Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Prevention and rehabilitation in the context of LTC for older people in Austria

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1 Introduction

This report, which has been prepared for the second project meeting of INTERLINKS (2008-2011), has a twofold aim. Firstly, to provide an overview on the Austrian state of the art measures concerning prevention and rehabilitation for older people in need of long-term care (LTC). Secondly, to reveal outstanding measures and initiatives in Austria, which may serve as examples of "good practice" in this context. As a starting point, the present introduction will outline the demographic background and the basic organisation of LTC in Austria as well as some cultural and political characteristics related to prevention and rehabilitation within LTC. Mainstream preventive and rehabilitative measures provided for older people in need of LTC in Austria are compiled in the next two chapters and are structured according to four different care settings – namely the 'Community', 'Intermediate', 'Acute' and 'Residential' setting. After a brief and general discourse about the concept and common understanding of "good practice" in Austria, chapter four presents a selection of concrete "good practice" examples concerned with prevention and rehabilitation in the context of LTC in the four defined settings. Some basic features of how the provision of LTC and related services are governed and financed in Austria are listed in chapter five. Chapter six, finally, rounds up with some concluding remarks.

At this point I would like to add my acknowledgements and thanks to all participants of the Austrian National Expert Panel (NEP), which was held on 29th of May 2009 in Vienna. The 13 participants (see Annex 1) all generously offered their time and professional expertise and contributed with valuable comments and input to the research for this report.

1.1 Demographic background

The country of Austria has a dimension of 83,853 square metres and currently around 8.3 million inhabitants (Statistik Austria 2008). Austria is subdivided into nine provinces (B, K, N, O, S, St, T, V, W[1]) with corresponding provincial governments and subordinated administrative districts in form of municipalities. Vienna as the capital of Austria represents in unison a municipality as well as a province. During the past 15 years, the Austrian population has aged to a consistently higher degree than the EU27 average, as the share of those aged 65 and older in the total population increased. As a consequence, Austria has a relatively aged population even for EU27 standards and according to projections from Eurostat this ageing process is not likely to stop in the next decades. Statistik Austria (2008) projects that the Austrian population aged 65 and over will increase between 2006 and 2030 by about 56%, while the younger population (0-19 years) might decrease by 7%.

[1] B=Burgenland, K=Kärnten, N=Niederösterreich, O=Oberösterreich, S=Salzburg, St=Steiermark, T=Tirol, V=Vorarlberg, W=Wien

Table 1 Main demographic information – trends and projections

	1990	*1995*	*2000*	*2006*	*2020*	*2030*
Total population	7,644,818	7,943,489	8,002,186	8,265,925	8,723,363	8,988,139
65+	1,139,841	1,196,874	1,233,667	1,361,804	1,688,465	2,129,450
80+	270,370	308,437	272,111	361,100	453,201	601,501
Share of total population						
65+						
Austria	14.9%	15.1%	15.4%	16.5%	19.4%	23.7%
EU-27 average	12.9%	13.9%	14.7%	15.7%	19.2%	22.6%
80+						
Austria	3.5%	3.9%	3.4%	4.4%	5.2%	6.7%
EU-27 average	2.8%	3.1%	3.0%	3.7%	5.0%	6.4%

Source: Eurostat.

The health status of older people is an important determinant in shaping the demand for long-term care. While health conditions deteriorate with age, the age group of 75-80 seems to mark the point from which prevalence of dementia and severe activity restrictions increases sharply, making the age group of the 80+ the most likely to have long-term care needs (Huber et al., 2009, forthcoming). According to existing studies on prevalence of dementia in Europe (Alzheimer Europe, 2006; Ferri et al., 2005), the share of the population affected by dementia in Austria has increased but it is in line with the EU average, totalling an estimated 94,000 to 104,000 people with Dementia in 2005. As for activity restrictions, the older age groups are also those with an increased share of people reporting severe activity restrictions, although these problems are much more likely to respond to adequate prevention and rehabilitation in earlier stages of life. In any case, women seem to have lower health conditions than men in their later stages of life.

Projections taking into account different assumptions concerning the development of the health status predict in any case a further increase of people with needs of help and care so that, in 2030, between 645,000 (Scenario “Better Health”) and 811,000 people (Scenario “Status Quo”) in Austria will need one or the other kind of support (Badelt et al, 1995). The number of beneficiaries of LTC allowances, almost 400,000 in 2007, is estimated to rise about 65 percent until 2030 (Hammer/Österle, 2006).

1.2 Organisation of long-term care in Austria

The Austrian government describes the social welfare sector in Austria as comprising three main ways of organising and funding social expenditure: social insurance, social assistance and “other support” such as the LTC allowance, support for people with disabilities, support for victims of war and crime (BMSK, 2009). Social insurance provides sickness, pension and accident insurance to defined population groups in return for mandatory contributions. Social assistance provides a means-tested safety-net for

individual social risks. “Other support” is provided as coverage for special groups for which the Federal State takes direct responsibility.

The most important in-cash entitlement for persons in need of care is the Austrian LTC allowance. Introduced in 1993 for all Austrian citizens as a non-means tested cash allowance it is generally administered at the level of the federal state and funded from general taxation. Additionally, publicly supported in-kind services for people in need of care are provided at the provincial/municipal level and require separate assessments as well as a means test for the client.

1.2.1 Services in cash

With the Federal Long-Term Care Allowance Act (“Bundes-Pflegegeldgesetz”) the Austrian long-term care allowance was introduced in 1993 for all Austrian citizens as a non-means tested cash allowance. Thus the formerly scattered and unequal cash benefit schemes for persons in need of care were comprehensively regulated. Austrian residents of all ages (and Austrians living in another EU country) are since then eligible for the LTC allowance if they are assessed as needing permanent (expected to last at least six months) care for more than 50 hours per month.

The Austrian LTC allowance has 7 levels depending on the hours of care needed due to physical and mental restrictions a person suffers from. The level of allowances (Table 2) depends on a medical assessment in which a specialised physician of the responsible administrative body (pension insurance agency or the regional social welfare office) assesses the applicant’s monthly care needs during a home visit. The social insurance institutions arrange the assessment procedures. Applications can be made at any public body such as the municipality and are then automatically forwarded to the appropriate administrative unit.

Table 2 The Austrian LTC allowance

Level	*Care needs per month*	*Amount in € per month*	*Beneficiaries in % per level*
I	> 50 hours	€ 154.20	20.1%
II	> 75 hours	€ 284.30	35.1%
III	> 120 hours	€ 442.90	17.4%
IV	> 180 hours	€ 664.30	14.7%
V	> 180 hours of heavy care	€ 902.30	8.2%
VI	> 180 hours of constant attendance	€ 1,242.00	2.8%
VII	> 180 hours of care in combination with complete immobility	€ 1,655.80	1.8%
Total number of beneficiaries			100.0%

Source: BMSK, 2009 (www.bmsk.gv.at)

Table 3 shows the numbers of male and female beneficiaries of the LTC allowance in Austria.

Table 3 Number of beneficiaries of the federal LTC allowance by sex

Level	*Men*	*Women*	*Total*
I	20.863	53.711	74.574
II	39.613	76.820	116.433
III	18.800	37.179	55.979
IV	17.790	34.556	52.346
V	8.711	18.418	27.129
VI	3.415	6.170	9.585
VII	1.880	4.052	5.932
Total	111.072	230.906	341.978

Source: BMSK, 2009

1.2.2 Services in kind

In principle, each citizen has the right to call social services if s/he is in need of care. Though their organisation, coverage, regulation and financing differ with each of the nine regions, it can be stated that their take-up rate depends much more on local availability, personal information and costs for out-of-pocket contributions than on individual needs.

In Austria, health and social care services for people living at home are almost entirely provided by third sector organisations, mainly associations affiliated to the churches or to political parties. In residential care, about 55% of the facilities are publicly provided; about 21% are managed by commercial providers and the remaining 24% by private non-profit organisations (Schneider et al, 2006).

The availability and accessibility of services, semi-residential and residential care facilities have increased significantly over the past ten years: in some regions supply of home care has more than doubled, though from a very low level. Notwithstanding this positive development, there are still considerable regional differences so that community care services – home help, home nursing, geriatric aides – remain inadequate to meeting needs in some of the nine regions (Österle, 2001). A particular challenge for home care services remain alpine and border regions with difficult accessibility and long distances between the agencies' headquarters.

Table 4 shows the kind of services used by carers of persons entitled to LTC allowance. Only about a quarter of all carers are using community care services and only 5.1% report the use of day care or short-term care facilities. Lack of information, lack of local availability and mainly lack of financial means to (co-)pay these services are the main motives given by carers for not considering these respite services.

Table 4 Types of services used by beneficiaries of LTC allowance

Kind of service	*LTC beneficiaries and their carers using the service*
Community care services	24.9%
• of which:	
Home nursing	46.0%
Home help	38.0%
Meals-on-wheels	29.6%
Day care	3.4%
Short-term care (respite care)	5.1%

Source: Pochobradsky et al, 2005.

A nurse from a regional or municipal care agency which is responsible for the distribution and control of publicly available and co-financed in-kind services in a certain region of Austria will assess the physical and mental state of a person and his/her respective care needs as well as the family and social situation. Based on this assessment, the nurse will determine what public services the client is entitled to and – for instance in Vienna – which sub-contracted care organisation will provide the services. As already mentioned, home help, home care and other social services needed for long-term care are subject to co-financing by the users (see below). The care agency calculates the cost-contribution the client is obliged to pay for the different kind of services. The calculation of personal cost-contributions usually takes into account the income / pension, the amount of LTC allowance scheme and personal property in the form of savings, deposits etc. For all different kinds of services a maximum contribution fee per hour is defined. In general, users pay about 1% of a calculation base (own income including LTC allowance) per hour of service, with exemptions for persons entitled to a minimum pension only.

For residential care there are currently about 68,000 places in about 800 old-age and nursing homes available in Austria. As in most other European countries, the average age of residents in most institutions is above 80 and residential homes are increasingly being transformed into nursing homes.

However, reforming large institutions into smaller units that are more adequate for hosting the increasing number of residents with dementia will still take several years. Apart from physical restructuring, first steps have been taken to improve the organisational framework of residential care: today, most regional governments have implemented specific legal regulations concerning institutional care, e.g. specifying education and training for managers of nursing homes, contracts with residents defining rights and duties, and some structural requirements concerning space, staffing or the maximum number of places. Once more, regulations differ remarkably from region to region (see also Leichsenring, Ruppe, Rodrigues, Huber 2009).

In some regions of Austria a precondition for the admission into an assisted- living facility is the entitlement to at least a level 2, for a nursing home to at least a level 3 of the Austrian LTC allowance. Unfortunately, a thorough geriatric assessment for example in hospitals is often missing before the decision for permanent admission into institutional care is taken. In general, permanent residents of nursing homes have to contribute 80% of their pension, their LTC allowance and all of their convertible property (incl. an owned house or apartment). 20% of the pension plus 10% of the level 3 public LTC

allowance (i.e. currently €44.29) remains as a private allowance (more or less "pocket money"). In any case, a minimum asset of €3000 is allowed for private use on the bank account of the resident.

Concerning in-kind services it is important at this point to add that in the Austrian health sector a professional specialisation in geriatrics has not been established so far. The lack of implantation of gerontology and geriatrics at Austria's three large public Medical Universities is partly responsible for the negative attitude of many of the responsible political and professional representatives towards the creation of a specialisation and postgraduate curriculum in geriatrics. At present, the Ministry of Health has established a working group with the goal of conceptualising geriatrics as a sub-specialisation within internal medicine, neurology, psychiatry, physical medicine/rehabilitation and general medicine. (http://www.geriatrie-online.at). The establishment of an institute and chair for geriatric medicine at the Medical University in Vienna is currently underway.

1.3 Cultural specifities in Austria concerning old age and LTC

Religion, the geographical position, the economic situation, the socio-political history or the development of a strong social welfare state over the last decades in Austria are some of many factors which have tailored and contributed to what one might call a national culture. Specificities of this national culture are also reflected and inherent in the current organisation of social, health and care services in Austria as well as in attitudes and expectations of people towards these services and towards old age and retirement.

One of such attitudes can probably be described as a tendency of Austrians towards relatively low self responsibility – e.g. for one's own health or for activities, such as voluntary engagement after retirement – combined with relatively high expectations towards assumed super-ordinate and responsible instances, such as the welfare state, health and care institutions, medical professionals etc. This might also explain why personal preventive measures, such as preventive medical check-ups – although free of charge for the patient – are not taken up to a great extent or why volunteer organisations and activities for older people have not yet developed on a large scale in Austria. Supported by a mandatory social health insurance system, which allows most Austrian citizens free access to health care services, personal health tends to become a self-evident (consumer) good that is expected to be delivered by medical professionals in the form of a certain intervention, be it only the prescription of certain drugs (Ruppe 2006).

The so called "Austrian way" ("Österreichische Weg") of managing or coping with certain deficits and inadequate regulations in public systems should also be mentioned here as a kind of cultural specificity in Austria. The adopted terminology "Austrian way" mainly refers to informal or personal arrangements, which are used and established in order to overcome and cope with insufficient or impedimentary public regulations and legislations or with a lack of services in certain individual situations. These kinds of often very useful, efficient and human "undercover" arrangements between individuals or institutions create positive as well as negative effects within a system. The positive effect is that many individual problems or officially desperate cases, such as unacceptably long waiting times for a patient or unaffordable caring arrangements for a client, can often be overcome or even solved in this way. The negative effect of the "Austrian way" is that "undercover" arrangements also create injustices and the

unequal treatment of people as usually those who profit have the best connections, are the most persistent or hold a fortunate social status. Additionally, informal arrangements are likely to create the false impression of a well functioning system and tend to hide problems or inappropriate regulations. This may finally impede changes or slow down innovation processes, which are essential to the development of a sustainable LTC system.

Finally, the fact that biomedical ideologies and paradigms are quite powerful in our culture and are also prevalent in the organisational culture of (long-term) care giving is not so much an Austrian specificity but rather a general phenomenon in modern societies. A certain trust and belief that *evidence-based* biomedical science can or will be able to either prevent or cure all different kinds of "age-related" diseases and in this way offer a universal solution for the complex "problem" of ageing seems still alive today. Such an ideology or vision tends to be gratefully taken up at the political and economical level, where "healthy ageing" is a major concern and a declared and widely promoted aim today. However, differing interests, needs and realities concerning "healthy ageing" at different societal and professional levels are likely to be disregarded. To leave common and mainstream standards and to associate e.g. prevention with other terms than merely with "vaccination" or "healthy nutrition" appears as a difficult challenge against this background (Ruppe 2006).

1.4 Current political discourse about prevention and rehabilitation in the context of LTC

As in all other member states including Austria, the consequences of a continuously ageing society combined with prolonged life expectancy have created political concern over the last years and decades and given rise to debates about the reorganisation of the national health and (long-term) care system. Additionally, the creation of numerous preventive programmes and projects for an ageing and aged population has been fostered in this way. However, the topic of prevention, health promotion or rehabilitation in the explicit context of long-term care has so far not been an important or obvious issue in the public discourse. The phase in which a person has become dependent from long-term care services, especially within an institution, is still widely seen as a dead-end and definite situation, where change, recovery or even regain of independence is usually no longer expected.

Preventive as well as rehabilitative programmes designed for elderly people in Austria usually aim to preserve people's independence by promoting different forms of healthy behaviour, changes of lifestyle or training and engagement in mental or physical activity. All in all they promote "healthy ageing" with a strong focus on medical and physical aspects and are geared towards the group of older people in general and not specifically towards older people in need of LTC. Although social, psychological and context-related aspects of prevention are often mentioned and highlighted in public and health policy statements, it obviously remains difficult to integrate, represent and evaluate them as successful and efficient elements in mainstream preventive and rehabilitative practice.

Thus, a common understanding of prevention and rehabilitation remains rather limited to the conventional scope of medically founded and linear interventions rather than to multilayered, systemic or process-oriented approaches. This situation combined with the fact that LTC is so far not recognised

as an interacting network of services and sectors but is rather associated with a dead-end situation *after* medical treatment contributes to a political discourse where prevention and rehabilitation *in the context of LTC* is not highly ranked on the agenda.

1.5 Four different settings in this report

In order to systematically represent the current state-of-the-art concerning prevention and rehabilitation in the context of LTC in Austria, four different settings of LTC provision are being differentiated for this report. Despite difficulties in the delimitation between primary, secondary and tertiary prevention (see 2.1), this kind of classification and structure has also been adopted and used as far as possible and meaningful.

The "Community" setting is defined here as the private surrounding of a client living at home while regularly and over a longer period of time using different kinds of formal or/and informal health and care services. The "Intermediate" setting encompasses living or care arrangements where LTC clients are either admitted for a limited period of time, such as respite care or short-term care facilities, or where they continue a relatively independent private life combined with a more intense supply of care, such as community and assisted living facilities. The "Acute" setting mainly comprises all kinds of acute or repetitive hospital stays for a person in need of LTC. Finally, nursing homes and old age homes, usually equipped with a care unit for people in need of more intense or continuous care, represent the "Residential" setting.

2 Mainstream prevention in the context of LTC

As stated already in the previous chapter, specific preventive measures, which are explicitly tailored and catered to older people in need of long-term care, are hardly existent on a systematic and well documented basis in Austria. Relevant national surveys, such as the comprehensive survey "Hochaltrigkeit in Österreich. Eine Bestandsaufnahme" (BMSK 2008) about the situation of very old people in Austria, usually dedicate separate chapters to the topic of prevention and health promotion for older people but do not explicitly focus on older people, who are (already) using LTC services. A distinction between primary, secondary and tertiary prevention is made in this report, although the debate about the meaningfulness of this kind of classification ranges (e.g. among the members of the Austrian National Expert Panel for INTERLINKS) from the opinion that clear delimitations are difficult to be made to the opinion that strictly defined primary prevention for older people does not exist at all. Also a differentiation between tertiary prevention and rehabilitation seems not to be feasible. Therefore, measures which per definition belong to tertiary prevention are treated under rehabilitation (point 3).

The following table provides a rough overview on mainstream activities of prevention according to the above defined four different LTC settings (1.5) in Austria.

Activities compiled in this table represent rather conventional and well known preventive interventions, most of them with a quite delimited and very medically defined scope and impact. Preventive measures understood more on a wider social, societal or environmental level as well as approaches which might bring about a preventive effect by improving organisational procedures and coordination between different settings, are rather scarce or still in their infancy. However, basic approaches and selected examples in this direction will be mentioned in chapter four as models of "good practice" for prevention as well as for rehabilitation.

A special case in this context is the preventive effect due to the – relatively generous – provision of a non-means tested LTC allowance in Austria (1.2.1). A preventive impact can be attributed to the provided cash allowance in the "Community" and in the "Intermediate" setting. For many older people in need of LTC in Austria this kind of financial support represents a basic means of support and can obviously prevent older people - with certain impairments - from dependency and further deterioration of their physical, psychological and social situation (see also 4.1).

Table 5 Preventive mainstream practice in four different LTC settings

	Community (Formal or/and informal health and care services in private settings)	Intermediate (Assisted and community living arrangements, day care, respite care, short-term care)	Acute (Hospital care)	Residential (Nursing homes, Old age homes with care units)
Primary Prevention	Vaccinations, Lifestyle Interventions (Nutrition, Smoking, Physical Activity, Adaptation of living arrangements ...), Preventive home visits, LTC allowance, Informal carers	Specific architecture and adaptation of living arrangements, Hip protectors, Vaccinations, Counselling, LTC allowance, Informal carers	Vaccinations	Specific architecture and adaptation of care/living arrangements, Vaccinations, Hip protectors
Secondary Prevention	Preventive medical check-up, Screening programmes, LTC allowance, Informal carers	Assessments, medical examination, mental tests and training, LTC allowance, Informal carers	Geriatric assessments (on wards for Acute Geriatric Medicine and Remobilisation, Neurol., Oncology,...)	Geriatric assessments (irregular), Mental tests and training, Psychotherapy, etc.
Tertiary Prevention → Rehab.	Fall prevention after previous fall, mobile Physio-/Ergotherapy, mobile Palliative Care, LTC allowance, Informal carers	(mobile) Physio-/ Ergotherapy, Palliative Care, LTC allowance, Informal carers	Physio- /Ergotherapy, Palliative Care	Internal units for remobilisation, Physio-/Ergotherapy, Palliative Care

2.1 Community

2.1.1 Vaccination

According to the public Austrian Immunisation Schedule 2009 (Impfplan 2009 Österreich), the following vaccinations are specifically recommend for older adults with and without actual LTC needs.

Above the age of 50 an annual influenza vaccination as well as a single dose of Varicella zoster vaccine in order to prevent complications of severe shingles (Zoster) is scheduled. For persons of 60 years and over a Pneumococcal vaccination as a single dose as well as a booster vaccination every 5 years against tetanus, diphtheria and pertussis is recommended. Additionally, for those 60+ the FSME vaccination should be administered every 3 years as distinct from every 5 years among the younger population.

The Austrian Immunisation Schedule is elaborated and revised every year by the Supreme Sanitary Council (*Oberster Sanitätsrat*) of the Austrian Federal Ministry of Health. Explanatory notes included in

the Immunisation Schedule refer to WHO recommendations and advise to use every patient/doctor contact as well as hospital treatments in order to check if the recommended immunisations have been accomplished and to make up for missed vaccinations if necessary.

However, vaccinations are the responsibility of the individual. The immunisation rate of the Austrian population 60+ against Influenza is currently around 33% (BMG 2009). In a public Health Survey 2006/2007 around 13% of those 75+ reported a valid immunisation against Pneumococcal infections and 47% of the male and 37% of the female population in this age group reported to be sufficiently vaccinated against Tetanus (Dorner, Rieder 2008).

2.1.2 Lifestyle intervention

Well-balanced and healthy nutrition as well as physical activity and non-smoking are all well known positive and health-related lifestyle factors. In Austria public lifestyle intervention programmes, which promote such factors on a mainstream basis are either geared towards the whole population or probably towards older people but not specifically towards those who are suffering from chronic conditions and are using LTC services at home. Nevertheless, some LTC services are used as occasions to provide relevant information or to make specific offers, such as healthy diets by meals-on-wheels services to this group of older people. Other occasions to deliver lifestyle-related information to older people who are in need of regular care or support and still live at home are preventive home visits or preventive medical check-ups as described below.

For specific adaptation or disability-friendly renovation of a person's private accommodation, some public funding exists in most Austrian provinces. This kind of measure, which is still very much in its infancy in terms of region-wide information, organisation and supply, aims at supporting the option to live at home for as long as possible as well as preventing injuries, such as falls at home (see also 4.1.4).

2.1.3 Preventive home visits

Nationwide home visits to older people with an explicitly preventive ambition are not yet established in Austria. .Nevertheless, in all Austrian provinces various forms of home visits to older people in need of long-term care and their relatives exist, which mainly have a counselling or supportive character concerning different practical and organisational issues of (long-term) care giving at home. Obviously some of the given advice during such a visit or the social component of the visit in itself can also be classified as a kind of preventive activity.

In five (B, N, St, V, W) out of nine Austrian provinces a *mobile counselling service ("Mobile Beratung")* is provided and delivered to older people in need of care and their relatives by care specialists. In two provinces (N, St) this kind of service is currently promoted and pilot tested via the distribution of so called counselling vouchers ("*Beratungsschecks*"). Counselling is either performed upon request or goes along with a positive decision on a long-term care allowance application as a so called initial counselling ("*Erstberatung*"). *Care counselling ("Pflegeberatung")* ie a home visit by a social worker or specialised nurse is offered in two Austrian provinces (S, O). (ÖBIG 2008)

Additionally over the course of a pilot project the Austrian Ministry of Social Affairs and Consumer Protection (BMSK) has accomplished country-wide *quality assuring home visits ("Qualitätssicherung für die häusliche Betreuung")* to all recipients of the Austrian LTC allowance (ÖBIG 2008).

In five Austrian provinces (N, S, St, V, W) *home visits ("Besuchsdienste")* are provided, which mainly aim to provide social contact with lonely older persons. In Vienna some of these home visits are also performed by volunteers (ÖBIG 2008).

Available specialised mobile or ambulant therapeutic services such as occupational or physiotherapy (see, for example: http://pflege.fsw.at/therapie/ergotherapie/) also have an important preventive character and are additionally mentioned under point 3.1 in this report.

Psychosocial services for older people are available in four Austrian provinces (B, N, St, W). Older people suffering from Dementia or other mental illnesses or acute psychosocial crises can in particular seek support from these services. Interventions include personal or telephone counselling, medical diagnosis and treatment as well as advice concerning appropriate living arrangements or further therapeutic and supportive measures (ÖBIG 2008).

2.1.4 Preventive medical check-up / GPs

All people living in Austria who are above the age of 18 have the right to make use of a free preventive medical check-up ("Vorsorgeuntersuchung") once a year. This kind of preventive examination has been introduced in Austria in 1974 and was recently restructured and improved in 2005. One aim of the examination is the early detection and treatment of risk factors or diseases indicators such as high blood-pressure, high blood fat, being overweight or diabetes. Another aim is to use the patient-doctor contact for lifestyle intervention, counselling, and to survey the social and mental health situation of the patient. Usually it is the GP who is performing the medical check-up. Due to regular visits to the doctor the GP might be a confidential person for the patient and therefore play an important role in successfully communicating and monitoring preventive advice and treatments.

The current preventive medical check-up has been adapted to the age groups 20-40, 40-60 and 60+ as well as 75+. For all age groups a health-pass has been developed including explanatory notes on results, advice or questionnaires to be filled in before an examination. Above the age of 60 the importance of the annual influenza vaccination and the pneumococcal vaccine should be pointed out in the course of the examination. From the age of 65 special attention is given to the early detection of problems with hearing and vision. Information to reduce the risk of falling is also handed out to attending patients. For the age group 75+ a specific questionnaire concerning his/her social situation and support is included in the health-pass as well as questions on mental/emotional health and incontinence problems. For the same age group the medical check-up includes an assessment of nutritional status and dental health. Screening programmes for cancer are not recommended on a general basis above the age of 70 (Dorner, Rieder 2008).

Despite various public information campaigns, only a minority of people in Austria make use of this free preventive examination. In 2005 11.3% of men and 15.5% of women used the preventive medical check-up. In the age group 75+ it were 10.5% of men and 9.5% of women (Hauptverband der Sozialversicherungsträger 2006). Part of the explanation for such a low uptake might be that most

people in Austria hold a social health insurance (which means that most medical services are anyway free for the client) and therefore “free of charge” medical examinations are not specifically attractive for them.

2.1.5 Fall prevention

As mentioned in the previous section the preventive medical check-up is one occasion were public information concerning fall prevention can be delivered to older people living at home. Another occasion to provide preventive advice concerning falls and the possible adaptation of living arrangements to people in need of care are home visits as described above under “Preventive home visits” (2.1.3).

2.1.6 Support by/for informal carers

For older people with continuous care needs in Austria, especially for those living in the community or intermediate setting, informal carers (mostly family carers) represent highly important and reliable safety networks in the form of social, physical and emotional support. In Austria 80-85% of care-dependent older people are being cared for by one or more family members (BMSK 2008a). Against this background, informal carers also significantly contribute to preventive measures as they might save older people in many cases from further physical and mental deterioration, deprivation, unnecessary hospital admissions and alike. Consequently, support to informal/family carers who are exposed to a huge burden and regularly run the risk to burn themselves out is an essential and preventive measure, both for the caregivers themselves as well as for the recipients of care.

The situation and status of family carers is quite precarious in Austria as specific and systematic public measures to acknowledge and support family care are still lacking. However, some concessions and improvements have been introduced in recent amendments to existing public regulations. First, networks and offers of counselling for caring relatives have been slightly increased both on the regional and on the national level. Since 2006, a pilot project (with the plan to be expanded nationwide in 2009) is trying to improve the information base for people with care needs and their families. Applicants for the LTC allowance have been provided with so called “counselling vouchers” for a visit by a home nurse to get information, advice and practical hints about the formal care system. Second, additional social security protection for family carers has been introduced. Informal carers who have given up regular employment to care for a close relative whose care needs are at level 4 are offered special public favours and contributions to their self-employment and respective pension insurance for a limited period (BMSK 2009; BGBl. Nr. 132/2005; SRÄG 2007). Third, a large effort to support informal carers during the past years has been put on the legalisation and establishment of official regulations for 24-hour care by migrant and family carers. For example, means-tested subsidies for the employment of a 24-hour assistant have been introduced, which go along with the requirement to either employ the assistant or to register as a self-employed 24-hours assistant.

All in all, with the new “Home Assistance Law” some legal aspects of this kind of assistance have been resolved but a number of organisational, educational and ethical questions remain to be solved (Leichsenring et al. 2009). Finally, according to the LTC Allowance Act, family members caring for a relative with assessed care needs of level 4 and above can apply for benefits from the support fund for people with disabilities. If the family member falls ill or is unable to fulfill his/her caring duties for other

reasons for a certain period of time, he/she thus has to be replaced by a professional or private service. About 10,000 carers have used this service during the past 5 years. In the future, carers of persons with dementia and/or with assessed care needs of level 3 may also apply for this support (BMSK 2009; Leichsenring et al. 2009). Parallel to this, smaller initiatives which launch supported holidays for carers are underway at the regional as well as at the national level (BMSK 2009).

2.2 Intermediate

2.2.1 Vaccination

As residents of assisted and community living facilities only make use of a specialised living arrangement and those in respite or short-term care are only entitled to a specialised caring- arrangement, all medical issues including the status of vaccinations are the personal responsibility of the resident. However, access to medical support is usually facilitated in this setting.

2.2.2 Counselling and Lifestyle Intervention

Due to the fact that intermediate settings allow for more regular and formal contact between the resident and care staff than at home, this surrounding also gives more opportunities for preventive counselling and lifestyle recommendations by professionals. Depending on the kind of intermediate institution, this may include advice on nutrition, physical activity, fall prevention programmes, mental training or the use of therapeutic and preventive appliances, such as hip protectors or walking aids.

2.2.3 Specific architecture/adaptation of living and care arrangements

Assisted and community living arrangements, which in Austria are mostly designed for about four to eight residents, usually conform to disability-friendly or Dementia-specific architectural guidelines. The preventive character of architecture, internal equipment and appropriate environment of facilities – usually nursing homes – for short-term or respite care varies considerably. Depending on the provider, the offered care concept, or the previous usage and development of the facility, respective institutions rank between small-scale intimate and large-scale hospital like environments (Rischanek 2008).

2.2.4 Assessments and examinations

In Austria a more or less thorough geriatric assessment will usually be performed before the admission and transfer from hospital to short-term care. To what extent assessments or examinations are performed before or at the moment of admission into respite care or into some kind of assisted living arrangement mainly depends on the individual regulation of the respective institution.

2.3 Acute

2.3.1 Vaccination

The status of immunisation of a patient is not checked as a mainstream preventive measure over the course of an average hospital stay in Austria. Exceptions are the control of sufficient tetanus immunisation or a respective precautionary vaccination in case of injuries with open wounds. Vaccinations specifically recommended for older people (see under 2.1.1) might become a topic during a geriatric assessment on specialised wards.

2.3.2 Geriatric Assessment

In Austrian hospitals geriatric assessments are mainly performed on wards for "Geriatric Acute Care and Remobilisation" ("Akutgeriatrie/Remobilisation, AG/R") as well as on some wards for Neurology, Internal Medicine or Oncology. The so called "Austrian Basic Geriatric Assessment", as adapted and recommended by the "Austrian Society for Geriatrics and Gerontology" (http://www.geriatrie-online.at) aims at a comprehensive evaluation of a patient's health and general condition. The multidimensional examination, ideally performed by a multidisciplinary team comprises and evaluates five dimensions namely physical, psychological, social and economic as well as self-help abilities of the older patient. In clinical examinations usually six different parameters are used and tested: 1)ADL 2)IADL 3)mood 4)cognition 5)nutrition and 6)mobility. For each parameter two different instruments of testing are up for election when performing the standardised assessment (ÖGGG 2006). A central purpose of every geriatric assessment is to estimate the rehabilitative potential and abilities of a patient and to use this information in a following process of rehabilitation. Since 2008 a benchmarking system for the standardised comprehensive geriatric assessment has been introduced in Austria (see also 4.2.1).

2.4 Residential

2.4.1 Vaccination

There are no generally valid regulations concerning vaccinations for older people, who are residents of LTC institutions. In general, nursing homes in Austria are only responsible for living and care giving services, whereas medical issues including vaccinations are the personal responsibility of each single resident (see 2.1.2). Medical treatments and regular check-ups are usually performed by a medical doctor, who is either available within the institution, e.g. on the care unit, or a GP who comes on request to see his/her patient living in the institution.

2.4.2 Lifestyle intervention / Psychotherapy

Preventive lifestyle interventions in Austrian nursing homes may include organised indoor and outdoor physical activity programmes, nutritional counselling and freely selected diets, various social activities and excursions, mental training, psychotherapy, individual physio- and ergotherapy etc. It depends on the provider and organisation of each institution which kinds of activities or interventions are available for the residents (Rischanek 2008). Some nursing homes engage dieticians for professional counselling to patients and staff.

2.4.3 Preventive appliances (hip protectors, etc.)

There are no general and public guidelines in force which regulate or recommend the preventive usage of hip protectors, walking aids or other appliances in Austrian old age and nursing homes. This again depends on single providers, which measures are taken or recommended to residents. As many medical aids need a medical prescription, the use or not of certain preventive appliances may also be the decision and responsibility of the attending doctor of the institution or patient.

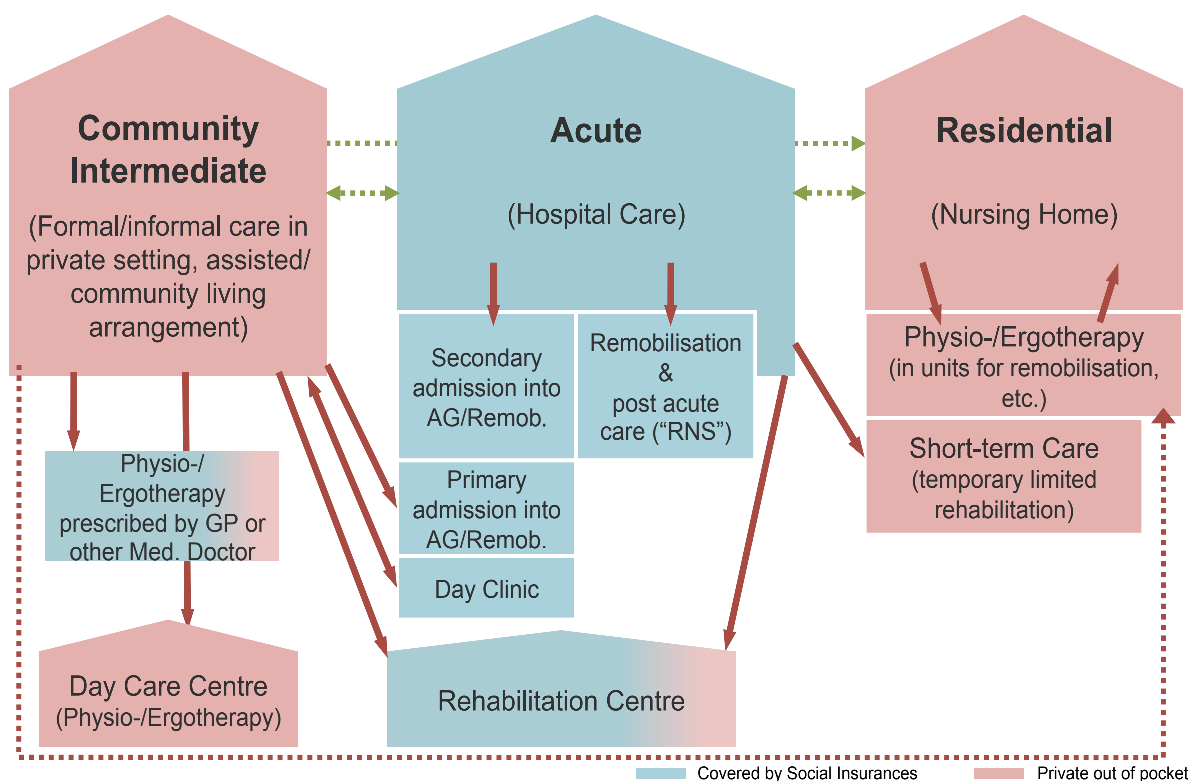
2.4.4 Assessments

The use and intensity of assessments varies significantly in Austria and usually depends on individual regulations in the respective region or institution. Some care institutions perform a thorough geriatric assessment at the moment of admission of a new resident; other facilities only do a basic physical examination or a simple survey of care needs.

3 Mainstream rehabilitation in the context of LTC

This chapter outlines how and which forms of rehabilitative services are currently provided and accessible for older people in different sectors and settings of long-term care in Austria. Table 6 provides an overview of mainstream access pathways across available rehabilitative services in the context of LTC in Austria. Again, the four settings "Community", "Intermediate" (here merged as one joint setting), "Acute" and "Residential" provide the structural basis for the illustration and the following description of the situation.

Table 6 Main access pathways to rehabilitative services from different LTC settings



3.1 Provision of rehabilitation in the "Community and Intermediate" setting

An older person with LTC needs, who lives at home or in an assisted/community living arrangement in Austria currently has various options to access rehabilitative services in order to improve his/her chronic and disabling conditions.

A rather indirect but frequent access to rehabilitative services goes through the admission – for whatever reason – into a hospital and is described in more detail in the following section (3.2).

A special case in this context is the direct admission into a Department for Geriatric Acute Care/Remobilisation (allowing for "primary admission" of patients from the community in contrast to a

"secondary admission" meaning rather the transition of a patient from another hospital ward). In addition to the treatment of acute disorders of older patients, the objectives of Geriatric Acute Care/Remobilisation (*"Akutgeriatrie/Remobilisation",* AG/R) departments are to enable patients to return to and keep leading largely independent lives by working with multidisciplinary teams and treatment procedures. Geriatric Acute Care departments have been established since 1999 in Austrian hospitals and are usually affiliated to departments for Internal Medicine or Neurology.

As AG/R units in Austria offer relatively high quality standards and up-to-date approaches concerning the treatment and rehabilitation for older people with complex health and care needs they are also mentioned and described in more detail as a model of "good practice" under 4.2.1.

Another available access to rehabilitation which is closely linked to hospital structures are Geriatric Day-Clinics, which offer treatment and remobilisation on an ambulatory basis. Geriatric Day Clinics have to be established in direct association to a department for Geriatric Acute Care /Remobilisation. The implementation of Geriatric Day-Clinics is under development in Austria; currently only three such facilities exist (in the provinces of "Wien"/W, "Oberösterreich"/O and "Kärnten"/ K).

A need for rehabilitation can also be confirmed by a medical doctor (e.g. the family doctor). The physician may then either prescribe limited units of ambulatory physio-/occupational therapy, which is to a basic extent covered by the social health insurance. S/he might also recommend and confirm an application for a stay in a rehabilitation centre, which has to be handed in at the responsible social insurance agency. Application and admittance procedures in the latter case are roughly the same as within the hospital setting (see below).

Special care units for remobilisation, which belong to a nursing home, are only theoretically accessible for persons living outside the nursing home. Internal waiting lists of nursing home residents are usually so long that a phase of rehabilitation within such facility is not a realistic option.

Finally, an older person living in the "Community and Intermediate" setting in Austria might also visit a Day Care Centre – usually integrated in a nursing home – on a regular basis and make use of physio/ergotherapy or other measures for rehabilitation and remobilisation offered in such facilities. Costs for the day-care centre have to be covered privately by the patient, at least in the form of a determined cost contribution.

In 2000 Palliative Medicine was for the first time mentioned and introduced in the Austrian "Krankenanstalten- und Großgeräteplan" (ÖBIG 2004). Since then a systematic planning and development of structures and respective quality criteria for Hospice and Palliative Care in Austria has taken place. The scheduled development and implementation of different structural elements for a graded Hospice and Palliative Care system (Table 7) in Austria have been compiled in the respective plan "Abgestufte Hospiz- und Palliativversorgung in Österreich" (ÖBIG 2004). As all various definitions of rehabilitation include in some way the objective to maintain a person's independence and to improve his/her quality of life for as long as possible using multidisciplinary measures ('Restitutio ad optimum') (Dorner, Rieder 2008), Hospice and Palliative Care are mentioned here as a specific but important part of rehabilitation in the context of LTC.

Table 7 Plan for a graded hospice and palliative care provision in Austria

<table>
<tr><th></th><th colspan="4">Hospice and Palliative Care</th></tr>
<tr><th></th><th>Basic Services</th><th colspan="3">Specialised Hospice and Palliative Services</th></tr>
<tr><th></th><th>Conventional Providers</th><th colspan="2">Supportive Services</th><th>Care Services</th></tr>
<tr><td>Acute</td><td>Hospitals</td><td rowspan="3">Hospice Teams</td><td>Palliative-conciliar services</td><td>Palliative-wards</td></tr>
<tr><td>Residential</td><td>Nursing Homes</td><td rowspan="2">Mobile Palliative-Teams</td><td>Hospice (Units)</td></tr>
<tr><td>Community</td><td>GPs, mobile services, nurses and therapists, etc.</td><td>Hospice with Day-Care Service</td></tr>
<tr><td></td><td>“Easy” Situation
80 - 90 percent of deaths</td><td colspan="3">Complex situation, Difficult questions and cases
10 - 20 percent of deaths</td></tr>
</table>

Source: HOSPIZ ÖSTERREICH, ÖBIG 2004

The implementation of these structures in all Austrian provinces is underway, although more investigations, efforts and commitments will be necessary to achieve a comprehensive service structure. So far, the coordination of Hospice and Palliative Care services in particular in the province of Styria (St) has reached an advanced level of quality as well as the “Mobile Hospice” services in Vienna (V) and Lower Austria (NÖ), which will be described more closely as a model of “good practice” under 4.1.6.

3.2 Provision of rehabilitation in the “Acute” setting

Despite the fact that hospitals in general are not qualified places for rehabilitation, they are often the initial access path to specialised rehabilitative facilities for older people with chronic conditions, who have originally been admitted to hospital either for an acute medical reason or for more psycho-social reasons.

If after a phase of acute hospital treatment further rehabilitative measures appear promising and are recommended from the medical side, there are usually three main options or pathways. The first option is rehabilitation in a Rehabilitation Centre of a public or private provider in Austria. Costs are covered to a large extent by the responsible social insurance agency (for older people entitled to a pension this is usually the social pension insurance). The patient in the hospital has to fill in and sign an application form, which additionally has to be confirmed by the attending medical doctor and which has to be handed in at the social insurance. The final responsible social insurance agency has to approve the planned rehabilitative stay and guarantee the reimbursement of costs. However, this option might turn out to be problematic for an older and care dependent patient who is offered a free place in a

rehabilitation centre only after his/her planned discharge from hospital, as the patient may not be able to go home for an interim period.

A *second option,* especially if there is no place available in a rehabilitation centre or if the social insurance refuses to cover the costs, would be rehabilitative measures in specialised hospital wards. This can in the best case be a department for Geriatric Acute Care/Remobilisation (AG/R) with the possibility for a "secondary admission" (transition from another hospital/ward), a department for Neurological Rehabilitation/Remobilisation or a ward for Remobilisation and Post Acute Care ("Remobilisation und Nachsorge/RNS"), which is a less specialised unit than AG/R wards are. In all three cases it is possible to organise and account for a more extended stay of patients than in other common hospital wards. As this would mean a transfer at the hospital level, costs are covered by the social health insurance and no further request is necessary. However, it often depends on the (informal) cooperation and willingness of the responsible doctors if such a transfer can be realised.

The third option after an acute institutional treatment is rehabilitation provided over the course of a short-term care stay. Facilities offering short-term care in Austria are usually integrated in nursing homes or closely affiliated to hospitals. In Vienna for example, short-term care facilities are integrated in so called Geriatric-Centres ("Geriatriezentren"), which are public nursing homes closely related to large hospitals. Short-term care in combination with rehabilitative treatment is arranged for a limited period of time, usually up to a maximum stay of 3 months. Places are restricted to patients, "where it is likely that they do not remain constantly care-dependent", who are "willing to actively collaborate in their rehabilitation process in order to enable a discharge to their own home" and where "the respective social health insurance does not accept the costs for rehabilitation" (www.pflege.fsw.at). Free places in short-term care facilities are scarce and usually require a "Nursing Home Application" ("Pflegeheimantrag"). In many cases a nurse of the respective short-term care facility will come to see the patient in the hospital before a transfer and assess the chance for successful rehabilitation. For this form of rehabilitation a patient has to pay a cost contribution, in Vienna this is currently €79.94 per day. If a person is not able to cover these costs, s/he would still have to pay a certain means-tested contribution.

3.3 Provision of rehabilitation in the "Residential" setting

Some nursing homes in Austria provide rehabilitation or remobilisation in specific care units. Such units usually only admit residents of the same nursing home for a limited period of more intense and rehabilitative care. An exception is, for example, one large nursing home provider running 31 nursing homes in Vienna, which has a special arrangement with a hospital concerning the takeover of a limited number of patients for rehabilitative measures in specific remobilisation units after acute care.

The provision of physio/ergotherapy within the nursing home is up to each nursing home provider. Usually diverse social activities which contain a certain rehabilitative character are offered to residents such as interactive music or dance sessions, garden therapy as well as mental tests and trainings.

In general there are no strong incentives for rehabilitation of residents of nursing homes in Austria. Part of the explanation is that the majority of nursing home residents in Austria have to give up their assets

and property (including flat or house), in order to be able to afford the entry into residential care. The way back to a life outside the nursing home is for that reason often blocked and rehabilitation – at least with the aim of managing an independent life – becomes thereafter a rather redundant, questionable or even sarcastic measure.

4 Models of “good practice” for prevention and rehabilitation in the context of LTC

This section provides a structured overview on promising or already successful preventive and rehabilitative approaches in the context of long-term care for older people in Austria. As preventive, rehabilitative and health promoting measures for older people suffering from chronic conditions are usually closely related and blend into each other as soon as they develop a more holistic approach, they are treated together in this chapter. A prevailing preventive or rehabilitative scope of initiatives has been figured as P<>R.

Most concrete preventive as well as rehabilitative activities listed below exceed conventional or narrowly focused measures and are characterised by a more comprehensive understanding of prevention and rehabilitation than in current mainstream practice. Multi-dimensional approaches capable to take the interaction of social, physical, psychological and spiritual aspects of human ageing into account, as well as measures which bear a preventive effect by improving the quality of procedures, transitions or cooperation between different LTC sectors, have in particular been selected as representing “good practice”.

Yet, the question of what “good practice” really means in Austria and if and by whom criteria for *good* or *bad* practice have been defined has to be put at the beginning of such a survey. Two findings from research for this report can serve as answers to this question. Firstly, what is often cited as “good practice” in the public and political discourse in Austria frequently refers to good *projects* or good *theory* developed within such projects. Most of these projects are specifically designed for a certain region in Austria and have a limited scope and duration. Sometimes it was even difficult to find out if a certain project was still in place or if follow up activities had been developed or funded. However, successful preventive or rehabilitative activities that are sustainably implemented in a region and have become everyday practice are rather scarce. Secondly, strict standards or agreed minimum criteria officially defining “good practice” in this context are actually not existent in Austria. Projects, which aim at developing or testing elements of good practice usually have to pass strict selection procedures for funding and in this way already have to prove defined criteria as relevant or “good” projects. Among better implemented interventions in everyday practice are again medically focused measures, which can most likely provide hard facts or “evidence base” for “good practice”. In contrast, providing acknowledged evidence for the – often indirect – effectiveness and efficiency of social, societal, psychological or even organisational preventive programmes remains a difficult challenge.

4.1 Community and Intermediate

The Austrian LTC allowance (1.2.1) has to be mentioned at this point as a measure, which obviously has an important preventive effect for people with LTC needs in the community or intermediate setting.

Beneficiaries entitled to a Level I or II within the Austrian LTC allowance scheme, who often manage to live and continue living independently at home, make up more than 55% of all LTC allowance beneficiaries in Austria (see Table 3). Although the cash allowance can be invested and used at will, it can be assumed that investments in different forms of personal assistance or in features relevant to increase individual quality and organisation of life can have an essential preventive impact and impede or postpone dependency as well as further deterioration of the health condition (see also 2).

The majority of the following concrete examples of "good practice" were located in the Community and Intermediate setting. The fact that projects concerned with health promotion and primary prevention in these settings frequently apply for co-funding from the powerful Austrian Health Promotion Fund ("Fonds Gesundes Österreich") partly explains this (http://www.fgoe.org/projektfoerderung/foerderphilosophie). Another explanation as mentioned previously is the often assumed dead-end situation within institutional LTC facilities.

4.1.1 "Comprehensive Geriatric Assessment in general practice"

Type, scope

Pilot study in nine general practices in the province of Vorarlberg (V); privately initiated and supported by "Caritas Stiftung Lichtenstein"; Prevention (P) > Rehabilitation (R)

Background

Comprehensive Geriatric Assessment (CGA) programs usually refer to hospital-based settings. However, the body of geriatric healthcare is provided by general practitioners in their office. Structured geriatric problem detection by means of assessment instruments is crucial for efficient geriatric care giving in the community (Mann et al. 2004). Aim of the study was to develop and pilot test a German language geriatric assessment instrument adapted for general practice.

Content and method

Nine general practices in a rural region of Austria participated in this cross-sectional study and consecutively enrolled 115 persons aged over 75 years. The prevalence of specific geriatric problems was assessed, as well as the frequency of initiated procedures following positive and negative tests. Whether findings were new to the physician was studied exemplarily for the items visual and hearing impairment and depression. The acceptability was recorded by means of self-administered questionnaires (Mann et al. 2004).

Target group

Older people (75+) with various health problems living at home (using or not using LTC services) or in an "Intermediate" facility and consulting – most of them on a regular basis – a general practitioner

Results

On average, each patient reported 6.4 of 14 possible geriatric problems and further consequences resulted in 43.7% (27.5% to 59.8%) of each problem. The items with either the highest prevalence and/or the highest number of initiated actions by the GPs were osteoporosis risk, urinary

incontinence, decreased hearing acuity, missing pneumococcal vaccination and fall risk. Visual impairment was newly detected in only 18% whereas hearing impairment and depression was new to the physician in 74.1% and 76.5%, respectively.
A substantial number of interventions were initiated not only following positive tests (43.7% per item; 95% CI 27.5% to 59.8%), but also as a consequence of negative test results (11.3% per item; 95% CI 1.7% to 20.9%). The mean time expenditure to accomplish the assessment was 31 minutes (SD 10 min). Patients (89%) and all physicians confirmed the CGA to provide new information in general on the patient's health status. All physicians judged the CGA to be feasible in everyday practice (Mann et al. 2004).

Conclusion and current state
The adapted CGA was feasible and well accepted in the general practice sample. High frequencies of geriatric problems were detected prompting high numbers of problem-solving initiatives. But a substantial number of actions of the physicians following negative tests point to the risks of too aggressive treatment of elderly patients with possibly subsequent negative effects (Mann et al. 2004). The CGA has not been implemented into mainstream practice so far. However, a follow up project under the title: “Preventive health risk appraisal for older people” had been developed.

4.1.2 “Preventive health risk appraisal for older people”

Type, scope
Prospective study in a rural community in the province of Vorarlberg (V); P > R

Background
Health risk appraisals (HRAs) are recommended for detection of potentially modifiable risk factors for health status decline of older people. Little is known how family physicians manage detected risk factors (Eichler et al. 2007).

Content and method
The study evaluated, if risk factors in one or more of five predefined domains were detected in a primary care-based HRA and how often these findings had an impact on the further management of patients. A prospective observational study was performed in a rural community in Austria and included persons (age > 70 years) living at home. The standardised assessment for elderly people in primary care (STEP) instrument was applied and risk factors for status decline were evaluated by assessing five domains (cognitive function, depression, urinary incontinence, hearing impairment and mobility/falls) (Eichler et al. 2007).

Target group
Older people (70+) with various health problems living at home (using or not using LTC services) or in an “Intermediate” facility and consulting – most of them regularly – a general practitioner

Results
Two hundred and sixty-four persons participated and the HRA revealed a wide range of risk factors for health status decline [from 4.5% (12/264) in the depression domain up to 31% (81/264) for mobility/falls and 41% (107/264) in the cognitive domain]. The findings had an impact on the further

management in four domains: hearing impairment (100% of findings with impact), mobility/falls (93%), depression (83%) and urinary incontinence (65%). In contrast, abnormal cognitive findings lead to action only in every fifth participant (18%; 19/107) (Eichler et al. 2007).

Conclusion and current state

In contrast to other domains, family physicians are hesitant to act upon abnormal findings of cognitive testing. The study shows that additional knowledge is needed to clarify the value of abnormal cognitive findings for management of patients and support of their carers (Eichler et al. 2007). No follow up project or implementation has been launched so far.

4.1.3 "Unabhängiges LandesFreiwilligenzentrum"(ULF) and "Gemeinsam Aktiv"(GEMA) (Volunteer engagement)

Type, Scope

An independent platform for volunteer engagement in different social sectors funded as a *model project* by the Austrian Federal Ministry for Labour, Social Affairs and Consumer Protection (BMASK) together with the province of Upper Austria (OÖ) for two years; Scope of the project is the province of Upper Austria (OÖ); P>R

Background and Aim

The "Unabhängige LandesFreiwilligenzentrum" (ULF) is the first independent organisation (as it does not belong to a super-ordinate for-profit or non-profit organisation) to motivate, promote and coordinate different regional and communal initiatives of volunteer work in the province of Upper Austria (OÖ). Central and declared aim (http://www.ulf-ooe.at/index.php) of the platform is to apply innovative approaches in order to motivate people of all age groups for regular engagement in volunteer work at the communal and regional level. ULF has legally been established as part of the larger society "Verein für Sozialprävention und Gemeinwesenarbeit" in Linz (capital of OÖ) in September 2008.

Content and method

A first important step in the work of ULF was the organisation of an idea contest called GEMA ("Gemeinsam Aktiv") in order to motivate the presentation of concepts and initiatives for volunteer work in different social sectors within the province of OÖ. In December 2008 twenty model projects had been selected and were presented as winners of the contest (http://www.ulf-ooe.at/node3,0,gema-modellprojekte.html). The selected projects, which since then are supported and comprehensively coordinated by ULF, have a wide scope and have been distributed in different thematic pillars, such as: Seniors, Children and Youth, Migrants and Asylum Seekers, Disabled People, Socially Disadvantaged People etc. Volunteer engagement within all different pillars and respective sub-project is open for everyone, including older people as long as they themselves feel physically and mentally capable for a certain activity. Activities can be home visits at lonely or sick (older) people, counselling and accompaniment for migrants, support in child care issues etc. In general the preventive aspect of all these initiatives builds on the concept of "active ageing".

ULF is additionally engaged in public relationship and regularly organises events for public information and promotion of volunteer work as well as for internal exchange between and development of volunteer initiatives, projects or (sub-) organisations.

Target group
People of all age groups, who are interested to voluntarily engage in different kinds of social work; special attention is given to socially endangered or disabled people as well as to older and lonely persons and children

Results, evidence
After a period of two years an evaluation as well as the takeover and continuation of the project ULF by the province of Upper Austria (OÖ) is planned.

Current state
So far the ULF in Upper Austria (OÖ) is the first and only independent provincial umbrella organisation for volunteer engagement. ULF is intended to serve as a kind of showcase project for other provinces in Austria.

Contact and further information
http://www.ulf-ooe.at/index.php
http://www.freiwilligenweb.at

4.1.4 "Mobil und Sicher zu Hause" (Adaptation of living arrangements)

Type, Scope
Project over 13 month (July 2009 – July 2010) run by "Wiener Sozialdienste" in cooperation with "Wiener Sozialdienste Team Idee-SÖB GmbH" and mobile ergotherapists from the "Fonds Soziales Wien"; scope of the project is the region of Vienna; P+R

Background and Aim
The "Wiener Sozialdienste" founded as a non profit organisation in 1946 offer different kinds of social services within the city of Vienna. Since 1979 ergotherapists provide mobile and free counselling for people in need of therapeutic appliances and specific adaptations within their private living arrangements. Since then the request for home visits by specialised ergotherapists has increased continuously (Wiener Sozialdienste 2009).
The overall aim of the project is to provide better ergotherapeutic counselling and to detect, reduce or overcome barriers in the private living arrangements of clients in Vienna. Special attention is given to a better coordination of services not at least by active inclusion of clients and their families as well as by intensified cooperation with hospitals, rehabilitation clinics and services of workmen.

Content and method
A first and cost free home visit, which sometimes may even take place before a client is discharged from an institution, is performed by an ergotherapist together with a workman. Small adaptations can be accomplished immediately. For more specific and elaborate adaptations the client will receive an estimation of costs and necessary services can be organised. In general, costs for adaptations have to be covered by the client. However, funding for disability friendly adaptations of living arrangements can be applied for at the "Fonds Soziales Wien" (http://pflege.fsw.at/finanzielles/wohnungsverbesserung.html). The project over one year can be

seen as a test phase, which – in case of a positive evaluation – is planned to be expanded and to continue in the existing work.

Target group
Older people with specific health or mobility problems living at home using or not using LTC services

Results, evidence
As the project and thus the test phase of this intervention just started when writing this report, interim results or evidence for effectiveness were not available so far.

Current state
Initial phase of the project; it is planned to integrate successful activities in existing services

Contact and further information
www.wienersozialdienste.at

4.1.5 "Unabhängig Leben im Alter – Hausbesuche zur Gesundheitserhaltung und -förderung" (Health promoting home visits)

Type
Project over a period of 3 years (2007-2010) in collaboration with15 nursing care associations in rural municipalities in Vorarlberg (V); funded by the provincial government Vorarlberg together with the Austrian Health Promotion Fund ("Fonds Gesundes Österreich"); P>R

Background
The early detection of incipient complaints in combination with professional counselling and information is the basic idea behind health promoting home visits in this project. Central aim is to prolong a period of health, mobility and independence for people 70+ living in the community.

Content and method
Older people 70+ in the respective region are directly informed by letter about the opportunity of a free preventive home visit. In case of acceptance a qualified nurse from the region performs the home visit and a structured interview along a standardised questionnaire. The questions and related advice cover topics such as general well-being, fall risks, nutrition and alike. Reversely participants are most interested in legislative and financial issues and have the opportunity to ask their individual questions. Analysis and interpretation of data is performed by a separately commissioned society.

Target group
Older people (70+) with different health problems living at home (already) using or not using LTC services

Results, evidence
A response rate of 15% is expected over the course of the 3 year project. After the first year 742 home visits had been performed. This exceeded the expectations of the project management. Two

third of the participants were women, 38% were living alone. More detailed information or an interim evaluation of the ongoing project was not yet available.

Current state
Ongoing project, follow-up unclear

Contact and further information
http://www.fgoe.org/projektfoerderung/gefoerderte-projekte/FgoeProject_660374

4.1.6 "Mobiles Palliativteam" (Mobile Palliative Teams)

Type, Scope
Implemented and differently developed services in almost all Austrian provinces; most important provider is currently Caritas Socialis; R>P

Background
Mobile Palliative Teams represent one essential element in the implementation plan for a graded hospice and palliative care system in Austria (see 3.1). Central objective is the provision of multidisciplinary and continuous mobile palliative and social care in order to maintain or improve quality of life and to allow a terminally ill person to stay at home or in a familiar surrounding as long as possible.

Content and method
Mobile palliative care in Austria is generally free of charge for the client. Services are usually financed by sponsoring, private donations and public funding. Quality criteria for the establishment of Mobile Palliative Teams have been determined by the Austrian Federal Institute for Health (ÖBIG 2004). Apart from 24-hour availability for telephone counselling and for acute (medical) interventions, the service provision by a multi disciplinary team is a basic requirement. Medical and nursing staff, social worker and administrative staff have to be present in the team. Additionally, physio-, psycho-, speech- and ergotherapist, as well as dieticians, pastors from different confessions and volunteer workers have to be available to each team. Clients have to be registered and receive, after an initial home visit and assessment, the necessary services, which are continuously adapted to individual needs (frequency, attending professions, etc.).

Target group
People with chronic and terminal illnesses living at home and using or not using other LTC and health services; also accessible for socially disadvantaged people; patients and their personal preferences are intensely integrated and respected when setting up an individual care plan

Results, evidence
An annual survey monitoring the development and delivery of hospice and palliative care services in Austria according to the guidelines of the plan "Abgestufte Hospiz- und Palliativversorgung in Österreich" (ÖBIG 2004) is accomplished by the "Dachverband Hospiz Österreich"

Current state

According to the last available survey of "Hospiz Österreich" a total of 31 mobile Palliative Care Teams had been established all over Austria till the year 2007 – fife more than in the year 2006 (Hospiz Österreich 2007). 4,255 clients had been taken care for by Palliative Care Teams over the year 2007 (Kratschmar, Teuschl 2008). A need of one team per 140,000 inhabitants (this would mean around 57 teams in Austria) is estimated for the year 2010 (ÖBIG 2004).

Contact and further information

http://www.hospiz.at

4.2 Acute

4.2.1 "Akutgeriatrie/Remobilisation" (Geriatric Acute Care and Remobilisation Units)

Type, Scope

Implemented clinical structures with policy commitment and defined plans for nationwide expansion; R>P

Background

Specific needs of geriatric patients are not yet sufficiently met within the currently provided acute health care structures in Austria. Therefore, in 1999 the decision for a network of Geriatric Acute Care and Remobilisation ("*Akutgeriatrie/Remobilisation, AG/R*") Units all over Austria was taken. The Austrian Federal Institute for Health Care (ÖBIG) determined the framework conditions for the planned facilities in the Austrian Structural Plan for Health ("*Österreichischer Strukturplan Gesundheit*") (ÖBIG 2009).

Content and method

The Austrian Structural Plan for Health (ÖBIG 2009) defines the official quality standards for Acute Geriatric Care and Remobilisation facilities. These criteria comprise minimum personnel requirement, adjustment of hospital infrastructure to the needs of older people (technology and room equipment, size), and the services required. The most recent revision of this plan was performed in the year 2006. As there is no professional specialisation in Geriatrics established in Austria so far, Geriatric Acute Care facilities are usually established under the lead of a specialist in Internal Medicine or Neurology. A multidimensional treatment regime is offered to patients in primary (admission from the community) and secondary (transition within the health care system) Geriatric Acute Care and Remobilisation units. In general, services are directed towards older people who are suffering from somatic and/or psychic multi-morbidity, who are limited in their autonomy due to functional or cognitive disorders or psychosocial problems and last but not least towards those who are in need of rehabilitative and reintegrative measures (ÖGGG 2008). A core element and tool of all AG/R facilities is a standardised and comprehensive geriatric assessment (see below) in order to develop an individually adapted treatment and rehabilitation plan.

Target group
Older patients admitted to (or transferred within a) hospital with multiple and chronic health problems and in need of multidimensional treatment and care

Results, evidence
The comprehensive geriatric assessment has been standardised and results are used for systematic benchmarking of Geriatric Acute Care since 2008. Initiated by the Austrian Society for Geriatrics and Gerontology, currently AG/R units in four Austrian provinces (K, OÖ, St, W) are fully participating in the related benchmarking process guided and evaluated by “Joanneum Research” in Graz (St).

Current state, Contact
So far approximately 40 units for Geriatric Acute Care and Remobilisation have been established in six of the nine Austrian provinces. By the year 2010 it is planned to have around 3,700 beds dedicated to AG/R integrated into existing hospitals in 61 locations (ÖBIG 2009).
http://www.geriatrie-online.at

4.2.2 “Geriatrisches Assessment” (Geriatric Assessment)

Type
Implemented and standardised assessment instrument; mainly applied on wards for Geriatric Acute Care and Remobilisation; sometimes also used in departments for Neurology or Internal Medicine as well as in some nursing homes; R>P

Background
A geriatric assessment can be described as a multidimensional and interdisciplinary diagnostic process intended to determine a frail elderly person´s medical, psychological and functional capabilities, resources and problems. A complete assessment allows for individual counselling of the patient and a thorough planning of treatment, rehabilitation, reintegration process and long term care measures.

Content and method
(see also 2.3.2) – The Geriatric Assessment has been adapted by the Austrian Society of Geriatrics and Gerontology as “Österreichisches Geriatrisches Basisassessment” (ÖGGG 2006) and as main diagnostic instrument for all Geriatric Acute Care structures in Austria. This comprehensive Geriatric Assessment also represents a basic and standardised instrument for a benchmarking system of all the geriatric institutions in Austria, which was introduced in 2008 in cooperation with “Joanneum Research Austria”.

Target group
Older patients with multiple and chronic health problems and in need of multidimensional treatment and care; sometimes with difficulties to continue and organise their life at home

Contact and further information
http://www.geriatrie-online.at

4.2.3 "Indirektes Entlassungsmanagement" (Discharge management)

Type, Scope

Implementation of professional discharge management for all hospitals in Vienna; Funding as part of the overriding project "PIK", a so called "Reformpoolprojekt" (see below), by the province of Vienna together with the regional social health insurance; P>R

Background

The concept for the implementation project "Indirektes Entlassungsmanagement" had been developed and validated within the larger framework programme "PIK" (*"Patientenorientierte Integrierte Krankenbetreuung"/ Patient-oriented Integrated Health Care*). In a needs assessment at the beginning of the project in 2005 it was shown that in average 12% of patients discharged from the participating hospitals in Vienna (already specialised geriatric care units were excluded) were in need of complex post acute care. Based on this result a demand for 95 FTE discharge managers has been calculated for hospitals in Vienna (PIK 2007).

Content and method

Over the course of the project a "standard" (http://www.pik.or.at/fileadmin/user_upload/Fachtagung_EM/PIK_EM_Standard_2007_03_19.pdf) for indirect discharge management has been developed. "Indirect" refers here to a specialised and separately situated discharge management unit within a hospital in contrast to direct discharge, which is accomplished directly in the respective department a patient (with no or less complex post acute care needs) is discharged from. The "standard" comprises general recommendations and necessary quality criteria, which serve as guidelines for an adapted implementation of indirect discharge management in various hospitals. Parallel to this a special curriculum for training courses as "Discharge Manager" has been launched. In autumn 2007 the first courses started in cooperation of scientific institutions together with some selected hospitals.

Target group

Older patients with multiple and chronic health problems, often with difficulties to continue and organise their life at home

Results, evidence

Till the end of 2008 around 36 "discharge managers" completed their first training courses in Vienna. Till 2010 the management of public hospitals in Vienna (KAV) plans to establish 77 new positions for discharge managers in the municipal hospitals – which makes up for already 80% of the estimated need. The project "PIK" is a so called "Reformpoolprojekt", which means that it is financed by the province of Vienna on the one side and the social insurance on the other side. The explicit aim of these kinds of projects is to improve the cooperation and efficiency between the extra- and intra-mural health care sectors, which in the longer term is expected to bring about a win-win situation for both sponsors. Over a period of 2 years around 1.9 million euro have been invested in the project by the two responsible organisations (http://www.wien.gv.at/vtx/rk?S=020070808008)in Vienna. However, due to complex financial flows and a lack of transparency in the health system and especially between intra- and extramural services a clear cost-benefit analysis is not available for such interventions.

Current state

The project is in an implementation phase and the establishment of specialised discharge management in Viennese hospitals is underway. Coordinators of the project plan the additional introduction of an electronic monitoring system for quality improvement as well as the creation of a platform for exchange of experiences between discharge managers as a sustainable structure after the project. Other "Reformpoolprojekte" also dealing with the development of an improved and coordinated discharge management are currently accomplished in Styria (St) and Lower Austria (NÖ).

Contact and further information

http://www.wien.gv.at/vtx/rk?S=020070808008
http://www.pik.or.at

4.3 Residential

4.3.1 „Hospiz und Palliativ Care in Pflegeheimen" (Hospice and palliative care in nursing homes)

Type, Scope

Model project in various selected nursing homes; one project had been accomplished in two waves (2004/05 and 2006/07) in the province of Vorarlberg (V) another follow-up project has just started in the province of Lower Austria (NÖ); R>P

Background, Aim

The umbrella organisation of Hospice and Palliative Care in Austria ("Dachverband Hospiz Österreich") initiated model projects in V and NÖ with the aim to foster the provision of hospice and palliative care services within nursing homes.

Content and method

When presenting the concept of the first project in Vorarlberg, nursing homes in the same province were invited to participate in a model project. In the end twelve nursing homes participated in this first project. Parallel to this a project team, bringing together representatives from the provincial government, the chamber of medical doctors and the umbrella organisation of nursing and care directors was established and coordinated by the regional Hospice movement. This project team initiated, supported and monitored in various meetings and events throughout the project the implementation of Hospice and Palliative Care in nursing homes according to developed guidelines and quality criteria. For this purpose each nursing home nominated an internal Palliative Team as well as a main coordinator, who intended to realize the predefined guidelines and establish necessary external cooperation with services and professionals in palliative medicine and care. Palliative Care coordinators had to have or to accomplish basic training in Hospice and Palliative Care (Beyer, Bitschnau, Pelttari-Stachl 2008). In May 2009 the second model project with eight participating nursing homes in Lower Austria (NÖ) has started.

Target group
All residents in the participating nursing homes with need for palliative care

Results, evidence
A quantitative as well as a qualitative evaluation of the project in Vorarlberg had been accomplished after the project. Results from these evaluations were summarised as quite positive, which contributed to the follow-up project in Lower Austria (NÖ).

Current state
Meetings for exchange of experiences between the different involved players in Vorarlberg (V) are planned to be held twice a year after the first project.

Contact and further information
www.hospiz.at

4.3.2 "CS Wohngemeinschaften für demente Menschen" (Dementia care in small living arrangements in Vienna)

Type, Scope
Implemented small scale assisted living arrangements for older people with Dementia in Vienna run by a private non-profit organization; R+P

Background, Aim
The four existing 'CS Wohngemeinschaften für demente Menschen' ("CS Appartments for people with Dementia") in Vienna which have been established in 2007 and 2008, are run by Caritas Socialis a private non-profit organisation providing different kinds of social and health services in Vienna. The basic idea is to provide small scale living arrangements for older people with slight and middle scale dementia, which allow for individual living habits, a high level of self-determination and well adapted and assisted participation in activities of daily living. Therefore it is a principle that the staff of the facility does things *with* the patient, not simply for them and that they encourage residents to maintain their independence.

Content and method
The appartments where the respective facilities are accomodated, have been built and designed for this purpose and are rented by the Caritas Socialis. Besides the apartments for people with Dementia, all other apartments in the same buildings are for general housing. A main feature of this care arrangement is that there is no fixed timetable; the residents can get up when they want. The only fixed arrangement is lunch. Furniture comes from the residents' home and each room has around 12 square metres. There are usually two nurses on duty during the day for11-hour shifts, and one during the night for13-hour shifts. Additionally, men who are doing their "civil service" alternatively to military service in Austria are engaged on a regular basis as assistants for all kinds of daily activities. For those residents who like to be active, they are taken out for garden therapy, on shopping trips or to restaurants in the surrounding. Guests are welcome at any time. They may take their relative for a weekend/an afternoon if they wish, but the residents cannot leave the home on

their own. It is possible to die in the appartment as the facility has access to mobile hospice services. Residents usually keep their own GP, who either comes to visit them or the resident has the chance to pay him a visit. Total costs of a place in this living arrangement are between 3000 and 4000 Euros a month. This includes rent, food, and basic care. If a resident cannot pay the whole amount, the family may pay or they can get support from the city of Vienna, which needs a previous means testing of the client. Almost all residents make use of these public subsidies, which roughly means that they have to give up 80% of their pension as part of the means test, as well as almost all of their LTC allowance. Approximately 20% of their pension and around 40 € of their care allowance remains as 'pocket money' (see 1.2.2).

Target group
Older people suffering from a slight to middle stage Dementia; also accessible for socially deprived persons

Results, Current state
The currently four assisted living arrangements for people with Dementia in Vienna, which exist since approx. one year, already have long waiting lists for available places. No official evaluation of this implemented measure was available so far.

Contact and further information
http://www.cs.or.at/view.asp?SID=532

5 Governance and financing

A brief outline of the basic organisation and public provision of (preventive and rehabilitative) LTC services in Austria can be found in the introduction to this report (see 1.2). The following points additionally compile some basic aspects concerning governance and financing of prevention and rehabilitation within the various health and social care settings in Austria.

The provision of the Austrian LTC allowance – as mentioned under 4.1 – carries an important but easily ignored preventive as well as rehabilitative potential for people in need of LTC. Basic regulations in the governance of the LTC allowance have already been described in section 1.2.1. In addition it should be mentioned that the provision of the LTC allowance in Austria does not go along with any incentives or offered plans for rehabilitation, neither with any recommended preventive measures. Thus, a possible and desirable improvement of the health condition of a LTC allowance recipient is not publicly monitored. A once adjudged level of LTC allowance is not automatically downgraded in such cases. Lack of transparency of financial flows and the multiple divisions of competencies within public authorities and financiers of intra- and extramural health, social and rehabilitative care services in Austria contribute to often contradicting interests and absent initiatives for better and more efficient regulations (Ganner 2008).

- Medical preventive measures within the Community and Intermediate setting, such as preventive medical check-ups, vaccinations, home visits by general practitioners but also medically prescribed units of physio- or ergotherapy are financed by the responsible local health insurance.
- Social measures of prevention within the Community and Intermediate setting, such as preventive home visits, organised volunteer engagement or assisted adaptation of private living arrangements are – as most social measures in Austria – more within the responsibility of the provinces and local municipalities. Many initiatives in this direction – some have been mentioned as examples of "good practice" (4.1) – are pilot programmes or projects, supported and co-funded by the Austrian Ministry for Labour, Social Affairs and Consumer Protection (BMASK) or by the "Fonds Gesundes Österreich / FGÖ". The latter is part of the so called "Gesundheit Österreich GmbH / GÖG" (http://www.goeg.at) and in this way is closely affiliated to the Austrian Ministry for Health (BMG). The Fonds Gesundes Österreich plays a powerful and decisive role in the co-financing of different kinds of research, pilot and network projects concerned with health promotion and primary prevention for all age groups.
- Rehabilitative measures accessed from the Community setting, such as therapies in a rehabilitation centre are for older people with entitlement to a pension financed by the responsible pension insurance (http://rehakompass.oebig.at/Information/Default.aspx). Only prescribed units of ambulatory rehabilitative treatment are the responsibility of regional health insurance agencies.
- Preventive and rehabilitative measures within the Acute setting, namely within hospitals, such as services provided on wards for Geriatric Acute Care/Remobilisation, in affiliated Day-Clinics or on other hospital wards and outpatient services are financed via the general and complex Austrian financing scheme for hospitals. All Austrian health insurance agencies have to contribute a lump sum into the respective financing funds administered by the provinces (*Landesgesundheitsfonds*).

- Rehabilitation in the Intermediate setting, such as rehabilitative measures in a Geriatric Day Care Centre or remobilisation over the course of institutional short-term care has to be paid privately *out of pocket* as part of the total costs charged by the institution. Usually one part of the real costs is paid in the form of a cost contribution by the client and the rest is covered by social assistance (which falls into the responsibility of each province).
- Preventive and Rehabilitative measures in the Residential setting are the responsibility and individual organisation of each single institution or provider. Financing of such measures, such as more intense care and treatment on a special unit for remobilisation within a nursing home has to be covered by the resident as part of the total living costs for the institution (see 1.2.2). The fact that residents usually have to give up all of their private assets when entering the nursing home is a strong disincentive for proper rehabilitative measures within the institution.

6 Conclusion

In conclusion some main Austrian features concerning the mainstream as well as the exemplary provision of preventive and rehabilitative measures for older people in need of LTC can be recited.

Mainstream prevention

Well established:

- A publicly available and regularly updated national immunisation plan with specific recommendations for elderly people (with and without LTC needs)
- Provision of a nationwide and cost free annual preventive medical check-up, specifically adapted for different age groups
- Various, although fragmented, initiatives for preventive and counselling home-visits in all Austrian provinces
- Performance of a comprehensive geriatric assessment has been introduced on specialised hospital wards
- The Austrian LTC allowance has an important preventive and rehabilitative potential as it obviously allows many beneficiaries to increase personal quality of life and independence

Lacking:

- Few measures explicitly tailored for older people in need of LTC
- Predominance of purely medical preventive approaches while few (overarching) initiatives can be revealed in the social or environmental domain
- Medical/ physical preventive measures are not sufficiently adapted to individual situations and to the context of a person with complex LTC needs
- Lack of social incentives and personal motivation to participate in certain (medical) preventive programmes, such as the offered preventive medical check-up
- Fragmented or unequally distributed preventive measures for older people within formal LTC, especially for residents within LTC institutions
- Lack of evidence and missing cost-benefit analysis for conventional as well as for innovative or multi-dimensional preventive measures for older people with and without LTC needs
- Inconsistent or missing guidelines concerning the use of assessments, preventative appliances or other measures in formal LTC

Mainstream rehabilitation

Well established:

- Short-term care including rehabilitation after a phase of acute treatment is generally available

- Primary and secondary AG/R care as well as affiliated 'day clinics' offer specialised multi-dimensional assessments, treatments and rehabilitation for older people with and without already existing LTC needs
- Well structured hospice and palliative care services are increasing in some provinces
- Therapies in Rehabilitation Centres as well as ambulatory physiotherapy units are relatively easily accessible and costs are usually covered by the social insurance system

Lacking:

- Almost no incentives for and measures of rehabilitation within institutional LTC
- Selection criteria and assessments for a transition into short-term care are often inconsistent and regularly rely on informal arrangements
- Acute hospitalisation is still a predominant access pathway to a first phase of rehabilitation, often due to a lack of information about options and entitlements
- The provision of the Austrian LTC allowance does not go along with recommendations or incentives for rehabilitation

"Good practice"

Well established:

- Many small initiatives, pilot projects and studies, especially in the Community and Intermediate setting
- Some implemented measures with concrete plans for further development, such as Geriatric Acute Care/ Remobilisation facilities, standardised Geriatric assessment procedures, coordinated discharge management or Dementia care in small assisted living arrangements

Lacking:

- Many initiatives and examples of good practice are projects with a very limited scope and little chance for follow-up and implementation on a larger scale
- Missing links in the form of mobile geriatric services or alike, which could fill the gap between GPs, AG/R units and mobile social, health and palliative services
- Few examples for preventive or rehabilitative initiatives for older people in need of LTC, which are based in the social sector or well linked with social and context related measures

References

Alzheimer Europe (2006), *Dementia in Europe Yearbook 2006*, Luxembourg: Alzheimer Europe. (http://ec.europa.eu/health/ph_information/reporting/docs/2006_dementiayearbook_en.pdf).

Badelt, C./Holzmann, A./Matul, C. & A. Österle (1995), *Kosten der Pflegesicherung, Strukturen und Entwicklungstrends der Altenbetreuung.* Wien: Böhlau Verlag.

Beyer, Bitschnau, Pelttari-Stachl (2008), *Hospiz und Palliative Care im Pflegeheim, Kurzfassung*. Wien: Dachverband Hospiz Österreich.

BMG (2009), *Influenza in Österreich. Epidemiologie und Durchimpfungsraten*. (http://www.bmgfj.gv.at/cms/site/attachments/7/9/0/CH0742/CMS1075899626901/influenza-epidemiologie_bmgf.pdf)

BMSK (2008), *Hochaltrigkeit in Österreich. Eine Bestandsaufnahme.* Wien: BMSK.

BMSK (2008a), *Bericht des Arbeitskreises für Pflegevorsorge 2006*. Wien: BMSK.

BMSK (2009), *Sozialbericht 2007-2008.* Wien: BMSK. (http://www.bmsk.gv.at/cms/site/attachments/5/6/9/CH0016/CMS1232705026761/sozialbericht_2007-2008.pdf)

Dorner, C./ Rieder A. (2008), 'Gesundheitsförderung, Prävention und Gesundheitsversorgung bei Hochbetagten' in: BMSK (Hg) *Hochaltrigkeit in Österreich. Eine Bestandsaufnahme.* Wien: BMSK: 317-350.

Eichler, K. / Scrabal, C./ Steurer J. & E. Mann (2007), Preventive health risk appraisal for older people and impact on GPs´ patient management: a prospective study. *Family Practice* Vol. 24: 604-609.

Ferri, C.P. /Prince, M. et al. (2005), Global prevalence of dementia: a Delphi consensus study. *The Lancet,* Vol. 366: 2112-17.

Ganner, M. (2008), 'Rechtliche Aspekte' in: BMSK (Hg) *Hochaltrigkeit in Österreich. Eine Bestandsaufnahme.* Wien: BMSK: 427-446.

Hammer, E. /Österle, A. (2006), 'Care Allowances and the Formalization of Care Arrangements: The Austrian Experience' in: Ungerson, C./Yeandle, S. (eds) *Cash for Care in Developed Welfare States.* Basingstoke: Palgrave Macmillan: 13-32.

Hauptverband der Sozialversicherungsträger (2006), Sonderauswertung: Inanspruchnahme von Gesundenuntersuchungen in Österreich im Jahr 2005. (September) Wien.

Hospiz Österreich (2007), *Datenerhebung 2007 von Hospiz Österreich.* http://www.hospiz.at/DBSQL/download/2007/Ergebnisse_Datenerhebung_2007.pdf

Huber, M. et al. (2009, forthcoming), *Long-term care for older people: Facts and Figures.*Occasional Papers. Vienna: European Centre for Social Welfare Policy and Research.

Impfplan 2009 Österreich
http://www.bmgfj.gv.at/cms/site/attachments/1/4/0/CH0780/CMS1038913010412/impfplan_2009_final.pdf

Kratschmar A. & H. Teuschl (2008), *Hospiz- und Palliativführer Österreich.* Wien: Bundespressedienst. http://www.hospiz.at/pdf_dl/Hospizfuehrer_2008.pdf

Leichsenring, K. /Ruppe, G. /Rodrigues, R. /Huber, M. (2009), *Long-term care and social services in Austria.* Unpublished working paper. Wien: European Centre for Social Welfare Policy and Research.

Mann, E. et al. (2004), Comprehensive Geriatric Assessment (CGA) in general practice: Results from a pilot study in Vorarlberg, Austria. *BMC Geriatrics* Vol.4:4

ÖBIG (2004), *Abgestufte Hospiz und Palliativversorgung in Österreich*. Wien: ÖBIG. (http://www.bmg.gv.at/cms/site/attachments/3/6/7/CH0716/CMS1103710970340/bericht_abgestufte_hospiz-_und_palliativversorgung.pdf)

ÖBIG (2008), *Leistungskatalog Pflege und Betreuung in Österreich*. Wien: ÖBIG.

ÖBIG (2009), *Österreichischer Strukturplan Gesundheit 2008. ÖSG 2008*. Wien: BMG.

OECD (2005), *Long-term care for older people.* Paris: OECD.

ÖGGG (2006), Basisassessment. An einem Strang ziehen. In *Geriatrie Praxis* Vol. 1 (http://www.medizin-medien.at/dynasite.cfm?dsmid=72613&dspaid=561354)

ÖGGG (2008), *Positionierung älterer Patienten im Gesundheitswesen. Strukturelle Voraussetzungen für die stationäre Geriatrie*. Medizin Medien Austria: Wien.

Österle, A. (2001), *Equity Choices and Long-Term Care Policies in Europe. Allocating Resources and Burdens in Austria, Italy, the Netherlands and the United Kingdom.* Aldershot: Ashgate.

PIK (2007), *Indirektes Entlassungsmanagement. Managementbericht*, Wien.
http://www.pik.or.at/fileadmin/user_upload/Management/Management_Summary_EM_2007_06_19.pdf
http://rehakompass.oebig.at/Images/prozess.gif

Rischanek U. (2008), 'Lebensformen und Wohnsituation der Hochbetagten in Österreich' in: BMSK (Hg) *Hochaltrigkeit in Österreich. Eine Bestandsaufnahme.* Wien: BMSK: 75-92.

Ruppe, G. (2006), '*Healthy Ageing' and its future. An exploratory study from Austria.* Master´s thesis. Amsterdam: UVA.

Schneider, U./Österle, A./Schober, C./Schober, D. (2006), *Die Kosten der Pflege in Österreich, Ausgabenstrukturen und Finanzierung. Forschungsbericht.* Wien: WU Wien/Institut für Sozialpolitik.

Wiener Sozialdienste (2009), *Mobil und Sicher zu Hause.* Wien: Wiener Sozialdienste.

Annex I

List of participants in the 1st Austrian NEP Meeting (29th of May, 2009)

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