Chapter 8
Long-Term Care Reform in Austria: Emergence and Development of a New Welfare State Pillar

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8.1 The Broader Context of Reform

The Austrian welfare state is commonly identified as a conservative, corporatist, and familialistic welfare state with social insurance against major social risks. Regulatory roles are divided between the central and the provincial level. The delivery of social services is mostly by public and private nonprofit providers (Österle and Heitzmann 2009). Until the early 1990s, social policies in Austria were characterized by expansion. From the 1980s, however, cost containment concerns became more prominent and led to a relative stability in the level of social expenditure from the mid-1990s. Public social expenditure as a percentage of GDP increased from 26.1 % in 1990 to 28.9 % in 1995, and stood at 28.3 % in 2008 (compared to 26.2 % in the EU27 average).

Developments in long-term care were different. Until the early 1990s, long-term care was not identified as a distinctive "social risk." The bulk of care was provided within families and households, mostly by women. Public support was based on provincial social assistance legislation. Strong family orientation was rooted in widely shared perceptions that it is the family's responsibility to provide care to family members, both children and frail older people. This perception was also supported by legislation, requiring family members, e.g., to contribute to the funding of care when residential care was needed. Historically, the major source of public cofunding for long-term care was poverty relief programs. These were replaced by provincial social assistance schemes in the 1970s. Different from earlier poverty relief programs attempting to provide a subsistence level, regional social assistance laws also began incorporating social services supporting older, chronically ill, and disabled people (Melinz 2009; Tálos and Wörister 1994). Until the 1980s, provision of long-term care services was dominated by residential care. Providers were either public authorities or private nonprofit organizations. Community care services have historically been

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available in some locations, but remained unavailable in large parts of the country. Only since the 1980s, there has been a stronger political rhetoric to expand community care services. Overall, until the early 1990s, long-term care was not addressed as a distinctive field of social protection. The provision of public support for long-term care was split between federal benefits (including a pension supplement from 1958 and medical home nursing introduced in 1992), regional benefits and services for people with disabilities, social assistance-funded services, and a child care benefit supplement for children with disabilities, and tax regulations (Pfeil 1996).

Initiatives and debates that started in the 1980s finally led to a major long-term care reform in 1993 (see Sect. 8.2). At the core of the reform was a novel and nationwide "cash for care" program. In addition, the reform has contributed to establishing a common understanding of the policy field and confirmed the regional responsibility for service development in residential care and in community care. In Austria, long-term care is now defined as care for people of all age groups in need of constant support due to chronic illness or disability. Care is now organized around three main pillars: family care, cash for care, and social services (Österle 2001). Since the 1993 reform, developments in long-term care have been characterized by gradual changes, by measures of expansion, in particular with regard to social service development and support for informal carers, but also in terms of retrenchment (see Sect. 8.3). A further intensely debated reform was implemented in 2007 as a response to a growing gray economy of migrant care (see Sect. 8.4).

This chapter analyzes the reform developments in the Austrian long-term care sector. In studying the developments from the establishment of long-term care as a separate social policy field in 1993 up until today, this chapter focuses on two major aspects: (1) it analyzes the aims, tools, and effects of major reforms and of gradual changes in that period; and (2) it studies the driving forces behind the changes, including the role of actors and the specific reform mechanisms. The analysis follows the framework introduced in the introductory chapter.

8.2 The 1993 Cash for Care Reform

Year 1993 marked a major turning point for the Austrian long-term care system. The reform implemented in that year included both central and provincial regulations and a so-called State–Provinces Treaty. The latter was a result of the federalist structure of this country, wherein both central and provincial levels have responsibilities in relation to the provision and funding of long-term care. State–Provinces Treaties are aimed at making arrangements between governmental levels where complex matters of competence have to be resolved. The 1993 Treaty on Long-Term Care was aimed at a system of uniform principles for social protection towards the risk of long-term care. The first major element of the agreement was a 'cash for care' system detailed in a Federal Long-Term Care Allowance Act, and, following the same principles, objectives, and provisions, in nine Provincial Long-Term Care Allowance Acts (see below). In addition, the agreement confirmed provincial responsibility for

social service developments. Provinces had to develop an adequate infrastructure of residential, semiresidential, and community care services. To achieve this, provinces were required to establish plans on the future need and development of services at the regional and local levels. The agreement included information on how to structure these plans, while criteria for services and quality remained rather vague. Finally, the central level took responsibility for developing a system of social insurance coverage for family carers. For the respective services and benefits, the treaty established that costs had to be covered by the competent governmental level. The treaty was signed in May 1993 and became effective on 1 January 1994.

Together with the treaty, the care allowance system became effective on 1 July 1993. The system was introduced with a Federal Long-Term Care Allowance Act and nine Provincial Long-Term Care Allowance Acts, following the same provisions (Pfeil 1994). Responsibility for funding the care of recipients in receipt of other current or potential federal benefits, such as pensioners, lies with the federal state, while provinces are responsible for funding the care of recipients with no federal benefits, such as recipients of social assistance and for provincial or local civil servants. From 2012, however, the central level will become the only competent governmental level for the administration of the care allowance scheme. According to the legislation, individuals of all age groups with care needs above 60 h per month (above 50 h per month prior to 2011) are eligible for the care allowance (*Pflegegeld*). The benefit is defined as a contribution to care-related expenses and is paid in seven different levels to those in need of care (see Table 8.1). Different from budget-oriented cash for care systems, there is no predefined use of the benefit in the Austrian system. The care allowance is paid to about 5.1 % of the Austrian population or 432,739 recipients (as of 31 December 2009). At the end of 2009, 54 % of recipients were in benefit levels 1 and 2 and 15 % of beneficiaries were in benefit levels 5–7 (see Table 8.1). The 82 % of beneficiaries were aged 61 and above and almost 50 % were aged 81 and above. Recipients of the care allowance account for about 19 % of the total population of those aged 61+ and for about half of the total population of those aged 81+.

According to Article 1 of the Federal Long-Term Care Allowance Act, the intended purpose of the new scheme is to provide a lump sum contribution for care-related costs, ensuring recipients of necessary care and help and to improve the opportunities for a self-determined life. Following the debates leading to the enactment, the care allowance system aims to enable chronically ill people to stay in their private homes; promote autonomy and free choice of care arrangements; support informal care provided in the family; and create incentives for consumer-driven community care development (Badelt et al. 1997; Gruber and Pallinger 1994; Pfeil 1994).

The State–Provinces Treaty, apart from the care allowance scheme, also addresses social service development. The Treaty confirms regional responsibility for service development and obliges regions to develop an adequate infrastructure for residential, semiresidential, and community care development. To achieve this, regions had to establish development plans covering the 15-year period between 1996 and 2010 (*Österreichisches Bundesinstitut für Gesundheitswesen* [ÖBIG] 1999). However, there are only few general standards defined. There are no common benchmarks in terms of service density and no sanctions attached to the agreement. The organization

Table 8.1 Long-term care allowance: benefit levels and benefits 1993, 2002, 2011. (Source: BMASK 2011)

Benefit level	Definition of care needs (January 2011)	Benefit recipients (31 Dec 2009)	Benefit level		
			1 July 1993 (€)[a]	1 Jan 2002 (€)	1 Jan 2011 (€)
1	>60 h[b]	90,889	181.70	145.40	154.20
2	>85 h[b]	142,250	254.40	268.00	284.30
3	>120 h	72,975	392.40	413.50	442.90
4	>160 h	62,279	588.60	620.30	664.30
5	>180 h, Exceptional care needed	38,622	799.40	842.40	902.30
6	>180 h, Care measures difficult to time or permanently required care day and night	16,484	1,090.10	1,148.70	1,260.00
7	>180 h, Complete immobility	9,240	1,453.50	1,531.50	1,655.80

[a]Austrian Schillings (ATS) converted to €: € 1 = 13.7603 ATS
[b]Minimum eligibility requirements have been changed from 50 h/month to 60 h/month (level 1) and from 75 h/month to 85 h/month (level 2) from 1 January 2011.

and governance of the two pillars—cash and services—is only loosely connected. While the care allowance scheme follows nationwide principles, regulations for social services differ across the nine provinces. Care allowances are established as a social right, while this is not the case for social services. While a specific cash benefit level is often used as a criterion defining access to publicly cofunded services, the content of service use is determined separately. Assessment procedures for the cash and the service pillar are not integrated. As a consequence, developments in the cash for care system and in the service sector are not systematically coordinated, leaving considerable room for unintended effects and reactions.

This leads to the question about the factors that have driven the development of a cash-oriented and tax-funded long-term care policy in Austria. Behning (1999) defines three phases leading to the 1993 reform. The period prior to 1985 is defined as a "period of problem definition." Activities started with emerging critique on the status quo in the 1970s and in particular with activities around the UN "International Year of Disabled Persons" in 1981. Key actors at that time were representatives of people with disabilities (organized in the Austrian Working Group for Rehabilitation) and an Austrian National Committee bringing together representatives of disability organizations, social service providers, and central, regional, and local levels. Documents from that period published by the aforementioned stakeholders already proposed a cash for care system. The second phase is defined as the "agenda setting period" lasting from the mid-1980s until 1990. In the second half of the 1980s, disability organizations and Members of Parliament intensify their efforts in lobbying for a long-term care reform. A 1988 Working Group, not specifically addressing people with disabilities, but individuals in need of long-term care, indicated an attempt to

broaden the focus beyond the interests of disability groups, even if the latter remained the main drivers of the reform debates. It was disability organizations and provinces in particular that pushed for long-term care reform in this phase. From the late 1980s, some provinces become increasingly active in the debate, the two Western provinces of Vorarlberg and Tyrol favoring a cash-oriented system and Vienna favoring a service-oriented system. At that time, the provision of social services was comparatively well-developed, both in Vorarlberg and in Vienna. Vorarlberg, a more rural region with smaller cities and dominated by conservative governments, in many respects, has a tradition as innovator in local social policies. At the same time, family orientation is strong in this province. In Vorarlberg and in Tyrol, the cash benefit approach was favored as a measure to support families in care provision and to facilitate care in the private environment of the user. Vienna is the most urban agglomeration in the country and is dominated by social democratic governments. This provincial government strongly preferred federal support for social service development. The Working Group, however, closed its activities in the early 1990s without consensus in terms of both cash versus service orientation and funding. Nonetheless, activists further drove debates towards a nationwide reform. Developments were also facilitated by the introduction of a regional 'cash for care' program in the province of Vorarlberg in 1990, which later became an important template for the nationwide scheme.

The third phase of "policy formulation" (1990–1993) started after the federal election in October 1990. The new government defined the objective as the development of a comprehensive nationwide system of social protection towards the risk of long-term care. Policy formulation was delegated to several working groups and was repeatedly pushed by manifestations of disability organizations, including a hunger strike. In 1991 and 1992, draft acts were sent out for expert opinions. Cash versus service orientation was a major issue of debate. While the Minister of Social Affairs (social democrat) was supportive of the 'cash for care' system, the capital city Vienna (which at the same time was a province), governed by the Social Democratic Party, promoted a service model. The 'cash for care' approach was also supported by the Conservative Party, in particular by some of the provinces, and by the Green Party. Disability groups, as throughout the reform process, were strongly advocating for the cash option. In this phase, funding became a second major issue in the discussions. Some provinces (in particular Vienna and Salzburg, governed by social democratic and conservative governments, respectively) and some representatives of the governing coalition parties (the Social Democratic and the Conservative Party) stressed the budgetary implications and recommended a step-by-step introduction. Social partners also became more involved in the debates in this phase. The trade unions (voluntary membership) and the Chamber of Labour (mandatory membership), who were representing the views of employees, were in favor of a service-oriented system, and so emphasized the need to strengthen employment in the social services. Before the enactment of the legislation, the social partners—in particular the Chamber of Commerce and the Chamber of Labour—articulated strong objections because of the financial implications for labor-related costs. Together with disability groups, however, the Minister pushed for full implementation in 1993. The Act finally became enacted in early 1993 and effective from 1 July 1993.

With the 1993 reform, Austria confirmed and clarified the traditional model of shared responsibilities between national, regional, and local levels in long-term care. Despite the roots in earlier provisions and despite continuity in the general organization of social service provision, 1993 signified a major turning point in terms of addressing the challenge of funding and organizing long-term care and in terms of considerable welfare state expansion from that point. Compared to an earlier federal benefit—*Hilflosenzuschuss,* which was paid at a flat rate benefit of about € 220 to pensioners—the introduction of the care allowance scheme led to an increase of central public expenditure by 64 % in 1994. While federal long-term care expenditure on the care allowance amounted to € 1.34 billion in 1994, it would have been just € 0.82 billion according to the pre-1993 legislation (*Bundesministerium für Arbeit, Soziales und Konsumentenschutz* [BMASK] 2011). In terms of the care regime or the broader welfare regime, the reform involved both continuity and change. Unlike Germany, Austria did not follow the tradition of social insurance. Establishing a fifth social insurance pillar was not an intensely debated option in Austria. Increasing labor costs, articulated by the Chamber of Commerce and the Chamber of Labour, was a major argument against social insurance. However, there was an intense debate on cash versus service orientation; the latter favored by the region of Vienna and by social service providers. The final decision for a 'cash for care' system was rooted in a variety of factors. As noted above, disability organizations, following independent living ideas, emphasized autonomy and self-determination throughout the reform debates and also strongly favored the cash approach. Political actors across the political spectrum were also in favor of a 'cash for care' scheme even if for very different reasons, including support for family care, support for autonomy, for user-driven market developments, or cost containment. In terms of benefit design, the new care allowance system replaced a previous highly fragmented and partly means-tested system of cash benefits. Apart from these policy-specific factors, the use of cash benefits is also rooted in the broader welfare regime setting. Similar to long-term care policies, cash orientation also characterizes family policies in this country (Leitner 2011). In terms of the welfare mix (dominated by public and nonprofit providers), the 1993 reform did not establish any particular incentives for changes. However, it was assumed that the cash benefit would induce consumer-driven developments in service provision. Finally, the new care regime retained a strong family orientation, even if actors pushing for the reform had very different perspectives on the role of the family in terms of the delivery of care (Behning 1999). Taken together, the reform was partly an abrupt transformation and partly it started a process of "reproduction by adaptation" (Streeck and Thelen 2005).

8.3 Stability with Gradual Changes After 1993

The period after the 1993 reform was characterized by gradual changes, both in the regulatory framework and as a result of actor behavior. The changes, which led to both extensions and retrenchment, occurred in three areas, in the 'cash for care'

system, in the social service sector, and in policies related to the role of informal carers. With regard to the care allowance, very little change occurred. There have been some adaptations in the criteria applied in the assessment, a cut in the benefit level 1 (in 1996), changes in the definition of benefit level 5 (in 1999), an extension in the definition of care needs recognizing the particular needs of people with dementia and of severely disabled children (in 2009), and a tightening of eligibility criteria for benefit levels 1 and 2 (in 2011). As agreed in the State–Provinces Treaty, benefit levels were price-adjusted in 1994 and 1995. After that, however, for many years benefit levels were not adjusted to inflation (see Table 8.2). As a consequence, the "no changes" policy has significantly decreased the purchasing power of the benefit by almost 20 %. A cost containment policy was not made explicit, but cost containment considerations have driven decisions not to adjust benefit levels. In particular, disability groups and social service providers opposed nonadjustment, but this was not widely supported in the policymaking arena or by the media.

As mentioned before, in the State–Provinces Treaty, provinces agreed to develop an adequate infrastructure of residential, semiresidential, and community care services. Even though the Treaty did not establish common benchmarks for levels of provision, the service sector has seen a substantial growth since 1993, with regard to staff numbers, service provision, and public expenditure. Surveys on long-term care workers indicate a significant increase in the total number of employees. Between 1999 and 2003, the number of employees in the long-term care sector increased by about 20 %, by 13 % in residential care, and by 32 % in home care (ÖBIG 2005). This trend was prolonged in the following period. Between 2003 and 2006, employment increased by 12 % in the long-term care sector overall, and by 36 % in the home care sector (ÖBIG 2008). At the same time, the average level of qualification among staff improved. With regard to service provision, in the residential care sector, the total number of beds remained relatively stable, but the number of nursing beds steadily increased while the number of beds with little or no nursing component decreased. By the end of 2008, residential care facilities provided a total of 72,358 places, with about 81 % designated as nursing care beds (*Bundesministerium für Soziales und Konsumentenschutz* [BMSK] 2008). Total public expenditure for nursing homes increased by 72 % between 2000 and 2008 (BMASK 2009). The home care sector has also seen a general increase in levels of provision. In 2008, 13.7 million h of community care services were provided in Austria, including home nursing, personal help, consultation, and other services. Compared to the year 2000, this is an increase of about 30 %. Total public expenditure for community care services increased by 46 % in the same period (BMASK 2009).

While there is no systematic analysis of the forces that led to the growth of the service sector, several factors have to be taken into account. Firstly, the care allowance has increased the purchasing power of potential users. At the same time, this effect was limited because copayments to be made by users have been increased since the introduction of the care allowance (Da Roit et al. 2007; Kreimer 2006; Österle and Hammer 2007). The calculation of copayments differs between provinces, but is usually designed as a combination of a flat rate contribution related to the care allowance, and a means-tested contribution related to the income of the user.

Table 8.2 Changes in the Austrian long-term care system 1993–2011

Effective from	Changes in the long-term care system	Central (c) Provincial (p)
1 July 1993	Introduction long-term care allowance (*Pflegegeld*): Federal Long-term Care Allowance Act (*Bundespflegegeldgesetz*), Provincial Long-term Care Allowance Acts (*Landespflegegeldgesetze*)	c, p
1 January 1994	State–Provinces Treaty: defining federal and provincial responsibilities in long-term care	c, p
1 January 1994	Increase care allowance by 2.5 %	c, p
1 January 1995	Increase care allowance by 2.8 %	c, p
1 January 1996	Regional development plans for residential, semi-residential, and community care services implemented (covering 1996–2010)	p
1 January 1998	Family carers: subsidized pension insurance (hypothetical employer contribution paid by the state)	c
1 January 1999	Redefinition eligibility criteria for care allowance level 4	c, p
1 July 2001	Elimination of the previous age limit (3 years) in the care allowance scheme	c, p
1 July 2001	Family carers: noncontributory social health insurance from care allowance level 4	c
1 July 2002	Family hospice leave scheme	c
1 January 2004	Financial support scheme for temporary respite care	c
1 July 2004	Residential Home Act (*Heimvertragsgesetz*)	c
1 January 2005	Increase care allowance by 2 %	c, p
1 July 2005	Residential Home Residence Act (*Heimaufenthaltsgesetz*)	c
26 July 2005	State–Provinces Treaty on a modular educational system for social care professions	c, p
1 July 2007	Regularization 24 h care: Home Care Act (*Hausbetreuungsgesetz*), amendments to several other Acts, introduction of financial support scheme for 24-hour care	c, p
10 April 2008	Amendment to the Health and Nursing Act	c
1 November 2008	Financial support for 24 h care: extension of benefit, abolition of asset test	c, p
1 August 2009	Family carers: free social pension insurance and noncontributory social health insurance from care allowance level 3	c
1 January 2009	Increase care allowance by 3–4 %	c, p
1 January 2009	Extension in the definition of care needs recognizing the particular needs of people with dementia and of severely disabled children	c, p
Till 1 January 2009	Recourse to family members in funding residential care abolished in all provinces	p
1 January 2011	Tightening eligibility criteria for benefit levels 1 and 2	c, p

For the provincial level, only changes implemented in the entire country are listed.

In addition, copayment schemes might differ in whether and how they refer to household composition. For example, in Vienna, copayment calculation considers the level of the care allowance, the income of the user, and the number of service hours needed. The maximum copayment is € 24.95 per hour for home nursing or € 19.00 for home help in 2011 in this province. For specific services, low-income users can be exempted from copayments. Another limitation in the purchasing power of the care allowances arises from the aforementioned lack of regular price adjustment of the benefit. Secondly, the evolution of social services was determined by the regional development plans, which led to activities on regional and local levels in expanding home care services (ÖBIG 2008). The rhetoric of "outpatient before inpatient" was increasingly translated into policies by offering residential care to those with more extensive care needs and by developing social services to enable users to remain at home. Thirdly, while family orientation and the sole use of family care are still widespread in Austria, community services increasingly became perceived as a supplementary option to cover specific care needs (Österle et al. 2011).

Throughout the past two decades, there have been repeated calls for some harmonization in the social service sector beyond provincial borders. While respective attempts have regularly received considerable opposition, harmonization became effective in three particular areas. The provisions of the Residential Home Act (2004) and the Residential Home Residence Act (2005) were aimed at transparent relationships between residents and homes and included regulations on contracts, personal rights, and confidentiality (Ganner 2005). In 2005, a State–Provinces Treaty established the framework for a modular nationwide educational system for social care professions, which was implemented at the regional level until 2008 (BMASK 2011).

The third area of change after 1993 was in relation to the provision of support measures for informal carers, or, more specifically for family carers. The State–Provinces Treaty required the central level to establish a system of social insurance coverage for family carers. The respective steps took more than a decade to implement. From January 1998, family members caring for a care allowance recipient with benefit level 5 and above had access to social pension insurance coverage at a reduced contribution rate. Later, this option was extended to family members of care allowance recipients in receipt of benefit level 3 and above. However, the take up remained low. Only from August 2009 have contributions for social pension insurance of family carers been fully covered by the state, if the care receiver is in receipt of benefit level 3 or above. Noncontributory coverage for social health insurance has been available for family members caring for someone with benefit level 4 and above since 2001. From August 2009, eligibility is extended to family members caring for a care allowance recipient with benefit level 3 and above. Apart from family members, this option is also open to nonkin if they have been living in the same household with the person in need of care for at least 10 months. Several other measures also address the needs of family carers; however, many of these, only as pilot programs or as programs limited to single regions or single provider organizations. A nationwide financial support program is offered for respite care for family members caring for someone in receipt of benefit level 3 and above, and—from 2009—when caring for people with dementia or for children in receipt of benefit level 1 and above. This support is means-tested

and is limited to a maximum of 4 weeks per year. Another major federal program supporting informal care is the Family Hospice Leave Scheme (introduced in July 2002) allowing 3 months leave (extendible to 6 months) when caring for a terminally ill family member. For seriously ill children, it can be extended to 9 months (since 2006).

The period from 1993 until today is then characterized by mostly moderate and gradual regulatory changes but quite substantial extensions in the level of social service provision. In the social service sector, regional development plans had an important indicative role for these changes. Changes were not the result of a major new legislation but of changes in the institutional and administrative practice between social service providers and provincial and local levels. Changes on the ground have also been important in terms of case management or quality management procedures. In this period, social service providers, in particular a Working Group representing the major provider organizations became key actors in pushing for further reforms. Disability groups remain another key actor, in particular in advocating the particular 'cash for care' approach, while representatives of senior organizations—at least until very recently—have not been proactive in calling for long-term care reforms.

Taken together, the period after 1993 can be characterized as one of regulatory stability. Changes in that period do not signify a move away from the model implemented with the 1993 reform. There has been a considerable extension in community care provision, but without any major changes in the regulatory framework. There have been repeated calls for some harmonization in social service delivery across the country. The aforementioned central laws on residential care and the State–Provinces Treaty on the educational system indicate some trend in that direction, but it is unclear whether this is the beginning of a "layering" process (Streeck and Thelen 2005), which will lead to convergence in the governance of social service provision. While debates on the future of long-term care arise now and then, it was only in the summer 2006 that long-term care again became a major public policy issue.

8.4 The Regularization of Migrant Care 2007

From the 1990s, an increasing number of migrant "24-hour care workers" have been providing paid care work in private households in Austria. What started as informal arrangements in border regions based on informal social networks across borders soon developed into a system where commercial agencies acted as placement organizations. The typical arrangement was with two carers working on a fortnightly shift in one household. The characteristics of the Austrian care allowance scheme, limitations in the availability and the affordability of home care services, and the availability of cheap labor just across the border in an increasingly open border regime have been identified as major drivers of the emergence of a gray economy of care (Österle and Hammer 2007; Schmid 2009).

It is estimated that at least 30,000 or so, 24 h care workers have been active in Austria in 2006 (Schmid 2009). The respective work arrangements have predominantly

been outside labor and social security regulations. After a media-driven debate (see below), the first regulatory step was an intermediate amnesty. Accordingly, there was no prosecution for illegal 24 h care work arrangements until June 2007, later extended until June 2008. The regularization of 24 h care became effective from July 2007. At the center of the reform was the Home Care Act (*Hausbetreuungsgesetz*) defining a new occupational group, the personal care workers. Such individuals can work as self-employed or as employees, though the latter are to some extent rare because of work time and social security regulations, which make this option considerably more expensive. The implementation into the broader care and labor market regime was achieved through amendments to several laws. The reform determines qualification requirements, which are linked to a financial support scheme, and the tasks that personal care workers are allowed to perform. As a qualification requirement, the reform accepts a training course equivalent to that of home helpers (amounting to 200 h), but also proof of previous care work experience in a private household for at least 6 months. To users of the arrangement, the regularization involves considerable additional costs. To ensure affordability, the second major objective of the reform, a financial support scheme, was added to the Federal and the nine Provincial Long-Term Care Allowance Acts. The respective benefit is means-tested and amounts to a maximum of € 1,100 per month (€ 800 until October 2008) for employed personal care workers and to a maximum of € 550 per month (€ 225 until October 2008) for a self-employment arrangement (BMASK 2009). In spring 2011, about 27,000 individuals have been registered and are active as self-employed personal care workers.

Apart from regularizing employment arrangements in private households, the reform has also some important indirect implications for the long-term care sector more generally, and will probably impact on the development of the sector to an even greater extent in the future. After the regularization, social service providers have also started to act as placement organizations. With the involvement of social service providers, a coordination of the different types of services and even the inclusion of personal care in case management procedures might gradually become more common (Österle and Bauer 2010). The personal care scheme allows a connection of a previously gray economy of care with the traditional social service system. However, the construction of the new personal care arrangement could also encourage a tendency toward deprofessionalization. Compared to social care workers with similar tasks, formal qualification requirements for personal 24 h care workers are smaller. Given both the costs involved and the work time the different arrangements allow, 24 h care can become a significantly cheaper and more attractive option for users than traditional home care services, in particular where users need extended hours of home care services and where they have to make larger copayments (Österle and Bauer 2010). However, while the regularization establishes labor and social security rights, personal 24 h care work often remains a precarious work arrangement. This is because of the dominance of the self-employment arrangements and because of the particular patterns of the work arrangement such as the hidden character of work in private households or the insecurity in the duration of the work relationship (Haidinger 2010; Kretschmann 2010).

The initial impulse for the regularization of 24 h care was an intense, media-driven debate in the summer of 2006. Prior to a federal election on 1 October 2006, the illegal status of migrant care arrangements suddenly became a major public issue in that summer. The starting point was a couple of cases in Lower Austria, where individuals were charged for the illegal employment of carers in private households. These cases were reported in the media. A few similar cases had been recognized in the media before, but this time the issue turned into a broad and intense public debate. Not least because media-disclosed cases included families of leading politicians who had been using migrant care work. The context of a preelection phase during the usual media summer slump allowed long-term care or rather, the issue of migrant care, to become a major issue of public debate. In view of the election, there was considerable consensus in the messages of the political parties, which were also widely supported in the media: (a) that the arrangements were illegal, (b) that care recipients should not be kept responsible (following the assumption that they often did not have any affordable alternative to receive the necessary care), and (c) that politicians should urgently find a response. The short-term response was a temporary amnesty, followed by the reform outlined above.

The main actors in the preelection period were the media and representatives of political parties. While early responses by the governing parties attempted to play down the significance of migrant care ("there is no stage of emergency in long-term care"), it soon became obvious that the public debate would not fade away. Soon, there was consensus on the aforementioned messages. However, there were significant differences in the ideas about how to regularize migrant care (Bachinger 2009). Most parties supported approaches to legalize 24 h care, except for the right-wing parties (after a split, one of these parties was coalition partner, the other opposition party), who were calling for approaches to employ Austrian workers rather than migrants. Representatives of the governing Conservative Party emphasized the need for legalization, but also a need to consider the costs that regularization would involve. Opposition parties and the unions strongly criticized low-cost regularization approaches for legalizing highly precarious work contracts. Overall, the two dominant issues in the debates were regularization and affordability. A call for extensions in community care and an emphasis on quality of care, mainly articulated by social service providers and by representatives of the nurse and social care professions, received little support beyond rhetoric. Altogether, the debates and the policy responses discussed in 2006 and 2007 were almost exclusively around 24 h care. Any attempt to take the opportunity for a more far-reaching reform of the long-term care system was not taken up.

The 2007 regularization reform consisted of two major elements. The Home Care Act defined a new occupational group, the so-called personal care workers in private households, who can work either as self-employed personal care workers or as employees. The self-employment mode became the preferred option, both because of the lower costs involved and because of the flexibility in work time arrangements. The second major effort of the 2007 reform was a financial support scheme to ensure affordability of the personal care arrangement as compared to the previous irregular 24 h care arrangement. The Home Care Act was passed as

proposed by the government, despite much criticism. The debate on the financial support scheme, however, continued for the entire year of 2007 (Bachinger 2009). In particular, it was disputed how to share funding responsibilities between central and provincial levels and how to define means-testing criteria. Originally, means testing considered income and assets of the user. After one province started to abolish the asset test, others followed soon, which led to the abolition across the country in November 2008. These debates led to an interesting side effect in the residential care sector. In the course of the discussions, recourse toward family members in funding residential care—still in place in the majority of provinces at that time—was abolished.

From a care regime perspective, 24 h care was an unintended development. There was no reference to the potential development of a gray economy of care in the early 1990s. However, the concept of 24 h care and the particular arrangement did fit with a predominant care responsibility culture (Weicht 2010). Most actors have always emphasized care at home as a preferred care arrangement, even if with very different understandings of the role of the family and other potential caregivers. The care allowance established social rights and extended public support, but at the same time followed the familialistic tradition. When families were unable to provide necessary care for long hours, 24 h care often offered the only option for home care. Before the regularization, however, 24 h care was a separate pillar, parallel to the traditional social service sector. Following law suits, service providers even followed a policy not to provide services when there was a 24 h care worker in the private household. The regularization was an effort not only to develop a framework for legal employment of care workers in private households, but also to establish qualification requirements and task descriptions to contribute to an integration of services.

Separate from the 1993 reform and the phase of continuity that followed over the next 15 years, the regulation of 24 h care can be described as "institutional change through process sequencing" (Jensen 2009). The reform very strictly focused on one aspect of the long-term care issue, namely the regularization of a previously gray economy of care. It did not change the general care regime characteristics, but has added an important new element. Given an estimated 30,000 irregular 24 h care workers in 2006, the 27,000 regularized personal care workers in Spring 2011 can be seen as a success, in terms of take up of the regularization. In an overall perspective, however, migrant care is less frequent than in countries like Italy or Spain. Considering the typical arrangement with two personal care workers on biweekly or monthly shifts in the private home of the user, the arrangement is used by about 3.1 % of those receiving a care allowance, or 6.7 % of those in receipt of benefit level 3 and above. While the personal care work arrangement is used by about 13,500 private households, there are 130,000 users of traditional home care services. How the two sectors evolve and whether the two types of services will become more integrated will have important implications for the future development of the care sector in Austria.

8.5 Developments, Dilemmas, and Perspectives

The 1993 reform marks an important turning point for the ways in which long-term care is addressed in the Austrian welfare system. Before that reform, responsibilities for the provision of long-term care were largely attributed to families. Welfare state responses were highly fragmented (in terms of target groups, eligibility criteria, and regional governance) and were mostly social assistance oriented. With the 1993 reform, a distinctive welfare sector was established that is regularly covered in public debates and in the media. Long-term care became defined as a sector that provides support for people in need of care and help due to chronic illness, disability, or frailty, independent of their age or the cause of the limitations.

The perception of family responsibility and the actual role of families in caregiving is still strong in this country, as shown, for example, in Eurobarometer surveys on preferences and expectations regarding long-term caregiving (European Commission 2007). At the same time, there is also increasing expectation that the welfare state should support those in need. The 1993 reform and subsequent developments have substantially extended public responsibility in this sector. The care allowance is designed as a universal benefit, but as a benefit that contributes to, rather than fully covers care-related costs. In the residential care sector, the major change has been a move towards settings that primarily focus on those with more severe care needs. The community care sector has seen a substantial increase in the level and the diversity of services. Services became available across the country, which has reduced previous enormous territorial inequalities in the availability of respective provisions. Despite these expansions, there has also been some significant retrenchment. A major example for cost containment is that care allowances for many years have not been price-adjusted. The tightening of eligibility criteria for benefit levels 1 and 2 in 2011 is another example. On the other hand, in 2009, eligibility for disabled children and for people with dementia was facilitated. This indicates that there is some trend to limit access for those with more moderate care needs and to extend it for those with more intense care needs. In the service sector, retrenchment is less visible because of a general expansion of services. However, limitations in publicly cofunded provisions or the specific rules for calculating copayments put a limit to the respective provisions. It was not least these limitations in social service consumption that helped the development of 24 h migrant care to become an additional option between family care and publicly cofunded community care provisions from the 1990s. The illegal work status only became a major political issue in 2006 leading to a regularization of migrant care work in private households in 2007 and a financial support scheme with the aim to ensure affordability for users. While the approach opened up a new regular option for arranging the necessary care, it was also recognized as a cost-effective way to provide long hours of care.

Overall, there is broad support for the major elements of the current long-term care system in Austria. There are, however, also important tradeoffs and dilemmas. The cash orientation is a strong pillar in the Austrian system. It is supported and defended with reference to concepts of autonomy and choice as well as recognition

and support for family care, but also for reasons of financial sustainability. Giving more substance to these aims reveals potential conflicts. For example, despite the existence of the cash benefit, choice is still limited as the benefit remains too small for many to actually exercise a broad range of choice options. The emergence of 24 h care was at least in part a response to this limitation. Another area for potential dilemmas is the link between cash provision and service consumption. In the German long-term care insurance system, 'cash for care' and services are integrated in the same system. Users have to make an explicit choice between 'cash for care' or services, or a combination of the two. In Austria, 'cash for care' and services are two separate pillars of the long-term care system. Applications for 'cash for care' and for service provision are two different procedures. Also, in contrast with Germany, there is no quality system in place to carry out regular inspection visits of the homes of care allowance recipients in Austria, even though recent programs attempt to at least partly cover recipients with such visits. These missing links between the cash and service system limit room for systematic quality assurance and for consultation and advice to care users and family carers. It is not least cost containment considerations that hinder broader implementation of such tools. Another area of conflict is the issue of professionalization. Evidence for the 1990s and the early 2000s shows that staff numbers have grown, in particular among those with larger levels of qualification (ÖBIG 2005, 2008). This is at least partly because of more intense care needs of users (in particular in the residential care sector), but it also indicates a further professionalization of the sector. On the other hand, the recent regularization of 24 h care offering relatively cheaper options for care work provision with smaller qualification requirements might create incentives for deprofessionalization, even more so when budgetary pressures increase (Österle and Bauer 2010).

While many of these issues regularly appear in the public debate, the current discourse is dominated by two major themes, the multilevel character of long-term care governance and the future funding of long-term care. Long-term care is characterized by the division of responsibilities between health and social care and between central, provincial, and local levels. While the care allowance scheme has been based on a Federal and nine Provincial Long-Term Care Allowance Acts, provisions have been harmonized across the country. According to a proposal already agreed between central and provincial levels, the central level will become the only competent governmental level for the administration of the care allowance scheme from 2012. In addition to the care allowance scheme, social insurance coverage for family carers is a federal responsibility. The provision and funding of residential and community care services, instead, is a provincial and local responsibility. In the health care sector, social health insurance funds—responsible for medically defined nursing care—are also important actors. As a consequence, attempts to further develop the system, to improve integration between health and social care, to better link cash provision and service provision, or to partly standardize procedures in the service sector across the country require cooperation and consensus between central and provincial levels.

Compared with other federal states, Austria is a relatively weak example (Obinger 2005). This is particularly true with regard to central fiscal jurisdiction. The

allocation of tax revenues to provinces and communities follows a fiscal equalization scheme. While federalism has often been identified as a barrier in welfare state expansion (Obinger et al. 2005), the federal structure in Austria, in a historical perspective, has also worked as a driver of innovation. The 1993 long-term care reform with some provinces as major drivers of the reform is an example of this. Currently, however, multilevel relations seem rather conflict-loaded in this country. This is true for long-term care, but also for other areas where competencies are split or where specific central and provincial responsibilities overlap, as in health, education, or child care. Despite considerable ideological differences between political parties, conflict lines on specific questions between the central level and the nine provinces often interfere with differences between political parties. This can work as a major hurdle for the development and implementation of reforms where central and provincial competences exist in the same sector. Many commentators have therefore called for a fundamental revision of central and provincial roles in this country.

In the recent past, the regularization of 24 h care, the introduction of the Residential Home Act, and the Residential Home Care Act are examples for federal legislation, while the harmonization of the educational system builds on a State–Provinces Treaty. In other areas, convergence took place. Examples are some convergence in social service development during the past two decades, which is due to provincial development plans and the political will to extend service infrastructure, or the abolition of recourse to family members in funding residential care in all provinces till 2008. Another typical feature of reform proposals with substantial financial implications is that representatives of central, provincial, or local levels call for a renegotiation of the fiscal equalization scheme. This was the case when the financial support scheme for 24 h care was introduced. Also, in current debates about the future system of funding long-term care, there are repeated calls to link this with a renegotiation of the fiscal equalization scheme.

Financial sustainability was always part of long-term care debates, but mostly just as one aspect among others. In the more recent and current debates, financial sustainability and the development of a new funding scheme have come to the forefront of long-term care debates. From the 1990s, several studies have looked at the implications of aging societies and the growing pressure on traditional family care models for future care needs and future long-term care expenditure (Badelt et al. 1996; European Commission 2009; Mühlberger et al. 2008; Streissler 2004). Arguments for a new funding scheme refer to the budgetary implications arising from sociodemographic changes, from the need to further expand publicly cofunded provisions and from already pressing budgetary situations on provincial and local levels, but also with reference to the existing general tax-funded system that might be more vulnerable to short-term cuts than a social insurance system. While the reform direction is still rather vague, various actors have become involved. A Working Group of the largest social service providers has worked out a proposal for a new funding scheme. Representatives of the Ministry, political parties, senior organizations, and disability groups have also articulated the need to establish a new funding scheme. The concept put forward for a structural reform is currently termed a “long-term care fund.” Indeed, a move towards social long-term care insurance is regarded

rather critically by most actors. Following the idea of an already existing fund in family policies, the long-term care fund idea implies that financial means should be pooled in a long-term care fund, which then serves as the major source for funding long-term care provisions. To what extent the fund should cover all or just part of current public long-term care funding is a major issue to be resolved. The multilevel character of long-term care could create a major hurdle for an agreement. While, e.g., the central level signals a willingness to financially support social service development, provinces oppose any attempt to link this financial contribution with a harmonization in the governance of social service provision, such as standardization in eligibility criteria, quality criteria, or copayment arrangements across the country. While representatives of the central level would be in favor of some harmonization, it is in particular social service organizations, which advocate for harmonization of eligibility and quality criteria. Disability groups do not oppose harmonization, but they fear that strengthening investment in the service sector will lead to a shift from a cash orientation to a service orientation in the Austrian long-term care system. As provinces and communities increasingly complain about the rapid growth of long-term care expenditure, this common challenge of budgetary pressure could finally work as leverage for a long-term care reform driven by the funding issue, but going beyond funding and involving broader structural reforms.

Summing up, long-term care is a latecomer in welfare state development in Austria as in many other European countries (Österle and Rothgang 2010). With the 1993 reform, however, long-term care became established as a distinctive welfare sector. The reform marks a major turning point in the history of Austrian long-term care policies, even if the reform also takes on board many traditional patterns of the long-term care system. Subsequent developments are characterized by continuity and adaptation but also by significant changes in specific parameters, in particular with the regularization of migrant care work. In terms of welfare coverage, the changes imply important extensions and a reduction of inequalities (as compared to the period before 1993), while cost containment considerations have continuously worked as a limiting factor. Whether current debates on a novel funding regime will lead to another major transformation of the Austrian long-term care system will not least be decided by how diverse interests and conflicts in the multilevel system are resolved.

References

Bachinger, A. (2009). *Der irreguläre Pflegearbeitsmarkt. Zum Transformationsprozess von unbezahlter in bezahlte Arbeit durch die 24-Stunden-Pflege.* (Doctoral Dissertation). Universität Wien, Wien.

Badelt, C., Holzmann, A., Matul, C., & Österle, A. (1996). *Kosten der Pflegesicherung. Strukturen und Entwicklungstrends der Altenbetreuung*. Wien: Böhlau Verlag.

Badelt, C., Holzmann-Jenkins, A., Matul, C., & Österle, A. (1997). *Analyse der Auswirkungen des Pflegevorsorgesystems*. Wien: Böhlau Verlag.

Behning, U. (1999). *Zum Wandel der Geschlechterrepräsentation in der Sozialpolitik. Ein policy-analytischer Vergleich der Politikprozesse zum österreichischen Bundespflegegeldgesetz und zum bundesdeutschen Pflege-Versicherungsgesetz.* Opladen: leske+budrich.

Bundesministerium für Arbeit, Soziales und Konsumentenschutz (BMASK). (2009). *Österreichischer Pflegevorsorgebericht 2008*. Wien: Bundesministerium für Arbeit, Soziales und Konsumentenschutz.

Bundesministerium für Arbeit, Soziales und Konsumentenschutz (BMASK). (2011). *Österreichischer Pflegevorsorgebericht 2009*. Wien: Bundesministerium für Arbeit, Soziales und Konsumentenschutz.

Bundesministerium für Soziales und Konsumentenschutz (BMSK). (2008). *Altenheime und Pflegeheime in Österreich. Ost, Mitte, West*. Wien: Bundesministerium für Soziales und Konsumentenschutz.

Da Roit, B., Le Bihan, B., & Österle, A. (2007). Long-term care policies in Italy, Austria and France: Variations in cash-for-care schemes. *Social Policy and Administration, 41*(6), 653–671.

European Commission. (2007). *Health and long-term care in the European Union. Special Eurobarometer 283/ Wave 67.3.* Brussels: European Commission.

European Commission. (2009). *The 2009 ageing report: Economic and budgetary projections for the EU-27 Member States (2008–2060). Joint report prepared by European Commission (DG ECFIN) and the Economic Policy Committee (AWG)*. Brussels: European Commission.

Ganner, M. (2005). *Selbstbestimmung im Alter: Privatautonomie für alte und pflegebedürftige Menschen in Österreich und Deutschland.* Berlin: Springer.

Gruber, G., & Pallinger, M. (1994). *BPGG Bundespflegegeldgesetz. Kommentar.* Wien: Springer.

Haidinger, B. (2010). "Was sind schon 1.000 Euro für 24 Stunden ohne Freizeit und Freiheit?" Undokumentierte Arbeitsverhältnisse von Migrantinnen in der häuslichen Pflege. In E. Appelt, M. Heidegger, M. Preglau, & M. A. Wolf (Eds.), *Who Cares?Betreuung und Pflege in Österreich. Eine geschlechterkritische Betrachtung* (pp. 77–85). Innsbruck: Studienverlag.

Jensen, C. (2009). Policy punctuations in mature welfare states. *Journal of Public Policy, 29*(3), 287–303.

Kreimer, M. (2006). Developments in the Austrian care arrangement: Women between free choice and informal care. In C. Glendinning & P. Kemp (Eds.), *Cash and care. Policy challenges in the welfare state* (pp. 141–153). Bristol: Policy Press.

Kretschmann, A. (2010). Die Legalisierung hat uns überhaupt keine Vorteile gebracht. Die Vorteile gibt es nur für die Österreicher. In E. Appelt, M. Heidegger, M. Preglau, & M. A. Wolf (Eds.), *Who Cares?Betreuung und Pflege in Österreich. Eine geschlechterkritische Betrachtung* (pp. 187–195). Innsbruck: Studienverlag.

Leitner, S. (2011). Germany outpaces Austria in childcare policy: The historical contingencies of 'conservative' childcare policy. *Journal of European Social Policy*, *20*(5), 456–467.

Melinz, G. (2009). Vom "Almosen" zum "Richtsatz": Etappen österreichischer Armenfürsorge-/Sozialhilfe(politik): 1863 bis zur Gegenwart. In N. Dimmel, K. Heitzmann, & M. Schenk (Eds.), *Handbuch Armut in Österreich* (pp. 646–663). Innsbruck: Studienverlag.

Mühlberger, U., Knittler, K., & Guger, A. (2008). *Mittel- und langfristige Finanzierung der Pflegevorsorge.* Wien: Österreichisches Institut für Wirtschaftsforschung.

Obinger, H. (2005). Austria: Strong parties in a weak federal system. In H. Obinger, S. Leibfried, & F. G. Castles (Eds.), *Federalism and the welfare state. New world and European experiences* (pp. 181–221). Cambridge: Cambridge University Press.

Obinger, H., Castles, F.G., & Leibfried, S. (2005). Introduction: Federalism and the welfare state. In H. Obinger, S. Leibfried, & F. G. Castles (Eds.), *Federalism and the welfare state. New world and European experiences* (pp. 1–48). Cambridge: Cambridge University Press.

Österle, A. (2001). *Equity choices and long-term care policies in Europe. Allocating resources and burdens in Austria, Italy, the Netherlands and the United Kingdom*. Aldershot: Ashgate.

Österle, A., & Bauer, G. (2010). *Migrant personal carers in private households: Motivations and perspectives*. Paper presented at the 8th Annual ESPAnet Conference. Budapest.

Österle, A., & Hammer, E. (2007). The formalisation of informal care work: The case of Austria. In C. Ungerson & S. Yeandle (Eds.), *Cash for care in developed welfare states* (pp. 13–31). London: Palgrave.

Österle, A., & Heitzmann, K. (2009). Welfare state development in Austria: Strong traditions meet new challenges. In K. Schubert, S. Hegelich, & U. Bazant (Eds.), *The handbook of European welfare systems* (pp. 31–48). London: Routledge.

Österle, A., & Rothgang, H. (2010). Long-term care. In F. G. Castles, S. Leibfried, J. Lewis, H. Obinger, & C. Pierson (Eds.), *The Oxford handbook of the welfare state* (pp. 378–390). Oxford: Oxford University Press.

Österle, A., Meichenitsch, K., & Mittendrein, L. (2011). Long-term care in Austria: Between family orientation, cash for care and service provision. In A. Österle (Ed.), *Long-term care in central and south eastern Europe* (pp. 41–66). Frankfurt: Peter Lang.

Österreichisches Bundesinstitut für Gesundheitswesen (ÖBIG). (1999). *Dienste und Einrichtungen für pflegebedürftige Menschen in Österreich. Übersicht über die Bedarfs- und Entwicklungspläne der Länder.* Wien: Bundesministerium für Arbeit, Gesundheit und Soziales.

Österreichisches Bundesinstitut für Gesundheitswesen (ÖBIG). (2005). *Beschäftigte im Alten- und Behindertenbereich. Entwicklung 1999–2003*. Wien: Bundesministerium für Soziale Sicherheit, Generationen und Konsumentenschutz.

Österreichisches Bundesinstitut für Gesundheitswesen (ÖBIG). (2008). *Beschäftigte im Alten- und Behindertenbereich 2006*. Wien: Bundesministerium für Soziales und Konsumentenschutz.

Pfeil, W. J. (1994). *Die Neuregelung der Pflegevorsorge in Österreich*. Wien: ÖGB Verlag.

Pfeil, W. J. (1996). *Bundespflegegeldgesetz und landesgesetzliche Pflegegeldregelungen*. Wien: ÖGB Verlag.

Schmid, T. (2009). Hausbetreuung. Die Legalisierungspolicy in Österreich. In C. Larsen, A. Joost, & S. Heid (Eds.), *Illegale Beschäftigung in Europa. Die Situation in Privathaushalten älterer Menschen* (pp. 53–78). München: Rainer Hampp Verlag.

Streeck, W., & Thelen, K. (2005). Introduction: Institutional change in advanced political economies. In W. Streeck & K. Thelen (Eds.), *Beyond continuity. Institutional change in advanced political economies* (pp. 1–39). Oxford: Oxford University Press.

Streissler, A. (2004). Geriatrische Langzeitpflege. Eine Analyse aus österreichischer Sicht. *Wirtschaft und Gesellschaft, 30*(2), 247–271.

Tálos, E., & Wörister, K. (1994). *Soziale Sicherung im Sozialstaat Österreich. Entwicklungen, Herausforderungen, Strukturen.* Baden-Baden: Nomos Verlag.

Weicht, B. (2010). Embodying the ideal carer: The Austrian discourse on migrant carers. *International Journal of Ageing and Later Life, 5*(2), 17–52.