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To Make or to Buy Long-term Care III: Quality Assurance to Avoid Market-failure

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Introduction: Marketisation and the regulation of care markets

With the implementation of New Public Management (NPM), market-oriented governance, deregulation, competition and strengthened user-choice eventually reached also the area of long-term care provision during the 1990s. In contrast to the classical neo-liberal postulations towards deregulation, however, both theoretical considerations and the emerging practice across Europe have shown the imminent necessity to increase efforts in quality assurance in the context of competitive markets in long-term care. To identify non-compliant behaviour of competitors, to ascertain value for money and enforce contracts, and to create fair conditions for all stakeholders are necessary preconditions for avoiding 'market-failure'.

This Policy Brief is the third 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. It draws on the Report ' "Make or Buy" – Long-term Care Services in Sweden: Lessons for Policy', edited by the European Centre, which is a result of research generously funded under a grant from the Swedish Ministry of Health and Social Affairs (Rodrigues, Leichsenring & Winkelmann, 2014).

This third part will focus on experiences in a number of European countries on existing practices of quality assurance in long-term care delivery to provide policy lessons on the 'make or buy' decision and its impact on outcomes for users and the organisation of care markets. Before doing so, the caveats of defining and assessing quality in long-term care and their implications for 'make-or-buy' decisions will be addressed. Following these considerations, current trends and challenges in quality assurance and quality development will be described.

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Different perceptions of quality in long-term care

Quality in long-term care is driven by vested interests of different stakeholders.

Mainstream quality management approaches define quality as the "degree to which a set of inherent characteristics fulfils requirements (…) [expressed] in the content of a document conveying criteria to be fulfilled if compliance with the document is to be claimed and from which no deviation is permitted" (www.iso.org; see also ISO, 2012; ISO, 2010), in simple words, as the 'decent delivery of a mutually agreed product or service' (see also Nies, van der Veen & Leichsenring, 2013). Long-term care delivery is characterised by a complex mixture of stakeholders with specific types of vested interests which in turn results in a variety of interests in defining the 'decency' of services and facilities:

- Users (and their families) who are usually contributing important parts of their income to purchase services want to have their voices heard in mutual agreements over who provides which services, at what time, and following which approach to satisfy individual needs and to experience quality of life.
- Public purchasers (regulators) are concerned to know what they pay for, in particular with rising constraints on public expenditures, and try to mediate between costs and regulation of quality requirements that are perceived as 'decent' by all stakeholders involved.
- Provider organisations will be interested in improving their bargaining position in relation to purchasers and to keep costs low, e.g. by avoiding additional bureaucratic requirements. However, they might also be interested in their performance against their competitors, to improve user and staff satisfaction or to optimise their processes.
- Finally, professionals might want to choose their workplace according to performance indicators of their employer and to get involved in measures to improve the quality of care, depending on their professional background and the specific care setting they are working in.

From structural aspects to outcome-oriented indicators.

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 from regulation of structural aspects of residential care (size of rooms, staffing levels etc.) and process-oriented standards (updated care-planning, safety measures, care standards etc.), both for home care and residential facilities, towards more 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).

Persisting challenges to measure quality in long-term care

In a competitive market regulators have to avoid moral hazard, cream-skimming and unequal competition.

Ongoing research, regulatory practice and political debates are nevertheless still struggling to overcome the persisting caveats to define and measure quality of outcomes in long-term care based on evidence concerning users' satisfaction, quality of life and functional capacity. 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 many variables and dimensions. If regulators strive to avoid moral hazard, cream-skimming or unequal competition among providers in a competitive market, the following aspects must be given particular attention:

- **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 these 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 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. An even more difficult area concerns informal care by family members and/or privately hired personal assistants with issues relating to privacy and missing transparency due to a lack of linkages with formal care provision.

The development of quality assurance in long-term care

A common interest to make quality of long-term care more measurable.

A first step towards quality assurance in the formal care sector consisted generally in implementing legal minimum standards and to construct instruments, methods and frameworks to better define individual care needs. This was followed by identifying 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 a few cases, also criteria for risk- and case-mix adjustment were developed, though they remained only seldom implemented. 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 1 showcases such instruments and mechanisms regarding their scope and focus in selected EU Member States (England, Germany, The Netherlands, Sweden). 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).

Important efforts have been undertaken across Europe 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. For instance, the assessment of needs and outcomes of care at the individual level has been improved by the 'Residential Assessment Instrument' (MDS-RAI; Carpenter & Hirdes, 2013), which has been implemented in the United States, but selectively also in other countries such as Finland or by individual providers in Germany, Austria and Belgium, and the more recent 'Adult Social Care Outcomes Toolkit' in England (ASCOT; Netten & Forder, 2010). The latter is a 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. Different countries have developed regulatory frameworks defining various performance indicators such as the 'Transparency criteria' in Germany (Büscher, 2010) or the so-called Quality Framework for Responsible Care (QFRC) in the Netherlands. In England, regulatory frameworks have been reformed several times over the past decade, eventually resulting in the 'Essential Standards for Quality and Safety' (CQC indicators) that are grouped into six so-called key areas in which defined 'outcomes' have to be verified with an ample range of ways to show compliance (Care Quality Commission, 2010). 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).

It would go beyond the scope of this Policy Brief to describe and analyse even only the most prevalent and long-term care-focused assessment tools and frameworks (see for a more extended analysis: Rodrigues, Leichsenring & Winkelmann, 2014: 67-86). It should have become manifest, however, that valuable methods have been put in place to drive further development, which will have to be underpinned by related regulatory policies.

Overview 1: 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, NFRC and CQI (NL), CQC Indicators (England)	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, England, NL, SE)	

Source:

Authors' compilation.

Quality assurance in long-term care has for a long time been based on professional ethics, trust and inspection by public authorities. This approach changed radically with the introduction of market-oriented regulation (competitive tendering, out-sourcing, privatisation, new commercial providers), for 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' in the process of competitive tendering, to set prices and define funding mechanisms – and to prevent 'market failure'. Therefore minimum standards had to be defined to regulate access to the market and to participate, for instance, in public tenders (authorisation, accreditation and licensure as quality assurance ex ante). This 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 (see Box 1). Furthermore, 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.

Apart from these influences, also the general professionalisation of the long-term care sector included a move towards quality management not only due to new legal regulations requiring it, but sometimes also to an intrinsic interest of providers to ensure safety or to signal quality in order to gain market shares *vis-à-vis* powerful incumbent competitors. Generic quality management (QM) systems such as ISO 9000ff. (International Organisation for Standardisation) or EFQM (European Foundation for Quality Management) were implemented in the first place, but this was followed by the elaboration of more appropriate systems for the long-term care sector, e.g. particular quality marks for care homes or provider-specific QM systems.

Investment in quality management is a necessary precondition for quality assurance.

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, because 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), the Health Inspectorate in the Netherlands 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, often linked to the publication of results in the public domain. Public reporting of defined performance indicators has become mandatory in the Netherlands (www.kiesbeter.nl), in Germany (www.pflegelotse.de) and the UK (until 2010) as well as in Sweden, where a set of over 70 quality registries and the Äldreguiden-website (http://www.socialstyrelsen.se/jamfor/aldreguiden/jamfor) serve this purpose (Du Moulin et al., 2010; Rodrigues, Trigg, Schmidt & Leichsenring, 2014). However, despite the emphasis placed on the user as the consumer of care, the introduction of public reporting mechanisms lagged considerably in the general process of marketisation that has taken place across Europe.

Box 1:
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 over the past two decades. It has been argued that quality measurement systems make residential care a good test case for examining differences in care quality across different types of providers (Amirkhanyan, Kim & Lambright, 2008).

During the project ' "Make or Buy" – Long-term Care Services in Sweden: Lessons for Policy', a systematic literature review has been undertaken to address issues concerning the impact of nursing home ownership on quality of care. 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 78 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 confirmed the relatively mixed and inconclusive findings of previous studies (Comondore et al., 2009; Xu, Kane & Shamliyan, 2013) as differences between care homes by ownership type depended heavily on the choice of indicators to define 'quality of care'. For

instance, non-profit and public care homes tend to deliver higher quality of care with respect to use of restraint (Castle & Engberg, 2005), reported numbers of deficiencies (Banaszak-Holl et al., 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 disparities in the management of care homes according to ownership, namely regarding the management of human resources that are an important factor in care homes' cost structure.

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 is 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.

Many stakeholders have realised that indicators and so-called 'outcomes' may serve as a proxy for measuring quality, but internal quality management is an important precondition for such measures and their transformation in tangible progress – based on further training, time and space for reflecting on potential improvement and the implementation of respective endeavours as promoted by the E-Qalin quality management system (Leichsenring, 2011).

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 initiatives are important contributions to further specify the vision of long-term care as a sector with genuine quality criteria that strengthen users' rights for dignity and quality of life.

Conclusions

While quality assurance and quality management in long-term care are only just emerging, the search for relevant indicators to operationalise quality in long-term care is still an ongoing process (see also Nies et al., 2013). Within competitive markets 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 anticipated from the fact that control and inspection are increasingly replaced by self-regulation and quality management based on self-assessment and third-party certification. 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, the same is true for international standards, patents, safety regulations and quality certification in ship-building, aviation or in general manufacturing industries, where no one would question the necessity of related expenditures. In a sector that contributes with up to 4% 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 are not only an add-on activity but at the heart of any service in long-term care. 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. For strengthening these aspects it could be useful to define a threshold of, for instance, 1% of the sector's yearly turnover that should be dedicated to 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 future of quality development in long-term care should provide policy-makers and public administrations with a broader evidence-base to better underpin 'make or buy' decisions. Such evidence must reflect outcomes produced by inter-organisational and multi-professional cooperation across health and social care sectors, rather than focusing on individual (clinical) indicators only. Further research will be needed to further develop quality measurement and quality assurance based on outcome indicators, and to investigate on guiding principles and the feasibility of such efforts:

Further research needs to elaborate on the evidence-base for outcome indicators.

- **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. Improvements in quality assurance and measurement would make quality 'easier' to observe and could therefore enhance competition on quality rather than price. 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.

Establish an independent agency for quality in long-term care.

- **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.

Incorporate quality assurance into commissioning integrated care.

- **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 will remain an ongoing challenge calling for

Involve users and carers in quality assurance.

external, proactive support strategies both during access procedures (information and counselling) and for the involvement in quality assessment and feedback.

- **Incentives for quality development**: 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 the correlation between the financial situation of an organisation and its performance is not always straightforward. 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.

Joint training, rather than financial incentives or penalties.

Further reading

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All governments of States that are members of the United Nations, in particular those of countries of the UN-European Region, are invited to participate in and contribute to the activities of the European Centre. This results in a geographical domain of potential Member Countries of more than 50 European nations as well as the United States of America, Canada and Israel.