interlinks

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

Developing and ensuring quality in LTC in Austria

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1 Introduction

Over the past decade, the quest for quality has gained momentum in the realm of the emerging Austrian LTC system. Following the introduction of the comprehensive LTC Allowance in 1993 (see Annex 1) it became obvious that both providers and purchasers of services had to search for mechanisms to define, monitor and ensure the quality of what they provided and purchased, respectively. However, the federal constitution, the arbitrary but strict division between health and social care (Ganner, 2008), the small size of municipalities and the long tradition of private non-profit providers, which are either affiliated to the political parties or religious organizations, continue to produce a mixed bag of regulations and standards throughout the country.

1.1 Structural preconditions for quality of long-term care

Regional governments, as the main purchasers/funders of services, had signed a state treaty with the Federal State to set up development plans for the LTC sector over a period of 15 years (1996-2011) with the aim to provide more equal provision across the country.[1] As the Constitutional Court had ruled out a federal framework law for care homes, the state treaty also stipulated that regional governments agreed to regulate the legal custody of residents as a specific matter, rather than just as a part of the social assistance law – with some regions still left to put up with this agreement. In the meantime, various regulations continue to persist in the nine regions:

- The minimum size of a single room in a care home must be 24 m^2 in Vorarlberg, 13.48 m^2 in Salzburg, 17-18 m^2 (without entrance) in Upper Austria, and 18 m^2 plus a bathroom of 4.2 m^2 in Carinthia (ÖBIG, 2004).
- Concerning the density of supply with places in care homes there are 153 places per 1,000 older people above 75 in Salzburg, 67 in Burgenland and 80.5 in Carinthia (ÖBIG, 2004).
- Care homes are generally funded by user contributions (pension + LTC allowance)[2] but residents in publicly authorised care homes may receive social assistance if these personal resources do not

[1] BGBl. Nr. 866/1993: Vereinbarung zwischen dem Bund und den Ländern gemäß Art. 15a B-VG über gemeinsame Maßnahmen des Bundes und der Länder für pflegebedürftige Personen.

[2] 10% of the pension and €44,30 (10% of LTC allowance level 3) remain as 'pocket-money' for the resident. As in Austria pensions are paid out 14 times a year, also the 13th and 14th payment of the pension insurance cannot be touched upon by third parties.

cover the price of a place in a care home which may vary between €1,500 an €5,700 per month according to the level of care needed.

- Similarly, very different regulations can be observed from region to region in relation to staffing ratios and the definition of "professional staff" – in Burgenland 50% of staff have to be registered nurses, but only 20% in Styria and Upper Austria, where so called "Altenfachbetreuer" (geriatric nursing assistants) are employed, a professional profile that does not exist in other regions (Schneider et al, 2006: 11). This situation is currently reformed by joint efforts of the Federal State and the regional governments.
- Also with respect to prices and user-contributions, huge differences and a lack of transparency prevail. For instance, in some regions such as Carinthia, family members are asked to contribute to fees, if the pension and LTC allowance of the resident do not suffice to pay for average monthly costs of about €2,200 for a place in a care home. However, respective regulations remain quite arbitrary, as the liability depends heavily on current expenses so that, in some cases, families with an average income had paid their due while wealthy families spent down and did not have to pay (RH Kärnten, 2008: 16).

Similar differences can be perceived in community care (home care), with diverse traditions and standards concerning structures, legal regulations, and resources. In all regions, however, the bulk of professional long-term care is provided by private non-profit providers of different size.

- In Vienna, about 25 providers are gathered under the roof of a municipal federation of providers, while in Lower Austria there are five larger non-profit providers covering the entire region.
- In Vienna, 21 professional carers (full-time equivalents) are registered per 1,000 older people above 75, in Upper Austria 6, and in Carinthia 9.5 (ÖBIG, 2004).
- In Carinthia, users of home care are charged €6 per hour of nursing home care if they receive LTC allowance plus a means-tested out-of-pocket contribution between 0 (income below €430/month) and about €26 (income above 2,200/month). Users of home help services are also charged according to their income between 0 and about €21 per hour, if their income is above 2,200/month. Providers receive between about €18 per hour for home help and about €56 for nursing home care (RH Kärnten, 2008: 10).
- In general, only persons with an entitlement for a LTC allowance will ask for services. In most regions the amount received will be considered, together with other income (pension etc.), to calculate an obligatory out-of pocket contribution, which is, on average about 1% of the calculated net personal income. As this calculation is relatively complicated, the Volkshilfe, one of the five non-profit providers in Lower Austria, provides a "price-calculator" for potential clients (http://www.preisrechner.at/index.php). For instance, a person with assessed care needs of level 3 (€442.90) and a net income (pension minus housing costs) of €1,200.00 would have to contribute €15.96 per service hour (€6/hour from his/her attendance allowance and €9.96 from his/her net income). This would cover between 30-50% of the actual costs but as many service users are paying less than in this example, the overall coverage of costs by users' out-of-pocket contributions is at about 25% (Leichsenring et al, 2009).
- In any case, persons with assessed care needs of level 3 (120 hours of care per month) would not be eligible to more than 60 (subsidised) service hours per month in Lower Austria. Similar regulations can be found in all Austrian regions with varying maximum contributions and subsidies.

Although general policies in Austria aim at keeping persons with LTC needs at home as long as possible, net expenditures by the regional governments for care homes (about €1 billion per year) still outrange those for home care and semi-residential care (about €330 million) by at least three times. Developmental plans by regional governments thus focus mainly on the quantitative extension of home care ser-

vices. Again, assumptions concerning actual needs are characterised by huge differences between individual regions. For instance, the projected density of supply with community care staff (full-time equivalents) for 2010 was defined with 7.2 per 1,000 inhabitants above 75 in Upper Austria, while the same indicator was set at 19.7 in Lower Austria and the Tyrol (ÖBIG, 2005: 19).

1.2 Structural preconditions for quality of health care

A completely different and separated discourse can be observed with respect to quality in health care settings. In the context of the 2004/2005 Health Reform, a specific Health Quality Act was adopted to promote a 'systematic quality approach' based on the principles of patient orientation, transparency, efficacy and efficiency (BGBl. I Nr. 179/2004). A nationwide quality system – defined as coordination, support and controlling system to continuously improve the quality of health care – is to be developed. The Federal Minister for Health may define quality standards and has been supported since 2006 by a purposely established 'Federal Institute for Quality in Health Care" (BIQG). The BIQG is part of the publicly owned "Gesundheit Austria GmbH" (Health Austria Ltd) with a research institute and a Health Promotion Fund as its other two branches.

This BIQG is also a member of the International Society for Quality in Health Care and is currently mainly working on standards for disease management (diabetes, dementia, Parkinson, discharge management) that will be presented in 2009/2010.[3]

Also in 2006, a Federal Health Care Agency (Bundesgesundheitsagentur, BGA), and similar agencies (Landesgesundheitsfonds, LGF) were established in each of Austria's nine regions. Key to this reform was to improve planning, controlling and financing of the health system by overcoming boundaries between the subdivisions within the health sector, and between the different stakeholders (social health Insurance agencies, regional governments, provider organisations). The federal health care agency is in charge of planning budgeting, the definition of quality and accounting standards, further development of remuneration systems and health promotion in all health care settings, including Primary Care. The regional health care funds should implement the guidelines on a regional level by pooling the financial resources from the social health insurance, the federal government and the regional hospital funds (Hofmarcher/Röhrling, 2006).

The different stakeholders on the regional level, including patients' and doctors' associations in an advisory role, meet regularly in the framework of so called "Health Platforms" (between 12 and 30 members) which are also to design, tender and select projects to improve the coordination of services between in-patient and out-patient services. Each regional health care fund has to earmark 2% of its funds, altogether about €260 million per year, to support these so-called "reform pool projects". These projects mainly aim at shifting service provision and financial resources from hospital to primary care and/or to improve management and coordination with respect to defined diseases. For instance,[4]

- to improve the allocation of stroke patients to reduce long-term consequences (Vienna, Upper Austria, Styria),

[3] http://www.goeg.at/de/Bereich/Metaleitlinie-Bundesqualitaetsleitlinien.html

[4] See Hofmarcher et al, 2007 for details.

- to improve the management of hospital discharges by strengthening patients' interests and the availability of information (Vienna, Lower Austria, Styria),
- to implement an effective, region-wide hospice and palliative care program (Lower Austria, Styria),
- to provide training courses and develop disease management for patients with Diabetes Mellitus Type 2 and insulin-dependent diabetes patients (Vienna, Carinthia, Upper Austria, Tyrol, Salzburg).

Most of the projects are still ongoing. As a matter of fact, the 2005 Health Care Reform is a good example for the negligence of the long-term care sector when it comes to debates and reform activities. Stakeholders of social care are only marginally represented in the Health Platforms, usually by the regional Social Assistance departments, and although the aim of optimising management and coordination at the interfaces between different care providers has been an explicit goal of the reform, long-term care facilities, be they residential or in community care settings, have not been considered as relevant stakeholders to be involved. Resources might thus be shifted within the health care sector, but potential consequences can easily effect the still fragile area of long-term care services. For instance, if clients with heavier workloads are discharged ever earlier from hospital to their own home, it is still not possible to receive more than 3 hours of home care services per day at a subsidised tariff. Even for a shorter period, e.g. at the start of the care programme to regain a certain degree of independence, there is no room for flexibility in the regional governments' guidelines – most regional governments restrict funding to a ceiling of between 60 and 100 hours of care per client and month. Additional hours would have to be paid the full price which is between €30 and €60 per hour.

It is thus not surprising that civil society has developed strategies to circumvent the increasing care gap for people who need between four and 24 hours of care per day. Given the vicinity of Austria to neighbouring Central European Countries with lower wage levels – the Slovak boarder, for instance, is only 50 km East of Vienna – the Austrian way of solving shortages in family care has developed over the past 15 years in the form of paying for undocumented informal carers on a "grey market". The so-called 24-hours assistance by migrant carers, usually from neighbouring countries in the East, has been a response of many families to the lack of responsive and affordable public services. In 2006, there were about 20,000 migrant women working in Austria and the public debate about "illegal carers" was growing (Prochazkova/Schmid, 2006) so that new regulations were developed, which will be outlined below (Section 5).

The above factors have contributed to a gradual rethinking process concerning quality also in the realm of long-term care services – both among the providers and by the legislating and funding bodies. This report will address some consequences of that process with a focus on the following issues at stake:

- The introduction of quality management mechanisms on the provider level,
- The request for "service charters" and/or quality management systems as an important criterion for the authorization of residential care providers on behalf of regional governments,
- The improvement of the quality of needs assessment procedures (LTC allowance) and information of claimants,
- Quality concerns in relation to "migrant carers" and family care.

2 Mechanisms to assess and ensure quality in LTC in Austria

2.1 Authorisation and accreditation

As authorisation of social and health care services we understand the right to deliver defined services in a specific region. Accreditation means that these services are acknowledged according to statutory requirements and thus have access to financial support by public authorities. In Austria, there is no specific distinction between authorisation and accreditation as, by tradition, most care homes are run by either public or quasi-public providers. Private for-profit or non-profit providers may, however, decide not to apply for public funding, i.e. their residents would have to cover all costs by own resources. Nevertheless, also these care homes have to comply with general legal guidelines. All other care homes are co-financed by public authorities – in most regions on the basis of generally defined 'daily care rates', in some regions providers may negotiate these daily rates on an individual basis. Furthermore, investment costs can be subsidised by public construction funds.

Care homes can only be constructed in accordance with local or regional authorities' development plans. Only a few regional regulations have stipulated an upper limit of places per care home: e.g. in Upper Austria no more than 120 places per care home are allowed (since 2002; OÖ LGBl Nr. 29/1996).

In Carinthia, when a regulation for care homes had been eventually approved in 2005, an upper limit of 50 places per care home was decided. However, the regulation is currently under discussion as providers sustain that, below 70 places, care homes would not be economically viable.

There are no purposely defined accreditation mechanisms for care homes in Austria, unless general structural quality requirements defined in the different regional legal regulations for care homes. As an example for these differences, Table 1 provides an overview of regional regulations.

For instance, in Carinthia, there has to be 1 full-time equivalent care professional for each 2.4 residents, in the Burgenland there are individual calculations taking into account the care needs and the number of residents. In most other regions the staff ratio depends on the level of care needs but with very different standards: for instance, for residents with intermediate care needs (level 3), in Lower Austria there has to be 1 full-time equivalent staff per 10 residents, in Upper Austria and Styria the same ratio is 1:3, while in Vienna it is 1:2.

However, over the past few years process quality criteria have been introduced and/or added in most regions. For instance, the Viennese Care Home Act (WWPG, LGBl. für Wien Nr. 15/2005) calls for a proper care documentation and quality management to provide care that complies with the scientific state of the art and measures to improve structural, process and outcome quality. Also in the Tyrol (LGBl. 23/2005) documentation and a service charter as well as quality management are stipulated by law.

In community care, which has emerged from initiatives by private non-profit organisations since the late 1970s, specific regulations are lacking in most regions. In Vienna, providers of community care services, which are increasingly offering both nursing home care and home help services, have to adhere to the 'Umbrella Organisation of Viennese Health and Social Care Services' which stipulates procedures and structural prerequisites for the coordination of meanwhile more than 25 different providers (Ertl/Schrems, 2001).

The regional government of Salzburg introduced its "Care Act" in 2000 and remains the only Austrian region that regulates both home care and residential care in one law. The Care Act defined minimum

standards for home care, semi-residential and residential care facilities, thus creating the basis for an integrated quality assurance. Special emphasis is given to the rights of users and clients in terms of privacy, personal rights[5] and care documentation.

Table 1 Staffing ratio and staffing structure in Austrian residential care facilities by region

Region	*Staffing ratio*	*Staffing structure*	*Comments*
	Nursing home (ward)		
Burgenland	Specific model, depending on number of places, weekly hours, day/night-shift etc.	50% Registered Nurses 50% Assistant Nurses	
Carinthia	1 FTE : 2.4 residents	40% Registered Nurses, 50% Assistant Nurses, 10% others (trainees)	1:12 in units without nursing care needs, but at least 2 Registered Nurses
Lower Austria	Depending on residents' level of care needs, e.g. Level 1 (lowest): 1:20; Level 3: 1:10, Level 7 (highest): 1:1.4	45% Registered Nurses, 55% Assistant Nurses	
Upper Austria	Depending on residents' level of care needs, e.g. Level 1 (lowest): 1:24; Level 3: 1:4, Level 7 (highest): 1:1.5	20% Registered Nurses, 50% Geriatric Assistant Nurses (Altenfachbetreuer); 30% Geriatric Assistants (Altenbetreuer)	No differentiation between nursing ward and units without nursing
Styria	Depending on residents' level of care needs, e.g. Level 1 (lowest): 1:12; Level 3: 1:4, Level 7 (highest): 1:2	20% Registered Nurses, 60% Assistant Nurses/Geriatric Assistants; 20% others	
The Tyrol	Day-time: depending on residents' level of care needs, e.g. Level 1 (lowest): 1:10; Level 3: 1:3, Level 7 (highest): 1:1.9 Night-time: 2.75-3.2 staff per 30 residents with at least Level 3 care needs.		In units with residents without care needs: 1 FTE : 50 residents
Vienna	Depending on residents' level of care needs, e.g. Level 1 (lowest): 1:20; Level 3: 1:2, Level 7 (highest): 1:1	40% Registered Nurses, 45% Assistant Nurses; 15% Home helpers	

Source: adapted from Riess et al, 2007: Annex (Table A6).

[5] Regulations concerning issues of 'residents rights' were eventually regulated in 2004/2005 by the federal "Heimvertragsgesetz" which regulates minimum standards for contracts between residents and care home providers, and the "Heimaufenthaltsgesetz" which stipulates procedures and principles concerning the restriction of freedom (physical and medical restraints) for residents and patients in all types of residential care facilities, including care homes for older people, for people with disabilities and patients in hospitals (Barth/Engel, 2004).

2.2 Inspection

Based on the different legislation concerning residential care homes for older people, each region has an inspection body that is usually a department of the regional administration. Given that most care homes are provided by public or quasi-public providers, the inspection body is thus often part of the very same administration, rather than a third party. An effective supervision has thus not always been given. In Lower Austria, inspections have even been foreseen exclusively for those care homes that are not publicly provided (Ganner, 2000). In general, care home inspection does not seem to have been carried out systematically and according to defined guidelines (Steiermärkischer Landtag, 2002).

In Vienna, this situation gave rise to the development of new supervision and control structures. With the Viennese Act on Care Homes (Wiener Wohn- und Pflegeheimgesetz, LGBl. für Wien Nr. 15/2005), the Viennese Care Home Commission was installed to support the public administration and the Viennese Patient Advocacy. While the public inspection agency assess care concepts of care homes as against the legal regulations and state of the art in care science, the Care Home Commission base their assessment on appraisal interviews during regular consultations with residents in care homes, complaints of residents and their cooperation with the Patient Advocacy. The Care Home Commission may consult the regional administration concerning care quality and the rights of residents (Wiener Heimkommission, 2008).

In this context, the development of quality improvement (disease management), quality management, training for a better management of hospital discharges, the spreading out of small housing units, and the establishment of a university chair for geriatric medicine – geriatrics as a specialisation has not yet been established at Austrian medical faculties – were promoted.

2.3 Certification of quality management, including third party audits

Legal requirements but also the intrinsic interest of provider organisations to assess and improve their quality have triggered a growing interest in quality management systems both in health and social care settings. While the hospital sector relied mainly on ISO 9001ff, EFQM and a specific system developed in Germany for hospitals, called KTQ (http://www.ktq.de; Möller, 2001), also some care homes and home care providers (e.g. Volkshilfe Steiermark; Red Cross Vienna) apply ISO or EFQM, in particular by its adapted version called QAP (www.freyakademie.com/QAP.htm; Leopoldt/Steinmetz-Ehrt, 1998).

Since 2006, an increasing number of care homes in Austria are working with E-Qalin, a quality management system that was developed during a Leonardo da Vinci project by a consortium of partners from Austria, Germany, Italy, Luxembourg and Slovenia. This model combines classical quality management instruments with organisational development and adequate learning and training methods as a potential starting point for the empowerment and involvement of staff and other stakeholders to participate in the enhancement of processes and results of services (www.e-qalin.net). By 2009, also a version for home care services will be available.

In 2006, representatives of ISO 9001, EFQM (QAP) and E-Qalin were invited by the Federal Ministry of Social Security, Generations and Consumer Protection into a working group with the umbrella organisation of care home managers and representatives of the responsible departments of the regional governments to develop a framework for external audits of care homes. This working group established a framework for the application of a National Quality Certificate (NQZ) which can be obtained by care homes through an external audit. Based on existing standards, quality management systems and seals of

approval selected standards of structural, process and result quality were successfully tested with 14 care homes so that the first national quality certificates were assigned in March 2009.[6]

2.4 General measures for quality improvement in long-term care

Since the introduction of the LTC allowance and respective state treaties with the regional governments, the following measures have been implemented to improve quality in the realm of long-term care over the past 15 years:

- Regional 'Needs and developmental plans' had been set up by the regional governments between 1995 and 1998 with objectives to be met by 2010: Though these plans were quite diverse in terms of methodologies and contents, this was a first step towards LTC planning in Austria. As most plans started from quite poor baseline data and rudimentary assumptions, they are mostly outdated and have in many cases been overtaken by events. New efforts in terms of ongoing planning to develop up-to-date approaches have been proposed by a study about interim results as huge gaps between planned needs and realised services still persist, in particular with respect to the extension of home care services, respite care and coordination structures (Schaffenberger/Pochobradsky, 2004).
- Since 2004, LTC services in the community have further increased in terms of hours provided (about +23%) and in terms of additional employment – between 2003 and 2006 employment in home care services has augmented by a further 36%; in residential care, where the substantial transformation of places in old-age homes into nursing wards has continued, by 7% (BMSK, 2007; 2008b). Table 2 shows the development in home care since the introduction of the LTC Allowance to 2007.
- Notwithstanding the existence of a toll-free telephone number for all questions concerning long-term care, a pilot study entitled 'Quality Assurance in Social Care' (Nemeth/Pochobradsky, 2002) and a report on the situation of family carers (Pochobradsky et al, 2005) had yet once more revealed the lack of information and counselling for family members. As a consequence, pilot projects were implemented to improve this situation by offering "counselling cheques" to each applicant for LTC allowance (Schober et al, 2007).
- Improvements for family carers with relatives suffering from dementia: A project to financially and organisationally support respite care for carers of relatives with dementia was initiated in 2007, and a "dementia handbook" was published in 2008 (http://www.pflegedaheim.at).

Further efforts for short- and long-term improvements were prepared by a working group of the Ministry for Social Affairs and Consumer Protection since 2007. First results, apart from a nominal increase of LTC allowance by 4-6%, were implemented by an amendment of the LTC Allowance Act that came into force on 1 January 2009 (BMSK, 2009a):

- Improvement of needs assessment for children and youth with a severe disability, and for people suffering from dementia – for instance, based on a medical diagnosis, additional care needs will be acknowledged to an extent of 25 hours per month for people with mental health problems and learning disabilities.
- Support for family carers of persons with assessed care needs of level 3 and for carers of persons suffering from dementia from level 1.

[6] http://www.lebensweltheim.at/cms/dv/index.php?option=com_content&task=view&id=80; http://www.prosenectute.at/index.php?module=announce&ANN_user_op=view&ANN_id=32; see also Scholta, 2008.

Table 2 Development of service hours provided in home care (1), mid-1990s to 2007

Region	*mid 1990s*	*2000*	*2007*	*Difference 2000 - 2007*		*Average hours per citizen 75+ (4)*
Burgenland	150,136	204,484	271,480	66,996	32.8%	10.2
Carinthia	447,329	540,860	799,130	258,270	47.8%	16.0
Lower Austria (2)	1,643,582	2,838,208	3,411,904	573,696	20.2%	25.8
Upper Austria	543,506	794,002	1,322,010	528,008	66.5%	12.1
Salzburg (3)	687,481	805,454	661,059	-144,395	-17.9%	17.7
Styria	586,038	857,435	858,604	1,169	0.1%	8.1
Tyrol	124,250	298,776	565,332	266,556	89.2%	11.6
Vorarlberg	105,000	235,443	426,243	190,800	81.0%	18.3
Vienna	4,330,422	4,017,591	4,669,386	651,795	16.2%	36.2
Austria	*8,617,744*	*10,592,253*	*12,985,148*	*2,392,895*	*22.6%*	19.6

Sources and notes: BMSK, 2008a; Statistik Austria; own calculations. (1) data include service hours for home help, home nursing, geriatric aide in most provinces; in some provinces home help only was reported. (2) Beneficiaries of LTC allowances only. (3) In 2001, the Regional Government of Salzburg introduced a new way of calculating tariffs and hourly rates (earlier data are thus not comparable); (4) Average number of service hours provided in 2007 per citizen above 75 years of age.

3 Contents of quality assurance mechanisms

Data on outcomes of quality assurance and quality development in LTC are not available in Austria. As of today, there are no incentives, not to speak of obligations, to publish inspection reports and/or results of self-assessment processes or audits by third parties. Thus, in the following, some general results of audits and public commissions will be outlined, followed by a general description of selected quality management systems.

3.1 Public audits and reports

While reports from the different regional inspection agencies (Heimaufsicht) generally remain disclosed, some regional audit commissions (Landes-Rechnungshöfe) have audited individual public care homes (Steiermärkischer Landtag/Landesrechnungshof, 2002) and/or the social care sector for older people (Rechnungshof Kärnten, 2008), mainly for their organisational efficacy, economic viability and accountability.

Also the Viennese "Care Home Commission" should be mentioned in this context as it started to influence the LTC sector by means of recommendations, studies and model projects derived from expert knowledge and direct contact with residents and their families. For instance, the following recommendations led to tangible improvements:

- Trainings for discharge management between hospitals and care homes have been established and discharge managers have been employed.
- A further extension of supply with small housing units for people with dementia has taken place.
- Disease management and care pathways for selected diseases are being developed and first results have been implemented.
- For the first time, social workers have been employed by care homes (sic!).

3.2 Quality management systems

3.2.1 ISO, EFQM and others

Since the mid-1990s, classical quality management systems have found their way also into health and social care provision. As a soft indicator for these developments in the health sector it should be mentioned that, in 2009, the third "qualityaustria Health Forum" will be organised (www.qualityaustria.com). The introduction of such systems, however, is still dependent on individual initiatives. Their results and reports are usually subject to disclosure.

3.2.2 An example of good practice:[7] The E-Qalin® model

E-Qalin supports initiatives to map the reality in residential care facilities by inviting representatives of all stakeholders to assess and improve 66 "enabling" criteria (structures & processes) and 25 key-performance indicators (results) from five different perspectives (residents, staff, management, social environment, and "learning organisation"). The assessment areas "structures & processes" and "results" are equally weighted (50% + 50%) to express the quantitative result of the self-assessment process in percentage points.

Following this self-assessment process, partly in small professional groups, partly in a core group, a list of mutually agreed improvement projects should guarantee enhanced services and further involvement of stakeholders. A key-word and key-value of the model is "involvement" because participation of relevant actors in planning, implementing, monitoring and improving – the classical PDCA cycle (plan-do-check-act) of quality management – is considered an explicit asset and reflected in the result of the assessment.

E-Qalin seeks to enable relevant stakeholders by means of specific training modules to enhance communication, social competence and systems-thinking within the organisation. These skills are particularly important in this sector as staff are working in a surrounding which is more than any other personal service dealing with the confrontation between lifeworld and political/economic subsystems, and thus between public and private. Trainings are focusing, among other, on the following aspects:

- E-Qalin process managers are trained to guide the self-assessment process within the care home, to set-up a steering group with representatives of all stakeholders and to coordinate specialist services groups.
- Group moderators are trained to facilitate these specialist services groups with the aim to assess criteria from a user and staff perspective involving residents or representatives of family members and, if adequate, also other external stakeholders.
- Shared learning is supported to develop key performance indicators, mainly by management staff, and respective tools to make results, including social accountability and sustainability, visible to internal and external stakeholders.

The experience showed that only few managers and staff in care homes are used to work with this kind of tools, in particular with controlling and results-oriented indicators. With the introduction of E-Qalin, a rising number of care homes in Austria have learned to identify key-performance indicators and to use these as a tool for strategic management and steering processes.

The E-Qalin model does not prescribe key-performance indicators to be chosen but the E-Qalin® manual supports applicants by providing examples used by other care homes for the various themes or domains. While in the area "Structures & Processes" the assessment of individual criteria follows the classical PDCA cycle (plan-do-check-act) of quality management (plus INVOLVEMENT), KPI in the area of "results" are assessed and analysed with respect to their tendency and the way they are used to steer quality and to implement measures for achieving defined targets.

[7] As the author has participated in the development of this model, it will be left up to other colleagues to assess the extent to which E-Qalin represents 'good practice'.

As a corollary it should be underlined that the self-assessment process both with respect to "structures & processes" and with a view on "results" will always result in a list of steering measures and measures for enhancement which help staff, management and other stakeholders in care homes to improve their performance and make change visible both internally and externally.

An evaluation study with participating pilot care homes (9 in Austria, 6 in Germany, 6 in Luxembourg, 2 in Italy, 6 in Slovenia) showed that, for the huge majority, E-Qalin helps to identify and analyse shortcomings, to develop new solutions and to implement improvement projects (Rosenbaum/Schlüter, 2007).

In Austria, there are currently about 100 care homes that have started to apply the E-Qalin model. In one region (Lower Austria) care homes are required and supported (costs for training of staff) by regional by-laws to introduce this model. In the future, it is foreseen to regularly organise events for applicants to exchange experiences and to compare results in a public forum.

3.3 Other indicators for change (for the better?)

3.3.1 Research

After an early evaluation study that showed broad satisfaction of recipients of the newly introduced LTC Allowance (Badelt et al, 1997), a survey on the situation of caring relatives (Pochobradsky et al, 2005) covered a random sample of 3,417 recipients of LTC Allowance who were contacted by letter and asked to forward an attached written questionnaire to their main carer. 1,151 carers (33.7%) responded and returned the questionnaire. The study is thus quite representative and allows for specific information on carers of persons receiving LTC Allowance.

One interesting result, among others, that should not be underestimated in the Austrian context of a "rurally ageing" country, is the significantly different take-up rate of services in rural and urban areas, which is partly due to the lack of services and different organisational concepts (Table 3). More than 70% of all carers reported that they did not make use of any home care services. As reasons for the non take-up, carers of beneficiaries of LTC Allowance mentioned the lack of availability (12.2% in rural areas), financial reasons (about 40% both in rural and urban areas), lack of information (about 13%), discontent with services (7.4% in urban areas, 2% in rural areas) or a general rejection of these services (45% in rural, 53% in urban areas) (Pochobradsky et al, 2005: 33).

Table 3 Take-up rates of community care services in rural and urban areas of Austria (2005)

	Pochobradsky et al, 2005			Badelt et al, 1997
	Rural area	Urban area	Total 2005	Total 1997
Home nursing care	51.0%	32.9%	46%	20%
Home help	32.3%	51.8%	38%	34%
Visiting services	6.1%	4.7%	6%	29%
Meals-on-wheels	28.3%	34.1%	30%	12%
Transport services	13.6%	22.4%	16%	47%
Therapies	18.2%	10.6%	16%	16%

Source: Pochobradsky et al, 2005: Annex (Tables 54, 55 and 76); Badelt et al, 1997: 264; own calculations. In both studies, multiple answers of family carers of beneficiaries of the LTC Allowance were surveyed by a written questionnaire. Percentages thus refer only to the multiple answers of those respondents who were making use of community care services.

Though data of the above mentioned studies may not be completely comparable, the results reflect the already mentioned increasing professionalization and utilisation of home nursing care services (see Table 2) but they also suggest that important 'soft' services such as visiting and transport are on the decline. The latter may be partly explained by the fact that these services, before the introduction of the LTC Allowance were provided free of charge (often by volunteers), in particular in Vienna. Further research is needed in particular on those beneficiaries of LTC Allowance who do not receive services, and on the need for specialised services to support people in need of LTC and their carers.

3.3.2 Monitoring

The Ministry for Social Affairs and Consumer Protection regularly gathers relevant stakeholders in a 'Working Group on long-term care' to monitor the development which is reported on a yearly basis (BMSK, 2008a). Data provided by the regional governments and the Social Insurance Agencies include the number of places in care homes, the number of service hours provided, prices (daily rates, hourly rates) of services, the number and type of staff employed but no specific quality indicators concerning the continuity of care, cultural diversity, care workers' satisfaction or satisfaction of beneficiaries and their family members.

3.3.3 Education, training and professionalisation of staff

An important step towards more transparent and cohesive professional structures in the area of LTC was the state treaty between the Federal State and the regional governments concerning social care professions, which was eventually signed in 2005 (Bundesgesetzblatt Nr. 55/2005). The regional governments thus strive towards a comprehensive, modular education system for Social Carers ("Altenfachbetreuer/in") with 1,200 hours of training and another 1,200 hours of practice, and Social Carerers with a diploma ("Diplomierte Sozialfachbetreuer/in") with 1,800 hours of training and another 1,800 hours of practice. Home helpers should receive 200 hours of training and 200 hours of practice. This regulation aims at enhancing quality both for the users and for staff in the areas of care for older people, people with disabilities, family care and home help (Rubisch, 2003).

Furthermore, training courses for "Quality Management in Health Care" and a university course on "Care Management" have been established at several Universities of Applied Sciences in Austria (see, for instance, www.pflege.noe-lak.at).

In 2006, a first effort was made to provide an inventory of the nursing care sector in Austria by means of an "Austrian Nursing Care Report" with an update in 2007. First data were collected with respect to the 60,000 to 80,000 people, mainly women, who work in hospitals, in the community, in nursing homes and other settings according to the Health and Nursing Care Act. Still, exact data are missing as a concept for a systematic central register has only just been proposed. One of the most striking results of the 2007 Report was the evidence of almost daily breaches of professional competences. About 80% of assistant nurses carry out at least one activity defined by law as being an exclusive competence of registered nurses. This percentage is particularly elevated in care homes (Riess et al, 2007).

Another indicator for the need of modernising 'nursing care' in Austria – where a first University Chair for Nursing had just been installed in 1999 – is the fact that in many care settings the practice of functional nursing (sometimes by rooms or teams) is still prevailing over primary nursing[8]. Only 27% of responding nurses in care homes and only 23% of nurses in hospitals are working according to primary nursing principles (Riess et al, 2007: 45-46).

3.3.4 Incentives and sanctions to measure, ensure and/or improve quality: Who needs and applies quality indicators?

It has become obvious at this point that quality has only just started to become an issue in long-term care services in Austria. Certainly, quality work has always been part and parcel of professional ethics in health and social care but the idea to systematically assess and measure structural, process and outcome oriented quality of care is far from being common practice. With the introduction of more competition and market-led mechanisms of governing health and social care, particularly public purchasers of these services but also users/patients have expressed a growing interest in getting information about the contents and outputs/results of what they are purchasing or consuming. Furthermore, public authorities seem to slowly move from pure inspection (quality assurance) approaches towards self-assessment and third party certification (Leichsenring, 2008). As these trends have yet only marginally affected the Austrian LTC market, corresponding incentives for providers are – as of to date – relatively weak. For some private commercial and non-profit providers trying to enter the relatively closed market of care homes in Austria, quality management and quality certificates are certainly one way to increase trust of purchasers and potential residents.

With a growing number of regional Care Home Acts that explicitly require decently trained management staff and quality management mechanisms in place, a more powerful lever to introduce quality management has been established. It remains to be seen, however, in which way this requirement will be

[8] Primary nursing is "a system for the distribution of nursing care in which care of one patient is managed for the entire 24-hour day by one nurse who directs and coordinates nurses and other personnel; schedules all tests, procedures, and daily activities for that patient; and cares for that patient personally when on duty. (…) Some advantages are continuity of care for the patient; accountability of the nurse for that care; patient-centered care that is comprehensive, individualized, and coordinated; and the professional satisfaction of the nurse" (http://medical-dictionary.thefreedictionary.com).

fulfilled, whether it will be complemented by financial incentives and which improvements will follow from the chosen mechanisms.

Another incentive for LTC organisations to increase the transparency of their services might be growing competition between different care settings. For instance, if care homes are facing growing difficulties to occupy vacant places and/or vacant jobs – which is the case in some Austrian regions already – or if care homes are closed down due to not being able to satisfy the relatively low minimum standards concerning safety and hygiene – which recently happened in the region of Styria.

3.4 How financially sustainable are the approaches being adopted?

Quality (management) costs: during its introduction (training of staff, consultancy), for its maintenance (working-time of staff involved, costs for third-party audits and certification) and for potential improvement measures derived from assessing structures, processes and results. These costs are relatively marginal, compared to those of some doubtful structural expenditures which occur in particular in care homes or considering the costs of a care home closure. In addition, costs for quality improvement certainly include a potential for reducing costs in a mid- and long-term perspective.

In the Austrian LTC realm these issues have only just started to be debated. In a recently published 500-pages report about the 'fourth age in Austria' (BMSK, 2008c) that covers the whole range of issues in relation to higher old age, quality management is addressed in two paragraphs only. The question is, therefore, whether cost containment strategies by the general budget policy will trigger or further hamper investments in quality and quality management.

3.5 Cultural diversity: an issue in quality management?

Since Austria has realised to have become an immigration country, and formerly called 'guest-workers' have now arrived at their second and third generation, also issues concerning care for older immigrants have gained momentum. In 2002, 1.5% of the about 700,000 foreign-born citizens living in Austria were above the age of 75. Most of them could still rely on a broad network of family members, none of them ever used community care services.

The availability of family care and existing access barriers are the main reasons for this situation which, however, will certainly change during the coming years – at least 30% could at least imagine to use social services as reported by an early survey (Reinprecht; 1999; see also Kremla et al, 2004 and Rappold et al, 2008: 383; Reinprecht, 2008) so that corresponding mechanisms and new orientations and training in intercultural care competences will have to be developed, in particular in urban areas.

4 Quality and informal care

4.1 The general debate on family and informal care

Since the introduction of the LTC Allowance, time and again some stakeholders argue that, with the distribution of cash benefits to people in need of LTC, incentives for using the money 'incorrectly' and/or 'to buy a bike for the nephew' have been established. Furthermore, family carers would certainly not be able to provide the quality of care persons in need of LTC would need.

Given the facts that 70-80% of care are provided by family, given that services would not be able to cover all care needs and considering that costs for care services would be much more elevated, the Austrian legislator opted for cash benefits as 'a contribution to care-related additional costs for people with long-term care needs'. Thus a 'correct' use of the benefit had not been legally defined and it is up to the beneficiary and/or his/her family to decide how to use the allowance which contributes about €3-4 per assessed hour of care needs.

A pilot study about "Quality Assurance in (Family) Care" provided remarkable results with respect to the quality of family care. During 2001 nine Registered Nurses visited a random-sample of about 950 beneficiaries of LTC Allowance in their homes to assess the quality of care. The result was that 77% of all cases good or even excellent care was provided by the family carers, in 20% some hygiene problems were remarked, though the general impression was still good, while only with 3% insufficient care or assistance were diagnosed (Nemeth/Pochobradsky, 2002: 21). Although one could critically refer to some methodological problems (announced visit, 10% refusals), the study showed impressively that the general quality of care in families is more than satisfying.

Nevertheless, additional support for family carers (information and counselling, training, respite), and for professional carers who sometimes are confronted with situations of abuse or maltreatment (training, defined procedures) is certainly necessary (Austrian Red Cross, 2009; Nemeth/Pochobradsky, 2002).

4.2 Training and counselling for family carers

Many of the non-profit providers of community care services have provided training courses during which for family carers are provided basic hints and technical support for caring at home .

Since 2006, a pilot project is trying to improve the information base for people with care needs and their families, an issue that has been well-documented as one of the major problems for family carers. 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. In a first wave, the voucher was sent to beneficiaries together with the notification about the positive decision concerning their application – as this notification often arrives only several months after the LTC needs have started to occur, the take-up rate was very low as most beneficiaries and their families had got organised already (Schober et al, 2007). In a second wave (2008-2009), the voucher has been sent to applicants immediately after their application had arrived at the Social Pension Insurance Agency dealing with the case – evaluations are ongoing but it goes without saying that information and counselling should be provided as soon as possible, ideally before LTC needs occur.

4.3 Social security for family carers

With an amendment to the comprehensive LTC Allowance Act, in 1998 family carers became entitled to enhanced social security protection. Family carers who had given up regular employment to care for a close relative with care needs above level 4 were invited to access the social pension insurance system by paying contributions in analogy to employees, while the federal state took over the fictitious employer's contribution (Rudda, 1998). As this opportunity was still quite expensive for carers at working age who did not have another (employment-based) pension insurance, only about 700 carers made use of this regulation.

Following recent amendments (BGBl. Nr. 132/2005; SRÄG, 2007) this regulation has become more attractive for caring relatives. For carers caring for a family member receiving at least level 4 of the LTC Allowance, since 2007, central government (Ministry of Social Affairs and Consumer Protection) pay not only the fictitious employer's contribution but also 50% of the pension insurance contribution, from level 5 even the total contribution for a maximum of 48 months. In all other cases the contribution for self-insured carers is (on a contribution basis fixed at about €1,450 per month) about €140 per month (BMSK, 2009a). It is expected that, by 2010, about 6,800 carers will have joined this scheme, with respective costs of about €25 Mio.[9]

4.4 Migrants as informal (illegal) carers

Another feature of the Austrian LTC realm is the important role of migrant (informal) carers who tend to fill the gap between a reduced availability of (female) family carers and the lack of LTC services. These carers arrive with tourist visa from neighbouring CEE countries but often without a work permit. They neither are covered by social protection in Austria. Specialised agencies in Austria, the Czech Republic and the Slovak Republic are organising these carers, whose training status is not well documented – most of their support consists in household chores and attendance. They generally remain 14 days with the person they care for before being replaced by a colleague and returning for their next turn 14 days later. Their costs are about €40 - €60 per day. Obviously, this practice violated a range of legal regulations, reaching from labour and social security law to regulations concerning the employment of migrant workers (Prochazkova/Schmid, 2006).

The main effort for supporting informal care during the past four years was thus put on the formalisation and respective amendments to legalise 24-hours care by migrant carers and family carers (see Annex 2). With the new "Home Assistance Act" some legal aspects of this kind of assistance have been resolved but a number of organisational, educational and ethical questions remain to be solved. For instance, the coordination between "24-hours assistants" and formal care services remains a critical issue as well as quality concerns, linked to the fact that "24-hours assistants" and their activities are difficult to control. Other concerns are that this kind of assistance is now legally based on working conditions that are much below usual standards: "24-hours assistants" are legally allowed to work 128 hours within 14 days with additional hours of attendance that are not counted as working time but have to be spent at the work place, i.e. at the home of the client (BMSK, 2009b).

[9] In a short-term perspective contributions will figure as additional income for the pension insurance. In the long-run, however, additional costs will occur to the pension insurance, once these carers will be eligible for pension payments. These costs are currently being estimated at about the double amount of current income (77 der Beilagen XXIII. GP – Regierungsvorlage: 7)

5 A brief evaluation of quality management in Austria

Some efforts have been made over the past few years concerning the development of quality management and the creation of preconditions to further improve quality in LTC. These initiatives include legal regulations at the federal and regional levels, e.g. Regional Care Home Acts, the Federal law concerning restraints and rights of patients and residents, a unification of education pathways in social care as well as institutional reforms such as the creation of the "Gesundheit Österreich GmbH" with its three branches: the Federal Institute for Health Research, the Federal Institute for Quality in Health Care and the Federal Fund for Health Promotion. The regional governments carry forward a constant expansion of community care as well as the transformation of residential housing places into long-term nursing units. Some regional governments have intensified their programmes to develop new forms of housing such as, for instance, service flats and intergenerational living arrangements.

Concerning the move from inspection to quality management, as a first step, a National Quality Certificate (NQZ) for care homes has been developed, tested and evaluated. This initiative could certainly constitute an additional incentive for care homes to introduce quality management but final political decisions to legally underpin the NQZ are pending. Such a move would be important to support bottom-up initiatives by individual providers.

These scenarios are still taking place in clearly distinguished health care and LTC 'silos', with lacking coordination mechanisms between LTC and health care, health care reforms that do not even consider LTC stakeholders as relevant stakeholders, and only half-hearted projects promoting a dialogue between the two sectors.

It is therefore most likely that efforts with respect to disease management and expert standards on health care, including discharge management, will carry on with a number of similar projects in different regions and/or by different providers, while standards in LTC will improve slowly by the introduction of different quality management systems, mainly pushed by the most 'enlightened' providers and managers. Inter-agency working, cooperation between community care and care home providers, the provision of integrated care packages, not to speak of continuity of care between hospital in-patient care and community care will thus remain wishful thinking for the near future.

Older people in need of LTC and their carers, however, have already chosen – in order to overcome persistent care gaps they prefer (or are forced to) the establishment of paid informal care relationships with doubtful consequences in terms of accountability, social security, labour law and the quality of care both for the 'self-employed' migrant carers and for the employers in need of care. It remains to be seen whether this type of care can be further integrated into community care services towards a regulated type of 'personal assistance' (Sweden as a model?), with equal rights and minimum standards for employers and employed persons.

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Annex I

The Austrian LTC Allowance

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 level of allowances (Table A1) depends on a medical assessment in which a specialized 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. There is a right of appeal against decisions to the Labour and Social Tribunal.

Table A1 The Austrian LTC Allowance

Level	*Care needs per month*	*Amount in € per month (1)*	*Beneficiaries (2)*	*Beneficiaries in % per level*
I	> 50 hours	€ 154.20	71,967	20.1%
II	> 75 hours	€ 284.30	125,686	35.1%
III	> 120 hours	€ 442.90	62,312	17.4%
IV	> 180 hours	€ 664.30	52,874	14.7%
V	> 180 hours of heavy care	€ 902.30	29,386	8.2%
VI	> 180 hours of constant attendance	€ 1,242.00	9,952	2.8%
VII	> 180 hours of care in combination with complete immobility	€ 1,655.80	6,369	1.8%
Total number of beneficiaries			358.546	100.0%

Source: BMSK, 2009a (www.bmsk.gv.at); own calculations.– (1) values as paid by 1/1/2009. (2) Given the different administrative entities on the federal and the provincial levels that are responsible for the comprehensive long-term care allowance, comprehensive data are only partially available. This table combines beneficiaries of the federal scheme from 2008 and beneficiaries of the regional schemes from 2007, but it does not include former teachers receiving pensions from the regional governments and victims of crime. Given the various stakeholders involved in the administration of the LTC allowance, it is impossible to receive complete data sets. Already for 2006, altogether 398.293 beneficiaries were reported (Mühlberger et al, 2008: 6), i.e. almost 5% of the population.

Annex 2

Support of 24-hours assistance in Austria

Since 1 November 2008 persons employing two 24-hours assistants as stipulated by the "Home Assistance Act" will receive subsidies between €800 and €1,100 monthly as a contribution to cover additional expenses for social insurance expenditures (€225 to €550 if two self-employed 24-hours assistants are providing care).

These subsidies are means-tested, i.e. entitled persons may not earn more than €2,500 per month (excluding LTC allowance, family allowance and similar benefits). This threshold will be increased by €400 for each household member entitled to maintenance, and by €600 for each household member with a disability. Assets of the person in need of care are not taken in consideration.

Furthermore, the following preconditions have to be fulfilled:

- Need for 24-hours assistance
- Entitlement to level 3 of the LTC allowance
- Defined assistance relationship (with the person in need of care, with his/her family or with a non-profit provider)

Since January 2009, the subsidy is only conceded if the 24-hours assistants have completed a theoretical training – usually according to the guidelines of trainings for home helpers – or if they prove to have successfully carried out assistance over a period of more than 6 months already or if they have a specific education in the area of health or social care anyway. Thus, in the meantime, most non-profit organisations providing home care now also act as brokers for 24-hours assistants. For instance, the Austrian Hilfswerk, a non-profit provider of care services, published the following offer for a person in need of care (level 3) who is entitled to the above subsidies:

- Entrance fee to the programme: €1,025
- Yearly contribution : €180
- Monthly payment for 24-hours assistants: €1.800
- Liability insurance: €9 per month
- Contribution to organisational costs: €197 per month

Altogether, this arrangement would cost around €2006 per month plus meals, accommodation and travel costs. These costs would have to be sustained by €442.9 from the LTC allowance (level 3) and €550 from the statutory subsidy for 24-hours assistance plus out-of-pocket payments of more than €1,000 (deductible from tax payments).

Total costs of the subsidy will amount to about €50 million per year to be financed from central budget.