6 How have countries worked to improve the quality of long-term care?

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6.1 Introduction

Securing high-quality long-term care is an important goal for all countries (OECD/European Commission, 2013). In this chapter we review the different ways countries are seeking to improve the quality of long-term care for older people, and the impact of these strategies on quality. Since long-term care is a relatively new element of welfare systems, the evidence base regarding how to improve quality is fairly limited. The scant data for most countries about the quality of long-term care makes it difficult to assess the impact of strategies and compare countries (OECD/European Commission, 2013; Cès & Coster, 2019). Consequently, in this chapter we provide an overview of different approaches for improving quality, drawing on evidence, where available, to understand the impact of these strategies on the quality of long-term care.

Although we present the strategies as options for improving quality, it is important to reflect on the extent to which these strategies would be feasible and valuable in different countries given differences in both the maturity and organisation of long-term care systems. In many Eastern European and middle-income countries, long-term care systems are more emergent, with lower levels of public expenditure and a more limited range of services on offer (Spasova et al., 2018). As interventions to assure and improve quality tend to lag the development of new forms of provision, the maturity of the long-term care system is an important factor determining existing strategies and the direction countries might take to improve the quality of long-term care. Additionally, while most countries rely on 'quasi-markets' for care delivery, they vary considerably in terms of purchasers, rules around providers and the availability of funding (Colombo et al., 2011; Rodrigues et al., 2014), as discussed in chapter 5 of this volume. The range of services and professions involved in the delivery of long-term

care varies, as does its governance, with services split across policy domains (e.g., in the United Kingdom long-term care is split across social services and the NHS) or designated as a new 'pillar' of social insurance (e.g., Germany). These differences in the organisation of systems affect what might be considered the most important targets for intervention to improve quality, the range of options countries can pursue and how quality is conceptualised.

This chapter is structured as follows. The next section discusses how quality of long-term care is conceptualised. The following section provides an overview of strategies to assure and improve the quality of long-term care, looking at the three levels where quality strategies might impact, that is, the individual, the care provider organisation and the care system. We provide an overview and review of the evidence on strategies available at each level.

In each case, we discuss both the promise and the limitations of the described strategies, before summarising and offering reflections for policy makers in the conclusion.

6.2 Conceptualising quality

Before reviewing strategies to assure and improve quality, it is helpful to define what we mean by quality in this context and explore how it can be, and is, measured, since many strategies depend on being able to monitor and measure quality.

Many competing conceptualisations of long-term care quality feature in the literature. A popular approach is to identify dimensions that are most relevant to care. The OECD's (2013) report, *A Good Life in Old Age,* provides a leading example of this approach. Through a review of national assessment frameworks for long-term care in OECD countries they derive four dimensions of quality: care effectiveness; user safety; person-centredness, responsiveness and empowerment; and care coordination and integration. Donabedian's (1980, 1988) work provides another approach. He defines care quality as having three components: the outcome, which captures the end results of care; process, which relates to care delivery and captures what is done in providing care; and structure, which refers to relatively stable physical and organisational characteristics of care. Although originally developed for medical care, Donabedian's approach has been influential in the long-term care context for developing quality measures and

as a way of structuring assessments of quality in national frameworks (see e.g., Castle & Ferguson, 2010; Milte et al., 2019; Igarashi et al., 2020; Everink et al., 2021).

The relative importance of the different dimensions and components of long-term care quality, how they are understood in practice and developed into indicators of quality varies between countries, depending on aspects such as the organisation of the long-term care system, the professional base and its values, and the type of care being delivered. For example, in countries where the nursing profession has a strong influence over delivery, as in Germany and the United States, historically there has been more emphasis on assessing care effectiveness through 'clinical' outcome measures (e.g., weight loss, pressure sores, dehydration) than on wellbeing and quality of life measures. By contrast, in England where the social work profession has more sway, 'social' outcomes like wellbeing and quality of life have been seen as critical measures for assessing care effectiveness for many years (Kane, 2001; Malley & Fernández, 2010). Another important difference is the greater availability of structural indicators of quality for long-term care services that have a physical building like nursing homes, compared to services like home care that involve a care worker visiting people in their homes to support them with daily activities. (Further examples of quality indicators used by countries and their relationships to the concepts in these frameworks are given in Box 6.1.) The way in which the context and type of care affects how dimensions and components are interpreted is a reason why it is difficult to compare the quality of different forms of services and support and to compare the quality of long-term care between countries.

Both Donabedian's and the dimensions approach are valuable ways of conceptualising quality for the purpose of measurement and assessment. In our view, however, they are less useful for structuring thinking about strategies for improving the quality of long-term care – the focus of this chapter. In previous work (see Malley et al., 2015), we categorised strategies by their aim and how they influence the behaviour of actors in the system. Here we use the intended level or object of quality improvement strategies (i.e. individual, organisational and system level) to categorise the strategies, as we are able to show the links to areas of policy debate more clearly (see Nies et al., 2010). This is not to disregard the conceptual frameworks mentioned nor the importance of developing good ways of measuring and assessing quality and better

Box 6.1. Examples of quality frameworks and indicators

InterRAI (Resident Assessment Instrument)

Used worldwide (e.g., Japan, Israel, Germany, Finland, Sweden; the United States includes the minimum data set) and has been adjusted for different services including residential care and home care. The instrument includes among others social outcomes indicators such as distress and loneliness, clinical indicators including falls and pain management, and functional indicators related to communication and cognition.

Consumer Quality Index Long-term Care

The index was developed and is used in the Netherlands. The index includes process indicators such as meals and reliability of caregivers, users' involvement in care planning, and outcomes indicators including mental and physical wellbeing and the users' sense of autonomy.

Elderly Guide

The guide is used in Sweden and the data collected are made publicly available on a dedicated website. It is focused on process measures such as users having a dedicated contact person, and outcome measures reported as users' perspectives on services including overall satisfaction with the service, and users' influence over the care they receive.

The Adult Social Care Outcomes Framework (ASCOF)

Used in England. Includes largely outcomes indicators, such as average social care-related quality of life (SCRQoL) which is measured using the ASCOT instrument (Netten et al., 2012). The ASCOT measure is constructed using responses to survey questions covering the eight domains: control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation.

data. Indeed, we see this as a critical issue for improving quality, since good measurement of quality underpins the implementation and evaluation of all quality improvement efforts. The challenges of quality measurement and assessment are beyond the scope of this chapter

and we refer readers to Malley et al. (2015) and Malley & Fernández (2010) for a discussion of the issues.

6.3 Delivering high-quality long-term care for older people

Our overview of strategies to assure and improve the quality of long-term care is structured around the three levels at which quality strategies might impact, that is, the individual, the care provider organisation and the care system. For each strategy, we outline how it is intended to either assure or improve the quality of long-term care, experiences with its implementation and the evidence for its effectiveness, and we identify some of the countries where it is being employed. The list of strategies outlined in this chapter is not exhaustive. In selecting strategies, we have concentrated on what we consider to be those most frequently employed by high-income countries over the last thirty years. We focus on high-income countries because long-term care systems are most developed in these countries and therefore the accumulated experience is greater.

Individual actors: the care user and carer relationship

At the individual level, the quality of care is intrinsically tied to the relationship between the user and the carer (Malley & Fernández, 2010). Although some older people may require specialist medical care or use assistive devices to manage their daily lives, most long-term care involves a carer helping the older person with activities related to daily living. Such care is highly personal, involving intimate tasks, such as washing and dressing, over which care users are likely to have strong preferences and views. For care to be high-quality, carers need to take account of users' preferences, and carers and users need to work together to get the care tasks done. A key strategy for improving the quality of long-term care is therefore to maximise the efficiency of the care user-carer relationship. There are broadly two areas of policy debate: empowering care users, and professionalising and investing in the workforce.

Empowering care users

For many years now a narrative of empowering care users has featured heavily in international and national policy debates about improving the quality of long-term care. The argument for empowering care users

is rooted in an understanding of autonomy as critical to a person's quality of life and therefore to successful ageing (Clark, 1988). The idea of increasing the autonomy of users of long-term care services has been implemented in various ways in many countries, for example Israel, Japan, the United States, many European countries and Taiwan, China (Moilanen et al., 2021). Initiatives to empower older people have been closely associated with the consumer movement of the last century and marketisation reforms. They have frequently emerged as a reaction against paternalistic services that tend to overwhelm individual preferences and expressions of control, as captured by the concepts of 'total' institutions or 'one-size-fits-all' services. In many countries, initiatives to develop more modern services that give people greater autonomy have coalesced around the concept of 'personalisation' or 'person-centredness', which broadly require that people can direct decisions about their care and services are designed around the person (McCormack et al., 2012).

To give older people greater autonomy over their care, the most significant policy has been cash for care schemes (Lundsgaard, 2005). Under these schemes people are given cash payments in lieu of services. The rationale is that care meeting the older person's preferences can best be met through giving them the money to choose the care they want. In addition to the positive effect of this increase in autonomy on their quality of life, through exerting their choice in markets it is argued that older people will drive quality improvements in care. Although such schemes are found in many countries (e.g., the Netherlands, Germany, the United Kingdom and Taiwan, China) there is substantial variation in how cash for care schemes operate and the rules around how cash can be spent. Differences tend to reflect the reason for offering cash benefits, such as encouraging informal care provision, and range from having choice over the type of services or care provider to being able to hire and supervise care staff (personal assistants) (e.g., England) or employ family members (e.g., the Netherlands) (Zigante, 2018; da Roit & Gori, 2019).

Despite the growth of cash for care schemes internationally there is limited evidence about their impact on the quality of long-term care. In one of the few literature reviews, Low et al. (2011) found that cash for care schemes improve satisfaction with care and community service use but had little effect on care outcomes. The review includes findings from an evaluation of the Individual Budgets programme in England (a form

of cash for care), which showed that individual budgets made users feel more in control of their care but an impact on other aspects of quality of life was not identified. Given the current era of austerity, there are also concerns about how well cash for care schemes work in practice (Pearson & Ridley, 2017). Issues are reported around the level of the cash payments (da Roit & le Bihan, 2010) and this has given rise to concerns over whether they are large enough to cover the care package the older person needs (let alone wants) and equally, whether there is a workforce in the local area willing and able to take up the work. Some argue that in European countries, cash for care schemes have 'de facto converted into policies supporting either informal care, low-paid market care, or both' (da Roit & Gori, 2019: 518), with consequences for quality (see discussion around professionalisation below).

Cash for care schemes focus largely on giving older people greater choice over their care, but empowering older people is not simply about offering them choice (Kane & Kane, 2001). For older people to be empowered with respect to long-term care, there is a need to address wider structures within society and long-term care systems that influence how older people are seen and treated, especially around attitudes towards safety and protection that can unnecessarily limit what people can do, with impacts on their quality of life (Kane & Kane, 2001; Clarke, 2007). There is also a need for a more nuanced debate around how autonomy can be realised in practice. Research illustrates that many older people can be reluctant to take control of decisions about their care (Baxter et al., 2013; Ottmann et al., 2013). Greater attention needs to be given to how older people can be enabled to strike a balance between being independent and receiving support as they age, including enabling them to make informed choices. Public reporting of quality information, discussed later in this chapter, is an important aspect of this.

Professionalisation of care work and investment into the workforce

For many countries, professionalising the workforce is a key strategy for improving the quality of long-term care. With respect to improving quality, the aim of professionalisation is to ensure that workers have the right skills, experience and up-to-date knowledge to deliver high-quality and safe care. Professionalisation includes a number of strategies such as: registration and regulation of the workforce; education, training and continuing professional development; and improving pay, progression and working terms and conditions

(OECD, 2020; Hemmings et al., 2022). Countries take different approaches to professionalisation, mixing strategies within these three broad areas, but much of the evidence examines the effects of professionalisation on recruitment and retention of workers as opposed to long-term care quality. This is because these strategies are also, even if not primarily, motivated by attracting and retaining workers to address the challenges almost all countries face of finding enough care workers to meet the demand from an ageing population (OECD, 2020), as discussed in chapter 2 of this volume.

Educational and training requirements for long-term care workers are generally low across OECD countries, and in many countries no qualification is required to become a care worker (OECD, 2020). It is increasingly recognised that this is problematic: as older people are living longer with multiple long-term conditions their needs have become increasingly complex and care work is becoming an increasingly skilled job. This makes upskilling through training and continuing professional development more important for quality. Countries have tried different approaches including mandatory training requirements, granting workers rights to training, integrating training with the health sector through placement rotations and training in health interventions, and training targeted at underrepresented groups, such as men and younger people (OECD, 2020; Hemmings et al., 2022). While there is not evidence for the impact of all of these approaches, the evidence does show that quality of care is influenced by the skills and expertise of staff as well as the environment and culture in care facilities (Haunch et al., 2021), and that quality, as measured by clinical outcomes such as pressure ulcers and urinary tract infections, is better in nursing homes with higher levels of more qualified staff (Clemens et al., 2021). Indeed, Clemens et al. (2021) argue their review suggests that as the complexity of older people's needs increases, replacing more qualified staff with less qualified staff risks negatively affecting the quality of care.

Too strong a focus on professionalisation of the workforce also poses risks with respect to quality. A highly professionalised workforce is likely to be a more expensive workforce. Long-term care is already seen as unaffordable by many and governments have not shown a willingness to spend proportionately more public money on funding long-term care. Without sufficient funding and with strict enforcement

of professional staffing requirements, there is a danger that workloads increase or more expensive workers, such as nurses, may be displaced by less expensive or unqualified workers, undermining the goal of professionalisation. Therefore, any steps to professionalise the workforce need to be planned carefully so as not to adversely affect retention or increase the unqualified workforce (Hemmings et al., 2022). However, as discussed in chapter 8, improvements in workforce training, and consequently in the quality of the long-term care provided, can boost economic growth as it can induce family caregivers to remain in jobs and/or choose more productive careers, because those they provide care to will instead receive care from trained aides.

The unqualified workforce is already significant in most countries given the heavy reliance on what is known as informal, or unpaid, care (provided by family members, neighbours and friends) (OECD, 2020). Given the importance of informal carers to long-term care, it is argued that governments should also aim to enhance the quality of care they provide (Schneider et al., 2015). Some countries, including Sweden, Germany, the Netherlands, Spain and England, have invested in training and support schemes for informal carers to support quality, but this approach is patchy and often dependent on local provision (see Zigante, 2018 for an overview).

Arguably more problematic with respect to long-term care quality, forms of temporary contracts are common in the long-term care sector (e.g., Japan, Spain, France, United Kingdom) and undeclared employment by migrant workers is a concern (OECD, 2020). The latter is found particularly in countries with policies that support the private hire of personal assistants in the home (e.g., cash for care, substantial co-payments for home care services and an undersupply of home care services). In Western European countries with access to relatively cheap labour in Central and Eastern European countries, these workers are often migrant carers who live in private households (Schwiter et al., 2018). There is evidence of substandard care and poor working conditions among this workforce (Simmons et al., 2022). Although some countries (e.g., Austria) have taken steps to regularise these workers, the lack of oversight and regulation of this workforce in other countries (e.g., Italy) raises ongoing concerns about the quality and safety of care for older people as well as precarity of employment for the care workers (da Roit & Moreno-Fuentes, 2019).

Care organisations: the care setting and the management of care delivery

Since much care is delivered by provider organisations, strategies to improve the quality of long-term care can also focus on these organisations and the range of care they deliver. Particularly where care providers compete for older people, theory would suggest that some of the strategies for improving quality are likely to be adopted by organisations for strategic reasons, without necessitating government intervention. As we discuss in the subsequent section, however, there are many reasons why organisations will not respond in this way in competitive markets. Governments may need to intervene to influence the balance of types of care and the adoption of innovative models that offer more effective and better-quality provision. Strategies for improving the quality of care organisations deliver revolve around these concepts: ageing in place, changing the culture of congregate living, the role of technology and the management of quality.

Ageing in place

Formal care systems have traditionally been focused on residential care forms of care, such as nursing homes, but for many years there has been a drive towards 'ageing in place'. This has been defined as 'the ability of older people to live in their own homes and communities safely, autonomously, and comfortably, regardless of age, income, or functional limitations' (Low et al., 2021:1). It is argued that more personalised (i.e. better-quality) care can be provided in the older person's own home and that it can help people to maintain connections with family and friends (i.e. better outcomes) (Wiles et al., 2012; Stones & Gullifer, 2016; Low et al., 2021). The evidence suggests that older people prefer to remain in their own home and communities as they age, at least until such time as they perceive that their care needs are too great (Lehnert et al., 2019). Yet, it is very difficult to find evidence in favour of ageing in place over institutional long-term care on grounds of quality, since an unbiased comparative evaluation of these alternatives is extremely difficult.

While ageing in place is a valuable ambition for long-term care systems, it is clear that it is not a panacea. Importantly, it brings new challenges for quality. The neighbourhoods in which people live can become more hostile and challenging as people age; in particular urban environments across the world have been found to lead to exclusion

and loneliness (Judd et al., 2020; Lewis & Buffel, 2020). Ageing in place is generally considered to be cheaper than the equivalent care in an institution, but it can become more expensive (Bakx et al., 2020), especially where people have very complex needs and live in poorly designed inaccessible housing, which is unfortunately the majority of housing in many high-income countries (Smith et al., 2018; Judd et al., 2020; Mulliner et al., 2020). Indeed poorly designed housing can precipitate care needs, for example where there are many steps, or where people are no longer able to maintain their properties causing them to become hazardous (Braubach & Power, 2011). There may also be safety concerns around people being left without supervision, for example if they have dementia, or without access to support when needed, for example for toileting or when thirsty. These factors limit the potential of ageing in place for people who live alone. As we discuss later in this section, innovative solutions are emerging to manage some of these problems (e.g., technologies to support people's independence), but many of the problems identified require massive, long-term investment and major infrastructure improvements, for example building lifetime homes, renovating the housing stock and making cities and places 'dementia-friendly' and 'age-friendly'. Hence, while it may be possible to improve the balance of care in favour of home-based care, institutional forms of care seem likely to remain a part of the long-term care mix in all countries for the foreseeable future.

A further challenge to ageing in place is dissatisfaction with home care, which has been the cornerstone of most countries' strategies for ageing in place (Genet et al., 2011). Home care services typically involve visits from care workers to older people's homes to help them with ADLs such as getting up, getting dressed, washing and mealtimes. Older people report that the timing of visits is frequently unsuitable, for example being put to bed at six in the evening, and that the tasks care workers can and will do are not always those that users would like them to do, with support for socialising, odd jobs, activities and outings being frequently mentioned as lacking in the United Kingdom context (Tarricone & Tsouros, 2008; Genet et al., 2011). These concerns over home care relate to challenges in managing busy times of the day and rigid contracting practices. In recent years new forms of home care have developed, such as examples based on the Buurtzorg model of self-managing neighbourhood teams from the Netherlands, that deliver a more flexible and holistic service. The evidence suggests that these

bring increased staff satisfaction, benefits to users' wellbeing and a reduction in costs, but most studies are of low quality and it has not been easy to translate this approach to other countries with different long-term care systems (Hegedüs et al., 2022).

Changing the culture of residential care

In recent years new models of congregate living have been promoted that are designed to overcome some of the more depersonalising aspects of care homes. The culture change movement aims to make institutions more home-like and person-directed. It is particularly strong in the United States, where a network exists to promote it, and it includes a range of models, such as Green Houses and the Eden Alternative (Koren, 2010). The movement has spread to a number of countries (Brownie, 2011), and similar types of models have emerged elsewhere, such as My Home Life in the United Kingdom (Owen, 2013). In Europe, initiatives associated with the movement are sometimes referred to as the household or home model of care, reflecting the preference for specially-designed, small-scale, home-like environments where a small number of people live together (Verbeek et al., 2009; Ahmed et al., 2019). Many of these household models have been developed specifically for people with dementia, including concepts such as group homes, Cantou and more recently the Green Care Farms in the Netherlands (Verbeek et al., 2009; de Boer et al., 2017).

There are difficulties determining the impact of culture change and household models as there are many variants and what is implemented can also vary considerably (Brownie & Nancarrow, 2013; Ausserhofer et al., 2016). Despite these challenges, the evidence suggests they are generally popular with their users. A systematic review found that these programmes are associated with positive impacts on staff outcomes, improvements in the psychological status of residents, and reduced levels of agitation in residents with dementia. These benefits, however, may come at the expense of an increased risk of falls (Brownie & Nancarrow, 2013). Additionally, implementing culture change is far from straightforward, since it depends on existing homes adopting the measures. A key barrier is the cost of introducing environmental improvements. Among other challenges it can be difficult to meet quality regulations (especially around the management of health and safety) while staying true to the model (Verbeek et al., 2009; Miller

et al., 2010; Kapp, 2013; Corazzini et al., 2015). As a consequence of these challenges, although awareness and uptake of these models is growing, they remain on the periphery of provision (Miller et al., 2010).

Technology to enhance and improve care settings

Technology[1] also has a role to play in making services safer and more productive and enabling people to age in place. It has risen in prominence in recent years and particularly so during the Covid-19 pandemic, as people sought ways to keep people safe and connected while minimising face-to-face contact (Chu et al., 2021). There are numerous technologies that can help organisations to deliver better and safer long-term care and help older people to age in place, but evidence of the impacts of these solutions on the quality of care is variable and generally fairly limited (for a recent review see Zigante, 2020). There are also well-known problems with adoption and routinisation of technologies in care settings, including the need for staff training especially if their digital literacy is limited, and acceptability for staff and older people (Greenhalgh et al., 2017). There is a vast array of technologies that can support ageing in place, and we highlight as examples a few for which there is a more substantial evidence base (for reviews see Carretero, 2014, 2015; Czaja, 2016). While our focus here is on how technology can enhance quality, the role of technology in improving efficiency and access to long-term care is also discussed in chapter 4 of this volume.

'Smart home' technology is increasingly researched as a means to enhance the quality of long-term care for people ageing in place. This includes technologies that contain a degree of artificial intelligence, such as wearable devices and other sensors, communication devices or connected devices for remote control operation. Marikyan et al. (2019) identified the core functions of smart home technology as offering comfort, access to care and improving users' safety. Smart homes can provide monitoring and disease management and enable care staff to monitor health remotely and detect life threatening changes early, as well as provide medical care when necessary. Smart home applications can also support virtual medical 'visits', meaning

[1] Technology both includes software (i.e. computer programs, ICT) and hardware (devices, assistive equipment, robots) (Mosca et al., 2017).

older people do not have to make tiring and potentially difficult trips to clinics and hospitals (Czaja, 2016). There is evidence that smart homes can improve socialisation and help users overcome the feeling of isolation (Marikyan et al., 2019). There is also evidence that smart home solutions help older people carry out everyday activities, improve physical safety and social communication. Older people reported that smart homes improved their sense of security, quality of daily life and activities, and provided them with information about the care they could receive (Turjamaa et al., 2019).

Another type of technology that supports ageing in place is ICT. A systematic review found that these technologies have a positive, yet short-term, impact on social support, social connectedness and social isolation among older people living independently, although the results for loneliness were inconclusive (Chen & Schulz, 2016). Examples of ICT included in the review were the use of communication tools (landline phones, smartphones, tablet computers, email and online chat rooms or forums) and high-technology apps (Wii, television gaming systems and GeriJoy, a virtual pet companion) which consistently reported a positive effect. Although noting a dearth of rigorous research, the review concluded that older people can benefit from ICT interventions and will use them frequently after proper training (Chen & Schulz, 2016). There is also evidence that ICT can be supportive of high-quality dementia care in care homes (see Goh et al., 2017) and social interaction in care homes, although more evidence is needed (Macdonald et al., 2021).

Management of quality

A key tool for organisations to improve quality is active quality management. Quality management rose to prominence as the quality movement gained momentum, introducing and adapting techniques for quality control from manufacturing to service industries and the public sector. Quality management systems provide organisations with a framework for measuring and monitoring quality and acting on the results. The focus of quality management systems is on achieving continuous quality improvement, and in this way they are different from quality standards and accreditation, which are tools used by governments to control the behaviour of organisations and provide a minimum level of quality. There are numerous examples of systems (e.g., ISO, EFQM, E-Qalin) which have been taken up to different

extents by organisations in different countries (for reviews see Nies et al., 2010; Cès & Coster, 2019). Some quality management systems include third-party certification linked to the use of internal quality management and self-assessment of quality, resembling voluntary accreditation schemes.

Reviews suggest that quality management systems are widely used by provider organisations across countries (Nies et al., 2010; OECD/European Commission, 2013). In some countries, such as England, adoption is high because the care standards require providers to have quality management systems in place. There does seem to be a willingness among providers to adopt these systems and participate in voluntary accreditation schemes because they are seen to signal quality in a competitive market. Their adoption in countries with less competitive markets suggests that this may be as much about attracting older people as it is about attracting and retaining staff (Malley et al., 2015).

Importantly, digital technology also has a place in supporting quality management. To date it has been used more widely for surveillance, such as monitoring the timeliness and duration of visits by home care staff (Moore & Hayes, 2018). Increasingly, however, as organisations introduce digital systems for care records, medicines management and other forms of monitoring (e.g., of vital signs or sleep) the data collected can be used to support audits and spot patterns in behaviours that can be targeted for quality improvement activities (Kruse et al., 2017). At present, however, most provider organisations lack the capacity and skills to analyse the data collected and use it to full effect (Ko et al., 2018). More broadly there is relatively little evidence of care homes developing quality improvement expertise (Chadborn et al., 2021).

The care system: behaviours of actors and relationships between them

From a systems perspective quality is understood in terms of the overall functioning of the care system for older people and tends to be assessed in terms of different aspects of aggregate performance of the sector (e.g., coordination and integration of care and information pertaining to care delivery, equity of access and outcomes, targeting efficiency). Strategies for improving quality within long-term care systems focus on changing the behaviours of and relationships between different actors in the system, and usually require regulation or the design of incentive

structures that encourage desirable behaviours. A key decision is the extent to which long-term care is delivered via markets[2]. Where this is the case, regulatory interventions focusing on quality assurance and oversight, public reporting of quality information and standardisation of care practices generally become more central to discussions about how to improve quality. In addition to these strategies, many countries also consider the role of procurement and how it can be used to improve quality. Interventions to improve coordination between actors across the system are also of relevance, but this topic is beyond the scope of this chapter. (Interested readers are directed to Wodchis et al., 2015; Harvey et al., 2018; WHO, 2022.). Integration as a means of achieving greater efficiency and access in long-term care services is also discussed in chapter 4 of this volume.

Markets for long-term care

As already mentioned, most countries operate quasi-markets for long-term care provision. This generally refers to a situation where state-funded services are provided by a plurality of independent providers who compete for business from state-appointed purchasers (i.e. commissioners/procurers of long-term care) or directly from users. In many cases quasi-markets were introduced as part of the wave of New Public Management reforms that swept across many countries towards the end of the last century (European Social Network, 2021). The rationale tended to be to promote choice for users, improve quality and reduce costs by subjecting providers to competitive forces (Lundsgaard, 2005). The characteristics of quasi-markets vary substantially across countries in terms of how financing works, how and when independent providers are allowed to engage in the market, as well as the regulations that govern the markets. For example, in Sweden certain municipalities allow independent providers while others operate a combination of public and private providers (Zigante & King, 2019). Whether these reforms have produced the desired effects is debated and the evidence around this (which comes largely from studies of the United States nursing homes market) is mixed with respect to its impact on quality.

[2] This has special relevance in the European context where EU directives around state aid and competition require special designation of services as 'non-economic services of general interest' to be excluded from the directive. If designated as 'services of general economic interest' they need to be procured through public contracts (European Social Network, 2021).

It depends on the methods used, the country (with some positive effects on quality from United States studies and negative from United Kingdom studies) and the presence of certain institutional features, such as public reporting of quality information, meaning it is important to understand the country context. The most consistent finding across studies is that competition depresses prices (for reviews see Forder & Allan, 2011; Yang et al., 2022).

There are many reasons why long-term care markets may not deliver good quality care. These include individual-level factors such as lack of, or difficulties assessing, information about quality of services a priori, reluctance on the part of users and families to switch providers (in particular care homes) and a distorted relationship between price and quality due to co-payments by the user and the local government/the state. There are also structural factors including the market power of public purchasers potentially leading to unsustainable prices, the cost of withdrawing contracts for publicly funded care (even when quality is poor), and market behaviours including private providers cream-skimming (selecting people who are easier to care for) and locating in densely populated wealthier areas (for a wider discussion of market failures, see Corlet Walker et al., 2022, and chapter 5 of this volume. Consequently, it is argued that a range of conditions must be addressed in order to realise the benefits from marketised long-term care provision and that it is crucial for governments to regulate long-term care markets to ensure at least a minimum level of quality. Key mechanisms for influencing the quality of long-term care markets are oversight and public reporting of information which we address next.

Oversight for quality

The goal of quality oversight is to address the problem of 'bad apples' by imposing external regulatory controls to ensure a minimum standard of quality and safety across care providers. Oversight systems for quality assurance tend to consist of three elements: a method for setting standards or *directions*, a method of *surveillance* for detecting compliance with the directions, and a method for *enforcing* compliance, should instances of noncompliance be detected (Hood et al., 1999). Responsibility for regulating the entry of providers, inspection and enforcement actions may be held by a single national regulator or multiple regulators, often at arms-length from government, or by a patchwork of regional organisations (Nies et al., 2010; Cès &

Coster, 2019). Countries also vary considerably in how they implement these elements, but often combine a mechanism for regulating entry of new providers to the market (i.e. accreditation, registration, certification) with a form of inspection to ensure providers continue to meet minimum standards while they are in operation (Mor et al., 2014; for a discussion and examples see Cès & Coster, 2019; Zigante & King, 2019). There is often a close relationship between the system for oversight and other mechanisms for quality improvement. For example, in some countries quality management systems are mandated through standards and there is often a relationship with public procurement of long-term care, for example with accreditation/authorisation a pre-requisite for access to public funds (European Social Network, 2021).

As a strategy to improve quality, oversight is often seen as expensive and its effectiveness is debated. Key challenges relate to: the degree of alignment between the standards and the goals of the system, especially in countries that rely solely on structural indicators of quality (e.g., single rooms, staff ratios); how standards can be adequately and appropriately measured; and the costs of surveillance and inconsistencies in measurement, especially for process and outcomes based standards, which rely on assessment by inspectors. In promoting or enforcing compliance, there is a further challenge involved in achieving a balance between strong sanctions and deterrence to identify 'knaves' on the one hand, and persuasion and education to ensure the system does not crowd out 'knightly' motivations on the other (for a more detailed discussion and description of approaches in countries see Mor et al., 2014; Malley et al., 2015; Cès & Coster, 2019; Zigante & King, 2019).

Public reporting of quality information

One reason long-term care markets fail is that they are subject to imperfect and asymmetric information. Older people are unable to assess the quality of care options with certainty prior to purchase due to a lack of easily searchable or comparable information about aspects of quality that matter, such as outcomes and experiential information (for a discussion see Konetzka et al., 2021). The purpose of public reporting is to correct this information problem by providing older people with information about quality that will inform their choice of provider and increase the probability of going to a high-quality

provider. It is also argued that providers will be incentivised to improve their performance, to bolster their reputation and ensure they do not lose market share (Berwick et al., 2003).

Much of the academic research around the effects of public reporting comes from the United States where information about the quality of nursing homes has been available for over two decades now via the website Nursing Home Compare (now Care Compare). In a wide-ranging review Konetzka and colleagues (2021) report evidence for a modest but meaningful change in provider behaviour and older people's choice behaviour, but note that this was only apparent after the (simpler) five-star ratings system for providers was introduced. More negatively, there was also evidence of providers gaming the system, focusing only on improving aspects of quality that were measured, and some indications that the policy is exacerbating disparities by race, ethnicity and income. There is much less evidence of the impact of public reporting schemes from other countries, which differ in terms of the range and format of quality information reported (Rodrigues et al., 2014). However, the evidence presents similar challenges to those found in the United States around the use of information by older people to choose providers. This suggests that the impact of public reporting is not likely to be substantially different in other countries, although it may be tempered by the degree of competition in markets and other features of the long-term care systems.

Notably in countries where public reporting occurs there appears to be fairly low awareness of the quality information that is made available. Questions are also raised about whether the publicly reported information covers the kind of experiential information people want and the ability of older people to play the role of the empowered consumer who actively seeks out detailed quality information. Most older people choosing care (and especially care homes) make this decision at a time of considerable stress, and evidence suggests that they require support to access the information and make use of it. In chapter 3 in this volume, other scholars have discussed how even eligibility rules to public long-term care benefits can be characterised by very different degrees of transparency and ease of access. Mistrust in the information available undermines its use, highlighting the importance of users having confidence in its reliability. Additionally, for most people quality is also not the only consideration – location and availability of places are more

important. The general conclusion from the accumulated evidence is that public reporting is a part of the solution to improving quality, but more effort is required to improve the information, raise awareness and support older people to make use of it (Rodrigues et al., 2014; Trigg et al., 2018; Konetzka et al., 2021).

Standardisation of care practices

Drawing inspiration from the evidence-based practice movement, a further mechanism for improving quality is standardisation of care practice. The aim is to ensure that care everywhere aligns with what is evaluated to be best practice. This strategy differs from standard setting associated with oversight in that it intends to move organisations away from a focus on delivering minimum standards towards a focus on delivering the best standards (OECD/European Commission, 2013). To facilitate the standardisation of care practice, however, an infrastructure is needed for generating evidence of good care practice, evaluating the evidence collected and synthesising it into guidelines. These guidelines then need to be adopted by organisations if they are to lead to the standardisation of care practice across organisations; all the evidence suggests that this requires as much investment and effort in the long-term care arena as it does in others (Diehl et al., 2016).

While there is a tradition of developing and using clinical guidelines in medical care, to date there has been much less attention given to developing and using guidelines to standardise the nursing and social care provided by long-term care workers and organisations. One area of care practice that has received more attention is the process for measuring and assessing needs, where standardisation is lacking (this is discussed in chapter 3 in this volume). All OECD countries use some form of needs assessment to assess the degree of disability and allocate benefits to older people, and in a growing number of countries standardised instruments are mandated (e.g., United States, France, Canada). A popular instrument is the interRAI (resident assessment instrument), which supports the assessment of needs, care planning, resource allocation and the monitoring of changes in needs over time. A major challenge with these tools is that they may not be sensitive enough to the varying needs of such a diverse group of people and can inhibit the tailoring and personalisation of care, hence some countries allow greater discretion in how the tools are applied in practice (for an extended discussion see OECD/European Commission, 2013).

A number of countries (e.g., Australia, Canada, France, Germany, United Kingdom) have developed guidelines for other areas of care practice. While there are guidelines for topics such as social work practice for adults with complex needs and safeguarding of adults in care homes in England, the implementation of these guidelines has not been studied (Bauer et al., 2021). The available evidence focuses almost exclusively on the management of aspects of clinical practice (e.g., oral health, medication review, pain protocols, pressure ulcer prevention) within nursing homes (Möhler & Meyer, 2015; Diehl et al., 2016). The accumulated evidence argues for the importance of having implementation strategies specific to the nursing home setting, identifying particular differences in the skills mix of staff, availability of resources and complexity of needs of residents compared to other settings (McArthur et al., 2021). These studies conclude that greater rigour is needed in the development of guidelines and their implementation within long-term care organisations (Möhler & Meyer, 2015; Diehl et al., 2016; Bauer et al., 2021).

Procurement of quality services

Many countries have some degree of public procurement of long-term care services, which we understand as the purchasing and contracting of long-term care by public authorities from for-profit or not-for-profit care providers. Procurement of services generally takes place at the local/regional level, except in very small countries where this may be managed at the national level. Procurement is common even in countries where long-term care benefits are provided via cash payments or have a substantial self-funder market as in the United Kingdom (European Social Network, 2021). Public procurement is generally highly regulated, and in the EU specific directives apply, but these allow public authorities to consider quality (and other factors) alongside cost in awarding contracts. In theory, the public authority can use public procurement to increase competition on quality by putting a higher weight on quality criteria and asking providers to compete on both price and quality, or by setting the price and output quantity (e.g., care hours provided) and asking providers to compete on quality criteria only (for examples see Malley et al., 2015).

In a review of public procurement practices in European countries, countries report a number of challenges affecting their ability to procure high-quality services. These include the bureaucracy of tendering

procedures, difficulties ensuring the quality of service delivery and problems with the continuity of provision that affects the ability of providers to create good quality secure jobs (European Social Network, 2021). Given the experiential nature of care quality, public authorities find it particularly challenging to assess and select providers based on quality, so despite the fact most respondents in the review report using quality criteria for procurement it is unclear how informative this information is and the degree to which it (rather than cost) influences decisions (European Social Network, 2021). In England, experience has also been that the often inflexible nature of contracts, which can be highly prescriptive around tasks, may not be working in the best interests of care users (Lewis & West, 2014).

Countries have tried a range of mechanisms to improve public procurement practices to ensure that they support and encourage high-quality long-term care. Firstly, some countries (e.g., United Kingdom and examples in Finland) seat procurement within the context of strategic commissioning, which is generally understood as a strategic process of specifying, purchasing and monitoring services to meet the local population's needs, drawing on analysis and evidence of needs and other market insight (for a discussion see Newman et al., 2012). Central to strategic commissioning is the intention that the decision to purchase services is made based on evidence about whether more value will be gained by purchasing services as opposed to delivering them in-house.

Secondly, and relatedly, there are examples in some countries of public authorities trying to establish greater dialogue and more of a partnership approach with providers, with examples of public authorities accompanying contract monitoring with support to improve and involving providers in the design and development of contracts, which seem to build trust and establish a positive approach to quality improvement (Malley et al., 2019; European Social Network, 2021).

Thirdly, in some countries public authorities seek to further incentivise quality, through tying the level of payments to the achievement of quality criteria (i.e. payments for performance), which can include the achievement of specified user outcomes (i.e. outcomes based commissioning) (Malley et al., 2019; European Social Network, 2021). As with any incentive scheme there are concerns that it may induce providers to behave in ways that maximise their profit but are not in the spirit of the scheme, including through gaming measures and cream-skimming. In

recent years more evidence about the impact of these programmes has started to emerge, largely from the United States. Studies present a mixed picture of the effect of pay-for-performance schemes on the quality of long-term care, with some showing a modest impact. The technical design of schemes with respect to quality measurement is critical. It is also important to get the target and size of the incentives right, as targets that are too distant will disincentivise actors to improve, while too easy a target can perversely reduce quality on targeted measures as good providers reduce their efforts (Norton, 2018; Li & Norton, 2019).

6.4 Conclusion

This chapter has reviewed different strategies being adopted by countries for improving the quality of long-term care for older people. While evidence about the impact of these strategies is still somewhat limited, we have noted a step change over the last ten or so years with respect to the quantity and rigour of studies investigating their impact on the quality of long-term care. Particularly notable are the increasing number of review articles examining some of the system-level strategies, such as the public reporting of quality information and pay-for-performance schemes. Although these reviews often call for more and higher quality studies (e.g., Li & Norton, 2019), the evidence presented tends to be more conclusive than we have found in previous reviews (Malley et al., 2015). While we cannot on the basis of this review offer a recipe that countries can follow to improve the quality of long-term care, the accumulated evidence points to the limitations and unintended consequences of strategies with respect to quality, with important implications for policy makers.

Reflecting partly the zeitgeist and the countries where much of the research has been carried out, studies to date have focused on the impact on quality of marketisation and strategies that are designed to address market failures. As we have noted, much of the evidence is conflicting about the impact of these strategies on quality. The main conclusion we draw from this work is that there is little evidence that competition on its own leads to higher quality. Policy makers need also to put in place strategies to address the lack of market forces to discipline providers. While there is evidence that public reporting of quality information can positively affect provider behaviour, the impact of

other initiatives (i.e. pay for performance, oversight for quality, and cash for care) is unclear. It is also not clear which strategies are key: both the United States and the United Kingdom have public reporting of quality information and oversight, but findings differ in terms of the effect of competition on quality with the United Kingdom being more negative. It may be that the design of quality information reporting and oversight is better in the United States than the United Kingdom or that other features of the long-term care system are important. Especially given the expense of many of these strategies addressing market failures, countries need to tread carefully if they wish to use market mechanisms to raise quality. More attention also needs to be paid to the assumptions these strategies make about older people's capacity to act in long-term care markets. The empowerment of older people is central and a more nuanced debate is needed around how, as older people age, they can strike a balance between dependence and independence and how this can be realised in practice.

In this chapter we have presented the idea that the balance of care, by which we mean the relative contribution different types of services and care settings make in a given system, is one strategy countries can pursue to improve quality. We include in this general idea calls to support people to age in place, for greater use of technology, and for different models of care (e.g., the household model or new ways of providing home care). Although there are powerful arguments for changing the balance of care, there is little evidence of the actual impact on quality (as opposed to the *potential* impact on quality). In the case of technology and different models of care this is because these options remain on the periphery of provision, limiting their system-wide impact on quality. In the case of ageing in place it is because the poor quality and accessibility of much housing and the built environment, in addition to the capacity of home care services, places a limit on the quality of care people living in their own homes can receive. Changing the balance of care requires an appreciation of the complexity of the system and recognition that investment may be needed in other sectors of the economy (e.g., housing, digital infrastructure, built environment, etc.). Countries wishing to change the balance of care to improve quality need to consider the level of investment required and where it is needed to realise the full benefits.

A clear message from this review is the growing importance of having a skilled and knowledgeable workforce to deliver good quality long-

term care. Problems retaining the existing workforce, combined with the often-substantial unqualified workforce and difficulties recruiting new workers to meet demand, mean there are no straightforward options for policy makers to deliver on this agenda. Investing in the existing workforce must be central to any strategy and in this context, given informal carers provide the majority of care, supporting and upskilling informal carers should be much more central to strategies that seek to improve quality by professionalising the workforce. While comparisons across countries do not reveal a clear direction for policy makers, experiences so far do demonstrate the importance of accompanying policies to professionalise the workforce with a concomitant increase in funding. Without sufficient funding, the experience is that the goals of professionalisation are undermined.

This review has identified some limitations in the evidence base. Specifically, there is far less evidence around how quality management systems and voluntary accreditation, oversight of quality, standardisation of care practices, and approaches to public procurement influence the quality of long-term care. We have also been brief in our discussion of the various strategies to improve quality. We could not do justice to the vast literature around many of the topics covered, such as ageing in place, technology and the care workforce. We focused on the evidence for better known and more prevalent services, technologies and issues. It is clear, however, that innovative solutions have a role to play in improving the quality of long-term care and governments a role in promoting innovations that seem promising.

Finally, we want to emphasise the value of comparative research for improving the evidence base and moving debates about improving quality forwards. As we noted in the introduction, a challenge is the lack of both data and consistent data about long-term care quality across countries. In recent years, however, there have been concerted efforts to harmonise measurement of long-term care quality across countries (Hoffmann et al., 2010; OECD/European Commission, 2013; Edvardsson et al., 2019) – a development that may improve the potential for comparative research. A further problem holding back comparative research is language, with similar forms of care or strategies referred to using different terminology in different parts of the world. This seems to be particularly an issue for more innovative forms of care and was especially evident in the discussion around changing the culture of institutional care. Cultivating opportunities to exchange

ideas will be important for overcoming differences in language and building a stronger evidence base for the international long-term care community.

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