Peer Review on "Germany's latest reforms of the long-term care system"

11 – 12 January 2018, Berlin (Germany)

Bypassing or catching up on Austrian standards?

Peer Country Comments Paper - Austria

DG Employment, Social Affairs and Inclusion

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1 Background to long-term care in the peer country

1.1 Overall organisation of long-term care

In Austria, long-term care (LTC) is formally not part of the social insurance system, public provisions for LTC are completely tax-funded. Thus, LTC is strictly separated from health care, whose organization and funding are dominated by social health insurers. Furthermore, there is a strict separation in responsibility between benefits in cash (federal government) and benefits in kind (nine *Länder*) in the LTC system. Therefore, regarding the organization of benefits in kind, there are nine different systems across the country. While persons in need of care have a legal right to receive *Pflegegeld*, the main cash benefit, no such right has been implemented for services in kind. Persons in need of care are expected to finance their care needs on their own, supported by *Pflegegeld*. If a person's income (including *Pflegegeld*) does not suffice to pay for nursing home care, social welfare steps in and covers the gap. The presumably largest reform of the *Pflegegeld* was the transfer of the *Länder*-administered *Pflegegeld* for certain population groups also into the responsibility of the federal government in 2012.

1.2 Definition and assessment of individual care needs

The main pillar of the Austrian LTC system is the *Pflegegeld*, which is granted in cases of care need unconditional of income, age and reason of care need, given the care need is assumed to last for at least six months. Since its introduction in 1993, seven levels of care need are defined by law, based on a carer's estimated time needed for care. Also the monetary value for each care level is defined by law, ranging from EUR 157,30 for at least 65 hours of care needed per month to EUR 1.688,90 for at least 180 care hours, given the care recipient is unable to move her/his arms and legs in a controlled manner. *Einstufungsverordnung zum Bundespflegegeldgesetz* (EinstV, national ordinance for assessing the care level) defines what is to be understood by help, support, regular need etc. and defines guidelines on how many minutes should be allocated for which support. For example, 1h/day to prepare food, 1h/day to help with eating, 2x20 min/day for (un)dressing. The definitions do not relate to an internationally used standard instrument such as ADL or iADL; national definitions are provided in EinstV. Types of support that are considered focus mostly on deficiencies in bodily functions and do not consider time for mobilisation or rehabilitation. Moreover, allocated times are completely carer- and setting-blind.

Since 2009, severe mental or psychic disabilities are explicitly mentioned as a reason for a mark-up in the calculation of care needs in order to respect the extended care needs (e.g. additional 25 care hours for dementia, but it has to be kept in mind that an additional 40 hours of care needs are required to qualify for the lowest care level). (§4(5) *Bundespflegegeldgesetz* – Act on the national care allowance)

1.3 Strengthen care at home and in the community

There are certain federal and *Länder* measures, aiming at supporting family carers and facilitating care at home. Among federal measures are different kinds of leave arrangements. In addition to an employee's right on short-time leave which is applicable to all kinds of care obligations (*Pflegefreistellung, Dienstverhinderung*), *Pflegekarenz* was introduced in 2014 as leave which needs an arrangement between employer and employee. If granted, it can last up to three or even six months, can be arranged for full-time or part-time leave and reduced hours are compensated by public funds, similar like unemployment benefits. At the same time, a compensation was introduced for persons caring for relatives during their last months of life (up to 6 months for adults; up to 9 months for children, also in case of severe not life-threatening illness; *Familienhospizkarenz*). During these kinds of *Karenz* carers are fully covered in pension and health insurance. Furthermore, there are subsidies for

enabling family carers to hand their caring obligation over for a short period of time, no matter whether for work, own illness or for a holiday.

Offering counselling and advice on care matters is in the responsibility of the municipalities. Some *Länder* delegate provision and counselling to – mostly non-profit – organizations. Many cases on LTC need start after acute care in hospital, but hospitals vary very much in their efforts to assist in arranging post-acute care or even LTC.

Since 2001, the program *Qualitätssicherung in der häuslichen Pflege* (QSPG, ensuring quality care at home) offers voluntary and cost-free home visits by registered nurses to consult in all matters (financial information as well as nursing and medical advice) regarding long-term care to recipients of *Pflegegeld*. There are about 20 000 such visits per year, plus another 11 000 for recipients of so-called 24-h-care.

Since 2015, beneficiaries can ask for a voluntary and cost-free QSPG session in order to discuss care matters. In addition, informal carers can ask for a separate consulting session on their role as carers, focusing i.a. on psychological strain (*Angehörigengespräch*).

1.4 Semi-residential arrangements

In 2011 the, *Pflegefondsgesetz* (Act on the Long-term Care Funds) introduced a new public funds arranged to co-finance increasing monetary needs for LTC. Projects eligible for funding should focus on diverse kinds of non- or semi-residential care. The same act requires *Länder* to collect some basic statistics on long-term care services in the so-called *Pflegedienstleistungsstatistik* at Statistics Austria. According to this source, there were 11 335 (2015) places in *Alternativen Wohnformen* (i.e. assisted living arrangements for persons in need for some care, but without constant presence of supportive or caring staff, only places with public co-financing). This is an increase of 14% since 2011. 82% of all places are in Vienna, another 14% in Styria, three *Bundesländer* governments do not support this kind of accommodation. There is no government definition for assisted living, therefore organization and standards offered are quite diverse[1].

For the year 2015, *Pflegedienstleistungsstatistik* records 399 080 billed days in semi-residential arrangements (daycare) consumed by 7 426 beneficiaries, thus approx. 1 day per week and user of such arrangements on average (also with public co-financing). Since 2011, there was an average increase of 24% in the number of days and of 47% in beneficiaries, which was stronger in the *Bundesländer* than in the capital Vienna. But there is still an urban bias, as 42% of all days and almost 30% of beneficiaries were recorded in Vienna in 2015.

In Austria, there are no official numbers regarding group homes (*Wohngruppen,* in Austria more often called *Senioren WG)*. Mostly, group homes are provided by institutions providing also other LTC services. *Länder* and municipalities decide whether or not to provide financial assistance for such facilities.

Note that semi-residential arrangements have not yet achieved a significant market share, in spite of being by no means 'new' ideas any more: In 2015, only about 2.7% of all recipients of *Pflegegeld* used assisted living arrangements, and about 1.6% used day care (Schrank 2017).

1.5 Coordination between health and social care

Generally speaking, systematic coordination of health and social care is rather poor due to the traditional fragmentation between both sectors. Social health insurers have no role in funding and organizing LTC services. However, for most beneficiaries the same social insurer that administers their pension benefits also administers *Pflegegeld,*

[1] https://www.help.gv.at/

but does not finance it. After the prospective beneficiary's application for *Pflegegeld*, a representative of the responsible insurer assesses the care needs. The insurer then decides whether or not to grant a certain level of the cash allowance and arranges for its payment. The representative is a physician or a registered nurse, who usually has undergone a special training course for the assessment which is undertaken according to the above mentioned *EinstV*.

We are not aware of planned policy measures to improve the coordination of social and health care. *Pflegefondsgesetz* §3 (1) states that case and care management, mostly to coordinate LTC services, but also for coordination with health care, can be funded from this source. Where special efforts to improve the coordination between health and social care exist, it is typically a bottom-up approach. E.g. hospitals differ in their efforts to help arrange care at home after discharge, and general practitioners often help in arranging care.

It remains to be seen if and if yes, which changes the new Austrian government will introduce after merging the ministries of health and social affairs, as envisaged by the prospective government in December 2017.

2 Assessment of the *Pflegestärkungsgesetz* (PSG)

An assessment of the success factors raises the question against which goals the success should be assessed, and which indicators to measure the potential success are already available. We assume that so soon after introduction of the PSG I-III, no evaluations are available yet.

2.1 Definition and assessment of individual care needs

The introduction of five care grades instead of three care levels is reasonable from the Austrian perspective, as more care grades allow more fine-tuning to individual needs. The Austrian experience with seven care levels supports this extension. Austria started off with an eligibility threshold of 50 h/month in level 1, and has raised this in the meantime to 65 h/month. The monetary value of level 1, however, was not raised accordingly and stands currently at EUR 157.30. Germany starts now with grade 1 at EUR 125, not in cash but as voucher only for benefits in kind. The option of cash starts in grade 2 with EUR 316.

In contrast to the German *Pflegegeld*, there is no formal link between the granted amount of benefit in cash and in kind in Austria: no matter whether a person receives publicly (co-)funded care from professional carers or not, the amount of *Pflegegeld* paid in cash remains the same. (Reason: fragmented responsibility as explained in 1.1.) From an equity point of view, a linkage as in the German case is preferable.

As in Germany, also in Austria there is no indexation of *Pflegegeld*, and since its introduction it lost considerably in purchasing power, approximately 25% compared to the consumer price index and 45% compared to selected health services' prices (Rainer, 2017). More recently, validations were more frequent than in the beginning. Thus, it seems reasonable that the monetary values per care level/grade were raised in 2015.

Austria included (severe) dementia explicitly into the coverage of *Pflegegeld* in 2009 and thus earlier than Germany, thus explicit inclusion of dementia is seen as necessary also by Austrian social policy. In the first year, 22 532 recipients were granted the mark-up for difficult care (including dementia), which resulted in a higher care level for about 8 400 of these beneficiaries. 86% of these were allocated to level 3-5. (BMASK 2010) In 2016, for all new or updated assessments to decide on granting an individual *Pflegestufe* the condition most relevant for the care need was coded using ICD10. This resulted in 30% coded as dementia. (BMASK 2016) Explicit

consideration of dementia therefore is highly relevant if coverage of all – mental and somatic - care needs is the goal.

2.2 Strengthen care at home and in the community

The PSG introduced a new, rather low level of care, which is allotted a monetary value of EUR 125 pm for recipients in residential care, and furthermore some benefits in kind. These other benefits aim at fostering independent living or providing short-term support for people otherwise not (yet) eligible for LTC insurance benefits. Other benefits are e.g. counselling on care-related matters at home, nursing lessons for informal carers, support for founding an assisted living group.

It seems reasonable to provide counsel and support (e.g. adaptation of apartments) to continue life at home before eligibility to actual hands-on professional care kicks in.

Arrangements for short-time leave in order to organize care or long-term leave to provide care have been installed also in Austria, usually dependent on care level 3 or higher. Like in Germany, family carers enjoy health and pension insurance coverage during care leave. Different from Germany, Austrian family carers under certain conditions can receive a benefit resembling unemployment benefit during a long-term care leave, while carers in Germany can ask for an interest-free loan. Thus, the Austrian version seems more generous in terms of monetary support, but not in duration.

2.3 Semi-residential arrangements

Day-care and night-care

Day-care and night-care were introduced into the list of services to be provided in kind in Germany, given fulfilment of certain eligibility criteria. Thus, care up to the grade-dependent upper limit is provided at no cost at the time of use, private contributions are required for investment costs and for costs like food. Furthermore, this service comes in addition to the financial limits for ambulatory services in kind. Thus, this service has the potential to improve (at least part-time) employability of informal carers and to relieve the stress for informal carers of dementia patients, while fostering the cognitive and motoric capacities of the care recipient.

If in contrast day-care is to be financed privately, as in Austria, informal carers especially in rural low-wage areas need to balance their earnings against day-care costs, which might have contributed to the low take-up rates in most Austrian *Länder*. E.g. in Graz basic co-payment per day might reach EUR 82, even though municipalities subsidize day-care tariffs. However, tariffs are very non-transparent in Austria and vary across *Länder* and providers.

Furthermore, night-care seems to be non-existent in Austria. An attractive feature of night care in Germany is that two settings exist in parallel: care and supervision either in the home of the beneficiary, or in a specialized institution. We assume that the possibility to stay at home may improve the possibilities to relieve carers of very irritable patients. As informal carers can be burdened very much by regularly interrupted nights, the possibility of e.g. an "undisturbed night" per week offers the potential for the sustainability of family care.

It is remarkable that under certain conditions, beneficiaries have a right on day/night care, not only a possibility to get it (*Anspruch* according to §41 SGB XI). In Austria, in contrast, no rights on benefits in kind have been implemented.

Assisted living

Only in two Austrian *Länder*, a significant number of assisted living facilities has been implemented with public support, Vienna and Styria. It seems that in rural areas, it is problematic to organize groups "fitting together", which is easier with higher population density.

Wohngruppen

Currently, the elderly population in Austria is not very prone to the idea of sharing accommodation; it is not uncommon that existing groups have vacancies. Providers still stick to the idea of supporting group homes as the hope is that following generations will see this setting of life more favourably due to the higher share of persons who enjoyed it already as young adults.

This form of living in Austria usually does not receive much financial support from public budgets, thus it still might be perceived as rather expensive considering the loss of freedom and the lack of regular professional care. German *Wohngruppen* can apply for a subsidy at kick-off and for a regular subsidy.

2.4 Coordination between health and social care

In reading the material on the *Pflegestärkungsgesetz*, it was not clear to me how the measures could improve the coordination between health and social care, apart from information for and counselling of (prospective) beneficiaries and their families.

3 Assessment of the success factors and transferability

I want to start with two general remarks. Regarding assessment of success factors, we would need evaluations to identify the success factors, thus anything said below can be only to some degree hypothetical. Regarding transferability, one has to keep in mind that transferability of cause always depends on budgetary limits, which according to LTC in Germany are largely defined by LTCI budgets. Thus, available budgets are more transparent and future budgets can be easier calculated than in some countries without LTCI, which might facilitate some reforms.

3.1 Definition and assessment of individual care needs

Given the rising need for dementia care, implementing dementia as an eligibility criterion for certain LTC benefits seems highly necessary, especially for countries that strive at raising labour market participation of persons during the last years before reaching retirement age.

3.2 Strengthen care at home and in the community

In many countries, LTC services are fragmented. Timely and low-threshold counselling on availability of practical and financial support as well as on medical matters arising from care needs therefore can be beneficial in many countries. Investment into such services may reduce worsening of health situations and thus reduce overall costs, but may also pave the way to more intensive use of implemented benefits or higher take-up of existing benefits. Therefore, the monetary outcome seems ambiguous and dependent on existing levels of use, effectiveness of measures and average knowledge / health and care literacy. Even in case of cost savings, it is not always clear whose budgets will enjoy the potential relieve – health insurance, LTCI, municipalities or *Länder* as responsible stakeholders for LTC. Doubts on the beneficiary of cost reductions can impinge the desire for efficient and effective counselling.

3.3 Semi-residential arrangements

A strong and promising feature of day and night care is, that under certain conditions a right to receive this type of care has been established, and that costs up to a care-grade dependent maximum are to be covered by LTCI, including costs of transport. As said above, such coverage is easier to establish, of course, in countries with an earmarked and substantial budget for LTC, as the German LTCI provides. Stable financing options provide financial security not only from the viewpoint of beneficiaries, but also for service providers.

Apart from financing issues, transferability of arrangements will have to take the local ramifications into account, like availability and age-friendliness of transport options or population density.

3.4 Coordination between health and social care

In systems as fragmented as the German and the Austrian health and LTC systems, efforts to improve the coordination are highly necessary. Currently, I do not perceive many such efforts in Austria, but realize in the related area of integrated care that successful efforts often rely on ambitious stakeholders on the micro-level (see forthcoming publications from the SELFIE project[2]). This is the case due to the responsibility for care provision also being allocated to the micro- or meso-level. It would be worthwhile to look how better coordinated countries facilitate cooperation, but there remain doubts whether improvements can be achieved as long as responsibilities remain fragmented and accountability is perceived as restricted to the areas of one's own formal responsibilities.

4 Questions to Germany in the Peer Review

- Exactly what is the **logic behind calculating the different monetary values** – e.g. why is the monetary value of a care grade in residential care always higher than the respective value for ambulatory benefits in kind – but not in grade 3? Or how do you explain the logic of a EUR 10 difference in grade 5 (residential vs in kind)?
- Are there already **numbers** available for uptake of semi-residential forms of care, e.g. whether day-care is supplied and demanded in sufficient quantities also in rural areas, and whether there is demand/supply for night-care?
- How is the idea of **prevention** embedded into the *Pflegestärkungsgesetz*?
- Some measures are financed by LTCI 'if this measure helps to avoid relocation to a nursing home'. How is this condition **operationalized**?
- In Germany, it has been observed that roughly 80% of beneficiaries chose benefit in cash, and about 20% benefits in kind. Are there evaluations as to why this is the case?
- Participation in quality assurance is mandatory. What happens if somebody **declines to participate**?
- Is there information available for which kind of service the EUR 125 in **grade 1** are actually used?

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Annex 1 Summary table

Situation in the peer country relative to the host country
• Tax funded LTC, no LTCI • Already long and positive experience with seven care levels • Explicit inclusion of dementia as needs-criterion since 2009 • Gradual increase of support measures for family carers over last decade similar to Germany, partly more generous (leave arrangements, short-term residential care) • Mixed experience with semi-residential care forms, low take-up, but gradual increase in use, most pronounced with day-care
Assessment of the policy measure
• Many similar developments as in Austria, e.g. kinds of care leave arrangements • Lack of data on 'real' evaluation in Austria, therefore true assessment of measures not yet feasible (even new database - since 2011 - is of limited quality) • In contrast to Austria, care grades were developed based on research and hopefully provide a good basis for evaluations to improve further development
Assessment of success factors and transferability
• Implementing dementia as an eligibility criterion for certain LTC benefits seems highly necessary, especially for countries that strive at raising labour market participation of persons during the last years before reaching retirement age. • Timely and low-threshold counselling on availability of practical and financial support as well as on medical matters arising from care needs therefore can be beneficial. • A strong and promising feature of day and night care is, that under certain conditions a right to receive this type of care has been established, and that costs up to a care-grade dependent maximum are to be covered by LTCI, including costs of transport.
Questions to the host country in the Peer Review
• Availability of numbers on use? • Evaluation results? • What happens if there is a lack of cooperation from beneficiaries? • Operationalisation of the measure related to help avoiding relocation to a nursing home? • For which kind of services the EUR 125 in grade 1 are actually used?

Annex 2 Example of relevant practice

Name of the practice:	*Betreute Senioren Wohngemeinschaften* (WG) (assisted living in shared apartments), Vienna
Year of implementation:	1993 (start of the first WG of the largest provider in Vienna)
Coordinating authority:	No coordinated action, but several bottom-up initiatives. Many providers apply for subsidies from *Fonds Soziales Wien* (the authority organizing most social services across Vienna) and therefore have to comply with their standards. Largest provider in Vienna: Wiener Sozialdienste (WS), a non-profit provider of several social services that is loosely linked to the Vienna City government. Several other – usually non-profit – smaller providers together provide approx. the same number of places. Due to low regulation of WGs, projects differ e.g. regarding specialisation, amount of care, support and equipment (e.g. shared bathroom?) that is provided. e.g. Caritas specializes in WGs for dementia patients.
Objectives:	To provide a decent form of living for older persons who need some support and/or care but do not (yet) qualify for nursing home.
Main activities:	WS runs 33 WGs providing places for 176 residents across 8 of 22 districts in Vienna. Each WG is an apartment in an ordinary apartment house, but is built or adapted to fulfil as far as possible national criteria for disability and senior friendly housing. In WGs, 2-8 people live in individual rooms and share kitchen, living room, bathroom. Residents typically have care level 1-3 and receive an old-age pension. In WGs run by WS, staff is present to help organize life in the WG only in regular intervals and when necessary. Nursing care can be arranged which then is provided by staff of WS and needs to be paid additionally. In WGs specialized on dementia patients, permanent presence of staff is provided. Stay and provided services in WGs are paid just like stays in any apartment, from income of inhabitants, including *Pflegegeld*. Low-income residents can apply for a subsidy.
Results so far:	Due to lack of evaluations, I report based on anecdotal evidence: - WGs aim at low-scale units. Organizing and running them cannot exploit economies of scale and is rather costly. - More organization efforts are needed than anticipated. - It can be difficult to find groups that harmonize, because three kinds of participants need to be matched: residents, their carers, but also the residents' families. - Only very few seniors seem to favour 'life in a WG', even in Vienna, the logical urban starting point in Austria. For a long time, there have been only few projects in small cities or rural areas, presumably due to matching-problems.

	- Nevertheless, experience spans a broad range from WGs working perfectly, to others with difficulties in 'taking off'.

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