
Changing long-term care needs in ageing societies: Austria's policy responses

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1 Introduction

Austria is a country of 8.3 million people in Central Europe. There are only five cities counting more than 100.000 inhabitants. While one in five Austrians live in Vienna (1.6 million people), more than every second Austrian lives in smaller towns and villages with less than 10.000 residents. Accordingly, the population density ranges from 4,000 residents per square kilometre in Vienna to just 55 in the province of Carinthia (the average for Austria being 99). By comparison, Japan's population density measures more than 340 persons per square kilometre.¹

In 2007, 17 per cent of the population was age 65 and older and the older population is about to increase markedly over the decades to come: According to projections by the United Nations Population Division (2002), the median age in Austria will increase from 38 in 2002 to 54 in 2050, drawing level to Japan by this time. As in other industrial countries, the marked and continuous increase in life expectation is a major driving force of population aging. Today, an Austrian male is expected to live further 29 years at age fifty. Women's life expectancy at age 50 is even higher and approaching 34 years. However, half of the remaining life years (men: 14.6 years, women: 18 years) will be troubled by health problems and functional limitations (see Jagger *et al.*, 2008).

These developments raise questions about the long-term sustainability of the country's pensions, health and long-term care systems. Recently, the debate has focused on long-term care, given the steady increase in the numbers of older persons drawing long-term care benefits over the past years and bleak projections for the future. In 2008, five per cent of the Austrian population received a LTC cash allowance, which can be taken as reliable indicator for substantial limitations in coping with activities of daily living. About 90 per cent of those who were entitled to the federal care allowance were age sixty and older. (see Bundesministerium für Soziales und Konsumentenschutz, 2008: 6).

¹ see http://www.statistik.at/web_de/statistiken/bevoelkerung/volkszaehlungen/bevoelkerungsstand/034208.html , http://www.statistik.at/web_de/services/wirtschaftsatlas_oesterreich/oesterreich_und_seine_bundeslaender/index.htm
And, for Japan, <http://www.stat.go.jp/english/data/handbook/c02cont.htm>

Latest projections which are shown in table 1 expect the number of Austrians receiving the federal long-term care allowance to increase by 41 per cent in the least between 2008 and 2030 (see Mühlberger *et al.*, 2008b: 33). As a result, the cost of providing long-term care (including cash allowances and spending on care infrastructures) is estimated to expand by 66 per cent to 207 per cent. In a middle scenario, spending on long-term care would claim 1.96 per cent of the country's GDP, which compares to 1.3 per cent in 2008 (see Mühlberger *et al.*, 2008b: 34).

TABLE 1 comes about here

Against this backdrop, this paper is to provide an overview of Austria's policy response to population aging in the area of long-term care. Section two will briefly reflect on basic characteristics of long-term care policies in comparison with other countries' approaches to the issue of eldercare and also in comparison with the design of health care policy. Section three provides details on different pillars of Austria's long-term care system, discerning cash benefits for care clients, public support in the development and provision of social care services and policies supporting family caregivers. In addition it will briefly discuss recent policy changes that were to solve the problem of illicit care, which has been provided by an ever growing number migrant care workers. The paper closes with a brief summary of Austria's policy efforts, emerging ideas on how to secure sustainable funding for long-term care and a comment on other hot spots of the current Austrian debate on long-term care.

2 Basic characteristics of the Austrian long-term care system in a comparative perspective

A brief conceptual discussion provides a useful backdrop for understanding characteristics of Austria's long-term care provisions to the elderly. This section will first sketch out typologies

(or “regimes”) of long-term care systems in Europe and explain Austria’s placement in this grouping of countries (2.1). For this purpose, we draw on the literature on social care models, which inspire cross-national comparisons on the outcomes of different policy regimes. The second sub-section will highlight major principles underlying the provisions for frail older persons in Austria (2.2). The aim is to unveil how these guiding principles in long-term care relate to system design and the course of action in the country’s health care and pension systems thus sensitizing for major differences in social policy design even within Austria.

2.1 Austria’s system in relation to other country’s models for long-term care

In the past twenty years, literature on welfare state models has burgeoned. Following Esping-Andersen’s (1990) work on “Three worlds of welfare capitalism” a number of authors (see e.g. Evers & Svetlik, 1993; Evers & Wintersberger, 1990) refined the notion that countries differ with regard to the roles assigned to families, nonprofit organizations, the market and the state in generating social security and equity. Given that each of these spheres of society is driven by different logics, varying patterns of responsibilities will bring about dissimilar mixes of welfare services and diverse ways for funding these services across countries. More specifically, the “welfare-mix approach” holds that solutions provided by families and nonprofit organisations primarily reflect affiliation or membership, norms, traditions, and moral obligations. The state and its institutions also emphasize commonality of purpose and solidarity, while at the same time catering to justice and universal access to services. By contrast, market-based transactions feature individualism and choice, and hence differences in the preferences for and access to social security.

Early on, empirical efforts were made to identify and empirically map types of welfare states based on the varying roles of the state, the market and the family and on major policy outcomes such as stratification and de-commodification (Esping-Andersen, 1990). Esping-Andersen himself suggested three types of welfare regimes and used data across a variety of cash based welfare benefits to assign single countries to a specific type of regime (Esping-

Andersen, 1990; criticism: Scruggs & Allan, 2006). A more recent strand of literature accounts for service benefits in addition to cash benefits (Bambra, 2005, 2007; Jensen, 2008) with some authors singling out specific areas of service provision, such as social care services to the elderly. These contributions not only complete and straighten the otherwise distorted picture of benefit systems but are also more suitable for an analysis of health and long-term care provisions to frail older persons where services take a mainstay role. In what follows, we will therefore sketch out a typology and grouping of countries, as developed in the literature on “social care models” (Anttonen & Sipilä, 1996: 96 ff.; Bettio & Plantenga, 2004; Jensen, 2008; Timonen, 2005). According to this approach, at least for types of social care models can be discerned in Europe:

In the “Mediterranean Model” the family assumes the main responsibility in caring for frail elderly people and access to social services is very limited. The state provides services mainly in hardship cases. Design, implementation and funding of public support falls in the responsibility of state or local actors which brings about a fragmentation of public services. Access to benefits as well as levels and types of support may vary across jurisdictions. The market for social care services is quite small and caters to higher income families. Otherwise, social care is provided through a “grey market” matching migrant care workers and private households at low hourly rates. Italy figures as a prominent example for this type of long-term care regime (see e.g. Bettio & Plantenga, 2004; Bettio *et al.*, 2006).

The Anglo-saxon Model, by comparison, is characterised by means-tested public benefits for persons in need of long-term care. While public support is still modest, there is less (if any) variation in the level of and access to cash benefits. Service benefits may still vary across jurisdictions or communities. The flow of public benefits to low-income households strengthens the market for social care services, yet families remain a major source of care.

The Continental European Subsidiarity Model still insists on family responsibility for caring to the elderly. However, the state has ventured on supporting families in a variety of ways. One major route of support is public funding for nonprofit organisations which provide long-term

care services but also services as “meals on wheels” to households of frail older people. In addition, the state provides caregiver benefits as for example counselling, pension contributions on behalf of family caregivers in specific cases, generous leave arrangements, respite care but usually no noteworthy attendance allowances. Benefits to care dependents (care allowances) are very limited. Additional public support is available on a means-tested basis only. The empirical literature on social care unanimously assigns *Austria* and Germany to this type of model.

Finally, the Scandinavian Model features a very developed system of long-term care services. Access to care services is a civil liberty and hence universal. The federal government set standards and procedures to secure quality of services. At the same time, the local government assumes major responsibilities in service delivery. While this model emphasizes the role of the state in catering to the needs of frail older persons, it also exhibits support to family members of care clients. Sweden is the typical reference country for this type of model and exhibits high rates of service use in the frail older population.

In summary, countries respond differently to care needs of older persons. Most importantly, the roles of the family and the state in providing care and access to public services differ widely across Europe. Conceiving the Mediterranean Model, which is also touted “all-in the family model” as one extreme case of providing eldercare and the Scandinavian Model with well-developed public provisions as another extreme, Austria is situated somewhere in between these two poles. About eighty per cent of persons age 60+ rely on family care in case of long-term illness or dependency (see Klimont *et al.*, 2007), expressing a strong reliance on the family system (as in Mediterranean countries). At the same time, the country established a universal, tax-funded LTC cash allowance in 1993 (see section 3.1). This benefit is not means-tested (as in the Anglo-Saxon Model) but neither is it generous enough to open vast access to formal services (as in the Scandinavian Model).

Before delving into the details of the Austrian long-term care system in section 3, the following sub-section will discuss two of its guiding principles and will briefly contrast them with the general rules shaping the provision of health care benefits.

2.2 Guiding principles of Austria's long-term care system compared to health care

Austria's welfare system in general and its long-term care system in particular are shaped by the two major normative principles of "subsidiarity" and "solidarity". Both principles are partly at odds with each other, which in the case of long-term care entails a system design that combines universal and selective (means-tested) benefits.

The principle of subsidiarity posits that the responsibility in dealing with a problem should lie with the person, organisation or level that is just about capable to resolve it. As a consequence, passing on a problem from the individual to the family level, from the family to the local informal community, from the private sphere to the local public sphere and – finally – from the local or provincial authorities to the federal government always requires that it cannot (or no longer) be solved at a lower level or sphere of action. At the same time, society and the state representing it need to maintain and foster self-help capacities of individuals and lower levels of government (see Badelt & Österle, 2001: 20-21).

In the context of eldercare, subsidiarity implies "family first". A person in need of long-term care is responsible for herself/himself in the first place and is expected to make use of his or her own resources and/or those of the immediate family before requesting help from others. A similar line of reasoning applies to public provisions for the population in need of long-term care, where major provincial and local governments share responsibilities with the federal government.

The principle of solidarity maintains that individuals are not just responsible for themselves but also for each other. Any form of social policy is a way of organizing support to other members of society. The very existence of a well-defined long-term care policy in Austria acknowledges the solidarity principle. Those who suffer from major limitations in their

activities of daily living are entitled to claim a needs-tested cash benefit, irrespective of their income. Furthermore, there is a public responsibility for long-term care infrastructures, which is not left to be developed by for-profit firms.

Taken together, the Austrian long-term care system reflects both guiding principles. The first tier of support for long-term care clients is a tax-funded cash benefit (see 3.1 for details). This care allowance is not means-tested which is in accordance with the solidarity principle.

However, this first tier of protection only offers limited protection against the financial cost of eldercare. By default, the level of the care allowance is falling far short of the amount required to cover the full cost of professional care services. Accordingly, the government report on social protection affirms that the care allowance “should be regarded as a lump-sum contribution towards care costs” (Federal Ministry of Social Affairs and Consumer Protection, 2007: 66). According to a report by the Austrian Court of Audit (Bundesrechnungshof, 2007), the allowance potentially covers between 6.6 and 57.7 per cent of the cost of an hour of professional care, depending on the type of care needed and on the benefit category.

As a consequence, long-term dependency - especially in old-age - still constitutes a poverty risk. In fact, a major share of spending on means-tested social assistance by the Austrian provincial authorities (“*Laender*”) - 54 per cent in 2006 - is flowing to nursing homes and skilled nursing facilities. So even with a federal and universal program in place, it is quite common that older persons in need of long-term care have to spend down their assets after the onset of a limiting condition and the provincial authorities still pay a solid amount in means-tested cash-benefits to long-term care clients, which form the second tier of protection. This poverty risk is being buffered by family resources in general and informal care in particular. According to a recent survey among on health issues, 9 per cent of Austrian men and 19 per cent of Austrian women in the age group 60 and over indicated that they use social care and other types of paid help in case of long-term dependency on care whereas 76 per cent rely on their family (Klimont et al., 2007: 27-28). However, access to

informal support is not always available and may reach its limits at higher levels of care need.

The fact that the principle of subsidiarity features so strongly in the Austrian long-term care system is in stark contrast to the provision of health care services. The social health insurance system covers 98.7 per cent of the Austrian population and is very visibly pervaded by the solidarity principle. Most importantly, for all services covered by the social health insurance benefits are open-ended: Patients are to receive all medically necessary services. Co-payments as an element of subsidiarity are in place for medication, assistive devices and for stays in hospital. Cost-sharing is however limited. As a consequence, acute illness in old-age does not usually entail catastrophic cost to patients and their families. By contrast, long-term dependency implies significant amounts of cost-sharing whenever formal professional services are used.²

Summing-up, long-term policy in Austria reflects two major principles of social policy design, namely solidarity and subsidiarity. Solidarity manifests itself in a universal cash-benefit system which is needs-based and not income-tested. Subsidiarity in the given context stresses self-responsibility and the role of families in providing care to frail older relatives. Public support is considered complimentary to these efforts. The tradition of subsidiarity also explains the mainstay role of nonprofit organizations in service provision and provincial authorities' responsibilities in long-term care policy. Comparing long-term care to health care, the principle of solidarity appears to rank higher in health policy whereas benefits in case of old-age dependency are less generous and offer less protection against the risk of impoverishment.

The following section will offer more details on different types of benefits offered to long-term care clients and their relatives in Austria. It will describe universal cash benefit system as well as design, funding and delivery of service benefits at the provincial ("*Laender*") level.

² Both systems also differ with regard to funding. Health care is predominantly financed by social insurance contributions.

3 Austria's policy response to the challenges of long-term care

While the **1993 legislation on long-term care** was a major step to reduce the fragmentation and differentiation in support offered across the country (see section 2), to the present day, Austria's response to the challenges of old-age dependency cannot be considered all of a piece. Responsibilities for long-term care are shared between the federal government and the 9 provincial governments. In 1993, an agreement was reached on the division of responsibilities across the different levels of government:

It was decided to govern **care allowances** by one federal law and nine provincial laws, while at the same time agreeing to harmonize program design with regard to needs assessments and benefits levels. The federal law on long-term care cash allowance (*Bundespflegegeld-Gesetz*) refers to care recipients who receive pension benefits or related benefits which are based on federal statutory provisions. Care allowances paid under one of the nine provincial laws address long-term care clients who are not (yet) eligible for pension benefits such as younger handicapped people, persons covered by social insurance as co-insured family members or recipients of social assistance payments. (see Da Roit *et al.*, 2007: 657; see Federal Ministry of Social Affairs and Consumer Protection, 2007: 66; OECD, 2005: 81; Oesterle & Hammer, 2006)

The development of **service infrastructures** (social care services, day care, residential care) remained a provincial responsibility. In this area, the provinces make use their undivided competences without putting much emphasis on coordinating or benchmarking their individual efforts. As a result, there remains considerable variation in funding and delivery of social care services across the nine provinces (see e.g. Trukeschitz & Buchinger, 2007c).

In what follows, we will first focus on the tax-based universal care allowance (see section 3.1). Since the vast majority of elderly long-term care clients are covered by the federal cash benefit ("Bundespflegegeld"), it will form the core of the discussion. Yet, we will also add corresponding information on the LTC cash allowances of the provinces where this appears

appropriate. Next, we will turn to the funding and delivery of long-term care services by the Austrian provinces. In doing so, we will identify core elements in funding rules that are shared by several provinces and hence alternate funding types emerging (section 3.2).

In addition, this section highlights two policy areas which have been addressed by both – the federal government as well as by provincial authorities: (i) Policies in support of informal carers (section 3.3) which are not coordinated among the federal and provincial authorities and (ii) policies to legalize and regulate the “grey” market for domestic support for long-term care clients in need of 24 hours stand by care (section 3.4).

3.1 Tax-based universal cash benefit to care clients

On July 1, 1993, federal legislation on a tax-based care allowance came into effect. As agreed with provincial governments, corresponding laws were enacted by each of the nine provinces, such that a universal system of long-term care entitlements was established for the first time in Austria. This legislation created a **legal entitlement** to a cash benefit for all Austrian residents in need of long-term care, irrespective of age, income, type of disabling condition (mental, physical, psychological or sensory) and regardless of the specific cause of the limiting condition.

Eligibility for the care allowance strictly depends on care needs. It is granted to persons with usual residence in Austria in need of continuous care (a) who require more than 50 hours of care per month on average and (b) who are expected to depend on care for at least 6 months and (Federal Ministry of Social Affairs and Consumer Protection, 2007: 66). The assessment of care needs is on a seven point scale, acknowledging that different kinds of functional limitations require differing types and intensities of care. More specifically, the grading scale is based on the number of hours of care needed per month and on the type of care (OECD, 2005: 81). For an applicant to be placed into scale grades 5, 6 or 7 additional criteria apply, underlining the severity of the care needed.

In order to assure that all assessments follow a well-defined and standardized procedure, the federal and provincial laws Long-Term Care Allowance Acts were complemented by specific

assessment regulations. The ordinance concerning the federal Care Allowance Act³ has been amended only recently (with changes becoming effective on January 1st 2009) to better account for the specific needs of children with severe disabilities and persons with mental disabilities especially those suffering from dementia in the assessment.⁴

Level of benefit: As displayed in Table 2, cash benefits in 2009 range from EUR 154 per month for scale grade 1 to EUR 1,656 per month depending on the level of care. As of January 1st, 2009 the level of benefits were increased by 4, 5 and 6 per cent for care clients in the lower, middle and higher benefit categories respectively. This increase in the level of benefit is modest (especially for the lower LTC cash allowance levels), compared to the inflation rate of about 3.4 per cent in 2008 alone.⁵

TABLE 2 comes about here

The level of the care allowance has not been adjusted for inflation on a regular basis, which is an issue of recurrent discussion. Adjustments of benefits are discretionary and require an act of parliament. Over the past 15 years, the benefit levels were adjusted only three times: 1994, 1995 and 2005 (see Mühlberger *et al.*, 2008c: 9). As a result, the purchasing power of the care allowance has eroded visibly (see figure 1). Österle and Hammer (2004) note that the purchasing power of the care allowance has diminished by 16 per cent between 1993 and 2004. The Austrian Court of Audit recently found that the LTC care allowance would cover at most 57 per cent of the cost of professional care. Care clients with the lowest care needs (grade 1) also face the lowest rate of coverage (just about 7 per cent of the potential cost of social care) (see Bundesrechnungshof, 2007; see also section 3.1).

FIGURE 1 comes about here

³ Verordnung über die Beurteilung des Pflegebedarfes nach dem Bundespflegegeldgesetz (Einstufungsverordnung zum Bundespflegegeldgesetz – EinstV), BGBl. II Nr. 37/1999.

⁴ see: http://ris1.bka.gv.at/App/finDBGbl.aspx?name=entwurf&format=html&docid=COO_2026_100_2_501255

⁵ see: http://www.statistik.at/web_de/statistiken/preise/verbraucherpreisindex_vpi_hvpi/index.html

Use of benefit: The cash transfer is untied, that is recipients have full autonomy over how to use it. It is paid to the person in need of long-term care but can be passed on to other persons (e.g. family caregivers). If a care recipients lives in a nursing home or skilled nursing facility, the transfer is paid to the residential care home, except for a pocket money. Concern has been expressed, that the cash benefit may be used for general consumption rather than improving the situation of a care client in catering to his or her specific needs. Yet, authorities have not followed up on the use of the benefit and scientific studies on this matter are very scarce.

According to findings from an early study by Badelt et al. (1997), formal employment relationships between care dependents and a family caregiver rather form an exception and that most payments are symbolic. As reported by a quarter of the informal carers in their study sample, part of the LTC cash allowance was used to cover (some of) the additional expenses of informal caregiving, or flowed to them as a regular transfers or gifts. However, about 30 per cent of informal caregivers (mostly partners co-residing with the care client) in fact stated that the LTC cash allowance merged into the general budget for housekeeping. In the past, the allowance has also been used to pay for (illicit) migrant care (see Oesterle & Hammer, 2006; see Österle & Hammer, 2006).

In 2001 and again in 2003, home visits of a random sample long-term care clients receiving a LTC cash allowance quality were conducted by professional care workers who were offering advice on the care arrangement to care clients and their families. Reports from about 2,000 visits show that the quality of home care was very good or good in three out of four cases. For another twenty per cent of care clients in this study, care workers found minor deficiencies in the care arrangement. The remaining three per cent of care recipients turned out to be neglected (see Nemeth & Pochobradsky, 2004: 20) Following the assessments of these counselling projects, the government decided to make counselling visits to the homes of care clients a permanent component of its quality assurance strategy in 2005. However,

these visits are not compulsory for recipients of a LTC cash allowance (as is the case in Germany).

Administration of payments: A total of 25 Austrian authorities deal with applications for care allowances. The lion's share of payments (about 80 per cent) is made by the supporting organisations of the pension insurance and accident insurance that are both reimbursed by the federal government. The Austrian court of Audit repeatedly criticised inefficiencies in handling applications, differences in assessment procedures as well as the duration of the duration of the proceedings (see recently: Bundesrechnungshof, 2008a, 2008b). As an example, the administrative expense as a percentage of all payments of the LTC cash allowance reached 8.2 per cent in the authority administering pensions for civil servants (*Bundespensionsamt*) (see Bundesrechnungshof, 2008a: 11, 33-34).

3.2 Public funding for long-term care infrastructures and service delivery (BT)

In Austria, responsibilities of public authorities for long-term care have been established on the federal and the provincial level. In general, public responsibility for **social care service provision** is located at the local level. An agreement based on Art. 15a of the Austrian Constitution between the federal government and the nine provincial authorities seeks to assure specific characteristics of service provision: social care services have to be established area-wide and provision has to be continually expanded. Furthermore, the agreement contains minimum quality standards and states that social services have to be organisationally interlinked. Beyond social service provision, provincial authorities are responsible for providing advice and information to people in need of long-term care. To ensure implementation of social care services according to the agreement, surveys of needs and development plans have to be elaborated by the provincial authorities.

It is up to local policy whether provincial authorities provide social services by themselves (**public provision**) or commission private (nonprofit or for-profit) organisations (**private provision**).

In *domiciliary care*, most provinces chose to accredit private social service agencies, mainly nonprofit organisations. Care clients demanding services from an accredited private social service provider can apply for means-tested individual subsidies from provincial authorities. Just one province (Tyrol) organises social care services mainly by areas of collaborating communities (called “Sozial- und Gesundheitsprengel”). Contrary to domiciliary care, the public sector is a dominant provider of *institutional social care* in Austria. In 2001, more than 56 % of all employees in care homes worked in care homes run by local authorities (see Schneider & Trukeschitz, 2005: 26). Again, private providers entering the market have to be accredited by provincial authorities to be eligible for subsidies (for investments in buildings of care homes) and public refunds in case of insufficient means of their care homes inhabitants. Differences in social service provision do not only come to the fore by the comparison of institutional forms of social care providers. Although national standards for aims and principles of care for old and handicapped people were legally settled from the very beginning (see e.g. Ruddy & Marschitz, 2006: 448), differences in social care provision on the local level remain respectively arise by reason of locally defined responsibilities. Social service supply also varies in qualitative and quantitative terms at the local level. Social care services are seen to be still underdeveloped in specific regions. Regional disparities occur not only in terms of labelling services, but also with regard to comprehensiveness/variety and quality of social care provision. (see Federal Ministry of Social Social Security, 2005)

3.2.1 Models of public funding of social care services in Austria

Local disparities can be found in modes of **public and private funding of social care services** in Austria. All nine provincial authorities have made use of their leeway created by the Austrian Constitution and adopted their own social care and funding systems.

In general, care **clients pay for using long-term care services** (domiciliary services, semi-institutional services and institutional services). Exceptions mainly apply for advice and information which are provided free of charge.

The universal long-term care cash allowance (see section 3.1) strengthens purchasing power of people in need of long-term care, but does not cover total costs arising with use of social care services. Moreover, some provincial authorities set the “price” of social care services provided by accredited providers in their territory. Some provincial authorities subsidise price of care work per hour, other provincial authorities grant a subsidy to the social service provider (for details see below).

In spite of universal care allowance and price setting, individual financial resources may be still insufficient to cover total costs of social care services. Especially when institutional social care is needed even savings are soon eaten up (Schneider *et al.*, 2006: 1). If income is too low to cover costs the social assistance system steps in as a lender of last resort: In case of need for domiciliary care services, local authorities calculate the financial contribution the person is able to pay and top up the difference to the costs of care services. In case of insufficient funds of care home recipients; income and assets of the person in need of long-term care are administered by the provincial authority, only a small amount of money (“pocket money”) remains for their own use.

Recipients of social assistance in general and people in need of long-term care whose financial resources do cover social care costs any more (especially care homes residents) are obliged to refund benefits received from the local authorities if their financial situation turns better. Provincial authorities even have the right to claim refunds from family members. Recently some provincial authorities waived their right to reclaim benefits.

An interesting funding arrangement is established in the most western province of Austria, Vorarlberg. For health related home care, private payments do not refer to service units. People in need of long-term care who became a member in one of the home care associations receive health care related home care services for free. Membership fee is about EUR 25 per year, donations are welcome if patients are in need of time-consuming care. (see Trukeschitz & Buchinger, 2007b: 154) Moreover, family members donate a fair

amount of money for the benefit of the home care association when their relative had passed away. Due to the low fees, this model does not require social assistance to step in.

Despite of differences in calculating individual fees and claiming refunds from family members, the **modes of public support for clients with insufficient resources** vary from provincial authority to provincial authority:

For **domiciliary care**, public funding is either a subsidy to the social service agency (to cover overhead costs) or a substitute payment per hour of care worker activity in case of insufficient private means. The latter can be regarded as the dominant funding arrangement for home care in Austria. Interestingly, there are two different modes how hour related local payments for care domiciliary care clients are calculated (see table 3). Some provincial authorities prefer regulating the amount of public payments per hour of care work (“fix payments per hour”). Other provincial authorities define types of costs that social service agencies can claim against the provincial authority (“cost related payments per hour of care work”). (For further information see Trukeschitz & Buchinger, 2007b: 146 ff.)

Public authorities that set the amount of public payments per hour of care work can do so in three different ways (see Trukeschitz & Buchinger, 2007a: 16):

- Type 1: Provincial authority regulates the price of one hour care work and sets the public payment paid per hour care work
- Type 2: Provincial authority sets the public allowance paid per hour care work only
- Type 3: Provincial authority regulates the price of one hour care work and pays for the difference between hourly rate and individual contribution.

TABLE 3 comes about here

Concerning **institutional care**, provincial authorities provide subsidies for accredited providers to cover parts of the building costs of private care homes. Provincial authorities also support people in need of long-term care staying with accredited care home providers if care client's income/asset is not sufficient.

Public funding varies due to different modes of calculating daily rates for care homes (see table 4). Again, provincial authorities may decide on a specific daily rate or calculate daily rates due to specific types of operating costs. In any case, daily rates refer to the residential costs; rates for personal care are added. Daily rates are subject to private payments of care home inhabitants and can be subsidised by provincial authorities in case of insufficient income of care home residents. (Trukeschitz & Buchinger, 2007b: 150)

Daily rates specified by the provincial authorities apply for all accredited providers in a province of the same category of service provision. In contrast, cost related daily rates vary between accredited care and nursing homes in a province.

TABLE 4 comes about here

3.2.2 Levels of public funding for social care services in Austria

In total, EUR 3.257,38⁶ million was spent on long-term care by the public sector in 2006 in Austria (see Mühlberger et al., 2008b: 11). As financial resources from specific local authorities (health funds and "Bezirkshauptmannschaften") are not included, this sum should be interpreted as minimum public expenditure. Table 5 displays the expenditures on long-term care in Austria.

TABLE 5 comes about here

⁶ USD 4.202,02, JPY 393.458,93

Provincial authorities contribute more than 50 % of all public expenditures on long-term care (provincial long-term care cash allowance and expenditures on social care). 41 % of total expenditure was spent on social care service provision by the nine provincial authorities.

FIGURE 2 comes about here

As figure 3 displays, three third of all provincial expenditures went to institutional care. Due to different provincial accounting systems, allocation of long-term care expenditures to the different types of social services (home care, semi-institutional care and institutional care) is not always precise. Especially, the share of expenditures on semi-institutional care might be underestimated.

FIGURE 3 comes about here

From 1994 to 2006 **public expenditures on long-term care increased by 54,4 %**. As Table 6 indicates increase in LTC cash allowances developed below average. High increases appear in expenditures on social care services which mirrors the expansion of service supply and a rise in social service take-up.

TABLE 6 comes about here

3.3 Public support to informal caregivers

Informal, unpaid caregiving is the mainstay of long-term care in Austria. Experts estimated an economic value of informal care amounting up to EUR 2-3 billion (see Mühlberger et al., 2008b: 14; Schneider & Oesterle, 2003: 236). As caregiving for frail or sick relatives and friends is also a burdensome task and implicate opportunity costs, public support for informal carers is necessary not only to compensate for risks occurring with caregiving but also to enable relatives or friends to engage in caregiving.

The following paragraphs describe **benefits for informal carer** that are nation-wide available (for an overview see table 7 for further details see Bundesministerium für Soziales und Konsumentenschutz (2008: 15 ff.):

Coverage of informal carer under social insurance law: Family members who care for their frail relatives have health insurance coverage without contributions. Unemployed informal carers who care for relatives receiving LTC allowance of level 3 are eligible to insure themselves under the pension insurance schemes at reduced rates. Since July 2007, relatives caring for LTC allowance recipients of level 5 or higher have not have to pay any contributions for full coverage in the pension insurance system for a period of 48 months.

A **family hospice leave system** was introduced in July 2002 and amended in March 2006. The benefit of this regulation for informal carer is a right to reduce working hours or to take leave for a specific period of time to care for a dying relative for a maximum of six months. Informal carers are still covered by social insurance but have to cope with the loss of income. Unlike maternity leave, no financial support is granted. Only in case of hardship, an informal carer on family hospice leave get an allowance from the “Familienhospizkarenz-Härteausgleich”.

Financial support for **respite care** was introduced in January 2004. Family members who provide informal care to a partner or close relative (LTC allowance level 4 or higher) but are temporarily (1 to a maximum of 4 weeks) not able to continue caring (due to illness or days of time-out/holidays) receive an allowance for paying respite care. This respite care allowance is granted for informal if net income per month without transfers) of the LTC allowance receiving relative does not exceed EUR 2,000 (LTC allowance levels 4 and 5) or EUR 2,500 (LTC allowance levels 6 and 7). Income threshold is adjusted in case of dependent family members. Financial support for respite care is capped depending on the need of LTC (indicated by the LTC allowance level).

As information is crucial for arranging care for relatives, two information services have been established. The “Pflegetelefon” is a hotline providing information on long-term care issues. In addition an internet platform for informal carers offers information and exchange of knowledge.

TABLE 7 comes about here

In addition to federal **support** for informal carers, **provincial authorities** engage in activities to facilitate and enable informal caregiving (for further information see Arbeitskreis 2007: 41ff.)

- In order to enhance and assure quality of long-term care service provision some provincial authorities support **care related advice and counseling** by a registered nurse. This support is either organized as a lump-sum allowance, a voucher or a benefit in kind.
- **Information events** and **regular meetings of informal carer** (“Stammtisch”) are planned to inform informal carers and to provide opportunities to exchange knowledge and share experiences.
- Some provincial authorities modify eligibility criteria for **respite care** in favour for informal carers (lower level of LTC cash allowance required or additional support contingent on income).
- At least one provincial authority provides support for a **stay in a health resort**. Co-payments for this one week stay of the informal carer are very low (EUR 50 per week).

3.4 A new approach to dealing with the influx of foreign “grey” labour in long-term care

Social care services, like home care, meals on wheels, contribute to improving living conditions for people in need of long-term care and prevent or delay transitions into nursing homes. Another aspect of social care services is that they facilitate informal care. As private co-payments for professional home care services are common in Austria (see also section 3.2), using social care can put pressure on family budgets, especially in severe cases of LTC dependency. As a consequence, a sizable number of long-term care clients or their relatives turned to agencies specialized on recruiting care attendants from abroad, sidestepping Austrian labour laws and tax authorities.

Moreover, a chronic shortage of both licensed mobile nurses and stationary nursing places lead to an insufficient supply of care in quantitative and qualitative terms (see e.g. Schmid & Procházková, 2006: 462). This again has prompted immigration of (legal and illicit) foreign care workers to Austria. A recent empirical study (Lenhart 2008: 127-129, Lenhart/Österle 2007: 9) reports that about 10.5 per cent of care workers in Austrian nursing homes and skilled nursing facilities have not been trained in Austria. Slightly less than two-thirds of care workers in this group had been trained in another EU-member state, all others in third countries. The eastward expansion of the European Union potentially facilitates free cross-border mobility of labour because citizens of the European Union do not need to apply for a working permit in the single European market. However, Austria took advantage of an interim arrangement with regard to countries joining the EU in the years 2007 to 2007 and sustained the restriction to its labor market for workers from these new EU Member States (see e.g. Adam, 2004)⁷

Against this background, Austria has experienced a significant influx of foreign “grey” labour from Central and Eastern Europe and the development of what is called a “grey” market of foreign care workers over the past decade. “Grey labour” refers to illicit personal care workers or homemakers working in private households. These foreign workers do not hold a work permit in Austria, do not pay income taxes in Austria and are not covered by social insurance. Experts estimate that approximately 40.000 illegal care workers support people in need of long-term care and their families (see Ruddy & Marschitz, 2006: 445). From the perspective of foreign care workers, labour market conditions (especially wages and employment opportunities) are less attractive in their home countries than in Austria. They commonly chose to commute between their home country and Austria every other week or every two weeks, staying with a care client for a full week or fortnight. Concern has been raised in policy discussions about the qualification of this group of care workers, the quality of care delivered but also about workers’ employment and living conditions and social protection.

⁷ This source can be accessed at <http://www.eurofound.europa.eu/eiro/2004/03/inbrief/at0403201n.htm>

Legal acts regulating the employment of foreign workers and long-term care as well as social care related issues were amended by the federal state in 2006, 2007 and 2008. On July 2007 the “Act on Home Care” (Hausbetreuungsgesetz, HBeG) entered into effect as did the amendment to the Industrial Code (GewO). According to these laws care workers from Austria or other EU Member States now have to be formally employed with the person in need of long-term care, a care client’s relative or with a nonprofit social care agency. Alternatively, foreign care workers can provide care on a self-employed basis, assisting care clients in housework and other instrumental and social activities of daily living (Federal Ministry of Social Affairs and Consumer Protection, 2007: 68). Since 10 April 2008, they have been authorized to also help their clients with personal hygiene and intake of food. Even a few medical treatments – like medication administration according to physicians’ instructions – have recently been added to the list of legally recognized tasks for this group of personal care workers.

The recent legislation also specifies working conditions and remuneration (see Federal Ministry of Social Affairs and Consumer Protection, 2007: 68). **Care workers** provide 24-hour home care as a member of his/her client’s household for at least 48 than hours per week but must not work more than 128 hours for two consecutive weeks. After 14 days care work has to be interrupted for leisure purposes for the same period of time. So, if 24-hour care is needed, two care workers have to be engaged. Care workers who are not self-employed have to be paid at least EUR 1,093.53⁸ per month (gross income for 238 hours, incl. stand-by duty) according to the national minimum wage in this occupational area.

If two nurses (as mentioned above) are required, the cost of 24-hour stand-by care may amount up to EUR 3,000 to 4,000⁹ (incl. payroll taxes) (see Adam, 2007a; see Adam, 2007b)¹⁰. From 7 January to 15 July 2008, the number of self employed care workers registered for an up to 24 hour home care increased from 578 to 9,786. (see Rupp / Schmid

⁸ = 1410,56 USD, 132284,32 JPY

⁹ =3.870-5.160 USD, 362.370-483.160 JPY

¹⁰ These sources can be accessed at <http://www.eurofound.europa.eu/eiro/2007/01/articles/at0701019i.htm> and <http://www.eurofound.europa.eu/eiro/2007/09/articles/at0709019i.htm>

2008: 5). To obtain the total number of workers providing paid 24-hour care, the number of 24-hour care workers with an employment contract has to be added. Unfortunately, these data are not available.

In addition to the regulation concerning the terms and conditions for taking on care workers for 24 hour attendance, a **financial support for 24-hour care** was introduced on 1 July 2007. This cash benefit is jointly funded by the federal state (60%) and the nine provincial authorities (40%). Access to financial support for 24-hour home care is tied to the following eligibility criteria: First, a care worker from Austria or another EU Member State has to be properly engaged (see above). Second, the care client has to be eligible for a universal long-term care allowance of level 3 or higher¹¹ and his condition necessitates 24 hour care. Third, the net income of the care client is not to exceed EUR 2,500¹² per month (since 1 November 2008 assets are no longer accounted for). Finally, the care worker has to meet qualification and process related quality requirements. (see table 8)

The grant for 24-hour care amounts to up to EUR 500 or up to EUR 1,100¹³ per month depending on whether the personal care worker is self-employed or not. (see table XX). At least one province, Lower Austria, provide access to the 24-hour care allowance for recipients of the LTC cash allowances in benefit categories 1 and 2 who suffer from dementia. A medical certificate on the need for 24-hour stand-by care is not necessary to access 24-hour care allowance (Arbeitskreis 2007: 47).

Until end of August 2008, 2,293 care clients had made a request for the 24-hour care allowance, 1,372 of them have been accorded the benefit so far (some request might still be under examination). Public expenditure on this benefit amounts to EUR 1.4 billion up to this point in time. (1,8 billion USD, 169 billion JPY)

¹¹ In case of dementia, the care client is eligible for support beginning with a placement in need category 2.

¹² =3.225 USD, 301.975 JPY (10 Dec 2008)

¹³ =645-1,419 USD, 60.395-132.869 JPY (10 Dec 2008)

TABLE 8 comes about here

Table 9 displays payment flows in the Austrian long-term care system.

FIGURE 4 comes about here

4 Challenges to the long-term care system and current policy debate in Austria

In European welfare states, it is not long since long-term care as social risk has appeared on policy agendas. Compared to social security systems against sickness, unemployment or old age poverty, policy approaches for covering a risk that almost everyone will be confronted with at least at the end of life – the risk of long-term care dependency – are comparatively new. Policy responses to this kind of risk are diverse. Some European countries, like the Czech Republic and Slovakia, have not yet established a distinct long-term care system. There, social security for people in need of long-term care is rooted mainly in health care systems, pension systems and systems supporting families. Other countries, like Germany and Austria, have established specific policy approaches to deal with the need for long-term care. Where specific policy solutions to cover the risks of long-term care emerged, they differ in coverage, funding structure, etc. from country to country and even within countries.

As mentioned in the introductory section, Austria (as other European countries) will face a marked increase in the share of old people on the whole population. Even with optimistic predictions on the expected number of healthy life years at age 50 or 60, it is common knowledge that the number of people in need for long-term care will increase in the future. Hence, given that Europe will be aging at a firm pace in the decades to come, one may well ask, whether current provisions for frail older people can be considered successful and sustainable. On the one hand, future challenges to long-term care systems stem from developments of need in terms of volume and diversity. On the other hand, they also result

on the specific structure of a nation's social security system in general and path dependencies in its approach to dealing with long-term care needs.

In Austria, the long-term care system rests on two pillars, namely family support and public provisions for long-term care. Families play an important role, as almost 70-80 % of older persons in need of long-term care rely on spouses and children to provide help. The public long-term care system is complementary and fulfils three important tasks: First, it should assure a landscape of different types of social services as well as sufficient social services in both number of services and geographical coverage (see section 3.2). Second, it should secure access to social care services. At present time, this is done by granting universal and selective financial support to people in need of long-term care (see section 3.2 and 3.4). Third, it recognises relatives as important actors in long-term care. In recent past, benefits for informal carer were introduced (see section 3.4).

In the current debate on the future of Austria's long-term care policy, **four challenges** figure very prominently:

To begin with, long-term dependency still presents a serious poverty risk for older persons. Today more a major share of social assistance spending is made up of payments on behalf of older persons in residential care. Accordingly, there is an ongoing debate on adjusting benefits to inflation on a year-by-year basis. Moreover, efforts are underway to prevent or delay institutionalization.

Secondly, all projections point to an increase in the number of frail older people while at the same time predicting a shrinking population of family caregivers. Therefore, long-term care policy pays increasing attention to supporting informal care. One way of reaching this aim is to invest in the supply home care and day care services.

Third, with an increase in the number of the oldest old, dementia care is gaining importance. Recent legislation has improved access to care benefits for persons suffering from a mental condition by changing assessment rules (see section 4.1). At the same time, there is a need to develop new approaches to caring to this specific group of frail older people.

Fourth, as public spending on long-term care is growing fast, provinces start realizing that they will not be able to assume sole responsibility in securing adequate infrastructures for long-term care. As a consequence, the government programme of the new federal government (2008-2013) suggests setting up a public fund that is to be earmarked for long-term care (Mühlberger *et al.*, 2008a). Details on where the initial endowment (or continuous flows of funding) will come from and the extent to which responsibilities will be shared between the federal government on the one hand and provinces on the other hand still need to be worked out.

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6 Appendix – Tables and Figures

6.1 Tables

Table 1: Projected increase in the elderly population in need of long-term care, Austria 2006 - 2030

| Jahr | Federal LTC cash care recipients | | Changes in % (2006-2030) | | Provincial LTC cash care recipients | | Changes in % (2006-2030) | |
|------|----------------------------------|----------------------|--------------------------|----------------------|-------------------------------------|----------------------|--------------------------|----------------------|
| | Lower-bound Szenario | Upper-bound Szenario | Lower-bound Szenario | Upper-bound Szenario | Lower-bound Szenario | Upper-bound Szenario | Lower-bound Szenario | Upper-bound Szenario |
| | (1) | (2) | (1) | (2) | (1) | (2) | (1) | (2) |
| 2006 | 334.162 | 334.162 | | | 58.958 | 58.958 | | |
| 2010 | 381.319 | 381.319 | 14,1 | 14,1 | 60.682 | 60.137 | 2,9 | 2,0 |
| 2015 | 401.569 | 419.355 | 20,2 | 25,5 | 60.460 | 62.156 | 2,6 | 5,4 |
| 2020 | 410.825 | 449.435 | 22,9 | 34,5 | 60.428 | 63.991 | 2,5 | 8,5 |
| 2025 | 435.226 | 493.752 | 30,2 | 47,8 | 62.805 | 65.760 | 6,5 | 11,5 |
| 2030 | 472.179 | 551.886 | 41,3 | 65,2 | 63.862 | 71.197 | 8,3 | 20,8 |

Source: Mühlberger et al (2008: 33)

Table 2: LTC cash allowance: Need categories and benefit levels 2008 and 2009

| Levels | Care need | LTC cash allowance (per month) 2008 | | LTC cash allowance (per month) 2009 | | Adjustment as of January 1, 2009 |
|--------|-------------------------|-------------------------------------|-------------------|-------------------------------------|-------------------|----------------------------------|
| | | EUR | USD ¹⁾ | EUR | USD ¹⁾ | Increase (%) 2009/2008 |
| 1 | 50 hours | 148,30 | 191,30 | 154,20 | 198,90 | 4% |
| 2 | 75 hours | 273,40 | 352,70 | 284,30 | 366,70 | 4% |
| 3 | 120 hours | 421,80 | 544,10 | 442,90 | 571,30 | 5% |
| 4 | 160 hours | 632,70 | 816,20 | 664,30 | 856,90 | 5% |
| 5 | 180 hours ²⁾ | 859,30 | 1.108,50 | 902,30 | 1.164,00 | 5% |
| 6 | 180 hours ²⁾ | 1.171,70 | 1.511,50 | 1.242,00 | 1.602,20 | 6% |
| 7 | 180 hours ²⁾ | 1.562,10 | 2.015,10 | 1.655,80 | 2.136,00 | 6% |

¹⁾ Exchange rate (December 10, 2008): 1 EUR = 1,29 USD, 1 USD= 0,77 EUR

²⁾ Additional requirements for eligibility:

Level 5: exceptional care need (e.g. at requiring at least 5 units of care one of which has to be provided at night);

Level 6: unpredictable/ erratic care needs day and night or need for permanent supervision to avoid endangerment of self or others;

Level 7: Impossibility of hortic movements of extremities (arms and legs) or necessity for life-supporting equipment.

Source: 15 Jahre Pflegegeld 2008: 11, 29, own calculations

Table 3: Provincial funding models for domiciliary care (Austria, 2007)

| Provinces | Hour related public payments | | Subsidy |
|---------------|-----------------------------------|--|---------|
| | fix payment per hour of care work | Cost related payment per hour of care work | |
| Burgenland | Type 1 | | |
| Lower Austria | | yes | |
| Carinthia | Type 1 | | |
| Upper Austria | | yes | |
| Salzburg | Type 3 | | |
| Styria | Type 2 | | |
| Tyrol | | | yes |
| Vorarlberg | Type 2* | | yes** |
| Vienna | | yes | (yes) |

note: * for home care only, ** for health related home care only; yes in brackets: existent but not very important

source: Trukeschitz/Buchinger (2007b: 150)

Table 4: Provincial models for determination of daily rates for institutional care (Austria, 2007)

| Provinces | daily rates | |
|---------------|--------------|-----------------------|
| | Fix payments | Cost related payments |
| Burgenland | | yes |
| Lower Austria | yes | |
| Carinthia | yes | |
| Upper Austria | | yes |
| Salzburg | yes | |
| Styria | yes | |
| Tyrol | | yes |
| Vorarlberg | | yes |
| Vienna | yes | yes |

source: Trukeschitz/Buchinger (2007b: 153)

Table 5: Expenditures on long-term care (Austria, 2006, EUR/USD/JPY in million)

| | | Total | LTC cash allowance | | Social care services | | |
|----------------------|------|------------|----------------------------|-------------------------------|----------------------|-------------------------|--------------------|
| | | | Federal LTC cash allowance | Provincial LTC cash allowance | Home care | Semi-institutional care | Institutional care |
| 2006 | EUR | 3.257,38 | 1.621,40 | 303,64 | 237,12 | 89,70 | 1.005,52 |
| | USD* | 4.202,02 | 2.091,61 | 391,70 | 305,88 | 115,71 | 1.297,12 |
| | JPY* | 393.458,93 | 195.848,91 | 36.676,68 | 28.641,72 | 10.834,86 | 121.456,76 |
| In % of total | | 100,00 | 49,78 | 9,32 | 7,28 | 2,75 | 30,87 |
| | | | 59,1 | | 40,9 | | |

Source: Mühlberger (2008b: 11), own calculations

* Notes: Vienna stock exchange: exchange rates USD, JPY 10 December 2008

1 EUR = 1,29 USD; 1 USD = 0,77 EUR

1 EUR = 120,79 JPY; 1 JPY = 0,01 EUR

Table 6: Changes in expenditures on long-term care (Austria, 1994 to 2006)

| | Total | LTC cash allowance | | Social care services | | |
|--------------------------|--------------|----------------------------|-------------------------------|-----------------------------|-------------------------|--------------------|
| | | Federal LTC cash allowance | Provincial LTC cash allowance | Home care | Semi-institutional care | Institutional care |
| Changes in % (1994-2006) | 54,4 | 20,9 | 23,3 | 92,1 | 275,0 | 167,5 |

Source: Mühlberger 2008: 11, own calculations

Table 7: Public support for informal carers

| Benefits for informal carer | Type of benefit | | |
|--|-----------------|-------------------|-----------------|
| | Right | Financial support | Benefit in kind |
| Federal level | | | |
| Coverage of informal carer under social insurance law | yes | yes | |
| Family hospice leave system | yes | (yes) | |
| Respite care | | yes | |
| Information (“care hotline” and platform for informal carer) | | | yes |
| Provincial level | | | |
| Support of care related advice | | yes | yes |
| Seminars on care | | | yes |
| Information events and regular meetings | | | yes |
| Respite care | | | yes |
| Support stay in a health resort | | | yes |

Table 8: Allowance for 24-hour home care (eligibility criteria & financial support)

| | |
|---|---|
| Eligibility criteria | |
| needs based | At least LTC level 3 & necessity for a 24-hour stand-by care LTC level 1 or level 2 for people diagnosed with dementia and need of a permanent stand-by care. |
| income threshold | net income per month less than EUR 2,500 ¹⁴ (excl. social transfers), plus EUR 400 ¹⁵ (for dependent relatives) and EUR 600 ¹⁶ (for disabled dependent relatives) |
| quality requirements | Qualification requirements: qualification equivalent to home care worker, or provision of care to the applicant/ care client for at least six months Documentation of care provided, agreement on “guidelines of care” between care client and care worker, and – in case of self- employed care worker – documentation of expenditures |
| | |
| Financial support | Updated level of support (1 November 2008) |
| Up to EUR 1,100 ¹⁷ /month | For two care workers being employed |
| Up to EUR 500 ¹⁸ /month | For two self-employed care workers |

(see BMSK 2008, Pflegevorsorgebericht: 37) und (Federal Ministry of Social Affairs and
Consumer Protection, 2007: 68-69)

¹⁴ =3.225 USD, 301975 JPY (10 Dec 2008)

¹⁵ =516 USD, 48.316 JPY (10 Dec 2008)

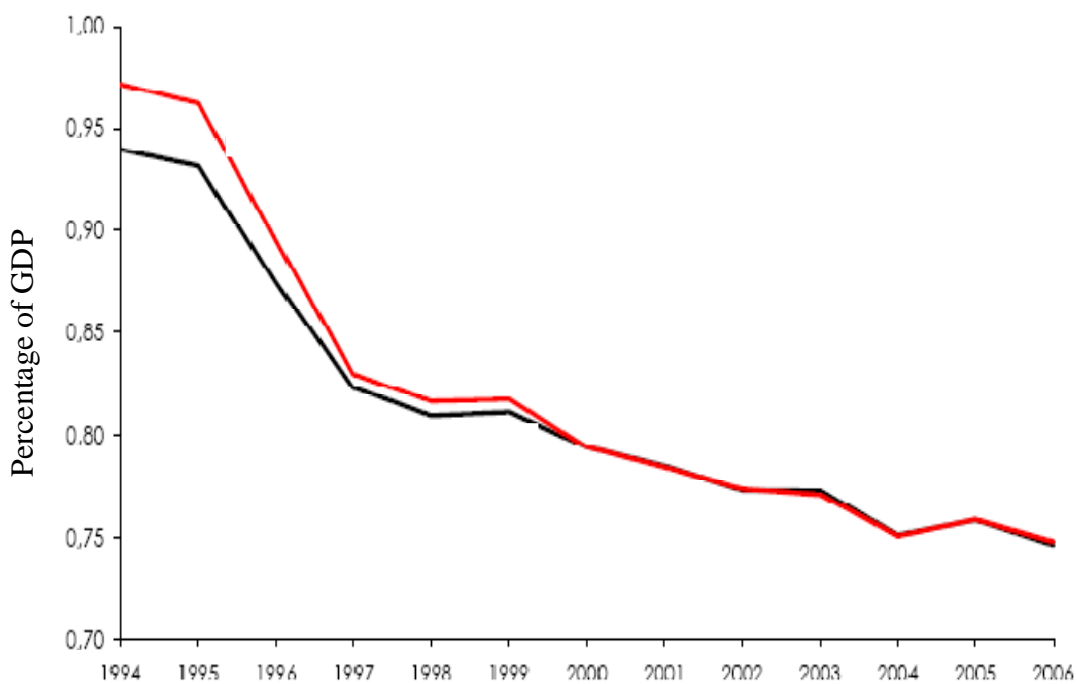
¹⁶ =774 USD, 72.474 JPY(10 Dec 2008)

¹⁷ =1419 USD, 132.869 JPY (10 Dec 2008)

¹⁸ =645 USD, 60.395 JPY (10 Dec 2008)

6.2 Figures

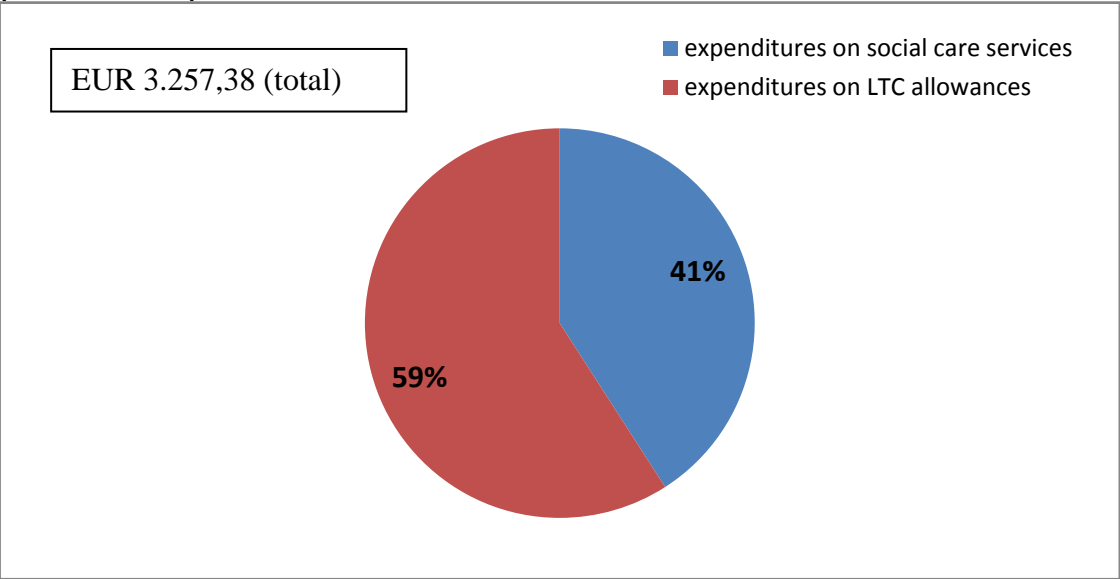
Figure 1: Spending on LTC cash allowances by the federal and provincial authorities as a percentage of real and nominal GDP, 1994 to 2006



Source: Mühlberger et al (2008c: 10)

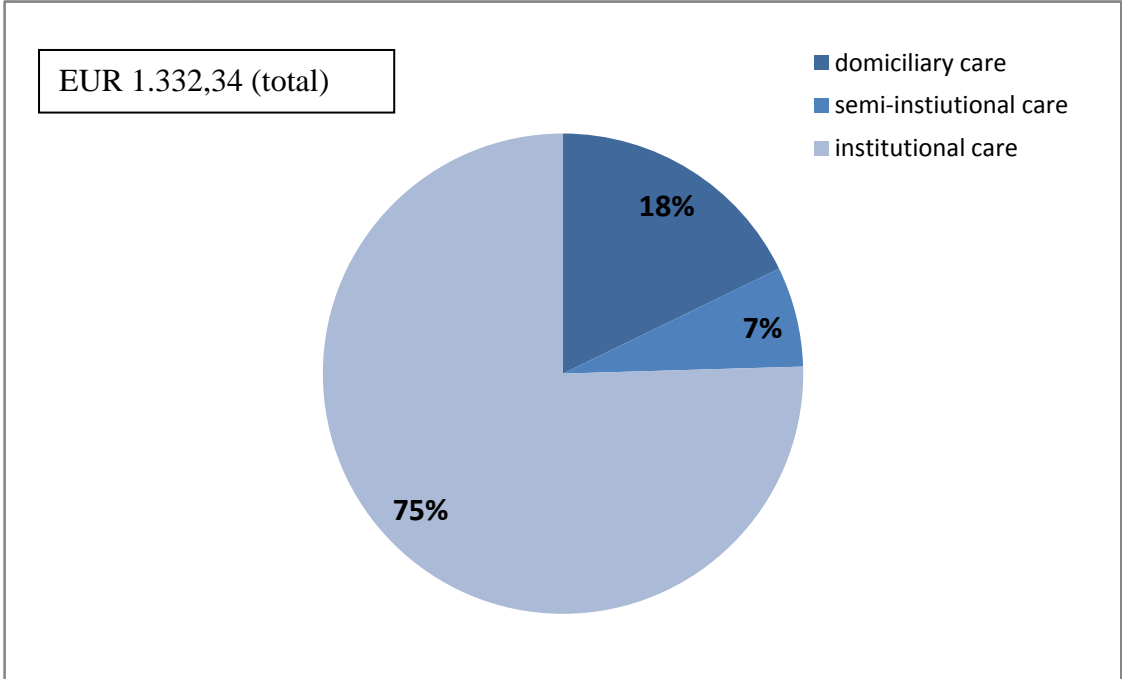
- LTC cash allowance as a percentage of real
- LTC cash allowance as a percentage of

Figure 2: Share of expenditures on social care services on total public expenditures (Austria, 2006)



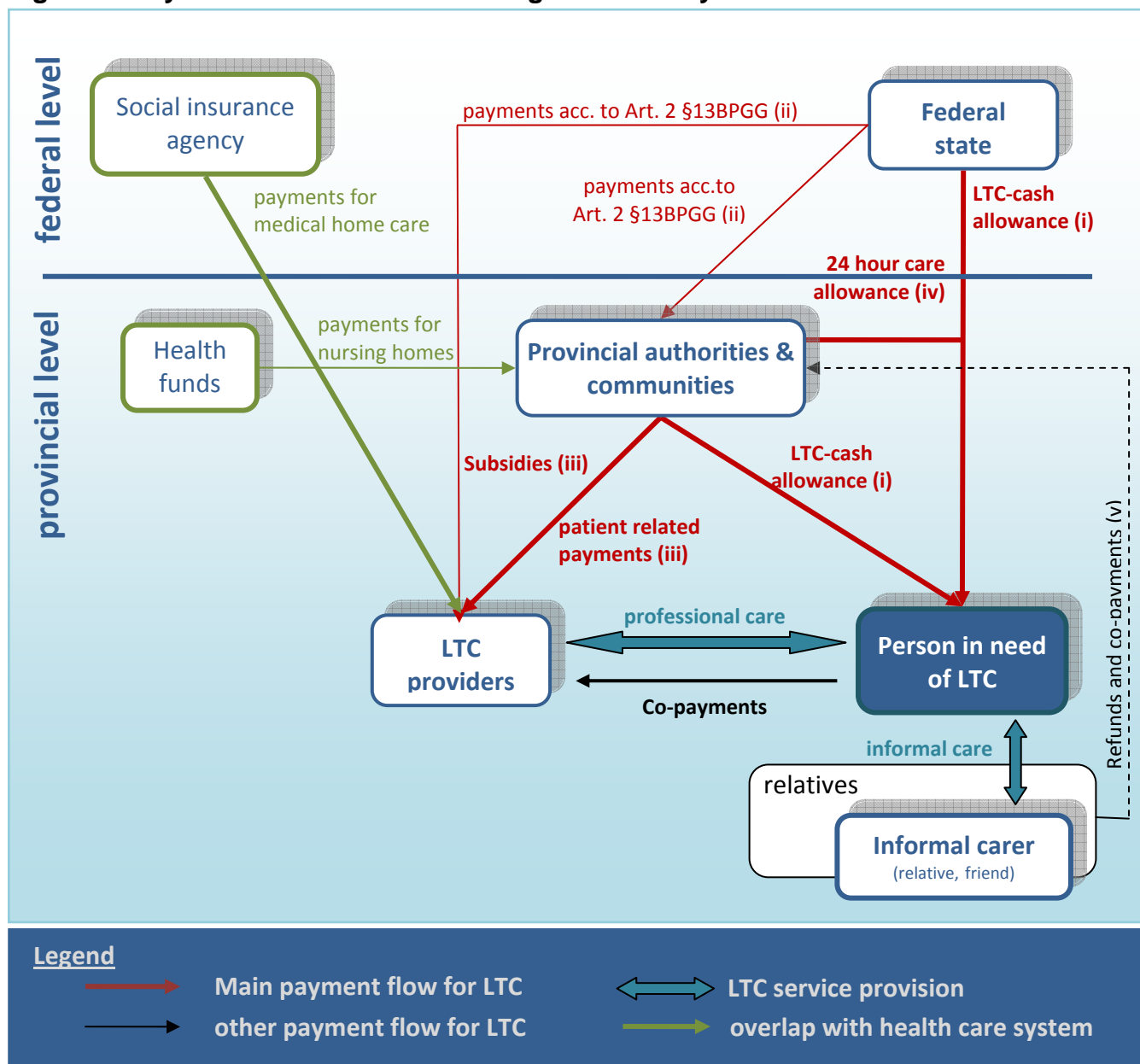
Source: Mühlberger 2008: 11, own calculations

Figure 3: Expenditures of provincial authorities on social care by type of service (Austria, 2006)



Source: Mühlberger 2008: 11, own calculations

Figure 4: Payment flows in Austria's long-term care system



Source: own display based on Arbeitskreisbericht 2007: 21.

Notes:

- (i) Federal state – person in need of LTC & provincial authorities/communities – person in need of LTC: **LTC cash allowance** is paid to the person in need of LTC either according to the Federal Act on long-term care benefits or to one of the nine provincial acts on long-term care benefits (see chapter XX)
- (ii) Federal state – LTC provider & federal state – provincial authorities/communities: Art 2 § 13 BPGG: in case of institutional care (e.g. nursing home), **LTC cash allowance** is not paid to the client, but goes straight to the nursing home provider. A “pocket money” of 10 % of LTC allowance level 3 is paid to the client. If the nursing home is run by the provincial authority LTC cash allowances are directed to the provincial authority. The regulation on pocket money applies analogously.
- (iii) Provincial authorities/communities – LTC providers: **subsidies** for establishing and supporting social care facilities, **patient related payments** in case of insufficient individual means (see section XX)
- (iv) Federal state – person in need of LTC care: & Provincial authorities/communities – person in need of LTC: shared public funding for **24-hour care allowance** (see section XX)

(v) Relatives – provincial authorities/communities: Depending on the regulation of provinces on social assistance, relatives can be obliged to **refund benefits** received by the social care client (mainly institutional care) (see section XX). Some provincial authorities **charge first-degree relatives** (children, parents) when care clients' income is insufficient and benefits of social assistance are granted.

Overlap with the health care system:

(vi) Social insurance agency – LTC-provider: Social security agency pays for **medical home care** (giving injections, artificial feeding, care of decubiti, etc.) according to § 151 ASVG; if the client is not cared by a provider that is not contract partner to the social insurance agency, costs of treatment are reimbursed acc. to § 131 ASVG.

(vii) Health funds – provincial authority/community: Health funds, founded to plan, govern and finance health care at the local level, level contribute the building of **nursing homes** or support operating nursing homes. Private long-term care insurance is not popular in Austria, therefore not displayed.