ESPN Thematic Report on Challenges in long-term care

Austria

2018

Marcel Fink (in cooperation with Katarina Valkova)
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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

The Austrian long-term care (LTC) regime is de facto characterised by a rather large sector of informal care. As a distinct area of social policy in Austria, LTC is relatively young, with the main elements of the LTC system deriving from legislation adopted in 1993.

The first main element of the LTC regime is 'LTC cash benefit' (*Pflegegeld*), which is granted without means testing (against income or assets) and according to seven different levels that correspond to different levels of individual care requirements or the health status of the person in need of care.

The second main element is institutional inpatient (stationary), semi-inpatient (day-care) and mobile/outpatient (i.e. at-home) care services. Establishing and upgrading these services is the responsibility of the nine federal provinces (*Bundesländer*).

Access to formal LTC benefits in kind and to LTC services is, in principle, not free of charge: the benefits are only covered by the federal provinces if the LTC services cannot be financed via a person's own resources. This is done within the context of Social Assistance and the Guaranteed Minimum Income (GMI) scheme. At the same time, LTC cash benefits are not sufficient to cover the costs of formal inpatient care. The same applies – especially in cases of extensive need of care – to the costs arising if all support were to be purchased within formal outpatient care.

This creates some pressure for people to cover a considerable part of LTC in an informal way, as many of them try to avoid applying for Social Assistance or GMI.

One other option increasingly used is so-called '24-hour care' at home, where people in need of LTC are looked after by privately hired carers, especially from Slovakia and Romania. Performed mainly as undeclared work prior to 2007, a reform in that year legalised such LTC arrangements, offering carers the option of self-employment or dependent employment and providing public financial co-funding.

The large variation in the coverage rates of formal LTC benefits in kind and LTC services indicates that substantial deficits are likely in a number of federal provinces.

Quality of institutional and informal care is an issue in Austria; however, more detailed and valid information on the topic is largely absent.

There is some evidence that working conditions in formal care are problematic in several respects, and jobs in this area are to a substantial degree filled by migrant workers. Regarding informal care, there is a lack of data-driven evidence on problems that relatives face in trying to – or having to – combine gainful employment with LTC tasks. However, given that the Austrian long-term care system is characterised by a rather large informal care sector, it is likely that the related problems are substantial.

The old-age dependency ratio in Austria (the proportion of the population aged 65 and over to the population aged 20-65) amounted to 28% in 2013 and is expected to exceed 50% by 2060; in the most optimistic scenario, the need for LTC will at least double by 2060.This means that the Austrian LTC system, not least due to demographic developments, will face several challenges if it is to cover increased need. Demand for LTC will significantly rise in future, which will cause major challenges for financial feasibility.

At the same time, recent reforms have not adequately addressed the evident challenges of the Austrian LTC scheme.

Overall, the prevailing trend in this policy area has been incremental adaptation, with problems and costs being shifted between different public bodies (i.e. the Federal Republic, the federal provinces and the municipalities), and also with shifts between public and private responsibility.

One basic precondition for evidence-based policy making in the field of LTC would be a proper and detailed assessment of the Austrian LTC regime, which is largely lacking at the time of writing.

1 Description of main features of the country's long-term care system(s)

1.1 General characteristics of policies and governance

As a distinct area of social policy in Austria, long-term care (LTC) is quite young. It was only in 1993 that the two major cornerstones of the Austrian long-term care regime were introduced (see OECD, 2015: 119ff; Österle, 2013 for an overview).

The first consists of the Federal Long-term Care Allowance Act (*Bundespflegegeldgesetz*), which codifies cash benefits for people in need of long-term care.[1] The second, also decided in 1993, is an 'agreement according to article 15a of the Austrian Constitutional Act' (hereafter: '15a agreement') between the Federal Republic and the federal provinces (*Bundesländer*).[2] According to this agreement, the federal provinces are responsible for developing and upgrading the decentralised and nationwide delivery of institutional inpatient, short-term inpatient, semi-inpatient (day care) and outpatient/mobile care services.

Institutional inpatient care is delivered in institutions specifically put in place for this purpose, like nursing homes and supervised residential communities for the elderly. Apart from housing and board, these institutions provide nursing and other care services (including day-structuring measures) and qualified nursing and care staff is always present.

Short-term inpatient care includes offers of temporary care in nursing homes for up to 3 months, in part to relieve relatives who offer care at home or to provide an alternative during their temporary absence (on leave or because of illness).

Semi-inpatient care offers whole-day or at least half-day support for persons in need of care who do not live in inpatient facilities. It is usually provided in facilities specifically set up for this purpose which offer care and social care, meals, activation and therapy and, where necessary, transport services between the place of residence and the care facility.

Outpatient/mobile care includes social support and care, as well as palliative care and other guidance and counselling (e.g. support in financial management) for people in need of long-term care who live at home. Concrete support includes home help and home nursing, where trained carers and nurses visit people in need of care once or twice a day at home to perform specific tasks (depending on the actual need) or to deliver meals ('meals on wheels').

The cash benefit, which is the second main pillar of the Austrian long-term care regime, is called long-term care benefit (*Pflegegeld*); since 2012 it has been exclusively the responsibility of the Federal Republic.[3] *Pflegegeld* is granted without means testing (against income or assets) and according to seven different levels, corresponding to a categorisation of seven different levels of individual care requirements/the health status of the person in need of care. The benefit currently (in 2018) amounts to EUR 157.30 a month at level 1 (the lowest level of benefits), but may be as high as EUR 1,688.90 at level 7 (see Annex Table A1). According to the related legal regulation, these cash

[1] BGBl. Nr. 110/1993 most recently changed by BGBl. I Nr. 116/2016; see http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10008859 (retrieved 30.01.2018).

[2] BGBl. Nr. 866/1993; see: http://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10001280 (retrieved 30.01.2018).

[3] For specific groups, the federal provinces granted this kind of benefit before 2012 as well.

benefits are intended to cover 'care-related additional expenses'. In other words, the benefit should especially be used to buy formal care services from public or private providers or to reimburse carers for informal caregiving. However, no control is exercised over the purposes to which the long-term care benefits are actually put by benefit recipients, who are the people in need of LTC (and not, for example, caring relatives).

Long-term care services (in-kind benefits), for which – under the above-mentioned 15a agreement – the federal provinces are responsible, are de facto implemented in cooperation with municipalities, not-for-profit organisations of the so-called intermediary sector (i.e. social non-governmental organisations of various types and orders), and, to a lesser degree, also in cooperation with for-profit providers (for an overview, see Riedel and Kraus, 2010: 21ff; Biwald et al., 2011; Trukeschitz et al., 2013; Österle, 2013; Grossmann and Schuster, 2017). Formal long-term services in Austria are basically financed by (co-)payments from those people in need of such services, who usually at the same time get the long-term care cash benefit, intended partly to cover this outlay. In case of insufficient financial resources of the person in need of long-term care, the costs are covered by the general budgets of the federal provinces and municipalities on a means-tested basis.

Apart from the LTC cash benefits and formal LTC services organised by federal provinces and municipalities, a number of other instruments are in place to support people in need of LTC and their relatives.

To serve demand for intensive care – especially when no institutional services are available or to meet specific needs – a '24-hour home-based care' sector has been established in Austria. Within the so-called '24-hour care', people in need of LTC are looked after by privately hired carers at home. This was largely operated by the grey economy sector until a reform in 2007.[4] The reform legalised this form of privately organised LTC, which is primarily dependent on temporary migrant carers from countries like Slovakia and Romania. Furthermore, for persons in need of 24-hour care who qualify for LTC cash benefits over level 3 and who are below the income threshold of EUR 2,500 a month, additional financial assistance is granted over and above the LTC cash benefit. This amounts to EUR 275 when care is provided by a self-employed carer, or EUR 550 if care is given by a carer in dependent employment; the amount may be doubled in both cases if two carers are required.[5]

Furthermore, two different leave schemes – 'Care Leave' (*Pflegekarenz*) and 'Family Hospice Leave' (*Familienhospizkarenz*) – allow caring relatives to take some time off from gainful employment or to reduce their working time. (For such persons, a specific leave-benefit – 'Care-leave Benefit' (*Pflegekarenzgeld*) – has also been available since 2014.) Yet take-up remains rather low, most likely because of these two schemes the potentially more important Care Leave does not come with a legal entitlement vis-à-vis the employer – the jobholder and the employer have to agree on it (see Fink, 2016 for more detail). For informal carers some additional consulting and communication services are also offered (counselling, hotlines, online platforms, etc.).

1.2 Type of financing

The LTC system in the narrower sense, i.e. without care provided by the health system and without private resources, is 100% tax financed in Austria. While long-term cash benefits come from the general budget of the Federal Republic, funding for benefits in kind come from the budgets of the Federal Republic, the federal provinces and the municipalities, via the general fiscal equalisation scheme (*Finanzlastenausgleich*), which basically transfers tax revenues of the Federal Republic to the federal provinces and municipalities, as well as from the so-called Long-term Care Funds (*Pflegefonds*), first

[4] For further details see https://www.help.gv.at/Portal.Node/hlpd/public/content/36/Seite.360534.html

[5] For further details see https://www.help.gv.at/Portal.Node/hlpd/public/content/36/Seite.360534.html

introduced in 2011 (for more details on financing, see 'financial sustainability' in section 2.1).[6]

1.3 The LTC mix in Austria

Concerning the distribution of institutional vs. home-based care, as well as regarding the share of informal provision in the total provision of long-term care, unfortunately no high-quality detailed data exist for Austria. However, the data available indicate that the prevalence of home-based care has declined since 2013 and there has been a simultaneous growth in inpatient and outpatient (mobile) services, as well as 24-hour care at home.

According to data provided by the Ministry of Labour, Social Affairs and Consumer Protection (BMASK),[7] in 2016 the majority (2016: 74%, 2013: 81%) of persons receiving long-term care cash benefits were in home-based informal care provided by relatives or friends at home, and did not receive formal care services (2016: 42%, 2013: 59%); or else were looked after by relatives or friends at home and at the same time received formal outpatient (mobile) care services (2016: 32%, 2013: 22%). Furthermore, 21% (2013: 16%) of long-term care cash benefit receivers lived in nursing homes and related institutions (inpatient care), and about 5% (2013: 3%) were looked after by privately hired carers at home (so-called '24-hour care at home').

One other possible data source is a programme organised by BMASK (for details, see BMASK, 2016a; 2016b), where certified healthcare and nursing professionals visit the homes of recipients of long-term care benefits to inform and advise all those involved in the specific care situation, in order to ensure the quality of home care throughout Austria.[8] Data from this 'home visit programme' of BMASK indicate that between 63% (level 7) and 85% (level 1) of all persons receiving LTC cash benefits for the first year and not living in an institutional care facility are looked after solely by relatives (and friends) and do not receive any institutional outpatient services (BMASK, 2016b), which is in line with previous data. It appears that informal care is especially utilised by individuals with few functional impairments; meanwhile, above a certain level of functional impairment, informal care primarily supplements formal home care (Firgo et al., 2017).

1.4 Projections on the need for LTC

The old-age dependency ratio in Austria (the population aged 65 as a proportion of the population aged 20-65) stood at 28%[9] in 2013 and is expected to exceed 50%[10] by 2060 (see also the Ageing Report (European Commission, 2015)). In the most optimistic scenario, the need for LTC will at least double by 2060; hence the number of individuals

[6] Overall, the main rationale for the decision on the 'Long-term care Funds Act', introduced in 2011, was not to improve organisational structures, but to ensure mid-term financial feasibility of the existing system. During 2010, it became evident that federal provinces and municipalities faced increasing problems in financing intra- and extramural benefits in kind. Against this background the Federal Republic, the federal provinces and the municipalities agreed in March 2011 on the introduction of a joint 'long-term care fund', planned to serve as an interim solution for financing problems until 2014. In sum, EUR 685 million were made available for the time until 2014; of this sum, two thirds were to be financed by the Federal Republic and one third by the federal provinces and the municipalities. In February 2012 it was decided to prolong the long-term care fund until 2016, and that additional funds of EUR 650 million would be made available. In December 2016, the decision was taken to prolong the long-term care fund until 2021. For 2017, the budget amounted to EUR 350 million, and it is supposed to rise by 4.5% each year until 2021.

[7] Data provided to the author by BMASK. According to BMASK, it derives from estimations by the federal provinces (*Bundesländer*).

[8] These visits concentrate on households with persons who have recently been granted LTC cash benefits. In 2016, around 19,515 such home visits took place – covering approximately 4% of the total number of LTC cash benefit recipients.

[9] Source: Eurostat Database, indicator [tps00198].

[10] Source: Eurostat Database, indicator [tps00200].

receiving LTC services will increase from 190,000 in 2015 to 380,000 in 2060, and the number of individuals receiving the LTC cash benefit will increase from 370,000 in 2015 to 740,000 in 2060 (Grossmann and Schuster, 2017). This means that the Austrian LTC system, not least due to demographic developments, will face several challenges if it is to cover increased need and ensure both the sustainability and the high quality of LTC provision.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Assessment of the challenges in LTC

2.1.1 Availability

Until recently, information on service accessibility and regional disparities lacked validity and direct comparability, as the federal provinces applied different models of documentation. One attempt to harmonise the data is the long-term care database provided by Statistik Austria (*Pflegedienstleistungsstatistik*), which covers information on individuals receiving LTC benefits and services, care personnel and spending according to different facilities.[11] However, the data include only information on LTC services financed or co-financed via Social Assistance or GMI and do not cover fully self-financed services.

To get a better picture of the situation, we establish the number of people looked after according to the different types of LTC services as a proportion of the number of recipients of long-term care cash benefits (with the latter used as a proxy for the number of people in need of long-term care). In doing so, the 'coverage rates' for different kinds of long-term care services are calculated (see Annex Table A2).

The coverage rates on outpatient and inpatient services differ substantially across the federal provinces. For example, for inpatient care the coverage rate calculated varies from 11.9% to 20.3%, and for outpatient/mobile services it ranges between 28% and 48%. There are similar – or even larger – variations in the reported numbers of care attendants in long-term care, when these are adjusted to the size of the likely demand (according to the proxy of recipients of long-term care cash benefits) and then indexed (see Annex Table A3).

Overall, the large variation in the coverage rates of LTC benefits in kind and LTC services points to the likelihood of substantial deficits in a number of federal provinces. However, fuller assessments on this point are largely missing at the time of writing (see also Österle, 2013). It is fair to say that there is a general lack of more in-depth analysis and data on availability and affordability, especially regarding formal outpatient services. But the findings (subject to the limitations) suggest that the availability of different kinds of long-term care services varies very substantially across (and partly within) the different federal provinces (see Riedel and Kraus, 2010; Österle, 2013; Fink, 2014) and that the lack of formal services contributes to the fact that the Austrian long-term care system is characterised by a rather large informal care sector (Mairhuber and Sardadvar, 2017).

2.1.2 Affordability

LTC cash benefits are based on legal entitlement. They are not means tested in terms of personal or family income or assets, and in principle are granted as a universal benefit, according to seven different levels of individual care requirements/the health status of the person in need of care. However, the LTC cash benefit only covers a fraction of the

[11] Outpatient care, inpatient care, semi-inpatient care, short-term (inpatient) care, alternative housing and case and care management.

costs of full-time formal inpatient care. The same applies, especially in cases of extensive need of care, to the costs arising if all support is purchased within formal outpatient care (Riedel and Kraus, 2010).

Access to LTC benefits in kind and LTC services is, in principle, not free of charge. These are only financed by the federal provinces if the LTC services cannot be financed via a person's own resources. This is done within Social Assistance and the GMI scheme. Here, means testing applies, where all kinds of personal income, including LTC cash benefits, are taken into account. Until recently, in the case of inpatient LTC, most federal provinces had means testing covering the assets of people in need of LTC; those assets normally had to be realised before the costs were covered by the public (*Pflegeregress*).[12] A recently voted Constitutional Provision (amending section §330a of the General Law on Social Insurance/ASVG), effective as of January 2018, prohibits recourse to the assets of persons living in inpatient LTC facilities, as well as recourse to the assets of their relatives, heirs or gift recipients.[13]

Overall, these regulations encourage a considerable part of LTC to be covered in an informal way (see also OECD 2015: 120), as many people are reluctant to apply for Social Assistance or GMI, where only a small personal budget remains freely available for disposal, and where until recently assets had to be realised.

2.1.3 Quality

In terms of institutional care in Austria, there is no common system of quality assurance and documentation (OECD, 2015: 50). The nine federal provinces have enacted different regulations on this issue (for an overview, see BMASK, 2016a: 46ff), but it is unclear if – and to what extent – these regulations actually guarantee high standards in institutional care, as outcome documentation is not publicly available on a regular basis.

The quality of informal care is even less well documented, but may be evaluated by data from the above-mentioned 'home visit programme'. However, in all relevant areas (such as personal hygiene, medical care provision, nutrition care and social activities) these data show the highest ratings ('A', equivalent to 'completely and reliably supplied') (BMASK, 2016a: 42); this might suggest problems regarding the methodology of evaluation. Other issues include the rather low number of persons with comparatively high need of care covered by the 'home visit programme' and the fact that results are not presented according to different levels of care needs and health condition. Overall, it is fair to say that there is a lack of sound information on quality issues of informal care (and also settings where informal care is combined with outpatient formal care).

Regarding '24-hour home care', it is worth noting that, irrespective of the legalisation of such care arrangements and the public co-funding, no effective qualification requirements for care workers (such as compulsory educational requirements for carers) were incorporated into the reform, and nor was a system of quality assurance drawn up (Bauer and Österle, 2013; Österle and Bauer, 2015).

Last but not least, quality assurance is closely linked to working conditions within the care profession. The high levels of strain, the high workload, precarious working

[12] This – inter alia – meant that dwellings could be subject to a lien within the land registry in favour of the federal province (normally after having received services financed via Minimum Income and/or Social Assistance for 6 months).

[13] This ad-hoc decision by Parliament also involved the Federal Republic transferring in total EUR 100 million per year to the federal provinces in order to compensate them for the loss of revenue which they face due to the ending of the possibility to have recourse to private assets (see Fink, 2017). However, it is estimated that these financial resources are not sufficient to cover the additional costs of the federal provinces, not least because the abolition of the *Pflegeregress* is likely to further increase demand for inpatient LTC.

conditions[14] and comparatively low income levels are all obstacles to attracting new applicants and might push educated carers to look for other employment opportunities. Therefore, the profession of carer features on the so-called shortage occupation list.[15] The high proportion of migrant workers with a lower socio-economic background that is found in this occupational group may also point to rather unfavourable working conditions. The 24-hour home-based care scheme, almost exclusively provided by migrant workers, appears to show even more serious deficits regarding working conditions (Österle and Bauer, 2015).

2.1.4 Particulars of the role of informal carers and the formal workforce in LTC

About 73% of all main informal carers visited within the 'home visit programme' (see above) were women (BMASK, 2016b). In the working-age group (16-65), the share of informal female carers was even higher (about 78%), clearly indicating a very strong gender-specific imbalance in the provision of informal care in working age. Overall, around 59% of main informal carers are aged under 65. Main informal carers are not often aged below 46 (around 9% of all female and 7% of all male informal carers). But over 40% of all female main informal carers are aged 46-60,[16] and about 40% of all male main informal carers are aged 46-65.[17]

As with informal carers, the formal nursing care workforce consists mainly of women. According to micro census survey data, women accounted for 80% in inpatient care facilities in 2015 (Riedel and Röhrling, 2016). In general, care professions in Austria are associated with substantial stress levels and health risks (AKOÖ, 2016). Furthermore, several responsibility and potential 'criminalisation issues'[18] (Meier and Kreimer, 2013) might reduce the attractiveness of the profession. Care professions in Austria also show a great proportion of migrant workers, with a share of c. 28% in 2015.[19]

Almost entirely, '24-hour care' at home is provided by migrant workers.[20] This form of LTC was performed mainly as undeclared work before 2007. A reform then legalised such LTC arrangements, offering carers the option of self-employment or dependent employment, and providing public financial co-funding (see above). While the objectives of limiting illegal work and maintaining the affordability of the system were fulfilled, the existing rules provide a legal framework that fosters unfavourable and precarious working conditions (a legacy retained from the time when such work was illegal) as well as limited de facto access to social protection rights, due to the widely used option of self-employment (Österle and Bauer, 2015).

2.1.5 Employment challenges

Overall, it is evident that the Austrian long-term care system is characterised by a rather large sector of informal care. This applies irrespective of the fact that institutional care

[14] See results from 'Work and Life Quality in New and Growing Jobs Project – Care profession', https://cordis.europa.eu/result/rcn/56349_en.html and http://bis.ams.or.at/qualibarometer/berufsfeld.php?id=212&show_detail=1&query

[15] See https://www.migration.gv.at/de/formen-der-zuwanderung/dauerhafte-zuwanderung/fachkraefte-in-mangelberufen/mangelberufsliste-2018/

[16] Sixty is the statutory retirement age for women.

[17] Sixty-five is the statutory retirement age for men.

[18] This means that care staff may be personally accountable for any suboptimal care, which may – in extreme cases – be interpreted as a criminal offence.

[19] Statistik Austria & Medien-Servicestelle Neue Österreicher/innen. http://medienservicestelle.at/migration_bewegt/2016/05/11/63-600-migrantinnen-arbeiten-im-gesundheitswesen/

[20] In 2013, according to social security records, the number of 24-hour care workers amounted to 44,143, of whom more than 85% originated from Slovakia or Romania, and only 1.9% from Austria; 95% of 24-hour care workers were female (Österle, 2015).

services have been substantially expanded over the past two decades (see above). Furthermore, the large variation in coverage rates of formal LTC benefits in kind and LTC services (see above) suggests that substantial deficits in accessibility are likely in a number of federal provinces, forcing relatives to take over LTC duties. More comprehensive assessments of this issue are largely missing at the time of writing, and there is a lack of data-driven evidence on problems that relatives face when they try to – or have to – combine gainful employment with the long-term care of relatives (Österle, 2013; Riedel and Kraus, 2010; Schneider et al., 2013).

However, some evidence is available from data provided by the Labour Force Survey (LFS). As already outlined above, there is some evidence that many informal carers are in the age bracket 40-65. Within this age group, 17.7% (men: 2.9%; women: 27%) of the population not in employment and seeking employment report that their status is caused first and foremost by 'family/caring responsibilities' (data for 2016).[21] Another 5.6% (women: 8.5%; men: n.a.) report 'looking after children or incapacitated adults' as the main reason.[22] These data have to be interpreted with caution, as they do not specifically address long-term care activities, but may also cover other 'family responsibilities', etc.

2.1.6 Financial sustainability

Overall spending on long-term care in Austria,[23] as reported within the OECD System of Health Accounts,[24] increased from 1.18% of GDP in 1990 to about 1.55% of GDP in 1994 (when long-term care cash benefits were introduced). Thereafter, this figure remained largely stable until 2008, but it increased to 1.62% in 2009 and remained at about the same level thereafter (2015: 1.58%). The growth in 2009 occurred due to falling GDP, a rise in the benefit levels of long-term care cash benefits, as decided in 2005 and 2008, and a growing number of people in need of long-term care. In 1994, about 82% of all spending on long-term care was covered by the public sector and about 18% came from private sources. The public share has since decreased somewhat, amounting to 71% in 2015. Between 1999 and 2015, the number of recipients of LTC cash benefits increased much more than overall spending on LTC as a percentage of GDP – by about 62%, compared to about 20%. However, a further factor was that GDP grew more slowly than total LTC expenditure, which doubled in that period, from EUR 3.842 million to EUR 7.716 million.

Population ageing is expected to put considerable pressure on Austria's public expenditure (OECD, 2017). The long-term budgetary projections for LTC expenditure assume an increase of 1.3 percentage points[25] to 2.7% of GDP by 2060 (European Commission, 2015). According to the most recent Austrian projections, public spending on LTC services, depending on scenario, will increase to between 1.42% and 1.85% of

[21] These rates are slightly higher than the average for the EU-28. Source: Eurostat Database, indicator [lfsa_igar].

[22] These rates are somewhat lower than the average for the EU-28. Source: Eurostat Database, indicator [lfsa_igar].

[23] The issue of data on actual public and private spending (see alos Trukeschitz and Schneider, 2012) for LTC is somewhat tricky in the case of Austria, as for a long time different types of documentation existed in the different federal provinces, so that within national documentation data repeatedly derived from estimates only. Moreover, LTC expenditure can be described by different systems, such as the System of Health Accounts (SHA), the European System of Integrated Social Protection Statistics (ESSOS), Statistik Austria - *Pflegedienstleistungsstatistik*, Classification of the Functions of Government (COFOG); but none of them reports LTC spending on an explicit and comprehensive basis (for an overview, see Grossman and Schuster, 2017).

[24] Source: Statistik Austria and own calculations. http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=019701

[25] Older OECD projections (de la Maisonneuve and Martins, 2013) have, under a cost-pressure scenario, assumed an increase of 1.0 percentage points of GDP; and under a cost-containment scenario – 0.7 percentage points of GDP.

GDP by 2030, and then further to between 1.94% and 3.59% by 2060 (Grossmann and Schuster, 2017).

Against this background, cost containment is an issue in political debates about the future of the Austrian LTC system and attempts to develop it further. However, it appears that the Austrian case and recent reforms at the regional and local level do not provide examples of a silver bullet to simultaneously reach the goals of cost containment and high accessibility and quality via increased efficiency.

2.2 Assessment of reforms

The reforms enacted over recent years have not changed the basic institutional design of the Austrian LTC system. They aimed more at:

- increased transparency and efficiency, e.g. by transferring LTC cash benefits (*Pflegegeld*) to the sole competency of the Federal Republic (as from 2017), and
- mid-term financial feasibility, e.g. by the joint 2011 agreement of the Federal Republic, the federal provinces and the municipalities on the introduction of a joint 'long-term care fund'; the agreement has been repeatedly prolonged and provides funds to extend the system against the backdrop of rising demand.

At the same time, no substantial new measures have been decided in recent years to secure the long-term financial sustainability of the system of LTC. The same is true of the possible harmonisation of accessibility and affordability of related services, with the goal of offering high standards in all federal provinces.

What might, however, have a structural impact on future development is the complete abolition of the *Pflegeregress* (recourse to the assets of people in inpatient long-term care) mentioned above. This might substantially increase the demand for inpatient formal care, which might be validated critically, inter alia especially from the perspective of cost containment.

2.3 Policy recommendations

One basic precondition for evidence-based policy making in the field of LTC would be a proper and detailed assessment of the Austrian LTC regime. This is largely lacking at the time of writing, and no detailed information is available either on the supply of or on the demand for institutional LTC on a regional and sub-regional basis. Furthermore, there is a lack of data-driven evidence on problems that relatives face when they try to – or have to – combine gainful employment with LTC for relatives. Such assessments would allow for better problem-driven planning and improvement in the area of formal LTC services, thus reducing the pressure to take up informal LTC and problems within informal LTC.

A related situation applies to quality issues both of formal and informal LTC, and especially regarding the so-called '24-hour care' at home.

Furthermore, it appears that no concrete plan to deal with issues of the long-term financial feasibility of LTC exists in Austria. Here, a renewed attempt would be necessary to find a longer-term common understanding between the Federal Republic and the federal provinces.

When it comes to LTC in Austria, the prevailing trend up to now has been incremental adaptation, with problems and costs being shifted between the different public bodies (i.e. the Federal Republic, the federal provinces and the municipalities), and also with shifts between public and private responsibility.

3 Analysis of the indicators available in the country for measuring long-term care

3.1 Data on the structure and resources of the Austrian LTC scheme

National data on the **structure and resources** of the Austrian LTC scheme derive in the first instance from the data provided by **Statistics Austria**; these are based on registry data from the Federal Republic and the federal provinces.

Long-term care cash benefits

Statistics Austria provides a time series (in English) on:

- beneficiaries of federal long-term care allowance, and
- expenditure on federal long-term care allowance.

The data are available on an annual basis (Statistik Austria, 2017). http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=032465

Additional information on beneficiaries of LTC cash benefits are available only in German. These data are available on an annual basis:

- by gender: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=020067
- by age group: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=020068
- by federal province: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=052518

Services and benefits in kind provided by the federal provinces and the municipalities

The Austrian *Pflegedienstleistungsstatistik* (LTC services statistics) provides information on services (co-)financed by Social Assistance, the means-tested income scheme or other public funds and is exclusive of care services in the field of help for people with a disability and basic welfare support for asylum seekers, and is also exclusive of clients not financially supported by public funds.

It provides information – according to the different types of services (outpatient services; inpatient services; semi-inpatient services; short-term care; 'alternative living facilities'; 'case and care management') and grouped by federal province – on:

- hours of service
- number of beneficiaries
- employment units: full-time units
- gross expenditure (annual sum in EUR), and
- net expenditure (annual sum in EUR), i.e. expenditure minus revenue (especially from private co-payments).

These data are available on an annual basis.

An overview table is available in English:

http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061945

More detailed data (on an annual basis) are available in German, providing time series on:

- outpatient services: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061950
- inpatient services: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061951
- semi-inpatient services: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061952
- short-term care: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061953
- 'alternative living facilities': http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061954
- 'case and care management': http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061955
- As well as the number of beneficiaries according to the different types of services, data (in German) are available on the regularly established units (headcount places) according to the different types of services. These data are again available on an annual basis: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=080937
- Additional alternative overview tables on LTC services (in German) are available on:
    - Public spending for LTC services: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061956
    - Beneficiaries according to gender: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061957
    - Beneficiaries according to age: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061958
    - Beneficiaries according to level of LTC cash benefits http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=061949
    - Employment units: full-time units: http://www.statistik.at/wcm/idc/idcplg?IdcService=GET_NATIVE_FILE&RevisionSelectionMethod=LatestReleased&dDocName=080309

3.2 Data on the quality of long-term care

Monitoring/measuring the 'quality' of long-term care is a long-standing issue in Austria. There have been various attempts to do so at the level of the federal provinces regarding formal (inpatient and outpatient) care; but when it comes to the common nation-wide monitoring of care, essentially the only results have been the indicators mentioned above, primarily measuring input.

One other attempt worth mentioning is that seeking to document the quality of care at home within the above-mentioned 'home visit programme' organised by BMASK (BMASK, 2016a; 2016b), where certified healthcare and nursing professionals visit the homes of first-time recipients of long-term care benefits to inform and advise all those involved in the specific care situation, in order to ensure the quality of home care throughout Austria.

At the time of these home visits, certified healthcare and nursing professionals grade the quality of care according to a modified ASCOT methodology (Adult Social Care Outcomes Toolkit)[26] (see also Trukeschitz, 2011).

'Quality of care' is assessed on six dimensions:

- accommodation functionality
- personal hygiene
- quality of medical care
- nutrition and hydration
- accommodation cleanliness, and
- activities and social participation.

It is also assessed according to a four-grade scale of quality (BMASK 2016b):

- A = completely and reliably supplied
- B = minor problems
- C+ = substantial problems
- C- = severe problems.

These data are available on an annual basis.

[26] See https://www.pssru.ac.uk/ascot/

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Appendix

1.1. Table A1: Long-term care cash benefit (*Pflegegeld*)

Care category	Monthly benefit (2018)	Minimum care need in hours per month	Number of claimants (November 2017)	Share of care category (%)
Level 1	157.30	65[1]	112,669	24.5
Level 2	290.00	95[2]	106,174	23.1
Level 3	451.80	120	83,144	18.1
Level 4	677.60	160	66,364	14.5
Level 5	920.30	180[3]	51,255	11.2
Level 6	1,285.20	180[4]	20,045	4.4
Level 7	1,688.90	180[5]	9,471	2.1

[1] *Until January 2015: 60 hours.*
[2] *Until January 2015: 85 hours.*
[3] *Plus: exceptional care requirements.*
[4] *Plus: permanent presence of a carer is necessary due to unpredictable care needs.*
[5] *Plus: serious disability impeding the use of hands and feet; no precise movements are possible.*
Sources: Federal Ministry of Labour, Social Affairs and Consumer Protection https://www.sozialministerium.at/site/Pension_Pflege/Pflege_und_Betreuung/Hilfe_Finanzielle_Unterstuetzung/Pflegegeld/#intertitle-3 ; Statistics Austria https://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/soziales/sozialleistungen_auf_bundesebene/bundespflegegeld/052519.html and own calculations.

2.1. Table A2: Care Services[1] of the federal provinces 2016; coverage rates according to number of recipients of long-term care cash benefits (*Pflegegeld*)[2]

Federal province	Number of recipients of long-term care cash benefits	Outpatient / mobile services	Inpatient services	Semi-inpatient services (day-care)	Short-term inpatient care	Alternative dwellings	Case and care management
		Coverage Rates					
Total[3]	454,676	32.3%	16.4%	1.6%	2.0%	2.6%	21.5%
Burgenland	18,612	28.0%	11.9%	1.2%	1.5%	1.1%	0.0%
Carinthia	35,078	31.8%	20.3%	0.6%	1.5%	0.3%	5.0%
Lower Austria	90,805	33.5%	13.1%	0.7%	4.5%	0.0%	23.1%
Upper Austria	70,355	29.3%	17.7%	2.0%	2.9%	0.1%	18.4%
Salzburg	25,848	29.0%	17.0%	3.2%	1.8%	0.0%	12.3%
Styria	80,513	29.6%	18.2%	1.0%	n.a.	1.7%	3.6%
Tyrol	31,337	33.8%	20.0%	2.3%	0.8%	0.0%	21.9%
Vorarlberg	17,270	48.2%	13.9%	3.0%	2.7%	0.6%	8.7%
Vienna	84,858	34.6%	15.6%	2.5%	1.4%	11.8%	56.1%

[1] *Services of long-term care, if (co-)financed by funds of Social Assistance and GMI, respectively; services without 'help for disabled' (Behindertenhilfe) and 'basic maintenance' (Grundversorgung).*
[2] *The number of recipients of LTC cash benefits serves as a proxy for people in need of care.*
[3] *Without recipients not living in Austria.*
Source: Statistik Austria. Pflegedienstleistungsstatistik; Prepared 11.12.2017 and own calculations. If data are not available for all federal provinces (n.a.), then the 'total' refers to the remaining federal provinces.

3.1. Table A3: Care attendants (full-time equivalents) per number of recipients of long-term care cash benefits (*Pflegegeld*), 2016, indexed: total = 100

Federal province	Outpatient / mobile services	Inpatient / stationary services	Semi-inpatient / stationary services (day-care)	Short-term inpatient / stationary care	Alternative dwellings	Case and care management
	Care Attendants (full-time equivalents) per number of recipients of LTC cash benefits; total=100 [1]					
Total	100	100	100	100	100	100
Burgenland	58%	70%	194%	n.a.	14%	0%
Carinthia	85%	90%	53%	n.a.	11%	83%
Lower Austria	116%	76%	20%	24%	0%	n.a.
Upper Austria	68%	109%	98%	n.a.	4%	162%
Salzburg	99%	115%	173%	n.a.	0%	165%
Styria	56%	95%	73%	n.a.	39%	15%
Tyrol	101%	128%	160%	n.a.	0%	n.a.
Vorarlberg	131%	100%	138%	n.a.	58%	200%
Vienna	161%	118%	160%	510%	476%	262%

[1] *Number* at the end of the year under review (31 December).

Source: Statistik Austria, Pflegedienstleistungsstatistik. Prepared 11.12.2017; and own calculations. If data are not available for all federal provinces (n.a.), then the 'total' refers to the remaining federal provinces.