who have little knowledge, those who are socially isolated, and those who are confronted with a multitude of problems as a result of their multiple chronic

illnesses. The SMC case study also shows that the term “multiple chronic illnesses” that underlies this theoretical model is not actively used by those involved. They prefer the term “sociomedical approach”. They also emphasise the unequal social access to medical care that is counteracted by the integrated sociomedical care provided by the SMC.

In integrated care of patients with multiple illnesses, it is also crucial that the exchange between doctor and psychologist or between social worker and doctor, etc. is immediate in a crisis case – through personal contact between the professionals. At the SMC, for example, the social workers are on call three mornings a week so that the physicians can introduce a patient with a corresponding problem to the social worker in person, and the social worker can then arrange an appointment with the patient or provide counselling on the spot. This type of personal communication and the afore-mentioned on-site counselling not only save the client time, they also establish low threshold access to complex, case-appropriate care, especially for social groups without corresponding institutional knowledge.

Also of special relevance in the provision of integrated care is the need to address all clients in a sensitive and target-group-appropriate manner. This requires skill, ability and training, which in the SMC’s case is assured on the one hand through its targeted selection of staff with the necessary sensitivity and communication skills. All members of staff – and not just the physicians – have a say in the selection process. In this way, they can contribute their own expectations of the new member of staff’s communication skills. This skill and ability is also developed through the regular exchange of experiences in crisis situations or in dealing with different client groups.

The clients themselves emphasise that they are very conscious of the fact that they get a special form of integrated care at the SMC. Many of them make use not only of the medical service, but also the other services on offer. They value the physicians and the whole team. They don’t want to swap the SMC for a single-doctor practice. Some clients also make use of the possibility to switch between physicians.

Quality assurance is carried out on the basis of medical, non-medical and social work services, in particular via the regular joint case conferences, where comprehensive notes are taken. At the same time, the physicians feel there is a need to expand quality assurance in the integrated care of chronically ill patients. To date, there is no corresponding legal basis or financial regulations for this in Austria.

d) Health and Social Care Financing

Access to the SMC is very low threshold on multiple counts. This implies free access to the integrated care services, including the diverse health promotion, health education, social counselling and support offers. This is appreciated by all SMC clients, but especially those on low incomes.

When patients are trained or encouraged, for example, to measure and record their personal health indicators or to self-inject, they receive no additional incentives. And they do not expect these either. When patients are in compliance, they do so willingly and to the best of their abilities. In cases where patients sporadically lack such willingness, the assistants and physicians repeatedly talk to them and try to get them to participate. This is achieved more through trusting encouragement than through incentives.

The salaries of the assistants are covered in part by the group practice (which is funded by the health insurance funds) and in part by the association. The assistants view their salaries as adequate payment for the particular work they do. They bear no negative effects from the split calculation of their salaries.

The physicians' salaries for their "normal" work are financed through the health insurance funds. In contrast, they are only paid in part for their additional work for the SMC through project funding. A further problem arises from the fact that funding for all SMC health promotion and community work projects has to be applied for and settled up on an annual basis by the association. This means that staff salaries can at times only be paid on time if the physicians defer their own salaries for six months or longer. So the physicians at times afford credit to the association and thus to the SMC and its staff.

This financing model is the SMC's primary problem, and is one that could jeopardise its future. If it does not succeed in the foreseeable future in securing long-term funding – which would also allow the targeted filling of the vacant doctor's position – this could jeopardise the SMC as a whole.

The SMC's broad portfolio of services is financed through part funding from various payer organisations. These include the Styrian health insurance fund (StGKK), the Styrian health fund, the city of Graz and the local district council. The SMC is currently in negotiations with the StGKK and the Styrian health fund to obtain multi-year pilot financing as an outpatient clinic or some form of other, similar construct. The output of this facility could then be evaluated, and it could be made permanent. This would be a regional (Styrian) solution, which is needed because there is still no corresponding national framework legislation in place. Financing problems thus exist on multiple levels:

- There is currently no financing framework for group practices or outpatient clinics in Austria.
- The health insurance funds only finance medical services in the narrower sense, but do not finance social or care services.
- There is a separation between the financing of GPS and the financing of hospitals at individual state level.

These conflicts in healthcare funding have been smouldering unresolved in Austria for years.

e) Health Workforce

Several new professional roles have been developed at the SMC over the years. These are:

- Responsible participation in joint case analyses;
- Case-related sociomedical communication between all professions,
- Assumption of wound management duties by assistants.

A common language has been developed at the SMC to facilitate participation in the case analyses and, above all, the daily case-related communication between physicians, assistants and social workers. This enables all involved to understand the different aspects of the holistic case analyses and client circumstances and to find common solutions. This indicates that systematic training courses are not the only way of equipping the health workforce for integrated care; long-term immersion and practice in a common language is at least equally important. This process has already reached a good quality level, but will never be concluded, since new members of staff will always have to be integrated and client problems likewise change.

In addition to a common language, the professionals at the SMC share their practical skills and knowledge with each other and offer one another mutual support in trying these out. For example, the mobile caregivers with nursing qualifications share, for instance, their knowledge of modern wound treatment techniques, equipment and materials with the assistants at the SMC. Likewise, the psychologist and social workers also share knowledge on the psychological problems of addicts with the assistants. This again demonstrates that the joint practicing of tasks that did not previously form part of a role contributes to the development of professional roles.

Particularly interesting from an organisational perspective is that the SMC as a result of its reputation as an integrated health centre quasi attracts from the outset people with multiple qualifications and with a

clear commitment to the sociomedical approach. This ensures a particularly high quality workforce and is reinforced and developed through the afore-mentioned joint learning activities. A further important role is played by participation in SMC events on a wide range of health promotion and social work topics in the district.

In addition to these activities on the micro and organisational levels, the desire for customised cross-sector training options was also formulated. The emphasis here lies on customised training courses, which take account of the demands of integrated care for groups with multiple illnesses.

f) Technologies and Pharmaceuticals

The use of new medical and communication technologies does not play a central role at the SMC. In contrast, given its own sociomedical “dialogue-based medicine” approach, the centre criticises medical practices that make euphoric use of new technologies without questioning whether these do not in fact cover over far more important aspects of integrated care. As far as the staff at the SMC are concerned, trust-based dialogue between the client and the doctor, medical and other staff and social workers is the central element in such a form of personal, patient-focused integrated care. One could add here that this also requires regular and respectful dialogue between all care professions, which is enhanced by a modern, electronic data gathering and processing system. Inequality-sensitive dialogue-based medicine also takes a critical attitude to various disease management programmes, in which the use of new technologies is tested without due consideration to the socio-structural limits of their use.

It is also pointedly asked if the introduction of more and newer technologies doesn’t frequently use up financial and other resources for the benefit of patients in mainstream society only, while appropriate resources for healthcare for people with low incomes and limited social contacts are not sufficiently available. The meaningfulness of technological development in the provision of medical care is thus measured by whether it secures access to integrated care for all people. In this context, the unfair distribution of the ability to use new ICT applications independently is also discussed.

One major problem in the battle against prescription medication addiction is mentioned not only by the physicians at the SMC, but also by caregivers and social workers. They raise the issue that physicians not infrequently contribute to medication addiction. They see this as a problem with older people in particular, who trust the doctor and then take medication over too long a time and thus become addicted to it. It is noteworthy that the entire SMC team works at not prescribing medication unnecessarily. Their focus thereby does not lie directly on the overlaps in the effects of different

medications, but on the avoidance of the unnecessary use of medication and on ensuring that undisciplined patients take their medication correctly and regularly. Alongside the physicians, the assistants in particular also play an important role here. They see this, however, not as an additional burden, but as an integral part of their responsibilities.

g) Information and Research

Patient data is stored and encrypted by the physicians and staff at the SMC in an internal SMC database. The database contains not only direct health data, but also data from social counselling activities and other sociomedical projects. However, the staff assign greater importance to systematic, face-to-face communication when it comes to the sharing and processing of jointly developed cross-sector knowledge. If the SMC were larger, with more staff and projects, both sides would probably be balanced. However, personal communication would still be of great relevance.

From the outset, the initiators of the SMC have oriented themselves on the latest scientific insights. They brought insights with them from their own time at university. Above all, they have oriented themselves on care approaches which take account of the relevance of social circumstances and social relationships for health and illness. They lament the prevailing narrow medical view taken by physicians and the health sector. Accordingly, they accorded particular relevance to the analysis of the health situation in the Liebenau district as a sound basis for integrated care. Based on this analysis, they have also always placed great importance on ongoing training and education both for themselves and for all staff at the SMC. They also hold regular events on health promotion topics, which are attended not only by local residents, but also by representatives of the health sector. They likewise support research into the sociomedical approach and the special features of the SMC by supervising doctoral theses. Overall, the SMC offers great research potential, and its commitment here extends well beyond the SMC itself. Nonetheless, the findings have so far not been adequately generalised in scientific terms.

Although the SMC forwards reports on its projects to the payer organisations each year, it does not have the resources to carry out a systematic evaluation of its work and its output. The physicians would welcome such an evaluation, since they are convinced of the medium and long-term results of their work. They are also equally interested in questions relating to the appropriate timeframe and the consideration of the complexity of sociomedical problems and care options, e.g. for addicts or other patients with multiple chronic illnesses.

4.10. Appendix – Original Quotes from Sociomedical Centre Liebenau Interviews

IP: Das heißt, ich muss sehen, dass jemand, der beispielsweise psychisch angeschlagen ist, jetzt nicht den Psychiater braucht, sondern einmal ein Ohr, das ihm zuhört, braucht usw. Das heißt, ich brauche das Verständnis, dass beispielsweise die Sicherung der Wohnung essentiell zur Gesundheit (lächelt) meiner Patienten beiträgt und dass das wesentlicher ist, als irgendeine Pille zu verschreiben z.B. Wenn ich [als Arzt] nicht verstanden habe, dass die soziale Lage konkret im Einzelfall ganz wichtig ist, wenn einer nicht weiß, wie er sich seinen Alltag finanzieren will, dann wird z.B. die Bewältigung seiner Diabetes oder seiner multiplen Krankheiten wahrscheinlich das kleinste Problem sein für ihn, weil er sagt: ‚Okay, das ist eine organische Krankheit, die ich habe, aber ich weiß nicht, ob ich die Wohnung behalten kann oder ich weiß nicht, ob mir das Jugendamt die Kinder wegnimmt oder so. Und dann habe ich als Arzt die Verantwortung, auch bei der Lösung dieser Probleme zu helfen, weil nur dann die verschriebenen Medikamente helfen werden. (...) Ich habe nicht den Eindruck, dass z.B. die schlecht eingestellten Patienten mit Diabetes die sind, die jetzt zu wenig Beratung im medizinischen Bereich haben, sondern die (...) sind, die extreme psychosoziale Probleme haben und das muss nicht einmal Migration und Sprachhindernis sein, auch quasi Analphabetismus oder so was, also wirklich schwerstwiegende Probleme, die einfach nicht gesehen werden. (P4_2, 303-319)

IP: Ich muss den Patienten dort abholen, wo er ist, nämlich mit seinen [psychosozialen] Problemen und nicht dabei, dass er jetzt noch bessere Schulung braucht bezüglich Diabetes, sondern der muss sehen, dass das zusammenhängt, seine psychosoziale Lage. Aber er muss auch wissen, dass ich [als Arzt] auch vielleicht der richtige Ansprechpartner bin für das. Das muss er überhaupt einmal akzeptieren, weil sonst sagt er: ‚Ja, Herr Doktor, ich weiß eh, ich sollte abnehmen und ich müsste Kalorien zählen.‘ Usw., aber er sagt natürlich nicht dazu: ‚Aber das kann ich nicht, weil ich andere Probleme habe. Diese Erkenntnis geht ihm ja ab und deswegen fragt ihn der Arzt nicht und das geht unter. (P4, 323-230)

IP: Wir sind in diesen Bezirk gegangen, weil er ein Arbeiterbezirk war und weil er damals auch unterversorgt war. Es gab ja freie Stellen. Und um dieses Feld, in dem wir tätig sein wollten, genauer kennenzulernen, braucht man ja halbwegs objektive Taten. Das betrifft die soziale Zusammensetzung und Anderes mehr. (P9_2, 28-31)

IP: Ich bin ja sehr oft bei diesen Gesundheitsveranstaltungen. Das SMZ veranstaltet ja alle ein/zwei Monate zu bestimmten Themen in ihren Räumlichkeiten Diskussionsrunden und da bin ich seit 30 Jahren regelmäßig dort. Ich habe den Spirit schon früher aufgesaugt, dass dieses intersektorale,

interdisziplinäre Arbeiten Sinn macht. (...) Du musst den Ärzten auch eine Möglichkeit geben, weil die müssen eng zusammenarbeiten, enger als bis dato und die müssen auch von der Chemie her stimmig sein. (P12_2, 828-838)

IP: Montag, Dienstag und Freitag bin ich immer von Acht bis um Zwölf in der Ordination fix. Falls jetzt Patienten bei einem der Ärzte sind, wo ihm auffällt, der Patient könnte auch sozialarbeiterische Unterstützung benötigen, kann er mich einfach drüben anrufen und ich kann spontan rüberkommen, mich gleich der Person vorstellen und wenn die Person Zeit und Lust hat, kann man auch gleich weiter das bearbeiten. Da war letzte Woche auch ein Beispiel, dass eine Patientin z.B. nicht gewusst hat, wie sie Pflegegeld beantragt, Dr. Y. mich angerufen hat und ich sie dann direkt nach dem ärztlichen Gespräch mit rübergenommen habe in den Beratungsraum und wir dort das Formular dann gleich gemeinsam ausgefüllt haben. (...) Das Besondere an meiner Arbeit im SMZ ist eben, dass es gemeinsam mit anderen Gesundheitsberufen unter einem Dach ist, z.B. mit den Ärzten. Und ich denke, der große Unterschied ist, dass für viele dadurch die Hemmschwelle ein bisschen wegfällt. Also es kann durchaus sein, dass Leute zu ihrem Hausarzt gehen und der meint: ‚Haben sie schon einmal mit einer Sozialarbeiterin drüber geredet?‘ ‚Nein, eigentlich nicht, ich überlege mir das.‘ Aber da ist dann meistens eine Hemmschwelle, wirklich dem nachzugehen. Wenn aber der Arzt sagt. ‚Warten Sie einmal, wir haben ja eine Sozialarbeiterin, die können sie gleich kennenlernen. Wenn die Leute mich dann sehen, und ich gleich mit ihnen in ein Gespräch bzw. gleich in Beziehungsaufbau übergehe, ist für viele das einfacher, und sie können für unterschiedliche Probleme zu ein und derselben Stelle kommen, müssen nicht wieder wo anders hingehen, müssen teilweise nicht nochmal ihre ganze Lebensgeschichte erzählen, weil ich entweder im Austausch mit dem Arzt- oder umgekehrt, dann schon weiß, was Sache ist ein bisschen. Gleichzeitig haben wir auch passende gesundheitsfördernde Projekte wie zum Beispiel das Walken, wie den Brunch (...) Und umgekehrt läuft das so, dass ich z.B. Leute über den Brunch kennenlernen, die aber sonst mit der Ordination z.B. nichts zu tun haben und im Gespräch kommt dann raus, er hat schon seit Längerem irgendein körperliches Leiden, war schon seit Jahren nicht mehr beim Arzt. Und das hilft dann natürlich auch in die andere Richtung, wenn man sagt: ‚Kommen sie doch vorbei, ich bin auch da, ich begleite sie mit hinein zum Arzt, wenn sie möchten, am Anfang und stelle sie vor.‘ Das hilft auch vielen. (P2_2, 120-162)

IP: Einmal im Monat treffen wir uns, am Montag zu Mittag und jeder überlegt sich einen Fall, was in dem Monat interessant war oder auffällig war und der wird dann kurz vorgestellt nach so einem System:

Wieso ist es wichtig fürs SMZ? Wer war alles daran beteiligt? Was hat es für Krankheiten? Gibt es eine Lösung? Usw. Und der Fall wird dann besprochen, manchmal wird nur einer diskutiert.

I: Wie lange dauert so eine Sitzung?

IP: Eine Stunde bis eineinhalb Stunden.

I: Machen nur die Ärzte Vorschläge für so einen Fall?

IP: Nein. Also auch Gemeinwesenarbeit, Sozialarbeit. Jeder ist einmal dran. Assistentinnen, Ärzte. (...) Also ich muss auch ab und zu mal wen vorbereiten zu einer Langzeitpatientin. (...) Weil sie täglich anruft. Sie ist sehr anstrengend, hat Angst bezüglich allem. Also sie hat u.a. eine Augenkrankheit und vor der hat sie extrem Angst und ich glaube, sie ist einfach nur einsam und möchte einfach sich täglich mit jemandem unterhalten und deswegen ruft sie einmal uns an und dann ruft sie die Apotheke an.

I: Und haben Sie eine Lösung gefunden?

IP: Ja. Ja, also wir haben die Patientin aufmerksam gemacht, dass sie mit der Sozialarbeiterin sprechen soll, weil, wir machen ja donnerstags immer einen Brunch, dass sie da mitgeht oder zum Walken usw. (...)

I: Werden da eher solche sozialen Probleme besprochen oder ist es gleich viel, dass medizinische Dinge besprochen werden?

IP: Gleich viel, ja, gleich viel. (P5_2, 65-94)

IP: Der integrative Weg ist sicher schwierig, weil de facto Integration meistens so gesehen wird: „Man kennt einander, man telefoniert miteinander, man überweist sich gegenseitig Patienten, das ist die Kooperation aber nicht das gemeinsame Arbeiten mit einem Patienten. Also, Helferkonferenzen, wo wirklich alle an einem Tisch sitzen, die mit oder an einem Klienten arbeiten, das ist nur mehr selten, das ist nicht so der Regelfall. (...) Gemeinsame Fallanalysen das ist bei uns irgendwie Alltag. Außerdem kann ich mir schwer was anderes vorstellen, als dass ich die Sozialarbeiterin anrufe oder sage, du, komm’ her, reden wir gemeinsam mit dem schwierigen Klienten. Oder wenn ich erfahre, dass unser Team mit irgendeiner Patientin, z.B. einer Suchtpatienten, arbeitet, und da sind plötzlich drei/vier Leute an einer Klientin dran, dann sage ich zu ihnen: „Kann ich sie auch einmal sehen, weil, vielleicht fällt mir als Arzt was dazu einfällt. (P4_2, 284-296)

IP: Das kannte ich ja vorher gar nicht so. Wo gibt es so etwas, dass Ärzte und Sozialarbeiterinnen gemeinsam an einem Patienten arbeiten. Ich habe in dieser Zeit wirklich viel gelernt, was ich im Spital

nicht gelernt hätte. Diese Art der ärztlichen Arbeit macht mir Spaß, ich könnte mir vorstellen, in Zukunft so zu arbeiten. Aber es ist schwer, eine solche Stelle zu bekommen. (P3_2, 150-153)

IP: Ich bin sehr zufrieden. Ja, ja.

I: Womit sind Sie denn zufrieden? Was ist gut im SMZ?

IP: Also in erster Linie mit dem Dr. Y. Mit dem spreche ich jedes Thema an. Völlig offen. Ja.

I: Okay, Sie sind schon viele, viele Jahre bei ihm?

IP: Ja, seit 20 Jahren, seit wann ich da wohne, ja. (...)

I: Was die- das SMZ so anbietet an sozialen Hilfen, ist da irgendwas dabei, was Ihnen nützlich wäre, außer dass Ihr Arzt ein guter Arzt ist?

IP: Ich habe mich hin und wieder erkundigt in die Richtung, aber es ist nicht wirklich etwas, was- weil ich alles selber mache, ja. Ja. Ja. (...) Was ich einmal in Anspruch genommen habe, das war sehr, sehr super, das [Projekt] ist dann aber beendet worden. Es hat mit dem Gymnasium da drüben, da haben die Jugendlichen so einen Besuchsdienst gemacht. Da sind sie hergekommen und sind halt eine halbe Stunde bei ihr gesessen. (...) Mich entlastet das nicht. Ich habe mehr Aufwand dadurch. Ich muss es entsprechend herrichten, weil, sie liegt sonst auch am Tag nackt im Bett. Das kann ich da nicht machen. Da muss ich ihr was anziehen. Es ist für mich Mehraufwand, aber für sie ist es besser. (P8_2, 285-289; 369-374)

I: Gibt es auch eine Gruppe von PatientInnen, die chronisch krank sind und die selber etwas übernehmen? Spritzen, Blutdruck messen usw.

IP: Es gibt Patienten, die stehen mitten im Leben und die können das und dann gibt es andere, da ist es schwer. Also, es war ja bei uns so bei der Aufnahme: Wenn jemand kommt- und auch nur ein Rezept wollte, z.B. einen Blutdrucksenker, dann haben wir gesagt: ‚Bitte, tun wir zuerst Blutdruck messen.‘ (...) Die Rezepte haben nur die Ärzte unterschrieben. Dann, nach dem Messen gehe ich hin und sage [zum Arzt]: ‚Bitte, das Rezept und der Blutdruck ist heute z.B. 220/100.‘ Dann hat es gleich geheißen: ‚Bitte da lassen, müssen wir besprechen, weil es hat keinen Sinn, was aufzuschreiben. Wenn der das Mittel wirklich genommen hat, dann kann er nicht solche Werte haben.‘ Oder z.B., relativ Undisziplinierte sind schon einmal die Diabetiker. (seufzt) Man sieht ja, wenn der Body-Maß-Index schon so und so ist und wir sagen: ‚Haben sie schon Zucker gemessen?‘ Antwort: ‚Ja, ja, ist ganz super, ist ganz toll.‘ Dann haben wir gesagt: ‚Na dürfen wir einmal messen?‘ Da war schon Abwehr. Natürlich sticht man die und tut ihnen weh. (...) Und dann kommen sehr schlechte Werte raus. Oder man sagt: ‚Sie haben keinen HbA1c

Wert, das ist ein Langzeit-Zuckerwert, bitte zuerst zum Labor, dann können wir weiter aufschreiben. Die sind teilweise schon zornig geworden ob dieser Bevormundung, aber eigentlich haben wir nur das eigene schlechte Gewissen verkörpert, zu sagen, ich müsste mich ein bisschen scheren.

I: Und diese Probleme treten oft auf?

IP: Die sind oft, weil solche Leute gibt es ja oft(...) Aber ich finde, die, die doch eher ein bisschen schwieriger oft zu führen waren, waren die Diabetiker. Das sind die, hätte ich gesagt, Schwierigsten, weil da gibt es ja Leute, die sind insulinpflichtige Diabetiker, (...) Die hören nicht auf zu essen, sondern sie sagen, okay, gut, jetzt eine Sachertorte und einen Schlag, vier Einheiten mehr. (.) Und die denken nicht dran, was das so mit ihnen nachher macht: In punkto offener Beine, in punkto Schlaganfallrisiko, in punkto ich sehe nichts mehr. Die muss man immer wieder anreden und führen. Die denken nicht drüber nach und die haben weniger das befolgt, was der Arzt gesagt hat als die Substitutionspatienten. Eigentlich, wenn man das genau betrachtet. (P10_2, 422-454)

IP: Also, das „Self-management“ würde ich eher für einen problematischen Ansatz halten. Ich meine, ich bin selber Arzt, ja, und wenn du krank bist, möchte man glauben, dass man als Arzt bei sich selber gut self-managen kann, es geht nicht. Du brauchst Bezugspersonen, ja. Du brauchst die außenstehende Person, mit der du über das kommunizieren kannst. Das geht ja kommunikationstechnisch gar nicht. Du brauchst jemand außenstehenden, der dir hilft, das zu managen. Also eine unserer wichtigsten Aufgaben, besteht ja darin, den Patienten beim Management seiner Krankheit zu helfen, weil er es alleine gar nicht kann. (P1_2, 806-812)

IP: Wenn im SMZ Sozialarbeit und andere Berufe dabei sind, dann ist es ja eine Entlastung. Ich muss nicht mehr alles selber machen. Man kennt es ja von den Kollegen, die am Land sind oder die ganz alleine vor sich hinarbeiten. Und jetzt wollen die jemandem helfen, aber wie denn?! Da müssen sie mit dem Amt telefonieren vom Sozialamt und dort telefonieren und da telefonieren. Das ist Arbeit, aber wenn ich zum Patienten sagen kann: „Bitte mit dem Sozialarbeiter [reden] oder so,“ da können Sie einen Termin ausmachen für Psychotherapie oder so was und das geht relativ schnell und unmittelbar. Dann ist viel schneller eine Hilfe gegeben und ist erleichternd. Ich muss nicht so viel organisieren für den Patienten wie andere Ärzte. Wir machen auch Supervisionen bei Drogenpatienten, wo Ärzte kommen, also die ja Drogenpatienten behandeln. Das sind abstruse Geschichten. Der Kollege muss herumtelefonieren, bis er einen Sozialarbeiter für eine Drogenpatientin findet und muss dann irgendwie sehr komplizierte Besprechungen machen. Das ist bei uns kein Problem, weil das erstens vor Ort informell immer passieren kann und zweitens über die Einrichtungen unserer Fallkonferenzen, die

sowieso ständig passieren, weil man wird ja betriebsblind, wenn man da immer selber drinnen steckt. Man sieht es [das Problem] gar nicht mehr in der Schärfe. Aber da sind wir im Versorgungsbereich, aber noch nicht so sehr im Gesundheitsbereich, in diesem Community Building Bereich oder Stadtteilgesundheitsarbeit. Man könnte da natürlich sagen: ‚Was hat Stadtteilarbeit mit Gesundheit zu tun und mit Sozialmedizinischem Zentrum?‘.

I: Und welche Antwort geben Sie?

IP: Naja, das kann man in WHO-Dokumenten nachlesen, dass Gesundheit eine intersektorale Angelegenheit und eine interdisziplinäre Angelegenheit ist. Und Gesundheit für alle, würde auch bedeuten, dass unterschiedliche Ressorts damit befasst sind, wie Sozialressort, Gesundheitsressort, bis zur Stadtplanung. Es geht ja bis zur Stadtplanung. Gesundheit hat was mit Stadtplanung zu tun. Zum Beispiel, im Bezirk da drüben, wo relativ viel arme Leute in Baracken wohnen, wenn Sie da um die Ecke jetzt ein Kraftwerk errichten und die haben fünf Jahre lang Schwerlastverkehr, was bedeutet das für die Gesundheit. Wenn die Leute nicht mehr schlafen können, wenn sie keine Ruhe mehr haben im Garten, weil ständig irgendwelche schweren LKW's herumbrummen, Baumaschinen arbeiten.

I: Ist das jetzt ein praktisches Beispiel oder?

IP: Ja, das ist geplant. Das ist ein praktisches Beispiel. (P1_2, 618-649)

IP: Von der Ärztekammer gab es eh Widerstände, die wollten das eh nicht. Die haben auch jetzt kein Interesse an PHC. (...) Es wiederholt sich, wie vor 30 Jahren. (P1_2, 241-244)

IP: Und als Ansatz (...) haben wir also Gesprächsmedizin im Vordergrund gehabt. (P4_2, 25-29)

IP: Es gibt ja heute kaum Arztpraxen, die mit SozialarbeiterInnen kooperieren, direkt, so- Face-to-Face. Das ist immer noch relativ neu (...) Das Konzept war immer ein kooperatives. Das heißt, ein Einzelarzt, der für sich alleine arbeitet, ist antagonistisch, ja, weil auch die Qualität in dem Fall nicht so gegeben ist. Wenn Ärztinnen oder Ärzte kooperieren, hast du immer eine höhere Qualität in Kooperationen (...) Und Kooperation eben vom Arztberuf weg, vom Gott in weißem Mantel, hin zur [direkten Kooperation] mit anderen Gesundheitsberufen. (P1_2, 165-179)

IP: Das war schon neu für mich, dass die Kommunikation im SMZ so direkt erfolgt. Das ist ungewöhnlich. Ich musste mich erst daran gewöhnen. Man wird von Dr. X und Dr. Y. immer wieder angesprochen. Man muss direkt reagieren. Das ist auch schwierig. (...) Aber das ist gerade das Interessante. Die Arbeit im SMZ ist eben etwas Besonderes. (P3_2, 250-254)

IP: Von der personellen Besetzung unserer Arbeit sind wir gerade in einer Umbruchsituation, wo wir schauen, dass wir praktisch einen Generationenwechsel zustande bringen und das ist nicht ganz so leicht. (...) Die Schwierigkeit ist, dass vielen dieser organisatorische Aufwand, den wir betrieben haben, irgendwie zu komplex vorkommt. Also es gibt große Begeisterung unter den, weiß ich, 30-/35-jährigen, die irgendwelche Projekte usw., Ideen haben, aber wenn das nichts wird, geht man einfach in eine andere Richtung. Das heißt, man ist zwar begeistert, man ist offen für psychosoziale Ideen usw., aber konkret dranzubleiben und quasi so über Jahre das zu verfechten, ist nicht so das Ding [der neuen Generation], weil die jungen Leute bauen halt was auf und sagen: ‚Okay, wenn es so nicht geht, dann mache ich was ganz anderes.‘ Und sie schwenken dann um und setzen sich in den VW-Bus und fahren zwei Monate wohin und sagen: ‚Dann mache ich ganz was anderes.‘ (P4_2, 136-144)

IP: Also die Patienten sind aufgeblüht. (...) Also, die Ärzte haben uns gefragt: ‚Wer, glaubt ihr denn, würde sich freuen und wer bräuchte auch jemanden, der kommt?‘ Dann haben wir Vorschläge gemacht. Dann haben wir die Patienten befragt. Die waren natürlich, wie soll ich es sagen, die waren begeistert und es waren auch die jungen Leute begeistert, weil die sind teilweise zu Besuchen geblieben, da war ihr Projekt schon längst fertig. Das gibt einem ein gutes Gefühl. (P6_2, 627-632)

IP: Also erstens konnten wir schon immer auch so, wenn jemand neu gekommen ist, schon irgendwie immer ein bisschen mit aussuchen. Also es war nicht so, da ist auf einmal serviert worden, der fängt morgen an, sondern es war schon immer auch ein bisschen schon mit eine Teamentscheidung, zu sagen, zum Beispiel bei den Assistentinnen, die wollen wir oder die wollen wir nicht oder wir glauben, das sind die, die vielleicht in die engere Wahl kommen und so und das ist schon immer berücksichtigt worden, das muss man schon ehrlich sagen. Und bei den anderen war es ja auch so in ihren Arbeitsbereichen. Z.B. Sozialarbeiter haben ja auch relativ viel gewechselt aus verschiedenen Gründen. Da waren welche, die weiter sich fortgebildet haben, die, aus anderen Bundesländern waren, da studiert haben, aber dann doch wieder nach Hause gehen wollten und so, und die konnten aber auch immer irgendwie Vorschläge machen oder jemanden bringen oder haben vielleicht jemanden gekannt, der mit ihnen Ausbildung gemacht hat und haben schon auch immer jemanden gebracht. Natürlich haben die Ärzte letztendlich schon entschieden, aber im Prinzip war schon immer das Team gefragt. Es hat immer gepasst, wer da nachgekommen ist, hat schon immer ins Team gepasst. Ich könnte mich nicht erinnern, dass da jemand gekommen wäre, dass wir gesagt hätten, nein, das geht eigentlich nicht, das ist für mich ein Grund aufzuhören oder mich unwohl zu fühlen oder sonst was. Das war eigentlich nie. (P10_2, 243-258)

IP: Im Umgang mit Suchtkranken, da lernt man so Dinge, wie: ein Hund kann für jemanden so wichtig sein. (...) Und was tun wir denn jetzt [da der Mann ins Krankenhaus muss und der Hund eingeschläfert werden sollte]. Wen könnte man anrufen, was können wir da machen, Sozialarbeiter fragen, wen noch fragen, was müssen wir beachten. Also das war wirklich schwierig, und da haben wir auch viel profitiert von den Sozialarbeitern. (...) Da haben wir eine Sozialarbeiterin gehabt, die hat ja in Wien gearbeitet bei diesen- wie heißt denn das? (...) Da gibt es eine niedrigschwellige Einrichtung, wo Leute, die nicht im richtigen Substitutionsprogramm sind, hinkommen können und dann trotzdem jetzt einmal was kriegen und dort vielleicht duschen können und die war dort und die hat uns das auch erzählt [was alles für Suchtkranke wichtig ist]. Das war für uns eine Bereicherung. weil man hat so seine Schienen, sein Netz und das war unglaublich. (...) Und das waren tolle Inputs eigentlich. Dann haben wir einmal eine Sozialarbeiterin gehabt, die hat vorher in einem Gefängnis gearbeitet (.) und- da hört man auch wieder ganz andere Dinge und so. Also- Wir haben unseren Horizont, glaube ich, unglaublich (schmunzelt) irgendwie erweitert und das war schon toll und auch natürlich, weil da so verschiedene in so einem Projekt arbeiten, glaube ich, schon andere Leute (.)- also es kommen andere Leute irgendwie. Auch im Team (..) und das war auch irgendwie spannend und dann ist ja das mit dem Verein mehr geworden, auch mit diesem wissenschaftlich arbeiten und so. (P6_2, 120-140)

IP: Eine Kollegin hat mich besucht und hat mich versucht, einzuladen für das Disease Management Programm in der Steiermark, und ich habe ihr versucht zu erklären: ‚Das ist ja selbstverständlich, dass man einmal im Jahr die Nerven prüft und die augenärztlichen Befunde einfordert oder alle drei Monate Laborkontrollen macht und dass man den Patienten einen Ausweis gibt und so, und wenn ich da jetzt elektronisch unterstützt werde durch dieses Disease Management Programm, ja, ist es gut. Dann sitze ich halt ein bisschen länger beim Computer und kriege pro Patienten 50 €.’ Aber, dann habe ich gesagt: ‚Ist ihnen bewusst, dass es psychosoziale Probleme bei den Klienten gibt? Weil, in ihrem Fragebogen gibt es diese Kategorie nicht. Sie wird bei den Schulungen nicht berücksichtigt, geschweige denn, wenn sie schriftliches Material austeilen. Vergewissern sie sich, dass unter den Befragten wirklich nicht, wie in Österreich die Studien ergeben, 15 % praktisch Analphabeten sind?‘ Da hat sie mich groß angeschaut, hat gesagt: ‚Nein, haben wir nicht, ist auch nicht unsere Aufgabe.’ Aber ich habe gesagt: ‚Wenn sie mit so einem Programm kommen, dann bin ich sofort dabei bei ihrem Programm, aber so finde ich das nicht notwendig. (...) Wenn die Leute eben einfach sind, muss man vielleicht das ganz anders sehen, also ganz andere Tools verwenden und so. Das ist ein Dilemma und dafür gibt es wenig Beispiele. Deswegen,

glaube ich, funktionieren auch die Disease Management Programme nicht so gut, weil sie eben diese psychosoziale Brille nicht haben. (IP4_2, 332-360)

IP: Wir haben auch Alkoholiker und wir haben doch eine nicht so kleine Gruppe, vor allem Frauen, alte, ältere, die total auf Benzodiazepine, also Schlafmittel abhängig waren. Also ich meine, wenn einmal ein junger Substitutionspatient randaliert, weil er irgendwas nicht kriegt, okay, aber da waren alte Frauen, wo wir gesagt haben, nein, sie kriegen jetzt nicht noch einmal Rohypnol, die zu weinen begonnen haben vor uns. Und das ist schon was, also wo man selber, wenn man viel jünger ist, schon mal ihnen hilft und sagt, Maria, ich habe eine arme alte Frau zum Weinen gebracht. Aber die war wirklich eigentlich auch arg und die sind dann nicht weggegangen und die waren viel penetranter und sagen: ‚Ich will das, ich brauch’ das, ich muss das haben.‘ Und die klappern mehrere Ärzte ab. Das ist uns dann erst bewusst geworden mit der eCard. Das merkst du vorher nicht so, weil die gehen halt von einem zum anderen und sage: ‚Mein Arzt ist auf Urlaub.‘ Wer fragt nach auf Erste-Hilfe-Schein! Und die sammeln von mehreren Ärzten das ein. Beim Kartenstecken [eCard] war das die Gruppe, die am meisten erstaunt war, dass das nicht mehr geht. Ich sage [nach dem Stecken der eCard]: ‚Sie waren schon bei einem praktischen Arzt, tut mir leid, sie sind gesperrt für uns, und zwar für drei Monate bei der Gebietskrankenkasse.‘ Sie: ‚Nein, ich war gar nirgends.‘ Dann haben wir bei der Kasse angerufen, haben gesagt: ‚Entschuldigung, da lässt sich die Karte nicht stecken, die Patientin sagt, sie war nirgends.‘ Dann hast du gehört, welche Ärzte mit dieser eCard aufgesucht wurden: ‚Dann rufst’ dort an: ‚Da haben wir Rohypnol aufgeschrieben, weil Sie waren ja auf Urlaub.‘ ‚Wir waren nicht auf Urlaub.‘ Das geht jetzt nicht mehr oder schwerer. (P4_2, 473-489)

IP: Im Beginn dieses Prozesses [der Erstellung einer Studie über den Gesundheitszustand der Liebenauer Bevölkerung] haben wir die lokale Bevölkerung miteinbezogen in diesen sogenannten Gesundheitskonferenzen, weil wir auch darauf hingewiesen haben, dass hier öffentliche Gelder in Verwendung sind und dass die Menschen, die hier leben, ein Recht darauf haben, zu wissen, was mit dieser Studie passiert. (...) Gesundheitskonferenzen das sind Zusammenkünfte der PatientInnen und BewohnerInnen, in dem das Thema Gesundheit und Krankheit thematisiert wird anhand von konkreten Fragestellungen, z.B. ökologische Einflussfaktoren auf Gesundheit oder Verkehrslärm oder was immer.

I: Und die haben Sie wo durchgeführt? Im SMZ oder wo?

IP: Zu dem Zeitpunkt, wo diese Studien erschienen- hatten wir noch keinen Raum, dann war es im öffentlichen Raum: In der Pfarre oder im Krankenhaus. (P9_2, 45-58)

IP: wir hatten in dem Sinn keine Evaluierung. Wir wollten das ganz am Anfang schon haben, weil in der Gründungsphase gab es ja schon ICD-10 Diagnosen oder so was Ähnliches. Wir haben den Kassen gesagt: ‚Wir schreiben genaue Diagnosen auf die Überweisungsscheine drauf und auf den Krankenschein. (...) Den Überweisungsschein und Krankenschein hat man damals noch mit der Hand ausgefüllt. (...) Und wir wollten damals schon schauen, ob man etwas verbessern kann. (...) Ich werde das nie vergessen, wie wir den damaligen Gebietskrankenkassen Obmann [X] gefragt haben, ob sie die bereit wären, unsere Krankenscheine exakt auszufüllen. Damals gab es noch keine ICD, aber zumindest die genauen Diagnosen und wir wären bereit, mit der Kasse zusammenarbeiten, Antwort, ja, wenn der Sozialminister [Y] zahlt, dann schon. So viel zum Atmosphärischen und interne Ressourcen zur Evaluierung hatten wir überhaupt nicht. (...) Wir hätten überhaupt kein Problem gehabt, eine Evaluierung zu machen, aber natürlich kannst du nicht jeden Tag dann noch einmal die ICD nachschauen und nachschauen und wirklich genau das machen oder Mehrfachdiagnosen prüfen etc. Der Aufwand explodiert ja. Der Dokumentationsaufwand wäre zu groß geworden, die Ressourcen haben wir nicht gehabt. Was wir sehr lange gemacht haben und immer noch machen im Gesundheitsförderungsanteil [des SMZ] waren gute Protokolle. Wir haben ganz, ganz viele Protokolle von Teamsitzungen und von Abläufen usw. angefertigt. Was ich sehr vertreten habe, damit man wenigstens, wenn es drauf ankäme, so eine Prozessevaluation machen kann Hat aber auch niemand interessiert, außer beim FPÖ Projekt. (P9_2, 607-632)

IP: Jährliche Förderungen sind ein enormer Verwaltungsaufwand für beide Seiten und wenn ich denen jetzt jährlich einen umfangreichen Bericht abverlange, obwohl ich schon weiß, was sie machen, weil sie es schon 20 Jahre gemacht haben, dann habe ich so einen Verwaltungsaufwand für beide Seiten, auch fürs Land. Ich muss ja das dann auch wieder lösen. (...) Ich bin insofern evaluierungskritisch, weil ich immer sage, bevor ich ein Projekt angehe, schon ganz am Anfang, will ich a) die Zielsetzung haben und b) schon vorher wissen, welche Entscheidung fällt, wenn das Ziel a) erreicht oder nicht erreicht wird, weil sonst ist das ja eigentlich überflüssig. Das war auch das Problem bei diesen Reformpoolprojekten. Also man hat sie alle angestoßen, man hat sie auch evaluiert, nur keiner hat dann gewusst, was machen wir denn am Ende und es ist auch tatsächlich so. (...) Also ich will gar nicht sagen, dass jedes Projekt funktionieren muss, sonst brauche ich es nicht als Pilot aufsetzen. Ich möchte nur gern vorher wissen, was ist das Ziel und ist das erreicht und wenn das erreicht ist, muss ich auch wissen, was mache ich dann in drei Jahren, weil dann muss ich entweder Geld reservieren oder muss ich ein Gesetz machen. Aber ich kann nicht einfach sagen, dann schauen wir einmal. (...) Und auch bei Evaluierungen habe ich das

Problem, dass ich viele Evaluierungsberichte gelesen habe. Die kommen mir ein bisschen so vor wie, alle haben sich wohlgefühlt, es war sehr gut. (P11_2, 531-561)

IP: Das ist die prinzipielle Grundproblematik auch beim SMZ, die dort nur überdeckt wurde durch diese Privatinitiative, die einfach irgendwann einmal gut [aufgestellt] war, aber die Grundproblematik ist, es gibt keinen Rahmen dafür. (...) Ich sage nicht, dass es das Geld nicht gibt, weil das ist eigentlich da, für alle diese Bereiche, die sie im SMZ machen, gibt es Geld und wird es auch ausgegeben, ist auch immer ausgegeben worden.

I2: Und woran konkret liegt es, dass es diesen Rahmen nicht gibt? Also man hätte ja auch die Mittel zusammenführen können.

IP: An der österreichischen Kompetenzverteilung. (P11_2, 103-111)

IP: Ja, das ist eine Katastrophe. Es gehen ja jedes Jahr, glaube ich, eineinhalb Monate mit Anträgen drauf. Wenn du von sechs [Payern] Subventionen hast, musst du sechsmal abrechnen, sechsmal Berichte schreiben. Ich meine, die beim Land waren eh großzügig, im Prinzip war es so ähnlich wie eine Basisförderung: Dann hast du halt nur das Wichtigste aufgeschrieben. Aber trotzdem musst Du es dann auch abrechnen: genau auf 2 Euro 25 und so einen Krampf. Das heißt, die Voraussetzungen also vom Organisatorischen her sind denkbar schlecht. (P9_2, 427-433)

IP: Ich kenne die Leute [vom SMZ] persönlich sehr gut, und dieser sozialmedizinische Gedanke ist auch in mir so ein Stück weit verankert, weil ich der Meinung bin, Gesundheit braucht ein bisschen mehr als Behandlung. Dieser Gesundheitsbegriff ist ein bisschen umfassender auch für mich und da waren die ja Vorreiter vor über 30 Jahren. (P13_2, 59-63)

IP: Das Sozialreferat der Stadt Graz zahlt einen Teil sozialer Aktivitäten in den Stadtbezirken, aber vorwiegend auch SozialarbeiterInnen. Der Gesundheitsstadtrat, die Stadträtin zahlt einige unserer Gesundheitsprojekte, sind aber kleine Beträge, das ist in einigen tausend Euro. Und das Wohnungsamt, das jetzt Wohnungsreferat ist, wird jetzt politisch von der KPÖ verwaltet. Das ist diese spezielle Konstellation in Graz mit einer solchen Vizebürgermeisterin. Dieses Ressort verwaltet auch die Stadtteilzentren und da haben wir seit vorigem Jahr einen recht großen Brocken, wo wir zwei kleine Stadtteilzentren betreiben, eines in einem prekären Bezirk im sogenannten „Grünanger“, und eines in dem sogenannten „Schöner Viertel“. Da sind unsere Mitarbeiter drinnen. Da waren wir praktisch am Anfang dabei und haben gesagt: ‚Wir wollen genauso eine Versorgung sicherstellen.‘ (P4_2, 81-92)

IP: Das SMZ ist in der sozialmedizinischen Form einzigartig für uns und wir wollen das SMZ in diesen Mehrversorgungsstatus bringen. Wir wollen es in der Institutionsform in diesen Rahmen bringen, weil die kassenärztlichen Verrechnungsmechanismen für diese Art von Tätigkeit [des SMZ] einfach nicht geeignet sind. Wir haben hier eine zweifache Herausforderung. Die eine ist, dass wir diese Institutsgründung betreiben, ohne von der Ärztekammer unterstützt zu werden. Und damit müssen wir uns juristisch und inhaltlich sehr genau mit dem Alleinstellungsmerkmal des SMZ beschäftigen, weil wir jetzt begonnen haben, ein Bedarfsprüfungsverfahren genau für diesen Mix an Leistungen zu entwickeln. (P12_2, 74-81)

IP: Und da war eine spezielle Förderung vom Land an den Verein und wir waren aber auch immer, zumindest ich war immer, auch für ein paar Stunden beim Verein angestellt. Weil, diese Arbeit, z.B. die Arbeit mit den Substitutionspatienten, schon sehr viel Zeit auch teilweise in der Ordinationszeit weggenommen hat. (P10_2, 265-268)

IP: Ursprünglich haben fünf Allgemeinmediziner ein so ein Projekt beantragt bei den Krankenkassen und so und haben wir auch bei der Ärztekammer und von denen sind dann drei [ÄrztInnen] übergeblieben für die Praxisgemeinschaft. Und der Ansatz, den wir damals gehabt haben mit „Gesprächsmedizin“ neben dem, dass man einfach eher wie ein Ambulatorium arbeiten wollte, der ist heute ironischerweise genau das Projekt, das jetzt in dieser Form bei den Verhandlungen [mit der StGKK] verhandelt wird. Und zur Umsetzung unserer arbeitnehmerfreundlichen evidenzorientierten Medizin gegen Profitinteressen und gegen Eminenzen haben wir parallel dazu gleich eine Beratungsstelle, eine Familienberatungsstelle gegründet, damit uns auch diese Beratungstätigkeit, diese Gespräche mit Patienten bezahlt werden. Das war so der Einstieg, und da haben wir praktisch zeitgleich mit der Praxis der ärztlichen Arbeit einen Verein gegründet. Und der Verein war dann die Drehscheibe für weitere Anstellungsmöglichkeiten von nichtärztlichem Personal. Zunächst war er eine Voraussetzung dafür, dass wir nach dem österreichischen Familienförderungsgesetz als Beratungsstelle anerkannt werden. Das war eigentlich ein Beratungsstellengesetz, um den Abtreibungsparagrafen abzufedern, als Zugeständnis an die kirchlichen Stellen, dass diese Beratungsstellen gründen dürfen und Personal haben usw. Wir waren halt eine von den nicht konfessionellen gebundenen Beratungsstellen. Da haben wir relativ bald dann damit angefangen, [in dem Rahmen] hat es [auch] Akademikerförderungen gegeben: Psychologen Psychotherapeuten, Sozialarbeiter über den Verein anzustellen. Der war eine ganz gute organisatorische Basis für die Ausweitung, ohne dass wir damals schon gewusst haben, dass wir so was Ähnliches wie

jetzt machen wollen. Wir wollten damals einfach im Team arbeiten und nicht nur als Ärzte allein. (P4_2, 22-43)

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