Long-Term Care landscape in Austria

InCARE Short Report

European Centre for Social Welfare Policy and Research, Chance B, Vilans October 2023

Supporting INclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches

Co-funded by the European Union

This document has received financial support from the European Union Programme for Employment and Social Innovation "EaSI" 2014-2020 (VS/2020/0258). For further information please consult http://ec.europa.eu/social/easi. The information contained in this publication does not necessarily reflect the official position of the European Commission."

Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz

Gefördert aus den Mitteln des Fonds Gesundes Österreich
Gesundheit Österreich GmbH

Geschäftsbereich Fonds Gesundes Österreich

Long-Term Care landscape in Austria

InCARE Short Report

InCARE (Supporting Inclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches) aims contribute to the design of a coordinated approach to the development of national long-term care policy and care services at local and regional level, by establishing socially innovative and participatory decision-making processes. We work with care users, care providers and policymakers in Spain, Austria and North Macedonia to design, implement and scale-up innovative care services.

More information on the project's website: https://incare.euro.centre.org/.

Table of Contents

Table of charts

Table of figures

Long-Term Care landscape in Austria Short Report

.

1. Introduction

This report presents information on the long-term care (LTC) landscape in Austria. It builds on two activities in the InCARE project: the situational analysis and the SWOT-Analysis. The SWOT analysis identified Strengths, Weaknesses, Opportunities and Threats of the LTC-system in Austria. The aim of this report is to inform the different elements of the InCARE project – from the pilot project, to the online survey on attitudes, experiences and expectations on LTC, to the modelling of future costs of LTC and the policy roadmap. It covers five different topics: key information about Austria, support-capacity and care needs in the community, service delivery, performance and system enablers. Together with findings from the situational analysis regarding these topics, we present current strengths, weaknesses, opportunities and threats relevant to the development of LTC in Austria based on the SWOT-analysis.

2. Key information about Austria

In 2019, 8,877,637 people lived in Austria (annual average), of which 19.3% were 19 years old or younger, 61.7% 20-64 years old and 18.9% older than 64 years (Statistik Austria, 2020a). In 2020, 58.7% of the population lived in urban areas, or over 5.2 million people (World Bank, 2021a; World Bank, 2021b). Austria is predominantly an alpine country, with nearly 60% of the country being mountainous (mostly in the western part).

Austria is a federal state comprised of 9 independent federal provinces that are responsible for social care services, resulting in 9 different regimes in the provision of long-term care services and facilities . It classified as a conservative or corporatist welfare state, in that the social insurance model dominates the protection against the risks of age (pensions), health, unemployment and workplace accidents, while at the same time, families play a large role in providing care for children, people with disabilities and older people in need of care as services in kind are less developed than, for instance, in universalist Nordic welfare states (Esping-Andersen, 1990). However, when it came to the first major reform to cover the risk of LTC in 1993, the traditional pathway was partly abandoned – rather than introducing a LTC social insurance, a budget line covered fromin general taxes was established to cover the cost of LTC allowances. These are individual cash benefits that are paid as a lump-sum contribution to cover care-related expenditures based on a needs assessment that allocates beneficiaries to seven levels of care needs.

According to 2020 EU-SILC data, Austrian households on average have a median household income of €39,549 per year (Statistik Austria, 2021a). Based on GDP per capita, Austria ranks among the 10 richest EU countries and has a very generous welfare state (higher social expenditure per inhabitant

than the EU average). In the 10 years prior to the COVID-19 pandemic, Austria on average experienced real GDP growth ranging from 0 (in 2013) to 2.6% (in 2018) (OENB, 2021).

The SWOT analysis defined two strengths (generous welfare state, LTC addressed as a social risk), two weaknesses (strong reliance on family care, regional differences), one opportunity (among richest countries in EU) and two threats (difficult to access areas, regional inequalities).

STRENGTHS	WEAKNESSES
• Generous welfare state • Long-term care addressed as a social risk by provision of cash benefits and services in kind	• Strong reliance on the family to provide care • Regional differences
OPPORTUNITIES	**THREATS**
• Among the 10 richest countries in the EU	• Alpine region – remote and difficult to access areas • Regional inequalities

TABLE 1- SWOT ON GENERAL COUNTRY CONTEXT

3. Support-capacity and care needs in the community

Demographics

By 1 January 2020, there were 1,693,627 inhabitants (19.0%) aged 65+ in Austria (Statistik Austria, 2020a). Demographic ageing has progressed considerably over the last two decades in Austria, with an increase of older population groups (65+) from 15% of the total population in 2002 to over 19% in 2020, and a corresponding contraction of the working age population. Over the same period, the oldest old (80 and above) have been the fastest growing population group: from 3.7% of the total population in 2002 to 5.3% in 2020 (Statistik Austria, 2020b – see Figure 1). This trend is expected to continue over the next decades, to reach an estimated 12% of the Austrian population aged 80 and above in 2050 (OECD, 2017). Recent national data place the number of individuals with migration background at 2,070,100, representing 24% of the Austrian population (Statistik Austria, 2020). Of these, 1.5 million (representing approx. 17%) are first generation migrants (Statistik Austria, 2020).

The average household size was 2.21 individuals in 2019 (Statistik Austria, 2020c). In only 60,000 households (1.5%) two or more nuclear families lived together. Mostly, the link between them was a parent-child relationship. Among individuals aged 65 and above, the most common living situation is in a couple (without other persons), followed by living alone (more common among older women).

Health

National statistics show a total of 83,975 people died in Austria in 2018, with cardiovascular diseases (38.9%) and cancer (24.5%) causing six in every ten deaths. Other major mortality causes were diseases of the respiratory organs (6.6%) and of the digestive organs (3.3%), other diseases (21.3%) and unnatural causes of death (injuries and poisonings; 5.3%) (Statistik Austria, 2021b).

The rates of depression in Austria for the general population are quite low compared to the EU average, but Austria does experience higher rates of anxiety disorders (OECD, 2018). A systematic literature

review carried out by Łaszewska et al. (2018) concluded that between 9% (point prevalence) and 15% (10-year prevalence) of the adult population in Austria may be affected by depression. Prevalence rates for depressive disorders were estimated to be higher in older adults (50+ years) and older persons (75+ years), at 19.6% and 16.3%, respectively. Following the COVID-19 pandemic, it is estimated that about 26% of the Austrian population suffer from depressive symptoms, 23% from anxiety disorders and 18% from sleep disorders, with young adults (18-24 years) being particularly affected (Donau Universität Krems, 2021).

In terms of the percentage of the total population, people with dementia will account for 3.18% in 2050, compared to 1.66% in 2018. The significant growth in the number of people aged over 65, in particular in the group of people over 85, which is estimated to more than double between 2018 and 2050, seem to be the key elements that will contribute to this increasing share of people with dementia.

Cardiovascular diseases, cancer, diabetes and Alzheimer's disease are the leading causes of disability and deaths in Austria, and contribute significantly to the burden of disease (Global Burden of Disease Study, 2020). In 2019 according to EU-SILC data, 35.1% of women and 32.7% of men living in Austria (adults, all age groups) reported long-standing limitations in usual activities due to health problems (Eurostat, 2019), placing Austria much above the EU average for the same year (25% for women and 21% for men). Levels of functional limitations have remained fairly stable for older women over the past decade, and are showing a marginal increase for older men.

Provision of informal care and care-related rights

Austria is viewed as a familialist country, where the family provides a large portion of informal care. While Austria is around the EU average in terms of gender stereotypes (Eurobarometer, 2017), a large number of individuals still view care as the role and responsibility of the woman. In the 2017 Eurobarometer, 41% of individuals agreed that "The most important role of a woman is to take care of her home and family", while 56% disagreed, about in line with the EU average (ibid).

As Austria is considered a familialist country, about 80% of people in need of care are cared for by family members at home (Riedel & Kraus, 2011). Around 947,000 individuals provide informal care to a relative, whether at home (801,000 individuals), or for relatives living in a care home (146,000) (Nagl-Cupal et al., 2018). A large number of individuals that receive a LTC allowance are cared for by a relative at home (71%), suggesting that the LTC allowance is being used to cover this informal care (BMASGK, 2018)

The average age of informal carers in Austria is 59 years for women and 65 years for men (BMASK, 2016b), with 59% of main informal carers (i.e. the individual providing the most care to the relative) being under the age of 65 (ibid). Providing informal care is highly gendered: of the 7% of individuals aged 50+ providing informal care, 70% were women (Riedel & Kraus, 2011). In the group of working-age individuals, the share of informal carers that are women is even higher at 78%.

In addition to having ratified a number of international treaties that both explicitly and inexplicitly outline the rights of older people, a number of Austrian laws also set out legislation for the protection of older people in a number of areas. The "Bundesgesetz über die Förderung von Anliegen der älteren Generation (Bundes-Seniorengesetz)" (BGBl. I Nr. 84/1998) outlines regulations to support the political participation of older people, the Federal Seniors Council, and the National Quality Certificate for care homes. The "Bundesgesetz über den Schutz der persönlichen Freiheit während des Aufenthalts in Heimen und anderen Pflege- und Betreuungseinrichtungen" (BGBl I 2004/11) regulates all issues of personal freedom and independence in care homes and other institutions, including the use of physical and other restraints. In 2019, the law on violence prevention (Gewaltschutzgesetz) was passed, which

impacts a range of other laws, and now includes e.g. reporting obligations for health professionals (Bundesgesetzblatt, 2019).

There are several regulations regarding social insurance and pension credits for carers caring for a family member with level 3 and above of LTC allowance, including paid care leave for employees caring for a family member (up to 6 months if two partners, up to 55% of previous net income), and respite care for a maximum of 28 days per year to substitute for the care of an informal carer. Carers benefit from continued social insurance if they were insured for 12 months out of the prior 24 months through their employment.

4. Service delivery

Types of services

In general, the federal states (regional governments: Bundesländer) are responsible by law for the provision of social (and long-term care) services for older adults. In practice, there is a long tradition of contracting-out service delivery to private non-profit and for-profit provider organisations (Rechnungshof Österreich, 2020). The federal states regulate the framework conditions for the mobile care services related to funding, collective bargaining agreements and out-of-pocket payments by users. In many cases, mobile services are coordinated and carried out at the district or local level (Rechnungshof Österreich, 2020).

These services include, e.g., food delivery (i.e. meals on wheels), transportation, mobile therapeutic services, cleaning services, repair services, and laundry services. These services are often provided by the same organisations that also provide home nursing (see below) and home help (cleaning, shopping etc.). In addition, there are voluntary services such as peer advice for people with disabilities by people with disabilities and visiting services for lonely older people. In terms of advice and support, consulting services are provided by various organisations. Day care centres, which can be visited regularly Monday to Friday, provide social contacts, skills training, activation through a daily schedule, professional care and support and therapies. Care by live-in migrant carers (often called 24-hour care) is also available as a form of support for personal care and household maintenance – this type of care is provided by care workers (often foreign) who work in several week shifts in tandem, providing care around the clock (more information available later in the report).

A number of health and intermediate care services are available across federal states (although not equally distributed) to provide care in the community, including mobile home nursing (which is to a small extent financed by social insurance depending on defined indications), and psychiatric home nursing. Ambulant care (e.g. psychosocial services), day care and residential care (nursing and old-age homes) are also available. In 2019, these services were used by around 382,120 individuals (including double-counts of users who may have used multiple types of services), of which 153,152 had used home care services (home nursing and home help), 1,933 everyday life support and relief services, 8,883 day or night care, 9,040 short-term care, 3,465 alternative housing facilities and 109,189 case and care management. 96,458 persons had used residential care during that year (Rechnungshof Österreich, 2020).

While nursing homes are an option for care users with higher care needs (i.e. care allowance level 4 corresponding to more than 160 hours of care needs per month), the number of places have remained relatively constant in the country. Available places in nursing homes slightly increased from 75,000 in 2016 to about 78,000 in 2018 (Statistik Austria, 2019). Hospice and palliative care have been implemented in the Austrian health care system since 1999. There are six different types of hospice

and palliative care services for adults, and there are efforts to include a 'hospice and palliative care culture' in general health care and care for older people.

Informal care tends to be the default option of care in Austria as relatively few care allowance beneficiaries receive formal care services. This is partly due to the limited number of hours which are offered through mobile services. In 2016, only 21% of care allowance recipients received mobile services in Styria, and 42% in Vorarlberg.

A number of services are available and offered by non-profit organisations with the aim of supporting informal carers, but these services vary considerably across regions. Available services include social/emotional support, psychosocial counselling, assistance with planning transitions to other types of care, online and video advice, telephone hotlines for answering questions about care in general, relief services (i.e. filling in for the caring relative for some hours) and help with organising care while the caring relative uses the legal entitlement to vacation. Peer support groups comprised of individuals providing relatives with informal care also exist, in particular with respect to dementia care. Training for informal carers is also available and provided by selected providers in some federal states.

Design of the LTC system

In Austria, the LTC allowance (Pflegegeld), paid by the federal government, is one of the main cornerstones of the LTC system. The LTC allowance is a needs-tested contribution towards the costs of care, intended to cover care-related expenses (i.e. formal care services, either from public or private providers, or to cover informal care from relatives). The allowance is not means-tested and there is no control over how the LTC allowance is used (Fink, 2018). The LTC allowance consists of seven different levels and is dependent on the number of hours needed for care tasks over the span of a month. Following a claim for the LTC allowance to the pension insurance institution, the applicant will be visited by a certified/qualified medical doctor or nurse in their home, nursing home or at the hospital if possible, who assess individual needs regarding (instrumental) activities of daily living (ADL and IADL, see below). Individual activities are assigned a certain prescribed amount of time needed per day and summed up to the monthly time needed, resulting in the allocation of one of seven levels of care needs and the related benefit (see Table 2):

Number of hours per month	Care level	Benefit level
>65 hours	1	162,50 Euro
>95 hours	2	299,60 Euro
>120 hours	3	466,80 Euro
>160 hours	4	700,10 Euro
>180 hours and a lot of organisation is needed	5	951,00 Euro
>180 hours and tasks that cannot be organised according to time (i.e. care regularly needed during the day and night)	6	1.327,90 Euro
>180 hours and no targeted movement of the 4 extremities, constant care needed required.	7	1.745,10 Euro

TABLE 2 CRITERIA FOR ASSIGNING LTC ALLOWANCE LEVELS

Source: Rechnungshof Österreich, 2020

To receive the LTC allowance, a person has to be in need of support and help for more than 6 months because of a physiological, cognitive or mental health impairment or a sensory impairment. The minimum threshold to be entitled to level 1 of the LTC allowance is a need for more than 65 hours of care per month regarding defined ADLs (activities of daily living) and IADLs (instrumental activities of

daily living). If the person applying for a LTC allowance receives financial care support from another source on the national level or from outside of Austria, the cash allowance is reduced (Sozialversicherung, 2020). Individuals can apply for a re-assessment of needs every six months or upon deterioration of their health condition. The care allowance is suspended during hospital stays or if the beneficiary does no longer meet the criteria.

In some cases, entitlements for care services are dependent on the LTC allowance level. For instance, for being eligible for a place in a care home, level 4 is a minimum criterion (Rechnungshof Österreich, 2020). The LTC allowance is then used to contribute to the costs of residential care, together with 80% of the resident's pension (except for some pocket-money). Moreover, out-of-pocket contributions for mobile services are calculated based on income of the user, including his/her LTC allowance, with the exception of Vorarlberg where users pay a fixed contribution (Rechnungshof Österreich, 2020). Additional subsidies are available for individuals receiving 24-hour care for beneficiaries with at least level 3 of the LTC allowance to help cover the costs of live-in personal carers.

For a long period of time, the LTC allowance had not been valorised, resulting in an important loss of 'purchasing power'. To compensate for this loss, in January 2020, the federal government valorised the allowance, and from that moment there will be an annual increase in line with the pension adjustment factor.

There are very limited instances of widespread national/regional arrangements of joint delivery of health and social care services in Austria. The integrated delivery of health and social care services is not common, and the sharing of information between these sectors is also limited. However, some endeavours have been undertaken at the level of hospitals where 'discharge management' has been introduced to improve coordination with post-acute care, and in some cases this entails also contacts with the providers of LTC services and family doctors. In the context of primary care, there have been first steps to develop primary care centres that would also provide better opportunities to cooperate with mobile (community care) services. Therefore, a number of pilot projects have been started, but in most cases, it still depends on individual engagement to make coordination happen around the client. Within the area of mobile home care services, however, multidisciplinary teams consist of nurses, nurse assistants and home helpers. In some regions, e.g. Upper Austria, the professional profile of the 'professional social carer – old age care' (FachsozialbetreuerIn Altenarbeit) has gained in importance. This profile, introduced in 2005, is a combination of social care work and nursing assistance, based on a 2-year post-secondary education, but it is also possible to add another year to receive a diploma. Another group of professionals that is not sufficiently integrated are the various therapists, from physio- to occupational therapists – they are often self-employed, and even in residential care there are only few physiotherapists employed.

There has been growing awareness about the necessity to address transitions within the different health care settings but also between health and social care services over the past 20 years. While more and more courses and further training for case and care management are being offered, and discharge management has become a common position in hospitals, the practice of transitions is still rather bumpy, in particular when it comes to transitions into long-term care.

Case and care management has developed slowly and in a piecemeal manner across Austria, in particular following the introduction of the so-called 'LTC Fund' in 2011. This fund guaranteed an additional subsidy from the federal budget to cover deficits of regional budgets due to increasing expenditures for LTC services and facilities, but also to expand community care services, day care and case and care management (BGBl. I Nr. 57/2011). Most regional governments, except Lower Austria and Tyrol, therefore introduced some kind of case and care management so that there are now a limited number of full-time equivalent workers that are registered as case managers and work in the area of case and care management. By the end of 2019, there were 216 full-time equivalent positions working in case and care management (Statistik Austria, 2019). The role of these professionals includes social

care planning and/or individual care planning based on a needs assessment carried out for them, in which they organise the necessary support and nursing services. In most cases, however, individual care planning is accomplished by the responsible nurse employed by the respective provider of services.

Workforce

Prominent roles in the field of LTC include qualified nurses (Diplomierte Gesundheits- und Krankenpflege), home helpers (Heimhilfe), professional social carers (Fachsozialbetreuung Altenhilfe), nursing assistants (Pflegeassistenz), and 24-hour live-in carers.

In absolute terms, the number of formal long-term care workers has been increasing over time. At the end of 2016, 65,407 full-time and part-time employees worked in professional care (47,246 full-time equivalents). This number increased to 68,417 full- and part-time workers (48,977 full-time equivalents) in 2018 (Statistik Austria, 2019).

Around 60% of long-term care staff are qualified health and nursing care staff, while 31% have undergone training as a nursing assistant (Rappold & Juraszovich, 2019). At the end of 2019, there were nearly 36,000 full-time equivalent positions in inpatient care and nursing services, 142 in short-term care in inpatient facilities, 590 in partial inpatient day care, 12,654 in mobile care and nursing services, and 138 in everyday accompaniment and relief services (Statistik Austria, 2019). Since 2018, it is mandatory for healthcare professionals to be registered (GBRG, BGBl. I Nr. 87/2016).

At the end of 2019, there were 216 full-time equivalent positions working in case and care management (Statistik Austria, 2019). These roles include the social and care planning of an individual based on a needs assessment carried out for them, in which they organize the necessary support and nursing services.

In 2016, the Austrian Health and Nursing Act was amended to redefine the job descriptions and areas of activity in LTC nursing (Universität Innsbruck, 2018). At this time, the Pflegefachassistenz (nursing assistant) role was introduced. In comparison to the care assistant role (Pflegeassistenz), this new role has extended qualifications in diagnostics and therapy (activities assigned by doctors) that do not require mandatory supervision (i.e. diagnostic programmes like EKG, insertion and removal of catheters, insertion of nasal tubes and IV fluids, etc.). The intention of this new role was to relieve doctors of these tasks. During this amendment, the training for some LTC roles was also amended to ensure their status in tertiary education.

In social care, regulations were enacted already in 2005 to streamline the various job profiles that had existed before – the roles of professional social carers in care for older persons (Fachsozialbetreuung Altenarbeit) were defined alongside respective curricula (2 years course, including the possibility to add another year to graduate with a diploma), their areas of activity in social and health care (nursing assistance) and their job description. Although first students graduated around 2010 and although most suitable for LTC work, this education and related job profiles are still not fully integrated into the Austrian LTC system.

Another idiosyncrasy of the Austrian LTC system is the existance of live-in care (24-hour care), mainly provided by foreign women, that was legalized and regularised in 2007 through the Home Care Act, which stipulates that live-in carers (PersonenbetreuerInnen) can either be employed or work under a self-employment model (about 98% work under the latter). About 33,000 individuals receive 24-hour care (Leichsenring et al., 2020), often for persons with higher levels of care needs. This model presents a cheaper option for middle- and upper-class households to afford care for older adults with extensive needs, while allowing them to remain living at home. Despite the vast majority of 24-hour carers working under the self-employment model, in practice, these personal carers are set up with families through

intermediate agencies that arrange the contracts and related working conditions. By the end of 2019, 62,000 24-hour carers were registered with the Austrian Chamber of Commerce (Aulenbacher et al., 2020), up from roughly 9,000 in 2008 when this type of work had been regulated for the first time (Bachinger, 2009). In a typical care arrangement, two carers alternate in two- or four-weekly shifts (Aulenbacher et al., 2018). In their off-time, these personal carers return to their home countries, mainly Romania and Slovakia. The 24-hour care model relies on migrant care workers that accept lower wages and worse working conditions than the local Austrian standards, which is made possible due to the 'self-employment' model.

Despite absolute increases in the care workforce, there is a significant shortage of workers that is anticipated to grow in the future as demand for care services increases. The retirement of about 42,000 current care workers in their 50s is expected by 2030 (Pflegepersonal-Bedarfsprognose für Österreich reportRappold & Juraszovich, 2019).). Simulations based on 2017 figures have suggested that Austria will need another 75,700 care workers (of all professional groups working with older adults with care needs) by 2030 to meet anticipated demand and replace care workers professionals that who will retire (based on 2017 figures) (Pflegepersonal-Bedarfsprognose für Österreich reportRappold & Juraszovich, 2019).). Not included in this figure are nurses in hospitals workers.

A number of issues currently threaten the sustainability of the LTC work force. As it stands, a high proportion of individuals are unhappy with their job and want to change within the LTC sector: 23.9% in home care, 15.7% in residential care according to a pre-pandemic study (Bauer et al., 2018). A relatively high proportion of LTC workers want to leave the LTC sector all together: 12.3% in home care and 12.8% in residential care. Most do not see themselves making a life-long career out of care work. 53% in the home care sector and 62% in the residential care sector do not intend to work in the sector until retirement age or assume that they will not be able to due to physical and/or mental limitations. Physical exhaustion is commonly experienced by all LTC workers, as well as sexual harassment. Care workers' general outlook on the care home sector is rather bleak: 46% perceive a deterioration in working conditions in recent years due to a low number of staff, lack of time for appropriately performing nursing and care activities, and a noticeable increase in occupational requirements (Bauer et al., 2018). Additionally, staffing calculation models are outdated and therefore insufficient to account for the current workforce needs and long-term care demand. Furthermore, the COVID-19 pandemic has put a larger strain on care workers through regular overtime, depression, anxiety, sleep problems, forgetfulness and concentration problems.

Quality management and quality assurance

There are no nationally accepted quality standards and/or accreditation mechanisms for long-term care. Some criteria or minimum standards are set out in the "Agreement between the Federal Government and the Länder pursuant to Art. 15a B-VG on joint Measures of the Federation and the Länder for Persons in Need of Care". Through this agreement, it was stipulated that the federal government would cover the costs of the LTC allowance, while the federal states are expected to organise care by respecting the following criteria (Fink, 2019): free choice between different types of services (residential and other forms of LTC), coordination between mobile and residential services, care service provision also on public holidays, appropriate quality and control. Regarding inpatient care, the agreement mentions: sufficient numbers of staff (qualified and auxiliary), medical care, free choice of doctor, visitation rights, small structures in newly built facilities, single rooms with accessible sanitary facilities, infrastructure such as therapy rooms, central location in a municipality, legal protection of residents through respective regulations by the federal provinces.

Sub-nationally, there is legislation on minimum income schemes and nursing homes as well as directives on organisation and implementation of specific LTC services (Fink, 2019). These vary considerably between

federal states and focus on structure and process rather than outcome (buildings and infrastructure, residents' rights, number of staff, qualification of staff, documentation duties for nursing homes; quality documentation and quality management tools for outpatient services).

As there are no over-arching, national quality standards for nursing homes and mobile care, each federal state has its own mechanisms for ensuring quality. Regional nursing home acts and nursing home decrees define requirements for the permission to run a nursing home (Fink, 2019). In some federal provinces this also includes annual documentation and reporting requirements, usually including very basic indicators (number of residents, number of staff, quality measures, quality strategies). The federal provinces act as supervisory bodies for nursing homes.

Quality standards for outpatient and mobile LTC are defined through acts on minimum income schemes and additional directives such as those on qualification of staff, on quality documentation instruments and on quality management tools by the federal provinces (Fink, 2019).

Organised by the Federal Ministry of Social Affairs, first-time recipients of the care allowance (Pflegegeld) are visited by certified health and nursing care professionals. During this visit, the care situation of beneficiaries is assessed in their home based on a modified ASCOT-methodology which defines LTC quality through "six dimensions, namely 1. accommodation functionality, 2. personal hygiene, 3. quality of medical care, 4. nutrition and hydration, 5. accommodation cleanliness, and 6. activities and social participation" (Fink, 2019: 7). In terms of LTC quality, this methodology focuses on outcomes. Besides the home visit programme by the Federal Ministry of Social Affairs, in its responsibility for consumer protection, there is only a voluntary quality assurance programme at national level, namely the "National Quality Certificate" (NQZ) for care homes that are applying one of several accredited quality management models (ISO, EFQM, E-Qalin). However, only about 40% of all care homes have an established quality management system, and not even 10% have attained the NQZ.

The SWOT analysis also included points related to service delivery. In terms of strengths, it highlighted for example the availability of different types of services and support for informal carers as well as some regulation regarding live-in carers. Costlyness and waiting lists were among the weaknesses as well as fragmentation of health and social care. The opportunities included pilot project to improve health and social care coordination. The threats described difficulties related to staff shortages.

STRENGTHS	WEAKNESSES
• Mobile services available • Care homes generally available • Support and training for informal carers (pension credits, respite, care leave) but limited uptake • Dementia strategy • Some regulation of live-in migrant care • Strong tradition of non-profit providers (linked to the churches and political parties) in LTC • Service providers cater for multi-professional services	• Mobile services relatively costly (out-of-pocket contributions) and unevenly distributed • Waiting lists for places in care homes due to lack of staff • Individual needs assessment does not measure real needs; cannot be linked to case and care management • Larger portion of female carers • Many informal carers, including young carers (also due to lack of available services and costs of services) • Live-in carers (24-hour care) cover about 7% of persons in need of care • Fragmented delivery of health and social care • Poor working conditions for LTC workers • Limited user engagement • Incentives pushing towards residential care instead of mobile services • Intransparent flows of funding

OPPORTUNITIES	THREATS
• Some ongoing pilots to improve coordination of health and social care services • Enhanced case and care management in some regions, but no exchange at the moment • Primary care centres hardly developed • Very high levels of life satisfaction • Low levels of deprivation • Strong support networks	• Competition on access to staff • LTC workers leaving the care sector • Lack of care workers increasing • Live-in care could diminish due to lack of migrant carers (mid-term perspective if, e.g., lower wage differential)

TABLE 3 - SWOT ON SERVICE DELIVERY

5. Performance

In 2014, about 35% of Austrians aged 65+ with some or severe activity limitations did not receive the assistance with household activities that they needed. Similarly, about 28% lacked assistance with personal care (Eurofound, 2020). The biggest reason for unmet needs in home care was financial reasons (54%), followed by the refusal of the person in need of services to use the services (19%), other reasons (15%), no care services available (12%) and quality of services not satisfactory (1%) (Eurofound, 2020). In some federal states, admission to residential care is based on a waiting list or points system (Rechnungshof Österreich, 2020: 59).

Long-term care services in Austria are relatively expensive and put a financial strain on many users. In 2016, of adults aged 65+, 44% of individuals stated they had a little difficulty with costs of long-term care, and 4% stated they had a lot of difficulty (EQLS, 2016). Residential care is particularly expensive. Residential care fees generally range from € 90 a day (Carinthia & Salzburg) to € 223 in Vienna (without considering public subsidies that care users may be entitled to). The proportion paid by the care user now relies strictly on their income (including any LTC allowance they receive). If the care user cannot cover the fees themselves, public assistance jumps in. Mobile care is less costly, ranging from an average of € 29.78 per hour in Vorarlberg and € 59.52 in Styria (Rechnungshof Österreich, 2020).

The Austrian LTC system is both a universal and means-tested system, depending on the benefit: while the LTC allowance is universal, in-kind benefits are means-tested and subject to co-payments. The out-of-pocket payment for services can vary depending on income. For residential care, an individual must contribute a certain percentage of their income (including the LTC allowance) to their fees before the state will cover remaining costs. Residents of care homes can keep a pocket money of € 45,18 from the care allowance, and 20% of their pension income, up to a minimum of € 214,07 euros and a maximum of € 481,78. Moreover, they can keep their 13th and 14th pension payments during the year.

There are no publicly available data about preventable hospitalisations in residential facilities, and even the average length of stay in residential care is not publicly documented. Although Austria has a quality strategy for the healthcare system and a number of indicators for measuring the quality of inpatient services (BMSGPK, 2021), this does not apply to the LTC system. While data on the length of stay in residential care institutions is theoretically collected, in practice, this data is not publicly available.

LTC is characterised by regional variability: In 2016, 11.7% of beneficiaries of the LTC allowance were living in nursing homes in Burgenland as against 20.6% in Vienna and 16.9% in Styria (Rechnungshof: 2020). The use of mobile and day-care among those who were neither living in nursing homes nor living with a 24-hour carer is rather low and does not exceed 2.1 hours per week in Vienna and reaches even only 0.5 hours per week in Burgenland and Styria. While costs for mobile care per care receiver is on

average less than € 1,000 per month in Burgenland, these are € 2,800 in Vienna. There is no regularly updated national data on whether needs are met and what the quality of care is across all types of care. The considerable variation of costs of care per inhabitant across the federal provinces is both the result of up to a 50% difference in the proportion of the population with care needs and up to 50% difference in the price of the same service (Rechnungshof, 2020: 148).

The SWOT analysis included some topics relating to performance, such as in terms of strengths user choice through the LTC allowance. Regarding weaknesses, a lack of data on performance was noted as well as gaps between needs and services and relatively expensive long.-term care services. Opportunities include using discussions on data privacy for integrating health and social care. Threats mentioned were for example the lack of data.

STRENGTHS	WEAKNESSES
• Data on care use and care allowance (Pflegedienstleistungsstatistik, Pflegegeldinformation) exists, but not publicly available • Increased user choice through LTC allowance • Quality assurance addressed, but only in residential care • Community nursing projects	• Lack of data on performance • Gap between needs and services • LTC services relatively expensive No national framework for assessing quality of LTC across Austria, criteria often focusing rather on structure and process than outcome
OPPORTUNITIES	**THREATS**
• Discussion on data privacy not taken up as opportunity for integrated care • E-card could include LTC data (pilot exists) • Electronic health record (ELGA)	• No interest in transparency (data linkage) • Lack of interest in coordination, multi-level governance • Lack of data

TABLE 4 - SWOT ON PERFORMANCE

6. System enablers

Governance

Austria is known for its extreme fragmentation between the health and long-term care system, with entirely separate legislation, competencies and financing systems. Although health care and LTC were joined under the responsibility of one federal ministry relatively recently, very little has been done to integrate the two systems. If anything, more discussion has taken place in terms of how to standardize certain aspects of the LTC system across the regions (i.e. out-of-pocket payments, data collection, quality indicators, staffing levels, etc.). Integration of health-services delivery seems to be placed higher on the policy agenda than a broader integration of long-term care and health.

The federal government is in charge of the care allowance benefit, while the regional governments provide long-term care services (i.e. in-kind benefits). These care services are implemented in cooperation with municipalities, non-profit organisations and with for-profit providers (Fink, 2018). The federal states are in charge of planning the number of places for care, the tariffs, the subsidies, etc., i.e. the delivery of care services and their framework conditions are under the responsibility of the federal states.

The Austrian long-term care system is a distinct entity entirely separate from the health system, with its own legislation, competencies and financing (Riedel, 2020). LTC Is financed through a combination of taxes and out-of-pocket payments, while the health care system is financed through social insurance.

The regional governments are in charge of the regulation and planning for long-term care services, while the federal government is responsible for the healthcare system, although other stakeholders such as regional governments (infrastructure) and the health insurance are also playing important roles. However, even health-related services in long-term care settings are rather disjointed from the health care system. For example, nursing care provided in residential settings or in home care is governed by the regional governments (Riedel, 2020) and funded through the long-term care system. Further fragmentation of the long-term care system is also seen across the provinces, where many aspects ranging from staffing levels, quality indicators and monitoring processes to co-payment levels and eligibility criteria vary (Rechnungshof Österreich, 2020).

While governance of long-term care has not kept up with the changing challenges and the growing demand for long-term care, there is also a conceptual and factual gap regarding support for people with disabilities whose life-expectancy has also increased and long-term care for older people. Also in this case, fragmentation and lack of co-operation between these two sectors of social services can be observed.

Funding

Payment flows between the providers of care homes, regional governments and residents vary between the federal states. The payment system is based on a capitation, fee-for-service basis with daily rates being negotiated between providers and regional governments. In some cases, the states set the rates for each individual provider and by a number of factors such as location, services provided, care level etc. (Rechnungshof Österreich, 2020). Some states set the rates by contract, others by ordinance or by a funding guideline.

In residential care, there are almost no self-payers as prices can seldom be covered by pensions and the LTC allowance of residents alone. Tariffs, including supplementary services, are therefore negotiated between the regional governments that have to cover the gaps from social assistance funds, and providers of care homes (Rechnungshof Österreich, 2020). Similarly, in home care, the federal states set the fees for services based on a calculation of personnel and material costs, according to personnel qualifications, and sometimes on normed costs by tasks or the period when the service is being delivered (i.e. regular working hours, Sundays, holidays, etc.).

Out-of-pocket payments by users also vary by state and for the type of services. Generally, the user's income is used to determine the user's contributions (save for some percentage allowed to be kept as pocket allowance) for accommodation and care in nursing homes. For mobile care services, users' contributions are calculated per hour, and also based on the user's income situation. In 24-hour care fees are determined by a free agreement between the caregiver, the agency and the user according to market prices (Rechnungshof Österreich, 2020).

LTC in Austria is financed through a combination of public-sector tax-based support and out-of-pocket payments. 61% of LTC expenditures are paid for publicly, and the remaining 29% are covered by out-of-pocket payments. Private expenditures have been estimated at € 2.9 billion. Gross public expenditure on LTC amounted to € 4.2 billion in 2019 (Statistik Austria, 2021).

Gross expenditure on LTC services and facilities was € 4.2 billion in 2019, of which 84% was used for (semi-)residential facilities (i.e. residential care, day-centres, etc.) and the remaining 16% on mobile care services (including everyday support and respite care services). Most of this was covered by the federal states and municipalities (59%), followed by out-of-pocket payments (OOP) of clients and/or their families (36%), and the remaining 5% from other sources (e.g. contributions by health insurances. User contributions are covering about 30% of total costs of mobile services, and about 48% of residential facilities. The bulk of OOPs thus incurred in residential care (€1.9 billion) (Statistik Austria,

2021), where large parts of personal income (pensions and LTC allowance) of residents are used to contribute to costs. While the total LTC allowance expenditure was 2.7 billion in 2020, about 0.6 billion were directly transferred to care home providers (see Figure 1 for a rough overview of cash flows).

The federal government is responsible for the care allowance, while regional governments cover benefits in kind. The regional governments are responsible for financing social assistance (i.e. the part of costs not covered by private out-of-pocket payments) and in-kind benefits, usually by reimbursing the providers of care services or less commonly through direct provision of services.

Gross expenditure on LTC services and facilities was € 4.2 billion in 2019, of which 84% was used for (semi-)residential facilities (i.e. residential care, day-centres, etc.) and the remaining 16% on mobile care services (including everyday support and respite care services). Most of this was covered by the federal states and municipalities (59%), followed by out-of-pocket payments (OOP) of clients and/or their families (36%), and the remaining 5% from other sources (e.g. contributions by health insurances. User contributions are covering about 30% of total costs of mobile services, and about 48% of residential facilities. The bulk of OOPs thus incurred in residential care (€1.9 billion) (Statistik Austria, 2021), where large parts of personal income (pensions and LTC allowance) of residents are used to contribute to costs. While the total LTC allowance expenditure was 2.7 billion in 2020, about 0.6 billion were directly transferred to care home providers (see Figure 1 for a rough overview of cash flows).

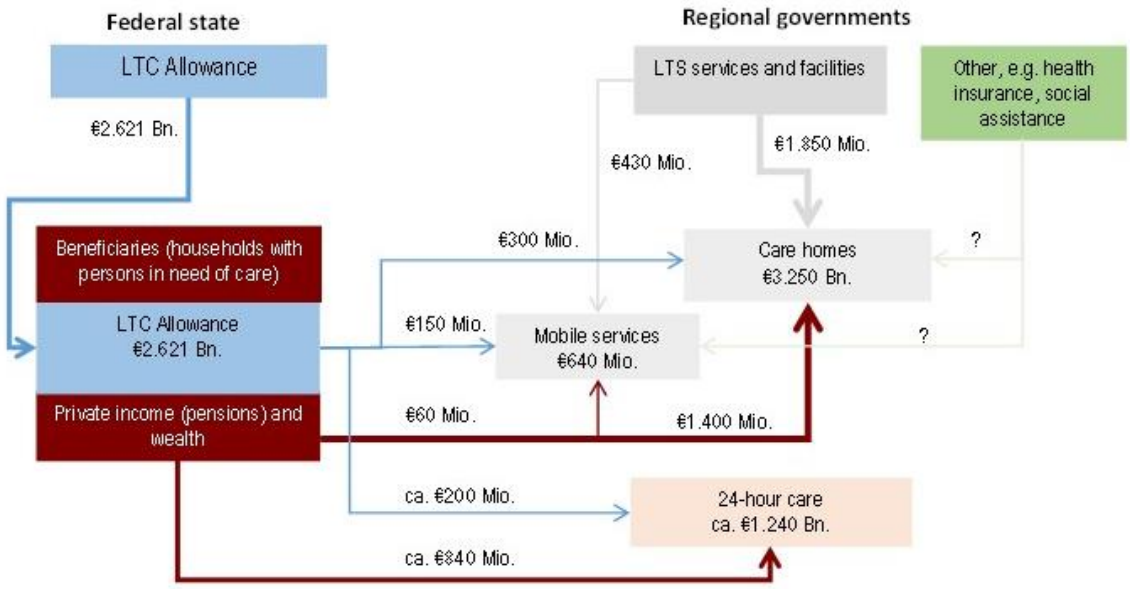

FIGURE 1 CASH FLOW OF FUNDING IN LTC IN AUSTRIA

In 2016, as part of support for informal caregivers, the federal government spent € 72.8 million, of which € 49.2 was for the social insurance contributions of informal carers, € 11 million was for respite care, € 10.7 million was for care leaves and € 1.9 million was for quality assurance (Schrank, 2017). Although the 'care-leave benefit' has existed since 2014, there is no legal entitlement and the employer must agree to it so that, in practice, take-up is limited (Fink, 2018).

Workforce development

For formal care providers in Austria, care workers are required to have a certain level of training/education for a particular position, as stipulated by the respective Act on health and nursing

care (Gesundheits- und Krankenpflegegesetz – GuKG) and the Decree on education and professional profiles (Gesamte Rechstvorschrift für Gesundheits- und Krankenpflegegesetz, 1997; Pflegeassistenzberufe-Ausbildungsverordnung – PA-PFA-AV, 2016). These education and training requirements are mandated for all of Austria, but roles themselves vary across regions. Once graduated, professionals receive a professional ID according to the health professions register (Gesundheitsberuferegister – GBR), which is a requirement for getting employed. Most positions require care workers to have a certain level of German proficiency (B2), and in the case of home care, depending on the region and job requirements, a driving license. Currently there is a large shortage of care workers across Austria resulting in huge efforts for recruiting in particular qualified care workers, both in the health system and in long-term care. However, the recruitment of workers in each federal state can also vary as a result of regional regulations. Notwithstanding the general guidelines of the GuKG related to long-term care professions, regulations can vary in terms of which workers are allowed to work in which settings for particular tasks, or the qualifications required for the position, or the staff required as a ratio to care users, all of which are rooted in regional legislation such as, for example the Decree on Care Homes (Alten- und Pflegeheimverordnung) in Upper Austria or the Act on Care Homes in the Tyrol (Tiroler Heimgesetz).

In 24-hour care, there are no regulations that require formal professional training of personal carers. However, if a personal carer is hired by a family claiming any type of allowance or subsidy, the personal carer must meet a (relatively low) level of qualification, which can even be waived if the personal carer can demonstrate to have had at least 6 months of practical care experience (Aulenbacher et al., 2020). In practice, intermediary agencies are acting as brokers and should ensure compliance of personal carers with respective regulations, even if almost all personal carers are formally self-employed and registered with the Austrian Chamber of Commerce. The agencies are however offering different care packages, according to the language skills, qualifications, tasks to be accomplished (i.e. housework, company, assistance, nursing care, etc.), and work experience of the personal carer (Aulenbacher et al., 2020).

Despite the typical assumption of care work not being skilled labour, a considerable portion of the LTC workforce has a higher education degree. The Austrian Health Professions Register reports about 54,000 professionals working in the LTC sector (residential and home care), of which about 38% have a diploma, i.e. 3 years of of higher education following secondary education (Holzweber et al., 2021),[1] with men having a slightly higher education level on average compared to women (Rodrigues et al., 2018). Around 13% obtained their recognized certificate abroad in another country, while the remaining 85% acquired their professional license through training at an Austrian health and nursing school (ibid). There is currently still a transition phase for the qualification requirements of nurses, whereby until 2023, the old diploma training for nurses is valid. From 2025 onward, a bachelor's degree will be necessary for registered nurses, while for active nurses the already acquired diploma will remain valid until their pension.

Apart from various professional groups of therapists and technical profiles, there are two other groups of professionals represented in the Health Professions register. The new profile of 'skilled nursing assistants' (Pflegefachassistenz) has been introduced to provide nursing care under supervision, with additional competencies such as preparing the rooms for new admissions and participating in practical nursing tasks such as injections, tests, insertion and removal of tubes. Respective training takes 2 years (3,600 hours). Finally, nursing assistants (Pflegeassistenz) provide nursing care under supervision and are required to have 1,600 hours (1 year) of training.

[1] In Austria, the reform of nursing studies only took place in 2008 when first bachelor studies were introduced at selected Universities of Applied Studies. The share of nurses with a bachelor's degree is therefore still around 2% of all registered nurses only. Moreover, the Health Professions Register with an obligation for all health and nursing professionals to register was only established in 2018.

Home helpers (Heimhilfe) are not represented in the Health Professions Register. They provide household care and support with Activities of Daily Living (ADLs) based on a 400-hour training course with training time equally divided between theory and practice.

Professional social carers (Fachsozialbetreuung Altenarbeit) have been trained in Austria since 2008 with a profile that combines competencies in social care and nursing assistance based on a 2-year course (2,400 hours of training). This course can also be extended by another year to obtain a diploma.

The mix of skills and grades in residential care settings is defined by regional regulations, resulting in variations across the country. In most regions, registered nurses (with diploma) must represent between 20-32% of staff, supplemented by nursing assistants that account for the largest portion, ranging from 50% to 70% of all workers. Home helpers may represent about 10-20% of staff.

24-hour carers also comprise a large portion of the LTC workforce, although they are not reported in Austria's yearly long-term care report. By the end of 2019, 62,000 of these workers had registered as self-employed (Aulenbacheret al., 2020).

The reconciliation of work and family remains an issue for LTC workers in Austria. About 42% of LTC workers had children below the age of 20, and 11% live with children under the age of 6. About one third of care workers have other care obligations, such as care for older relatives. This means that a sizeable portion of LTC workers have informal care obligations either to their children or to relatives, resulting in a large share of them working part-time (Bauer et al., 2018). Still, nearly 17% of care workers reported having difficulties conciliating their work and family life.

In Austria, collective agreements set the wages paid to LTC workers depending on the role and respective education and training. However, these wages can vary across regions and even across and within providers, making comparisons to other wages difficult. According to a study done by Eurofound in 2018, residential care workers on average earned 92% of the average hourly wage in Austria, while non-residential LTC workers earned 93% (Eurofound, 2021). This is in comparison to healthcare workers, who on average are earning 111% of the national average wage in Austria.

Nursing professionals are required to regularly follow continuing professional education. General nurses must complete 60 hours within 5 years; first- and second-level nurse assistants must have 40 hours (Bachner et al., 2018). There are also specifications for the social care professions (Sozialbetreuungsberufe). For example, home helpers must complete at least 16 hours of further training within a period of two years, while skilled social care workers (Fach-Sozialbetreuer/innen) and those with a diploma (Diplom-Sozialbetreuer/innen) are required to complete at least 32 hours of continuing education within each 2-year period (Art. 15a B-VG zwischen dem Bund und den Ländern über Sozialbetreuungsberufe StF: BGBl. I Nr. 55/2005).

The current workforce in long-term care is insufficient to address the rising care needs of the population. This challenge is likely to worsen as at least another 72,900 care workers (of all professional groups working with older adults with care needs, including nursing care in hospitals) are estimated to be needed by 2030 (Rappold & Juraszovich, 2019).

The ongoing care reforms at federal level and selective activities taking place in the federal states and at organisational level are addressing these challenges in a piecemeal manner, ranging from advertising campaigns to improve the image of care work by showcasing career opportunities, a waiver of enrolment fees for nursing education and increased wages and an extension of nurses' competencies to enhanced conditions for recruiting foreign care professionals. These and other measures for recruiting and retaining the care workforce were also suggested by the "Care Taskforce" gathering all relevant stakeholders in long-term care (Rappold et al., 2021). It remains to be seen, whether these reforms will be sufficient to close the gap between supply and demand of care workers in Austria. In particular, there are ongoing debates if the now introduced 'care apprenticeship' (Pflegelehre) will result in additional workforce in long-term care over time.

Technology use and information exchange

There are currently no national guidelines or strategies for encouraging the adoption of technological innovation in the long-term care sector.

Over the years, a number of projects have been funded through the Digitalisierungsfonds Arbeit 4.0, financed and organised by the Chamber of Labour (Arbeiterkammer) that relate to implementing information and communication technology solutions in formal care work, or in the provision of informal care. Projects that have been supported range from digital apps aimed at making nursing work easier for staff, to orienteering and onboarding of new care staff, digital tools aimed to improve collaboration and autonomy in mobile care work. In addition, there are various projects throughout the remaining regions that relate to long-term care.

Moreover, Austria is part of the Ambient Assisted Living Programme, a transnational research and development programme supported by 23 EU Member States and the European Commission. The aim of the research programme is to improve the quality of life of older people through the use of new information and communication technologies.

There are currently no nationally-agreed upon mechanisms in place in Austria to facilitate information transfer between the health, LTC and other social services. Any information transfer that may exist is likely at the regional and local level between services.

The SWOT also included some topics linked to the development of the long-term care system. Examples of strengths are that there are training and education requirements for formal carers or that there are staff ratios for certain types of formal carers as well as the care reform measures. Weaknesses include the complicated cash flow and the different prices for users depending on location. Incentives to work in hospitals for formal carers and to move to residential care for care users were also discussed as weaknesses. Opportunities identified were the modular system of education in care professions, new job profiles and funding for innovation and research. Threats included foreseen continuing staff shortages.

STRENGTHS	WEAKNESSES
• Care allowance and reimbursements available; less administration compared to other countries • Training/education requirements for formal carers • Ratio for certain types of care workers across Austria • Registry of nursing professions • care reform	• Complicated multilevel cashflow for LTC; no harmonisation of prices and fees for users; many collective bargaining agreements • Slow implementation of 2017 LTC reform • Incentives for care workers to work in hospital rather than in long-term care • Incentives for people in need of care to move into residential care rather than to use mobile services
OPPORTUNITIES	**THREATS**
• Modular system of education in care professions, now also including tertiary education • Expansion of the job profile 'skilled social carers' and related training (incl. diploma) • Funding for innovation/research in LTC	• One third of care workers also have caring oblications in their private context (children and older parents) • Shortage of LTC workers imminent and likely to increase • No lasting impact of ongoing care reforms

TABLE 5 - SWOT ON SYSTEM ENABLERS

7. References

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2021). The Promise of Decent Care and the Problem of Poor Working Conditions: Double Movements Around Live-In Care in Austria. SOZIALPOLITIK.CH V, 20(2). Retrievedd from https://www.sozialpolitik.ch/fileadmin/user_upload/2020-2-5-Aulenbacheretal.pdf

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2020). Jetzt kümmern sich zwei slowakische Frauen abwechselnd um meinen Vater ...“ Institutionelle Logiken und soziale Ungleichheiten in der agenturvermittelten 24h-Betreuung. In: Seeliger, Martin, and Julia Gruhlich. Intersektionalität, Arbeit und Organisation. Weinheim, and Basel. Beltz Juventa: 127-141.

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2018). Ein neuer Sorgemarkt in Wohlfahrtsstaat: 24-Stunden-Betreuung in Österreich Dienstleistungsangebote von Wiener Wemittlungsagenturen. In U. Filipic and A. Schönauer (eds.), Zur Zukunft von Arbeit und Wohlfahrtss Perspektiven aus der Sozialwissenschaft, Wien: ÖGB, pp. 47 – 56.

Bachinger, A. (2009) Der irreguläre Pflegearbeitsmarkt zum Transformationsprozess von unbezahlter in bezahlte Arbeit durch die 24-Stunden-Pflege Dissertation. Universität Wien. https://utheses.univie.ac.at/detail/7245#

Bachner et al. (2018). Austria: Health System Review. Health Systems in Transition, 20(3), 1 – 256 . European Observatory on Health Systems and Policies. Retrieved from https://jasmin.goeg.at/434/1/HiT%20-%20Austria%20-%20final_web_version_Oktober18.pdf

Bauer, G., Rodrigues, R. & Leichsenring, K. (2018). Working conditions in long-term care in Austria. The perspective of care professionals. (Policy Brief 2018/8). Vienna. Retrieved from European Centre for Social Welfare Policy and Research website https://www.euro.centre.org/publications/detail/3283

BMSGPK (2021). Qualitätsindikatoren. Retrieved from https://www.sozialministerium.at/Themen/Gesundheit/Gesundheitssystem/Gesundheitssystem-und-Qualitaetssicherung/Ergebnisqualitaetsmessung/Qualitaetsindikatoren.html

Esping-Anderson, G. (1991). The Three Worlds of Welfare Capitalism. Princeton University Press.

Eurofound (2021). Wages in long-term care and other social services 21% below average. Living conditions and quality of life. Retrieved from https://www.eurofound.europa.eu/publications/article/2021/wages-in-long-term-care-and-other-social-services-21-below-average

Eurostat. (2019). Self-perceived long-standing limitations in usual activities due to health problem by sex, age and income quintile [Data file]. Retrieved from https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_12 http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do.

Fink, M. (2018). Mapping long-term care quality assurance practices in the EU: Austria, Brussels: ESPN European Commission

Holzweber L., Zach, M.,Gruböck, A., Juraszovich, B., MathisEdenhofer, S., Rappold, E., & Wallner, A. (2021): Jahresbericht Gesundheitsberuferegister 2020. Gesundheit Österreich, Wien

Łaszewska, A., Österle, A., Wancata, J., & Simon, J. (2018). Prevalence of mental diseases in Austria. Wiener Klinische Wochenschrift, 130(3-4), 141-150. doi: 10.1007/s00508-018-1316-1

Leichsenring, K., Rodrigues, R.. & Bauer ,A. (2020). The situation of ’24-hour care’ from the perspective of migrant caregivers in Austria. Retrieved from LTC responds to covid website

https://ltccovid.org/2020/04/08/the-situation-of-24-hour-care-from-the-perspective-of-migrant-caregivers-in-austria/

Nagl-Cupal et al. (2018). Angehörigenpflege in Österreich. Einsicht in die Situation pflegender Angehöriger und in die Entwicklung informeller Pflegenetzwerke. Retreived from Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz (Hg.) website. https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=664

OECD. (2017). Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris, Retrieved from https://doi.org/10.1787/health_glance-2017-en.

OECD/European Union. (2018). Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/European Union, Brussels. Retrieved from https://doi.org/10.1787/health_glance_eur-2018-en.

Oesterreichische National Bank (OENB) (2021). GDP Growth. Entwicklung des Bruttoinlandsprodukts. Retrieved from https://www.oenb.at/isaweb/report.do;jsessionid=510F4DE9D5600F292EC61204E15BC668?report=7.3

Rappold, E., & Juraszovich, B. (2019). Pflegepersonal-Bedarfsprognose für Österreich. Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz, Wien. https://jasmin.goeg.at/id/eprint/1080

Rappold, E., Juraszovich, B., Weißenhofer, S., & Edtmayer, A. (2021). Taskforce Pflege. Begleitung des Prozesses zur Erarbeitung von Zielsetzungen, Maßnahmen und Strukturen. Gesundheit Österreich, Wien. Retrieved from https://jasmin.goeg.at/id/eprint/1576

Rechnungshof Österreich, (2020).Pflege in Österreich. Bericht des Rechnungshofs. https://www.rechnungshof.gv.at/rh/home/home/004.682_Pflege_Oesterreich.pdf

Riedel, M. (2020). The Austrian Pflegefonds – only a small fund, but with a large agenda. Peer Review on "Financing Long-term Care". DG Employment, Social Affairs and Inclusion. Retrieved from https://irihs.ihs.ac.at/id/eprint/5306/1/riedel-2020-peer-country-comments-austria-pflegefonds.pdf

Riedel, M., & Kraus, M. (2011). Informal care provision in Europe: regulation and profile of providers. ENEPRI Research Report No. 96, November 2011. Retrieved from https://www.researchgate.net/publication/265536923_Informal_care_provision_in_Europe_regulation_and_profile_of_providers_ENEPRI_Research_Report_No_96_November_2011

Rodrigues, R., Bauer, G., & Leichsenring, K. (2018). The long-term care workforce in Austria. Who are they and what do they do? (Policy Brief 2018/7). Vienna: European Centre. Retrieved from Eutoepean Center Social Welfare Policy and Research Center website https://www.euro.centre.org/publications/detail/3281

Schrank, S. (2017) Das österreichisches Langzeitpflegesystem – aktuelle Herausforderungen und Reformen im Bereich der Pflege und Betreuung zu Hause https://www.euro.centre.org/downloads/detail/1587

Sozialversicherung (2020). Pflegegeld. Retrieved from https://www.sozialversicherung.at/cdscontent/load?contentid=10008.738625&version=1599032618

Statistik Austria. (2019). Betreuungs- und Pflegedienste 2018: 153.500 Personen zuhause, 95.100 in Heimen betreut. Retrieved from https://www.statistik.at/web_de/presse/122290.html

Statistik Austria (2021). Betreuungs- und Pflegedienste. Retrieved from http://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/soziales/sozialleistungen_auf_landesebene/betreuungs_und_pflegedienste/index.html

Statistik Austria (2020a). Bevölkerung. Retrieved from https://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/bevoelkerung/index.html

Statistik Austria. (2020b). Bevölkerung nach Alter und Geschlecht. Retrieved from https://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/bevoelkerung/bevoelkerungsstruktur/bevoelkerung_nach_alter_geschlecht/index.html

Statistik Austria. (2020c). Haushalte. Retrievedd from https://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/bevoelkerung/haushalte_familien_lebensformen/haushalte/index.html

Statistics Austria (2021a). Household Income. Retrieved from http://www.statistik.at/web_en/statistics/PeopleSociety/social_statistics/household_income/index.html

Statistik Austria. (2021b). Deaths since 1970 by causes of death. Retrieved from https://www.statistik.at/web_en/statistics/PeopleSociety/health/causes_of_death/index.html

Universität Innsbruck (2018). Arbeitswissenschaftliche Analyse und Bewertung Pflegerischer Humandienstleistungstätigkeiten In Der Stationären Langzeitpflege Als Basis für eine leistungsgerechte Personalbemessung. Retrieved from https://wien.arbeiterkammer.at/service/studien/Sozialpolitik/Arbeit_in_der_Langzeitpflege.pdf

World Bank (2021a). *Population density (people per sq. km of land area) - Austria.* Retrieved from https://data.worldbank.org/indicator/EN.POP.DNST

World Bank (2021b). U*rban Population (% of total populati*on) - Austria. Retrieved from https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=AT

Recommended citation : European Centre for Social Welfare Policy and Research, Chance B, Vilans (2023) Long.-Term Care landscape in Austria. InCARE Short report.


InCARE


EUROPEAN CENTRE FOR
SOCIAL WELFARE POLICY
AND RESEARCH


LSE
CPEC
CARE POLICY AND EVALUATION CENTRE


Vilans


EURO
CARERS


Federal Ministry
Republic of Austria
Social Affairs, Health, Care
and Consumer Protection


CHANCE B
GRUPPE


Republic of North Macedonia
Ministry of Labor
and Social Policy


Republic of North Macedonia
Ministry of Health


Црвен крст на Република Северна Македонија
Red Cross of The Republic of North Macedonia


IMSERSO


MATIA
INSTITUTO GERONTOLÓGICO