

Achieving quality long-term care in residential facilities

Discussion Paper

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'To the intellect the process of defining Quality has a compulsive quality of its own. It produces a certain excitement even though it leaves a hangover afterward, like too many cigarettes, or a party that has lasted too long.' (Pirsig, 1991: 72)

Introduction

With the growing importance of long-term care services, rising expectations of citizens and, at the same time, governance structures moving towards market-oriented mechanisms, it has become decisive to have enhanced methods at hand that are able to define, assess and improve quality in a sector that, notwithstanding important co-payments of users, is still mainly funded by public resources.

Indeed, the extension of long-term care services and facilities for older people over the past two decades has coincided with what has been labelled 'New Public Management', i.e. the introduction of quasi-markets, purchaser-provider split, competitive tendering, privatisation and out-sourcing of hitherto public services. In more market-driven systems and with new actors entering the 'long-term care industry' public authorities should strive to guarantee equal conditions for all providers. This has triggered new requirements on the side of the (public) purchasers to describe, what kind of service is being tendered, with which means it should be accomplished and which outcomes are expected. Respective authorisation and accreditation systems, inspection and other mechanisms as well as institutional structures have been established and enhanced in most Member States.

At the same time, new approaches to conceive and organise long-term care for older people have been developed, responding at least partly to the changing needs and expectations: community care services have been extended, first steps towards more coordination between health and social care have been taken, more differentiated care services have been installed, and residential care facilities have started to adjust their conceptual approaches (Billings/Leichsenring, 2005; Pavolini/Ranci, 2008). On the one hand, residents have become more frail and move into care homes with more severe care needs as older people try to stay at home as long as possible, with the help of informal family carers and/or formal services. Traditional old-age homes have thus been transformed, reluctantly or willingly, into nursing homes or facilities with service housing. On the other hand, potential residents and their relatives have passed their life in rapidly modernising consumer societies generating novel and elevated expectations towards social and health services. With the introduction of care and attendance allowances and related systems to increase their purchasing power, people in need of care have also become purchasers of services themselves – and they want to know what they can get for their money (Glendinning, 2009). Policy makers and the care home industry have therefore set off to define new structural and procedural standards, though such efforts are still most unevenly

distributed within and between Member States both in quantitative and in qualitative terms. For instance, the percentage of older people with long-term care needs (according to the national definitions) who are living in care homes, ranges from about 5% in Estonia to almost 36% in Sweden (see Annex, Table 1) and many challenges remain with respect to the adaptation of care homes to increasingly complex needs of older people.

Based on these general observations on developments in long-term care, this paper will discuss the German and Bavarian as well as other Member States' approaches to quality assurance and quality management in residential long-term care for older people from a quality management view. In this perspective, *quality is defined pragmatically as the decent delivery of a mutually agreed service or product*. To assess the quality of a service such as long-term care in residential settings it would thus be necessary to agree upon structural and procedural standards,¹ and upon expected outcomes within an acceptable range of costs/prices, between all stakeholders involved. This does not only include residents, the different types of providers and professionals and the purchasers or funders, but also relatives, in some cases suppliers, researchers and the general public – and it is this vast range of stakeholders that complicates the definition of quality in residential care, where frail older people live and work together with staff and management 24 hours per day and 7 days per week: What is 'decent delivery' and from whose perspective? What can be 'mutually agreed', e.g. in nursing care? What is an 'acceptable range of costs/prices' and for whom does it have to be acceptable?

Yet, as long-term care services are predominantly purchased or commissioned by public authorities, it will typically be those statutory authorities who take the lead in defining standards. It thus has to be distinguished between *quality assurance* on a governance level, i.e. a control mechanism to ensure that all providers are respecting the same (minimum) standards defined by law, and quality assurance on the level of the provider organisation, where it will become part of its general quality management system.

Quality management is a method to ensure and improve structural, process and outcome quality of any kind of service or product on the organisational level. This entails the application of the management cycle consisting in the definition of goals, the planning and organisation of processes to achieve the objectives, the evaluation of the results and the implementation of corrections or further improvements (plan – do – check – act). Internal quality management is usually complemented by an external auditing process (certification) by a third party to control for the compliance with defined standards. This approach, originally conceived in the manufacturing industry, has partly been adapted by social and health organisations to the specificities of the sector (Evers et al, 1997; Blonski, 1999; Peters, 2006).

Following a brief outline of the policy debate on quality assurance and quality management at the European level, the main elements of the German and Bavarian approaches to these issues will be presented. Therefore it will also be necessary to briefly outline the German long-term care system as a background to respective quality assurance activities. The final part of the paper will

¹ In a context of quality and quality management, the term standard has a double meaning and thus often provokes misunderstandings: on the one hand, the term is used meaning management standards that provide requirements or give guidance on good management practice; on the other hand, in measuring quality, standards are predefined normative values to be achieved in order to judge quality as good.

consist in some thematic vignettes and suggestions to be discussed at the Peer Review meeting.²

Part A

The policy debate on quality assurance and quality management

The policy framework at European level

Though long-term care facilities, as a part of health and social services, have originally not been an issue of EU policies, they have eventually gained ground on the European policy agenda in debates about Social Services of General Interest (SSGI) and in the context of the Open Method of Coordination (OMC). The former have focused on imminent issues with respect to basic principles and respective EU legislation concerning the EU rules on the internal market, competition and freedom of movement which, indirectly, call for a growing coordination between Member States and EU institutions also in the area of health and social services. This growing interaction is organised, among other, by means of the OMC which is backed up by the Social Protection Committee. In this context, two Communications from the Commission have mainly influenced the focus of EU policies on quality in long-term care over the past few years:

- Following the Communication 'Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union' (European Commission, 2005) the existing OMCs in the fields of social inclusion and pensions were merged with cooperation in health and long-term care. Apart from some overarching objectives for the OMC for social protection and social inclusion, three specific objectives were defined for health long-term care, namely to provide access, *high-quality* and sustainability.
- As a result of the debates about SSGI, the Communication 'Services of general interest, including social services of general interest: a new European commitment' (European Commission, 2007) proposed 'a *strategy for supporting the quality* of social services across the EU' in the framework of the OMC, 'the development, within the Social Protection Committee, of a *voluntary EU quality framework* providing guidelines on the methodology to set, monitor and evaluate quality standard' as well as the support of bottom-up initiatives under the programme PROGRESS.³

The ongoing activities and achievements on the European level coincide with national efforts to develop and implement quality guidelines, minimum standards or accreditation mechanisms in a context of – notwithstanding first signs of a 'revival of the state' – ongoing market-driven governance. Quality of personal social services has for a long time been based exclusively on professional ethics and relationships of trust between public purchasers and public or non-profit service providers. With the opening of quasi-markets to new actors and the reduction of social

² The following deliberations are based particularly on ongoing research, in which the author is involved in the FP7 project 'Health systems and long-term care for older people in Europe'. Modelling the interfaces between prevention, rehabilitation, quality of services and informal care (INTERLINKS): www.euro.centre.org/interlinks.

³ See, for instance, the project 'Quality management by result-oriented indicators. Towards benchmarking in residential care for older people' (http://www.euro.centre.org/detail.php?xml_id=1396); or 'Benchmarking European standards in social services transnationally' (<http://www.josefsheim.net/josefsheim/progress.shtml>).

planning processes it has become necessary in all Member States to cater for regulating access of suppliers, for criteria to choose between different providers (e.g. in case of public tendering) and for guaranteeing accountability (see Annex, Table 2; see also Bertin/Leichsenring, 2003; Huber et al, 2008).

In practice, we can retrieve a range of different mechanisms that have been introduced by Member States during the past few years (see Nies et al, 2010):

- In *Finland*, where the percentage of non-public providers is still rather low, the National Framework for High-Quality Services for Older People from 2001 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 also seeks to improve the accessibility, safety and comfort of residential care environments for older people.
- In *Austria*, an example for a more decentralised governance system with a strong impact of long-term care allowances, differing regulations can be observed from region to region in relation to staffing ratios, structural preconditions or other criteria to become an authorised provider. Some regions have started to include the implementation of a quality management system as a compulsory requirement for authorisation. Recent developments have led to the introduction of a National Quality Certificate (NOZ) that should complement regional control mechanisms by means of a voluntary certification of care homes' quality management.
- In the *Czech Republic*, where reforms have created a mixed bag of responsibilities, registration conditions and obligations of social service providers have been defined by the Social Services Act 2006. Legal requirements, for the most part defining structural and technical standards, are controlled by inspections performed by the Federal Ministry of Labour and Social Affairs on services managed by the regions and by the regions on services provided by NGOs or municipalities.
- In *England*, one of the most centralised and market-driven Member States, 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 registration and inspections at the level of individual care homes ensuring that common quality standards are achieved. As of 2010 care services are being judged against 28 outcome standards in six domains such as 'involvement and information', 'personalised care, treatment and support', 'safeguarding and safety', 'suitability of staffing' and 'quality and management' that were defined as 'Essential standards of quality and safety' following the Health and Social Care Act 2008 (CQC, 2010). A further aim of the CQC 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 *France*, several agencies are responsible for quality control, in particular the National Inspectorate for Social Affairs (IGAS). The National Agency for the Assessment of Nursing Home and Home Care Providers (ANESM) was founded in 2007 to evaluate and adapt guidelines and recommendations for quality health and social care, based on good practice, to support providers in internal and external quality assessment processes. It also authorises

provider organisations to adhere to the external assessment process which will be carried out by third parties.

- *Spain* is currently engaged in a complete modernisation and reorganisation of its long-term care system by implementing the 'Law on the promotion of personal autonomy and care for dependent persons'. Among other, a service and resources database is being created to guarantee quality and effectiveness of services provided. Standards and other quality issues are currently being elaborated. On the level of the Autonomous Regions, various criteria are used to choose between different providers, the existence of a certified quality management being one of them.
- In *Sweden*, another example of a Nordic welfare state, the National Board of Health and Welfare (Socialstyrelsen) and the Swedish Association of Local Authorities and Regions have agreed to establish a model that allows for comparison of care services (Swedish Ministry of Health and Social Affairs, 2007).

On the level of care homes, a general trend towards the introduction of quality management systems can be retrieved, be it on a voluntary basis, due to market necessities or because of the above mentioned legal directives:

- An increasing number of care homes in *Austria, Germany, Luxembourg* and *Slovenia* are working with E-Qalin, a quality management system that was developed by a consortium of partners from these countries and Italy. 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.
- 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 organisation top-down. Many municipalities, which are still the main providers of services, use indicators derived from Inter-RAI (Resident Assessment Instrument) to develop their services. Organisations use indicators for benchmarking purposes to work directly on improving care and the wellbeing of clients.
- In *Spain*, all providers participating in competitive tendering have to maintain a certified quality management system, usually based on ISO 9001 or EFQM (European Foundation for Quality Management).

The policy framework and debate in Germany

In Germany, the opening of the 'care market' for providers came with the introduction of the long-term care insurance (LTCI; see Part B and the Host country paper for details) in 1995. Relationships between the LTCI which is now acting as the main purchaser/regulator of care, regional and local authorities that are now mainly co-funders (local authorities) and providers changed radically, calling among other for new forms of contracts:

- 'Provision contracts' between the provider and the regulator which basically represent an authorisation of the provider based on a number of basic structural prerequisites.
- 'Framework contracts' on the regional level between the Federation of Providers and the regulator (regional branch of the LTCI) concerning the content of services, financial stipulations (reporting and accounting), personnel levels, and control mechanisms.
- Agreements concerning the funding of services by the LTCI are made between each provider and the regulatory authority on regionally defined 'care packages', i.e. a set of services in which each individual service included is rated by means of points, and individual arrangements.

As these agreements, based on the LTCI legislation (SGB XI, § 80), also stipulate that authorised providers have to dispose of a quality management system, a plethora of approaches have been developed. Adaptations of the classical ISO and EFQM models have been introduced in particular by the larger provider organisations, though it has been argued that, in practice, providers tend to comply with the necessary minimum standards, rather than actively searching for quality improvements and competitive advantages (Blonski, 1999).

Important efforts concerning quality assurance and improvement have been undertaken with the establishment of the 'Medical Service of the Federation of Sickness Funds' (Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen – MDS) and its operative units on the regional level (Medizinische Dienste der Krankenversicherung – MDK). The MDK is responsible for training and organising medical doctors and specialist nurses who assess the individual needs of applicants for LTCI benefits. It also carries out quality inspections with an orientation to consult providers on potential improvements. The MDK may also cut payments or exclude care home providers entirely if quality problems are detected and not improved within a defined period, but these remedies are seldom used.

Reports of the MDS (the latest report stems from 2007) and related research (Garms-Homolova/Roth, 2004) detected important quality problems in German care homes concerning both structural, process and outcome quality (see Annex, Table 3). For instance, in 2006, prevention and therapy of pressure ulcers was deficient in 35.5% of all inspected care homes; deficits with nutrition and hydration prevailed in 34.4%, while problems with incontinence management were registered in 15.5% of all cases.

The reports of the MDS on the quality of care providers, though presented in an anonymous way without blaming individual care providers, have demonstrated positive effects. Between 2003 and 2006 aggregated data have shown a general tendency towards improvement with respect to the inspected criteria, i.e. care home managers have generally started to adapt to the requirements, though enforcement measures have only scarcely been used. Still, the question remains whether providers have just learned how to prove compliance with prescribed standards or whether systematic quality management has been put in place.

Based on its experiences till 1995, the ample inspection guidelines were complemented in the context of the 2008 reform of the LTCI legislation by an agreement on transparency between all parties, which stipulates the external assessment in five quality domains: care and medical provision; attendance of residents suffering from dementia; social care and day-time activities; accommodation, meals, domestic economy and hygiene; residents' satisfaction (based on a

survey). The aim of these guidelines is to provide an easy access for (potential) users to valid data that can help to judge the quality of each care home. The results for each domain as well as the end result are thus made public in the form of school marks (MDS, 2009).

The quality reports of the MDS and the agreement on transparency have triggered a fierce debate about quality in long-term care, mainly between provider organisations and the MDS – including a number of trials at the social court – concerning the validity of inspection results and the rating system. As a consequence, the transparency reports were evaluated (Hasseler et al, 2010) and are currently being revised to prepare for compulsory yearly inspections for each care home from 2011 onwards (MDS, 2010). User organisations are less involved, with the exception of a small initiative supported by the Ministry for Consumer Protection (www.heimverzeichnis.de) that has started to check those care homes that apply voluntarily according to a list of 120 criteria in three quality of life domains: autonomy, participation and dignity. This check is carried out by trained volunteers who scrutinise care homes based on a one day visit. Only results of those care homes that comply with at least 80% of the criteria, are published on the website.

Though regional governments and local authorities have lost most of their steering competencies in long-term care, the latter participate in the shared public responsibility for guaranteeing care, e.g. in the framework of municipal services of general interest ('Kommunale Daseinsvorsorge'), while the former are also carrying out inspections in care homes. In relation to this responsibility, the Bavarian government has transformed the former inspection unit ('Heimaufsicht') into a Department for Quality and Inspection ('Fachbereich Qualität und Aufsicht/FOA') that developed guidelines for the assessment of quality in care homes, based on the 'Bavarian Care and Housing Quality Act' (2009). The guidelines focus on the quality of life of residents in care homes that is assessed in the context of so-called 'key situations' with respective criteria and indicators. Observation, interviews and a consensus-building dialogue between the external auditors and the management of the care home are used as methods applied to support self-assessment and to draft a report that should help (future) users to judge the quality of the care home and to make choices accordingly (Bayerisches Staatsministerium, 2009; see also the host country paper).

Quality assurance and quality development have thus been key issues on the political agenda in Germany over the past few years. Both the Ministry for Family, Senior Citizens, Women and Youth and the Ministry for Health as well as the Regional Governments initiated numerous measures to improve the framework for quality assurance in residential care, among other the 'Round Table for Care'. Involving all relevant stakeholders, the round table elaborated, among others, the 'Charter of Rights for People in Need of Long-Term Care and Assistance' and recommendations for improving framework conditions in long-term care to face challenges of demographic ageing, e.g. concerning quality assurance and improvement (DZA et al, 2005). Other institutions carrying forward quality debates are the 'Federal Conference for Quality Assurance in Health and Long-Term Care' (Bundeskonzferenz zur Qualitätssicherung im Gesundheits- und Pflegewesen e.V./BUKO-QS) and the German Network for Quality Assurance in Long-Term Care (Deutsches Netzwerk für Qualitätssicherung in der Pflege/DNQP) which has been the main driver for developing expert standards for care.

European comparative aspects

The experiences with quality assurance on the governance level as well as those with quality management on the organisational level in Germany provide a large amount of expert knowledge concerning the opportunities, but also the limitations of tools and methods applied. The same holds true for other countries where quality assurance in long-term care has developed over the past few years. As a corollary, we can observe a general tendency towards more transparency '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)' (Nies et al, 2010: 56). Though quality criteria are still often based on minimum standards focusing on structural and process quality and on clinical indicators, rather than on outcomes in terms of quality of life for residents, efforts towards more person- and result-oriented indicators and criteria can be observed. The validity of indicators, their weighting, and even their purpose as a basis for consumer choice have been questioned and will need further research, but in daily practice they can always be used as a proxy to assess current performance, to plan improvements, and to verify achievements.

Another trend is to move away from pure inspection based on tick-boxes towards quality management approaches and supporting measures to enable care home managers and staff to apply these methods (training for quality management, working with indicators, surveys etc.). However, as long as there is no intrinsic motivation of care homes for continuous improvement, which is still true in many areas, it seems that external support (and sometimes also enforcement) strategies are of significant value (see Box). However, enormous differences have to be considered: While some pioneers are moving towards working with more sophisticated and adapted tools for quality management in residential care settings such as certified quality management systems, evidence-based expert-standards and result-oriented performance indicators, in many care homes training for quality management is still being regarded as a loss of time, work with quality management tools is perceived as a bureaucratic exercise and expenditures for these activities are in any case considered as too high.

Compared to the important part of public budgets spent on long-term care, in particular on residential care, investments in quality assurance and management in Europe have remained scarce, e.g. compared to respective efforts in other sectors such as health care or countries such as the US (see Wiener et al, 2007; Sorenson, 2007). Even if quality management methods themselves need to further develop evidence for their effectiveness in long-term care, it is obvious that, without planning and assessment of structures, processes and results, no further improvement can be expected. This is true for both the systems and the organisational levels.

The reluctance towards evidence-based working, the lack of data on quality of life, but even on quality of care, and the fact that the debate about outcome-oriented indicators to steer quality of care homes is just starting also points towards the general need for more appropriate education and training in this sector to attract and maintain the increased number of care professionals that will be needed to face the challenges of ageing societies. Among other, this will also include the development of quality management models with a scope that goes beyond the individual care home and covers the integrated provision of long-term care across health and social care boundaries.

The governance dilemma of quality assurance and management

In general, we can assume that nobody would like to produce 'bad' quality in care homes on purpose – no provider, no policy-maker, and no single professional. It is typically a mixture of aspects such as missing communication, economic interests or 'necessities', lack of knowledge and other framework conditions that impact on the result of very complex care processes – and their perception and co-production by users and professionals involved. Quality assurance and in particular quality management are addressing this challenge by trying to identify tangible reasons and motives for success or failure in planning and implementing care processes, and to develop ways to better control the various interfering aspects. At best, this assessment and reflections about how to put improvements into practice are realised by a broad range of stakeholders representing residents, families, staff and management.

These activities are time-consuming and sometimes relatively costly – depending on, for instance, the model to be applied, on additional external costs for consultancy or certification, and on the structural preconditions of a care home.

In order to make sure that internal quality assurance and quality management are in place, a regulator (and purchaser) has the following options:

- To impose on each provider already during the accreditation process that a quality management system has to be in place, being aware that costs for training and implementation as well as consultancy and certification will have to be at least co-funded (or added to prices);
- To create a funding opportunity for training, implementation and consultancy as an incentive for providers, while running a regular inspection system, and to leave it up to the market, whether a specific quality mark will suffice to attract residents;
- To inspect quality according to a defined system and/or agreed performance indicators and to make the results of each individual care home public (internet).

Most Member States have used a mix of these options, with varied experiences. For instance, in Germany (also in Belgium, France), all providers have to have a quality management system by law, but it also can be one developed by the provider (without certification). Training for staff is scarce as costs are tried to be reduced as much as possible, e.g. by focusing on the minimum standards prescribed by law or legal regulations.

Also the disclosure of 'bad' figures concerning agreed performance indicators in each care home could have a paradoxical effect: organisations might get an incentive to fudge their data for public purposes, rather than engaging in improvement measures. This would particularly be the case, if bad performance would be linked to lower payments. Therefore, if external quality assurance or inspection finds out about bottlenecks and failures in a care home, one solution would be to stipulate support programmes that help overcome negative situations in the particular care home.

Experiences from related Peer Reviews

Similar findings and issues have been brought to the fore during related previous Peer Reviews. In Belgium, the assessment and improvement of quality had been identified as a key issue for 'The future of social services of general interest' (2007) – the growing emphasis on 'value for money' calls for active quality assurance and a move towards quality management strategies, even if this approach will render regulation more complex.

In the Netherlands (2009) the debate on 'Long-term care: How to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and

responsibilities' also came to the conclusion that, to further develop long-term care systems, it is decisive to develop strategies 'to erode boundaries that obstruct integrated care' and to face the challenge of labour shortages (Rothgang, 2007: 31). In Romania (2010) the Peer Review 'Achieving excellence in social service provision' the use of specific quality management tools was discussed.

Some important issues of quality assurance were also taken up in Denmark (2009) in a Peer Review on 'Combining Choice, Quality and Equity in Social Services'. There was an argument by countries where the supply and overall coverage of services remains poor being concerned that 'the rigorous enforcement of quality standards could result in some providers being forced to close with existing users losing their services'. This risk was in tension with other priorities of improving the overall supply of services and 'the costs of compliance with new quality standards' (Glendinning, 2009: 47). Furthermore, the lack of user involvement in quality assurance was addressed. This tension between the definition standards, costs and the role of users will be taken up in Part C.

Part B

Main elements of the German and Bavarian long-term care policy

Germany represents a group of countries where issues of long-term care have been identified and acknowledged as a social risk that calls for specific institutional, political and regulatory efforts. While this acknowledgement has been realised in all European countries, the tangible measures, the significant public expenditure as well as the experiences in regulating an open market for LTC that have been made in Germany over the past 15 years are a most interesting source of knowledge and experience for other Member States.

Following a long policy debate that reaches back to the 1970s, the introduction of the long-term care insurance (LTCI) in 1994 as a 'fifth pillar' of the social insurance system represented a huge step towards new rules and regulations in this area. First of all, users were given guaranteed rights to cash benefits and/or in-kind services or residential care within a defined range of benefits (partial coverage) – the position of users in terms of purchasing power and opportunities for choice has thus been strengthened. This implied, secondly, an open market policy which invited new providers and investors to join into an area that had hitherto been mainly supplied by non-profit organisations with a long tradition in social and health care.

One aim of the contribution-based financing of the LTCI was to guarantee that people with long-term care needs should no longer be dependent on discretionary social assistance payments, in particular if they moved to residential facilities. Furthermore, regional and local authorities' social assistance budgets should be unburdened from care-related expenses. Indeed, social assistance expenditures for long-term care were reduced by 70%, but still more than 20% of residents in care homes need to apply for social assistance benefits as their resources (including benefits from the LTCI) do not suffice to cover their costs (BMG, 2008).

Other important aims of the LTCI were to increase the number of services to support people with long-term care needs at home, and to improve the quality of services and residential facilities. In fact, until the year 2000, new, mostly small-scale private providers mushroomed in particular in German's larger cities. After some years of consolidation there are now about 11,000 home care

providers, 58% of which are organised by private for-profit, 40% by non-profit organisations and less than 2% by public authorities. However, also the residential care sector grew considerably: from 2000 till 2006 the number of people with care needs living in institutions increased by almost 15% to 660,000 (including about 80,000 younger people with disabilities in residential care). In this sector, 55% of care homes are run by non-profit, 38% by private for-profit organisations, and about 7% by public authorities (BMG, 2008).

As with other long-term care systems in Europe, the German system is facing three key challenges for the sustainability of the current system: financial sustainability, socio-demographic challenges, staffing and quality of services.

Expenditure growth was relatively moderate since the introduction of the LTCl due to strict cost-containment measures that, however, led to a marked devaluation of benefits in real terms. The 2008 Reform has therefore put in place a number of measures to extend the financial basis of the LTCl, namely a higher contribution rate as well as additional subsidies from general taxation which allows for a step-wise increase of benefit levels during the next few years. Yet it is unclear whether additional funding will also be available to make salaries of staff in long-term care competitive, to improve qualifications of staff and to enhance residential care structures, not to speak of measures to overcome coordination problems between health, social and long-term care systems and other recommendations made by the 'Round Table on Long-term Care' (DZA, 2005).

Socio-demographic challenges in Germany are also in line with other European countries – the share of people over 80 is expected to grow from 4.6% of the population to about 15% in 2050 (European Commission, 2009), with respective challenges for care and assistance. While labour shortages are felt already, it will become a critical success factor over the next few years to attract staff into care professions. Immigration has been identified as a way out both in the formal and the informal care sector, but it remains to be seen, whether these solutions remain sustainable in a mid-term perspective, in particular if high quality care should be ensured. Indeed, the issue of migrant care workers providing informal care in private households, still seems to be an issue to be addressed. Contrary to other Member States (Austria, Italy), less public debate and few tangible policy measures have been reported from Germany, where the availability of cash benefits can be an incentive to purchase informal care (Döhner et al, 2008; Di Santo/Ceruzzi, 2010).

German care homes are relatively large. An average care home offers around 70-80 places, about 50% of places are in double rooms, about 50% of staff are registered nurses, and there are about 2.5 staff members per resident. In 2008, average daily rates in care homes were ranging, for nursing care, between €39.7 for residents with lower care needs (level 1) and €68.9 for those with higher care needs (level 3). For accommodation and meals (hotel costs) another €19 are charged on average plus investment costs of €11.42 per day. In Bavaria, monthly charges were ranging from about €2,200 to €2,900 (BMG, 2008). Again, it has to be seen, whether competition will focus on prices or quality, and which quality improvement measures will be feasible with given funding structures and at reasonable prices.

Another issue concerns the regulation of long-term care in Germany and the division of responsibilities between the federal state, the Länder and the municipalities (Kreise, Städte). It has already been described that, with respect to inspection, there is some overlap between the

MDK inspection and the inspection by regional authorities ('Heimaufsicht'). At the same time, social planning of supply and necessary investments at the level of the Länder has been reduced. New care homes have been built primarily by the private for-profit sector during the past decade, thus producing overcapacities at least in some regions – the average occupancy rate is at about 90%, private for-profit providers report about 85%; and the profitability is low: 50% of private care homes are making a loss (Care Invest, 2009: 9).

An important challenge will thus be to face the existing fragmentation and to integrate care home providers into networks providing coordinated care packages over the whole range of long-term care needs, with more differentiated and targeted services for special needs, e.g. people suffering from dementia. The question is, whether purely market-oriented mechanisms will facilitate such strategies or whether Länder and municipalities will take an active role to provide institutional frameworks to facilitate such approaches – and respective initiatives to improve and develop quality. An important tool in this context will be so-called 'Care Bases' (Pflegerstützpunkte) that were promoted by the 2008 reform in order to improve information and counselling as well as the coordination of services and providers (for details of the reform, see Igl et al, 2007).

Part C

Key issues for debate at the Peer Review meeting

Based on the above deliberations, the Peer Review meeting on 'Quality of long-term care in residential facilities' will be a forum to exchange experiences in Member States and to discuss approaches to quality assurance by involving all relevant stakeholders and enabling mechanisms to facilitate their involvement in quality management. In the following, an attempt is made to inform these discussions by means of 5 thematic vignettes and ensuing questions to be tackled.

1 Political debates involving all relevant stakeholders are needed to decide upon the desired and sustainable quality of long-term care and to overcome the social-health care divide

The German 'Round Table on Long-Term Care' (2003-2005) with more than 200 representatives gathering interest organisations of users, providers and employees, different levels of government as well as experts and associations, the Finnish 'National Framework for High-Quality Services for Older People' (2001; update 2008) or the Dutch conferences on developing a shared vision on long-term care (1999-2001) are examples for a political dialogue to define common goals for long-term care against which the quality of respective systems can be assessed. These approaches have to be underpinned by integrated planning processes to overcome budgetary and policy silos. Synergies and gains – also in terms of financial returns – can only be achieved, if health care reforms focus explicitly on the interfaces between health and LTC provision: 'Considering the prevailing decision-making and political power structures, relevant stakeholders under the leadership of public authorities are invited to develop a dialogue between equals, rather than just shifting the burden from health to LTC facilities' (Marin et al, 2009: 23). This is particularly true for countries where long-term care systems are just emerging.

Related questions to be discussed:

- How can a national dialogue on key-issues of long-term care be organised?
- Which resources are needed to inform the public about alternatives and to set common goals with defined resources?
- How can a dialogue between health and social care produce synergies and gains?

2 Quality in care homes is a complex issue that calls for regulation and external quality assurance

Care homes are not simply 'products' being assembled and sold to informed clients. Their services are part of the welfare state and respective long-term care systems, which means that they are to a large degree funded by public resources, and that access and delivery of services should be based on social rights, choice and equal opportunities. Given the high percentage of residents being frail and/or suffering from cognitive impairments, professional ethics alone – particularly in a context of competition and cost-cutting – do not suffice to guarantee residents' wellbeing. External control is thus to ensure that care homes comply with *mutually agreed* criteria for structural, process and outcome quality, at best expressed in terms of indicators that are not only focusing on quality of nursing care, but also at aspects of quality of life, leadership, economic performance and social accountability. 'Mutually agreed' means that the development of indicators to measure quality in care homes should involve all relevant stakeholders, both on the policy level and on the organisational level. Such indicators may partly allow for benchmarking and comparison, with respective risk-adjustment, but they should not be detrimental to flexibility and innovation.

Related questions to be discussed:

- How and by whom is quality in care homes being defined and ensured?
- What external quality assurance mechanisms exist in participating countries? What approach to monitoring and inspection is characteristic for these mechanisms?
- Which type of indicators are used to prove and check compliance?
- Who and which institutions are involved in external quality assurance (inspections) of care homes?
- Are enforcement measures in place and have they been applied?

3 External quality assurance is indispensable, but insufficient to establish quality thinking in care homes

Inspections in care homes will take place, at best, once per year during one or two days. It is thus quite obvious that, for the remaining 364 days, mechanisms are needed to guarantee the decent delivery of what has been agreed upon, to improve performance and to prepare for the next inspection. This calls for the involvement of different stakeholders, leadership and respective methods and resources.

Related questions to be discussed:

- What type of mechanisms to secure the implementation of quality thinking in care homes have been put in place in participating countries?
- What kind of indicators are being used to ensure that expected results have been achieved?
- Which (positive or negative) experiences have been made with quality management in care homes?
- Are legal regulations and/or accreditation standards defining quality management for care homes as a compulsory or voluntary requirement?

4 Quality management in care homes calls for enabling mechanisms and the involvement of all stakeholders in continuous improvement

Care home managers and other staff in care homes are usually not specialised in quality management; in some Member States, education and skill requirements for care home managers have only recently or still not at all been defined. Confronted with more and more legal regulations, standards to comply with, and a rather shaky financial basis it is a constant challenge for care homes to ensure and develop their service quality. Further training and resources targeted at these challenges seem to be needed to enhance incentives and capabilities to make quality work, also in care homes.

Related questions to be discussed:

- What type of training for managers and other staff is being offered to support quality assurance and quality management in care homes?
- Which resources are accessible to care homes to improve skills of staff and management in quality assurance and quality management?
- In what (other) ways do public authorities support and stimulate care homes to define, assess and improve quality?

5 Modernising care homes means to re-construct quality and innovation in long-term care

Building a care home today implies its preservation and maintenance for a minimum period of 20-30 years. Their purpose and concept should thus be planned with scrutiny and a view to future requirements. At the same time, there still remain many care homes stemming from the 1960s or even earlier periods that need structural modernisation to comply with today's standards as, in general, care homes have experienced harsh structural and contextual changes over the past decades. In a context of increasingly market-oriented governance, both professionalisation and a re-orientation towards residents' growing expectations and increasing care needs set off a shift from traditional old-age homes towards service housing that is expected to be open to the public,

to network with the community and to cater for all kinds of social and health care needs. Policies focusing on the extension of social and health care services in the community are desirable and welcome – and they need to include residential facilities as a vital part in the 'chain of care'. However, in reality, the largest part of long-term care expenditures keeps being spent on residential care. Care homes will thus remain interesting for investors, but they should also remain in the focus of policy-makers and regulators.

Related questions to be discussed:

- How do Member States ensure that newly built residential care structures and/or restructuring in existing care homes respond to local needs and demand, rather than to the interests of private investors?
- How do Member States make sure to live up to policy papers in which care at home is being considered as key – and which future role for residential care facilities has been anticipated?
- Do Member States discuss about incentives for innovation and modernisation of care homes?

Annex

Table 1 People with long-term care needs and their care arrangements in countries participating in the Peer Review

Peer countries	Number of older persons with LTC needs (1)	in residential care		supported by care services at home (2)		living at home with informal, family or no support	
		n	per cent	n	per cent	n	per cent
CZ	256,000	51,000	19.92%	73,000	28.52%	132,000	51.56%
DE	3,201,000	561,000	17.53%	1,028,000	32.11%	1,612,000	50.36%
EE	81,000	4,000	4.94%	6,000	7.41%	71,000	87.65%
ES	1,728,000	180,000	10.42%	181,000	10.47%	1,367,000	79.11%
FR	2,263,000	552,000	24.39%	953,000	42.11%	758,000	33.50%
LU	14,000	3,000	21.43%	4,000	28.57%	7,000	50.00%
MT	9,000	2,000	22.22%	n/a	n/a	n/a	n/a
AT	268,000	63,000	23.51%	122,000	45.52%	83,000	30.97%
FI	274,000	50,000	18.25%	56,000	20.44%	168,000	61.31%
SE	312,000	111,000	35.58%	207,000	66.35%	0	0.00%
EU27	20,705,000	2,897,000	13.99%	5,536,000	26.74%	12,272,000	59.27%

Source: Adapted from European Commission, DG ECOFIN, 2009. (1) According to national definitions and criteria; (2) data in this column are to be interpreted with special caution as individuals using two or even several services might be included.

Table 2 Differences between public programming and market-oriented regulation – and the need for correcting mechanisms

Category	Public programming	Market-oriented regulation	Correcting mechanisms
<i>Regulation of supply</i>	In relation to available resources	In relation to demand (minimum standards to facilitate access)	Time-limited accreditation of providers, regular quality control, monitoring supply
<i>Provider system</i>	Closed	Open (determined by demand and supply)	Case management (Public administration as purchaser)
<i>Choice of provider</i>	Public administration as purchaser	Public administration or citizen or user as purchaser (costs are controlled by purchaser)	Accreditation, certified quality management (quality control ex ante and ex post)
<i>Accountability (Warranty)</i>	Public administration controls quality ex ante and monitors services (inspection)	Quality is defined by provider (accreditation); citizen as a purchaser (often co-financed by public resources)	Needs assessment and control visits on individual level; choice between vouchers and benefits in cash; quality management system (incl. external audit) requested and in place

Source: Adapted from Bertin/Leichsenring, 2003.

Table 3 Compliance of German care homes with selected quality criteria from MDK inspections between 2003 and 2006

Indicator	2003 (1)	2006 (1)
<i>Quality of structures/processes</i>		
Care concept available	83.1%	90.9%
Care concept implemented	58.0%	75.6%
Individual care planning: objectives defined	45.1%	48.4%
Check of care results and according measures to adapt objectives and interventions	49.5%	63.5%
Internal quality assurance accomplished (2)	75.7%	89.6%
Staff assignment according to qualification	68.7%	76.6%
<i>Quality of results (nursing care and user satisfaction)</i>		
Overall care condition appropriate	82.6%	90.0%
Nutrition and hydration appropriate	59.0%	65.6%
Prevention and therapy of pressure ulcers appropriate	56.9%	64.5%
Incontinence care appropriate	79.9%	84.5%
Satisfaction of residents concerning respect of their expectations	92.3%	95.6%

Source: MDK, 2007. Note: (1) the care homes inspected in 2003 do not coincide with those inspected in 2006; (2) 5.4% of all 4,217 care homes that were inspected by the MDK between 2004 and 2006 (about 40% of all care homes) have a certified quality management system (DIN ISO or other).

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