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

Work Package 6:

Governance and Finance

Austrian National report

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1 Key contextual factors

Austria was one of the first countries in Europe to establish a comprehensive universal attendance allowance[1] (*Pflegegeld*) scheme as the main instrument to address long-term care needs of individuals, in 1993. Presently it is one of the countries in Europe with the highest share of older people receiving attendance allowances (Huber et al., 2009). To understand the option to rely on such an innovative approach (at that time) it is necessary to look at the factors that shaped this decision, as they continue to greatly influence the financing and governance of long-term care in Austria to this date.

The Austrian social-insurance-based health system is characterized by an arbitrary distinction between cure (curable illnesses) and care (disability and incurable or chronic diseases), excluding the latter from the federal public health insurance funding. Up until the 1990s, all issues concerning long-term care and disability had been a responsibility of the nine regions (regions) with scattered rules in the framework of social assistance regulations (Evers et al., 1994). As a consequence, once a person was deemed as a "care case", health insurance would no longer cover for the care-related expenses and these would have to be mainly privately financed. Public benefits would only be available through a myriad of limited cash benefits or through means-tested social assistance[2] schemes that would address cases of poverty or income/asset exhaustion.

As with other countries, also professional social and long-term care services were provided in this regulatory framework since the 1970s when regional governments began to cater for home help and home nursing services, in most regions by subsidising charities and private non-profit organisations that had a traditional stance in providing social care. Still, services remained relatively underdeveloped, while both national and regional cash benefits were introduced and/or extended. Based on the particular traditions and rationales of the Austrian welfare state, these cash benefits were conceived in various ways as complementary payments for pensioners (flat-rate national attendance allowance), war-veterans, blind and deaf people, and for recipients of social assistance (Evers et al., 1994). In fact, war veterans had already been entitled to a relatively generous national attendance allowance, dating from the 1950s, and from there onwards other such benefits evolved to cover specific sub-groups of the population or established by regions individually.

This pathway of the Austrian welfare state's development greatly explains the option for a comprehensive, cash-based benefit in 1993. Furthermore, a comprehensive approach to cash benefits in terms of "equal treatment" (i.e. extending the generous benefits of war veterans in need of care to all)

[1] The term attendance allowance is meant to define cash benefits, conditional on need for care, provided to those in need of care (distinguishing them from care allowances provided directly to carers) so that they may arrange and pay for their own care (professional services or informal carers through "routed wages").

[2] Social assistance is meant as public transfers not conditional on prior contributory records and meant to bring the income (or in this case means of payment) up to a certain level.

was claimed and supported by several groups representing people with disabilities of working-age (Evers et al., 1994).

Apart from this historical process, the following features of the Austrian welfare state's governance have to be considered:

- The federal structure of Austria leads to a specific division of responsibilities between the federal and regional governments. In the case of long-term care, different government levels and departments take responsibility and finance different components of the system. Indeed, the reform of financing LTC in Austria was ultimately facilitated by the fact that regional governments had faced increasing difficulties during the 1980s to fund long-term care related expenses from their own budgets.
- Cash benefits have played an important role in supporting individuals with care needs, even before the present attendance allowance (henceforth denominated LTC allowance) was set up. Historically, public authorities "had always used cash benefits rather than the development of services when it came to compensation for disability and care dependency" (Evers et al., 1994: 192).
- The importance of non-profit organisations as providers of care. From the 1970s regional governments started to subsidise existing non-profit organisations that were affiliated either to churches or to political parties to provide home help and nursing care. Unlike other countries where non-public providers had to be encouraged to enter the care market, in Austria these charities and non-profit organisations had a long-standing tradition in providing welfare services, – and continue to be the main source of provision. Today, care services provided at home are almost entirely managed by third sector organisations, and 24% of residential care facilities are run by private non-profit organisations; with approximately 55% of residential care facilities being public, and 21% being owned by commercial providers (Leichsenring et al., 2009; Schneider et al., 2006).

2 Governance and financing of long-term care services for older people

Austrian citizens being assessed as needing care, irrespective of age, are entitled to a LTC allowance according to their assessed level of care needs (see Table A1 in the annex for the benefit amounts). This cash benefit is intended to be used by the beneficiaries at their own discretion, e.g. to help cover the user charges demanded by providers of care services, or to be used to compensate informal carers. If the LTC allowance is not sufficient to cover for user charges (the latter are usually income-related), namely in institutional care, the individuals have to come up with the remaining amount from their own income or savings. If this is still not enough, asset and means-tested social assistance may provide the remaining funds. The rationale for this regulation is based on the subsidiary principle which originally guided the division of responsibilities between federal and regional governments.

According to the Austrian Constitution, long-term care is a responsibility of the existing nine regional governments (*Länder*), unless competencies are covered by the social insurance system. Since no federal framework law on social assistance exists, there are nine Social Welfare Acts regulating long-

term care services. This meant that each regional government has set its own regulations concerning benefits, means-testing and eligibility (Grilz-Wolf et al., 2004).

Nonetheless, the LTC Allowance is mainly administrated and paid out by the federal government. This is due to the fact that, before the Federal Long-term Care Allowance Act (*Bundes-Pflegegeldgesetz*) was eventually introduced in 1993, a state treaty had to be signed between the federal government and the regions. According to the terms of this treaty, the federal state – though constitutionally not responsible – guarantees financing of LTC allowance expenditures from general taxation, while the regions were compelled to the following tasks (Grilz-Wolf et al., 2004; Österle/Hammer, 2007):

- to develop their institutional as well as home care services by 2010
- to create development plans for social care facilities and community care services,
- to set objectives regarding minimum standards for their social care services, and
- to harmonise their regional LTC allowance schemes according to the new standards, for which in turn the federal government would transfer the additional financial resources needed.

Both citizens with a pension entitlement – the majority of beneficiaries – and beneficiaries of social assistance benefits (traditionally dependent on regional governments) receive the same level of LTC allowances. This is legally framed by nine corresponding regional Long-term Care Allowance Acts. The amounts and eligibility criteria are otherwise the same between the Federal and Regional LTC allowances, both of which are financed from general taxes.

Table 1 illustrates the existing division of responsibilities in financing and governance between federal and regional governments:

Table 1 Responsibilities of the Federal and Regional governments in long-term care in Austria

	Federal Government		**9 Regional Governments (*Länder*)**
Framework	LTC Allowance Act (cash benefits)	***State Treaty*** (responsibilities) **Regions:** 1. Develop social care services 2. Development plans 3. Set minimum standards of care 4. Harmonise LTC allowances **Federal government:** Transfer of financial resources	Regional LTC Allowance Acts (cash benefits) Regional Social Welfare Acts (in-kind benefits).
Responsibilities	Federal LTC allowance (for those with pension entitlements) Regulation of health care (staff training, quality requirements)		Regional LTC allowance (for those benefiting from social assistance). Social assistance (for those with insufficient resources to pay for care) Regulation of social care (eligibility, financing, means-testing, staff training and quality requirements)
Financing	Federal LTC allowance: general taxes. Health care: contributions (social insurance based)		Regional LTC allowance: general taxes (transferred from the federal budget) Social care: general taxes (regional budgets) and users' charges

Regarding health and social services in Austria, a strict division between the two is still very much present, concerning for example legislation, competencies and financing. Thus, health care is mostly a social insurance-based system, financed to a great extent by contributions and regulated mainly by the Federal government. Social care is financed mostly by general taxation and user charges. Health insurance funds may reimburse some designated "hospital-avoiding" activities provided by home nurses subject to a GP prescription, but budgets between social and health care are kept separated.

3 Key barriers to joint working

3.1 Structural

The health and social care-divide has a great impact on the coordination of both sectors, which is hampered not only by the differences in financing, but also because health care is regulated by the federal government, while social care falls under the responsibility of regional governments (Grilz-Wolf et al., 2004) – see Table 2.

These difficulties of coordination between health and social care are complemented by a lack of coordination within social services. The latter is caused by competition between different providers (the fact that most are linked to political parties probably adds to this), by gaps and differences in the legal framework adopted by different regions and by the existence of different budgets. The distribution of large shares of competences to the regional governments would in principle allow them to better shape care services to the specific needs of their older population.[3] However, this approach also created large differences between regions, e.g. regarding the limits to subsidised care and rules for maximum user charges (see Table A2 in the annex, for an example of the later).[4]

Table 2 The health/social care divide in long-term care in Austria

	Health Care	Social Care
Focus	Cure (curable illnesses)	Care (disability and incurable or chronicle diseases)
Regulation	Federal government (e.g. hospitals and nurses' education) through the Ministry of Health and self-governing management of health funds	Regional governments and their different departments of health and social affairs (e.g. regulations on home and residential care, staff training and education, staff ratios, eligibility for social services), and the Federal Ministry of Social Affairs
Financing	Social insurance, health funds	General taxes and users' charges

[3] Even in a relatively small country as Austria, large differences can be found between Vienna, as opposed to the alpine and more scarcely populated region of Voralberg.

[4] See also Leichsenring (2009) for examples on this diversity of regulations regarding staff ratios and staffing structure (likely to impact expenditure).

3.2 Procedural

The links that do actually function between acute treatment units (hospitals) and long-term care services (such as rehabilitation, home-care and nursing care) are mostly based on informal arrangements between institutions or on personal relationships, e.g. between a GP and the director of a nursing home (Leichsenring et al., 2009) – the so-called "Austrian way" (*Österreichische Weg*) of overcoming insufficiencies. To overcome some of these barriers, several initiatives have been developed that aim to integrate or at least improve the coordination between health and social care (see sections 4 and 9 below).

3.3 Financial

In the Austrian long-term care system, care needs are mainly addressed through the entitlement to cash benefits (the federal and regional LTC allowance) rather than through access to in-kind benefits. This means that the Austrian system is – in theory – quite demand-driven as, once assessment for care needs is cleared, individuals are entitled to the LTC allowance, which they may use to pay care services or to compensate informal carers. In such a system, budgetary pressures are kept under control not so much through rationing on the supply-side (i.e., existing capacity of care services), but by tightening eligibility criteria or limiting the amount of the cash benefit. In practice, the last option has been predominant. The amounts of LTC allowances may only cover a fraction of the costs – this feature was aggravated by the fact that benefit levels were kept constant between 1995 and 2005 (see section 6). Moreover, subsidised care falls short of total assessed care needs: for instance, a person assessed with 120 hours of care needs per month is eligible to a maximum of 60 hours of subsidised care in Lower Austria, and other Regions have similar limits, leaving the beneficiary to cover the full costs of care (Leichsenring et al. 2009).

This shortfall has created a gap between care needs and what beneficiaries are able to buy in the formal market of care with their available financial resources. The solution has been to resort to a relatively large and by now well established informal market of care, based on migrant carers from neighbouring countries who provide care in exchange for the amount of the LTC attendance allowance.[5]

The several stakeholders involved in long term care in Austria have also embarked in practices of "cost-shifting" – trying to shift costs to other stakeholders. This has been the case with the introduction of a Diagnosis Related Groups (DRG) funding system in hospitals[6], which reduced the patients' length of stay and produced cost-savings for hospitals at the expense of increased pressure over long term care (Leichsenring et al., 2009). The introduction of the LTC allowance provided regions with significant

[5] Wage differentials between Austria and neighbouring countries, as well as geographical and cultural proximity and the labour market situation of the sending countries (the Slovak Republic in particular has had a much higher unemployment rate than Austria) facilitate this flourishing market. As an example, Bratislava and Vienna are only one hour away by car or bus and the average wage in Slovak Republic was equivalent to €596 in 2007 (OECD, Benefits and Wages) against a monthly LTC allowance ranging from €148.30 to €1562.10.

[6] The previous financing system based on a per day payment, which perversely incentivised extending the length of stay, was replaced by a payment per case.

savings in their long-term care expenditures, but these savings were not used to invest in community care, but rather consumed in balancing social assistance budgets of the regions (Grilz-Wolf et al., 2004).

3.4 Professional

Health care professionals benefit from a more regulated and generally better job profile, pay and social status than their colleagues working in the long-term care sector. Particularly the training and education of staff in long-term care services for the elderly has had a notoriously poor legal framework. These differences affect the ability and willingness of health and long-term care professionals to work together (Grilz-Wolf et al., 2004: 114). In 2005 and 2007 the Federal and Regional government passed legislation that seeks to enhance the regulation of professionals working in the long-term care sector, which hopes to improve the position of those professionals

As part of the 2005 Health Care Reform, "Health Platforms" were established to improve coordination in planning, controlling and financing within the health system and to overcome barriers within the health sector and between different stakeholders (see more on this below in section 4.1). Different stakeholders on a regional level are represented in these "Health Platforms" (including patients' and doctors' associations), but stakeholders from the social sector are only marginally represented and long-term care providers have not always been considered as relevant stakeholders worthy of integrating these platforms.

3.5 Issues of status and legitimacy

The convergence of a relatively underdeveloped care service provision, with a reliance on a non-earmarked attendance allowance (Österle and Hammer, 2007; Huber et al., 2009) and diminishing real value of benefits (see more on this below) has opened the way to the establishment of an informal market for care, provided by migrant care workers. Despite recent changes in legislation that sought to provide the means to formalise the status of these informal carers providing 'round the clock care' ("24 hours assistants"), issues remain regarding the status of these carers and the sustainability of the current arrangement: these "24 hours assistants" are allowed to work 128 hours over a 14 day period, which is a far longer working schedule than legally allowed to other workers.[7] Besides this, organisational issues remain in linking these "24 hours assistants" with formal care services, even if some non-profit organisations have started to integrate "24 hours assistants" into their range of services (either serving as brokers or by employing these assistants themselves, Leichsenring et al., 2009).

[7] Besides these 128 hours of care work, there are additional hours of attendance to be spent at the working place, i.e., in the client's home, that are not counted as working time (BMSK, 2009).

4 Key enablers

4.1 Shared vision

The idea of integration in the context of care delivery in Austria is very much anchored around case management – i.e., cooperative and organisational responsibilities are concentrated in one person (usually a certified nurse) acting as the interface between the patient and the care service providers (Grilz-Wolf et al., 2004: 122). As an example, pilot projects on discharge management have been introduced and many hospitals now have nurses trained as discharge managers (Leichsenring et al., 2009; see also Ruppe, 2009). However, the experiences with integrating social and health care remain confined to pilot projects (see below section 9 on good practices), usually taking place in urban areas, involving one specific hospital or hospitals and social care organisations or providers. Introducing geriatric medicine in acute care settings is slowly making its way and may lead to a more interdisciplinary approach being used in the assessment of care needs (thus far too much focused on medical assessments, leading to insufficient consideration of care needs motivated by cognitive impairments) and treatment.

The "Health Platforms" set up by the 2005 Health Care Reform, despite their above mentioned shortcomings, also represent an effort to bring together different stakeholders and coordinate their efforts, even if relatively restricted to the health sector only. Besides providing a framework for representatives of stakeholders to meet regularly, Health Platforms should also design, tender and select projects to improve service coordination, designated as "reform pool projects", for which there is an overall budget of approximately €260 million per year.

4.2 Clarity of roles and responsibilities

The gaps arising from lack of coordination between health and social care, namely those located at the boundaries between hospitals and long term care services, have been recognised by the stakeholders involved and efforts have been made to overcome them by means of integrating or coordinating health and social care. The initiatives aimed at clarifying the role of each stakeholder and improving the outcome for the individual (such as the above mentioned discharge management pilot projects). The experience from these projects is that social service providers have managed to move from competition to working together (Grilz-Wolf et al., 2004). Despite these positive steps, it is still not uncommon that no one takes the initiative to prepare the discharge of a patient (Leichsenring et al., 2009).

4.3 Appropriate incentives and rewards

As outlined above (see section 3.3), the compartmentalisation of responsibilities between stakeholders means that the benefits are not always accrued by those bearing the costs of the initiatives – the rationale of incentives and rewards thus tends to operate within a single stakeholder. This may be illustrated by the example of prevention and rehabilitation which are in most cases funded by local health insurance agencies, while it is mainly other stakeholders that benefit from it. When in institutions, residents have to pay for preventive rehabilitative measures themselves as part of their living costs and since they usually have to give up most of their private assets to pay for institutional care (including selling their own house), there is no strong incentive to take up adequate prevention and rehabilitation measures (also, as returning to their own home would probably no longer be possible).

4.4 Accountability for joint working

Stakeholders of health and social care systems have engaged in innovative ways to work together, namely, by establishing cooperation agreements between regional governments and hospitals, or between specific hospitals and social care providers focusing on discharge management (see Grilz-Wolf et al., 2004, for an extensive overview). Still, even though these innovative ways have many times shared resemblances there is no exchange between them. Grilz-Wolf et al., 2004: 124, point out that this is due to different responsibilities that fall on the federal state and the regions (a recurrent issue), to competition between providers and to the fact that there is no specific government programme for integrated care.

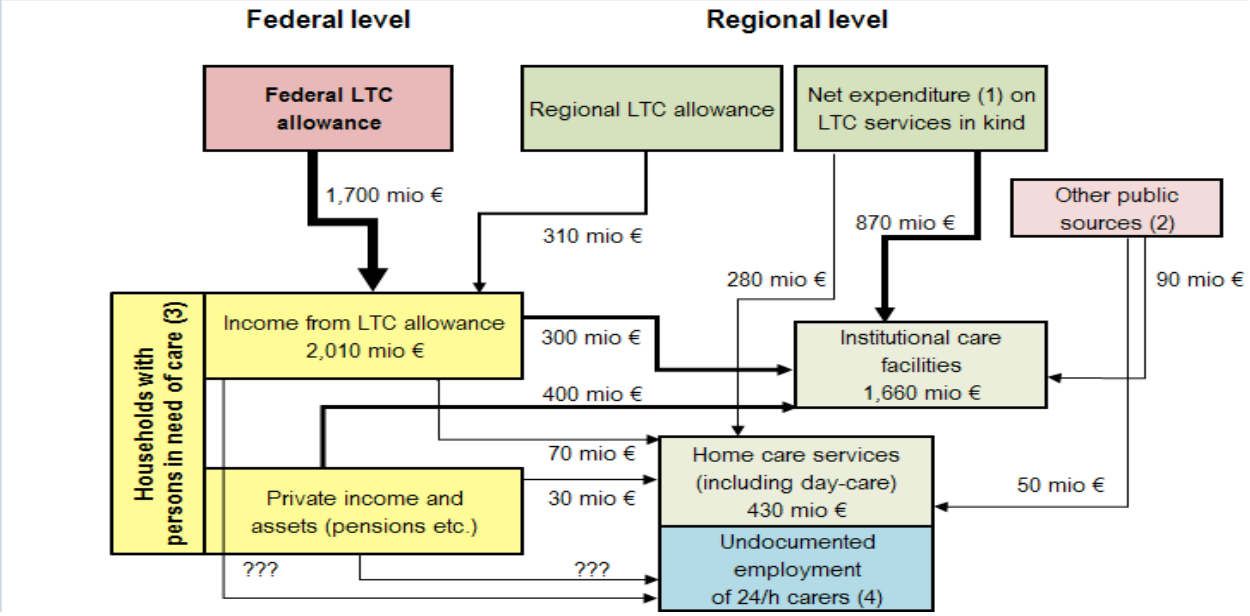
The 2005 Health Care Reform has also sought to establish interfaces for cooperation, albeit confined to the health sector and particularly to in-patient and out-patient care on a regional level. The regional bodies are now more constrained on a vertical level by the guidelines (e.g. regarding quality of care provision) set by the Federal Health Care Agency (*Budesgesundheitsagentur*), but in turn they will gain more autonomy to coordinate the supply chain within a region (Hofmarcher and Röhrling, 2006).

5 The funding of long-term care services

Public expenditure on long-term care in Austria is estimated to amount to €3,300 million, approximately 1.21% of GDP, in 2007. This is an estimate based on own calculations from several sources as accounting for public expenditure on long-term care in Austria remains difficult.[8] Figure 1 provides a schematic view of both the financing flows and the amounts involved. The Federal and Regional LTC allowances provided to households with dependent people account for the bulk of public expenditure. Considering expenditure by the regional governments on in-kind services (e.g. through social assistance) and the part of the LTC allowance that is used to pay for formal care services, most public expenditure is devoted to institutional care. Available data does not allow for a clear distinction between what is spent on disability and on long-term care in old-age.

[8] For example, expenditure data on in-kind benefits by regional governments remain fragmented.

Figure1 Financial flows between stakeholders in long-term care in Austria (2007)



Source: Own calculations based on BMSK (2008); Statistik Austria, 2009 (www.statistik.at).-

Notes: (1) Total expenditures minus income from clients and other sources; (2) Health funds and other contributions; (3) Estimates, as it cannot be distinguished exactly, whether expenditures (out-of-pocket contributions) of private households to institutional care or home care services stem from LTC allowance or private income (pensions) as this kind of data is available for Vienna only; (4) A rough estimate is between 20,000 and 50,000 24 hours carers with a financial turnover of between 400 mio. up to 1.000 mio. €.

Private expenditure is more difficult to quantify. Data constraints make it difficult to disentangle the part of the LTC allowance that households use to pay for care services and the additional out-of-pocket expenditure. It is naturally even harder to quantify how much households spend on undocumented carers. Nonetheless, the contribution of households to pay for care can be quite substantial. According to Leichsenring et al. (2009), about 25% of costs with home care are borne by out-of-pocket contributions by households. As for institutional care, residents could expect to contribute with their LTC allowance, 80% of their pension and assets that could be converted to cash, including their own home – which may seem unfair when compared to user fees for health care. Until recently, in a few of the Austrian regions social assistance would also oblige children to contribute to the costs with institutional care, but this obligation has since been revoked.

6 Financial sustainability

During the first decade of its existence the number of beneficiaries of the LTC allowance grew due to the increased number of people in need of care and their increased life expectancy (Leichsenring et al., 2009). The overall effect over costs was offset by a freeze in benefit amounts: between 1995 and 2009 these were only once (2005) adjusted to the consumer price index (a 2% increase). This policy led to a sharp decrease in the real value of benefits (15.9% between1995 and 2004 – Huber et al., 2009: 108)

and proved socially unsustainable in the long-run, so that an increase in the benefit amount between 4% to 6% took effect in the beginning of 2009.

As the Austrian population is expected to age in the future, the fiscal sustainability of its long-term care system remains an important topic. In 2008, the Austrian Institute for Economic Research (*Österreichischen Institut für Wirtschaftsforschung*) published a study on the financing perspectives of long-term care in Austria for the coming 25 years (Mühlberger et al., 2008). The study acknowledged the existing difficulties in accounting for public expenditure in long-term care in Austria (mentioned above), which made estimates imprecise. Nevertheless, depending on the scenarios, public expenditure could be expected to rise between 66% and 207%, but even in the upper bound scenario the end result would be below 2.5% of GDP – i.e., below the estimated current expenditure by Sweden or the Netherlands (Huber et al., 2009).

When setting up the Austrian LTC allowance, one of its aims was to "provide an incentive for informal care within the family and other primary networks" (Österle and Hammer, 2007: 16) and this type of cash benefit was seen as one that could also entail a cost containment advantage (Hammer and Österle, 2003). The availability of migrant carers from neighbouring countries and care provided by family carers has certainly helped to keep the purchasing power of beneficiaries of the LTC allowance, despite the fact that the amounts were kept constant for many years. Shifts in future availability of informal care thus are likely to have a potentially significant impact in future expenditure in the Austrian case, as pointed out by different projections made on Austria (ECFIN, 2009; Streissler, 2004).

7 Good practice

Some good practices exist concerning governance and finance of long-term care for older people, even if they are still confined or at least very much focused on the health care system. Some particular aspects of the LTC allowance can also be highlighted as examples to be considered.

With the 2005 Health Care Reform, the Federal Health Care Agency is now responsible for planning, budgeting and establishing guidelines for the health care sector (e.g. on the remuneration system, quality and accounting standards). Regional bodies must now operate within the boundaries set by these regulations but the reform provided these regional bodies with the legal means to pool financial resources from different sources (health insurance, federal government and regional hospital funds) and establish supra-regional cooperation agreements (Hofmarcher and Röhrling, 2006).

The "Health Platforms" established in each region are also entrusted with design, tendering and selection of projects aimed at improving the coordination between in-patient and out-patient services. A total of €260 million per year has been earmarked to support these projects, which have sought to compensate shifts in provision between health care settings (e.g. from hospitals to primary care) and improve coordination and management regarding certain diseases (e.g. improved allocation of stroke patients to reduce long-term consequences or improved discharge from hospitals – see Hofmarcher et al., 2007, for a survey of these reform projects).

Despite its shortcomings, ongoing tensions and debates over "using the allowance to buy a bike for the nephew", the Austrian LTC allowance has put an emphasis on the empowerment of people to make their own decisions towards securing the care they need.

8 Ongoing tensions

From the above picture on the current financing and governance of long-term care in Austria, a number of tensions and policy changes are lurking that could reshape long-term care in Austria:

- As mentioned above, informal carers play an important role in the Austrian long-term care system. Reliance on informal carers has managed to keep expenditure under control and helped beneficiaries of the LTC allowance to somehow continue to receive care amidst real benefit cuts in the past. The government has recognised the burden placed upon informal carers and has moved towards formalising their status (especially migrant carers – see 3.5 above) and enhancing their social protection by providing social security rights to family carers. Nonetheless, it is doubtful that these amendments, albeit in the right direction, have sufficiently addressed both the issue of informal care and migrant carers – the latter also linked with labour shortages in the care sector. Particularly in the case of migrant carers, the present solution still allows for very demanding working conditions and regulation of quality of care is still lagging behind.
- The divide between health and social care remains strong in the context of long-term care in Austria. Health and social care stakeholders have certainly enhanced their cooperation, but the two systems have fallen short of full integration, despite the best efforts by several stakeholders from both sides of the divide. Distinctions between health and social care are deeply rooted in the legal framework, professional practices and in the "pillarisation" (Grilz-Wolf et al., 2004: 125) regarding both sectors.

9 Embedding good practice in everyday practice

The barriers and constraints outlined throughout this report testify to the difficulties of embedding good practices in the everyday procedures of governing and financing long term care in Austria. While risking repetition to what it was said before, the examples that can be put forward here remain confined to specific regions or sectors and apparently have not yet been mainstreamed.

The establishment of Health Platforms with their mandate, and most importantly financial resources, to set up innovative projects in the coordination of in-patient and out-patient services has the potential to foster good practices. Agreements between hospitals and social care providers aiming at improving the discharge management process may also contribute to make an everyday reality of coordination between stakeholders. Similarly, some regions (Vienna, Upper Austria and Salzburg) have established joint needs assessment (by nurses, social care workers, etc.) that also aim to provide information to the beneficiaries on the all range of services available to them and to coordinate the different services

within the region. It remains to be seen however, if 'good practices' will be able to spread among regions and to the social care sector.

In 1990 it was decided that Integrated Health and Social Care Districts (*Integrierte Gesundheits und Sozialsprengel* – IGSS for short) should become one of the building blocks of future health policy in Austria. The IGSS would be regional bodies of coordination of health and social care organisations, acting also as both planning bodies and partners of patients and their families, helping them find the service providers that best suited their care needs (Grilz-Wolf et al., 2004: 119). Each IGSS should cover 10,000 to 20,000 people and their main objectives would be:

- To guarantee and improve adequate provision of health and social care within its boundaries;
- To coordinate and harmonise the services of health and social care organisations, including public services;
- To enhance the cooperation and exchange between health and social care organisations;
- To improve the output of health and social care services by catering to the requirements of patients (e.g. ensuring continuity of care and avoiding overlapping services);
- To help patients and families to find the best suitable organisation for their care needs (e.g. acting more as an information centre rather than advising or counselling).

According to Grilz-Wolf et al. (2004: 126), critics of the functioning of some IGSS, particularly in the regions of Tyrol and Vorarlberg, argue that these are nothing more than a group of providers that get together and provide services, which might even result in diminishing choice of care services for users. The same authors argue however that the IGSS have shown professional ways of working, focusing on patients' needs and bringing together providers from different political backgrounds with a history of competition. However, the experience of integrated care districts has thus far failed to extend to other regions in Austria.

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11 Annex

Table A1 Benefit amounts of the Austrian LTC allowance, by 1/1/2009

Level	*Care needs per month*	*Amount in € per month*
I	> 50 hours	€ 154.20
II	> 75 hours	€ 284.30
III	> 120 hours	€ 442.90
IV	> 180 hours	€ 664.30
V	> 180 hours of heavy care	€ 902.30
VI	> 180 hours of constant attendance	€ 1,242.00
VII	> 180 hours of care in combination with complete immobility	€ 1,655.80

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

Table A2 Maximum user charges: Out-of pocket contribution (non-subsidised) for clients of long-term care services by regions, 2004 (all values in Euros)

Region	*Home nurses*	*Geriatric aides/Nursing assistants*	*Home helpers*
Burgenland	24.80	19.70	14.20
Carinthia	29.10 – 40.00 (incl. 5.82€ from LTC allowance)	29.10 (incl. 5.82 from LTC allowance)	18.66
Lower Austria	27.00 (incl. 5.45 from LTC allowance)	22.00 (incl. 5.45 from LTC allowance)	19.00 (incl. 5.45 from LTC allowance)
Upper Austria	22.41 (incl. 3.85 from LTC allowance)		
Salzburg	23.98	23.98	
Styria	42.26 (incl. 6.00 from LTC allowance)	31.28 (incl. 4.90 from LTC allowance)	20.30 (incl. 3.80 from LTC allowance)
Tyrol/Vorarlberg	depending on provider		
Vienna	22.13	22.13	16.86

Source: Simsa et al. 2004: 231; cf. Schneider et al, 2006.