Nine European trends in quality management of long-term care for older people

In the INTERLINKS study long-term care in 10 European countries was studied and many experts were interviewd. Through INTERLINKS 9 trends were identified in quality improvement in the long-term care sector.

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Long-term care (LTC) for older people has existed in many forms for some time, but in recent years it has begun to receive more attention. LTC can be positioned between health care and social care, and involves both formal and informal care. In some countries (such as the Netherlands and Germany) it has a specific legislative and financial basis, in other countries it is funded and provided by different services and systems. Countries differ to the degree in which this type of care is a public or a private responsibility and in the extent to which care is provided by public, or private non-profit, or by commercial providers (Leichsenring et al., 2012). As regards quality management in LTC, the various systems that have been implemented have often been derived from quality systems in the health care sector. Currently, there are various attempts to enhance the importance of social care characteristics (e.g. by defining desirable outcomes in terms of quality of life) rather than only medical quality-of-care and disease-oriented health outcomes.

Appropriate concepts for improving quality in LTC should strengthen values such as independence, autonomy, participation, personal fulfilment and human dignity (WHO, 2000) and promote a holistic view. However, there is still a long way to go to implement such concepts, and to the acknowledgement of the respective responsibilities at all governance levels and across the various organisations responsible for assessment, planning, delivery and monitoring.

Context and methods

A landmark recent study was the INTERLINKS project (2008-2011), funded by the European Commission, to develop a framework for LTC for older people in Europe. Apart from in-depth explorations of the role of informal care, prevention and rehabilitation, it also included a study about the mechanisms by which the stakeholders in ten European countries are managing and assuring quality in LTC. For this purpose, ten national reports, backed up by a wide range of national experts, provided information that was compiled in a draft European overview and presented to a group of representatives of various stakeholders at European level (http://interlinks.euro.centre.org). Based on these data and feedback, nine trends in quality management and quality

assurance were identified in the final European report (Nies et al., 2010).

The search for quality and its transparency

Firstly, it appeared that quality management in LTC is only just emerging, even in countries with a relatively long history in LTC (e.g. The Netherlands). Qualifications, processes and outcomes are much less standardised, compared to those in acute care. The same applies to the concreteness of criteria. However, LTC is strongly influenced by elements of acute care, e.g. in assessing needs. Moreover, the eligibility criteria that are used are often only determined by physical indicators, rather than considering also behavioural and social problems. For instance, the German long-term care insurance system (Pflegeversicherung) has only been reformed in 2008 to cover care for people with dementia but without physical care needs.
The assessment of social care quality elements is, in most cases, operationalised by user satisfaction surveys – wich lead to a number of methodological issues. In some countries such ratings are published on websites, in care guides or in newspapers (England, Finland, Germany, The Netherlands, Sweden), while they still remain confidential in others (Austria, France, Spain).

Secondly, there is a general trend towards more transparency of LTC organisations' performance. Transparency in current systems usually focuses on characteristics of the services (e.g. size of the rooms, buildings, qualifications and number of staff, safety measures), on the process of care delivery (e.g. use of care plans, timeliness of delivery, protocols, safety measures, social activities) and increasingly also on rights and experiences of clients (e.g. user involvement, informed consent, choice, satisfaction with service delivery). These criteria are traditionally monitored by inspections, but an increasing number of care providers are also using them in the framework of certified quality management systems.
Quality indicators are collected to serve different objectives for various stakeholders. For instance, they may support users in choosing a service or inform citizens on what is being provided; they may inform commissioners (public authorities) and insurers about the quality they pay for (public accountability); they serve to help inspectorates identify potential risks and certifying third parties to decide whether defined quality standards have been met. Moreover, transparency is required to provide data for internal quality management and improvement, as care professionals and their managers want to know how they are performing, perhaps also to compare their performance with other providers.
These diverse objectives are not always compatible. In particular if negative results have negative economic consequences for the organisation, providers may be reluctant to provide valid figures. The issue of transparency thus remains partly unresolved, because of the wish to combine different objectives in one system – but this might undermine the original aims of quality management approaches. Transparency is, ideally, a multi-layer concept to be operationalised at various levels of governance. For instance in England, existing (and future) quality indicators are used on a national level by the Care Quality Commission for evaluating service performance, by the services to evalu-ate their own performance, and by the service users to help make informed choices for care (Holdsworth and Billings, 2009, and CQC web site).

From control and inspection to self-regulation

A third quality trend identified in the INTERLINKS LTC study relates to the balance between legal minimum standards and ideal care. While legal mechanisms of quality assurance have focussed on minimum standards of quality, current policies tend to motivate organisations to work towards excellence or 'optimum care', which is exemplified by school ratings (Germany), star-rankings or bronze-yellow-gold rankings (England, The Netherlands). In spite of meth-

Samenvatting

Tijdens een Europees onderzoeksproject (INTERLINKS) zijn landenstudies gedaan en een aantal deskundigen geïnterviewd die negen Europese trends signaleerden in het kwaliteitsmanagement bij langdurige zorg voor ouderen.
Deze trends zijn:

1. Pas zeer recent zijn proces- en uitkomstmaten voor kwaliteitsmanagement bij langdurige zorg voor ouderen opgesteld, waarbij ook wordt gelet op gedrag en sociale componenten.
2. Deze maten worden in toenemende mate extern gepubliceerd.
3. Tegenwoordig gebruiken instellingen steeds vaker indicatoren in hun streven naar excellente zorg, in plaats van alleen te voldoen aan minimum vereisten.
4. Systemen ontwikkelen zich van controle en inspectie naar gebruik bij kwaliteitsmanagement.
5. Systemen schuiven op van structuur- en procesindicatoren naar uitkomstindicatoren.
6. Er is nog steeds een zoektocht gaande naar relevante indicatoren en instrumenten.
7. De langdurige zorg in veel landen is bezig met een professionaliseringsslag door het toenemende gebruik van richtlijnen en standaardisatie.
8. Er bestaat zorg over de bureaucratische last die kwaliteitsmanagement met zich meebrengt.
9. Er is behoefte aan kwaliteitsbeleid over individuele organisaties heen.

odological shortfalls, such rankings are publicly reported on specific websites or in the media (France, the Netherlands).
Related to this is the fourth trend, i.e. that systems are moving from control and inspection by public administration towards quality management, self-assessment and third party certification (Austria, France, Italy, Switzerland, The Netherlands). This is often linked with more autonomy for service providers to choose their own quality management system. Where public funding and state regulation are dominant, inspection and sanctions are the main mechanisms of quality assurance. Where market-oriented governance mechanisms are introduced, accreditation (ex ante) and certification (ex post), but increasingly also self-regulation, are more appropriate mechanisms.
Quality criteria and indicators are often used as a prerequisite for public funding and for legitimising the operation of services. However, the underlying principle of strengthening users' choice and competition may not always be an adequate incentive to develop quality across the 'chain of care' because competitors are unlikely to cooperate across organisational boundaries. As a remedy, and to enhance links between various services, some countries have introduced protocols and expert standards for care pathways which, in turn, implies standardisation of processes that may run counter to clients' individual preferences.

Measuring quality

A fifth trend is towards person- and outcome-quality measures, compared to traditional approaches that focused on structural or process indicators (England, Germany, Finland, France, The Netherlands). It is increasingly understood, that neither external inspection nor self-assessment necessarily lead to better outcomes, if they are merely focussing on the size of rooms, the number of staff or defined procedures flowcharts. The debates about outcome indicators and pay-for-performance systems address these shortcomings. Unfortunately, effective ways to appropriately define outcomes in LTC that go beyond current quality of care indicators have yet to be found.
The sixth trend is thus a search for relevant indicators to operationalise quality in LTC (European Centre, 2010). As data collection and the development of methodologies are becoming more sophisticated, the development of instruments and quality indicators is becoming more centralised (Austria, Slovenia, Spain). In the medium term, this could facilitate intra-national service comparisons, and this appears to be particularly relevant in countries where policies and citizens are calling for equal access and equal quality (Austria, Italy, Slovenia, Spain, Switzerland).

Implementing quality measures

Compared to the health care sector, guidelines for professionals in LTC are underdeveloped. Evidence-based practice appears to be of less concern, because evidence as such remains poorly developed. The seventh trend observed is hence that many countries are striving to further professionalise the LTC sector in terms of working with guidelines, protocols and expert standards (France, Sweden, Germany) – with concurrent debates about the appropriate depth of standardisation to be achieved in LTC.
In various countries, the eighth trend to be observed consists in the rising concern about the effectiveness and efficiency of quality management as such (England, France, Italy, the Netherlands) – or whether its primary result is only new bureaucracy and higher costs for service providers. Quality management does require considerable paper work, the way it currently is organised: for example, writing reviews, carrying out surveys, training staff, recording outcomes and describing processes. It is argued that too much time and money are invested in such procedures, rather than on time spent with clients. It is possible that, if the quality work involves all stakeholders as a part of daily routines, it may combine cost-containment and enhanced quality of life. However, the evidence of the positive impact of quality systems and the business case of quality management in LTC is still very limited.

This leads to the ninth trend, which might become an issue of specific concern in the future of LTC. To date, quality management systems are directed towards individual organisations, rather than focusing on links with other relevant stakeholders. Especially in LTC such links can help to develop quality assurance for frail older people suffering from multiple problems and requiring multidisciplinary and inter-organisational interventions. First steps in this direction are some examples of care pathways, multi-professional teamwork and quality management at local and regional level. Across Europe these can be found in end of life care (palliative care), stroke services and dementia care (Austria, France, England, Italy, the Netherlands, Sweden) and the 'traditional' disease management target groups, such as COPD, diabetes and cardiovascular diseases. Moreover, in some countries cohesion of services at local or regional level is monitored. For instance, the Comprehensive Area Assessment in England combines information from the service assessment and an area assessment. The CAA is important for ensuring that services work in partnership to meet the needs of the service user at a local level. National indicators are to be adapted by local areas to create their own indicators that meet the needs of the local population. Provision by multiple services can be used to meet a requirement. The CAA assesses how well care is integrated in an area, although this is presented more as a framework for services rather than as indicators of quality (Holdsworth and Billings, 2009). Notwithstanding some good examples, further development of inter-organisational quality management, for example through incentives such as joint funding mechanisms, are needed as well as generally agreed indicators of quality outcomes in LTC across services.

Conclusion

Quality management and quality assurance in LTC are at an early stage of development, but the quality of LTC is of increasing concern in all countries. As a response to this concern, improvement infrastructures, institutions and programmes have been developed in countries like the United Kingdom, France, Sweden and the Netherlands. One of the largest-scale improvement programs in LTC has been the Care for Better programs in the Netherlands. From 2005 to 2011 nearly 900 teams in some 700 organisations systematically worked on improvement. The results were impressive with quality gains of 30 to 50 per cent for individual indicators such as pressure sores, medication errors, use of restraints and behavioural problems (Minkman et al., 2011). This relatively cost-effective methodology could be transferred and scaled up to other settings to enable cross-national benefits.

Although systems differ across Europe, even more than in acute care, many debates about quality in LTC are similar in different countries. The blending of health and social systems and the linkage of professional and informal care call for enhanced synergy of quality systems across organisations. European policies are increasingly acknowledging this need, but intensified efforts are required to increase quality with diminishing financial and human resources and to examine which quality improvements might also reduce waste and costs.

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