

Quality and cost-effectiveness in long-term care and dependency prevention



COUNTRY REPORT

A decade of piecemeal changes in Austria

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Introduction

Austria has long pioneered social protection against the risk of needing long-term care (LTC), with the introduction of a universal cash for care allowance (*Pflegegeld*) in 1993. The system was designed to create conditions for users to remain at home, by supporting informal care provided within the family. Demographic ageing and rising female employment rates have put pressure on the system, with the number of beneficiaries of the *Pflegegeld* nearly doubling in the 20 years since the introduction of the scheme. Families have partially adapted to this by hiring carers from neighbouring countries to provide ‘24-hour care’ – an idiosyncratic feature of the Austrian LTC system that enabled many users with high needs of care to remain in their homes. This phenomenon has been facilitated partly by the *Pflegegeld*, but mainly by the vicinity of countries with lower wages and high unemployment (despite legal regulations implemented to combat moonlighting and to guarantee minimum standards).

Nonetheless, recent years have witnessed a growing concern with the fiscal sustainability of the system. Although responses have fallen short of a complete system overhaul, several policy measures have been implemented which have potential to affect the cost-effectiveness of care in Austria.

This report summarises trends and recent policy developments in Austria over the last ten years in relation to quality and cost-effectiveness in the LTC area. In the next sections, the report provides a highly summarised overview of the LTC system in Austria, after which it reviews key policy developments in the following four areas:

- Reducing dependency rates cost-effectively
- Supporting unpaid carers
- Use of innovative care models/technologies
- Strategies for maximising care coordination.

Brief overview of the formal LTC system in Austria

Social protection provided to those in need of LTC in Austria is a responsibility shared between different levels of government and the health and social care systems. All citizens assessed as needing care are entitled to a LTC allowance, the amount of which varies according to assessed need alone (there are no means-tests to access the *Pflegegeld* and the benefit is also carer-blind) along seven levels of care need (see appendix table T3.1).

The *Pflegegeld* is an un-regulated cash benefit (i.e. users may spend it at their own discretion to purchase services and/or compensate informal carers) that is administrated and financed at the federal level via general taxation. LTC beneficiaries are free to decide how to use the benefit. If they choose to use LTC services (home care or residential facilities) the benefit is added to their income for the purpose of calculating their out-of-pocket contributions (which are income-related).

Prices of home and residential care services are further subsidised by the regional states (Länder). The amount of the allowance is meant to be a contribution to cover additional expenditures occurring due to LTC needs. It is however not meant to fully fund all costs of care services. As a result, individuals (and in some regions also their families) moving into residential care are often forced to use their savings or assets to pay for the difference between the costs and their income (e.g. pension plus *Pflegegeld*).

Beneficiaries without sufficient income may resort to means-tested social assistance which is administrated and financed by the Länder (Grilz-Wolf *et al.* 2004). The amount of the *Pflegegeld* was kept constant between 2009 and 2016 – resulting in a reduction of its real value – but the government has since then undertaken to update its value more regularly. This was coupled with changes to the eligibility criteria, tightening the conditions required to access the two lower levels of the *Pflegegeld* for new entrants.

Health care in Austria is organized around social insurance funds, to a large degree financed by contributions and regulated by the Federal government. Health insurance funds can reimburse some 'hospital-avoiding' activities provided by home nurses subject to a GP prescription, but otherwise the funding of social and health care is separate.

Achieving better coordination and integration between health and social care has long been identified as a priority area to improve the cost-effectiveness of the Austrian LTC system as a whole. Among the issues raised are lack of coordination between acute and social care; prioritization of in-patient health care at the expense of primary and community care; cost-shunting between health and social care sector, for example, following the introduction of Diagnosis-related group (DRG) funding in Austrian hospitals (Leichsenring *et al.* 2009).

A number of proposals, initiatives and pilot projects both within the health system (disease management, hospital discharge management) and between health and social care (case management) have been implemented in this area, but the fragmented nature of both the health and social care systems, with multiple stakeholders and distinct sources of funding, has somewhat hindered their success.

As mentioned before, one of the main purposes of the Austrian LTC allowance is to support informal care and family carers. Informal care remains the main form of care provision in Austria, with an estimated 7% of those 50 and over providing informal care (Riedel & Kraus 2011), the majority of them women. There has been a growing recognition of the role of informal carers, who are entitled to a number of benefits such as free health insurance and pension contributions (if they have not yet reached pension age and care for a person in care levels 3 to 7).

A new benefit entitles informal carers to paid care leave for a period of three months (renewable) if the level of care of the person with care needs has been

assessed as between 3 and 7, and/or if the person has been diagnosed as suffering from dementia (Sozialministerium 2017).

Care services have steadily increased in the past years, in part thanks to initiatives set up specifically to provide regions with sufficient funding to develop services. The financing and regulation of care services (both home and institutional care) remain a prerogative of the Länder, which has resulted into significant differences between the regions in access to services.

According to the latest figures 2.3% of Austrians receive care services (Sozialministerium 2016). Of these 38% are cared for in institutional homes. Non-profit providers, usually large organizations linked to faith denominations or political parties, have traditionally played a substantial role in the provision of care in Austria. In residential care, 24% of facilities are run by non-profit organisations, while for-profit providers account for 21% of care homes and approximately 55% are public (Schneider & Österle 2006; Leichsenring *et al.* 2009).

As mentioned above, a distinctive feature of the Austrian LTC system is the role played by '24-hour carers', usually migrant carers from neighbouring eastern European countries. Until 2007 these migrant carers were mostly unregulated, working in the grey economy (paying no taxes or social contributions and not covered by social or health insurance). Since new legislation was passed that allowed for them to work legally and households employing them to claim extra benefits to meet the social contribution payments, their activity has been regulated, resulting in the registration of more than 60,000 'self-employed personal carers' (*Selbständige Personenbetreuer*) with the Austrian Chamber of Commerce (Wirtschaftskammer Österreich 2017).

As there are usually two '24-hour carers' working in one household in fortnightly shifts, and as not all registered personal carers are 'active' at any time, it can be estimated that a minimum of around 25,000 households with a person in need of care are

currently using 24-hour care. Of these, about 22,000 beneficiaries per month on average receive the means-tested subsidy that serves to cover the social insurance contributions for which they are liable. The subsidy, which can amount to €550 per month per carer, is provided to beneficiaries with a net income below €2,500 and care needs of at least level 3 (Sozialministerium 2016).

Policies aiming to reduce dependency cost-effectively

Managing demand through needs assessment or welfare retrenchment by stealth

One important topic of discussion regarding the LTC allowance in Austria has been its perceived relative generosity in terms of eligibility for the lowest levels of the allowance – about 5.2% of the Austrian population are entitled to the allowance, most of whom are above the age of 65 (Rodrigues *et al.* 2012).¹ From 1993 to 2011, frail older people assessed as in need of at least 50 and 75 hours of care per month had been entitled to the first and second levels of the *Pflegegeld*, respectively. By 2011, these thresholds were raised to 60 and 90 hours, respectively. Together, these two levels of the LTC allowance still account for about 50% of beneficiaries (Table 1).

Advocates of the lower eligibility threshold have pointed to its potential preventive effect; allowing people to have their needs assessed from a lower level before their condition deteriorates and allowing them to purchase services that might postpone the

deterioration of their needs. Since 2015, the eligibility threshold for these two levels has been raised to 65 and 95 hours respectively, although this only applies to new claimants. This measure was expected to slow down the expansion of beneficiaries, in particular by reducing the number of new claimants from 71,000 to 65,000 per year.

One of the strongest arguments put forward in the discussion leading up to the tightening of the eligibility conditions was that only 14% and 23% of beneficiaries of the first and second level of the *Pflegegeld* were actually using the allowance to purchase services, with the overwhelming majority electing to compensate family carers instead. While this change has the potential to impact cost-effectiveness, by either improving targeting and reducing payments for lower care needs (if indeed the eligibility thresholds were too low), no evidence exists about the possible preventive effect of the lower eligibility threshold to support either critics or advocates of the change.

Table 1: Average number of beneficiaries of the Austrian LTC allowance, by level of care needs (2010–2015)

	Year		
	2010	2015	2015
Level 1	94,051	104,393	112,788
Level 2	146,164	130,803	118,882
Level 3	74,729	78,170	79,919
Level 4	62,021	63,463	64,479
Level 5	39,676	46,089	48,121
Level 6	8,050	18,806	19,212
Level 7	8,884	9,435	9,200
Total*	443,395	451,159	452,601

Source: Sozialministerium (yearly reports on LTC), various years.

Note: * The totals do not exactly correspond to the sum of beneficiaries in individual levels of needs due to specific adjustments.

¹ The relatively low threshold for eligibility is due to the fact that, before the *Pflegegeld* was introduced in 1993, a variety of similar schemes had been in place with different access regulations and paid amounts, and associated with various government levels and target groups. In particular, there had been a so-called ‘helplessness allowance’ that had been linked to the pension scheme since the 1960s and served to top-up low pensions, rather than to cover care needs. This allowance had a relatively low threshold and so had been received by a high proportion of pensioners. In order to facilitate the transition phase in 1993, all those qualifying for the ‘helplessness allowance’ were assigned to level 1 in the *Pflegegeld*.

The issue of prevention and rehabilitation has also featured prominently in a number of initiatives at the regional level (Ruppe 2011b). These have ranged from adaptation of living arrangements in the region of Vienna (*'Mobil und Sicher zu Haus'*), which include visits by ergonomists before patients are discharged from in-patient care; to health promoting home visits by nurses in the region of Vorarlberg targeted at older people (*Unabhängig Leben im Alter*). What is common to these initiatives is the lack of evaluation of their cost-effectiveness, small scale and regional or even local scope. These and similar initiatives have nonetheless further highlighted the need for better coordination across several systems and levels of government.

Maximising coordination in care provision

The fragmented nature of both health care (where for example care funds often have a regional scope) and social care in Austria has long been identified as a barrier to achieving better outcomes and cost savings (Grilz-Wolf *et al.* 2004; Riedel & Kraus 2011).

The Austrian health system covers the population by means of a mandatory social health insurance which is supervised by the Federal Ministry of Health. However, a wide range of responsibilities, even within the health system, rest with the nine regional governments. For instance, regional governments are responsible for the provision of hospitals based on 'Regional Health Funds'. Patients have free choice of their GPs and specialist doctors who are remunerated according to a mixed system of fee-for-service and a capitated element for basic services (Hofmarcher & Quentin 2013).

This situation triggered a number of initiatives that attempted to improve coordination of care provision – in the first place within the health care system, and to a minor degree also in the area of social/long-term care, where services and facilities are mainly provided by private non-profit organisations (e.g. Caritas, Austrian Red Cross and other large welfare organisations, many of which are affiliated to political parties) and a rising proportion of private

for-profit providers. Competition between providers is however relatively lacking, both in acute health care and in the long-term care sector, as demand exceeds supply.

The most recent attempts at improving coordination within the health care system were mainly initiated by the *Health Care Reform 2005*. This reform established so-called 'Health Platforms' at the regional level to improve coordination in planning, controlling and financing with the aim of overcoming barriers within the health sector and between different stakeholders, including social care providers. Within this framework two key policy instruments were implemented: a 'reform pool' of virtual funding to address the divide between inpatient and outpatient care via projects jointly financed by social health insurance and regional governments, and disease management programmes (DMPs) to improve care coordination specifically for people with chronic conditions (Schang *et al.* 2013, p.6). The 'reform pool' projects were less influential as on average only 15.8% of the virtually available funds have been used, with regional variations ranging from 1.5% (Tyrol) to 33% (Styria). Among the projects implemented in Vienna was 'patient-oriented, integrated health care' (*Patientenorientierte Integrierte Krankenbetreuung – PIK*), aimed at implementing independent discharge management across the whole city (www.pik.or.at). Similar projects were started in a few other Austrian regions so that discharge management has become a mainstream service in most hospitals over the past ten years.

Even though integrated planning of health services was introduced by 2008 to further strengthen the implementation of needs- and patient-based pilot projects, the Health Platforms came to an end in 2013 due to the generally low interest by stakeholders and the meagre effects produced, which fell short of policymakers' expectations. For instance, by 2012, only 32,000 patients and fewer than 1,000 physicians had participated in the DMP 'Therapie Aktiv' introduced in six of Austria's nine regions.

The available evidence suggests that in all these endeavours and projects there was only very limited involvement of stakeholders from the social care sector. This highlights a long-standing issue with the coordination of care in Austria: the relatively under-valued role attributed to the social care sector as against health care providers. Even within the LTC sector in the narrow sense (home care and residential care) progress towards integration has been poor. For instance, it is still not possible (in some regions it is prohibited) to provide community care services in residential-like settings, with the exception of some regions where 'service housing' has been established. On the other hand, it is also not possible for staff in residential care to provide community care, for instance in the neighbourhood of a care home.

A peculiar measure to increase integration was implemented in two regions – Upper Austria and Styria – where public administration defined operational districts each of which was then allocated to a single home care provider organisation. No evaluation has yet been presented to show whether this intervention, to the detriment of consumer choice, has really resulted in the expected increase of cost-effectiveness in home care, for example due to reduced travel time.

Against this backdrop, it must be mentioned that one of the most active and reform-oriented areas in linking health and LTC in Austria has been hospice and palliative care. Driven by a dedicated 'Hospice Association', important steps to raise awareness for end-of-life care and to establish concepts of palliative care across health and long-term care provision have been taken, such as the project 'Palliative Care in Care Homes' and the further extension of 'Mobile Palliative Care Teams' (Ruppe 2011a). Indeed, the ways of working in palliative care (multidisciplinary teams, patient-orientation, holistic approaches, lump-sum funding of teams) have potential as a general model for person-centred care. Although palliative currently mainly provides services for cancer patients, it is increasingly involved with clients at higher ages,

with multi-morbidity and needs for LTC. Its further integration in mainstream provision of LTC remains to be seen.

Policy measures to support unpaid carers

Forming the backbone of the provision of LTC in Austria, informal carers have slowly been receiving greater recognition and benefits for the role they play in meeting the needs of an ageing population. As a significant share of the *Pflegegeld* is used to compensate informal carers, it can be argued that the decision to regularly increase the amounts of the allowance from 2016 will disproportionately benefit carers. Other measures have been enacted that are targeted specifically at informal carers.

Working-age informal carers who provide care to relatives already had the option to pay health and pension insurance voluntarily. Since August 2009, however, old-age pension contributions are paid by the Federal Government and not by informal carers themselves. Approximately 9,600 informal carers were covered by this measure in 2013 at a total cost of €38.9 million (Sozialministerium 2014). Other benefits for informal carers include an extra allowance to pay for respite care, which was taken up by approximately 9,100 people in 2013 at a total cost of €11 million.

Since 2014, employees may also take a paid care leave (*Pflegekarenz*) or part-time care leave (*Pflegezeit*) to care for dependent relatives (not only older dependent people). The leave can be taken for up to three months and the amount is income-related and at the level of unemployment benefit. Approximately 2,600 people benefit from one of these care leaves, according to the latest available data, at an estimated cost of €5 million (Schmidt *et al.* 2016). There is, again, no available evaluation of the cost-effectiveness of these measures, even if they seem to improve the possibility that informal carers can remain employed (in the case of care leave) and avoid burnout (in the case of the allowance for respite care).

Innovative care models/technologies to improve outcomes for people with LTC needs

As mentioned above, the Austrian LTC system has been characterised by its reliance, on the one hand, on migrant carers, and on the other hand on cash benefits and informal care. Two significant policy changes have been introduced in the past ten years that could potentially impact this profile and with it the costs and outcomes of care. The first of these changes was the legalization of migrant carers paid by families. The second was the setting up of the LTC Fund (*Pflegefonds*) to fund the development of services at the regional and local level. We describe and discuss each in turn.

Legalizing migrant carers

Starting in 2007, a number of legislative changes were introduced that legalised the status of 24-hour carers from a migrant background, attempted to regulate quality of 24-hour care and provided subsidies on the demand side for those hiring those carers. Under the new law, 24 hour carers may register as self-employed or be employed by private households or home care providers. Regulations were also enacted as to the working times (24-hour carers usually work for rotating periods of two weeks, spending a fortnight working and another one in their home country) and social and health insurance coverage. The large majority of 24-hour carers are formally registered as self-employed and thus pay corresponding contributions to social and health insurance funds (excluding unemployment insurance), amounting to about 25% of the agreed honorarium.

Beneficiaries of the *Pflegegeld* who use 24-hour carers may apply for a means-tested subsidy to cover the increased costs (see above under 'Brief Overview of the Austrian LTC System'). This subsidy varies according to the nature of the employment relationship of the 24-hour carers, ranging from €275 per carer per month in the case of self-employed personal carers; to €550 per carer per month in the (relatively few) cases where users

employ the personal carers directly and are thus liable to pay about 37.5% of their gross wage as social insurance contribution. Although the threshold for the means-tested benefit is relatively high, 24-hour care remains concentrated among middle and upper income quintiles, not least as appropriate housing conditions such as having an extra room are needed (Schmidt *et al.* 2016). The qualifications of 24-hour carers, ranging from previous nursing training or practice in their home country to minimum language skills, were also regulated. Carers are now required to provide proof of theoretical knowledge (equivalent to 200 hours of training), practical experience in the past six months, or have a doctor or nurse delegate tasks to them. Random inspection visits are also carried out by the Welfare State Office.

By 31 December 2016 personal carers registered with the Austrian Chamber of Commerce as self-employed numbered 60,589 (WKO, 2017, p.11). They represent the overwhelming majority, although 24-hour carers may also be directly employed by users or providers. The self-employed option has considerable advantages both in terms of costs and flexibility of working times for families (Österle & Bauer 2011). Most evaluations of the reform have concentrated on its effects on the 24-hour carers themselves (Bauer & Österle 2016; Österle & Bauer 2011; Schmidt *et al.* 2016) and these have generally concluded that they perceive their working conditions to have somewhat improved – although this was mostly linked with having health and social insurance coverage. The inspection visits carried out thus far have mostly reported good quality of care (assessed mostly as process indicators) (Schmidt *et al.* 2016).

Rigorous data on outcomes of 24-hour care are not available as yet. Nonetheless, 24-hour care has usually been credited with allowing older people with higher care needs (and income) to remain at home and avoid institutionalization (Schmidt 2016); and lauded as meeting the preferences of users, i.e. as improving allocative efficiency (Schmidt *et al.* 2016). Despite the quality assurance mechanisms

put in place, 24-hour care remains a relatively low paid and low status job, with high pressure put on personal carers who, in many cases, have to face long (unpaid) travel time as well as constant availability, social isolation and separation from their family during their fortnightly shifts in Austria (Leichsenring *et al.* 2015).

The legalization measure entailed an increase in the costs borne by the Federal Government, due to the subsidy paid to users of 24-hour care that meet the eligibility criteria – the number of beneficiaries increased from about 5,800 in 2009 to 21,900 in 2015 (see table 2). During the same period, yearly expenditures which are shared between the Ministry of Labour, Social Affairs and Consumer Protection (60%) and the regional governments (40%) escalated from €41.2 million to €138.6 million. In practice, however, these amounts directly increased the income of the social insurance system as care work that had previously been part of the ‘grey economy’ became legalised and contributed to tax revenue. The net effect can currently only be roughly estimated. To do so, it can be assumed that at least 50% of the current approximately 22,000 beneficiaries would need to move to a care home if the 24-hour care alternative were not available. Given that net public expenditures per care home

resident amount to about €26,000 per year, the average amount of about €6,500 per year per beneficiary of the subsidies for 24-hour care can safely be considered as cost-effective. Even without taking into account indirect public revenues, additional subsidies needed for extended home care services, and potential investment costs for additional care homes, it can be estimated that a minimum of €200-300 million of public expenditure per year is currently being saved by 24-hour care in Austria.

Changing the care mix of services and of the workforce

The federal LTC allowance had been introduced on the premise that the Länder would use the resulting savings to fund service development (they had previously been responsible for all LTC funding). However, this has only partly been realized (Rodrigues 2010). While the LTC allowance amounts had been basically frozen since 1993, costs for services and facilities constantly increased, resulting in a transfer of the funding burden of LTC back to regional and local levels of government, which faced difficulties in meeting increasing demand and related expenditures. In response to this, the LTC Fund (Pflegefonds) was set up in 2011. The Federal Government and the regions agreed to earmark

Table 2: Development of subsidies for 24-hour care (2009-2015)

Year	Number of applications	Average number of beneficiaries per month	Yearly expenditures in €million
2009	4,200	5,800	41.2
2010	5,800	8,600	58.5
2011	6,700	11,200	73.5
2012	7,700	14,100	89.2
2013	9,000	16,600	105.4
2014	9,500	19,300	122.9
2015	10,100	21,900	138.6

Source: Sozialministerium (several years).

Note: The subsidy was introduced in 2008 and is funded at 60% by the federal government and at 40% by regional governments; it amounts to up to €550 per month for two self-employed, and up to €1100 per month for two directly employed personal carers.

funds to a common pool to which the Federal Government contributes two thirds, which can be used by regions and municipalities to create additional services and to subsidise existing services and facilities. Originally foreseen as an interim solution until 2014, the Fund was soon extended to 2016 with a total of €1.335 million assigned to it. A further extension of the Fund to 2018 has since been agreed.

The establishment of the LTC Fund represents another attempt to increase service provision (although anecdotal evidence seems to indicate that the available funds are mostly financing existing services) and as such it could impact the care-mix between formal and informal care and thus have potential effects on the cost-effectiveness of the system as a whole. Some of the money available has been used by regions to set up case management to improve integration of care between the health and social sectors. To this date however, there is very little information on the impact of the Fund on actual service provision and even less on whether it has been cost-effective.

The development of services funded by the LTC Fund has the potential to change the care-mix of the Austrian LTC services towards greater reliance on community care services. Concomitantly, it may also spur demand for care professionals. Training and qualification of nurses and care staff have recently undergone a significant overhaul, the consequences of which may also impact the cost-effectiveness of care provision.

The new curricula for the nursing professions approved in 2016 (*GuKG Novelle 2016*) have in practice established three types of professional profiles for the care sector (including acute health care): qualified nurses (*Krankenpflege*), qualified care assistants (*Pflegefachassistenz*) and care assistants (*Pflegeassistenz*). As of 2018, qualified (and eventually also registered) nurses will receive a 3-year generalist education for nursing at a university of applied science (*Fachhochschulen*) with a greater emphasis on organization, planning and evaluation tasks, as well as assisting in medical

tasks, rather than hands-on (nursing) care. Specializations, such as psychiatric nurse, paediatric nurse, are added at a later stage. The profession of qualified care assistants was created with the aim to replace qualified nurses in the execution of nursing tasks and to collaborate with therapeutic and diagnostic tasks. To this end, a new 2-year education course was instituted and qualified care assistants may perform nursing tasks independently. Finally, care assistants (previously denominated care helpers, *Pflegehelfer*) now receive a 1-year training that may be continuously upgraded in a modular system towards qualified care assistant or nurse.²

The reorganization of the nursing profiles has potential far-reaching implications in terms of cost-effectiveness, and these were reflected in the debate surrounding its implementation. On the one hand, qualified nurses are now able to take on a wider range of responsibilities (for similar wages), while some of their more time-consuming nursing tasks have been transferred to the (cheaper) qualified care assistants. However, this will mostly impact the health care sector, since the social care sector (particularly institutional care) mostly employs care assistants, with qualified care assistants deemed over-qualified (and thus too expensive) for the current demands of home and institutional care providers.

The new curricula are also expected to reduce education costs and speed up the training of nursing personal (*GuKG Novelle 2016*). On the other hand, some have concerns about the possible downgrading of profile of the nursing profession and its effects on quality and outcomes of care –

² In the Austrian educational system, the training for *Pflegeassistenz* is considered a first level training for the nursing profession (*Erstausbildung*), which means that under specific conditions, care assistants have the option to go on and become qualified care assistants or even nurses. In the period leading up to the implementation of the law there was debate about whether this possibility should be kept in the new legislation. A crucial argument in favour was that a large proportion of older workers undertake training as *Pflegeassistenz* as vocational training; they could eventually obtain higher qualifications and help to meet the growing demand for nursing professionals.

particularly those resulting from qualified care assistants performing nursing tasks unsupervised.

It should be noted that a parallel development with significant potential to establish appropriate education and training for skills needed in LTC has taken place since 2005 originating from a reform started by the Ministry of Labour, Social Affairs and consumer protection in coordination with the regional governments. Social care related education and training³ had been highly fragmented as it had been organised by the regional governments and even individual service provider organisations, ranging from short-term training to courses with a duration of two years and appropriate practical training. Some certificates were acknowledged only within individual organisations or regions. The reform in 2005 managed to streamline the various curricula by establishing a two-year course as specialised social carer and a three-year education for specialised social carers with a diploma. Both curricula combined the training in social care skills with an integrated training as care helper (Pflegehelfer) and a specialization for specific target groups such as people with disabilities or older people.

However the first of those who entered the labour market in 2010 with these qualifications have faced difficulties in finding appropriate jobs. First, they have not yet been considered in staffing regulations nor in collective agreements. Second, providers and employers in most regions have not yet taken on board this new job profile. This results in specialised social carers being employed (and paid) as care helpers and those with a diploma searching for further education or jobs in other sectors. Indeed, there is some evidence that employers, in particular in residential care, are very satisfied with the performance of specialised social carers, while continuing to pay them at wage levels stipulated for care helpers (Leichsenring *et al.* 2015).

³ It should be noted that social workers have tended to play a very small role in the development of long-term care. This is partly due to the lack of related training and the nursing-oriented tradition of long-term care in Austria.

With regard to cost-effectiveness, the areas of training, recruiting and retention of workforce certainly have potential for increasing cost-effectiveness in a Taylorist perspective, but individual measures and initiatives need to be seen in the context of trade-offs concerning the quality of care, working conditions (job satisfaction), older and younger workers' recruitment and retention, as well as those related to the health system, as against the LTC system:

- Delegating individual tasks to 'lower' levels might liberate registered nurses from certain duties, leaving them with managerial and administrative functions – thus reduced costs may come with lower job satisfaction;
- An increasing division of work might also result in higher coordination needs;
- The 'race to the bottom' in terms of delegating the care workload to lower trained and lower paid staff might be counterproductive. Current practice in home care shows that home helpers often have a coordinating function due to the fact that they spend more time with the clients. An emphasis on more appropriate training and job profiles for LTC workers (qualified care assistants) could be preferable.

Introducing mechanisms to assess and improve quality

In the Austrian LTC system, quality assurance has been a responsibility of regional governments, resulting in nine different sets of standards and procedures with which mainly structural and process criteria are monitored by respective public authorities. As any interference in the constitutional division of responsibilities would call for a 'state treaty' between the federal state and the nine regions, some issues have been tackled at the federal level in the framework of 'consumer protection' and 'senior affairs' both of which are assigned to the Ministry of Labour, Social Affairs and Consumer Protection. For instance, issues concerning residents' rights were regulated in 2005 by the federal Care Home Contract Act

(Heimvertragsgesetz), which regulates minimum standards for contracts between residents and care home providers, and the Care Home Habitation Act (Heimaufenthaltsgesetz) which regulates the restriction of freedom (physical and medical restraints) for residents and patients in all types of residential care facilities. Similarly, the voluntary 'National Quality Certificate' (NQZ) for care homes was introduced in 2012 in the context of a federal law to improve the political participation of older citizens (*Bundes-Seniorengesetz*).

The NQZ had been a reaction to the nine different standards and procedures by a broad coalition of stakeholders, including some regional governments, the Federation of Care Homes and a number of professionals interested in promoting quality improvement in long-term care. As only about 20% of care home providers had already introduced quality management systems, the so-called NQZ organization had been established to promote voluntary quality management in care homes. Its main task is however to act as a third party to certify the existing quality management systems by means of external audits. Following a pilot phase between 2010 and 2012, the system was established as a mainstream procedure (Leichsenring *et al.* 2014). However, the initiative has continued on a voluntary basis as experience has shown that organizational improvement is likely to work better if management and staff are engaged in quality management, rather than perceiving it as yet another bureaucratic exercise to please funders, regulators or purchasers. It remains to be seen how far this initiative will be able to drive future outcome-oriented quality improvement not only in care homes but in the entire LTC care system.

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Tightening Eligibility Criteria of the LTC Allowance

Policy theme	Policies aiming to reduce dependency cost-effectively/Cross-cutting measure
Design and implementation level	National design, national implementation
Policy objective	Reduce the number of people eligible for long-term care allowances
Start date – End date	2011, amended in 2015

Aims	The Austrian LTC Allowance scheme embraces the highest share of people eligible across Europe – about 5.2% of the population are receiving this benefit (as against about 2.6% in the Netherlands or in Germany). In order to put a brake on the constantly rising number of beneficiaries, thresholds for accessing the benefit (determined by the number of hours of care needed per month) were raised.
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Implementation	By 2011, the thresholds for entitlement to levels 1 or 2 (out of 7) were raised from 50 to 60 hours of care needed (level 1) and from 75 to 85 hours (level 2). In 2015, the thresholds were further raised, to 65 hours for level 1 and 95 for level 2.
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Target group	All citizens with long-term care needs (the Austrian LTC allowance covers all age groups, although more than 80% of beneficiaries are over 65).
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Eligibility criteria	General eligibility criteria are still based on needs assessment to identify individual care needs in terms of hours of care needed per month. Depending on the assigned level of care (1 as the lowest, 7 as the highest) the following (lump sum) amounts are paid to the beneficiary (2017):	Level	Amount (hours/month)	Care needs
		Level 1	€157.30	65 hours
		Level 2	€290.00	95 hours
		Level 3	€451.80	120 hours
		Level 4	€677.60	160 hours
		Level 5	€920.30	180 hours*
		Level 6	€1.285.20	180 hours*
		Level 7	€1.688.90	180 hours*
		* For levels 5, 6 and 7 additional conditions need to be fulfilled		

Resources	The tax-funded Austrian LTC Allowance is the key instrument for funding and tackling the risk of LTC in this country. Currently, about €2.5 billion of the federal budget is spent on this scheme.
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Performance assessment and monitoring

Not available – the performance of the LTC System is monitored and reported by a working group consisting of representatives of regional governments and the Federal Ministry of Labour, Social Affairs and Consumer Protection, which publishes a

yearly report. Apart from the estimated reduction in the number of new beneficiaries – see Evidence of Success below – there has been no rigorous study on the effects of this measure (e.g. on the onset or pace of frailty).

Evidence of success (outcomes, quality, satisfaction, awareness)

The amendment in 2011 resulted in a nominal short-term reduction of about 8,000-10,000 new beneficiaries (not controlled for potential demographic factors) in 2012. A large number of stakeholder organisations contested the measure but without success

– on the contrary, more severe measures were implemented in 2015, raising the threshold for levels 1 and 2 to 65 hours and 95 hours, respectively. It is expected that this will reduce the number of beneficiaries by another 6,000.

Transferability/uniqueness

The ‘re-definition’ of the target group and more restrictive definitions of eligibility criteria are a relatively widespread cost-cutting strategy.

The issue is whether it is cost-effective to exclude persons with lower levels of care needs from accessing the LTC system.

Is this an emergent practice? (degree of innovation)

There has long been a discussion on the relative generosity of the Pflegegeld in Austria, particularly when compared with similar benefits in Europe, and on the need to limit eligibility. This was, however the first

time such a measure has been implemented since the inception of the Pflegegeld.

Sustainability

Targeting and regulating eligibility criteria may contribute to the sustainability of benefit schemes.

Academic literature on this action

No specific studies available for Austria.

Regulating 24-hour Care

Policy theme	Policy measures to support unpaid carers
Design and implementation level	National design, national implementation
Policy objective	To legalise so-called 24-hour care performed by mainly migrant carers and to combat moonlighting in the area of personal assistance in private households; to support care at home; to provide social security coverage for 24-hour care.
Start date – End date	2007/08, ongoing

Aims	The legalisation of 24-hour care through amendments in labour law (working time), professional legislation (delegation and liability issues), registration of personal carers (Code of Trade and Commerce), and the introduction of minimum standards of quality (qualification).
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Implementation	By 2007, the ‘Personal Care Act’ (Hausbetreuungsgesetz, BGBl. Nr. 33/2007) was enacted to ensure legal employment of 24-hour carers in private households and to avoid a (further) loss in social security contributions and tax payments. The Act, based on an ancient law for maids and butlers, was introduced and the Code of Trade and Commerce was amended in 2007. Both regulations created a legal basis for the 24-hour care arrangements with the following options for hiring a 24-hour carer: • The first option is direct employment of 24-hour carers by care organisations or by families who pay social contributions and income taxes. Apart from minimum wages and leave entitlements this arrangement includes working time regulations that stipulate a maximum working time of 11 hours per day and 128 hours during a biweekly shift. • The second option, which has been chosen by the large majority of 24-hour	carers, is self-employment. This arrangement allows for more flexible (unregulated) working times, does not enforce minimum wage rates specified by trade unions and offers relatively straightforward registration procedures. Social security contributions and taxes are due to be paid by both employers and employees, in the second option by the self-employed carers. As these additional payments have increased the costs of hiring 24-hour carers significantly, legislators also introduced means-tested subsidies to incentivise regular arrangements. These subsidies for employers were aligned with the Austrian long-term care allowance scheme. The law stipulates qualification requirements for the public subsidy to be paid. A number of other eligibility criteria have been specified for the subsidy, including the availability of a separate room in the household for the carer.
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Target group

24-hour carers (mainly migrant carers from Slovakia, the Czech Republic and Hungary); families employing 24-hour carers; people with long-term care needs.

Eligibility criteria

The public subsidy for 24-hour care is granted only to people in need of at least 120 hours of care per month (at least care level 3 of the long-term care allowance scheme, except in cases of dementia, where a lower threshold can be agreed on), if they

have a personal income of less than €2,500 per month. The monthly subsidy amounts to €1,100 for two employed 24-hour carers (€550 for one) and €550 for two self-employed 24-hour carers (€275 for one).

Resources

The subsidy is provided by the Federal Ministry of Labour, Social Affairs and Consumer Protection and tax-funded from its budget.

In 2015, about 21,900 beneficiaries received subsidies amounting to €138.6 million.

Performance assessment and monitoring

'Quality assurance visits' are carried out by specialised nurses on a random basis covering annually about 20,000 beneficiaries of the LTC allowance, among which in 2015 there were 4,487 with a 24-hour carer.

In 99% of these cases the care provided was rated good or satisfactory (Sozialministerium 2016).

Evidence of success

(outcomes, quality, satisfaction, awareness)

Moonlighting in the area of 24-hour care has been quite successfully avoided through this regulation. There is no robust evidence on changes in the real quality and working conditions in 24-hour care. However, scandals or complaints seem to be relatively scarce.

Regulation is often addressed as a win-win situation for all involved, but in interviews some 24-hour carers clearly underline the exploiting character of these care relationships (Leichsenring *et al.* 2015).

Transferability/uniqueness

As live-in care by migrants has become a widespread phenomenon in Europe, in particular in the Mediterranean countries, but also Germany, the Austrian regulation provides at least a first step towards

regulation that is completely lacking in many countries. As it is generally difficult to regulate employment in private households, further efforts are needed.

Is this an emergent practice?

(degree of innovation)

Austria remains the only country in Europe where 24-hour care by migrants has been regulated in this way.

Sustainability

The support of 24-hour care recipients through subsidies to cover social insurance costs contributes eventually to higher tax income and social security contributions. A relatively low amount of subsidy was therefore sufficient to avoid moonlighting.

Wage differentials between neighbouring countries and Austria may reduce or disappear over the next decades and under changing conditions it may be harder or impossible to attract personal carers from these countries.

Academic literature on this action

Winkelmann *et al.* 2015;
Schmidt *et al.* 2016;
Schmidt 2016

Documents

www.ris.bka.gv.at/Dokument.wxe?Abfrage=BgblAuth&Dokumentnummer=BGBLA_2007_I_33

Introducing a Voluntary Quality Certification System in LTC

Policy theme	Innovative care models/technologies to improve outcomes for people with LTC needs	
Design and implementation level	National design, national implementation	
Policy objective	To spread quality management and improve quality assurance in LTC, in particular, in care homes	
Start date – End date	2012 (following a pilot phase 2010–2012)	
Aims	To establish a third-party certification procedure for all care homes that have introduced one or other of the accredited quality management systems (EFQM, ISO, E-Qalin) and promote quality management through certification.	
Implementation	During a pilot phase (2010-2012), NQZ auditors were trained. They were recruited from ‘peers’, i.e. care home managers with skills in quality management, and auditors from classic quality management systems (ISO, EFQM). A number of care homes volunteered to go through the procedure of certification, based on an audit of self-assessed criteria of structures and procedures, and related performance indicators showing individual results.	Following an amendment of the Austrian ‘Senior’s Law’ the NQZ organization was established to roll out the system across all care homes in Austria. However, only a small number of care homes have chosen to get (re-)certified. There are discussions to extend the NQZ to home care providers and further attempts to extend coverage.
Target Group	All residential care and nursing homes in Austria	
Eligibility criteria	Only care homes with an accredited quality management system may apply for certification	
Resources	The NQZ organization (administration, auditors, training) is funded by the Austrian Ministry of Labour, Social Affairs and Consumer Protection; individual certifications of care homes are co-funded by regional governments.	Auditors are trained, selected and paid by the NQZ organization, which has only a few employed staff.

Performance assessment and monitoring

The NQZ is supervised by the Ministry of Labour, Social Affairs and Consumer Protection. There are regular meetings of auditors to further improve the procedure.

A research project is currently assessing the results and impact.

Evidence of success (outcomes, quality, satisfaction, awareness)

Too early to judge. However, only a few care homes have applied (about 60). As these 'pioneers' are quite well motivated most of them have been assessed positively, but more awareness-raising measures will have to be developed.

Transferability/uniqueness

The voluntary character of the NQZ is relatively distinctive (although underpinned by the quality assurance visits by regional authorities, which continue). A similar system could be implemented in other countries.

The question is if care homes with a classic quality management system (ISO, EFQM) will 'buy in', as these systems also offer an external audit and system-related certification.

Is this an emergent practice? (degree of innovation)

Yes, the innovation consists in the specific adaptation of the certificate (criteria, performance indicators) to LTC facilities, rather than providing just a certification of the quality management system (as in ISO and EFQM).

Sustainability

Targeting and regulating eligibility criteria may contribute to the sustainability of benefit schemes.

Academic literature on this action

No specific studies available for Austria.

Documents

Website of the NQZ Organization (German only): www.nqz-austria.at