

Achieving quality long-term care in residential facilities

Host Country Report

Bavarian State Ministry of Labour and Social Welfare,
Family Affairs, Women and Health

Federal Ministry of Health

I. Introduction

In the following there is a short overview about the structure of the Federal Republic of Germany, the social insurance and especially in the statutory long-term care insurance in Germany. Further on there are described some measures of quality assurance in Germany and the State of Bavaria.

The Federal Republic of Germany is a country, which comprises 16 states (*Bundesländer*), which are further subdivided into 439 districts (*Kreise*) and cities (*kreisfreie Städte*).

Legislative power is divided between the federation and the state level. The Basic Law presumes that all legislative power remains at the state level unless otherwise designated by the Basic Law itself.

Any federal law overrides state law if the legislative power lies at the federal level. A famous example is the purported Hessian provision for the death penalty, which goes against the ban on capital punishment under the Basic Law, rendering the Hessian provision invalid. The Bundesrat is the federal organ through which the states participate in national legislation. State participation in federal legislation is necessary if the law falls within the area of concurrent legislative power, requires states to administer federal regulations, or is so designated by the Basic Law. Every state has its own constitutional court. They are competent whether the action is based on federal or state law. Many of the fundamental matters of administrative law remain in the jurisdiction of the states, though most states base their own laws in that area on the 1976 *Verwaltungsverfahrensgesetz* (Administrative Proceedings Act) covering important points of administrative law. The *Oberverwaltungsgerichte* are the highest level of administrative jurisdiction concerning the state administrations, unless the question of law concerns federal law or state law identical to federal law. In such cases, final appeal to the Federal Administrative Court is possible.

The following five branches of social insurance exist in Germany:

- statutory pension insurance (gesetzliche Rentenversicherung),
- statutory health insurance (gesetzliche Krankenversicherung),
- statutory long-term care insurance (gesetzliche Pflegeversicherung),
- statutory accident insurance (gesetzliche Unfallversicherung),
- statutory unemployment insurance (gesetzliche Arbeitslosenversicherung).

II. Social Insurances in Germany

Statutory pension insurance

The statutory pension insurance (Gesetzliche Rentenversicherung) is organised by the German Pension Insurance – Federal Institution (Deutsche Rentenversicherung Bund), the Regional Institutions of the German Pension Insurance (Regionalträger der Deutschen Rentenversicherung) the German Pension Insurance – Mining, Railways, Marine (Deutsche Rentenversicherung Knappschaft-Bahn-See) and the old-age pension funds for farmers (Landwirtschaftliche Alterskassen).

Statutory sickness insurance

The statutory sickness insurance (Gesetzliche Krankenversicherung) is in the hands of currently 163 insurance funds, some of which operate regionally (local sickness insurance funds; Ortskrankenkassen) and some of which operate at a national level (e.g. most of the Substitute funds; Ersatzkassen). These funds are open to all members regardless of occupation or employment in a Company (exceptions are the fund for seamen and the agricultural funds for farmers). Apart from a few special categories (e.g. civil servants, judges, soldiers) all employees are subject to compulsory insurance, unless the remuneration is above the annual assessment ceiling in three consecutive years. For minor employment, special rules are applied. The sickness insurance funds administer the collection of the overall social insurance contributions for all branches.

Statutory long-term care insurance

Each statutory sickness insurance fund has established a long-term care insurance fund which is responsible for granting benefits to beneficiaries who are in need of long-term care. All persons who are members of a statutory sickness insurance fund are covered against the risk of need for long-term care in the same fund. Persons with private sickness insurance coverage must correspondingly conclude a private long-term care insurance contract

Statutory accident insurance

The relevant organisations of the statutory accident insurance (Gesetzliche Unfallversicherung) are the Employers' Insurance Associations (Berufsgenossenschaften) and the Accident Insurance Institutions of the Public Sector (e.g. Accident Insurance Funds). The following categories of persons are covered: employees, certain self-employed persons, pupils and students, children in Kindergartens or in day-care, certain volunteers, persons undergoing rehabilitation and certain other persons.

Statutory unemployment insurance

Statutory unemployment insurance (Gesetzliche Arbeitslosenversicherung) is implemented by the Federal Employment Agency (Bundesagentur für Arbeit). It is divided into the main office, the regional directorates and the local agencies. All employees are covered (manual workers, white-collar workers, trainees including young disabled persons.).

Self-administration

The individual branches of social insurance are self-governed by representative's meetings and board meetings or administrative boards which consist of the same number of representatives of the employers and the persons insured. In the field of unemployment insurance representatives of the public sector are included as a third party. The self-administration of substitute funds consists only of the representatives of the persons insured.

Supervision

As regards supervision the Federal Ministry of Health (Bundesministerium für Gesundheit) is responsible for the branches of sickness and long-term care insurance. The Federal Ministry of Labour and Social Affairs (Bundesministerium für Arbeit und Soziales) is responsible for (old-age, survivors' and invalidity) pension, accident and unemployment insurance. As regards the competence of the supervisory authorities it is decisive whether the insurance fund is a state (Länder) or a federal institution.

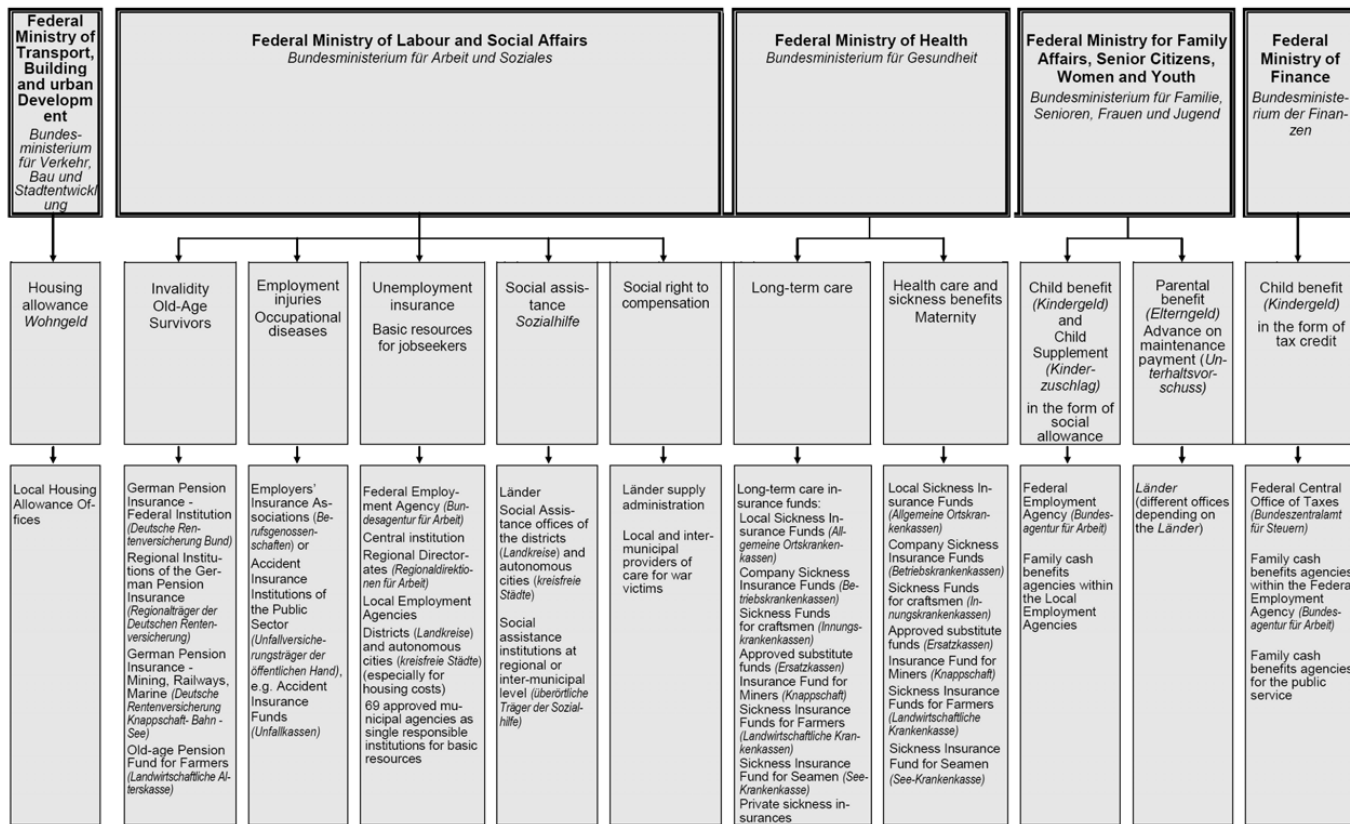
An insurance fund qualifies as a state (Land) institution when its responsibilities do not extend beyond its state (Land). Furthermore, a fund whose responsibilities touch over onto other states (Länder), but do not exceed three is also to be considered a state (Land) institution, provided the states (Länder) involved stipulate one supervising state (Land). In such a case, supervision falls under the responsibility of the highest social insurance administrative body at the states (Länder) level, or the authority stipulated by the states (Land) legislation. This is also the case for associations at the states (Länder) level. In all other cases, the insurance fund qualifies as a federal institution (as for instance the German Pension Insurance – Federal Institution (Deutsche Rentenversicherung Bund), German Pension Insurance – Mining – Railway-Sea (Deutsche Rentenversicherung Knappschaft – Bahn – See) and the Substitute Health Insurance Funds (Ersatzkrankenkassen). The Federal Insurance Office (Bundesversicherungsamt) is the competent supervisory body.

HOST COUNTRY REPORT

Organisation of social protection

Germany

1/7/2009



Federal Insurance Office (*Bundesversicherungsamt*): Supervisory body for insurance funds exceeding more than 3 *Länder*. Where the German Pension Insurance – Federal Institution is responsible for basic issues and horizontal functions, the supervision is carried out in some cases directly by the Federal Ministry of Labour and Social Affairs, in other cases supervision is done by the *Länder* ministries for social affairs or by appointed institutions.

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III. Long-term-Care in Germany

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| Financing principle | Contributions (insured persons and employers). |
| Contributions of insured and employers | <p>1.95% total, of which 0.975% employee, 0.975% employer.</p> <p>Compulsorily insured pensioners pay 1.95% of the pension. Insured persons born since 1940 without children pay from the age of 23 years a supplement of 0.25% of all contributory earnings.</p> <p>Annual ceiling: €44,100</p> |
| Public authorities' participation | No participation of public authorities |
| Applicable statutory basis | <p>Statutory long-term care insurance (Gesetzliche Pflegeversicherung): Social long-term care insurance for persons insured under statutory sickness insurance and private compulsory long-term care insurance for persons insured under private sickness insurance: Social Code (Sozialgesetzbuch), Book XI (SGB XI), as of: 1 July 2008 Law on further development of care (Pflege-Weiterentwicklungsgesetz) of 28 May 2008 (BGBl. I, S. 874).</p> <p>Social assistance (Sozialhilfe): Social Code (Sozialgesetzbuch), Book XII, – social assistance –, of 27 December 2003 As of: Law on Family Benefits (Familienleistungsgesetz) of 22 December 2008 (BGBl. I S. 2955).</p> |
| Basic principles | <p><i>Statutory long-term care insurance:</i> In 1995 the long-term care insurance was codified into the Social Code (Sozialgesetzbuch), comparable to the risks concerning sickness, accident, unemployment and old-age insurance. It is a contribution financed compulsory independent social insurance scheme, in accordance with compulsory affiliation and sickness insurance limits (see Table I "Financing"). Furthermore the possibility for a voluntary additional insurance for long-term care is given to every citizen.</p> <p>The statutory long-term care includes two independent parts next to each other - social (SPV) and private long-term care insurance (PPV), which are both compulsory insurances with identical benefits. No financial compensation between the two compulsory insurance schemes, there is a financial compensation regulated by law only within the respective schemes (SPV, PPV).</p> <p><i>Social assistance:</i> Tax financed. Persons incapable of work in need of care, who cannot help themselves and do not receive assistance from other persons, are entitled to care assistance.</p> |
| Risk covered | <p><i>Statutory long-term care insurance:</i> According to the legal guidelines, persons in need of care are those who, as a result of a physical, emotional or mental disease or handicap, are expected to need substantial long-term assistance for presumably at least 6 months or to an even higher degree to execute usual and regularly recurring activities of daily living.</p> |

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| <p>Definition</p> | <p>Further benefits are granted to persons mentioned above as well as persons with the need of basic care and provision of general care and domestic help, who have not reached category I (so called 'category 0'), if the examination of the medical service of the sickness insurance results in extensive general need of care resulting from dementia, mental disability and mental illnesses, which lead to considerable limitation of daily living.</p> <p><i>Social assistance:</i> Persons who, as a result of a physical, emotional or mental disease or handicap, are expected to need permanently and regularly substantial long-term assistance for at least 6 months or to an even higher degree to execute usual and regularly recurring activities of daily living, are granted care assistance. Care assistance shall also be granted to ill and disabled persons who will be in need of care for presumably less than six months, whose need for care is less than stipulated in sentence 1, or who are in need of care for other activities. This applies to care provided in institutional or semi-residential centres only if this is individually required, in particular if benefits provided under outpatient or semi-residential care are neither acceptable nor sufficient.</p> |
| <p>Field of application</p> | <p><i>Statutory long-term care insurance:</i> Nearly the entire population is insured through one of the two compulsory insurance schemes. Basic principle: 'long-term care insurance follows sickness insurance'. Every person that is insured with the statutory sickness insurance is automatically insured with the social long-term care insurance. Persons who are insured with a private sickness insurance concerning the risk of sickness with entitlement to general hospital services have to conclude a respective insurance to cover long-term care.</p> <p><i>Social assistance:</i> Every person who fulfils the requirements.</p> |
| <p>Conditions 1. Qualifying period</p> | <p><i>Statutory long-term care insurance:</i> Legislation provides for a pre-insurance period of 2 years. The pre-insurance period for children is fulfilled if one of the parents has carried it out.</p> <p><i>Social assistance:</i> No qualifying period.</p> |
| <p>2. Means test</p> | <p><i>Statutory long-term care insurance:</i> Benefits are not income related.</p> <p><i>Social assistance:</i> Benefits for care assistance are only granted in case of dependency, i.e. if the person in need of care can neither bear the costs of the care service him/herself nor receive it from others.</p> |
| <p>3. Minimum level of dependency</p> | <p>The condition for granting the care service is the classification of the person in need of long-term care into a category by the medical service of the sickness insurance. To reach category I there has to be at least a daily need of at least two activities laid down by law in the areas of personal hygiene, feeding or mobility as well as additionally provision of general care and domestic help. The time the family member or other person, who is not a professional carer, need for the basic care service including provision of housekeeping has to be on weekly basis at least 90 minutes as a daily average. Thereof more than 45 minutes daily need to be spent on personal hygiene, feeding or mobility.</p> <p>Further benefits are granted to persons mentioned above as well as persons with</p> |

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| | <p>the need of basic care and provision of general care and domestic help, who have not reached category I (so called 'category 0'), if the examination of the medical service of the sickness insurance results in extensive general need of care resulting from dementia, mental disability and mental illnesses, which lead to considerable limitation of daily living.</p> |
| 4. Age | <p><i>Statutory long-term care insurance:</i> No age limits.</p> <p><i>Social assistance:</i> No age limits.</p> |
| 5. Duration of benefits | <p><i>Statutory long-term care insurance:</i> Benefits have an unlimited duration as long as entitlement conditions are fulfilled.</p> <p><i>Social assistance:</i> Benefits have an unlimited duration as long as entitlement conditions are fulfilled.</p> |
| Providers and Evaluation | <p>Doctors in close cooperation with staff specialised in care and other qualified personnel carry out the assessment to determine the need of long-term care. The assessment of the need of long-term care of children is in principle carried out by trained experts with a qualification as health and paediatric nurse or paediatrician.</p> |
| 1. Evaluators | |
| 2. Providers | <p><i>Service guarantee for long-term care insurance funds</i> The long-term care insurance fund as an insurance company of statutory service guarantee must ensure an appropriate long-term care of the insured persons in the framework of providing the benefits. As these funds do not maintain their own facilities and services they conclude care and remuneration contracts with single care persons and the insurance institutions managing nursing homes and outpatient care services. Every care facility which fulfils the admission requirement is legally entitled to be admitted to carry out care services. That is why facilities of local, non-profit or private ownership cooperate next to each other. There are also so called low-threshold care services, where volunteers under professional guidance temporarily provide long-term care for persons in need at their homes or in groups.</p> <p>Financing system of the long-term care infrastructure Länder are responsible for provision and investment financing of the care facilities; the ongoing operating and care costs are to be paid by the persons in need of long-term care or their financing institutions.</p> <p><i>Social assistance:</i> Providers of care assistance are institutions of social assistance.</p> <p>Informal caregivers: Persons who are taking care of a person in need of long-term care in their home environment on a non-professional basis (e.g. relatives, neighbours, friends).</p> <p>Professional providers: Integration of care providers by authorisation in a form of care contracts. The basis for the authorisation to provide care services is the so called care contract. It regulates the benefits in kind and services, which insured persons can legally claim, and is concluded between the care funds and the provider of outpatient as well as residential care.</p> <p>Prospective compensation rate The contractual provisions in the care contract are binding for all parties concerned, especially in the prospective orientated compensation negotiations as ceiling for the compensation. The (agreed) charges per day have to be economic and performance related, a retroactive</p> |
| – informal caregivers | |
| – professional providers | |

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| | <p>reimbursement of costs is not possible. The person in need of care has to pay the compensation parts that exceed the benefits of the long-term care insurance as well as the costs for lodging and board (in certain circumstances investment costs as well).</p> <p>Quality assurance All authorised care facilities have to guarantee high quality, decent and activating care and supervision.</p> |
| <p>3. Evaluation of care dependency - indicators</p> | <p>According to the assessment procedure of the need of long-term care four statutory based indicators (activities) are taken into consideration:</p> <ol style="list-style-type: none"> 1. <u>personal hygiene</u>: assistance by washing, showering, bathing, brushing teeth, combing, shaving as well as using the toilet facilities; 2. <u>food</u>: assistance with bite-sized preparation and food intake; 3. <u>mobility</u>: assistance with getting out and into bed, dressing and undressing, walking, standing, walking up stairs, leaving and finding the way back home 4. <u>housekeeping provisions</u>: assistance with shopping, cooking, cleaning the house, washing dishes, changing and washing clothes and heating the house. |
| <p>Care Levels</p> | <p>For the determination of the need for long-term care the following categories exist:</p> <p>Level I For significant long-term care there has to be at least once per day the need for assistance with at least two activities laid down by law in the areas of personal hygiene, feeding or mobility as well as additionally provision of general care and domestic help. The time the family member or another person, who is not a professional carer, need for the basic care service including provision of housekeeping has to be at least 90 minutes as a daily average on a weekly basis. Thereof more than 45 minutes need to be spent on personal hygiene, feeding or mobility.</p> <p>Level II For hard long-term care there has to be a need for assistance with personal hygiene, feeding and mobility at least three times a day at different times of the day and additionally several times a week assistance with housekeeping activities is needed. The time the family member or another person, who is not a professional caregiver, need for the basic care service including provision of general care and domestic help has to be at least three hours as a daily average on a weekly basis. Thereof at least two hours need to be spent on personal hygiene, feeding or mobility.</p> <p>Level III For severe long-term care there has to be a need of assistance with personal hygiene, feeding and mobility around the clock, even at night, and additionally several times a week provision of general care and domestic help is needed. The time the family member or another person, who is not a professional caregiver, need for the basic care service including provision of housekeeping has to be at least five hours as a daily average on a weekly basis. Thereof at least four hours need to be spent on personal hygiene, feeding or mobility.</p> <p>Persons in need of long-term care of Level III can be recognised in individual cases as cases of particular hardship, if at least six hours, of which at least three hours at night, are needed for personal hygiene, feeding and mobility or if the night care can only be provided by several persons at the same time.</p> <p>The assessment of the need of long-term care has to be repeated in reasonable time periods. Important for the date of reassessment are the circumstances of every individual case, decisive are next to the prognosis also the expected</p> |

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| | <p>changes in the care and supervision situation. The assessor has to estimate the expected development of long-term care and document it. It also has to be stated if reasonable curative, care-based or rehabilitation-active measures as well as the usage of aids and care-aids or with the improvement of the living environment the need of care can be changed with. This is especially the case regarding recommended measures of the existing or anticipated deficient care. In particular if the assessment was carried out in a hospital a short term reassessment can be demanded. For children the reassessment has to be carried out at the latest after two years.</p> <p><i>Social assistance:</i> Through care assistance for persons in need of long-term care of the categories I-III assistance to care is also granted to ill and disabled persons who will be in need of care for less than six months, whose need for care is less, or who are in need of care for other activities. This applies to care provided in residential or semi-residential centres only if this is individually required, in particular if benefits provided under out-patient or semi-residential care are neither acceptable nor sufficient.</p> <p>Care assistance is preferably carried out as home care.</p> |
| <p>Benefits in kind of long-term-care</p> <p>Benefits in kind</p> <p>1. Home care</p> | <p>Monthly benefits in kind (provision of basic care, general care and domestic help by outpatient care centres or individual carers) amounting to:</p> <p>category I: up to €440, category II: up to €1,040, category III: up to €1,510, in cases of particular hardship: up to €1,918</p> <p>Several persons in need of care, especially in new forms of housing, can combine entitlements to benefits in kind (the so-called 'pooling') and the increased efficiency, especially of care benefits, are to be used in favour of the 'pooling'-participants.</p> |
| <p>2. Semi-residential care</p> | <p>Monthly benefits in kind for care in day and night centres in addition to home care amounting to:</p> <p>category I: up to €440, category II: up to €1,040, category III: up to €1,510.</p> <p>Apart from the entitlement to day/night care, a 50% entitlement to the respective outpatient care benefit in kind or care allowance remains.</p> |
| <p>3. Residential care</p> | <p>Lump-sum payment of the costs for care, medical care treatment and social care expenses as a monthly benefit in kind in the following categories:</p> <p>category I: €1,023 category II: €1,279 category III: €1,510 in cases of particular hardship: €1,825</p> |
| <p>4. Other benefits</p> | <p>Benefits for home care are complemented by aids and appliances to facilitate the provision of care, unless, as a result of illness or disability, they have to be provided by another fund, and by technical aids and appliances for household activities, used for alleviation of home care or mitigation of ailment of the person in need of long-term care or to support an individual way of life of such a person.</p> |

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| | <p>Expenses for aids and appliances meant for usage are reimbursed up to €31. Technical aid is provided preferably on loan. In certain circumstances participation of 10% is due, but not more than €25.</p> <p>Courses of instruction in the provision of care for caring family members and other voluntary carers.</p> <p>Respite care (Pflegevertretung): payment up to an amount of €1,510 for a maximum of 28 days in calendar year for the substitution of a carer, if he/she is on holiday or ill.</p> <p>Short-term care (Kurzzeitpflege): In case of absence of a carer or following the inpatient care, the costs of residential care during a short period up to a maximum of 28 days per year are covered for an amount of €1,510. Short-term care for children in need of care up to 18 years is also possible in the support institutions for disabled people or in other appropriate institutions.</p> <p>Additional care benefits for persons with an extensive general need of care (e.g. people with dementia, mentally disabled and people with mental illnesses) up to €100 per month (basic amount) or up to €200 per month (increased amount).</p> <p>Reimbursement of expenses for measures to improve the living environment up to €2,557 per measure with regard to appropriate participation.</p> |
| <p>Cash benefits</p> <p>1. Amount</p> | <p><i>Statutory long-term care insurance:</i> If a person in need of care provides for the care him-/herself, he/she can get care allowance in order to assure necessary basic care and household assistance in an adequate way. For this benefit the monthly amount is:</p> <p>category I: €225 category II: €430 category III: €685</p> <p><i>Social assistance:</i> The same benefit amounts as under the long-term care insurance.'</p> |
| <p>2. Discretionary use</p> | <p><i>Statutory long-term care insurance:</i> Instead of benefits in kind for home care the person in need of care can claim care allowance.</p> |
| <p>Combination of benefits</p> <p>1. Mixed benefits</p> | <p><i>Statutory long-term care insurance:</i> Cash benefits and benefits in kind may be combined: if the person in need of care only claims the benefits in kind partly, s/he is entitled to receive proportionate care allowance next to it. The care allowance is reduced by the percentage corresponding to the claimed benefits in kind. The person in need of care is bound by the decision relating to ratio between cash benefits and benefits in kind for a period of six months.</p> |
| <p>2. Free choice between cash and benefits in-kind</p> | <p>Free choice between benefits in kind and cash benefits.</p> <p>In order to exercise their right to self-determination the person in need of long-term care has in principle the free choice between home care and residential care as well as the choice between several licensed facilities and services. Together with the notice of approval the care funds provide a list with a comparison of services and prices of the facilities in the catchment area, the nearest care station and suggestions for individual care consultation. Since January 2009 the insured person has the right to additional care consultation vis-à-vis their care funds or private insurance organisation. Normally the care advisers are staff members of the care funds, they analyse the need of care on the basis of a MDK-report, set up</p> |

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| | <p>a plan for the provision of in the individual case needed social benefits and rehabilitation, healthy, preventive, curative or other medical and care based social assistance and they work towards approval and conduction of the corresponding measures. If so-called care stations ('Pflegerstützpunkte') are set up, the care advisers have to be placed there.</p> |
| <p>Accumulation</p> <p>1. Accumulation of cash benefits with benefits in kind</p> | <p>Cash benefits and benefits in kind may be combined (see above).</p> |
| <p>2. Accumulation with other social security benefits</p> | <p>For the different social security benefits of the Social Code there are certain ranking rules concerning benefits of long-term care.</p> <p>Social assistance: Benefits of care insurance precede the corresponding benefits of social assistance.</p> |
| <p>Benefits for the carer</p> | <p><i>Statutory long-term care insurance:</i> Payment of pension insurance contributions for caring family members and other informal carers by the long-term care insurance. A protection without contribution is also provided for these persons by the accident insurance. Contributions to the statutory pension insurance are also paid during the carer's holidays.</p> <p>Employees in companies with at least 15 employees have an entitlement to unpaid leave for up to 6 months in order to take care of a relative (so-called care time). As a general rule, their family health insurance continues in this time and the pension-insurance continues via the long-term care insurance fund. The entitlement from the unemployment insurance remains because of the contributions of the long-term care insurance fund. The contributions for health insurance and long-term care insurance are borne by the long-term care insurance fund up to the minimum contribution amount if necessary.</p> <p>If a person suddenly becomes dependent on long-term care, employees can stay away from work at short notice for up to 10 days in order to ensure care in need during this time or organise suitable care (so-called short-term work incapability).</p> <p><i>Social assistance:</i> Payment of the contributions for the carer for adequate old age provision, unless this is provided otherwise.</p> |
| <p>Participation of the beneficiary</p> | <p><i>Statutory long-term care insurance:</i> Care benefits contribute to mitigate the physical, mental and financial burden resulting from the need of long-term care. Not all costs relating to care are covered; only the cash benefits and benefits in kind mentioned above. If the total expenses of long-term care of a single person exceed the covered amount, the person pays the difference as participation.</p> |
| <p>Taxation</p> | <p><i>Statutory long-term care insurance:</i> Benefits of long-term care insurance are tax-free; furthermore, expenses relating to care may be deducted from taxes.</p> |

IV. Quality assurance in long-term care facilities

Licensed long-term care facilities (non-residential/residential) are responsible for ensuring and advancing the quality of the services they provide. In Germany, quality assurance in long-term care facilities is not only the responsibility of the facilities themselves (internal quality assurance), but also that of two different institutions (external quality assurance). These are, firstly, the medical review boards of the health insurance funds (*Medizinische Dienste der Krankenversicherung – MDK*) that check compliance with federal provisions and the contractual agreements based thereon on behalf of the long-term care insurance funds. Secondly, by the supervisory authorities of the Land concerned that monitor compliance with the Land regulations governing residential accommodation. In the Free State of Bavaria, these are the specialised bodies for quality advancement and supervision in long-term care facilities and facilities for disabled persons (*Fachstellen für Pflege- und Behinderteneinrichtungen – Qualitätsentwicklung und Aufsicht – (FOA)*). The existence of this institution which is unique to Bavaria follows from the federal structure of the Federal Republic of Germany as set out above.

The Land associations of the long-term care insurance funds task the medical review boards of the health insurance funds (MDK) with auditing residential and non-residential long-term care facilities licensed by means of a service contract to provide benefits-in-kind under Social Code Book XI. The boards have to inspect for compliance with the requirements of Social Code Book Eleven (SGB XI) and Social Code Book Five (SGB V) and the supplemental contractually agreed quality requirements. First and foremost, the aim is to establish whether the benefits agreed between the contracting parties (i.e. the facilities as service providers and, especially, the long-term care insurance funds and the social assistance carrier as payers) are provided according to the generally recognised state-of-the-art of medical and nursing care.

The FOA Bavaria are affiliated to the rural district and county borough administrations. The FOA concentrate on checking compliance with the quality requirements for long-term care facilities under the Bavarian Act on Long-term Care and Living Quality. The focus is on the services provided and the approaches taken by the entity responsible for the facility concerned to ensure service quality.

Both types of review bodies always carry out unannounced inspections. MDK and FOA must closely cooperate in reviewing long-term care facilities in order to effectively coordinate their respective tasks. In the process, it must be expressly ensured that they consult with each other both on the measures necessary in each individual case and duplicate audits are avoided as far as possible (section 117 of SGB XI).

Quality assurance and, in this context, transparency of service quality, is a subject that commands not only utmost attention but also harbours major conflict potential.

Sanctions

A differentiated range of instruments are available to address existing deficits and major deficiencies (e.g. serious care errors). Available options range all the way from a notice requiring to remedy the defects that includes tiered deadlines, via fee cuts, up to the termination of service contracts. If a residential care facility has its service contract terminated, this means, for instance,

that residents either have to move to another licensed long-term care facility or, if they stay, no longer receive any benefits-in-kind from their long-term care insurance fund. Then they are only eligible for the lower cash benefit with which to pay the professional care-related portion of the overall nursing home fee. As a result, the benefit paid by the long-term care insurance for a resident with care level II, can fall from €1,279 to €430. However, owing to the (parallel) regulatory sanctions imposed by the FOA as the supervisory authority of residential institutions, the termination of the service contract is very likely to lead to the closure of the long-term care facility concerned, as set out below.

A regulatory instrumentarium is also available to address defects identified during FOA inspections, ranging from consultation, via orders (such as a ban on admitting new residents), to the imposition of employment bans or operating bans.

IV.1. MDK approach

Audits explained

The Long-term Care Further Development Act that became effective on 1st July 2008, radically reformed the internal and external quality assurance system in the field of long-term care insurance (Social Code Book Eleven – SGB XI). Quality development is based on the internal quality management programmes operated by the long-term care facilities, their professional rigour (implementation of expert standards in care provision) and external quality audits.

The quality audits done by the MDK are based on section 114 Social Code Book XI. In carrying out the reviews and inspections this involves, the MDK assessors/MDK community overall follow the quality assurance guidelines (QPR) issued by the Central Federal Association of health insurance funds (effective since 1st July 2009). The QPR regulate details of the audit, such as the audit order, process and scope. In addition, they include provisions on co-operation with the supervisory body for residential institutions.

The Land associations of the long-term care insurance funds task the MDK with carrying out audits under section 114 (1) of SGB XI. These audits are to be conducted as standard, complaint-related or repeat audits. The standard audit specifically looks at major indicators of the extent to which residents are well cared-for and nursing and care provision measures are effective (outcome quality). It can also be broadened to include the sequence of care processes, their implementation and evaluation (process quality), as well as the immediate conditions surrounding care provisions (structure quality). Ten per cent of the residents/clients, but not less than five and not more than 15 residents/clients are included in the audit. To this end, a random sample is selected reflecting the distribution of care levels I - III in the non-residential or residential care facility.

In residential and semi-residential care, standard audits look at the quality of

- general care services,
- medical/technical nursing including home nursing services provided according to section 37 of SGB V,

- social care,
- additional custodial and activating care as set out in section 87 SGB XI (in fully residential long-term care facilities),
- services relating to accommodation and meals,
- additional services (section 88 SGB XI).

In non-residential care, standard audits look at the quality of

- basic nursing,
- home-making services,
- home nursing services according to section 37 SGB V.

The audit also refers to the requirements set out in the relevant recommendations of the Commission on Hospital Hygiene and Infectious Disease Prevention under the Protection Against Infection Act (*Infektionsschutzgesetz*).

By the end of 2010, the MDK has to inspect all residential and non-residential long-term care facilities. From 2011 onwards, all long-term care facilities will be subject to an annual MDK audit. These audit are consistently unannounced. Night-time inspections are only permissible if and to the extent that the objective of quality assurance cannot otherwise be achieved.

The audit team is usually comprised of nursing professionals. These teams are sometimes accompanied by physicians.

The contents of a quality audit that has to cover all aspects of quality-assured long-term care, includes particularly interviews with residents that also address their quality of life, aspects of health and grooming and involves a visual check. Equally, the audit factors in interviews with staff and, where appropriate, relatives of the persons with care needs. In addition, a review of the care documentation also feeds into the evaluation. This is the only way to obtain a comprehensive overall picture.

It is also worthy of mention that, in the context of the quality audit, the MDK's audit team holds an exit conference to especially discuss the complaints identified and advise the long-term care facilities on matters of quality assurance with the aim to immediately correct these complaints, where possible, to prevent other ones from occurring in the first place and to strengthen the facilities' sense of responsibility for securing and further developing their quality of care.

Transparency of the audit results

Another important innovation, the obligation to disclose audit results (section 115 (1a) SGB XI) was introduced in 2008. On this basis, the partners of the self-administration structure in long-term care concluded agreements on transparency in the residential sector (December 2008) and

in the non-residential sector (January 2009). The transparency criteria consented to through these long-term care transparency agreements are part of the overall audit according to the quality audit guidelines. The MDK's quality audit will continue to cover a more comprehensive spectrum, focusing on outcome quality. The preparation of the audit reports and the publication of the transparency reports are two separate procedures.

The long-term care transparency agreements of the self-administration structure in long-term care and the national criteria agreed therein are the first step towards giving visibility to long-term care quality levels. Published since 1st December 2009, the transparency reports firstly give persons with care needs and their relatives the opportunity to get an idea of the quality of care provided in a residential long-term care facility or by a non-residential nursing service they are interested in, to comparison shop and make a self-reliant and informed decision. This has taken the quality discussion in long-term care provision forward and is a major advance from the consumer perspective.

Overall, the quality audit of a residential facility is based on 82 evaluation criteria that fall into the following five quality areas:

1. nursing care and medical care (35 criteria),
2. behaviour towards and interaction with residents who suffer from dementia (10 criteria),
3. social care and day-time activities (10 criteria),
4. accommodation, meals, home economics and hygiene (9 criteria),
5. resident interviews (18 criteria).

All criteria are evaluated both individually and grouped in one of the quality areas (area result). The overall result of the audit is determined on the basis of quality areas 1 to 4 (i.e. without resident survey). The overall result is compared to the reference value in that Federal Land. The marking of the audit results is modelled on the German school system, ranging from 'excellent' (mark 1) to 'poor' (mark 5).

Quality audits of non-residential facilities are based on 49 assessment criteria that fall into four quality areas:

1. nursing care services (17 criteria),
2. medically prescribed nursing care services (10 criteria),
3. service provision and organisation (10 criteria),
4. client interviews (12 criteria).

The overall result of the audit is determined on the basis of quality areas 1 to 3 (i.e. without client survey). Otherwise, the procedure for non-residential care is identical to that for residential facilities.

Now, the further development of the long-term care transparency agreements through practical experience and know how and its evaluation is the task of the long-term care insurance funds and the service providers. They are responsible for the critical observation and further development of the system.

A systematic scientific evaluation of the long-term care transparency agreements including the published results has taken place under the leadership of the Central Federal Association of health insurance funds by the partners to the agreement. The results and recommendations of the evaluation that were published in July 2010 refer, *inter alia*, to the quality criteria selected in the long-term care transparency agreements, the rating system and the layout of the transparency reports.

Regardless of the need for revision identified in the context of the evaluation, the long-term care transparency agreements are an important step towards strengthening consumer interests and an incentive for quality development in long-term care facilities. According to the advisory council for the evaluation of the long-term care transparency agreements 'there are neither national nor international data on transparency systems that would lend themselves as an alternative to the transparency agreements that could be implemented in the near term.' Also the scientific assessors stressed that 'only recent experience with transparency initiatives is available even on the international level'.

Therefore, it is the aim and task of the partners to the agreement to translate the results and insights gained in the process into the further development of the long-term care transparency agreements by means of modifications or amendments.

Further development

The Federal Ministry of Health is supporting, together with the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, a research project for the development and trialling of instruments to assess the outcome quality of residential assistance for the elderly. The project aims to support the publication of facilities' quality ratings, the intensification of audits and inspections and the strengthening of the importance of internal quality management programmes. In the process, evidence-based nursing science is to provide practical answers to the question of how long-term care quality can be even better measured and reliably described in long-term care facilities.

The project is expected to bring results that can be used in various sectors: The quality indicators under development are to be used both for external quality audits and in the facilities' internal quality management and enable the quality-based comparison among facilities. This approach is based on an understanding of outcome quality that equally includes health aspects, the self-reliance of the residents and social aspects of quality of life.

IV.2 FQA Approach

The audits performed by the FQA are based on the Bavarian Long-term Care and Living Quality Act (*Bayerisches Pflege- und Wohnqualitätsgesetz*). The audit team that is expected to consist of

a physician, a qualified community worker, a registered nurse and an administration employee, inspects the facilities once a year and always unannounced. Night-time inspections must be limited to investigating matters that would not be feasible during day-time.

The FQA has to address two dimensions of evaluation:

- judging the extent to which the facility itself complies with the Long-term Care and Living Quality Act and
- to provide guidance to (future) users of a facility through publication of the audit reports.

The FQA is the only authority to have regulatory competencies. The FQA makes an important contribution to the rating of facilities on the basis of the Long-term Care and Living Quality Act. This rating together with other perspectives (e.g. MDK, self-rating of the facilities), helps the informed citizen to make an educated choice of facility. When auditing, the FQA checks the facility's compliance with the statutory requirements. Nevertheless, responsibility for compliance with these requirements ultimately rests with the facility. In carrying out their audits, the FQA are guided by observation and perception. Assessments are based on various perspectives and rely on the observations and skills of the FQA team. The agreed reporting base ensures high-quality reporting.

The focus is on protecting the dignity and independence of the residents and on safeguarding their quality of life. To be able to rate the foregoing, it takes a method of observation and judgement which places the concrete individuality and values of those concerned stage centre – and less so a scientific method that rates criteria unrelated to the individual person. During their on-site inspections, therefore, the FQA uses a 'fact-finding' method appropriate to their task – called hermeneutics – to form their opinion based on perceptions gained by participatory observation, documentation review and interviews with residents and staff. This method of gaining insights is based on understanding, identifying and interpreting the myriad observations, sensations and perceptions made in the course of an inspection with all senses (hearing, smelling, seeing, reading). To arrive at a valid opinion, the team form hypotheses from the perceptions made in individual key situations, i.e. assumptions and presumptions, that are verified by additional observation and specific questions. This then shows hypotheses right or wrong.

Invariably, every evaluation starts out from the disinterested observation of life situations. The realised practice in the facilities is what residents immediately experience. Therefore, an adequate form of observation and perception of life situations is the basis of any kind of evaluation. An appropriate sample of observed life situations leads to a credible description of the experienced quality of life third parties can relate to. The important thing in the process is to keep consciously recalling what has really been perceived and what to conclude therefrom, hence, to separate perception and evaluation.

In order to afford the greatest possible diversity of observations, the key situations offer various types of assistance to guide the attention, e.g. guiding quality questions, suggestions for perceptual and observational criteria, suggestions for more specific questions, suggestions for reviews of documents and quality management records. This 'material' tends to provide initial assumptions and suppositions. The important thing is for the team to keep their attitude during the on-site inspection as open and unbiased as possible and try to understand what approach the

facility has taken in implementing the requirements of the Long-term Care and Living Quality Act. This does not rule out that patent evidence of major deficiencies is sometimes found very quickly. In this case, the focus is not on understanding, but stringent action.

The 'key situation' instrument enables the team to gain, within a limited timeframe, insights into how the facility plans, implements and evaluates its tasks, where it succeeds, how it deals with poor outcomes, where counselling needs emerge and where deficiencies exist. Key situations as the basis of inspections are, on the one hand, observation-based and action situations for the on-site inspection, hence 'way stations' to go through during an on-site inspection. On the other, it is situations that offer endless possibilities for judging the quality and culture of life in the facilities from the perspective of the Bavarian Long-term Care and Housing Quality Act. They enable conclusions to be drawn as to how the facility implements this Act and translates its own mission, custodial and nursing care concept into reality. This, in turn, facilitates a holistic view and prevents one-dimensional action.

Key situations can be grouped into three functions:

1. Firstly, it is situations related to central life situations of the residents, such as receiving care, living in a room of one's own, in the common room, at mealtimes, social care, residents meetings.
2. Furthermore, it is situations that the FQA considers to be 'critical' and that requires particular scrutiny by the government to ensure the residents' protection, such as handling of medication or policies regarding any restriction of movement etc.
3. Finally, it is situations that provide a particularly rich source of information for the FQA, such as the tour of the premises, interviews with residents, interviews with the home management and the management of the outpatient nursing service, with the residents' council, with relatives etc.

Each of these key situations is structured into three parts:

1. Preparation for assessment,
2. Quality criteria and indicators for assessment,
3. Questions for reflexion.

The section 'preparation of the assessment' contains suggestions on what information can be pre-selected or obtained beforehand, such as mission, nursing and custodial care concept, activity plan, organisation chart, a compilation of the legal bases relevant for this situation and notes on what should be awarded particular attention in assessing the situation or where experience with these situations is already available.

As a suggestion for assessment, the section 'Quality criteria and indicators for assessment' includes one or more guiding quality questions. They refer to the Act on Long-term Care and Living Quality and afford experienced FQA team members a sufficient basis for assessing the housing, skilled care and custodial care situation. Detailed suggestions for assessment provide additional indicators, perceptual and observational criteria that draw attention to major aspects and that stress the on-site inspection's character of fact-finding and supervisory visit.

The section 'questions for reflexion' contains more detailed questions both on reflexion during the assessment of the facility and on follow-up.

The FQA's assessment refers to the facility's legal mandate and its ability to comply with it. Since the facility has committed itself to complying with this statutory mandate, it must prove that it is sufficiently competent to do so. The FQA support the facility in achieving this by virtue of its self-adjusting capabilities and checks this capability to implement this mandate. If the FQA finds that the facility is unable to do this either in isolated instances or systematically, it issues recommendations or initiates regulatory measures.

Opinions are formed and decisions made according to the consensus principle. Consensus-based decisions need no patent consent and, particularly, do not imply the need for unanimity. Consensus principle means that decisions are discussed and – if no party dissents (e.g. vetoes it) – are endorsed by everyone. Therefore, the FQA, when presenting its assessment, must give those in charge at the facility the opportunity to set out their reservations and perspective, for proper consideration.

The decision-making responsibility for an FQA audit lies with each member of the FQA – with each of them personally. All assessments that end with a notice are evaluated within the framework of the FQA quality management programme to identify common features and differences in selecting the criteria. Experienced members are available for 'collegial consultation', wherever possible, to help with difficult decisions. In such cases, the governments' technical supervision authorities should be involved, as well.

From 1st January 2011, the results of the FQA are to be published in a report that, while drawn up in layman's terms, is nevertheless valid. The format and contents of the publication are in progress.

Also the Bavarian Audit Guide (*Bayerischer Prüfleitfaden*) is to be evaluated in 2011 and 2012 and adjusted to accommodate the resulting requirements.