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Assessing Needs of Care in European Nations

# QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

## COUNTRY REPORT: AUSTRIA

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**THOMAS CZYPIONKA, MARKUS KRAUS  
AND MARCEL KALMAR**

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### Abstract

In Austria, the responsibilities for long-term care mainly lie with the provinces, although federal and organisational-level initiative has grown. Quality assurance policies focus overwhelmingly on the health system and are only slowly appearing in the realm of long-term care (LTC). Although the Austrian LTC system is still very fragmented owing to the division of competencies, there are enhanced efforts underway to harmonise LTC provision, standards and quality nationwide. Currently, quality assurance remains mostly at the stage of setting general frameworks or launching small-scale projects, with some notable exceptions. Additional efforts are needed for concerted reforms and for furthering implementation activities.



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# Quality Assurance Policies and Indicators for Long-Term Care in the European Union

## Country Report: Austria

ENEPRI Research Report No. 105/February 2012

Thomas Czypionka, Markus Kraus and Marcel Kalmar \*

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### 1. Introduction

According to the Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK), more than 425,000 people in Austria are in need of care (BMASK, 2010a).<sup>1</sup> Austria, like many European countries, has a more or less clear distinction between social and health care policies (Grilz-Wolf et al., 2003: 97). Following the Federal Long-Term Care Allowance Act of 1993 (Bundespflegegeldgesetz, BPGG), granting financial support to individuals based on an assessment of their care needs, the federal government has increased its efforts to take on greater responsibility in the provision of long-term care (LTC). Further complicating the assessment of the responsibility structure, the competencies in this field lie with two separate ministries, the Federal Ministry of Labour, Social Affairs and Consumer Protection as well as the Federal Ministry of Health. The introduction of quality assurance policies has been a very recent development in the Austrian health and social care system. As both systems fall into the split sphere of responsibility of the federal state and the provinces, nationwide standards cannot be easily determined. The most important activities have originated from so-called 'Art. 15a B-VG'<sup>2</sup> negotiations, as well as the Health Reform Act of 2005 (Gesundheitsreformgesetz 2005).

To enable us to provide a more or less complete picture of the complicated system of LTC-related competencies that are relevant for quality aspects, we start by identifying the institutions entitled to develop, implement and monitor policies. Subsequently, the legal frameworks on LTC quality that target the different levels and implementation in practice are addressed. Finally, the results of the various policies are outlined by describing evaluations and the state of affairs of policy processes (where information is available). In accordance with the country report structure specified for this Work Package, we include a section on the types of quality indicators and selected data. In Austria, however, there has been almost no activity in this regard (see section 3).

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\* Thomas Czypionka is a Senior Researcher, Markus Kraus is a Researcher and Marcel Kalmar is a student assistant at the IHS HealthEcon, Institute for Advanced Studies, Vienna. Acknowledgements: The authors would like to thank all those who patiently endured our questions and requests for clarification.

<sup>1</sup> No reference for this figure is provided. Taking estimates from the Micro Census 2001 and the latest statistics of care allowance recipients into account, the stated number is plausible (see Riedel and Kraus, 2010).

<sup>2</sup> Art. 15a refers to a central article of the Austrian constitution concerning the financing of matters where competencies are split between the levels of government. Every few years the regions and the federal government meet to negotiate the organisation and financing arrangements of these matters, setting them out in a 15a B-VG Agreement between the Federal State and the Provinces.

## 2. Methodology

Work Package 5 of the ANCIEN project sets the structure for country reports, accompanied by a questionnaire. We have tried to gather information from all available sources to answer the questions and give a concise picture of quality assurance in LTC in Austria. We have used all of the official literature and statistics as well as the laws referring to the topic in a wider sense. As there is still room for improvement with respect to transparency, we have also had to use grey literature, and have conducted several interviews with experts from research, administration, the professional bodies and service provision.

### 2.1 Organisation of quality assurance in LTC

#### 2.1.1 Responsibilities for LTC policies

Competencies in the Austrian social care and the health care systems are fragmented. This stems from the divided responsibilities of the federal and provincial authorities as set out by the Austrian federal constitution (Bundes-Verfassungsgesetz, B-VG). Social care services are cross-sectional matters. Both the in-patient sector of health and social care (hospitals, nursing homes, residential homes, etc.) and home-based social services are mainly subject to provincial legislation and administration. The federal state must only pass elementary laws in this area, whereas the provinces have the authority to pass and responsibility to implement laws (Art. 12(1) B-VG).

#### 2.1.2 Federal level

At the federal level, the Federal Ministry of Labour, Social Affairs and Consumer Protection is mainly responsible for the development of policies on long-term care and its quality. Yet as noted above, the ministry is only capable of setting up framework regulations. As a vehicle for persuading the provinces to standardise rules and regulations on LTC quality, the ministry uses the constitutional institution of the 15a B-VG negotiations between the federal government and the provinces.

Another player at the federal level concerning the development of quality assurance policies in LTC, although not officially authorised to deal with issues of long-term care, is the Federal Ministry of Health. The ministry takes action in the realm of operational tasks and the education of medical personnel, including those in the field of professional care. This excludes the education of physicians, which falls under the competency of the Federal Ministry of Science and Research. Thus, it formulates legal propositions affecting parts of the structure, process and even outcomes in terms of quality in LTC. An additional aspect of quality in LTC seems to be the ministry's efforts in quality assurance work across the entire health system, as stated in the Health Reform Act of 2005. Although not primarily targeting services belonging to the area of long-term care, there are points of contact in relation to interface-management and the working profiles of care personnel (see subsection 3.2.1.2).

In 2006, the Federal Ministry of Health established another institution by law to further the activities outlined in the Health Reform Act of 2005 (see the Law to Establish Health Austria GmbH, Erlassung des Bundesgesetzes über die Gesundheit Österreich GmbH 2006, GÖGG). The Health Austria GmbH (GÖG) fuses separate units formerly attached to the ministry, as a national research and planning institute for health and to a lesser extent social care. Especially its subdivisions – the Austrian Federal Institute for Health (Österreichisches Bundesinstitut für das Gesundheitswesen, ÖBIG) and the Federal Institute for Quality in Healthcare (Bundesinstitut für Qualität im Gesundheitswesen, BIQG) – are involved in developing quality standards in health and social care. For the ÖBIG, this includes planning, developing and

distributing guidelines on quality in relation to the structure of health and social care organisations, evaluating and monitoring policies and projects, developing professional curricula and so on (§4 GÖGG). The BIQG is obliged to develop standards and indicators for quality assurance, promote documentation in this regard, prepare reports on quality, etc. Nevertheless, it has to be mentioned that the application of the institutes' work is not legally binding, since the competencies for health care and (to an even greater extent) social care lie with the provinces.

### **2.1.3 Provincial level**

Provinces are the main authorities concerning the in-patient sector of health and all social care services. Therefore the provinces are in charge of all social assistance services associated with LTC, such as institutional care services and home-based services, with the notable exception of the federal care allowance (Bundespflegegeld). All nine of the province parliaments are entitled to pass laws in accordance with basic federal law, if existing. Provincial governments and the responsible provincial departments, respectively, implement the passed regulations. This concerns most importantly the planning, provision and supervision of institutional care and home-based services as well as assuring LTC quality, commonly by setting minimum standards.

Based on the legal framework given to the provinces by the constitution and the 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993 (Vereinbarung gemäß 15a B-VG über gemeinsame Maßnahmen des Bundes und der Länder für pflegebedürftige Personen), all nine provinces have passed (or amended) their own social assistance laws (*Sozialhilfegesetze*). Accordingly, the provinces are responsible for the provision of social services and the supervision of their quality, with provision often being delegated to other institutions or administrative levels. Generally, four types of providers can be found: provinces, municipalities, social organisations (*Sozialhilfverbände*) and social funds (*Sozialfonds*). In Burgenland and Lower Austria, only the province provides social services, including LTC. Carinthia and Styria delegate certain LTC tasks to social organisations and municipalities. Upper Austria passes on competencies solely to social organisations, whereas Vienna exclusively does so to their social fund. Salzburg delegates some aspects of LTC provision to municipalities. Tyrol and Vorarlberg share their responsibility for the provision of social services with social organisations and social funds, although Tyrol retains liability for all LTC services (Biwald et al., 2007: 12ff).

According to the 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993, institutional, semi-institutional and home-based care services have to be provided in a coordinated manner. Seven out of nine provinces have chosen to coordinate their services following the concept of an Integrated Social and Health District (Integrierter Sozial- und Gesundheitssprengel, ISGS) developed by the ÖBIG. These ISGS districts are supposed to be regional organisations, aiming at the cross-sectional management of health and social care services within a defined geographical area of 10,000 to 20,000 inhabitants. Furthermore, they have the tasks of analysing the level of provision, guaranteeing the existence of health and social care services and acting as contact points for patients, care recipients and their families to find the appropriate services (Riedel and Kraus, 2010: 30). In reality, the structures of the ISGS vary significantly in the respective provinces owing to different prerequisites in the pre-existing coordination infrastructure and the diverse strategies pursued to attain their integration goals.

## 2.2 The different settings of LTC

### 2.2.1 Legal frameworks concerning care institutions

#### 2.2.1.1 Minimum standards of quality

A fundamental step that has been taken to harmonise the LTC system in Austria is the above-mentioned 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993. This agreement had become necessary for implementing the policies of the Federal Long-Term Care Allowance Act of 1993, which introduced a nationwide financial support system for individuals according to their need for care. An essential part of this agreement is Art. 5 and its formulations, by which the provinces commit themselves to the assurance of minimum standards for the institutional, semi-institutional and home-based care services as described in the appendix of the agreement. These encompass the following aspects:

- for home-based services
  - free choice of the kind of service;
  - coordination of cross-sector transfers between home-based and institutional care services;
  - quality assurance and supervision (no further objectives specified);
- for semi-institutional (e.g. day/night care and short-term institutional care) and institutional care services (only newly built)
  - the amenities of a home environment (to enable family-like living);
  - room environment (care-friendly, supply of sanitary facilities, single room if possible);
  - visitation rights (visiting must be possible at all times);
  - infrastructure (institutions must provide therapy, visiting and service facilities);
  - personnel (providing care personnel who are sufficiently qualified);
  - medical provision (the responsibility of the home's management to make medical treatment available if needed); and
  - supervision (homes must be supervised by the provinces, and especially the individual rights of care recipients must be guaranteed).

Furthermore, Art. 5 refers to a benefits catalogue in the appendix, which lists all the LTC services that have to be provided. As a result of this agreement, the provinces were obliged to devise and implement so-called 'Demand and Development Plans' (Bedarfs- und Entwicklungspläne) for the area-wide provision of these care services until 2010 (Art. 6), with several provinces having published updates on these plans with varying timeframes.<sup>3</sup> The stated LTC services consist of

- home-based services (meals on wheels, home care, etc.);
- information services;
- auxiliary devices for home care;
- semi-institutional care (day/night care, short-term care); and
- institutional care (nursing homes, residential homes).

The 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993 has been introduced into provincial social assistance laws (*Sozialhilfegesetze*),

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<sup>3</sup> These provinces include Carinthia, Upper Austria, Salzburg and Vorarlberg (last updated mid-2011).

resident and nursing home laws (*Alten- und Pflegeheimgesetze*) and regulations (*Verordnungen*) as well as general LTC laws (*Pflegegesetz*, only Salzburg). Certainly, there is a common body of policies stemming from the agreement, but numerous interests and different foci have made the legal status of LTC quite diverse.

### 2.2.1.2 Quality improvement

Minimum standards for quality in LTC have been part of the dominant regulatory system for a long time, with an overwhelming emphasis on facility structures. In the last decade, quality as a process of continuous effort and improvement has made its way into legislation.

Central to this issue has been the Federal Act on the Quality of Health Services of 2004 (*Gesundheitsqualitätsgesetz, GQG*), as part of the Health Reform Act of 2005. The stated objective is to assure quality work throughout the entire health system, following the principles of patient orientation, transparency, effectiveness and efficiency (§1(1) GQG). Accordingly, the Federal Ministry of Health is obliged to ensure a nationwide system of quality assurance overarching all sectoral and professional boundaries, which comprises quality in structures, processes and outcomes (§1(2) GQG) by securing the required coordination among the stakeholders (§1(3) GQG). The minister for health is also obliged to support initiatives for articulating quality standards (§4 GQG), developing quality criteria (§5 GQG) and setting up nationwide reporting on quality (§6 GQG). Following comments on the Act about the scope of applicability (§3 GQG), all health institutions and professions are subject to this law. This also concerns care (in the widest sense) as long as it is within federal competence or not regulated elsewhere. This is a crucial point, since there are various federal and provincial laws and regulations pertaining to care in different settings. The applicability of the law on quality in LTC depends heavily on the legal discourse between the federal state and the provinces.

Relevant to the latter are the 15a B-VG Agreement(s) between the Federal State and the Provinces Regarding Organisation and Financing of the Health System of 2005–08 and 2008–13 (*Vereinbarung gemäß Artikel 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens 2005-2008 und 2008-2013*), which function as agreements to set the stated objectives of the Health Reform Act of 2005 in motion and for which the provinces are (co-) authorised. As stated in the agreement, this document only applies to care in the realm of interface-management. The term ‘interface-management’ refers to the “frictionless organisation of those interfaces in the health system [through] which the patient has to pass in the course of his treatment” (see *Materialien 2008: 6*). This also seems to be relevant for the interpretation of the above-described Federal Act on the Quality of Health Services. Yet at present it is unclear to what extent the efforts of the Health Reform Act of 2005 concerning quality are applicable to the LTC sector or how it might change over time.

Both 15a B-VG agreements concentrate on an integrated health service encompassing all sectors of the health system. The Austrian Structural Plan for Health (*Österreichischer Strukturplan Gesundheit, ÖSG*) functions as its basis, whereas the Regional Structural Plans for Health (*Regionale Strukturpläne Gesundheit*) provide the detailed planning at the provincial and community levels. The current version of the Austrian Structural Plan for Health (2010) constitutes the legally binding framework for planning and managing the health system for the current decade. Although the LTC sector is not included as a distinct part of the ÖSG, planning for the LTC sector comes under the framework the interface-management in health care. Embedded in “integrated regional provision planning”, the ÖSG aims at the demand-activated supply of institutional LTC services together with home-based services and semi-institutional homes (e.g. short-term care for the relief of carers). In addition, there are plans to institutionalise the regional coordination and cooperation of institutional and home-based services (*ÖBIG*,

2009: 3). It is the obligation of the regional administrations to put these rather general formulations into effect.

Besides federal efforts to provide frameworks for the improvement of quality, only Tyrolean and Viennese regulations on institutional care call for continuous quality assurance work as a prerequisite to running nursing or residential homes.

## **2.2.2 Legal framework concerning professionals**

### **2.2.2.1 Training and professional tasks**

Among the important aspects of quality in LTC are standards for operational tasks and the education of care professionals. In principle, the job descriptions of health professionals (excluding physicians) as well as education and advanced training (voluntary and compulsory) are addressed in the Health and Nursing Law of 1997 (Gesundheits- und Krankenpflegegesetz, GuKG), which is overseen by the Federal Ministry of Health. Central to this law is the description of a separate area of activity for qualified nursing personnel (Hofmarcher and Rack, 2006: 53). Three areas – namely those of exclusive responsibility, joint responsibility (together with a physician) and interdisciplinary responsibility (shared with other medical professionals) – are defined (§14, §15, §16 GuKG). This is intended to clarify the tasks and liabilities of qualified nursing personnel, which includes care assessment, diagnosis, planning, implementation and evaluation (in their area of exclusive responsibility). In reality, however, the separation of tasks and responsibilities is less clear and handled very differently. Also regulated in this law are the job descriptions and education of so-called ‘nursing aids’ (*Pflegehelfer*), who are certified to support nurses and doctors in their work. Regarding the education of care personnel (nurses and nursing aids), the Health and Nursing Law describes the necessary content of nurses’ theoretical education (§42 GuKG) in a quite detailed manner. With respect to care services and their quality, such educational content as professional ethics, documentation and supervision, the care of older persons, home-based care and so forth is explicitly mentioned. Practical education comprises activity in hospitals, care institutions and institutions for other social or care services (e.g. home-based services) (§43 GuKG). Nursing aids have a somewhat condensed version of the above-mentioned educational requirements (§92, §93 GuKG).

Special education for leading and teaching care professionals is also regulated by this law (§65 GuKG). In the academic year 2004–05, the Medical University Graz together with the University of Graz introduced its syllabus for a Nursing Care Science degree (bachelor’s level). The University of Vienna also offers a separate Nursing Care Science degree. Since summer 2005, bachelor programmes at universities of applied science have been legally introduced to provide education for the higher-level medical services staff.

Care aids (*Heimhilfen*) play a vital role in home care. Before 2005, educational issues were regulated by each province independent of one another. Since 2005, the 15a B-VG Agreement between the Federal State and the Provinces Concerning Social Care Professions (Vereinbarung gemäß Art. 15a B-VG zwischen dem Bund und den Ländern über Sozialbetreuungsberufe) has broadly defined the content and scale of the educational programmes as well as the scope of activity. In addition, the provinces are obliged to mutually recognise each other’s educational programmes for the working authorisation of care aids. This agreement also concerns matters associated with social workers’ profile – a profession that is becoming more and more involved in the field of LTC, especially in institutional care.



### **2.2.3 Legal framework concerning care recipients**

The most important regulations directly pertaining to LTC recipients in Austria are those covering residents' rights in institutional care and standards for informal care at home.

#### **2.2.3.1 Personal rights and advocacy**

Residents' rights are stated in a quite detailed way in most of the provincial laws and encompass very similar issues, such as the right to socially and medically adequate treatment or the right of access to one's care documentation. Exceptions are Upper Austria and Salzburg. Upper Austria's regulations are unspecific general directives, whereas Salzburg's formulations follow the logic of consumer protection. Additionally, the federal legislator passed a law to assure the correct respect of care recipients' individual rights. More precisely, the Federal Nursing and Residential Home Law of 2004 (Heimaufenthaltsgesetz, HeimAufG) serves as a directive on the prerequisites and validation of the process of restricting individual freedom due to the mental or physical limitations of, for instance, older care-dependent persons.

Patient and resident advocacy services are institutionalised in some of the provinces in separate laws (Burgenland, Carinthia, Styria, Tyrol, Upper Austria, Vienna and Vorarlberg), while others have incorporated these services into the provincial laws on hospitals (Lower Austria and Salzburg). The organisation of advocacy services differs across the provinces with respect to service competencies. While most provinces have combined patient and resident advocacy into one institution, Salzburg lacks a residents' advocacy service altogether, and Tyrol and Carinthia have established separate units. This is accompanied by diverse responsibilities among the advocacy services in terms of their duties and their rights.

#### **2.2.3.2 Informal care**

According to estimations, around 80% of care-dependent persons receive informal home care (BMASK, 2009: 21), and as such its legal framework seems fairly modest. There have only been two federal policies put into action that target quality in informal home-based care. This was done in an amendment to the Federal Long-Term Care Allowance Act of 1993, which came into effect in 2001. It entitles the responsible authority (§22 BPGG) to send qualified care personnel to check on the condition and needs of a care-dependent person at home receiving a long-term care allowance (§33(a) BPGG). Additionally, the visiting care professionals have the duty to inform the care-dependent person or his/her custodian about the aim of the allowance and are obliged to quickly assess the health and well-being of the care-receiving person (§33(b) BPGG). Another quality aspect was built into the BPGG in 2007, whereby financial support for around-the-clock care services is only granted if the carer has at least a theoretical education equivalent to the curriculum of the care aids as stated in the 15a B-VG Agreement of the Federal State between the Provinces Concerning Social Care Professions of 2005 (see §21(b) BPGG). This has since been complemented by a measure allowing financial support if six months of continuous care practice is proved (BMASK, 2009: 14). Section 21(b) BPGG was passed following a second federal act on home care. The Home Care Act of 2007 (Hausbetreuungsgesetz, HBeG) is intended to ensure legal, around-the-clock care by non-medical personnel, since the shortage of personnel in home care has often been filled by workers having no legal working authorisation. So-called 'quality assurance measurements' have been built into the Act, requiring action by carers according to their contractual directives (private contracting with the care-dependent person and his/her custodian, respectively, or a working contract with an agency) and the obligation to work together with other medical and non-medical persons in taking care of the care recipients (§5, §6 BPGG). Nevertheless, it has to be mentioned that there is no legal obligation for home care service personnel to have any formal education or practical experience (unless the care-dependent person applies for financial support in accordance with

§21(b) BPGG). Additionally, not much information on the educational and practical skills of the carers who fill this niche is available at the moment (Expert interview: Rappold and Rottenhofer, 2010).

## 2.3 Implementation in practice

### 2.3.1 Institutional level

Although several legal policies for quality in LTC have been implemented, these regulations vary in their extensiveness and the degree of detail. Minimum standards in the realm of institutional care for the provision of care services and such structural quality issues as the room environment and the amenities of the home are legally specified in a detailed manner. Quality improvement matters are put rather vaguely and their contextual interpretation is often delegated to the providers. The following subsections introduce some initiatives in which bottom-up as well as top-down approaches have been taken.

#### 2.3.1.1 The care process

Years of efforts have been dedicated to the development of the ÖNORM K 1160 published by the Austrian Standards Institute. Developed by a multi-professional team located in the Lower Austria State Academy (NÖ Landesakademie) and an expert board of the Austrian Standards Institute, this norm comprises care assessment, diagnosis, planning, implementation and evaluation, required by §14 GuKG as an area of exclusive responsibility for qualified health and nursing professionals. A draft of this evidence-based norm was made available to the public at the beginning of 2010 to provide the possibility for the professional community to take a stance on it. In April 2010, the final version was published (Austrian Standards Institute, 2010a, 2010b).

Section 5 of the Health and Nursing Law of 1997 requires documentation of the care process, which is defined as care assessment, diagnosis, planning, implementation and evaluation. The “Arbeitshilfe für die Pflegedokumentation” (Rappold and Rottenhofer, 2010) aims at assisting professional care personnel to meet the legal obligations of documenting by providing detailed guidelines on how to operationalise the documentation process. Since the inception of work to develop the guidelines, care personnel from different settings have been involved. To test the applicability of the documentation guidelines, they were disseminated to organisations that volunteered to put them into practice. After analysing the results of the project, improvements and changes were integrated into the guidelines and checked again by external experts (Rappold and Rottenhofer, 2010: 1).

Moreover, there are a few single initiatives at the provincial level to further quality assurance in the LTC process. One of these is the area-wide, LTC assessment tool RAI-HC 2.0 in Styria to determine the actual scale of care needed by care recipients (Amt der steiermärkischen Landesregierung, 2010). Since 2004, qualified personnel in home-based care services in Styria have been required to assess the condition as well as the problems and potential of care recipients and to enter such information into an individual care plan (*ibid.*). The RAI-HC tool consists of the following elements: first a minimum dataset, which is used for a standardised inquiry of the care recipient’s health condition; second, a risk recognition tool to spot problems and potential; and third, 27 client assessment protocols regarding, for example, the care recipient’s capabilities, social and living environment and care needs, including guidelines and recommendations for appropriate action (Klampfl-Kenny, 2006: 3)

Another legal initiative on quality assurance is incorporated into Vienna's Residential and Care Home Act of 2005 (Wiener Wohn- und Pflegeheimgesetz, WWPG). As mentioned above, Vienna is the only province<sup>4</sup> besides Tyrol that goes beyond requiring minimum standards of quality in institutional care. As stated in the Act, providers are obliged to set the prerequisites for internal quality assurance. Thereby quality in structures, processes and outcomes have to be considered. Additionally, this quality assurance work has to be capable of including regular comparative inspections of residents' living conditions (§18 WWPG). Very similar formulations are found in the Specific Funding Directive for institutional LTC (Spezifische Förderrichtlinie für stationäre Pflege und Betreuung) of the Vienna Social Funds (Fonds Soziales Wien), declared as prerequisites for obtaining funding (Fonds Soziales Wien, 2006: 5).

Helping the institutional care providers to implement the rather vague directives of the WWPG, the Umbrella Organisation of the Viennese Social Institutions (Dachverband der Wiener Sozialeinrichtungen) published guidelines covering several areas of quality assurance work. In a very detailed manner, their guidelines cover the legal requirements of the institutions specified in the WWPG, regarding residents' rights and the personal and organisational data supplied, together with quality indicators. To give practical assistance on how to fulfil the various legal obligations, the guidelines include questionnaires on every issue, serving as a tool to standardise information gathering and documentation (Schrems, 2007). Such quality indicators as the prevalence of pressure ulcers and falls, the degree of immobility and so on are named and related questions are included in the guidelines. At present, the degree of implementation of these standards is not known. This is even truer for the other provinces in Austria. Different documentation 'traditions' from province to province and even from provider to provider lead to fragmentary datasets, which have not been incorporated into any scientific quality measurements so far.

### 2.3.1.2 Evidence-based guidelines

Evidence-based guidelines in general are very recent developments in the Austrian medical discourse (Czypionka, 2006: 8). This is even truer for guidelines concerning LTC. Up to now, two evidence-based sets of LTC guidelines have been developed in Austria, respectively covering the prevention of falls and the prevention of pressure ulcers and therapy. Another set of guidelines will be published this year on dementia.

The evidence-based guidelines on the prevention of falls (2009) were commissioned by the State Hospital University Clinic of Graz within the framework of the project "Evidence-Based Nursing". Its objectives are to set out the most effective methods to prevent or reduce the incidence of falls in institutional care as described in scientific literature (Bachner et al., 2009: 21). According to the levels established by Association of the Scientific Medical Associations in Germany (Arbeitsgemeinschaft der wissenschaftlichen medizinischen Fachgesellschaften, AWMF) for categorising guidelines, the present ones seem to reach the highest level, called S3. S3-level guidelines have to involve a) a representative board, b) a systematic evidence-based approach and c) structured consensus building (Czypionka et al., 2006b: 3). Furthering the quality of the guidelines, the authors' team decided to adopt the GRADE method to assess the scientific literature found. Accordingly, evidence is classified by study design, quality and logic as well as the definitiveness of study results to determine the evidence-based significance of the recommendations presented (Bachner et al., 2009: 8, 30).

The evidence-based guidelines on the prevention of pressure ulcers and therapy were developed by the Austrian Wound Association (Österreichische Gesellschaft für Wundbehandlung). In contrast to the guidelines on the prevention of falls, its formal standards are rather poor. No

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<sup>4</sup> Vienna is legally considered a province, a municipality and a city.

information can be found on the development process of the guidelines or the methods used to gather evidence. Most of the recommendations are not properly referenced. Therefore, decisions about the quality of the information provided cannot be made (Zöch et al., nd).

Finally, the Federal Institute for Quality in the Health Care System (BIQG) has stated that “Federal Quality Guidelines” on Dementia and Parkinson’s disease are currently being developed.

### *2.3.1.3 Quality management*

Quality management systems (QM systems) for institutional and home-based care are not legally mandatory in Austria, although Tyrol, Upper Austria and Vienna require continuous quality assurance work, which is not further specified. Nevertheless, QM systems have been implemented by several providers voluntarily to continually evaluate the quality of their services themselves. In Austria, the most prominent system is E-Qalin<sup>®</sup>, which was created by a consortium of partners from Austria, Germany, Italy, Luxembourg and Slovenia (Nies et al., 2010: 26). The model concentrates on the needs of the stakeholders and evaluates satisfaction with the activities undertaken. It enhances learning processes by calling for regular self-assessments, organised under the framework of classical quality dimensions. Up to now, around 180 of the 750 nursing homes nationwide have taken up E-Qalin<sup>®</sup> to improve their quality assurance work (Expert interview: Wallner and Ertl, 2010). Another approximately 60 nursing homes have attained either ISO 9001 standards (a set of detailed norms to meet the requirements for setting up a QM system – see Czypionka et al., 2006a: 12) or QaP<sup>®</sup> (Quality as Process), a QM system based on the EFQM model (European Foundation of Quality Management) (Expert interview: Wallner and Ertl, 2010).

### *2.3.1.4 External assessment*

At the national level the efforts of quality management have been assisted and enhanced by developing a National Quality Certification (National Qualitätszertifikat, NQZ) for residential and nursing homes. This external assessment programme was initiated by the Umbrella Organisation of Residential and Nursing Homes Austria (Dachverband der Alten- und Pflegeheime Österreich, ÖDV) and the Federal Ministry of Labour, Social Affairs and Consumer Protection to complement self-evaluating QM systems and provide objective assessments of institutional care. The enterprise was voluntarily piloted by 14 institutions from every province in 2008–09 and evaluated in 2010. At present, the nationwide implementation of NQZ on a legal basis is being discussed by the working group in charge of the project (BMASK, 2010b; Expert interview: Wallner and Ertl, 2010).

### *2.3.1.5 Monitoring the frequency of institutional care*

Monitoring institutional LTC in Austria is done within the framework of supervision/inspections, which are part of the provinces’ competencies. Supervision is a task of the provincial governor, but is delegated to local administrative entities. Table 1 gives an overview of the (legally defined) frequency of supervision of all authorised institutions.

*Table 1. Frequency of supervision/inspections*

<b>Province</b>	<b>Frequency</b>	<b>Law/regulation</b>
Burgenland	Regularly (not specified)	Burgenland's Residential and Nursing Home Law (1996)
Carinthia	Regularly, minimum every two years	Carinthia's Care Institutions Law (1996)
Lower Austria	Regularly, possibly once a year*	Lower Austria's Social Assistance Law (2000)
Salzburg	Regularly, minimum once a year	Salzburg's Care Law (2000)
Styria	n.a.	Styria's Nursing Home Law (2003)
Tyrol	n.a.	Tyrol's Care Institutions Law (2005)
Upper Austria	n.a.	Upper Austria's Social Assistance Law (1998)
Vienna	Regularly, minimum once a year	Vienna's Residential and Nursing Home Law (2005)
Vorarlberg	n.a.	Vorarlberg's Nursing Home Law (2002)

\* The provincial government's official homepage states that supervision is done regularly and if possible once a year (Amt der NÖ Landesregierung, 2010).

Source: Compiled by IHS HealthEcon in 2011.

### 2.3.1.6 Publication of quality measures

As previously described, the majority of activities by the federal or provincial administration on quality assurance in LTC is directed towards legislation and the supervision of minimum standards of quality. This approach usually does not lead to the publication of quality measures, since all prerequisites to run LTC institutions or services are stated in the designated laws or regulations. At present, quality assessments, as mentioned, are not being conducted in a standardised and comparable manner in Austria.

Still, the 'working group for LTC provision' established by the 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993 and run by the Federal Ministry of Labour, Social Affairs and Consumer Protection publishes data and facts on long-term care annually. This report (Pflegevorsorgebericht) consists of information concerning policy progression in all areas touching LTC – the activities of the federal and the provincial governments aimed at quality as well as data about the monetary benefits and benefits in kind provided by the authorities. But to be clear, none of the information given pertains to quality measures in a narrow sense, such as quality indicators.

One approach, at least to the gathering of nationwide quantifiable data on quality, is being pursued through the development of standardised care documentation. In the foreword of the "Guidelines for care documentation" 2010 (Arbeitshilfe für die Pflegedokumentation), the minister of health stresses that an area-wide standard for care documentation is an important tool in the provision of care and human resource planning for LTC. Furthermore, he assumes it is capable of enabling nationwide quality comparisons. Although it is not clear whether the (planned) accumulation of data will be published, it seems that this project could help to further efforts in this regard by providing the prerequisites for the publication of quality measures.

Another aspect of the publication of quality measures seems to be the critical stand of LTC institutions and services towards such a policy. Negative sentiments towards the publication of data on quality seem to stem from the insecurity about the financial consequences. Providers would expect more competition in their sector as well as higher costs in keeping up with competitors (Expert interview: Rappold and Rottenhofer, 2010).

## **2.3.2 Professional level**

### **2.3.2.1 LTC professional curricula**

LTC professional curricula have been addressed by various legal documents. Relevant to educational issues is the above-mentioned Health and Nursing Law of 1997, the latest version of the Regulation on the Training of Physicians of 2006 (Ärztinnen-/Ärzte-Ausbildungsverordnung, ÄAO) and the 15a B-VG Agreement of the Federal State between the Provinces Concerning Social Care Professions of 2005.

The GuKG defines the content and duration of the training for qualified health care and nursing professionals. Thus it covers the education of the most important professional group involved in LTC in institutional care and the home-based care sector.<sup>5</sup> The training of qualified health care and nursing professionals lasts three years (Hofmarcher and Rack, 2006: 154) and must include 4,600 hours of theoretical and practical education (§41(2) GuKG). Besides the detailed listing of modules in theoretical training,<sup>6</sup> practical education includes activity in hospitals, care institutions and institutions for other nursing services (e.g. home-based services). Accountable for the development of the curricula for health care professions (excluding physicians) is the Austrian Federal Institute for Health (Österreichisches Bundesinstitut für Gesundheit, ÖBIG), commissioned by the Federal Ministry of Health. Based on concepts of professionalism, the ÖBIG analyses the training requirements and defines learning objectives. This work is combined with the participation of stakeholders in transferring the concepts into practice. Between 1998 and 2003, the ÖBIG developed a curriculum for qualified health care and nursing professionals, integrating the opinions of over 190 experts and practitioners into the work progress. According to the authors, it contributes to the quality assurance and development of nursing in Austria by encompassing the characteristics and skill requirements of the respective levels of competence, introductions to all the theoretical modules and a catalogue of tasks for practical training (ÖBIG, 2003).

The Health and Nursing Law of 1997 also defines and regulates the education of nursing aids, which has to last a year and requires 1,600 hours of training at minimum (Hofmarcher and Rack, 2006: 154). Since an amendment to the regulation of nursing aids' training in 1999, there have been efforts to readjust the curriculum for nursing aids with the help of experts from the various training schools. In 2001, a pilot version was returned to the institutions for testing and evaluation, with the official curriculum being disseminated in 2004.

Although physicians' main objective is to "cure" and not to "care" (Grilz-Wolf et al., 2003: 97), they take part in the process of nursing by giving directives for medication or injections, for example (§15 GuKG). This predominantly concerns acute nursing in hospitals and less so LTC. A more important role is attributed to physicians in LTC by the legal task of assessing the stage of care needs, which determines the amount of the LTC allowance. Accountable for the content of physicians' training is the Austrian Physicians' Chamber (Österreichische Ärztekammer).

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<sup>5</sup> The GuKG acknowledges nursing as a realm in its own right, giving exclusive responsibility to the qualified health care and nursing professionals of the actual process of nursing (§14 GuKG).

<sup>6</sup> It entails 19 areas with different relevance to the requirements of LTC (see §42 GuKG).

The modules, duration and objectives of the training are stated in the Regulation on the Training of Physicians of 2006, which is also supervised by the Austrian Physicians' Chamber. The minimum duration of university studies is six years, after which – depending on the specialty – another three to six years of postgraduate training has to be completed (Hofmarcher and Rack, 2006: 152f).

The basic training modules and their duration for care aids and other service personnel providing social care are defined in the appendix of the 15a B-VG Agreement of the Federal State between the Provinces Concerning Social Care Professions of 2005. Care aids receive 400 hours of dual training (theoretical and practical modules). The curriculum has existed since 1993 for theoretical training, which was developed together with the older version of the nursing assistants' curriculum and covers descriptions of the main tasks (ÖBIG, 1993).

### **2.3.3 Recipient level**

#### **2.3.3.1 Residents' rights and advocacy**

The rights of residents in institutional care are usually guaranteed by the activities of the patient and resident advocacy services. The advocacy services provide information on residents' rights for the recipients of care as well as the providers. Additionally, they are assumed to gather complaints and settle disputes (typically between providers and their care recipients) extrajudicially. By law these advocacy services are obliged to publish an activity report annually, enabling policy-makers to overview the situation of lawful practice concerning care recipients in institutional care. As mentioned above, Salzburg and Tyrol do not have an advocacy service specifically competent for the realm of care institutions. In Salzburg, there is a legal obligation for providers to facilitate so-called 'co-determination rights'. Hence at least annual resident meetings are held to provide information and give residents (or their custodians) the possibility to articulate their needs or complaints (§28, §29 SlzG-PG).

#### **2.3.3.2 Activity in informal care**

In 2001, the legal basis was passed to enable authorities to check on the condition and needs of care-dependent persons at home receiving the long-term care allowance (see subsection 3.2.3.2). For this activity, a competence centre under the auspices of the Social Insurance of Farmers (Sozialversicherung der Bauern, SVB) was established to facilitate the organisation of this quality assurance task, which targets informal care. Since then, two studies (in 2001 and 2003) have been conducted, surveying the documentation of the visiting care professionals. The results of analysis have shown that almost 80% of LTC recipients received good quality care, usually provided by female family members. Nevertheless, (informal) carers were grateful for the services provided in light of a lack of information about such matters as the correct handling of a care recipient or alternative care services (Nemeth and Pochobradsky, 2004: 11f). In 2005, this visitation model was properly institutionalised, serving an increasing number of care recipients every year. In 2010, 17,000 care recipients were supposed to be visited (BMASK, 2010c).

## **2.4 Results of quality assurance policies**

Owing to the Health Reform Act of 2005 and especially to the Federal Act on the Quality of Health Services of 2004, quality issues in the health care sector have gained importance. Long-term care, at present, is not directly included in these developments since it is administrated under the logic of social assistance, although LTC is included in the work on interface-management.

### **2.4.1 Provision planning**

What has been evaluated is the progress of the Demand and Development Plans and their implementation in terms of the area-wide distribution of nursing services (see subsection 3.2.1.1), which were negotiated in the 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care of 1993 (Schaffenberger and Pochobradsky, 2004). These efforts are supposed to deliver the structural prerequisites to meet demands in the nursing sector, setting up minimum structural standards of quality for nursing supply and choice of service. An evaluation of the standards was conducted in 2003 to assess the state of progress, although the time frame for implementing them was by 2010. The results of the evaluation drew a differentiated picture, depending on the kind of service and the province. With reference to the contingents planned,<sup>7</sup> it seemed possible that the objectives of expanding the home-based services up to 2010 could be met from a nationwide perspective. On the other hand, in 2003 the supply of home-based services was highly diverse, as in Vienna there were 21 full-time equivalents per 1,000 75+ year-olds, compared with 6 per 1,000 of 75+ year-olds in Upper Austria. Semi-institutional facilities had not become 'mainstream', with the exception of Vienna. Provinces aim at developing these services further in urban areas. Concerning nursing homes, the contingents planned<sup>8</sup> for 2010 were already in place in 2003. Although residential home units were reduced and the supply of nursing home units expanded, the overall provision of institutional care had fallen, because of the faster increase of persons beyond 75 years of age. The average in 2003 of 103 home places (residential and nursing homes) per 1,000 of 75+ year-olds nationwide was projected to fall (according to the plans) to 95 units by 2010 because of demographic changes (cf. Schaffenberger and Pochobradsky, 2004). Independent of the analyses, it has to be emphasised that the entire evaluation pertains to developments in terms of primary political decisions about the necessary quantity of nursing services. How close this is to actual demand cannot be answered because of a lack of transparency and data.

### **2.4.2 Integration/coordination**

Coordination between institutional, semi-institutional and home-based LTC services as well as between the LTC sector as a whole and the health care has been further enhanced by all the provinces. This progress, however, has been heterogeneous, depending on the administration's scale of ambition as articulated in the plans. The Integrated Social and Health Districts (ISGS), which aim at the cross-sectional management of the health and social care services at the community level, had been introduced in seven of nine Austrian provinces by 2003. Yet according to the evaluation, these concepts were not implemented sufficiently (Schaffenberger and Pochobradsky, 2004: Iff). The European Center for Social Welfare Policy and Research also analysed the integration efforts of social and health care services in Austria. This was done within the framework of the European project "PROAGE" in the first half of the last decade. The results were rather pessimistic, concluding that the integration of the two sectors would not take place in the near future. On the other hand, the authors recognised greater efforts for better coordination among the sectors (Grilz-Wolf et al., 2003). An important example was the publicly funded project "Medtogether", lasting from 2002 to 2004. In this project, 16 hospitals and their outpatient partners (including a few LTC institutions) tried to optimise admission and discharge management by forming a local network of providers (BMGFJ, nd: 7). The lessons learned from the project were integrated into the Health Reform Act of 2005 to further work in this area. Since then, follow-up projects have been conducted, but more recent information on

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<sup>7</sup> These are determined by the individual administrations of the provinces, except for Vienna and Vorarlberg, whose administrations did not quantify their supply objectives.

<sup>8</sup> An exception here is Vienna, whose administration did not quantify its supply objectives.



the performance of interface-management in Austria is not available. Today, several initiatives concerning case management<sup>9</sup> are being undertaken by regional health insurance (*Gebietskrankenkassen*) and social insurance authorities. Besides the Lower Austrian Health Insurance (NÖGKK) and the Upper Austrian Health Insurance (OÖGKK), also the Social Insurance Authority for Business (SVA) and the Insurance Institution of the Austrian Railways and Mining Industry (VAEB) have undertaken area-wide case management for their insured clients (in 2008). Other institutions are planning to do so (Czypionka et al., 2008: 5). Furthermore, projects in Vienna, Vorarlberg and Lower Austria have been launched to improve admission and discharge management (*ibid.*: 6).

### **2.4.3 Training**

Current work is underway, conducted by the ÖBIG, to evaluate the training of qualified health care and nursing professionals. The objective is to make the training fit the necessities of present and future demands in the nursing sector (ÖBIG, 2010). Several problems have already been identified by the research team. The failure to provide qualified nurses with sufficient competencies in decision-making and responsibility, which is required by the GuKG of 1997, especially in the area of exclusive responsibility (§14 GuKG), seems to be central. Analytical and reflexive approaches would be necessary for proper quality assurance work, but are also neglected by the educational programmes (Expert interview: Rappold and Rottenhofer, 2010). Another concrete problem reported is the gap between theoretical and practical training in relation to the quality of LTC. Although taught the highest quality standards in theoretical education, the trainees often have to cope with the more modest quality levels of the respective institution where the practical training is completed (Expert interview: Rappold and Rottenhofer, 2010).

### **2.4.4 Documentation**

Offering some of the greatest potential for quality assurance and development in LTC at present is legally-required care documentation (§5 GuKG). A standardised but individually adapted care process of assessment, planning, implementation and evaluation (Rappold and Rottenhofer, 2010: 12) would be an effective approach to further care, the recipient's safety, nursing continuity, quality assurance, transparency, replicability, etc. (*ibid.*: 10). Additionally, it could be a source of data, making nationwide quality benchmarking and planning possible. Yet since the GuKG was passed in 1997, standardised methods of documentation have neither been implemented at the national nor the local level. According to Rappold and Rottenhofer, the situation is "improvable" (*ibid.*: 1).

## **3. LTC quality indicators**

### **3.1 Types of quality indicators at the national and local levels**

As described earlier, types of quality indicators have been listed in the guidelines of the Umbrella Organisation of the Viennese Social Institutions in relation to Vienna's Residential and Care Home Act of 2005. These guidelines for nursing documentation (*Arbeitshilfe für die Pflegedokumentation*), developed in 2010 by a research team of the Austrian Federal Institute for Health, also mention LTC indicators as essential for formulating appropriate nursing

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<sup>9</sup> Case management is defined by Ewers and Schaeffer (2005) as "a method targeted to the isolated case, i.e. one that is applicable by different persons in various settings, to implement patient orientation and patient participation as well as outcome orientation in complex social and health systems that are characterised by a high level of division of labor".

objectives and delivering comparable LTC outcomes (Rappold and Rottenhofer, 2010: 19f). At present, the legal task of documenting the nursing process has not been standardised (ibid.: 1) beyond the provider's level (Expert interview: Rappold and Rottenhofer, 2010). The implementation of quality indicators is not legally binding and the scale of current application is unknown. Systematic data gathering at an administrative level is still in the development phase. Standardised assessment using quality indicators in Austria does not exist at the local or national level. Some organisations use basic indicators in their quality management.

### **3.2 Selected data about quality indicators**

No data are available.

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- Landtag Vorarlberg (2002), Vorarlberger's Nursing Home Law (Vorarlberger Pflegeheimgesetz, Vbg – PHG), Rechtsinformationssystem Bundeskanzleramt, LGBl, Nr. 16/2002.
- Landtag Wien (2005), Vienna's Residential and Care Home Act (Wiener Wohn- und Pflegeheimgesetz, WWPG), Rechtsinformationssystem Bundeskanzleramt, LGBl, Nr. 15/2005.

### **Interviews**

- Expert interview with Elisabeth Rappold and Ingrid Rottenhofer from the Austrian Federal Institute for Health (Österreichisches Bundesinstitut für das Gesundheitswesen, ÖBIG) on 17 August 2010, Vienna.
- Expert interview with Johannes Wallner and Regina Ertl from the Umbrella Organisation for Residential and Nursing Homes (Lebenswelt Heim, Bundesverband der Alten- und Pflegeheime) on 7 September 2010, Vienna.

**Appendix. List of legal documents**

<b>Federal law/agreement/regulation</b>	<b>Bundesgesetz/Vereinbarung/ Verordnung</b>	<b>Abbreviation</b>
15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care	Vereinbarung gemäß 15a B-VG über gemeinsame Maßnahmen des Bundes und der Länder für pflegebedürftige Personen	
15a B-VG Agreement between the Federal State and the Provinces Regarding Organisation and Financing of the Health System of 2005-2008	Vereinbarung gemäß Artikel 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens 2005-2008	
15a B-VG Agreement between the Federal State and the Provinces Regarding Organisation and Financing of the Health System of 2008-2013	Vereinbarung gemäß Artikel 15a B-VG über die Organisation und Finanzierung des Gesundheitswesens 2008-2013	
15a B-VG Agreement between the Federal State and the Provinces Regarding Social Care Professions	Vereinbarung gemäß Art. 15a B-VG zwischen dem Bund und den Ländern über Sozial-betreuungsberufe	
Austrian Federal Constitution	Bundes-Verfassungsgesetz	B-VG
Federal Act on the Quality of Health Services	Gesundheitsqualitätsgesetz	GQG
Federal Law to Establish Health Austria GmbH	Erlassung des Bundesgesetzes über die Gesundheit Österreich GmbH	GÖGG
Federal Long-Term Care Allowance Act	Bundespflegegeldgesetz	BPGG
Federal Nursing and Residential Home Law	Heimaufenthaltsgesetz	HeimAufG
Health and Nursing Law	Gesundheits- und Krankenpflegegesetz	GuKG
Home Care Act	Hausbetreuungsgesetz	HBeG
Regulation on the Training of Physicians	Ärztinnen-/Ärzte-Ausbildungsverordnung	ÄAO

<b>Province law</b>	<b>Ländergesetz</b>	<b>Abbreviation</b>
Burgenland's Residential and Nursing Home Law	Burgenländisches Altenwohn- und Pflegeheimgesetz	
Carinthia's Care Institutions Law	Kärntner Heimgesetz	K-HG
Lower Austria's Social Assistance Law	NÖ Sozialhilfegesetz	NÖ SHG
Salzburg's Care Law	Salzburger Pflegegesetz	Slzg-PG
Styria's Nursing Home Law	Steiermärkisches Pflegeheimgesetz	StPHG
Tyrol's Care Institutions Law	Tiroler Heimgesetz	T-HG
Upper Austria's Social Assistance Law	Oö Sozialhilfegesetz	Oö SHG
Vienna's Residential and Care Home Act	Wiener Wohn- und Pflegeheimgesetz	WWPG
Vorarlberg's Nursing Home Law	Vorarlberger Pflegeheimgesetz	Vbg – PHG

*Source:* Compiled by IHS HealthEcon in 2011.





INSTITUT FÜR HÖHERE STUDIEN  
INSTITUTE FOR ADVANCED STUDIES  
Vienna

The Institute for Advanced Studies (IHS), Austria's premier post-graduate research and training institute, combines theoretical and empirical research in economics and other social science disciplines. It was founded as a private non-profit organization by Paul F. Lazarsfeld and Oskar Morgenstern in 1963. From its very beginnings, the IHS has operated on the principle that scientific enterprises, scientific cooperation and scientific problem solutions offer a platform for critical discussions, an opportunity for consensus formation, and an open and interdisciplinary arena for scientific research and critical scientific expertise. The Institute's Board of Trustees is composed of leading figures in politics, science, and economics. In addition there is an international Scientific Advisory Board. The Institute is financed by subsidies from federal ministries (Federal Ministry of Finance and Federal Ministry of Education, Science and Culture), the Austrian Central National Bank, the City of Vienna and other institutions. More than 40% of the Institute's budget is earned from research contracts. The Institute for Advanced Studies is divided into three departments: 1) Economics and Finance, 2) Political Science and 3) Sociology. The institute has approximately 60 scientific employees and 23 administrative employees. There are about 50 students.

The Team IHS HealthEcon at the Department of Economics and Finance (EcoFin) is one of the leading research groups in the field of applied health economics in Austria. Reflecting the requirement for a multidisciplinary approach, its members stem from a variety of different fields like economics, business administration, statistics, medicine and pharmacy; currently, there are also three young economists working as part of the team. IHS HealthEcon explores topics as diverse as the future of financing healthcare and long-term care, efficiency studies and evaluation, equity in healthcare, healthcare systems comparisons, national and international health policy analysis, health services research and interactions of healthcare with other sectors.

**L**aunched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long-term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiological and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

**Work Packages.** The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the back of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance.

#### Principal and Partner Institutes

CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Università Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d'Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medicine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).