# Quality assurance practices in Long-Term Care in Europe

## Emerging evidence on care market management

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## EXECUTIVE SUMMARY

The importance of keeping older people safe from harm, ensuring the protection of human rights and enabling anyone needing long-term care (LTC) to continue to live a life of as much independence as possible is widely acknowledged. Availability of services is highly influenced by the presence of private markets for LTC provision, which has increased substantially in recent decades compared to state (or local government) run services. In quasi markets for LTC services, for profit or not-for profit providers are commissioned by (local) government to provide nursing, residential and community/home based services. Alternatively, LTC users purchase services directly using cash benefits or with own funds if not covered under the national LTC system. A large literature deals with the various aspects of quality assurance in LTC, however, little comparative research has been carried out on the details of the approach (local) governments take to quality assurance of privately provided LTC. Nevertheless, it is well known that in many countries both access to and quality of LTC provision varies significantly between localities and references are often made a 'post code lottery' of LTC. This research note surveys approaches to the management of the quality of privately provided LTC services in England, Sweden, France and Poland. Evidence was collected through a survey of the academic literature, reports and websites as well as through semi-structured interviews with country experts. We found a wide diversity of national and local approaches to quality assurance and the underlying assumptions of how quasi-markets in LTC functions.

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# 1. INTRODUCTION

Quality assurance practices, including approaches to reduce risk and improve performance, vary considerably between and within European countries. These approaches depend on many factors: public, private for profit and non-profit care providers, and play an important role in the increasingly common quasi-markets[1] currently developing across Europe. Market-oriented governance in long-term care (LTC) calls for special endeavours to assess, measure and control quality of services. The governance mechanisms at the national, regional and local levels also influence quality assurance, at times in conflicting ways, for the large number of important stakeholders: service users and families, care providers, local government and national regulators. Increasingly, indicators of care quality are collected and are, albeit slowly, branching out from the previous focus on quality of clinical care to include quality of life measurements and indicators capturing the extent to which care is provided in a personalised manner.

A noteworthy European-wide trend in the area of LTC is the increasing importance of quasi-markets as a means of organising the provision of LTC services. The extent to which this is taking place in different countries depends on historical artefacts, relation between the LTC and the health care system, political ideology and geography. The process often dovetails with the development and growth of formalised LTC systems in many Central and Eastern European countries. Traditionally, LTC services have been the business of either the state, through an offer of formal care services, both publicly funded and publicly provided (such as in Sweden), the health care system – however generally offering limited formal services predominantly in a residential setting (such as in Poland) or the business of the family, with a high reliance on and duty for children/relatives to provide informal care (England, France). More recently markets have opened up for private (both for profit and non-profits) LTC providers in most countries. Indeed, a recent study by the Eurofound found that in all European countries except Spain, the private provision of care home beds has increased more than the equivalent public provision (2017).

The governance of quality in LTC is organised at various administrative levels in different countries, often including a national regulator and significant local responsibility for both funding of LTC services (for example through local taxation) and provision of services in the local area, although this varies. For example, administration is located at the national level in The Netherlands and Slovenia, at the regional, provincial or cantonal level in Italy, Spain, Switzerland or at both national and regional or municipal levels in England, Finland,

[1] Quasi markets in the setting of LTC provision are denoted by a public purchaser (most often local government) purchasing services from private (for profit or not-for profit) providers to provide nursing, residential and community/home based services. This tends to be done in accordance with public procurement legislation and to a lesser extent through individual users purchasing care using a cash benefit. In both cases there is a public responsibility for the care provided by private providers, and quality assurance measures to regulate, monitor and enforce that the desired standard of care is offered.

France, Germany, Sweden (Nies et al. 2010). Nies et al further argue that endeavours to define, measure and assess quality in LTC across providers, is in the interest of all of the national administrative levels, but also, importantly, of the European Union and its institutions (2010). There are also calls for the establishment of a "European Charter" at the EU level, in the first place geared at preventing abuse of older people with LTC needs, but also to improve quality of care more broadly (AGE platform Europe 2010).

The research note analyses and assesses what strategies national and local governments implement to assure and improve the quality of formal LTC services provided by private providers in their areas. We focus on the underlying assumptions, the extensiveness and the intensity of quality assurance activities and on the interplay between key actors and stakeholders, including the national regulators, local government and service users and families and how these are informed. Following Malley et al. we categorise activities to influence quality in terms of regulatory, economic and information-based instruments (2015). This approach will help make sense of the various quality assurance activities in order to inform European policy choices around LTC quality management knowledge sharing and collection of data. This note uses a case study approach and describes and analyses different approaches to quality assurance in four European countries: England, Sweden, France and Poland. We do not strive to compare the systems in detail, but rather draw on each of them as cases of LTC quasi-market development and assess the quality assurance systems in the four countries.

The first three are 'mature' LTC systems with between 1.5 (UK) and 3.2 (Sweden) percent of GDP spending on LTC and a long history of public funding and provision of LTC (OECD 2018). There are however important differences in the historical trajectory and characteristics of quasi-markets for LTC services. Poland on the other hand represents an 'emerging' LTC system, with comparatively low spending of 0.5% of GDP (OECD 2018) and where the full range of services are only becoming widely available in later years. All four countries have a LTC system that are funded through general or local taxation and subject to means-tests or income related co-payments. England has one of the most developed private markets for LTC in Europe and there is a large variety of approaches to managing markets as well as assuring quality. Sweden represents the Scandinavian cluster of countries. The extent of private non-profit providers is relatively large in Denmark, for-profit service providers play a more significant role in Sweden, while in Norway, the roles of both of these types of private actors comparatively modest. (Segaard and Saglie 2017). France has a complex system of actors on different levels of governance compared to for example Germany (also in the continental cluster of countries) and is less commonly explored in comparative research. Finally, Poland has one of the most developed LTC systems out of the Central and Eastern European group of countries.

We reviewed the international academic literature, reports from international research projects as well as national reports, legislation and research and where possible we survey the types of data collected both at national and local level in the four countries. Where possible (England, Sweden and to some extent France) we also accessed publications and reports in the national language. The case study on England draws extensively on research carried out within the ELSCQua study (Malley et al. 2017-2019) where the research team carried out process evaluations of quality interventions in three local authorities (LA) as well as an extensive survey of the use of quality assurance instruments (regulatory, economic and information based, see Malley et al 2015) in English local authorities. Informed by the findings of the ELSCQua study, this research note combines analysis of the national regulatory framework and data collection with data collection on local quality assurance practices in the three remaining case studies. We build the analysis on evidence from semi-structured interviews carried out by the authors during December 2018 and April 2019. Appendix 1 lists the interviews carried out, including organisation, role and whether informing mainly on the national or local level.[2]

The research note is focused specifically on the quality assurance arrangements that are in place to govern the quality of LTC provided by private providers. This includes non-profit and for-profit organisations. The focus on privately provided care is motivated by the lack of direct mechanisms of control of the care provided by private providers, on the part of public purchasers of care, which brings about a need for structures to monitor and enforce quality standards (The World Bank 2015). The focus is on services that are publicly funded, however, the quality assurance arrangements for publicly funded providers also often apply to providers where users fund their own care, out of pocket, and we note where this is relevant. We focus on elderly care, which primarily includes long-term care provided to individuals over the age of 65. However, given the differences in systems some aspects will apply also to other services such as those for young people with learning disability and young disabled. We include all service types available for older people, including nursing and residential care facilities,[3] home care provision, day care and other community care and where available sheltered living type facilities. Where relevant we will discuss quality assurance of services provided by personal care assistants who are hired directly by the user and paid through cash benefits (for example a personal budgets in England and cash benefits in Poland).

The note is organised as follows: we first explore the concepts of quality, before turning to the state of LTC markets in Europe and how they have developed over recent decades. We

[2] The interviews were carried out via telephone/skype and have been recorded but not transcribed and can be made available on request. Search terms and interview guides are also available on request from the authors.
[3] Nursing homes provide all the support that a care home would but registered nurses are also on-site throughout the day and night. Residents usually have a medical condition that needs regular attention from nurses or doctors.

then analyse the characteristics of quality assurance arrangements in the four countries and finally, in section 6 we draw conclusions and identify further avenues for research.

## 2. Long-term care markets in Europe

It has been argued that the main public policy question vis-à-vis provision of any welfare services is whether to 'make or buy', i.e. how much formal LTC services should be provided by the public sector and how much should be contracted out to private facilities. The public–private mix seems to be determined, to a great extent, by path dependency – for example, who the main provider was when services where first developed. Current evidence of trends in private provision indicates that an increasing share of LTC is provided by private (for profit or not for profit) organisation across Europe. A recent report by the Eurofound, focused on nursing and residential care facilities, found that over the last 10 years, public provision of care homes has decreased (or increased to a lesser extent) than the private sector (2017). There are however issues with accessing comparable Europe wide data on market structure. The Eurofound data came from estimates from experts, national studies and national statistics, however, making comparisons is made more difficult due to the fragmentation of services, the lack of data in many countries about service providers outside of the public sector and the fact that LTC includes both health and social care which affects reporting given that data on health and LTC are collected separately.

The underlying rationale of allowing competition is to improve quality and lower costs. We can think of LTC markets as quasi-markets, where competition is promoted, however not all providers are profit-maximisers and care is often purchased on behalf of the user, who may or may not exercise choice of the end provider. In quasi-markets for LTC, services may be delivered more efficiently, i.e. an equivalent quality of the service is delivered at a lower cost. However, given that quality is difficult to specify and evaluate (which is indeed reflected in selection criteria as part of public procurement and commissioning) a critique of marketization is that cost reductions are achieved by lowering quality. In the case of LTC, this risk is underlined by the fact the payment providers receive is at least partially set by the national or local public purchaser (Nies et al. 2010) and is, for example in England, argued to be too low.[4] Leichsenring et al argue that in a number of countries insurers or local government are mainly concerned with controlling costs, and quality assurance beyond minimum standards is a secondary concern (2013).

On the other hand, quality may improve due to larger responsiveness and positive outcomes of increased user choice. Private providers are thought to be more responsive to

[4] The picture is further complicated by the presence of users funding their own care, fully or partially. This can be due to means-testing, income related co-payments or top-ups. In many countries there is cross-subsidisation from self-funders, i.e. provider use people paying for their own care to make up for fees from the public sector not being large enough.

user needs than their public sector counterparts. The introduction of competition creates incentives to innovate and adapt to consumer needs and hence improved standards of care should follow. It can also be argued that the increased choice generally available to users under quasi-markets for LTC services, is valuable in and of itself and may leave to an increase in the differentiation in the types of provision available, for example by size, geography and level of care provided (Barron and West 2017). However, competition will only have an impact if potential service users have a real choice, can accurately assess the quality of care they will receive, and if existing users are able to switch providers if they are dissatisfied. Evaluating the quality of residential facilities prior to moving in is challenging, in particular given that LTC is an experience good. This is compounded by the fact that people often move in to residential care in a time of crisis and that LTC users often find it difficult or impossible to move to a different facility if they are not happy with their first choice (Grabowski and Hirth 2003). The situation for different community care services is possibly somewhat better in that it is easier to change provider and there may be wider offer of different providers available in the local area.

## 3. What is quality in LTC?

The literature defining and conceptualising quality of formal LTC is broad and there are many diverse approaches. The purpose of this section is not to arrive at a clear definition of quality to use in the latter parts of the research note, but rather to illustrate some of the key themes and concepts to help make sense of quality assurance and management in European LTC systems. Part of the challenge in settling on anything but a broad conceptualisation is that, as Spilsbury et al (2011) point out, quality is a dynamic concept and context matters. System-level context includes the diverse range of views, values, expectations and preferences held by different key stakeholders. These can include policy makers, providers, care professionals and consumers. Spilsbury et al. argue that "questions about quality are essentially questions about values" (2011: 733). Further, in many LTC systems we cannot discount the structural role of public authorities as purchasers and/or commissioners of services who have an influence in assuring quality through their governance arrangements (Nies et al. 2010). Context relates to for example the type of LTC provision: for instance, level of physical function may place limitations on processes and outcomes in residential care in a way that they may not in home care.

Quality of care is often discussed in terms of Donabedian's distinction between structure, process and outcome aspects of quality (1980). The structure related aspects of quality consists of 'what you have' (factors which can be defined as the preconditions to achieve good quality in your operations), process quality is about 'what you do' (how the care is actually provided), while outcome quality is the actual result. Donabedian's model is broadly accepted within the academic literature though there has been a gradual shifting

of focus from structural aspects of quality to process and outcome aspects (Jongen et al. 2015). However, there are concerns over quality as determined by outcome measures, particularly user defined, as they may not give insight into the nature or location of deficiencies within the structure or process of care delivery.

Many competing conceptualisations of LTC quality feature in the literature. A focal point are dimensions of LTC quality that are most relevant to care and amenable to change through LTC policies. For example, Murakami and Colombo, in an OECD report, discuss these dimensions as effectiveness, safety, patient-centeredness, care co-ordination and integration (2013). These dimensions emerged by taking a 'real-world' view by reviewing national frameworks for LTC in OECD countries and re-framing structure, process and outcome to reflect technical aspects of quality as well as the experience of LTC users. European agents have documented their own frameworks for quality. The EC Social Protection Committee identified principles of availability, accessibility, affordability, person-centeredness, comprehensiveness, continuous improvement and outcome-oriented for addressing quality across all social service provision (2010). The SPC Working Group on Ageing, in their report, 'Adequate Social Protection for Long-term Care Needs in an Ageing Society', documents how these principles apply in long-term care. They identify the importance of the well-being of recipients, their increasing demand in having more control of their care and the pressure for services to be accountable given their increasing costs as key drivers of quality in long-term care provision.

A key motivation for conceptualising and understanding quality in LTC is to be able to measure, assess and consequently influence quality of service delivery. However, a significant challenge in employing either of these frameworks is that structural measures, while easier to measure than process or outcome measures, do not take account of the experience of care recipients. It has been argued that these approaches relies on a portrayal of care recipients as 'dependent and helpless' (Ungerson 1990) and does not make feasible for service users to voice their expectations of care. Another challenge is how to address conflicting quality principles. In particular, concerns about the well-being and safety of service users may be in conflict with the challenge for services to be responsive. Evans et al. argue that in the context of care home management there is a "real tension between risk management and autonomy to the level of both policy and practice" which is exacerbated by the prioritisation of risk management by regulatory agencies. As there is little guidance from regulators as to how best to balance these competing principles, and partly due to limited time and staff resources, safety concerns are typically prioritised (2018: 264).

Increasingly, user preferences and level of subjective satisfaction has been promoted as a key component of quality in LTC. User preferences can act as a basis for determining quality

through their role in choosing, directing and evaluating many features of their care. The theories of New Public Management casts the user, or client, as a consumer who through active choices influence and define what is good quality (Clarke et al. 2007). However, there are significant issues around this view. Firstly, some LTC clients may lack capacity to consider and express preferences and secondly, the idea that quality is improved through competition given that consumers 'vote with their feet' does not map well onto the LTC environment. LTC users are often vulnerable to change, i.e. less likely to, for example, move from one nursing home to another. The choice of the initial (and often permanent provider) is often carried out at a time of stress and the user generally already has significant needs. This means that the, from economic theory, expected link between choice, competition and quality is less likely to work in LTC markets than in other markets.

Quality of informal care is often understood as the basic ADL needs of the user being met (Christie et al. 2009), however, the conceptualisation and measurement of the quality of informal care is one of the least researched areas in the LTC literature (Courtin et al. 2014, Gori et al. 2015). This lack of research may stem from the inherently private nature of the informal care relationship between carer and user. However, some current trends such as cash-for-care schemes and other cash benefits are becoming increasingly common and represent what can be thought of as a formalisation of informal care. This formalisation of informal care changes the extent to which informal care is a 'private' matter given that it becomes publicly funded and in some cases regulated (Zigante 2018).

## 4. Understanding quality assurance in LTC

This section explores the literature on quality assurance and management and how this relates to LTC quasi-markets. LTC has a relatively short history as a recognised social risk which explains some of the scarcity of quality assurance practices, for example in comparison to health care (Rodrigues et al. 2014). In relation to quasi-markets we address the tools, or instruments, available to national and local government purchasers to influence quality as part of the procurement process and beyond. Simply put, in order to assess the quality of a service it is necessary to, drawing on Donabedian's (1980) conceptualisation of quality, agree upon structural and procedural standards and upon expected outcomes within an acceptable range of costs and prices. It is worth reiterating that it is the introduction of quasi-markets and public tendering that has activated the need to increase transparency of providers' service quality towards both public purchasers and users5. Ultimately, quality assurance in quasi-markets is about preventing provider failure and the detrimental effects this may have on service users. Many countries have

[5] It is important to note that in several European countries there is a considerable market for *privately* purchased LTC (in England referred to as "self-funded" care). The privately purchased care can be both publicly funded (for example through a direct payment in England) or through private funds, often by LTC users who do not meet means-test/income related thresholds.

experienced damaging scandals of poor quality of care or outright abuse getting huge attention in media (Nies et al. 2013). These are key characteristics to keep in mind when exploring quality of LTC.

Starting from a pragmatic definition of quality as "the appropriate delivery of a mutually agreed service or product" (see Nies et al. 2013:224) is helpful for thinking around the ways of assuring and influencing quality in LTC quasi-markets. Firstly, the idea of a "mutually agreed" product is important given the complex and highly specialised and personalised character of LTC services. Issues such as quality of life, dignity and personal preferences are difficult to standardise in contracts/agreements and consequently to measure (Rodrigues et al. 2014). Secondly, the set of stakeholders is wide and includes service users as clients of formal services, public purchasers, different types of providers and professionals but also importantly informal caregivers (often family, relatives and friends) as well as the general population because LTC as an acknowledged social risk, is to a large degree funded by public resources (Nies et al. 2013). It is worth noting that the four countries surveyed in the note have different conceptions of quality, and also that the conceptions vary between levels of government, organisations and stakeholders within the countries.

### *4.1. Key concepts for quality assurance*

Nies et al. (2013), uses the term quality assurance as the "activity of third parties to ensure and certify defined quality criteria from an external perspective" (drawing on Bauer et al. 2006). Quality assurance is generally seen as a component to quality management at the delivery level of any good or service. In the particular case of LTC services, however, as in other services of general interest, the fact that public authorities act as purchasers and/or commissioners on behalf of the users adds an important governance level to quality assurance (Huber et al. 2008). In the setting of quasi-markets, ensuring adequate quality and avoiding provider failure necessitates that the quality of structures, processes and outcomes of services is defined ex ante by the purchaser (by means of accreditation and contracting) and be assessed and monitored ex post by various actors. In the words of Malley et al. the cycle of quality assurance relies on the setting of standards, the surveillance of provider performance and "punishment" or sanctions when quality requirements are not met (2015). In the below we single out key actors, concepts and the 'levels' or organisations where the phases of quality assurance tends to operate.

Central government is the principle regulator of LTC quality and most countries have a national oversight body (such as the CQC in England). It is however also common to assign the responsibility for implementing quality control and monitoring compliance to a range of decentralised bodies, sub-national governments and arms-length organisations.

Regulation aims to safeguard users and control quality, as well as to guarantee accountability for resources invested into LTC and the channelling of public funds towards private (in particular for profit) organisations). Regulation is based around principles, which are specified into standards, designed to ensure the effectiveness and safety of care. Standards (or minimum standards) outline the expected level of quality in measureable terms, however, the level of detail varies significantly between and within countries. Standards are often focused on structural quality such as staff ratio and details of the living environment, as well as administrative matters and governance of care provision. In later years a move towards more process and outcomes oriented standards including quality of life, human rights and dignity can be observed in many countries. These principles are typically embedded into legislation. Standards are a key feature for both regulation and accreditation and indeed when setting out specific contracts with individual providers.

Registration and licensure, or certification, also referred to as accreditation, is often a requirement for market entry. Accreditation can be seen as meeting minimum standards required in order to be able to operate in the relevant LTC market. The requirements for accreditation are often uniform and standardised nationally, but the requirements may differ depending on care setting (nursing, residential home care, home care etc.). Accreditation can also, Murakami and Colombo argue, require above minimum obligations as a requirement for practicing and does in practice often form a condition for public funding (2013). The accreditation process generally involves a national accreditation body (often the national regulator) and involves both an internal and external review. First, the provider is required to draw up policies and documents that meet the required criteria and then the external review evaluates the provider against a set of quality criteria. The external review is often a combination of desk-based review, on-site visit and a comprehensive assessment which sometimes includes interviews with users, families and staff.

### *4.2. What instruments are available to influence quality?*

A useful tool for understanding how (local) government strive to influence quality of providers is through the instruments they have at their disposal. Malley et al. (2015) argue that from the perspective of promoting good quality care, local government can select from three types of policy instruments: regulatory, economic and information-based instruments. Regulatory instruments aim to promote quality through rules and directives which set requirements for various actors. Most regulations are set in national legislation and have high binding force, but regulations can be entered into voluntarily, for example where organisations decide to participate in accreditation and certification schemes. At the local level, regulation can be understood in terms of the management of contracts and important facets of contract management are distinctive from regulation at the national

level, importantly the complexity of contracts and the duration and intensity of relationships between the purchaser and the provider. Economic instruments refer to sets of policies that aim to incentivise behaviours that promote good quality care. These may be financial incentives, such as quality-related subsidies or reimbursement schemes, or they may include the use of quality-related criteria for procurement. Information-based instruments seek to change behaviour through the transfer of knowledge and evidence-based arguments. Instruments within this category are diverse and can be directed at both care users and providers. They include educational and knowledge management schemes, quality management systems, public reporting and mechanisms to capture feedback from care users.

From a regulatory perspective, the literature on inspections and audit processes differentiates between deterrence approaches that emphasize formal, legalistic regulations, and compliance approaches that are characterized by more supportive methods to assist the home in improving quality (Walshe 2001). While professionals tend to value more compliance-based approaches to inspections (Furness 2008), Choiniere et al. highlight arguments that in highly privatised LTC markets compliance approaches are not effective (2016). Partly this can be due to the many possible perverse incentives and opportunities for gaming in relation to the regulatory approach to assuring quality. Hanberger et al. (2017) mentions how nursing homes prioritise completing forms on outputs and other required information instead of resolving important problems, in what is called 'documentation ritualism' or 'get[ting] the documents right but the care wrong' (Braithwaite et al. 2007: 221). This conflict can be seen also at the contract management level, where however, due to the relationship aspect the focus is more on compliance and support. Different types of regulation can have unintended consequences such as tunnel vision (i.e. providers being overly focused on what is measured in quality monitoring), myopia (excessive focus on short-term objectives at the expense of longer-term benefits), gaming (changing behaviours only to meet standards through for example selecting less risky and challenging clients) and finally measure fixation ('hitting the target and missing the point') (See Trigg 2018).

Economic incentives include quality-related subsidies or reimbursement systems that reward providers for extra efforts to improve quality. Financial incentives can be grouped into quality-related subsidies, quality-related payment schemes or price regulation and quality-related procurement modes. Quality related subsidies include schemes which reward providers for specific behaviour that is intended to improve quality, for example, investment in staffing levels or skill development through formal training or other strategies such as thematic champions. Quality related payment schemes include different types of pay-for-performance schemes, with the goal of encouraging ongoing

improvements and rewarding high quality care. Quality related procurement models tie the eligibility of providers for public funding to the adoption of quality management systems or quality improvement strategies. Public procurement can also be used to incentivise providers to focus on the quality of their services more broadly. The public purchaser can increase competition on quality by putting higher weights on predefined quality criteria and asking providers to compete on both price and quality.

Information related instruments are by Malley et al (2015) interpreted as education and knowledge management; quality management systems; public reporting; and feedback on quality from users, staff and other members of the public. Education and knowledge can influence quality by supporting providers to follow best practice. In many countries there are arms-length bodies for the purpose of supporting transfer of knowledge to providers. Quality management systems, such as for example ISO system accreditations, can be used by providers to improve quality. These can be seen as self-regulation (voluntary accreditation) but given the learnings they offer they can also work as information-related tools to increase providers' awareness and skills in monitoring. Finally, information related instruments include the involvement of care users and members of the public in improving care provision. The public reporting of quality information aims to directly address the lack of information about quality in LTC markets, which undermines the ability of consumers to make effective choices about their care and creates market inefficiencies. We can think of the role of consumers as a driver of providers 'self-regulating' through increased competition between providers who are hoping to establish a 'good reputation' in order to generate business. This includes making performance transparent to potential users and purchasers to support with users choice of service (Simonazzi 2012). There are however issues around relying on consumer choice as a driver of quality in LTC: LTC users often make choices in situations of great strain and time pressure, it is often family members who make the choice and users are relatively unlikely to switch providers once they have for example moved into a care home.

### *4.3. What Indicators are used to monitor quality?*

Measuring quality of LTC provision and systems has many challenges. The extent to which quality indicators are routinely collected varies significantly between countries, but also what indicators are focused upon (The World Bank 2015). There has, predominantly for practical reasons, been a focus on indicators of structural quality (Donabedian 1980) in LTC. These indicators refer to the characteristics of the providers, their tools and resources, and the physical and organizational setting (including the qualifications of staff and their training levels). These are the most common indicators used (The World Bank 2015) and indeed most European countries collect some kind of structural quality indicators, often with a focus on staff ratios and the environmental character of facilities.

Process indicators, i.e. indicators capturing the activities within and between care workers and service users such as punctuality and methods for lifting, feeding or bathing, are as discussed above more difficult to define and this is evident in data collection. These processes can be argued to be more directly linked to the experienced quality of care users relative to structural indicators, if we understand care provision as primarily a relational good. The difficulty with, in particular, structural measures, but also in relation to process indicators, stems from the fact that their relationship with outcomes is not clear and is particularly hard to establish where services are very diverse.

Finally, outcome indicators are receiving much focus on the literature and also in policy debates. These relate to the final results of the activity, such as the functional status of individuals, their satisfaction with care and their quality of life (The World Bank 2015). These can further be conceived as care effectiveness and safety, responsiveness and care co-ordination (AGE Platform Europe 2010). There is also an important division in the approach to whether to collect clinical quality outcomes indicators or to focus on users' quality of life (Makai et al. 2014). A further key challenge in understanding the meaning of outcomes indicators of LTC quality is how to attribute these to an effect of services. The ASCOT measure has made significant head-way in linking outcomes to services through the "social care related quality of life score" (Forder et al. 2018). ASCOT is a suite of measurement tools designed to measure the impact of services on dimensions of quality of life. These domains are, for service users: control over daily life, personal cleanliness and comfort, food and drink, personal safety, social participation and involvement, occupation, accommodation cleanliness and comfort and dignity; and for carers: occupation, control over daily life, self-care, personal safety, social participation and involvement, space and time to be yourself and feeling encouraged and supported. Preference weights have been derived for ASCOT allowing it to be used in economics evaluations of social care interventions or policy. ASCOT has widespread use by central and local government as well as LTC providers in England. It has also been translated to Dutch, Finish and Japanese and has been employed in research projects in these countries. ASCOT is not used at a national level.

#### *4.3.1. Quality indicators used in the four countries*

As we explore further below, the four case study countries use a host of approaches to quality assurance including regulatory, economic and information based policy instruments. These do, in different ways, rely on the collection and assessment of various indicators of quality. Detailed analysis of the indicators collected is beyond the scope of this note, but we here give an overview of what the countries focus on and on what level of governance the indicators are collected. For more detail, see Dandi and Casanova (2012) who provide a comprehensive outline and comparison of quality indicators in

European countries, including the four countries analysed in this note. There are considerable differences in the number of indicators used overall and for the different provider types in the four countries. Similar to what Dandi & Casanova (2012) found, Poland, the newer EU country in our sample, uses fewer types of quality indicators across all organisation types compared to the three older member states.

Table 1 provides an overview of the most commonly referred to collections of indicators, the governance level (national or local) and whether they include indicators in terms of the categories devised by Donabedian: structure, process and outcomes quality (1980). The table does not represent an exhaustive overview of collection of LTC quality indicators, but rather an indication of what the main approaches to collections of the various indicator types are in the four countries. Structural (or input) indicators are used in all four countries. These include character of the accommodation (care homes), for example size of rooms, accessibility and number of bathrooms, meals and staff ratios. Some of these indicators can be argued to be static, i.e. more appropriate for initial accreditation or certification of a care provider and less important to monitor continuously. Process indicators are also collected in all four countries. In Sweden, tender documents for procurement of care services (LOU) emphasises process indicators such as individual participation in care planning and overall personalised care provision. Process indicators, besides structural requirements, are also common in English LAs contract standards and monitoring and include care planning, personalisation, treating users with dignity and respect, equal opportunities etc. In Poland, it is argued that little comprehensive indicators are collected, however, some of the indicators do cover what can be seen as process, i.e. how meals are to be prepared and made available, and how self-care should be supported (Golinowska and Styczyńska 2012). In the case of France, it matters whether we consider the external quality monitoring or the internal quality assurance (self-assessment which is reported to the supervisory authority). The external official monitoring is focused on structure and process, but mandates the existence of internal quality monitoring. Various schemes are used for the internal assessment and some (for example ANGELIQUE) incorporate outcomes indicators, including user satisfaction. Further than the internal self-assessment in France, outcome indicators are collected to the greatest extent in Sweden and England. The Swedish approach is focused on users' opinion of the care received, often gathered through direct questions in surveys, i.e. asking users "how satisfied are you with your care?". The English approach also included direct satisfaction questions regarding various aspects of the care received, but also includes the suite of questions in the ASCOT questionnaire (as outlined above) which links individual level outcomes to the service received (social care related quality of life). Outcome indicators are often focused around individuals' satisfaction with care, but there are also medical oriented indicators such as

avoidable hospital admissions and delayed discharges, and falls (nationally collected in England).

**Table 1 Overview of quality indicators collected in England, Sweden, France and Poland**

| | Structure | Process | Outcomes |
|---|---|---|---|
| England | LA contract monitoring (varies by LA) | LA contract monitoring (varies by LA), National Adult social care survey<br>For example, personalised caregiving, carer continuity | National Adult social care survey (includes ASCOT)<br>Social care related quality of life, satisfaction with service received |
| Sweden | Open Comparisons (national)<br>Registration/accreditation of new providers (LOV) and tender specifications (LOU) (local) | Open Comparisons (national)<br>Registration/accreditation of new providers (LOV) and tender specifications (LOU) (local)<br>For example implementation of personalised caregiving | Open Comparisons (national)<br>Satisfaction with a range of aspects of care received. |
| France | HAS mandated CPOM contracts (with département and regional health authority)**<br>ANAP (dashboard – national) | HAS mandated CPOM contracts (with département and regional health authority)**<br>ANAP (dashboard - national) | Internal quality monitoring, mandated in CPOM. (selected by provider – can include user satisfaction indicators) |
| Poland | Social sector: Act on Social Assistance (2006) (staff ratios, environment, meals, cleaning etc.)*<br>Health sector: National Insurance Fund (2008) | Social sector: Act on Social Assistance (2006) (staff ratios, environment, meals, cleaning etc.)*<br>Health sector: National Insurance Fund (2008) | |

References: * See Golinowska and Styczyńska (2012), ** See Fermon and Joël (2012)
The distinction between structure, process and outcomes is not entirely clear cut. See Dandi and Casanova (2012) pages 112-114 for comparison.

## 5. Quality assurance profiles in England, Sweden, France and Poland

This section outlines the characteristics of the four LTC systems and then moves to describe in detail the particularities of quality assurance and the current debates. First the evolution and current state of the quasi-market environment is discussed, followed by the relevant

levels of governance and the key actors and stakeholders. Finally the quality assurance system is discussed in terms of the activities of local government, such as managing contracts, and assuring and supporting quality to the "quality instruments" discussed in section 3.3 (See Malley et al. 2015): regulatory, financial incentives and information based instruments. It is important to note that the level and character of municipal use of instruments to influence quality varies significantly given the extensive devolution of responsibility for LTC to municipalities in each of the countries.

### *5.1 England*

English LTC is financed through Local Authority (LA) taxation, subject to a means-test, which means that many users pay the full or part of the cost of their care.[6] Assessment processes and eligibility thresholds are set nationally, however, LAs still have considerable discretion over who receives services and the characteristics of the care packages which means that levels and patterns of services vary between LAs (Glendinning 2018). English LAs are operating in an environment of highly constrained financing: since 2010, LA budgets have been reduced by on average 30%. This has translated into a steep reduction in the numbers of clients receiving publicly-funded home care and other community services (Fernandez et al. 2013). The reduction in residential and nursing home provision has however only been minor, which illustrates how LAs have had to focus their limited resources on those with the highest need (Glendinning 2018).

LAs are legally responsible for market management under the Care and Support Act 2014 ('The Care Act'). This includes assessing population-level and individual care needs and ensuring appropriate support is available (from private or in-house providers), in residential or community care settings or from informal carers. The LTC market is denoted by a high proportion private providers (on average more than 80%) (Barron and West 2017).

The majority of care is provided under so-called framework agreements which tend to run over several years. These are procured in accordance with EU legislation. Within the

**Box 1: England**
Health care system: Tax funded universal National Health Service (NHS)
Financing of LTC: Means-tested tax funded at the local authority level
National regulator: Care Quality Commission (CQC)
Key legislation: the Care and Support Act 2014

[6] Those with assets over £23,250 (EUR 26,500) pay the full costs of LTC; below £14,240 (EUR 16,274) the LA pays in full and in between these boundaries the costs are split between LA and care user.

framework agreements a number of providers then get allocated a certain number of care packages to deliver.

### *6.1.1. Levels of governance*

English long-term care is governed primarily on two levels: the national level through the independent regulator, the Care Quality Commission (CQC), and on the local level through 152 LAs7. The LAs are in charge of contracting with and purchasing LTC services directly from providers. This is generally done under public procurement processes and has a broad range of quality assurance activity attached to it as we discuss in the section **Error! Reference source not found.**. At the national governance level, all providers of residential, domiciliary and community-based care services must register with the CQC. The CQC undertakes routine monitoring and regular inspections which are generally unannounced. Providers are required to fill in a 'provider information return', essentially a pre-inspection self-assessment. The inspections use a range of evidence gathered by means of interviews with residents and staff, observations of care, reviews of records and care plans, inspections of the physical environment, and a review of documents and policies (similar to what is carried out by LAs as outlined below under regulation). Each inspection results in the production of a report, publicly available on the CQC website. By law, CQC ratings have to be displayed in residential care facilities where they can easily be seen, and they also have to be shown on all providers' websites (Barron and West 2017).

**BOX 2: Care Quality Commission's fundamental standards (England)**

Each of the five standards is each given one of four ratings: Outstanding ("the service is performing exceptionally well"); Good ("the service is performing well and meeting expectations"); Requires improvement ("the service isn't performing as well as it should, and has been told how it must improve"); or Inadequate ("the service is performing badly, and enforcement action has been taken").

1. Is the service safe? Are the residents protected from abuse and avoidable harm?
2. Is the service effective? Residents receive care that achieves good outcomes, helps maintain quality of life and is based on the best available evidence.
3. Is the service caring? Staff involve residents and treat them with compassion, kindness, dignity and respect.
4. Is the service responsive to people's needs? Services are organized so that they meet the needs of residents.
5. Is the service well-led? The leadership, management and governance of the organisation make sure it's providing high quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

[7] These are also referred to as Councils with responsibility for social care services.

### *6.1.2. The quality assurance framework at local authority level*

The Care Act of 2014 stipulates that local authorities have a legal duty to ensure that people in their area who need care have 'a variety of high quality services to choose from' (Trigg 2018). The way in which local authorities approach this responsibility can vary greatly, with councils using a variety of tools, including outcomes-based commissioning8, the use of specialised improvement teams and their own quality ratings. The literature has found that LAs are using a variety of policy instruments, including local inspection regimes, training programmes and quality related payments, to influence and assure the quality of the local provision of LTC (Granville et al. 2014, Malley et al. 2015). The quality assurance work related to LA contracts with providers takes place in addition to, and at times replicating the work of the national regulator, the CQC, as described above.

#### *6.1.2.1. Regulatory instruments*

Within the contract specifications between LAs and private providers, directions, surveillance and enforcement processes are set out. The general approach is similar, however, the specific characteristics and processes are different across LAs. The directions include quality standards which are set out in contracts. These include procedures that must be in place, such as medication procedure, complaints procedure, governance, health and safety, staffing (including background checks) etc. LAs generally set out the relative weight given to quality versus price in the procurement process. The contracted standards are then monitored through a wide range of approaches. These vary in terms of frequency (yearly, bi-annually and less frequent) and type of monitoring (collection of quality indicators through regular data submissions, self-assessments, on-site visits). On site visits and self-assessments employ in-house quality ratings that they use to guide monitoring. These vary between LAs but usually focus on aspects such as staffing/volunteers, involving service users/carers, safeguarding and protection from abuse, security, health and safety, needs and risk assessment, care and support planning, health and hygiene (including infection control), medication, nutrition and hydration, deprivation of liberty, end of life planning. They also monitor whether required policies and procedures are in place, for example business continuity plan, care and support planning, infection control, quality assurance and quality management. The quality indicators that are collected are often focused around structural and process related quality, for example, staff ratios, numbers of staff having the appropriate training in place, visits taking place on time (home care) etc. Most LAs carry out relatively frequent on-site visits which often include interviews with service users, relatives and staff. Most LAs also have more or less formalised ways of using intelligence to support quality monitoring. Intelligence can come from various sources, for

[8] Outcome based commissioning is different to the traditional approach to public procurement in that it goes beyond activities and processes to focus also on results, i.e. it does not only focus on how a service operates (what it does) to the good that it accomplishes (what it achieves) (Bovaird et al. 2012).

example, complaints, social workers interacting with the service, safeguarding concerns and so on. Intelligence is then followed up through various interactions with the provider, ranging from an informal chat to a short notice on-site visit.

There is generally a process of sanctions set out in contract which apply to providers that fail to meet the standards. These again vary in severity: at the lower end are remedial action plans; while penalties, such as fines and termination of business, are reserved for more extreme cases or repeated failure. Most LAs operate some sort of "executive strategy" process within which providers who are struggling enter into a pre-defined structure of escalating sanctions, such as suspensions of placements and ultimately decommissioning of the contract. The process often includes a support element where specialised LA staff work with the provider to ensure that improvement is being achieved. The intensity and extensiveness of that support again varies significantly between LAs.

In difference to many other countries (see Malley et al. 2015) where regulation for residential (and in particular nursing) homes is much more developed than for other services, in England, home care agencies are subject to the same type of standards, surveillance and enforcement regime as care homes, although again the specifics vary between LAs.

##### *6.1.2.2. Economic instruments*

Economic instruments most commonly take the shape of quality related payments (either linked to regular monitoring or voluntary accreditation), various subsidies (for example free training) and various incentives linked to user conditions or particular challenges facing the LA.

Quality related payments resulting from regular quality monitoring usually work in a way that providers receive a rating and are placed into quality bands depending on results of regular inspections using the quality standards as outlined in the 'regulations' section above, which then determines the level of payment per client. The way these schemes are set up varies between LAs, however, the inspections usually consider mainly structural and process related indicators, but tend to include some kind of 'outcomes' component such as user and staff surveys. LAs also apply these incentive schemes to different types of services in different ways, driven by local quality concerns, local relationships and demands. Quality related payments can also be tied to voluntary accreditation. Providers must reach a particular quality level to receive the payment, but in this case the additional monitoring and quality level is voluntary. Examples of this are accreditation schemes linked to particular conditions or types of users such as dementia premiums or complex care

premiums. The quality levels required vary and are determined in relation to the "topic"[9] of the voluntary accreditation, but generally include training and competence among staff and specific procedures to be put in place. The schemes vary in terms of whether and how often follow-up monitoring takes place beyond the initial accreditation process. Providers are interested in these both due to the enhanced payment linked to qualifying users, but also due to the reputational aspect as they are often able to make these achievements public.

Finally, subsidies for LAs includes free or subsidised training schemes or other free support facilities (Malley et al. 2017-2019). Some LAs offer extensive programmes of free or heavily subsidised training which providers can send staff to attend. This can both be 'optional' training for quality improvement and the more basic training packages that all staff are required to have within a certain amount of time of taking up a care professional position. The training can be directed at everyone from new staff to managers, one example being the Lead to Succeed programme run by Skills for Care.

#### *6.1.2.3. Information-based instruments*

There is evidence of both internal and external information based instruments being used as a way of influencing quality in English LAs. Firstly, LAs sharing information with providers is a common practice, which can entail best practice evidence etc. which goes beyond standard training. One example of education and knowledge management is the dissemination of guidance on best practice from arms-length bodies such as the National Institute for Health and Clinical Excellence and two independent, but partly government-funded, organisations (the Social Care Institute for Excellence, focusing on social care processes, and Skills for Care, focusing on the workforce). Further, the use of benchmarking to support quality improvement goals is commonplace in England. For example, 'Adult Social Care Benchmarking Clubs' are often run by specialist benchmarking firms who assist local commissioners in sharing and comparing performance information, to identify opportunities to transfer learning for more effective commissioning and quality monitoring (Malley et al. 2015). External information sharing, predominantly with the public, including users and other stakeholders, often includes information provided through the LA websites. This can include information on amounts of complaints, directories of LA funded providers and their CQC and sometimes internal quality ratings and other accreditation (i.e. quality information about providers).

[9] One example of a dementia care premium requires providers to show evidence of commitment to person centred care, specific training among staff, leadership policy, dignity and respect as guiding themes, supervision to support staff to provide high quality dementia care.

### *6.1.3. Summary and assessment*

The English quality assurance system functions as a combination of national regulation and oversight from the CQC and local contract management which includes use of a range of regulatory, financial and information based instruments. There is some overlap between national and local quality assurance work and providers feel overwhelmed with monitoring and the lack of coordination between CQC and LA visits and processes.

Any assessment of the English quality assurance system must be set against the constrained fiscal situation and the downward pressure on fees paid to LTC providers has had significant impact on care markets. Over two thirds of LAs reported care providers closing down or handing back contracts in 2016/2017 and many LAs reported struggling to find places for users (ADASS survey 2017, quote in Glendinning 2018), which represents a significant quality concern. There are considerable workforce issues (providers struggling with recruiting and retaining staff) and LAs quality work is as a result an ‘up-hill battle’. However, there is a massive effort spent on assuring that services are safe and high quality for users and intense support available.

Finally, fees paid for LA funded users are substantially lower than those paid by self-funders and there is considerable cross-subsidisation which means that providers who also serve self-funders may have an advantage in quality terms.

## *6.2. Sweden*

Box 3: Sweden
Health care system: Universal tax funded with co-payments for appointments, medicines and hospital stays.

Financing of LTC: Tax funded system with income related co-payments.
National regulator: Inspektionen för vård och omsorg (IVO) (Health and Social Care Inspectorate) https://www.ivo.se/

Key legislation: LOV (The Act on System of Choice in the Public Sector), LOU (Public Procurement Act)

The Swedish LTC system is tax financed with universal entitlement, however there are income and wealth related co-payments. The principles of Swedish LTC have a long tradition: universality, strong public financing, comprehensiveness and serving all citizens according to need, not the ability to pay. Sweden has a very long tradition of publicly funded LTC, initially only in institutions and from the beginning of the 1950s also in peoples’ homes. The governance of LTC is devolved to the 290 municipalities (“kommuner”), and each municipality decides how this task will be organised and carried out.

The shape of LTC markets vary hugely between municipalities and even though the overall proportion of private providers is fairly low (around 20%), in some municipalities, close to 100% of providers are privately run. Private providers have since the 1990s been allowed to operate in the market for LTC services, including both residential and home care. Two separate systems govern market based LTC services and municipalities can choose between using open calls for tenders according to the LOU (Public Procurement Act) and implementing LOV (The Act on System of Choice in the Public Sector, introduced in 2009), or both. Under LOV users can freely choose between service providers approved by the municipality, however not directly contracted by the municipality (Segaard and Saglie 2017). Swedish national guidelines have favoured the use of LOV and a key motivation is that LOV allows smaller actors to enter the market. It is important to note that according to LOV the local authority cannot restrict the number of companies in the choice system – all companies that apply and meet the standards set by the municipality must be accepted as providers (Erlandsson et al. 2013).

#### *6.2.1. The levels of governance*

***6.2.2.*** *The main responsibility for quality assurance of elderly care services (both residential and community based) lies with the municipalities in Sweden as we discuss further in section* ***The quality assurance framework at municipal level***

##### *6.2.2.1. Regulatory instruments*

Under LOU, i.e. public procurement, tender documents from local authorities lay out required quality standards for the services to be purchased and determine how those services will be monitored and evaluated. Quality requirements made by local authorities that outsource eldercare services tend to focus on process quality: more than half of the on average over 200 requirements in tender documents are about the process of care and the remainder about structure (Choiniere et al. 2016). Erlandsson et al. argue that only half of the requirements were possible to monitor (2013). Guidance on how to write quality requirements in procurement documents emphasised the trade-off between specific requirements which are measureable compared to more general requirements which are easier to implement but less clear in terms of measurement. When the municipality has contracted out the running of a, for example, nursing home, the municipality is responsible for the quality of care provided. If a provider does not meet the quality criteria stipulated in the contract, the local authority can end the contract. IVO can, but rarely does, impose a fine or even close down a facility if they find issues around safety (Choiniere et al. 2016). Under LOV, all providers must be accredited by IVO and the local municipality who formulate local standards. The money then follows the user. (Segaard and Saglie 2017). Enforcement includes fines if certain quality requirements are not met, for example lack of nursing staff onsite in a nursing home in accordance with the contract.

There is further a voluntary accreditation available that is managed at the national level. 'Äldrestandarden', the 'standard for the elderly' was created by the (Socialdepartementet) includes a set of demands for LTC at home or in residential homes. The standard is based on the needs of the elderly and includes basic requirements such as spending time outside, having choice of food, spending time interacting with others. The accreditation is carried out by a specific organisation, Swedac (see SIS Swedish Standards Institute).

#### *6.2.2.2. Economic instruments*

The economic instruments used by Swedish municipalities predominantly include quality-related procurement models. It is envisaged that introducing competition in markets will lead providers to improve quality to attract users. This is the case under both LOU and LOV. More specific schemes, including quality-related payments are uncommon. According to an ALMEGA study less than 5% of all payments to nursing and residential care homes are related to any quality goals. In 2015 the study found no evidence of any municipalities using quality related payments for home care. There are scattered examples of quality bonus schemes, for instance Taby kommun's quality bonus (Kvalitetsbonus). The quality bonus is used by providers to attract staff and users. Free or subsidised training is offered by municipalities, but again this is not systematic. The indicators used to judge quality bonuses or payments are interestingly sometimes related to the national average rather than absolute standards. For example Alingsås municipality introduced a quality payment in 2017 which is paid if a provider recieves a proportion of users that are satisfied with the care (Socialstyrelsens survey "Vad tycker de äldre om äldreomsorgen?") that is higher than the national average or and not lower than 3% below the municipality wide average. If the proportion is higher than the municipal average an additional payment is paid.

#### *6.2.2.3. Information-based instruments*

The Swedish system offers ample resources for learning, for example the online resource "kunskapsguiden.se" where evidence based information and knowledge is collected, available to individuals as well as providers of care. The Swedish choice model further relies on user choice as a driver of quality and for this to work as envisioned several conditions need to be met. Firstly, in order for consumers to be able to make an active choice, municipalities have an important role to play in providing objective, comparable and accessible information about the various providers and their practices. This might take the form of brochures, information on a website or oral presentations. Here the needs assessments officers/care managers have a key role to play, both with regard to providing neutral information about the options available and also in supporting users to make a choice. They should also provide information to users about the possibility of switching to another provider if they are not satisfied and explain to users how they should go about changing providers if they so choose. There are however no concrete recommendations on

providing information to users, even though this topic has received considerable attention in many of the reports issued by Swedish national authorities.

Data on quality of care in Sweden as collected and provided to users and providers through the Elderly Guide primarily focused on indicators of process related quality aspects (how users are treated, risk assessments etc.) and to some extent structure related quality aspects (staff skills, staff continuity). Outcomes include feedback on quality from users, staff and other members of the public. IVO (the Health and Social Care Inspectorate) reports the findings from inspections online, however these are not specific to particular municipalities or facilities. Instead an online Elderly Guide is published as well as online and hard copy of Open Comparisons – Eldercare. The former is aimed at supporting choice for care users and families. Process indicators are the main focus (Erlandsson et al. 2013). At the municipal level, a larger number of indicators are reported in the Open Comparisons – Eldercare, aimed at local politicians in order to benchmark quality at the municipal level (Choiniere et al. 2016). It is argued that the focus is on the individual as an actor for influencing care and that less emphasis is placed on institutionalised influence, participation and empowerment of users through for example user boards and patient involvement.

#### *6.2.3. Summary and assessment*

The Swedish system is denoted by huge variation between municipalities and the success of the QA system depends on local approaches. There is a lot of information and direction on how to best manage the markets as well as regarding how to best provide person centred and safe care. There are however concerns regarding providers working under LOV where there is little regular monitoring. Instead there is a strong reliance on individual users and staff making complaints or whistleblowing. There are complaints that monitoring and follow-up of contracts are insufficient and that proper attention is only paid when there has been a media scandal (Lloyd et al. 2014). For both tendering under LOU and market choice under LOV, there are political and geographical patterns in the uptake of the model among municipalities. These systems have predominantly been introduced in large urban municipalities and where there is a right-wing majority in the local government (Stolt and Winblad 2009).

A significant effort is place on comparing municipalities and providers through the data collected. It is however unclear whether the Swedish system is overly reliant on the link from data to quality improvement. Also particular for Sweden is that there is an expectation that setting standards for private providers can drive quality for public providers, i.e. LOV, right to choose means that whole new quality control structures are set up which are then also applied to public providers. Further, by exposing in-house LTC provision to competition, efficiency and quality gains in the publicly provided services are envisaged [interview SWE local].

### *6.3. France*

Similar to the systems in the countries outlined above, France has a highly localised LTC system strongly reliant on private providers. The financing of the French system is tax based with significant income related co-payments and the largest market for private LTC insurance in any country except for the US (Le Bihan and Martin 2010). The LTC system in France has traditionally relied heavily on family-oriented values and a high reliance on informal care provision. A move has been made towards a mixed system, with a comparatively large proportion of institutional care. LTC is governed at different levels and several institutional, organisational and professional actors are important. The key benefit, the personal autonomy allowance (*allocation personnalisée d'autonomie* – APA) is a cash-for-care benefit that is managed at the local level by the département and is paid, at home or in institutions, to any person aged 60 or over who needs assistance with activities of daily living (ADLs). When care is provided in institutions, the APA is paid directly to the organisation and there is normally an income related co-payment from the user (Le Bihan 2018).

The Act on Adapting society to an ageing population (2015) has revived the importance of the professionalization of the care work sector. Focusing on home-based care and suggesting increasing the amounts of the cash-for-care allowance, the law also proposes a new funding for the training of social care workers. The 2015 Act also emphasises the role of local actors and the development of measures at the territorial level (Le Bihan 2018).

The market for nursing home care and home care in France has in the past 15 years seen an increase in for-profit providers. In 2015 around 50% of care home places (EHPAD) were private (for profit 21% or non-profit 29%) (Muller 2017). The market for nursing and residential care homes is highly concentrated, partly due to the small number of providers overall, but the "Hospital, patients, health and territories" Act of 2009 which introduced a tendering process for the setting up of EHPAD which encouraged over-concentration in the sector. The occupancy rate is close to 100% which means that users face difficulty accessing care and often have to wait several months to get a care home place. The situation is however different in the home care sector. The market for home care is still dominated by publicly provided services and non-profit organisations. Since the 2005 Plan Borloo, a private, for-profit market, referred to as the personal services sector has developed, however, the private market for home care services is considerably more developed in urban areas compared to rural areas (Le Bihan and Sopadzhiyan 2017).

### *6.3.1. The levels of governance*

Responsibilities are divided between the various levels of government in France; municipalities, départements and regions. Given this, and complex legislation, Bertezene highlights significant coordination issues in the regulation of nursing and residential care homes. She argues that the various types of control that have been imposed since the 1990s, "creating a stack of controls with no interconnection" (2018). Similarly, a report by the French Inspectorate General of Social Affairs (Inspection Générale des Affaires Sociales – IGAS) in 2013 pointed to the abundance of control and the absence of any connection between the control of quality (carried out at the national level), the other supervisory inspections carried out at the local level, and the control of strategy carried out at the local level (Bertezene 2018). The 2015 Act, the most recent piece of legislation governing quality in LTC, emphasises the role of local actors and the development of measures at the territorial level (Le Bihan 2018). The act is argued to have come some way in dealing with the issues around poor coordination but challenges remain (Bertezene 2018).

There are both regional and national regulatory bodies for LTC. The regional health agencies ARS (Agir pour la santé de tous) sign CPOMs with care providers, with the national Health Ministry (Ministère des Solidarités et de la Santé). The remit of ARS include regulation of providers of health and LTC as well as authorization of health and LTC establishments and to control of their functioning and the allocation of their resources.

### *6.3.2. The quality assurance framework*

The quality assurance framework in France is fragmented and complicated. The defining features are the use of regulatory instruments, i.e. standards, surveillance and enforcement as well as an extensive collection of data for quality monitoring.

#### *6.3.2.1. Regulatory instruments*

The quality assurance of LTC relies on the "convention tripartite" which constitutes an agreement, or contract, between the local-departmental government, the government representative in the region, and the care provider and is overseen by the local-departmental authority. Quality assurance is stronger for residential and nursing providers while in the case of home care, there is a lack of evaluation.

Regulation in France ranges from accreditation with a national body to monitoring and enforcement by the local départements. The control of quality in nursing and residential care homes is provided for in the Act of 2002. Homes must obtain a quality approval, given by the HAS (Haute autorité de santé), prior to being allowed to operate in the sector. The authorisation to operate sets capacities for care provision (number of places, number of hours, geographical radius, etc.) and assumes the existence of internal and external monitoring of the quality of service. The residential care home's quality assurance is then

managed through a contract, a 'contrat pluriannuel d'objectifs et de moyens' (CPOM) between the organization which manages the residential homes (different residential homes often managed by one managing organization), the local authority (the département) and the ARS, the Regional health agency. The CPOMs set out the quality improvement approach and its implementation, the objectives, the development of networks and the satisfaction of residents (Bertezene 2018). The specific requirements of each CPOM are negotiated locally and a study found them to often include development of good care, risk management and continuous internal and external evaluation (Fermon and Joël 2012). The CPOM:s are since 2016 compulsory for nursing and residential care homes (Bertezene 2018).

Surveillance visits are carried out every seven years by independent experts and covers the activities and services delivered, in relation to the people dealt with and to their needs. The reference framework for quality norms is selected by the nursing home and validated by the supervisory body HAS. This is very important for nursing homes since the results of the control determine the renewal of their operational authorisations, i.e. if they do not meet the standards the home may be forced to close. There are further 'control inspections' that are carried out if there are indications that resources are misused or services not being provided to the expected standard (for example when there are concerns about abuse or mistreatment). These inspections also focus on quality standards and ensure that regulations (such as infection control procedures) are followed. Also the control inspections can lead to the supervisory body to advise the home to take action, or indeed impose action. Beyond this, the results of inspections are rarely used which is seen as a waste of resources (Bertezene 2018). The CPOMs are monitored periodically mainly through management dialogue.

The ANAP (Agence Nationale d'Appui à la Performance) requires nursing and residential care homes to maintain dashboards in order to ensure the control of performance. The dashboard (in place since 2015) includes 337 indicators under the following headings: provision of treatment and accompaniment for their residents, human and material resources, finance and budget, and objectives. The ANAP further suggests homes complete a corporate social responsibility (CSR) dashboard, which was introduced in 2017 but is not yet compulsory. Overall, the system for nursing and residential care homes is complex and viewed as overly cumbersome. Quality objectives are incorporated in the CPOM, but at the same time quality is covered by another independent control. Similarly, the indicators proposed by the ANAP are disconnected from the other administrational indicators and may seem unnecessarily repetitive (Bertezene 2018).

Secondly, regulation in the field of community and home based services is to date scattered and predominantly focused on the capabilities of the workforce. There are no regular

surveillance across providers similar to the controls in the nursing and residential care home sector. The characteristics of the home care sector further makes quality assurance more complex. For example, there are three different forms of care work employment set-ups which place different levels of control with the employer relative to the care user. Private nurses' freedom to practise results in important differences between départements and the activities of "domestic workers" which, despite being financed by the APA, are only supervised by the Labour Code and the collective labour agreement. The fragmentation is further an obstacle to the development of training for care workers. Recent developments include the introduction of the educational and social assistant's certificate in 2016 (a combination of the community care worker and the medical and psychological assistant's certificates) which validates a more cross-cutting training course and widens the range of places of work and duties. The Program for long term care professions (introduced in 2014), also allows for adaptation of the provision of initial and ongoing training (Le Bihan and Sopadzhiyan 2017).

#### *6.3.2.2. Economic instruments*

Financial incentives are not clearly present in the French system. However, the funding reform created competition between the different public and private establishments in terms of quality, which conditions the allocation of budgets. The locality has an annual budget which is distributed among providers according to the terms of the convention. Providers with better quality and a more ambitious quality strategy will get more financial resources. Malley et al (2015) understand this as an economic instrument, however, this relies on providers reacting to this kind of incentives. Given that the nursing and residential care home market in France is oversubscribed and there are waiting lists, it is likely that providers are less likely to react give that there is plenty of demand. Indeed, Bozio et al. (2016) argue that institutions are subject to little (or no) pressure from competition; they are encouraged neither to improve the quality of their care provision nor to reduce their prices.

#### *6.3.2.3. Information-based instruments*

Firstly, the requirement within the CPOMs to maintain an internal quality and performance strategy can be seen information based instrument. Further, the data collected by the ANAP is published and resources various publications show the situation of the medico-social sector in terms of for example territorial comparisons, thematic analysis, and evolution over time. ANAP further supports health professionals in health and medico-social institutions and services in the evolution of their organizations to improve service rendered to the user. Publications and resources are produced by experts and are evidence based. The purpose of the ANAP is to help LTC institutions to improve service through developing and disseminating recommendations.

### *6.3.3. Summary and assessment*

The French system is denoted by a complex web of legislation, governance levels and organisations. The focus is on regulatory instruments to influence quality and the majority of activity is centred on nursing and residential care homes. A lot of effort goes into contracting, and interestingly it is only recently that that CPOMs have become compulsory for care homes. Less emphasis seems to be placed on monitoring and enforcement. Regarding community care on the other hand, the complex and fragmented regulation of community care provision is a significant barrier to quality assurance and improvement. There are several areas that are essentially unregulated, or regulated within legislation that is not directly relevant to LTC quality. There are currently ongoing debates about LTC quality and whether enough is done to assure the safety and living standard of elderly in need of care.

6.3.4, however, the state and national actors are becoming increasingly active in supporting and advising municipalities on how to assure quality, in particular in services that are contracted out. The national regulator, the Health and Social Care Inspectorate (IVO) has the responsibility for monitoring and evaluating elder care services, compiling information from the municipalities, developing standards and supervising legal compliance (Hanberger et al. 2017). The Inspectorate carries out both announced and unannounced inspections (the frequency is not regulated), as well as inspections in response to complaints in residential care homes and home-help services (Erlandsson et al. 2013). The majority of inspections are caused by complaints or deficiencies reported by staff or according to annual themes or focus areas for monitoring (Choiniere et al. 2016). A yearly summary report compiled for all supervisions consisted of conclusions regarding the state of eldercare and recommendations for action (Hanberger et al. 2017).

Finally, 'national evaluation' criteria, so-called "Open Comparisons" (Öppna jämförelser) include detailed indicators, which are used as a starting point for national supervision of municipal care. National authorities also recommend that municipalities use these indicators in their supervision and specification of requirements for private providers (Segaard and Saglie 2017). These include indicators which capture various work processes such as coordination between different parts of municipal organisations, staff training, whether municipalities systematically manage organisational development (in terms of quality and evidence based practice) and the extent to which interaction with users is personalised10. The indicators are published at municipal level (Socialstyrelsen 2019).

[10] The systematic approach to working with care users in a personalised way is being promoted for use in Sweden (IBIC - Individens behov i centrum). In 2019 around 40% for municipalities had implemented IBIC.

### *6.3.4. The quality assurance framework at municipal level*

#### *6.3.4.1. Regulatory instruments*

Under LOU, i.e. public procurement, tender documents from local authorities lay out required quality standards for the services to be purchased and determine how those services will be monitored and evaluated. Quality requirements made by local authorities that outsource eldercare services tend to focus on process quality: more than half of the on average over 200 requirements in tender documents are about the process of care and the remainder about structure (Choiniere et al. 2016). Erlandsson et al. argue that only half of the requirements were possible to monitor (2013). Guidance on how to write quality requirements in procurement documents emphasised the trade-off between specific requirements which are measureable compared to more general requirements which are easier to implement but less clear in terms of measurement. When the municipality has contracted out the running of a, for example, nursing home, the municipality is responsible for the quality of care provided. If a provider does not meet the quality criteria stipulated in the contract, the local authority can end the contract. IVO can, but rarely does, impose a fine or even close down a facility if they find issues around safety (Choiniere et al. 2016). Under LOV, all providers must be accredited by IVO and the local municipality who formulate local standards. The money then follows the user. (Segaard and Saglie 2017). Enforcement includes fines if certain quality requirements are not met, for example lack of nursing staff onsite in a nursing home in accordance with the contract.

There is further a voluntary accreditation available that is managed at the national level. 'Äldrestandarden', the 'standard for the elderly' was created by the (Socialdepartementet) includes a set of demands for LTC at home or in residential homes. The standard is based on the needs of the elderly and includes basic requirements such as spending time outside, having choice of food, spending time interacting with others. The accreditation is carried out by a specific organisation, Swedac (see SIS Swedish Standards Institute).

#### *6.3.4.2. Economic instruments*

The economic instruments used by Swedish municipalities predominantly include quality-related procurement models. It is envisaged that introducing competition in markets will lead providers to improve quality to attract users. This is the case under both LOU and LOV. More specific schemes, including quality-related payments are uncommon. According to an ALMEGA study less than 5% of all payments to nursing and residential care homes are related to any quality goals. In 2015 the study found no evidence of any municipalities using quality related payments for home care. There are scattered examples of quality bonus schemes, for instance Taby kommun's quality bonus (Kvalitetsbonus). The quality bonus is used by providers to attract staff and users. Free or subsidised training is offered by municipalities, but again this is not systematic. The indicators used to judge quality

bonuses or payments are interestingly sometimes related to the national average rather than absolute standards. For example Alingsås municipality introduced a quality payment in 2017 which is paid if a provider recieves a proportion of users that are satisfied with the care (Socialstyrelsens survey ”Vad tycker de äldre om äldreomsorgen?”) that is higher than the national average or and not lower than 3% below the municipality wide average. If the proportion is higher than the municipal average an additional payment is paid.

#### *6.3.4.3. Information-based instruments*

The Swedish system offers ample resources for learning, for example the online resource “kunskapsguiden.se” where evidence based information and knowledge is collected, available to individuals as well as providers of care. The Swedish choice model further relies on user choice as a driver of quality and for this to work as envisioned several conditions need to be met. Firstly, in order for consumers to be able to make an active choice, municipalities have an important role to play in providing objective, comparable and accessible information about the various providers and their practices. This might take the form of brochures, information on a website or oral presentations. Here the needs assessments officers/care managers have a key role to play, both with regard to providing neutral information about the options available and also in supporting users to make a choice. They should also provide information to users about the possibility of switching to another provider if they are not satisfied and explain to users how they should go about changing providers if they so choose. There are however no concrete recommendations on providing information to users, even though this topic has received considerable attention in many of the reports issued by Swedish national authorities.

Data on quality of care in Sweden as collected and provided to users and providers through the Elderly Guide primarily focused on indicators of process related quality aspects (how users are treated, risk assessments etc.) and to some extent structure related quality aspects (staff skills, staff continuity). Outcomes include feedback on quality from users, staff and other members of the public. IVO (the Health and Social Care Inspectorate) reports the findings from inspections online, however these are not specific to particular municipalities or facilities. Instead an online Elderly Guide is published as well as online and hard copy of Open Comparisons – Eldercare. The former is aimed at supporting choice for care users and families. Process indicators are the main focus (Erlandsson et al. 2013). At the municipal level, a larger number of indicators are reported in the Open Comparisons – Eldercare, aimed at local politicians in order to benchmark quality at the municipal level (Choiniere et al. 2016). It is argued that the focus is on the individual as an actor for influencing care and that less emphasis is placed on institutionalised influence, participation and empowerment of users through for example user boards and patient involvement.

### *6.3.5. Summary and assessment*

The Swedish system is denoted by huge variation between municipalities and the success of the QA system depends on local approaches. There is a lot of information and direction on how to best manage the markets as well as regarding how to best provide person centred and safe care. There are however concerns regarding providers working under LOV where there is little regular monitoring. Instead there is a strong reliance on individual users and staff making complaints or whistleblowing. There are complaints that monitoring and follow-up of contracts are insufficient and that proper attention is only paid when there has been a media scandal (Lloyd et al. 2014). For both tendering under LOU and market choice under LOV, there are political and geographical patterns in the uptake of the model among municipalities. These systems have predominantly been introduced in large urban municipalities and where there is a right-wing majority in the local government (Stolt and Winblad 2009).

A significant effort is place on comparing municipalities and providers through the data collected. It is however unclear whether the Swedish system is overly reliant on the link from data to quality improvement. Also particular for Sweden is that there is an expectation that setting standards for private providers can drive quality for public providers, i.e. LOV, right to choose means that whole new quality control structures are set up which are then also applied to public providers. Further, by exposing in-house LTC provision to competition, efficiency and quality gains in the publicly provided services are envisaged [interview SWE local].

## *6.4. France*

Similar to the systems in the countries outlined above, France has a highly localised LTC system strongly reliant on private providers. The financing of the French system is tax based with significant income related co-payments and the largest market for private LTC insurance in any country except for the US (Le Bihan and Martin 2010). The LTC system in France has traditionally relied heavily on family-oriented values and a high reliance on informal care provision. A move has been made towards a mixed system, with a comparatively large proportion of institutional care. LTC is governed at different levels and several institutional, organisational and professional actors are important. The key benefit, the personal autonomy allowance (*allocation personnalisée d'autonomie* – APA) is a cash-for-care benefit that is managed at the local level by the département and is paid, at home or in institutions, to any person aged 60 or over who needs assistance with activities of daily living (ADLs). When care is provided in institutions, the APA is paid directly to the organisation and there is normally an income related co-payment from the user (Le Bihan 2018).

The Act on Adapting society to an ageing population (2015) has revived the importance of the professionalization of the care work sector. Focusing on home-based care and suggesting increasing the amounts of the cash-for-care allowance, the law also proposes a new funding for the training of social care workers. The 2015 Act also emphasises the role of local actors and the development of measures at the territorial level (Le Bihan 2018).

The market for nursing home care and home care in France has in the past 15 years seen an increase in for-profit providers. In 2015 around 50% of care home places (EHPAD) were private (for profit 21% or non-profit 29%) (Muller 2017). The market for nursing and residential care homes is highly concentrated, partly due to the small number of providers overall, but the "Hospital, patients, health and territories" Act of 2009 which introduced a tendering process for the setting up of EHPAD which encouraged over-concentration in the sector. The occupancy rate is close to 100% which means that users face difficulty accessing care and often have to wait several months to get a care home place. The situation is however different in the home care sector. The market for home care is still dominated by publicly provided services and non-profit organisations. Since the 2005 Plan Borloo, a private, for-profit market, referred to as the personal services sector has developed, however, the private market for home care services is considerably more developed in urban areas compared to rural areas (Le Bihan and Sopadzhiyan 2017).

**Box 4: France**
Health care system: National health insurance
Financing of LTC: Tax-funded APA
National regulator: HAS (Haute autorité de santé)
Key Legislation: The Act on Adapting society to an ageing population (2015)

### *6.4.1. The levels of governance*

Responsibilities are divided between the various levels of government in France; municipalities, départements and regions. Given this, and complex legislation, Bertezene highlights significant coordination issues in the regulation of nursing and residential care homes. She argues that the various types of control that have been imposed since the 1990s, "creating a stack of controls with no interconnection" (2018). Similarly, a report by the French Inspectorate General of Social Affairs (Inspection Générale des Affaires Sociales – IGAS) in 2013 pointed to the abundance of control and the absence of any connection between the control of quality (carried out at the national level), the other supervisory inspections carried out at the local level, and the control of strategy carried out at the local level (Bertezene 2018). The 2015 Act, the most recent piece of legislation governing quality in LTC, emphasises the role of local actors and the development of measures at the

territorial level (Le Bihan 2018). The act is argued to have come some way in dealing with the issues around poor coordination but challenges remain (Bertezene 2018).

There are both regional and national regulatory bodies for LTC. The regional health agencies ARS (Agir pour la santé de tous) sign CPOMs with care providers, with the national Health Ministry (Ministère des Solidarités et de la Santé). The remit of ARS include regulation of providers of health and LTC as well as authorization of health and LTC establishments and to control of their functioning and the allocation of their resources.

### *6.4.2. The quality assurance framework*

The quality assurance framework in France is fragmented and complicated. The defining features are the use of regulatory instruments, i.e. standards, surveillance and enforcement as well as an extensive collection of data for quality monitoring.

#### *6.4.2.1. Regulatory instruments*

The quality assurance of LTC relies on the "convention tripartite" which constitutes an agreement, or contract, between the local-departmental government, the government representative in the region, and the care provider and is overseen by the local-departmental authority. Quality assurance is stronger for residential and nursing providers while in the case of home care, there is a lack of evaluation.

Regulation in France ranges from accreditation with a national body to monitoring and enforcement by the local départements. The control of quality in nursing and residential care homes is provided for in the Act of 2002. Homes must obtain a quality approval, given by the HAS[11] (Haute autorité de santé), prior to being allowed to operate in the sector. The authorisation to operate sets capacities for care provision (number of places, number of hours, geographical radius, etc.) and assumes the existence of internal and external monitoring of the quality of service. The residential care home's quality assurance is then managed through a contract, a 'contrat pluriannuel d'objectifs et de moyens' (CPOM) between the organization which manages the residential homes (different residential homes often managed by one managing organization), the local authority (the département) and the ARS, the Regional health agency. The CPOMs set out the quality improvement approach and its implementation, the objectives, the development of networks and the satisfaction of residents (Bertezene 2018). The specific requirements of each CPOM are negotiated locally and a study found them to often include development of good care, risk management and continuous internal and external evaluation (Fermon and

[11] The HAS was prior to 2018 known as the ANESM (National agency for assessment and quality of social and medico-social institutions).

Joël 2012). The CPOM:s are since 2016 compulsory for nursing and residential care homes (Bertezene 2018).

Surveillance visits are carried out every seven years by independent experts and covers the activities and services delivered, in relation to the people dealt with and to their needs. The reference framework for quality norms is selected by the nursing home and validated by the supervisory body HAS. This is very important for nursing homes since the results of the control determine the renewal of their operational authorisations, i.e. if they do not meet the standards the home may be forced to close. There are further 'control inspections' that are carried out if there are indications that resources are misused or services not being provided to the expected standard (for example when there are concerns about abuse or mistreatment). These inspections also focus on quality standards and ensure that regulations (such as infection control procedures) are followed. Also the control inspections can lead to the supervisory body to advise the home to take action, or indeed impose action. Beyond this, the results of inspections are rarely used which is seen as a waste of resources (Bertezene 2018). The CPOMs are monitored periodically mainly through management dialogue.

The ANAP (Agence Nationale d'Appui à la Performance) requires nursing and residential care homes to maintain dashboards in order to ensure the control of performance. The dashboard (in place since 2015) includes 337 indicators under the following headings: provision of treatment and accompaniment for their residents, human and material resources, finance and budget, and objectives. The ANAP further suggests homes complete a corporate social responsibility (CSR) dashboard, which was introduced in 2017 but is not yet compulsory. Overall, the system for nursing and residential care homes is complex and viewed as overly cumbersome. Quality objectives are incorporated in the CPOM, but at the same time quality is covered by another independent control. Similarly, the indicators proposed by the ANAP are disconnected from the other administrational indicators and may seem unnecessarily repetitive (Bertezene 2018).

Secondly, regulation in the field of community and home based services is to date scattered and predominantly focused on the capabilities of the workforce. There are no regular surveillance across providers similar to the controls in the nursing and residential care home sector. The characteristics of the home care sector further makes quality assurance more complex. For example, there are three different forms of care work employment set-ups which place different levels of control with the employer relative to the care user. Private nurses' freedom to practise results in important differences between départements and the activities of "domestic workers" which, despite being financed by the APA, are only supervised by the Labour Code and the collective labour agreement. The fragmentation is further an obstacle to the development of training for care workers. Recent developments

include the introduction of the educational and social assistant's certificate in 2016 (a combination of the community care worker and the medical and psychological assistant's certificates) which validates a more cross-cutting training course and widens the range of places of work and duties. The Program for long term care professions (introduced in 2014), also allows for adaptation of the provision of initial and ongoing training (Le Bihan and Sopadzhiyan 2017).

#### *6.4.2.2. Economic instruments*

Financial incentives are not clearly present in the French system. However, the funding reform created competition between the different public and private establishments in terms of quality, which conditions the allocation of budgets. The locality has an annual budget which is distributed among providers according to the terms of the convention. Providers with better quality and a more ambitious quality strategy will get more financial resources. Malley et al (2015) understand this as an economic instrument, however, this relies on providers reacting to this kind of incentives. Given that the nursing and residential care home market in France is oversubscribed and there are waiting lists, it is likely that providers are less likely to react give that there is plenty of demand. Indeed, Bozio et al. (2016) argue that institutions are subject to little (or no) pressure from competition; they are encouraged neither to improve the quality of their care provision nor to reduce their prices.

#### *6.4.2.3. Information-based instruments*

Firstly, the requirement within the CPOMs to maintain an internal quality and performance strategy can be seen information based instrument. Further, the data collected by the ANAP is published and resources various publications show the situation of the medico-social sector in terms of for example territorial comparisons, thematic analysis, and evolution over time. ANAP further supports health professionals in health and medico-social institutions and services in the evolution of their organizations to improve service rendered to the user. Publications and resources are produced by experts and are evidence based. The purpose of the ANAP is to help LTC institutions to improve service through developing and disseminating recommendations.

### *6.4.3. Summary and assessment*

The French system is denoted by a complex web of legislation, governance levels and organisations. The focus is on regulatory instruments to influence quality and the majority of activity is centred on nursing and residential care homes. A lot of effort goes into contracting, and interestingly it is only recently that that CPOMs have become compulsory for care homes. Less emphasis seems to be placed on monitoring and enforcement. Regarding community care on the other hand, the complex and fragmented regulation of community care provision is a significant barrier to quality assurance and improvement.

There are several areas that are essentially unregulated, or regulated within legislation that is not directly relevant to LTC quality. There are currently ongoing debates about LTC quality and whether enough is done to assure the safety and living standard of elderly in need of care.

### *6.5. Poland*

The Polish LTC system is to date highly reliant on family and informal care provision. The formal system is very fragmented and there is no separate social protection for LTC and no separate long-term insurance. The term 'long-term-care' (opieka długoterminowa) is mainly used by experts, especially in the health sector. The reliance on informal care can be explained by several factors: traditionally strong family relations, intergenerational co-residency is common (i.e high share of elderly residing with their children), domestic division of labour are traditional and importantly, there is an insufficient institutional offer of publicly financed care and a lack of affordable private care establishments (Styczynska 2012). The lack of formal services is due to many factors. LTC has not been distinguished as a separate sector, instead services are fragmented in the health and social sectors. LTC services have also traditionally been focused around nursing and residential care facilities and the community care offer is to date limited. This means that it is only when LTC users have quite significant needs that the formal care system comes into play, before this, informal carers provide care.

The LTC sector in Poland is currently developing substantially, partly due to demographic pressures, and recent legislation and policy that affects LTC are worth noting. For example, the notion of senior policy (polityka senioralna) specifically addresses issues in the field of LTC financing and provision as well as focuses on developing an active ageing approach. Further, in 2012 the Ministry of Health published a policy paper "Facts and Perspectives of Long-Term Care Development in Poland" focused on LTC definitions, terminology, and description of the LTC provision, as well as future possible developments in this field and key recommendations focus on coordination, increasing financing and importantly, the quality of LTC. The current strategic document covering LTC, "The Preconditions for Long-Term Senior Policy in Poland for the period of 2014–2020" covers the development of social and care services responding to the needs of the older population (Ministry of Labour and Social Policy) but does not define quality as such. (Golinowska and Sowa 2017).

**Box 5: Poland**
Health care system: National Health Fund (NFZ): mandatory universal SHI (around 98% coverage)
Financing of LTC: General taxation
National regulator: General Sanitary Inspection (inspections), statutory health insurance NFZ (contracts)
Key Legislation: Social Assistance Act (2004) and several other across the fields of health and social care (See Golinowska and Styczyńska 2012)

Private entities providing nursing and care services to, among others, the elderly, were allowed to enter care markets from the 1990s when market mechanisms were introduced through the Polish economy. Private (for profit and not for profit) LTC facilities for older people are bound by the Commercial Companies Code. In later years private institutions are taking up an increasing market share and the number of elderly who take advantage of private services are growing. The Social Assistance Act of 2004 "confirms that there are no legal obstacles to establishing private and profit-making residential homes and it regulates the functioning of private residential homes that provide care services for the elderly and/or chronically ill."(Golinowska 2010).

### *6.5.1. The levels of governance*

The Polish LTC system is fragmented and complex. Different services are the responsibility of the health care sector and the social sector respectively, and also different levels of government. These differences prevail also with regards to the duty of care in terms of quality assurance (Golinowska and Styczyńska 2012). The responsibilities include occupational qualifications required, definition of the tasks and activities entailed in LTC occupations, the range and quality of LTC services financed from public source and standards required in institutional LTC. Municipalities (local government) are responsible for assessing the provision of care in nursing and residential care homes. Local government are further active in providing services to older people in community and often incorporating innovative solutions in care (Golinowska and Sowa 2017). The local situation is important for access to services, and there are significant differences between rural and urban areas in the availability of both public and private services.

Nursing and residential care homes are run either by the health care sector or by the "social sector", or the social assistance (welfare) system. In the health care sector, the main types of facilities are care and treatment facilities (ZOL), nursing and care facilities (ZPO), and hospice and palliative care homes (Styczynska 2012). LTC services in the social sector are mainly provided in residential social assistance homes (DPS) and day-care social assistance homes (DDPS) (Golinowska and Sowa 2017). Home care services are exclusively the responsibility of local governments. These include nursing services provided through the health sector (managed by primary health care units) and care services provided through the social sector and managed by social assistance centres (Golinowska and Sowa 2017).

### *6.5.2. The quality assurance framework*

#### *6.5.2.1. Regulatory instruments*

Private nursing and residential care homes are regulated through the Social Assistance Act (2004) and must have permission from the voivoda (a governmental representative at the regional level) and are required to be registered every year. The basic conditions for obtaining permission are that the home is compliant with the required standards as defined

in the directive concerning residential homes in the Social Assistance Act of 2004. The Act entitles a voivoda to control residential care institutions with respect to living standards and observance of the residents' rights. Private nursing and residential care homes, once registered with the voivoda can compete for contracts with the statutory health insurance (NFZ) (Golinowska 2010). The standards include staff ratios (0.4 staff per resident), environment (including size of rooms and number of residents sharing a bathroom), food (frequency) and cleaning. Overall the standards applied to care homes in the health sector are more stringent than in the social sector – where essentially a few structural indicators are all that are collected and monitored [interview POL national].

Further to the permission from voivoda, residential care providers may be registered as associations, as business entities or not registered at all. Given that there is little clear information about quality of providers in Poland, there is anecdotal evidence that the type of registrations is viewed as a signal of quality. For example, a Pilot Qualitative Study in Katowice found that residential homes registered as associations were fully occupied and had waiting lists, while those registered as business entities or un-registered had vacancies (The World Bank 2015). Additionally, the Order of the National Insurance Fund president of 23 October 2008 defines conditions for the negotiation and implementation of contracts for the provision of nursing and care services, palliative care and hospice care. The Order clarifies the requirements related to personnel, residential conditions and equipment, medical and aid equipment, and other requirements, including ISO certificates and certificates of the Centre for Development of Quality and Safety in Health Systems (CMJ).

Overall, surveillance and enforcement of standards is an issue. According to a report by the Supreme Chamber of Control (NIK), the control functions by the voivoda are not being fully performed and the regulations as part of the law on social welfare (amended in 2004) are being introduced rather slowly (Golinowska 2010). It is argued that this is due to the difficulties and costs entailed for both the authorities to supervise and for the providers to comply and with them (The World Bank 2015). In the health sector, standards for nursing and residential care homes are monitored through and annual procedure governed by the National Health Fund. The basic quality of provision is assured through the monitoring of staff ratios (Golinowska and Styczyńska 2012). Requirements regarding caregiver's education and training are set locally within nursing and residential care homes and is not part of public quality monitoring. Steps are taken to improve monitoring of quality, for example, the National Qualifications Framework and the development of a network of institutions and institutions validating quality assurance (Sonik 2014-2020).

There are clear issues around enforcement of quality standards. Essentially the only route is police action when significant cases of malpractice or abuse are identified. There is also an Ombudsman and the General Sanitary Inspection which cases can be referred to. None

of this is part of the quality assurance process, but rather responses of last resort, and is by default focused on assuring minimum standards. Public intervention – family labour ministry or ministry of health [interview POL national].

#### *6.5.2.2. Economic instruments*

There is no evidence of economic instruments being in place in Poland. Even quality related procurement models, though technically present, are unlikely to influence quality given the excess demand and sometimes long waiting times for user to enter residential facilities. For example, Jurek makes the argument that with regards to quality certificates, the high demand for LTC, combined with the restricted and insufficient supply of these services, discourages institutions from making the effort to obtain any quality certificate (Jurek 2012).

#### *6.5.2.3. Information-based instruments*

Information-based instruments are not employed in a systematic manner in Poland. There are suggestions that providers are required/incentivised to have ISO certificates in place, but it is unclear to what extent this is taking place. Public reporting is mainly related indicators non-specific to quality, for example, the Law on older people of 2015 (Ustawa o osobach starszych) is aimed at improving data collection and information on the situation of older people. Reports summarise public statistics collected in various fields in relation to the situation of older people. They do not, however, report comprehensively on the use of LTC services by the older population. (Golinowska and Sowa 2017). There is on the other hand a Patients' Rights Ombudsman which investigates the opinions and complaints of patients and their families, and attempts to resolve them in matters related to LTC provision. The Act on Patients' Rights and the Patients' Rights Ombudsman of 6 November 2008 has created a significant platform for societal oversight of health and LTC services (Golinowska and Styczyńska 2012).

### *6.5.3. Summary and assessment*

In Poland the main features of the quality assurance approach are centred on regulatory instruments, with little or no role for financial incentives and information instruments. Accreditation and minimum standards are in place, but there is less role for monitoring and enforcement. Ensuring quality of LTC services is the responsibility of several national institutions that are located in different segments of government. Also, LTC standards are defined in several unrelated regulations established by a number of public institutions (such as the Ministry of Health, the Ministry of Labour and Social Affairs and the National Insurance Fund). This makes the system overall difficult to assess.

It is argued that the standards in place are not sufficient and are not monitored in a systematic way. Moreover, the standards for home-based LTC are not defined well enough

or monitored in terms of the quality of the care provided. Finally, this lack of monitoring of quality in informal LTC poses a huge problem in terms of LTC quality assurance. Finally, no specific indicators for assessing LTC quality are used by supervisory institutions (Golinowska and Styczyńska 2012). Further, there is to date no comprehensive research on the variation and characteristics of quality assurance in LTC in Poland. There however are pilot projects ongoing in various parts of the country which are implementing and evaluating new and innovative ways of assuring and improving LTC quality [interview national].

We note that, private facilities has been associated with a risk of abuse and mistreatment, however there is also a view that there are good quality private providers but that these are expensive. Public institutions are on the other hand seen as stable both financially (i.e. less risk of bankruptcy) and institutionally (Jurek 2012) quoted in (Eurofound 2017). Similar to other countries, there are price differentials between public and private LTC providers in Poland. The commercial price has been found to be 2-2.5 times higher than the fee that takes into account the NFZ's financial contribution. There is evidence that users pay the higher rate while waiting to receive funding from NFZ. The fee is negotiated by the organization and the client (Leszko et al. 2015).

## 6. Conclusion

This note has analysed the use of policy instruments in order to influence quality in four European countries. These were 1) regulatory instruments aiming to promote quality through rules and directives which set requirements for various actors, 2) economic incentives including quality-related subsidies or reimbursement systems that reward providers for extra efforts to improve quality, 3) information related instruments including education and knowledge management; quality management systems; public reporting; and feedback on quality from users, staff and other members of the public. The analysis revealed a huge disparity in shape of the market for privately provided care, the approaches to quality, and the actors and instruments used to influence quality.

In terms of the shape of LTC markets, the case studies showed considerable differences not only in the size of markets for publicly funded private LTC provision (ranging from nearly 100% or LTC in England to a small proportion in Poland), but also in terms of the environment in which private providers are allowed to operate and what possible implications for quality and quality assurance this may have. Indeed, the overall approach to quality ranged from a rather "hands-off" approach in Poland to the intense involvement of LAs in provider's level of quality in England. The approach in Sweden is much more focused on individual choice and advocacy as well as knowledge transfer and information compared to in England where the defining feature, beyond the intensity of activity, is the

focus on contract management and the associated use of regulatory instruments, including standards and frequent monitoring as well as clear enforcement processes.

Thirdly, regarding the use of policy instruments to influence quality, regulatory instruments to influence quality are most commonly used in all four countries. Regulatory instruments often take the shape of accreditation requirements in order for providers to get access to LTC markets, contracted standards and monitoring at various frequencies are common features across the countries. Enforcement is more variable. Much of the quality assurance across the countries is focused on ensuring that minimum standards are met. One of the most commonly employed standard is staff ratios which is present in all countries and number of care users each provider is allowed to serve[12]. Similarly, structural indicators such as the care environment and staff ratios are present across the countries. Sweden, England and France all impose extensive requirements for providers to have the policies and procedures in place regarding aspect of care such as handling of medication, care planning and personalisation. Outcome indicators as part of regulatory standards are less common, and more frequently used as information-based instruments for influencing quality. The English and Swedish systems have the commonality of a relatively even level of standards setting and monitoring across types of providers, i.e. residential care as well as community care. Regulation in all countries, except England, is much more developed for residential (and in particular nursing) homes. While many countries have directions and surveillance for home care agencies, standards are usually fewer and surveillance activity less frequent. It is only in England where home care agencies are subject to the same standards, surveillance and enforcement regime as care homes (Malley et al. 2015).

Financial incentive instruments are less common and more scattered. However, as Malley et al. (2015) argue, the presence of markets and competition on quality as well as price, does in itself function as a financial incentive for improving quality. This is present in England, Sweden and France. In Poland it is argued that the market is not structured enough and excess demand mean that there is little real effect of competition. Examples of improvement oriented activities include quality bonuses (England and Sweden) and subsidies for staff training.

Information based instruments are important in Sweden, England and France and the most prevalent in Sweden. Sweden indeed has one of the most extensive systems for measuring and understanding quality and outcomes in LTC in Europe through its systems of "Open Comparisons" and the "Elder Guide" and lessons are channelled back to municipalities and providers in order to provide evidence based learning and development. France (through

[12] This is indirectly a quality indicator given that it is an established view of how many users the environment of the provider (if residential) can serve with decent quality.

ANAP) as well as England (NIHR, Skills for Care etc.) also has extensive structures for the creation and dissemination of knowledge evidence based knowledge and best practice.

Comparing the countries, in summary, we find that the English and Swedish systems are the most similar out of the four countries. Both France and Poland have very complex LTC systems overall, and we found large differences in terms of quality assurance practices depending on whether a provider is in the health or social sector and whether it is a residential care home or community care providers. When LTC is provided both in the health and social care system, issues with quality assurance seems to arise. In France, recent reforms improved things, however, the differences in quality assurance system are noticeable and cause confusion (Bertezene 2018). Integration is an important issue in many countries –clear implications for quality assurance. However not covered in this note. In both France and Poland quality of LTC is a point of debate and in France a string of cases of poor care and mistreatment have recently come to light. This has caused substantial debate over how quality can be better assured and monitored. The frequency of inspection visits are comparatively sparse (every 5 years compared to more or less yearly inspections in for example England).

Finally, the four case studies in this note suggests that the more promoted and incentivised private markets for LTC are, the more developed is the quality assurance system. The most extensive privately provided care market as well as the widest range of quality assurance instruments was found in England, while on the other hand in Poland where care markets are a more recent feature, quality assurance is also very limited. There are ongoing considerable debate in all four countries, often emphasised by media scandals about poor care, on how to best assure the quality of the care provided by private organisation in an efficient and effective way.

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