



Health systems and long-term care for older people in Europe  
Modelling the interfaces and links between  
prevention, rehabilitation, quality of services and informal care

## Quality Management and Quality Assurance in Long-Term Care

### European Overview Paper

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Utrecht/Vienna, May 2010

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Funded by the European Commission  
under the Seventh Framework Programme  
Grant agreement no. 223037

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# 1 Introduction

## 1.1 The objective of this paper

In most EU member states long-term care (LTC) services for older people have originated in charities, voluntary organisations, social services for people with disabilities, ‘poor law’ regulations, i.e. in the context of local or regional social assistance legislation (Means/Smith, 1998; Leichsenring, 2004; Kerschen et al, 2005). In recent decades LTC has gradually developed into an acknowledged area of social security in-between social and health care – with increasing traits of a proper policy field and LTC services develop a quality of their own: Policies explicitly focusing on LTC have been developed to regulate access, quality and extent of benefits and services, public funding of LTC has increased, and in a growing number of countries even new benefit schemes were introduced. However, the complexity of governance levels, provider structures and the variation of rights, funding levels as well as cultural and political legacies in the individual countries have contributed to the fact that LTC for older people has developed most diversely across and within countries. While the health care sector is a well-established policy field with a leading role of the central state, LTC in terms of social care has mainly been governed at the regional and local level (Kerschen et al, 2005: 41ff.; Huber et al, 2008). The efforts to integrate different types of health and social services for people with LTC needs have to consider not only most different professional groups, but also different providers, reaching from family and informal support, voluntary organisations and the third sector to public and private for-profit organisations (Evers, 1997; OECD, 2005; Huber et al, 2009). Endeavours to define, measure and assess quality in LTC across providers, types and levels of supply is thus not only in the interest of users as well as central, regional and local authorities, but also of the European Union and its institutions.

Though not directly responsible for social and health services, the EU has a role to play in framing the principles and conditions for their operation. This is reflected mainly in the context of the debate on services of general interest (European Commission, 2007; Huber et al, 2008) and the ‘Open Method of Coordination’ (OMC). Both mechanisms aim to ensure equal access for all as well as quality and sustainability of health and LTC. With a strategy for supporting quality of social services across the EU the Commission will, in particular, support the development of a “voluntary EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standard” (European Commission, 2007: 13). Respective projects have been supported in the framework of the PROGRESS programme.<sup>1</sup>

This overview paper explores the mechanisms by which the stakeholders involved are managing and assuring quality in LTC in ten European countries. As LTC is a latecomer in terms of being acknowledged as a public responsibility, a rather patchy pattern emerges across Europe regarding quality assurance and quality management (Huber et al, 2008; MISSOC, 2009). Moreover, many LTC systems are just emerging or ‘under development’: existing systems are restructured in order to achieve mechanisms that ensure quality, access, financial and labour market sustainability. Several

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<sup>1</sup> <http://ec.europa.eu/social/main.jsp?catId=327&langId=en>.

EU member states have only started to develop LTC systems recently as a reaction to the pressure of demographic changes and economic development.

This paper is based on the lessons learnt from the national reports provided by ten country teams who participated in work package 4 of the INTERLINKS project. Additional information from other countries participating in INTERLINKS, namely Germany, have been integrated based on feedback from partners and Sounding Board Members. The paper intends to serve as an input to national debates on how to (further) develop the LTC system in terms of quality assurance for vulnerable older people needing LTC. This category of older people is vulnerable “due to (a combination of) multiple chronic conditions, disability or frailty. The compensation capacities of these persons are diminished and this implies that relatively small changes in or around the patient can have large consequences for the individual’s functioning” (Melis, 2008: 10). Frailty, as a familiar and related concept has been defined in many ways. It refers to older people who are in a delicate balance being at risk for many adverse outcomes. It is an unsteady state which includes a reduced physiological reserve, a diminished ability to carry out the practical and social activities of daily life, the presence of chronic diseases and multisystem decline (Puts et al, 2005). In this paper we use the terms vulnerability and frailty interchangeably, as there is no clear consensus about these terms. However, they do indicate the multiple problems that older people being frail envisage in various domains of life that are relevant for quality of life. Health, social relationships, housing, income, social inclusion/participation, and spiritual needs (e.g. Petzoldt, 1994; Nies, 2009) contribute to quality of life. In this paper we take the position that it is the objective of LTC systems to support and strengthen self-care and self management competences of the older person and the informal carers involved.<sup>2</sup>

The principles of self-determination, inclusion and quality of life of older people are supported across all European countries, as can be read from a wide variety of national and international policy notes. These views are acknowledged by the general population, as well as by professionals and policy makers in LTC. Therefore, INTERLINKS takes the WHO definition of LTC as its point of departure:

*“The system of activities undertaken by informal caregivers (family, friends and/or neighbours) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity.” (WHO, 2000)*

Although these values are widely shared across member states, taking them into consideration in every-day practice is still far away. Policy documents often meet cynicism as they are seen as pure rhetoric. This paper aims to bring the national and local debate on quality of LTC further, by describing practices and principles across Europe, how they contribute to improved service delivery. No final answers can be given, as between and within member states wide variations exist of cultural, geographical, demographic and economic conditions. In particular, quality management

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<sup>2</sup> These issues are in many respects equally valid for people with disabilities at working age, in particular as many of them will enter pension age during the coming years. Although this paper is focusing on LTC for older people and links to the health system, ongoing endeavours to overcome the division between LTC for older people and services for people with disabilities (EASPD, 2006) will be considered as an important aspect in establishing LTC systems.

across LTC services, respectively at the interfaces between social and health care is still a relatively unknown area, in particular compared to health and nursing care.

This paper thus addresses, firstly, policy-makers at (inter)national, regional and local level, representatives of service user organisations, organisations of volunteers and service providers at policy level who are involved in developing LTC. Secondly, the paper is meant for those who are involved in funding and/or commissioning LTC services. A third target group is the research and development community in the various European countries where – in close connection with practice – innovation and improvement is evaluated, developed and disseminated, and where implementation can be supported.

The paper is written from a supranational perspective, looking at the similarities and differences across countries. The objective is to distinguish overarching trends in LTC, which may serve as lessons learnt to merging fields in LTC where quality assurance is still a blank spot and to the various European countries in comparing each others' perspectives. Due to this supranational perspective, the analyses start with a description at system-level, to be continued by the organisational and professional level and to be concluded by the client and informal carer level. This latter is in fact the most important level, as systems' and organisations' aims should be to provide optimum quality for end-users.

## 1.2 Quality management and quality assurance

The present paper is about LTC for older people with multiple needs which – in contrast with general stereotypes about older people – represent only a minor proportion of the older population. Also, frail older people are not just 'clients' of professional services or 'dependent' on informal carers: they are more than just care recipients. For that reason, INTERLINKS works from a holistic perspective with a view on citizens' enhanced quality of life as an outcome of LTC systems. To achieve this goal, all stakeholders have to constantly assess, measure and improve their structures, processes and results (Vaarama et al, 2008).

By its very nature LTC combines a wide range of services that address the multiple needs of users. This means that outcomes, i.e. quality of life, depend on the co-ordination and timing of service delivery – the 'what', the 'how' and the 'why' are important to deliver the right service at the right moment.

Using the three quality-of-care dimensions defined by Donabedian (1980) in the context of LTC services, quality management is a method to ensure and improve processes, structures and results (or outcomes) of care (see also Section 4.4). This entails the application of a permanent management cycle consisting of the definition of goals, the planning and organisation of processes to achieve the objectives, the evaluation of the results and the implementation of corrections if the results do not comply with the original objectives. While quality management thus includes quality assurance on the delivery level, in the particular context of LTC services, a further distinction has to be made concerning quality assurance on a governance level. This is due to the fact that – in LTC as in other services of general interest – public authorities usually act as purchasers and/or commissioners on behalf of the client/user (Huber et al, 2008).

From a governance point of view quality assurance thus consists of a control mechanism to ensure that providers (public, private non-profit or commercial) are respecting (minimum) standards de-

fined by law. Public authorities are thus legitimised to impose specific requirements on providers such as:

- to organise internal quality assurance and quality management,
- to provide data and access to external control (inspection) whether minimum standards and norms were respected,
- to regularly report to the (health and social) authorities.

The concept of quality management covers features reaching from quality assurance to continuous improvement. Quality assurance has traditionally been the most common approach where minimum standards were set for the adequacy of care provided (see also 1.3 and 2.2). From a provider perspective, quality management thus intends, first of all, to ensure the required minimum levels of quality, but the broader aim should be to improve the current quality level by installing a continuous improvement process. On their way to 'excellence', organisations may make use of a variety of tools, such as guidelines, protocols, benchmarks, surveys etc. In terms of developments in quality assurance a tendency is recognized to strive from minimum standards in quality assurance towards higher levels of quality. Organisations not only want to serve their clients with optimum care, but also feel the need to demonstrate what their unique selling points are. Porter and Weisberg (2006) have recently argued that an added value to (end) users should be the discriminative factor as well as the basis for funding, in order to get a health care sector that is sustainable.

In the context of LTC, with various links and interfaces between purchasers and providers, between private and public, between health and social care, the challenge is to apply the quality instruments and measures not only to individual organisations that are governed by one responsible body but to a multitude of stakeholders that often depend on a variety of governing bodies at different levels of governance. Until now, only few examples exist of integrated quality assurance across sectors or provider organisations.

This paper will thus describe and analyse how far the different European countries included in this paper have come in meeting this challenge to assure *and* develop quality in a system of LTC. However, before going into detail, the concept of quality needs further elaboration.

### 1.3 Conceptions of quality

Quality can be conceived as a social construct. The perception of quality can differ from actor to actor, depending, on one hand, on the values and cognitive categories of a particular person, and on the other hand, the way he or she conceives care and caring work.

#### Quality as intrinsic characteristic of a good

Quality can be defined – for instance in terms of colour, hardness or density – as a particular feature or modality of a good. But quality cannot be evaluated for itself. It is always evaluated regarding the finality/ies the considered good is expected to fulfil (Haddad, 1997). Regarding care, Donabedian (1980) proposes to consider efficacy, efficiency, optimality, acceptability, legitimacy and equity (Donabedian, 1980) as quality parameters. Care is effective, when it is able to produce the expected effect; it is efficient when it is produced faultlessly, free of malpractice; and it is optimal, when the provided solution corresponds to the state of the art. Underlying these three dimensions of quality, Donabedian suggests that care has to be economically sustainable and of high quality.

Nonetheless, with the next three criteria: acceptability, legitimacy and equity, he insists on the ethical and philosophic-political dimensions of care. Care is of bad quality, when sustainability has been achieved in a way which is individually and/or collectively perceived as unfair.

### Quality as excellence

Moreover, quality can be approached as an absolute value. It occurs as excellent, when it is determined considering only its propensity to fulfil the goal it has been produced for. In this perspective, quality points out the very best. It is generally the conception of quality which dominates in all daily life: the best fruit is the tastiest, or the one which can be conserved for the longest while; the best car is the fastest, the safest, or the fanciest, depending what function it has to achieve in the eyes of its buyer. Generally, the professional conception of high quality care refers implicitly to this conception: professional high quality care is care on its highest possible level, from both technical and relational points of view.

### Quality as norm

Quality can also be defined relatively in terms of 'goodness'. In this perspective, the 'goodness' of a certain quality will be evaluated, comparing it to the 'goodness' produced to achieve the same goal. In the domain of care, the quality of a product or service is satisfying, when it can reach the defined medical and economic objectives. Cost-utility and cost-benefit analysis are based on this conception of quality. Quality can also be estimated by comparing the provided care level to the expected one, which functions as a norm. So, for example, it is often conceived as four levels of care: optimal, adequate, secure and dangerous care (Fiechter/Meier, 1981). Here, quality will be considered as good, when provided and expected care levels match together, regardless how demanding the expected care level is (dangerous care will be avoided). The managerial conception of care refers to this conception of quality, which appears, besides the price, as a second measure of performance on which markets can be distinguished and providers can compete.

### Natures and functions of care

The way quality of care is defined depends on the nature of care as well as on the goals which have to be achieved. However, there is no consensus neither about the nature nor about the function of care.

There are two main conceptions of the nature of care. Care can be conceived as analogous to a service such as those provided by banks and insurances. In this perspective, care is a good which has the features of an industrial product: production and consumption are two processes, which occur separately; producers and consumers do not know each other, the former supply a market of anonymous consumers; it is possible to rationalize the production process in order to produce the same service in less time. But care can also be defined as a special type of service, as a human service. In this perspective, the dissimilarities to industrial goods, and not the resemblances to them, will be stressed. As a human service, care contains the following characteristics (Madörin, 2007):

- the processes of production and consumption cannot be separated,
- the duration of work is an integral part of the work output,
- the interpersonal relationship, and the mutual emotions which are related to it, constitute an integral part of the economic exchange,



- the relationship between care provider and care consumer is often characterized by the dependency of the latter.

Considered as a human service, care does not appear as a product (an object) which can easily be transferred from one person to another, but as a process in which at least two persons are involved. It is not brought on an anonymous market and it can only be rationalized to some extent. In an asymmetrical relational process, economies of care lay not in efficacy, efficiency and optimality but rather on the reciprocal confidence between caregiver and care receiver. Without this ingredient a care relationship which supports its objectives effectively cannot be established. Mutual confidence is also the key to fairness.

The quality parameters of care do not only change with the nature of care. They also vary with the function, which is attributed to it. Three different, competing functions of care are to be considered:

- First, care may guarantee the basic needs of the care receiver. Because they are derived from fundamental human rights, basic needs are barely negotiable. They have something absolute. When it has to satisfy basic needs, care has to be at its best, because a failure would have intolerable consequences. For this reason, the evaluation of needs-oriented care is better served by an absolute approach of quality.
- Second, care may aim to satisfy individual preferences. In this perspective, care is of high quality when a satisfying balance for both the care receiver and the care provider is found between what the former wants and what the latter is ready to offer for a given price. As preferences may differ from individual to individual, they are subjective. Therefore, the quality of preferences-oriented care can without risk of incoherence be evaluated on basis of a relative approach of quality.
- The third function of care may be to fulfil the expectations that both parties have put in the care relationship. Expectations are the goals of care, as they are co-constructed by the care receiver and the care providers on the basis of their particular life-world. The evaluation of an expectation-oriented care is founded neither on an absolute (objective), nor on a relative (subjective), but on an inter-subjective approach to quality. In this context, the degree of the co-construction of expectations and the empowering content of the caring relationship are two main quality parameters.

### The social embedding of the different conceptions of quality of care

Constitutionally, the State has to guarantee the basic needs of the population. It may conceive care as an industrial product, which aims to meet the needs of the population. The manager and the manufacturer will consider care rather as an industrial product with the ambition of meeting the preferences of the care receivers. In this way care provision can be conceived as a (profitable) market. The persons directly engaged in the care relationship may approach care as a human service which intends to meet the expectations they co-constructed within the relationship.

In this report, as in reality, these various ideal-types of quality are not always discernible as such – still, they are to be reflected in the analysis of political and strategic choices concerning quality development in LTC.

## 1.4 Methods

The paper presents an overview of the current state of affairs on LTC in ten European countries: Austria (AT), England (EN), Finland (FI), France (FR), Italy (IT), Slovenia (SI), Spain (ES), Sweden (SE), Switzerland (CH), The Netherlands (NL).<sup>3</sup> Based on a number of key questions that were agreed at the first plenary INTERLINKS meeting in Vienna (2-3 March 2009), national reports were written by all national teams. The national reports received inputs by the various National Expert Panels. In the second plenary INTERLINKS meeting (14-15 September 2009 in Athens) the research team established the outline for the present paper based on an analysis and discussion of the national reports. The individual sections of the paper were written by separate teams, posted on the project website and all teams had the opportunity to provide comments, corrections and additional text. The following step was to integrate and edit all chapters and to have it reviewed by members of the research team.

In addition to these activities, it was important at this stage to start to extrapolate examples of good practice from partner countries aligned to the interpretation and analysis in the main body of the document. This was conducted within the emergent themes of management, service support and training, institution building, and an additional category of miscellaneous practices connected to areas such as accreditation mechanisms and audit. This analysis will act as an important ground work for the ensuing phases of the project and is documented in the appendices.

The national reports have thus been the building bricks of this paper. They were based on national and international sources in the respective country. Many sources are national and 'grey', because of the policy related contents of the issue and the aim to provide up-to-date information. In general, there is not a huge body of research on quality management and/or assurance in LTC in the various countries. For that reason, the present paper contains only a limited number of references. Where specific countries are mentioned without reference, the source is the particular national report and/or comments of (one of) the national researchers.

A first draft of this paper was presented to the INTERLINKS Sounding Board Conference in Brussels (19 February 2010). The Sounding Board Members represent European stakeholders and umbrella organisations of users, providers and professionals dealing with LTC. This final version of the paper profited from comments and feedback provided during and after the conference. Furthermore, a final internal peer review helped improve and complement the analysis.

## 1.5 Reading guide

The paper is divided into three main sections, covering first the prerequisites for ensuring quality in LTC. Secondly, the legal regulations, tools and methods for quality assurance and quality management are exposed in relation to several levels of governance, reaching from the systems and organisational level to the individual level of professionals, users and their informal carers. Finally, the more salient trends and features of quality assurance and quality improvement are discussed in terms of conclusions and recommendations for further research.

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<sup>3</sup> These are the countries that participated in work package 4 of INTERLINKS.

## 2 Prerequisites for ensuring quality in care for vulnerable older people

This section will highlight fundamental features and basic background issues of various conceptions and practices of quality management systems and quality assurance in LTC for vulnerable older people. Any such analysis has to address and differentiate the sometimes opposed interests of stakeholders in LTC systems. Providers of services, purchasers, professionals, users and informal carers, to name but a few, hold different stakes, pursue distinct goals and hold different views of quality (see Section 1.3). Moreover, approaches to quality take different tracks which underpin the systems and organisation of quality-related tasks and programmes found in the area of LTC. Quality assurance approaches, the management of quality systems and quality improvement programs thus do not represent linear phases of development, but constitute facets simultaneously found in the field, which are variously invested by stakeholders.

### 2.1 Shared vision of stakeholders

A common view of the boundaries of the LTC system, of its nature, its goals and of the conditions of access to services provided between the stakeholders involved is a fundamental prerequisite to quality and quality management in LTC.

The definitions of needs in the LTC field, as well as the rules of provision and access to services that govern the satisfaction of these needs, are highly complex endeavours. According to theoretical considerations, a democratic process, involving as many relevant actors from civil society as possible and taking into account the specific nature of the care process, is needed to take steps toward defining care and quality expectations (Gobet et al, 2008) and to respond to them with appropriate policies and delivery mechanisms.

Some countries or regions have started to engage in such a process by involving multiple actors, interest groups and categories of stakeholders in order to reach priorities and define goals to be pursued. Such attempts do not guarantee that long-term care delivery systems fulfil their promises, or that linkages between components are adequately integrated. Even if they might not always have a direct impact on how access is organised in terms of insurance coverage, direct financial help, or other financing mechanisms: they demonstrate a willingness to base policy not only on financial, managerial or professional priorities, but also on the voice of civil society as an indispensable component of planning for the care of persons with long-term care needs.

In particular, a discussion of visions concerning the respective roles of families and informal carers, of health and social care professionals, of support at home, by means of community care or in residential structures can be a useful step to precede the definition of quality standards. The involvement of concerned groups in civil society, whose voice may not usually be heard, is often necessary for identifying appropriate ways across health and social care not only to deliver services but to evaluate their suitability and promote high levels of quality. Nevertheless, examples for attempts to develop a shared vision across health and social care involving the voices of all actors have been identified in a few countries only:

- In the *Netherlands*, four conferences focusing on this very goal were organised between 1989 and 2000, to work on issues of quality management in health care. An effort was made to include all parties concerned such as care providers, insurers, clients, policy-makers and representatives from the Ministry of Health and the Health Inspectorate. The idea of a quality system for health care organisations was developed and taken up by the Ministry of the ‘Quality Act’ and the ‘Act on Professionals in Healthcare’. Central to the Quality Act is the principle that health care organisations are responsible for implementing quality management systems to ensure and improve quality of care. A governmental framework has now been put into place ensure its implementation. Each organisation is expected to make its own data available in a mandatory quality report that must be accessible to the public. The Inspectorate gives feedback to each organisation individually and compiles a report of the collected data. Other intervention methods used in quality promotion are crisis supervision in case of serious difficulties or large-scale problems, as well as thematic supervision to deal with overarching issues involving multiple institutions. The goal is to obtain a national overview of the effects of government policy on specific risks occurring in health care and to trace structural failures and problems in quality and safety. It must however be noted that health – rather than social care – is at the core of the elaboration of national legislation in this case.
- In *Finland*, the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities jointly published the National Framework for High-Quality Services for Older People in 2001. The original framework was updated in 2008 to take account of government strategies, national targets for old-age policy, the findings of framework assessments, new research data and changes in the operating environment. This Framework aims at increasing services supporting older people living at home and reducing the necessity for residential care. It seeks to promote health and welfare in old age and to improve the quality and effectiveness of services to the elderly. It also seeks to improve the accessibility, safety and comfort of residential and care environments for the elderly. This framework was explicitly based on recognition of the need for common ground between health and social care, central and local organisations, and user perspectives. The framework set national quantitative targets for services for older people. For example, by 2012 the following structural targets were set: 92% of those over 75 years of age will live at home independently or using appropriate health and social care services, 14% will receive regular home care, 5-6% will receive informal care-support, 5-6% will live in sheltered housing with 24-hour assistance and 3% will live in care homes or in health centre hospitals. Also, national targets were set for staffing level for 24-hour care and for home care personnel.
- In order to improve the conditions of persons in need of care in *Germany*, the Federal Ministry for Family Affairs, Senior Citizens, Women, and Youth and the German Federal Ministry for Health and Social Security initiated the “Round Table for Long-Term Care” in 2003, thus representing both the health and social care sectors. Between 2003 and 2005, about two hundred experts from associations, the Federal and Regional Governments, municipalities, practice and science worked together and developed recommendations. This resulted, among others, in the “Charter of Rights for People in Need of Long-Term Care and Assistance” and expertises on the “Improvement of Quality and Supply Structures in Out-patient Care” and the “Improvement of Quality in In-patient Care”.

These examples demonstrate the role of national governments and/or national stakeholders to provide a framework for quality assurance on a national level, which is implemented at local or regional level. However, it is the local/regional stakeholders who formulate and operationalise a shared vision which applies to their idiosyncrasies. European countries differ in the extent to which

a common national framework is seen as a responsibility of the state or whether it is a decentralised responsibility of lower administrative levels.

## 2.2 Aims of quality management

Quality management consists of various features reaching from quality assurance to continuous improvement (in terms of the earlier described conceptions in terms of quality as a minimum standard or quality as excellence, see Section 1.3). For a long period of time, quality assurance has been the most common approach in social care, with public authorities setting minimum (structural) standards for the adequacy of care provided (OECD, 2005; MISSOC, 2009), thus keeping the most inadequate providers out of the field. Quality management with broader objectives in terms of quality improvement is focusing on care processes, implying that desired outcomes derive from the defined quality of 'care production' processes. Furthermore, quality management may also entail the definition and the attainment of desired results or outcomes of LTC activities, while paying comparatively scant attention to how (by which processes and based on which structures) they are reached (Donabedian, 1980). It may focus on efficiency of delivery as a proxy for quality or, last but not least, it may focus on notions of excellence or rely on professional norms of quality performance based on evidence of good practice.

Quality of care measurements and the use of benchmarking – for instance between hospitals or hospital departments – are relatively well established in the acute health care field, where outcomes may be more easily operationalised, especially in areas where well-established technical procedures and protocols are in place. It is well known that such approaches have advantages but also inconveniences, as they tend to lead to inappropriate competition as well as to a somewhat mechanical application of predefined measures. Their use in LTC is still less prevalent and more tentative. This has to do with the objectives of LTC: while quality of care may be the predominant objective in acute health care, in LTC it is a prerequisite for achieving quality of life as the more relevant paradigm. Benchmarking, as a specific quality management tool, therefore, appears to be only partially feasible in the context of LTC provision. In this sector individualised, person-centred care is largely carried out by staff who are not highly trained or professionally recognized – or other type of helpers or informal carers. Still, comparisons of (good) practice may be useful in contexts where organisational objectives are set with the aim of continuous improvement and where staff are being explicitly involved in reviewing benchmarking results. An important prerequisite for introducing quality assurance and quality management is thus the training and enablement of staff and other stakeholders involved.

As individualised, context-dependent care is central, direct involvement of primary users (including their informal carers) in quality development is crucial in LTC. The pitfalls of satisfaction surveys and the lack of other means to assess the users' view of services offered are a specific challenge for LTC services and facilities (Roth, 2002). Alternative approaches to elicit user involvement in quality development will need further support. Innovative techniques, particularly in the context of Dementia Care Mapping, may point the way to collecting more relevant data on user preferences and satisfaction.<sup>4</sup>

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<sup>4</sup> In Finland, methods like dementia care mapping (Brooker, 2005) or ELO-D (Salo, 2006) have been introduced as tools for observing interactions between staff and service users or residents in care homes. So

Another challenge characterising the area of LTC is the lack of involvement of different stakeholders when it comes to planning, defining and assessing quality at the interfaces and transitions between different settings or organisations, between health and social care, and between different providers and professions. Also in this context, the facilitation of the involvement of all actors – starting with a shared vision (see Section 2.1) – may be an overarching prerequisite of quality management. Still, setting goals for defining and evaluating the quality of passages or transitions from one part of the system to another, questions of choice, information, breadth of evaluation, and multi-disciplinary input into decisions has not yet become common practice – and even ‘good practice’ in ‘transition management’ and its impact on outcomes in LTC is scarcely documented.

Looking at the practice in Europe, it becomes obvious that the definition of legal minimum standards has been the key tool to regulate and ensure quality in LTC. These standards are focusing mainly on structural characteristics of care provided such as room size, safety features, training and staffing levels etc. However, new kinds of standards, e.g. for process quality, targets for excellence (expert standards, disease management standards or good practice) as well as benchmarking in terms of outcomes can increasingly be identified:

- In *England*, the Care Quality Commission (CQC) is the health and social care regulator whose primary aim is to ensure high quality care for all. This is done through inspections ensuring that common quality standards are achieved. A further aim is to drive up standards through review processes which focus on areas in need of improvement and should serve to identify and share good practice in health and social care fields.
- In the *Netherlands*, efforts to set standards of good practice in connection with quality standards (Quality Framework for Responsible Care) have been carried out. The Healthcare Inspectorate works on specific aspects such as tracing medical errors, improving work processes and quality over time. Transparency on quality is one of the crucial conditions set forth by the Health Care Authority to regulate the impact of market approaches, based on competition, in home care services. Moreover, a widely implemented system of benchmarking has been implemented in LTC (Poerstamper et al, 2007).
- The *Finnish* system focuses on improving the quality of its LTC system towards high-level standards. Many municipalities/organisations use indicators derived from RAI to develop their services. Organisations use indicators for benchmarking purposes to work directly on improving the care and the wellbeing of clients (Finne-Soveri et al, 2008; Noro et al, 2005).
- In *France*, even if the process is still in its infancy, the ‘National Agency for the Assessment of Nursing Home and Home Care Providers’ (ANESM) has elaborated a set of practice guidelines that are supposed to go beyond standards set in existing authorisation procedures.
- In *Germany*, reports about the quality of home care services and residential care facilities are generated by inspections of the Medical Service of the Health Insurance Funds. Their results are made publicly accessible. As of 2011, inspections will be carried out once per year at each service or facility.
- *Austria* provides another example of quality management going beyond basic minimal standards. The aim of the Austrian Health Quality Act is to promote a systematic quality approach

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far the use of these instruments has been limited to research, but there is reason to believe they also could be well accepted in practice.

based not only on the principles of transparency, efficacy and efficiency, but also specifically focused on patient orientation. It must be noted, however, that these approaches mostly concentrate on the acute health care field and that specific approaches that consider the specificities of LTC services are being put forward in a detached manner: while legal regulations mainly pursue the goal of defining structural quality frameworks, providers have started to apply quality management systems (E-Qalin, QAP+) that were explicitly developed for the LTC sector. These systems are based on training, on involvement of different stakeholders, on process and results-orientation as well as on exchange of interdisciplinary learning as means to trigger a process of continuous improvement.

Overlooking these examples, a development from quality assurance which aims to improve structural aspects of quality in LTC to process and result-oriented (outcome) measures can be observed, though the latter are mainly related to the level of individual organisations, rather than to a system level. Moreover, there is a tendency from minimum quality standards towards quality that aims at excellence. This tendency is more evident in the acute sector, but also in individual LTC services first signs of this trend have become visible.

## 2.3 Responsibilities

Even more than in the acute health care sector, a clear devolution of responsibilities is important in order to achieve and maintain a level of quality in LTC that can be viewed as corresponding to agreed upon standards or improvement targets. Agencies responsible for overseeing the delivery of care must also be concerned with the implementation and oversight of quality management systems. This necessitates putting various measures into place to enable authorities, or mandated third parties, to verify the implementation and to evaluate the effectiveness of the quality management systems providers are using. In all respects societies ask for transparency: the quality standards and indicators, but also the responsibilities.

In many cases, national governments are responsible for quality control at systems level (for instance in Slovenia the Ministry of Labour, Family and Social Affairs and Ministry of Health, and in The Netherlands the Healthcare Authority depending on the Ministry of Health, Welfare and Sport) but they may share this responsibility with others such as regional (Austria, Italy, Spain, Switzerland, The Netherlands) and/or local governments (in France by the General Council and in Finland by the municipalities) and national agencies (France). There are significant differences between the participating countries in the degree to which responsibilities are centralised or decentralised (see Section 4.1.1). Moreover, there is a distinction whether the measures and systems are compulsory or voluntary.

In order to verify that quality standards at organisational level are met, different tools of control and evaluation have been created. Generally, in addition to professional training, certain categories of health care professionals also require official authorisation or a license to practice their profession. Authorisations and accreditations of individual services and/or provider organisations are very common within the European countries (Austria, England, Finland, France, Italy, Spain, Switzerland, and The Netherlands; see also Section 3.1.3). By authorisation, social and health care services have the right to deliver defined services in a specific region. In some countries, such as France, Spain and Italy, accreditation is necessary for services to be recognised as meeting statutory requirements and thus have access to financial support by public authorities. In France and Italy (depend-

ing on individual regions), accreditation is focused on process or even result-oriented criteria, whereas authorisation relies primarily on structural characteristics.

Inspection is the classical tool to control quality by public authorities and is thus applied in all countries in order to monitor and verify that quality standards established by law are being met. Inspection is usually carried out by state agencies and can be viewed as the *a posteriori* counterpart of authorisation.

Certification in Quality Management can be obtained through procedures and standardisations developed by the International Standards Organisation (ISO) or the European Foundation for Quality Management (EFQM), but also by initiatives such as E-Qalin<sup>®</sup> and others that try to adapt quality management approaches to the specific environment of social and health services. In some countries such as Finland, ISO 9000 norms are mainly applied in the private sector. Specific methods for reaching quality standards have been mandated in the Netherlands and in some regions in Austria and Italy.

In general, there is a tendency across the participating European countries where responsibilities in quality assurance move from control and inspection by public administration towards responsibilities of the care providers themselves by means of self-assessment, self-regulation and by third party certification.

## 2.4 Aspects of service delivery to be addressed

In order to describe and assess quality of services, standards and indicators have been developed all over Europe both by governments or public authorities and by provider organisations, but also by research and professional federations.

- An example of criteria and indicators to assess quality in LTC is provided by the E-Qalin<sup>®</sup> Quality Management System which is applied by care homes in Austria, Germany, Luxemburg, Slovenia and Italy. E-Qalin<sup>®</sup> supports initiatives to map the reality in residential care facilities by inviting representatives of all stakeholders to assess and improve 66 'enabling' criteria (structures & processes) and 25 key-performance indicators (results) from five different perspectives (residents, staff, management, social environment, and 'learning organisation').
- In Finland, the national government has developed a *National Framework for High-Quality Services for Older People* (2008). It sets the quantitative and qualitative targets of the service structure and of staffing level in national level. Other indicators followed by Finnish LTC providers are related to the promotion of health and welfare, financial monitoring and quality, effectiveness and availability of services. The RAI quality indicators used in Finland cover areas such as nutrition, use of various psychotropic medications, rehabilitative care and social interactions (Achterberg et al, 2009; Feng et al, 2009).
- In Italy, accreditation in the health care field assesses minimum structural, technological and organisational requirements. Apart from some general indicators specific requirements are defined for individual services such as rehabilitation facilities, social care etc. according to their particular requirements.
- In England the Care Quality Commission (CQC) has outlined six quality domains that apply equally to health and social care. These domains are: safe care, improving outcomes for people, a good experience for people, prevention and healthy independent living and quality of life, ac-



cess to services and value for money. The six quality domains are very broad and they are not LTC specific, though LTC services do have to work within this framework. At both service and local levels there are no specific provisions for the LTC continuum, except for guidance relating to care homes.

- In The Netherlands the *Quality Framework for Responsible Care* (QFRC) was launched in 2007. The QFRC contains measurable indicators that show whether the organisation provides responsible care. The professionals are actively involved in the preparation and execution of measurements. The QFRC is an important part of the professionals' work and connects with the ambitions of professionals to deliver responsible and 'good' care. Results from the QFRC provide a basis for further discussion with professionals. In this discussion the results can directly be translated into tangible improvements and adjustments in programmes and practices.
- In Germany quality criteria for quality of health care, but also specific social care and customer satisfaction issues have been developed by the Medical Service of the Health Insurance Funds in cooperation with other key actors like the National Association of Municipalities and the Association of Care Service Providers. They are used in annual inspections as an assessment basis from which publicly accessible 'care marks' are derived.

The general tendency is to assess and monitor not only quality of care, but also aspects that reflect quality of life. As already mentioned, there is also a shift from monitoring aspects of structure and process (or: input and throughput) to results (output and outcomes) and a shift from organisation and profession oriented approaches to person oriented measures.

## 2.5 Costs and cost-effectiveness

To evaluate the cost of any quality management system, several aspects must be taken into consideration: the cost of its introduction (training of staff, consultancy, new technology), of its maintenance (working-time of staff involved, costs for third-party audits and certification) and finally the cost of the improvement measures derived from it.

There is not much research about the outcomes of quality management as against the global cost incurred (see Minkman et al, 2007, for a recent review). Still, these costs are relatively marginal when compared to those resulting from structural expenditures occurring in residential facilities or considering the costs of their unanticipated closure due to failure to meet quality standards. In addition, costs for quality improvement include a potential for reducing costs in a mid- and long-term perspective. While quality management methods may potentially enhance quality and/or save money for the regulating bodies, they will clearly increase the workload for the providers (and thus necessitate more resources).

For several countries it has been reported that quality management may also give rise to complaints by health and social care professionals who feel burdened by increased paperwork, if they do not see tangible results in daily practice. The proof of a positive impact of quality management measures may indeed be difficult to obtain, if these measures do not become part and parcel of the general strategy and leadership, both within provider organisations and on the side of the (public) purchasers. Lack of clear positive outcomes may lead to quality management implementation being patchy, with those having more resources to spend on its development or a more quality oriented culture being better able to provide a higher quality of services, thus leading to inequity in the distribution of quality. The role of regulating bodies will thus remain important in this regard, not only

to ensure the conditions for comparing the quality level of services but also to lead the way to a 'culture' of systematic quality assessment in LTC taking into account managers', professionals' and users' views.

A specific challenge for public authorities is to adopt quality management approaches, rather than a mere inspection strategy. In this context it is difficult to balance positive incentives as against sanctions: for instance, if low performance results in reduced payments it is quite evident that improvement strategies will be bound to fail. In a quality management perspective it would be exactly the low performing organisations that would need training and financial support to increase their quality in a mid-term perspective.

Finally, it has to be considered that both ex ante and ex post mechanisms to control quality have been introduced in a context of new public management strategies with the aim to increase choice and competition (Huber et al, 2008). Public authorities are therefore challenged to govern the newly emerging 'quasi-markets' in social and health services, while at the same time striving towards more coordinated LTC systems (Leichsenring, 2004). However, privatisation and new public management without quality management would be half-hearted as quality management and benchmarking, both requiring transparency, represent the most important tools for public authorities as purchasers to steer provider systems based on market-mechanisms.

## 2.6 Involvement of staff

The most traditional method to assure and develop quality in health and social care has been the experience of staff and the divulgence of professional knowledge. The role of professional organisations in setting up profession-specific norms or standards of good practice has thus become an important feature of quality in LTC. However, both research-based evidence and systematic quality management as part of daily work has only started to gain grounds in the area of LTC.

Professionals in the acute health and nursing care field produce protocols for intervention in many care situations such as monitoring intensive care patients, mobilisation after surgery etc. This kind of disease management has also been introduced in LTC, for instance in the field of nursing concerning bedsores prevention, or handling care decisions with non-verbal users. However, the implementation of such expert standards (see Schiemann/Moers, 2007; Meyer/Köpke, 2006 for Germany) is not as widely accepted or used in LTC, which is partly due to the specific characteristics of LTC services and facilities. For instance, in the area of home care the context in which care must be delivered cannot be controlled to the same extent as in an institutional setting, even though inspections of home care providers have become a common standard. Possible resistance of social care professionals, in particular, to the pre-eminence of evidence-based approaches is partly due to this high degree of 'context sensitivity' and the higher autonomy of professionals concerning discretionary decision-making, e.g. in the context of home care.

It is thus quite understandable that, where professionals are excluded from the conception of quality systems, they express dissatisfaction with such systems as they may experience direct conflict between professional guidelines and requirements of quality management tools. The inclusion of professionally agreed standards is certainly useful when elaborating quality management systems in LTC. Top-down quality management systems which do not sufficiently integrate feedback from line workers are known to be subverted in their implementation as they are not recognised as valid by care staff; besides, the indicators or outcomes defined without staff input may bear little rela-

tionship to other types of quality measures such as staff loyalty to care organisations, or patient satisfaction.

It is certainly necessary that management takes lead responsibility for the introduction and maintenance of quality management systems. Respective training and leadership approaches have to be supported such as, for instance, in Finland where the RAI-system stipulates compulsory training for managers two times per year. This training consists of information on how to use benchmark data in management, in strategy planning and in developing services. These ‘top-down’ approaches have to be complemented by genuine efforts to integrate professionals, including front-line staff, in the design and implementation of quality management systems. Although such efforts sometimes figure as goals to be pursued they are still difficult to pinpoint in European LTC systems. For instance, Austria and the Netherlands seek to involve professionals into the elaboration of actual quality standards.

- In *Austria*, various stakeholders on the regional level, including patients’ and doctors’ organisations in an advisory role, meet regularly within the framework of so called ‘Health Platforms’ which also design, tender and select projects to improve the coordination of services between in-patients and out-patients services. In an area more specific to LTC, E-Qalin<sup>®</sup> is a quality management method which involves professionals, users and other stakeholders. Following a self-assessment process, a list of mutually agreed-upon improvement projects is elaborated, the goal being further enhancement of services and continued involvement of stakeholders. Third party audits are then provided in the context of the still voluntary Austrian “National Quality Certificate” for care homes.
- *The Netherlands* provide similar examples explicitly based on a dialogue between stakeholders, with care associations, professional groups and clients representatives having come to an agreement on working nationwide with the *Quality Framework for Responsible Care* (QFRC).
- In *The Netherlands* KICK (Quality Information Centre) supports healthcare organizations with current knowledge for daily practice. KICK is a module with ‘Reserved, High Risk and Other Acts’ available within over four hundred protocols. These protocols are being updated together with the KICK members (carers, nurses, quality staff). The experience and expertise of the members being professionals on the job, is essential for a practical use of the protocols file. KICK has 120 members from the following sectors: home care, nursing homes, residential centres, mental health, disabled care, education, hospitals. In short, organisations that have a KICK membership have an active role in developing and exchanging practical up to date knowledge.

Another challenge concerns the involvement of informal carers in quality management as the boundaries between formal and informal care have become increasingly blurred and because informal carers do not always represent the same interests as the older person being cared for (Triantafillou et al, 2010). However, it is exactly this situation between formal and informal or between intimacy and distance that would qualify informal carers for being considered as a vital stakeholder in defining, planning and assessing quality criteria and performance indicators.

## 2.7 Users’ involvement

The role of users in quality management presents several specificities in the LTC field. First of all, the term encompasses more than direct recipients of services. This is particularly true in community care, where informal carers are also involved in care activities, for example by supplementing

nursing care (Bonsang, 2009). Even if they cannot always be considered as a representative of the primary user, informal carers are an important stakeholder in quality assurance and assessment.

At the policy level, users are usually represented by organisations that defend their interests and act as advocates to make sure concerns are heard. The relationship of such organisations – from general seniors' organisations in Austria to Carers UK or even Eurocarers at European level – to actual users may vary, as well as their degree of professionalisation and the integration into the policy-making process.

Questions relating to patient (or resident, or user) satisfaction must be approached with caution in the LTC field. Opinions of frail older people about the quality of their care might be biased by fear of discontinuation of service or other forms of retribution. However, the interactional characteristic of care and the specific situation of informal carers call for quality management systems that are designed to include users and carers, even if their expectations may be conflicting, over the entire process reaching from needs assessment to the evaluation of service quality.

Some specific examples stemming from various approaches to quality management may be highlighted:

- In *The Netherlands*, client and consumer organisations have become increasingly active in controlling care providers, for example through the collection and publication of performance information. Furthermore, The Netherlands uses a Consumer Quality Index, which is a standardised system for measuring, analysing and reporting customers experience in health care. Moreover, The Netherlands has a strong users' organisation in LTC. This organisation has formulated its strong and emancipatory view on LTC which states that an older person in need of care is a valuable person as such, and not only a care recipient. According to this view care should focus on people's values (LOC, 2010) and not primarily on the values of the care providers, the policy makers or the commissioners.
- In *Finland*, clients are explicitly granted the right to participate in and influence the planning and implementation of treatment and services intended for them. The patient and the service provider jointly draw up a plan and must agree on how the treatment, service, care or rehabilitation concerned will be carried out. Users are formally entitled to be told of possible alternative procedures, to receive and examine all information concerning them; in return, they must provide relevant information about themselves. Patients are guaranteed transparency of information concerning their health, patient records and relevant information on waiting periods for treatment.
- In *Germany*, residents of nursing homes, represented by an elected board, are legally entitled to have a say in decisions concerning e.g. residence, board and social care, planning and organising events as well as financial and organisational issues. This entitlement includes their support by relatives and volunteers if they cannot make use of their rights, e.g. due to their health conditions.
- In *Slovenia*, the introduction of E-Qalin<sup>®</sup> in some care homes shows a move towards quality assessment explicitly based on residents' satisfaction and quality of life.
- *Swedish* quality policies give an important place to the point of view of the patient about care services allocated by various care organisations. Each county council and each municipality has a patients' committee. Its function is to support and help individual patients and to contribute to quality development in the healthcare system. Based on patients' views and complaints, the committees help them to get information, promote contacts between patients and health care

staff and assist patients in getting in touch with the appropriate agency. Last but not least, the committees report significant irregularities to care providers and care units.

- Finally, *English* experiences also show that specific attempts have been made to include the views and experiences of care users, as well as outcome measures, in the assessment of the quality of medical and social care. The performance of Primary Care Trusts is assessed using the points of view of services users. As for the Local Councils and social care commissioners, they receive an aggregate grade based on the outcomes of people who use their services.

These examples hint to the fact that informal carers and users are getting a stronger voice, when it comes to quality assurance. In spite of practical and methodological difficulties, users' opinions are heard more often and satisfaction measures are collected. Although these are very subjective and individually determined, it appears to be worthwhile to investigate principles and perspectives, that are shared by many older people. Still, while active participation in quality assurance by older people and their carers is growing at the individual level, it is poorly developed at a collective level.

### 3 Quality assurance on four levels

This section looks into different approaches to quality assurance and quality development from four different perspectives that are linked to the sometimes diverging interests on a systems level, on the provider or organisational level, and on the individual levels of professionals, users and carers.

#### 3.1 System level

Across the countries represented in this study, there are laws to ensure that health care and social services are rendered to the population on an adequate level. Quality of care has been given ongoing attention in legislation. The involvement of service users in judging the quality of care and increased transparency of services provided is becoming more stringent. In general, authorisation is provided by public authorities if a provider of services complies with legally defined standards. Compliance is imposed by legislation and bureaucratic procedures, including inspection. Emerging are systems of self-regulation and of third party certification (see Section 2.3).

##### 3.1.1 Legislation

Though there are only few examples of laws or regulations that were created with the aim of improving the quality of care specifically for LTC services, specific laws and acts have been launched in the past decades for health care and social services. Many legal procedures aim to safeguard fair services and equity among the care and service recipients regardless of their age.

According to the different constitutional contexts, legal regulations with a nationwide scope can be found in the more centralised countries, while countries with a federal constitution and/or decentralised welfare systems are governed also by regional or local regulations (Austria, France, Germany, Spain, Sweden, Switzerland). New developments entail the following issues:

- In 2009 three commissions merged in England into one Care Quality Commission (CQC), thus covering health care, social care and mental health services. This transition will continue through the end of 2010. Regulation is moving away from national minimum standards towards outcome based assessments.
- In Finland, the 'National Framework for High-Quality Services for Older People' is a guideline by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities launched in 2001. The original framework has been updated in 2008 to take account of Government Programme strategies, national targets for old-age policy, the findings of framework assessments, new research data and contextual changes due to the reform of the Finnish municipal structures. In addition, planning for 2011 stipulates the implementation of a new Health Care Act.
- In Germany, the LTC Development Act of 2008 intends to ensure more quality by the implementation of expert standards, annual inspections of home care services and nursing homes with transparent results. It also includes plans to strengthen prevention and rehabilitation in LTC as well as the nationwide establishment of local Care Support Centres which are to perform care and case management.
- In Spain a service and resources database (called Network of Services of the SAAD) is being created to guarantee issues of quality and efficacy of the benefits and services provided to cover LTC. In this country the System for the Autonomy and Attendance to Dependence also considers the creation of a consultative committee and other consultative bodies to contribute to, among other issues, the elaboration of standards and quality issues.
- In Switzerland, as in many other countries, LTC does not have its own legal basis. The cantons are responsible for devising and implementing policies of quality control in LTC services.
- Sweden has two frameworks of laws, one to assure good health and care on equal terms for the entire population with priority to those who are in greatest need, and another that urges municipalities to deliver required support and assistance to their residents.
- In France, at least three agencies are involved in quality activities with different roles: CNSA (National fund for autonomy and solidarity) acting as a 'coordinating body'; ANESM (National agency for assessing LTC providers) responsible for practice guidelines and certification both on behalf of the Ministries of Health and Social affairs; and ANSP on behalf of the Ministry of Labour and responsible for the quality of type of services delivered at home. A new situation has been created since July 2009 with the introduction of Regional Health Agencies which will cover primary and hospital care but also LTC services. However, it is still not clear how this will translate and impact on quality regulations.

From this list emerges a picture showing that the national and regional legislative frameworks for LTC are often less coherently developed and more fragmented than the frameworks that govern acute health care. LTC services thus have to operate within and between various systems and governmental layers, which are not necessarily developed in a coherent way. This is particularly relevant when it comes to combine LTC with acute care, rehabilitation and prevention for frail older people.

### 3.1.2 Inspectorate

Inspection is the most common way of assuring minimum quality standards. In countries with an inspectorate there usually is a national body responsible to inspect each acknowledged organisation in health and social care (The Netherlands, Switzerland, England). In Austria, each region has an inspection body that is usually a department of the regional administration. In France, this task is carried out by the *Départements*, which constitute an additional administrative layer between the regional and the municipal level. In Switzerland the delivery of specific data is required from the health care providers by the Federal Statistical Office so that cost-efficiency and quality of care services can be monitored.

The submission of a data set to the CQC is mandatory in England as well as a self-assessment to evaluate how well the service feels it is meeting service users' needs. These data are required from both health and social care service providers, and they are both subject to inspections. However, the burden of inspections is greater for social care service providers which can be confronted by key inspections, or random and thematic inspections. Service quality is graded with stars.

In the Netherlands health care providers deliver annual data requested in the set of performance indicators to the inspectorate. A quality report must be accessible to the public. Every two years a *Quality Consumer Index* is presented, presenting users' experiences and appreciations.

### 3.1.3 Accreditation and certification

Accreditation is a voluntary (or sometimes compulsory) method of quality assurance (*ex ante*) which generally is carried out by an independent, 'third' party which neither represents the purchaser nor the provider of a service, but usually a public authority. Service requirements are defined and compliance is assessed by expert consultants. In many countries, accreditation is a precondition for services to receive subsidies and/or reimbursement of service costs by public funds.

- Recently an experimental procedure has been launched in *France*, where any commercial firm having objective records in the audit and certification field and specialized in the LTC sector, can be enlisted in the task force for accreditation of home care services and care homes. They must have endorsed the engagement to meet and follow all the defined criteria set up by the national agency ANESM which will monitor the accreditation process that has started by the end of 2009.
- Two accreditation bodies have been set up by the *Dutch* health care field: one for accreditation of hospitals (NIAZ) and the other for harmonization of quality reviews in health care and social services (HKZ). The latter produces certification schemes and is an initiative of care providers, insurers and clients.
- In *Spain*, all service providers have to obtain their accreditation in order to be integrated into the 'Network of Services' of the 'System for the Autonomy and Attendance to Dependence' (SAAD), but also to be able to provide their services. The SAAD establishes the need to develop minimum criteria in order to have national homogeneous standards to guaranty the quality of the service providers in the whole nation. The Autonomous Communities, on their hand, are responsible for establishing their own criteria, taking into account the minimum established by the SAAD, to obtain the accreditation in their region and also to deliver the accreditations to the service providers when they meet those criteria.

Certification is a voluntary method of quality assurance. During this procedure, compliance with a specific quality management system (ISO 9000, EFQM, etc.) is assessed regularly by a third party, usually an accredited private certification agency which issues a certificate that the organisation complies with the principles defined in their standards.

- In *Italy*, certification of quality guarantees the capacity of a certified organisation to structure and manage its own resources and productive processes so as to understand and meet customers' needs. In order to get a certification a care provider has to clarify which work processes are used and has to describe them in a quality manual. Assessments are made by various certification bodies. For instance, they look into organisational structure, management of human and material resources, the content of services provided, diagnostic and therapeutic protocols, personnel qualifications and correct performance of experimental activities.
- Health care providers have to meet minimum standards set by the cantons in *Switzerland*. Two leading organisations in the field of certification of institutions in LTC support and develop ISO standards. Both certification and accreditation of care providers is voluntary.

As outlined before, these forms of self-assessment and self-regulation are becoming more common in LTC, supporting quality management which aims at improvement and higher levels of quality or excellence, instead of working towards minimum standards.

### 3.1.4 National standards and guidelines

In several countries standards and guidelines are nationally developed in order to support local authorities to develop service provision that meets the needs of the population and to ensure a certain level of quality at regional or local system level.

- The National Framework for High-Quality Services for Older People is a guideline launched in *Finland* to serve as a tool for decision makers and municipal managers in developing and evaluating their services for older people. The framework sets national targets for services. It outlines strategies for raising the quality of services for older people in three dimensions: promoting health and welfare, staffing and management, and living and care environments.
- In *England*, a National Service Framework for Older People has been established to look at the problems older people face in receiving care in order to deliver higher quality services. The key standards that underpin the Framework include plans to eradicate age discrimination and to support person-centred care with newly integrated services. A new layer of intermediate care has been developed at home and in care settings. The NHS is also to take action on stroke prevention, in the promotion of health and active life and a reduction in the number of falls for older people. Integrated mental health services are to be provided for older people.
- In the LTC system of *France*, national bodies such as DGAS and independent agencies (such as ANESM) have issued various norms and guidelines which are to be transformed by local authorities and care providers into services that meet the population's needs. The goals of the agencies are to set best professional practice guidelines, staff's recertification, accreditation of residential and home care (ANESM). They also function to promote innovative organisation or new services, encouraging research (CNSA) and to enhance professionalization (CNSA, ANSP).
- Since 1999 National Expert Standards are developed by the *German* Network for Quality Development in Care. With special view to LTC, the 'Round Table on Care' gathered experts from the health and social care sectors between 2003 and 2005 to discuss standards and guidelines for



political decision-makers and practitioners, among others resulting in the 'Charter of Rights for People in Need of Long-Term Care and Assistance'. As a follow-up, an Information Centre was established in 2009 by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth with the objective to support further improvements in the quality of long-term care and assistance by providing support and advice to professionals and the general public.

- The National Board of Health and Welfare in *Sweden* has developed several guidelines providing decision-makers and professionals with recommendations within defined areas of disease. The national quality registries collect information on individual patient's problems, interventions, and outcomes of interventions in a way that allows the data to be compiled for all patients and to be analysed at unit level. The vision for the quality registries, 70 throughout Sweden, is to constitute an over-all knowledge system that is actively used on all levels for continuous learning, quality improvement and management of all health care services (see Box 1).
- *England* has indicators for how the central government will monitor local government in all areas of public services which extend to healthcare, the police and other local bodies. In health care, national metrics, or quality indicators, are currently developed for acute settings and in due time for community services, however it is unclear how well these indicators will reflect the links between services. The National Quality Board which brings together key stakeholders to drive the quality agenda forward will be leading the way in quality indicator development for the NHS. Also the NHS will have to publish quality accounts which will reflect the three themes of patient safety, experience and outcomes. The comparative information will be available on the NHS Choices website. National minimum standards for care homes and domiciliary care outline the minimum quality of care for their services, but they do not encompass the pathways across services.

The advance of national standards and guidelines can be observed particularly in those countries with a tendency to develop LTC according to a medical model. National standards and guidelines may have a better chance to ensure equality within the national territory and it appears to be more efficient to develop the often complex instruments by the national leading experts.

### **Box 1: Five registers with an explicit relevance to LTC in Sweden**

The registers often contain data on specific problems, diagnoses and procedures and results. In those registers that are in use within the field of LTC data are collected from existing registers but also by surveys to the municipalities and other care providers.

#### **1) National Board of Health and Welfare – Regional Comparisons in healthcare and “LTC” (Äldreguiden)**

In recent years the discussion about client empowerment has arisen. There is an emerging movement towards more transparency. The National Board of Health and Welfare provides a guide on elderly care (Socialstyrelsen: Öppna jämförelser inom vården och omsorgen av äldre – Äldreguiden) where people can compare different quality indicators for care homes and short stay facilities online (<http://aldreguiden.socialstyrelsen.se/>). Some indicators also concern support for family and the educational level for staff. The register uses indicators such as access, participation, number of staff, competence, food, support to informal carers, participation of medical doctors, management, evaluation and information. Data are collected from official population statistics and the National Board of Health and Welfares statistics on providers.

#### **2) Local Authorities and Regions and National Board of Health and Welfare – Regional Comparisons of quality in healthcare and efficiency comparisons between county councils**

The register measures 57 indicators on clinical results, patients’ experiences, access and costs. Data are collected from several other registers (SKL och Socialstyrelsens – Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet – Jämförelser mellan landsting).

#### **3) Local Authorities and Regions – Regional Comparisons care of elderly**

The register measures 13 indicators grouped in five dimensions such as good practice, social care and service, staff, costs, number of persons receiving home help, nursing homes. Data are collected from official statistics, from other registers and surveys. Most of the indicators are related to persons older than 80 years of age (SKL – Öppna jämförelser äldreomsorg).

#### **4) National Board of Health and Welfare – The Swedish register of palliative care**

The register measures 8 indicators. Staff is asked about the conditions of a client during the last week in life (Socialstyrelsen – Svenska palliativa registret).

#### **5) Senior Alert**

The register uses indicators such as nutrition, prevention of falls and pressure ulcers. This is not a national register. Data are derived from screening instruments and are collected from primary care and other branches of healthcare. Furthermore there are additional reports on costs of care in the municipalities (Vad kostar verksamheten i din kommun? Rapport från KSL) and user surveys (Socialstyrelsens brukarundersökningar).

## 3.2 Organisational level

The methods and concepts for measuring and assessing quality in LTC are not only driven by national and regional governments, but also by individual organisations’ initiatives. In particular larger organisations have started to use quality management for strategic reasons, but also – in an increasingly competitive market – in order to comply with external requests for transparency. Methods used are influenced by classical quality management systems (ISO, EFQM) and by the hospital sector where management systems have started to be applied much earlier. In spite of these difficulties there is also a move toward innovative methods and indicators that are more adapted to the social care sector.

### 3.2.1 Quality management systems and audits

A variety of quality management systems is applied in the various countries, some are based on generic international systems and frameworks, such as Total Quality Management, EFQM or ISO9000, but several efforts have been made to adapt these systems to the characteristics of hospitals or even specifically to LTC care services. Both individual provider organisations and public authorities at several levels have contributed to a further extension of third party certification linked to internal quality management and self-assessment of quality. Furthermore, audit commissions may contribute to control economic viability and the efficient use of public resources. As outlined before, there are rising endeavours to address results and outcomes representing quality of care, rather than merely input variables (structures and processes) (see Section 2.4). Moreover, the tendency is to combine quality assurance with continuous improvement strategies to enhance the overall level of quality.

- An increasing number of care homes in *Austria* are working with E-Qalin<sup>®</sup>, a quality management system that was developed by a consortium of partners from Austria, Germany, Italy, Luxembourg and Slovenia. This system combines classical quality management instruments with organisational development and appropriate learning and training methods. It is a potential starting point for the empowerment and involvement of staff and other stakeholders to participate in the enhancement of processes and results of services. Recently, also a version for home care services became available for use. Some regional audit commissions have audited individual public care homes and/or the social care sector for older people, mainly for their organisational efficacy, economic viability and accountability. The Viennese 'Care Home Commission' should be mentioned as it started to influence the LTC sector by means of recommendations, studies and model projects derived from expert knowledge and direct contact with residents and their families. For instance, their recommendations led to tangible improvements on discharge management, extension of supply with small housing, development of disease management and care pathways for selected diseases as well as to the first introduction of social workers to core staff in care homes. Finally, a National Quality Certificate for care homes has been piloted in 2009 as an external audit and certification process for organisations applying accredited quality management systems.
- In *France*, more and more home care agencies are approaching quality management by engaging in various types of certification procedures (ISO9001, Qualicert, AFNOR), which are delivered by private 'certification firms', with specific criteria for each of them. Nursing homes use the model 'Angelique' which offers a potential entry into quality management as does the new accreditation program. Reports from the different French departmental inspection bodies generally remain disclosed. This is not the case for those coming from the National Inspectorate for Social Affairs (IGAS) as well as from the accounting court. Both institutions have issued a series of reports after having audited various home care agencies and care homes for their organisational efficacy, economic viability and accountability. The 2005 report of the accounting court looked at all types of LTC providers while the more recent one in June 2009 by IGAS focused on quality in home care agencies. Both delivered a severe judgment not only regarding the quality of governance but also providers' bad performance impacting on user's satisfaction and quality of life. The reports also pointed out that the inclusion of informal carers' views in quality assessment were poor.
- In *Finland*, municipalities and care organisations are free to choose their quality mechanism. The quality assurance can be systematic or sporadic. One popular way is to adopt Total Quality Management (TQM) typed systems or the Balanced Score Card model that involves the entire organ-

isation top-down. There are no national obligations or specific recommendations to adopt one or the other of these systems. Municipalities and other provider organisations monitor their performance autonomously. The various aspects of quality are surveyed on client level. The national framework for high-quality services for older people set quantitative and qualitative targets for the service structure and for staffing levels at a national level.

- In *Italy*, quality of health, social-health and social care services is ensured by institutional instruments (accreditation mechanisms on the regional level) and voluntary certification (e.g. by means of ISO 9000).
- The Quality Framework for Responsible Care (QFRC) was launched a few years ago in the Netherlands based on indicators that were mutually agreed between service providers, professionals and service users. On the organisational and professional levels several guidelines must be met. The QFRC contains measurable indicators that show if the organisation provides responsible care. The QFRC gives the Board of Directors the opportunity to review whether management is 'in control' of the quality and responsible care. Based on the results of the QFRC the board and the employees' and service users' committee can speak with the management about how the results are translated to quality policy and improvements, the measures that are taken and the extent to which these improvements are actually achieved. QFRC is important for attaining membership of the Netherlands' Organisation of Care providers.
- Within the E-Qalin project, *Slovenia* carried out the first pilot introduction of quality indicators in care homes. With support of a training agency, which is providing training and supporting the implementation of E-Qalin<sup>®</sup> in Slovenia, there are now more than 30 care homes that have introduced this model. According to the representatives, the management of the homes recognized E-Qalin<sup>®</sup> as a tool that enables a comprehensive approach towards quality assurance and to satisfy the specific needs and characteristics of LTC for older persons. With E-Qalin<sup>®</sup> care homes are assessing both criteria concerning structures and processes and performance indicators that are largely based on customer satisfaction surveys. Results of the self-assessment procedure basically serve to involve all stakeholders and to stimulate quality improvement. From 2011 there will also be an external audit and certification for E-Qalin<sup>®</sup> care homes.
- The *Spanish* SAAD establishes some regulations about the documentation and information, regarding service users and staff, needed by the service providers in order to obtain their accreditation. In this sense, all service providers must communicate their internal regulation, a quality management plan, a service charter, documentation referred to the service user and staff, an emergency plan, an action protocol and other information or documentation relevant to the competent authorities.
- In *England* health and social care services are registered and inspected by the CQC. Social care service providers must complete an Annual Quality Assurance Assessment (AQAA) for the CQC. This procedure includes a self-assessment on how well the service feels it is meeting service users' needs. Furthermore, basic facts and figures, such as the number of people who have dementia and residents' funding sources, has to be reported to the CQC. The CQC may also send a survey to service users for their feedback. Given this framework, only some larger providers have introduced internal quality management systems and obtained certification by third parties. Quality assessment is also increasingly being based on self-assessment, such as with the AQAA. While this may save the regulator money, it increases the workload on care providers and commissioners. The paperwork burden is a common complaint among professionals who feel it takes them away from providing hands on care.

Systems of self-assessment and self-regulation are not synonymous. There are significant differences between countries in the degree to which quality systems are obligatorily imposed on care providers. There are no clear indications yet from research to what practice is to be preferred.

### 3.2.2 Benchmarking, monitoring and performance indicators

Working with quality management systems has increasingly led to more attention on outcomes of service delivery and the quest for performance indicators that may be monitored and compared across a variety of services (see for instance: Poerstamper et al, 2007). Many technical problems still exist, such as controlling for case mix and taking into account historically determined differences (see Zimmerman et al, 1995). Methodological reliability and validity are easily challenged, especially when there is a debate to what extent the findings should be published.

- The *Austrian* Ministry for Social Affairs and Consumer Protection regularly gathers relevant stakeholders in a 'Working Group on long-term care' to monitor the development which is reported on a yearly basis. Data provided by the regional governments and the Social Insurance Agencies include the number of places in care homes, the number of service hours provided, prices (daily rates, hourly rates) of services, the number and type of staff employed, but they still lack in consistency. In addition, there are no specific quality indicators concerning the continuity of care, cultural diversity, care workers' satisfaction or satisfaction of beneficiaries and their family members.
- In *Finland* the RAI-based quality-efficiency ladder shows roughly that, in general, resources meet the needs of clients and are not wasted. In rural areas distances are long and living standards are poor: more attention should be paid to this issue. Several items of the structural quality are collected either nationally or among the RAI-participants together with 300-400 item RAI-assessments. RAI users increase year by year so that detailed, quite representative information is available for national and local level decision-making. Other quality monitoring for structural quality might not be needed on national level. Key questions in the area of LTC are: how much staffing is enough and what education do they need to have?
- The *Italian* national and regional laws have introduced a lot of indicators in health care and social assistance during the past years. Most of these indicators are focused on aspects such as the costs of individual services or processes, structural characteristics (number of beds available, number of general practitioners), the organisation of health services and the use of resources, but not across social and health care services.
- As no specific framework is provided at national level, the *Spanish* National Agency for Regional Health Services set up a partnership as a permanent forum on the issues of quality and accreditation in health care, which involves 16 Regions and Autonomous Provinces. One of the themes discussed concerns quality criteria in selecting accredited suppliers for the National Health Service. These criteria range from aspects linked to clinical quality to organisational quality and a series of mixed criteria, such as care pathways, the ability to provide assistance, protocols of coordinated discharge, services given according to clinical indications of proved effectiveness, presence of formal assessment methods, quality evaluation of the services supplied, training, uniformity in filling in forms and files, implementation of monitoring systems on essential levels of performances, direct link to the local health authority's booking centre, accessibility.
- The *Swedish* Board of Health and Welfare is responsible for the development of national quality indicators. This is based on a model that was developed by the Stockholm County Council which, in turn, has similarities to the ones that are used in the Netherlands and England. The related

process starts by gathering information about the specific area of interest, e.g. from guidelines and/or care programmes. The indicators are then discussed and defined in expert groups and other stakeholders. The indicators should have scientific reliability and validity; the indicator must also be relevant, important and possible to measure. They should also be based on the best evidence possible.

- Health care in *England* is organised through trusts, namely Primary Care Trusts (PCTs) and NHS trusts. PCTs both commission and provide health services and they account for 80% of the NHS budget. PCTs are meant to develop their own quality indicators in line with the three national quality domains: patient safety, effectiveness of care, and patient experience. They use the quality indicators to determine how well they are meeting the quality domains and government targets. A range of quality measures including Patient Reported Outcome Measures (PROMs) will be used to determine payments for hospitals. Care homes are not required to use any specific quality indicators, apart from meeting the national minimum standards. They are required to use an assessment tool, some of which may produce quality indicators, such as the MDS-RAI. However, the validity and reliability of these tools is not regulated, only the content.
- In *The Netherlands* most services in LTC for older people are participating in a national benchmark. The benchmark covers issues such as staff (quality of work), financial performance, clients indicators (Responsible Care Standards), services delivery, satisfaction of employees and quality outcomes (partly based on the CQ index) (Poerstamper et al, 2007). The national umbrella organisation for LTC plays a stimulating role in this benchmarking system. There are still methodological questions to be answered. In particular, quality is hard to operationalise. Any follow up improvement activities is the responsibility of the organisation.

Benchmarking thus appears to be an instrument which is gaining popularity in several countries. However, there are serious methodological problems in carrying out these benchmarks: control for case mix, the operationalisation of quality of care and of life and the comparability of circumstances in which the services operate are questions that cannot easily be resolved. It can also be questioned whether the instrument is sufficiently sensitive for the multiple facets of LTC for older people.

### 3.2.3 Improvement measures and processes

Both public and private providers of services have taken an active stance in searching for improvements in quality development and assessment. Often the efforts are directed towards separate organisations, but also across services in some countries steps are taken to develop and spread integrated care pathways in which LTC plays a significant role. The incentives for improvement activities have not always been terrific and the positive outcomes in terms of quality are yet to be demonstrated.

- In *Austria*, improvements for family carers with relatives suffering from dementia have been promoted not only by the Ministry, but also by provider organisations. For instance, a project to financially and organisationally support respite care for carers of relatives with dementia was initiated in 2007, and a dementia handbook was published in 2009 (<http://www.pflegedaheim.at>). Furthermore, the E-Qalin<sup>®</sup> initiative was actively supported by the Austrian Federation of Care Homes.
- The National Framework for High-Quality Services for Older People in *Finland* as a guideline specifies the principles behind the staffing levels used and the recommendations for minimum

levels in 24-hour care. The framework promotes improvements in accessibility, safety and comfort of care environments for older people, aiming for instance to provide an adequate number of single rooms in care homes.

- In *France* the Ministry of Health through its department of research (DREES/mire) and in collaboration with the CNSA (National Fund for Autonomy and Solidarity) has launched various research tenders regarding quality in home care. It includes assessing new interventions, like case/care manager/coordinator, discharge and integrated care programmes and multidisciplinary team work. Also many innovative packages regarding case management and innovative respite care platforms have been launched with a focus on Alzheimer disease. Altogether, the CNSA forwarded €290 million in 2009 to innovative actions related to investments and modernization of providers; training and professionalization of staff. Ten million Euros were devoted to innovation and research. The CNSA thus assumes its monitoring and expertise” functions through different instruments: information exchange between researchers and providers about the design and the methodology of the various experiments and their assessment; monitoring and counselling; synthesizing results and good practices, transferring validated innovation into legislation, and monitoring the dissemination of innovation.
- The Healthcare Inspectorate (IGZ) in the Netherlands has determined which set of data health care providers have to deliver in 2010 for integrated care. These sets of indicators for integrated care concern four diseases: diabetes, COPD, heart failure and stroke. Five indicators must be pursued in integrating care for clients with one or more chronic diseases. Health care providers who have a contract with an insurer are required to supply the data and for other organisations it will be on a voluntary basis. The IGZ expects to have a full set of indicators for integrated care in 2012. The set will be mandatory nationwide. Further, a standard for dementia care pathways will be developed in 2010 and 2011.
- In the Netherlands the foundation PREZO promotes a quality management system that describes which activities of professionals and the organisation can help provide responsible care and which conditions are necessary to carry out those activities. Care providers have to create conditions for the activities of professionals by ensuring an adequate and competent staff, appropriateness of devices, adequate method for information and communication, organising a cyclical secured care plan living system. The provider monitors the effectiveness of these conditions on the quality indicator and if necessary sets improvement actions (Care for Better program). The results of the QFRC mentioned earlier, are being shown on the website [www.KiesBeter.nl](http://www.KiesBeter.nl) (‘choose better’). The intention of presenting these results is transparency of data and that organisations are stimulated to improve their quality of care.
- The necessity to achieve true integrated dementia care exists in a lot of the regions that participated in the Dutch National Dementia Program. On instigation of the Ministry of Health, the Alzheimer Association with the national umbrella-organisation of care insurers began with a new Program for Integrated Dementia care last year. Several regions are making progress in developing integrated care. The first results have been recently presented and full-fledged integrated dementia care is expected to be implemented throughout the country in 2012.
- Also in Finland the need for co-operation between different professionals and the need for integration of services is continuously growing. New methods of working such as case/care management/coordination, discharge management and integrated care programmes with multidisciplinary team work have been developed. For instance, the aim of the KASTE programme is to achieve its objectives by ensuring the adequacy of staff, by strengthening skills, and by social and health care services using effective models of cooperation. Another project entitled PER-

FECT had the aim to develop assessment indicators, based on national registers, to enhance impact, costs and efficiency of the chains of care through different settings for different patient groups.

- ‘Esther’ is a Swedish project designed to create co-operation between acute care, primary care and community care, with focus on older patients. The project was designed according to the method of Health Care Re-engineering (HPR/BPR). Several processes were redesigned to fit the needs of older patients, e.g. that the information should follow the patient’s process through the boundaries of different organisations and providers.
- Another model that is widely spread in Sweden is the joint care planning model: When a patient is referred from acute care representatives from acute care and the local needs assessment unit meet with the patient and, if applicable, an informal carer to plan rehabilitation and future care together.
- In England the National Service Framework for Older People provides a range of specific organisational standards for health and social care integration within intermediate and long term care, as well as for stroke pathways and health promotion in older age. In addition, special reviews will be undertaken by the CQC with providers to look at patient pathways across health and social care. Topics for the special reviews will be chosen each year in response to identified gaps in provision. One of the first potential topics is how well the health and social care pathway is working for people who have had a stroke and their carers. The outcomes of these reviews could be scored assessments or recommendations for practice.

The examples demonstrate that there are several countries which are aiming at the integration of LTC services with acute care, prevention and informal care. These developments are not mainstream at this moment. Many pilots exist or the first steps are made, but the sustainability of these new forms of integrated care has yet to be proven, as are the outcomes for clients and society. It appears, however, a development that makes sense to policy makers, care providers and – possibly – service users. It aims to improve the currently fragmented systems and organisations and, thereby, the fragmented ways in which older people with multiple problems are cared for.

### 3.3 Professional level

Professionals are at the frontline in managing quality of care for service users. They must constantly be aware of any changes in service user status and devise interventions to improve outcomes. A professional’s ability to carry out these tasks depends on skills, communication, and the use of appropriate assessment systems and guidelines. Outcomes also depend on the right skill mix of professionals working together to meet users’ needs. With increasing managerial tasks – including quality management – there is less time for contact with service users. In response to rising demand new roles have been developed to accommodate requirements in an effort to improve seamlessness, continuity and quality in care for service users. Some examples of these emerging developments will be described below.

#### 3.3.1 Professional profiles/new professionals/new roles

Across the countries represented in this study, there are several examples of new roles that have been created in LTC with the aim of improving the quality of care that is delivered to service users. The most common innovation in job profiles has been the development of discharge managers



whose task consists of facilitating the transition between hospital and home care services (Austria, France, Germany, Switzerland, England, Finland, The Netherlands). In France, medical doctors may obtain the status as 'coordinating physician' in care homes following respective training. In several countries (e.g. Austria, Slovenia, Italy) staff responsible for quality management, often in addition to other roles, has been introduced. While in the Netherlands nursing home medicine has developed as an officially acknowledged medical specialty, no other country has yet followed this example. This is less surprising if one considers that it has still not become a general standard in all countries that directors of nursing homes must have specific training.

While new professional roles are emerging, there is also increased multidisciplinary working and the blurring of professional boundaries to meet the complex needs of older people (Triantafyllou, 2004). Professionals are working across more settings and performing activities which are not strictly within their professional profile. Coordination of care sometimes, such as in the functions of case and care management, enables a joint venture on the professional level, with the aim also to follow and evaluate (review) the care given to the client. Though still quite exceptional there is a growing tendency to assign 'boundary spanners' as cross-functional liaisons. These individuals' task is to integrate different professions, e.g. in health care settings they combine the roles of case managers and primary nurses.

Other examples stem from Austria, where social workers have been introduced as core staff in care homes, and from some cantons in Switzerland, where home care services, which traditionally employ health and social care personnel only, have started to employ social workers for the first time. In England, Intermediate Care Services, which is in itself a new service focussed on LTC, have begun a partnership with psychologists to help service users cope with a loss of function and increased dependency.

### 3.3.2 Improvement structures

Structures and systems in place for improving quality of care through continued professional education and skill development are represented in both mandatory and voluntary schemes. However, increasing minimum standards on staff skills has led the health and social care sector more towards mandatory training.

- Two countries (Finland, Italy) have already mandated that all personnel working in health and social care must continuously maintain and develop their skills in line with current knowledge. In Finland the employer is responsible for providing and financing further education and training. The recommendation stipulates 3-10 days of training per year depending on the employee's level of professional education. Further, the employer is responsible for reporting further education (number of participants, duration, costs) to the Commission for Local Authority Employers.
- Countries with voluntary schemes employ a system of incentives and/or disincentives to promote continued development, such as increased pay or a negative appraisal. However, this has perhaps greater potential for creating skill gaps in the workforce as it does not ensure that 100% of the workforce is compliant. Appraisals are used to assess professional performance and may have consequences if professionals have not regularly engaged in improvement activities (England, Italy). In France wages are linked to the education level, but as staff with the highest diploma are earning just 20% more than the minimum salary financial incentives for completing the diploma course are relatively weak.

- Formalised degrees and diplomas with an emphasis on LTC are increasingly becoming the norm (Austria, Finland, France, Germany, Italy, England). In some instances this higher level of education is voluntary, but incentivised with increased pay. Roles in LTC which once did not require education are now requiring a minimum level of training. In England it has become common for healthcare assistants to be required to train for a National Vocation Qualification (NVQ) when they take up employment. Employers may often cover the cost of the training in order to ensure a highly qualified workforce as this may prove favourable when seeking service contracts. Where improvement mechanisms are neither mandatory nor incentivised, LTC providers must rely on goodwill and professional desire for improvement. Organisations which are well funded and thus can afford to pay staff for training are likely to achieve a higher level of practice than those that are not well resourced.

Vocational training and education, and professional qualifications are increasingly recognised as being relevant for the LTC sector. In that sense LTC envisages a phase of professionalization. However, this is often on a voluntary basis, services cannot always afford professional training and many staff members are still unqualified. Professional qualifications and training may be of strategic importance to develop a sustainable workforce for LTC as only a decent status may attract the high number of employees needed now and in the future. Moreover, poorly qualified staff may cause too many errors, which leads to significant quality drawbacks and avoidable dependency of clients.

### **3.3.3 Accreditation, registration**

Though LTC providers (organisations) are accredited and registered at a system level, there are also mechanisms for ensuring that professionals at an individual level are qualified to practice. Regulators set requirements with respect to education, training, and qualifications that professionals must meet to be registered. In most cases these requirements are set at a national level (England, Finland, France, Spain, Sweden, The Netherlands), but there can be local or regional variations for some requirements (Sweden, Switzerland). There are also ethical and professional codes of conduct that professionals must follow (Deontological Code). Regulations and codes that professionals must adhere to are legally binding and violations of codes of practice can result in professionals being struck off the register or even imprisoned (Italy).

### **3.3.4 Communication and information sharing**

There has been a growing trend towards using electronic or web based assessment systems to improve the communication of patient information between professionals in different settings (Finland, Germany, Netherlands, Sweden, Switzerland). Electronic web based systems improve the timeliness of information transfer and allow different professionals to amend patient information in real time. However, electronic systems do not exist everywhere and they are not necessarily seen as supportive to the care delivery process. Where these systems are not available, professionals continue to rely on written and spoken communication in their multidisciplinary and joint working settings (England, Italy). The quality and regularity of information shared will depend on the skills of the professionals involved.

### 3.4 User level

Generally, a development towards a more consumer oriented way of thinking about the delivery of care and other services can be observed. User and informal carers' movements towards empowerment are growing (Nies/Berman, 2004). This development is creating new demands and opportunities for providers, users and informal carers to be active in different ways in ensuring the quality of the care that is delivered and received.

Care at home has been identified as the preferred option of care by most EU citizens and therefore families will continue to play a role in providing long-term home-based care. However, not everyone is capable of providing care and not everyone has family members or friends available to do so. Therefore, a certain amount of formal services must be provided publicly. How then can informal carers and service users be active in ensuring the quality of the care and services they receive? In the participating countries we see that service users and informal carers have started to become active in ensuring the quality of care through shared decision making and consent, choice, satisfaction surveys, and increased information seeking. In this section we explain each of the ways that service users are involved in managing the quality of services received and we present examples from the European partner countries.

#### 3.4.1 Informed consent and shared decision making

In the partner countries a set of ethical principles and/or regulations can be identified that include features to stimulate shared decision making, and empower service users and informal carers to play an active role in care planning. What is common for all countries is that there are systems and models for including the service user in care planning and ways of reaching informed consent. What differs in these mechanisms is whether they are imposed by law (England, Finland, Italy, the Netherlands) or a voluntary guidance for good practice (France, Sweden).

- In Finland, a country where consent practices are supported strongly by law, treatment and services are provided on the basis of mutual consent between health and social care providers and service users. Service users must be given the right to participate in and influence the planning and implementation of their treatment and services. The user and the service provider jointly draw up a plan agreeing on how the treatment, service, care or rehabilitation concerned will be carried out. This is similar to systems in Sweden, England and The Netherlands.
- In England a user's consent should be sought at all stages; from the care planning process to the programme of service delivery. This is true even in situations when service users are not able to make decisions about their care. If a service user does not have the capacity to make their own decisions, the informal carer and any other care provider must follow the Mental Capacity Act. The Act is meant to help guide them in making decisions on behalf of the person and they can only act if it is in the best interest of the person. Even if they lack capacity, the service user must still be engaged as much as possible in decision-making.
- In contrast, in France a legal requirement stipulates that service users and/or their families have to be informed about decisions regarding entitlements to cash benefits and services, but there is no requirement to gain their formal consent or to involve them in the overall decision process. It is only recommended that service users participate in the process and give their opinion regarding the care plan and the care setting.

User involvement, in terms of informed consent and shared decision making is not a common practice in LTC in a number of countries, nor is it obligatory in all cases. Special arrangements are needed and often laid down in legislation for people who have limited judgement capacities.

### 3.4.2 Choice

In the context of New Public Management and the introduction of market mechanisms the notion of 'more choice for users' has heavily influenced the development of emerging LTC systems in Europe. The idea to increase the purchasing power of users by providing them with funds (attendance allowances, personal budgets, direct payments etc.) to purchase services individually has spread in almost all European countries (MISSOC, 2009). On the supply side, the move towards more market-oriented provision has led to the emergence of new private, non-profit and for-profit providers and, in most countries, to additional services and a new welfare mix. However, while users may choose between different kinds of providers, this is not always the case in relation to different types of services or 'care-packages'. Furthermore, the increasing number of (small) provider organisations has contributed to even more fragmentation of LTC and new challenges for co-ordination and integration as efforts to develop and ensure quality across the 'chain of care' are lagging behind. Public authorities who are contracting individual services, rather than 'care packages', have only started to develop quality criteria that go beyond the individual organisation or service. New case and care management approaches as well as concepts for 'commissioning'<sup>5</sup> could be a driver for the future development of such criteria and respective quality assurance.

In most partner countries, entitled service users can choose between purchasing their own care or having their care managed by the authority by choosing between benefits in cash or services in kind, but a range of mixed systems have developed over time (Lundsgaard, 2005; Glasby/Littlechild, 2009).

- In Finland, entitled users may receive a service voucher from the municipality to buy services from the private sector. The service user may then select from a list of providers accredited by the municipality. This system of accreditation can help ensure the quality of care provided by individual services as well as appropriate spending of resources.
- The German LTC insurance stipulates the possibility to choose between a cash benefit and services in kind or a combination of both. While the cash benefit is usually forwarded to an informal carer, entitled persons opting for services in kind may choose between different local service providers that are accredited and inspected by the Medical Service of the Health Insurances. Entitled persons may also choose to move to a care home, where nursing costs are largely covered by the LTC insurance.
- In Austria, England, France and The Netherlands service users can receive cash to directly employ a carer or spend as needed. In Austria it is up to the beneficiary and/or their family to decide how to use the allowance which contributes about €3-4 per assessed hour of care needs. In England, individual and personal budgets and direct payments give service users more choice in

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<sup>5</sup> The term 'commissioning' denotes "a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers "(see [http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/DH\\_865](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/DH_865)) and should be distinguished from pure procurement, tendering or contracting.

the services they use as they are given the money to buy in the services they want. Individual budgets pool money from a number of different health and social care sources (Independent Living Fund, disability benefit, social services, etc) which means that users can often solve problems more creatively than would care that is managed by social services as the budget is less restrictive. However, direct employment means that the service user or their family is responsible for related employer practices, such as payroll and legislative requirements.

- Commissioning practices in England are still an ambivalent mechanism. If authorities acting on behalf of the user as commissioners (e.g. PCTs), it is up to them to select and to contract providers according to established criteria. This may limit the choice at the user level as the selection of available service providers will have been narrowed by the authority, but the procedure also may also offer an opportunity to compose a more appropriate 'care package'

The fact that specific mechanisms for funding LTC have been put in place is an important aspect for emerging and developing LTC systems. Choice is an important indicator for quality of LTC at both the systems and the individual level. Existing tensions between personal choice and commissioning practices across health and social care services as well as between personal responsibility of service users and the quality of services of their choice will remain an important issue for governance and the future sustainability of LTC systems.

### 3.4.3 Client satisfaction

Client satisfaction surveys as a method for measuring quality are used widely in the participating countries. On a general level there are two trends when it comes to measuring client satisfaction. In some countries such as England, Sweden and the Netherlands there are national surveys that are mandatory. In other countries such as France, Finland and Slovenia the surveys are mostly voluntary and carried out as local initiatives by individual providers.

- In France quality of services in LTC is emerging as a high priority topic in the social debate as users and their families are expressing a growing interest in gaining information about the contents and outputs/results of what they could purchase and/or consume. Repeated surveys on behalf of the Ministry of Health, Labour and Finance or LTC stakeholders provide more general information about how users consider LTC issues in terms of financing, governance, caring conditions and out-of-pocket payments, links with their health and labour status, but quality of services is not the main domain being analysed. In this regard no national, public or private, information system based on sound data exist nowadays. Only media, as it has been the case for acute hospitals, are beginning to display various forms of rankings of care homes and of satisfaction surveys which, however, are often poorly designed.
- Countries with mandated satisfaction surveys use for the most part standardised questionnaires to measure the service user's experience of care, which seem to be more developed in primary and acute settings than in home care and nursing homes. In England and France it is unclear how surveys are used to change practice, but in Sweden survey results have monetary incentives with either increased funds for good results or a fine for poor. In Germany surveys on client satisfaction are part of the annual inspections of nursing homes and home care services. The results are expressed in one of the 'care marks' which must be published at a 'well visible location' in the nursing home or the office of the home care service provider – and on the internet. In the Netherlands the CQ-index (Consumer Quality Index) is a standardised system for measuring, analysing and reporting service users' experience in healthcare. The information from the CQ-index can be used by: clients to choose a health insurer or health professional; client organisations

who represent the interests of their members; insurers who want to buy good quality care; managers and professionals who want to improve their quality of care; and the Healthcare Inspectorate to improve its functioning. The CQ-index shows the quality of care from the client's perspective in a standardized way and provides insight in to what clients find important.

- Satisfaction surveys are voluntary in other partner countries. For instance, E-Qalin<sup>®</sup> is a voluntary assessment system based on customer satisfaction used in Slovenia and Austria, partly also in Germany and Luxembourg. It measures residents' and their relatives' satisfaction and stimulates managers in care homes to improve performance within the home.
- In Finland service user satisfaction is assessed both with and without using surveys. On a client level the views of the care recipient are surveyed either ad-hoc or data are collected by regular client satisfaction surveys by the local authorities. Alternatively, if service users in Finland are dissatisfied with the decisions, services, assistance, treatment or behaviour toward them, they may seek a change of decision, file an objection concerning a particular service or treatment procedure to the responsible authority, or complain to the supervising authority. Complaints and objections are handled by the municipal social service ombudsmen or health care ombudsmen, and by the social and health departments of the Regional State Administrative Agencies. Inspections or site visits are not carried out on a regular basis, but only initiated by complaints.

Client satisfaction is a relatively widely used instrument to monitor quality of services. The validity of satisfaction scores is often limited, as dependent people tend to award high rankings to the services they receive, irrespective of more 'objective' aspects of quality. Nevertheless, there appears to be a common feeling that the experience of service users cannot be neglected – in particular when used in conjunction with other user-based measures, they can be an informative source for improvement. New and promising developments in measuring quality as experienced by services users can be retrieved in the context of research on quality of life (see for instance Schallock et al, 2008; Vaarama et al, 2008).

#### 3.4.4 Information

There are strategies in place in a number of countries for systematically communicating information about the quality of available services and providers to service users and informal carers. One of the most basic strategies is to increase transparency by publishing rating scores and inspection reports (England, Finland, Germany, Sweden, The Netherlands).

- In Finland, Sweden and The Netherlands public availability of quality indicators that compare services and service providers aim at helping the service user to make informed choices for care. Service users in Finland are guaranteed transparency of information concerning their health, patient records and waiting periods for treatment.
- In The Netherlands the National Healthcare Authority improves transparency on quality and efficiency and creates a level playing field for care providers to compete. Organisations are required to compile their data and make a report available to the public.
- In recent years in Sweden there has been a growing discussion about client empowerment which is seen to be achieved through increased transparency. The National Board of Health and Welfare provides for instance a guide on older people's care (Äldreguiden) where people can compare different quality indicators for nursing homes and short stay homes online. In some countries reports are available online. Though internet use among older generations is increas-

ing, it is still low compared to other age groups (Selwyn et al, 2003), which means that a large number of service users do not have instant access to these quality indicator reports.

- In France surveys have consistently shown that there is a need for transparency in terms of information about availability, access and choice of providers. The existing information and counselling services, that are targeting also informal carers, have not been evaluated for efficiency at national level.

Although there is a movement towards transparency there are still countries in which systematic information on quality of LTC services is not provided at all. There is some evidence that transparency to the general public may have a positive effect on quality outcomes, even if users are hesitant to change their patterns of service utilisation.

### 3.4.5 Role of informal and non-formal care

Though an increasing amount of care is being provided by informal carers, mechanisms to ensure and measure the quality of informal care is lacking. As informal or family care has been conceived as a matter of private relations based on love and affection, and as a 'cheap' alternative to formal care services, no major efforts have been made to formalise informal care, also in terms of quality assurance. Nevertheless, some first steps towards strengthening the role of informal carers have been made during the last decade throughout the participating countries. The majority of informal carer policies are centred on supporting carers in their caring role, for instance through education and increasing access to equipment. There is also evidence of a growing number of projects and legal regulations concerning informal carers: carers have larger access to resources in the form of money, equipment, and emotional support and they also have rights to flexible working time or leave from work – if they are still in employment – in some of the partner countries (England, Finland, France, Germany), and they might even get an employment status as informal carers in Finland, France, Sweden, Italy and Austria.

The relatively new phenomenon to supplement family care by employing migrant carers has spread mainly in Austria, Italy, Germany and Spain triggering a series of measures and initiatives that will contribute to further blurring the boundaries between formal and informal care, e.g. with compulsory training for employed migrant carers or the extended possibility to pay family carers in the framework of an employment contract (Di Santo/Ceruzzi, 2010). It will thus have to be seen, whether these developments will further impact also on quality assurance in this area.

## 3.5 Summing up

The above depicted overview can be summarised in the below table which demonstrates how the various countries have developed their quality assurance and quality management systems. There appears to be a wide variety between countries, where England, Finland and the Netherlands have the most extensive systems and instruments at the various levels (system, organisational, professional and user).

**Table 1** Overview of Quality Assurance at the system, organisational, professional and user levels

	AT	UK	FI	FR	IT	NL	SI	ES	SE	CH
Legislation	**	**	**	**	*	**	*	***	*	*
Inspectorate	*	**	**	*		**	**	-		**
Accreditation/Certification at a system level	**	***	*	*	***	**	*	*		*
National standards and guidelines	**	***	**	**	*	***	*		**	*
Quality management systems and audits	***	**	**	**	*	**	*	*		**
Benchmarking, monitoring and performance indicators	*	*	***	-	*	**		*	***	**
Improvement measures and processes: towards integrated pathways	**	**	***	**	*	***	*	*	**	
Professional profiles/new professionals/new roles	**	**	*	**	*	***	*	*	*	**
Improvement structures	*	**	***	**	***	**		**	*	
Professional accreditation, registration	**	**	***	*	*	**		*	*	*
Communication and information sharing	-	*	***	-	*	***		*	**	**
Informed consent and shared decision making	*	***	**	*	*	***		-	**	
Choice	*	**	***	**	*	**		*	*	
Client satisfaction	*	**	**	*	*	***	**	-	**	
Information	*	**	**	**	*	***		*	**	
Quality of informal and non-formal carers	**	*	**	**	**	*	-	-	**	-

Source: INTERLINKS, WP 4 National Reports.- Notes: 0 - \*\*\* indicates estimate of emphasis/importance/development within the country; - = no/very little widespread evidence of this element existing; \*\*\* = high priority given to this element within the country; blank cell= situation unknown; no reports available due to non participation of the country in WP4, or lack of information in available reports. Country codes: AT = Austria , UK = United Kingdom, FI = Finland, FR = France, IT = Italy, NL = The Netherlands, SI = Slovenia, ES = Spain, SE = Sweden, CH = Switzerland,



## 4 Looking backward and looking forward

In the following section some transversal issues and puzzles relating to quality assurance and development in Europe will be addressed, reflecting on the developments that were outlined in the previous chapters. These issues mainly concern choices in governance and different approaches to incentivise all stakeholders towards continuous improvement, in particular when it comes to the links and interfaces within and between health and social care.

### 4.1 Tensions and choices in governance

LTC services have often originated in charities, voluntary organisations and “poor law” regulations, i.e. in the context of local or regional social assistance legislation. The growth of needs, the differentiation of the health care system and the modernisation of social welfare policies, however, have moved LTC into the position of an acknowledged area of social security. Though still chiefly relying on unpaid, mainly female, informal care work, social and health policies have been developed to regulate access, governing principles, quality as well as control and inspection mechanisms for LTC services. These processes took place in the framework of European welfare states and respective health systems, calling for political choices that were influenced by national traditions and preconditions. For instance, the role of the central state, the development of voluntary organisations and the third sector, general employment rates and traditions in education and vocational training. In the following, we therefore address some of these choices that have been most influential for the assessment, control and development of quality in LTC. The aim of this chapter is to compare different national frameworks as they have evolved over the past few decades and the bases that have been laid down as a consequence for future development:

- Do central and decentralised approaches matter, when it comes to defining, controlling and improving quality of LTC?
- What impact can be derived from more private or more public provision?
- Which quality mechanisms have been established at the boundaries between health and social care towards the construction of LTC systems?
- Which tools are used to assure and develop quality of LTC?
- Which incentives and disincentives for quality improvement have been built into governance systems?

The national reports demonstrate that quality in LTC requires governance and monitoring. To ensure quality of and access to health care for its citizens most countries have laid down this responsibility in their Constitution. For LTC and social care this responsibility is less clear, if not absent. Governance of quality in LTC is organised at various administrative levels: national (The Netherlands, Slovenia), regional, provincial or cantonal (Italy, Spain, Switzerland) or at both national and regional or municipal levels (England, Finland, France, Germany, Sweden). Given the peculiar welfare mix in the provision of LTC services in most countries, it has to be underlined that multi-level governance in LTC does not only concern the vertical distribution of responsibilities but also the horizontal level. It is thus not surprising that also provider organisations (public, non-profit or commercial) do have an important stake in initiatives to develop and assure quality by means of various mechanisms (see 4.2).

#### 4.1.1 Central or de-central approaches

On a systems level, in all member states quality assurance of health care is a national responsibility, especially when it refers to professional qualifications. Also a number of member states have national funding systems for LTC (Austria, England, France, Germany, The Netherlands), while others have foreseen important responsibilities at local level for funding LTC by taxes or insurance systems and/or for regional and local legislation (Austria, Finland, Italy, Sweden, Switzerland). Moreover, in a number of member states, national frameworks exist for quality in LTC and social care, expressing what is desired or required at regional or local level (Austria, England, Finland, France, Germany, Italy, Sweden). However, in some of these countries it is a local or regional responsibility to integrate national recommendations according to their idiosyncrasies (England, Finland, France, Italy). Local care provision is in some countries monitored at national level, providing feedback on performance to local or regional authorities (England, Finland, Sweden, The Netherlands). Other countries position responsibilities for monitoring and ensuring quality more at the local or regional level (Austria, Finland, France, Spain, Switzerland). The development of quality systems, standards and indicators is in some member states organised at national level but implemented at a local level (England, Finland, France, Spain, Sweden). In a number of cases local authorities are free to use the national indicators as examples and apply them according to their preferences (England, Finland, France).

The most centralised model can be found in the Netherlands: a national insurance system for health and for LTC and a national tax based system for LTC as well as respective legislation, inspection and quality assurance are regulated at national level. The quality framework and corresponding indicators, applicable to all LTC services, have been developed by the joint national stakeholders.

In the more decentralised countries, service provision differs a lot across the nation (Austria, Switzerland, Finland, Slovenia). This may be a reason why support and development of quality management are discussed at national level, in order to meet national standards of quality (Austria, England, Finland, France, Germany, Slovenia, Sweden, Switzerland). In Austria, for instance, efforts to develop professional qualification and education standards for social care at national level were considered as an important improvement, as regional regulations had hitherto resulted in enormous differences. Moreover, some national governments stimulate the transfer of innovations and good practices, and nationally developed guidelines and standards for better care (Austria, England, Finland, France, Germany, Sweden, The Netherlands).

For more centralised member states, a tendency towards decentralisation of responsibilities can be observed, partly for budgetary reasons, but also in order to better meet local or regional peculiarities (England, France, The Netherlands). Regions and municipalities are therefore increasingly in charge of regulating the provision of care services and even setting up their own quality regulations within guidelines approved at a central level. When these responsibilities are actually shared by several levels of governance this may create further challenges of coordination between different regulatory bodies (Table 2).

Another concern is that decentralisation may lead to differences in quality standards within countries – Table 3 provides an overview of examples for residential care.

There are arguments for and against both decentralisation and centralisation. The advantage of national governance of quality assurance is that economies of scale are applicable: national quality

standards and indicators, as well as monitoring systems can be developed, national inspection schemes can ensure quality standards, large scale benchmarks are possible as comparable data across the country are available (cf. Finland). Thus, centralisation may lead to a higher level of technical quality of legislation, funding and instruments to ensure a more equal distribution of services across the country. Moreover, inefficiencies can be avoided, as every region or canton does not have to ‘invent its own wheel’. Finland and England try to overcome ill-considered regional differences by defining a national framework and a national set of quality indicators to be selectively implemented at local level.

**Table 2 Division of tasks between different levels of government regarding quality**

<i>Country</i>	<i>Higher levels of government (central or federal)</i>	<i>Intermediate levels of government (regions, cantons or provinces)</i>	<i>Lower levels of government (municipalities)</i>
<i>Austria</i>	Regulation of quality of health care (training, staffing), procedures and principles for restriction of patients.	Regulation of quality of social care (staffing, training, standards); setting minimum standards of care.	Provision and organisation; ‘Care Home Commission’ (Vienna)
<i>England</i>	A central public body, the Care Quality Commission regulates and assesses quality on service level. Local governments are assessed on how they commission services by a Comprehensive Area Assessment. Professional training standards are set by professional bodies and government.		
<i>Finland</i>	Regulation of quality of health and social care (qualification, duties, licensing an authorisation of health care professionals). Supervision and guidance of municipalities and Regional State Administrative Agencies in executing legislation and supervising its implementation. Handle complaints in case of death or suspicion of malpractice resulting in serious disability. Recommendations for quantitative and qualitative targets for service structure and staffing level (minimum standards).	The Regional State Administrative Agencies guide and supervise public and private health and social care services (quality standards), ensure that both public and private services comply with legislation and license private health and social care providers. They also handle complaints and objections.	Responsibility to arrange health and social care services, and mainly responsible for monitoring health and social care services that they organised (public, private, third sector). Complaints and objections are handled by municipal social service and/or health care ombudsmen. As employers, municipalities are responsible for providing and financing further education and training of staff.

<i>France</i>	<p>The general direction for social affairs (DGAS) and the direction for hospital organisation (DHOS) of the Ministry of Health and Social Affairs are responsible for national legislation.</p> <p>Statutory bodies and national agencies (CNSA, ANESM, ANSP) have issued national reference guides.</p>	<p>The General Councils of the Départements are responsible for organising LTC and monitoring the quality of the delivered services by authorised organisations in coordination with the decentralised directions of the Health and Social Affairs administration (DRASS).</p>	
<i>Italy</i>	<p>The Ministry for Health and Social Policy defines essential levels of health care social, criteria to separate free from paid services (needs and means-tested), and criteria for the accreditation of services, to be followed by regional laws.</p>	<p>Regional governments are responsible for ensuring the service network and for quality assurance of local services.</p>	<p>Local Health Authorities and Local Councils organise services.</p>
<i>Slovenia</i>	<p>The Ministry of Labour, Family and Social Affairs is responsible regulating and monitoring quality in institutional care.</p>		<p>Responsible for provision and organisation of home care and licensing of providers. Supervision of quality in home care.</p>
<i>Spain</i>	<p>The 'Dependency Law 39/2006' stipulates the promotion of quality in LTC to ensure the efficiency of services. It establishes the System for the Autonomy and Attendance to Dependence (SAAD). This Act is supported by an agreement about common criteria to guarantee the quality of services.</p>	<p>Quality legislation depends on the Autonomous Communities (AC). Not all of them have quality legislation at the moment and the legislation from one AC is not valid in another.</p>	
<i>Sweden</i>	<p>National quality indicators are set through the National Board of Health and Welfare.</p>	<p>County Administrative Bodies supervise compliance of Municipalities (that are responsible for elderly care) with legislation. They manage medical and health care.</p>	<p>Responsibility for arranging LTC for older people and monitoring these services (public or private).</p>
<i>Switzerland</i>	<p>Oversees the implementation of dispositions relative to quality of care.</p> <p>May mandate controls on quality and delegate their implementation to professional associations.</p>	<p>Cantons are responsible for devising and implementing quality control policies and minimum standards in LTC.</p> <p>Cantons are grouped in 4 regional conferences that act as coordinating entities to harmonise cantonal arrangements and legislation.</p>	
<i>The Netherlands</i>	<p>The Ministry of Health regulates quality assurance of or-</p>		<p>Based on the law for social support/participation (Wmo)</p>

<p>ganisations and individual professionals.</p> <p>Multiple public and private supervisory bodies exist, presently co-exist.</p>	<p>the mission of the Wmo-service counter is a customer-focused, efficient, and uniform implementation of the AWBZ (Exceptional Medical Expenses Act).</p> <p>Insurers should have equal rights.</p> <p>The Wmo-service counters should maintain a close relationship with health care providers and client organisations in the region.</p>
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**Table 3** Intra and inter-country differences in quality regulations in residential care

<i>Country</i>	<i>Structural quality</i>	<i>Staffing and training</i>	<i>Quality management systems</i>
<i>Austria</i>	Maximum limit of places per care home in place only in some regions (e.g. 120 in Upper Austria and 50 in Carinthia).	Staffing ratios vary between regions, as well as the staffing structure (registered nurses, assistant nurses, assistants).	Only some regions demand proper care documentation and a quality management system to be in place (Vienna, Lower Austria and Tyrol)
<i>Finland</i>	The same rules and regulations concern the whole country but there are variations in services and quality of services between regions and municipalities.	The same rules and regulations concern the whole country but there are variations in staff ratios and staff mix between organisations.	Municipalities and organisations are free to choose their quality mechanism.
<i>Spain</i>	Differences as to minimum areas for rooms and existence of specific spaces (e.g. rehabilitation rooms) in institutions.	Staffing structures, staff ratios and the way these are calculated (e.g. some regions stipulate the minimum requirements in terms of hours of care, rather than staff ratios) vary between regions.	

However, as geographical, economic and cultural differences within EU member states exist, systems that are sensitive to local or regional differences are required (see for instance Finland, Italy, Spain, Switzerland). The principle of ‘one size fits all’ does not apply to geographically large nations or nations with large regional and cultural variation, such as Switzerland, Spain and even France.

Decentralisation may hamper comparability of quality outcomes (benchmarking, accreditation etc.), but it can go hand in hand with standardisation of quality assurance methods and instruments that are applied across regions. Some systems are applicable across the country, even if it is very decentralised (Switzerland). There are also quality indicators and methods that are operated across national borders but not universally applied within one individual country (e.g. E-Qalin<sup>®</sup> in Austria,

Germany, Italy, Luxemburg and Slovenia and RAI in Finland, Sweden and other countries). In these cases it is a matter of entrepreneurship of those who provide quality systems and those who use them. In several cases it is up to the care providers or local authorities to choose a quality system or methodology (Austria, France, Italy, Slovenia, Spain, Switzerland). However, if financing of such systems depends on (poor) local level financing, their implementation will be a cumbersome task (England, Slovenia), in particular if systems are used on a voluntary basis and no other incentives are given.

All countries encompass some form of inspection for health care and often also for LTC services. However, LTC inspection tends to be much more decentralised and is often restricted to structural quality indicators that are not often based on evidence. For instance, in Austria, there are nine different regional standards for staffing levels for care homes, partly depending on the composition of residents' levels of care needs and reaching from 1:1 with at least 40% of Registered Nurses to 1:20, of which only 20% Registered Nurses. Indeed, there is no evidence, whether quality of care homes is dependent on a specific composition of staff.

The various administrative levels, on which health and social care and emerging more autonomous long-term agencies are organised and governed, remains a problem for both vertical and sometimes even horizontal coordination and the provision of seamless services in most countries (e.g. Austria, England, Finland, Sweden). With quality assurance systems operating alongside each other it is often difficult for users to compare services and performance. It is thus high time for the development of quality management and quality assurance practices that cut across geographical and organisational boundaries.

#### **4.1.2 Public or private provision**

Member states differ with respect to the extent to which care provision and service delivery on the one hand, and quality management on the other hand are a public or a private responsibility. In most countries, LTC as such is only partially considered as a public responsibility. In any case, co-payments are much more common and much more important than in the acute sector. For instance, in Slovenia children are obliged to pay for their parents' care if costs of LTC exceed public funding and exceed their assets.

The majority of care providers of LTC are either run by public authorities and/or private non-profit organisations (Austria, Italy, England, Finland, France, Slovenia, Sweden, Switzerland, The Netherlands), with a growing share of for-profit providers in Austria, England, France and The Netherlands, but also in Finland, Germany and Sweden. Usually, LTC services need to meet the same requirements, whether they are public, private, for-profit or not-for-profit. In some countries, significant differences exist between regions with regard to public or private service delivery (Spain). However, there may be an exception to this rule. If providers do not receive public funding and are entirely paid by the service users, they do not have to fulfil any requirement and thus do not have to obtain an accreditation. Some private providers do not apply for public funding (Austria). In Italy accreditation of public services is compulsory, while it is voluntary for private providers even though only accredited providers are entitled to receive public funding.

While health care elements of LTC have a certain tradition for being subject to public quality control, social care elements – especially if no public funding is concerned – are often beyond the remit of public quality measures (Austria, Italy, Spain, Switzerland, The Netherlands).

The lack of control thus plays an increasing role where individual budgets or cash benefits for people needing LTC have been introduced (Austria, England, France, Italy, Slovenia, The Netherlands). Positively formulated, this type of LTC funding bestows purchasing power on service users (Austria, Germany) as users can directly contract the services they prefer, public or private, if they are accredited as service providers (Austria, France, Spain). In some systems the budgets can also be used outside the formal care system: informal networks (friends, neighbours, family) and the emerging 'grey' area of migrant carers (Austria, France, Germany, Italy) are thus obtaining a crucial role in the delivery of care (Di Santo/Ceruzzi, 2010). They provide flexibility and have the potential of giving more say to the service users. However, misuse or sometimes abuse, due to the users' frailty and dependency, has also been reported. In this context a wide range of quality issues and legal regulations still remain to be stipulated in all systems, reaching from general policy concepts (personal freedom and self-determination vs. public funding and control) to labour law and standards with respect to training, employment and social security. Furthermore, the consequences of this phenomenon in the countries of origin remain to be considered.

Reliance on competitive markets or market-like arrangements (quasi-markets) to assure the provision of care is a widespread trend in LTC in Europe (Huber et al, 2008). This tendency has met with various preconditions, e.g. in continental Europe with strong third-sector organisations (non-profit organisations) catering for LTC services, or in the UK and Nordic countries, where exclusive public provision had been the key principle in social and health care. In all systems, however, the introduction of market mechanisms was linked to the appearance of a new set of stakeholders and a growing discussion on quality in LTC: private providers, their umbrella organisations, or private health or LTC insurance companies to mention a few.

An increasingly repeated argument for the advantage of quasi-markets of care has been that enhanced competition brought by private providers would bring about gains in quality as providers compete to gain the users' preference, while at the same time an increase of responsiveness to users' needs bring about gains in efficiency (Huber et al, 2008). Still, as financing remained mainly public and with public authorities as purchasers of services, new regulatory frameworks have been introduced to define and control quality ex ante and to replace traditional trust in professional ethics by contract relationships. Many private providers (profit and non-profit) have therefore started to implement quality certification of their services. This certification emerged without formal external pressure but was also in many cases an intrinsic interest of private providers as public authorities often failed or were not able to define compulsory quality regulations. Providers may also have sought to signal their commitment to quality by supplementing the existing legal quality requirements with a third party certification due to different motivations: the need to signal quality, a true commitment to quality of services, the pursuit of perceived increased efficiency and cost-effectiveness or as a way to enter the established LTC market, which may have been dominated by public services (Finland, Sweden) or large non-profit organisations (Austria, France, Germany). In general, transparency is becoming more important the more LTC quasi-markets are characterised by competition between different types of providers (Austria, France; see also: Porter/Weisberg, 2006).

Still, there are contradictory signs as to what extent quasi-markets have led to improvements in quality of services. Contracting of services has often been based mainly on price criteria, rather than quality. As money is easier to operationalise than quality, in a number of cases insurers or authorities are mainly concerned about cost control, rather than about quality assurance (England, France, Switzerland). Authorities have also used their market power as purchasers to bring down prices through competition, thus putting pressure on providers to cut their costs at the expense of

quality standards (for England: Kendall et al, 2002). The incentives to improve quality may thus have been jeopardised. In addition, contracting, though sometimes even called commissioning, was always reduced to individual services – sometimes, as in the case of spot purchasing, even to very short-term delivery – rather than to a ‘chain of services’ which would be an indicator for emerging LTC systems. Finally, competition seems to be detrimental to emerging LTC systems for two additional reasons: On the one hand, some authorities have produced new monopolies of (private) providers by tendering services for an exclusive geographical area. On the other hand, opening the market for a range of competing providers might result in reduced cooperation between these organisations, rather than for integrated service provision.

The idea that quality could play an important role in driving the choice of users has also failed to be completely tested, as users are faced with lack of information as well as with financial and mobility constraints that often prevent them from choosing providers exclusively on the basis of quality.

In some cases, the above mentioned new stakeholders have taken up responsibilities in the supervision of quality of care provided by their associates. As an example, in France, the umbrella organisations of private home help providers have been called upon to supervise the work of their associates, based on their supposed expertise in management in LTC. This reliance on providers’ umbrella organisation for quality assurance goes hand in hand with the observed trend in some countries towards self-regulation (see also England, Austria, Germany, Finland).

Once quasi-markets have been introduced, another issue is to guarantee equal opportunities for all kinds of providers. In at least one country (France) the opening of care provision to private providers entailed differences in quality regulations according to the nature of providers (authorization procedures for home care agencies are subject to different legislative bodies and criteria according to providers being private for profit, private non-profit or public).

#### **4.1.3 From inspection to self-regulation of quality**

Traditionally, authorities responsible for quality control have relied on inspections to assess quality in LTC. While inspections are still very much part of public authorities’ procedures to ensure adequate quality, self-regulation and self-assessment are increasingly gaining ground. Part of this trend is associated with the push from structural quality indicators to outcome oriented indicators and to quality management methods, as well as with the take-up of responsibilities by umbrella organisations of providers. However, in several countries there are concerns over the fulfilment of supervising tasks by these umbrella organisations (France), if left unchecked by public authorities.

Control can also be exerted by other stakeholders such as health insurance companies, in which case quality appears linked with concepts of cost-efficiency, or by (private) third parties in the context of classical quality management tools such as EFQM or ISO 9001ff. (Switzerland).

Parallel to the above mentioned trend towards increased self-regulation a move from purely administrative approaches to quality towards self-assessment (e.g. ‘Angelique’ in France or E-Qalin<sup>®</sup> in Austria and Slovenia) and third party certification can be observed. The difference between these quality management approaches and ‘pure’ inspection is that the former are aimed at triggering a continuous improvement process, while the latter is often perceived as a bureaucratic control mechanism. Still, the introduction of quality management is often subject to failure, if staff and



other stakeholders are not adequately enabled to participate in the assessment process and the implementation of improvement measures.

Public disclosure of information of quality assessments remains a delicate procedure, even if advocated as part of the market mechanisms introduced in the provision of LTC. This stems from the above mentioned limitations that users may have in actually relying on quality to choose their care provider. Another issue in this context concerns fears that 'public humiliation' could have counter-productive effects by seducing providers to mask their reporting in a favourable way. In any case, the Netherlands, Germany and England have paved the way for a more transparent information by creating public websites where quality reports of services and care homes can be retrieved and compared.

#### 4.1.4 Quality assurance or improvement?

All countries surveyed have defined quality standards linked to authorisation or accreditation procedures necessary to deliver services and receive public funding, or reimbursements from health insurance. Such standards serve as mechanisms to ensure the fulfilment of minimum criteria, but they are not able to motivate providers to trigger a continuous improvement process.

Existing standards are still very much focusing on structural or process quality, rather than on the outcomes for the individual in need or other relevant stakeholders, e.g. family or staff members. However, there are signs that practices to actively approach the importance of professionals' interaction with older people in LTC have definitely improved with the introduction of methods like dementia care mapping, biographical working and a more active involvement of informal carers (Austria, England, Finland, Germany, The Netherlands). Another development pointing in the same direction, i.e. towards a more user centred approach to quality, is the institution of Service Charters by regions in Italy and a more general 'Charter of Rights for People in Need of Long Term Care and Assistance' in Germany.<sup>6</sup>

Very few countries have thus far set up quality targets to be met. The few that have done so, have set targets for staffing levels and qualifications (Finland, Spain), structures (The Netherlands, concerning for instance shared rooms in care homes; Austria) and in some cases for service structure on a systems level, e.g. in Finland municipalities have set targets to be met by 2012 on the share of those aged 75 and older accessing different types of service.

From the profusion of quality management systems that have been introduced in different regions and municipalities across Europe, no clear frontrunner system seems to have emerged. Even within countries there is the fear that benchmarking of care services will become impossible in the midst of such diverse quality procedures and indicators gathered.

Apart from the lack of mutually agreed indicators of quality in the chain of services in LTC, one of the main difficulties seems to be that legally implied quality management is seldom underpinned by

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<sup>6</sup> This Charter forms an important basis for the criteria, against which care homes are assessed on a voluntary basis by the German interest organisation for users of housing and care services (BIVA). Trained volunteers are assessing interested care homes and the results are published on [www.heimverzeichnis.de](http://www.heimverzeichnis.de). Failure in one or more of the criteria includes the offer for consultancy on potential improvements.

respective supporting or enabling measures such as training of staff, organisational development, funding of improvement projects etc. to promote continuous improvement within and between organisations.

## 4.2 Interlinking health care, long-term care, social care and prevention

Quality regulations still reflect the boundaries between health and social care, and the still under-developed identity of LTC in most countries. A “silo approach” is therefore still very much present. This in turn leads to a fragmentation of responsibilities between a wide range of bodies. In this context it is not uncommon for quality in LTC to assume a subordinate role to health – the merger of the Commission for Social Care Inspection and other organisations into the Care Quality Commission in England, or the debates in France to subordinate social and health care services to health care regulations could figure as examples. Another consequence of the social and health care divide can be that social care might not even be taken into account at all, when quality issues are discussed in the context of health reforms (Austria, Slovenia).

Most national reports demonstrate that the LTC sector has no distinct place in the system. A patchy landscape of funding and legislative systems, providers and other stakeholders (Austria, France, Finland, Italy, The Netherlands, Slovenia, Spain) can be observed, with fragmented funding and quality assurance systems. Even within countries, different views on social security and, therefore, on LTC may exist (Switzerland, Spain). For instance, the French speaking cantons in Switzerland have based their policies on home care, while the German speaking cantons have retained policies emphasizing care homes as an option (Ruedin et al, 2006). The view on public funding of LTC may also differ: Is LTC a universal right each citizen is entitled to in analogy to health? Does LTC need to become a part of the social insurance system, comparable to health care? Or is the main aim in LTC to avoid poverty by means of a social assistance rationale, with users having to pay most of the services themselves?

Unsurprisingly, the social and health care divide can also be observed in relation to quality assurance. There is hardly any correspondence between quality assurance systems in health care, LTC, social care, prevention, informal care and support provided by volunteers. While these differences are mainly due to differences in professional and organisational cultures, there are, however, several policy initiatives to improve integration and the quality of coordination mechanisms.

- In England, the Health Care Commission, the Commission for Social Care Inspection and the Mental Health Act Commission were merged in April 2009 with the intention to reduce the incompatibility in quality criteria that apply to integrated services. The implementation of this integration at administrative level is still ongoing.
- In Spain the ‘Act on the Promotion of Personal Autonomy and Care for Dependent Persons’ aims to ensure quality, sustainability and equity of services covering LTC. Integration of services is part of the quality requirements of this regulation. But again, implementation appears to be difficult: this holds for the connection of LTC with health care, but also with prevention. While a new Ministry of Health *and* Social Policy has been installed recently in order to improve links between health and social care, legislation on LTC has not been developed in the same perspective, even if, in some regions, case management is being implemented. National policies at the interface between social and health care thus stand on shaky ground (Rodenas et al, 2008).

The fragmentation of responsibilities regarding quality does not only arise from the division between health and social care, or from the different levels of government with the occasional participation of umbrella organisations. In some countries, even within the same level of government a further compartmentalisation of tasks is found as several bodies are responsible for different procedures regarding quality.

- In France, the ANESM (National Agency for Assessing LTC Organisations) takes on the responsibility for staff recertification, accreditation of providers and criteria setting for best professional practice; while the CNSA (National Fund for Autonomy and Solidarity) fosters research, new services and innovation in organisation. Another set of organisations – the CNSA and the ANSP (Agence Nationale des Services à la Personne) – work towards enhancing skills and expertise of staff, which in turn require further coordination with the Labour and Education Ministries. The proliferation of acronyms within care systems of some of the countries illustrates this fragmentation (see France and the Netherlands), but these new institutions could also stand as a positive sign of differentiation of LTC systems.

As LTC systems still are in a differentiation phase, it has been questioned whether full integration of health and social systems was desirable and attainable at all (for a discussion of the added value of integration versus co-ordination and linkages between services, see: Leutz, 1999; 2005; 2009). In any case, the complexity of and the variety in arranging care and services at client level calls for more consistency and the reconciliation of different professional cultures. The national reports reveal four promising options in this respect:

- integration at the local level
- integration in the context of care pathways
- integration at professional levels
- funding mechanisms to promote integration of care and service delivery

In many countries we can observe policy initiatives to *integrate services at area level*. For instance, in Finland municipalities have the obligation to integrate healthcare, LTC, social care and prevention for their citizens. Therefore, local strategies have to be drafted by a wide variety of stakeholders. The strategies should cover areas such as community planning, traffic and housing, cultural and recreational activities, education and participation, wellbeing and health. Furthermore, regional networking of primary care units is encouraged in Finland. In 90% of The Netherlands regional networks of dementia services are developed, with users' inputs as the point of departure. At this moment, integrated packages of care for dementia patients are contracted by the regional offices for the Exceptional Medical Expenses Act. Performance indicators are developed to monitor the actual quality of care delivery (Nies et al, 2009). Also in France similar experiments for Alzheimer patients into the integration of services have been launched in 18 different areas.

In Italy, there is national legislation with the aim to integrate the health and social care system on a local level, though implementation has still a long way to go. In England, quality indicators at local level are issued, related to timeliness of acute and social care delivery, assessments and care packages. Also in Spain, LTC legislation requires local authorities to develop networks of services to integrate a variety of services but quality indicators across services still do not exist. In some countries instruments for monitoring integration of services across sectors have been put in place (England, Finland, Italy, Sweden, The Netherlands) or are being developed (France), though it seems that most of these measures are either lacking sensitivity and reliability or they follow models from the health care system.

Another method of integration has been proposed in terms of *care pathways or clinical pathways*. These strategies to integrate health and social care processes for specific user groups are based on guidelines and evidence (if available) and have been primarily developed in the acute sector (Vecchiato, 2004). The concept of care pathways appears to be primarily applicable at the interfaces between acute and LTC care, in particular in the ‘traditional’ areas of disease management for diabetes, cardiovascular diseases or stroke (Austria, England, Finland, France, Italy, Sweden, The Netherlands). Moreover, care pathways are also elaborated for some more ‘typical’ geriatric diseases or conditions such as Parkinson’s Disease, dementia and palliative care (Austria, Slovenia, The Netherlands). Also, some interlinking processes are standardised accordingly, such as discharge policies, coordination mechanisms between primary and secondary care, and assessment procedures (Austria, England, Finland, France, Slovenia, Sweden, The Netherlands). Performance indicators and respective standards are to be developed (The Netherlands). In these forms of integration the acute sector often plays a dominant role, for instance in the Health Platforms that are developed in Austria. Though such approaches have nowadays been chosen in most countries, it is interesting to observe that each of them (sometimes even individual regions) have developed own pathways rather than learning from forerunners. In this respect, some transnational initiatives in the context of EU programmes such as PROGRESS (DG Employment) should be mentioned – several projects are currently co-financed to develop mechanisms for the definition, measurement, assessment and improvement of quality of social services of general interest, including those for older persons and people with disabilities.

At the *professional level* several countries are introducing new professional roles, such as case managers as bridge-builders between organisations and/or advocates of users (Austria, England, Finland, France, Italy, Slovenia, Spain) and as facilitators of multidisciplinary working across services (Finland, France, Slovenia, The Netherlands). These new roles and ways of working require additional skills and instruments. Also quality management has become an explicit job profile in the area of LTC, with instruments such as RAI HC, E-Qalin<sup>®</sup> or EQ-5D as methods explicitly designed for LTC services (Austria, Finland, Sweden).

A fourth way to integrate the various silos around LTC consists in the construction of incentives for stakeholders by means of funding mechanisms (see also Section 4.4 for incentives concerning the introduction of quality management). In this context, two types of mechanisms can be observed. One approach is to provide money or vouchers to the users in the form of individual budgets, direct payments and/or cash allowances (Austria, England, The Netherlands). In its most consumerist application this means that the user can choose to spend his/her money according to his/her needs and preferences. However, information and transparency of the (quasi-)market which are indispensable prerequisites for choosing services, are quite shaky in most countries. The same is true for the amounts of benefits. In spite of relevant websites with consumer information (England, The Netherlands), choice that is based on realistic data may be difficult (England). In any case, these financial instruments create competition between service providers, rather than integration. In such a context it is the service user, respectively his or her representative, who has to be the integrating factor according to his or her purchasing power, competences and other resources. The second approach to enhance coordination by funding mechanisms is to pull funding together at the level where commissioning takes place. An example is the creation of Primary Care Trusts that act as commissioners of integrated services (DH/Commissioning, 2007).

There is little research and evidence concerning integrated care and its effectiveness and cost-effectiveness. One example for such research was reported from Finland, where a project entitled ‘Integrated Services in the Practices of Home Care and Discharge’ (PALKO) was carried out from

1997 to 2007. The aims of the project were to develop, implement and evaluate a new approach in the practice of hospital discharge and continuing care at home, called the PALKO model. The contents of the PALKO-model include clients' self-determination, human-centred care, proactive discharge planning, integration of services across interfaces and organisations, and seamless and continual transfer of information. The PALKO-model decreased the use and cost of services and showed some improvements in health-related quality of life. The results of the PALKO-project suggested that, by developing the discharge and home care practices according to the PALKO-model, municipalities will be able to offer services to their older citizens more efficiently (Hammar et al, 2009; Perälä et al, 2004).

In spite of all these instruments and initiatives, the connection between LTC systems and the quality of informal care, respectively care and support by volunteers remains poorly developed, even if some first steps can be identified. In England, the 'Carers (Equal Opportunities) Act' aims to ensure that carers' needs for education, training, employment, and leisure are recognised and supported. The Netherlands ensure in needs assessment that usual informal care is provided. In Finland, the Act on Support for Informal Care (937/2005) defined informal care as a statutory social service, with the municipality being responsible for organising support that includes a care allowance, leave and any necessary services to support both the caregiver and the person being cared for.<sup>7</sup> In line with legal requirements (Social Security Code XI, § 45) the German LTC insurance funds offer courses for informal carers in order to improve the quality of care. The courses provide family carers or other interested persons with a basic knowledge of home care for old and frail persons, strategies to ease and improve care as well as conflict management, and they teach essential hands-on techniques in looking after persons in need of care.

### 4.3 Incentives and disincentives for quality improvement

It has proven difficult for public authorities to establish adequate incentives for providers to enhance quality, as providers are faced with trade-offs between keeping operating costs low and improving quality. The same holds for public entities acting as purchasers of care services in quasi-market settings as they try to conciliate improved quality with budgetary constraints.

The question of incentives also affects staff qualifications. Training courses for social workers and home helps in France have not met the anticipated expectations of success, as qualified workers may expect to have a relatively low return from their investment in qualifications (the wage of a home care nurse with the highest diploma is still only 20% above the minimum wage).

Still, internal or external incentives remain important contextual aspects for the implementation of quality management systems. In various countries care providers need to meet certain standards, apply defined instruments and report on performance indicators in order to qualify for registration (Austria, England, France, Italy, The Netherlands, Spain). Authorisation (Austria) and/or accreditation (France) is a prerequisite to qualify for public funding (Italy), but often also to operate on the private market (Finland). In Italy a so called Service Charter is required: an instrument which de-

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<sup>7</sup> The caregiver is entitled to three days leave/month which is paid by the municipality/state as well as the support for informal care, which is a social benefit that amounts on average to €416.25 per month.

scribes the services supplied, duration, professionals involved, access conditions, operating times, waiting lists, prices and users' rights and duties.

This mixed and often contradictory set of motivations also applies to sanctions and transparency. 'Public pressure' on providers by the disclosure of quality reports might have the opposite effect, leading providers to bias their reporting. Authorities are also reluctant to sanction bad performance by closing down services or care facilities as it may reflect badly on their own previous performance as non-compliance might be a consequence of poor budgeting, which is a responsibility of the commissioning or contracting agencies (England). The closure of facilities may also create difficulties in providing alternatives for users or residents with the risk of short-term deterioration of the users' situation (France).

Usually, governments apply a stepwise system of sanctions upon inspection. If care providers do not meet certain criteria, sanctions are enforced according to the duration and/or the extent of non-compliance. Such sanctions reach from public warning and fines to the suspension of service delivery and the withdrawal of registration (England, Finland, Spain, The Netherlands). These sanctions are imposed by public authorities (England, Finland, France, Spain), sometimes on different administrative levels, according to the importance of sanctions (Spain). In some cases, inspection, administration and provision of care and services might be gathered within one governmental body so that it is doubtful, whether the principle of 'third party' inspection is always followed (Austria).

In some countries quality assurance is not only focusing on providers, services or professionals but also on the local or municipal level (England, Finland, Italy). This mechanism assures that commissioning bodies and/or local authorities have to provide transparency concerning defined quality standards themselves.

In England and Finland, also positive incentives for meeting the standards are foreseen in terms of financial rewards (pay-for-performance) and greater freedom in setting priorities. Furthermore, star ratings in England can be achieved according to the level of functioning. Public labelling as providing high or poor quality can be an important incentive for quality improvements, as their status and legitimacy is being publicly challenged. Good or bad marks may have an impact on users' choices for these organisations and on the position on the labour market for the particular providers: as there is shortage on the labour market, well qualified professionals prefer to work for high performing organisations. However, public labelling is still not common practice in most countries. The fear of public blaming and shaming may be stronger than the reward of being seen as a trustworthy sector (Austria). The German website [www.heimverzeichnis.de](http://www.heimverzeichnis.de) has solved this dilemma by publishing only results from provider organisations which fulfil the criteria for quality of life in care homes. As participation is voluntary, those who are mentioned have a competition advantage; for the others it remains open if they failed to reach the threshold or if they have not yet applied for an assessment.

As inspection and monitoring are often externally imposed, there are also internal drivers for care providers to apply quality systems. Registration, accreditation and certification are often required to operate within the system. These instruments may also have the function of creating trust of the population and thus of service users and relatives (Austria, France, Italy). Therefore, these measures of self-assessment may improve their position on the public and private market.

The application of existing systems for internal quality assessment or external audits are driven by external factors and intrinsic interests of provider organisations. For instance, it may be encourag-

ing for organisations to improve their performance if benchmarking is possible. Appropriate quality methodologies and instruments facilitate improvements of processes within the organisation: when it comes to organisational learning and organisational development, they may support training methods and empower staff and service users. Ideally, this pays off in the performance of the organisation (Austria, Finland). When quality appears to be too poor, national programs or support may be organised to improve the organisational performance, for instance on quality issues such as falls prevention, reduction of prevalence of pressure ulcers, poly pharmacy, and pain control, but also on 'soft' factors concerning the satisfaction of users, staff and relatives, leadership and sustainability. Quality management may render services more transparent and contribute to the dissemination of good practice (Austria, Finland, Spain, The Netherlands,). Performance comparisons or even benchmarking need, however, clear objectives and ways to support improvement measures, rather than pure media interest in rankings and 'bad news' from LTC.

#### 4.4 Dimensions and perspectives

Quality in LTC embraces multiple dimensions, reaching from quality of care and quality of life aspects to quality of management, governance and contextual determinants. It has already been mentioned that Donabedian's conceptual framework in assessing structural, process and outcome quality has been widely acknowledged in health care, and over the past few years also increasingly in LTC. The corresponding indicators for quality of care usually include effectiveness (appropriateness, competence), safety, responsiveness (often referred to as: patient-centeredness and including values such as acceptability, continuity and timeliness), accessibility, equity and efficiency (Kelly/Hurst, 2006).

Over the past decade quality of life indicators have gained ground as a measure for outcomes in LTC (Vaarama et al, 2008; Faulkner et al, 2006) as they encompass four key areas:

- Physical health and functional abilities
- Psychological health, subjective well being and life satisfaction
- Social networks, activities and participation
- Socio-economic conditions and living environment

Furthermore, both in the acute health care sector as in LTC, quality can be assessed from different perspectives: users and professionals (staff, managers), informal carers and other interest groups, but also from the organisational or from a systems level.

From a service user perspective, quality of life seems to be a more significant concept than quality of care. In this dimension, values are addressed such as human dignity, respectful communication, autonomy, choice and control, user centeredness, privacy/confidentiality, intimacy, safety, wellbeing, comfort, rights and empowerment, social participation (or a positive social contribution), normalisation and access to care and services, end-of-life care (Austria, England, Finland, France, Germany, Italy, Slovenia, Spain, Sweden, Switzerland, The Netherlands). These values are operationalised by means of user experience and/or consumer satisfaction measurements. Moreover, records, process indicators, rules and regulations reflect the implementation of these measures. For instance, it can be checked how informed consent is applied, what information is given to clients, how complaints are treated and how long waiting times are (Finland). Apart from these measures, also health outcomes are measured and monitored, by means of indicators such as falls, prevalence

of pressure ulcers, polypharmacy, (mal)nutrition, incontinence, behavioural problems, depression (Austria, France, Finland, Spain, The Netherlands). It requires sophisticated case mix control to ensure that data are comparable.

From a professional perspective, quality of care is monitored in almost all countries by professional tools (protocols, guidelines, records, care plan) and defined processes (programs, needs assessments, procedures, coordination, measurements of timeliness, defaults, accidents, safety), though more frequently in health professions than in social care professions. Further, reports on professional qualifications, training and staffing ratios are frequently used as indicators of quality of care (Finland, Italy, Spain, Switzerland). Also service users' feedback and employees' satisfaction questionnaires appear to be useful instruments (Finland, Italy, The Netherlands).

From an organisational perspective, aggregated outcome indicators on quality of life and quality of care, as described above, are frequently used inputs for quality management, but indicators focus more on procedures concerning information, complaints or safety. Quality of life and quality of care should reflect the shared vision within the organisation, its mission and vision as well as its concept of care. Furthermore, staffing, HRM-policies and working conditions appear to be relevant factors, but also infrastructure (equipment, technology, information systems, buildings, environment), organisation and capacity (Austria, England, Finland, France, Italy, Slovenia, Spain, Sweden, Switzerland). Apart from these structural quality indicators, some process indicators are relevant, such as waiting times, access, safety, management and administration procedures, sometimes even collaboration with other services (England, Finland) while results are most often reduced to cost-effectiveness ('value for money').

At the supra-organisational dimension (municipality, region, state), quality is monitored on supply of services, their access (appropriateness, fairness and timeliness), costs and general health indicators such as mortality (England, Finland). In Finland benchmarking is developing at all levels based on the gathering of data by means of the RAI assessment: approximately one third of the residential facilities and home care services in 2009 were using RAI-systems for benchmarking at the organisational and even local level. In this context, it depends very much how and where responsibilities for service provision and coordination are situated and which governance mechanisms are in place, whether these outcomes can be managed according to principles of quality management. It appears that these indicators are more reflecting on transparency, rather than on the question whether what had been commissioned is actually being delivered.

A dimension that is getting more and more recognized officially is informal care and work of volunteers. Family carers play a crucial role in LTC, which is in a number of countries well recognised (England, Finland, France, Germany, Italy, Spain, Sweden, The Netherlands). For instance, in England carers can be assessed and may be entitled to support, education, training and employment. In Austria, Italy and Sweden training is offered both to family carers and to informal migrant care workers. In France and The Netherlands innovative forms of carers' support by means of respite care, training or education for the informal carers are being developed.

However, no specific quality policies exist regarding these groups. As individualised budgets are becoming a significant factor in many countries, this practice might change in the near future when an increasing number of care workers outside the official domain, including migrant carers, will be paid for their work by service users themselves. In a number of countries migrant carers play an increasingly important role in a 'grey' area of professional regulations, labour law and immigration legislation (e.g. Austria, Italy, France,). It is high time to also develop the quality of these forms of



LTC in cooperation with users and their informal (migrant) carers. This is even more crucial as, currently, cultural diversity is not a specific issue in quality management (Finland, France, Spain), except from general notions of non-discrimination and equity (England, Italy). First steps towards greater awareness of cultural diversity in this sector may be reflected by materials in other languages, experiments with specific quality indicators, complaint procedures and participation of not native citizens in advisory bodies.

## 5 Conclusions

Examining the reports provided by the national teams from participating countries it appears that quality management in LTC is only just emerging. Respective developments differ from similar initiatives in health care with respect to their remit, the way in which qualifications, outcomes and processes can be standardised, the concreteness of criteria and the budgets that are available. The latter may be a consequence of the not always acutely life-threatening character of quality in LTC. The acute care elements for older people who need LTC are often scrutinised according to health care principles. The social care elements are in most cases operationalised by way of user satisfaction surveys. In some countries such ratings are published on websites, guides or in newspapers (England, Sweden, Germany, The Netherlands), while they are still confidential in others (Austria, France, Spain). In Finland, the data of user satisfaction is published in research reports.

These differences lead towards the second observation that can be asserted across Europe. There is a general tendency towards transparency with various objectives: to support users in choosing a service, to inform citizens what is being provided as well as to inform commissioners about what quality they pay for (public accountability). For (local) governments it is important to know whether they serve the population appropriately while for managers and professionals who work in care providing organisations it becomes increasingly important to know how they are performing and in what respect they may improve their work.

These objectives are not always compatible, in particular if negative results have direct or indirect negative economic consequences for the organisation. In this case, organisations may be reluctant to provide valid figures (England, France). Paradoxically, stakeholders may not be interested in bad figures if additional resources would be needed for improvements, thus perverting the original aim of quality management approaches. If organisations are honestly intending to improve their services, they should feel safe to be transparent on both positive and negative outcomes, rather than filling in tick-box questionnaires. As a corollary, measurable and documented progress in quality improvement should be perceived a more relevant indicator than nicely written reports. Respective endeavours should therefore be more rewarded than in the current practice.

A third tendency is that systems are initially striving to define minimum standards of quality. However, a newly emerging trend shows that, in a next stage, organisations are being motivated to work towards levels of optimum care, sometimes exemplified by star-rankings or bronze-yellow-gold rankings (England, Italy, The Netherlands).

A fourth tendency is that systems are moving from control and inspection by public administration towards quality management, self-assessment and third party certification (Austria, France, Italy, The Netherlands). This often goes together with more autonomy for service providers to choose their own quality management system. This trend is very much influenced by types of governance, too. Where public funding and state regulation are dominant, inspection and sanctions will be the main mechanisms of quality assurance; where market mechanisms are introduced and users' discretion in choosing and contacting services, accreditation (ex ante) and certification (ex post) of self-assessment may be more corresponding mechanisms. However, changing governance mechanisms and changing rationales in quality development are not easily manageable for the different stakeholders as new types of partnership thinking, team working and trust-building have to be developed and trained. Both top-down and bottom-up initiatives will be needed to support the ongoing transition from inspection to real quality management (towards models of excellence) in LTC.

Competition and New Public Management tools as such will not improve quality at the many interfaces between health and social care, if these transitions will not be supported by measures to enable stakeholders to focus on users' needs.

The fifth trend is that quality indicators are becoming more person and outcome oriented (England, Finland, France, The Netherlands). Process and system indicators do not always reflect high quality for service users (Groenewoud, 2008). Also, systems of self-assessment do not always lead to best outcomes. This was a reason for the Dutch government to implement a general set of quality indicators which had been developed and adopted by the national umbrella organisations of care providers, professionals, service users, health care insurers and inspection, and which is implemented throughout the country. A great number of these indicators are person oriented, reflecting users' opinions and health and well being scores according to professional standards to enable national benchmarking.

This leads to a sixth trend: data collection for quality management and the development of quality systems and instruments are becoming more sophisticated and more centralised (Austria, Slovenia, Spain). Sometimes lower level authorities can choose the indicators and systems that are most applicable to them (England, Finland, France). A more centralised system enables comparisons across the nation which appears to be particularly relevant in countries where policies and citizens are calling for equal access and equal quality (Austria, Italy, Slovenia, Spain, Switzerland).

The seventh development is that guidelines for professionals in LTC are less developed than in the acute sector. Evidence-based working appears to be of less concern in LTC. Nevertheless, many countries are striving to further professionalise the LTC sector in terms of working with guidelines, protocols and standards (France, Sweden). It remains to be questioned to what extent this sector is suitable for this type of standardisation. Moreover, even in the acute sector the implementation of guidelines and protocols is a cumbersome task.

Another feature that comes with the introduction of quality management approaches are discussions throughout Europe (England, France, Italy) whether quality management only leads to a new bureaucracy and higher costs for service providers. In the first place, quality management has a most positive connotation: who would be against better quality? However, as it also requires a lot of paper work such as, for instance, writing reviews, carrying out surveys, training staff, recording outcomes and describing processes, it is argued that too much time and money are spent on bureaucratic procedures, rather than on care of and time with users (see Section 2.5). Furthermore, as cost containment is a driving force behind many developments in LTC, the question may be raised whether further investments into quality management will be feasible (Austria, France).

It was also observed that most quality management is directed towards individual organisations (e.g. Austria, France, Italy, Switzerland). Quality management of interlinking mechanisms is in its very first stage. Some examples exist of care pathways, the emergence of interlinking professionals, multi-professional teamwork and quality management at area level. In general, joint funding mechanisms can be an incentive to quality management at inter-organisational relationships, but in that case a number of issues on governance have to be solved.

As a corollary, these first steps, examples of good practice and initiatives to assess and improve quality at the interfaces between health and social care will be further analysed during Phase 2 of the INTERLINKS project, with a focus on mutual learning and contextual peculiarities in the individual countries and regions.

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