

The 'Make or Buy' Decision in Long-term Care: Lessons for Policy

Final Project Report

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Executive Summary

This report was commissioned by the Swedish Ministry of Health and Social Affairs with the aim of analysing the decision to make or to buy long-term care services, i.e. whether to deliver long-term care services through public providers or contract them out to public and non-public providers. This report reviews existing literature on the theoretical underpinnings of the make or buy decision and how it applies to the specificities of long-term care. It analyses the implementation of quasi-markets in four European countries that represent different long-term care systems: England, Denmark, Germany and the Netherlands. It also critically reviews six quality assessment and quality management systems in Europe and the issues surrounding the definition and assessment of quality in long-term care.

What theory tells us about make or buy decisions

Competition should mean more efficient production, but care markets are not the usual textbook markets

- According to neo-classical economic theory, competition should increase efficiency and push providers to deliver services that are more adapted to people's needs. Public service markets such as long-term care or health care differ, however, from textbook competitive markets in a number of significant ways. There are potential risks of imperfect information, e.g. regarding quality; and long-term care is a derived demand, i.e. people demand long-term care not because they want it but because they need it. Long-term care markets are thus usually highly regulated, i.e. they are more akin to 'quasi-markets'.
- Several market mechanisms can be put in place to create such quasi-markets of long-term care. Chief among these are: tendering, which allows open access and competition for the market; commissioning, when integrated networks are important (e.g. in integrated care); user choice, which is aimed at improving the responsiveness of providers to users' needs; user fees, which seek to replicate the role of prices in limiting demand and rewarding providers that live up to users' preferences; vouchers, which link payment to the actual delivery of services and allow fees to more closely reflect costs without pricing poorer users out of the market.

Competition incurs costs

- The regulation of quasi-markets will incur transaction costs and under some circumstances these might be higher than the savings incurred in more efficient production through pure competition. Transaction costs are likely higher if performance and compliance with contracts is difficult to measure and if there is scope for powerful providers (e.g. monopolies) to emerge.
- The decision whether to make or buy long-term care must involve consideration of the specific characteristics of long-term care. There is a wide body of evidence suggesting that people do not always make the best decisions for themselves without assistance, while on the other hand, allowing users to choose may be an important value of long-term care in itself. The outcomes of markets are not always equitable and as a result people with lower incomes – often those most in need of care – may not get what they need through the market. Finally, competition may erode trust and volunteering and become an obstacle to integrated delivery of care.
- Whether to make or buy long-term care involves trade-offs that need to be analysed empirically to overcome what may otherwise be a purely ideological debate.

How have countries introduced markets and what can we learn from them?

Learning from the experience of other countries means understanding different starting points

- The introduction of market mechanisms in England, Denmark, Germany and the Netherlands took place in the context of New Public Management (NPM) ideas and country-specific legacies which led to different starting points. In the English and Danish long-term care regimes, for instance, a monopoly of public provision developed, while large private non-profit welfare organisations prevailed in Germany and private non-profit providers in the Netherlands.
- The initial steps taken in implementing care markets were often reflected in shifts in the mixed-economy of care provision, i.e. to concede market access to new providers and to implement a split between public purchaser and provider units, rather than to enhance user choice.
- While there were similar rhetorical arguments for introducing market mechanisms, some key stakeholders played an important role in shaping care markets (e.g. the disability rights movement in the expansion of choice allowed to users in England).
- As experiences accumulate and markets mature, countries continuously redesign their systems, i.e. by establishing new public procurement options or by shifting responsibilities for care management. Most countries delegate the management of care to the local level with Germany serving as an exception in that insurance funds play a central role.

Users are slowly gaining more leeway to choose, yet user choice still means different things

- As cost-containment played an important role in the introduction of market mechanisms, most countries initially opted for having monopsonic purchasers of care, e.g. municipalities, rather than allowing users to choose what care to receive, how to receive it and from whom. Germany was again an exception as users were conceived of as purchasers of care from the very beginning when 'quasi-markets' were first implemented.
- User choice is much more than just being able to choose a specific provider. In England and Germany users seem to have more leeway in defining what, how and when care is provided to them and by whom – namely by directly employing personal assistants – while in the Netherlands and especially in Denmark user choice is generally much more limited.

Mixed evidence of competition impacting quality and concerns about concentration in care markets

- There is limited and mixed evidence of the impact of market mechanisms on quality. The frequent regulatory changes and the budgetary cuts that accompanied the implementation of care markets make it difficult to assess the impact on quality over time. There are concerns, however, about the impact these budgetary cuts will have on the qualification and training of the workforce, and ultimately on users as well.
- As care markets mature there are some concerns about market concentration in all four countries. On the one hand, it could enhance efficiency in care delivery and lead to more professional management. On the other hand, market concentration raises concerns about the nature of the ownership of some providers (e.g. equity funds) and increases the importance of issues concerning 'provider failure'.

How can quality of long-term care be defined, assessed and ensured?

Market-oriented governance in long-term care calls for special endeavours to assess, measure and control quality of services

- In order to avoid market failure the quality of structures, processes and outcomes of services needs to be defined *ex ante* by the purchaser (by means of accreditation and contracting) and be assessed and monitored *ex post* by a third party.
- As a consequence of the wide range of elements and key-issues that characterise long-term care services and facilities, their structural, procedural and outcome quality is dependent on just as many variables and dimensions. Nevertheless, a number of instruments and mechanisms to describe, assess and improve quality in long-term care have taken shape across a variety of countries. While these methods remain largely focused on individual organisations, first steps have been undertaken to assess quality across organisations and settings.

A wide range of quality measures are available and should underpin the governance of quasi-markets in long-term care

- Tools and methods that help assess care needs and outcomes at the individual level are a crucial precondition for defining potential interventions and for assessing and measuring expected outcomes.
- Regulatory frameworks to assess and ensure quality at the organisational level are key instruments with which regulators may define, steer and control services and facilities. The challenge is striking a balance between over- and under-regulation, between resource allocation and standards setting, as well as between standardisation and respect for person-centred care.
- External quality assurance, e.g. by means of inspections, is a necessary precondition but is alone insufficient in ensuring the quality of long-term care services and facilities. Internal quality management and continuous improvement processes are needed to embed quality thinking at all levels of care delivery, to underpin choice processes with tangible information, and to give all stakeholders involved a 'voice' if 'exit' is not a feasible option in long-term care delivery.

Investment in quality assurance and quality development in long-term care is necessary independently from general governance options

- As long-term care is an area with a relatively short history, both quality management and quality assurance mechanisms lag behind those in place in other services sectors and industries. Issues such as quality of life, dignity and personal preferences are difficult to standardise and measure. These challenges call for further research and development in order to be better able to define and compare outcomes within quasi-markets of care.

Introduction

The current reality of population ageing has heightened concerns about the fiscal sustainability of social protection systems, in particular long-term care for dependent older people. How to deliver social services in the most efficient manner possible has thus come to occupy centre stage in the minds of policy-makers. It is not surprising then that the set of economic theories which gained prominence in the 1980s and came to be known as New Public Management (NPM) and were taken on board in several areas of public services including long-term care, placed efficiency at the core of its objectives.

Portraying the introduction of competition in long-term care as merely a reflection of a paradigm change in economic theory tells only part of the story, however. In the more nuanced version, members of a new cohort of older people who were brought up in a more affluent and consumerist society were no longer satisfied with being passive recipients of social services. A strong undercurrent among disabled people of working age – dating back at least to the 1970s – demanded greater empowerment and control over the social services they were receiving. User choice emerged as the answer to these demands.

The process of introducing market mechanisms for the delivery of long-term care has been characterised by a strong ideological debate. This debate has encompassed economic and other theoretical arguments, yet it has oversimplified these arguments for the sake of ideological discussion. While the rationale for markets may be deceptively simple – undoubtedly part of its appeal – the operation of such markets is in reality rather more complex. Looking beyond the oversimplified arguments and economic theories provides important insights and can lead to recommendations about whether to make or buy long-term care.

Today, many countries in Europe have introduced some measure of competition and user choice in the delivery of long-term care and these changes in policy have profoundly changed how services are being provided. As long-term care systems in Europe are so diverse, country-specific information constitutes a formidable pool of knowledge and experience about the make or buy decision. The European community might be compared to a social policy laboratory where one can study the effects of social policies in real time and learn from the outcomes. Comparative research in this area is therefore able to provide evidence on the outcomes of national responses to the make or buy decision.

Discussions of competition and user choice have sparked other debates around the topic of long-term care as well. Arguably one of the most important is how to assess, manage and improve quality in long-term care. How to define quality *ex-ante* and assess it *ex-post* is central to contracting decisions in long-term care if one is to buy services, just as assessing and improving quality is crucial if long-term care is to be delivered by the State insulated from competition, i.e. if one is to make long-term care.

Against this backdrop, this report aims to synthesise and to critically discuss existing knowledge and experience about the make or buy decision in long-term care, applying a comparative approach between countries in Europe. By marrying theoretical and empirical knowledge it seeks to map the several policy options available and the trade-offs involved. It deliberately takes a comparative approach by focusing on multiple countries in Europe, and does not specifically cover Sweden,

reflecting both the strengths of the research team and the goal of making this report as salient as possible.

Chapter 1 outlines the theoretical considerations of the ‘make or buy’ question and frames the discussion around public or market provision in long-term care. This chapter will also set the research focus and specify the guiding questions for the subsequent empirical analysis of the make or buy question. Before turning to the empirical analysis itself, the methods applied in the two empirical parts of the research will be outlined in **Chapter 2**.

Chapter 3 sets out to describe the reorganisation of care provision triggered by the introduction of quasi-markets, the diversification of service providers (for-profit and non-profits providers) and the implementation of user choice (e.g. vouchers, cash benefits) in four countries. Given the diverse starting points and institutional contexts of European welfare states, these processes have developed differently in different countries, thus providing an opportunity for research and policy to draw lessons from market and government failures in long-term care provision. The empirical analysis focuses on four case studies: England, Denmark, Germany and the Netherlands.

The measurement of quality of care is relevant for the question of whether to internally produce or to contract out long-term care. **Chapter 4** will therefore focus on the assessment and management of quality in long-term care settings by critically reviewing six quality management systems in Europe using SWOT analyses.

Finally, **Chapter 5** concludes with a number of policy recommendations that attempt to make sense of the information reviewed in the previous sections of the report. The report will thus conclude with lessons learned from the theoretical considerations and empirical research to aid the discussion and policy decision-making process surrounding the make or buy decision for long-term care in Sweden.

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Chapter 1

Theoretical considerations in the 'make or buy' question

The past decades have witnessed an increased reliance on market mechanisms for the delivery of public services, among these health and social care (Taylor-Gooby & Lawson, 1993). Apart from a general crisis of the welfare state and ensuing attempts to improve public sector effectiveness and efficiency, market-oriented steering and related management tools gained in importance under the general umbrella of NPM (Hood, 1995). One line of reasoning links this move towards market mechanisms with the new found emphasis on the idea that the behaviour of providers may best be characterised by the pursuit of self-interest, rather than by altruism (Niskanen, 1971). This shift may be more readily understood in light of the prominence that several streams of thought gained in mainstream economics during the 1980s. Foremost among these were the notion of 'government production failure' (Vining & Weimer, 1990) or simply 'government failure', the set of measures that came to be known as NPM, and transaction costs economics. These theories contributed greatly to laying the theoretical groundwork for the 'make or buy' decision in social services. Other explanations for a greater reliance on market mechanisms to deliver welfare are increased consumerist values, erosion of trust in professionals, louder clamour for the empowerment of users, and changes in prevailing ideas about the limits and appropriate size of the state (Greener, 2008).

These were fundamental shifts in the functioning and theoretical foundations of public services, and the expansion of market-based mechanisms, particularly competition and choice, did not occur without controversy and fierce discussions (Clarke, Smith & Vidler, 2005). Although the arguments exchanged during the process were clothed in economic jargon, the actual insights and teachings of economic theory were often quickly forgotten or distorted in the fog of ideological debate.

Against the backdrop of these changes and debates, this chapter sets out to frame the discussion around public versus market provision of services, in particular long-term care, by drawing on a wide array of theoretical concepts. This will provide the foundation for a subsequent review of empirical findings on quasi-markets and the contracting process in long-term care across the four countries presented as case studies. On a more operational level it will help to sharpen the research focus and specify guiding questions for the case studies in Chapter 3.

The chapter is organised around five sections, each briefly presenting one theoretical aspect relevant for the make or buy decision and discussing it in the context of long-term care. These include competition and markets (first section), transaction costs and contract design (second section), market-mechanisms design (third section), organisational theory (fourth section) and social policy (fifth section). The sixth section concludes and summarises the main issues for the empirical review.

1.1 Competition in markets for public services

In textbook competitive markets (Varian, 1978), competition between private firms ensures that they produce homogeneous services in the most efficient way, i.e. at the lowest possible production costs. Assuming no barriers to entry or exit – an important pre-condition for competitive markets – incumbent firms can be challenged by new entrants and the firm that performs best will have an increasingly higher share of consumers. Prices reflect both the costs that firms face in delivering a service as well as the preferences of consumers. Prices are known to consumers in advance, and they

then have enough time to shop. Competitive markets are thus appealing ways to produce services as they ensure lower production costs and that demand is met by supply. By comparison, public provision may be less efficient for the following reasons:

1. Production takes place insulated from the market and therefore prices do not reveal costs of public providers or preferences of consumers (Wolf, 1979; Vining & Weimer, 1990);
2. Public providers face no real threat of ownership take-over or transfer – this is usually a political decision – and therefore there might be less of an incentive to strictly monitor the performance of public managers and consequently more scope for slacking in this area, resulting in higher production costs (De Alessi, 1983; Vining & Weimer, 1990).

Public service markets such as long-term care or health care differ, however, from the textbook competitive markets described above in a number of significant ways.

Firstly, services are differentiated, either because of the geographical location of nursing homes or the different types of care that nursing homes or home care agencies can provide. In the face of service differentiation, the effect of competition on the variety and quality of services provided is ambiguous (Proper & Leckie, 2011). Firms may produce too little variety of services, e.g. all home care agencies may deliver the same standardised tasks, if they cannot gain additional revenues from the increased variety.¹ Firms may also produce too much variety of services if they think they can deviate demand from other firms. In the presence of product differentiation, being able to assess quality and price becomes paramount. When information on price and/or quality is imperfect, the impact of competition on either is not straightforward (Dranove & Satterthwaite, 2000). If, unlike prices, quality is not easily observed, consumers will be less responsive to the latter and quality of services will decrease. If the opposite happens, providers may increase prices or engage in an ‘arms race’ for quality, i.e. overproduce quality. Furthermore, if quality is multidimensional, as in long-term care, providers may over-produce the quality dimensions that are easily observable and neglect those that are not easily measured.

Secondly, long-term care is a derived demand (Baxter, Glendinning & Greener, 2011) where people seek care not because they want it but rather because they need it. Those most in need of care might not be able to afford it, which is an outcome that society might not be willing to tolerate.² In private markets consumers choose the quantities of the service they want to consume, given the price offered by firms. Because long-term care is a derived demand there might be a wedge between need for care and ability to pay for it. The state may set the prices paid for services in order to make them affordable for a wider share of the population.

For these reasons, public service markets tend to be much more regulated than private markets, which is why they are usually termed ‘quasi-markets’ (Le Grand, 1991; Bartlett & Le Grand, 1993). Their ‘quasi’ nature arises from the fact that i) prices will not reflect supply and demand as the budget of purchasing bodies and prices of social services may be administratively set; ii) demand may

¹ In economic terms this is coined ‘capture of consumer surplus’ with consumer surplus being the difference between what consumers would be willing to pay for a different service and what they pay at market prices. Monopoly firms can usually capture part of the consumer surplus, namely through price differentiation, and may thus provide more variety of products.

² In economic jargon this creates a caring externality: e.g. the sight of people that the market has left without adequate care negatively impacts the well-being of the other members of society.

be expressed in non-monetary forms (e.g. through vouchers) or by a third-party buyer (e.g. monopsonic public bodies purchasing on behalf of users); and iii) not all providers will be driven by profit motivations, since some providers may be non-profit organisations, which points to issues of motivation that will be addressed later.

Production costs, however, are not the only costs incurred in the provision of services. Delivering public services through the market may also incur in transaction costs and these will be influenced by the characteristics of public services (Williamson, 1985; 1975). This is particularly the case when demand is expressed by a third party buyer, such as the state, contracting out services to competing providers.

1.2 The economics of transaction costs

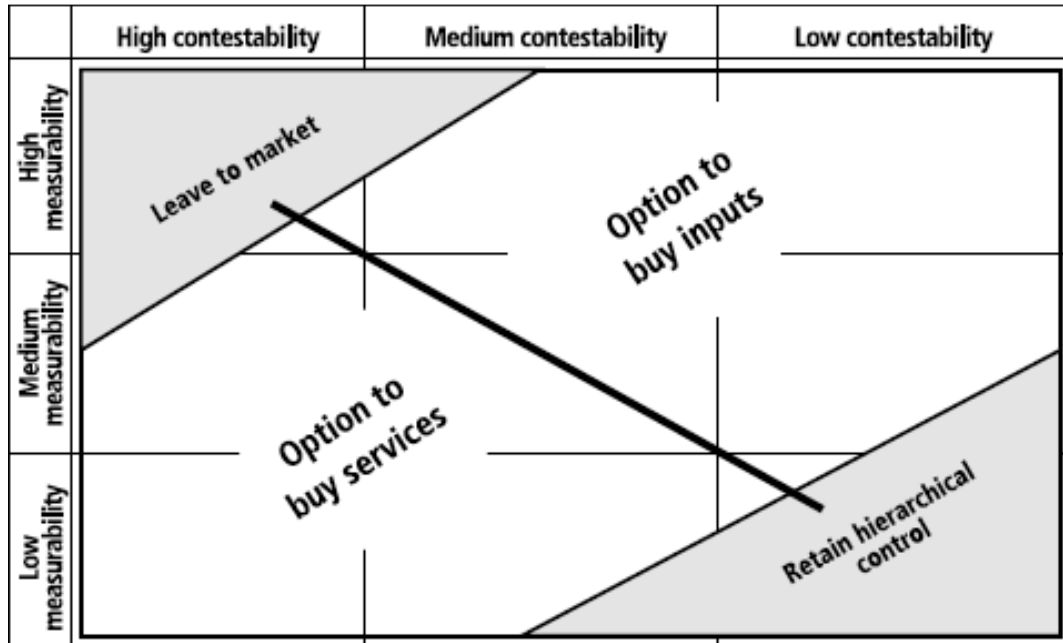
In transactions such as those involved in the make or buy decision typically one side, the principal, seeks to accomplish a goal for which it needs the active involvement of the other side, the agent. Usually, the goals or interests of the principal are different from those of the agent, what is termed as the 'principal-agent' problem (Kelman, 2002), opening the possibility for the latter to 'shirk', i.e. not to accomplish the goal set by the principal or to do so inefficiently. There is thus potential for *opportunistic behaviour*.

Opportunistic behaviour alone, however, is not sufficient to provide an indication of whether to make or buy. In a contestable market, changing the provider can punish opportunistic behaviour. However, often the production of services requires *specific assets* to be used, i.e. assets that are important for a specific service, but have much lower value or chance of being redeployed for other purposes. Taking the example of long-term care, specific assets can be physical, such as the building and equipment of a nursing home, or/and intangible assets, such as knowledge about user's preferences regarding care. Specific assets provide an incentive for current contractual relationships to continue, i.e. they give incumbents an edge over competitors, which could be detrimental to competition. It is important to bear in mind that asset specificity is not necessarily a negative feature and may well be one that is sought for or seen as desirable for the service. The rapport established between a user and a carer is an example of asset specificity that also contributes to better quality of care. Nonetheless, the potential negative effects from opportunistic behaviour are liable to be greater if the market is less contestable.

Contracting parts could still write the necessary provisions onto the contract so as to forestall opportunistic behaviour, even in the presence of asset specificity. In the example above, the asset specificity associated with building nursing homes could be circumnavigated by leasing the facilities. However, the human brain has a finite capacity to take up and process information, even if working in connection with others. In other words, people cannot fully anticipate all the possible combinations of outcomes resulting from their actions and are thus limited by *bounded rationality* (Simon, 1957). The conjugation of opportunistic behaviour, asset specificity and bounded rationality could thus increase the costs with contracting, e.g. by increasing the need for lawyers and other specialised staff to draft, manage and control contracts. This is likely to be less of an issue if measurement of outcomes is relatively straightforward. In this case, ex-ante contract design and ex-post monitoring and evaluation become easier and transaction costs are likely to be lower.

The potential importance of transaction costs and thus the scope for contracting out services or publicly produce them can be depicted along a matrix (Preker, Harding & Travis, 2000) such as the one reproduced in Figure 1.

Figure 1 'Make or buy' decision grid



Source: Preker et al., 2000: 784.

The matrix reproduced in Figure 1 has been applied to healthcare, yielding the following examples. The production of consumable items and the retailing of pharmaceutical drugs would be the best example of highly contestable goods where outputs are also easy to measure. At the other end of the spectrum contestability diminishes due to specialisation and cost, in addition to measurement problems, e.g. in in-patient care and public health interventions. The 'make or buy' decision grid that follows from this approach (see Figure 1), seems quite straightforward as mainly highly contestable and easily measurable outputs could become 'marketised'. In all other cases of reduced contestability (asset specificity) or measurability, governments need to use various instruments to deal with or to counteract market imperfections, for instance information disclosure, accreditation and licensing or other forms of contractual regulation (Preker et al., 2000:784).

To summarise, contracting will be preferred under the following conditions (Kelman, 2002):

- i. **The tasks can be detailed in advance:** this means that the principal is able to state clearly what it wants. When tasks are liable to change frequently, employment contracts (i.e. in-house production) may be more suitable, for they allow for greater discretion in the modification of tasks.
- ii. **The goals or tasks can be easily evaluated in terms of compliance:** this means that not only are outcomes easy to measure, but it is possible to distinguish between poor performance due to shirking from poor performance despite best efforts. This is especially relevant for long-term care, where the functional or health condition may decline in spite of top quality care being provided. It is also why quality measurement in long-term care is key, an issue

that will merit further discussion in Chapter 4. Difficulties in evaluating outcomes may also translate into higher litigation costs to settle disputes on contract compliance.

- iii. **The market is competitive or at least contestable:** this means that there is a credible threat to enter or exit the market. Firms operating in competitive markets are liable to have lower production costs than in-house production insulated from competition and possibility for take-over. Alternatively, insufficient competition could see the principal being forced to do business with a dominant monopolistic agent. The latter situation is liable to arise in activities that are asset specific.
- iv. **Tasks are not central to the core mission of the principal:** a typical example is the contracting of tasks such as IT maintenance, cleaning or catering in both private and public companies. The argument is that by contracting these ancillary tasks management can better concentrate on the tasks (primary processes) that are its main competences.
- v. **The demand is irregular:** irregular demand risks tying up expensive resources (e.g. specialised manpower) that are only necessary to respond to spikes in demand for short periods of time.
- vi. **Production involves economies of scale:** there are greater cost savings to be gained when some tasks can be grouped across firms or government agencies and thus benefit from economies of scale. For example, adjacent municipalities may choose to contract-out garbage collection in a single tendering process rather than separately.
- vii. **Private providers can better hire specialised staff to perform tasks:** the argument is linked to wage differentials between the public and private sector, which tend to favour low-skilled employees in the public sector and thus render difficult to recruit specialised staff. In long-term care however, the argument may be turned around. The state may choose to contract rather than produce in-house to avoid paying carers (traditionally a low-skilled occupation) higher civil servant wages.

Building on this list of conditions for contracting out public services, Overview 1 attempts to use the theoretical insights of transaction cost economics to assess how suitable long-term care is for contracting out.

Overview 1 Applying transaction costs economics to long-term care

Theory-driven questions	Applicable to Long-term care
Tasks can be detailed <i>ex-ante</i>	Limited. There is scope to define in advance which tasks are to be delivered. There is however the risk that, as tasks become more detailed, this will lead to a standardisation of care provided and reduce scope for shaping services to the idiosyncratic needs of users – with a potentially negative impact on quality of services.
Compliance with objectives is easily monitored	Limited, but expanding. It is possible to monitor compliance, but this requires sophisticated quality assessment mechanisms and/or that end-users of services are able to choose and assess quality of care. Some outcomes may also depend on network functioning of several providers along the continuum of care.
The market is competitive or contestable	Yes. Certain geographic locations might be too small and in practice be natural monopolies – this can be mitigated through leasing contracts for nursing homes but requires mechanisms to address provider failure or exit.
Tasks are not central to the state's mission	Provision of adequate means to compensate for the risk of dependency may be central missions of the state, but some specific tasks may be contracted out (e.g. meals).
Demand is irregular	No. It is nonetheless possible to lease the operation of the service and make only the capital investments.
Production involves economies of scale	Limited scope for economies of scale without seriously compromising quality, even in nursing homes. Leasing the operation of the service and making the capital investment can contravene possible economies of scale.
Private providers can better hire specialised staff	Operating staff costs of private providers may be lower due to reduced unionisation or lower benefits or pay of private employees vis-a-vis civil servants. This could, however, have detrimental effects on staff turnover and compromise quality.

Source: authors' compilation.

Whilst there is apparently no clear obstacle to contract out long-term care services, a number of mechanisms need to be in place to ensure that this would be a preferred option over public provision. Of particular importance is how to define and assess the multi-dimensional quality in long-term care and create the correct incentives via contract design.

The choice of contract

The replacement of public hierarchical organisation with market provision in the delivery of long-term care calls for new institutional arrangements to frame transactions: contracts. As seen above, transactions take place amidst information asymmetries and imperfections, not just about future circumstances, but also about users' needs, quality of services provided and motivation of providers (Hart, 1995; Vickers, 1996; Forder & Netten, 2000; Forder et al., 2004; Fernandez, Forder & Knapp,

2011). In particular, contracts need to address two particular issues associated with the principal-agent problem mentioned above: (a) adverse selection and (b) moral hazard behaviour.

Adverse selection (a) in the form of *cream-skimming* – i.e. strategic selection of users – may occur if there is information asymmetry between provider and purchaser. Cream-skimming of users is possible when providers have better information of the user's characteristics (e.g. levels of care needs) than purchasers. They are able to exclude users with high needs (bearing high-cost) in favour of low-cost users based on the factors not observed by the purchaser. Cream-skimming is likely to take place in contexts where the price paid per user is fixed (Cookson & Dawson, 2012).

The problem of moral hazard (b) refers to the misrepresentation of the components of the user's care package. Although the purchaser has information on the general characteristics and needs levels of users, the provider may have better information on the composition of the service package that best meets the user's needs. As the cost structure is only known by the provider, this may give the provider the opportunity to exaggerate the real costs (Forder & Netten, 2000).

The problems of cream-skimming and moral hazard are far from unsolvable though, and some typologies of contracts may be more prone to one or another, depending on being fixed-price contracts or cost/quality-contingent contracts.

Fixed-price contracts

Conventional types of fixed-price contracts are *call-off contracts* or *block contracts*. Call-off contracts have fixed prices per individual service unit. These are set in advance for the contract period and independent of client characteristics and services provided, or reflect only broad categories of clients, i.e. old-age, physically disabled, mentally ill (Forder, 1997). Block contracts only differ from call-off contracts in that they are agreed on the basis of the quantity of services anticipated to be required for a period of time, i.e. number of hours, regardless of whether they are consumed or not (Forder et al., 2004). In block contracts the money does not directly follow the patient and thus competition is limited to the initial stage of setting the contract (Cookson & Dawson, 2012). They can however provide a stable flow of income to providers, allowing them more flexibility or long-term planning. Block contracts, which in practice assure providers a certain volume of care and respective payment independent of actual use, may therefore have quantity discounts attached.

In long-term care, commissioners may negotiate these types of contracts with care providers using fixed prices stipulated from external sources such as (1) population and user surveys on care and service needs and costs, (2) experience from in-house providers and (3) social benefit rates for older people seeking income support for care.

Block and call-off contracts give providers limited incentives to overstate their user's needs levels – the moral hazard problem discussed above, also called *up-coding*. Overstating user's needs is further limited because assessments of care needs usually lies with the public bodies and not with providers, and because the providers may usually cater for the same category of users and re-classification would be of little additional benefit (Forder, 1997). If up-coding is not likely to be an issue, the same cannot be said of user selection. Cream-skimming behaviour can exclude high-costs users as providers have an incentive to lower costs in relation to a fixed income (Forder & Netten, 2000).

The above insights on provider incentives imply a motivation and behaviour framework driven by profit-maximization. Contracts with fixed price systems may however be more in line with the behaviour and motivations of professional ethics and/or altruistic nature of non-profit providers. Misrepresentation or cream-skimming of clients may thus be less of an issue with this type of providers (Forder, 1997).

Cost or quality contingent contracts

In contrast to fixed price contracts, payments in cost or quality contingency contracts are a function of the costs incurred by the provider, which may vary with needs of users or quality of care provided (Forder et al., 2004; Grabowski, 2001). An example of this type of contract is the *spot contract*, in which prices depend on the specific condition or needs level of the user, i.e. it is contingent on the expected costs incurred with the user. Spot contracts usually allow the purchaser to gather information on the user's needs, as reported by the provider, prior to the issuance of each new contract (Forder et al., 2004). The provider is obviously penalised if it under-assesses the user's needs level. Still, the purchaser needs to invest in monitoring and assessing the user's level of needs. This may demand considerable resources and it is an important drawback of this type of contracts. If the monitoring and assessment is fragmented and non-exhaustive, there is scope for the provider to overstate and misrepresent the needs level of the user. Under conditions of imperfect information, spot contracts may thus allow providers to extract an informational rent (Forder, 1997: 519ff). In contrast, if reimbursement rates truly reflect costs incurred with users, there is little incentive for cream-skimming by providers.

Transaction costs theories highlight the influence of institutional arrangements, such as contracts, on costs. It is worth bearing in mind though, that there are many possible ways to introduce market-like arrangements for the provision of public services. The following section surveys these different market mechanisms.

1.3 Market mechanisms for social and health care services

As stated before, markets are characterised by private ownership, choice, competition and price signals. The decision to make or buy is also a decision on which and how much of these market characteristics should be used to provide public services. On the one extreme there are 'less market-like' arrangements, such as public monopolies funded through taxes. On the other end there are 'more market-like' arrangements, such as those where users choose among competing providers and pay fees reflecting costs of services that in many cases may have been negotiated or defined by (public) purchasers. Following Savas (2005) and Blöchlinger (2008), several market mechanisms can be used for the provision of public services:

- a. *Tendering (public procurement)*: whole public service provision is contracted-out with competition between providers taking place at the bidding stage, i.e. there is 'competition for the market'. It is usually employed for services where integrated networks are important, or where there is potential for monopolies (e.g. provision of long-term care in sparsely populated areas). Following a purchaser-provider split within the public administration, public provider units may also participate in tendering.
- b. *Outsourcing*: only support tasks are contracted-out (e.g. catering), with core tasks remaining in-house.

- c. *Public-Private Partnerships (PPP)*: construction, funding and (sometimes) the operation of facilities are carried out by a private provider in exchange for periodic annual subsidy. It has the advantage of spreading high capital costs over time.
- d. *Competition*: this is inherently linked to the (in)existence of barriers to entry and exit the market (see discussion above on efficient production under competition). Restrictions to entry may arise from limited market size (e.g. provision of long-term care in rural areas), economies of scale (e.g. hospitals) and/or high sunk costs (e.g. building or adapting facilities to function as nursing homes that cannot be easily used for other purposes). In fact, perfect competition is seldom observed in markets (Stiglitz, 2000) and what is more likely to occur are forms of imperfect competition which can have a non-negligible impact on price or quality, as seen above.
- e. *User choice*: allowing the end user of services to choose providers is meant to enhance allocative efficiency by improving providers' responsiveness, i.e. supply users services with the characteristics they prefer (Le Grand, 1991). The State acting as a monopsonic buyer may not always know users' preferences or have the incentive to pursue them. User choice could have a negative impact on equity though, if providers can select users (cream-skimming) or if some groups are better able to exercise their choice, e.g. by having access to better information on social services or by being able to purchase additional services privately (more on this below).
- f. *User fees*: users may be required to pay for part or the full cost of public services, thus replicating some of the effects of prices in normal markets: to limit demand (if it is sensitive to price); and to reward providers (by means of mechanisms where the 'money follows the user'). User fees, however, may price poorer users out of the market (equity issues) and have a limited impact on expenditure if fixed costs are high.³
- g. *Vouchers*: this type of mechanism links payment to actual demand, while at the same time allowing for user choice and for user fees to more closely reflect costs. Vouchers can thus be used to selectively increase the purchasing power of poorer users (who would face the risk of being priced out of accessing services), while still allowing for well-off users to pay for the full cost of care (akin to price discrimination). Vouchers are also considered as a steering mechanism to address potential 'misuse' inherent to cash benefits. Vouchers, however, are not without caveats. They can lead to price increases if there are barriers to entry; they may be prone to problems of asymmetric information (i.e. providers have better information on quality than users and may shirk) unless information on quality is available (e.g. public reporting mechanisms); and, more importantly, vouchers require users to have the resources, time and ability to search for information and wisely choose among services or providers (Taylor-Gooby & Lawson, 1993).

Preker et al. (2000: 786) suggest some additional levers by which governments may counteract market failure, in particular by means of changes in the relationship between public purchasers and private providers of health care services, e.g. the rights given to managers to make decisions; the residual claimant status; the degree of market exposure; accountability arrangements (e.g. tightening reporting, monitoring and accountability mechanisms) and subsidies to cover social functions.

³ If fixed costs are high, reduced demand induced by user fees may actually raise the cost per user.

Quasi-markets seek to mimic the functioning of textbook competitive markets for the transaction of public services using the range of above-stated market mechanisms. The market-like governance of social services does, however, raise specific issues. Some of the issues pertain to the nature of these services, not least of all the fact that they are part of the welfare system and are therefore means to meet ends of social justice, equity or citizenship rights. Other issues are more context-specific and relate, for example, with the initial conditions in setting-up care markets, e.g. what providers were already in place and operating. Thus far the analysis of the make or buy decision has been based on economic theory and arguments. What follows are attempts to broaden the analysis by incorporating contributions from social policy analysis to this discussion.

1.4 Market-oriented governance of public services – specific governance issues at stake

Developing ‘quasi-markets’ for the provision of public services has not been limited to the opening of service provision by private organisations. It included also changes to the governance structure of existing public organisations, which was dubbed NPM (Hood, 1995). These included the breaking-up of larger organisations into smaller units, with the aim to make them more manageable or to increase intra-organisational competition; an emphasis on contractualisation and performance measurement and less discretionary decision-making; and the adoption of private-sector management rules and paradigms.

Health and long-term care services, however, contain a series of prominent features that might contrast with market-oriented governance (cf. Evers et al., 1997; Huber, Maucher & Sak, 2008):

- A. Public services are an important factor for generating social cohesion in the local context and where personal relationships between professionals and their clients are of greater importance, not least of all because users share the responsibility for the outcome of the services they receive, i.e. they are ‘co-producers’ (Baldock, 1997). The need for cooperation and coordination of various service providers and institutions to guarantee ‘seamless service provision’ might easily clash with claims for the free choice of providers and competition between them. Related measures to avoid this type of ‘market-failure’ focus on accreditation mechanisms and quality assurance, but might fall short due to the complexity of tasks and the difficulties in monitoring their performance and outcome.
- B. Public services are a component of the welfare state and have therefore other aims such as social justice, equality of access and social inclusion based on a broader political debate on individual rights and obligations. The replacement of this debate and ensuing social planning by a purely market-oriented governance could further hamper the provision of equal access due to informational and regional asymmetries.
- C. Public services have a long history as part of public social assistance programmes originating from ‘poor laws’ with services provided by public agencies or voluntary charities. In particular the latter have developed their own identities by emphasising that ‘they not only just provide services, but contribute, through their particular organisational features, to developing solidarity, social networks and bonds, voluntarism, democracy and participation’, while market-oriented governance might undermine ‘the very specificity of the social contribution of civil society organisations’ (Enjolras, 2009: 289).

In reality, and despite the above-stated features, the adoption of market-mechanisms in public management over the past decades has definitely changed the planning, delivery and monitoring of social services in itself, thus shifting also the characteristics of the different stakeholders and the relations between them. For example, Evers (2005) argues that the implementation of the modernisation agenda in the area of social services in the broad sense has led to a 'hybridisation' of all parties involved: public agencies have adopted market-oriented steering mechanisms, some define themselves similar to third-sector organisations as 'public social enterprises' while (new) private commercial providers (not only those of social services) underline their 'corporate social responsibility'. It seems, however, that these "hybridization processes are not the outcome of strategic choices but, rather, of coping strategies of actors and organisations under conditions of uncertainty" (Evers, 2005: 745). In terms of mutual relationships, the 'hybridisation' process has contributed to new types of public-private partnerships, policy networks and a more pragmatic view on the tensions between market-based and partnership-based governance regimes (Enjolras, 2009).

These partnerships can also be viewed as a response to the particular features of long-term care services. It is thus salient to understand exactly what is meant by the 'special nature' of long-term care services and what implications it might have for the adoption of market-based mechanisms.

1.5 Considerations on the nature of long-term care and its implications for the market

The discussion around governance of public services highlighted a number of issues that are supplementary to the make or buy decision only in appearance. These theoretical considerations and arguments of the special nature of long-term care are important to keep in mind when discussing the introduction of market mechanisms in this sector. They will also be of importance in Chapters 3 and 4. The issues range from the collective nature of social services to the more recent developments in behavioural economics and the limits of choice and can be grouped in five headings:

1. Empowerment of users and the disability critique of social services;
2. The private nature of choice and limits to its use;
3. Equity considerations arising from using market mechanisms in social services;
4. The role of motivations in social services;
5. The necessity to provide coordinated (integrated) services across organisational, professional and often systemic boundaries.

Each of these arguments is critically summarised below.

Empowerment of users

The disability critique has emphasised self-determination, independence and autonomy of users (Fine & Glendinning, 2005), arguing that although disabled people may be limited in their 'executorial autonomy', i.e. the ability to carry out self-care, they still maintain 'decisional autonomy', the ability to decide over one's life (Collopy, 1995). This line of thought questioned not only the discretionary power held by bureaucrats in defining needs and allocating social services, but also the view of 'one-size fits all' social services (Clarke, Newman & Westmarland, 2007).

In this context, user choice came to be viewed as an essential tool to empower users with agency to choose the services that best fitted their heterogeneous needs and preferences and to be in control

(Clarke et al., 2005). The disability critique thus argues for user choice not only on the grounds of improved responsiveness – in line with those defending choice on the basis of increased allocative efficiency (cf. Le Grand, 2007a) – but also on the grounds of the intrinsic value of choice, i.e. that users derive satisfaction from being in control of the process of choice. The distinction between the two approaches – choice as having intrinsic value and the instrumental value of choice to bring about desired outcomes (e.g. increased efficiency) – is an important one in terms of how choice is operationalised. For example, choices made on behalf of users by public officials may produce desired outcomes in terms of efficiency or responsiveness of users, while failing to address the issue of agency of end-users of long-term care.

Limits to choice

The idea that choice has an intrinsic positive value, i.e. that people enjoy choosing, remains nonetheless contentious. In a review of literature on choice, Barry Schwartz argues that when too many options are present, the increased costs of gathering information and the perceived possibility of making the wrong choice may cause dissatisfaction (Schwartz, 2004). Other authors refer to the psychological costs of regret associated with certain decisions, which could make people better off by delegating the decision to an expert, i.e. a GP for an operation (Dowding & John, 2009). Furthermore, long-term care is not a want but a derived need resulting from dependency or ill-health, which means that choice of care can hardly be conceived of as an “unalloyed blessing, actively sought by its recipients” (Clarke et al., 2005: 176).

A growing body of literature on behavioural models of choice, dating back to the late 1970s (Kahneman & Tversky, 1979), has incorporated insights taken from psychology to question the narrow neoclassical model of rational choice. In the real world, choice is driven by perceptions (prospect theory and endowment effect), the way information is presented (‘framing’), prevailing social norms and by instant gratification rather than future rewards (hyperbolic discounting) (Kahneman & Tversky, 1979; Granovetter, 1985; Kahneman, Knetsch & Thaler, 1991; McFadden, 1999; 2006; Frey & Stutzer, 2005). For example, systematically misrepresenting the future and uncertain losses associated with long-term care could explain why individuals shy away from buying insurance against long-term care needs at younger ages (Barr, 2010).

In the context of long-term care, decisions are often made in conditions of duress and in moments of crisis, e.g. following a deterioration of the health condition, where uncertainty about future needs is high (Glendinning, 2008). Indeed, both theoretical and empirical research findings suggest ‘that those older people who are most dependent on care services and who could benefit most from a “good choice” are also those who have the highest prevalence rates of cognitive, physical and sensory limitations associated with the capacity to manage and carry out (on their own) informed choices of care providers’ (Meinow, Parker & Thorslund, 2011). In these circumstances it is not unlikely to conjecture that choices may be driven by instant gratification or deeply influenced by how choice is presented. It is also clear that exerting choice requires accessing information and this can raise issues of equity.

Equity

Quasi-markets imitate the functioning of ‘pure markets’ but their supporters argue that the outcomes under the former are nevertheless more equitable as benefits are allocated on the basis of need (Bartlett & Le Grand, 1993). Furthermore, choice gives users the possibility to ‘vote with their

feet', i.e. to abandon a given provider. Julian Le Grand (2007a) argues that this makes choice much more equitable than Hirschman's 'voice' (Hirschmann, 1970), because voice – e.g. expressing complaints – is more likely to be heard when users are affluent, well articulated or have influential roles in society (social capital). Those with louder voices are more likely to get better services.

However, as discussed above, user choice requires information and in turn gathering this information requires resources: time, money, cognitive skills and social capital. As these are not equitably distributed among different user groups, lack of access to information may translate into less equitable outcomes in terms of care (Greve, 2009).

Market mechanisms may impact equity also if providers can select users, i.e. cream-skimming. Providers may select users that are more amenable or easier to care for (Glendinning, 2008) or those that come with lower costs, if payments do not reflect needs or costs (Bartlett & Le Grand, 1993).

Motivations

Issues such as 'cream-skimming' are likely to be exacerbated in contexts where demand clearly exceeds supply, as it is usually the case with long-term care. For a number of authors, choice and the consumerism discourse that accompanies it are hardly compatible with the logic of rationing and gate-keeping of social services, unless it is accompanied by sufficient resources to make choice come true (Clarke et al., 2007; Arksey & Glendinning, 2008). The question is how the empowerment of users – defended on different grounds by both the consumerism rhetoric and the disability critique – fits with deciding about priorities and allocation of public resources (Clarke et al., 2007). This is far from being a purely conceptual discussion as the implementation of user choice in England has shown. In England, tensions remain between the policy aims of devolving agency to users to define their needs and how to address them and public authorities' views on what is considered as an adequate use of public resources (Stevens et al., 2011).

The introduction of market mechanisms can affect the inherent motivations of social services providers. Williamson noted that transactions that have attached important non-pecuniary rewards could be jeopardised with the introduction of the 'cash nexus' (Williamson, 1993). A point developed in Frey's (1998) theory of motivation, which hypothesizes that extrinsic motivations (e.g. monetary rewards) may crowd-out intrinsic motivations (e.g. self-fulfilment). To use Le Grand's (1997) terminology, the introduction of cash incentives could thus turn knights – providers acting on the users' best interests – into knaves – providers that have their self-interest in mind. In the case of personal social services, there is a long history of provision of services by voluntary charities. This renders the above-quoted arguments by Enjolras (2009) – on how market mechanisms may undermine the contribution of charities to foster the growth of intangibles such as participation, solidarity or voluntarism – particularly pertinent in long-term care. The motivational argument also extends to the managing of contracting. For example, non-profit providers, to the extent that they may be driven by other motivations rather than profit-maximising alone, may have less of an incentive to cream-skin, the same way that trust may reduce contracting costs (Steinberg, 1997; Forder, 1997).

Providing coordinated and integrated long-term care services

One of the key-features in current debates and activities about long-term care at several policy and government levels relates to the necessity to improve the coordination and integration of hitherto

fragmented services to make these more user-centred by increasing their performance and effectiveness (Hofmarcher, Oxley & Rusticelli, 2007; Øvretveit, Hansson, & Brommels, 2010; Leichsenring, Billings & Nies, 2013). This prospect seems to clash with many features and consequences of market-oriented governance, e.g. in relation to choice if users and/or public purchasers (case managers) buy individual services, rather than ‘packages’ of care; if competition between providers prevails over cooperation and transparent information; or if funding mechanisms are linked to different budget-lines or government levels (yet another issue of governance). Furthermore, better coordination and integration of care pathways might impact on asset specifications, criteria for accreditation and contracting, as well as on quality assurance across organisations and service levels. These are issues also to bear in mind in the ‘make-or-buy’ decisions.

1.6 Summarising the theoretical arguments

The theoretical arguments presented above cover a wide range of subjects. To a great extent this is because long-term care is dissimilar to other sectors of public services where market-based mechanisms were introduced. Social services have a broader range of objectives such as contributing to social cohesion or ensuring equity. These objectives may not preclude the contracting of long-term care services, but raise issues that are not present, for instance, in waste removal or telecommunications.

While the discussion on competitive markets and transaction economics might sound a long way from the disability critique around empowerment of users, the topics and arguments are actually intertwined. Who has the agency to choose – end users or public officials – has important implications in terms of the information needed to make informed choices. Agency is also crucial for the structure of the market as it makes a difference, for instance, if there are multiple atomised consumers in the case of end users of care with command over choice or if there is a monopsonic public purchaser with public officials being entrusted with agency.

Given the characteristics of long-term care services, economic theory alone is unable to provide a straightforward answer to the question of making or buying long-term care. The issues presented in Overview 1 above illustrate related ambiguities of transaction costs economics in long-term care and so does the previous theoretical discussion around the impact of competition on quality or provider diversity in health care (Dranove & Satterthwaite, 2000; Gaynor & Vogt, 2000). Whether to make or buy long-term care is thus an empirical question.

The review of relevant theory does however highlight a number of salient issues to analyse the make or buy decision in long-term care and to bear in mind when developing quasi-markets, in particular:

- i. The importance of users having sufficient funding to purchase care, as need might not be correlated with ability to pay.
- ii. The role of barriers to entry and exit (for providers), as well as switching costs (for purchasers), in shaping competition among providers and the market power enjoyed by providers in either negotiating with public bodies or end-users of care.
- iii. The salience of having complete and adequately framed information on prices as well as quality for a) purchasers of care (either public bodies or end-users) to be able to do informed choices and b) competition on these dimensions to achieve its desired outcomes.

- iv. Similarly, contract design plays an important role in creating the correct incentives to bring about desired outcomes.
- v. Long-term care is liable to be provided through a mixed economy of care that includes not only private providers, but also non-profit organisations whose different motivations and organisational structures may play a role in the steering of 'quasi-markets'.
- vi. Long-term care is part of broader welfare systems and as such it may have other societal agreed goals such as assuring social cohesion, ensuring equity of access to care and enhancing agency of users, against which the outcomes of 'quasi-markets' must also be assessed.

The subsequent empirical analysis on the impact of introducing 'quasi-markets' on long-term care systems will thus focus on the issues of user choice and impact of competition on prices, quality and diversity in a mixed economy of care provision (private and non-profit providers). Before turning to the analysis of the empirical findings, the next chapter briefly outlines the methods employed on the subsequent stages of this research project.

Chapter 2

Methods

Review of the theories underpinning the ‘make or buy’ decision in long-term care underscored the importance of resolving the question of whether to internally produce or contract-out long-term care empirically. The review also highlighted that assessment and management of quality is a key element in the answer. The remainder of this report is therefore focused on these two issues.

The challenge in answering the make or buy question empirically is that long-term care does not operate in a vacuum. Like other social services it is strongly shaped by pre-existing structures and societal values, e.g. the role of the family and of the state. In other words, the empirical answer to whether to make or buy long-term care likely depends on a number of contextual factors, e.g. on how long-term care is organised in a particular country, what kind of mix exists between home care and residential care, whether the system is characterised by public monopolies or a well-established non-profit sector, and if long-term care has been acknowledged as a social risk throughout the development of social welfare policies. Starting from these pre-existing conditions, the introduction of market-mechanisms becomes very much path-dependent and self-reinforcing. The comparative analysis of empirical findings on ‘quasi-markets’ drawn from the case studies must necessarily account for this. Furthermore, in order to inform policy making it is arguably just as important to understand why long-term care should be produced internally or contracted out as how it can be. Against this backdrop, we sought to gain a better understanding of how the decision to make or buy long-term care has been implemented in selected countries; why the decision to contract out services, i.e. to ‘buy’ long-term care, has been undertaken; and in what ways it has affected outcomes for users.

Quality assurance and quality development in long-term care are topics that have garnered considerable attention in the literature (Capitman, Leutz, Bishop & Casler, 2005; Du Moulin, van Haastregt & Hamers, 2010; Glendinning, 2009; Grabowski & Town, 2011; Nies, van der Veen & Leichsenring, 2013; OECD & European Commission, 2013; Rothgang, 2010). This is reflected in practice by an increase in the number of quality management systems that have been developed and applied specifically to long-term care. Until now, however, only limited attempts have been made to comparatively analyse these different quality management systems in order to draw useful policy lessons for assessing quality in long-term care and to explore the strengths and weaknesses of each system. This report contributes to bridging the knowledge gap in this area.

2.1 Country case studies on marketisation in long-term care

Bearing in mind the challenge of analysing the make or buy question in the context of dynamic, ever-changing long-term care systems and the nature of the research questions we hoped to analyse, an analytical framework consisting of a multiple case study design with competition and user choice in long-term care as the units of analysis have been employed (Yin, 2008). The decision to use a case study methodology was made on the basis of the fact that although the long-term care systems analysed here have experienced a similar ‘policy shock’ – in generic terms the introduction of competition and user choice – the trajectories and outcomes were deeply influenced by a series of factors individual to each case, where initial conditions (e.g. relative importance of for-profit and

non-profit providers), but also path-dependency played an important role. The case study approach allows the reader to draw on valuable lessons from other countries' experiences and to compare trajectories, bearing in mind national institutional settings and organisation of long-term care. Our analysis of experiences with competition and choice in long-term care systems in Europe involves four countries that are representative of different welfare regimes in long-term care (Jensen, 2008): England as a means-tested system; Denmark as an example of a Nordic long-term care system with generous support for dependent older people and de-familiarisation of care; and Germany and the Netherlands as examples of insurance-based long-term care systems, each with different approaches to the payment of informal carers with cash benefits.

Data gathering for the case studies followed a two-step approach. First, desk research on existing peer reviewed articles, studies and policy documents was carried out in order to gather contextual information about the lead-up to the introduction of competition and user choice, and on the national institutional and regulatory settings and system design.

In a second step, the information gathered for the individual case studies via desk research was complemented by interviews with experts in each country. Expert interviews generate special knowledge and expertise on a specific subject which would otherwise require extensive field and desk research (Bogener, Littig & Menz, 2005). The experts were identified via existing professional networks, referrals and internet searches and were selected on the basis of their expertise in the organisation of long-term care for older people within their respective countries. The interviewed experts are representative of different stakeholders including providers, financiers, local authorities and regulatory bodies, and include officials at different levels of government, given the fact that responsibility for long-term care often rests with municipalities. A total of fifteen experts were interviewed for the four case studies (see list of anonymised interviewed experts, Annex I). The number of expert interviews carried out was considered to be sufficient as previous research has demonstrated that small samples can provide precise and fairly detailed information when interviewees are experts in a given theme and the interviews capture knowledge rather than perceptions (Romney, Weller & Batchelder, 1986; Guest, Bunce, & Johnson, 2006). The majority of interviewed experts have been active in the field of long-term care for more than 20 years which testifies not only to their knowledge, but also to their ability to reflect on market developments that have occurred in the past decades.

The interview guidelines were first constructed around a common heading structure to ensure comparability of findings. Within this common heading structure, however, the contents of the interview guidelines were tailored to the national context and to the specific area of work and expertise of the interviewee. The topics addressed in the interviews covered the following key issues (see general interview guideline, Annex II):

- Mechanisms to govern planning, organisation, delivery and control of long-term care services
- National debate on market-oriented governance in long-term care and the 'make or buy' decision
- Change in public administration of long-term care with new governance mechanisms
- Organisation of access to new types of (private) providers
- Evolution of the relative 'market share' of different types of providers
- Organisation of contracting process (tendering, contract negotiation, monitoring)

- Relationship between public administration and providers
- The extent to which users (and/or their relatives or advocates) are empowered to make choices and the mechanisms in place to make their choice possible
- Need for specific training and skills for new types of tasks and managing relationships (e.g. preparing tender documents, networking, controlling, etc.).

The interviews lasted between 40 and 60 minutes and were conducted face-to-face or via telephone in English or German and were recorded and transcribed. Prior to each interview, informed consent to record the interview was obtained from each participant. The information collected in the interviews was used to complement and update the results of desk research.

2.2 Quality management systems review

The assessment of quality management systems will be focused on some of the most prevalent and long-term care-focused assessment tools and frameworks. In particular, two methods for assessing needs as a precondition for defining quality of care will be analysed, followed by three regulatory systems for quality assurance at the national level, and two models for internal quality management. The selection of these methods and frameworks was based on the following criteria:

- Their implementation in those countries that had been selected for the case studies in order to complement the analyses provided by the country case studies
- Their pertinence to the area of long-term care, i.e. their adoption of specific characteristics in the delivery of long-term care, and
- Their ability to underpin make or buy decisions by complementary measures in the governance of quasi-markets.

The selected methods and frameworks will be described based on a review of relevant literature and authors' previous own research and development in this area (European Centre, 2010; Leichsenring, 2010b). The comparison of different approaches has been a special challenge. Due to their different scopes and framework conditions it is hardly possible to compare these approaches literally. It has therefore been decided to carry out a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats), which is usually used as an analytical tool for elaborating on strategic decision processes (Pickton & Wright, 1998). In the context of this study it lends itself to expose and analyse various options for regulatory frameworks and methods to assess and ensure quality development in long-term care. This analysis is focusing on a range of pertinent criteria such as

- The degree to which an instrument/method promotes standardisation of care, rather than person-centred care,
- The degree of stakeholder involvement (in particular users),
- The degree to which it addresses specific characteristics of long-term care such as quality of life, user satisfaction and dignity,
- The degree to which it may motivate staff to consider quality development as part of their job profile,
- The degree to which it allows quality assurance across organisations and sectors, and
- Cost considerations.

To underpin these considerations with further empirical knowledge, a rapid systematic literature review has been undertaken focusing on research about differences in the quality of the various

types of residential care home providers in long-term care. The preliminary results of this exercise will be highlighted in a text box under the quality section.

Chapter 3

Case studies on marketisation in long-term care

In the course of the reorganisations of care provision and changes in regulations that have taken place in Europe, countries have implemented similar reforms that can be characterised as a common shock to long-term care systems. Despite marked differences, attempts to reform long-term care systems have shared one trait in particular: they have all demonstrated an increasing reliance on market mechanisms and user choice, supported by a strong consumerist rhetoric (Pavolini & Ranci, 2008) and NPM theories (Theobald, 2012). Reforms have focused in particular on strengthening of user choice through cash or in-kind benefits and on the contractualisation and standardisation of care services.

Despite this commonality, countries began implementation of these reforms from very different starting points in terms of institutional settings (insurance-based or tax-funded systems), the nature of existing benefits (e.g. means-tested or universal), and existing stakeholders (e.g. public monopolies of care provision or existing for-profit or non-profit providers). An understanding of the differences in national pathways to reform and reorganisation of long-term care across countries provides learning opportunities and important policy lessons with regard to the national experiences of introducing competition and choice. This chapter will map these experiences in England, Denmark, Germany and the Netherlands by drawing on the issues identified in the previous theoretical review.

As highlighted in Chapter 1, the most salient issues when it comes to analysing the question of whether to make or buy and the instruments most commonly used by countries in designing quasi-markets in long-term care are: i) the choice for users, ii) the market access of providers, iii) contract design, iv) the organisational structures of different types of providers, and v) information to make informed choices. As markets have matured, countries have accumulated valuable experiences related to these issues through their attempts to steer market developments while ensuring efficiency and quality in care provision. We will trace the lessons learned from each country in three sections organised as follows: Section one will present the trajectories of the introduction of market mechanisms and the key players and arguments involved in the establishment of competition and choice. The markets, governance and funding mechanisms of each long-term care system will also briefly be described. Section two will outline the main contractual mechanisms and providers involved in the provision of long-term care in each of the four countries. The third section takes the perspective of the end user of long-term care and will describe the dimensions of choice available to users and the outcomes of competition and choice for users. Following these three mostly descriptive sections the findings will be discussed comparatively in the final section.

3.1 The context of competition and choice

To compare the reorganisation of care markets and the respective outcomes across the selected countries, it is helpful to juxtapose the individual pathways of market introduction and the institutional contexts of each country. In the following section we will therefore describe the major political factors and arguments, governance mechanisms and key players that facilitated development towards quasi-marketisation in England, Denmark, Germany and the Netherlands.

3.1.1 Pathways to competition and choice

By the early 1990s, long-term care in **England** was based on means-tested and assessed need. At the beginning of the decade a series of reforms changed the way in which long-term care was provided to older people but means-testing was retained. Competition and user choice in long-term care were first introduced in England in 1993 following the 1990 implementation of the *National Health Service (NHS) and Community Care Act* which called for the creation of a quasi-market of care (Bartlett & Le Grand, 1993; Lewis & Glennerster, 1996; Hardy & Wistow, 1998; Glendinning, 2008). The purchaser-provider split became compulsory for English Local Authorities (LA), whose care managers became responsible for assessing users' needs and purchasing care on behalf of users from competing home care or residential care providers. User choice at this stage was limited to choice of provider. As a consequence of the reforms introduced, LAs — which in England are responsible for providing long-term care — gained the status of monopsonic purchasers for both residential and home care. In residential care, however, self-funding users had a significantly larger role than in home care as many users had assets (e.g. their homes) which excluded them from eligibility for public funding of residential care (Forder & Netten, 2000). This situation has remained unchanged to the present day as self-funded users continue to account for a significant proportion of users in residential care (Baxter et al., 2011).

For the first time in 1997, LAs were allowed to provide cash benefits known as Direct Payments (DP) to eligible users of home care instead of care services (Glasby & Littlechild, 2009). Initially restricted to disabled people of working age, eligibility for DPs was extended to older people in 2000. DPs took on the value of the care services allocated to users and could be spent on formal care services directly purchased by the user, or they could be used to hire a personal assistant including a relative (with the caveat that until 2007 co-residing relatives were barred from being employed as personal assistants). Although DPs were more akin to an opt-out option – it was only after 2003 that it became mandatory for LAs to provide DPs to those who requested them – they did grant users the ability to choose their provider, the type of care and manner in which it was provided, and when. DPs could not be used for residential care. While take-up among most groups of users was high, use of DPs among older users remained low even though provision of DPs was used as a performance indicator for LAs.

Between 2006 and 2008, Individual Budgets (IB) were piloted in 13 LAs as part of an experiment that sought to: widen the range of choice in home care to all groups of users, streamline funding and assessment by bringing together several funding streams into one benefit, allow greater user flexibility in assessing their own needs, and encourage users to spend their IBs more creatively, for example on leisure and social activities (Glendinning et al., 2008).

Halfway through the IB piloting period the coordinators decided to roll-out a slightly modified version of the benefit, renamed Personal Budgets (PB). PBs aggregated funding from social care and could be deployed in three different ways (or in a conjugation of the three) (National Audit Office, 2011). The first option (a) was to have the LA manage the PB on behalf of the user – LA-managed PB – although the user's preferences regarding provision of care would be taken into consideration. A second option (b) was to take the PB as a DP, which would be managed directly by the user to purchase care from a formal home care provider or to employ a personal assistant – or a combination of both – in which case the user would be responsible for the associated taxes, employment contracts and insurance (National Audit Office, 2011). Finally, (c) the PB could also be managed by a third party

(e.g. a formal provider) chosen by the user and subject to the user's wishes on how to spend the money. PBs could not be used to pay for residential care.

PBs were provided to all new users of home care from April 2011 onward and a target was set to have 70% of all users of care (including older people) on PBs by April 2013 (Baxter, Rabiee, & Glendinning, 2013). The latest available figures for 2011/2012 show that among older people, 7.2% received PBs as a DP (option b), 88% had their PBs managed by their LAs or a third party (option a or c), and 5% received PBs as a combination of DP and managed PBs (NHS, NASCIS Database). Take-up of DPs among older users remained lower than for other groups of disabled users.

Until 1990, provision of care in **Denmark** was based on assessed need and sought to enable older people to remain in their own homes where formal home care services were provided by the municipalities (Rostgaard et al., 2011). Denmark first began to move away from this public monopoly in the provision of home care in 1996 by giving municipalities the option to have for-profit organisations provide care, thereby giving users greater choice among providers (Bertelsen & Rostgaard, 2013). What was essentially a voluntary option to outsource certain home care services (limited to some services only, e.g. personal care remained with the public provider) was met with low take-up by municipalities: only 2.5% of home care was provided by for-profit organisations in 2002 (Fersch & Jensen, 2011).

In the 1990s, measures were taken to separate the assessment of need from the provision of care (akin to a purchaser-provider split) and to minimize the discretion of case managers in assessing need by establishing a standardised assessment tool across municipalities – the 'Common Language' instrument was implemented in 1998 at the initiative of the Association of Local Authorities (KL) – which detailed the allocation of care tasks according to four levels of care need (Rostgaard, 2011).

In the beginning of 2003 it became compulsory for municipalities to offer users choice of home care providers, i.e. to have more than one public or private provider, and private providers were for the first time also allowed to provide personal care. The municipalities retained the power to set the prices and quality standards for the tendering procedure and remained responsible for the assessment of needs and allocation of hours and care. Only for-profit providers were allowed to provide extra services to users, including mainly cleaning, delivery of meal or laundry services, or to provide additional personal care beyond the assessed needs of the user. Both kinds of supplementary services were subject to private payments by users. This was meant to buoy private providers against incumbent public monopolies.

These changes did not alter the universal (needs-based) nature of the system and personal care remained free at point of use for users. The introduction of competition and choice was confined to home care, although some services in residential care could be outsourced (e.g. delivery of meals) and the majority of care homes were operated by non-profit providers.

User choice and competition were further enhanced in 2009 with the introduction of a tax allowance for costs of some services offered by private home care providers, and by the introduction of the possibility to exchange services for a voucher (Bertelsen & Rostgaard, 2013). The voucher system offers users the possibility to employ their own carers including their relatives, yet it remains a voluntary scheme and is not very popular with municipalities: only 3 out of 98 have introduced it (Bertelsen & Rostgaard, 2013).

Until 1995, the provision of long-term care in **Germany** was based on the principle of subsidiarity with large non-profit welfare organisations providing care in close cooperation with local and state authorities often supported by different state subsidies. Within this subsidiarity framework, a principle which is strongly embedded in Germany's tradition of a welfare mix in care provision, civil society organisations formed the basis for user-oriented, diversified service provision (Theobald, 2012). Before 1995, however, no funding mechanism for long-term care had existed and around 80% of people in residential care relied on social assistance funded by local authorities and federal states (Rothgang, 2010).

The introduction of statutory long-term care insurance (LTCI) in Germany in 1995 established the universal right for support in dependency as well as a quasi-market in long-term care in which care providers other than the incumbent non-profit welfare organisations could compete. The LTCI is based on market-oriented governance, meaning that any provider that meets certain formal criteria (qualification levels, cost-efficiency, high-quality care provision) is free to enter the local market, independent on existing capacity or providers, and is eligible to be contracted by the long-term care funds ('Pflegekassen') (Theobald & Hampel, 2013). This regulation aimed to increase competition between providers and the mixture of private for-profit organisations as well as non-profit and public care providers.

User choice was facilitated by the opening up of the market, enabling care recipients to choose between benefits in cash and services in kind from a wide range of private and public care providers both for home care and residential care. In practice, LTCI recipients can choose to use their LTCI benefits to pay for home or residential care in what is similar to a voucher system. They may also opt for cash benefits which are granted at a lower rate and may be used to compensate the work of informal carers, or users may choose a combination of cash and in-kind services.

In the German context, the LTCI funds are key actors in the regulation of the care market, the assessment of needs and the inspection of quality of care provided (Arntz, Sacchetto, Spermann, Steffes & Widmaier, 2007). They are also responsible for setting prices and the payment of cash and in-kind benefits (Rothgang, 2010). LTCIs do not make the purchasing decisions themselves, however; it is the users who choose their preferred care provider with LTCIs financing these services according to the assessed level of care need. Despite the acknowledgement of universal rights for support in old age that was brought about by the introduction of the LTCI scheme, the system is based on a limited insurance entitlement and does not intend to cover all care demands of insured persons, just as it continues to rely strongly on informal family carers. In particular, private co-payments are needed to complement the LTCI and social assistance still plays an important role, especially in residential care (Eichler & Pfau-Effinger, 2009; Theobald, 2011; Rothgang, 2010).

The **Netherlands** was a trailblazer with regard to the introduction of a universal mandatory social health insurance scheme covering a broad range of long-term care services provided in a variety of care settings. In 1968, it was the first country to introduce a comprehensive LTCI scheme within the framework of the *Exceptional Medical Expenses Act* (AWBZ) (Schut & Van Den Berg, 2010). Presently, the Netherlands has one of the highest long-term care coverage rates in the OECD, with around 21.1% of people aged 65 or above receiving home care and 6.7% receiving residential care services (Rodrigues, Huber & Lamura, 2012). The AWBZ covers not only residential and home care for older people, but in principle covers services for all chronically ill patients, thus also including care in

institutions for the mentally and physically disabled and for chronic psychiatric patients (Da Roit, 2013). The AWBZ scheme covers about 40% of total health care expenses and approximately 3.6% of the total population receive AWBZ benefits (Glendinning & Moran, 2009). The AWBZ is financed by contributions, co-payments and state subsidies.

Since 2007, the responsibility for funding home help and other assistive care services has been devolved to local authorities under the *Social Support Act* (WMO), with the exception of Personal Budgets (van der Veen, Huijbers, & Nies, 2010). WMO is tax financed and entitlements are influenced by the funds received by local councils as non-earmarked and non-ring-fenced budgets (Mot, Aouragh, de Groot & Mannaerts, 2010). Municipalities are also in charge of assessing needs for home help and thus have important leverage on the allocation of this type of services. Consequently, the assessed needs for home help vary across municipalities and regions.

A major reform expected to come into effect in January 2015 will transfer the central government's responsibility for providing home care stipulated under the existing social insurance law to local services. Claims based on social support will thus be transferred to municipalities and only nursing care will fall under the responsibility of the central government. The latter will be covered by the AWBZ insurance and focus on the most intensive forms of long-term care, provided mainly in institutions to older and disabled people (Ministry of Health, Welfare and Sport, 2014; van der Burg & van Asselt, 2013; Information from consultant in long-term care).

The introduction of Personal Budgets ('Persoonsgebonden Budget') in 1995, similar to the English DPs mentioned above, was undertaken in order to enhance user choice in home care services. Instead of receiving in-kind benefits, those eligible for home care were given cash benefits to arrange their own care and to purchase various types of care and assistance from formal and informal providers, or from a combination of both. The number of Personal Budget holders still represents a small minority of AWBZ users but take-up has increased considerably over the past few years (Da Roit, 2013). With the introduction of Personal Budgets, user choice in home help and personal care providers increased considerably. Home help services are usually provided by private for-profit companies that tender for contracts with municipalities under the WMO, while personal care services within the Personal Budgets scheme are provided by private non-profit home care organisations.

Overview 2 summarises the main characteristics of governance and funding mechanisms in the above described quasi-markets.

Overview 2 *Characteristics of governance, funding mechanisms and markets in long-term care in England, Denmark, Germany and the Netherlands*

Country	Governance	Funding	Providers
UK (England)	Long-term care services fall under the responsibility of local authorities whereas health care is regulated by the National Health Service (NHS).	Social care for adults is based on means-tests, eligibility criteria and user charges.	Most providers are private (for-profit and non-profit); Informal carers such as relatives and friends can receive several support services upon assessment of their needs.
Denmark	Municipalities are responsible for long-term care, including funding, certification, needs assessment and quality inspection.	Municipalities allocate benefits that are financed by federal block grants, local contributions from regions and municipalities.	Most providers in residential and home care are public. Since 2003, municipalities must roll-out user choice models in home care, but for-profit providers only offer home help services.
Germany	Regional markets of care with open access to providers that comply with standards. Quality inspections are carried out by federal bodies (Medical Service of the German Health Insurance) and regional authorities ('Heimaufsicht').	Main benefit (long-term care allowance) is funded through a LTCI at the federal level.	Open markets of care contributed to a sharp increase in private for-profit provision regulated by specific contracts and intense monitoring (public reporting). Strong reliance on paid informal care by users residing in their own homes.
The Netherlands	Governance of long-term care is shared between the social insurance (the Exceptional Medical Expense Act – AWBZ) and local authorities along service lines (WMO Act).	Nursing homes are financed by a centrally managed social insurance (AWBZ). Home help is funded by the local authorities. Personal Budgets are funded by both, depending on the services covered.	Most providers are private non-profit organisations. There is some competition between insurance companies in relation to supplementary insurance. Hired informal carers and personal assistants play an important role via the Personal Budgets. By 2015, for-profit providers could play a bigger role with the shift of responsibilities for home care to municipalities (WMO).

Source: INTERLINKS country information, available at <http://interlinks.euro.centre.org>;

3.1.2 Arguments, stated aims and key players

In the early 1980s, **England** experienced a rise in public expenditure on long-term care, partly because board and lodging expenses in private nursing homes could be claimed back from the social security budget. This was in practice a voucher system for private residential care with the (unintended) consequence that the existing mix of long-term care provision was tilted in favour of residential care, spurring the creation of many small scale for-profit providers of residential care (Lewis & Glennerster, 1996).

The introduction of competition and choice in the early 1990s, although clothed in strong consumerist rhetoric (Bartlett & Le Grand, 1993), actually strove to achieve cost-containment, to enhance home care vis-à-vis residential care, and to create a mixed economy of care provision. As such, 85% of a special fund created by the 1993 *National Health Service (NHS) and Community Care Act* to develop home care was to be spent on the so-called independent sector, i.e. on private providers, thereby cushioning the nascent small-scale private providers that had flourished under the previous voucher-like system (Lewis & Glennerster, 1996:9). The role of care managers as gatekeepers was strengthened in order to enhance efficiency – hence their role as purchasers of care on behalf of users.

At the same time, disabled people had long been campaigning for more control both over the use of benefits and over the definition of their needs, due in part to what they considered to be unresponsive care services and an excessive dependency on the verdicts of professionals in defining their needs (Scourfield, 2005). While smaller scale programmes enabling users to receive cash payments and employ personal carers had previously existed, it was only with the introduction of DPs by the Labour government in 1997 that the disabled community's requests began to be partially addressed.

Although the option to receive the cash equivalent of care services and to choose the identity of the carer was allowed by the DPs, decisions regarding assessment of needs were left in the hands of care managers. As LAs continued to be faced with budgetary constraints and increasingly limited funding to personal care, these pressures were reflected by the DPs as they in theory only covered funded services. In part, the IB experiment grew out of a response to disabled people's calls for greater latitude and flexibility in defining needs and spending benefits with the goal of leading independent living (Glendinning et al., 2008). Another powerful argument emerging in official documents at around the same time was one to make services more responsive to the needs and preferences of older people – ending what was considered to be a “one size fits all” approach –by way of user choice (Glendinning, 2008).

Throughout the process of establishing first DPs and then PBs, older people seemed to have played a lesser role in shaping user choice policies.

Denmark experienced a period of relative welfare retrenchment in the 1980s, but this trend came under criticism in the early 1990s for threatening to undermine quality and efficiency of public services (Rostgaard et al., 2011). Unlike in England, cost-cutting motivations did not feature prominently in the stated objectives of introducing competition and choice in Denmark.

Instead, arguments supporting competition and choice were more closely related to the intrinsic value of choice and NPM principles of contractualisation and formal, measurable standards.

Evidence of this can be found in official documents that portray users not only as autonomous consumers, but also as deriving satisfaction from being able to choose between different providers (Rostgaard, 2006, 2011). In line with this argument, greater emphasis was placed on developing private provision of care as an alternative to the previous public monopoly. It also explains the measures taken to foster the development of private providers: from the tax allowance for personal services to the possibility to top-up personal care hours and provide additional paid services that only private providers are allowed to offer.

The influence of NPM is exemplified by the purchaser/assessor-provider split and the introduction of the 'Common Language' instrument which standardises needs and tasks down to the minute.

Arguments around empowerment and autonomy also did not feature as prominently in the Danish context as they did in other countries. In fact, there were few signs of dissatisfaction with public provision of care or calls for greater control from the disability rights movement throughout the reform process (Rostgaard, 2006).

A key player in the process of implementation of choice and competition in Denmark were the municipalities. In Denmark, municipalities have considerable discretion in determining their own policies regarding care for older people (Jensen & Lolle, 2013). The implementation of user choice and competition thus depended on support for the reforms among municipal officers (Fersch & Jensen, 2011) and this was evident in the slow take-up of user choice mechanisms whenever their implementation at the local level was voluntary.

The establishment of the **German** LTCI scheme and the restructuring of formal care provision was influenced on the one hand, by elements of NPM that sought to achieve efficient formal care provision and on the other hand, by the strengthening of family care (Theobald, 2012; Da Roit, 2013; Theobald & Hampel, 2013). The restructuring of the care system in Germany thus placed particular emphasis on user choice and the role of the market in the provision of care. At the same time, users were allowed to choose not only between various public, non-profit and for-profit providers of home or residential care, but also to choose between formal care provision by any of these organisations and publicly funded family care (Theobald & Hampel, 2013; Eichler & Pfau-Effinger, 2009).

A major objective of the LTCI was to insure comprehensive provision of care services by opening up the market, particularly in the home care sector, and to introduce competition between non-profit long-term care providers by reducing barriers to entry faced by for-profit providers. The LTCI was intended to break the 'cartel' of a few traditional welfare organisations that were in privileged positions but that provided only a limited number of services (Glendinning & Moran, 2009; Theobald, 2012; Leichsenring, Barnett, & Rodrigues, 2010). As a consequence, the mode of cooperation between providers, new purchasers (LTCI funds), co-funders (municipalities) and public regulators was restructured not only by opening up the market but also by the introduction of contract management that adhered to stringent cost-containment policies (Theobald, 2012).

The introduction of LTCI also aimed at reducing the reliance on social assistance provided by local authorities and federal states, which previously had been the only source of public funding for many families (Glendinning, Davies, Pickard & Comas-Herrera, 2004). As a result of this, local authorities saw their burden eased but they also lost control over service provision, community care planning and responsibilities for the social needs of their citizens. Before the introduction of LTCI in 1995,

municipalities were the sole steering body of service supply. Their long-standing cooperation with primarily five large traditional welfare organisations⁴ acting as providers was based on trust, governing via social planning and subsidies. With the shift in responsibility for assessment, financing, regulation and quality inspections to the LTCI funds, the provision of long-term care lost some of its local embeddedness (Allen et al., 2011; Information from representative of Medical Advisory Service and responsible at municipal level for social services; Leichsenring et al., 2010) and the state gained a more comprehensive and central role with regard to funding and regulation of long-term care (Theobald, 2012). Indeed, planning local long-term care demand, a task that was formerly conducted by municipalities, is lacking at present and has resulted in an overabundance of residential care places (Allen et al., 2011; Information from representative of Medical Advisory Service and responsible person at municipal level for social services).

In the **Netherlands**, reforms to the well-established long-term care insurance scheme AWBZ have been strongly influenced by the principles of cost containment and consumerism.

Since its inception the AWBZ has undergone several structural changes with regard to coverage and financing triggered by the debate surrounding the issue of cost containment. The debate on efficiency in care provision and the reduction of public expenditure on long-term care accompanied the debate about user choice, market principles and increased individual responsibility for one's own care. This discussion led to the ratification of the *Social Support Act (WMO)* in 2006 which specifically aimed to increase individual responsibility and decentralise care policies.

Shifting responsibility for personal care from regional AWBZ Care Offices to the municipalities under the new WMO Act scheduled for January 2015 has the objective of enabling older people to stay at home longer and to transfer the assessment of needs, and the organisation and purchasing of home care services to the local level. It is expected that this transfer to municipalities will result in a stronger integration of different care services that respond more fully to individual needs (van der Burg & van Asselt, 2013; Information from consultant in long-term care).

The Personal Budget is considered a major innovation in the Dutch welfare state, strengthening users as consumers and providing market incentives. Introduction of the Personal Budgets was triggered by the disability rights movement's grievances concerning major organisational problems in the delivery of care, including high turnover rates, impersonal care provision and inflexibility in the timing and delivery of care (Kremer, 2006). The main objective of the Personal Budget scheme was the creation of a care market that empowered users to purchase the care most suited to their needs and preferences.

The Personal Budget also intended to create a care market and enhance competition between care providers by facilitating the entry of new for-profit home care providers, thus improving quality and increasing efficiency of service delivery. Similar to the German model of choice in long-term care, users can use the Personal Budget to pay formal and informal carers who deliver care in the home (Kremer, 2006). However, expectations regarding the creation of a market and competition between providers have not been met as Personal Budget holders used the benefits mainly to compensate

⁴ Traditional welfare organizations include church-related charities, unions and cooperatives such as Caritas, Diaconates of the Protestant Church, Federal Workers' Welfare Association, the German Red Cross and The Paritätische.

informal family carers. Furthermore, its goal of cost containment — which depended on the substitution of expensive formal care for less expensive informal care — was not achieved. Research has shown that it only partly substituted for in-kind benefits (Da Roit, 2013). The widespread uptake of this scheme by users of all ages who would otherwise not have applied for care and the resulting increase in expenditure led the Dutch government to impose restrictive measures. The admission of new budget holders to the system was restricted to persons deemed to be in need of residential care. In addition, new Personal Budget holders had to have been assessed as needing at least ten hours of care per week in order to receive support in the household (Sadiraj, Oudijk, Kempen, & Stevens, 2011; van der Torre, Ooms, & Klerk, 2013; Information from consultant in long-term care and representative of Dutch Council for Public Health and Health Care).

3.2 The operationalisation of competition

The previous section synthesised several of the political objectives and underlying theories, in particular the influence of NPM, cost containment and consumerism that guided the implementation of similar governance arrangements, processes and schemes in different countries, albeit in the context of different starting conditions. The following section describes how political reforms and stated objectives transformed the markets as well as contractual arrangements and relationships between key players in the home care and residential care sectors. We will also compare how the level of increased competition and user choice changed positions and responsibilities of governing bodies and providers and led to the emergence of new stakeholders such as private for-profit providers.

3.2.1 Market mechanisms and contracts

A number of prominent patterns have emerged alongside the development of quasi-markets and the governance of residential and home care in **England** over the past two decades. For instance, in residential care it is estimated that 45% of users self-fund their care (Care Quality Commission, 2011) meaning that they pay market prices. Given the tightening of LA budgets, self-funders are likely to cross-subsidise LA-funded residents. Despite the importance of self-funding, LAs still play an important role as purchasers of care through a variety of contract arrangements, and almost two thirds of LA expenditure on care is still allocated to residential care (Forder & Netten, 2000; Knapp, Hardy, & Forder, 2001; Wanless, 2006).

In home care, it is interesting to observe an idiosyncratic development in the relationship between purchasers and providers. Between the mid-1990s and 2000 spot and call-off contracts were the preferred type of contract with fees based on the actual use of services and prices agreed case by case. These contracts offered flexibility to LAs and could be tailored to the particular needs of users, but they often came with higher transaction costs and generally left the providers bearing more of the risk. Indeed, spot contracts have traditionally been the preferred form of contracting, especially at the beginning of quasi-markets when LAs still had little experience with tendering practices for long-term care (Hardy & Wistow, 1998; Ware et al., 2001). This type of contract also allowed purchasers a greater level of choice as the exact contents of care and providers were not defined in advance. With time however, block contracts and their associated price discounts gained some traction reflecting the increased budgetary pressure experienced by LAs (Forder et al., 2004), the maturing of relationships between providers and purchasing LAs and the fact that most older users of care remained on LA-managed care (Baxter et al., 2013). Another practice that came to be

implemented by LAs in home care was the so-called 'zoning' of care markets (Baxter et al., 2011). This practice was meant to encourage private provision by guaranteeing a certain demand for preferred providers operating in a given geographical area and by allowing providers to better organise their workforce schedules by concentrating their users in a relatively smaller area. The importance of the latter point should not be underestimated, particularly as LAs do not fund the travel costs of carers.

The most common procedure for tendering home care by **Danish** municipalities has involved competition with fixed prices – competition is thus meant to take place on quality, e.g. by ensuring continuity of staff – set in advance by the tendering municipality (Bertelsen & Rostgaard, 2013). Under this '*model of approval*' the municipality as purchaser and regulator sets both the price and quality standards, but it must contract with any for-profit provider that meets these requirements. Public providers may continue to operate alongside for-profit providers. The latter may decide to provide personal care and/or home help if they wish but they are not allowed to turn down users.

In principle, tendering with competitive prices is also possible. In this case private and public providers compete on price to become the preferred provider of a municipality for a given period. Until recently, however, this procedure carried the risk that the in-house municipal provider would no longer be able to provide care if their bid was unsuccessful and therefore this method was seldom used (Bertelsen & Rostgaard, 2013).

In November 2012, the Danish government passed legislation that opened up new possibilities for competition on prices in the privately-paid segment of the home care market, i.e. the segment that includes additional services such as cleaning or additional (beyond assessed needs) care hours of personal care (Bertelsen & Rostgaard, 2013). Currently in the process of being implemented, this new legislation enables municipalities to increase competitive tendering and the free choice of providers. In contrast to previous tendering processes, this new *public procurement model* does not oblige municipalities to contract with all providers that take part in the bidding process and meet the quality requirements, although contracts with a minimum of two providers must be established. Furthermore, in-house (public) providers may decide not to take part in the bidding process despite being allowed to provide these kinds of services. Municipalities determine the type of services to be included and the quality requirements without setting the prices for for-profit providers. The tendering process is thus based on competition on price in the private part of the market. In this new model residential care and nursing care may also be included in the contracts although neither have yet been subject to procurement processes (Information from Danish experts; Bertelsen & Rostgaard, 2013).

The major objectives of the reform, among others, are to reduce the complexity of the procurement process for municipalities and to enable better monitoring of care quality by allowing fewer providers into the market (Information from representatives of procurement portal, KL, Competition and Consumer Authority and University Professor).

Policy makers expect municipalities to use this model to increase tendering for contracts for additional services in home care. The new possibilities for competition and real bidding for prices in the private part of the home care market will certainly create new types of quasi-markets (Information from representative of KL), but the question is how this will affect competition between private and public providers as the competitive tendering takes place mainly in the privately paid

part of the home care sector. The change in policy allows municipalities greater leeway in designing contracts to stimulate competition and efficiency by setting specific requirements, objectives and incentives (Information from representative of the Competition and Consumer Authority and representative of procurement portal, KL). In principle, municipalities can design the contracts to incentivise for-profit providers to provide enabling care and reablement services which are currently inhibited by the hourly payment as well as by the fact that providing enabling services would reduce dependence on their services. Policy stakeholders involved in the implementation of the reform are currently working on new pilot projects to better involve private providers in rehabilitative services (Interview with representative of KL, February 2014; Bertelsen & Rostgaard, 2013). Only a few municipalities so far are using the new contract model. As one of the first municipalities to do so, Copenhagen recently applied the new model and has reduced the number of private providers from 54 to three providers (Information from University Professor and representative of Competition and Consumer Authority).

With the new legislation, municipalities may also provide *free choice vouchers* instead of services and these can be used to employ a carer from registered private companies. Managing the voucher can be delegated to a family member or to a for-profit provider. In this case, it is up to the municipality not only to set the value of the voucher and the services that can be purchased with it, but also to decide whether the user can be provided with a voucher in the first place (Bertelsen & Rostgaard, 2013). However, vouchers have been used to a very limited extent by the municipalities.

The **German** LTCI Act has established the possibility for all registered care providers to enter the care market (Allen et al., 2011). Since benefits are capped and providers do not assess beneficiaries' entitlements to benefits, the federal government does not regard oversupply as a problem for the system and this practice is actually rather encouraged in order to increase competition. The federal law requires that private and charitable organisations are given preference over public providers in contract negotiations in order to stimulate market development and competition (Glendinning & Moran, 2009).

For these reasons, legal conditions under which private and charitable groups operate remain different to this day: non-profit providers can enjoy tax breaks and exemptions from charges which do not apply to private for-profit providers. In addition, they can accept donations although these cannot officially be used for the same purposes as subsidies and tax breaks. These advantages as well as the lower level of public subsidies of capital granted to for-profit providers (10% compared to 25%-30% of capital for public and non-profit providers) distorts competition and creates difficulties for for-profit providers to invest in human resources, maintenance and purchase of new buildings (Augurzky & Mennicken, 2011; Interview with representative of private provider association).

While entry and quality requirements are equal for all care providers, open competition in the long-term care market is not only impeded by the above-mentioned conditions but also by the negotiation process between providers and funds as well as the asymmetric information between LTCI funds, care providers and customers (Allen et al., 2011). Further, price competition is inhibited by the combination of fixed reimbursement rates for defined care packages (Arntz et al., 2007).

The framework contracts between purchasers and providers regulate quality standards as well as type of care, contents, and the extent of care tasks that a care home or home care agency must provide as well as financial reporting, personnel requirements and inspection regimes. General

guidelines of good care and requirements (minimum standards) to enter the market are negotiated and agreed upon in collective bargaining procedures between providers and payers at the federal level (*Bund*) (Rothgang, 2010; Leichsenring et al., 2010). The framework contracts are usually agreed to by the involved funding agencies (regional federation of LTCI funds, federal governments and communities) and providers in long and elaborate negotiation procedures at the regional level (*Länder*). In general, a product may only be offered on the long-term care market if it has been included in a care package defined by the insurance fund and the providers in the framework contract.

As mentioned above, it is up to users of care services to choose their provider. While price competition is limited, providers can still compete on quality. In order to foster this competition on quality, increase transparency and aid users' choice, the Medical Advisory Service of the German Social Health Insurance developed a public reporting mechanism on quality indicators derived from inspections (Leichsenring, 2010b; Rodrigues, Trigg, Schmidt & Leichsenring, 2014). In general, however, the quality marks tend to differ only slightly from each other and competition on aspects of quality between providers becomes largely inconsequential given the weak discrimination between quality marks (see Section on user choice below and Chapter on quality).

As a consequence of the fixed price system for services covered by the LTCI and the low variability of quality marks, nursing homes tend to compete mostly on the supply of supplementary services. These include services provided by care homes for which users usually have to pay out-of-pocket (except social assistance beneficiaries), namely catering and location (rent) (Information from representative of private provider association). Home care providers even go so far as to forego the user copayment, thus making services free of charge for the beneficiaries (Information from representative of LTCI fund).

In the **Netherlands**, the most important body for governance of the long-term care market is the Care Authority for monitoring conditions of competition and setting tariffs (NZa). This monitoring body oversees whether all insurers and providers in the long-term care market follow legislation and set budgets and rules in accordance with the Netherlands Market Authority (NMa) which monitors competition on the free market at large. The NZa has an important role in enabling choice (on the market) as services are made transparent to care applicants. Quality of long-term care services is measured by the Quality Framework for Responsible Care introduced in 2005. This system incorporated the Consumer Quality Index (CQI) that has been in place since 2008 to measure the experiences of users in care homes. The results of the inspections and the CQI are published on the website 'Choose better' (www.kiesbeter.nl) managed by the Quality Institute ('Kwaliteitsinstituut') (Rodrigues et al., 2014; OECD, 2013).

The existing 32 regional AWBZ Care Offices act as purchasers of care from providers in a given region on behalf of the insurance funds (van der Veen et al., 2010). The Care Offices are responsible for the allocation of benefits to individual applicants based on the needs assessment of the CIZ (Centre for Assessment of Care Needs). It is up to the CIZ to decide whether an individual claim for care services is legally reimbursable. Before the creation of the independent organisation CIZ, the assessment of needs was carried out by care providers, which created obvious information asymmetries and incentives for up-coding or cream-skimming of clients. The transfer of responsibility for needs assessment to the national CIZ body was also associated with the progressive standardisation of

assessment procedures and the introduction of further assessment protocols and benchmarking that have been implemented in order to render the AWBZ more cost efficient and transparent (Da Roit, 2013). Health insurances are mostly public limited companies (private for-profit organisations) or mutuals (non-cooperatives). Since 2006 all health insurances operate under private law, and are allowed to make profits and pay dividends to shareholders. Of the four major insurance companies that hold together 88% of the market share, only one is a for-profit company (Achmea) (Schäfer et al., 2010).

With regard to contracts, regional AWBZ Care Offices commission services through annual contracts with care providers that are selected in tendering procedures and from whom users can then choose their provider. Usually, Care Offices contract with experienced providers that have been on the market for many years (Information from long-term care expert). The NZa funding rules and tariffs that are linked to assessed care levels set maximum tariffs for home and residential care providers. Most bids by providers in home care are much lower than these thresholds and the tariffs retained in the final contracts are often still lower. In fact, 75% of residential care providers used the maximum tariffs in their bids to the Care Offices while only 7% of home care providers exhausted this threshold in their bids. If the annual budget in a contract is exceeded, uptake of new clients may temporarily be suspended or a waiting list may be established (van der Veen et al., 2010). However, with the planned transfer of home help from AWBZ to WMO in January 2015 responsibilities of the regional AWBZ Care Offices will decrease and be limited to more intensive care needs, namely residential care and Personal Budgets.

Since the introduction of the WMO Act in 2007, municipalities have to comply with public procurement regulations using open tendering processes to establish usually 4-years contracts with for-profit home help companies. Prices for home help services under the WMO Act are either set by the municipalities or are defined in the tendering process through competition. Open competition thus only exists in the home help sector under the WMO Act. With the shift in responsibility for home help to municipalities, a transition organisation ('TransitieBureau Wmo')⁵ was set up in 2006 to train local government staff in tendering and contracting processes which are expected to increase starting in 2015 in light of the reforms mentioned previously (Information from consultant in long-term care).

⁵ www.invoeringwmo.nl/content/het-transitiebureau

Overview 3 Summary of market operationalisation in case study countries

Country	Contracting	Competition	Purchasers
UK (England)	From spot and block contracts to preferred provider (framework contracts), deregulated PAs and self-funded residents	Competition on price & quality LAs still price-setting in home care Quasi-private residential care	Care managers, PB as DPs, self-funders
DK	Limited tendering Marginal use of vouchers Taylorisation of tasks	Fixed prices and competition on quality with minimum standards (until 2013) Extra services for additional private out-of-pocket payments only	Care managers
DE	Free access Framework contracts Fixed reimbursement rates Taylorisation of tasks	Competition on quality with minimum standards Limited competition on quality via public reporting Limited price competition	Users, LTCIs have some market power in defining services
NL	Annual contracts Fixed budgets Relative taylorisation of tasks	Competition on price (home help) & quality Public reporting with limited influence	Insurance funds, municipalities, users of PBs

Source: authors' compilation.

3.2.2 The mixed economy of care: key and absent players

Profit and non-profit providers played a subsidiary role in the **English** long-term care system until the introduction of quasi-markets in the early 1990s. The system that had allowed board and lodging expenses incurred with private providers of residential care to be claimed nonetheless witnessed the establishment of a nascent private sector in residential care made up of small family-owned nursing homes (Lewis & Glennerster, 1996). In home care, the great majority of providers were LA providers (Knapp et al., 2001).

With the introduction of competition and choice, the mixed economy of home and residential care shared one common characteristic: private providers (also called 'independent providers' in the English context) quickly came to represent the majority of care providers in both markets (Knapp et al., 2001; Baxter et al., 2011; Glendinning, 2012). In residential care, private providers made up 37% of available places in 1970, 61% in 1990 already and 78% in 1998 (Knapp et al., 2001). In home care, the number of care hours contracted to independent home care providers was only 5% of the total in 1993, but it quickly expanded to 51% in 1999 and according to the latest available data (2011)

currently accounts for 89% of total care hours (NHS, Community Care Statistics). Similarities between the two sectors end there with the two markets evolving in distinctly different ways in other areas.

In residential care there was a perceptible movement towards greater concentration of ownership already by the late 1990s (Knapp et al., 2001). According to data available from a recent review of long-term care in England, one third of providers in residential care owned three or more facilities and these tended to be much larger than those run by LAs or smaller non-profit and for-profit providers (Wanless, 2006). In a trend that is similar in the Swedish case, roughly 22% of the market was concentrated among 18 large for-profit providers listed in the stock exchange at the turn of the century (Knapp et al., 2001). This trend continued into the 2000s (Scourfield, 2007).

The picture in home care is somewhat different, for although there has been a degree of provider concentration, the market for home care is nonetheless much more fragmented (Baxter et al., 2011; Glendinning, 2012). Smaller home care providers have found it difficult to bid for larger block contracts that guarantee stable funding streams and the practice of zoning may bar these smaller providers from entering certain care markets. This has left some providers over-reliant on spot contracting and faced with uncertain funding streams, which might explain the significant turnover in home care agencies in the market (Baxter et al., 2011). Take-up of DPs has not been significant enough to date to be a driving force for change in the home care market, but the introduction of PBs is expected to produce some changes (Baxter et al., 2011; Glendinning, 2012): barriers to entry could decrease as providers will be faced with multiple individual buyers to whom they could tailor services; the range of services supplied might potentially widen as PBs offer the possibility for more creative use of money; instability might increase with an expected fading of block contracts and zoning and fiercer competition for workforce, e.g. by DP users 'poaching' staff from agencies to become their personal assistants.

In the **Danish** context, municipalities traditionally had the monopoly of home care provision and this remained so in practice until 'choice of provider' became compulsory in 2003. Since then the proportion of home care recipients who have chosen a for-profit provider has increased to 37.2% in 2012 (Statistics Denmark, *Statabank*). For-profit home care providers mostly provide practical assistance, only 6% of users received personal care from for-profit providers in 2012. The increase in private for-profit providers of practical assistance over the last years was thus much stronger than that of private for-profit providers of personal care (Bertelsen & Rostgaard, 2013).

In 2012, there were 488 private for-profit home care companies in all 98 Danish municipalities (Bertelsen & Rostgaard, 2013). In general, the number of for-profit home care providers per municipality depends on the population density (Information from representative of KL) with urban areas having higher concentrations of private for-profit providers while rural municipalities can provide free choice in home care only to a limited extent (Bertelsen & Rostgaard, 2013).

With the introduction of new tendering procedures it is expected that larger companies will also be attracted to the home care market due to the fact that municipalities will try to limit the number of providers and stipulate more requirements in the contracts with regard to objectives that need to be attained and possible inclusion of residential care in the contracts. Thus large providers might find it more attractive to offer a broader scope of services (Information from representative of KL).

In residential care, there are no figures available for non-profit providers in home care, although they make up the bulk of home care providers (Bertelsen & Rostgaard, 2013). The role of for-profit providers is (still) marginal, the result of resistance on the part of municipalities to outsource services and a perceived lack of interest to expand the number of for-profit providers (Rambøll, 2009 referred by Bertelsen & Rostgaard, 2013: 151). With the introduction of new legislation it remains to be seen whether or not municipalities will decide to include residential care in procurement processes.

The introduction of the **German** LTCI in 1995 and the concurrent opening up of the long-term care market brought an increasing number of small private for-profit and non-profit agencies to the home care market (Allen et al., 2011). A vibrant provider market developed in which for-profit providers gained centre stage and the leadership position of well-established non-profit welfare organisations was challenged, in particular in the home care market (Bode, Gardin, & Nyssens, 2011). Today, three different types of care providers exist in the German home and residential long-term care market: public, non-profit (including organisations affiliated to the churches such as Caritas, diaconates of the Protestant Church, etc.) and private for-profit providers. In 2011, private for-profit providers in residential care accounted for 40% of all residential facilities while in home care privately owned providers accounted for nearly two thirds of the market. The latter have gained in prominence since 1995, increasing their market share to 63% in 2011. Despite the significant market share they occupy, on average they serve fewer users than non-profit providers (35 users on average were cared for by for-profits and 64 users by non-profits in 2009). Also, regional differences in market shares of for-profit and non-profit organisations have developed as evidenced by the fact that private for-profit providers are dominating in large cities and in the new Federal States (Theobald & Hampel, 2013).

Thus with the opening of the market and deregulation of care provision with the LTCI Act in 1995, the traditionally privileged if not protected status of large non-profit service-providers ('Wohlfahrtsverbände') was abandoned and care provision was opened to all providers (Wollmann, 2008). As a result, the number of for-profit service providers in residential care, for example, increased by 50 % (Lennartz & Kersel, 2011). Nonetheless, non-profit care providers continue to benefit from a positive public image given their nationwide involvement in most areas of social services spanning the last decades (Information from representative of private provider association, representative of Medical Advisory Service and responsible person at municipal level for social services). While public care providers were the major stakeholder in the market before the introduction of the LTCI, their importance has since decreased substantially in the residential care sector between 1999 and 2009 (Lennartz & Kersel, 2011; Information from representative of private provider association).

Overview 4 *Share of residential care and home care providers by ownership, in %, England (2007/2008), Denmark (2012), Germany (2011), and the Netherlands*

	Public providers	Non-profit providers	Private for-profit providers
England			
Home care agencies	14%	11%	75%
Residential care places	7%	13%	80%
Denmark			
Residential care agencies	~ 99%		< 1%
Home care users			
<i>Practical assistance</i>			37%
<i>Personal care</i>			4%
Germany			
Residential care places	6%	56%	37%
Home care users	1%	50%	49%
The Netherlands			
Home care users	0%	80%	20%

Sources: Statistisches Bundesamt, 2013a, 2013b; CSCI, 2009 referred by Leichsenring, Barnett, & Rodrigues, 2010; Bertelsen & Rostgaard, 2013, Ramboll, 2009 referred by Bertelsen & Rostgaard, 2013.

One prominent feature of the German long-term care system is directly related to the importance of informal (family) care and migrant carers. In 2012, more than two thirds of people with care needs were looked after at home. The majority of them chose cash benefits which were usually passed on to informal, mostly family carers as a payment for care (Eichler & Pfau-Effinger, 2009). Only 20% of LTCI beneficiaries at home received formal care services (Berringer & Suhr, 2013; BMG, 2013). Furthermore, it is estimated that unregulated personal assistance provided by an estimated 120,000 migrant carers covers between 2% and 3% of the total number of LTCI beneficiaries above the age 65 (Theobald, 2011; Theobald & Hampel, 2013). Regarding migrant carers, no formal employment contract or proof of expenditure are required to date (Theobald, 2011; for an example of private carers' regulation, see Winkelmann, Schmidt, & Leichsenring, forthcoming). Although a recruitment scheme to encourage families to formally hire domestic workers was created in 2005, only 3,032 domestic workers were officially employed through the scheme, leaving the vast majority of 24-hour care relationships unregulated (Theobald & Hampel, 2013).

In the **Netherlands** the majority of services for older people are provided by private non-profit providers offering services under the AWBZ insurance scheme. As was mentioned above, with the reform of home help under the WMO Act in 2007, the home help market was opened up to for-profit companies and contracts became subject to competitive tenders. Private for-profit providers thus started to represent a minor but increasing part of the market of home care services, currently accounting for 20% of all home care providers (Leichsenring et al., 2013). Usually, private for-profit providers render home help services within the framework of the Personal Budget scheme (i.e. cleaning tasks, daily support) and under the WMO Act. The size of these for-profit companies ranges from one-person companies to large companies operating in all regions of the Netherlands (Information from long-term care expert; van der Veen et al., 2010).

With the shift in responsibilities for home help to the municipalities under the WMO Act in 2007, municipalities were newly in charge of the provision of home help, including the assessment of user's needs, the definition of tariffs paid to providers as well as procurement processes. While there were no major consequences for users, care providers were considerably affected by cost containment measures. These have led to a reduction of hourly wages for care workers and a replacement of staff by home helpers with potential detrimental effects on the quality of care (Da Roit, 2013, Information from consultant in long-term care; Keuning & Boon, 2009). With municipalities prioritising cost-efficient care provision the focus of tenders shifted from care tasks to lighter domestic chores (e.g., cleaning) with less of a focus on care (Tjadens, 2008). As a consequence, traditional providers were obliged to tender at below-cost prices or be sub-contracted by new providers. In addition, new cleaning companies won many of the contracts (Glendinning & Moran, 2009; van der Veen et al., 2010). With the introduction of the Social Support Act in 2007, one third of the institutions providing home and elderly care experienced losses in 2007, nearly twice as many as the year before (Keuning & Boon, 2009). Thus, many companies specialising in both residential and home care have stepped out of the home help market over the past few years as their business models were not adapted to this increasingly competitive market (Information from long-term care expert). On the other hand, alternative arrangements of care provision emerged out of dissatisfaction with decreasing wages and care organisation (see Box 1).

In contrast to the home help market created under the WMO Act, Personal Budgets had a less significant impact on for-profit home care providers. While the number of Personal Budget holders has increased in recent years, beneficiaries tend to use the cash benefit to compensate informal carers or to turn to non-profit home care organisations. As the traditional home care organisations still have a near-monopoly, entrants and smaller home care providers have had difficulty increasing their market share. Instead, many mergers between providers financed by the AWBZ have taken place in the past decades. As a result, the actual number of providers to choose from has decreased (Da Roit, 2013; Kremer, 2006). The creation of a market through the Personal Budget scheme has also been impeded by the bureaucratic nature of the system as up to ten different organisations are involved in the provision of Personal Budgets.

As occurred in Germany, a major shift in the planning of residential care has taken place in the Netherlands as a result of the 2003 reform. The central government no longer assesses the need for new residential care capacity. Institutions are fully responsible for their investment decisions (van der Burg & van Asselt, 2013).

Box 1 *The Netherlands: an innovative response to taylorised care*

The grassroots initiative 'Buurtzorg' ('Care in the Neighbourhood') is an innovative attempt to provide an alternative to the provision of 'industrialised and taylorised care' by large providers by providing instead local, consumer-oriented, and more efficient care. The Buurtzorg model was designed in 2006 by experienced district nurses dissatisfied with the organisation of care and with low staff wages. The scheme aims to provide person-centred care through integrated home care by connecting social services with general practitioners and other providers. Care is delivered by small self-managed teams consisting of a maximum of 12 professionals. To keep administrative costs as low as possible, only a small centralized back-office is maintained as a kind of headquarters, where staff makes ample use of ICT for the organisation of care. The Buurtzorg method incorporates six sequential components which are delivered as a coherent package and cannot be delivered separately. The package includes assessment, mapping and involving the network of informal care as well as formal carers, care delivery, support of the client in his/her social roles and the promotion of self-care and independence. The principles of Buurtzorg are based on care independence and an integrated care arrangement that renders care unnecessary as soon as possible.

By mid-2010, teams were active in 250 locations with a total of 2,600 staff members across these teams (among them 1,500 qualified district nurses) serving approximately 30,000 clients annually. Buurtzorg's growth has continued since 2010 with the organisation adding about 70 staff members every month spread out across 5-10 teams. The central office consists of about 30 professionals who provide support in assessment of clients' needs and medical insurance situations, municipal tendering processes, labour contracts and client administration. The model has to compete with other providers for clients and contracts. According to results of the mandatory national quality of care assessment, Buurtzorg currently ranks number one among all home care organisations in terms of user satisfaction. In 2011, the organisation was awarded a prize for best employer in the Netherlands among organisations with more than 6,000 employees. One significant outcome of the model is the impressive decrease in costs which appear to amount to less than half the costs for usual home care. Buurtzorg is setting a new standard for home care in the Netherlands, capitalising on its strength in successfully bridging gaps in home care at the local level (Huijbers, 2011; Sprenger, 2013).

Box 2 Funding flows in old-age care across municipalities – examples from Denmark, Germany and the Netherlands

Funding mechanisms are a decisive factor in the organisation of long-term care. In many European welfare regimes processes on the vertical governance axis (central state, regional, local government) such as decentralisation and subsidiarisation explain the fragmentation of service provision and public funding (Kazepov, 2008). This fragmentation of long-term care funding between local, regional and federal levels also plays a major role in the allocation of benefits. The common distinction made between systems with universal rights to care in old age is the tax-based model (Nordic countries) and the public long-term care insurance model (Germany, Netherlands, etc.) (Colombo et al., 2011). Ultimately, these models impact the organisation of a country’s funding flows and also determine the funding mechanisms in place when beneficiaries move to another constituency. The tax-based model creates different incentives for cross-funding than the insurance-based model, a fact that is most evident in the Netherlands: while benefits under the tax-financed WMO Act are not transferrable to another municipality, AWBZ insurance-based benefits move ‘automatically’ with the beneficiary. Countries have thus created different mechanisms to steer funding flows across administrative units (Table 1).

Table 1 Cross-financing mechanisms in case study countries

<i>Denmark</i>	A mechanism ensures that a municipality receiving new clients who have already been registered as beneficiaries in another municipality are compensated. It is the original municipality that finances home care services provided to people living in residential facilities or retirement homes even if the benefit is spent in another municipality. Financing of home care benefits, however, are taken over by the municipality to which the beneficiary has moved.
<i>Germany</i>	The insurance-based system allows LTCI payments to be transferred and paid to recognised long-term care providers in any region. If a beneficiary moves to another region, the LTCI pays the services according to the respective regional prices.
<i>The Netherlands</i>	For home help services financed under the WMO Act, the municipality to which a beneficiary moves must take care of the financing of home help. Benefits will not be transferred from region A to region B. Care services financed under the AWBZ Act are insurance-based benefits which can be transferred to different municipalities without cross-financing being necessary.

Sources: Information from country experts.

3.3 Choice and agency

The most important point to address when analysing the introduction of quasi-markets in long-term care in European countries concerns the outcomes for users in terms of quality of services provided and choice. This last section will therefore address the dimensions of choice granted to users with the introduction of market mechanisms and user choice models. User satisfaction and the impact of

major changes in the organisation of care will also be addressed, specifically the taylorisation of care tasks and the definition of eligibility criteria.

3.3.1 Dimensions of choice available to users

The dimensions of choice available to **English** users of long-term care strongly depend on how they decide to deploy their PBs. Greater leeway is afforded those who use their PB as a DP in which case they may choose the provider or the identity of the carer (e.g. when employing a personal carer) and negotiate directly how and when care is provided. Usually, DPs also allow users to top-up their care and to pay out-of-pocket either for additional hours of personal care or for different services (e.g. home help). When opting for PBs managed by a third party, evidence shows that the scope for the user to determine the details of the daily delivery of care depends on each LA's respective policy and can be substantially limited (Baxter et al., 2013). Similarly, LA-managed care has been characterised as allowing for only a limited choice of providers – as providers must express interest in bidding for the care package – and limited agency over other dimensions of choice such as what care is provided, how and when (Baxter et al., 2013).

With regard to residential care, England's Department of Health recommends that users be allowed 'reasonable choice over the service they receive'. In practice, however, this depends on the chosen provider being considered adequate, cost-neutral for the LA, having available places, and being willing to sign a contract on the LA's standard terms (Age UK, 2013). These criteria do not apply to the majority of users who are self-funders.

In **Denmark**, user choice came to be synonymous with choice of provider being restricted to home care. Of the dimensions of choice set forth by Le Grand (2007b), older users of home care in Denmark have only restricted agency over their provider. The care package, i.e. what and how care is provided is defined by the case manager using a highly standardised definition of times and tasks – a procedure that has been criticised for failing to account for individual needs.

There are a number of features allowing for user choice over a wider range of dimensions of care that the Danish senior citizens' association ('Eldremobiliseringen'), an important stakeholder in Danish old age policy, has strongly advocated for over the past few years (Information from representative of KL). For example, users of for-profit providers' services may top-up care or purchase additional home help such as cleaning services. This offers users a degree of flexibility to construct their care package beyond what is defined by case managers. Those using vouchers may also employ the carer of their choice. These features are, however, only marginal ways in which users can exert choice beyond the simple choice of provider. In contrast to the liberal system of choice in England, Denmark does not provide users with such a wide range of choice over providers (Information from University Professor).

The introduction of the LTCI in **Germany** has strengthened the autonomy of users by enabling them to choose between benefits in kind and in cash as well as between residential and community care. Eligibility for care benefits is assessed by the Medical Service of the German Health Insurance ('Medizinischer Dienst der Krankenversicherung – MDK') on behalf of the LTCI funds. Under the LTCI, users of home care and their relatives can choose between a cash benefit and services in kind or a combination of both, although the amount of the cash benefit is considerably lower than the value of the in-kind benefits paid for a similar level of care need (Eichler & Pfau-Effinger, 2009). Also, the

fixed-rate amounts paid by the LTCI to non-profit or for-profit home care providers up to a certain ceiling are usually neither enough to cover the entirety of the costs nor do they cover all assessed needs of the beneficiary (Rothgang, 2010).

Although its value for money is potentially lower than opting for formal home care services, many beneficiaries and their families have chosen to use the cash benefit to employ migrant carers as private assistants. Hailing mainly from Eastern European countries, these migrant carers provide the functional equivalent of family-provided home-based care. As was mentioned above, these working arrangements have not been regulated to date.

Within home care, people opting for benefits in kind can choose among service providers with whom their LTCI fund has a contract and they can also choose the specific service they wish to receive from the provider (Glendinning & Moran, 2009). However, the choice and ability of users to define their own care package is limited as the availability and service offerings are standardised in defined care packages negotiated between providers and LTCI funds (Arntz et al., 2007). In early 2013, a number of LTCI reforms came into effect offering home care users additional choice in supportive services and the ability to opt for time allotments in addition to 'activity-based' services in agreement with their service provider. In theory, these changes will enable improved adaptation of care provision to the needs of beneficiaries as certain care tasks will no longer be tailored exactly down to the minute (Augurzky & Mennicken, 2011; Berringer & Suhr, 2013).

As was mentioned above, a public reporting system on quality indicators for both home and residential care was introduced in 2009 (the results are available on the Care Guide website: www.pflegelotse.de), with grades awarded on the basis of inspections carried out by the German Health Insurance's Medical Service (Rodrigues, Trigg, Schmidt, & Leichsenring, 2014; Leichsenring, 2010a) (see also Chapter 4). The rating system has been publicly criticised, however, for two main reasons. First, for its focus on care documentation and service provision rather than on outcomes, and second, due to the fact that the final mark is the unweighted average of all criteria, meaning that a care provider's score can be positive overall even if it receives very poor results in one domain (Augurzky & Mennicken, 2011).

The majority of older people in need of care and their relatives are overwhelmed by having to make decisions regarding type of services and choice of provider (Information from responsible person at municipal level for social services). In 2008, in order to assist beneficiaries and their relatives in organising tailored care arrangements and choosing appropriate care providers, the German government allocated additional funding for the creation of 400 new community care centres ('Pflegestützpunkte') in 14 federal states to provide care management and counselling services (Glendinning & Moran, 2009). In order to increase the appeal of home care and the user choice of providers of home care, a legislative amendment was passed to pilot Personal Budgets ('Pflegebudgets') as an alternative to in-kind home care in seven regions between 2005 and 2008. Personal Budgets allows beneficiaries to use in-kind benefits with greater flexibility within a professionally assisted, consumer-directed home care programme. Services are selected from among a wide range of providers with the assistance of care managers employed by the municipalities. The experience with Personal Budgets revealed substitution effects of informal care by formal care. However, for former users of cash benefits, use of Personal Budgets did not come with significant increases in terms of total care hours. This raised major questions on the cost effectiveness of the

scheme due to the associated increase in LTCI spending (Arntz & Thomsen, 2008; Glendinning & Moran, 2009).

In the **Netherlands**, users have free choice over care providers, including for residential care, and the regional Care Offices which allocate care to patients try to respect users' choices and preferences as much as possible. If the type of care chosen by the user is less intensive and less costly than that prescribed by the CIZ, the regional Care Office will accept the chosen type of care. As mentioned previously, beneficiaries can choose their care provider based on the results of quality inspections made publicly available online (www.kiesbeter.nl) (see also Chapter 4). Users appear to be making use of these results although they also strongly rely on recommendations from family, neighbours and friends (Information from consultant in long-term care).

Because they have an overview of available places and waiting lists, regional Care Offices are responsible for helping a user if he or she does not succeed in finding an appropriate care provider. At the request of the user, Care Offices can also transform an in-kind benefit in home care to an allocation in cash – the Personal Budget (van der Veen et al., 2010). With the introduction of the Personal Budget in 1995, the Dutch government sought to strengthen the position of users as consumers by enabling them to manage their own budgets for personal care and assistance at home, either by employing carers (including relatives) directly, or using the cash benefit to purchase care from formal providers, or a combination of the two. The Personal Budget cannot be used for medical treatment or residential care. In principle, budget holders have some leeway to set conditions and details on how care is provided in the contractual arrangements with the carer. Budget holders must establish a valid contractual relationship with the carer and ensure payment of taxes and social contributions in addition to wages (Grootegoed, Knijn & Da Roit, 2010). Due to a strong bureaucratic logic, however, a 'care consultant' guides the budget holders through the process and often arranges all administrative procedures.

Personal Budgets are calculated on the basis of the number of hours of care needed with a 25% reduction. This reduction is applied on the grounds that informal care does not involve the same costs and overheads as residential care (Glendinning et al., 2004). Users have to account for how they have spent the benefit at least every 6 months, excepting 1.5% of the budget which they can spend freely (up to a maximum of €2,500 yearly).

Overview 5 *Dimensions of user choice in England, Denmark, Germany and the Netherlands*

Country	Agency	Who	What	When
England				
Residential care	User, but with key limitations	Limited to available care homes, and this is conditional on available places and must be at no added costs to the LA	Needs and how best to meet them are assessed by the care manager	Very limited possibility
Home care	User, depending on how the PB is used	Choice of provider (LA-managed PB) when available; choice of provider and identity of carer (PB taken as DP)	Users partially determine their needs. DP users may spend their benefit on other services (e.g. home help) and negotiate the care package directly with provider or carer	Usually limited and depending on LA procedures for LA-managed care and PB managed by third party. Care schedule negotiated directly with provider or carer for DP users
Denmark				
Home care	Case manager (mostly)	Choice between private and public formal providers (except for those with vouchers)	Needs and how best to meet them are assessed by case manager based on standardised tasks and minutes. Some leeway to top-up and get additional privately paid home help services	Limited possibility (home help)
Germany				
Residential care	LTCI recipient	Choice between various public and private care homes (regional differences); to a limited degree based on public reporting of quality	Medical Service of the German Health Insurance assesses care needs based on standardised care packages	Very limited possibility
Home care	LTCI recipient	Choice between public and private, formal and informal home care providers	German Health Insurance's Medical Service assesses care needs based on standardised care packages. Benefit can be paid as cash to compensate informal care and as in kind benefit to receive formal home care	Usually users are able to participate in decisions related to time of service. Care schedule negotiated directly with provider or carer for users of the cash option. However, violations of time agreements are reported

Continuation of Overview 5

The Netherlands (valid until 31 December, 2014)				
Residential and nursing care	Regional AWBZ Care Offices in close cooperation with user	Choice between private non-profit providers	Centre for assessment of care needs (CIZ)	
Home care	Regional AWBZ Care Offices, within Personal Budgets the user	Choice between private non-profit and for-profit providers; under Personal Budget also between formal and informal care	Centre for assessment of care needs (CIZ)	Usually users are able to agree with provider on time of service. Some contracts stipulate a certain time frame for services.
Domestic help	Local authorities	Choice between private non-profit and for-profit providers	Local authorities	

Source: authors' compilation.

3.3.2 Outcomes for users

While the introduction first of DPs and then PBs widened the scope for user choice in long-term care in **England**, different groups have benefited unevenly and older people in particular have not benefited significantly from the scheme. Although older people are known to value added control, flexibility over care received, and continuity of care afforded by PBs taken as DPs, they have also reported added anxiety caused by having to manage DPs and make crucial choices (Glendinning et al., 2008; Hatton & Waters, 2011). Older people have also tended to make more conservative use of DPs, spending them primarily on personal care. Many receive amounts that are barely enough to cover the basics (Glendinning et al., 2008). As was mentioned above, only a very small minority of older users have taken their PBs as DPs and for those on LA-managed PBs there is evidence of little scope for choice (Baxter et al., 2013).

An on-going issue in long-term care in England has been the funding of the system and the tightening of resources available to LAs with which to fund care (Glendinning, 2012). The inadequacy of available resources is reflected in the share of self-funders in residential care, in the downward pressure exerted on the prices paid out by LAs, in providers struggling to keep staff, as well as the tightening of eligibility criteria for receiving PBs (Wilberforce et al., 2011; Glendinning, 2012).

The **Danish** experiment with competition and choice seems to have enhanced users' abilities to choose only to a very limited extent (see Overview 5). In fact, a number of studies have highlighted the standardisation and tailoring of care tasks that accompanied the introduction of user choice (Rostgaard, 2011; Rostgaard et al., 2011). This would suggest a decrease in the quality of care provided. In the last few years the government has started to adapt the standardisation of care tasks in the context of the 'trust reforms'. The municipality of Copenhagen has recently taken steps to loosen the standardisation of care by setting up more generous time slots and adding an additional hour of flexible care per month (Information from University Professor).

In general, increased choice for users over their home care provider has been positively received. Older people can find it difficult, however, to choose from a long list of for-profit home care

providers (i.e. cleaning companies), and a third of users were not aware of the possibility to choose a provider (Epinion, 2011, referred by Bertelsen & Rostgaard, 2013:154). Online provider databases do not add much information as they function merely as directories of available providers and do not have information on quality indicators (Information from representatives of KL & KL procurement portal).

A survey of home care users found high overall satisfaction with care received regardless of the nature of care (personal care or home help) or type of provider (public or for-profit). (Capacent, 2009, referred by Rostgaard, 2011: 11). According to the same survey, however, more complaints about (lack of) continuity of staff were made by users of public home care providers (21%) than by users of for-profit providers (10.2%) (Epinion, 2011, referred by Bertelsen & Rostgaard, 2013:154). Older people's primary reason for choosing for-profit home care providers is the continuity of care personnel (Information from representative of procurement portal, KL).

Regarding efficiency gains, Hansen found little evidence of an increase in overall efficiency in the operations of municipalities with home care providers in the years immediately after the introduction of compulsory user choice (Hansen, 2010). He speculated that larger and less densely populated municipalities – which had no for-profit providers – could more efficiently manage resources by providing in-house care with just one provider, particularly if competition on price was absent from the tendering procedures employed by most municipalities.

The introduction of the 'Common Language' instrument significantly changed the relationship between carers and care recipients by reducing the autonomy and flexibility of the carer as well as limiting time for actual care due to increased documentation and monitoring obligations⁶. At the same time, users gained autonomy and care services have become more transparent for older people and their relatives as a result (Bureau & Dahl, 2013).

In summary, the Danish experience with the introduction of marketisation is in general positive. Users seem to be satisfied with choice and service quality of private providers. At the same time, Denmark is trying to adapt the current system, observe the developments of the current reforms being implemented, and work towards better solutions and new ways to ensure efficient and high quality provision of elderly care services within a mixed market. This ongoing process is part of a larger discussion and research initiative in Denmark revolving around the topic of public-private partnerships in welfare services (Information from University Professor, representative of procurement portal, KL, and representative of Danish Competition and Consumer Authority; <http://produktivitetskommissionen.dk/publikationer>).

Beneficiaries of the LTCl in **Germany** can use their insurance benefit to select a provider from a wide range of care suppliers. This is particularly true for people living in urban areas. While patterns in care allowance utilisation adapted to new possibilities to combine cash and in-kind benefits for home care, the reliance on informal family care provision remains very high (Bode et al., 2011). Overall, the introduction of the LTCl and the sharp increase in the number of care providers led to comprehensive provision of services in all regions of the country. Prior to 1995, only a few thousand

⁶ In 2003, England reorganised its assessment criteria around four levels of need – low, medium, substantial and critical – partially to provide some homogeneity in eligibility rules across municipalities, but this reorganisation did entail a standardisation of care tasks.

non-profit service providers delivered long-term care services while today LTCI beneficiaries can choose from a highly diversified market of providers consisting of approximately 25,000 home care and residential care providers, including specialised services (Information from representative of private provider association).

The number of beneficiaries opting for in-kind benefits increased from 12% in 1995 to 35% in 2002. In particular, beneficiaries in residential care increased while beneficiaries receiving formal home care services remained stable (Glendinning & Moran, 2009). On the other hand, cash-benefits have consistently proven to be more popular than in-kind services even though the latter yields higher payments for similar levels of care need. This preference for the cash-benefit option has contributed to sustaining high levels of informal care-giving by relatives (Glendinning et al., 2004). In 2010, more than two thirds of persons eligible for LTCI benefits used cash-benefits to pay spouses or daughters (Bode et al., 2011) or to employ migrant carers in non-regularised working arrangements. The share of beneficiaries that chose a combination of informal care and formal home care services increased only slightly. As a consequence, the objective of creating 400,000 new jobs in the home care sector through the introduction of choice was not met (Pfau-Effinger, Och & Eichler, 2011).

Reduced demand for formal home care may also be explained by an apparent mismatch between the standardised care packages offered by formal providers and the type and quality of home care that is needed by beneficiaries and their families at home (Pfau-Effinger, Och & Eichler, 2011; Eichler & Pfau-Effinger, 2009). The LTCI Act called for the definition of these “normalised and standardised” care packages which are delivered rapidly at predetermined times and at defined reimbursement rates (Eichler & Pfau-Effinger, 2009; Rothgang, 2010). Care services that exceed minimum requirements are not covered by the LTCI (Pfau-Effinger et al., 2011). This mismatch and the ‘taylorisation’ of care tasks inhibiting the humane provision of care for frail older people are widely criticised by family members, carers, as well as long-term care experts and are the subject of public debate in Germany.

Deficiencies in residential care have also been reported and have been subject to criticism by the media in the past decades (Klie, 2014; Fussek & Sven, 2005). These shortcomings are largely explained by the over-standardisation of care, including the meticulous definition of care tasks and tedious documentation of care provided for quality and monitoring purposes. As a consequence, care workers are continually faced with a high work burden and psychological stress (Klie, 2014; Fussek & Loerzer, 2005; Winkelmann et al., forthcoming). This conflict has considerable consequences for the job satisfaction of long-term care professionals; only 12% of care workers report having sufficient time for the psychological care of residents, indicating that the majority of carers feel under pressure in their work (IGES, 2006). This view is also shared by users who complain about their relationship with care staff and the lack of respect for their individual needs and preferences. The same survey also reveals, however, that residents are satisfied with their overall situation in residential care homes (Wingenfeld et al., 2007).

As a consequence of the reorganisation and opening up of the long-term care provider market, the formal care labour market expanded while working and employment conditions deteriorated due to the need for flexible working time, the need for cost containment, the emergence of for-profit providers and increased quality assurance. In particular, part-time work increased substantially from

1995 to 2009 both in home (54.2% to 73.2%) and residential care (39.1% to 66.7%) (Theobald & Hampel, 2013).

However, according to public opinion these developments are not attributed to the opening up of the market and the arrival of for-profit private care homes. In fact, private for-profit care homes manage to deliver the same level of quality of care as non-profit providers. In particular, large for-profit care homes achieve similar quality scores while small private care homes often have lower scores on average. Despite the difficult starting position of private for-profit care homes given the lower public subsidy level they receive, they offer services at 5%-10% lower prices than non-profit providers (Augurzky & Mennicken, 2011; Information from representative of private provider association). Their arrival in the care market also lowered the prices of non-profit care homes in areas with a high share of private providers (Augurzky & Mennicken, 2011).

In the **Netherlands**, Personal Budget users report being very satisfied with services. Research carried out in 2004 on user perceptions revealed that 95% of respondents rated the care they purchased as being of very good quality. Budget holders especially appreciated and considered it an improvement that they could now choose the care received through Personal Budgets (Kremer, 2006). High satisfaction is also reflected in the increasing number of Personal Budget holders. While in 1996 only 5,400 clients managed their own budgets, this figure increased more than tenfold to 65,000 in 2003, 80,000 in 2007 and 115,000 in 2009 (Kremer, 2006). In 2007, one third of budget holders relied on care provided by relatives, one third on services from formal home care providers and another third on a combination of both. There are no figures available regarding user outcomes in residential care.

Evaluations conducted on the shift in responsibilities for home help from AWBZ to the municipalities under the new WMO legalisation cite relatively high service satisfaction rates with services, especially the professionalism of providers. Nonetheless, users are less satisfied with lack of continuity of personal assistants and with the information made available by providers (Tjadens, 2008).

3.4 Summarising the findings: similar policies but mixed evidence of outcomes

The different starting points and legacies of the four case study countries analysed in this research clearly conditioned the trajectory and pace of reforms concerning user choice and market-oriented governance in long-term care. In all four countries there were strong incumbent providers already in place when implementation of the reforms began. While there was a monopoly of public provision in the English and Danish long-term care regimes, large private non-profit welfare organisations prevailed in Germany and private non-profit providers dominated in the Netherlands. In all countries, market mechanisms were first introduced in long-term care in the 1990s, but at different points in time and the first steps were aimed at creating a newly mixed economy of care, i.e. to foster market access to new entrants. This was evident in tendering, contracting and regulatory practices in England, in the possibility to provide extra services afforded only to private providers in Denmark, in the reduction of entry barriers for for-profit providers in Germany, and in the opening up of the home care market for for-profit providers in the Netherlands. To some extent, one could say that the goal was achieved, as traditionally dominant providers in all countries lost their stronghold within a consistently growing market.

Public authorities initially relied on monopsonic purchasers in all four countries – be it local authorities in England and Denmark or health and insurance funds in the Netherlands – before slowly providing end users with agency in purchasing care. Germany is the exception as it allowed users to choose a cash benefit redeemable for services from the very start of the LTCI scheme. In addition to concerns over the well-being of frail older people and their ability to make the right choices, monopsonic purchasers was mainly motivated by cost-containment as monopsonic purchasers could potentially set prices and better manage care.

Becoming monopsonic purchasers of care entailed a shift in the role of municipalities in England, Denmark and to a lesser extent in Germany from ‘providers’ to ‘enablers’ of care (Hardy & Wistow, 1998). These changes did not come without costs. As the outcomes of long-term care are not easy to measure, Denmark and Germany opted to standardise care tasks, while in England it was not uncommon for purchasers to make tendering decisions based mainly on price (Hardy & Wistow, 1998; Knapp et al., 2001). One alternative introduced just recently would be to devolve decision-making – and thus assessment of quality – to the end-users of care.

A new concern emerging in all four countries has to do with market concentration as care markets mature. The English residential care market is perhaps most illustrative of this. Once characterised by small family-run facilities, it is now going through a concentration process following a series of mergers, resulting in five to seven monopolising companies. On the one hand, this process could mean more professional management and efficiency in terms of economies of scale. On the other hand, concentration could also lead to a decrease in quality due to overemphasis on economies of scale, as some of these large providers have been taken over by private equity firms whose core business is not long-term care, and due to increased challenges to regulators in the absence of appropriate ‘provider failure’ plans. The bankruptcy of England’s largest private care home provider, Southern Cross, provides a cautionary tale of this latter point.⁷

‘User choice’ has thus come to mean different things across countries and time periods. Users of DPs in England and German users who remain at home and opt for the LTCI’s cash benefit are arguably granted a wider scope for choice. In theory, English users have some leeway in determining how best to satisfy their needs in that they can choose the identity of their carer and can use the DP to pay for services other than just personal care. In Germany, in practice the LTCI cash option allows beneficiaries to use the benefit as they see fit. In Denmark, apart from the option to privately purchase home help services, user choice is largely limited to choice of a particular provider. In the Netherlands, user choice in long-term care is likely to be diminished with the phasing out of the Personal Budget from 2014 on. Moreover, given the challenges involved in making decisions in long-term care (Baxter, Glendinning, & Clarke 2008; Glendinning, 2008b) countries were generally much slower to implement measures to support users in their choices. Availability of quality indicators with which to evaluate providers – public reporting of quality indicators – came only much later in the Netherlands and Germany (Rodrigues, Trigg, Schmidt & Leichsenring, 2014). In England, although DP users can employ their own personal carers, these are not subject to compulsory registration and there is currently no national registry of personal carers (Lewis & West, 2014). In Germany, a largely

⁷ Southern Cross, a private care home provider owned by a private equity group, went bankrupt after it had leased back its care homes and found itself unable to pay for increasing debts and rents, leaving its 31,000 residents at risk (Wachman, R 2011, ‘Southern Cross’s incurably flawed business model let down the vulnerable’, *The Observer*, Saturday, 16 September, online edition).

unregulated sector consisting mainly of migrant workers exists, while supportive structures such as 'Pflegestützpunkte' are not available everywhere, and it remains to be seen if beneficiaries will perceive them as facilitators of choice or as yet another control mechanism.

As for the outcomes of care for users, there is mixed evidence on the effects of competition and choice across countries. As mentioned earlier, many users now have some choice over the care they receive. Across the four countries, users also have access to a wider range of providers from which to choose, and at least in England, Germany and the Netherlands a significant share is able to choose the identity of their carers and shape the care they receive more or less to suit their preferences. It is more difficult to attribute changes in quality to choice and competition, given on the one hand the frequent regulatory changes that have accompanied the introduction of quasi-markets in each country, and on the other the budgetary cuts that have accompanied some of these reforms (e.g. England and Germany). Budgetary cuts may have had a particularly important impact on the workforce by contributing to difficulties in retaining staff and ensuring continuity of care (Baxter, Wilberforce & Glendinning, 2010).

In order to exert 'agency' in choosing individual care arrangements that suit their preferences, people in need of long-term care are dependent on a demanding array of preconditions, including:

- the availability of different services and/or facilities to choose from,
- the ability and/or willingness to pay, and
- the ability to assess differences in quality and prices.

Some of these preconditions have been achieved in all the countries presented here through reform processes undertaken over the past two decades. However, achieving these preconditions has also resulted in very high transaction costs in terms of quality assurance and other regulations that, in line with efficiency rationales, eventually resulted in further taylorisation (Germany, Denmark) and the emergence of new types of oligopolies (England). At the same time, an increasing share of older people with long-term care needs, particularly the most vulnerable groups suffering from cognitive diseases, had to delegate decisions regarding choice to family members or third persons.

Interestingly, based again on concerns of public expenditure, long-term care regimes in the countries analysed here have tended to focus their efforts precisely on those groups with the most intensive care needs, while those whose ability to choose might often remain with a limited purchasing power.

Compared to two decades ago the purchasing power of people with long-term care needs has significantly increased. It has also become more difficult to choose between providers, most of which have streamlined in order to adhere to universally defined quality standards and 'care packages'. These regulations have not yet succeeded in devising a convincing and satisfying way of assessing quality of care in relation to available or necessary resources. The next chapter reviews the challenges involved in assessing quality in long-term care and critically assesses the developments in this field between different quality assessment systems.

Chapter 4

Quality in long-term care

As we have outlined in Chapter 1, one of the crucial issues in ‘make-or-buy’ decisions of public administration is the question, whether it is possible to define the quality of a service or product to be purchased ex ante and to assess its adequate delivery ex post. Furthermore, we have argued that with the ‘outsourcing’ of service delivery from public administration transaction costs will incur due to tendering and contracting procedures. These costs have to be considered, in particular when it concerns the delivery of personal social and health care services for people with long-term care needs. This chapter therefore addresses the caveats of defining and assessing quality in long-term care and its implications for ‘make-or-buy’ decisions, based on a review of literature on leading quality assessment and management systems. Following some introductory considerations, current trends and challenges in quality assurance and quality development will be analysed in section 2. In the third section, the development of related quality frameworks, indicators and methods in selected countries, in particular in Germany, The Netherlands, and England will be described and analysed. This will be complemented by a description of quality management systems applied by individual organisations as a precondition for future improvements and change processes in long-term care. The final section will discuss and summarise these findings, showing in particular that quality development in long-term care will need further endeavours independently from the type of provider organisation as long as framework conditions are regulated on an equal level.

Theoretical considerations about market-oriented governance are speaking a remarkably clear language when it comes to the necessity to assess, measure and control quality of services, to identify non-compliant behaviour of competitors, to ascertain value for money, help to monitor and enforce contracts and to create even conditions for all stakeholders. Although in contrast to the classical neo-liberal tenet towards deregulation,⁸ this holds in particular for the area of long-term care where there are a number of additional reasons why quality issues have appeared on the agenda of policy and practice over the past decade (European Centre, 2010; Leichsenring et al., 2013; OECD/European Commission, 2013):

- Long-term care is a rather young sector of social protection with a legacy of social assistance rationales and, in spite of a changing variety of ‘welfare mixes’ across Europe, a strong involvement of public administration in planning, providing, funding and monitoring of services and facilities. The relatively recent acknowledgement of long-term care as a social risk implies that also a number of routines, procedures and methods, e.g. concerning quality assurance, have only emerged and developed over the past two decades, partly triggered over and above the introduction of market-oriented governance mechanisms.
- The user of long-term care services is generally not in the position to behave as an independent ‘consumer’, in particular if vulnerable older people are concerned. Therefore, public ‘purchasers’ will subsidise costs, professionals from different ‘providers’ will have their say as well as family members or other stakeholders.

⁸ Indeed, regulatory efforts and measures for quality assurance were often introduced subsequently to the introduction of competitive markets and market-oriented governance, e.g. as a reaction to scandals or bankruptcies (Armstrong, 2013).

- All these stakeholders have specific types of vested interests in defining the quality of services and facilities: users (and their families) would like to know what type of services and what level of quality they can expect, in particular if there are several to choose from; purchasers (regulators) are concerned to know what they pay for, in particular with rising public expenditures in long-term care; and providers will be interested in how they perform as against their competitors and/or to improve their bargaining position in relation to purchasers. In addition, larger provider groups are also using quality management for internal comparisons and improvements, and finally care workers might want to choose their workplace according to performance indicators of their employer.

As a consequence of this variety of interests in the context of changing welfare mixes and the introduction of market-oriented governance, the concept of quality in long-term care as such has gradually shifted its focus: till the early 1990s mostly structural aspects of residential care such as size of rooms, staffing levels or number of beds per room, were defined by regulators. Over the past two decades process-oriented standards (updated care-planning, safety measures, care standards etc.) have been developed both for home care and residential facilities, which eventually also included result-oriented indicators to measure nursing-related outcomes and quality of life. This development, however, was not linear, did not affect all countries in the same way, and led to a wide range of frameworks, instruments and methods to define, assess and communicate quality in long-term care (Nakrem et al., 2009; Minkman et al., 2007).

In general, quality of long-term care services and facilities has to be understood as the compliance with a mutual agreement of decent delivery of services or products. To manage and develop quality, the currently used instruments and methods are designed to assess compliance, to compare the level of services – in particular for users who have to choose between different services – and to trigger improvement processes. However, as already mentioned, the wide range of stakeholder interests and the caveats to measure evidence-based outcomes in long-term care remain critical issues that have fuelled research, regulatory practice and on-going political debates.

4.1 Challenges in defining long-term care and its quality

Long-term care is a multi-dimensional concept describing an emerging system at the interfaces between health and social care, where people with multiple long-term care needs and informal carers are co-producers of services (OECD/European Commission, 2013). Long-term care services are characterised by the following features:

- They are addressing the consequences of physical, cognitive and/or mental impairments or disabilities, chronic diseases and general frailty resulting in restricted abilities to perform activities of daily living (ADL) and/or instrumental activities of daily living (IADL). While long-term care needs may occur at any age the large majority of beneficiaries is above the age of 75. New directions in the assessment of needs point in particular to the inclusion of consequences of cognitive disease and a focus on (remaining) capabilities.
- They may be performed by trained staff with various backgrounds, ranging from medicine and nursing (with specialisations e.g. in geriatrics, psychiatry, continence care, community care etc.) to psychology, various therapists and social work, including home help and other forms of social care. However, the bulk of long-term care is still provided in all countries by informal or family carers.

Innovative approaches underline multi-professional cooperation and the inclusion of informal resources.

- They may be accomplished in various settings – sometimes concomitantly, sometimes consecutively – ranging from own homes, day care centres and assisted housing facilities to hospitals and nursing homes. Apart from the (lack of) coordination between health and social care systems, housing issues (including adaptation, use of ICT, smart homes) are an important variable to determine needs for care and support. Innovations are hence focusing on coordination and integration as well as on the local environment of people in need of long-term care.
- They are funded by different sources both vertically (state, regions, local administration, user's out-of-pocket payments) and horizontally (health insurance, long-term care schemes, social assistance) in the context of social security or social welfare systems with their respective national idiosyncrasies. While the financial crises has hit in particular those public funding schemes for long-term care that were introduced only recently, structural reforms are being discussed in many European countries.
- They involve a significant share of emotional labour and bonding between carers and end users of care, for not only carers perform intimate tasks often in the user's own home, but these care tasks may also involve socialisation. Finally, there are also relationships of mutual dependency established between the carer and the user of care.

As a consequence of the wide range of elements and key-issues that characterise long-term care services and facilities, their structural, procedural and outcome quality (Donabedian, 1988) is dependent on as many variables and dimensions. Apart from the potential impact of ownership structures, which would go beyond the scope of this paper, the following caveats for quality assurance must be underlined when it comes to influence quality on behalf of public purchasers or regulators that want to avoid moral hazard, cream-skimming or unequal competition among providers as well as on behalf of users and their families that want to obtain high-quality services:

- **Guiding principles and values across services and facilities in long-term care:** Contrary to health care that is clearly focused on 'curing' patients from ill-health, the focus of long-term care services on outcomes such as quality of life, dignity and resilience is only slowly developing (Billings et al., 2013) and dependent on the collaboration of stakeholders across multiple governance levels, settings and professional boundaries.
- **Needs assessment:** As there is no generally agreed definition of 'long-term care needs' the number of people and the type of needs they present will to a large degree depend upon administrative procedures and access mechanisms, most of which are still focusing on physical limitations and specific medical diagnoses, rather than on cognitive impairments and the impact of multiple morbidities on individual capabilities. A decent definition of needs and expected outcomes of interventions that consider the idiosyncratic nature of long-term care are therefore necessary to facilitate the assessment of quality that may be expected from individual interventions.
- **Care professionals (social, medical, nursing) and/or informal carers involved:** It is widely acknowledged that the quality of staff and their working conditions have a considerable impact on the quality of services, not only in long-term care. However, the mere definition of staffing ratios or minimum standards of qualification profiles is not sufficient to guarantee user-centred care and

dignified care. Quality assurance and quality development therefore have become part of professionals' job profiles, though often without an explicit training and related job descriptions.

Given these challenges, a first step towards quality assurance consisted in all countries in implementing legal minimum standards and to construct instruments, methods and frameworks to better define individual care needs. This was followed by identifying criteria for risk- and case mix adjustment, indicators for quality of care, expert standards for individual care tasks (disease management) as well as indicators for organisational performance by measuring quality of life, user experiences and user satisfaction. In fact, these methods address and reflect upon the interdependency of economic framework conditions, organisational performance and the health and living conditions of the individual user.

Overview 6 showcases such instruments and mechanisms regarding their scope and focus in selected EU Member States. In fact, these instruments are often focused either on the individual beneficiary in terms of his/her needs and status before and after an intervention (service) or on the provider organisation with respect to its access to the market (*ex ante*) and its service performance (*ex post*). A new and emerging area with particular relevance to long-term care services is the development of mechanisms that tend to define and ensure quality across individual organisations and sectors (inter-organisational level).

Overview 6 Methods to ensure quality in long-term care by scope and level

Scope \ Level	Individual level	Organisational level	Inter-organisational level
Regulation of providers' market access	Professional training and access regulations	Accreditation, registration (e.g. England)	Joint strategic needs assessment (England)
Needs assessment	Administrative needs assessment (e.g. German long-term care insurance); MDS-RAI, ASCOT	Individual care planning by professionals, e.g. RAI-RUGs and Clinical Assessment Protocols (CAP)	
Regulation of structural standards		Legally defined minimum standards, authorisation and accreditation, e.g. staffing levels, size of rooms	
Regulation of process quality		Compulsory quality management; Netherlands' Framework for Responsible Care (NFRC); Transparency criteria (Germany)	
Measuring outcomes	MDS-RAI, ASCOT, QFRP and CQI (The Netherlands), CQC Indicators	Generic (ISO 9001, EFQM) and adapted (E-Qalin, EQUASS) quality management systems; Netherlands' Framework for Responsible Care (NFRC); Transparency criteria (Germany)	interRAI is about to release the first fourth generation assessment system for use in the continuum of care; NFRC (first steps)
Transparency		Public reporting of selected quality indicators and/or inspection reports (DE, UK, NL,SE)	

Source: authors' compilation.

To sum up, as long-term care at the interface between social and health care is a relatively young area of social intervention, so is the debate about its quality and related indicators. Efforts to address the challenges of measuring quality in long-term care have mainly focused on residential care. Even when the area of home care was included, regulations concentrated in the first place on individual provider organisations. Only lately, first endeavours may be retrieved to assess quality across organisations and settings.

4.2 Assuring quality by measuring and assessing performance

Quality assurance in long-term care had for a long time been based on professional ethics, trust and inspection by public authorities. This related to the fact that facilities and services tended in most countries to be provided by charities and other non-profit organisations or by public institutions that were regulated by local administrations and close personal relationships. By the end of the 20th century, this approach changed radically, mainly due to two developments:

- First, with the increasing number of providers and the introduction of market-oriented regulation (competitive tendering, out-sourcing, privatisation, new commercial providers), it became necessary to create a 'level playing field' for all stakeholders and to describe tasks, service levels and responsibilities in order to select 'best bidders', to arrange prices and funding mechanisms – and to prevent 'market failure'. Furthermore, minimum standards to be fulfilled to access the market and to participate, for instance, in public tenders had to be defined (authorisation, accreditation and licensure as quality assurance *ex ante*). The introduction of market-mechanisms was accompanied by other incentives beyond and sometimes in conflict with professional ethics – e.g. monetary incentives – and stakeholders whose main motivation might be profit-seeking.
- Secondly, in particular people with disabilities at younger age promoted independent living strategies, stressing their abilities to assess and steer their assistance autonomously without being subject to the authority of professionals. Although being based on human rights movements and cooperative values ('peer-counselling') this approach, later also called 'consumerism', fits well with the market-oriented discourse based on consumer choice, individualism and the reduction of statutory powers.

In addition, with the growth of organisations providing long-term care, the increasing number of mergers, the rise of provider groups, the rise of new small providers (e.g. home care agencies) and a general professionalisation of the long-term care sector, managerial tools derived from industry found their way also into the area of health and social care. This included quality management, with new legal regulations requiring its introduction, but sometimes also an intrinsic interest of providers to ensure safety and to comply with minimum standards. In some countries, an additional motive for providers to introduce quality management consisted in rising competition, even if care continued to be undersupplied, and the intention to improve the image of, particularly, residential care facilities. As a result, many organisations, in particular care homes, introduced quality management either for intrinsic reasons or to comply with new legal requirements. As a first step, generic quality management (QM) systems such as ISO 9000ff. (International Organisation for Standardisation) or EFQM (European Foundation for Quality Management) were implemented, but this was followed by the elaboration of more adapted systems such as particular quality marks for care homes or provider-specific QM systems.

This development triggered in the first moment additional expenditures for all providers as staff needed to be trained and consultants and certifications needed to be paid. Also for regulators additional costs arose, as new or additional institutions for monitoring, quality control and enforcement needed to be established such as, for instance, the Medical Service of the German Health Insurance (MDK) in Germany or the Care Quality Commission (CQC) in England. These agencies elaborated on various and often revised quality frameworks, criteria and indicators against which providers have to prove compliance. For instance, in the Netherlands the Health Inspectorate requires care homes to carry out a quality assessment based on the so-called Quality Framework for Responsible Care (QFRC) that also includes a Consumer Quality Index (CQI). This instrument was developed together with service providers, professionals, service users, health insurers, and the national government. It includes the publication of results on a dedicated website (www.kiesbeter.nl) and will be described more extensively below.

Public reporting of defined performance indicators has also become mandatory in Germany and the UK (until 2010) as well as in Sweden, where a set of over 70 quality registries and the Äldreguiden-website serve this purpose (Du Moulin et al., 2010, Rodrigues, Trigg, Schmidt & Leichsenring, 2014).

Finally, the need for specific guiding principles and values that reflect the idiosyncrasies of long-term care has been addressed by a number of initiatives at national and EU-levels to promote 'Charters of Rights' for people in need of long-term care, e.g. in Germany (BMF/BMG, 2007), the Netherlands (LOC, 2009) and by European stakeholder organisations (AGE Platform Europe et al., 2010), as well as generic quality frameworks, e.g. The Social Protection Committee (2010). These documents promote visions to all stakeholders and strengthen the role and rights of people in need of long-term care by summarising their basic and indisputable rights as an expression of respect for human dignity.

To sum up, a number of efforts have been undertaken to make quality of long-term care more measurable, to improve assessment and monitoring mechanisms, to establish specialised agencies and to make performance more transparent.

Some of the most prevalent and long-term care-focused assessment tools and frameworks will be described in the next sections. In particular, two methods for assessing needs as a precondition for defining quality of care, followed by three regulatory systems for quality assurance at the national level, and two models for internal quality management (see Chapter 2 for more details on the selection of these frameworks).

The selected methods and frameworks will be described in relation to their scope and context, always followed by a brief SWOT analysis (strengths, weaknesses, opportunities and threats) according to selected categories such as

- The degree to which an instrument/method promotes standardisation of care, rather than person-centred care (*standardisation*),
- The degree of evidence provided by its implementation (*evidence-base*),
- The degree to which it allows for stakeholder involvement, in particular users and their families (*stakeholder involvement*),
- The degree to which it addresses specific characteristics of long-term care such as quality of life, user satisfaction and dignity (*long-term care specificity*),

- The degree to which it may motivate staff to consider quality development as part of their job profile (*applicability*),
- The degree to which it allows quality assurance across organisations and sectors (*inter-organisational quality assurance*), and
- Cost considerations (*cost*).

4.2.1 Assessing needs and outcomes at the individual level

This section deals with tools and methods that help assess care needs and outcomes at the individual level as a central precondition for defining potential interventions and for assessing and measuring expected outcomes.

The Resident Assessment Instrument (interRAI)

The development of the ‘Resident Assessment Instrument’ (RAI) since the mid-1980s was linked to endeavours in the United States to improve nursing home regulation (following a series of major scandals) by means of a comprehensive ‘minimum data set’ to assess the physical, cognitive and social functional status of older people as most important indicators for high-quality care of older people. The first version of the MDS-RAI was implemented in all US nursing homes in 1990-92, but following the foundation of the interRAI non-profit collaboration in 1992 with US and European partners, the instrument was further elaborated, and additional versions for home care, acute care, mental health services etc. were completed over the past two decades. To date, the so-called interRAI Suite represents a fully integrated assessment system, which will be further underpinned by quality of life measures and assessments that can be applied across the continuum of care (Carpenter & Hirdes, 2013).

While the use of MDS-RAI is obligatory in the US, it is implemented on a voluntary basis by many organisations across Europe, in particular in Finland, where its introduction has been supported by public authorities and about one third of care homes have incorporated the system. Indeed, the use of indicators based on RAI may help management and staff to measure results and outcomes of care and to take measures to improve quality and avoid adverse events. This was shown in a number of studies, although not always conclusive (Stolle et al., 2012). As with many other tools and methods to improve quality of care, it remains a methodological challenge to single out the impact of a specific intervention in a highly complex context. In any case, though the interRAI system as such is not replacing a quality management system, it can be an important basis for triggering and monitoring improvement processes.

The interRAI system for assessment of care needs (www.interRAI.org) generates data that can be aggregated from routine clinical practice where 181 core items and, according to the setting, up to 198 additional items are collected by specially trained care professionals, mainly registered nurses, supported by manuals and Clinical Assessment Protocols (CAPs) that help to interpret data and aggregated results. CAPs are “clinical algorithms that identify the need for care plans to address factors that may lead to adverse outcomes that are amenable to clinical intervention” (Carpenter & Hirdes, 2013, p.101).

MDS-RAI assessment items are also used to cluster so-called Resource Utilisation Groups (RUGs) as a classification system to determine the relative cost of caring for a nursing home resident and thus to support purchasers in defining payment systems.

Furthermore, due to its standardisation and indicator-specific risk adjustment, RAI lends itself to comparisons within and between individual facilities as well as between settings (Mor et al., 2003; Wu, Mor & Roy, 2009) and countries, as was also shown in two major EU projects over the past decade (AdHOC and SHELTER).

The SWOT analysis (Box 3) shows that interRAI has great potential to assess clinical items of care, both in residential and in home care, but it needs to be underpinned by an explicit engagement of provider organisations to work with derived quality indicators towards continuous improvement. This calls for incentives that might motivate management and staff to engage in intra- and inter-organisational comparisons and reflections about learning from each other and the coordination of improvement projects.

Box 3 SWOT analysis of interRAI

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Standardisation:</i> The RUGs classification system is likely to improve efficiency of care delivery in terms of resource utilisation • <i>Evidence-base and inter-organisational quality assurance:</i> MDS-RAI is based on a long-standing scientific collaboration with proven reliability and validity of items providing a systematic data collection of items that facilitates comparison of care outcomes over time and across organisations (e.g. through risk-adjustment) • <i>Applicability:</i> Training, manuals and tools to help interpret data are provided and evidence for improvement processes is triggered by working with indicators derived from RAI items 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Standardisation and long-term care specificity:</i> Notwithstanding its wide range of clinical items assessed, MDS-RAI promotes standardisation of care, rather than person-centred care • <i>Stakeholder involvement:</i> it depends on the individual organisation whether data are used by all staff to improve quality; no involvement of users and families • <i>Applicability:</i> Difficulties to explain variations between organisations even if results are controlled for case-mix; staff feel strained by efforts of documentation • <i>Cost:</i> Resources for data collection must not be underestimated
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Long-term care specificity:</i> Further development to include quality of life items, rather than clinical items only 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Long-term care specificity:</i> RAI results are sometimes confounded with ‘quality of care’ as such

Source: Carpenter & Hirdes (2013); author’s analysis

The Adult Social Care Outcomes Toolkit (ASCOT)

The Adult Social Care Outcomes Toolkit (ASCOT) is the result of latest policy shifts from assessing structural and process quality towards outcome measurement, and from assessing disabilities towards measuring opportunities for independence, choice and control of people with long-term care needs. In this perspective, choice and control are seen as major determinants for ‘social care’⁹ related quality of life’ (SCRQoL): “This focus on choice and control encourages us to aim to measure what people can do, rather than what they actually do, across all aspects of SCRQoL. Thus, when

⁹ Social care is a term used in the UK to describe long-term care services at home or in residential care facilities, in particular regarding personal hygiene, dressing, feeding and keeping the living environment clean and tidy.

thinking about basic aspects of QoL, such as personal grooming, outcomes are not just about whether or not people have their personal care needs met but whether or not they can dress as they would like.” (Netten et al., 2011, p.6)

As a reaction to rising criticism of assessment instruments that rely on functional disabilities only, the ASCOT measure “is designed to capture information about an individual’s social care-related quality of life (SCRQoL)” (Netten et al., 2011, p.1). It builds upon Sen’s capability framework and considers the distinction between functioning and capabilities as particularly important to the development of outcomes in long-term care.

ASCOT draws on eight conceptually distinct domains (see Overview 7). Each domain has one item with four response options, reflecting four different outcome states: “The top two states both reflect states where outcomes are fully realised but were designed to differ in the extent to which respondents have choice over how the outcome is realised, so that the best state reflects a person with choice and the second state one without choice” (Malley et al., 2012).

Overview 7 Social care-related quality of life (SCRQOL) domains

Domains of SCRQOL	Definition
Personal cleanliness and comfort	The service user feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed and groomed in a way that reflects his/her personal preferences
Safety	The service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed
Control over daily life	The service user can choose what to do and when to do it, having control over his/her daily life and activities
Accommodation cleanliness and comfort	The service user feels their home environment, including all the rooms, is clean and comfortable
Food and nutrition	The service user feels he/she has a nutritious, varied and culturally appropriate diet with enough food and drink that he/she enjoys at regular and timely intervals
Occupation	The service user is sufficiently occupied in a range of meaningful activities whether it be formal employment, unpaid work, caring for others or leisure activities
Social participation and involvement	The service user is content with their social situation, where social situation is taken to mean the sustenance of meaningful relationships with friends, family and feeling involved or part of a community should this be important to the service user
Dignity	The negative and positive psychological impact of support and care on the service user’s personal sense of significance

Source: Netten et al. (2011, p.3)

Furthermore, the extended research that underpinned the development of ASCOT also included the development of a set of weights for calculating social care QALYs¹⁰ (SC-QALYs) and weighting measures of social care output based on preferences among the general population (Netten et al., 2012).

¹⁰ Quality-adjusted life years, an outcome measure that is used in health economics and public health studies to express the arithmetic product of life expectancy and a measure of the quality of the remaining life-years generated, for instance, as a result of a health intervention.

The ASCOT measure thus contains much potential to assess and compare outcomes as experienced by the user (and partly by carers) for various types of services (Box 4). It has started to become implemented in a number of English jurisdictions to complement the local needs assessment schemes.

Box 4 SWOT analysis of ASCOT

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Evidence base:</i> The tool has been validated and tested (in England) • <i>Long-term care specificity:</i> ASCOT is clearly focused on assessing capabilities and quality of life outcomes • <i>Inter-organisational quality-assurance:</i> It may be used to calculate an indicator for the overall benefit generated by long-term care services; it may thus be used to better compare different services • <i>Applicability:</i> Relatively low effort needed for assessments; ASCOT can be combined with any quality management approach 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Evidence base:</i> ASCOT still needs to be adapted to other cultures and contexts, in particular concerning validity, reliability and sensitivity as well as the weighting of preferences • <i>Applicability:</i> It is not a quality management system as such (but helps to gain outcome-oriented indicators for generic QM systems) • <i>Cost:</i> ASCOT can be used free of charge, but no information is available about resources needed for implementation and monitoring
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Evidence-base:</i> ASCOT is currently being translated and adapted to other countries; it could be linked to the European Quality of Life-5 Dimensions tool to estimate and compare QALYs • <i>Long-term care specificity:</i> It could be further developed for service users with cognitive impairment (dementia) and communication difficulties • <i>Inter-organisational quality assurance:</i> It can be used across different care settings 	<p>Threats</p> <ul style="list-style-type: none"> • None so far

Source: Netten & Forder (2010); authors’ analysis

4.2.2 Regulatory frameworks for quality assurance in long-term care provision

Regulatory frameworks to assess and ensure quality at the organisational level are the key instruments for regulators to define, steer and control services and facilities. The challenge for policy-makers consists in the necessity to strike a balance between over- and under-regulation, between resource allocation and standard setting as well as between standardisation and respect for person-centred care.

German MDK-Indicators and transparency guidelines

The introduction of the long-term care insurance (LTCI) in Germany (1995) was based on a clearly market-oriented governance model that established an open market in long-term care provision (see Chapter 3). As a consequence, hitherto regulation levels were consistently revised, putting quality

assurance of professional nursing services and nursing facilities at the top of the implementation agenda. In this context quality assurance has been based on the principles and standards of quality that were agreed between the LTCI as a regulator and the federations of providers of care homes and services. Mandatory internal quality assurance was complemented by inspections carried out by the Medical Service of the German Health Insurance (MDK). These inspections focused primarily on professional aspects of care quality in terms of structural, process and outcome quality. Although some improvements could be registered, the MDK still revealed a number of deficits in its 2007 report, e.g. problems with food and fluid intake have been reported in 29.6% of cases in home care and 34.4% of cases in nursing homes, and similarly for incontinence care (21.5%, respectively 15.5%), based on a consistent sample of nursing home and home care providers (Büscher, 2010).

The inspection process was therefore revised in the context of a long-term care reform in 2008 that introduced so-called 'transparency criteria' and yearly inspections of all providers (without prior notice) from 2011 onwards, linked to the public reporting of inspection results on a dedicated website (<http://www.pflegelotse.de>). The 'transparency criteria' are based on items and questions taken from the general guideline for inspections by the MDK and were agreed upon by the most important stakeholders. Altogether 64 items were chosen for nursing homes in the areas of nursing and medical care (35), care of residents with dementia (10), social and everyday life support (10), and housing, meals, housekeeping and personal hygiene (9). In home care, 37 items were chosen in the areas of nursing care (17), activities prescribed by the GP (10), and quality of organisation (10).¹¹ During the unannounced inspection process that takes 1-2 days depending on the size of the organisation, the individual performance is rated according to school grades where 1 is the best rating and 6 the worst, both in individual areas and as an overall grade.

Notwithstanding the involvement of relevant stakeholder federations, the introduction of this scheme and the publication of results have been accompanied by fierce critique and even legal action of individual care homes. A scientific expertise, too, came to the conclusion that the applied method contains a number of caveats such as, for instance, restricted objectiveness, reliability and validity, scaling problems and very small samples of residents who are randomly selected for resident satisfaction surveys (Hasseler et al., 2010). In reality, the scheme reveals only very little differences between organisations and does not seem to sufficiently discriminate between quality levels: for instance, the average grading in care homes ranges from 1.1 in Brandenburg to 1.6 in Rheinland-Pfalz, with a total average of 1.3 across Germany.¹² In addition, it seems that care providers have continuously learned how to deal with the inspection and are thus focusing their quality assurance activities exclusively on those criteria that are controlled by the scheme. The public debate was further fuelled by an initiative taken by a number of experts and other stakeholders asking for a moratorium and the development of a more valid and reliable instrument by an independent entity, rather than by the sickness funds as (co-)purchasers.¹³ The related claim was however rejected by the Federal Social Court in 2013. Further improvements of this quite costly scheme (an estimated 3

¹¹ Parallel to these endeavours, the German Network for Quality Development in Nursing (DNQP) has developed a number of so-called expert standards for nursing processes to underpin internal quality development by evidence-based guidelines (<http://www.wiso.hs-osnabrueck.de/dnqp.html>). Furthermore, structural quality issues are also inspected by regional governments, with some innovative approaches that were implemented in Bavaria (Leichsenring, 2010b).

¹² See: <http://www.mdk-pruefung.com/statistiken-transparenzberichte-pflegenoten/>

¹³ See <http://www.moratorium-pflegenoten.de/index.php/moratorium>

billion Euros per year for documentation and inspection) have nevertheless been announced in a mid-term perspective by the MDK.

Box 5 SWOT analysis of the MDK-Transparency criteria

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Stakeholder involvement</i>: Transparency criteria were identified by involving relevant stakeholders • <i>Inter-organisational quality assurance</i>: The establishment of the MDK as a federal entity to carry out needs assessment and quality assurance (see also weaknesses) • <i>Standardisation</i>: Public reporting of individual organisations' performance is made available on a website 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Providers focus quality management on transparency criteria only • <i>Evidence-base</i>: Transparency criteria are not based on scientific evidence; reporting of unweighted measurements may lead to distortions • <i>Inter-organisational quality assurance</i>: The scheme does not sufficiently discriminate quality levels between providers (grades are hardly meaningful) • <i>Cost</i>: High costs and bureaucratic burden for intensive yearly inspections • <i>Applicability</i>: Reported demotivation of staff; little incentives for quality improvement • <i>Stakeholder involvement</i>: Little user involvement and no evidence about use of public reporting by users • <i>Other issues</i>: Problematic mixture of interests within the MDK: health insurers are responsible for both funding and quality monitoring
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Applicability and evidence-base</i>: A revision of the criteria has been announced in a mid-term perspective 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Other issues (governance)</i>: Duplication of quality assurance by new approaches of individual regions (Bavaria); further legal action by providers

Sources: Klie & Stoffer (2013); Hasseler et al. (2010); own analysis

The Netherlands' Quality Framework for Responsible Care and the Consumer Quality Index

The extension of market-oriented governance with increased autonomy for health insurers, more competition between (merged) provider organisations and the rise of individual budgets and choice for users in the Netherlands, too, triggered the expansion of more sophisticated quality assurance mechanisms and related performance measurement. This process involved a number of stakeholders, including researchers and policy-makers, and resulted in the compulsory introduction of quality management at the level of providers of health and long-term care. Furthermore, the implementation of the Netherlands' Quality Framework for Responsible Care in 2007 has been combined with the so-called Consumer Quality Index (CQI) to measure user satisfaction. Over the past decade this process has been accompanied by the establishment of dedicated entities and

agencies and a number of large-scale projects to improve long-term care delivery across the country (<http://www.zorgvoorbeter.nl/>).

The Netherlands' Quality Framework for Responsible Care (NKVZ) is a guide for care providers to assess their performance in ten areas (see Overview 8) by means of a self-assessment concerning organisational and client-related criteria based on internal documentation as well as results of the CQI questionnaire (Frijters, 2010). The latter is carried out by a third party with a large sample of residents, i.e. clients of care services or their legal representatives (Zuidgeest, 2011). These results are translated into indicators by combining relevant items of the questionnaire. Altogether, the NKVZ originally consisted of 44 indicators (ActiZ et al., 2007).

Overview 8 The performance areas of the Netherlands' Framework for Responsible Care

1	Care and life-plan (2 indicators)	6	Participation and social skills (2 indicators)
2	Communication and information (3 indicators)	7	Mental well-being (2 indicators)
3	Physical well-being (2 indicators)	8	Safety (3 indicators)
4	Care-related safety (13 indicators)	9	Workforce (4 indicators)
5	Housing and living conditions (3 indicators)	10	Experience of integrated care (1 indicator)

Source: ActiZ et al. (2007)

Results from the self-assessment and the CQI questionnaires are published on a website – Choose Better (<http://www.kiesbeter.nl/>) – that has been commissioned by the health insurers and is maintained by the National Institute for Public Health and the Environment (RIVM).¹⁴

Over the past few years, some revisions have been made to reduce the number of indicators and bureaucratic burden as well as to focus more on quality of life, timeliness, availability and reliability. This resulted in a revised framework with 25 indicators in the areas quality of life (physical and mental well-being, housing, participation), quality of health care, organisational quality and the care-related quality and safety (Inspectie voor de Gezondheidszorg et al., 2012).

A recent study about the development of user-related quality indicators between 2007 and 2009 revealed a slight improvement of performance for somatic care and home care, while the quality for psycho-geriatric care decreased for 6 out of 15 indicators, which may partly be explained by the fact that questionnaires are answered by the legal representatives of clients. Furthermore, significant regional differences could be observed, which hints at the influence of different support mechanisms such as specific guidance and training of management and staff at the regional level (Winters-Van Der Meer et al., 2013).

¹⁴ From 2014 the site will be managed by the Quality Institute (Kwaliteitsinstituut), which will be one branch of the Netherlands' Care Institute (Zorginstituut Nederland), a newly founded organisation that helps healthcare providers to improve quality.

Box 6 SWOT analysis of the Netherlands' Quality Framework for Responsible Care

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Public reporting of aggregated results by organisation • <i>Stakeholder involvement</i>: Indicators were developed by involving most relevant stakeholders; standardised questionnaires for users and their representatives • <i>Long-term care specificity</i>: Combination of organisational self-assessment and the assessment of user satisfaction • <i>Applicability</i>: Surveys are carried out by independent agencies • <i>Inter-organisational quality assurance</i>: incorporation of case-mix risk adjustment to facilitate comparison as well as 'facility admission profiles' and 'agency intake profiles', respectively • <i>Other issues</i>: Supported by large-scale improvement projects 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Focus on selected indicators may incentivise providers to concentrate on those indicators only • <i>Evidence-base</i>: improving, but still restricted; furthermore, no evidence whether users' choice is based on published data • <i>Applicability</i>: Unclear how the Framework is connected to internal quality management; data collection is not part of the routine in provider organisations, but takes place within one 'measurement week' • <i>Cost</i>: No information available, but resources for documentation and surveys are certainly considerable
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Inter-organisational quality assurance</i>: Benchmarking is being facilitated • <i>Stakeholder involvement</i>: The Framework has been continuously developed with providers and representatives of users, now coordinated by the new 'Quality Institute' 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Other issues</i>: No further investment due to budgetary restrictions

Sources: Zuidegeest (2011), authors' analysis.

Essential standards for quality and safety in England

The history of long-term care and its regulation in England has been marked by continuous change over the past 25 years, except for its guiding principles based on market-orientation, the quest for user choice and competition between providers. The countless efforts to overcome fragmentation between social and healthcare as well as to improve the quality of services since the Griffiths Report and the implementation of the Community Health and Care Act in 1990 have been guided by a strong believe in managerialism and top-down policy reforms within a mixed economy of welfare that is characterised by a strong reliance on both for-profit and non-profit providers. With respect to quality assurance the emergence of new types of providers triggered new legal provisions (Care Standards Act 2000) with new institutional arrangements and regulations, namely 'National Minimum Standards and Key Lines of Regulatory Assessment' (KLORA) that were monitored by the Commission for Social Care Inspection (CSCI). The Minimum Standards and KLORA served to assess residential care facilities in relation to 7 outcome groups, which had been developed by the Department of Health in consultation with older people and the residential care sector. In 2008, the CSCI introduced new quality ratings for all care providers, ranging from no stars ('poor') to three stars ('excellent'). These were published on a dedicated website to help users choose suitable providers.

However, as these regulations turned out to be costly and burdensome for providers, many of which had not been used to quality management in the social and health care sectors, in 2009 the Health and Social Care Bill established the Care Quality Commission (CQC), which took over the functions from CSCI, the Healthcare Commission and the Mental Health Act Commission (MHAC).¹⁵ CQC then developed a new methodology and criteria for assessing compliance with the requirements and established a new registration system that has been implemented since April 2010. The new approach also included that inspections of services should be based on risk rather than routine inspections of all providers, i.e. CQC in a short-term perspective will limit its inspections only to organisations and premises where there is a cause for concern. Furthermore, new criteria for self-assessment and inspection were stipulated by the Health and Social Care Bill 2008. CQC provides guidance for how providers must document compliance with, according to the type of service, up to 28 ‘essential standards for quality and safety’ that are grouped into six so-called key areas in which defined ‘outcomes’ have to be verified as depicted in Overview 9 (Care Quality Commission, 2010).

Overview 9 Essential standards for quality and safety in England

1	Involvement and information (2 outcomes, e.g. ‘Respecting and involving people who use services’)	4	Suitability of staffing (3 outcomes, e.g. ‘Requirements relating to workers’)
2	Personalised care, treatment and support (3 outcomes, e.g. ‘Meeting nutritional needs’)	5	Quality and management (7 outcomes, e.g. ‘Assessing and monitoring the quality of service provision’)
3	Safeguarding and safety (5 outcomes, e.g. ‘Cleanliness and infection control’)	6	Suitability of management (7 outcomes, e.g. ‘Requirements relating to registered managers’)

Source: Care Quality Commission (2010)

This approach offers an ample range of ways to show compliance, as it is up to each individual provider organisation how to prove that processes are defined and put in place, and how to measure outcomes. Indeed, the CQC guidance does not mention any indicators to measure outcomes but provides prompts for which kind of documents, plans and procedures have to be prepared. As a result, neither gathering of data, nor any standardised method for exposing information that could be comparable within and between organisations has been defined. Ample discretion is therefore left to individual inspectors in judging on compliance. The latter are, hence, guided by a ‘judgement framework’ to facilitate the interpretation of evidence provided. Furthermore, ‘continuous assessment’ is realised by means of ‘Quality and Risk Profiles’ (QRP), which is a tool to gather key information about care providers from various sources, including users’ experiences and whistle-blowing. It prompts inspectors to specific risks of each provider and allows to continuously monitor a provider’s risk of non-compliance (Care Quality Commission, 2013a). CQC inspectors are sometimes accompanied by so-called ‘experts by experience’, i.e. service users or informal carers, to get an additional perspective.

¹⁵ CQC counts on about 2,150 professionals (full-time equivalents), of which about 1,000 are working as frontline inspectors, carrying out about 30,000 inspections per year across the range of health and social care providers. The organisation reports expenditures of about £165 million, covered by a grant from the Department of Health and by about £95 million of income generated through payments of providers for registrations and inspections (Care Quality Commission, 2013a).

Under this new regulation public reporting on providers' performance in the online care directory is restricted to information about compliance or non-compliance of organisations based on inspection reports, rather than on a 4-scaled star-rating as in the previous scheme. However, due to the short experience both with star-ratings and the recent reforms it is difficult to say, whether information on quality improved, whether public reporting facilitated users' choice of a provider and/or whether quality in health and social care as such was enhanced.

According to the latest CQC report, problems were uncovered "in more than 10 per cent of the different aspects of care", including safety concerns in nursing homes, staffing problems in residential care settings and home care (Care Quality Commission, 2013b, p.22).

Overview 10 provides insight in some more details of inspection results. It is interesting to observe that the percentage of judgements for unmet standards with moderate and major impact has continued to increase, which might be due to more severe inspections, but it also shows that providers seem to be hesitant, unwilling or unable to meet standards, one of the problems being that Local Authorities, who are responsible for (top-up) funding have and "appear to be using their buyer power to drive down fees for publicly funded users" (Malley et al., 2014).

Overview 10 Selected CQC inspection results in social care for 2012/13

Setting	No. of Judgements	Standards not met	of which with major or moderate impact	Percentage point change to 2011/12*
Outcomes 4 (Care and Welfare) and 5 (Nutritional needs)				
<i>Residential homes (no nursing)</i>	13,583	1,457	816	+8%
<i>Nursing homes</i>	5,791	1,002	655	+10%
<i>Home care agencies</i>	2,492	534	279	+10%
Outcomes 7, 8, 9 and 10 (Safeguarding and safety)				
<i>Residential homes (no nursing)</i>	16,334	2,162	1,188	+5%
<i>Nursing homes</i>	6,750	1,214	708	+3%
<i>Home care agencies</i>	5,741	491	260	+7%
Outcomes 13 and 14 (Suitability of staffing)				
<i>Residential homes (no nursing)</i>	11,400	1,374	684	0%
<i>Nursing homes</i>	5,010	923	526	+2%
<i>Home care agencies</i>	4,340	512	246	+2%
Outcomes 16 and 17 (Monitoring quality)				
<i>Residential homes (no nursing)</i>	10,706	1,158	560	+3%
<i>Nursing homes</i>	4,158	556	326	+9%
<i>Home care agencies</i>	5,180	561	237	-2%

Source: Care Quality Commission (2013b, p.70)

As a response to these public regulations and complementary to CQC information, some new initiatives have been launched. For instance, 'The Good Care Guide' (www.goodcareguide.co.uk)

gives the opportunity to users of care homes and home care services to rate their provider for its quality of care and staff, facilities and cleanliness and value for money (similar to hotel booking sites). Also the Social Care Institute for Excellence (SCIE) provides a website called 'Find Me Good Care' (www.findmegoodcare.co.uk) to complement CQC information in compliance with information from the providers and the views of service users (see also Malley et al., 2014). The repeated changes in regulations by means of top-down reforms also triggered an initiative supported by providers of residential facilities, user organisations and the scientific community, called the *My Home Life* (MHL) programme (www.myhomelife.org.uk). This voluntary programme is based on 8 evidence-based, relationship-centred themes identified in a vision for good practice that is supported by all the key umbrella organisations representing care homes across the UK. These themes are highly relevant to current discussions about the personalisation of residential care practice and the work on dignity in care. The MHL programme is a UK-wide collaborative initiative, led by Help the Aged in collaboration with the National Care Forum (representing non-profit residential care facilities across the UK), Dementia UK and City University, which brings together residential care providers, voluntary organisations, statutory agencies and care home residents and their relatives to promote quality of life in care homes. MHL is a voluntary programme for care home managers, providing guidance and visions for improvement towards personalisation and transformation of long-term care.

The SWOT analysis (Box 7) reveals the difficulties of an allegedly 'outcome-oriented' scheme to monitor compliance under conditions of increasing budgetary restrictions. Following a period of intensive inspection before 2010, self-assessment and remote control mechanisms have gained ground, resulting also in a weak policy towards measurement and data collection.

Box 7 SWOT analysis of the Essential standards for quality and safety

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Stakeholder involvement</i>: The ‘Essential Standards’ are based on debates with relevant stakeholders and on a large-scale public consultation • <i>Standardisation</i>: The ‘outcomes’ provide ample space for proving compliance (see also ‘weaknesses’) • <i>Inter-organisational quality assurance</i>: A dedicated entity (CQC) was established to monitor quality in all areas of health and social care; providers are ‘continuously assessed’ (but differences between health care and social care in terms of data availability) • <i>Long-term care specificity</i>: Risk-based approach (to be improved) 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Evidence-base</i>: The ‘outcomes’ are not measured by gathering data against clearly defined methods and indicators (paucity of data) • <i>Applicability</i>: Inspectors dispose of large discretion for judging on individual ‘outcomes’; opportunities for mutual learning and exchange of knowledge are missing or have not yet been realised • <i>Cost</i>: CQC might not have sufficient resources for inspection • <i>Inter-organisational quality assurance</i>: no link to purchasers (Local Authorities), e.g. related to incentives for improvement
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Inter-organisational quality assurance</i>: Care providers could learn from each other (but probably difficult in a competitive environment) • <i>Evidence-base</i>: The risk-based approach could be underpinned by better data to predict the risks of non-compliance; risk-profiles could be better linked to other on-going initiatives for monitoring and improving long-term care 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Cost</i>: Budget-cuts and further attempts to reduce costs for monitoring and quality development • <i>Long-term care specificity</i>: Increase of an ‘unregulated care market’ for users with Direct Payments and Personal Budgets • <i>Other issues</i>: Overhasty new reform

Sources: Malley et al. (2014); author’s analysis

4.2.3 Internal quality management as a precondition for improvement in long-term care

The exploration of existing frameworks and tools to measure performance and to ensure quality in long-term care has revealed that assessments, inspection methods as well as the definition of standards and indicators are flawed by a number of caveats and conflicting interests of stakeholders. Indicators and so-called ‘outcomes’ must therefore be perceived as a proxy for an expected quality that, at best, has been agreed upon by all stakeholders involved during a process that helps to mediate between expectations, feasibility and sustainability. The amalgamate of factors that impact on outcomes as experienced by residents of care homes or users of services are to be regularly and systematically reflected upon by management, staff, residents and other stakeholders involved – time and space for this type of reflections are however scarce, even in organisations with quality management in place. Care professionals are often overburdened and experience quality management as yet another bureaucratic load that detracts them from personal care of users. This occurs in particular if the gathering of data is not linked to tangible improvement measures, at least within their own organisation. The same holds true for external inspections, if the revelation of deficiencies remains restricted to sanctions, rather than as an opportunity for mutual learning and improvement. In the following, we therefore outline an initiative that set off to overcome existing hesitations to deal with quality management in long-term care organisations (3.3.1) as well as a

quality management system that has explicitly addressed the challenges in the area of disability and rehabilitation services (3.3.2).

The E-Qalin Quality Management System¹⁶

The E-Qalin Quality Management System (QM) system responds on the one hand to shortcomings of generic QM systems (ISO, EFQM) that have often been criticised by long-term care professionals as being too complicated and not appropriate for their requirements. On the other hand, it is an initiative – realised in the framework of a Leonardo da Vinci project (2004-2007) – to complement the increasing number of statutory regulations on quality assurance with meaningful involvement of stakeholders in the improvement of quality in long-term care.

E-Qalin is based on training, self-assessment and systemic organisational development. Selected staff members are trained to qualify as Process Managers and Group Facilitators to enable management and staff to implement QM with an orientation towards involvement and participation of all relevant stakeholders.

Following an internal self-assessment process, improvement should be achieved by projects with a focus on identified problems and suggestions that emerged from this process. During the self-assessment 66 criteria in the area ‘Structures & Processes’ and 25 foci in the area ‘Results’ are judged from five different perspectives (see Overview 11): residents, staff, leadership, social context (social accountability) and ‘learning organisation’ (future orientation). The self-assessment process is implemented by two Process Managers, a steering group (with representatives of all major stakeholders, including the residents’ council and/or other advocates of residents and families/friends), and E-Qalin Group Facilitators who are facilitating the assessment groups. The latter consist of professional staff and serve to assess defined criteria from different stakeholders’ views, in particular from different professions and hierarchical levels. Individual criteria, e.g. those affecting residents and their families directly, may also be assessed in special groups with these stakeholders. Apart from the initial training, the assessment process is supported by a manual and a software tool.

¹⁶ We would like to mention a potential conflict of interest with respect to this section as one of the authors (K.L.) has been actively involved in the development of E-Qalin since the very beginning.

Overview 11 Selected criteria for self-assessment by the E-Qalin Quality Management system

Structure & Processes (extract)				
1. Residents	2. Staff	3. Leadership	4. Social context	5. Learning organisation
1.1 Admission of new residents	2.1 Labour employment	3.1 Corporate policies	4.1 Family members and visitors	5.1 Learning
1.1.1 Care approach and information policy	2.1.1 Employment according to individual competences	3.1.1 Values and organisational culture	4.1.1 Communication and information	5.1.1 Learning from experience and from others
1.2 Transfer to external facilities	2.1.2 Direct responsibility, creativity and own initiative	3.1.2 Strategy	4.1.2 Participation and cooperation	5.1.2 Education, further education and training
1.2.1 Care approach and information policy	2.2 Working time	3.1.3 Marketing and Lobbying	4.2 Partners	5.1.3 Learning from practice
1.3 Biographical approach	2.2.1 Working time arrangements and working time distribution	3.2 Organisation	4.2.1 Choice of partners	5.2 Transfer
1.3.1 Rituals and different life styles/cultures	2.2.2 Reconciling work and family life	3.2.1 Organisational structure	4.2.2 Communication and cooperation	5.2.1 Management of complaints and continuous improvement
Results (extract)				
1. Residents	2. Staff	3. Leadership	4. Social accountability	5. Future orientation
1.1 Quality of health care	2.1 Staff satisfaction	3.1 Economic viability	4.1 Satisfaction	5.1 Development
1.1.1 Care process	2.1.1 Staff retention	3.1.1 Labour costs	4.1.1 Satisfaction of family members	5.1.1 Analysis
1.1.2 Individual care planning	2.1.2 Corporate and team climate	3.1.2 Material costs	4.1.2 Satisfaction of other interested parties	5.1.2 Education and training
1.2 Quality of social care	2.1.3 Opportunities for development	3.1.3 Financing	4.2 Image	5.1.3 Networks

Source: www.e-qalin.net

Only after having terminated at least one assessment cycle and having initiated a continuous improvement process (6-12 months), the organisation may apply for an external audit to achieve an E-Qalin certification. This is realised by a third party, for instance the National Quality Certificate Organisation in Austria or the certification agency Bureau Veritas in Slovenia.

Today, more than 200 care homes in Austria, Germany, Luxembourg and Slovenia have implemented E-Qalin. Experience has shown that the training of Process Managers and Group Facilitators is of utmost importance as knowledge and skills concerning quality management, organisational development, group facilitation and project management are relatively underdeveloped in care homes, and even more so in home care. An important precondition for the implementation of E-Qalin is a participative leadership approach that allows for involvement and participation.

Costs for training are relatively contained: the 5-day training course per participant costs less than a daily rate that would be charged by a consultant. An assessment cycle, for which usually no

additional external consultancy is needed, requires about 700 to 1,000 person-hours per care home with 80-100 places over a period of 6-12 months (every 3 years), depending on its size and the extent of staff involvement. Furthermore, as a result of the assessment, numerous improvement projects will have to be organised and implemented following each assessment cycle to live up to a continuous improvement process. Resources for making this process sustainable will have to be dedicated by management according to priorities, feasibility and urgency.

An evaluation during the pilot-phase has shown a remarkable acceptance of trainings and most positive results concerning the implementation of quality-thinking in care homes (Rosenbaum & Schlüter, 2007). The implementation of E-Qalin (version for residential care facilities) is mainly addressing the inter-professional cooperation of staff within the organisation and, in a second step, the care home's relationship with families, friends, volunteers and other stakeholders. In particular inter-professional relationships have been found to improve in terms of team-working and information-sharing. On the organisational level, staff and other stakeholders involved in the assessment-process have increased their perception of residents' and their families' needs.

The SWOT analysis (Box 8) highlights the fact that a number of preconditions have to be fulfilled to implement E-Qalin in long-term care organisations, but further research is needed to enlarge the evidence-base of continuous improvement processes.

Box 8 SWOT analysis of E-Qalin

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Long-term care specificity:</i> As a fully-fledged QM system E-Qalin helps management and staff to understand and improve quality management in long-term care services and facilities • <i>Applicability:</i> Based on training of selected staff, rather than pure consultancy; positive feedback from providers who implemented the system on a voluntary basis; visible improvement processes • <i>Cost:</i> Relatively contained cost for training and implementation • <i>Stakeholder involvement:</i> Involvement of stakeholders at the basis of self-assessment • <i>Inter-organisational quality assurance:</i> Exchange between users of E-Qalin within and between countries 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Evidence-base:</i> Restricted, but items were developed in cooperation with relevant stakeholders • <i>Long-term care specificity:</i> Working with performance indicators is still not usual in long-term care settings; openness for organisational development and participative leadership needed • <i>Stakeholder involvement:</i> Restricted involvement of residents, particularly those with cognitive impairments, and their families • <i>Cost:</i> Requires considerable involvement of and efforts by staff and management
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Inter-organisational quality assurance:</i> E-Qalin may serve to assess quality across organisations and services; transfer to other countries and sectors • <i>Applicability:</i> The self-assessment process may trigger organisational development and continuous improvement • <i>Stakeholder involvement:</i> Further involvement of users and carers could be promoted 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Standardisation:</i> As E-Qalin is in the first place a voluntary QM system, it may be overhauled by statutory quality assurance mechanisms • <i>Cost:</i> E-Qalin requires investment which, even if relatively contained, might be hampered by cost containment strategies • <i>Evidence-base and inter-organisational quality assurance:</i> Ample discretion is given to care homes to choose outcome indicators, which might hamper comparability and envisaged public reporting

Sources: www.e-qalin.net; Leichsenring (2011); authors' analysis.

The 'European Quality Assurance for Social Services' (EQUASS)

Since the end of the 1990s, the European Platform for Rehabilitation (EPR) has engaged in identifying and enhancing quality in the area of services for people with disabilities. By adapting the more generic approach of the European Foundation for Quality Management (EFQM) a set of European Principles of Excellence was elaborated by most important stakeholders (Frings et al., 2010). Based on these principles that represent core values of the social sector the EPR developed the 'European Quality in Rehabilitation Mark (EQRM)' and the 'European Quality Assurance for Social Services' (EQUASS) launched in 2006. EQUASS is a voluntary accreditation service to ensure quality of social services to service users and other stakeholders. Its latest version consists of 50 defined criteria (100 indicators) covering ten principles of quality (see Overview 12) that are based on the key values of the social sector and cover key elements of quality management adapted to the characteristics of

social services for people with disabilities. A questionnaire is used for an internal self-assessment that is followed by an external audit carried out by an independent and qualified auditor during a site visit that takes two days. The auditor checks the evidence provided by the applicant organisation by means of document analysis and interviews with staff, service users and other stakeholders.

Following a positive audit report an organisation is accredited according to EQUASS criteria for a period of two years.

Quality in terms of EQUASS criteria is defined as “meeting and exceeding the needs and expectations of all stakeholders” (Frings et al., 2010: 39). The EPR provides all services of certification, training and consultancy with the aim to make social service providers engage successfully in continuous improvement.

Overview 12 *The nine principles of quality assessed by EQUASS*

Principle of quality	Definition
Leadership	Organisations demonstrate leadership within the social sector internally by good governance and within the wider community by promoting positive images, challenging low expectations, best practice, more effective use of resources, innovation, and a more open and inclusive society.
Staff	Organisations lead and manage their personnel and their performance to achieve the organisation’s business objectives and the delivery of person-centred services. They are committed to the employment and promotion of qualified personnel based on required knowledge, skills and competences. They promote a culture of engagement, development and continuous learning of staff and professionals for the benefits of persons served and other stakeholders. The organisation provides health, safety, well-being and appropriate working conditions of its personnel.
Rights	Organisations are committed to protecting and promoting the rights of the person served in terms of equal opportunities, equal treatment and freedom of choice, self-determination and equal participation. Organisations are ensuring informed consent and adopting non-discrimination and positive actions within their own services. This commitment is apparent in all elements of service development and delivery and in the values of the organisation.
Ethics	Organisations operate on the basis of a Code of Ethics that respects the dignity of the person served and their families or carers, that protects them from undue risk, that specifies the requirements for competence within the organisation, and that promotes social justice.
Partnership	Organisations operate in partnership with public and private sector agencies, employers and worker representatives, funders and purchasers, organisations of people with disabilities, local groups and families and carers to create a continuum of services and achieve more effective service impacts and a more open society.
Participation	Organisations promote the participation and inclusion of people with disabilities at all levels of the organisation and within the community. Organisations involve users as active members of the service team. In pursuit of more equal participation and inclusion, organisations should facilitate the empowerment of the person served. They work in consultation with representative bodies and groups to support advocacy, the removal of barriers, public education and active promotion of equal opportunities.

Continuation of Overview 12

Person-centred	Organisations operate processes aiming at the improvement of quality of life of persons served that are driven by the needs of both the person served and potential beneficiaries. They respect the individuals' contribution by engaging them in self-assessment, service-user feedback and evaluation and they value personal as well as service goals taking into account the physical and social environment of the person served. All processes are subject to regular review.
Comprehensiveness	Organisations ensure that the person served can access a continuum of holistic and community based services, which value the contribution of all users and potential partners including the local community, employers and other stakeholders and that span from early intervention to support and follow up. The services should be delivered through a multi-disciplinary team approach or multi-agency partnership with other service providers and employers.
Result orientation	Organisations are outcome focused, in terms of both perceptions and achievements, on the benefits to the person served, their family/carers, employers, other stakeholders and the community. They also aspire to the achievement of best value for their purchasers and funders. Service impacts are measured, monitored, and are an important element of continuous improvement, transparency and accountability processes.
Continuous improvement	Organisations are proactive in meeting market needs, using resources more effectively, developing and improving services and utilising research and development to achieve innovation. They are committed to staff development and learning, strive for effective communications and marketing, value user, funder and stakeholder feedback and operate systems of continuous quality improvement.

Sources: Frings et al. (2010, p.41f.); EQUASS & van Beek (2012)

The SWOT analysis (Box 9) shows that potentials of EQUASS are in particular based on the consequent stakeholder (user) involvement, which is facilitated by the fact that the European Platform for Rehabilitation unites both users and service providers in the area of social services for people with disabilities. A rights-based approach to multi-agency partnership is certainly a promising way to be adopted across the long-term care sector.

Box 9 SWOT analysis of the EQUASS

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Stakeholder involvement</i>: Based on quality principles that were developed by relevant stakeholders and reflect the idiosyncrasies of social care • <i>Applicability</i>: Training is provided to enable organisations to carry out self-assessment and prepare for external audit • <i>Inter-organisational quality assurance</i>: About 450 organisations across Europe were certified 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Evidence-base</i>: Restricted; no systematic collection of data, but outcome-orientation according to 'individual plans'; Ample discretion for organisations to demonstrate compliance • <i>Long-term care specificity</i>: generic principles that apply to all types of social and health care services
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Inter-organisational quality assurance</i>: Compatible with organisations across cultures and regulatory frameworks; further expansion to other countries 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Cost</i>: The spreading of voluntary certification systems might be hampered by financial restrictions

Sources: Frings et al. (2010), author's analysis.

4.3 Quality assurance and quality development as a precondition to avoid market-failure

This chapter has shown that quality assurance and quality management in long-term care are only just emerging (see also Nies et al., 2013). Even in countries with a relatively long history in long-term care, evidence about the impact of specific measures is scarce.

Departing from the fact that qualifications, processes and outcomes are much less standardised than, for instance, in health care, regulatory measures still seem to be introduced as a ‘trial and error’ process. In the context of market-oriented governance and competition for scarce resources these measures and their further development are certainly necessary, but often lead to demotivation and strain of care professionals who are probably the most important factor to ‘produce’ value, quality of life for users and dignity in care. The latter are certainly difficult to measure, but the general tendency towards more transparency in long-term care organisations’ performance needs to be underpinned by further endeavours to inform purchasers, users and the providers themselves to improve quality in terms of mutual agreements about the decent delivery of services. This includes a multi-stakeholder and multi-level governance approach considering the different interests and objectives of users, providers (management and staff), and public authorities.

A certain trend in this direction might be derived from the fact that control and inspection are increasingly replaced by self-regulation and quality management based on self-assessment and third party certification such as E-Qalin and EQUASS. This process is relatively independent from market-oriented governance, even if it might be driven by cost-containment strategies, too. For it cannot be denied that quality assurance and quality management warrant additional resources in terms of new (quasi-)public regulation agencies, training of staff, working-time and inspections or certification audits, respectively. However, it is difficult to understand why the discussion about costs for quality assurance is so prominent in long-term care, while no one would question the necessity for international standards, patents, safety regulations and quality certification in ship-building, aerospace or in general manufacturing industries. Compared to these established fields of quality assurance, related efforts in long-term care are still in their infancy. It might be a matter of time for policy-makers, management and professionals to realise that quality management is part of the business and individual job-profiles in long-term care, rather than just an additional bureaucratic burden. Still, it could be useful to define a threshold of, for instance, 1% of the sector’s yearly turnover on quality assurance and quality development.

The introduction of market-oriented governance mechanisms has certainly fuelled the establishment of quality assurance mechanisms, as accreditation (*ex ante*) and mandatory or compulsory certification (*ex post*) needed to be installed, at least at the individual organisations’ level. Similar regulations or incentives for developing quality across the ‘chain of care’, i.e. integrating various providers and services across sectors, are yet missing. It remains to be seen whether quasi-markets with providers acting under competitive framework conditions are suited to generate and implement such attempts.

The search for relevant indicators to operationalise quality in long-term care is an on-going and still open process. It has been increasingly understood that neither external inspection nor self-assessment as such lead to better outcomes, if they are merely focusing on the size of rooms, the number of staff or defined procedures that are collected in a file. The debates on outcome indicators

and pay-for-performance systems address these shortcomings but satisfying ways to appropriately define outcomes in long-term care have yet to be found. This is also a major caveat when it comes to debates about alleged differences in quality between different types of provider organisations (see Box 10).

Box 10 *Does ownership impact on the quality of care?*

Over the past decades long-term care has been subject to fundamental reorganisation in the context of New Public Management and market-oriented governance. While the US has seen this process starting in the 1980s (Grabowski, Feng, Hirth, Rahman & Mor, 2013), the share of private for-profit providers in residential care markets in most European countries increased considerably in the past two decades. As a result of rising competition between public, private and non-profit organisations, research on the dynamics and outcomes of competition in the long-term care sector has become highly relevant also in the European context. Within the mixed economy of care a wide range of interests represented by public funders, providers and users fostered the introduction of quality measurement mechanisms with the aim to improve transparency and to monitor the performance of different types of providers. It has been argued that quality measurement systems make nursing home care a good test case for examining differences in care quality across different types of providers (Amirkhanyan, Kim & Lambright, 2008).

In the context of the present research project a systematic literature review has been undertaken to address issues concerning the impact of nursing home ownership on quality of care. To this purpose, peer-reviewed research papers and published studies that empirically examined the relationship between ownership and governance of for-profit, non-profit and public nursing homes with various quality measures of care, were identified by a comprehensive search of eight electronic databases (ScienceDirect, PubMed, Social Care Online, DARE, SciSearch, EBSCO, Google Scholar, Web of Knowledge) by hand search of relevant scientific journals and by reference screening. The search resulted in 250 studies by title and abstract review. Included studies reported findings from ten different countries dating from 1990 to 2013. Study characteristics and results of 83 articles that met the inclusion criteria were extracted and reviewed using Donabedian's quality framework of structure, process and outcomes. Quality results were pooled by these dimensions and critically examined, stratified by study design and risk adjustment methodologies.

The results of this review will be published in a separate paper, but it can already be revealed that they will confirm relatively mixed and inconclusive findings of previous studies (Comondore et al., 2009; Xu, Kane, & Shamliyan, 2013) as differences between care homes by various types of ownership heavily depend on the choice of indicators to define 'quality of care'. For instance, non-profit and public nursing homes tend to deliver higher quality of care with respect to use of restraint (Castle & Engberg, 2005), reported number of deficiencies (Banaszak-Holl, 2002) and staffing levels (McGregor et al., 2010; Stolt, Blomqvist & Winblad, 2011) while for-profit providers attain better outcomes on managed care participation (Zinn, Mor, Castle, Intrator, & Brannon, 1999; Stolt et al., 2011;). These differences seem to point to differences in the management of care homes according to ownership, namely, regarding the management of human resources that are an important factor in the cost structure of long-term care.

However, many outcome measures do not reveal any significant differences between nursing homes of different ownership. In addition, there is a substantial risk for bias of the results given that a number of studies do not sufficiently control for certain factors (e.g. users' purchasing power, cost structure or market competition) that can have important implications for quality differences. Furthermore, the overwhelming majority of results pertain to the United States and it is not entirely clear how they could translate in the dissimilar regulatory environment of Europe as the number of studies available for Europe is scarce.

Arguably the most important result is not so much that for-profit or non-profit are preferred, but rather that the presence of both in the market could provide users with differentiated choice and regulators with increased opportunity to benchmark providers' performance and steer quality improvements.

Tools to measure, assess and reflect upon existing indicators to develop and monitor improvements therefore have to be further elaborated as an integral part of quality management in long-term care (European Centre, 2010). Further professionalisation of the long-term care sector in terms of working with performance indicators, but also with guidelines, protocols and expert standards might be one way forward to construct an own identity of long-term care workers as most important resource for quality development.

Respective training and the integration of quality thinking into daily routines certainly warrant some investment. This type of investment would be desirable in emerging long-term care systems in any case, but more transparency in funding and performance becomes a general precondition, if users and policy-makers (purchasers) place greater emphasis on choice and competition, not to speak of first ideas about 'pay for performance' funding systems. In a sector that contributes with up to 4 per cent to GDPs across Europe in supporting the most vulnerable people in ageing societies, it seems to be high time to acknowledge that quality assurance and quality development is not only an add-on activity but at the heart of any service in long-term care.

Further quality development in long-term care would help policy-makers and public administration to better underpin 'make or buy' decisions with a broader evidence-base that is not only focused on individual (clinical) indicators, but on outcomes produced by inter-organisational and multi-professional cooperation. While there is certainly still a long way to go to achieve this goal, the following principles could enhance the dialogue within and across health and social care sectors:

- *Checks and balances*: While the principle of splitting purchaser- and provider-units within public administration has been relatively widespread, this is still not the case with respect to purchasing and quality assurance. Although it is quite straightforward that (public) purchasers have an interest in what they are purchasing, it is also consequential that issues of price will often prevail over quality features – and the practice of public tendering has revealed ample evidence for these preferences over the past 20 years. Another consequence of linking purchasing and quality assurance is often both under-regulation in 'soft' areas such as quality of life and dignity, and over-regulation in more easily measurable areas such as structural standards. An independent agency for quality-related issues in long-term care (from accreditation to tendering and

monitoring, including training and research for and with all stakeholders) would be a visible sign for the creation of a level playing field.

- *Coordination within a competitive market and inter-organisational quality assurance:* A critical feature that accompanied the introduction of competitive quasi-markets in long-term care has been that already fragmented service and delivery-structures were additionally challenged by competition between different types of providers. Commissioning within 'zones' and/or of local 'preferred provider' networks could be a way to address this shortcoming and work towards incentivised cooperation and mutual learning. As this would lead to a further 'hybridisation' of providers, combining different rationales in personal service delivery, it remains to be monitored in how far principles of profit-orientation, mutual help (solidarity) and public provision (equity) will be balanced.
- *Empowerment of users:* It has been argued that future generations of older people might be more demanding in choosing between services and providers, and more interested in getting involved in the co-production of service quality. However, under conditions of vulnerability and frailty this might remain an on-going challenge without external, proactive support strategies. These concern both access procedures (information and counselling) and the involvement in quality assessment and feedback concerning service provision.
- *Incentives for quality development:* It goes without saying that quality development will be hampered if there are no incentives for providers to out-perform contractually agreed minimum standards, in particular in quasi-markets with regulated access mechanisms – demand being usually greater than supply and the general preference to guarantee continuity in care provision rather than closing down underperforming services. Even financial incentives are not always helpful. For instance, if underperforming services are 'punished' by means of lower reimbursement it is unlikely that they will be able to improve, even if there is often no direct correlation between the financial situation of an organisation and its performance. Joint training of staff and management of different organisations to develop the long-term care sector's identity might be a soft, but perhaps more effective way to promote quality thinking.

Conclusions: Learning from experiences across Europe and transferring them to realities in Sweden

Theory provides guidelines about policy implementation

The theoretical review discussed in Chapter 1 concluded that the question of whether to make or buy long-term care was likely to be best answered empirically. This should not be taken, however, as a recommendation to disregard theory. In fact, one pertinent criticism of the discussion and implementation of competition and choice in long-term care is that it has not taken into consideration the insights of theoretical deliberations.

It seems clear that transaction costs can be an important issue in introducing quasi-markets and this has probably been overlooked by policy-makers. Not only do markets imply added costs for tendering, accreditation and quality assurance, but they also call for additional training, e.g. for municipality commission officials on contracting or for inspection agencies.

Markets and choice require adequate information. For example, if quality cannot be easily assessed, users will not be responsive to it and the quality of services could decrease. The issue is compounded in long-term care because quality is multidimensional, which means that there is a real danger that providers will invest in improving only those dimensions that may easily be observed and measured. Improving information on quality seems thus like an obvious pre-condition for competition and choice.

Markets can produce inequitable outcomes. In the case of long-term care, this is especially worrying because long-term care is a derived demand, i.e. demand for long-term care reflects a need rather than want. Those more likely to need it may well be those less able to afford it. Competition and choice are better able to produce the desired outcomes when those choosing have the means to exercise choice: both in financial terms and by means of information they can understand.

Competition and choice involve trade-offs

Often competition and choice have been limited to choice between agencies providing rather similar types of care given high degrees of standardisation of care packages and universally defined quality standards. Allowing users to choose what care they need, how they want to receive it, when to receive it and by whom can enhance their well-being, improve their sense of independence and better tailor care to their needs. This means discussing risks (e.g. that sometimes less than optimal choices will be made) with users and carers, and providing leeway to unorthodox choices (e.g. socialising instead of personal care) in connection with professional support and advocacy.

Improving accountability of providers and information on quality has often been pursued through standardisation of care. Detailing care tasks to the minute could arguably facilitate benchmarking and managing of contracts, but at the expense of diminished quality.

Over the past few years, issues of integrated care, person-centred and holistic approaches have gained ground together with a critical stance towards the 'Taylorisation' of care. Indeed, as the example of 'Buurtzorg' has shown in the Netherlands (see Chapter 3.2.2), it is possible to combine productivity gains with better-trained staff and a less fragmented organisation of care – in combination with transparent monitoring of quality. This example also shows that competition in

long-term care also means a competition for workforce, i.e. professionals will seek employment in those organisations that offer better working conditions and a more meaningful division of tasks. In recent years also other countries (i.e. Germany and Denmark) started to take steps to roll back standardisation by offering more flexible time allotments for person-centred care

Learning from others – common trends of care markets

Arguments for introducing markets are characterised by similar political goals across countries whose pathways show common trends: while some countries introduced market mechanisms in residential and home care sectors (UK, DE), others used contract tendering in a first place only in the home help sector while slowly opening the entire home care and also residential care market to private for-profit providers (DK, NL).

In a number of these ‘quasi-markets’ there seems to be a move towards concentration through mergers and acquisitions. Part of this trend could just signal the maturation of the market, but it has also raised concerns about achieving a sufficiently diversified provision of care and ‘provider failure’, especially when providers have large market shares.

In general, the backdrop and sometimes unstated aim of introducing competition and choice was to bring down costs. However, budgetary constraints can have a significant impact on the training and retention of staff with potential detrimental effects on quality and continuity of care as well as caring relationships.

Existing evidence on differences in quality of care is mixed but seems to favour non-profit providers across a number of countries with respect to selected criteria such as staffing and certain process measures, e.g. restraint use (Banaszak-Holl & Hines, 1996; Grabowski & Castle, 2004; Hillmer et al., 2005; Kash & Miller, 2009). This type of competition between different types of providers can thus be an important tool for regulating quasi-markets and to alleviate the pure juxtaposition of ‘private vs. public’. Given that quasi-markets are still very much regulated by public authorities, the leeway for any type of provider remains relatively small – it may therefore be useful to actively promote the ‘hybridisation’ of provider organisations in terms of common values, objectives and shared quality indicators. This implies to install a regular and systematic dialogue involving all relevant stakeholders. In particular, mutual agreements for installing a process of continuous improvement need to be negotiated to overcome the ‘quality-price’ chasm and to embed quality thinking across organisations and sectors.

This study has shown that outcomes on introducing competition and choice are dependent on the cultural and political context, pre-existing provider structures as well as the design of policies in a country. Market developments and outcomes of competition in the home care sector (e.g. NL) and user choice (vouchers, Personal Budgets) vary across countries given different decisions and preferences of purchasers (e.g. municipalities) and users. Thus there is no ‘one size fits all solution’ on whether increased competition and user choice produce the desired outcomes of more competition and user choice.

This study has also revealed that decisions whether to make or buy long-term care services are clearly showing both pros and cons. The weighting of trade-offs may probably lead to different answers with respect to different types of services. The advantages of competition may, for instance, fit better with the delivery of services such as household help (e.g. cleaning) and provision of meals.

Competition may, however, stand in the way of cooperation and network functioning needed to provide integrated care. Taking Hirschman's concepts of voice and choice, some groups of users might prefer to be able to choose, while others would rather have their voice heard. Both voice and choice can lead to inequitable outcomes. Public provision, competition and choice are ultimately not the ends of social policy in long-term care. They are merely the means or mechanisms to provide adequate, affordable and equitable long-term care services that empower users and enhance their independence. The choice is thus likely not whether to make or buy, but rather what are the objectives that policy-makers want to achieve with their policies, how providers and professionals can be involved and steered to achieve these objectives, and how mechanisms of competition and choice are implemented in each system.

Annex I: Interview partners in case study countries

England

- Senior commissioning official in one local authority
- Senior official responsible for social care services for older people in one local authority
- Senior official responsible for social care services for older people in one local authority
- Representative of one support agency for older people with Personal Budgets
- Social worker responsible for assessment and management of LA-managed care

Denmark

- Consultant at the Association of Local Authorities (KL), Health and Social Care Department
- Representative at Udbudsportalen (procurement portal) of the Association of Local Authorities (KL)
- Representative of the Danish Competition and Consumer Agency, Department for Competition and Publicly Provided Goods that carries out market analysis and writes legal notes and works as the secretariat for the council for public-private collaboration
- University Professor in Political Science and Comparative Welfare Studies

The Netherlands

- Consultant in health and long-term care
- Consultant in public health, former member of the Council for Public Health and Health Care

Germany

- CEO of the Association of Private Providers in Social Care, representing 4000 home care providers and 4000 residential care providers which is equivalent to 25% of all care providers in Germany)
- Representative of the Medical Advisory Service of the German Social Health Insurance (MDS), Department 'Nursing care'
- Programme director for older people at municipal social service agency
- Director of Care Department, Long-term Care Insurance Fund (AOK Rheinland/Hamburg)

Annex II: General questionnaire for expert interviews

Introduction

- Government level and responsibilities: What are your responsibilities in governing long-term care?
- How long are you working in this position?

Discussion in regard to Make or Buy decision

- Has there been a debate about market-oriented governance in long-term care in your country? What were the key-issues and objectives at stake? Who were the main stakeholders involved (e.g. users' associations, provider organisations)? Which solutions did you find to involve different stakeholders? Could you briefly narrate the introduction of market mechanisms?
- Has there been a debate (political or within your administration) about the 'make or buy' [Note: on whether the state or private providers should provide care] decision? If yes, what economic and political arguments were key in this debate (costs, quality, competition, more innovation, increased productivity, choice etc.)? [Note: When inquiring a local officer, ask how these discussions took place in their municipality/city]
- In how far did public administration of long-term care change with new governance mechanisms? (e.g. purchaser-provider-split, budgeting, planning etc.)

Governance, public procurement and contracting in quasi-markets

- How is the contracting process (tendering, contract negotiation, monitoring) organised in your jurisdiction (what is your role in it)? Which institution/public authority is responsible for establishment of contracts with providers?
- What type of contracts is used when contracting with providers? What kind of payment mechanisms? Who makes the ultimate decision about purchasing care (e.g. a care manager, the user)?
- How are prices set? How is quality defined in contracting?
- How is access of new (private) providers organised and facilitated? Are there different levels of subsidies for different types of providers (public/non-profit/for-profit and home care/residential care)?
- What kinds of mechanisms have been developed in your jurisdiction to govern the planning, organisation, delivery and control of long-term care services?
- How would you characterise the relationship between public authorities and providers in your jurisdiction?

- In which sector has competition increased (home help, personal care)? And due to which legislation has competition increased? Can we speak of open competition? If all providers are competing for tenders, how is a basic level of service provision ensured?
- What degree of discretion do public authorities have at different levels to take specific decisions?
- What competences and skills in public procurement do they have/need to take these decisions: related to tendering, service specifications, monitoring, access (accreditation), contracting, vouchers, price-setting, stakeholder forum (plural or individual negotiation), reporting, (joint) training, organisational development?
- Are critical requirements stated in procurement and authorisation procedures in order to give more room for competing providers to offer new methods and new procedures (to increase productivity and innovation and to improve quality)?
- How important is the level of competition with regard to how the relationship with a provider is managed?
- What are the measures of success/quality your institution uses to evaluate the performance of the contracted provider? How does the monitoring take place? How are providers held accountable

Market share developments

- Since the introduction of market mechanisms in long-term care, has a concentration/diversification of providers in home care, residential care or personal assistance taken place?
- Has there been a change in the relative 'market share' of different providers? How has the share and size of for-profit and non-profit providers developed over the last decades? Are there specialised small providers or rather large providers with comprehensive care service packages? Who did survive? Differences between regions (rural/urban)?

User choice & user perspective

- To what extent are users (and/or their relatives or advocates) empowered to make choices (e.g. do they have choice over the carer coming to their home or over the car schedules)? What mechanisms are in place to make their choice possible (e.g. vouchers, cash benefits, public reporting of information on quality)?
- In your opinion what have been the outcomes of marketisation: user perspective (Do they appreciate to choose, have they really chosen?, What do they think about private providers?); carer perspective (impact on carers, satisfaction, use of public reporting?) Provide examples of evidence/studies if possible.
- What in your opinion are the main constraints faced by users in making their choices? (Are users taking advantage of increased choice between different care providers? Do they really choose? Is choice of provider and care packages too complex for most of them? What do users think about private providers (vs. altruistic non-profits?)

- Has quality improved due to more choice? What are the trade-offs of more choice? Is the market in long-term care demand-driven?
- How is information for users provided? How and from whom do users receive counselling to make appropriate choices? Independent advisor (other than financier, e.g. insurance)?

Evidence and experiences with relationship of competition, quality and price

- Are there any studies in your country that addressed financial or social consequences of privatisation in long-term care service delivery: e.g. impact on equity of use, cost reduction/efficiency, quality of care?
- Are there any (spill-over) effects on the quality of care provided in nursing homes in one region due to increased competition?
- Is there any evidence on transaction costs? (Extra costs with competition and choice vs. in-house; municipal/state)

Funding streams

- Funding mechanisms, funding flows: How do cross-regional funding mechanisms in long-term care take place, e.g. if care recipient moves to different region?
- What are your experiences with your funding mechanism in terms of efficiency and effectiveness of service provision? (Can you compare it to other type of funding mechanisms (insurance based/tax based) of other countries, regions, previous experiences?)

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