



Germany 2010

# Peer Review: Achieving quality long-term care in residential facilities

Short Report



On behalf of the  
European Commission  
DG Employment, Social Affairs and Equal Opportunities



Held in Murnau (Germany) on 18-19 October 2010, the Peer Review was hosted by the Bavarian State Ministry of Labour and Social Welfare, Family Affairs, Women and Health, and the German Federal Ministry of Health. In addition to the host country, nine peer countries were represented: Austria, Cyprus, the Czech Republic, Estonia, Finland, France, Luxembourg, Spain and Sweden. Moreover the stakeholder organisations AGE Platform Europe and European Social Network (ESN) took part in the Peer Review in addition to representatives of DG Employment, Social Affairs and Equal Opportunities of the European Commission.

## 1. The policy under review

The long-term care insurance system in Germany was created in 1994 as the fifth pillar of social security insurance. It is based on compulsory contributions: employees and employers currently each pay in the equivalent of 0.975% of the employee's gross income, without the contribution of public authorities. The main elements covered are personal care, nutrition and mobility. Benefits are payable for home care, semi-inpatient care and inpatient care. A broader definition of care needs is currently being discussed, given the steep increase in the number of people suffering from dementia.

Reform legislation in 2008 intended to improve quality assurance by intensifying regular quality checks and increasing transparency, whilst the financial element of this reform consisted in increases in both contributions and benefits. Additional resources were also mobilised, such as extra staff for residential care. Structural improvements include the creation of 'care support points' which provide advice and services to people who suddenly find themselves in need of care, and to their relatives. The 2008 Act makes the setting of specific care standards a compulsory task for the self-management structures that bring together the care insurers and providers. Previously, expert standards had been developed only within model projects financed by the Federal Health Ministry. The Act assigns the responsibility for quality assurance to the care insurance funds. They delegate it to their medical advisory services (MDK). The MDK is responsible for quality inspection, but they also control access of individual applicants to care insurance benefits and rehabilitation measures. A fairly broad definition of 'quality' is embodied in the Act, including structure, processes and outcomes. The general aim over the past few years has been to focus quality assurance and respective audits mainly on the quality of outcomes. The inspection process of the MDK in care homes (and home care organisation) is highly structured and also includes the provision of advice based on the result of the inspection visit. From 2011, each facility will be inspected annually. Previously, only about 20% of care homes per year were inspected. The staffing of the MDK has been increased to meet the new inspection schedule.

A quite new departure in the 2008 Act is the creation of a transparency requirement. Here too, self-management is to the fore. The providers and insurers jointly agreed upon and adopted transparency criteria and the respective assessment methodology by the MDK. These criteria are more narrowly drawn than the inspection criteria, as the aim is to glean the most essential information and to express results in the form of a points system similar to German school marks. The aim of this approach is to provide a transparent and accessible support for consumers to comparison care homes. The transparency requirement has been implemented for over a year now, and more than 10,000 reports are already available online. Apart from a general mark covering four of five quality areas (e.g. 'nursing care and medical care' or 'social care and day-time activities'; resident interview results are not included in the general mark), those interested can also distinguish the marks given for each of the five quality areas separately and additionally

the points awarded for all 82 specific items addressed within these areas. This proceeding has proved controversial, with some arguing that key care issues should be given greater weight in the overall marking. Some care home owners have also questioned the marking system as such, and have taken court action over their ratings.

The MDK audits are federal (with reference to the Federal LTC Insurance legislation), whilst each of the states within Germany remained responsible for the general surveillance of care homes – with respective own regulations, structures and proceedings for monitoring compliance. In Bavaria, this is the role of the specialised bodies for quality development and monitoring in long-term care facilities and facilities for disabled persons (FQA). The FQA, which are affiliated to local government administrations, check compliance with the quality requirements of the Bavarian Act on Long-Term Care and Quality of Life. The focus is on the services provided and the approaches taken to quality assurance. Both MDK and FQA inspections are conducted unannounced. German law requires coordination between federal quality assurance and the supervisory bodies in each state. Debates about respective co-ordination mechanisms have therefore been started.

## 2. Key learning elements

Among the main points to emerge from the Peer Review:

- It was generally agreed that **minimum standards** are needed for long-term residential care and that **compliance should be monitored**.
- **Policy debates involving all stakeholders** are needed in each country to decide upon the desired, and sustainable, quality of long-term care.
- At the European level, a discussion is in progress on **social services of general interest**. In some countries, the voluntary **European Quality Framework for Social Services** could be a basis for national debate. However, this framework is certainly not intended to replace, or to be superimposed upon, existing quality assurance and quality management systems.
- A number of countries are moving away from an inspection-only approach to a **quality management approach that combines inspection with advice and self-assessment reports with an effective internal quality management system**.
- **Benchmarking of care quality** is more than just comparing aggregated data. Some benchmarking initiatives within groups of care homes or on a regional level have started to emerge in some Member States. However, this requires major investment, notably in training, and may therefore not be feasible in all countries.
- There is a need for a **dialogue on quality between purchasers, providers and other stakeholders**, including residents and their families.
- The **relationship between health services and social services** needs further discussion. Some countries' perspectives on long-term care are more health-oriented while others are more focussed on social services.

- The **intensity of external checks on quality** varies considerably from country to country. The frequency of inspection of each long-term care facility ranges from every year to every seven years.
- **Quality management systems** are being developed in the various peer countries. The more sophisticated the external inspection system is, the more it calls for effective internal quality management. Otherwise, a large gap between results of inspections and actual quality in daily work will persist.
- **Care services** are increasingly provided **across Europe** as more and more care services providers as well as beneficiaries operate and live outside their home country. This represents an additional challenge for **quality assurance**.
- Care staff are not used to working with **indicators**. The introduction of such systems thus requires **participative leadership and human resource management**. Both management and staff need training on quality management and related issues. Here, a **lifelong learning** approach is required that will often go beyond legally prescribed training.
- The use of **European Social Fund (ESF)** means to support quality thinking, training and mutual exchange in the area of health care and social services was discussed.
- An essential aspect of quality deals with ensuring **dignity and rights** in daily care: it is about creating living and working conditions that foster **respect** against individuals and protect them from abuse.
- Some concerns were expressed about the **sustainability of parallel national and regional inspection systems** (sometimes in conjunction with a third system – the providers' own internal quality management).
- **Modernisation** of care homes entails **openness to other parts of the care chain**. In future, the quality of long-term care facilities will also depend on their openness to the community, networks, volunteers and other social services.
- **Transparency of quality** could facilitate the regulation of pricing according to the quality of the care home. Starting to move towards performance-based financing of care homes calls for a careful approach of positive reinforcement, i.e. incentives for those who are able to prove good performance by means of transparent criteria should be conceived.