Peer Review on "Financing Long-term Care"

Peer Country Comments Paper – Austria

The Austrian *Pflegefonds* - only a small fund, but with a large agenda

Estonia, 22-23 September 2020

DG Employment, Social Affairs and Inclusion

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Table of Contents

1 Introduction

This paper has been prepared for the Peer Review on "Long-term care financing models". It provides a comparative assessment of the policy example of the Host Country Estonia and the situation in Austria. For information on the host country policy example, please refer to the Host Country Discussion Paper.

2 Situation in the peer country

In Austria, there is a strict division between the health system and long-term care (LTC) system in terms of legislation, competencies and financing: social health insurance (SHI) is the major player in the organization and financing of health care, while governments of the nine federal states (*Bundesländer)* are responsible for the provision of LTC services, resulting in regional variation regarding coverage, structural quality regulations and quality assurance mechanisms across Austria (Bachner et al. 2018).

Financing one's LTC needs is an individual responsibility. There are, however, many services that are partly financed from public funds and a major care allowance (*Pflegegeld*) helps finance one's care needs. Apart from the user's private contribution, LTC services are completely financed via taxes which are levied at the national level. The main income of the *Bundesländer* and municipalities to finance their tasks is organised via the general fiscal equalization scheme (*Finanzausgleich*), which defines their share in national taxes. This allocation of funds is mainly via the (not age- nor morbidity-adjusted) number of inhabitants. There are no ear-marked LTC-funds for the *Bundesländer* or municipalities apart from the LTC fund (*Pflegefonds*[1]*,* see Annex 2*)*. In 2011, the *Pflegefonds* was introduced by the Ministry of Social Affairs and was amended in 2013 and 2017. The purpose of grants from the fund is to ensure the provision and sustainability of LTC services, which are provided by states and municipalities in cooperation with non-profit organizations. The grants should primarily be used for measures concerning patients not (yet) in residential care, as it is one of the main principles of the fund to allow people to live at home as long as possible. It receives a defined sum from national tax revenues, amounting to 366 mio EUR in 2018. For the national government, the *Pflegefonds* is a crucial instrument in spite of its small size[2] because it provides some leverage to foster common standards in provision of services in kind across the *Bundesländer*.

Fragmentation of financing, provision, and organization of LTC benefits is an issue in Austria. While benefits in cash are regulated at the national level and jointly financed with fixed contributions of federal and central governments, responsibility to finance and provide benefits in kind lies by and large with *Bundesländer* governments. According to health insurance law, provision of nursing care in the context of LTC is NOT a responsibility of health insurance, no matter whether at home or in an institution. Only care provided by physicians and provision of medication are matters of health insurance, also in LTC.

The **care allowance** in Austria is of major importance for the whole LTC sector. In contrast to services in kind, inhabitants of Austria have a right to receive this allowance, independent of their income, insurance status, age and nationality, given that their care needs are at or above the eligible level. Eligibility for a certain care allowance level also serves as criterion to define eligibility for other services, e.g. most nursing homes require level 4 (with 7 being the highest level of care needs).

[1] There is another very small subsidy to replace the lost income due to the abolished so-called *Pflegeregress,* the obligation of nursing home residents to use also their assets (not only income) to finance their stay in nursing home.
[2] The *Pflegefonds* represents slightly less than 0,1% of GDP, while public expenditure on LTC amount to about 1,9% of GDP.

3 Assessment of the policy measure

Obviously, Austria is in a different position from Estonia due to the higher general income level (Austria: 127% of EU-27 average GDP per capita, Estonia: 84%[3]), which affects also other essential aspects, for instance the stance regarding the migration of care staff: The Austrian health and care systems are highly dependent on staff with migration background, mostly but not exclusively from Eastern Europe. The wage level in LTC is perceived as low by many national workers, considering the high emotional and physical demands incurred in these jobs. For persons from countries with lower wage levels as well as lower costs of living, the Austrian wages have acted as a pull factor for migration over many years already. Additionally, long-lasting ties going back to the times of the Austrian-Hungarian monarchy and the relative proximity of these countries have facilitated migration patterns.

Even though Austria is none of the big countries of the EU, the population number of Estonia (1.3 million) is comparable rather to the four biggest *Bundesländer* of Austria, than to the whole country[4].

3.1 Fragmentation

As explained above, fragmentation is an issue also in Austria. Dividing lines of responsibility of stakeholders, however, are placed differently in both countries:

- Provision of nursing care in institutions as well as in the person's home is a responsibility of the *Bundesländer*, not of the national health system. *Bundesländer* handle this responsibility differently: Responsibility e.g. for nursing homes can be kept within a government department (e.g. Lower Austria), be handed over to a special fund (e.g. Vienna), to groups of municipalities that cooperate for this task (e.g. Carinthia) or to individual municipalities (e.g. Tyrol).
  In Estonia, (home) nursing care falls into the responsibility of the Health Insurance Funds.
- The different ways how *Bundesländer* handle their responsibility for LTC spills over into statistics: Separate definitions of services make statistics across the *Bundesländer* hard to compare, and the existing database contains only the most basic information (see Annex 2).
- Uneven distribution of services can be perceived e.g. in residential care capacities. The recipient quota (overall number of recipients of any type of public LTC service divided by number of care allowance recipients) varies in 2018 between 65% in Carinthia and 85% in Vorarlberg (BMASGK 2019). Furthermore, average intensity of care needs in residential care varies across *Bundesländer*, which inhibits comparisons across *Bundesländer* further.
- It might be interesting to note that also the responsibility to provide hospital care rests with the *Bundesländer*, not health insurance. Seen from the outside, this construction might contribute to good coordination between hospital care and nursing home care, but it seems that the strict division of respective departments has hindered direct cooperation up to now.
- While LTC services in kind are a responsibility of the *Bundesländer*, benefits in cash are regulated on the national level in a common fashion across Austria. In Estonia like in most other countries, responsibility for both - benefits in cash as well as in kind - lies with the same institution, in this case with the Estonian welfare system (with the above-mentioned exception of nursing care).

[3] Source: https://ec.europa.eu/eurostat/databrowser/view/tec00114/default/table?lang=de
[4] Vienna ranks first with a population of 1.9 million, Styria fourth with 1.2 million.

3.2 Unmet need for care and importance of informal care

The national care allowance eligibility scheme in Austria defines care levels according to the hours of care and attendance needed per month. It ranges from a minimum of 65 hours of care needed (level 1, 160.10 EUR in 2020) to 180 and more hours of care needed (level 5-7, plus additional requirements like mobility or need for constant supervision, ranging from 936.90 EUR to 1 719.30 EUR). Over the last years, the minimum was raised from 50 hours to 65 hours.

Most public LTC services relate to eligibility for care allowance. Thus, persons in need of care below 65 hours/month in general do not have recognized LTC needs and, oftentimes, respective families or individuals will have to manage completely on their own. Even **if the minimum threshold is fulfilled, the granted sum allows to pay for a very small number of professional care hours only**. Thus, people are forced to pay out of their income, or to organize informal support, which most often is provided by (female) family members. Therefore, also in the Austrian LTC system the most important providers of care are family members and other relations. A recent report estimates that informal carers, exclusively, provide care for about 55% of all recipients of care allowance; another 34% of recipients are cared for by a mix of formal and informal care (Nagl-Cupal et al. 2018).

In case of a more severe need of care, necessitating residential care, the usual procedure is that (prospective) residents have to disclose their income: any difference between income (minus specified amounts to cover some other needs) and actual costs of the care home is born by welfare. Thus, persons in need of care can finance their care in a residential setting, but more often than not prefer to stay at home as long as possible. A popular model to avoid moving to residential care is the model of so-called 24-hours care, where typically two carers - mostly from Bulgaria, Romania or Slovakia - alternately live for two or three weeks in the care recipient's home to provide necessary care, housekeeping and company. (Österle, Bauer 2016)

3.3 Financing of LTC

A recent study on the financing model of the Austrian LTC system concluded that there are more weaknesses in the allocation of funds than in the raising of the funds (Riedel et al. 2020). The main weakness is that while local governments have to decide on structure and level of the services they provide, they have hardly any possibilities to adjust their LTC budget. The Austrian financial equalization mechanism does not adjust for demographic structure, only for population size and – to a small degree – to urbanization. Thus, very diverse structures and levels of co-payments emerged. Current national regulation aims at reducing the resulting regional differences in co-payment levels for services.

Considering differences in local government budgets in Estonia and the aim of a similar level of service provision across local governments, it seems very worthwhile to safeguard a minimum income for service users after co-funding for LTC services.

3.4 Needs-based local government and state partnership model

In the envisaged new Estonian LTC partnership, the role of the state will be to develop

a) LTC services that are not possible or reasonable for local governments to develop, including a list of services that actually will be provided by the state,

b) a common standardised needs assessment tool including material for guidance, counselling and training of the persons executing the assessments,

c) guidance materials to develop minimum criteria for LTC service provision,

d) the further exchange of good practice in needs assessment and service provision between local governments.

The role of local governments will be

e) to choose and purchase from the list of state-provided services, as well as

f) provide the services (on their own or by contracting service providers) that will not be provided on state-level.

Considering the size of Estonia, the combination of a) and e) seems wise in terms of economies of scale. The tricky issue will be which services to include in the list, as local provision and accessibility for the rural population is often a challenge with LTC services.

In the Austrian experience, it was necessary to provide b) in order to avoid different standards across the country. It has been a necessity to provide also common training and explaining material, because the mere assessment tool initially had been interpreted in different ways, resulting in different assessments for persons in similar situations, depending on the assessor. Against the backdrop of (relative) oversupply of physicians and (relative) undersupply of qualified nurses in Austria, a development in recent years was to recognize the experience of (geriatric) nurses in the assessment process, and thus reduce the overwhelming role of physicians a bit. Now, the first assessment for *Pflegegeld* is still done by a GP contracted for this purpose, but later assessments can be done by specified nurses.

For c), differences amongst the *Bundesländer* e.g. concerning minimum criteria for nursing homes, have repeatedly been criticised in Austria (e.g. Rechnungshof 2020). There are neither uniform staffing levels, nor uniform quality indicators, monitoring processes, co-payment levels, entry procedures or criteria. Considering the size of Estonia and the necessary efforts in developing sound criteria, it might even be worthwhile to develop one common set of minimum standards / criteria, and offering local governments the possibility to aim higher if wished and feasible.

Furthermore, a pilot exploring the possibilities of coordinating primary health care and social care for persons with complex needs seems very promising for a country suffering from a low share of healthy years in the remaining life expectancy at the age of 50.

4 Assessment of success factors and transferability

4.1 Fragmentation

In Estonia, in contrast to Austria, nursing care at home as well as in residential care is financed via health insurance, while social services are in state responsibility (in both countries). A transfer of nursing care into the responsibility of health insurance in Austria would:

- decrease the privately born payment for services, because most services in kind provided by health insurance are free from co-payment in Austria, while social services usually require private contributions. Even though co-payments for LTC services are typically income-dependent, they can pose a serious financial burden on the users.
  Especially in the context of residential care, it is hard to understand that nursing care is currently supposed to be paid privately, while care for chronic conditions is in the realm of the health insurance. The exclusion of (long-term) nursing care from health insurance might become even more arbitrary, if current efforts to foster primary care succeed in giving nurses and allied health professionals a larger role.[5]

[5] The health system reform of 2013 aims i.e. at introducing primary care centres, including not only GPs but also nurses and at least some other health professions in a more structured fashion than before. This reform needs to be seen against the backdrop of the typical primary care provision in Austria: GPs working in a solo practice with a far smaller area of responsibilities than GPs in countries like UK, The Netherlands or Spain.

- introduce another line of fragmentation. Currently both, support at home and home nursing care, are mostly provided by the same organisation (if both is used). Dealing with another provider would mean additional administrative work and stress for the respective families, who often struggle already with managing their situation. Thus, in case that nursing care should be moved into the responsibility of health insurance, the administrative extra burden for families should be kept as low as possible, e.g. by cooperation with the GPs, or by introducing community nurses, care coordinators or similar professionals with such a task.

4.2 Financing of LTC

In the new financing model planned for Estonia, legal providers in the **family are obliged to assist** if care recipients are unable to meet the cost of care, and it is planned to analyse whether grandchildren can be exempt from this obligation.

An obligation of (adult) children and grandchildren would meet severe resistance in Austria. Until 2018, also assets (not only income) had to be spent in Austria before welfare started to contribute to costs for residential care (*Pflegeregress*). This was a highly disputed topic in several political elections. Obligations of children to pay for their parents' care seem very problematic, especially in view of families with only loose ties between (one) parent and the children and increasing geographical spread of families.

In the new Estonian financing system, local governments can apply for additional **earmarked financial incentives** to increase the investment for developing accessible LTC services. With the *Pflegefonds*, Austria introduced an earmarked incentive for innovative care arrangements in 2011, focussing on care at home. The *Pflegefonds*, however, was criticized for being mostly used to supplement LTC finances, with only very limited impact on innovative arrangements. Eligibility rules, therefore, should be very clearly communicated and monitored, in order to safeguard that the planned effects take place.

In contrast to Estonia, the Austrian **fiscal equalisation mechanism** does not contain any morbidity or disability indicators. This neglect puts local governments of aging, often rural communities in a detrimental position and was criticized accordingly (Riedel et al. 2020).

5 Questions

- If care recipients are unable to meet the cost of care, family members including the younger generation(s) are obliged to assist. How will you prevent that this obligation increases the pressure to emigrate and earn more abroad, to be able to contribute to care costs?
- In the new financing system, local governments can apply for additional earmarked financial incentives to increase the investment for developing accessible LTC services. They will have to contribute at least half of these costs. How will the state prevent that poorer regions refrain from taking up this incentive, as they have to contribute at least half of the costs?
- Please elaborate on the mentioned pilots where care coordinators link primary care and social services. Is a description or an evaluation available? Which / How much impact did they have, as an implementation in eight regions is planned?

The reform, however, is quite slow in gaining momentum and does not receive much support from the *Ärztekammer* (physicians' representative chamber).

- How does Estonia plan to foster the exchange of good practice in needs assessment and service provision between local governments?

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Annex 1 Summary table

The main points covered by the paper are summarised below.

Situation in the peer country
• Fragmentation of responsibility is also an issue in Austria, albeit along different lines. • Unmet care needs might be an issue for care needs below the eligibility level, while higher care needs by and large receive public funding. • About 55% of all persons eligible for care allowance are cared for by informal (family) carers only. Use of informal rather than formal care is implicitly supported by the design and level of the care allowance in combination with comprehensive co-payments for services in kind. • Public expenditure on LTC are financed from national taxes; *Bundesländer* and municipalities contribute from their share earned via the fiscal equalization scheme, which however is independent from indicators of morbidity and age.
Assessment of the policy measure
• For a state the size of Estonia, a stronger role of the state seems worthwhile to guarantee equal access to services across the country. • Local responsibility in assessments and purchasing is a good combination for national standards. • Developing accompanying material in order to apply common assessment standards has already proven necessary elsewhere. • In an area of considerable co-payments for social services, implementing measures to safeguard a minimum disposable income for service users seems essential.
Assessment of success factors and transferability
• The obligation for family members to finance care (if the care user's resources are insufficient) might turn problematic. • An earmarked financial incentive for local governments to develop further LTC capacities needs clear rules and strict monitoring, if it is intended as a steering tool.
Questions
• How to prevent emigration if (grand)children have to participate in costs? • How to make sure also poorer municipalities can participate in programmes with cost-sharing? • Effects of pilots with care coordination between primary care and social care? • How to foster exchange of experience between municipalities?

Annex 2 Example of relevant practice

Name of the practice:	*Pflegefonds*
Year of implementation:	2011, amendments in 2013 and 2017
Coordinating authority:	Ministry of Social Affairs
Objectives:	In view of population ageing, • ensure the provision and sustainability of LTC services; • prioritize nationwide expansion of services at home; • harmonize care services and capacities. Since 2013, funds can also be used for innovative measures in LTC (e.g. Ambient Assisted Living), in order to better adjust to the changing environment. Funding is divided between national (2/3) and *Bundesländer* governments and municipalities (1/3)
Main activities:	Implementation of the *Pflegefonds* with increasing volume starting with 100 mio EUR in 2011, rising to 417 mio EUR in 2021. Additional 18 mio EUR p.a. (2017-2021) for the expansion of hospice and palliative care. Implementation of a database on LTC services and expenditure.
Results so far:	**Harmonization**: *Richtversorgungsgrad* (LTC minimum coverage rate) was defined as the share of persons receiving LTC services, as percentage of all care allowance recipients. Minimum levels of *Richtversorgungsgrad* per *Bundesland* were defined and gradually increased. Between 2012 and 2018, variations of this indicator decreased (from standard deviation 0.084 to 0.061), while the minimum level of this indicator observed in a *Bundesland* increased from 52% auf 65% **Database**: To improve transparency and comparability of data about LTC services, an Austrian care database (*Pflegedienstleistungsdatenbank*) was set up by Statistics Austria[6] in 2012 on behalf of the Social Ministry. The data is based on information provided by Länder and shows e.g. expenditures in LTC, how many people were cared for, etc. However, the database still provides only very basic information with limited comparability across *Bundesländer*.

[6] http://statistik.at/web_de/statistiken/menschen_und_gesellschaft/soziales/sozialleistungen_auf_landesebene/betreuungs_und_pflegedienste/index.html


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