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Health data on pandemic management in the first year of the COVID-19 pandemic

Performance audit

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What we assessed and why

From August 2020 to February 2021, we reviewed the use of health data to address the COVID-19 pandemic. The objective of the audit was to assess the availability, quality and preparation of health-related data on the incidence of infection and on epidemiological management, as well as data on selected resources used for pandemic management, and on healthcare provided in the outpatient sector and in hospitals during the pandemic.

For our audit, we took into account that the pandemic had often necessitated exceptional procedures and measures, which had to be decided at short notice and posed various unique challenges for those involved. We took such challenges into account when defining our audit criteria (focusing on the effectiveness of measures to manage the pandemic) and approach (giving consideration to ongoing operational measures and to the resources needed to manage the pandemic). The conclusions of our report should be understood as “lessons learned” for future crisis management.

What we found

Since 2009, epidemiological surveillance has been carried out using the Epidemiological Reporting System (ERS). Compared with the tools available to other countries, this database provided a good starting point for collecting data on the incidence of infection. However, the entry of data proved to be inadequate.

While the Austrian Epidemics Act applies uniformly across the country, the provinces used different workflows and IT tools to implement it. This was partly due to the available infrastructure, but also to the number of available staff, space constraints, and the IT infrastructure in place. The provinces sometimes also interpreted the Ministry of Health’s instructions differently.

Different federal and regional authorities published data in different formats at different times, according to different definitions. This was the case, for example, for the number of newly infected people, the number of tests carried out, and the number of deaths caused by COVID-19, which had an adverse impact on the credibility of the authorities and thus on the acceptance and effectiveness of pandemic management measures.

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People at particular risk of contracting COVID-19 were identified once during the period under review. The primary objective of this measure was to regulate claims for continued remuneration and the means of financing this, and to deal with aspects of employee protection law. It did not include a comprehensive management of protection measures for high-risk people.

At the beginning of the COVID-19 pandemic, neither the Federal Government nor the provinces had a comprehensive picture of available personal protective equipment (PPE) or medical supplies. The Federal Government was able to compensate to a large extent for temporary PPE shortages by running more procurement procedures and optimising distribution measures. However, the establishment of additional procurement channels at provincial level made it difficult to gain a comprehensive overview of procurement operations.

Both the Hospitals and Sanatoriums Act and the General Social Insurance Act lacked appropriate rules for crisis and disaster situations. The health planning system was also unprepared, which meant that at the beginning of the pandemic it was unclear who was responsible for measures to adapt the health system in the event of a pandemic.

The data used to make assessments in respect of standard healthcare was also very limited. Particularly during the first wave of the pandemic, there was a significant decrease in regular medical care (medical consultations and screening). The largest decrease was recorded in paediatric and youth medicine, followed by dentistry and ophthalmology. The number of days spent by patients in hospitals decreased, as did the number of outpatient visits.

The consequences of these developments are not clear. In the absence of routine data and of a plan for accompanying research, neither the Ministry of Health nor the Austrian Health Insurance Fund was able to provide information on the health consequences.

What we concluded

The ERS should be further developed, its objectives clarified and further technical specifications drawn up, in particular to improve how it documents the course of a disease and how it monitors self-isolation measures. In addition, an obligation to register should be introduced.

The key indicators and timelines for epidemiological control should be identified, assessed to maximise their quality, and used as uniformly as possible for public communication.

In order to deal with future crises and disasters, efforts should be made to establish a legal and technical basis for timely and uniformly defined data to be made available on hospital capacity, and to ensure that this data, as well as diagnostic and performance data, can be linked to the ERS.

Legal and organisational bases for the systematic use of all available data relating to high-risk patients for care/health policy objectives (e.g. for the specific protection of individual patient groups and for a vaccination strategy) should be established or promoted.

Agreements should be reached between the Federal Government and the provinces for the strategic stockpiling of PPE and medical supplies in the medium and long term.

Efforts should be made to establish a general statutory requirement for information-sharing and mutual cooperation between health insurance institutions, hospitals and public health bodies, especially in the event of crises and disasters.

The structure of the data available in the healthcare sector should be further developed to not only enable correct billing, but also to facilitate an assessment of healthcare policy objectives from a public health perspective, taking into account epidemiological data and data on the quality of treatment outcomes.

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