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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN AUSTRIA

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AND MARKUS KRAUS**

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The Long-Term Care System for the Elderly in Austria

ENEPRI Research Report No. 71/May 2010

Monika Riedel and Markus Kraus*

1. The long-term care system in Austria

1.1 Overview and philosophy of the system

The social welfare system in Austria is divided into three aspects:

- social insurance
- social protection
- social assistance.

Social insurance provides sickness, pension and accident insurance in exchange for mandatory contributions. Social protection is provided as coverage for special groups for whom the state has to take direct responsibility, e.g. war victims, and for whom benefits are provided from general taxation. Social assistance provides a needs-based safety net for individual cases. It is only provided if other benefits are unavailable or inadequate and is financed by provinces from taxation.

In general the Austrian long-term care (LTC) system is a combination of benefits in cash and in kind. The core part of it is a long-term care allowance programme at the federal and provincial levels. Thus, unlike other European countries, the cash benefits are the most important ones. All persons in need of care can receive benefits in cash according the Federal Long-Term Care Allowance Act (*Bundespflegegeldgesetz*, BPGG). Persons in need of assistance not covered by this law (disabled persons or recipients of social assistance) can apply for benefits in cash provided by the provinces (*Landespflegegeld*). These cash benefits can be used to buy formal care services from public or private providers or to reimburse informal caregiving. Additionally, the provinces are obliged to provide places in institutions, in day/night-care centres and home care services. Only if the recipient's income (including the care allowance) and assets do not suffice to cover the costs of these services will the social welfare scheme cover the difference.

The long-term care allowance is

- an earmarked benefit exclusively dedicated to additional expenditure incurred due to care needs; it should be noted, however, that recipients are free to choose how they spend the allowance, which is not taxable;
- based on the need for care; the level is determined by the specific amount of personal service and assistance required;
- granted irrespective of the cause of care needs or the age of the person concerned;

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- granted irrespective of income and assets and based upon a legal entitlement;
- subject to uniform criteria and governed by one federal law and nine corresponding provincial laws; and
- financed from the general federal budget and the nine provincial budgets, but organised and managed by social insurance institutions.

Another core part of the Austrian long-term care system is the Article 15a B-VG Agreement of 1993 for people in need of care (*Vereinbarung zwischen dem Bund und den Ländern gemäß Art. 15a B-VG über gemeinsame Maßnahmen des Bundes und der Länder für pflegebedürftige Personen*).¹ Accordingly, provinces have to develop demand and development plans (*Bedarfs- und Entwicklungspläne*, BEP; see also section 4.1 of this report, “Policy goals”) for an adequate and comprehensive system of institutional, semi-institutional and home-based care services with full geographical coverage, observing minimum standards. The binding force of this Agreement is rather limited as there are no sanctions attached.

The philosophy of the Austrian LTC system is largely determined by the aim of the BPGG. It should enable those in need of care to lead a self-determined and needs-oriented life and improve the opportunity to choose among different settings of care. Most persons in need of care prefer staying in a private environment and receiving informal care from relatives or family members over formal care; consequently, roughly 80% of persons in need of care do receive informal care. By providing the cash allowance irrespective of the chosen care setting (formal/informal, institution/home-based), the philosophy of the system again is one supporting the possibility of individual choice. On the other hand, the cash allowance alone usually does not suffice to cover the total cost of care if the need is high. This could be seen as an indicator that informal (and thus, less costly) support is favoured by the system, even more so as the current BEPs state that home-based care is to be prioritised over residential care. But then one has to concede that social assistance covers any financial gap if persons with a sufficiently high need of care are not able to finance residential care. Summing up, we would conclude that the philosophy of LTC provision mirrors the preferences of the population: according to the 2002 Eurobarometer survey, Austria is in an intermediate position with regard to the main responsibility for care, perhaps somewhat closer to the Mediterranean–Catholic model of a high degree of family responsibility than to the Nordic–Protestant model of a high level of individual responsibility and a more pronounced role for the government in service provision.

1.2 Assessment of needs

In the Austrian LTC system no definition of being in ‘need of care’ exists, but the eligibility requirements for the cash allowance could partly be seen as a substitute for such a definition. The assessment of need for long-term care is rather based on individual requirements for personal services and assistance. The need for both personal services and assistance is required in order to qualify for the federal or provincial long-term care allowance. The needs assessment is based on a doctor’s expert opinion; representatives of other fields (e.g. nursing) are also brought in for an extensive assessment of the situation. The expert opinion is usually drawn up after an examination in the home. It is possible for a trusted third party to be present during the medical examination, if desired by the person applying for the long-term care allowance. The eligibility decision is communicated by means of an official notification with the possibility to appeal against this decision at the appropriate Labour and Social Court. The

¹ Henceforth this is referred to as ‘Art. 15a Agreement of 1993’. ‘Art. 15a B-VG’ refers to the Federal Constitution Law on joint measures by the federal government and the provinces.

medical examination, the classification and the payment of the long-term care allowances are carried out by social insurance institutions, specifically those covering pension insurance and accident insurance.

The specific provisions regarding the assessment of being in need of care are laid down in the Ordinance on Care Allowance Levels (*Einstufungsverordnung*) pursuant to the Federal Long-term Care Allowance Act. This ordinance defines care and assistance and the time allotted to individual tasks, e.g. dressing and undressing, care of the body, preparation of food and feeding as well as mobility assistance. In addition, the Federation of Austrian Social Insurance Institutions (Hauptverband der Sozialversicherungsträger, HV) has the right to define national guidelines for assessing the need for care. Such guidelines have been issued and updated several times in order to assure the uniform interpretation of the respective laws in practice and among different decision-makers (Rudda, 2003).

The law defines seven levels of care needs, resulting in a care allowance that ranges from €154.20 for the need of between 50 and 75 hours of care per month (level 1) to a maximum of €1,655.80 (level 7) for more than 180 hours of care per month in combination with complete immobility (see Table 1). The amount of time spent on care services is the relevant criterion to qualify for levels 1-4. An additional criterion has to be met to qualify for levels 5-7 (Table 1).

The level of the care allowance granted is important for care recipients not only because of the care allowance itself. The eligibility for other benefits also relates to the care levels granted. The most notable example is nursing home care: there is no special assessment procedure in the course of entry into a residential or nursing home. Given vacant places, it is usually up to the administration of the nursing home to accept/reject applicants for places. In cases of more demand than the supply of places, nursing homes usually require a certain level of care needs, e.g. homes run by the city of Vienna (or more precisely, by the Fonds Soziales Wien) are supposed to accept persons with at least level 3.

Table 1. Eligibility criteria for care allowance levels and allowance per month (01.01.2009)

Level	Need for care per month	Care allowance per month in €
1	More than 50 hours	154.20
2	More than 75 hours	284.30
3	More than 120 hours	442.90
4	More than 160 hours	664.30
5	More than 180 hours of care needed per month, if an unusual need for long-term care is required	902.30
6	More than 180 hours of care needed per month, if 1) care measures are required, which cannot be coordinated in terms of time and these are provided on a regular basis during the day and night, or 2) the continuous presence of a caregiver is required during the day and night, because it is probable that there is a danger for the care recipient or for other persons	1,242.00
7	More than 180 hours of care needed per month, if 1) it is not possible for the four extremities to move intentionally, or 2) a similar situation occurs	1,655.80

Source: Bundespflegegeldgesetz.

1.3 Available LTC services

The Austrian LTC system is, as mentioned above, a combination of benefits in cash and in kind. In addition to the uniform care allowance, social services are provided for those in need of care. Generally, the provision of social services is characterised by a widely fragmented system with various providers (most of them non-profit), diverse forms of provision and different regulations regarding financing. Providers in some regions are acting in an almost monopolistic situation. The social services are the responsibility of the provinces, thus the system is not only fragmented within a province, but also the fragmentation differs in each province.

The Art. 15a Agreement of 1993 requires all provinces to provide decentralised institutional, semi-institutional and home-based services. For this purpose a catalogue of services and quality criteria for social services was included in the Agreement. The provinces are also responsible for interlinking the services offered and guaranteeing information and counselling.

The objectives of the system are the following:

- Persons in need of care should be able to choose freely among the services offered.
- The expansion of home-based services has clear priority in relation to the expansion of institution-based facilities.
- Nursing homes should be small, decentralised and integrated into residential areas.
- The expansion of new care services/facilities has to reduce the burden of caregiving for family members. The range of services provided is of crucial importance (e.g. day care, short-term care, respite care).

Note, though, that those objectives are stated in a qualitative way only, leaving room for provinces to make judgements in their BEP, e.g. how small ‘small’ homes are or exactly what ‘clear priorities among care settings’ means.

The Austrian LTC system distinguishes between two main types of social services:

- **institutional care services**, which are mainly provided by provinces and municipalities, or by religious and other non-profit organisations. These services usually include care in residential homes, nursing homes, day-care centres and night-care centres; and
- **home-based services**, which are predominantly provided by non-profit organisations, such as Caritas, Hilfswerk, Red Cross and Volkshilfe. Among others these include home care, home nursing care, mobile therapeutic services, meals on wheels, transport services, home cleaning, laundry services and weekend help.

Furthermore, services/support for informal caregivers are available, among which are the following:

- **financial support for contributions to retirement plans** (*Begünstigte Selbst-/Weiterversicherung in der Pensionsversicherung*), the amount of which for the caregiver depends on the level of long-term care allowance of the care recipient to whom he/she provides care. At least level 4 is required for the caregivers to receive financial support. Since 2009, there has been the possibility that the public will cover the entire contribution;
- **financial support for respite care** (*Ersatzpflege*), which is a temporary, limited financial support/allowance for informal caregivers, earmarked to finance respite care; and
- the **family hospice leave system** (*Familienhospizkarenz*), a system that enables the informal caregiver to take job leave, a job change or change of working hours in order to care for terminally ill close relatives. It is limited to a period of six months for each case.

Benefits in cash and in kind are subject to certain eligibility criteria:

- for **benefits in cash** (i.e. care allowance), eligibility is subject to
 - a permanent need for personal services and assistance owing to a physical, mental, psychological or sensory disability that is expected to last at least six months;
 - a permanent need for at least 50 hours of care per month;
 - Austrian citizenship (or persons legally equal to Austrian citizens);
 - residence in Austria;
- for **benefits in kind**, eligibility is subject to
 - the health-related need for care;
 - Austrian citizenship (or persons legally equal to Austrian citizens); and
 - residence in Austria.

1.4 Management and organisation of LTC

The provinces have taken over responsibility for an appropriate provision of social services. If the provinces do not provide these services themselves, they must ensure that other institutions provide them to an appropriate standard of quality. Thus the management and organisation of social services differs among provinces.

Generally, there are four providers of social welfare/long-term care: provinces, municipalities, social organisations (*Sozialhilfeverbände*) and social funds (*Sozialfonds*). In Burgenland and Lower Austria, the provinces are the only providers of social services. In the other provinces the provider structure is two- or threefold. Salzburg delegates the provision of social services to municipalities, Upper Austria to social organisations and Vienna to social funds. Carinthia and Styria pass it on to municipalities and social organisations, Tyrol and Vorarlberg to municipalities and social funds.

The main basis for the management and organisation of social services are nine corresponding provincial Social Welfare Acts. These laws not only cover assistance to secure daily needs and aid in specific situations but also social services. There is no legal entitlement to these services.

Social services are provided by entities under private law. Persons in need of care may be requested to make contributions to the costs of social services but the social aspects have to be taken into consideration in assessing the share to be borne by them. Thus, there is in general some kind of means-testing regarding social services, but the concrete form differs by province.

(Quality) standards

The provinces are also responsible for adequate, professional quality assurance and control of social services. Annex A of the Art. 15a B-VG Agreement of 1993 defines respective minimum standards for institutional and home-based care.

The required minimum standards for institutional care are the following:

- small, manageable homes,
- the integration of homes into the community,
- minimum furnishing standards for rooms,
- minimum equipment,
- unlimited visiting time and the right to visit at any time,

- free choice of doctor,
- legal protection for female inhabitants of homes, and
- supervisory regulations by the provinces.

The required minimum standards for home-based care are the following:

- free choice among the services offered,
- a comprehensive and integrated range as well as a network of services,
- availability on Sundays and public holidays, and
- quality assurance and control by the provinces.

These regulations, however, leave room for considerable differences in interpretation. Scholta 2008 (p. 398) provides examples for institutional care: maximum size per facility ranges from 350 places in Vienna to 50 places in Carinthia. While Upper Austria requires 90% of all places to be in single rooms, Lower Austria requires only 50% of all places to be in single rooms, and in some cases allows triple rooms. Vienna allows 4-bed rooms for persons ‘who wish social contacts’; Burgenland also allows 4-bed rooms. Vorarlberg requires that new facilities are equipped with single rooms only; Styria still allows single and double rooms for new facilities. Minimum size per single room ranges between 14 and 18 m². For differences with regard to staff, see section 3.4.

The legal basis for quality assurance in the long-term care sector was created in an amendment to the Federal Long-term Care Allowance Act with effect from 1 July 2001. Accordingly, decision-makers (i.e. social pension insurance, accident insurance and other authorities in charge of care allowances) may implement measures for quality assurance. In particular, the care provision can be monitored as to whether it meets the quality standards and the requirements of the persons in need of care. This monitoring is done in the form of home visits. If necessary, information and advice is given to improve the situation of caregiving. Note, though, that the law does not make this kind of continuing quality assurance compulsory.

Capacity planning

According to the above-mentioned Art. 15a B-VG Agreement, the range of social services offered in all provinces are to be expanded. Reaching this goal obviously necessitates long-term planning. For this purpose the provinces prepared demand and development plans between 1996 and 1998 (BEPs – see section 4.1 of this report). These plans have to include the legal framework in each province, a structural analysis of socio-demographic data, the required human resources in the social sector, minimum standards for provision, development aims with cost assessments as well as an implementation plan. Gradual implementation is to be completed by 2010. The provinces adjust their planning to current developments on an ongoing basis.

1.5 Integration of LTC

In general, different institutions are responsible for the provision and financing of long-term care and of health care. While health care is funded and organised by the social health insurance system, long-term care is provided by social services organised by communities and largely funded through taxes. In spite of what seems at first glance a clear division of responsibility, there is a close connection between long-term care services and the social insurance system, as it is the apparatus of the insurance system, which organises and manages the long-term care allowance. Furthermore, a care recipient’s entry into the long-term care system is often triggered or initiated by providers of health services (like family doctors), and the conceptual dividing line between core health services and long-term care services is not always exactly executed in

order to smooth services provision. (Regarding institutional efforts to coordinate care, see section 4.2.)

2. Funding

In general, it is up to the individual to finance his/her long-term care needs using the care allowance as well as private income or assets. In most cases of institutional care, however, those means are not sufficient to cover the overall costs arising from care or the fees for institutional care, and the respective providers of social assistance step in to cover the difference. Home-based care is funded from private means as well as from social assistance, depending on income and the care allowance. Social health insurance plays only a marginal role by financing home nursing care of a kind that often does not fulfil the definition as specified here, i.e. long-term care rather than ‘recuperating’ care (for instance, after hospital stays).

Total expenditure on long-term care in 2005 amounted to €3.664 billion, €2.826 billion of which was funded through taxes and €0.838 billion through private means. There are two major groups of expenses funded by taxes – care allowances (55% of tax-funded LTC expenses in 2005 for federal, and 10% for provincial care allowances) and funding for services in kind by social assistance (33%) as mentioned above. Both care allowances and social assistance are tax-financed. As a result of the poor data situation we cannot distinguish between the amount financed from national budgets versus those of provinces and municipalities. Almost all tax funding stems from national rather than regional or local taxes, as the latter are of minor importance in Austria and all province and municipality budgets rely heavily on their shares in national taxation. There is no tax that is specifically earmarked for funding long-term care.

Following Biwald et al. (2007), Austrian provinces contributed a total of €1.936 billion to long-term care in 2005. The major part of those expenses, €1.44 billion, was used for institutional care, €30 million for semi-stationary facilities and €360 million for home-based care. Those figures are roughly in accordance with Schneider et al. (2006), who produced a more detailed picture of funding by the setting of care for 2004. According to their estimate, the value of informal care per year is between €2 and 3 billion, i.e. if the services actually provided by informal carers were provided by formal carers at minimum wage, the cost for this would be between €2 and 3 billion. In reality, however, the existing social care workforce would not suffice to actually provide those services in the formal long-term care sector (Hörl, 2008, p. 351).

Since its introduction, expenses for federal care allowances increased from €1.34 billion in 1994 to €1.69 billion in 2007 (see Table 2). We include only expenditure on **federal** care allowances here because most recipients of provincial care allowances are below the age of 65 years. There is no comparable time series for total long-term care expenditure, but there is hope that the availability of funding data for long-term care will improve as the SHA project² develops.

² Statistik Austria has been calculating health expenditure according to the OECD system of health accounts for several years. Until recently, however, their calculations of expenditure on long-term care has been restricted to expenditure on the care allowance.

Table 2. Expenditures on the federal care allowance

Year	Million €
1994	1,341
1995	1,379
1996	1,322
1997	1,266
1998	1,300
1999	1,356
2000	1,398
2001	1,427
2002	1,433
2003	1,471
2004	1,489
2005	1,566
2006	1,621
2007	1,692

Source: BMSK (2008b).

Institutional care

In general, the individual is responsible for financing his/her stay in a residential or nursing home out of personal income and assets, which typically consist of a retirement pension plus a care allowance for LTC. If the care recipient's income and assets do not suffice to cover the fees, the respective provider of social assistance steps in to cover the difference. In the latter case, the care recipient usually keeps 20% of the pension income and a smaller share of the care allowance (10% of the care allowance at level 3) as 'pocket money', but has to use this pocket money to also cover pedicures, cost sharing for drugs, etc. The provider of social assistance, however, has the possibility to subsequently ask relatives, i.e. spouses or children, to refund the difference, a process referred to as *Regress* [recourse]. According to provincial law, all provinces in theory can approach relatives that way, but provinces make use of this possibility to a varying degree, e.g. with regard to the question of *which* relatives can be approached – spouses, children or grandchildren. Recently, the regulation with regard to *Regress* was alleviated. Since 2009 provinces can only approach spouses,³ with the immediate reaction of increasing demand for nursing home places. At the time of writing (autumn 2009), it is still unclear if and which provinces will re-introduce some kind of *Regress*. Due to provincial legal responsibility, provinces also regulate other aspects of financing differently, e.g. the minimum amount of assets exempt from funding institutional care.

Table 3 shows that roughly half of all institutional care is financed by social assistance. More than 40% is financed from the care recipients' income (including federal LTC care allowances).

³ In the provinces of Carinthia, Lower Austria and Styria, even spouses cannot be approached with regard to *Regress*.

The provincial care allowance plays only a minor role, as most elderly persons in need of care are eligible for the federal care allowance. Funding from care recipients' assets and from refunds by care recipients' relatives contribute 7% to overall funding, with refunds having been the far more important component. Note, though, that these percentages give only a rough estimate, as data for some provinces are missing and differences among provinces prevail.⁴

Another indicator of the importance of social assistance for the funding of institutional care is that it contributes to the funding of at least 80% of all places. The high share of welfare recipients is easily explained by the fact that the monthly fee for a residential or nursing home place varies between €1,000 and over €6,000, depending on equipment and the level of need for care (Schneider et al., 2006, p. 8, figures for 2004). However, the median pension income was €840 (women) and €1,480 (men), and the average monthly care allowance was €375 (women) and €428 (men) in 2006.⁵

Table 3. Sources of funding for institutional care (2006)

Source of funding	Percent of all expenditure, average of provinces	Percent of all expenditure, min–max of provinces
Social assistance (<i>Sozialhilfe</i>)	48	29–54
Pension and federal LTC care allowance	43	31–50
Provincial care allowance	1	0–3
Assets and <i>Regress</i>	7	3–17
Other income	3	0–6

Note: No information for Salzburg and Vienna are available, thus all percentages have to be seen as inexact.

Source: Hofmarcher, Kraus and Bittschi (2008), Table 3.

Home-based care

The data situation regarding home-based care in Austria is even poorer than the data situation for institutional care; thus all values provided have to be seen as indicative rather than exact. Schneider et al. (2006) estimate the total expenditure on home-based care in 2004 at €445 million, of which care recipients provide on average at least 27%. There is broad variation among provinces: in Burgenland, the most eastern and a rather poor province, recipients contribute less than 4%, in Salzburg and Lower Austria care recipients contribute almost 60%. As most provinces do not report expenses for home-based care as defined in this project, the sum of €445 million comprises more than just long-term care for the elderly, e.g. family care under several definitions. Schneider et al. (2006) report costs per hour of care of €14.20–42.60, depending on the province and the qualifications of the formal carer.

⁴ Using data from Schneider et al. (2006) for 2004, we can also calculate the privately financed share (34–39%) and the publicly financed share (66–61%), depending on the mode of calculation and the resulting inclusion/exclusion of provinces.

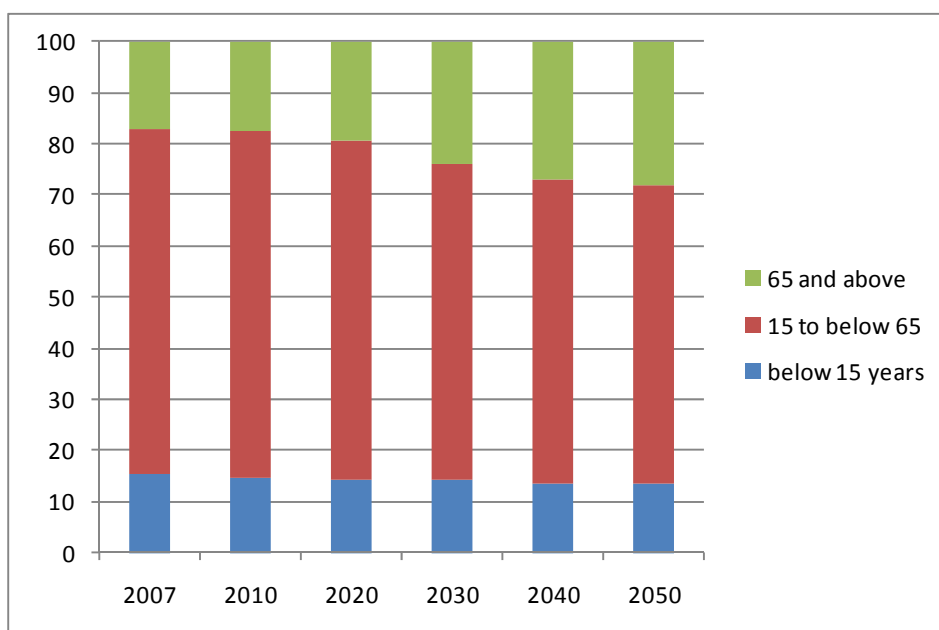
⁵ Note that according to Austrian legislation, individuals receive their retirement pension 14 times a year, which led to a yearly median pension income of €11,767 (women) and €20,720 (men) in 2006.

3. Demand and supply of LTC

3.1 The need for LTC

In 2007 some 8.3 million people lived in Austria. About 17.3% or 1,412,904 persons were 65 years old or above, and about 4.5% or 376,022 persons were 80 years old or above. Like in other European countries it is expected that the share of the elderly will increase markedly in the future. By 2050, 28% of the population is expected to be 65 years old or above (see Figure 1). As the need for care is strongly related to age we can expect that the need for care will also increase.

Figure 1. Age structure of the Austrian population (2007-2050)



Source: Statistik Austria, IHS HealthEcon calculation.

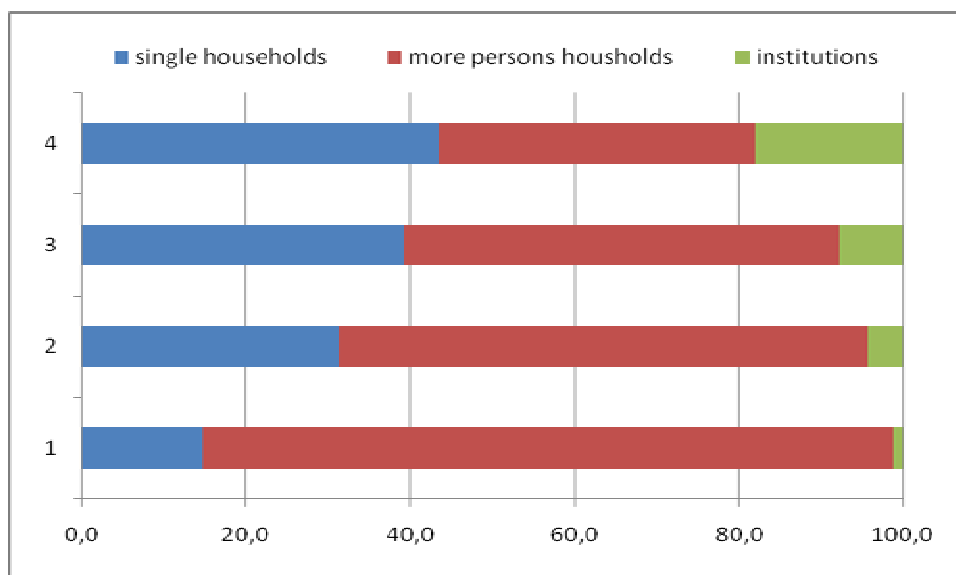
In Austria 464,315 persons aged 65 or above need help with at least one ADL (activity of daily living) or one IADL (instrumental activity of daily living) (SHARE database, wave 2, 2006). As mentioned above, in Austria no national definition of being in ‘need of care’ exists.

The need for care also depends on the living situation of the elderly. Singles are more likely to need help from outside the household than persons living with a partner. Whereas only 31% of the population 65+ live alone, the respective shares for the population 75+ and 85+ are 39% and 44%. On the other hand, whereas 18% of the 85+ population lives in institutions, the corresponding share of persons 65+ is only 4%. As in particular the number of the oldest old will increase sharply in the near future, the need for care will likewise grow dynamically.

In Austria, the hardest data available on the need for care are those related to the care allowance. As neither federal nor provincial care allowances are mean-tested, but they distinguish among seven levels of care, they probably provide the best statistical description of being in need of care in Austria. It has to be kept in mind, though, that there is a minimum level of care involved: care needs of less than 50 hours of care per month are not covered. Additionally, persons who for whatever reason did not apply for care allowances can obviously not be covered. Yet as the care allowance seems to be widely appreciated and general knowledge about it seems to be

high, the latter group might not be very substantial (see section 3.2, Table 4 for the number of care recipients by level).

Figure 2. Living arrangements of the elderly in Austria, shares of the respective population (2006)

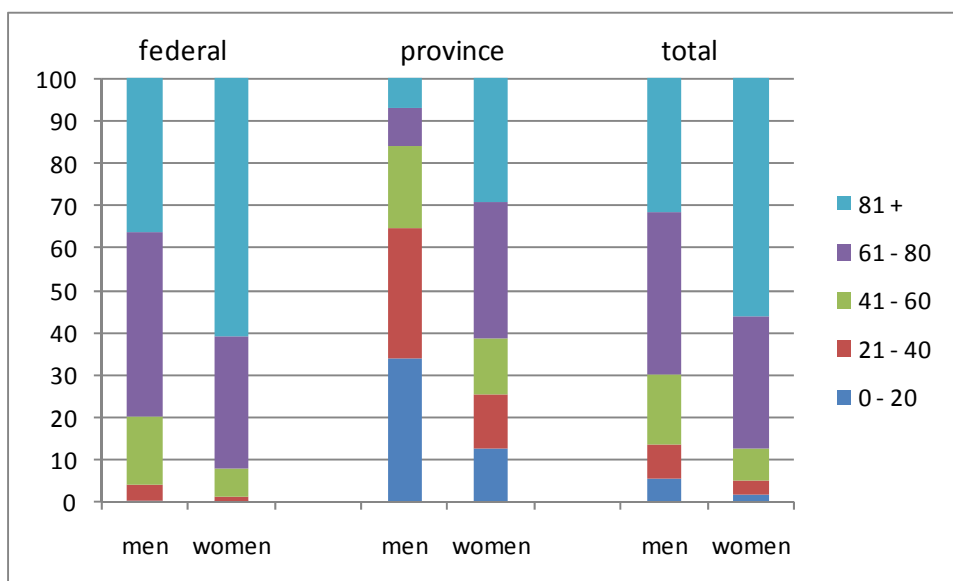


Legend: 1 = total population, 2 = population 65+, 3 = population 75+, 4 = population 85+

Source: Statistik Austria, IHS HealthEcon calculation.

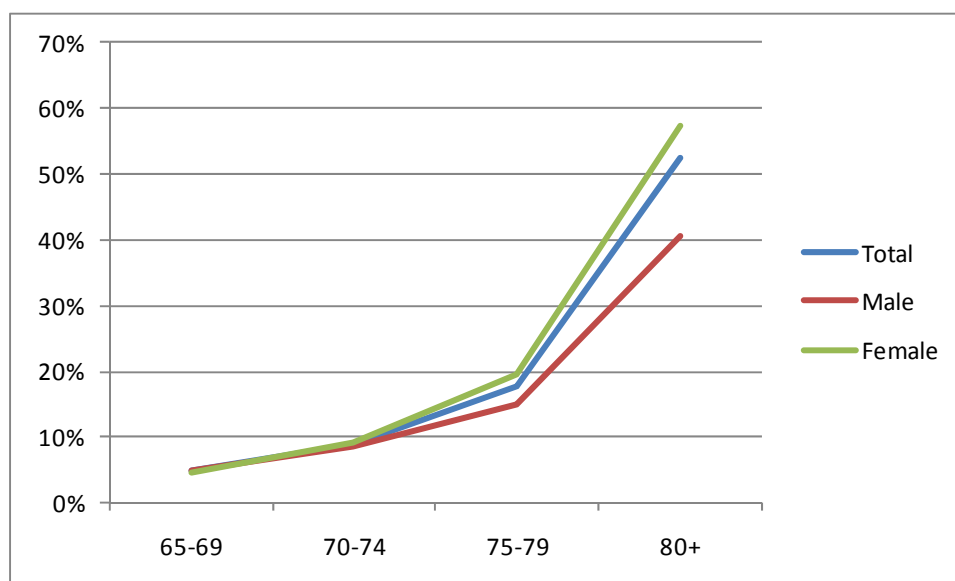
Federal and provincial care allowances co-exist and are applicable to different population groups, resulting in a different age structure of recipients (see Figure 3). While 80% of all men (92% of all women) receiving federal care allowances are over 60 years old, the comparable shares for provincial care allowances are 16% (men) and 61% (women).

Figure 3. Recipients of federal and provincial care allowances, by age and gender (2007)



Source: BMSK (2008b), IHS HealthEcon calculation.

Figure 4. Share of recipients of federal care allowances among the total population, by age group (2007)



Source: Hauptverband der Sozialversicherung (2009), IHS HealthEcon calculation. The likelihood of receiving a federal care allowance increases dramatically with age. While roughly only 5% of persons in their late 60s receive the care allowance, 40% of men and 57% of women aged 80 and older the receive care allowance, as shown in Figure 4.

3.2 The role of informal and formal care in the LTC system

Forward-looking models on how to deal with changes induced by the increasing elderly and old population and also their changing needs are not yet very well developed. Service provision is still characterised by the traditional forms of informal care by family members at home and formal care in a residential or nursing home; the continuum of possibilities between those rather extreme forms of care is only sparsely inhabited. Furthermore, a national consensus on what constitutes ‘adequate’ care for elderly persons with care needs has not been developed yet. We are still in the process of developing models and common standards suitable for providing adequate care adjusted to the present society (Scholta, 2008, p. 389).

In spite of the lack of hard data to support this estimate, most study authors agree that in Austria roughly 80% of all elderly persons in need of care are receiving informal care (Badelt et al., 1997; Nemeth and Pochobradsky, 2004; Hörl, 2008). In most cases care is provided by family members, mostly women. Obviously, providing care for all persons in need of care would be impossible with providers of formal care alone. While there is an entitlement to receive a care allowance in the event of needing care, there is no entitlement to be allocated a place in a nursing home or to receive formal care at home.

Even though this affects only a minority⁶ of persons in need of care directly, the public discussion of recent years has focused on the provision of care in the private environment with

⁶ There are obviously no exact or official numbers explaining how many persons used or provided this legal/illegal type of care. Estimates put the number of carers at between 10,000 and 40,000. For comparison, the number of recipients of at least the level 6 care allowance in 2006 was roughly 9,400.

the help of live-in care providers, often from neighbouring countries to the east, on a 24-hour, 7-day per week basis. Increased interest in this type of care reflects several facts:

- the unwillingness of care recipients to leave the usual private environment, and/or that of their relatives to have them transferred;
- the high costs of nursing home places for high levels of need for care; and
- the increasing need and/or wish that working-age women remain in their jobs rather than give them up to take care of relatives in need. Part of this decision may be the realisation of difficulties at the point of re-entering the labour market, and consequently of financing their own old-age care needs.

After implementing a legal basis for this kind of care, public discussions on it more or less ceased.

The genesis of the current cash benefits in the Austrian LTC system⁷

Until the early 1990s, popular perception as well as politicians saw long-term care in Austria mostly as being the responsibility of the family. Policies were highly fragmented, with competences mainly devolved to the provincial administrations. There were three types of public support available for the care of the frail elderly. First, cash benefits were mostly low and restricted to specific groups and circumstances. Second, many municipalities had been providing institutional care, either in residential homes and nursing homes or in mixed institutions. The availability of social services in the municipalities as the third kind of benefits differed substantially among the provinces and the regions and was often limited to nursing care.

Three factors shaped the reform of 1993: representatives of the handicapped were a driving force in the discussions, leading to a policy focused more generally on the social risk of dependency rather than on the elderly alone. Cash provision was strongly advocated as an approach to further the empowerment and autonomy of the recipients and to foster market-driven developments in long-term care. And finally, three Austrian provinces had introduced new cash benefit schemes that granted cash for care on a needs and means-tested basis.

The 1993 reform programme consisted of two main parts: cash benefit legislation, and an agreement between the federal and provincial authorities on responsibilities for long-term care provision. The agreement is still valid and states that the development of services in the institutional, semi-institutional and home-based care sectors remain a provincial responsibility, while the federal level is responsible for developing arrangements with regard to social insurance coverage for carers. Even though there were numerous amendments to the relevant laws in the meantime, the 1993 reform has to be seen as the milestone for LTC in Austria, and still very much shapes the whole sector.

The cash benefit programme

The core part of the Austrian LTC system is, as mentioned above, a long-term care allowance programme at the federal and provincial levels to provide financial help with institutional care, semi-institutional care and home care (formal and informal). According to §1 of the Federal Long-Term Care Allowance Act, the aim of the allowance is to contribute to the compensation of care-related additional expenses arising from being in need of care, to ensure adequate care and to improve opportunities for a self-determined and needs-oriented life.

⁷ This section is largely based upon da Roit et al. (2007).

The long-term care allowance is designed as a payment to the care recipient and ranges from €154.20 in level 1 to €1,655.80 in level 7. In the case of institutional care, the care allowance is transferred directly to the body in charge of the institutional care facility. For most recipients of institutional care this means that they receive only a monthly personal allowance (pocket money) amounting to €14.30 per month, while the bulk of their long-term care allowance together with other income, e.g. pension income, is used for financing care.

In 2007, 351,057 persons received the federal long-term care allowance and 60,919 persons received the provincial long-term care allowance, together representing 4.8% of the Austrian population. About half of those received long-term care allowances according to levels 1 and 2. More than two-thirds (67.5%) of all recipients are women. Table 4 provides an overview by level of care allowance and gender of recipients. About 85% of the persons receiving the federal long-term care allowance were 65 years or older.

Table 4. Persons receiving long-term care allowance (31.12.2007)

Level of long-term care allowance	Federal long-term care allowance			Provincial long-term care allowance		
	Total	Men	Women	Total	Men	Women
1	76,444	21,309	55,135	12,565	3,992	8,573
2	119,086	40,458	78,628	19,426	6,320	13,106
3	57,372	19,167	38,205	11,263	3,943	7,320
4	53,942	18,324	35,618	7,730	2,731	4,999
5	28,397	9,281	19,116	4,668	1,554	3,114
6	9,732	3,443	6,289	3,295	1,509	1,786
7	6,084	1,966	4,118	1,972	800	1,172
Sum	351,057	113,948	237,109	60,919	20,849	40,070

Source: BMSK (2008b).

The Austrian long-term care allowance programme covers all persons in need of care. Apart from the elderly, who represent the largest group of beneficiaries, also handicapped children, physically, psychologically and mentally handicapped persons receive care allowances. As mentioned above, the care allowance scheme is the product of one Federal and nine Provincial Long-Term Care Allowance Acts. The federal level is responsible for care recipients receiving pensions or similar benefits based on federal statutory provisions, whereas the provinces grant allowances, based on standardised principles, to all those to whom the federal level does not apply, like the handicapped or recipients of social assistance. This differing responsibility explains the different age structures of the recipients at the federal and provincial levels (as discussed in section 3.1).

3.3 Demand and supply of informal care

The number of persons receiving informal care according to the Mikrozensus for 2002 (see Statistik Austria, 2003) is 464,800; this is roughly 100,000 persons more than the number of recipients of care allowances in the same year, because two additional groups of persons in need of care are included here: individuals who did not apply for care allowances, and persons who

do not qualify for care allowances, e.g. because their need for care is estimated to be less than the required 50 hours per month.⁸ Note, though, that the Mikrozensus only covers the non-institutionalised population, while the number of recipients of care allowances includes both settings of care, institutional and home-based. According to the Mikrozensus, 281,900 women and 144,000 men over 18 years care for one or more persons due to their longer lasting health problems without being fully compensated for this care. Furthermore, 38,900 persons or one in ten persons out of this group care for more than one person, with the age group 50-54 being that with the highest share of multiple carers. It has to be kept in mind, however, that the Mikrozensus 2002 does not ask for the age of the care recipient. The numbers for both care recipients and care providers therefore overestimate informal care for the elderly (Hörl, 2008, p. 351).

In 2005, a representative survey was conducted in order to learn about the situation of informal carers (Pochobradsky et al., 2005). A sample of all recipients of LTC care allowances was drawn, and benefit recipients were asked to hand the questionnaire to the main (informal) carer. This approach was necessary because there was and is no database on informal carers, just one on care allowance recipients. The survey was complemented by interviews with representatives of self-help groups and providers of formal home-care. The main results of this study are broadly comparable with those of the Mikrozensus of 2002:

- Of the responding main carers, 79% were women. The Mikrozensus additionally shows that there is a tendency towards choosing main carers of the same gender as the care recipient when the main carer is the child of the care recipient, but that women are by far the more important carers for parents-in-law and for care recipients who are not family or relatives.
- The average age of carers is 58. Also Hörl (2008) emphasises that the majority of the burden of informal care is born by the middle-aged and elder generations, but that a considerable share of care is delivered by persons of 80 and older.
- Spouses/partners provide 40% of all informal care, while a quarter of it is provided by children.
- Among the main carers, 30% are gainfully employed, while 68% are not; 56% of all main carers, however, state that they were employed before taking over caring responsibilities. According to the Mikrozensus, 43% are employed, 2% unemployed and 55% not or no longer employed. This somewhat higher employment according to the Mikrozensus might be related to a lower burden of care in this sample, which is not restricted by a minimum amount of care. According to Badelt et al. (1997), 23% of all informal caregivers were employed and 37% of all caregivers were below 60 years of age.
- In terms of education, 32% of carers have no more than compulsory education, 30% finished apprenticeship programmes (*Lehre*), 21% attended some kind of vocational school (*berufsbildende mittlere Schule*), 7% have a high school degree (*Matura*) while only 4% of carers finished tertiary education.
- Concerning income, 47% of carers have no personal monthly income or it is below €700 (excluding any caring remuneration). One in five carers has no income, 91% of whom are women.
- The study found that 82% of carers pay contributions to the public retirement pension system, which means that income during their own old age is unclear for one in five carers.

⁸ We do not know how many of those persons received formal care as well.

- Three out of four carers provide care for persons in need of lower levels of care (levels 1-3), one out of five carers for recipients of level 4 or 5, and 7% for recipients of level 6 or 7. The latter share has doubled since 1997.
- Among carers, 58% state that only the existence of the care allowance makes care at home possible; but the care allowance is not seen as sufficiently high to enable carers to refrain from employment.
- One in three carers sees the necessity of adapting the private apartment to caring needs.
- Around one in three carers feels unable to quantify the hours of care. These seem extremely hard to determine if both live in the same house or if the – often confused – care recipient needs more supervision than (active) care. On average, 20% (5%) of carers spend time with a care recipient at levels 1-3 (levels 4-7) no more than five times per week, 11% (5%) daily and 27% (20%) several times per day.
- Almost three out of four care recipients are more or less mobile. Almost every second care recipient is confused several times per week, 17% are completely confused.
- If no formal care is received, 48% of respondents view formal care generally as an adversity and 42% cite financial reasons as the cause. In rural areas there is additionally the problem of low supply. In one in four cases informal care is complemented by formal home-based care services. Home nursing care (47%), home care (39%) and meals on wheels (30%) are the most common types of formal services.
- Formal care is significantly more used by persons with their own income, by carers with full-time jobs and by carers with higher education levels compared with persons without income, full-time employment or lower education, respectively.
- Not surprisingly, formal care is more intensively used to complement informal care in cases of higher levels of care. On average, five hours of home care and nine hours of home nursing per week are used.
- In cases of the usual informal carer's absence, 83% have provided for a replacement for acute incidents, and 71% for planned absences.
- About 70% of informal carers feel the burden of caring to be sometimes or even most of the time too high. Responsibility, hopelessness and feeling overtaxed are seen as the most important psychological stress factors.

Meanwhile, policies have taken care of some of the desired improvements in the situation of informal carers: enhanced accessibility of information on legal and medical matters of care; a telephone hotline; at least a moderate increase in the monetary value of the care allowance; and increased additional supply, such as formal home-based care services, short-time care, day care and night care (see section 4.3).

3.4 Demand and supply of formal care

The Art. 15a Agreement of 1993 states that provinces are responsible for providing a minimum standard of institutional, semi-institutional and home-based care services; thus, services have to be provided in all geographical parts of the country. The Agreement contains a basic framework, while most details have to be regulated on the provincial level and differ accordingly. Therefore in reality we find a broad variation between and within provinces, regarding availability and quality of services. This regional diversity is found in both settings of formal care, institutional and home-based care.

Institutional care

Better living standards and increased capacity of formal home-based services improved the abilities of elderly persons to cover their care needs in their private environment. This has resulted in higher levels of both average age and care needs when entering into institutional care. Scholta (2008, p. 391) provides the average entry age into institutional care for two provinces in 2005. In Carinthia, the average entrant was 74.2 years old, in Upper Austria 81.4 years, while the average age of home residents was only slightly higher: 74.8 years in Carinthia and 82.9 years in Upper Austria.

Roughly 66,000 persons in Austria receive institutional care (see Table 5). During the last six years, the number of recipients increased by 13.6%, but not homogeneously over the whole country. Some but not all provinces reported a shortage of places for nursing care. Regional differences in this respect have to be seen not only in the context of different capacities, but also of different financing rules: as a general rule, provinces with more severe *Regress* regulation and practice did not experience waiting times for nursing home places. Experience after the recent drop of *Regress* shows that in some provinces existing capacities are no longer sufficient. Note the pronounced recent increase of recipients in provinces that abolished *Regress* with respect to children, as in Carinthia and Vorarlberg.

Table 5. Recipients of institutional care (residential and nursing homes) (31.12.2007)

Province	2000	2005	2007	% Change 2000-2005	% Change 2000-2007
Burgenland	1,297	1,554	1,696	19.8	30.8
Carinthia	2,761	3,785	3,402	37.1	23.2
Lower Austria	9,589	10,468	10,712	9.2	11.7
Upper Austria	11,219	11,285	11,601	0.6	3.4
Salzburg	2,501	3,199	3,406	27.9	36.2
Styria	6,000*	8,720	9,250**	45.3	54.2
Tyrol	4,800	4,873	5,015**	1.5	4.5
Vorarlberg	2,271	2,932	3,726	29.1	64.1
Vienna	17,653	19,316	17,165	9.4	-2.8
Austria	58,091	66,132	65,973	13.8	13.6

* No data available before 2005; Biwald et al. assume 6,000 for the year 2000

** 2006

Sources: Biwald et al. (2007); BMSK (2008b).

In 2006, slightly more than half of all institutional places were provided by public facilities, 40% by other private institutions and 8% by facilities run by religious organisations (see Table 6). In addition to nursing and personal care, most for-profit facilities also provide a range of hotel services. Many of those facilities focus on care recipients with higher incomes, and such homes ('*Seniorenresidenzen*') are often not eligible for social assistance co-funding (Schneider et al., 2006, p. 8). Usually there are no special eligibility requirements for places in *Seniorenresidenzen*, provided one can afford the place. Provincial legislation regarding institutional care has successively been extended from public homes to private homes, the effects of which have varied by province: in some provinces the supply of private homes has

gone down or is even supposed to disappear by 2010 (Carinthia), while in other provinces the quality rather than quantity of private homes has altered (Lower Austria) (Scholta, 2008, p. 398).

Even though there is a distinction between residential homes and nursing homes, nursing care can be provided in both settings – some residential homes have a defined number of places for care recipients with nursing care needs. In 2006, roughly half of all places were in nursing homes, but more than half of all places in residential facilities were also equipped for providing nursing care. Thus, nursing care is provided at almost 80% of all places, with a higher share in public and religious facilities.

Table 6. Capacity in institutional care by type of provider (2006)

	Facilities	Residential homes		Nursing homes	Total places	Share nursing care
		Residential care places	Nursing care places			
Public facilities	399	3,117	11,672	21,335	36,124	91.4
Private facilities	307	10,466	5,683	12,229	28,378	63.1
Facilities run by religious organisations	67	663	2,562	2,380	5,605	88.2
All facilities	773	1,4246	19,917	35,944	70,107	79.7
Share public	51.6	21.9	58.6	59.4	51.5	-
Share private	39.7	73.5	28.5	34.0	40.5	-
Share religious	8.7	4.7	12.9	6.6	8.0	-

Source: BMSK (2009), IHS HealthEcon calculations.

The share of residential places for persons without or with only very limited (below level 3) care needs is decreasing, as most homeowners are re-structuring their homes to provide nursing care. In 1999, 44% of all institutional places were residential, compared with only 8% in 2004. According to public planning for LTC (see section 4 of this report on “Policy goals”), the residential share will drop further. This corresponds to the often-felt desire to stay in the private surroundings as long as possible, and to transfer to a home only when nursing care needs cannot be properly addressed in the private environment. Purely residential needs are increasingly covered by **supported living** (*betreute Wohnungen*) (Scholta, 2008, p. 400). When comparing with Table 6 above, note that the definition of ‘institutional place’ can vary, depending on whether all institutions or only those under contract with social assistance are covered, whether only institutions that require authorisation are included or whether places in specialised hospitals are included, etc.

There is no national database on employment in long-term care or in institutional care. Regional databases exist or are in the process of being developed, but as a rule are not comparable. Most provinces define different minimum standards regarding adequate staffing per place, while some provinces simply state that ‘adequate’ staffing has to be provided. Applying provincial minimum standards, a model calculation resulted in values from 1 full-time equivalent (FTE) per 4.5 residents to 1 FTE per 1.9 residents. Obviously, minimum standards can be exceeded. A calculation of actual employees (FTE) per place results in values from 1:1.62 to 1:3.39. As this calculation does not correct for differences in the level of need, differences in staffing ratios cannot directly be interpreted as differences in the quality or efficiency of service provision.

Furthermore, those calculations solely refer to social workers and nurses, while we do not know how many additional employees provide other services, from simple assistance in cooking and administration to therapies (Scholta, 2008, p. 402).

Not all provinces require minimum shares of different groups of employees. The required share of registered nurses varies from 20% to 50% (but the latter refers to more severe care needs only) (Scholta, 2008, p. 402).

Home-based care

In Austria, home-based care is provided mostly by supraregional organisations like Caritas Österreich, Diakonisches Werk Österreich, Österreichisches Hilfswerk, Österreichisches Rotes Kreuz and Volkshilfe Österreich. In Vorarlberg, local *Krankenpflegevereine* and in Tyrol *Gesundheits- und Sozialsprengel* are the main providers of home-based care (see also section 4 on the integration of care). In addition, there are small providers of care that work in the local area.

In 2002-2003, about 80,000 persons received formal home-based care in Austria. On average, 13% of the 75+ population or 23% of all recipients of LTC care allowances received formal home-based care. There is much variation among provinces: in Vorarlberg, 49% of the population 75+ or 92% of all recipients of care allowances used formal home-based services, in Tyrol and Upper Austria the respective shares are almost 20% and roughly a third (Rappold et al. 2008, p. 374f).

On average, almost nine hours of care were used per person in age group 65+, and 18 hours per person in age group 75+ (see Table 7). Again, there is wide variation among provinces, with 30 hours of care per person 75+ in Vienna and less than 10 hours in Styria and Upper Austria.

Table 7. Hours of formal home-based care, Austria (without Vorarlberg) (2001-2003)

	All home-based care	Home care	Home nursing care
Hours/person and year	1.37	0.85	0.52
Hours/person 65+ and year	8.8	5.4	3.3
Hours/person 75+ and year	18.3	11.3	7.0

Source: Rappold et al. (2008).

Use of home-based care is related to the level of need, which in Austria is usually described by care allowance levels. Among those at level 7, 29% of recipients use home-based care between several times per week and daily, and about a quarter use it several times per day. At level 3, 17% of recipients use home-based care between several times per week and daily, and 4% several times per day. Two out of three recipients of care allowance levels 3-6, however, do not use any formal home-based care (Rappold et al., 2008, p. 375 citing ÖBIG, 2004).

Supply of formal home-based care is subject to considerable change in Austria. This development has to be seen in the context of the general goal of favouring home-based care over institutional care (see section 4 on policy issues). We find an increase of supply: between 2000 and 2007, the number of service hours increased on average by 23% (see Table 8). The table highlights the heterogeneous development in several Austrian provinces: while service hours more than doubled in provinces like Carinthia, Tyrol or Vorarlberg, there has been a decrease in one province (Salzburg), caused by changes in the fee schedule.

The table also emphasises data limitations. In most provinces it is not possible to statistically disentangle information for help for families, help for the elderly and other kinds of support. Therefore, those data have to be seen as an overestimation of home-based care for the elderly (Biwald et al., 2007; BMSK, 2008b).

Table 8. Hours of formal home-based care

Province	Services	2000	2007	Change – h 2000-2007	Change – % 2000-2007
Burgenland	HH, HK	204,484	271,480	66,996	32.8
Carinthia	HH, HK, FH, DH	540,860	799,130	258,270	47.8
Lower Austria	HH, HK, AH	2,838,208	3,411,904	573,696	20.2
Upper Austria	HK, FH, MH	794,002	1,322,010	528,008	66.5
Salzburg	HH, HK	805,454	661,059	-144,395	-17.9
Styria	HH, HK, AH	857,435	858,604*	1,169	0.1
Tyrol	HH, HK, AH	298,776	565,332	266,556	89.2
Vorarlberg	HH	235,443	426,243	190,800	81.0
Vienna	HH, HK	4,017,591	4,669,386	651,795	16.2
Austria – Total		10,592,253	12,985,148	2,392,895	22.6

Notes: HH = home care, HK = home nursing care, FH = family help, AH = help for elderly, DH = ‘village help’, MH = mobile helpers; * data from 2005

Sources: Biwald et al. (2007); BMSK (2008b).

Semi-institutional care

Differences among provinces are even more prominent with regard to semi-institutional services; yet notably, the last official summary report on care services (BMSK, 2008b) does not mention any semi-institutionalised services for three provinces. Many of the existing facilities are more concentrated on handicapped rather than on elderly persons. Where data for institutions for the elderly are available, they report a significant increase in services.

Several kinds of services have already been implemented, but not all of them in every province (see Scholta, 2008, p. 407):

- Concerning **day/night care**, day-care centres are available in general only in urban areas, as transport and low demand would result in severe financial strains for recipients in rural areas. There are specialised services for dementia patients. Some centres for supported living offer to accept additional persons for day care; it seems that this is an acceptable solution for everybody involved. Some institutions offer the possibility to spend the night in the institution but the day in a private apartment, because some seniors feel safer that way. There are no national statistics on day or night care.
- In most if not all provinces there has been capacity for **short-term institutional care** in order to allow informal carers some time off-duty or to allow patients a short time of professional care after more severe illness or acute care. Some provinces have special places earmarked for short-term care, while some use otherwise vacant long-term care beds. As vacant beds were increasingly filled when *Regress* from children was abolished, it

remains to be seen whether additional earmarked capacities will become necessary. There are no national statistics on short-term care.

- As residential homes are progressively replaced by nursing homes, **supported living** is increasingly covering the respective need. All provinces have this kind of service. The goal is to enable more or less independent life in their own apartments for the elderly, and to reduce or postpone the necessity of transfers to institutional care.⁹ Existing apartments are adapted or new barrier-free apartments are erected, often close to and in combination with residential or nursing homes. A contact person is available for predefined hours, and home care and home nursing care can be provided if desired. Two provinces have included this form of care in their BEPs, while in other provinces such apartments are erected as part of general housing plans or supported with special funds.

4. LTC policy

4.1 Policy goals

Neither the Austrian constitution nor the current or the last government has specified official goals for national Austrian social policy. Also, there is no strong tradition of stating health policy goals. There are no detailed and quantifiable national health policy goals, apart from the obvious intention to provide all necessary health care in a high-quality and financially sustainable way, as stated in the ASVG (*Allgemeines Sozialversicherungsgesetz*, the main law governing health care, retirement and disability pensions, and unemployment benefits for roughly 80% of the population) and similar laws. There are health policy goals in only roughly half of the nine Austrian provinces. One province (Lower Austria) mentions geriatric care/hospice care among the health policy goals, while other countries' health policy goals lack even this peripheral aspect of long-term care (Spitzbart, 2006). Likewise, the 10 health policy goals formulated by social health insurance do not mention specific long-term care aspects, although these goals are not binding and are mostly intended for internal use and orientation (Spitzbart, 2006).

The BEPs, which have to be elaborated in each of the nine provinces since the Art. 15a Agreement of 1993, come closest to goals in long-term care policy but are rather means of capacity planning than policy goals per se. Even though provinces are responsible for the provision of long-term care, all provinces are required to follow the same principles and broad goals of care. BEPs have to include inter alia a comprehensive quantification of capacity shortages in institutional care, semi-institutional care and home-based care including geographical aspects. Provinces were required to prepare the first BEP in 1996 and most provinces succeeded in doing so by 1998. Furthermore, the Agreement states that identified shortages have to be consistently reduced by a third by 2000, 2005 and 2010, respectively (see the Art. 15a Agreement, Annex B, 6 and 9). BEPs are typically evaluated by the social departments of the respective province government (e.g. Burgenland and Lower Austria) with or without support from academic institutions and not necessarily published results. Furthermore, the MoH-affiliated institution (ÖBIG) carried out a mid-term survey taking stock of the extension of social services. It confirmed a considerable extension of institutional and home-based services. Goals for formal home-based care in Austria are only broadly defined: increased number of staff, increased qualifications of staff and quality assurance. Concrete targets

⁹ In Upper Austria, of 229 such apartments that had already been rented for the second time, the cause for the vacancy was death of the first inhabitant in 69% of all cases.

developed by provinces differ much in the degree of detail and the definition of ‘adequate’ staffing levels. On average, the staffing levels in home-based care rose by about 50% from 1995 to 2002, then reached 13.4 FTE per 1,000 inhabitants aged 75+, which is already close to its target for 2010 of 13.6 FTE. Note, though, that some provinces like Vienna restrain from defining target values and Austrian averages therefore cannot truly cover the whole country. A general trend towards better-qualified staff can be observed. Different definitions of ‘adequate’ care in provinces result in a high variation of staff ratios across the provinces, among other things. There are two clusters regarding provision of home care: in Lower Austria, Salzburg, Vienna and Vorarlberg, the number of staff (FTE) in home care and home nursing care (together) is about double the respective number in other provinces. Still, three provinces did not specify targets and those for the remaining provinces vary considerably between 20.0 FTE/1,000 inhabitants 75+ in Tyrol to 9.6 in Upper Austria (ÖBIG, 2004, Table 2.3).

Regarding institutional care there is no such clear regional divide. In 2002 the availability of places in care institutions had risen to 116 per 1,000 inhabitants aged 75+, yet by 2010 it is assumed to drop again to 94.5 places per 1,000 inhabitants aged 75+. Original targets for institutional care have already been exceeded in some provinces, but the targets have to be and are being revised, e.g. owing to new population statistics like the 2001 census results (which suggest that population ageing is progressing more rapidly than anticipated). For updated target values for 2010, see Table 9 above. Several provinces (Lower Austria, Upper Austria and Vienna) aim at reducing the number of ‘purely residential’ home places to nil, i.e. all places offered should then be linked to needs for nursing care.

Table 9. Number of places in institutional care, development and target values according to BEPs

	<i>Development between 1995–97 and 2002 (increase/decrease of places)</i>					
	Residential home care		Nursing home care		Total	
	Places	Index	Places	Index	Places	Index
Burgenland	-	-	-	-	109	107.9
Carinthia	-259	79.1	162	107.1	-97	97.2
Lower Austria	-2,897	31.4	3,966	172.2	1,069	111.0
Upper Austria	-	-	-	-	863	108.0
Salzburg	-1,668	34.7	2,352	237.7	684	116.0
Styria	-2,506	0	4,002	178.7	1,496	119.7
Tyrol	544	178.3	-126	96.5	418	109.6
Vorarlberg	-904	32.1	693	182.4	-211	90.3
Vienna	-871	92	-648	93.8	-1,519	92.8
Austria (excl. Burgenland, Upper Austria)	-8,561	63.1	10,401	135.3	2,812	104.3

Table 9. cont'd

	<i>Updated target values 2010</i>					
	Residential home care		Nursing home care		Total	
	Places	Per 1,000 75+	Places	Per 1000 75+	Places	Per 1000 75+
Burgenland	-	-	2,223	83.4	2,223	83.4
Carinthia	1,211	25.5	3,159	66.5	4,370	92.0
Lower Austria	0	0	8,310	61.8	8,310	71.6
Upper Austria	0	0	14,042	124.8	14,042	124.8
Salzburg	-	-	-	-	-	-
Styria	-	-	-	-	-	-
Tyrol	1,862	37.9	4,397	89.5	6,259	127.4
Vorarlberg	0	0	2,148	86.7	2,148	86.7
Vienna	-	-	-	-	-	-
Austria	3,073	4.9	34,279	86.8	37,352	94.5

Note: The past numbers for Burgenland and Upper Austria do not allow for a breakdown into residential vs. nursing homes; as most places in Burgenland are nursing home places, values for 2010 count all places as nursing home places. Furthermore, it should be noted that not all provinces state target values explicitly.

Source: ÖBIG (2004).

4.2 Integration policy

The Art. 15a Agreement of 1993 states that services in all settings of care (institutional, semi-institutional and home-based) are to be provided in a coordinated way. The existence of facilities for coordination and cooperation between services are inter alia mentioned as minimum requirements for service provision. While all the provinces mentioned necessary improvements in this respect in their BEP, the provinces pursue different strategies (ÖBIG, 2004, ch. 7):

- on whether institutions that are specialised and focused on coordination are deemed necessary;
- on whether such institutions provide care (Tyrol, Upper Austria, Vienna and Vorarlberg) or only coordination of care;
- in geographical approach, i.e. should the entire province be covered or only some key areas; and
- in legal background, which can be based on provincial laws or different grounds.

Those differences can be seen as a response to differences in the structure and quantity of the services provided as well as in different urban/rural situations. Most institutions additionally provide information and counselling for the population. Seven of nine provinces rely on *Sozial-*

und Gesundheitssprengel (integrated health and social care districts)¹⁰ as the main institutions for coordination, albeit following quite heterogeneous models. In some provinces, *Sprengel* had to be built from scratch (Burgenland and Styria) while in others (Carinthia, Lower Austria, Tyrol and Vorarlberg; in Upper Austria there were local projects) they were already in existence but were to be upgraded and improved. Building upon a theoretical concept developed by ÖBIG (see Grilz-Wolf et al., 2003), *Sprengel* should be regional organisations for the coordination and cooperation of health and social care organisations within a defined geographical area of 10,000 to 20,000 inhabitants, with the concrete work being guided by the regional situation. *Sprengel* are to analyse the existing provisions, guarantee the existence of health and social care organisations and act as partners for the patients and their families by helping them find the organisations to meet their specific needs.

Grilz-Wolf et al. (2003) see case management as the main area of integrated care in Austria and find other concepts of integrated care and the idea of integrated care itself of subordinate interest and use in Austria. They only exist in connection with case management, often lacking explicit definitions. Case management carried out by social health insurance concentrates mainly on discharge management after acute care in hospitals and thus is only partly relevant for LTC questions. Two regional and two occupational social health insurers have already implemented some area-wide case management, while most other social health insurers are still in the process of further developing their plans (Czypionka et al., 2008, Table 1). In its 2004 report, ÖBIG mentions that two provinces (Burgenland and Upper Austria) explicitly intend to develop case management in order to improve the coordination of long-term care.

4.3 Recent reforms and the current policy debate

In a publication to celebrate the 15th anniversary of the introduction of the LTC allowance, the relevant ministry summarises the milestones in Austrian LTC legislation as shown in Table 10 (BMSK, 2008a).

The most recent reform efforts have concentrated on the situation of informal caregivers and a legal background for 24-hour care. In 2007, the Federal Ministry for Social Affairs and Consumer Protection created a working group to redesign and further develop LTC provision so as to ensure affordable care and assistance. The group is composed of representatives of the federal government, the provinces, the social partners and stakeholders. It is to develop solutions that are most satisfactory for the persons concerned and cover all fields of the Austrian LTC system. The most urgent problem was seen to be a legislative and financial solution for 24-hour home care. As a result, the Act on Home Care (*Hausbetreuungsgesetz*), which entered into force on 1 July 2007, and an amendment to the Industrial Code create a basis under labour and trade law for legal and contract-based 24-hour care in private households. Both options – employment or self-employment of care providers – are possible. (For detailed requirements on the contracts, see BMSK, 2007.)

In the past, concerns about the quality of nursing in informal home care were repeatedly voiced. On the other hand, several studies reveal need of informal caregivers for more or better information and counselling (e.g. Ostermeyer and Biringner, 2003; Nemeth and Pochobradsky, 2004). In October 2004, a pilot project was started to address both concerns: registered nurses visit selected recipients of informal care to check the quality of care and offer information. During the first years, 63% of recipients were rated as in ‘very good’ and 35% in ‘good’ condition. In most cases, requests for information could be sufficiently answered by the visiting

¹⁰ Henceforth this is referred to as ‘*Sprengel*’.

nurse. Following the positive evaluation results of the pilot, the nurse visits for selected cases were included in the list of public services. In 2008, 17,000 visits were conducted.

Table 10. Legal milestones for LTC provision in Austria since 1993

Date	Legal milestone
01.07.1993	The federal and nine provincial LTC allowance acts take effect.
01.01.1994	The federal and provincial governments sign an agreement on joint measures to develop and extend decentralised social services in all parts of Austria. The LTC allowance is raised by 2.5%.
01.01.1995	The LTC allowance is raised by 2.8%.
01.01.1998	The ministry of social affairs introduces a free-of-charge care hotline (<i>Pflegetelefon</i>).
01.01.1999	The need requirements for level 4 care are reduced from 180 to 160 care hours needed per month.
01.07.2001	The (lower) age limit for eligibility for the LTC allowance is abolished.
01.07.2002	A family hospice leave system (<i>Familienhospizkarenz</i>) is introduced, i.e. providing a possibility for informal carers to take job leave, a change of jobs or their working hours in order to care for close relatives who are terminally ill or most severely ill children.
01.01.2004	Temporary, limited financial support is introduced for informal caregivers, earmarked to finance respite care (<i>Ersatzpflege</i>).
01.07.2004	The institutional home act is passed to clarify and improve the legal situation of inhabitants in residential and nursing homes (<i>Heimvertragsgesetz</i>).
01.01.2005	The LTC allowance is raised by 2%.
01.07.2005	The institutional home stay act is passed to improve the personal freedom of inhabitants in residential, nursing and some other kinds of homes (<i>Heimaufenthaltsgesetz</i>).
26.07.2005	The agreement between federal and provincial governments on social care workers takes effect, introducing uniform education standards and job descriptions for those workers in all provinces for the first time.
01.01.2006	Informal caregivers can receive financial support for contributions to retirement plans (<i>Sozialversicherungs-Änderungsgesetz 2005</i>).
18.03.2006	<i>Familienhospizkarenz</i> is amended to further support relatives providing care.
01.07.2007	Changes in the industrial code and implementation of a new home care act provide a legal background for 24-hour care at home, a new care allowance model provides support for care recipients to finance this type of care, and the support for the retirement plans of informal carers is extended.
01.11.2008	The care allowance for (legal) 24-hour carers is raised by up to 100%, and the respective mean-testing based upon assets is abolished.
31.12.2008	In the course of 2008, three provinces abolished the <i>Regress</i> possibility for a spouse and the last provinces abolished it for children and grandchildren.
01.01.2009	The by-then most substantial amendment to the LTC allowance act comprises a raise of the allowance by 4-6%, improved eligibility criteria for some levels of care and further extensions of support for informal carers.

Source: Adapted from BMSK (2008a).

In August 2008, a number of measures increasing the financial means for LTC were enacted: the care allowance, the level of which had attracted recurring criticism because it had been

stagnating rather than keeping up with inflation, was raised (+4% for levels 1 and 2, +5% for levels 3, 4 and 5, +6% for levels 6 and 7). The classification of dementia patients (and that of severely handicapped minors) was upgraded. The subsidy for 24-hour care was raised and the means-testing with regard to assets abolished.

Another aim of the Austrian LTC system is to strengthen the position of relatives providing care. Over recent years, the following measures have been taken (BMSK, 2007, p. 69):

- preferential terms of self-insurance and continued insurance under the pension insurance scheme for those who had to give up their job in order to take care of a close relative entitled to an LTC allowance at level 3 or above;
- reduction by half of the employee's contribution in the context of preferential self-insurance or continued insurance under the pension insurance scheme if an LTC allowance at level 4 or higher is received or non-contributory insurance starting from an LTC allowance at level 5; since 2009, there has been the possibility that the public will cover the entire contribution;
- supporting measures under the family hospice leave system (advance payments and a modified pay-out procedure);
- support for informal caregivers who are unable to provide care due to illness, holiday or other material reasons;
- the *Pflegetelefon* care hotline offering counselling for informal caregivers;
- the *Handynet-Österreich* database (an Internet-based information pool on technical aids); and
- a platform for informal caregivers (for the exchange of information and experience).

4.4 Critical appraisal of the LTC system

The most important and influential feature of LTC provision in Austria is the LTC allowance. The introduction of this cash benefit in 1993 aimed at providing LTC patients with the possibility to choose among settings of care, most notably between moving to a specialised facility and remaining in one's own home and receiving all necessary care there, be it provided by professionals or by family members or other relations. Recognising the importance of the care allowance to finance this choice, we have to state that fulfilment of this objective has been severely deteriorating due to only very infrequent adjustments of the monetary value of the allowance (see Table 10 on reform activity above). During 1997-2007, the overall price level increased by 18%, and the net median wages of women by 21%. Average expenditure on the federal care allowance per year and beneficiary, however, grew by only by 2.4%. Thus, the average number of care hours a beneficiary could buy with the allowance dropped considerably during this time. This shortcoming mostly stems from infrequent rises in the monetary value of the care allowance in the past. The current government is aware of this problem and has pushed through the first rise for several years, which took effect in January 2009.

Another frequent criticism relates to the lack of transparency regarding various aspects. On the macro level, it is very hard to grasp the true costs of or the expenditure on long-term care in Austria owing to a highly fragmented system, relying on nine differing provincial legislations plus several municipal ways of naming, handling and financing respective services. The lack of transparency at the national level continues with basic supply data. Even though some provinces are already collecting structural data in order to compare and project services, other provinces are still in the process of doing so. The working group for provision of care (*Arbeitskreis für Pflegevorsorge*) collects national data on care on a yearly basis; an extension of this very limited

database with comparable and more detailed data for all provinces would be desirable to improve forward-looking capacity planning and steering. Yet this would require the development of a new tool for their yearly data collection (Scholta, 2008, p. 410).

On the micro level, the published aim of supporting informal caregivers wherever possible is in some provinces sharply contradicted by a complete lack of transparency on eligibility criteria for several services provided by the welfare system. For instance, there is no unique and public definition of what constitutes a social hardship, and consequently there is no reliable information on what constitutes eligibility for certain welfare services. It is hard to explain why municipalities have freedom to decide which circumstances are to be seen as a social hardship, even though we see that not all cases and possibilities can be dealt with prospectively in a systematic way (and ultimately, we do not assume that an exhaustive list can be the optimal solution). But there are areas where consistent, transparent and also publishable guidelines could be formulated and would improve consumer orientation. Such an area with possible but still lacking public and countrywide common guidelines is *Regress* from spouses of nursing home inhabitants.

Demographic developments make the future growth of care activities inevitable and labour market and pension law developments make an increase in formal care very likely. There is consensus in Austrian academia that the likely future developments will require greater levels of professional training, quantitatively but also qualitatively. In Austria, nursing care as an academic field of education has a history reaching back no more than several years, and consequently there are not yet many academically trained nurses integrated into the 'everyday business'. In addition to four Austrian universities that offer programmes in nursing science, there are several universities and universities of applied sciences offering programmes related to nursing. Nevertheless, Rappold et al. (2008, p. 380) argue that a sustainable professionalization of nursing needs academization. This is deemed necessary not only to cover needs, but also to avoid lagging too far behind compared with other European states. Rappold et al. (2008, p. 380) further argue that education plans for nursing are still too focused on hospital care and there is insufficient emphasis on geriatric care and specifically geriatric care in the family environment. However, they report the introduction of one programme for family health nurses, following the respective WHO concept in autumn 2007. Curricula should be broadened to put more emphasis on communication and counselling skills instead of concentrating solely on reducing bodily harms.

Also education plans for other jobs in care for the elderly are currently under revision. New programmes have recently been introduced (a two-year programme for *Sozialfachbetreuungsberufe*, and a three-year programme for *Sozialfachbetreuungsberufe* with a diploma); yet it is still too early to forecast their impact on the overall provision of care.

Finally, Rappold et al. (2008) raise the issue that planning does not yet sufficiently take the special needs of several groups of persons into account. This issue is raised for persons in need of around-the-clock supervision like dementia patients, but also for migrants, who in general have not yet entered into the critical age and their special needs owing to cultural or linguistic differences are therefore not yet fully realised.

Bibliography

- Badelt, C., A. Holzmann-Jenkins, C. Matul, A. Österle (1997), Analyse der Auswirkungen des Pflegeversorgungssystems. Forschungsbericht im Auftrag des BM für Arbeit, Gesundheit und Soziales. Wien.
- Biwald, P., B. Malz and K. Mitterer (2007), Neuorganisation der Altenpflege und -betreuung aus kommunaler Sicht. Grundlagenpapier zum Arbeitskreis I, Österreichischer Städtetag 2007, KDZ - Zentrum für Verwaltungsforschung.
- BMSK (2007a), Österreichischer Pflegevorsorgebericht 2006.
- (2007b), Social protection in Austria, Vienna.
- (2008a), 1993 bis 2008. 15 Jahre Pflegevorsorge. Bilanz und Ausblick.
- (2008b), Österreichischer Pflegevorsorgebericht 2007.
- (2009), Statistik (Anzahl Heime, Summe Wohnplätze, Summe Pflegeplätze, Summe Wohnplätze mit Pflege), Stand 29.12.2006, Excel-Dokument.
- Czypionka, T., M. Kraus, G. Röhrling and H. Straka (2008), “Case Management in Österreich und Europa”, *Health System Watch*, 1/2008.
- Da Roit, B., B. Le Bihan and A. Österle (2007), “Long-term Care Policies in Italy, Austria and France: Variations in Cash-for-Care Schemes”, *Social & Administration*, Vol. 41, No. 6, pp. 653-671.
- Federal Ministry of Social Security, Generations and Consumer Protection (2006), Provision for long-term care in Austria (in three languages), Vienna.
- Grilz-Wolf, M., C. Strümpel, K. Leichsenring and K. Komp (2003), *Providing integrated health and social care for older persons in Austria*, PROCARE National Report Austria, European Center for Social Welfare Policy and Research, Vienna.
- Hammer, E. and A. Österle (2003), “Welfare State Policy and Informal Long-Term Care Giving in Austria: Older Gender Divisions and New Stratification Processes Among Women”, *Journal of Social Policy*, Vol. 32, No. 1, pp. 37-53.
- Hauptverband der Sozialversicherung (2009), Bundespflegegelddatenbank.
- Hofmarcher, M.M., M. Kraus and B. Bittschi (2008), Pflegeversorgung in Österreich, Projektbericht, Institut für Höhere Studien (IHS), Wien.
- Hörl, J. (2008), Pflege und Betreuung I: Informelle Pflege. In: Hörl, Kolland, Majjce: Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Herausgegeben vom Bundesministerium für Soziales und Konsumentenschutz. S. 351-372.
- Kytir, J. (2008), Demographische Entwicklung. In: Hörl, Kolland, Majjce: Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Herausgegeben vom Bundesministerium für Soziales und Konsumentenschutz. S. 45-74.
- MISSOC-INFO (2006), *Long-term Care in Europe*, Country report for Austria, European Commission, Brussels, February.
- Nemeth, C. and E. Pochobradsky (2004), Qualitätssicherung in der häuslichen Pflege. ÖBIG i.A.d. BMSK.
- ÖBIG (2004), Ausbau der Dienste und Einrichtungen der Langzeitpflege in Österreich.

- Ostermeyer, E. and E. Biringer (2003), Qualitätssicherung in der Pflege und Beratung für Pflegende. Soziale Sicherheit 5/2003, S. 229-231.
- Pochobradsky, E., F. Bergmann, H. Brix-Samoylenko, H. Erfkamp and R. Laub (2005), Situation pflegender Angehöriger. Studie im Auftrag des Bundesministeriums für soziale Sicherheit, Generationen und Konsumentenschutz, Endbericht, ÖBIG, Projektnummer 4488.
- Rappold, E., M. Nagl-Cupal, I. Dolhaniuk and E. Seidl (2008), Pflege und Betreuung II: Die formelle ambulante Pflege. In: Hörl, Kolland, Maijce: Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Herausgegeben vom Bundesministerium für Soziales und Konsumentenschutz. S. 373-388.
- Rudda, J. (2003), Die Richtlinien des Hauptverbandes zum Bundespflegegeldgesetz. Soziale Sicherheit 5/2003, S. 235-139.
- Schneider, U., A. Österle, D. Schober and C. Schober (2006), Die Kosten der Pflege in Österreich. Ausgabenstrukturen und Finanzierung. Forschungsbericht 02/2006, Institut für Sozialpolitik, Wirtschaftsuniversität Wien.
- Scholta, M. (2008), Pflege und Betreuung. Vom Armenasyl zur Hausgemeinschaft: Gemeinschaftliches Wohnen bei Betreuungs- und Pflegebedarf. In: Hörl, Kolland, Maijce: Hochaltrigkeit in Österreich. Eine Bestandaufnahme. Herausgegeben vom Bundesministerium für Soziales und Konsumentenschutz. S. 389-412.
- Spitzbart, C. (2006), Vergleich der Gesundheitsziele in Österreich. Institut für Gesundheitsplanung.
- Statistik Austria (2003), Haushaltsführung, Kinderbetreuung, Pflege, Ergebnisse des Mikrozensus September 2002.



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ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched 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, epidemiologic 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.

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 will 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 backbone 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. 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.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).