

Freedom of choice and dignity for the elderly

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1. Relevance of the policy to Austria: similarities and differences

In his discussion paper, Clemens Tesch-Römer describes Austria as a “standard-care mix country” with a care system that is characterised by “medium to high demand for care, medium to low provision of informal care provision and medium provision of formal care.” This sums up some of the main features of the Austrian care system as opposed to Sweden, where there is a “high provision of formal care and low provision of informal care provision”.

70% of the total social expenditure in Austria consists of monetary benefits that flow to the respective beneficiaries; this puts Austria, together with Germany, among the top European countries regarding monetary social benefits. The corresponding shares are lower in the UK (64%) and Sweden (58%). Only 30% of the Austrian social expenditures went to the recipients as benefits in kind or services. These were provided especially in the health care system, in residential and nursing homes for the elderly and in kindergartens. (Badelt & Österle, 2001, p 21f.).

Table 1: Comparison of instruments: monetary benefits – benefits in kind

Instrumentenvergleich	Osterreich	EU - 15	Deutshl.	UK	Schweden
Sozialausgaben in % des BIP (2000)	29 %	27%	30 %	27 %	32 %
Pro-Kopf-Sozialausgaben in KKS*	7.396	6.155	7.025	6.048	7.367
davon nicht für Alter, Pflege, Gesundheit, Familie, Arbeitslosigkeit	2 %	4 %	3 %	7 %	5 %
% Geldleistungen : Sach-/Dienstleistungen (1999)	70 : 30	69 : 31	70 : 30	64 : 36	58 : 42
% beitragspflichtige : beitragsfreie Leistungen (1999)	74 : 26	---	70 : 30	43 : 57	39 : 61
% Nichtinanspruchnahme von Sozialhilfeleistungen	50 – 99%	---	36 – 79%	23 – 46%	---

Kaufkraftstandards = Eine von Landeswährungen unabhängige Einheit, die Verzerrungen aufgrund von Unterschieden im Preisniveau ausschaltet.

Beitragspflichtig: der Bezug von Sozialleistungen ist an die Voraussetzung geknüpft, dass Beiträge in ein Sozialversicherungssystem eingezahlt wurden (Bismarck'sche Tradition). Beitragsfrei: um einen Anspruch auf Sozialleistungen geltend zu machen, genügt es gebietsansässig und bedürftig zu sein. (Beveridge Tradition)

Quellen: Abramovci, 2002: 3; Abramovci, 2003: 2f.; Dimmel, 2000: 399f.; Van Oorschot, 1991: 18f.

(Social expenditure in % of the GNP (2000)

Per-capita social expenditure in PPS*

of these spent in fields other than age, care, health, family, unemployment

% monetary benefits : benefits in kind/services (1999)

% services subject to contribution : non-contributory services

% social services not claimed)

1.1. Financial flows and competencies

Financial flows and competencies are distributed among diverse actors and levels of administration. While health care is a federal issue, social care lies in the competence of the provinces. Austria consists of nine provinces, and services differ according to province.

The separation of health care and social care has a long tradition in Austria. Health care is financed via social insurance contributions, taxes and private co-payments. Social care is funded by various individual contributions and welfare benefits in the provinces, with nine different systems.

1.2. The long-term care allowance

In 1993, the long-term care allowance was introduced as a tax-financed benefit granted regardless of earnings. It is fixed according to the need for care rather than the height of income. There are seven levels differentiated by the minimum time of care needed. To be eligible, the absolute minimum time is 50 hours care per month. The benefit amounts to between EUR 148 for level one and EUR 1 562 for level seven.

If the beneficiary lives in a nursing home (or residential home, home for the elderly or educational home) with costs or part of the costs covered by a province, municipality or authority responsible for welfare benefits, up to 80% of the monthly care allowance is transferred to the bearer of the costs to cover living expenses.

The long-term care allowance strongly benefits lower income groups. 26% of the recipients hold a monthly pension of less than EUR 570, and 60% have less than EUR 860 per month at their disposal.

Currently more than 390 000 people receive long term care allowance, which is 5% of the population. The allowance only covers part of the care costs.

Table 2 : The Austrian comprehensive long-term care allowance (2007)

Level	Care needs per month	Amount per month in Euro	Share of beneficiaries per level
I	> 50 hours	148,30	21,9%
II	> 75 hours	273,40	33,7%
III	> 120 hours	421,80	16,7%
IV	> 180 hours	632,70	14,8%
V	> 180 hours of heavy care	859,30	7,9%
VI	> 180 hours of constant attendance	1 171,70	3,1%
VII	> 180 hours of care in combination with complete immobility	1 562,10	1,9%
	<i>Total number of beneficiaries</i>		390 764

1.3. Services and care

90% of the long-term care allowance recipients are mainly attended to by a family member. 25% are supported by a mobile care service, 15% are in residential and nursing care, while 5% receive care provided by illegal care workers.

More than 26% of the care services for elderly people are managed by non-profit organisations, 53% by public providers and 21% by commercial providers. There are great regional differences regarding the services available (see Badelt 1999).

Table 3: Capacities of institutional care in Austria (2002)

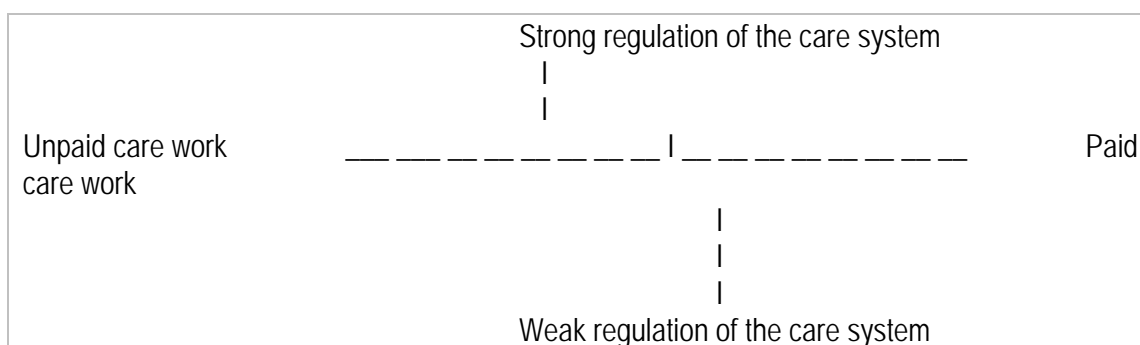
Province	Population 2002	of these		Total no. of places	of these in			No. of institutions
		<i>65 years and older</i>	<i>75years and older</i>		<i>Residential Care</i>	<i>Nursing Care</i>	Short term Care	
Burgenland	278 600	50 136	22 257	1 487	0	1 487	0	26
Carinthia	561 126	91 137	42 378	3 195	982	2 213	0	45
Lower Austria	1 549 658	248 656	113 169	10 499	2 548	7 851	100	99
Upper Austria	1 381 933	204 620	93 005	11 961	0	11 630	331	110
Salzburg	518 587	69 901	32 369	5 201	1 698	3 454	49	82
Styria	1 186 379	196 252	91 241	8 315	0	8 315	0	163
Tyrol	675 070	90 307	40 842	4 786	1 221	3 522	43	74
Vorarlberg	351 570	43 588	18 752	2 131	889	1 156	86	60
Vienna	1 620 170	250 121	129 389	20 936	10 666	10 141	129	81
<i>Austria</i>	<i>8 123 093</i>	<i>1 244 718</i>	<i>583 402</i>	<i>68 511</i>	<i>18 004</i>	<i>49 769</i>	<i>738</i>	<i>740</i>

Source: Departments for Social Affairs of the Provincial Governments, compiled by the Salzburg Provincial Government (2002).

Family care is almost exclusively women's work. Another gender-specific aspect is that the majority of men providing care have reached retirement age, while more than half of the women engaged in care are between 40 and 60 years young (see Österle & Hammer, 2004, p. 36).

In the right upper quadrant there is a strong correlation between strict regulation of the care system and paid, formal care work, while the opposite applies to the lower left quadrant, i.e., weak regulation of the care system linked to unpaid work.

Figure 1: Correlations in care systems



Source: Chart according to Ungerson (2002)

For example, a care system in which there is little regulation and in which care work is by and large paid work, but governed by illegal work relations, would be located in the lower right quadrant.

“The Austrian system of care, in which, compared to other European countries, care work is constructed as unpaid or low-paying work provided by family members, and has little regulations of care provision, would therefore be positioned in the left lower quadrant” (Österle & Hammer, 2004, p.31).

1.4. Social exclusion and poverty risk

On a European average, the risk of poverty in Austria is low, similar to the situation in Sweden. Still, 11% of all people in need of care live in moist, mouldy flats. 95 000 are not prepared for unplanned expenses, such as having a broken washing machine repaired, etc. 105 000 cannot afford a holiday. 23 000 of the long-term care allowance beneficiaries in private households are at risk of poverty, according to the EU-SILC household survey. Another 54 000 social benefit recipients living in homes for the elderly or nursing homes are not able to pay for the care they need.

The poverty risk is above average among the people over 65 (19.7%) and those over 80 (20.2%).

Table 4: Poverty risk by age of the head of the household

	30 years and younger	30–59 years	60–64 years	65–79 years	80 years and older	total
Median equivalent income in EUR	1 350	1 608	1 501	1 305	1 235	1 495
Share of poverty risk in %	21.8	12.0	11.5	19.7	20.2	14.8

Source: Statistik Austria: consumption survey 2004/2005, WIFO calculations. – Poverty risk threshold: 60% of the median equivalent income

However, the risk of poverty should not be solely regarded from the perspective of incomes, as with age consumption expenses decrease significantly more than incomes. This somewhat alleviates the poverty risk that grows with age. But when care is needed, expenses explode.

Table 5: Savings quota of households by age of the head of the household

	30 years and younger	30–59 years	60–64 years	65–79 years	80 years and older	total
Household income in EUR*)	2 067	2 920	2 405	1 967	1 670	2 547
Index, total = 100	81.2	114.6	94.4	77.2	65.6	100.0
Consumption expenses in EUR	2 107	2 648	2 310	1 745	1 185	2 319
Index, total = 100	90.9	114.2	99.6	75.6	51.1	100.0
	Share of savings in the net household income, in %					
Savings quota	-2.0	9.3	3.9	10.9	29.1	8.9

Source: Statistik Austria: consumption survey 2004/2005, WIFO calculations. – *) per month, extra payments included, i.e., 12 times annually.

For elderly people with low incomes, the financing of high quality care close to their household by familiar persons is a vital issue.

2. Important questions about the policy that are being raised and debated in Austria

In recent months, the debate about care in Austria has been dominated by the issue of 24-hour care. Around 5% of the people in need of care are assisted by illegal care workers from Austria's neighbour countries, especially from Slovakia. Women carers take turns to stay with the older people day and night for two weeks at a time. Costs are between EUR 1 500 and 2 000 a month. In the Austrian social care system, this – as yet illegal – form of care has given rise to discussions about:

- a) care at home and family-like care
- b) job profiles between nursing and care
- c) financially affordable nursing and care services
- d) diversification of services between 3 and 24 hours as well as choice options
- e) dividing line between health and social care

2.1. Care needs as a life risk

Beside illness and unemployment, care needs have become the third major life risk which, contrary to the two other factors, is not covered by a security system of shared risks. To be confronted with care needs in one's family can happen to everyone. And yet, care needs are mainly regarded as a private risk which has to be met by every individual her or himself. Where social care is needed, co-payments are higher than anywhere else in the social system, and private assets of one's own and those of family members are relentlessly drawn on. This causes a series of false incentives as well as misdirection.

2.2. Health and social care

While in hospital, we receive high quality treatment, but as soon as therapy is completed, we are left on our own or become a case for welfare in old age.

The division of health care and social care is an obstacle to joint budgeting and the integrated provision of health and social care services.

2.3. Disburdening welfare

The welfare benefits system was created for emergency situations rather than structural unemployment, the working poor, old age poverty or nursing care; it was actually conceived as a tool for helping overcome extraordinary hardships. Therefore it is not the adequate instrument for accommodating regular and widely recurring risk phenomena such as nursing and care. This is too much of a burden on welfare and goes far beyond its structural capacities.

2.4. Nationwide standards

In Austria the quality of nursing and care primarily depends on where people live. There are great differences as to the amount of co-payments to be borne by care recipients. According to the structure of nursing and care for the elderly in Austria as described by Simsa & Schober (2004), the density and variety of supply differs greatly from province to province. There is also a wide range of prices that those concerned have to pay for care. In an extreme case a citizen will pay up to 42% more just for living in the wrong province. In view of the fact that the financial means are primarily provided via nationwide uniform funding instruments, there appears to be no justifiable reason why supply standards should vary in each province.

2.5. Investing in social services: closing the care gap

Public investments are necessary wherever nursing care can be *closer to the place of residence*, *more self-determined* for those concerned and *relieving* for the carers.

A care gap exists between the mobile services that have been established and the care needed up to 24 hours per day. In this field there is great demand for professional, affordable support for care and nursing in private homes: expansion of the mobile services, part-time care provided by municipal care workers and care assistance services, night care, emergency night care call centres, short-term care at home, coordinated community support, assisted and assistable housing, part-time service units such as day care centres and community centres.

2.6. Long-term care allowance classification

If the classification for long-term care allowance (see 1.2.) is to become a basis for other public services that are granted in addition to this allowance, the assessment procedure will have to be reconsidered. Otherwise the problems that already occur in the assessment of long-term care allowance, such as rating dementia patients too low, will also be transferred to other services.

3. Key issues and main questions for the meeting in Sweden

3.1. Ädelreformen

- “The division of responsibility between the authorities responsible for care services meant that municipal nursing assistants did work of a social character and county council assistant nurses carried out health care in the individual's home”, as Karin Hellquist and Kent Löfgren outline the situation before the reform of 1992 (Ädelreformen) in the Swedish Host Country Report. They go on to state that “patients in emergency medical care whose treatment there had been completed were obliged to remain in too resource-intensive a form of care because there was a lack of places in other forms of care.”

What were the political and economical framework conditions of the 1992 reform? How was the reform implemented in detail? Which stakeholders were in favour of and which against the reform? What were the main conflicts, and how were they solved?

- “The possibility for the elderly to live at home has been reinforced even if the elderly need extensive care, by for example providing home care around the clock.”

What are the services that guarantee home care around the clock? What are the costs for the person needing care? What are the support systems for the individual or funding plans for services financed by the state?

- “The former problem of ‘bed-blockers’ in hospital care has been reduced.”

How does the interface between health care and social care operate?

- “Both the volume and the standard of special housing for the elderly have increased considerably.”

What incentives were made in order to move elderly people from permanent residence in nursing homes to special housing? Which form of living is accepted best, and why?

3.2. Other issues and questions:

- **What are the financial flows, especially for social care?** Which support systems are provided for which nursing and care services, what are their funds and the reasoning behind them?
- **What exactly are the measures taken by the case manager – established under the Social Service Act of 1982** – in order to find the suitable care arrangement for those concerned? Does the case manager only assist people with low incomes, or everyone? If poverty is among the criteria, does s/he assess the income and assets of those concerned?
- **Are there nationwide uniform standards and costs of care** that persons in need of care can refer to?
- What are the effects of “client choice” on the quality and affordability of social services? **Has there been a development of “poor services for poor people” caused by competition and choice?**
What has been the experience with the concept of “personal budgets”, if any?
- **What occupations in the field of nursing and care exist in Sweden?** What are the training curricula for obtaining these qualifications?

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