

Projektbericht
Research Report

The Austrian long-term care system

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Final Report

March 2010

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Acknowledgements:

This report is an Austrian contribution to Work Package 1 of the research project 'Assessing Needs of Care in European Nations' (ANCIEN). The project is funded by the Austrian Federal Ministry of Science and Research and the European Commission under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483).

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1 The LTC system of Austria¹

1.1 Overview and philosophy of the system

The social welfare system in Austria is divided into three sectors:

- Social insurance
- Social protection
- Social assistance

Social insurance provides sickness, pension and accident insurance in exchange for mandatory contributions. Social protection is provided as coverage for special groups for whom the state has to take direct responsibility, e.g. war victims, and for whom benefits are provided from general taxation. Social assistance provides a need-based safety net for individual cases. It is only provided if other benefits are unavailable or inadequate and financed by provinces from taxation.

In general the Austrian long-term care system is a combination of benefits in cash and in kind. The core part of it is a long-term care allowance program at federal and provincial level. Thus, different to other European countries, the cash benefits are the most important ones. All persons in need of care can receive benefits in cash according the *Federal Long Term Care Allowance Act (Bundespflegegeld)*. Persons in need for assistance not covered by this law (handicapped or recipients of social assistance) can apply for benefits in cash provided by the provinces (*Landespflegegeld*). These cash benefits can be used to buy formal care services from public or private providers or to reimburse informal care giving. Additionally, provinces are obliged to provide places in institutions, in day/night care centres and home care services. Only if the recipient's income (including care allowance) and assets do not suffice to cover the costs of these services the social welfare scheme will cover the difference.

The long-term care allowance is:

- An earmarked benefit exclusively dedicated to additional expenditure incurred due to care needs; note, though, that recipients are free to choose how they spend the allowance; the allowance is not taxable,
- Based on the need of care; the level is determined by the specific amount of personal service and assistance required,
- Granted irrespective of the cause of care needs and the age of the person concerned,
- Granted irrespective of income and assets and based upon a legal entitlement,

¹ We are grateful to Erika Schulz (DIW, Berlin) and August Österle (Vienna University of Economics and Business, Vienna) for valuable remarks on an earlier draft of this report.

- Subject to uniform criteria and governed by one federal law and nine corresponding provincial laws,
- Financed from the general federal budget and the nine provincial budgets, but organized and managed by social insurance institutions.

Another core part of the Austrian long-term care system is the so-called *Article 15a B-VG agreement of 1993 for people in need of care (Vereinbarung zwischen dem Bund und den Ländern gemäß Art. 15 a B-VG über gemeinsame Maßnahmen des Bundes und der Länder für pflegebedürftige Personen)*². According to that provinces have to develop demand and development plans (*Bedarfs- und Entwicklungspläne, BEP*, see also chapter 4.1 Policy goals) for an adequate and comprehensive system of institutional, semi-institutional, and home based care services with full geographical coverage, observing minimum standards. The binding force of this agreement is rather limited as there are no sanctions attached.

The philosophy of the Austrian long-term care system is largely determined by the aim of the *BPGG*. It should enable those in need of care to lead a self-determined and needs oriented life and improve the opportunity to choose between different settings of care. Most persons in need of care prefer staying in the private environment and receiving informal care from relatives or family members over formal care; consequently, roughly 80% of persons in need of care do receive informal care. By providing the cash allowance irrespective of the chosen care setting (formal/informal, institution/home based), the philosophy of the system again is one supporting the possibility for individual choice. On the other hand, the cash allowance alone usually does not suffice to cover total cost of care if need is high. This could be seen as an indicator that informal (and thus, less costly) support is favored by the system, even more so as current BEP state that home based care is to be prioritized over residential care. But then one has to concede that social assistance covers any financial gap if persons with sufficiently high need for care are not able to finance residential care. Summing up, we would conclude that the philosophy of LTC provision mirrors the opinion of the population: According to the 2002 Eurobarometer survey, Austria is in an intermediate position with regard to the main responsibility for care, perhaps somewhat closer to the Mediterranean-Catholic model of high family responsibility than to the Nordic-Protestant model of high individual responsibility and a more pronounced role for the government in service provision.

1.2 Assessment of needs

In the Austrian long-term care system no definition of “need of care” exists, but eligibility requirements for the cash allowance partly could be seen as a substitute for such a definition. The assessment of need for long-term care is rather based on individual requirements for personal services and assistance. The need for both personal services and assistance is required in order to qualify for federal or provincial long-term care allowance.

² In the following short Article 15a agreement 1993. Article 15 a B-VG: Federal Constitution Law on joint measures by the federal government and the provinces

Needs assessment is based on a doctors' expert opinion, representatives of other fields (e.g. nursing) are also brought in for an extensive assessment of the situation. The expert opinion is usually drawn up after an examination in the home. It is possible for a trusted third party to be present during the medical examination, if desired by the person applying for long-term care allowance. The eligibility decision is made by means of an official notification with the possibility to appeal against this decision at the appropriate Labour and Social Court. The medical examination, the classification as well as the payment of the long-term care allowance are carried out by social insurance institutions, specifically pension insurance and accident insurance.

The specific provisions regarding the assessment of need of care are laid down in the *Ordinance on Care Allowance Levels (Einstufungsverordnung)* pursuant to the *Federal Long-term Care Allowance Act*. This ordinance defines care and assistance and the time allotted to individual tasks, e.g., dressing and undressing, care of the body, preparation of food, feeding as well as mobility assistance. In addition to that, the Federation of Austrian Social Insurance Institutions (*Hauptverband der Sozialversicherungsträger, HV*) has the right to define national guidelines for assessing needs of care. Such guidelines were issued and updated several times in order to assure the uniform interpretation of the respective laws also in practice and over different decision makers (Rudda 2003).

The law defines seven levels of care need, resulting in a care allowance between € 154.20 for need between 50 and 75 hours of care per month (level 1) and a maximum of € 1,655.80 (level 7) for more than 180 hours of care per month in combination with complete immobility (see Table 1). The amount of time spent on care services is the relevant criterion to qualify for levels 1-4. An additional criterion has to be met to qualify for levels 5-7 (see Table 1).

The granted level of care allowance is important for care recipients not only because of the care allowance itself. Also other benefits relate to granted care levels for eligibility. The most notable example is nursing home care: There is no special assessment procedure in course of entry into a residential or nursing home. Given vacant places, it is usually up to the administration of the nursing home to accept/reject applicants for places. In case of more demand than supply of places nursing homes usually require a certain level of care needs, e.g. homes run by the city of Vienna (or more precisely, by the Fonds Soziales Wien) are supposed to accept persons with at least level III.

Table 1: Eligibility criteria for care allowance levels and allowance per month as of January 1st, 2009

| Level | Need of care per month | Care allowance in € per month |
|-------|---|-------------------------------|
| I | More than 50 hours | 154.20 |
| II | More than 75 hours | 284.30 |
| III | More than 120 hours | 442.90 |
| IV | More than 160 hours | 664.30 |
| V | More than 180 hours of care needed per month, if an unusual need for long-term care is required | 902.30 |
| VI | More than 180 hours of care needed per month, if 1) care measures are required, which cannot be coordinated in terms of time and these are provided on a regular basis during day and night or 2) the continuous presence of a care giver is required during day and night, because it is probable that there is a danger for the care recipient or for other persons | 1,242.00 |
| VII | More than 180 hours of care needed per month, if 1) it is not possible for the four extremities to move intentionally or 2) a similar situation occurs | 1,655.80 |

Source: Bundespflegegeldgesetz.

1.3 Available LTC services

The Austrian long-term care system is, as mentioned above, a combination of benefits in cash and in kind. In addition to the uniform care allowance social services are provided for those in need of care. Generally, the provision of social services is characterised by a widely fragmented system with different providers (most of them non profit), various forms of provisions and different regulations regarding financing. Providers in some regions are acting in an almost monopolistic situation. The social services are in the responsibility of the provinces, thus the system is not only fragmented within a province but also differently fragmented in each province.

The Article 15a agreement 1993 requires all provinces to provide decentralized institutional, semi-institutional and home based services. For this purpose a catalogue of services and quality criteria for social services was included in the agreement. The provinces are also responsible for interlinking the services offered and guaranteeing information and counselling.

The objectives of the system are the following:

- Persons in need of care should be able to choose freely between the services offered.
- The expansion of home based services has clear priority to the expansion of institution based facilities.
- Nursing homes should be small, decentralised and integrated in residential areas.
- The expansion of new care services/facilities has to reduce the burden of care giving for family members. The range of services provided is of crucial importance (e.g., day care, short term care, respite care).

Note, though, that those objectives are stated in a qualitative way only, leaving room for provinces to judge in their BEP e.g. how small “small” homes are, or exactly what “clear priorities between care settings” means.

The Austrian long-term care system distinguishes between two main types of social services:

- **Institutional care services**

Institutional care services are mainly provided by provinces and municipalities, or by religious and other non profit organisations. These services usually include care in residential homes, nursing homes, day care centres and in night care centres.

- **Home based services**

Home care services are predominantly provided by non profit organisations, such as Caritas, Hilfswerk, Red Cross and Volkshilfe. They include among others home care, home nursing care, mobile therapeutic services, meals on wheels, transport service, home cleaning, laundry services and week-end help.

Furthermore, there are also services/support for informal care givers available such as:

- **Financial support for contributions in retirement plans** (*Begünstigte Selbst-/ Weiterversicherung in der Pensionsversicherung*): The amount of the financial support for the care giver depends on the level of long term care allowance of the care recipient he/she provides care to. At least level 4 is required for the care givers to receive financial support. Since 2009, there is the possibility that the public covers the complete contribution.
- **Financial support for respite care** (*Ersatzpflege*): A temporary limited financial support/allowance for informal care givers, earmarked to finance respite care.
- **Family hospice leave system** (*Familienhospizkarenz*): It enables the informal care giver to take a job leave, change or change working hours in order to care for terminally ill close relatives. It is limited to a period of six month for each case.

Eligibility criteria for benefits in cash and in kind

- **Benefits in cash** (i.e. care allowance): Eligibility is subject to:
 - A permanent need for personal services and assistance owing to a physical, mental or psychic disability or a sensory disability that is expected to last at least for 6 months
 - A permanent need for at least 50 hours of care per month
 - Austrian citizenship (or persons legally equal to Austrian citizens)
 - Residence in Austria

- **Benefits in kind:** Eligibility is subject to:
 - The health related need for care
 - Austrian citizenship (or persons legally equal to Austrian citizens)
 - Residence in Austria

1.4 Management and organisation of LTC

The provinces have taken over responsibility for an appropriate provision of social services. If the provinces do not provide these services themselves, they must ensure that other institutions provide them in appropriate quality. Thus the management and organisation of social services differs between provinces.

Generally, there are four providers of social welfare/long-term care: Provinces, municipalities, social organisations (*Sozialhilfeverbände*) and social funds (*Sozialfonds*). In Burgenland and Lower Austria the provinces are the only providers of social services. In the other provinces the provider structure is two- or threefold. Salzburg delegates the provision of social services to municipalities, Upper Austria to social organisations and Vienna to social funds. Carinthia and Styria pass it on to municipalities and social organisations, Tyrol and Vorarlberg to municipalities and social funds.

The main basis for the management and organisation of social services are nine corresponding provincial Social Welfare Acts. These laws do not only cover assistance to secure daily needs and aid in specific situations but also social services. There is no legal entitlement to these services.

Social services are provided by entities under private law. Persons in need of care may be requested to make contributions to the costs of social services but the social aspects have to be taken into consideration in assessing the share to be borne by them. Thus, there is in general some kind of means testing regarding to social services, but the concrete form differs by province.

(Quality) Standards

The provinces are also responsible for adequate professional quality assurance and control of social services. Annex A of the *Article 15 a B-VG agreement 1993* defines respective minimum standards for institutional and home based care.

The required minimum standards for institutional care are the following:

- Small, manageable homes,
- Integration of homes into the community,
- Minimum furnishing standards for rooms,
- Minimum equipment,
- Unlimited visiting time and right to visit at any time,
- Free choice of doctor,
- Legal protection for female inhabitants of homes,
- Supervisory regulations by the provinces.

The required minimum standards for home based care are the following:

- Free choice among the services offered,
- A comprehensive and integrated range as well as a network of services,
- Availability on Sundays and public holidays,
- Quality assurance and control by the provinces.

Those regulations, however, leave room for considerable differences in interpretation. Scholta 2008 (p. 398) provides examples for institutional care: Maximum size per facility ranges from 350 places in Vienna to 50 places in Carinthia. While Upper Austria requires 90% of all places to be in single rooms, Lower Austria requires only 50% of all places to be in single rooms, and in some cases allows triple rooms. Vienna allows 4-bed-rooms for persons “who wish social contacts”; also Burgenland allows 4-bed-rooms. Vorarlberg requires that new facilities are equipped with single rooms only; Styria still allows single and double rooms for new facilities. Minimum size per single room ranges between 14 and 18 m². For differences with regard to staff, see chapter 3.4.

The legal basis for quality assurance in the long-term care sector was created in an amendment to the *Federal Long-term Care Allowance Act* with effect from 1st July 2001. According to that, decision makers (i.e., social pension insurance, accident insurance and other authorities in charge of care allowance) may implement measures for quality assurance. In particular, it can be monitored if the provided care meets the quality standards

and the requirement of the persons in need of care. This monitoring is done in form of home visits. If necessary, information and advice is given to improve the situation of care giving. Note, though, that the law does not make this kind of continuing quality assurance compulsory.

Capacity planning

According to the above mentioned *Article 15 a B-VG agreement* the range of social services offered in all provinces are to be expanded. Reaching this goal obviously necessitates long-term planning. For this purpose the provinces prepared demand and development plans between 1996 and 1998 (*Bedarfs- und Entwicklungspläne*, see chapter 4.1). These plans have to include the legal framework in each province, a structural analysis of socio-demographic data, required human resources in the social sector, minimum standards for provision, development aims with cost assessment as well as an implementation plan. Gradual implementation is to be completed by the year 2010. The provinces adjust their planning to current developments on an ongoing basis.

1.5 Integration of LTC

In general, different institutions are responsible for provision and financing of long-term care and of health care. While health care is funded and organized via the social health insurance system, long-term care is provided via social services organized by communities and largely funded via taxes. In spite of this at first glance clear division of responsibility, there is a close connection between long-term care services and the social insurance system as it is the apparatus of the insurance system which organizes and manages the long-term care allowance. Furthermore, a care recipient's entry into the long-term care system often is triggered or initiated by providers of health services (like family doctors), and the conceptual dividing line between core health services and long-term care services is not always exactly executed in order to smooth services provision. For institutional efforts to coordinate care see section 4.2.

2 Funding

In general, it is up to the individual to finance his/her long-term care needs using the care allowance as well as private income or assets. In most cases of institutional care, however, those means are not sufficient to cover the overall costs arising from care or the fees for institutional care, and the respective providers of social assistance step in to cover the difference. Home based care is funded from private means as well as from social assistance, depending on income and care allowance. Social health insurance plays only a marginal role by financing home nursing care of a kind which often does not fulfil the definition as chosen here, i.e. long-term care rather than “repairing” care e.g. after hospital stays.

Total expenditure for long-term care in 2005 amounted to € 3.664 billion, € 2.826 billion of which were funded via taxes and € 0.838 billion via private means. There are two major groups of expenses funded via taxes, care allowances (55% of tax funded LTC-expenses in 2005 for federal, 10% for provincial care allowances) and funding for services in kind via social assistance (33%) as mentioned above. Both, care allowance and social assistance are tax financed. As a result of the poor data situation we cannot distinguish between the amount financed from national budgets versus those of provinces and municipalities. Almost all tax funding stems from national rather than regional or local taxes as the latter are of minor importance in Austria and all province and municipality budgets rely heavily on their shares in national taxation. There is no tax which is specifically earmarked for funding of long-term care.

Following Biwald et al. 2007, Austrian provinces contributed a total of € 1.936 billion for long-term care in 2005. The major part of those expenses, € 1.44 billion, was used for institutional care, € 130 million for semi-stationary facilities and € 360 million for home based care. Those figures are roughly in accordance with Schneider et al. 2006, who produced a more detailed picture of funding by setting of care for 2004. According to their estimate the value of informal care per year is between € 2 and 3 billion, i.e. if services actually provided by informal carers were provided by formal carers at minimum wage, the cost for this would be between € 2 and 3 billion. In reality, however, the existing social care workforce would not suffice to actually provide those services in the formal long-term care sector (Hörl 2008, p. 351).

Since its introduction, expenses for federal care allowances increased from € 1.34 billion in 1994 to € 1.69 billion in 2007, see Table 2. We include only expenditure for **federal** care allowance here because most recipients of provincial care allowances are below the age of 65 years. There is no comparable time series for total long-term care expenditure, but there

is hope that the availability of funding data for long-term care will improve as the SHA project³ develops.

Table 2: Expenditure for federal care allowance

| Year | Million € |
|------|-----------|
| 1994 | 1,341 |
| 1995 | 1,379 |
| 1996 | 1,322 |
| 1997 | 1,266 |
| 1998 | 1,300 |
| 1999 | 1,356 |
| 2000 | 1,398 |
| 2001 | 1,427 |
| 2002 | 1,433 |
| 2003 | 1,471 |
| 2004 | 1,489 |
| 2005 | 1,566 |
| 2006 | 1,621 |
| 2007 | 1,692 |

Source: BMSK 2008b.

Institutional care

In general, the individual is responsible to finance his/her stay in a residential or nursing home out of their income and their assets, which typically consists of retirement pension plus care allowance for LTC. If the care recipient's income and assets do not suffice to cover the fee, the respective provider of social assistance steps in to cover the difference. In the latter case, the care recipient usually keeps 20% of pension income and a smaller part of the care allowance (10% of the care allowance of level III) as "pocket money", but has to use this pocket money also to cover pedicure, cost sharing for drugs, etc. The provider of social assistance, however, has the possibility to ask later relatives, i.e. spouses or children, to refund the difference (*Regress*). According to provincial law, all provinces in theory can approach relatives that way, but provinces make use of this possibility to a varying degree, e.g. with regard to the questions *which* relatives can be approached, spouses, children, or grandchildren. Recently, regulation with regard to *Regress* was alleviated. Since 2009

³ Statistik Austria has been calculating health expenditure according to the OECD system of health accounts for several years. Until recently, however, their calculation of expenditure for long-term care had been restricted to expenditure for care allowance.

provinces can only approach spouses⁴ with the immediate reaction of increasing demand for nursing home places. At the time of writing (Fall 2009) it is still unclear if and which provinces will re-introduce some kind of *Regress*. Due to provincial legal responsibility, provinces regulate also other aspects of financing differently, e.g. the minimum amount of assets being exempt from funding for institutional care.

Table 3 shows that roughly half of all institutional care is financed by social assistance. More than 40% are financed from the care recipients' income (including federal LTC care allowances). Provincial care allowance plays only a minor role as most elderly persons in need of care are eligible for federal care allowance. Funding from care recipients' assets and from refunds by care recipients' relatives contribute 7% to overall funding, with refunds having been the by far more important component. Note, though, that those percentages give only a rough estimate as data for some provinces are missing, and differences between provinces prevail.⁵

Another indicator for the importance of social assistance for the funding of institutional care is that it contributes to the funding of at least 80% of all places. The high share of welfare recipients is easily explained by the fact that the monthly fee for a residential or nursing home place varies between € 1,000 and over € 6,000, depending on equipment and the level of need for care (Schneider et al. 2006, p.8, figures for 2004). However, the median pension income was € 840 (women) and € 1,480 (men), and the average monthly care allowance was € 375 (women) and € 428 (men) in 2006.⁶

⁴ In the provinces Carinthia, Lower Austria and Styria even spouses cannot be approached with regard to *Regress*.

⁵ Using data from Schneider et al 2006 for 2004, we can as well calculate the privately financed share as 34-39%, and the publicly financed share as 66-61%, depending on the mode of calculation and the resulting inclusion/exclusion of provinces.

⁶ Note: According to the Austrian legislation persons receive retirement pension 14 times a year, which leads to yearly median pension income of € 11,767 (women) and € 20,720 (men) in 2006.

Table 3: Sources of funding for institutional care in 2006

| Source of funding | Percent in all expenditure – average of provinces | Percent in all expenditure – min - max of provinces |
|--|---|---|
| Social assistance (<i>Sozialhilfe</i>) | 48% | 29 - 54% |
| Pension and federal LTC care allowance | 43% | 31 - 50% |
| Provincial care allowance | 1% | 0 - 3% |
| Assets and Regress | 7% | 3 - 17% |
| Other income | 3% | 0 - 6% |

Note: No information for Salzburg and Vienna are available, thus all percentages have to be seen as not very exact.

Source: Hofmarcher, Kraus, Bittschi 2008, Tab. 3.

Home based care

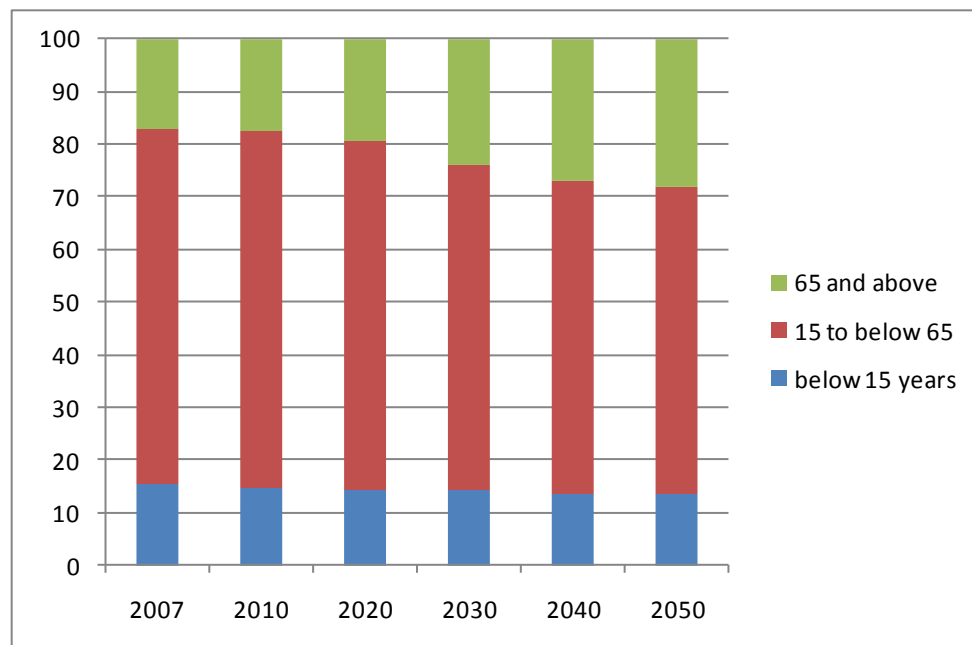
The data situation regarding home based care in Austria is even poorer than the data situation for institutional care; thus all values provided have to be seen as indicative rather than exact. Schneider et al. 2006 estimate the total expenditure for home based care in 2004 at € 445 million, of which care recipients provide on average at least 27%. There is broad variation between provinces: In Burgenland, the most eastern and a rather poor province, recipients contribute less than 4%, in Salzburg and Lower Austria care recipients contribute almost 60%. As most provinces do not report expenses for home based care as defined in this project, the sum of € 445 million comprises more than just long-term care for the elderly, e.g. family care under several definitions. Schneider et al. 2006 report costs per hour of care of € 14.20 - 42.60, depending on province and qualification of the formal carer.

3 Demand and supply of LTC

3.1 The need for LTC

In 2007 some 8.3 million people lived in Austria. About 17.3% or 1,412,904 persons were 65 years old or above, and about 4.5% or 376,022 persons were 80 years old or above. Like in other European countries it is expected that the share of elderly will increase markedly in the future. For 2050 28% of the population is expected to be 65 years old or above (see Figure 1). As the need of care is strongly related to age we can expect that the need of care will also increase.

Figure 1: Age structure of the Austrian population 2007-2050

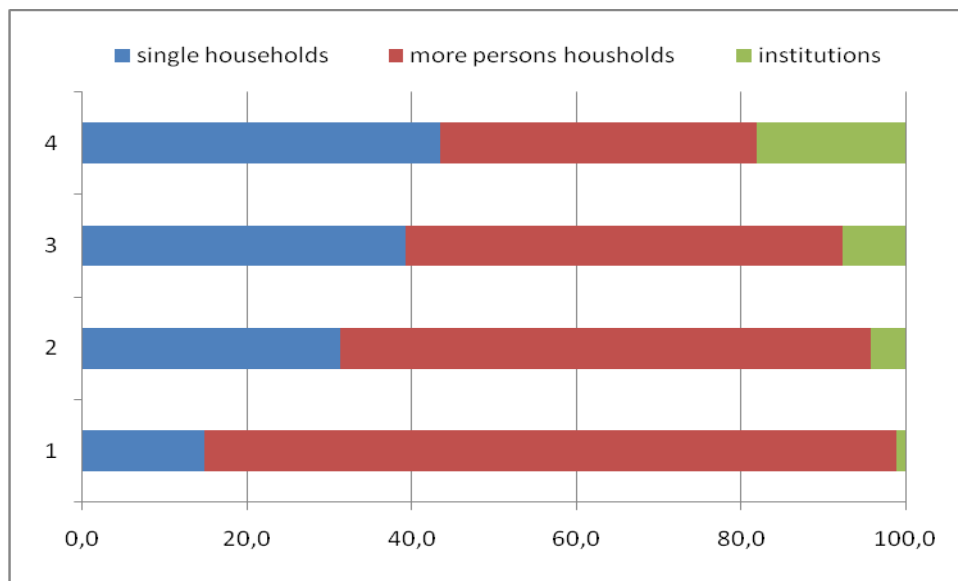


Source: Statistik Austria, IHS HealthEcon calculation.

In Austria 464,315 persons aged 65 or above need help with at least one ADL or one IADL (SHARE-database, wave 2, 2006). As mentioned above in Austria no national definition of “need of care” exists.

The need of care depends also on the living situation of the elderly. Singles are more likely to need help from outside of the household than persons living with a partner. Whereas only 31% of the population 65+ live alone, the respective shares for the population 75+ and 85+ are 39% and 44%. On the other hand, whereas 18% of the 85+ population lives in institutions, the corresponding share of persons 65+ is only 4%. As in particular the number of the oldest old will increase sharply in the near future also the need of care will grow dynamically.

Figure 2: Living arrangements of the elderly in Austria, shares of respective population, 2006



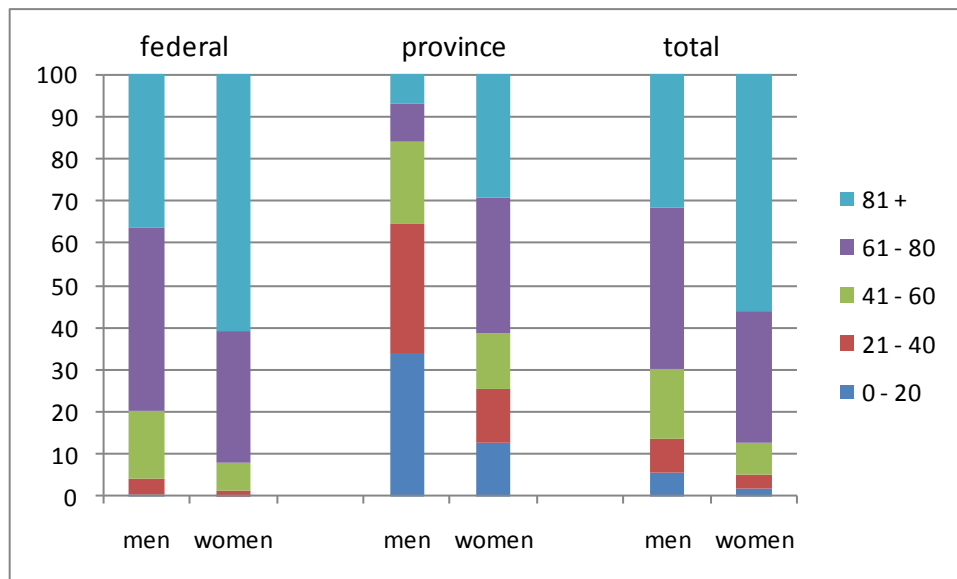
Legend: 1: total population, 2: population 65+, 3: population 75+, 4: population 85+

Source: Statistik Austria, IHS HealthEcon calculation.

In Austria, the hardest data available on need of care are those related to the care allowance. As neither federal nor provincial care allowance are means tested, but distinguish between 7 levels of care, they probably provide the best statistical description of need for care in Austria. It has to be kept in mind, though, that there is a minimum level of care implemented: Care needs below 50 hours of care per month are not covered. Additionally, persons who for whichever reason did not apply for care allowance can obviously not be covered. As the care allowance seems to be generally appreciated and general knowledge about it seems to be high, the latter group might not be very substantial. Please see chapter 3.2, Table 4 for the number of care recipients by level.

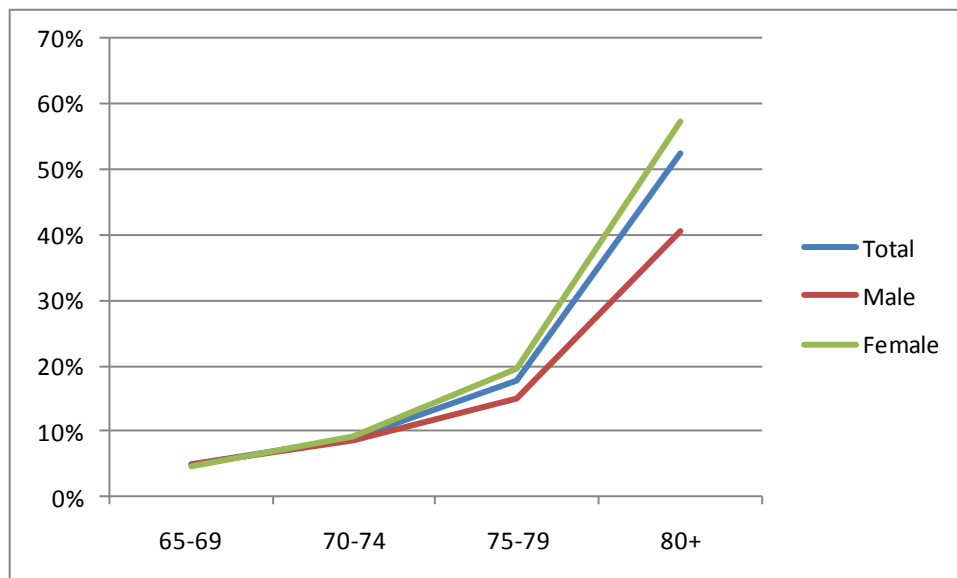
Federal and provincial care allowances co-exist and are applicable to different population groups resulting in a different age structure, see Figure 3. While 80% of all men (92% of all women) receiving federal care allowance are over 60 years old, the comparable shares for provincial care allowance are 16% (men) and 61% (women).

Figure 3: Recipients of federal and provincial care allowance by age and sex, 2007



Source: BMSK 2008b, IHS HealthEcon calculation.

Figure 4: Share of recipients of federal care allowance in total population, by age group, 2007



Source: Hauptverband der Sozialversicherung 2009, IHS HealthEcon calculation.

The likelihood to receive federal care allowance increases dramatically with age. While only roughly 5% of persons in their late sixties receive care allowance, 40 percent of men and 57 percent of women aged 80 and above receive care allowance, see Figure 4.

3.2 The role of informal and formal care in the LTC system

Forward-looking models how to deal with changes induced by the increasing elderly and old population and their also changing needs are not yet very well developed. Service provision is still characterized by the traditional forms “informal care by family members at home” and “formal care in a residential or nursing home”; the continuum of possibilities between those rather extreme forms of care is only sparsely inhabited. Furthermore, a national consensus on what constitutes “adequate” care for elderly persons with care needs has not been developed yet. We are still in the process of developing models and common standards suitable for providing adequate care adjusted to the present society. (Scholta 2008, p. 389).

In spite of the lack of hard data to support this estimate, most study authors agree that in Austria roughly 80% of all elderly in need of care are receiving informal care (Badelt et al. 1997; Nemeth and Pochobradsky 2004; Hörl 2008). In most cases care is provided by family members, mostly women. Obviously, providing care for all persons in need for care would be impossible with providers of formal care alone. While there is an entitlement implemented to receive a care allowance in case of need of care, there is no entitlement to be allocated a place in a nursing home or to receive formal care at home.

Even though this affects only a minority⁷ of persons in need of care directly, the public discussion of recent years, however, was focussed on the provision of care in the private environment with the help of live-in care providers, often from neighbouring countries to the east, on a 24 hours/7 days per week basis. Increased interest in this type of care reflects several facts:

- The unwillingness of care recipients to leave the usual private environment, and/or that of their relatives to have them transferred
- High costs of nursing home places for high levels of need for care
- Increasing need and/or wish that working-age women remain in their jobs rather than give it up to take care of relatives in need. Part of this decision may be the realisation of difficulties at the point of re-entering the labour market, and consequently of financing their own old age care needs.

After implementing a legal basis for this kind of care, public discussions on it more or less ceased.

⁷ There are obviously no exact or official numbers explaining how many persons used or provided this legal-illegal type of care. Estimates put the number of carers between 10,000 and 40,000. For comparison, the number of recipients of at least level VI care allowance in 2006 was roughly 9,400.

The genesis of the current cash benefits in the Austrian LTC system⁸

Until the early 1990s popular perception as well as politicians saw long-term care in Austria mostly as being the responsibility of the family. Policies were highly fragmented, with competences mostly devolved to the provincial administrations. There were three types of public support available for the care of the frail elderly. First, cash benefits were mostly low and restricted to specific groups and circumstances. Second, many municipalities had been providing institutional care, either in residential homes and nursing homes or in mixed institutions. The availability of social services in the municipalities as the third kind of benefits differed substantially between the provinces and the regions and was often limited to nursing care.

Three factors shaped the reform 1993: Representatives of the handicapped were a driving force in the discussions, leading to a policy focused more generally on the social risk of dependency rather than on the elderly alone. Cash provision was strongly advocated as an approach to further the empowerment and autonomy of the recipients and to foster market-driven developments in long-term care. And last not least, three Austrian provinces had introduced new cash benefit schemes which granted cash for care on a needs- and means-tested basis.

The 1993 reform programme consisted of two main parts: Cash benefit legislation, and an agreement between the federal and provincial authorities on responsibilities for long-term care provision. The agreement is still valid and states that the development of services in the institutional, semi-institutional and home based care sectors remain a provincial responsibility, while the federal level is responsible for developing arrangements with regard to social insurance coverage for carers. Even though there were numerous amendments to the relevant laws in the meantime, the 1993 reform has to be seen as the milestone for LTC in Austria, and still very much shapes the whole sector.

The cash benefit program

The core part of the Austrian long-term care system is, as mentioned above, a long term care allowance program at federal and provincial level to provide financial help with institutional care, semi-institutional care and home care (formal and informal). According to §1 of the Federal Long Term Care Allowance Act the aim of the allowance is to contribute to the compensation of care-related additional expenses arising from being in need of care, to ensure adequate care and to improve opportunities for a self-determined and needs oriented life.

⁸ This section is largely based upon da Roit et al. 2007.

The long-term care allowance is designed as a payment to the care recipient and ranges from € 154.20 in level 1 to € 1,655.80 in level 7. In case of institutional care the care allowance is transferred directly to the body in charge of the institutional care facility. This means for most recipients of institutional care that they receive only a monthly personal allowance (pocket money) amounting to € 44.30 per month, while the bulk of their long-term care allowance together with other e.g. pension income is used for financing care.

In 2007, 351,057 persons received federal long-term care allowance and 60,919 persons received provincial long-term care allowance, together representing 4.8% of the Austrian population. About half of those received long-term care allowance according to level 1 and 2. More than two thirds (67.5%) of all recipients are women. Table 4 provides an overview by level of care allowance and sex of recipient. About 85% of the persons receiving federal long-term care allowance were 65 years or older.

Table 4: Persons receiving long-term care allowance, 31.12.2007

| Level of long-term care allowance | Federal long-term care allowance | | | Provincial long-term care allowance | | |
|-----------------------------------|----------------------------------|---------|---------|-------------------------------------|--------|--------|
| | Total | Men | Women | Total | Men | Women |
| I | 76,444 | 21,309 | 55,135 | 12,565 | 3,992 | 8,573 |
| II | 119,086 | 40,458 | 78,628 | 19,426 | 6,320 | 13,106 |
| III | 57,372 | 19,167 | 38,205 | 11,263 | 3,943 | 7,320 |
| IV | 53,942 | 18,324 | 35,618 | 7,730 | 2,731 | 4,999 |
| V | 28,397 | 9,281 | 19,116 | 4,668 | 1,554 | 3,114 |
| VI | 9,732 | 3,443 | 6,289 | 3,295 | 1,509 | 1,786 |
| VII | 6,084 | 1,966 | 4,118 | 1,972 | 800 | 1,172 |
| Sum | 351,057 | 113,948 | 237,109 | 60,919 | 20,849 | 40,070 |

Source: BMSK 2008b.

The Austrian long-term care allowance program covers all persons in need of care. Apart from elderly people, who represent the largest group of beneficiaries, also handicapped children, physically, psychological and mentally handicapped people receive care allowances. As mentioned above, the care allowance scheme is the product of one Federal and nine Provincial Long-Term Care Allowance Acts. The federal level is responsible for care recipients receiving pensions or similar benefits based on federal statutory provisions, whereas the provinces grant allowances, based on standardized principles, to all those to whom the federal level does not apply, like the handicapped or recipients of social assistance. This different responsibility explains the different age structure between recipients on federal and provincial level, see chapter 3.1.

3.3 Demand and supply of informal care

The number of persons receiving informal care according to Mikrozensus 2002 is 464,800; this is roughly 100,000 persons more than the number of receivers of care allowance in the same year, because two additional groups of persons in need of care are included here: Persons who did not apply for care allowance, and persons who do not qualify for care allowance, e.g. because their need for care is estimated to be lower than the required 50 hours per month. ⁹Note, though, that Mikrozensus covers only the non-institutionalized population, while numbers of recipients of care allowance include both settings of care, institutional and home based. According to Mikrozensus, 281,900 women and 144,000 men over 18 years care for one or more persons due to their longer lasting health problems without being fully compensated for this care. 38,900 persons or one of ten persons out of this group care for more than one person, the age group 50-54 is the age group with the highest share of multiple carers. It has to be kept in mind, however, that Mikrozensus 2002 does not ask for the age of the care recipient. The numbers for both, care recipients as well as care providers, are therefore overestimating informal care for the elderly. (Hörl 2008, p. 351)

In 2005, a representative survey was conducted in order to learn about the situation of informal carers (Pochobradsky et al. 2005). A sample of all recipients of LTC care allowances was drawn, and benefit recipients were asked to hand the questionnaire to the main (informal) carer. This approach was necessary because there was and is no data base on informal carers, just one on care allowance recipients. The survey was complemented by interviews with representatives of self-help groups and providers of formal home-care. The main results of this study are broadly comparable to the Mikrozensus 2002 results:

- 79% of responding main carers are female. Mikrozensus additionally shows that there is a tendency towards choosing main carers of the same sex as the care recipient when the main carer is the child of the care recipient, but that women are by far more important carers for parents-in-law and for care recipients who are not family or relatives.
- The average age of carers is 58 years. Also Hörl 2008 emphasises that the majority of the burden of informal care is born by the medium and elder generations, but that a considerable share of care is delivered by persons of 80 years and above.
- 40% of all informal care is delivered by spouses/partners, one quarter by children.
- 30% of all main carers are gainfully employed, 68% not; 56% of all main carers, however, state that they were employed before taking over caring responsibilities. According to Mikrozensus, 43% are employed, 2% unemployed and 55% not or no longer employed. This somewhat higher employment according to Mikrozensus might be related to a lower burden of care in this sample, which is not restricted by a minimum

⁹ We do not know how many of those persons received formal care as well.

amount of care. According to Badelt et al. 1997, 23% of all informal care givers were employed, and 37% of all care givers below 60 years of age.

- 32% of carers have no more than compulsory education, 30% finished apprenticeship programs (*Lehre*), 21% some kind of vocational school (*berufsbildende mittlere Schule*). 7% of carers have a high school degree (*Matura*) while only 4% of carers finished tertiary education.
- 47% of carers have no own monthly income or it is below € 700 (excluding any caring remuneration). One of five carers has no income, 91% of those carers are women.
- 82% of carers pay contributions to the public retirement pension system, which means that income during their own old age is unclear for one of five carers.
- Three of four carers care for persons in need for lower levels of care (level 1-3), one of five carers for recipients of level 4 or 5, and 7% for recipients of level 6 or 7. The latter share doubled since 1997.
- 58% of carers state that only the existence of the care allowance makes care at home possible; the care allowance, however, is not seen as sufficiently high to enable carers to refrain from employment.
- One of three carers sees the necessity to adapt the private apartment to caring needs.
- About one of three carers feels unable to quantify their hours of care. These seem extremely hard to determine if both live in the same house or even household, or if the - often confused - care recipient needs more supervision than (active) care. On average, 20% (5%) of carers spend time with the care recipient of level 1-3 (level 4-7) no more than five times per week, 11% (5%) daily, and 27% (20%) several times per day.
- Almost three of four care recipients are more or less mobile. Almost every second care recipient is confused several times per week, 17% are completely confused.
- If no formal care is received, 48% of respondents see a general adversity to formal care and 42% financial reasons as cause. In rural areas there is additionally the problem of low supply. In one of four cases informal care is complemented by formal home based care services. Home nursing care (47%), home care (39%) and meals on wheels (30%) are the most frequent types of formal services.
- Formal care is significantly more used by persons with own income, by carers with full-time jobs, and by carers with higher education levels compared to persons without income, full-time employment, or lower education, respectively.
- Not surprisingly, formal care is more intensively used to complement informal care in case of higher levels of care. On average, 5 hours home care and 9 hours home nursing per week are used.
- In cases of the usual informal carer's absence, 83% have provided for a replacement for acute incidents, and 71% for planned absences.

- About 70% of informal carers feel the burden of caring to be sometimes or even most of the time as too high. Responsibility, hopelessness, and feeling overtaxed are seen as the most important psychic stress factors.

Meanwhile, policy has taken care of some of the desired improvements for the situation of informal carers: Better accessibility of information on legal and medical matters of care, a telephone hotline, at least a moderate increase in the monetary value of the care allowance, increased additional supply like formal home based care services, short-time care, day care and night care (see chapter 4.3).

3.4 Demand and supply of formal care

Introduction

The *Article 15a agreement 1993* states that provinces are responsible to provide a minimum standard of institutional, semi-institutional, and home based care services; services have to be provided in all geographical parts of the country. This agreement contains a basic framework, while most details have to be regulated on the provincial level and differ accordingly. Therefore in reality we find a broad variation between and within provinces, regarding availability and quality of services. This regional diversity is found in both settings of formal care, institutional and home based care.

Institutional care

Better living standards and increased capacity of formal home based services improved the abilities of elderly persons to cover their care needs in their private environment. This has resulted in higher levels of both, average age and care needs, when entering into institutional care. Scholta 2008 (p. 391) provides the average entry age into institutional care for two provinces in 2005. In Carinthia, the average entrant was 74.2 years old, in Upper Austria 81.4 years, while the average age of home residents was only slightly higher: 74.8 years in Carinthia and 82.9 years in Upper Austria.

Roughly 66,000 persons in Austria receive institutional care, see Table 5. During the last 6 years, the number of recipients increased by 13,6%, but not homogeneously over the whole country. Some but not all provinces reported a shortage of places for nursing care. Regional differences in this respect have to be seen not only in the context of different capacities, but also of different financing rules: As a general rule, provinces with more severe *Regress* regulation and practice did not experience waiting times for nursing home places. Experience after the recent drop of *Regress* shows that in some provinces existing capacities are no more sufficient. Note the pronounced recent increase of recipients in provinces that abolished *Regress* from children, like Carinthia and Vorarlberg.

Table 5: Recipients of institutional care as per 31.12. (residential and nursing homes)

| Province | 2000 | 2005 | 2007 | % change 2000-2005 | % change 2000-2007 |
|----------------|---------------|---------------|---------------|-----------------------|-----------------------|
| Burgenland | 1,297 | 1,554 | 1,696 | 19.8 | 30.8 |
| Carinthia | 2,761 | 3,785 | 3,402 | 37.1 | 23.2 |
| Lower Austria | 9,589 | 10,468 | 10,712 | 9.2 | 11.7 |
| Upper Austria | 11,219 | 11,285 | 11,601 | 0.6 | 3.4 |
| Salzburg | 2,501 | 3,199 | 3,406 | 27.9 | 36.2 |
| Styria | 6,000* | 8,720 | 9,250** | 45.3 | 54.2 |
| Tyrol | 4,800 | 4,873 | 5,015** | 1.5 | 4.5 |
| Vorarlberg | 2,271 | 2,932 | 3,726 | 29.1 | 64.1 |
| Vienna | 17,653 | 19,316 | 17,165 | 9.4 | -2.8 |
| Austria | 58,091 | 66,132 | 65,973 | 13.8 | 13.6 |

Notes: * no data available before 2005. Biwald et al. assume 6000 for 2000.

** 2006

Source: Biwald et al. 2007; BMSK 2008b.

In 2006, slightly more than half of all institutional places were provided by public facilities, 40% by other private institutions and 8% by facilities run by religious organizations, see Table 6. In addition to nursing and personal care, most for-profit facilities provide also a range of hotel-services. Many of those facilities are focussing on care recipients with higher income; and those homes (“Seniorenresidenzen”) are often not eligible for social assistance co-funding (Schneider et al. 2006, p.8). Usually, there are no special eligibility requirements for places in Seniorenresidenzen, provided one can afford it. Provincial legislation regarding institutional care was successively extended from public homes to private homes, the effects of which have been varying by province: In some provinces the supply of private homes went down or is even supposed to disappear by 2010 (Carinthia), in other provinces rather quality than quantity of private homes was adjusted (Lower Austria) (Scholta 2008, p. 398).

Even though there is a distinction between residential homes and nursing homes, nursing care can be provided in both settings: Some residential homes have a defined number of places for care recipients with nursing care needs. In 2006, roughly half of all places were in nursing homes, but more than half of all places in residential facilities were also equipped for providing nursing care. Thus, nursing care is provided at almost 80% of all places, with a higher share in public and religious facilities.

Table 6: Capacity in institutional care by type of owner, 2006

| | Facilities | Residential homes | | Nursing homes | Total places | Share nursing care |
|--|------------|-------------------------|---------------------|---------------|--------------|--------------------|
| | | residential care places | nursing care places | | | |
| Public facilities | 399 | 3,117 | 11,672 | 21,335 | 36,124 | 91.4 |
| Private facilities | 307 | 10,466 | 5,683 | 12,229 | 28,378 | 63.1 |
| Facilities run by religious organizations | 67 | 663 | 2,562 | 2,380 | 5,605 | 88.2 |
| All facilities | 773 | 1,4246 | 19,917 | 35,944 | 70,107 | 79.7 |
| Share public | 51.6 | 21.9 | 58.6 | 59.4 | 51.5 | |
| Share private | 39.7 | 73.5 | 28.5 | 34.0 | 40.5 | |
| Share religious | 8.7 | 4.7 | 12.9 | 6.6 | 8.0 | |

Source: BMSK 2009, IHS HealthEcon calculations.

The share of residential places for persons without or with only very limited (below level 3) care needs is decreasing, as most home owners are re-structuring their homes to provide nursing care. In 1999, 44% of all institutional places were residential, in 2004 only 8%. According to public planning for LTC (see chapter 4 on policy goals), the residential share will drop further. This corresponds to the often felt desire to stay in the private surrounding as long as possible, and to transfer to a home only in case of nursing care needs which cannot be properly cared for in the private environment. Purely residential needs are increasingly covered by **supported living** (*betreute Wohnungen*) (Scholta 2008, p. 400). When comparing with Table 6 above note that the definition of “institutional place” can vary, depending on whether all institutions or only those under contract with social assistance are covered, whether only institutions are included which do require authorization, or whether places in specialized hospitals are included, etc.

There is no national database on employment in long-term care or in institutional care. Regional databases exist or are in the process of being developed, but as a rule are not comparable. Most provinces define different minimum standards regarding adequate staffing per place, while some provinces simply state that “adequate” staffing has to be provided. Applying provincial minimum standards, a model calculation resulted in values from 1 FTE per 4.5 residents to 1 FTE per 1.9 residents. Obviously, minimum standards can be exceeded. A calculation of actual employees (FTE) per place results in values from 1:1.62 to 1:3.39. As this calculation does not correct for differences in the level of need, differences in staffing ratios cannot directly be interpreted as differences in quality or efficiency of service provision. Furthermore, those calculations refer to social workers and nurses only, while we do not know how many additional employees provide other services, from simple assistance over cooking and administration to therapies (Scholta 2008, p. 402).

Not all provinces require minimum shares of different groups of employees. The required share of registered nurses varies from 20% to 50% (but the latter refers to more severe care needs only) (Scholta 2008, p. 402).

Home based care

In Austria, home based care is provided mostly by supraregional organizations like Caritas Österreich, Diakonisches Werk Österreich, Österreichisches Hilfswerk, Österreichisches Rotes Kreuz, and Volkshilfe Österreich. In Vorarlberg local *Krankenpflegevereine* and in Tyrol *Gesundheits- und Sozialsprengel* are the main providers of home based care (see also chapter 4 on Integration of care). In addition to that, there are small providers of care who work in the local area.

In 2002/2003, about 80,000 persons received formal home based care in Austria. On average, 13% of the 75+ population or 23% of all recipients of LTC care allowances received formal home based care. There is much variation between provinces: In Vorarlberg, 49% of the population 75+ or 92% of all recipients of care allowances used formal home based services, in Tyrol and Upper Austria the respective shares are almost 20% and roughly a third. (Rappold et al. 2008, p. 374f).

On average, almost nine hours of care were used per person in age group 65+, and 18 hours per person in age group 75+, see Table 7. Again, there is wide variation between provinces, with 30 hours of care per person 75+ in Vienna and less than 10 hours in Styria and Upper Austria.

Table 7: Hours of formal home based care, 2001-2003, Austria (without Vorarlberg)

| | All home based care | Home care | Home nursing care |
|---------------------------|---------------------|-----------|-------------------|
| Hours/person and year | 1.37 | 0.85 | 0.52 |
| Hours/person 65+ and year | 8.8 | 5.4 | 3.3 |
| Hours/person 75+ and year | 18.3 | 11.3 | 7.0 |

Source: Rappold et al. 2008.

Use of home based care (HBC) is related to the level of need, which in Austria usually is described by care allowance levels. 29% of level 7 recipients use HBC between several times per week and daily, and about a quarter use them several times per day. At level 3 17% of recipients use HBC between several times per week and daily, and 4% several times per day. Two out of three recipients of care allowance level 3-6, however, do not use any formal home based care (Rappold et al. 2008, p. 375 citing ÖBIG 2004).

Supply of formal home based care is subject to considerable change in Austria. This development has to be seen in the context of the general goal to favor home based care over institutional care, see chapter 4 on policy issues. We find an increase of supply: Between 2000 and 2007, the number of service hours increased on average by 23%, see Table 8. The table highlights the heterogeneous development in several Austrian provinces: While service hours more than doubled in provinces like Carinthia, Tyrol, or Vorarlberg, there is even a decrease in one province, Salzburg, caused by changes in the fee schedule.

The table emphasises also data limitations: In most provinces it is not possible to statistically disentangle information for help for families, help for the elderly and other kinds of support. Therefore, those data have to be seen as an overestimation of home based care for the elderly. (Biwald et al. 2007; BMSK 2008b)

Table 8: Hours of formal home based care

| Province | Services | 2000 | 2007 | Change – h 2000-2007 | Change % 2000-2007 |
|-----------------------|-------------------|------------|------------|-------------------------|-----------------------|
| Burgenland | HH, HK | 204,484 | 271,480 | 66,996 | 32.8% |
| Carinthia | HH, HK, FH, DH | 540,860 | 799,130 | 258,270 | 47.8% |
| Lower Austria | HH, HK, AH | 2,838,208 | 3,411,904 | 573,696 | 20.2% |
| Upper Austria | HK, FH, MH | 794,002 | 1,322,010 | 528,008 | 66.5% |
| Salzburg | HH, HK | 805,454 | 661,059 | -144,395 | -17.9% |
| Styria | HH, HK, AH | 857,435 | 858,604* | 1,169 | 0.1% |
| Tyrol | HH, HK, AH | 298,776 | 565,332 | 266,556 | 89.2% |
| Vorarlberg | HH | 235,443 | 426,243 | 190,800 | 81.0% |
| Vienna | HH, HK | 4,017,591 | 4,669,386 | 651,795 | 16.2% |
| Austria -total | | 10,592,253 | 12,985,148 | 2,392,895 | 22.6% |

Notes: HH = Home care, HK = Home nursing care, FH = Family help, AH = help for elderly, DH = “village help”, MH = mobile helpers; * Data from 2005

Source: Biwald et al. 2007; BMSK 2008b.

Semi-institutional care

Differences between provinces are even more prominent with regard to semi-institutional services; the last official summary report on care services (BMSK 2008b) does not mention any semi-institutionalized services for three provinces. Many of the existing facilities are more concentrated on handicapped rather than on elderly persons. Where data for institutions for the elderly are available, they report a significant increase of services.

There are already several forms of services implemented, but not all of them in every province (see Scholta 2008, pp. 407):

- **Day / Night care:** Day care centers are available in general only in urban areas, as transport and low demand would result in severe financial strains for recipients in rural areas. There exist specialized services for dementia patients. Some centers for supported living offer to accept additional persons for day care; it seems that this is an acceptable solution for everybody involved. Some institutions offer the possibility to spend the night in the institution but the day in the private apartment, because some seniors feel safer that way. There are no national statistics on day or night care.
- In most if not all provinces, there has been capacity for **short-term institutional care** in order to allow informal carers some time off-duty or to allow patients a short time of professional care after more severe illness or acute care. Some provinces have special places earmarked for short-term care, some use otherwise vacant long-term care beds. As vacant beds were increasingly filled when *Regress* from children was abolished, it remains to be seen whether additional earmarked capacities become necessary. There are no national statistics on short-term care.
- As residential homes are increasingly replaced by nursing homes, **supported living** is increasingly covering the respective need. All provinces have this kind of service. The goal is to enable more or less independent life in their own apartments for the elderly, and to reduce or postpone the necessity of transfers to institutional care.¹⁰ Existing apartments are adapted or new barrier-free apartments are erected, often close to and in combination with residential or nursing homes. A contact person is available for predefined hours, home care and home nursing care can be provided if desired. Two provinces have included this form of care in their BEP (*Bedarfs- und Entwicklungsplan*), in other provinces such apartments are erected as part of general housing plans or supported with special funds.

¹⁰ In Upper Austria, of 229 such apartments which were already rented for the second time, the cause for the vacancy was death of the first inhabitant in 69% of all cases.

4 LTC policy

4.1 Policy goals

Neither the Austrian constitution nor the current or the last government has enacted official goals of national Austrian social policy. There is also no strong tradition in stating health policy goals. There are no detailed and quantifiable national health policy goals, apart from the obvious intention to provide all necessary health care in a high-quality and financially sustainable way, as stated in ASVG (*Allgemeines Sozialversicherungsgesetz*, the main law governing health care, retirement and disability pension, and unemployment benefits for roughly 80% of the population) and similar laws. There are health policy goals in only roughly half of the nine Austrian provinces. One province (Lower Austria) mentions geriatric care / hospice care among the health policy goals, while other countries' health policy goals lack even this peripheral aspect of long-term care (Spitzbart 2006). Also 10 health policy goals formulated by social health insurance do not mention specific long-term care aspects; those goals are, however, not binding and mostly intended for internal use and orientation (Spitzbart 2006).

The *Bedarfs- und Entwicklungspläne* (demand and development plans, BEP), which have to be elaborated in each of the nine provinces since the *Article 15a agreement of 1993*, come closest to goals in long-term care policy but are rather means of capacity planning than policy goals per se. Even though provinces are responsible for the provision of long-term care, all provinces are required to follow the same principles and broad goals of care. BEP have to include inter alia a comprehensive quantification of capacity shortages in institutional care, semi-institutional care and home based care including geographical aspects. Provinces were required to prepare the first BEP in 1996 and most provinces succeeded in doing so by 1998. Furthermore, the agreement states that identified shortages have to be consistently reduced by a third until 2000, 2005 and 2010, respectively (see 15a agreement, Annex B, 6. and 9). BEP are typically evaluated by the social departments of the respective province government, with (e.g., Burgenland, Lower Austria) or without support from academic institutions and not necessarily publishing results. Furthermore, a MoH affiliated institution (ÖBIG) carried out a mid-term survey taking stock of the extension of social services. It confirmed a considerable extension of institutional and home based services. Goals for formal home based care in Austria are only broadly defined: Increase number of staff, increase qualification of staff, quality assurance. Concrete targets developed by provinces differ much in the degree of detail and the definition of "adequate" staffing levels. On average, the staffing levels in home based care have risen by about 50% from 1995 to 2002, then reaching 13.4 FTE per 1,000 inhabitants aged 75+ which is already close to its target for 2010 of 13.6 FTE. Note, though, that some provinces like Vienna restrain from defining target values and Austrian averages therefore cannot cover truly the whole country. A general trend towards better qualified staff can be observed. Different definitions of "adequate" care in provinces results e.g. in high variation of staff ratios between provinces.

There are two clusters regarding provision of home care: In Lower Austria, Salzburg, Vienna and Vorarlberg the number of staff (FTE) in home care and home nursing care (together) is about double of the respective number in other provinces. Note, though, that three provinces did not specify targets and targets for the remaining provinces vary considerably between 20.0 FTE/1,000 inhabitants 75+ in Tyrol to 9.6 in Upper Austria (ÖBIG 2004, Tab. 2.3).

Regarding institutional care there is no such clear regional divide. In 2002 the availability of places in care institutions had risen to 116 per 1,000 inhabitants aged 75+, by 2010 it is assumed to drop again to 94.5 places per 1,000 inhabitants aged 75+. Original targets for institutional care have already been exceeded in some provinces, but note that targets have to be and are being revised, e.g. due to new population statistics like the 2001 census results (which suggest that population ageing progresses more rapidly than anticipated before). For updated target values for 2010 see Table 9 below. Note that several provinces (Lower Austria, Upper Austria, Vienna) aim at reducing the number of “purely residential” home places to nil, i.e. all places offered then should be linked to needs for nursing care.

Table 9: Number of places in institutional care, development and target values according to BEP

| Development between 1995/96/97 and 2002 (increase / decrease of places) | | | | | | |
|---|-----------------------|--------------|-------------------|--------------|--------|--------------|
| | residential home care | | nursing home care | | total | |
| | places | index | places | index | places | index |
| Burgenland | | | | | 109 | 107.9 |
| Carinthia | -259 | 79.1 | 162 | 107.1 | -97 | 97.2 |
| Lower Austria | -2,897 | 31.4 | 3,966 | 172.2 | 1,069 | 111.0 |
| Upper Austria | | | | | 863 | 108.0 |
| Salzburg | -1,668 | 34.7 | 2,352 | 237.7 | 684 | 116.0 |
| Styria | -2,506 | 0 | 4,002 | 178.7 | 1,496 | 119.7 |
| Tyrol | 544 | 178.3 | -126 | 96.5 | 418 | 109.6 |
| Vorarlberg | -904 | 32.1 | 693 | 182.4 | -211 | 90.3 |
| Vienna | -871 | 92 | -648 | 93.8 | -1,519 | 92.8 |
| Austria (excl. Burgenland, Upper Austria) | -8,561 | 63.1 | 10,401 | 135.3 | 2,812 | 104.3 |
| Updated target values 2010 | | | | | | |
| | residential home care | | nursing home care | | total | |
| | places | per 1000 75+ | places | per 1000 75+ | places | per 1000 75+ |
| Burgenland | | | 2,223 | 83.4 | 2,223 | 83.4 |
| Carinthia | 1,211 | 25.5 | 3,159 | 66.5 | 4,370 | 92.0 |
| Lower Austria | 0 | 0 | 8,310 | 61.8 | 8,310 | 71.6 |
| Upper Austria | 0 | 0 | 14,042 | 124.8 | 14,042 | 124.8 |
| Salzburg | - | - | - | - | - | - |
| Styria | - | - | - | - | - | - |
| Tyrol | 1,862 | 37.9 | 4,397 | 89.5 | 6,259 | 127.4 |
| Vorarlberg | 0 | 0 | 2,148 | 86.7 | 2,148 | 86.7 |
| Vienna | - | - | - | - | - | - |
| Austria | 3,073 | 4.9 | 34,279 | 86.8 | 37,352 | 94.5 |

Note: that past numbers for Burgenland and Upper Austria do not allow breakdown into residential vs. nursing homes; as most places in Burgenland are nursing home places, values for 2010 count all places as nursing home places. Further note that not all provinces state target values explicitly.

Source: ÖBIG 2004.

4.2 Integration policy

The *15a agreement 1993* states that services in all settings of care (institutional, semi-institutional, home based) are to be provided in a coordinated way. The existence of facilities for coordination and cooperation between services are inter alia mentioned as minimum requirements for service provision. While all provinces mentioned necessary improvements in this respect in their BEP, provinces pursue different strategies (ÖBIG 2004, chapter 7):

- Whether institutions specialized and focussing on coordination are deemed necessary,
- Whether such institutions provide care (Tyrol, Upper Austria, Vienna, Vorarlberg) or only coordination of care,
- In geographic approach: should all the province be covered or only some focus areas,
- In legal background, which can be based on provincial laws or a different base.

Those differences can be seen as a response to differences in structure and quantity of provided services as well as in different urban/rural situations. Most institutions provide additionally information and counselling for the population. Seven of nine provinces rely on “*Sozial- und Gesundheitssprengel*” (Integrated health and social care districts¹¹) as main institutions for coordination, albeit following quite heterogeneous models. In some provinces, *Sprengel* had to be built from scratch (Burgenland, Styria) while in others (Carinthia, Lower Austria, Tyrol, Vorarlberg; in Upper Austria there existed local projects) they were already in existence but were to be upgraded and improved. Building upon a theoretical concept developed by ÖBIG (see Grilz-Wolf et al. 2003), *Sprengel* should be regional organizations for co-ordination and co-operation of health and social care organizations within a defined geographical area of 10,000 to 20,000 inhabitants, with the concrete work being guided by the regional situation. *Sprengel* are to analyse the existing provisions, to guarantee the existence of health and social care organizations and to act as partners for the patients and their families by helping them find the organizations to meet their specific needs.

Grilz-Wolf et al. 2003 see case management as the main area of integrated care in Austria and find other concepts of integrated care and the idea of integrated care itself of subordinate interest and use in Austria. They only exist in connection with case management, often lacking explicit definitions. Case management carried out by social health insurance concentrates mainly on discharge management after acute care in hospitals and thus is only partly relevant for LTC questions. Two regional and two occupational social health insurers have already implemented some area-wide case management, while most other social health insurers are still in the process of further developing their plans (Czypionka et al. 2008, Table 1). In the 2004 report, ÖBIG mentions that two provinces (Burgenland, Upper Austria) explicitly intend to develop case management in order to improve coordination of long-term care.

¹¹ In the following short *Sprengel*.

4.3 Recent reforms and the current policy debate

In a publication to celebrate the 15th anniversary of the introduction of the LTC allowance, a brochure published by the relevant ministry summarises the milestones in Austrian LTC legislation as follows (BMSK 2008a):

Table 10: Legal milestones for LTC provision in Austria since 1993

| | |
|------------|---|
| 01.07.1993 | Federal and nine provincial LTC allowance acts take effect |
| 01.01.1994 | Federal and provincial governments sign an agreement upon joint measures to develop and extend decentralized social services in all parts of Austria LTC allowance is raised by 2.5% |
| 01.01.1995 | LTC allowance is raised by 2.8% |
| 01.01.1998 | The ministry of social affairs introduces a free-of-charge care hotline (Pflegetelefon) |
| 01.01.1999 | The needs requirement for level 4 care is reduced from 180 to 160 needed care hours per month |
| 01.07.2001 | The (lower) age limit for eligibility for LTC allowance is abolished. |
| 01.07.2002 | Introduction of a family hospice leave system (Familienhospizkarenz), i.e. a possibility for informal carers to take a job leave, job change or change working hours in order to care for terminally ill close relatives or most severely sick children |
| 01.01.2004 | Introduction of a temporary limited financial support for informal care givers, earmarked to finance respite care (Ersatzpflege) |
| 01.07.2004 | Institutional home act to clarify and improve the legal situation of inhabitants in residential and nursing homes (Heimvertragsgesetz) |
| 01.01.2005 | LTC allowance is raised by 2% |
| 01.07.2005 | Institutional home stay act to improve personal freedom of inhabitants in residential, nursing and some other kinds of homes (Heimaufenthaltsgesetz) |
| 26.07.2005 | Agreement between federal and provincial governments on social care workers takes effect, introducing uniform education standards and job descriptions for those workers in all provinces for the first time |
| 01.01.2006 | Informal care givers can receive financial support for contributions in retirement plans (Sozialversicherungs-Änderungsgesetz 2005) |
| 18.03.2006 | Amendment to Familienhospizkarenz to further support relatives providing care |
| 01.07.2007 | Changes in industrial code and implementation of a new home care act provide a legal background for 24-hours-care at home, a new care allowance model provides support for care recipients to finance this type of care; |

| | |
|------------|--|
| | support for retirement plans of informal carers is extended |
| 01.11.2008 | The care allowance for (legal) 24-hours-carers is raised by up to 100%, the respective means testing based upon assets is abolished |
| 31.12.2008 | In course of the year 2008 three provinces abolished the regress possibility for spouse and the last provinces abolished it for children and grandchildren. |
| 01.01.2009 | The up to now most substantial amendment to the LTC-allowance act comprises a raise of the allowance by 4-6%, improved eligibility criteria for some levels of care and further extensions of support for informal carers. |

Source: adapted from BMSK 2008a.

The most recent reform efforts concentrated on the situation of informal care givers and a legal background for 24-hours-care. In 2007 the Federal Ministry for Social Affairs and Consumer Protection created a working group to re-design and further develop LTC provision so as to ensure affordable care and assistance. The group is composed of representatives of the federal government, the provinces, the social partners and stakeholders. It is to develop solutions that are most satisfactory for the persons concerned and cover all fields of the Austrian LTC system. The most urgent problem was seen to be a legislative and financial solution for 24-hours home care. As a result, the Act on Home Care (*Hausbetreuungsgesetz*), which entered into effect on 1 July 2007, and an amendment to the Industrial Code create a basis under labour and trade law for legal and contract-based 24-hour care in private households. Both options, employment or self-employment of care providers, are possible. For detailed requirements on the contracts see BMSK 2007.

In the past, repeatedly concerns on the quality of nursing in informal home care were voiced. On the other hand, several studies reveal need of informal care givers for more or better information and counselling (e.g., Ostermeyer, Biringer 2003, Nemeth, Pochobradsky 2004). In October 2004, a pilot project was started to address both concerns: Registered nurses visit selected recipients of informal care to check on quality of care and offer information. During the first years, 63% of recipients were rated as in "very good", 35% in "good" condition. In most cases, requests for information could be sufficiently answered by the visiting nurse. Following positive evaluation results of the pilot, the nurse visits for selected cases were included into the list of public services. In 2008, 17,000 visits were conducted.

In August 2008, a number of measures increasing the financial means for LTC were enacted: The care allowance, whose level had been repeatedly criticised because it had been stagnating rather than keeping up with inflation, was raised (+4% for level 1 and 2, +5% for level 3,4, and 5, +6% for level 6 and 7). The classification of dementia patients (and that of severely handicapped minors) was upgraded. The subsidy for 24-hours-care was raised and the means-testing with regard to assets abolished.

Another aim of the Austrian long-term care provision system is a stronger position of relatives providing care. Over the last years, the following measures were taken (BMSK 2007, p. 69):

- Preferential terms of self-insurance and continued insurance under the pension insurance scheme for those who had to give up their job in order to take care of a close relative entitled to LTC allowance of level 3 or above,
- Reduction by half of the employee's contribution in the context of preferential self-insurance or continued insurance under the pension insurance scheme if LTC allowance level 4 or higher is received, or non-contributory insurance starting from LTC allowance level 5; since 2009, there is the possibility that the public covers the complete contribution,
- Supporting measures under the family hospice leave system (advance payments, modified pay-out procedure),
- Support for informal care givers who are unable to provide care due to illness, holiday or other material reasons,
- The "Pflegetelefon" care hotline offering counselling for informal care givers,
- The "Handynet-Österreich" database (an Internet-based information pool on technical aids),
- A platform for informal care givers (for the exchange of information and experience).

4.4 Critical appraisal of the LTC system

The most important and influential feature of LTC provision in Austria is the LTC allowance. The introduction of this cash benefit in 1993 aimed at providing LTC patients with the possibility to choose between settings of care, most notably between moving to a specialized facility and remaining in one's own home and receiving all necessary care there, be it provided by professionals or by family members or other relations. Recognizing the importance of the care allowance to finance this choice, we have to state that fulfilment of this objective has been severely deteriorating due to only very infrequent adjustments of the monetary value of the allowance; see Table 10 on reform activity above. During 1997-2007 the overall price level increased by 18%, and net median wages of women by 21%. Average expenditure for federal care allowance per year and beneficiary, however, increased only by 2.4%. Thus, the average number of care hours a beneficiary could buy with the allowance dropped considerably during this time. This shortcoming is mostly due to infrequent raises of the monetary value of the care allowance in the past. The current government is aware of this problem and pushed through the first raise for several years which took effect in January 2009.

Another frequent criticism relates to lack of transparency regarding various aspects. On the macro level, it is very hard to grasp the true costs of or the expenditure for long-term care in

Austria due to a highly fragmented system, relying on nine differing provincial legislations plus several municipal ways of naming, handling and financing respective services. The lack of transparency on the national level continues with basic supply data. Even though some provinces are already collecting structural data in order to compare and project services, other provinces are still in the process of doing so. The working group for provision of care (*Arbeitskreis für Pflegevorsorge*) collects national data on care on a yearly basis; an extension of this very limited data base with comparable and more detailed data for all provinces would be desirable to improve forward-looking capacity planning and steering. This, however, would require the development of a new tool for their yearly data collection. (Scholta 2008, p.410)

On the micro level, the published aim to support informal care givers wherever possible is in some provinces sharply contradicted by a complete lack of transparency over eligibility criteria for several services provided via the welfare system. For instance there is no unique and public definition what constitutes a social hardship, and consequently there is no reliable information what constitutes eligibility for certain welfare services. It is hard to explain why municipalities have freedom to decide which circumstances are to be seen as a social hardship, even though we see that not all cases and possibilities can be dealt with prospectively in a systematic way (and ultimately, we do not assume that an exhaustive list can be the optimal solution). But there are areas where a consistent, transparent and also publishable guideline could be formulated and would improve consumer orientation. Such an area with possible but still lacking public and countrywide common guidelines is regress from spouses of nursing home inhabitants.

Demographic developments make a future increase in care activities inevitable and labour market and pension law developments make an increase in formal care very likely. There is consensus in Austrian academia that the likely future developments will require increased levels of professional training, quantitatively but also qualitatively. In Austria, nursing care as an academic field of education has a history reaching back no more than several years, and consequently there are not yet many academically trained nurses integrated into the “everyday business”. In addition to four Austrian universities that offer programs in nursing science, there are several universities and universities of applied sciences offering programs related to nursing. Nevertheless, Rappold et al. 2008 (p.380) criticize that a sustainable professionalization of nursing needs academization. This is deemed necessary not only to cover needs, but also to avoid lagging behind too much when comparing with other European states. Rappold et al. 2008 (p.380) criticize further that education plans for nursing still are focussing too much on hospital care, there is no sufficient focus on geriatric care and geriatric care in the family environment. However, they report the introduction of one program for Family Health Nurses following the respective WHO concept in fall 2007. Curricula should be broadened to put more emphasis on communication and counselling skills instead of concentrating solely on reducing bodily harms.

Also education plans for other jobs in care for the elderly are currently under reconstruction. New programs were recently introduced (two year programs for *Sozialfachbetreuungsberufe*, three year programs for *Sozialfachbetreuungsberufe* with diploma); it is still too early to forecast their impact on overall provision of care.

Rappolt et al. 2008 raise the issue that planning does not yet sufficiently take special needs of several groups of persons into account. This issue is raised for persons with need for around-the-clock supervision like dementia patients, but also for migrants, who in general have not yet entered into the critical age and their special needs due to cultural or linguistic differences are therefore not yet sufficiently realized.

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Titel: **The Austrian long-term care system**

Final Report

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