

Local care policies in the case of long-term care in Austria

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Abstract

The Austrian Care System focuses on cash benefits for care receivers. As a consequence long-term care is provided to a very large extent by informal care givers within the family. Professional mobile home care services are funded to support these arrangements in order to avoid expensive residential care. The Austrian long-term care system is a rather complex field with many different actors involved. At the local level we find communities as financiers and about five different non-profit organizations offering and organizing long-term care services. At the national level new regulations such as that for the legalization of the grey market for home care (the so-called 24-hours-care) are challenges for the regional organization of long-term care.

Our Paper explores the regional differences concerning professional home care services in Austria with special regard to the quality of care.

Methods: Expert Interviews with heads of mobile home care services; analysis of the supply and the structure of the Austrian home care services at the local level.

Results: There are large differences concerning supply and costs of professional care services within Austria as well as differences in the long-term care allowance between the provinces of Austria. For example, home care services are rather cheap in Vienna but in fact most expensive in Styria. However, all local suppliers of home care services face increasing pressure to reduce costs and to work more efficiently; and all suppliers are confronted with increasing needs from the care receivers and their families. As a consequence non-profit organizations adopt service hour limits. Austria is one of three countries within the EU with no academic degree in the education of nurses. There is not even a general qualification for university entrance provided nation widely. This has a great impact on the salaries and the conditions of employment in this female dominated occupational field and results in manpower shortage, again with regional differences.

1. Introduction and Background

In Austria, estimations show about 600.000 persons in need of care; 60.000 are in residential care (nursing homes, hospitals) and approximately 540.000 in private household care (Volkshilfe 2010).

Thus informal care givers provide about 75 percent of the services in long-term care within the family. Professional (mobile) care services exist to support these arrangements in order to avoid rather expensive residential care. However the utilization of these mobile care services is optional and rather expensive, independently from the level of disability or care needs. Furthermore there is no legal claim for these services.

The Austrian care system does not only support unqualified care within families and therefore neglects preventive and rehabilitative aspects of (professional) care, but also leaves the care management to a large extent within families. There is no easily accessible information centre for potential clients and their families, which would coordinate the different services and would systematically inform them about their entitlements and the various existing facilities. As a consequence the clients (and in fact their caring relatives) have to act on their own initiative and they are constrained in deciding for and organizing the adequate care arrangement.

The Austrian care system is a rather complex arrangement of different actors and decision makers on the local, provincial and federal level. Egger de Campo identifies three different models of home based care provision in Austria (Egger de Campo 2008, 4f):

- The Western model (provinces Tyrol and Vorarlberg) has a long tradition of civil society organizing help for dependent people. Almost all citizens of the communities are members of non-profit Home Nursing Associations and pay a yearly membership fee which offers integrated service for free when the person is in need of care. In fact the membership of the citizens to those associations covers almost half of the total population of Vorarlberg.
- A kind of top-down model exists in Vienna and Salzburg. The registered nurses in those provinces are employed by the provincial government. Therefore the public administration is responsible for organizing and assessing social and health services. Especially in Vienna this model provides a big variety of services.
- Egger de Campo names the third model (in Burgenland, Styria, Carinthia, Lower- and Upper Austria) public-private-partnership model. Here the welfare organizations operate on behalf of the public authority; the latter only commissions the contracts but has no direct client contact. The non-profit providers work rather autonomously in the assessment and provision of services.

Against this background our paper explores the consequences of regional differences concerning the entitlements and availabilities of persons in need of care with a special regional regard to the third model identified by Egger de Campo. It asks for the impact of nationwide regulations on care services at the local level and finally for the consequences of those arrangements with special regard to the quality of care.

2. Methodical approach

We analyzed the care system in Austria critically with a special regard to the entitlements of care receivers and care giving relatives using a literature survey, various studies and sources. Based on these findings we selected eight experts for interviews whose job functions give an insight into home care situations.

These experts include the Nurse Managers of the five non-governmental providers of professional mobile nursing and care services, the manager of subsidy control for the mobile care service providers at the Regional Health Directorate of Styria, the managing director of a private agency arranging personal attendants for 24 hours care and a medical assessor for the Austrian long-term care allowance.

The results provide insights into the Austrian care system and its impacts on the quality of care, into regional differences in terms of the availability and costs of professional care services and finally into proposals for improving the Austrian care system.

3. Results

While the application of funds (primarily via taxes) is carried out nationwide consistently, there are regional differences in the responsibility for the provision of grants and allowances for persons in need of care. The general responsibility is divided between the social welfare system and the health system. However the ministry of economics and the ministry of education are also concerned with elder care. Within these systems the responsibility for the provision of care is split between the federal, the provincial and the municipal level. The connection between these institutions is rather weak; hence efficient work in the provision of care is hindered according to the interviewed experts.

The consequence of these arrangements is not only a jungle of responsibilities and contact agencies which worsens the situation of persons in need of care, but also regional differences in the accessibility of care services and entitlements and even in their costs.

Examples for regional differences are:

- The assessment of care needs for the long-term care allowance differs between provinces because there is no compulsory standardization.
- The percentage of self paid costs for mobile care services differs between municipalities.

- If a person in care needs is unable to stay at home (or has not any relatives able or willing to take over caring tasks) he or she has to move into residential care in a nursing home. If this person is unable to bear the costs with his or her pension and care allowance (which is typically the case) it is subsidized by Social Welfare (Sozialhilfe). This benefit is means tested, thus real property and financial assets of the care receiver will be sold in all provinces of Austria. However the proportion of retained estates and assets in state subsidized resident care differs between provinces.

Those regional differences could have the consequence that persons in need of care move to another province within Austria because they are unable to effort the costs of care in their originally registered residence (Volkshilfe 2010).

Our results will be carried out along the main entitlements for persons in need of care: the cash for care allowance and the professional mobile care services to support home care arrangements. Afterwards the impact of nationwide regulations concerning care services on a regional level will be showed using the example of the legalization of 24 hours care services. Finally we discuss the educational level of nurses in connection with the high dropout-rate in this occupational field and the social value of caring tasks in Austria.

3. 1 The Austrian System of unregulated cash for care allowances

In 1993, Austria introduced a cash for long-term care allowance [Pflegegeld] that is organized in seven ascending levels based on the required amount of care and paid out directly to the person in need of care.

The assessment of the level of care needs is done by a doctor who is hired by the pension insurance (which is the agency administrating the long-term care allowance). Thus it is based on medical expertise. Suggestions or advices of professional nurses or familial caregivers are not (yet) demanded. The interviewed experts have criticized this as out-of-date. The anti-practical approach of this medical classification is underlined by the fact that the situation of care is not 'played through' in the present assessment process, since the medical expertise is based on a check of the client's motor capabilities (Heitzmann/Schenk 2009, 140; 143).

One interviewed expert described this assessment process as follows:

Interviewee 1¹: „He [the doctor] works with the person in need of care, relatives [as persons of trust] are often present. This process works as follows: The doctor puts the patient through his paces: Is he able to raise his arms? Is he able to conduct financial transactions? But the care situation is not played through. I would say only that [the focus on the care situation rather than on motor capabilities in the assessment of care needs] makes sense, because only in this way I can see: how does it really work? “

¹ The quotes were translated from German to English by the authors.

The consequence of the present assessment process is a strongly body- and activity-oriented medical assessment of care needs (Schroeter 2005; Bauch 2005).

Hence, certain clinical pictures, such as dementia and the consequential need for care and assistance are not assessed adequately. Although dementia patients may be mobile enough, they would frequently have to be classified in the highest level of care since their illness makes them unsure in movement, in assessing danger, and sometimes aggressive. An interviewed expert exemplifies the caring effort that dementia causes:

Interviewee 2: "What nobody knows is that dementia patients have the highest care needs but they are in [the long-term care allowance] level 3 to 5. Long-term care allowance receivers in the levels 6 and 7 [the two highest levels, usually granted to bedridden persons] have in fact also strong care needs, but the effort to care for them can be reduced. If I care for them professionally and I come every third or fourth hour to move them, to lay them correctly, it will be enough. But in a phase in which care receivers are rather active, move a lot and probably collapse or dump in doing so, care needs are really extensive and cause enormous efforts to care givers. [...] This really brings caring relatives into burn out."

The granting process of the long-term care allowance does not adequately consider these facts. In addition, the Austrian system of care levels 'rewards care in bed', since reactivating measures in order to improve the client's condition could be 'punished' with the perspective of falling back to a lower care level for which a lower allowance is granted. Another interviewed expert brings an example:

Interviewee 3: „Care allowance in the level 7 brings the highest amount of money for the person in need of care as well as for Mobile Care Services providing organizations. This system hardly motivates care givers to care in a reactivating way in order to improve or at least to sustain the abilities of the persons in need of care. Usually I do not like the comparison of elder care and child care, but if I teach a child to tie its shoes, it takes more time as if I do it by myself. However the child needs to learn it. It's the same with elder persons in need of care, I have to care that the person in need of care is able to use his resources and abilities longer.

The cash allowance is too low to cover the costs of care; an estimated maximum of 25 percents of the costs for professional care services can be covered with this allowance (Volkshilfe 2010, 8).

Furthermore the use of the long-term care allowance is unregulated and thus up to the client's discretion; it is not subject to compulsory control. The interviewed experts reported that the allowance often forms a part of the family income what makes a misuse possible. For this reason, the interviewed experts claim for compulsory control and counseling by the qualified personnel of mobile care services.

Regional differences in the long-term care allowance

The long-term care allowance was introduced by the federal government of Austria. There has been an agreement between the federal government and the provinces according to which the federal budget bears the larger burden of the cash for care allowance. In return the provinces carry the smaller part of the cash for care allowance costs; but they are furthermore responsible for the delivery of (mobile) care services and therefore obligated to establish care institutions (Egger de Campo 2008, 3).

If the person in need of care is in retirement, usually the retirement pension insurance (Pensionsversicherungsanstalt) is the decision maker for the long-term care allowance.

If the person in need of care is still in working age or a co-insured relative (e.g. a housewife), he or she receives the allowance from the provincial government of the residential place.

Because there is no compulsory standardization in the medical assessment of care needs to receive the cash for care allowance there are regional differences concerning its adjudication (including the medical assessment) and its verification. Furthermore there are even differences in the dates of payment. An inspection report of the Austrian Court of Audit² shows that more than 280 agencies administrated the long-term care allowance nation widely in 2007. This arrangement is not only expensive but also intransparent and complex. An example: Within Austria the duration of applications for long-term care allowance reaches between 40 and 137 days. Beside from that there are no standardized criteria concerning the medical estimations of care needs for the entitlement to the cash for care allowance. For this reason there are major differences in the quality of those estimations. This fact may assert the following finding of the above named inspection report: The amount of long-term care allowance receivers in level 6 is in the western province of Vorarlberg thrice as high as in the Austrian average.

This arrangement is not only inequitable; it also impacts on the mobility: If a receiver of the cash for care allowance moves from one province to another, his or her entitlement to care allowance expires till the level of care needs is estimated again in the new region of residence. Hence the interviewed experts claim for a nationwide standardization of the entitlements and a downsizing of administrative tasks concerning the cash for care allowance.

3. 2 Professional mobile care services in Austria

Mobile care services are systematically separated from cash benefits (e.g. the cash for care allowance) and basically funded by the government. As mentioned above the provinces are obliged to deliver those care services by the federal government. Thus “need and

²http://www.rechnungshof.gv.at/fileadmin/downloads/2009/berichte/teilberichte/bund/bund_2009_09/bund_2009_09_4.pdf

development plans” were introduced to identify shortages and regional needs of care by the provincial governments (Egger de Campo 2008, 3f). Those benefits in-kind are financed to one third by the communities, to one third by the provinces and to one third by the clients themselves based on their level of income. However there are different financing models at the local level (e. g. grants or subsidies, benefits, cost sharing or part payback models) (Dimmel/Schmid 2009, 579).

As introduced above the provincial government of Styria contractually assigns five non-profit organizations to provide those services. The delivered mobile care services are divided into three skill levels: professional home care services provided by nurses; they include nursing and medical tasks (e. g. injections), furthermore elder care services provided by carers who are specially qualified to incur the needs and requirements of senior citizens. They support in personal hygiene, food intake and mobility as well as in the care for people with incontinence. At the third level there are low-threshold home help services and volunteer companion services available for persons in need of care.

The interviewed heads of those providing organizations reported that the above named “need and development plan” for professional services in Styria (with measures the need of professional care services and therefore the funding of the providing organizations) derives from the year 1997. Therefore it accounts neither for the current demographic trends nor for the increasing awareness of dementia. As a result the demand for mobile services exceeds the hourly allocations of the carrier organizations, thus they are chronically underfunded. Therefore they are forced to refuse clients, to limit available service hours per client or to introduce waiting lists. At the same time the government confronts the providers of those services with an increasing pressure to work more efficiently through budget cutting measures (Krenn et al. 2004, 1).

The demand for mobile care services will increase in the future through demographic changes and the constant promotion of long term care in private households by the Austrian care system. Even at the current stage this trends have strong impacts on the working conditions in this occupational field: mobile home care workers often work overtime and under pressure. As a result this occupational field is rather unattractive and therefore the labor supply is rather weak. These trends tend to result in a quality impairment of professional care services or at least in an accessibility reduction.

But as introduced above regional differences are also visible in the provision of mobile care services.

Regional differences in the availability of professional care services in Austria

There are comprehensive hour limitations concerning the availability of professional care services in Austria. Furthermore these services are unavailable at night and only in

emergency cases on Saturday and Sunday (with a significant rise of self-paid costs). However there are local differences concerning the allocations of mobile care service hours funded by the provincial governments as well as in the client's self-paid costs. The allocation of care hours for persons in the highest needs of care ranges between 80 hours per month in Upper Austria to 191 hours in Vienna. Although there are no hour limitations in Styria, the self-paid costs are the highest in Austria; therefore care receivers are able to afford estimated 25 hours per month on average (Volkshilfe 2006, 4). An interviewed expert state:

Interviewee 2: "We [the providing organization of mobile care services] extrapolated it: in Styria we have the highest payment rates for care receivers of all provinces in Austria. In Styria care receivers can afford a maximum of 25 hours [per month] of our services no matter if their income is high or low and this is badly few. In Vienna they get 180 service hours for the same amount of money."

Therefore this system results in inequalities between the provinces of Austria. Furthermore the government's access to the income for the self paid third for mobile care services is organized differently within the provinces. For example unlike the Province of Styria, the City of Graz (the capital of Styria) has integrated a margin that limits its access to the client's income (Krenn 2004).

The interviewed experts criticize these local differences in the legal regulation as inequitable but even more they criticize the chronic underfunding of their services. They not only suggest a budget increase for professional care services but furthermore a 'care cheque' in the sense of a voucher to be granted for persons in need of care at a certain level. This cheque could be granted as an alternative to a part of the cash for care allowance in order to improve the quality of care and to alleviate the burden of caring relatives.

However recent developments within the Austrian Government, namely the legalization of 24 hours care services did not result in a disburdening of the non-profit organizations providing mobile care services but rather in a further exposure.

3. 3 Legalization of 24 hours care services: New responsibilities for the underfunded Mobile Care Services

24 hours carers were formerly recruited through the grey market, especially in Austria's Eastern neighbor countries because of their rather low pay and rather high unemployment rates (Hammer 2002). For example a qualified nurse with a university diploma in Slovakia earns approx. 400 € per month, according to the interviewees. Some of those nurses and also persons who are unqualified in the field of long-term care came to Austria to be employed in 24 hours live-in elder care. They worked for extremely low salaries (compared to the wage plan of Austria) and without working time restrictions. In 2006, the issue became a

priority on the political agenda in Austria, and led to a new regulation of 24 hours care, called “legalization” (Egger de Campo 2008).

The costs arising from the obligation to formal employment of 24 hours carers are (partly) subsidized by the Austrian Federal Ministry of Social Affairs and Consumer Protection (BMASK). Although 24 hours carers have to be registered, there is hardly any monitoring of working conditions or documentation duties, because they are mostly self-employed. The self-employed status of 24 hours carers is preferred by care receivers and their families because it is attended by lower costs and lower bureaucratic efforts. However legal experts are very skeptical whether the nature of self-employment contradicts the job of a live-in care worker (Egger de Campo 2008, 12).

An interviewed head of a mobile care services providing organization gives an insight into the problematic status of this kind of self-employment:

Interviewee 2: “According to the Austrian law they [the self employed 24 hours carers] are entrepreneurs but in fact they are not. If you compare the law and the real working conditions it won’t match. If I was an entrepreneur I would be able to negotiate the working conditions with my client, I would be able to explore my working conditions before I sign the contract. This happens not in practice because they [the 24 hours carers] are dependent on this work, they support their families with their income and they leave their families to get employed abroad.”

Even if the subsidy is granted by the government, controls are only conducted in kind of a random way, according to the interviewees. However many receivers of 24 hour care do not even apply for this subsidy; especially for them the possibility to be controlled or monitored by professional care services is really weak. An interviewed expert delivers an insight into the working conditions of the former informal employed 24 hours carers:

Interviewee 2: “They [the 24 hour carers] work under extremely bad conditions. For me, this is a kind of modern slave trade. The 24 hours carers often work together with our colleagues [the mobile home care services] and talk with them, thus we get an insight into their working conditions. An example: The whole family [of the care receiver] is sitting around the table and enjoys supper while the 24 hour carer only gets a snack and furthermore has to eat apart from the family table. The rooms of the 24 hour carers are often unacceptable and some of them not even get their own room. There are really bad conditions for some 24 hours carers.”

The legalization of 24 hours care is based on the law on household care and on the design of personal care attendance as a free trade service. Free trade service means in this connection that there is in general no qualification required for the business registration. Anyhow even unqualified 24 hours carers may take on nursing and medical tasks – just like care giving relatives – if fully qualified mobile care services personnel train them. Therefore the professional mobile care services personnel is responsible for the knowledge and skills of (unqualified) 24 hours carers who take on nursing and medical tasks. Thus the government

confronts mobile care services with additional responsibilities and activities, although they have not enough resources to fulfill their originally assigned responsibilities and at the desired level.

This “new responsibilities” of professional care services are not only a problem because of their underfunding but also because of the language problems occurring in interactions with 24 hours carers as the interviewed experts pointed out. They have a negative impact on the training process and complicate the verifying of the 24 hours carer’s skills. To this an interviewed expert says:

Interviewee 1: “There are always massive language barriers; the 24 hours carers are often unable to speak German. Our nurses [the nurses of the mobile care services] have always said: ‘Oh my god, this [the delegation of medical and nurse tasks and the verification of the 24 hour carers knowledge] is now my responsibility but she [the 24 hours carer] cannot understand me and works against my advices.’ That really is a great uncertainty.”

The absent language skills are not only a problem regarding the quality of care in a medical point of view but even in an social one concerning the relationship between the carer and the care receiver. According to the interviewees especially people with dementia diseases need a lot of verbal guidance and addressing. Hence language skills are very important for the quality of care even on a rather low skilled level where no medical tasks are necessary.

However daily practice has shown that the 24 hours carers are not always trained by qualified personnel in taking on care and medical tasks, but even more by the former caring relatives. Therefore, the mobile care services personnel are continuously confronted with unprofessional treatment and its consequences (e.g. decubitus ulcers) when they conduct home visits. Due to the lack of inspections and sanction options, exploitative practices are still prevailing. The new regulation of 24 hours care in fact led to a kind of legalization of the former informal situation and fewer to its improvement.

Some non-profit organizations of Mobile Care Services cooperate with agencies for 24 hours personal carers. They provide need assessments and quality control visits as well as counseling services for clients and their families. Private agencies do not offer these services they rather focus on the procurement of personnel according to their individual preference and needs (e.g. the gender of the carer or their lifestyle) regardless to the level of caring needs. Private agencies also fail to assess the potential workplace (the situation for the care giver), both in terms of requirements (will carers have their own room?), and in terms of the necessary level of care (will it be possible to cover all arising problems through unqualified care?).

In the experts’ opinion only compulsory advice, compulsory checkups, and compulsory routine contacts with professional care providers will amend the situation (but this – of course – is only possible through a budget increase). Furthermore according to the experts

interviewed, the use of 24 hours care or inpatient care would not be necessary in many cases, if the mobile care services could be used more flexible, if they could offer long-term presence instead of selective services and if they could provide services hours at night. This expansion of professional care services would not only support family caregivers in conducting care tasks, but also disburden these caregivers by provided attendance.

Therefore experts suggest a mixed system of professional care services and cash benefits. The legal entitlement to cash benefits could be associated with a claim to benefits in-kind (Badelt 1997; Österle/Hammer 2004, 102).

This would not only support caring relatives but also bring in preventive and rehabilitative aspects of care at an early stage; daily or hourly support to care giving relatives could be ensured by mobile care services, long-term support – e.g. in case of an illness or of vacation – could be offered by (partly) inpatient institutions.

3. 4 The educational level of nurses in Austria

Elder care is in the public opinion mainly a family task and the social value of this work is rather low in Austria. As Egger de Campo points out that the general public has little knowledge about the tasks involved in elder care (Egger de Campo 2008, 10).

That becomes apparent through the educational level of nurses: Austria is one of three EU-countries (Luxemburg, Germany and Austria) that allows access to training as qualified nurse below the Vocational Certificate level, and fails to offer a nationwide academic education for this profession. While all medical-technical “daughter professions” in the field of nursing are already taught at college level, nurses-to-be are neither admitted to college nor to universities, although particularly mobile nurses carry a lot of responsibility. Thus even the professional care services in Austria are rather “unqualified” compared to those of other EU-countries. The need for a nationwide and comprehensive academization in the qualification of nurses becomes evident not only by comparing EU-countries but rather in concerning the (also scientific) tasks and responsibilities of nurses. An interviewed expert to the need for nurses with academic degrees:

Interviewee 2: “For the assessments we need good qualified nurses in mobile care services. Especially the analysis and interpretation of the standardized assessment instruments are a challenge. Our Case Management questionnaire consists of 250 items. They have to be interpreted by the nurses in order to deduce the needs for mobile care services and to adopt the right care services. We are in a very practical business – that is right – but we need the university graduates also at the bedside. You won’t ask a doctor why he needs an academic degree but he also works at the bedside, similar to nurses. The question whether a nurse needs an academic degree or not is ridiculous for me.”

The combination of high requirements and responsibilities and low qualification standards and therefore low salaries explains the unattractiveness of this occupational field. Therefore

we find staff-shortages³ and high dropout rates. Providers of professional care services claim for better qualification standards and therefore for higher salaries of nurses in order to make this occupational field more attractive. In this connection they refer to the current economic crisis to legitimate their claim: while unemployment rates increase through the crisis, staff-shortage is still remaining in the field of elder care. Thus the providers of professional care services claim for measures in the education level in order to make the field of elder care to a “job motor” within the economic crisis and to improve the quality of care services (Volkshilfe 2010).

4. Conclusions

If a person is in need of care, many questions occur concerning the organization and provision of the adequate care services. However the Austrian care system is kind of a jungle of competences and responsibilities between communities, provinces and the federal government. Especially cost-free information for care receivers and their relatives is scarce and hard to find, first of all that concerning the individual care management. The usage of supporting and advisory services by experts and a professional care assessment by the nurses of the mobile home care services is optional, affiliated with costs and difficult to access. In fact the Austrian care system leaves the care management within families and supports unqualified home care provided by mostly female relatives through unregulated cash benefits. This system not only stresses the relatives of persons in care needs but is furthermore problematic concerning the quality of care services. The following points may sum up the core regulations of the Austrian care system and the main problems affiliated with them.

- **Unregulated cash benefits for care receivers.** The Austrian care system is a system of unregulated cash benefits for care receivers which maintain unqualified care services within families.
 - The assessment of care needs for the cash for care allowance is body- and motor orientated and therefore neglects mental illnesses like dementia to a large extent. As a result the amount of the granted cash for care allowance is mostly too small. Because there is no nationwide standardization concerning the medical assessments of care needs there are regional differences in quality.
- **Underfunding of professional care services.** The providers of professional care services are chronically underfunded by the provincial governments although rising

³ An example: There is a staff-shortage of estimated 6.500 full-time jobs in the field of elder care (Volkshilfe 2010).

demands. As a result clients in need of care find themselves on waiting lists; furthermore these services are available only on a selective level and there are hardly any night and weekend services. Due to the provincially obligation for the delivery of these services, there are regional differences in the availability and the self-paid cost rates within Austria.

- **Unqualified 24 hours care services.** Because of demographic and social trends the ability of relatives to overtake care services for the elderly is decreasing. 24 hours live-in care services recruited from Austrias Eastern neighbor countries partly compensate these trends. Those often unqualified and less German speaking carers have to be trained by the underfunded professional care services. Because of the lower costs and efforts, they are mostly self-employed although they live in the households of the clients. In fact not only their working conditions but also their qualifications are to a very low degree subject of compulsory control.
- **The low educational level of professional care services.** Compared to the EU-countries the educational level of nurses in Austria is very low but the requirements and tasks are the same. This results in high drop-out rates and staff-shortage in this field.
- **Regional differences.** The divided responsibility for the provision of care services (cash benefits and in-kind transfers) into the federal, the provincial and the municipal level results in inequalities and complicates the introduction of new regulations and innovations. Furthermore it constraints the care receiver's mobility within Austrian.

The interviewed experts claim for a consolidation of the different competence- and responsibility-agencies or at least for more interconnectedness between the institutions and departments who are responsible for the provision of care services. Only by such regulations more transparence, nationwide fairness and innovation are possible. Furthermore they claim for an institutionalization of the case management and therefore for a legal entitlement to it (Volkshilfe 2010).

The importance of comprehensive social-political measures, such as the extension of (mobile) professional care services and those of part-inpatient care becomes even more evident as the situation of caring relatives is regarded. The actual rather selective and inflexible interventions of the mobile services do hardly relieve the burden for caring relatives, especially if they are formally employed beside their caring activities.

In this connection not only a budget increase for the non-profit care providing organizations is necessary but also an educational level upgrade for nurses in order to make this occupational field more attractive to reduce the staff shortage.

A care system like the Austrian one lags behind the demographic and social trend towards an overage population and leaves increasing job demands and career orientations of the

former “silent reserves” of caregiving persons, namely women, out of the picture. There is hardly any policy to support caregivers in the widely unforeseeable area of eldercare: most people have two parents who will sooner or later need some help up to 24 hours care. For the time being, the care system of Austria leaves these caregivers alone with that situation.

5. References

- BADELT Christoph; HOLZMANN, Andrea; MATUL, Christian; ÖSTERLE August (1997): Analyse der Auswirkungen des Pflegevorsorgesystems, Wien
- BAUCH, Jost (2005): Pflege als soziales System In: SCHROETER, Klaus; ROSENTHAL, Thomas: Soziologie der Pflege. Grundlagen, Wissensbestände und Perspektiven, Juventa Verlag, Weinheim/München, S. 71 – 84
- BAUCH, Jost (2000): Medizinsoziologie. Lehr- und Handbücher der Soziologie. München, Wien: Oldenbourg
- DIMMEL, Nikolaus; SCHMID, Tom (2009): Soziale Dienste, in: DIMMEL Nikolaus; HEITZMANN Karin; SCHENK Martin: Handbuch Armut in Österreich, Studienverlag, Wien u. a., S. 579-609
- EGGER de CAMPO, Marianne (2008): The Rhetoric of Reaction in the Austrian Debate about Legalisation of Migrant Care, Paper to be presented at the conference “Transforming elderly care at local, national and transnational levels” International Conference at Eigveds Pakhus, Copenhagen
- HAMMER, Elisabeth (2002): Die Regelungen zur Pflegevorsorge in Österreich. Aspekte der (Re-) Produktion von Klassen- und Geschlechterverhältnissen im österreichischen Wohlfahrtsstaat, Diplomarbeit, Wien
- HEITZMANN, Karl, SCHENK Martin (2009): Soziale Ungleichheit und Armut: Alter (n) und Pflegebedürftigkeit, in: DIMMEL Nikolaus, HEITZMANN Karin, SCHENK Martin (Hg.): Handbuch Armut in Österreich, Studien Verlag, Wien u. a., S. 138-143
- KRENN, Manfred; PAPOUSCHEK Ulrike; SIMSA Ruth (2004): Soziale Dienste (Mobile Pflege) in Österreich – Skizze eines Sektors. Auszug aus dem EAP-Zwischenbericht, Forschungs- und Beratungsstelle Arbeit, Wien
- ÖSTERLE, August; HAMMER Elisabeth (2004): Zur zukünftigen Betreuung und Pflege älterer Menschen. Rahmenbedingungen – Politikansätze – Entwicklungsperspektiven, Wien
- SCHROETER, Klaus (2005): Pflege als figuratives Feld In: SCHROETER Klaus; ROSENTHAL Thomas: Soziologie der Pflege. Grundlagen, Wissensbestände und Perspektiven, Juventa Verlag, Weinheim/München, S. 85 – 106
- VOLKSHILFE ÖSTERREICH (Hg.) (2010): Positionen. Pflege und Betreuung. Fakten, Hintergründe und Forderungen, Wien

