Questionnaire: Austria

1. There needs to be a careful balance between collective and individual arrangements and responsibilities, which is not easy to achieve. Individuals can be involved in collective arrangements (through co-payments; or personal budgets) while local authorities can help people to cope independently with long-term care.

1.1 Is collective funding of long-term care in your country a part of the fiscal taxation or a part of the obligatory care-insurance or both?

Long-term care funding is based on fiscal taxation. The total public budget is around 3.3 billions € (1.3 % of GDP).
(To a very limited extent, medical home nursing is funded from social health insurance. This, however, refers to medical care and is only paid temporally.)

1.2 Is long-term care the same for everybody (packet / content; cost) or does a possibility exist that someone receives (after assessment) a "better" or "more luxurious" packet of long term care by paying a higher or additional premium?

Long-term care allowance is federal and provincial responsibility. The federal law (*Bundespflegegeldgesetz*) and nine provincial laws (*Landespflegegeldgesetze*) are following the same principles and benefit levels. All those eligible for other federal benefits (e.g. old age pensions) as well as employees of the federal public system are covered by the federal scheme. All others are part of the provincial schemes.

The long-term care allowance is paid in seven levels according to care needs (ranging between € 154.20 in level 1 and € 1655.80 in level 7). There is no further differentiation among recipients. (see BMSK, 2007: 65-70)

About 400,000 persons (5 % of the Austrian population) are receiving a LTC allowance.

Social services (residential care, ambulant care) are provincial responsibility (nine provinces). Service structure (providers, density), co-payment regulations and accessibility differ across the country. Residences and social services are funded by a combination of public and private sources. (*see below 1.3*) There is no differentiation among recipients in general access. However, residents or users can have the opportunity to top up their service consumption with out-of-pocket payments.

We estimate about 100,000 persons receiving ambulant care services at home and 70,000 persons living in residential care settings.

Private long-term care insurance is possible, but very limited in practice. (In provision, most existing schemes are related to the public long-term care allowance scheme.)

1.3 Referring to the system of objective assessment / indication of long-term care: is it common practice to take personal characteristics into account, like age, personal income and / or wealth, to belong to and behave (or not) as a part of a social network of family / friends / neighbours?

Care allowance scheme: Personal characteristics except for care needs are not taken into account. There is no means-testing and no asset-testing. Dependent people of all age groups are eligible.

Social services (residential care, ambulant care): Personal characteristics are taken into account.

- **Assessment** in the social service sector does not follow nationwide assessment criteria.

- ***Personal income and / or wealth**:* Provision and funding of social services is based on provincial social assistance regulation. Regulations differ in detail, but follow the following principles:

  Ambulant services are covered by a combination of public funding (in most provinces an application for public coverage is required) and private co-payments. Co-payments refer to disposable income (long-term care allowance and personal income of the recipient). There is an upper limit for these co-payments.

  In residential care, first of all, pensions and care allowances are transferred to the owner of the residence (up to some pocket money). Also, personal wealth has to be used for funding places in nursing homes. If this does not cover the costs (according to the fees contracted with the residence), the difference is funded from social assistance. These funds can be reclaimed. Respective regulations differ across the country. In all provinces, personal wealth has to be used for funding residences. Also, partners have to contribute from their income. Until recently, in some provinces, children also had to partly contribute from their income. These regulations have been abolished recently.

- **Long-term care allowance level**: In some residences, application for a place requires a minimum long-term care allowance level (e.g. level 3).

- **Age**: There is no general age limit. In the residential care sector, there often is a differentiation between residences for younger and for older people.

- **Waiting lists**: Waiting lists are often used as a means to administer situations where the demand for places / services exceeds the number of places / service units available.

- **Social network**: is not explicitly taken into account.

2. Clear boundaries need to be drawn between long-term care and related schemes like subsidised housing or home-help, so that people are aware of what services they are entitled to and how this is decided.

*2.1 Are residential or living arrangements part of long-term care, (**a**) in the current legal / financial system and / or **(b)** in the practice of care delivery?*

Long-term care allowances do not refer to living arrangements. Subsidisation for housing is not related to the consumption of care allowances or social services.

Residential care provision and funding includes care and residence. When living in a nursing home, there is no differentiation between hotel costs and care costs. The funding arrangement refers (see above) to total costs.

*2.2 Is medical treatment ("cure") part of long-term care, (**a**) in the current legal / financial system and / or **(b)** in the practice of care delivery?*

Medical Care is not part of long-term care. To a very limited extent, medical home nursing is funded from social health insurance. This, however, refers to medical care. It is only paid temporarily.

When living at home, medical treatment is provided by the general practitioner (or in a hospital when intramural medical care is needed).

When living in a residence, medical treatment is provided by hospitals or medical doctors visiting the residence. An exception is the capital city of Vienna where some residences also have medical departments (either covered in the provincial care funding context, or – based on special arrangements – partly covered from social health insurance).

Hospitals stays of frail elderly people have often been prolonged because of lack of places in nursing homes and/or a lack of social service provision in the community. In the past 15 years, increasing pressure in the hospital sector has substantially reduced these "long-term care beds".

*2.3 Is there a separation between residential (intramural) care and ambulant (extramural) care concerning (**a**) the current legal / financial system and / or (**b**) the actual organisation of the care system?*

(a) Both, residential and ambulant care is provincial responsibility (in terms of regulation and funding).

(b) Services in the two sectors might be offered by the same or by different provider organisations. In general, residences themselves are not offering ambulant care services.

Financing in both sectors is based on social assistance laws. The details of the funding schemes, in particular the division between public and private contributions to funding, differ for the two sectors (see above).

There is no common assessment procedure. Accessing the two sectors can take different ways, following an initiative of the family of the dependent person, the family doctor or in the context of a previous hospital treatment.

2.4 Do you observe (or expect) that clear boundaries between long-term care and related schemes will improve or complicate an integrated and client-oriented approach (traject management, case management, chain management)?

There is support for clear boundaries between long-term care and health care. But, there is a lack of systematic cooperation, in particular between the hospital sector and the residential as well as the ambulant care sector. There are already various programmes and practices of care management or case management. However, there is no country-wide systematic approach for better integration yet.

Another issue is linking the long-term care allowance scheme with social service provision. A recent programme aimed at connecting the receipt of the long-term care allowance with a consultation offer has not been taken up widely.

3. Qualified personnel are as important as funding being available, while balancing supply and demand needs to take account of demographic and, labour market factors.

*3.1 Is the availability of sufficient personnel a worrisome item for long-term care, (**a**) now and (**b**) in the coming decennia?*

In the past 10 years, there has been a significant **increase in employment** in the long-term care sector. **We estimate about 80,000 employed persons in the formal LTC sector**, **82 % of them women**. Increasingly, experts and providers are pointing at a shortage of nurse and home help personnel. To a considerable extent, availability of foreign trained nurses allows coverage of open jobs.

Taking into account the increasing demand for long-term care, this shortage will further grow if jobs are not becoming more attractive. Apart from the future demand for qualified personnel, future quality standards, technological developments, policy decisions but also the expectations of care receivers and their families will determine the level of qualified care work needed.

3.2 Do you expect that long term care, as a branch, will be able to compete with other branches in terms of a tight labour market? Do you expect that branches within the public sector (like education) will challenge long-term care in this respect in the future or do you expect more competition from the side of trade and industry branches?

Whether long-term care will be able to compete depends on broader economic and labour market developments. From the public sector perspective, and taking into account the forecasts in terms of demand for and potential supply of long-term care, additional public funds will be necessary to allow funding of long-term care services for all. Whether long-term care will be able to compete with trade or industry branches depends on the **attractiveness of work** in the care sector, which includes wages, labour related conditions such as working times, and the general perception and recognition of care work in the long-term care sector and in society.

3.3 Are there programmes or initiatives to make schooling and training of future personnel in long-term care enough attractive and large-scale so that sufficient supply of personnel can be guaranteed in the future?

There are various initiatives pointing at attractive future perspectives in care jobs.

Many are interested to enter schooling in the nursing sector. The major challenge is that many do not stay long in the profession. Particular emphasis, therefore, should be on strengthening continuity in care jobs and opening up opportunities to return into care jobs.

Except for qualified nurses, training in long-term care jobs has varied between provinces. This has led to different qualification requirements across the country. A recent **Agreement on Social Care Professions** aims at harmonising training programmes for jobs in the long-term field and, herewith, increasing competences and opportunities for mobility.

Basic information and data on the Austrian long-term care system

BMSK (2008): Österreichischer Pflegevorsorgebericht 2007,Wien.

BMSK (2007): Social Protection in Austria, Wien.

BMSK (2006): Policies for People, Wien.

BMSK (2006): Beschäftigte im Alten- und Behindertenbereich im Jahr 2006, Wien.

ÖBIG (2006). Österreichischer Pflegebericht. Wien, ÖBIG.