Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Austria

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More than two-thirds of all dependent old persons in Austria are cared for by next of kin. This proportion has remained rather constant over the years. One out of 15 adult Austrians can be considered as a family carer, above all as parent carers. Women are disproportionately engaged in eldercare. Research results suggest that better educated people with higher incomes are less willing to take over responsibilities for ageing parents. In the future, the pool of available family carers will shrink because of demographic reasons.

There is abundant evidence that most family carers are confronted with physical and psychological burdens The whole family system can develop a severe if often concealed crisis when the carer reaches her / his limitations in providing eldercare. In extreme cases experiences of overwhelming stress, strain, and lack of leisure-time may even lead to elder abuse and neglect.

More than two-fifths of all carers are fulfilling duties in gainful employment as well as in family care. There can be no doubt that the overwhelming majority of them have to overcome severe difficulties in combining work and care successfully.

There is only limited tangible assistance provided to help family carers carry out their tasks. They have also to deal with a lack of information. There is a range of training programmes for family members caring for elderly relatives. Nevertheless, deficiencies are felt particularly with regard to methods of prophylaxis, supply of auxiliary care devices, and respite care. Essentially, research has shown that little co-ordination and co-operation between family members and service providers exists.

The introduction of the Austrian long-term care allowance system has strongly affected the situation of care-dependent people and their families. Especially women of lower social classes can afford it financially to care for their parent because cash benefits are available. How to assure quality of informal care without professional supervision and accountability remains a major concern.

Recommendations

- Combining work and eldercare should be easier to accomplish. Social policy should be more responsive to the needs of caring employees.
- Appreciation of care work by the general public and the authorities should be enhanced. In particular, unnessecary bureaucratic obstacles must be removed when asking for support from community service agencies.

- Family carers should be encouraged to organize themselves at the national level as an official lobby organization in order to be able to raise their voice in caring issues.
- Support by installing permanent supervision programmes and effective telephone counselling is needed; family carers' complaints or proposals for improvements of their situation have to be investigated more actively and systematically.
- The development of quality assurance methods within the sphere of family care is necessary as well as the implementation of non-intrusive control mechanisms.
- More light is to be shed on the "dark figures" of elder abuse and neglect in family care situations.

Service Providers

Principally, provincial governments contract-out community care services to a variety of NGOs. Commercial firms do not play a significant role in extramural care. Although in each province there is a minimum standard of professional training and certification for care workers, Austria is lacking in nation-wide regulations and standards. In particular, home helpers, geriatric aides and family helpers are trained on the basis of regional regulations. There are also curricula developed by non-profit providers. Consequently, community care differs from region to region with regard to organization, selection of services, and status of development.

The number of community care services has increased significantly since the 1970s. There are still areas of vacuum in service coverage and enormous regional disparities. Since the 1990s the speed of expansion has slowed down. The general trend is that services are targeted towards people with critical medical care needs. Peripheral services like cleaning, laundry services or friendly visiting are cut back. Day care and respite care have also been established successfully. Last but not least, there is a growing trend towards terminal care in specialized institutions such as hospices and palliative care departments.

There are considerable efforts to implement case management techniques. In particular, the tasks of home nurses include not only medical care but also advice and training for family carers and fulfilment of linkage functions between clients, general practitioners, family members and hospitals.

Currently, there are only a few efforts addressing the social care needs of older migrants; a growing demand for community services is anticipated for the future.

Recommendations

- More efforts should be directed towards the improvement of co-ordination between the different intramural and extramural professional services and agencies in the field of health and social care.
- Home nurses should be in a position to accomplish functions as case managers as well as performing linkage functions between formal and informal care sectors.
- Nation-wide harmonisation of training standards for health and social professions is crucial in making these professions more attractive.
- There is an urgent need (also in rural areas) for additional provisions of care in semi-stationary centres offering protective day care while family carers are at work.
- The number of beds for respite care is not sufficient.
- More attention must be paid to the problems of eldery with dementia or other mental impairments by establishing communicative, creative, and therapeutic programmes.
- Service providers have to pay more attention to the special needs of the growing proportion of older migrants.

Policy Makers

Principally, it is fully recognized by all relevant political bodies and decision-makers that family care is indispensable. The most important development in national eldercare policy in the last decade was the introduction of the Federal Long-Term Care Allowance which takes the form of a cash payment to compensate for care-related additional expenses. Thus, consumer choice is on the agenda as a way to ensure the elderly flexibility in both quality and quantity, and a more individualized organization of home care. Probably, re-privatization will be of even greater importance in the future.

There is large regional variation with regard to legal definitions for social services, residential care, the structure of nursing homes and with regard to the organization and range of existing services, eligibility criteria, cost-sharing etc. Moreover, adult children are treated differently as far as cost-sharing for nursing home accommodation etc. is concerned.

Recommendations

- LTC assessment instruments bias eligibility in the direction of those who have medically related needs. The programme does not sufficiently take into account the special life circumstances and supervision needs of people with cognitive impairment.

- One main objective of care policy should be to find ways to support informal care by developing models of shared responsibility between the family and social service organizations, which prevent superfluous overlap and detrimental gaps in the supply of support and care.
- The existing legal arrangement between the federal and the provincial authorities which contains a catalogue of benefits and quality criteria for social services must be implemented more effectively.
- Provincial authorities should pay more attention ensuring that the services offered are organizationally interlinked.

Introduction – An Overview on Family Care

According to the 2001 census Austria has 8 million inhabitants. Growth of the number of inhabitants will continue into the late 2020s, due to gains from immigration, before the population is expected to decline as the result of a high excess of deaths over births (Hanika et al., 2004). The Austrian population, like the population of most European nations, is in a phase of accelerated demographic ageing. This transition process is the consequence of a declining birth rate and a simultaneous increase in life expectancy. Currently (2001), there are 1.7 million people aged 60 or over living in this country. Forecasts predict that by 2030 this number will increase by more than half to 2.7 million people. The percentage of people aged 60 or over will increase from 21.1 % of the total population at present to 32.1 % (see tables 18-20, appendix).

Increasing life expectancy implies that more people will survive into advanced old age. Thus, the trend towards "double demographic ageing" (i.e. an over-proportional increase in the number of people in very old age) is a crucial feature of demographic development. The number of people aged 80 years and over will double from 294,000 at present to nearly 590,000 in 2030. Looking even further into the future, the number of over 80 year olds will more than triple by 2050. In terms of gender, the group of older persons living today is marked by an over-proportional number of women. For every 100 women over the age of 60 there are only 69 men of the same age. For people over 80, the gender ratio is 100 women to 39 men. The main reason for this imbalance is the shorter life expectancy of men. Another reason – though one that is becoming more and more irrelevant – is the large number of men who lost their lives in the war. A much more balanced gender ratio is predicted for the future.

In pay-as-you-go public insurance schemes, such as in Austria, demographic ageing gives reason for serious concerns about how pensions are financed, because an ever increasing group of retirees will rely on a shrinking group of people of working age.[1]

Apart from general social security concerns, the worsening dependency ratio implies an increase in demand for long-term care services and facilities. Yet considerable uncertainties remain about the actual development of the number of old people dependent on care.

There is evidence that the elderly do not only live longer, but also that at least their somatic health status has improved considerably over time. From survey data we can conclude almost definitely that the occurrence of somatic decline has already been postponed. The results of the 1998 microcensus survey

[1] Asked to choose between different alternatives to secure the financing of the pension system, Austrians overwhelmingly prefer elevated contributions to the pension insurance scheme over any ideas to make adult children legally responsible for support of their parents (Schimany, 2004: 59).

indicate that the health status of both men and women has improved significantly among the elderly Austrian population[2]. Among the 80-84 year olds only 16 % of men and 25 % of women rate their health status as "bad"; twenty years earlier, twice as many respondents had rated their health negatively. Among the 85-89 year olds, an improvement in self-rated health could be observed, too (Kytir et al., 2000: 307). Likewise, healthy-life expectancy doubled in all age groups examined within 20 years. Healthy-life expectancy of 80-year-old women increased from 0.7 years (1978) to 1.8 years (1998). The tendency observed with men is similar (Doblhammer, Kytir, 2001).[3]

There is also evidence for improvement with regard to specific activities of daily life. For example, a significant upward trend in the ability to climb stairs without difficulties can be shown. In 1998, 94 % of people aged 60 years and over report no difficulties in climbing stairs whatsoever; in 1971, this percentage was 84 %. Among people aged 75 years and older, 90 % of men and 87 % of women do not have any difficulties in climbing stairs; a quarter of a century ago these percentages had been as low as 75 % and 67 %, respectively (Hörl, 2001).

The overall conclusion is that the elderly do not only live longer, but also that their health status and functional status has improved considerably over time. The years of life the Austrians have gained are apparently mainly years lived in good health. Thus, data so far supports the theory of a compression of morbidity into the last years of life. In the long run, these improvements should also significantly dampen expenditure growth (Hofmarcher, Riedel, 2002).[4]

As far as family life is concerned there will be decreasing family sizes. The pool of available family carers will shrink because more and more old people will have fewer and fewer children, whilst still more will have no children at all.

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[2] The microcensus survey methodology employs subjective health status ratings; it has frequently been reported that self-rated health is a valid predictor of mortality and of change in physical function (Doblhammer, Kytir, 2001).

[3] The microcensus survey does not cover the population living in institutions and this may result in an estimate of health status that is too positive. However, since the proportion of the institutionalized population only changes slightly over time, one may assume that this does not introduce a bias into the time trend with respect to healthy-life expectancy. Of course, this statement only holds true under the assumption that the frailty distribution of those living in institutions does not significantly change over time.

[4] As far as nursing needs and overall costs at the macro-level are concerned, it must be taken into account, however, that the oldest old (80 years and over) comprise the fastest growing segment of the total population. On the other hand there is, of course, still a much greater likelihood for the very old to develop cognitive impairments and / or functional deficiencies and to become dependent on care (see tables 18 and 25, appendix). There is also evidence that long-term allowance receivers are confronted with severe restrictions in performing activities of daily life (see table 24, appendix). Consequently, health expenditure rise noticeably with age; per capita expenditure in the 85-89 age group, for example, are five times as high as in the 35-39 age group; people in the 80+ age group comprise 4 % of the total population but the corresponding share of health expenditure spent on this group is more than twice as high (11 %) (Riedel, Hofmarcher, 2003: 198, 210).

Around 2015, approximately, a greater proportion of women (and men) who were born in the mid-1950s or later and who never had a child will enter early old age. One consequence will probably be an increase in one-person-households and maybe a greater reliance on non-family institutions, as well as commercial and social services of all kinds. Such developments should prove even more substantial in rural out-migration areas where the decline in birth rates has been more significant than in the cities, and social services are still relatively sparse.

On the other hand, due to increasing life expectancy there is an increased likelihood of there being more generations (of course, if there are children at all) within the family, i.e. the emergence of the so-called “beanpole family”, and an ever-later incidence of parentlessness among adults. Nowadays three-generation families exist for about 30 years.

Finally, judging from current societal trends it is not unlikely that divorce rates and “incomplete family forms” will continue to grow, with the consequential complication of the generational structure of older persons, and possibly weakened loyalties.

More than two-thirds of all dependent old persons in Austria are cared for by next of kin. This percentage has remained rather constant over the years (Badelt, Leichsenring, 2000: 439; Kytir, Münz, 1992). In terms of quantity, non-family informal networks, as well as community care services and residential care are of minor importance.

In order to explain the persistent social pattern of family care, three distinct sets of reciprocity processes between carer and old person can be extracted from various empirical studies (Amann et al., 2001; Hörl, 1989, 1992; Majce, 2003; Rosenmayr, 1990):

- Obligation and gratitude. Asked after motivations for caring, feelings of natural obligation prevail among carers; gratitude and obligation stretch over the life cycle and are felt most strongly to parents or spouse but to some extent also to more distant kin or even non-relatives;
- Financial and / or material donations to the carers. There is evidence that family carers receive rather generous cash donations and legacies (as heirs of real estate etc.). Although financial or other material advantages are seldom primary motivations for informal care it is reasonable to assume that remunerations are considered as important fringe benefits of caring;
- Mutuality in social relationships. Data suggests that those who are dependent on another person may also be needed by the carer. Not so few carers are themselves threatened by feelings of loneliness because of low cultural aspirations and a restricted social network. Caring is a way to get social recognition and improve morale.

Of course, in addition to family interaction and reciprocity dynamics there are still powerful norms of spousal or filial duty and responsibility at work. To violate societal norms of appropriate filial behaviour causes feelings of guilt among adult children. Notwithstanding modernisation processes many people are still heavily influenced by historical traditions and religious teachings.

On the one hand it is certainly a myth that families abandon their elderly – in terms of contact frequencies as well as in terms of caring; on the other hand it would be dangerous to overestimate the future role of kin relationships in the lives of the elderly. Declining marriage rates, declining birth rates, rising divorce rates, rising female labour participation rates and new demands with regard to occupational and leisure roles for men and women contribute to an already emerging social behaviour pattern of more “individualised” modern life styles. There is widespread agreement that women will play a greater role in working life. The self-sacrificing, austere attitude of the older generation, the ability to “do without” things and the custom of obedience cannot be taken for granted in the future.

Thus, for demographic and sociological reasons there can be little doubt that family support networks will become more loosely knit in the coming decades and will be characterized by changes in mentality focused on career, earnings and consumption. Hence, in spite of the high level of solidarity and help provided within today’s families on the whole, decision-makers are faced with the necessity of expanding social and health services, as well as geriatric and nursing facilities, in order to compensate for the higher probability of deficiency in families in the future.

Each of the nine Austrian federal provinces is developing and expanding its special strategy for out-patient provision, home health care and community services for the elderly. To guarantee at least a minimum common standard the federal and the provincial authorities came to a legal arrangement containing a catalogue of benefits and quality criteria for social services.

Traditionally, community care provision in Austria is a stronghold of non-profit welfare associations (NGOs). To a lesser degree they also play a role in residential care. There are dozens of different non-profit agencies operating in the provinces with remarkable regional differences in terms of quantity, quality and type of services provided. The welfare organizations are reimbursed by the province or municipality. Many NGOs still rely heavily on work by volunteers or by young men who choose community work instead of military service; this makes them very competitive against commercial service providers.

In Austria, such as in some other countries, a major trend in care-giving for elderly persons is the development of consumer-directed home care. The Austrian variant of the long-term care (LTC) system (see section 2) gives consumers, rather than established community care agencies, control over who provides services and how these services are delivered. Beneficiaries

receive cash payments enabling them to purchase the services they want. At least theoretically, the consumer is endorsed to hire, train, supervise, and fire her / his care worker; it is of no relevance whether carers are family members, social agency workers or commercial providers. Of course, for several reasons this is only a quasi-market. The empowerment philosophy behind consumer-directed home care has been slow to take hold among decision-makers because of concerns about whether older persons either want to direct, or are capable of directing the services they need. How to assure quality of informal care without professional supervision and accountability is a major concern, too.

There can be little doubt that the introduction of the long-term care allowance has strongly affected the situation of care-dependent people. Elderly who are assertive and have a broad family support network are most likely to want consumer direction, especially by giving cash to their children. Isolated older people with disabilities tend to accept traditional care distribution by welfare agencies more readily. All things considered, since the mid-1990s, in some sectors of community work (e.g. home help) stagnation or decline in the amount of professionally delivered home care services can be observed. Obviously, a certain re-privatization of care (by way of family or other private carers) has taken place.

While in Vienna and other cities it is only recently that more energetic steps have been undertaken to integrate volunteers systematically into service provision[5], rural areas have a strong tradition of volunteering in various fields of community work. The (Roman Catholic) Church plays a prominent role in volunteering. Additionally, there are several organized neighbourhood support programmes. For instance, in the province of Burgenland existing neighbourhood networks are subsidized by the regional government.

Regarding unpaid private care given to friends, neighbours, etc., no detailed data is available but it may be estimated that one out of 15 carers is involved in such an informal non-family relationship (see section 1.7).

Due to the improvement in overall health it is quite reasonable to assume that per capita consumption of nursing care services is likely to decrease in the long run. Up to the present day, however, the unfavourable ratio between revenue and expenditure in the health insurance scheme has frequently been the subject of very heated debates conducted at the political level and in the media for a number of years. On the one hand, it is proposed that revenue should be increased through a general hike in contributions or additional payments made by the insured for benefits provided in individual cases, while others call for a reduction in expenditure through lower payments for drugs

[5] Currently (2005), in selected nursing homes in Vienna a pilot project is being carried through to test whether a substantial number of volunteers can be recruited to support residents (by taking meals, running errands, contacting family members, etc.)

and services by the contracting parties, as well as for enhancing general health awareness.

A permanent discussion centres on problems of hospital funding, which has been regulated by way of extremely complicated agreements between the federal government and the provinces. The funds provided by the Federation are paid into a structural fund and then transferred on to the nine regional funds according to an agreed allocation ratio. These regional funds are also financed by contributions to the social health insurance scheme, tax resources and other contributions from the federal provinces and local authorities. As a cost-containment measure, in 1997 a system of performance-oriented hospital funding (instead of a non-differentiated daily flat rate system) was introduced.

The long-term care allowance is not financed by contributions like social insurance but from general tax revenue. The cause of the need for care is immaterial with regard to entitlement to the allowance, so that an essential element of the maintenance systems is absent. It is also by statute a lump-sum benefit that is not subsidiary to other systems, which differentiates it from social assistance. To a certain degree the specific way of funding shields long-term care from discussions such as those conducted with regard to health insurance. Nevertheless, because of the perpetually rising number of beneficiaries a costs upsurge has taken place. Up to now the government has handled the problem by refusing to adjust the cash benefits to inflation.[6]

[6] As of Jan. 1, 2005 LTC benefits were slightly raised by 2 %.

1 Profile of family carers of older people

The profiling of family carers of older people[7] is based on several sources. The most recent results are drawn from the microcensus "Household Tasks, Childcare, Social Care" (Kytir, Schrittwieser, 2003). This survey is based on a very large sample and therefore yields statistically reliable results, yet is lacking in details concerning social relationships and living conditions of carers and / or care receivers. Detailed results are available from the mid-1990s study "Consequences of the Long-term Care Provision System" which evaluates all aspects (including financial and psychological) of the living conditions of long-term care allowance receivers and their family carers (Badelt et al., 1997). More recently, a study "Quality Control in Social Care" was conducted (Nemeth, Pochobradsky, 2002); the focus here is on assessing the quality of home care provided by family carers and / or social services for long-term care allowance receivers.[8]

Number of carers

Nation-wide microcensus data is available on unpaid informal carers of relatives[9] who are in need of more or less permanent support because of frailty, disability or chronic illness. According to the results of this survey 425,900 Austrians aged 18 years or over (i.e. 6.7 % of the adult population) can be considered as family carers.[10] Among carers, 38,900 are caring for more than one person; that means that one out of ten carers (9.1 %) is engaged in caring for at least two people (Kytir, Schrittwieser, 2003).

Taking double carers into account the total number of people who are supported by family carers is 464,800. This figure compares with about 356,400 people[11] who receive federal or provincial long-term care allowances (see also section 2, table 13).

As expected, the number of care receivers according to microcensus data by far surpasses the number of beneficiaries of long-term care allowances. The picture of informal care-giving reflected by official data is rather narrow and incomplete since the long-term care allowance is awarded only after a thorough medical examination, and only if the examining doctor comes to the

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7 Some studies include a certain (but always quite small) percentage of young and middle-aged care receivers.

8 When comparing and interpreting results from different studies it has to be taken into account that definitions of populations covered are variable.

9 A wide definition of kin is applied; close friends or neighbours are considered as quasi-family members.

10 It should be noted that in accordance to the microcensus definition the care receivers are not required to be of a certain chronological minimum age. No data on the age of care receivers is available; looking at relationships (see section 1.7) it seems a reasonable guess that about one out of ten family carers provides care for a person below the conventional age limit of 60 years.

11 About 293,300 or 82 % of long-term care beneficiaries are over 60 years old.

conclusion that the applicant is in need of at least 50 care hours per month. In contrast, survey respondents, as a matter of course, report lower levels of assistance as well.

Age of carers

Care-giving is much less likely to occur in younger years than in later life. Only around 2 % of 18-29 year olds identify themselves as carers, compared with more than 10 % of 50-64 year olds (table 1). This difference is due to the fact that most carers support either members of their own generation or members of the immediate generation above. Grandchildren are very seldom involved in any tasks encompassing substantial help and support. Obviously then, care-giving becomes a salient feature of life only when either someone's (widowed) parent enters old age and becomes frail, or someone's ageing spouse is in need of more intensive help and assistance.

Table 1: Age of carers

Age	% of carers in age group
18 – 24	1.4
25 – 29	2.6
30 – 34	3.0
35 – 39	4.0
40 – 44	6.8
45 – 49	9.1
50 – 54	10.4
55 – 59	11.8
60 – 64	10.6
65 – 69	9.6
70 – 74	9.4
75 – 79	10.6
80 – 84	5.0
85+	4.1
Population estimate	(425,900)

Source: Kytir, Schrittwieser, 2003.

Younger adults – if they have to take over the carer role at all – are primarily involved in care-giving for their own (disabled) children. Only for people over 35 years of age does parent (or in-law) care gain any importance. Starting approximately at the age of 55 years, more and more people are involved in care for husband or wife. People between 55 and 65 years old are involved in simultaneous caring for their partner and for their parents more frequently than other age groups.

Gender of carers

Female family members disproportionately engage in care of the elderly. Among carers there are 281,900 women and 144,000 men (Kytir, Schrittwieser, 2003).[12] In relative terms, 8.5 % of adult women and 4.7 % of adult men consider themselves as family carers. Further analysis reveals remarkable gender differences in caring patterns: almost two-thirds of mothers are supported by daughters, whereas fathers can rely a little bit more often on sons – more than two out of five fathers are supported by sons. This gender pattern does not apply to in-laws – the proportion of caring daughters-in-law is almost identical for fathers-in-law (79 %) and mothers-in-law (78 %). Care for non-kin is almost exclusively (83 %) performed by women.

It seems unnecessary to outline that the persistent "female character" of care is a result of the powerful influence of role patterns traditionally attributed to men and women in our society. To a certain extent, however, the preponderance of women among family carers can simply be explained by the combined effects of (a) the typical age difference of husband and wife, and (b) the difference in life expectancy of the sexes. On average, wives are a couple of years younger than their husbands and outlive them by quite a few years.[13] Therefore, at least the current generation of elderly men can – in customary circumstances – trustfully count on their wives in case support needs should emerge. In contrast, when women finally become frail themselves they either happen to be already widowed or often their aged husbands are no longer in a physical and mental condition to perform care tasks adequately. Even so, since males – if they perform care tasks at all – concentrate on their spouses, a higher percentage of male than female carers (22 % vs. 16 %) are occupied in care for their marriage partner; most male carers for spouses are already retired.[14]

Income of carers

Unfortunately, no systematic statistics on the income of carers are available. It is possible, however, to gain some insights into the general income conditions of long-term care allowance receivers in 2002 (see table 2). Almost two-thirds of all recipients earn gross incomes below 860 euros per month and only one in hundred earns more than 3,270 euros per month.[15] Not least thanks to the cash benefit most recipients live well above the poverty line; nevertheless, a rather modest income situation is revealed. Apart from other consequences it

[12] In other words, 34 % of all microcensus family carers are male and 66 % are female; other studies report an even higher female proportion among carers, up to 80 % (Badelt et al., 1997).
[13] See table 21 (appendix) for marital status by gender.
[14] Similar results with regard to gender differentiations are reported by Badelt et al., 1997: 231.
[15] See table 26 (appendix) for information on the general income situation of pensioners.

becomes obvious that most elderly are not in a position to buy services from commercial care suppliers in any substantial quantity.

Table 2: Monthly gross income of LTC allowance receivers (2002)

Income	%
Under 570 euros	27.6
570 – 859	33.9
860 – 1,789	31.3
1,790 – 2,859	5.5
2,860 and over	1.7
Total receivers	348,561

Source: BMSG, 2003: 10.

Their restricted income situation leaves care-dependent persons with two principal options.[16] Firstly, they may apply for community care services from local governmental or non-profit welfare agencies. However, with the introduction of the long-term care allowance and the supposedly higher incomes of beneficiaries, agencies have increased clients' contributions, and also introduced fees for those services which had been free of charge previously. At the same time, the number of subsidized service hours was made subject to a limit with respect to the assessed level of the individual's care needs.

The second alternative is to rely on the next to kin (if available); this option provides the opportunity to augment the household budgets. Actually, there is evidence that the money from the long-term care allowance ameliorates the financial situation of families. 82 % of receivers report that the allowance covers a "significant portion of costs" and 81 % acknowledge that the allowance gives them a better opportunity to be "grateful" to their family carers, meaning they are able remunerate them for the care provided (Badelt et al., 1997: 99).

The assumption that the income of family carers is increased is corroborated by the carers themselves. No less than 86 % of carers declare that they have direct or indirect access to the old person's long-term care allowance, either through the receipt of regular payments or through joint handling of the household budget (Badelt et al., 1997: 136).

[16] A third option may be to employ (foreign) low-cost carers who work illegally.

Hours of caring and caring tasks

Almost half of microcensus carers spend between 5 and 15 hours per week on caring purposes; a quarter of respondents are occupied with caring tasks for 15 hours or more per week (table 3).[17]

Table 3: Hours of caring per week

Hours	%
Less than ½ hour	1.5
½ hour – less than 1hour	9.9
1 hour – less than 5 hours	18.5
5 hours – less than 15 hours	45.6
15 hours and more	24.3
Population estimate	(425,900)

Source: Kytir, Schrittwieser, 2003.

As expected, women differ significantly from men as regards the intensity of their involvement. On average women devote 11.4 hours per week to caring tasks while men spend only 9.0 hours per week – this makes a difference of almost 2.5 hours. For 28 % of female carers the amount of time for care-giving exceeds 15 hours a week; the corresponding proportion for male carers is only 17 %.

It goes almost without saying that informal caring comprises a wide variety of different tasks. Over three quarters of carers give personal assistance, especially with regard to personal hygiene, bathing, dressing and undressing or help with taking meals; the same percentage of the carers provide transport services, e.g. driving the old person to the doctor or accompanying her / him to social agencies; almost half of the carers fulfil various other kinds of support tasks, in particular shopping, preparation of meals and cleaning (table 4). Gender differences stand out regarding the types of care given. Male carers provide transport or escort services more frequently (83 %) than female carers (75 %); on the other hand only 40 % of male carers but 55 % of female carers provide personal assistance (Kytir, Schrittwieser, 2003).

[17] Compared with general family carers (microcensus data), carers of long-term care allowance receivers spend much more time caring; 38 % devote up to 20 hours, 30 % devote 21-40 hours, and 32 % devote more than 40 hours per week (Badelt et al., 1997: 263).

Table 4: Caring tasks (multiple answers)

Tasks	%
Assistance with food intake and personal hygiene (washing and dressing)	49.1
Transport and escort services	77.4
Other forms of help (e.g. household activities)	77.5
Population estimate	(425,900)

Source: Kytir, Schrittwieser, 2003.

Level of education and / or Profession / Employment of family carer

According to the microcensus data 43 % of all carers are employed, 2 % are jobless, and 55 % are not (or no longer) employed. In comparison, the general (i.e. the non-caring) population is comprised of 60 % employed persons, 2 % jobless persons, and 38 % persons who are already retired or have been never employed (Kytir, Schrittwieser, 2003).[18] Obviously, the carer population includes a larger proportion of people who do not (or no longer) participate in the job market than the general population. In interpreting this fact it has to be taken into account that, on average, carers are older than non-carers and therefore stand a better chance of being already retired. Furthermore, more women than men are carers and the female employment rate is generally lower than the male employment rate; the retirement age of women is lower, too.

Nemeth and Pochobradsky's (2002: 21) research yields almost identical data – 30 % of informal carers are engaged in full-time work, a further 14 % in part-time work whereas 55 % (nine-tenths amongst them over 60 years old) are not (or no longer) members of the labour force. Furthermore, women have been found to engage in caring even if they are in employment, while men usually only engage in caring when they are unemployed or have taken early or ordinary retirement.

Altogether, it seems accurate to say that more than two-fifths of all carers are "doubling" by occupying both roles: fulfilling duties in gainful employment as well as in informal family care.

Information on the carers' levels of education can be found in table 5: more than two-fifths of carers report compulsory schooling only, almost half have completed vocational schools for apprentices or secondary technical and vocational schools, less than one in ten carers has been awarded the so-

[18] Jobless people appear to be under-represented in the microcensus survey when compared to official national social insurance data.

called "matura"[19] leaving certificate, and only a few hold some kind of university degree.[20]

Table 5: Level of education of carers for LTC allowance receivers

Level of education	%
Compulsory school	42.9
Vocational school for apprentices / secondary technical and vocational school	48.1
"Matura"	7.5
University degree	1.5
N	(1,268)

Source: Badelt et al., 1997.

Information is also available on (current or former) professions or occupations of carers in broad categories. More than two-thirds of carers have participated in the labour market at some point in their life: 80 % as gainfully employed persons (one third each as workers and as salaried employees and one seventh as public employees), 17 % as farmers or wives of farmers, and 7 % as self-employed (mostly small) businessmen or -women (table 6). Compared with the general population we find above average rates in the low-status jobs of labourers / workers and occupation in the agricultural sector.

Table 6: Profession of carers for LTC allowance receivers

Profession	%
Self-employed businessmen or -women	7.0
Salaried employees	33.3
Public employees	13.5
Workers	32.8
Farmers	16.7
Others	7.1
N	(1,282)

Source: Badelt et al., 1997.

The presented data on levels of education and on occupations allows some preliminary conclusions on the social status of carers to be made. Evidence seems convincing enough to characterize the carers' background as of relative low social status. To a substantial degree, this is due to the simple fact that

[19] Under regular circumstances, the "matura" level of education is reached after completing 12 or 13 years of education in secondary academic schools or in secondary technical and vocational colleges.

[20] The comparable educational levels in the general adult (i.e. 18 years or older) population in 1998 (microcensus data) are as follows: 31 % compulsory schooling only, 49 % vocational schools etc., 12 % "matura", and 9 % university degree; the definition of some categories varies slightly.

carers predominantly belong to the older (i.e. less formally educated) generations and are more likely to be female.

Additionally, shifts in behavioural patterns may very well be in effect, in the sense that better educated people with higher incomes – working in more highly qualified and professional jobs – are less willing to take over responsibilities for ageing parents by carrying out care work and domestic work personally. Of course, affluent people are in a better position to buy such services on the free market.

Generation of carer, Relationship of carer to OP

Parent care dominates care relationships. More than half of all cases of family care are dedicated to the parent generation. Specifically, 30 % of all cases include the carers' mothers, and an additional 11 % include the carers' mothers-in-law. A further 9 % of all cases include fathers and 3 % include fathers-in-law. Obviously, in the realm of parent care mothers are much more frequently supported than fathers (because the likelihood of being widowed is much greater for women than for men).

18 % of all support is given to the (marriage) partner; 7 % of care receivers are (adult) children and 15 % of care receivers are more distant kin. Just 7 % of all informal unpaid care is provided for non-kin, i.e. close friends and neighbours (table 7).

Table 7: Relationship of dependent person to carer

Relationship	%
Male / female partner / spouse	18.3
Mother	29.7
Mother-in-law	10.8
Father	8.6
Father-in-law	3.1
Child	7.2
Other relative	15.2
Friend	6.8
Population estimate	(464,800)

Source: Kytir, Schrittwieser, 2003.

Residence patterns

Residence patterns are characterized by the carers' close proximity to the person needing care. 40 % of people needing care are sharing a household with the carer, and a further 15 % of elderly people live in a separate apartment but situated in the same house. The remaining minority of 45 % of

elderly people do not live "under one roof" with their carers (table 8). There is one exception to this residential pattern: in the capital of Vienna living apart is much more common – here, 63 % of care receivers do not live in the same house as the carer. Obviously, the housing situation in a big city does not easily allow joint living; in Vienna there is also a larger percentage of more distant kin (e.g. siblings or aunts) among care receivers. No other significant differences in care-giving patterns can be found between the geographical regions (provinces) of Austria. As can be seen in table 9, carers of long-term care allowance receivers live very close to the dependent elderly as well.

Thus, co-residence rates between carers and the elderly are much higher than intergenerational co-residence rates between people of comparable age in the general adult population. Although no longitudinal research on this matter is available, to a certain extent the difference can probably be attributed to relocations in later life. Dependent parents either move into the house or apartment of their children or vice versa after more intensive and time-consuming care becomes necessary.

Table 8: Place of residence of dependent persons

Place of residence	%
Living in the same household as carer	40.1
Living in the same house as carer	15.0
Living somewhere else	44.9
Population estimate	(464,800)

Source: Kytir, Schrittwieser, 2003.

Table 9: Distance of carer to LTC allowance receiver

Distance	%
Same house as receiver	68.8
Up to 15 minutes	17.8
Up to 30 minutes	8.0
More than 30 minutes away	5.6
N	(1,475)

Source: Badelt et al., 1997.

Of course, quality of housing and neighbourhood infrastructure has a direct impact on how effectively carers can cope with the care situation. Details on the housing and infrastructural living conditions of long-term care receivers can be found in tables 10 and 11. Sanitary installations and the installation of time-saving modern household appliances appear to be of more or less satisfactory standards, and should have become even better since this data was collected.[21] As far as the quality of neighbourhood infrastructure is concerned,

[21] See table 29 (appendix) for information on general housing standards of the older population.

however, much is left to be desired. Between three quarters and four-fifths of old people do not live within walking distance of 15 minutes or less of a general practitioner, pharmacy, food store, etc. Since these are averages, in remote rural areas the infrastructural situation is even worse. There is little opportunity for old people to accomplish any outdoor activities of normal life without assistance from someone else.

Table 10: Living conditions of LTC allowance receivers (multiple answers)

Furnishing of the apartment	%
Toilet inside the flat	88.3
Bathroom inside the flat	84.8
Refrigerator	95.2
Microwave oven	23.5
Washing machine	73.2
Central heating	64.6
Telephone	83.8
Telephone which can be reached from the bed	22.4
Stairs inside the flat	33.4
N	(1,450)

Source: Badelt et al., 1997.

Table 11: Infrastructural conditions of LTC allowance receivers (multiple answers)

Facilities which can be reached without any help in less than 15 minutes	%
General practitioner	24.8
Pharmacy	18.9
Food store	27.0
Restaurant	18.9
Hairdresser's shop / pedicure	17.2
Post office	18.8
Public transportation	27.7
Park / garden	35.0
Nothing at all from above	46.6
N	(1,450)

Source: Badelt et al., 1997.

Working and caring

Speaking in terms of the general population, caring for an old person is not a relevant reason for not being gainfully employed. In a microcensus survey

among 15-49 year old non-working housewives[22] just 2.6 % declare that caring for a sick or dependent adult person (e.g. parent or marriage partner) is the most important reason for not being employed (Kreimer, Leitner, 2002: 12).

In spite of that, in the special field of eldercare policy it is one of the most burning issues whether women (and men) can be provided with opportunities to choose between informal care work and paid employment or – if preferred – to combine these two.

The problem of reconciliation between work and eldercare is only marginally acknowledged in existing legislation.[23] It is even more sobering to notice that this topic does not figure in prominent positions in the social policy agendas of political parties, unions or interest groups. For the old people's organizations, too, this is an issue of only secondary importance.

As has been stated previously, more than two-fifths of all carers are also members of the labour force. The opportunities for adult children of older people to engage in paid work depend largely on the available options for organizing everyday care. Combining work and care is considerably easier to accomplish if one or more of the following four factors are present (Badelt et al., 1997: 121-122):

- The condition of the elderly is such that the intensity of caring can be kept at a relatively low level;
- The place of working, living and caring is the same; typically, this is the case with farmer families;
- Additional support resources are available besides the primary carer, for instance other family members or social services;
- The employer's attitude is responsive to needs of caring employees.

There can be no doubt that the overwhelming majority of working carers have to overcome severe difficulties in combining work and care successfully. A substantial minority of carers fail in this effort and consequently reduce or leave work. About one-quarter of all family carers have cut back or abandoned gainful employment as a consequence of their care responsibilities; depending on the intensity of care this percentage varies between 21 % and 61 % (Badelt et al., 1997: 173-174).[24]

However, this should not lead to the false conclusion that renunciation or abandonment of gainful employment is always involuntary and forced. All things considered, a number of women, especially those of lower social classes, seem to prefer to stay at home and care for their parent instead of

[22] Students, pensioners etc. were not subsumed under the "housewife" category.

[23] With the notable exception of compassionate care, leave scheme regulations in Austrian law are targeted at maternity.

[24] According to Nemeth and Pochobradsky's data (2002) only 12 % of carers have reduced paid work or quit work completely. There are many missing answers to this question for unspecified reasons.

pursuing a low-paid job. Because of the long-term care benefits they can afford it financially even if they provide more care hours than they are (hypothetically) paid for (Nemeth, Pochobradsky, 2002).

General employment rates by age

Table 12: Employment rates, census 1991-2001, projection 2011-2031 (main scenario; % of employed among gender and age groups)

Age	Men					Women				
	1991	2001	2011	2021	2031	1991	2001	2011	2021	2031
15 – 19	56.2	47.5	45.5	42.5	40.0	46.7	32.7	30.5	28.8	26.0
20 – 24	82.2	77.9	75.6	74.5	72.3	76.1	69.1	69.0	70.0	70.2
25 – 29	91.3	89.6	88.5	87.5	86.5	72.6	78.8	80.0	81.3	82.5
30 – 34	95.9	95.7	93.5	94.0	93.5	68.9	77.9	79.0	80.1	81.5
35 – 39	96.8	96.6	96.1	95.8	95.3	69.0	76.8	79.2	82.0	85.0
40 – 44	96.5	96.4	95.4	94.9	94.2	68.4	77.4	82.0	87.0	90.0
45 – 49	95.1	94.6	94.4	93.8	93.4	65.1	74.2	78.0	81.5	84.6
50 – 54	89.8	88.4	88.8	89.2	90.0	56.3	64.9	68.3	72.3	75.9
55 – 59	63.1	63.7	71.0	74.0	77.3	23.1	22.4	42.0	48.5	58.5
60 – 64	12.3	11.9	32.0	44.0	46.0	4.9	3.7	5.0	14.0	29.0
65+	1.7	1.5	2.0	2.0	2.0	0.7	0.5	0.5	0.5	0.5
Total employment rate 15-64	81.4	79.5	80.6	80.6	80.3	58.2	60.5	63.3	65.1	68.8

Source: Statistik Austria, Statistisches Jahrbuch Österreichs 2005; Wirtschaftsforschungsinstitut.

Positive and negative aspects of care

As far as positive aspects of care-giving are concerned two principal factors can be distinguished as playing a key role in family care:

First, the reaction of most elderly persons can be described in terms of gratitude towards the carers. In turn, this expression of gratitude serves as a powerful immaterial gratification for the carer. She / he can maintain and reinforce her / his self-image as a truly helpful and competent helper.

Second, love and affection for the next of kin: the adage that “blood is thicker than water” still accounts for patterns of behaviour in the family – the experience of late-life caring can draw e.g. mother and daughter even closer together.

Still, the negative aspects of caring cannot be ignored. There is no doubt that the excessive amount of time given, the physical strain (e.g. caused by lack of

sleep due to nightly disturbances), the psychological strain (often experienced just because the carer has to face the deteriorating physical and mental health status of the old person without much power to stop deterioration) frequently exceed the tolerable degrees of intensity and time-consumption.

The vast majority of family carers are confronted with physical burdens, psychological burdens, and other burdens, such as lack of time. No less than 69 % of carers report physical burdens, such as back aches, psychological burdens, in the sense of feeling overburdened by too much responsibility, or of feeling left alone and not credited for their efforts. Social isolation is another severe problem, caused by the necessity of permanent attendance to the elderly person (Nemeth, Pochobradsky, 2002: 22-26).[25]

Obviously, little has changed since the late 1980s when research had already demonstrated that most carers feel severely burdened and that restrictions in personal freedom, and problems in coping with psychological stress are much more burdensome than physical tasks or financial problems. Particular strain is brought about by the fact that eldercare will last for an indefinite period (Hörl, Rosenmayr, 1994).

Apart from the concrete personal care situation, the social environmental conditions are very important with regard to how stressfully caring is experienced. The non-appreciation of care work by other family members or the general public is especially negatively felt; e.g. they feel humiliated when they are forced to struggle with bureaucratic obstacles when asking for support from social care agencies (Nemeth, Pochobradsky, 2002: 26).

To summarize, although the basic motivation of family carers seems to be unbroken and care provision to be secured, there is a certain latent, dangerous potential to overestimate the quality of kin relationships in the lives of the elderly.

The whole family system can develop a severe if often concealed crisis when the principal carer reaches her / his limitations in providing eldercare. Experiences of overwhelming stress, strain, and lack of leisure-time may lead to attempts at gaining more personal independence. However, family carers "opting out" are frequently plagued by guilt-feelings. This vicious circle can produce burn-out and subsequent elder abuse and neglect, as empirical research has shown. Moreover, the dynamics of later life are heavily influenced by a family's history of interpersonal conflict and problem-solving. In-law relationships are often strained and characterised by an absence of warmth; in particular, life-long oppression of women by their mothers-in-law can result in revenge actions later in life, especially when the daughters-in-law have take over the carer's role (Hörl, Spannring, 2001).

[25] The sample in this study encompasses only family carers with severely handicapped long-term care allowances receivers (levels 3-7).

Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

There are strong indications that a private "grey" nursing market is developing on the basis of illegally and semi-legally hired low-cost care workers and domestic workers from Eastern and Eastern Central European countries, such as the Czech Republic, Slovakia, Poland or Hungary.[26] Yet no precise figures on the numbers of such carers are available.[27] Estimated costs for a 24-hour in-home service are around 1,200 to 1,800 euros per month. It is conceivable that the authorities are not fully satisfied with this development for reasons of tax evasion, job shortages for authorized personnel, and the lack of quality assurance. Nevertheless, this type of an all-inclusive in-home service is a realistic alternative to nursing home entry. Because of strong demand, authorities make no serious efforts to curb this influx of foreign workers.

It is too early to conclude whether the flow of migrant workers will increase significantly after the enlargement of the European Union starting May 1, 2004. For several years, home nurses and domestic workers will not be allowed to participate in the regular Austrian job market. However, self-employed persons are exempt from this regulation. Hence, it is not unrealistic to expect a certain increase in cross-border "one-person-enterprises" based in neighbouring countries. Lack of language skills is a barrier but not a crucial impediment to (temporary) migrating or commuting of health and social care workers.

Other relevant data or information

Not applicable.

[26] In one extensively used scheme, carers and old persons hold membership of non-profit mutual associations. There is the additional problem that long-term care allowance beneficiaries – when hiring individual workers outside of the family group – are at least theoretically required to pay all relevant social insurance contributions. Only outright moonlighting and tax evasion or the hiring of foreign workers would help avoid paying these taxes. Foreign workers (not residing permanently in the country) would not receive the social insurance benefits that Austrian workers do.

[27] According to some experts the number of semi-illegal home care workers from foreign countries can be estimated at 40,000 persons, supporting about 10,000 to 20,000 care-dependent people („Die Presse", Dec 2, 2004: 13).

2 Care policies for family carers and the older person needing care

Care policies for family carers and the older persons needing care must be seen in the broader context of societal developments and related reform trends in social care.

The need for long-term care because of physical or mental impairments has become a risk of enormous magnitude. In consequence of the "double demographic ageing" the problem of dementia especially may become even more precarious in the coming decades. Conventional care policy would have responded to this problem with an increase in "closed" residential care (i.e. old people's or nursing homes).

This standard solution which was rather commonly applied well into the 1980s is no longer feasible. There is a broad consensus nowadays that we have to respect the wishes of older people to remain in their own homes for as long as possible. Older people in need of care are seen as self-confident clients and consumers of social services and to remain as autonomous and independent as possible, especially in deciding their care arrangements (Grilz-Wolf et al., 2003). As a result, in Austria, as in other European countries, the expansion of community care is given unequivocal priority over institutional facilities. The principal aim is to ensure that persons in need of long-term care can make a free choice between the services on offer. New developments such as sheltered accommodation, communal dwelling in small units and various forms of interim and temporary nursing are increasingly gaining ground vis-à-vis traditional residential and non-residential nursing care.

Regardless of these trends, it is fully recognized that family care is indispensable. All relevant political bodies and decision-makers agree unanimously that fully professionalized eldercare – apart from all other considerations – cannot be financed. Yet reduction of the burden on family carers is an urgent necessity because modern individualized nuclear families cannot be expected to provide unlimited human resources for long-term care as a matter of course.

The most important political response came along with the introduction of the Federal Long-Term Care Allowance Act (Bundespflegegeldgesetz).[28] This provision was put into effect as of July 1, 1993 and opened a new era in financing and organizing social care. The allowance replaced the unsatisfactory previous system of miscellaneous cash benefits by simplifying the legal situation and improving and standardizing benefits. The allowance takes the form of a single cash payment to compensate for care-related

[28] In addition, there are Provincial Long-Term Care Allowance Acts, which guarantee that persons for whom the provincial authorities are responsible will receive care allowances in the same amounts and according to the same principles as under the Federal Long-Term Care Allowance Act.

additional expenses. It serves both to ensure that persons requiring care receive, as far as possible, the personal services and assistance they require, and also to improve their chances of leading a life that is oriented towards their needs and that permits them self-determination. About 300,000 old persons receive LTC cash benefits, more than two-thirds of recipients are female (for further details and definition of care levels see section 2.1.2).

Table 13: Number of elderly LTC allowance receivers (2003)

Level	61 – 80 years	81 years and more	Total
1	30,908	27,815	58,723
2	46,156	58,190	104,346
3	20,811	30,236	51,047
4	16,656	28,193	44,849
5	8,228	15,648	23,876
6	2,442	3,808	6,250
7	1,733	2,504	4,237
Total	126,934	166,394	293,328

Source: BMSG, 2003: 36-37.

It is essential to repeat and to emphasize that this is a consumer-directed programme; the allowance is linked to a full transfer of responsibility to the beneficiaries.[29] They are completely autonomous in their decisions. For persons classified at levels 1 to 4 there is no need whatsoever to furnish proof of whether or how the means have been concretely consumed.

As far as the reality of the recipients' family life is concerned, it seems reasonable to assume that many children will help their care-dependent parents with administrative tasks. Joint budgets are kept in more than a quarter of cases (Badelt et al., 1997); budget sharing almost certainly implies that the children are the ones to make decisions, whether they are formally authorized to do so or not.

Of course, people with cognitive impairment need even more support in managing services, if they are in a position to make decisions at all.[30]

[29] It should be explicitly mentioned that not the elderly or family carers but younger persons with physical impairments had been the driving force behind this legislation. In particular, the Civilian Disabled Persons' Association organized street demonstrations and a petition to the parliament, which was signed by 60,000 people. Younger people with physical disabilities are the most vocal in expressing their preference for a consumer-directed programme, primarily because they are more aware of this option and want to be independent of their families.

[30] Among long-term care allowance beneficiaries living at home 4 % are under legal guardianship. If available, the family carer takes over the role of the surrogate decision-maker in most cases (Nemeth, Pochobradsky, 2002: 11). Among nursing home residents this percentage is much higher, e.g. 38 % of residents in the Vienna Geriatric Centre Wienerwald are living under legal guardianship (personal communication by ombudsman Dr. Werner Vogt at a press conference, Nov. 20, 2003). As another indicative detail it should be mentioned that in the evaluation study,

There are no substantial restrictions on use of the cash benefits and the national government does not monitor how beneficiaries (those living in private households) spend the additional money. No detailed data on private budgets is available, so we have only scarce information on how the cash benefits are actually spent. All the same, it seems to be rather evident that benefits are quite often passed along to informal caregivers or are contributed to household budgets rather than used for purchase of formal services. This is in accordance with the apparent (if not explicit) intention of the lawmakers that family carers should be remunerated this way.

There remain several contradictions and unresolved questions in this issue of long-term care allowance.

On the one hand we have to acknowledge that the allowance can never cover the real full costs of regular professional services, no matter whether they are performed by governmental, non-profit or commercial care workers. On the other hand family carers will never be in a position to receive the same quality and amount of training, supervision, and benefits (including fringe benefits like vacation, sick leave, and unemployment insurance) as employed care workers.

It is obvious that the allowance (indirectly) improves the financial situation for many informal carers. Thus family caring can even be more attractive than a low paid job in the formal labour market. But it is also clear that caring is a taxing job with uncertainty how long it will last and – at least for those who do not have a formal employment alongside their care-giving job – connected with certain disadvantages in the social security system. These preconditions make any long-term planning difficult.

Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

As far as family relations in general are concerned the long-standing formula of “intimacy at a distance” has been verified many times (Hörl, 1993; Rosenmayr, 1990). “Intimacy at a distance” reflects the wish of the generations to be “somehow” close, for practical and emotional reasons and support on

more than half of all interviews with old persons were conducted as proxy interviews because the old respondent was not ready or able to answer questions (Badelt et al., 1997: 20). Generally speaking, court cases have dramatically increased in recent years, dealing with the issue of whether or not to deprive elderly people of their legal capacity and to appoint guardians who would act on their behalf, especially in settling financial matters (Hammerschick, Pilgram, 2004: 26).

both sides; and yet – also on both sides – the wish to remain separate, for reasons of autonomy and in order to "domesticate" dependencies. Care-giving, though, might easily force generations into undesired closeness. This prospect is met with mixed feelings. The elderly consider emotional and affective ties with their children as extremely important (in fact, more important than tangible services) and, consequently, they are reluctant to "overstrain" family nursing resources. As a result, there appears to be a decidedly ambivalent attitude among the elderly with regard to the question of filial obligations towards old parents.

Notwithstanding the attitude of non-interference and despite the emphasis on highly individualized and emotionalized family relations, intergenerational solidarity in daily real life is virtually unbroken as the research study "Intergenerational Relations in Austria" (Majce, 2000) has clearly demonstrated.[31] Only 0.5 % of Austrians list no one upon whom they can rely in minor cases of need. In serious cases of need as well there are few people (1.7 %) who consider themselves without any support from relatives or friends.[32] Just under one-fifth of the population (19 %) can be viewed as a "risk group", as they only have one person available. One-quarter of the population can count on two people to help, while 17 % of the population is in a quite secure position, even in serious cases, as they have at least five relatives or friends who would help them. Investigating actual cases of help and solidarity, it is worthy of note that the extent of help which is insufficient is surprisingly low.[33] If one considers only the group of respondents who actually need help, the highest level (5 %) of unfulfilled need occurs with respect to persons who take care of other sick people and need help in this respect. The level of insufficient help does not amount to greater than 2 % in any of the other areas of life, including shopping, housework, and long-term care. Generally, it is interesting to note that it is primarily the youngest generation (18-30 year olds) which needs help and almost always receives it promptly – and not, as tends to be propagated by the media in contradiction to the facts, the older generation. The only major exception is long-term care which is primarily needed by the elderly.

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[31] The sample of this study consisted of 1,000 Austrians aged 18 years and over living in private households. Another study, the "Population Policy Acceptance Survey" (Schimany, 2003: 157), has produced similar results on family responsibility: support for elderly people is considered as a spousal responsibility by 94 % and as a filial responsibility by 81 % among respondents; there are no significant differences between age groups.

[32] These are hypothetical ideas of the respondents as to who would help them if they needed it. Minor cases of need were considered to be, for example, check in on the apartment once in a while, because one is on vacation; serious cases of need were considered to be, for example, to visit a sick person every day, to bring food, keep the apartment tidied up, etc. with weekly time required being at least five hours.

[33] The question was posed regarding a number of areas of life where needs are typically experienced, as to whether the respondent needed help within the last two years, whether the help was sufficient and who provided the help.

The survey also investigated the anticipation of a hypothetical long-term care situation: the mother or father would be in need of care due to an accident or old age. Thoughts on how one would react in such a situation do not necessarily represent a reliable basis for prognosis of future behaviour, but nevertheless such thoughts can give a picture of the emotional atmosphere in which generations (within the family as well) react to one another and develop feelings of solidarity and conflict. 44 % of the respondents[34] answer that they would "certainly" assume care of the mother, while 37 % give the same answer in respect of the father. Conversely, 11 % state that they would "under no circumstances" care for the mother and 19 % for the father. The respondent's own career activity is the main obstacle to assuming responsibility for care and nursing. This is followed by too large a distance between the residences (table 14).[35]

[34] Percentages quoted refer to a sub-group of respondents whose parents are currently not in need of care and are not in residential care.

[35] Another study (IMAS, 2004) investigated this issue from the older generation's perspective of hypothetical care situations: 26 % of respondents aged 50 years and over say that they would encounter difficulties in receiving care if they were bed-ridden. This percentage is below average in small communities of fewer than 5,000 inhabitants and above average in Vienna and other major cities.

Table 14: Reasons why one would not care for mother / father (N = 1,000, 18 years and over, multiple answers, %)

Reasons not to care	Mother[36]	Father[37]
I would have to give up too much in terms of career	63	60
I would have to give up my job completely	56	49
Homes are too far apart	29	30
He / she wouldn't want me to take care of him / her	28	36
My nerves wouldn't stand it	26	27
Would have to move in together, but the apartment is too small	25	26
I would jeopardize my own family life	20	18
Such close contact would only lead to conflicts with him / her	20	27
I would suffer too much with him / her	20	15
It would be too much for me physically	18	15
It would be too much for me financially	17	12
My partner would be against it	12	15
He / she isn't close enough to me	7	18
I already have health problems	6	5
My children wouldn't accept it	3	5
I am already taking care of somebody else	0	2
N	(314)	(276)

Source: Majce, 2000: 126.

Taken as a whole, the data gives points to the conclusion that in the family, especially between parents and children, there is not only a very high potential for acts of solidarity, but that this solidarity is expressed in actions. The vast majority of cases of need for support and help are covered primarily by acts of solidarity on the part of family members.

Intergenerational relationships are certainly not free of conflict; yet solidarity in the family is not threatened by these conflicts and is experienced in real life in Austria. This is expressed in the high amount of help available in cases of need, primarily through help from close family members. Ideas of remuneration may play a noticeable role, but this give and take is not directed at a "balanced intergenerational result" between the participants; rather, it signifies the acceptance of the obligation on the one hand to help in cases of need, and on the other hand, to essentially adopt a position of "over-balance" (Rosenmayr, 1990) with regard to the successor generation.

With a view to the future, though, based on this broad-scale fulfilment of the family's functions and good family-internal intergenerational relations, it would

[36] Basis is respondents who would not care for mother; summary of the answers "very probably true" and "probably true".

[37] Basis is respondents who would not care for father; summary of the answers "very probably true" and "probably true".

be wrong to think that all is in order with respect to the complex set of problems related to care and nursing of the old which will be experienced in the coming decades. On the contrary: precisely because the family is so good at handling this problem at present, there are dangers for the future, due to demographic and socio-structural, socio-economic and socio-cultural reasons. Today, only a few indications of a possible shift in attitudinal patterns towards caring can be found: e.g., in a study on "Social Cohesion" (SWS, 2003), younger respondents (below 36 years of age) and better educated respondents (those holding the "matura" certificate) disagree more frequently with the statement that it is one of the "most important functions of the family to take care of the elderly".[38]

However, since longitudinal research data is still missing, it remains unclear whether such deviations in attitudes reflect lasting behavioural changes or are only temporary and unstable; perhaps, attitudes towards caring change several times in the course of one's life span, dependent on the current life situation.

Little attention has been paid to the growing proportion of older migrants living in Austria. As the stay of migrants had ever been regarded as temporary, there are no policies for addressing the social care needs of older migrants in particular.

There are a number of particularities which distinguish the migrant from the majority population, and which may have important implications for social care. First, older migrants are predominantly from the younger age groups under 65 years (see table 27, appendix). Second, the feminization of old age is less of an issue for the migrant community. Finally, there is a higher proportion of single men among migrants over 60 than among older Austrians. The differences in the gender distribution and marital status may be attributed to the fact that many migrants came to Austria as single young men. Since women constitute a major resource for family care, there may be substantial implications for caring patterns in the minority communities (Brockmann, Fisher, 2001). So far, only a few empirical pilot studies have been conducted in this area (Fernández de la Hoz, Pflegerl, 2000; Reinprecht, 2000). On the one hand they provide evidence that extensive, tightly knit social networks represent an important resource for many older migrants and intergenerational solidarity is considered to occur as a matter of course, including caring for the cognitive impaired;[39] in the case of hospital admissions, frequent visits by relatives are of central importance in support of the patient and to demonstrate compassion. On the other hand, migrants living on their own have much more

[38] 81 % of respondents aged under 36 agree with this statement, whereas among people aged 36 years or more between 89 % and 95 % agree; 84 % of persons with the "matura" certificate agree with this statement compared to 91 % of persons with a lower level of education.

[39] There is anecdotal evidence that frail elderly parents are transferred from Turkey to Austria, in order to be cared for by their emigrated adult children.

fragile support networks and a growing demand for community services is anticipated for the future. Elderly persons from minority groups have little knowledge about community services offered – primarily they have to rely on word of mouth propaganda. The lack of language knowledge and the scarcity of interpreters and of native speakers among professional staff is a major problem.

Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

The Federal Long-Term Care Allowance Act introduced a scale of need-oriented allowances to which there is a statutory entitlement. The main principle is that equal degrees of need for care should be matched by equal benefits and those benefits should be oriented towards need, irrespective of the cause of disablement and irrespective of the age of the recipients.

The grant of a long-term care allowance is subject to the meeting the following criteria (Rubisch et al., 2001, see also table 15):

- A permanent need for personal services (e.g. personal hygiene) and assistance in routine activities of daily life (e.g. shopping) owing to a physical, mental or psychic disability or a sensory disability that is expected to last at least six months; the need for both personal services and assistance is required;
- The duration of need for permanent care must be more than 50 hours per month;
- Normal residence in Austria (exceptions in the European Economic Area).

Table 15: Long-term care allowance: Scale of benefits

Level	Monthly benefits in cash[40]	Monthly extent of need for care	Further criteria to be met
1	148.30 euros	More than 50 hours	
2	273.40 euros	More than 75 hours	
3	421.80 euros	More than 120 hours	
4	632.70 euros	More than 160 hours	
5	859.30 euros	More than 180 hours	An extraordinary degree of care is required. Additionally, qualified nursing care is required at levels 5, 6, and 7.
6	1,171.70 euros	More than 180 hours	Care which cannot be co-ordinated time-wise is required and this has to be provided regularly during the day and night or the continuous presence of a carer is required during the day and night, because the elderly person is likely to endanger themselves or others.
7	1,562,10 euros	More than 180 hours	No co-ordinated movement of the four extremities with functional use is possible or an equivalent state is ascertained.

Source: Rubisch et al., 2001: 13-14.

The benefit is paid 12 times a year. Benefit amounts are not automatically indexed with regard to inflation; this is an important element of cost-containment. In consequence of an amendment in 1998, however, it has become easier to be classified at levels 4 to 7.

Certain groups of disabled persons who have by and large the same type of need for care are guaranteed a long-term care allowance of at least the following levels: Persons with high-grade impairment of sight level 3; blind persons level 4; deaf and blind persons level 5; seriously disabled persons confined to wheelchairs who are effectively using these wheelchairs to be able to manage an independent manner of living receive at least a level 3 allowance or, subject to certain requirements, a level 4 or 5 allowance.

Persons are placed at the individual levels of the scale on the basis of medical reports, in which context persons in other specialities, e.g. nursing staff, psychologists or social workers, must if necessary also be consulted. If the persons requiring long-term care wish this, it is also possible that an intimate person is present during the medical examination (e.g. to assist persons with cognitive impairment).

[40] As of Jan. 1, 2005.

Some critics contend that the assessment instrument biases eligibility in the direction of those who have medically related needs. The programme does not sufficiently take into account the special life circumstances and supervision needs of people with cognitive impairment (Andersen, 2002; Badelt et al., 1997).

As far as legal entitlements to benefits for carers are concerned one has to underline that – in principle – employment is an essential precondition for participation in the Austrian welfare system. All gainfully employed people must pay contributions to the social security system in order to be eligible to receive social insurance benefits. However, there are preferential terms for the insurance of persons providing long-term care who are not employed. They can take out self-insurance under the health and pension insurance schemes. Free non-contributory co-insurance within the statutory sickness insurance scheme is granted for carers of persons who are in receipt of a long-term care allowance of level 4, 5, 6 or 7. In the sector of pension insurance a 1998 amendment of the Long-Term Care Allowance Act facilitated the inclusion of family carers into the social security system. Family carers who care for a dependent person with substantial care needs (defined as long-term care allowance levels 4-7) may contribute to pension insurance (e.g. using part of the long-term care allowance), while the state takes over the employer's contribution. Thus, caring does not lead to the loss of carers' entitlements under social insurance law (Rubisch et al., 2001).[41]

Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

Principally, in Austrian civil law marriage partners are legally responsible for each other's maintenance. This obligation can be fulfilled by payments or in kind (e.g. by providing personal care services). Some specific rules refer to the particular position elderly persons are in. Within well-defined limits, the elderly can claim maintenance from their descendants; in the province of Vorarlberg even grandchildren are responsible for maintaining their grandparents.[42] Under most provinces' social assistance laws children are obliged – again, under certain conditions – to make a financial contribution to costs of community services and especially to costs of residential care for their parents. However, provinces' regulations are highly incoherent and the degree of actual law enforcement is variable (Pfeil, 2001: 312-332).

[41] In a pilot project in the province of Salzburg family carers are (formally) employed by a non-profit welfare association (Soziales Hilfswerk) at a minimum wage; thus, carers receive social insurance benefits and are eligible for future pension payments.

[42] On the other hand, parents may also be liable to pay maintenance, if their offspring is in need. Grandparents will have to pay, if the child's parents are not able to do so. A special case is the so-called generational contracts which are still common among peasant families. In these contracts detailed care obligations are sometimes written down.

The most important legal responsibility for care for older people is held by the social security system. In Austria it has two major components: social insurance and social assistance. While social insurance is mainly financed by earnings-related contributions shared between the insured and employers, and to a smaller and varying degree, by central government subsidies, social assistance is financed out of the budgets of the federal provinces.

Almost anybody is enrolled in one or more sub-sections of the social insurance system. It is responsible for more than nine-tenths of total social expenditure; the proportion that social assistance represents of total expenditure on social security has somewhat gone up in the last few years. An important reason for this is the increasing cost of care for very old and / or dependent persons.

Under the constitution, both legislation for social insurance and its implementation are a federal responsibility. The social insurance institutions are formally autonomous self-governing bodies, although their respective status is subject to control by the central government authorities. More or less following the model of social security legislation in Bismarck's Prussia during the 1880s, Austria developed a legal basis for social security. A very gradual development took place, originally excluding the elderly from social security. It is only since 1992 that professional, qualified medical home nursing has been covered by the health insurance system in order to postpone or shorten hospitalisation periods. Health insurance agencies reimburse providers for specific tasks provided by home nurses and prescribed by the general practitioner.

It has to be emphasized that in Austria a strict distinction is made between sickness, covered by social insurance and the need for (long-term) care, covered by social assistance.

Statutory sickness insurance provides benefits only in the event of sickness. Sickness lasts for the period in which treatment (comprising medical care, medicines and therapeutic aids) is justified owing to the prospect that the patient's condition will improve or at least that deterioration can be prevented. If that is no longer the case, the sickness insurance authorities are not allowed to provide any further benefits.

By constitutional law, legislative, administrative, and executive responsibility for social assistance matters comes within the competence of the nine Austrian provinces. Thus, all provinces have enacted their own Social Assistance Acts, passed between the late 1970s and the early 1990s (Barta, Ganner, 1998: 7-8; Pfeil, 2001). The various bodies responsible for social assistance are the provincial authorities, the local authorities through the social assistance unions, and independent district-towns.

Although there is considerable variation between the provinces, at least the following principles are common to all nine provincial social assistance laws:

- Benefits to secure the vital needs are provided only if all other possibilities have been exhausted, especially income from work and coverage under the social insurance system (the so-called principle of subsidiarity);
- Benefits are granted on the grounds of individual needs alone;
- Benefits are intended to maintain existing family relationships and to strengthen the ability for self-help.

As far as the long-term care allowance is concerned, the uniformity of this system is guaranteed throughout Austria by a legal arrangement between the federal and the provincial authorities. The agreement contains a catalogue of benefits and quality criteria for social services. Furthermore, the provincial authorities are responsible for ensuring that the services offered are organizationally interlinked, and for providing information and advice. The provincial authorities undertake to make arrangements for the decentralized establishment and expansion of community, semi-institutional and institutional social services, with full geographical coverage, observing minimum standards. The federal and provincial authorities have agreed to improve the working and training conditions of staff, and also to help ensure the compatibility of work in nursing with family responsibilities (Rubisch et al., 2001).

Up to the present day, these pronouncements and propositions are laid down more or less on paper only. Because of labour shortages and lack of infrastructure, fully comprehensive community services for everybody in need of long-term care still cannot be ensured completely.

Is there any relevant case law on the rights and obligations of family carers?

There are numerous decisions by the Supreme Administrative Court and other legal bodies which relate to the conditions under which provincial authorities have a right to demand cost contributions from family members for community services or residential care of parents (Pfeil, 2001).

What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

A national legal definition of old age as such does not exist. By conventional definition, “old age” is supposed to begin with retirement age. The statutory retirement age is 65 for males and 60 for females. For many decades, however, early retirement schemes prompted many workers to leave the labour force much earlier, in some cases as early as in the low fifties. Until

recently, the average retirement age used to be well below 60 years for both genders.[43]

The recent pension reform, passed in June 2003, is above all geared towards restricting early retirement. The earliest age at which employees may take early retirement and receive a state retirement pension – on grounds of a long contribution history or of unemployment, or to receive a partial retirement pension – has been increased to 56.5 years for women and 61.5 years for men.[44] Future reform priorities will include equalizing men and women's retirement age[45], and further raising the minimum retirement age.

In the wider public arena, the elderly are conferred various benefits. Women aged 60 years and over and men aged 65 years and over are granted reduced rates for the public transport system (especially railways) and for a variety of admission tickets (in museums, swimming-pools etc.); there are also reduced prices for a number of goods and services in the commercial business sector (e.g. hairdressers). In some cases these benefits are means-tested or are valid only at restricted times or are bound to membership of a pensioner's organization.

Currently existing national policies

Family carers?

Within the Federal Ministry for Social Security, Generations, and Consumer Protection the Centre for Population and Ageing Policies (Kompetenzzentrum für Senioren- und Bevölkerungspolitik) has been founded to co-ordinate national policies. Even though the centre is lacking in resources it acts as a focal point for ageing policies and promotes scientific research.

In accordance with the 1999 "International Year of Older Persons" the "Austrian Report on the Life Situation of Older Persons"[46] was published. The knowledge obtained from this study has been incorporated in the first Austrian national plan for senior citizens, which was developed as a political-strategic steering instrument of ageing policy. This plan should provide a basis for political decisions in the field of social, economic, health, housing and cultural affairs (FMSSG, 2002: 3).

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[43] In 2003, the average retirement age was 58.2 years (59.0 years for men and 57.3 years for women) (BMSG, 2004).

[44] There are exceptions for long-time workers in health-hazardous occupations and, of course, for persons qualifying for disability pensions. Generally, larger penalties are imposed for those taking benefits before age 65. At the same time, a bonus for later retirement is given.

[45] The statutory retirement age for women will be increased gradually between 2019 and 2034 until it is unified with the retirement age for men at 65.

[46] This report has been officially approved by the Austrian parliament, the federal government and the provincial authorities.

Notwithstanding that the report's propositions and recommendations are of non-obligatory character only, a set of guiding principles for policy-making is outlined. In particular, it is emphasized that ageing policy must reduce social inequities both between and within generations. This requires an integrated approach to ageing, including the family, working life, education, social and cultural participation, material security and health. The inherently transversal nature of ageing should be reflected by public and administrative measures. There is no justification whatsoever for the exclusion of older people on the basis of "usefulness". The promotion and strengthening of intergenerational solidarity as the basis for the peaceful and productive co-existence of the generations is seen as a key principle upon which Austrian generational policies are based. Policy must balance the material flows between the generations and has to break down the barriers of ignorance and prejudice between generations (Amann, 2000: 610-619).

Disabled and / or dependent older people in need of care / support?

A cornerstone of the system of long-term care is the availability of a wide range of community care services throughout the country. As a co-ordinated action plan is necessary to expand such services in quantity and quality, the provincial authorities elaborated a survey of needs and development plans between 1996 and 1998 and must gradually put them into effect by the year 2010 (Schaffenberger et al., 1999).

In the 2004 parliament a law was passed which bans age discrimination. Over and above that the federal ministry, in co-operation with the pensioners' organizations, is planning to implement a senior citizen advocate. In monitoring the non-discrimination law, this person would deal with issues brought to her / his attention and also hunt aggressively for cases of age-related discrimination. Obviously, regulations of this kind would especially protect impaired and dependent older people against discriminating practices, e.g. in the field of medical care.

Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

Under current law, working carers may claim care leave for up to a maximum of one working week per year to perform the necessary care for a sick close relative (including parents and grandparents) living in the common household. Care leave is only granted under the provision that no other carer is available. Such care leave can be availed of from the time of commencement of employment. The requirement for entitlement to continued pay for care leave is that the employee proves that she / he is prevented from performing her / his work during the necessary care period. Where required, care leave can be availed of on a daily or also on an hourly basis. Further, employees with a care obligation vis-à-vis a close relative, arising from an obligation to support the

family which is not only of a temporary nature, can agree a reduction of their normal working hours with their employer. Once the care obligation ceases to exist, employees can demand a return to their original normal working hours.

Obviously, under these provisions it is difficult to perform long-term care effectively. No data is available on how frequently care leave for eldercare is actually claimed.[47]

More far-reaching care leave regulations are included in several collective labour agreements at industry or company levels. Again, no systematic data is available but some insight into corporate reality is to be gained from a study conducting expert interviews (Hörl, 1998). Results indicate that probably no more than approximately 1 % of all Austrian companies have agreed to family-friendly standards which significantly exceed statutory obligations. Almost all of these companies or agencies belong to the service sector and employ well-qualified female personnel (e.g. insurance companies, banks, software companies, consulting and accounting firms, as well as some governmental agencies, municipalities, and non-profit organizations). Agreements usually include extended periods of fully paid care leave, unpaid "caring sabbaticals" with a guarantee of re-employment afterwards, and, last but not least, individual adjustments, in particular the right for (temporary) part-time work or flexible working hours and a flexible work location (e.g. flexi-time, teleworking). Although all these legal measures and mutual agreements are basically oriented towards the case of maternity and childcare they are applied without problems to the case of eldercare.

Since 2002 persons caring for dying family members are legally entitled to compassionate leave / family hospice leave (Familienhospizkarenz). Employees enjoy protection against dismissal for up to six months. The eligible family members are spouses, linear family members (parents, children, and grandchildren), adopted and foster children, life partners and siblings. Several members of the family may take this leave simultaneously. An employee may start this leave only five days after giving notice of her / his intention. If the employer refuses to agree, the employee may take recourse to the industrial tribunals. The employee may take leave until the court has reached a decision. Protection against redundancy and dismissal starts upon commencement of leave and ends four weeks after it has ended. The family hospice leave is basically an unpaid leave but in some cases financial support might be granted. This leave entitles leave-takers to one of three different possibilities: either a reduction of working hours, a change of working hours or an unpaid leave period. Under certain conditions employees on leave retain full health, pension and unemployment insurance coverage. This also applies to the unemployed who renounce unemployment benefit or emergency welfare relief in order to take this leave (Bernroitner, 2004).

[47] Actual utilization should be rather low since even leave for childcare is claimed by less than one-fifth of employees (Rosenberger, 1995).

To encourage employers to take greater account of family needs, in their own business interests, the "Family and Work Audit"[48] is promoted (FMSSG, 2002: 11). This is basically a consulting instrument which allows companies to examine their family orientation – including a cost-benefit analysis – and take specific measures to improve it, irrespective of the size of the company and field of business. This instrument can be used repeatedly internally to check up on departments and divisions. After the audit has been successfully completed the company receives a certificate that may be used for advertising purposes. So far, around 20 companies and organizations have participated in a Family and Work Audit.[49]

Are there local or regional policies, or different legal frameworks for carers and dependent older people?

In various provinces there are declarations with regard to the life conditions of the elderly. For example, in 1993 the city council of Vienna approved and ratified an action plan called "Help in Old Age" (Hilfe im hohen Alter). Relating to the (at that time new) federal long-term care allowance a line of goals was set for future health and social service development. The leading principle was that "care should be provided at home as long as possible, and in an institution only when absolutely necessary." In the last decade this goal has been accomplished by developing mobile services. Respite care has also been established successfully (although the number of beds is still not sufficient) and is now offered by public and private providers.

On the other hand the over-all policy goal to integrate family carers more strongly into the local care framework and to give them permanent support by installing supervision programmes, telephone counselling, self-help groups, etc. was realized only in a fragmentary fashion.

Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

There is enormous variation between the provinces (and sometimes also at local levels) with regard to legal definitions for social services, residential care, the structure of nursing homes and with regard to the organization and range of existing services, eligibility criteria, cost-sharing etc. There are also differences concerning curricula and training conditions of care personnel. Moreover, adult children are treated differently as far as cost-sharing for nursing home accommodation etc. is concerned.

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[48] Although the audit's prime target group are younger women and families with children it can without difficulty be adopted for eldercare.

[49] In the initial phase auditing has been especially targeted at organizations providing intramural professional care for the elderly because in this field particularly family-unfriendly working conditions prevail (many night shifts, week-end work etc.).

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)	X							
Counselling and Advice (e.g. in filling in forms for help			X		X	X	X	
Self-help support groups			X				X	X
"Granny-sitting"[50]		X						X
Practical training in caring, protecting their own physical and mental health, relaxation etc.			X			X	X	
Weekend breaks[51]		X			X		X	
Respite care services		X			X		X	
Monetary transfers		X			X		X	
Management of crises		X			X		X	
Integrated planning of care for elderly and families (in hospital or at home)		X			X		X	
Special services for family carers of different ethnic groups	X							
Other								

Examples

Good practices

See section 3.1.2.

Innovative practices

Surveying the projects and models of innovative practice in the field of health and social care, one must come to the conclusion that most efforts are directed towards the improvement of co-ordination, at management level,

[50] Friendly visiting only.

[51] Breaks of up to 14 days (in combination with respite care services) are offered by the farmers' social insurance agency (Scholta, 2001).

between the different intramural and extramural professional services and agencies.

One concept of service provision is called “Integrated Health Care and Social Services Districts” (Integrierte Gesundheits- und Sozialsprengel[52]). Their purpose is twofold. First, to ensure co-ordinated and full geographical coverage of high-quality care by the provision of medical, nursing and social services in small area units, and second, to expand preventive health care and health promotion. The Federal Institute for Health worked out a basic model containing proposals, and a manual for the organizational establishment of such service districts. In this model it is proposed that the services offered should be co-ordinated from district centres, in reasonably sized areas with about 10,000 to 20,000 inhabitants. The district centre should inform the inhabitants, provide help on the take-up of services, and also carry out community-oriented health work. The objectives of the concept are as follows: to improve and guarantee the provision of health and social care in a district; to co-ordinate and harmonize the services of health and social care organizations; to optimize co-operation and exchange between the health and social care organizations; to increase the effective output of the health and social care organizations in a district by catering to the special requirements of the patients; to help patients and their families to find the correct organization for their needs; and to initiate and develop health programmes (Grilz-Wolf et al., 2003: 20). Until now there are only a few examples of the realization of this concept. The province of Tyrol offers information and advice for family carers, methodical instructions for better caring, respite services (including during the night), and supervision groups. Professional care for the elderly and counselling and training courses, etc. for family members are integrated (i.e. carried out by the same home health nurse). Other provincial governments or regional branches of health insurance have been hesitant to put this model into full action.[53]

As a top-down initiative by the federal government to promote volunteer work “Citizen Bureaus for the Young and the Old” (Bürgerbüros für Jung und Alt) have been established. Currently, more than two dozen of them are in operation covering almost all provinces. These offices function as exchanges and clearing-houses for voluntary and charitable work. The idea is to create locally based and autonomous generation hubs of old and young volunteers working on social projects, for example providing care for the very old or very young, friendly visiting, help with minor repair work, etc.

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[52] This is the “official” label created for the model project; regionally varying designations are in use (if this type of centre exists at all).

[53] Because of regional traditions and for historical reasons the implementation of nation-wide standard solutions is difficult to achieve. For instance, in predominantly rural Burgenland the development of community care structures is linked to small village development; in Vorarlberg there is a long-standing institution of locally based mutual home health care associations – as a result, the percentage of patients cared for by home nurses has always been much higher than elsewhere in Austria.

The “Housing for Help” scheme – run by the GEFAS old people’s association and the students’ union of Graz University – is an example of a new form of living arrangement. Older people who live in large flats but who require a little help with everyday tasks provide students with rooms in exchange for their practical assistance. Students and older people wishing to take part in the scheme can get to know each other at a co-ordination centre.

A special model for residential care of the elderly has been developed in the province of Upper Austria. In this scheme the elderly person lives together with a farmer's family on the farmstead. This arrangement provides a family-like setting for the elderly and opens a new field of activity for farmers’ wives who must carry a certificate in eldercare. The farmer must no longer be engaged in the agricultural business as the main source of income. There are also certain quality specifications for the standard of housing (separate, barrier-free room of their own for the elderly person, free access to the garden, availability of alarm systems etc.)

The “Memory Clinic Donauspital” in Vienna was established to serve dementia patients (especially those diagnosed with a mild cognitive impairment in its early stages) and their family carers in order to avoid institutionalization as long as possible. The average age of patients is between 65 and 70 years. Relatives get psychological counselling and information about possible family predispositions. In guided group discussions, carers have a chance to exchange experiences and express feelings of aggression, despair etc. which may be caused by caring for cognitive impaired parents or other family members. To develop coping strategies for those caring for dementia patients is a central goal, including recognizing and protecting one’s own physical and mental health when taking on burdens. In co-operation with the Alzheimer self-help group (Alzheimer Angehörige), training courses are held four times a years lasting 1½ days each. The aim is to educate family carers to be “co-therapists” at home (Rainer et al., 2002).

There is a range of other training programmes – mostly organized by non-profit welfare associations – for family members caring for elderly relatives. Training courses contribute to making the family carers’ indispensable care work easier; equally important, courses provide an opportunity to meet other family carers and to exchange experiences.

For example, there is a course called “Activation Programme to Promote, Reactivate and Preserve Cognitive and Motor Skills and for Sensitising and Training Sensory Modality”. It was designed to show older people and those who care for them – not only family members but also community care workers like home helpers – how they can use targeted exercises to help the individual requiring care to preserve and improve their mental facilities, recover physical mobility and make conscious use of their sensory organs. After trials have been completed and the programme evaluated, multiplicator training courses will be held within the target group of family carers and domestic carers

working for social services, old age people's homes and nursing homes (FMSSG, 2002: 9).

The fact that people in urbanized areas are much more likely to die in a hospital than those living in rural, and in some way backward areas, confirms that death in hospital is an indicator of modernization. Hospitals and nursing homes, however, are not designed for the dying as there is hardly time for a talk as well as love and affection. Since the 1970s critical voices have been raised about death in institutions. Nowadays, the trend is changing, towards terminal care in specialized institutions such as hospices and palliative care departments. Additionally, mobile hospice and palliative care teams are offering out-patient treatment (which enables patients to stay at home) and guidance of family carers. Some providers of in-home hospice services (Caritas, Hilfswerk) offer special support programmes for family carers after the death of the old person.

4 Supporting family carers through health and social services for older people

Health and Social Care Services

Home-based elderly require both health and social support. Their ability to continue with independent living arrangements relies in the first place on effective health care, normally delivered by family doctors and specialists. Yet physicians usually perceive treatment of sickness in a rather narrow way. Often enough they function in complete isolation from the social services.[54] One reason for this is the different professional-background orientation of the disciplines involved. On the one hand acute health care is situated within the framework of sickness insurance and dominated by the medical profession. On the other hand the social services are situated within the framework of social assistance and more or less dominated by standards of social work. Organizational separation is total; doctors are fully occupied with treatment of illness, while social workers are oriented primarily towards the functioning of the individual within her / his environment. The discrepancies in professional status impede efforts to link health and social services. The medical profession traditionally commands authority to make all the decisions regarding health care. Social care is just not considered as an equal partner. Historical development, traditional patterns of training and disciplinary orientation are still powerful enough to prevent substantial innovations.

As far as social care services are concerned we are confronted with a lack of data and / or inconsistency of official data collection in the provinces. If data are available at all there is a bewildering array of different definitions and labelling. This deplorable state of affairs is extensively documented in the national report on the life situation of older people (Badelt, Leichsenring, 2000: 425-430).

What one can say with certainty is that the number of community care services has increased dramatically since the 1970s. Nonetheless, there are still areas of vacuum in service coverage especially outside of urban areas, and enormous regional disparities in the organizational form, quality, degree of development, and co-ordination of services. Furthermore, since the 1990s the speed of expansion of the number of clients and service hours has slowed down everywhere.

[54] An earlier study investigating records for sources of referral to the home help service in Vienna found out that only 2 % of all referrals were made by doctors, compared with 20 % by hospitals (Hörl, 1988). No recent data is available but it might still be true that many general practitioners do not know much about community services, let alone co-ordinate efforts for the benefit of their elderly patients.

Non-profit welfare associations (NGOs) provide about 90 % of community and semi-institutional care services and are reimbursed by the province or municipality. These associations are not limited to service provision, but are also heavily involved in policy formulation and regulation, for the reason that their representatives are either performing double-roles as politicians and NGO board members, or interact frequently with political decision-makers.

As far as the employment conditions for social and health service workers are concerned they have now formally been improved and harmonised by the first nation-wide collective agreement (2004) in this sector. The conclusion of this agreement has to be regarded only as a first step. This is because the agreement does not cover the whole of the sector (large establishments such as the church-related Caritas and Diakonie, as well as Rotes Kreuz, have concluded their own company agreements) and has only set the minimum provisions which are common in most other sectors. Each province still has its own training standards for social and health service professions.

Health services

4.1.1.1 Primary health care

In Austria (1999 / 2000)[55] there are 16,200 independent physicians working in the extramural health sector. Two-thirds of them have a contract with one or more health insurance agencies. Among contracted doctors there are 4,000 general practitioners, 3,000 dentists and 2,900 other specialists. About 500 further physicians are employed by out-patient clinics or out-patient hospital departments. Regional variation in the density of health provision is fairly high, especially with regard to specialists. The highest density of active physicians can be found in urban areas, whereas the density in rural areas is relatively low (compare e.g. Vienna with 6.8 doctors vs. largely rural Burgenland with only 3.0 doctors per 1,000 inhabitants (BMGF, 2004: 71-73)).

Routinely, people turn first to her / his customary general practitioner for help or advice in health matters. Home care teams (in the sense that doctors of different specialisations, home nurses, physiotherapists etc. work closely together in one unit) exist only sporadically. Home blood tests and other ambulatory lab tests are performed more frequently due to recent technological progress. About 1,000 family doctors in rural areas have some kind of mobile pharmacy equipment.

Education of certificated nurses and nurse's aides is regulated by federal law, but the daily schedule of home nurses is co-ordinated by provincial authorities within the system of community care. Tasks of home nurses include medical

[55] Between 1999 and 2001 the number of independent physicians rose about 2 % annually; no figures or details are available for more recent years.

care and increasing the mobility of patients,[56] as well as advice and training for family carers and fulfilling linkage functions between clients, general practitioners, family members and hospitals. It is not known, however, to what extent home nurses are able and willing to accomplish this interface function.

4.1.1.2 Acute hospital and Tertiary care

In 2001 there were approximately 310 hospitals with 71,700 beds[57] and 2.4 million patients treated. The elderly are the majority among users; patients aged 60 and over account for 53 % and patients aged 75 and over for 26 % of total stays in hospitals (Kytir et al., 2000: 263).

Between 1991 and 2001 the number of beds per 1,000 inhabitants decreased from 10.2 beds to 8.9 beds and in the same time period the admissions per 1,000 inhabitants increased from 236.4 to 300.8 a year.[58] Consequently, the average stay has decreased drastically, from 12.3 days in 1991 to 8.4 days[59] in 2001 (BMGF, 2004: 27, 90). Obviously, medical treatment is becoming more efficient. In earlier years it happened quite often that patients were left in acute hospital care owing to "welfare" considerations (e.g. because no nursing-home places were available).[60] It is one of the specific purposes of the long-term care allowance to help ensure that such persons are discharged from costly hospital care and can be looked after at home or in a nursing home. Of course, a kind of a knock-on effect is created because after hospital discharge either family care or social services (community services or residential care) have to take over further responsibility.

Apart from general and special hospitals there are hospitals for the chronically ill who need not necessarily be old (Pflegeanstalten für chronisch Kranke). Most geriatric facilities fall into this category. These institutions belong to the area of social care but partly offer the same medical provisions as hospitals and can treat patients with cases of acute illness as well. There is no specialized curriculum for geriatric medicine at university level.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Altogether there are around 68,000 places (in 740 institutions) in homes of all kinds for elderly people. There are remarkable regional differences in terms of

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[56] Advice and counselling concerning incontinence problems is given by home care persons specialized in this field.

[57] In 1992 almost 80,000 beds were counted.

[58] To a certain degree, the increase in admissions can be explained by formal re-definitions (of day-care and semi-stationary patients).

[59] If only patients with stays between 1 and 28 days are taken into account the average stay (in 2001) is further reduced to 6.2 days.

[60] According to a study in the mid-1990s between 14.1 % (as assessed by physicians) and 18.6 % (as assessed by nurses) of those hospitalized in internal-medical departments are frail elderly people, who could receive the same quality of care in alternative residential or domiciliary care settings at considerably lower cost (Badelt et al., 1996).

quantity and coverage: in Salzburg and Vienna, for example, there are more than 150 places per 1,000 inhabitants above 75 years, in Carinthia 80 places, and in Burgenland only 67 places. All in all there are about 50,000 “nursing” beds in old age and nursing homes in Austria and 18,000 places in residential care for less frail elderly; however, “as most institutions, i.e. also former old age homes, have at least some nursing beds, a distinction between old age and nursing homes has become more or less impossible” (Grilz-Wolf et al., 2003: 11). Although the quantity of nursing beds in residential care has been raised during recent years (partly because of the fact that numerous places of residence were changed into nursing beds) additional high-quality nursing beds will be required in the future. The provincial authorities are responsible for the construction, up-keep and operation of nursing homes and for guaranteeing minimum standards. With regard to this responsibility the provincial authorities have already enacted laws concerning the nursing homes or are in the process of doing so.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Experiences with the hospice movement show that terminally ill patients want to live right until the end if they are offered appropriate palliative therapy, individual care and psychological support. The hospice movement is an answer to the ongoing discussion about active euthanasia. Hospices offer good palliative care combined with a release from pain in the hope to make dying more humane. The government emphatically rejects euthanasia and instead promotes palliative medicine and mental care and support for the dying. Hospices get a lot of support from the Catholic Church (Caritas) but they are open to everybody from any religious belief. Hospices are specialised in palliative care for patients suffering from a long-term life threatening illness. This is not the place where most people pass away; the majority still die in hospitals and only about one person out of thirteen spends her / his last days in a hospice. Most hospitals have palliative care departments or practise palliative care programmes; palliative care is part of the curricula and permanent education programmes for nurses and nurse’s aides (Bernroitner, 2004; Nemeth, Rottenberger, 2004).

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

Family members are not officially expected to play an active role in in-patient health care; however, it is not unusual for relatives or volunteers to extend some form of support, e.g. helping a patient with taking meals.

Social services

4.1.1.6 Residential care (long-term, respite)

4.1.1.6.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

According to microcensus results only a small minority of elderly Austrians aged 60 and over – approximately 40,000 women and 11,000 men – lives in some kind of institutional setting.[61] Most of them live in old people's homes or nursing homes. The overall proportion of elderly people living in institutions is basically unchanged since the 1960s. There are no signs that major growth in institutional care is to be expected in the coming years. Among the "young old" under 75 years residential care is almost unknown (about 1 %). With advancing age the institutionalization rates are increasing noticeably, especially among the female population. No less than 17 % of all women aged 85 years or more are cared for in residential settings. Among men residential care does not exceed 8 %, not even for those in the highest age group above 85 years (Hörl, Kytir, 2000: 54-57).

4.1.1.6.2 Criteria for admission (degree of dependency, income etc.)

Dependent persons (as defined by the criteria for receiving long-term care benefits) have a legal right to admission to a public institution of residential care, regardless of their income. Almost all residents are beneficiaries of long-term care allowances.[62] The allowance, up to the level of institutional care costs but at most up to 80 % of the resident's total income (i.e. allowance plus pension) is transferred to the agency bearing the costs, usually the provincial authority. The balance is paid as "pocket money".

4.1.1.6.3 Public / private / NGO status

There is a variety of different providers of residential care in each province. About 26 % of institutions for older persons (45 % of total places in residential housing and 25 % of total places in nursing homes) are provided by non-profit organizations, 53 % by public providers (46 % of total places in residential housing, 67 % of total places in nursing homes), and about 21 % by smaller commercial providers (10 % of total places in residential housing and 8 % of total places in nursing homes) (Badelt, 1999: 81). No general statement can be made with regard to differences in quality levels between public (i.e. operated by provinces, municipalities or social assistance associations) and other providers of residential care. However, public homes are usually much

[61] Due to variable counting methods microcensus data do not correspond with administrative figures cited in section 4.1.1.3.

[62] For instance, in Lower Austrian institutions more than half of all residents are classified at long-term care level 4 or higher; only 6 % of all residents do not receive long-term care allowances (Löger, Amann, 2001: 67).

bigger than homes operated by private persons or companies or by NGOs.[63] As a rule there are long-term contracts between governments and NGOs. Virtually all NGOs uphold formal and informal inter-organizational ties with regional governments.

4.1.1.6.4 Does residential care involve the participation of carers or work with carers?

A very high proportion of residents of old people's homes are unmarried and / or childless. So many elderly do not have even a theoretical chance of being visited by close family members. Other residents get frequent visits from their next of kin and, naturally, receive some assistance during the visits. However, as observational studies have shown, due to lack of time or lack of initiative between care personnel and family members there is communication or planned co-operation only by way of exception (Rosenmayr, 2002: 25).

4.1.1.7 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Typically, provincial governments contract-out community care services to NGOs. Usually, there are long-standing contracts and a multiplicity of personal and political connections between provincial officials and NGO representatives. These networks are a major reason for commercial firms not playing a significant role in extramural care up to now. Some of the NGO providers are active in the whole country, while the smaller ones are more specialised in their range of services and offer them sometimes only in specific regions. It must always be kept in mind that community care services differ from region to region with regard to organization and financing, selection of services, status of development, and degree of professionalization. For example, while in Vienna home helpers provide the backbone of community care, some provinces, such as Vorarlberg and Tyrol, rely much more on nursing personnel with diplomas and other provinces, such as Upper Austria prefer nurse's aides.[64]

More than half of all persons receiving a long-term care allowance require some kind of social community service. This is regionally varying, as high as 84 % in Vorarlberg and as low as 34 % in more rural Burgenland and in Carinthia. Services are utilized by 60 % of persons living alone but only by 41 % of persons sharing the household with someone else. Since the introduction of the long-term care allowance, about one-third of persons

[63] The most extreme case is the Geriatric Centre Wienerwald (formerly called Lainz nursing home), run by the municipality of Vienna, which houses approximately 2,500 residents; this makes this centre one of the world's most populous institutions for the elderly.

[64] In Vienna, 85 % of all professional carers are home helpers, and 15 % are home health nurses (and nurse's aides); in Vorarlberg only 35 % of all professional carers are home helpers, and 65 % are home health nurses (Badelt, Leichsenring, 2000: 426).

receiving this cash payment are now able to receive more community services than before (Badelt et al., 1997: 79).

Two examples of rather sophisticated and fairly efficient systems of assessment, co-ordination and distribution of services should be described briefly.

In Lower Austria more than 200 Social Stations (Sozialstationen) are in function, which are operated by four different NGOs (Caritas Erzdiözese Wien, Caritas Diözese St. Pölten, NÖ Volkshilfe, NÖ Hilfswerk). According to the principle of one-stop-shop the whole spectrum of services is offered, with home nursing and home help as core competencies. Some stations also provide respite care (Löger, Amann, 2001).

In Vienna about a dozen Local Support Centres (Soziale Stützpunkte) – operated by the municipality – are serving as information and meeting points for the elderly and for informal carers of all kinds. They are also utilized, for example, by police departments when they have to deal with social emergency cases where elderly people are involved. Recently, eight of the support centres have been transformed into more comprehensive units named Health and Social Care Centres (Gesundheits- und Sozialzentren) giving more detailed and far-reaching information, e.g. about day centres, residential homes and respite care; in these locations some services are offered, too.

Within a very short time-span after first contact, a district nurse assesses the prospective client's needs by visiting her / him at home; in particular, she makes an assessment of what kind of services should be granted. She is also responsible for the subsequent paperwork required for administrating and co-ordinating the services. Finally, it is decided which one of the welfare organizations will provide the concrete services. In Vienna no less than 17 welfare organizations are providing community services having partisan[65], religious or charitable backgrounds. Big providers with more than 1,000 care receivers are: Caritas Erzdiözese Wien, Sozial Global, Wiener Hilfswerk, Wiener Sozialdienste, Wiener Volkshilfe, and Wiener Rotes Kreuz. Taken together, the Vienna welfare organizations employ about 3,600 full-time workers (mostly home helpers). [66]

The general trend in community care is that services are targeted towards people with critical medical care needs. Peripheral services like cleaning, laundry services or friendly visiting are cut back.

[65] Traditionally, in Austria the political parties and their subsidiaries are engaged in numerous aspects of social and cultural life. Thus, especially for the older generation it is still of interest to know to what political or religious affiliation a certain care provider belongs.

[66] Virtually all home helpers and the vast majority of social care workers in general are female.

4.1.1.7.1 Home-help

Both in terms of scope and organizational density, in most Austrian provinces home help is a quite extensively developed community service. Since there is no standard definition of home help, overlapping with other professions, and inconsistent counting methods, it is only possible to give a rough estimate with regard to the number and proportion of receivers. Around 5 % of all Austrians aged 65 and over benefit from the home help service. Of course, among care-dependent elderly this proportion is much higher – 17 % according to Badelt et al. (1997: 77). Up to the present day there are remarkable regional differences; big cities are much better provided with home help than remote areas.

Home help is usually granted twice a week; in critical cases home help is granted five days a week or even daily. Between the early 1970s and the mid-1990s a tremendous expansion has taken place. For instance, in Vienna, for this period an eight-fold increase in home help caring hours can be observed. However, since 1993 client numbers have been stagnating or even shrinking. In other provinces services are still growing, although the speed of expansion has slowed down.

4.1.1.7.2 Personal care

As far as medical care and improving the mobility of patients is concerned these tasks are performed by home health nurses; hygiene and personal care (bathing, dressing / undressing etc.) belongs to the duties of home helpers or nurse's aides.

4.1.1.7.3 Meals service

Meals-on-wheels services are offered almost everywhere (except in very remote areas) by a variety of providers. The choice is restricted but diet meals are available. Usually, deep frozen meals require microwave-ovens for preparation. There are also scores of local private restaurants which deliver freshly made meals to the apartments of the elderly.

4.1.1.7.4 Other home care services (transport, laundry, shopping etc.)

Cleaning services are offered for heavy-duty or dangerous cleaning (e.g. windows) which cannot be carried out by home helpers. In Vienna, between 1993 and 2001 a reduction of 67 % in service hours could be observed. Friendly visiting, which is another more peripheral service, also declined significantly during this period (44 %). A similar negative trend can be observed for laundry services.

4.1.1.7.5 Community care centres

Community care centres are known under different label, e.g. as pensioners' clubs. These facilities offer cultural and leisure programmes and light meals. They can be found in many regions and sometimes even in smaller villages. In

Vienna, there are more than 180 clubs which are operated by the municipality and many more run by pensioners' or other organizations.

4.1.1.7.6 Day care ("protective" care)

Day care, in the sense of protective care, has proved to be especially useful for elderly people with milder forms of dementia or other mental impairments, offering communicative, creative, and therapeutic programmes. Day care centres are especially useful in taking over responsibility for elderly people while family carers are at work. There is an urgent need for additional provisions of care in such semi-stationary centres; in Lower Austria, for instance, there are only six day care centres, which are partially still in a pilot phase. Even in Vienna fewer than 400 places are available, two-thirds of them run by the municipality.[67] Most day care centres apply an integrated approach whereas others are specialized, e.g. caring for multiple sclerosis or Alzheimer patients.

Recently, there has been growing interest in developing special forms of day care centres for rural areas (e.g. in the province of Burgenland).

4.1.1.8 Other social care services

Counselling and specific training courses for providing care at home are offered to family carers by various NGOs (Red Cross among others) and local governments. There are also subsidized loans available for home adaptations and renovations (improving sanitary installations, removing dangerous thresholds, etc.) to facilitate care-giving at home.

Quality of formal care services and its impact on family care-givers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

Who manages and supervises home care services?

As a result of the fragmented character and the enormous variety of actors involved in the different processes of home care services there is no overall responsibility, and no general monitoring or supervisory body. The federal and regional governments have outlined minimum standards for long-term care and services for older people. The regional governments, however, are free to implement and enforce these standards as they see fit. In differing combinations federal, provincial and local governments as well as non-profit organizations are responsible for funding and provision, controlling and inspection, in addition to developing and planning tasks.

[67] In 2000, on average 680 clients per month visited the Vienna day care centres (Andersen, 2002: 54).

As far as the somewhat special area of the long-term care allowance system is concerned there are more or less regular visits to randomly selected beneficiaries to make sure they are getting adequate care from their family or community services. These assessments are carried out by physicians assigned by social insurance institutions. Controllers have to announce their visits in advance. According to an assessment study carried out by independent nurses, for 90 % of long-term care allowance beneficiaries the quality of care is rated as excellent; the standard of personal and household hygiene is reported to be highly satisfactory as well (Nemeth, Pochobradsky, 2002: 13).[68]

At the policy level an informal working group of representatives of the federal and provincial authorities, the disabled, the social insurance institutions and the social partners monitors the development of long-term care, makes proposals for improvement and publishes an annual report. This is not a steering group but rather an advisory council which does not hold executive power.

Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls

Formally, departments within the provincial governments (not everywhere the same departments) are authorized to run controls of services. However, in reality quality assurance activities are fairly minimal, consisting mostly of responding to complaints of clients or family members, periodic home visits, and telephone contact with beneficiaries. At the administrative level there is "structural quality assessment" concerning parameters such as the client / carer ratio etc. The NGOs have internal quality assurance programmes but little is known about results.

Is there any professional certification for professional (home and residential) care workers? Average length of training?

Although in each province there is a minimum standard of professional training and certification for care workers, Austria is lacking in nation-wide regulations and standards. In particular, home helpers, geriatric aides and family helpers are trained on the basis of regional regulations. Additionally, there are curricula developed by non-profit providers.

As both the Association of Employers for Professions in Health and Social Services (Berufsvereinigung von Arbeitgebern für Gesundheits- und Sozialberufe) and the unions argue, a nation-wide harmonisation of training standards for well-defined professions would be indispensable in making these

[68] There remain serious doubts about the universal accuracy of these conclusions since controllers had to announce their visits in advance and 10 % of households (more in urban, less in rural areas) refused to be visited altogether.

professions more attractive, which is a prerequisite for securing future social and health services. Such a harmonisation would be decisive for these professions and training certificates to be acknowledged by other EU Member States, which would grant many more mobility opportunities as well as professional prospects for the employees concerned.

An example of a rather progressive curriculum is to be found in Vienna. According to the Viennese Home Help Act (1997) home helpers have to attend a course to the extent of 400 hours (200 theory hours plus 200 practice hours). Additionally, further education is compulsory. The programme is planned and carried out by the non-profit organizations and an umbrella organization (Dachverband Wiener Gesundheits- und Sozialdienste).

Is training compulsory?

As a rule training for care workers is compulsory, but volunteers and semi-volunteers (e.g. those engaged in local initiatives or doing community work in church parishes) can operate in certain fields of community eldercare without any specific formal training.

Are there problems in the recruitment and retention of care workers?

The analysis of the provinces' needs and development plans shows that in the coming decades quite a large amount of additional personnel is needed in community care as well as in institutional care for the elderly (Schaffenberger et al., 1999). At the moment there are no serious problems as far as the recruitment and retention of home helpers and related professions is concerned. In particular, for lower educated, middle-aged women who want to re-enter the labour market home help is one of the few accessible job opportunities. Notwithstanding that one must be aware that home help up to now remains a low-wage job; the average hourly (net) wage of a home helper is approximately 8 euros. Furthermore, they have to cope with on-demand working hours and challenging working conditions (e.g. commuting all day between clients).

There are actual shortages of certified home health nursing staff because working conditions are regarded as poor, there is a high degree of self-responsibility, and the wages and status are lower than in acute care hospitals. Until the present day the training available for nurses in the extramural sector in Austria compares very badly internationally; only short spells of further training are available. Permanent training and education programmes could serve as incentives to attract additional personnel.