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Ricardo Rodrigues is Head of "Health and Care", *Kai Leichsenring* and *Juliane Winkelmann* are Researchers at the European Centre for Social Welfare Policy and Research, Vienna
http://www.euro.centre.org/rodrigues
http://www.euro.centre.org/leichsenring
http://www.euro.centre.org/winkelmann

To Make or to Buy Long-term Care II: Lessons from Quasi-markets in Europe

Juliane Winkelmann, Ricardo Rodrigues, Kai Leichsenring

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Introduction: In search of efficiency

The current reality of population ageing has heightened concerns about the fiscal sustainability of social protection systems, including 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. Against this backdrop a set of economic theories which gained prominence in the 1980s and came to be known as New Public Management (NPM) were taken on board in several areas of public services, including long-term care. With efficiency as its core objective, it stipulated the introduction of increased competition, contractualisation and performance measurement. In parallel, a strong consumerism discourse advocated for users of long-term care services to be empowered to make their own choices, which reinforced the calls for the introduction of user choice. By this wave of marketisation of long-term care, the provision of services for frail older people has come to rely on increasingly diversified provider markets including for-profit, non-profit and public providers in most European countries. At the same time, the high complexity of long-term care and the difficulty of defining clearly measurable outcomes have posed particular challenges to policy-makers to steer and regulate quasi-markets in this sector by means of competitive tendering and contracts.

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Series Editor is *Pieter Vanhuysse*, Deputy Director and Head of Research
vanhuysse@euro.centre.org

This Policy Brief is the second part of a trilogy dedicated to the reliance on markets for the delivery of long-term care, or in other words to the 'make or buy' decision in long-term care.[1] This second Policy Brief will focus on evidence from four selected European countries on existing experiences with competition and choice in long-term care systems to

1 All three Policy Briefs draw from the Report ' "Make or Buy" – Long-term Care Services in Sweden: Lessons for Policy", edited by the European Centre, that is a result of research generously funded under a grant from the Swedish Ministry of Health and Social Affairs (Rodrigues, Leichsenring & Winkelmann, 2014).

provide policy lessons on the 'make or buy' decision and its impact on outcomes for users, on quality of care, and the organisation of care markets. The four countries are representative of different welfare regimes in long-term care: England as a means-tested system; Denmark as an example of a Nordic long-term care system with universal 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.

A fleet of different ships hit by the same storm

Today, many European countries have reorganised the provision and regulation of long-term care. Despite marked differences across Europe, attempts to reform long-term care delivery have shared one trait in particular: they relied 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 user choice, e.g. through cash benefits, and on the contractualisation of care services.

However, governments have implemented these reforms from very different starting points as respective public administrations and individual long-term care systems were shaped differently by national welfare pathways. Contextual factors including the institutional settings (insurance-based or tax-funded systems), the nature of existing benefit schemes (e.g. means-tested or universal, insurance or tax-based), and types of stakeholder relations (e.g. public monopolies of care provision or the role of for-profit or non-profit providers) were decisive for how long-term care was organised in each particular country. Distinct sets of political objectives and key players that facilitated the development towards marketisation were also key. Starting from these preconditions, the introduction of market-mechanisms becomes very much path-dependent and self-reinforcing. Implementation processes of the reforms related to competition and choice have thus been shaped differently and provide great opportunity to draw lessons for research and policy in relation to market and government failures in long-term care provision, in particular with regard to the national experiences of introducing competition and choice.

Countries' path dependencies are key for the understanding of market reforms in long-term care.

At the onset of the market reforms there were strong incumbent providers already in place in all four countries. While there was a monopoly of public provision in the English (home care) 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 England, Denmark and Germany municipalities and local authorities were key actors in planning, providing and monitoring long-term care services, while in the Netherlands the long-established *Algemene Wet Bijzondere Ziektekosten* (AWBZ) insurance had taken a central role since the end of the 1960s.

In all countries, market mechanisms were first introduced in long-term care in the 1990s and the first steps were aimed at creating a newly mixed economy of care, i.e. to foster market access to new entrants. However, beyond this common objective different arguments lay behind the introduction of competition and choice in each country. For example, in England and the Netherlands competition and user choice strove to achieve cost-containment and to enhance home care *vis-à-vis* residential care. The consumerist rhetoric was particularly dominant in these two countries, and it was pushed forward by the disability rights movement that advocated for increased user choice and more rights for disabled patients (Kremer, 2006). The prevailing arguments in Denmark and Germany supporting competition and choice were more closely related to the intrinsic value of choice and NPM principles of contractualisation and formal, measurable standards (Rostgaard, 2011; Theobald, 2012). In Germany competition between providers and the role of the market in increasing efficiency of care provision were particularly dominant objectives for the introduction of the long-term care insurance (LTCI) system in 1995 that marked the opening of the market to all registered providers. At the same time reforms sought to strengthen informal care provision as a means for keeping costs low and enhance efficiency of care provision (Bode, Gardin & Nyssens, 2011).

In the wake of the storm – common trends

One of the stated political objectives was achieved in all four countries as the long-term care markets were opened for new entrants, mostly private for-profit and non-profit providers. Traditionally dominant public and non-profit providers lost their stronghold within a growing market. In the case of public providers this took place as governments sought to disconnect them from their funding departments (purchaser-provider split). However, this new welfare mix relied on competition between providers and new contractual relationships between public authorities and provider organisations, albeit to a different extent in the four countries (Table 1). In England and Germany for-profit providers quickly came to represent the majority of care providers or took at least a consider-

able share in both the residential and home care sectors as contracting practices (e.g. zoning) sought to foster the entry of new types of providers (Glendinning, 2012; Knapp, Hardy & Forder, 2001). Conversely, in both countries the home care market has become very fragmented and volatile, especially where cash-for-care payments have gained importance, e.g. with providers often unable to survive under economic pressure and increased quality norms in Germany. While in England competition has taken place on price and quality of care, in Germany providers compete on quality of care with minimum standards and on the supply of supplementary services as framework contracts between providers and LTCI funds define fixed prices for care packages (Arntz, Sacchetto, Spermann, Steffes & Widmaier, 2007).

In Denmark and the Netherlands quasi-markets were introduced exclusively in the home care sector. While this gave rise to a wave of mergers between non-profit providers and to the entrance of for-profit providers in the Netherlands, the opening of the market was more restricted in Denmark. In the latter case, private for-profit providers are mostly confined to provide privately paid extra services which can in most municipalities not be supplied by public providers. In Denmark the municipalities retained the power to set prices and quality standards for tendering procedures with home care providers. In the Netherlands prices for home help are either set by the municipalities or are defined in the tendering process through competition, but open competition only exists in home help (van der Veen, Huijbers & Nies, 2010). Residential care institutions continued to be operated almost exclusively by public providers in Denmark and to a vast extent by private non-profit providers in the Netherlands (Table 1).

Table 1: Share of residential care and home care providers by ownership, in %, England (2007/2008), Denmark (2012), Germany (2011), and the Netherlands (2008).

Source:

Statistisches Bundesamt, 2013a; 2013b; CSCI, 2009 referred by Barnett, Molinuevo, Leichsenring, & Rodrigues, 2010; Bertelsen & Rostgaard, 2013; Huber, Maucher & Sak, 2008.

	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			
Practical assistance			37%
Personal care			4%
Germany			
Residential care places	6%	56%	37%
Home care users	1%	50%	49%
The Netherlands			
Home care users	0%	80%	20%

Power to the user

All four countries introduced mechanisms and schemes that increased user choice over providers and care arrangements. Initially, public authorities relied on monopsonic purchasers in all four countries – be it local authorities in England and Denmark or health insurance funds in the Netherlands – before slowly providing end-users with agency in purchasing care. Germany and the Netherlands, however, allowed users to choose cash benefits redeemable for services from the very start of the LTCI and the Personal Budget schemes, respectively.

The dimensions of choice users were entitled to in the four countries differ considerably as they were influenced by specific national stakeholders such as organisations of people with disabilities, and by different legacies and pathways. Germany and the Netherlands were the first countries to entitle home care recipients to cash benefits to arrange their own care and to purchase various types of care and assistance from informal (Germany) and formal (Netherlands) personal assistants. While the use of Personal Budgets to pay for informal carers in the Netherlands is regulated in terms of payment of taxes and social contributions, the German long-term care cash benefit can be used to pay informal carers (often family carers, but increasingly also migrant carers) without any preconditions, thus contributing to the emergence of non-regularised care arrangements. In Germany cash benefits have consistently proven to be more popular than in-kind home care services even though the latter yield higher payments for similar levels of care need. In the Netherlands, Personal Budgets proved to be similarly popular despite their highly bureaucratic logic. However, in the latter case, the objective to create a market through the Personal Budgets and enhance competition between providers was not achieved as Personal Budget holders used the benefits mainly to compensate informal family carers or to turn to non-profit home care organisations (Da Roit, 2013).

User choice was expanded in the early 2000s with the introduction of Direct Payments (DP) and later Personal Budgets (PB) in England and in Denmark with vouchers and the obligation for municipalities to offer user choice of home care providers. However, in Denmark, apart from the option to privately purchase additional home help services, user choice is largely limited to select a particular provider. In England users have in theory choice over the residential services they receive, although this depends on the acceptance of the choice by the municipality and availability of places (Age UK, 2013). In any case, self-funders make up for an important share of the users of residential care in England. In both countries care managers of local authorities are strongly involved in the definition of care packages.

'User choice' has thus come to mean different things across countries and time periods. Users of DPs in England and beneficiaries of the German LTCI who remain at home and opt for the cash benefit are arguably granted a wider scope for choice. In theory, English DP 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. Those on PB managed by the local authority have much less leeway for choice. In Germany, in practice the LTCI cash option allows beneficiaries to use the benefit as they see fit. 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. Despite the challenges involved in making decisions in long-term care (Glendinning, 2008) countries were generally much slower to implement measures to support users in their choices, such as introducing directories for personal assistants or support agencies.

To make or to buy? Between success and unresolved tensions

The introduction of quasi-markets in long-term care has brought positive and negative outcomes for care markets as well for users of care. It thus created new opportunities but also tensions for all stakeholders, which are encountered differently in each country.

Lesson #1: Mixed outcomes for users

As for the outcomes of care for users, there is mixed evidence on the effects of competition and choice across countries. 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 proportion of users are able to choose the identity of their carers and shape the care they receive more or less to suit their preferences, when using the cash benefit option. In all four countries users seem satisfied with choice and service quality of private providers. Nonetheless, users also complain about the lack of continuity of home care professionals – as they would prefer to build on a continuous relationship with a defined carer – and about the information made available by providers (Kremer, 2006; Rodrigues & Glendinning, 2014; Tjadens, 2008; Rostgaard, 2011; Wingenfeld et al., 2007).

As outcomes of long-term care need to be measured for the assessment of providers' compliance with quality and efficiency standards and of us-

While marketisation increased autonomy and choice for users it also led to more standardisation of care and fragmented provider markets.

ers' needs, Denmark and Germany opted to standardise care tasks. This standardisation of care took place under different headings. In Denmark it came with the introduction of the 'Common Language' and in Germany it accompanied the introduction of the LTCI and the scrupulous definition of care packages (Rostgaard, 2011; Eichler & Pfau-Effinger, 2009). This increased taylorisation of care 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 obligations with considerable consequences also for the job satisfaction of long-term care professionals (IGES, 2011). However, in recent initiatives Germany and Denmark started to take steps to roll back standardisation by offering more flexible time allotments for person-centred care.

Lesson #2: Diversification vs. market concentration

The increased competition between care providers created in all countries a diversified provider market, in particular in Denmark for home help and both in home care and residential care in Germany and England. The reforms created a mixed economy of care supply and providers were thus facing increased competition in the care market. This had positive effects on prices and resulted in a more comprehensive provision of services (Germany) (Kremer, 2006; Augurzky & Mennicken, 2011).

Concentration of providers bears opportunities for the reduction of transaction costs but also the risk of provider failure.

However, a new emerging concern is market concentration as care markets mature. This is particularly true for England where the residential care market, once characterised by small family-run facilities, has gone through a concentration process following a series of mergers that resulted in six large providers. 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 limitation in the scope for choice, to less competition and 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, regulators are facing increasing challenges, particularly 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.[2] Concentration processes have been less marked in Germany, in particular in home care, where 'for-profit

2 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.

providers' are still mainly characterised by small local enterprises with a small number of staff. Interestingly, in the Netherlands market concentration took place only in the home care market among traditional non-profit organisations (Da Roit, 2013). This process was pro-actively promoted already during the 1990s by local authorities to limit the number of providers they contract in order to lower transactions costs (i.e. commissioning, quality monitoring). A similar rationale guided public administration in Denmark, where market concentration of for-profit home help providers was a major objective of the newly introduced procurement model (2013).

A noteworthy example of using a market environment to improve care delivery and drive quality of care can be observed in the Netherlands where an originally small non-profit initiative called 'Buurtzorg' (Care in the neighbourhood) has taken over large shares of the home care market over the past seven years. Based on autonomous teams of 'community nurses' providing comprehensive home care, 'Buurtzorg' succeeded in reducing overhead costs and in increasing the efficiency of home care staff by more than 40% as against traditional home care provision – while at the same time improving quality and creating high user- and staff satisfaction (KPMG International, 2013; Huijbers, 2011).

Lesson # 3: The role of price and competition

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 came along some of these reforms (e.g. England and Germany). The backdrop and sometimes unstated aim of introducing competition and choice was to bring down costs. Prices thus became important instruments of public purchasers for stimulating competition between providers (e.g. England and home help sector in Denmark) and for setting caps in the tendering process (e.g. Netherlands).

Tendering and price-setting stimulate competition but also create pressure on the care workforce.

However, budgetary constraints may have had a particularly important impact on the workforce by contributing to difficulties in retaining staff and ensuring continuity of care (Stolata, 2010; Baxter, Wilberforce & Glendinning, 2010) – with potential detrimental effects on quality of care as well as caring relationships. The Netherlands is a case in point as home care agencies were seriously affected by cost containment measures. These have led to the reduction of hourly wages for care workers and a replacement of staff by home helpers (Da Roit, 2013). However, dissatis-

faction with decreasing wages and taylorised care organisation was also a trigger for the development of some very successful alternative arrangements of care provision, i.e. the above-mentioned 'Buurtzorg' initiative in the Netherlands (Huijbers, 2011).

Lesson # 4: The agony of choice

With the introduction of competition and choice users gained autonomy and as a result care services have become more transparent for older people and their relatives (Burau & Dahl, 2013). Users in all four countries are generally satisfied with the increased range of different service types and suppliers (i.e. cleaning, home help, social activities etc.)(Kremer, 2006; Rostgaard, 2011; Wingenfeld et al., 2007).

Competition and choice lead to more transparency and variety of care service for users who are however overwhelmed with complex decisions.

At the same time they seem to be overwhelmed by having to make decisions regarding the type of service and the choice of provider (Bertelsen & Rostgaard, 2013). To assist beneficiaries and their relatives in organising tailored care arrangements and in choosing appropriate care providers several local initiatives have been set up in the last years that try to provide care management and counselling services (Glendinning & Moran, 2009). For example, in 2008 the German government allocated additional funding for new community care centres ('Pflegestützpunkte') that provide case and care management by assisting older people to set up local care support networks with adequate providers and care services. More local and individual support by agencies and adapted information sources might be needed to guide users through increasingly diversified provider markets. In parallel, public reporting systems were introduced in Germany, the Netherlands and England between 2005 and 2010 (in England the system was later discontinued) with the objectives to support users in their choices of both home and residential care providers as well as to allow providers to improve their performance by benchmarking. However, users seem hardly to be aware of these quality indicator systems which thus have limited impact on the choices made (Rodrigues, Trigg, Schmidt & Leichsenring, 2014).

Lesson # 5: What about transaction costs?

Mechanisms to regulate markets (e.g. definition of contracts, quality measurement) involve important transaction costs.

The access of new types of providers to quasi-markets in long-term care has been accompanied by the introduction of more defined quality assurance mechanisms, not least to avoid market failure and assist in the contractualisation of care. This side-effect of marketisation led to the elaboration of quality assurance systems to assess and monitor compliance with defined quality standards and to compare the level of services

offered by different providers. This in turn triggered the introduction of quality management systems at the level of providers, facing management and staff with new and additional documentation tasks that are often perceived as bureaucratic and burdensome. While improved quality management facilitates better comparability for purchasers and users (and their families) that are interested to know what type of services and what level of quality they can expect from different providers, these systems also generate costs for regulation agencies, training of staff, working time and inspections or certification audits. At the same time quality measurement and management may also lead to more standardisation of care tasks as mentioned above. It should however be underlined that the introduction of quality management in long-term care is not a mere consequence of marketisation but is also linked to the general professionalisation of the sector (see also Part III of this trilogy: *'Quality Assurance as a Precondition for Purchasing Long-term Care'*, forthcoming). Other transaction costs that come along with the 'external production' of long-term care services are not easily measurable as the specific assets that are used in the production of services (e.g. knowledge on user's preferences) are often low contestable outputs (see also Part I of this trilogy: *'Learning from Theory'*).

Conclusions

It has become evident that decisions whether to make or buy long-term case as well as 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 any given country. Market developments and outcomes of competition in the home care sector, as well as the scope for user choice vary across countries given different decisions and preferences of purchasers (e.g. municipalities) and users. This review of the countries' experiences has shown that 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. While searching for adequate solutions policy-makers and stakeholders are in an ongoing process to balance the above-described tensions of market mechanisms and adequate quality of long-term care provision. Denmark is a case in point as it is part of a larger public discussion and research initiative to integrate market-based solutions in public welfare provision by ensuring equitable, sustainable and continuously improving quality of care provision. In that sense, competition between different types of providers and 'hybridisation' of provider organisations may be important tools for regulating quasi-markets and to alleviate the pure juxtaposition of 'private vs. public' towards a revival of the debate on the mixed economy of care. However, users need to be at the core of these

developments playing a decisive role in the definition of quality of care as well as in the scope of choice they want to be provided. Identifying feasible solutions to integrate users' voice and preferences will remain a major challenge in the coming years.

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European Centre
for Social Welfare
Policy and Research

Berggasse 17
A – 1090 Vienna

Tel: +43 / 1 / 319 45 05 - 0
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