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The long-term care mix in Austria: An overview of community-based care provision by formal and informal caregivers

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Introduction

This Policy Brief provides insights into the individual characteristics associated with the use of formal, informal and mixed (i.e. both formal and informal) care by older Austrians living in the community. These are instrumental in understanding how care services can be structured to best complement informal care provision and respond to care users' needs, as well as how long-term care policies can be expected to impact different care users and caregivers' groups. The results presented in this Brief have been elaborated as part of an international project on the study of the determinants of use of care in Austria and Slovenia (DET_CAREMIX).[1]

***Keywords*:**
care mix, long-term care, informal care, formal care services, inequality in care use

Long-term care in Austria

Austria pioneered the introduction of cash-for-care benefits in 1993 as a way to support families in the provision of care to frail older people. According to official statistics, in 2015, there were approximately 452,000 people receiving the universal care allowance – *Pflegegeld*, corresponding to 5.3% of the total population in Austria that year (Statistik Austria). In the European context, this is a relatively high figure. Among the beneficiaries of the care allowance, 16.7% were cared for in institutions, with the remainder living in community-based settings. An additional 32.4% of recipients use home care services and more than 50% receive informal care (BMASK, 2017). While informal care remains the main source of support for frail older people, in the last years a number of policies have attempted to increase the supply of care services in Austria. One prominent example is the denominated long-term care Fund (*Pflegefonds*) set up in 2011 by the federal government and the regions, that have agreed to

1 The Policy Brief is based on the work done in the frame of the project 'Exploring and understanding welfare state determinants of care provision for older people in the community in Slovenia and Austria' (DET_CAREMIX), financed by the Slovenian Research Agency (ARRS: J5-8235) and the Austrian Science Fund (FWF): I3422-G29 (for reference, see the project website: https://www.euro.centre.org/projects/detail/204). The opinions expressed in this Policy Brief are those of the authors and do not necessarily represent those of the funding organisations. We are grateful for comments received from Kai Leichsenring and Sonila Danaj and would also like to thank Willem Stamatiou for editing and layout.

earmark funds for the development of care services.[2] The fund has currently been extended to 2021.

Even though the vast majority of total care is provided in community-based settings, existing official statistics based on administrative data provide little information about the mix of care provided in the community in Austria. In particular, we currently know very little about which older individuals use specific types and mixes of services, namely, informal care only, formal care only or a combination of both. Nationally representative survey data, collected as part of the Survey of Health, Ageing and Retirement in Europe – SHARE (Börsch-Supan, 2019), has the potential to fill this gap and to provide insights into the patterns of formal and informal care utilization among older Austrians, as well as into the socio-economic profile of older care users (Börsch-Supan et al., 2013). Throughout this Policy Brief, we present results based on the analysis of data from the 6th wave of SHARE, collected in Austria in 2015.

Within the scope of this Policy Brief we use the following terminology:

- **Informal care** includes unpaid help with personal care (dressing, bathing or showering, eating, getting in or out of bed, using the toilet) and domestic tasks (home repairs, gardening, transportation, shopping, household chores or help with paperwork) provided during the last 12 months inside or outside the household.
- **Formal care** includes any professional or paid services provided in the care recipient's home due to a physical, mental, emotional or memory problem. This might refer to help with personal care or help with domestic tasks, as well as to the provision of meals-on-wheels and help with other activities (e.g. medication management).
- **Mixed care** refers to a situation where the care recipient concomitantly receives help in her / his home from family and informal caregivers and from care professionals.

Note: In a broader acceptation, formal care services also include care provided in institutions and residential facilities (i.e. nursing homes, assisted living facilities), excluded here due to our focus and that of the SHARE survey on care provided to older people living in the community.

Long-term care use in the community – a distribution by care type and gender

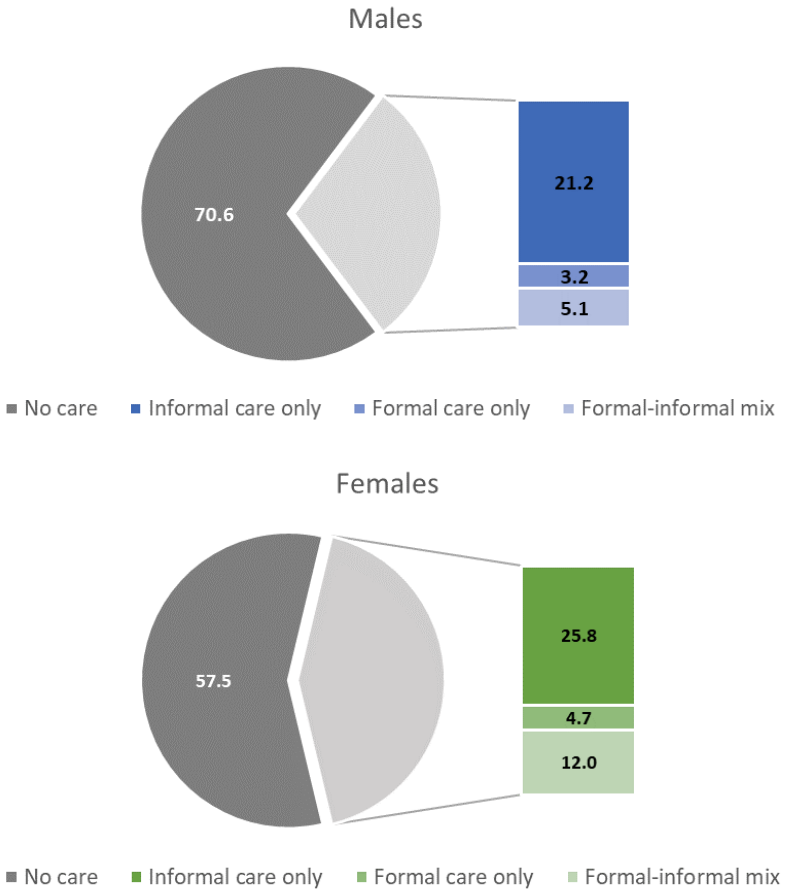
As the Austrian population continues to age at an accelerated pace, the share of older people will increase in all nine provinces over the next decades (Statistik

2 Although part of the funds has also been used to cover deficits, for example those arising due to growing wage costs.

Informal care accounts for the bulk of care provided to older people living in the community

Austria, 2018). This raises concerns that the resulting increase in the demand for long-term care and support will represent a significant challenge for the sustainability of the Austrian care system. However, associating ageing with dependency and high demands for care is a false equivalency. Even as the population ages, the large majority of older individuals living in the community have no support or care needs and do not rely on care in their day-to-day living (63%). Approximately one third of the older population receives some form of care (37%), with a clear demarcation between genders (Figure 1). More than 70% of men aged 60 and above reported receiving no care and support, while the equivalent figure among women was only 57.5%, partly reflecting higher functional decline levels among older women.

Figure 1: Share of individuals aged 60 and above receiving care (by care type)



Source: Own elaboration based on data from SHARE, wave 6.

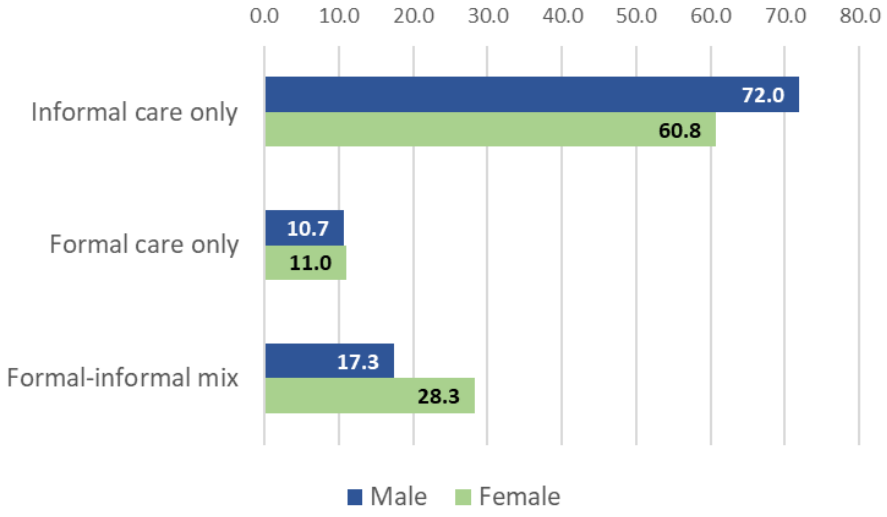
Formal care use is considerably more prevalent among women

Even though the rates of care use vary considerably, the distribution by care type across genders shows remarkable similarities. The largest proportion of older individuals in need of support rely exclusively on informal care. As much as a quarter of all older women and one fifth of all older men report receiving

support only from family and informal caregivers, while only 8% of older men and 16% of older women received any formal care in their homes during 2016.

The gender gap is even more apparent when analysing the distribution by care type only among those individuals who report any care use in the past year (Figure 2), rather than in the older population as a whole.

Figure 2: Share of older care users receiving informal, formal or mixed care (by gender)



Source: Own elaboration based on data from SHARE, wave 6.

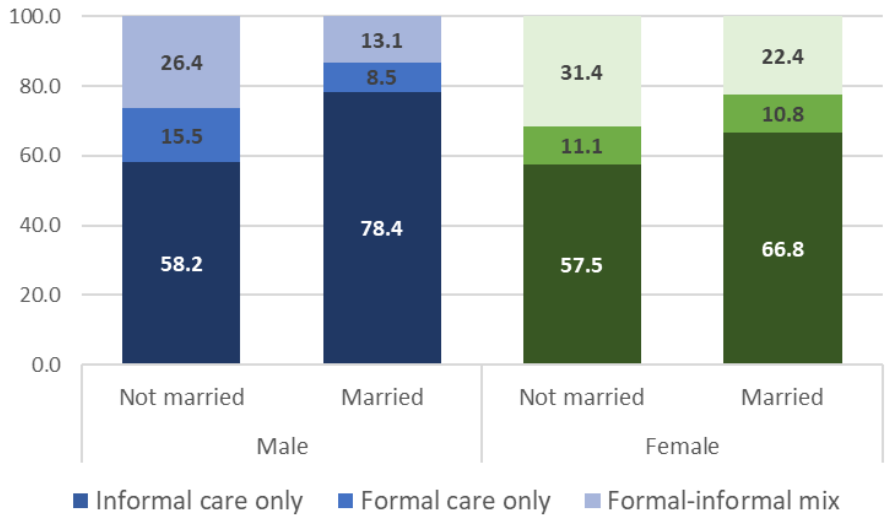
Women more often receive formal and mixed care (28.3%), whereas almost three quarters of all older men who receive support rely exclusively on informal caregivers (72%). This situation is in large part a reflection of a persistent gender gap in care provision, with women providing the bulk of informal care but also providing more intensive care, including personal care tasks. Our results echo previous findings from administrative data, in that supplementation of care by formal providers is more common when an older man is the main informal care provider, whereas women carers are more likely to provide all needed support unaided by formal care professionals (Schmidt, 2017). The low rates of use for formal care are only partly a consequence of imposed limits in terms of care intensity for formal support in the home. The number of hours of home care is capped and could only cater for relatively low-level care needs in the total absence of family support. In cases where an older person with higher care needs relies exclusively on formal care, it is likely that care will be provided in a residential setting.

The effect of marital status on type of care utilization

Marital status might act as a moderator for the effect of gender on care use

The gender gap in the share of informal versus formal care use is closely connected with living arrangements and relationship status. These, in turn, are influenced by gender differences in marriage patterns and life expectancy. As a large part of care to older people in Austria is provided within the household (i.e. both the caregiver and the care recipient living within the same home) by a spouse (36.3%) or by children (34.7%), the marital status of older people acts as a powerful proxy for the availability of informal support (OECD, 2011). These results are confirmed in our data. Older people who report not being married received less informal care than those who live with a spouse and therefore rely more heavily on formal care services. 41% of older men and 42.5% of women who are not married report having received formal care, while almost one third of all not married older women relied exclusively on care professionals for needed support.

Figure 3: Share of older care recipients using informal, formal and mixed care (by gender and marital status)



Source: Own elaboration based on data from SHARE, wave 6.

In fact, gender differences are more evident among married than among not married older people, particularly in terms of exclusive use of informal care. These results suggest that marriage, in as much as it functions as an indicator for co-habitation with a spouse (and the presence of children), is a moderator of the effect of gender on the probability of care use and type of care used. For

men, marital status associates with a considerable increase in the availability of informal support, whereas for women the same effect is much reduced. These findings could be explained by two reinforcing gender dynamics. On the one hand, there is a higher propensity for women to provide more frequent and intense care tasks unaided by formal care professionals whereas male spouses might be more reluctant to engage in some care tasks (e.g. personal care). On the other hand, some gender differences in preferences for care type have been documented in the literature, with men reporting stronger preferences for informal and mixed care than women (Pinquart & Sörensen, 2002; Eckert et al., 2004). It is also interesting to note that the positive effect of having been married on the probability to receive informal care is limited to older people who have children. Previously married individuals without children are no more likely than those who never married to use informal care in later life (Larsson & Silverstein, 2004). Such results indicate that children are an important social asset in older age, particularly in the case of bereavement, given that support networks consisting of in-law relatives and friends are unlikely to compensate for the informal care needs of older individuals following the loss of a spouse.

Age and functionality

Large increase of mixed care use with age

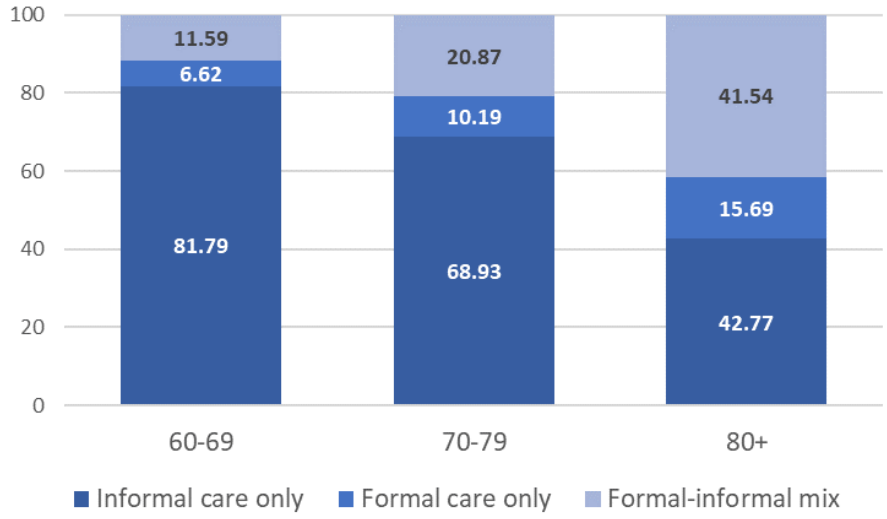
The specialized literature documents a clear age gradient in care use, particularly with respect to formal care services (Sole-Auro & Crimmins, 2014). We confirm a similar pattern for Austria. As older individuals age, their care utilization increases markedly along all care types but is particularly pronounced for mixed care arrangements (Figure 4). Whereas at ages 60 to 69 only 18% of older people use any formal care services, by age 80 the share has almost tripled and a majority of the population rely on some type of formal support (57%). The rise is primarily driven by large increases in the share of older people who receive mixed care, which almost doubles with every 10 years of increase in age: from 12% for those aged 60 to 69, to 21% for those aged 70 to 79 and to over 41% after the age of 80+.

Formal care use increases with higher dependency levels, where more intensive and more specialized care is needed

The increasing reliance on formal care as individuals grow older is partly explained by declining availability of spousal care, either due to bereavement or to the decreasing ability of the ageing spouse to provide support. However, another key driver is the strong association of age with functional decline and limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Levels of dependency and the intensity of needed care are substantially higher in older ages, which in turn means that both more intensive and more specialized care is needed. Informal carers might therefore find themselves in need of supplementation and complementation of their efforts

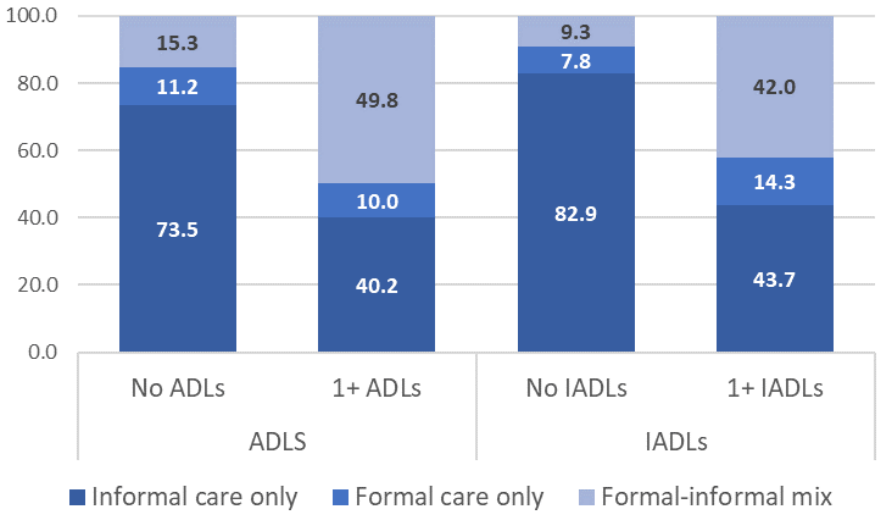
by formal care professionals, in order to cover all the care needs of very old individuals. Figure 5 emphasizes this association. The majority of older people who report IADL and ADL limitations receive formal or mixed care support, while those who are functionally independent rely overwhelmingly on informal support exclusively.

Figure 4: Share of older care recipients using informal, formal and mixed care by age group



Source: Own elaboration based on data from SHARE, wave 6.

Figure 5: Share of older people using informal, formal and mixed care (by functional status)

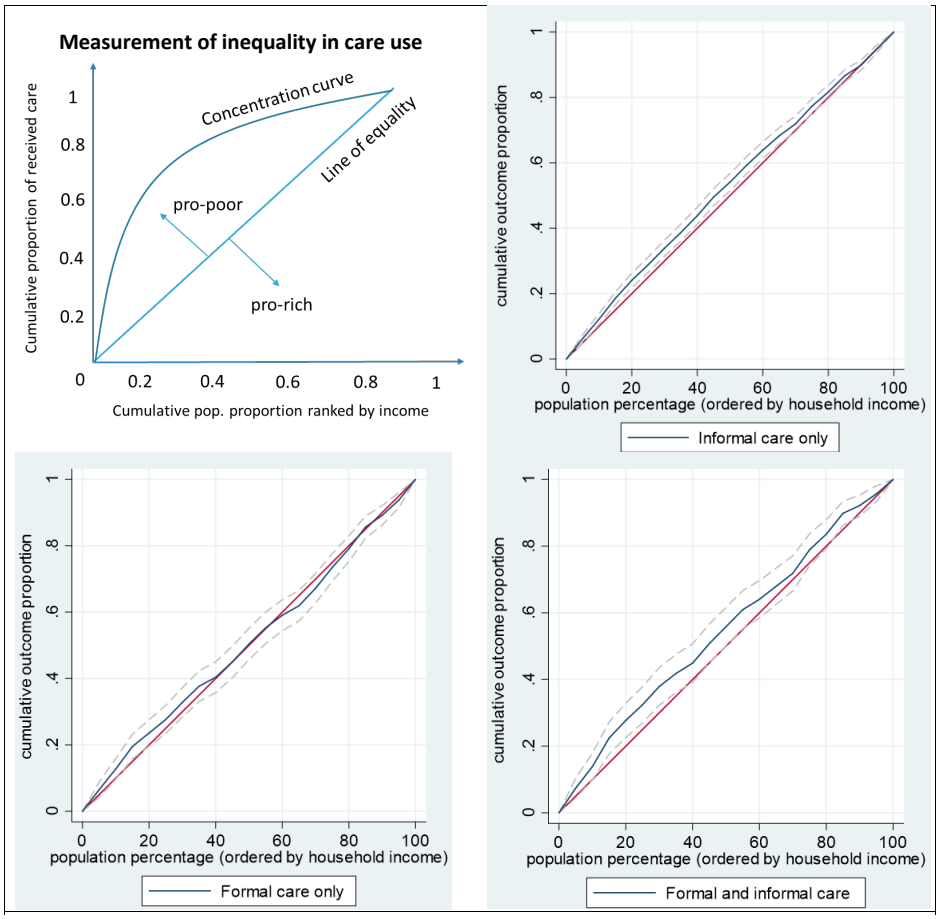


Source: Own elaboration based on data from SHARE, wave 6.

Income-related inequalities in care utilization

Formal care use also tends to increase with higher income, indicating barriers in accessibility of long-term care for poorer individuals. In parallel, informal care utilization decreases for individuals with higher incomes, while the proportion of mixed care arrangements remains relatively stable across income groups. This suggests that individuals from different socio-economic backgrounds might not have the same opportunities to access needed care despite the application of means-tests in most European countries (Ilinca et al., 2017).

Figure 6: Concentration curve plots for informal, formal and mixed care use



Note: Concentration curves plot the distribution of a given outcome (here, the use of care) against the population proportion ordered by a 'living standards' measure (here, household income). If each individual were to receive an equal share of total provided care, irrespective of her income level, the concentration curve (in blue) would overlap the 45-degree diagonal line (in red), marking a perfectly equal distribution of care in the population. If systematically higher values for care use are registered among poorer (richer) people, the concentration curve will lie above (below) the line of equality describing a situation of pro-poor (pro-rich) inequality (see upper, left-hand side panel for visualization).

Source: Own elaboration based on data from SHARE, wave 6.

We use concentration curve (CC) plots to test the presence of income-based inequalities in the use of long-term care by older Austrians, for each care type (Figure 6).

Lower income individuals face higher barriers in access to formal long-term care services in the community

We find no statistically significant evidence of income-based inequality in formal care utilization, but our results suggest a slightly pro-poor distribution of informal and mixed care use among older Austrians. However, it is well-documented that individuals from lower-income groups have higher care needs (lower heath and functional status) than richer population groups. Considering this need differential, the absence of a significant pro-poor distribution of care (i.e. higher care use for the groups with higher care needs) is indicative of remaining barriers in access to needed formal care for poorer individuals.

Discussion / Policy recommendations

Formal care service development is essential to ensure growing numbers of older people can age in place

The Austrian long-term care system relies heavily on informal care provision despite the sustained growth in supply of formal services in the past decades. The role of informal carers has started to be recognized, albeit with delay, by a series of policies oriented towards supporting family caregivers. Among these are the payment of notional contributions to old-age pension for informal carers, extra allowance to pay for respite care and, since 2014, a paid care leave (*Pflegekarenz*) or part-time care leave (*Pflegeteilzeit*) for up to three months and calculated on the basis of income (Schmidt et al., 2016). Despite these positive developments, the Austrian long-term care system cannot ensure that growing numbers of older individuals with higher care needs can age in place if they so wish. Achieving this goal will require a more explicit combination of formal and informal care use, thus vindicating the policy of increasing supply of formal care services that has been carried out in the past years.

One aspect that this Policy Brief highlighted is the mediating role of marriage or co-habitation in the use of services: gender differences are much more pronounced among married and co-habiting older people. This raises two policy-relevant questions. Firstly, how should welfare systems adapt to changing marriage and co-habitation patterns in old age? Secondly, how can policies support spousal care without overburdening the caregivers, risking that their health and wellbeing is severely affected? Some glimpses into possible solutions can be derived from international best practice examples. Even though the share of older people co-habiting with a spouse or partner is decreasing, older people can have large and dynamic social networks and build strong social bonds outside the immediate family circle. New initiatives focusing on strengthening and expanding solidarity in neighbourhoods and local communities (e.g. dementia-friendly communities,

Buurtzorg – neighbourhood care in the Netherlands) have proven successful in reducing social isolation in old age and building up community capacity to provide care and support. In France, in recognition of the widening circle of care around older dependent people, eligibility criteria for carer support services have been expanded to include friends and neighbours, not only family members. In parallel with efforts to distribute the burden of care to wider social support networks, initiatives that focus on establishing comprehensive and appropriate support services for carers have been effective in reducing care burdens and improving wellbeing for family members of older people in need of care. Noteworthy are: case management (including a comprehensive needs assessment of family carers), access to counselling and psychological support, flexible respite care arrangements, peer-to-peer learning and support groups and regular contact with supporting care professionals. Expanding access to similar services in Austria would contribute to ensuring system sustainability and to improving the experience of care both for those providing it and for the care recipients.

The results presented here show little evidence of income-based inequalities,[3] but do not account for differences in needs, which tend to be concentrated among poorer older people. Results from other studies that controlled for differences in needs, but without accounting for the combined use of formal and informal care as a separate category, indicate that informal care use is significantly concentrated among poorer older individuals in Austria (Ilinca et al., 2017; Rodrigues et al., 2017). This suggests caution is warranted when interpreting the potential inequalities in care use in Austria. Another factor to bear in mind in the analysis of inequalities in care use is the self-selection of individuals with higher care needs (and likely poorer) into residential care, which is not covered by SHARE data. Finally, it needs to be considered that, in 2017, the Austrian government abolished the asset contribution to residential care costs (*Pflegeregress*). The data on which this Policy Brief is relying was collected before this decision. The new regulation has made informal care less attractive for wealthier families as moving into a care home is now less expensive and may even allow for the family carer to return to the labour market. Subsequent waves of SHARE will allow for the estimation of the potential effects of this policy change on inequalities in use of home care and on the care mix in Austria.

3 Please note, inequality in care use is not the same as inequity, or unfair inequality in use: the concentration curves do not account for differences in care needs.

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