Putting Quality First
Contracting for Long-Term Care

About the European Social Network (ESN)

The European Social Network (ESN) is the independent network for local public social services in Europe. It brings together the organisations that plan, deliver, finance, manage, research, and regulate local public social services, including health, social welfare, employment, education and housing. We support the development of effective social policy and social care practice through the exchange of knowledge and expertise.

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The European Centre for Social Welfare Policy and Research is an intergovernmental organisation affiliated to the United Nations. Its purpose is to foster collaboration in social welfare policy between governments and other relevant agencies by providing expertise in applied social science and comparative empirical research. The European Centre promotes future-oriented ideas to enhance social rights and sustainable development in work, welfare, health and care.

European Funding

About this report

This report assesses the role of public procurement, contracting and commissioning in ensuring quality long-term care. It is based on a literature and practice review, the responses to a questionnaire from ESN members as well as their input at a seminar held on 12 and 13 November 2020.

Country Abbreviations

AT	Austria	IE	Ireland
BE	Belgium	IT	Italy
CH	Switzerland	LV	Latvia
CZ	Czech Republic	MT	Malta
DE	Germany	NL	The Netherlands
ES	Spain	PL	Poland
FI	Finland	RO	Romania
FR	France	SE	Sweden
HR	Croatia	SI	Slovenia
HU	Hungary	UK	United Kingdom

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Introduction

With populations ageing and changes in family models, the use of formal long-term care for adults with long-term care needs is growing in all European countries. Higher demand for formal long-term care and services is also due to people's rising expectations for high-quality care.

Public authorities in Europe, in particular local and regional authorities, have engaged in developing long-term care (LTC) services over the past few decades. From the late 1980s to 2020, LTC has become an area of service management involving multiple public authorities and stakeholders. The complexity of the funding and regulatory structures of countries' care systems, and the wide range of organisations delivering care and services, has given rise to a web of relationships in the form of contracts which impact the quality of care and in turn the quality of life of older adults with care needs.

These developments have taken place in the context of a demographic trend towards an older population, which makes it all the more pressing to understand how long-term care systems work and can further develop to better meet the needs of older adults with long-term care needs.

Demographic ageing also has major implications for public expenditure on care services. In addition, the rising pressure on public expenditure makes it vitally important to promote a focus on quality of care and quality of life as governments' attention shifts to consider effectiveness and economic performance.

Indeed, these trends are occurring in the context of a downsizing of public provision and public social services as well as outsourcing in many countries linked to debates about ways to make social and health 'services of general interest' compliant with market rules, competition law and public procurement regulations. Both the regulatory guidelines issued by the European Commission and the general debates about quality in LTC – including requests to expand community care – have met with hugely diverse national, regional and local structures, legacies and approaches in Member States.

This publication is not the first activity the European Social Network (ESN) has undertaken in view of the challenge of long-term care. For a number of years, ESN has considered funding, planning and quality, providing opportunities for its members to share and acquire knowledge as well as to input into European policy developments.

In 2007, ESN organised its first working group on ageing and care, which discussed choice of care for older people and the changing relationships between public authorities and care providers.

In 2010, ESN launched a **study** that analysed in detail these relationships with a focus on planning, regulation, case management and provision between public authorities, providers, and representatives of people using long-term care. The present publication builds on that study.

In 2012, the European Year of Active Ageing and Solidarity between the Generations, ESN organised a seminar centred on how to design social and health services to assist older people in retaining and regaining independence and inclusion in later life. A series of practice-based examples were identified and gathered in a **paper** published in 2013 covering early prevention, integrated services, ICT, involving older people in care design and delivery.

As a follow-up to this seminar, ESN members, directors and senior professionals in long-term care, came together at a workshop with representatives from health agencies to address in more detail the issue of choice of care for older adults. Specifically, participants discussed the challenges and opportunities to support active and healthy ageing as well as social inclusion through social and health care, especially at home.

This workshop led to the establishment of a **working group** that met five times between 2014 and 2017 and culminated in the production of the toolkit **'Investing in later life'**, with guidance for social services directors and practitioners on the development of care programmes for older people. The main issues discussed by the group were:

- Participation in society as well as independent, healthy, and secure living and enabling environments for active ageing of older adults in need of support.
- Managing the social care workforce (professionals, family carers, community) of those working with older people, as well as skills development, support for families, and workforce planning.
- Service coordination and integration with a focus on the social aspects of integrated long-term care and information sharing across sectors.
- How to ensure quality of care and services for older adults with long-term care needs.

The group's work on this last issue is what inspired further work contained in this publication, although all four issues resurface throughout the report.

How does the quality of care contribute to the quality of life of people using LTC services? This question was central in the debate that ESN members had around quality. Compared to the health sector, guidance on quality indicators for long-term care is still not agreed upon at a European level. Such guidance is needed and should especially focus on participation, integration and coordination of services, social innovation and autonomy as much as on health-related indicators, according to ESN members.

In the working group, ESN members stressed that public services are accountable for externally provided services, since "where a public duty is partly or wholly delegated to another organisation, it is still a public duty" (ESN, 2010). Therefore, while care and social service delivery may be outsourced (whether through a competitive tender or a grant) to a private provider, whether not-for-profit or for profit, accountability for the service - and by implication its quality - lie with the public authority, most often at local level. In this context, public procurement, commissioning and contracting of care services impact regulation and financing of LTC. Likewise, the application of such mechanisms is profoundly conditioned by national traditions, e.g. legal and administrative systems, the level of development of LTC policies, and the distribution of responsibilities between government levels and sectors.

This publication intends to approach quality of care not just from an organisation's quality management perspective or the relationship between the public authority financing the service and the provider that delivers it. Rather, it will shed light on national choices, experiences, structures and services as well as on the stakeholders involved in regulation and governance of LTC procurement and on related issues of quality assurance. Therefore, the aim is to assess different approaches and to address key issues in assuring quality when procuring, contracting, and commissioning LTC.

With this in mind, the study is guided by the following questions:

- How can procurement contribute to ensuring affordable and quality long-term care?
- What is the impact of public procurement rules in public authorities' ability to ensure quality long-term care?
- How has procurement impacted the delivery of long-term care in Europe?
- Which mechanisms are implemented to ensure quality in long-term care?
- What frameworks or processes are there to ensure quality in long-term care?
- What stakeholders are involved in quality assurance and how is quality being ensured?

These issues are often addressed in 'silos' in policy and research, ranging from public administration, legal and political science, social or health policy and institutional economics, to the growing debate on the future of long-term care in an ageing society. With this publication, we propose to break down these silos to find out whether and how procurement, or the acquisition of services at the best possible value or cost, can steer quality in service delivery and enhance people's lives, and if so, under which conditions.

Structure

The report starts by outlining and defining the key concepts that characterise the organisation of long-term care in Europe with a view on market-oriented governance, procurement and quality assurance. As it will become evident, the way in which the framework for procurement and contracting services has changed not only led to an increase in the complexity of LTC (e.g. by enabling private providers to enter the market), but also changed how LTC services are organised by public authorities, e.g. through tendering processes and the need to manage contracts.

The second part of the publication addresses the opportunities and threats of these approaches as per the views of public authorities. ESN gathered views and details about practice from our members regarding the organisation of long-term care markets and the impact of EU rules on public procurement of LTC services.

Next, we analyse whether and how procurement may have triggered promising methods for quality assurance; for instance, the emergence of new tools and dedicated agencies responsible for quality assurance.

In the final part of the publication, we conclude with recommendations for national and European policymakers to advance quality of care for older adults with long-term care needs.

Methodology

This publication is based on literature desk research and a questionnaire developed to gather data and information from ESN members on legislation, policy and practice related to the procurement and quality of long-term care in their countries.

The questionnaire investigated how public authorities in Europe manage and organise public procurement of long-term care services, as well as how the quality of those services is ensured.

The questionnaire was divided in four parts:

1. state of play of long-term care procurement,

2. state of play of long-term care commissioning and contracting,

3. state of play of quality assurance in long-term care,

4. request for practice examples.

The questionnaire was administered during the first wave of the Covid-19 pandemic, which certainly hampered the capacity of many members to fill it in or dedicate time and energy to answer some rather demanding questions.

Different types of organisations answered the questionnaire. Most were public authorities at local (12), national (9) and regional (4) levels. Other respondents included national quality inspectorates (2), an association of service directors (1), and applied research centres (2).

The 30 respondents came from Belgium (2), Croatia (2), Czech Republic, Denmark/Faroe Islands, Finland, France, Hungary, Ireland, Italy, Latvia, Malta, Poland, Romania (3), Scotland (UK), Slovenia, Spain (9), Sweden, and Switzerland.

Complementary information was provided respectively by ESN members from Spain, Sweden, France, Romania, and England (UK).

The information gathered, though not fully representative of all European countries, provides an overview of ongoing trends and issues in procurement and contracting for quality in long-term care, which were further investigated at an ESN seminar that took place in November 2020.

Differences in long-term care across countries

Public expenditure and financing

Public expenditure and financing range from small budget lines within social assistance schemes, as in many Eastern European countries, to expenditures for LTC that amount to more than 3% of GDP such as in the Netherlands or Sweden.

This difference in expenditure also reflects the extent to which access to services is guaranteed and which rights and entitlements are granted by legislation. While in Germany, Luxembourg and the Netherlands there are social insurance branches granting access to LTC, countries such as Ireland, Switzerland or Poland grant access to services and facilities based on a social assistance rationale. Differences in expenditure are also linked to the extent to which LTC schemes grant services in kind, such as in the Nordic countries and the Netherlands, rather than cash benefits, as in Continental welfare regimes (AT, FR, DE, CZ).

Provision

Another area of variation is the extent to which services and facilities are delivered by public, private not-for-profit or for-profit providers. While in the UK and Germany the share of private providers is comparatively high, the Nordic countries are still characterised by extended public service provision. Also, the role of not-for-profit organisations is dependent on national traditions. For instance, in Germany and Austria not-for-profit organisations have traditionally delivered LTC services, which led to their expansion in recent decades. In Eastern Europe, where not-for-profit organisations had to be reintroduced during the transition to market economies, there is still a lack of such providers in LTC.

There is a general tendency to organise LTC services at local level, be it in the Nordic or in Mediterranean countries – and local authorities are characteristically of various sizes with significantly different scopes of autonomy. For instance, municipalities in Nordic countries are larger than in Southern Europe, they levy local taxes and enjoy autonomy within national framework legislation. In Spain, this autonomy, except for taxes, is granted to the regions, while in Italy there are inter-communal entities that manage health and social care within the regions and impact the organisation of LTC.

Support for informal carers

The acknowledgement of LTC as a social risk has included an increasing awareness about the role of informal carers in providing unpaid support to people in need of LTC. Countries such as Sweden, Germany and Austria have identified this as an area of social intervention and each of those countries supports informal carers with specific services such as day-care for older adults and respite breaks for their carers. The German LTC insurance system compensates informal carers with a small allocation of cash payment, while in Spain informal carers who receive an allowance also contribute to social security to build towards their pensions. Most countries offer special training courses for informal carers, e.g. in Finland or Slovenia (UNECE 2020). The extent to which such services are available is an important indicator for the quality of LTC.

Coordination between health and social care

The coordination of health and social care has been a cornerstone in the development of LTC services. In general, fragmented service provision is still a challenge in most countries. When it comes to public procurement, it is important to note that the quality of services can be impacted by new and changing providers. Here, the concept and practice of contracting is key as the contracts between public authorities as funders and private social and health care services as providers could and should help to align the quality of respective services by means of standards and criteria that are set out in the contracts. This latter function has been a key objective of 'joint commissioning' approaches in the UK, but also in contract specifications in selected local authorities in Sweden and Spain.

Defining quality

Last but not least, the definition, monitoring and improvement of quality of care has become an important variable in LTC systems. While some countries have only just started to define minimum structural standards (e.g. Central and Eastern European countries) and to establish inspection agencies, others have moved to quality management and eventually the definition of outcomes-based quality (e.g. NL, UK, DE, AT, CH).

1. Concepts underpinning the development of Long-Term Care

Over the past few decades, we have seen an impressive expansion of initiatives and services, including reform packages and schemes to support people with long-term care needs. This development has not been uniformed across Europe but dependent on national resources, demographic and economic pressures as well as political choices. Furthermore, the expansion of health and social services for people with long-term care needs has, for the most part, not fallen under the heading 'long-term care', but rather under social care or within the health care system.

This chapter intends to present an understanding of long-term care as an area in its own right, as a system of integrated services with its own identity aiming at an improved quality of life for people with long-term care needs. This understanding has also been underscored by Principle 18 of the European Pillar of Social Rights (ESPR), which states that "everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services".

1.1 Long-Term Care

Definitions of **Long-Term Care (LTC)** regarding the needs of potential beneficiaries and the ways in which these needs can or should be addressed differ both in research and practice between and within Member States. At EU level, the following definition was provided by the Social Protection Committee (SPC), which consists of representatives of national ministries of social affairs and the European Commission's Directorate General for Employment, Social Affairs and Inclusion:

"Long-Term Care (LTC) encompasses a range of services and support for people who are dependent over a long period of time on help with their daily living. This need is usually the result of disability caused by frailty and various health problems and therefore may affect people of all ages. But the great majority of the recipients of long-term care are older people." (SPC/ECS, 2014: 9)

Taking this definition as a starting point, we shall analyse the state of play of long-term care in different parts of Europe, as well as the challenges and opportunities within public procurement of care and services for older adults with long-term support needs. Long-term care has traditionally been an area where a significant responsibility lied with the family, often (female) partners, daughters, sons and in-laws, and other relatives. The professionalisation of care has been a relatively recent development, with social care services and facilities being established in the context of social support schemes.

However, with demographic trends towards ageing and living longer alongside an increase in chronic illnesses and changing family patterns, the need for formal care has increased. Some countries have become frontrunners e.g. the Nordic countries and the Netherlands, but since the 1990s other Western European countries have also established policies designed to support people in need of care at all ages (Leichsenring et al., 2013). However, others have only started to take the first steps towards a more systematic development of LTC, e.g. countries from Central and Eastern Europe after joining the EU (WHO, 2020; Bogdanov & Georgieva, 2018).

These differences can be gathered from rough indicators such as public expenditures for LTC as a share of GDP (Figure 1) or from the growing share of social and health care professionals in the total labour force (Figure 2; OECD, 2017; Rodrigues et al., 2012).

Figure 1 Public spending on long-term care as a percentage of GDP, 2016 to 2070 (estimation)
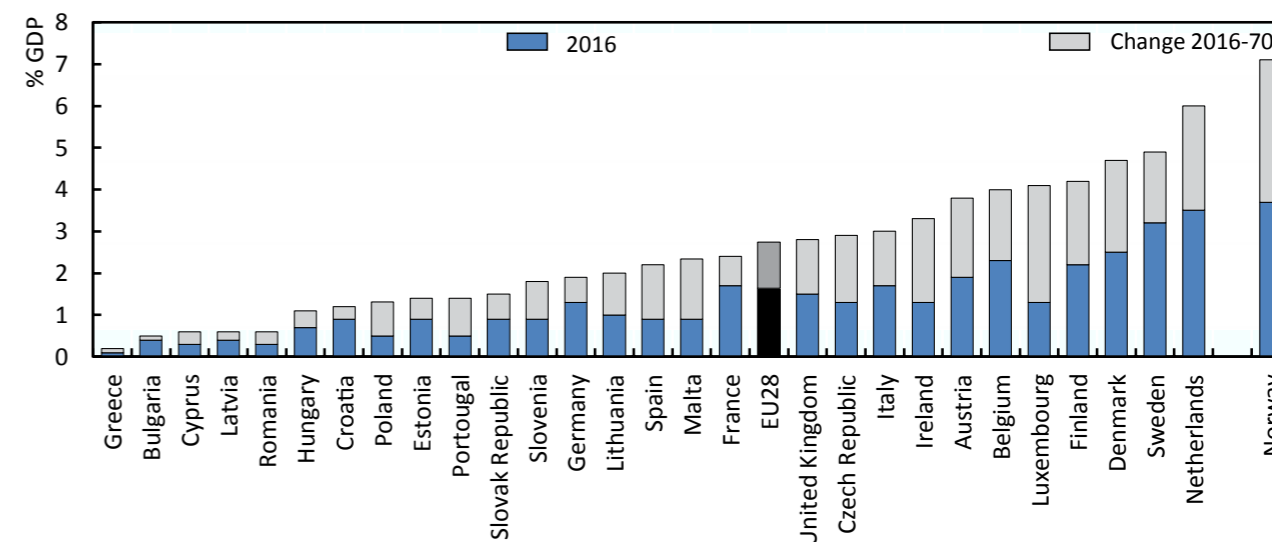
Source: EC and EPC, 2018.

Figure 2 Growing share of social and health care professionals in the total labour force, 2000 to 2015
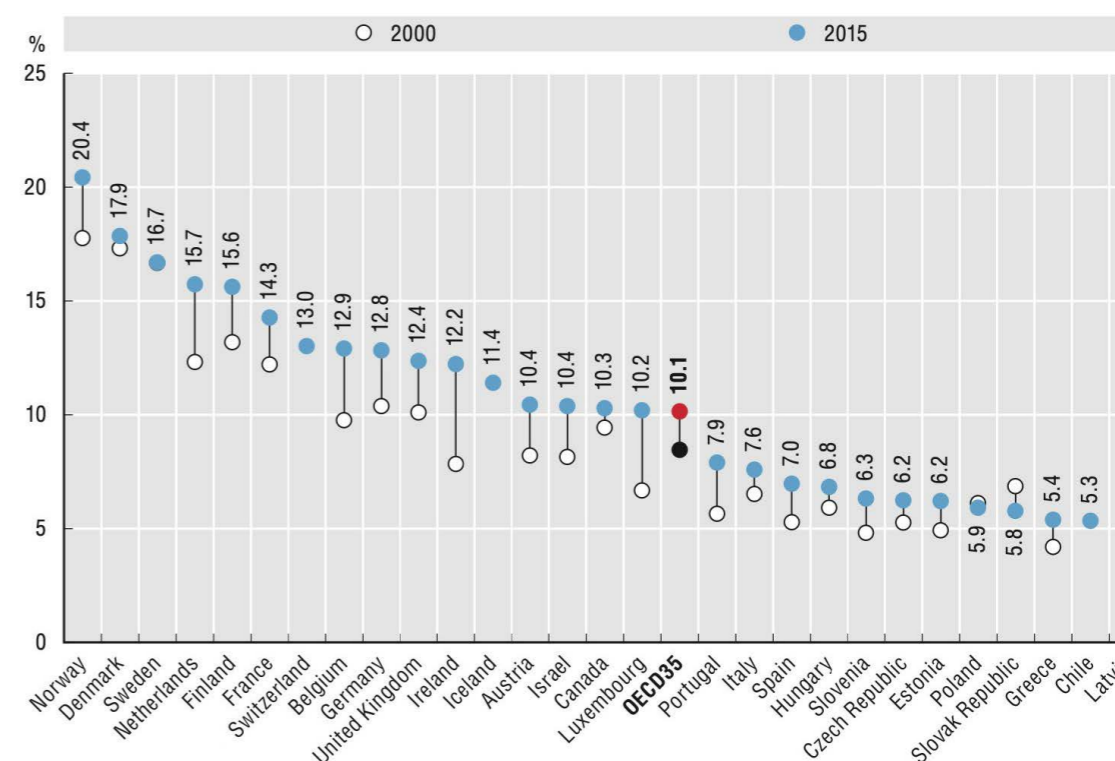
Source: OECD, 2017

Building the infrastructure for long-term care has for a long time been equated with the construction of care homes, but policies such as 'ageing in place' (Pani-Harreman et al., 2020) or the development of community care (European Social Network, 2011) have promoted care in the community. Community care may include supported housing, day-care and active participation centres, and the provision of care and adaptations at home to allow people to stay in their own homes and communities for as long as possible.

At the same time, within health care systems it has become increasingly evident that new treatments and care pathways are needed to deliver person-centred care for the rising number of older people with multiple chronic diseases. Therefore, there has been a need for more communication, interprofessional collaboration and networking, as well as for coordination between services and organisations to overcome fragmentation and increase joint planning and delivery of services (Billings & Leichsenring, 2005).

This led to the concept of **integrated care**, which has underpinned the debate about reforms in health and social care over recent decades, with thousands of pilot initiatives, research and evaluation projects, local and national reform programmes, green and white papers, legal action at national level, and policy initiatives also at supra-national levels (SPC, 2010; WHO, 2019; OECD, 2013; European Social Network, 2016). As a result, a wide consensus has been established that long-term care, with its health and social care components, needs to be addressed in an integrated way.

1.2 Procurement, Contracting, Commissioning

With the dissemination of New Public Management principles (see box below) over the past three decades, practices of **procurement, commissioning, purchasing** and **contracting** have entered public service provision and governance in Europe, though with rather different meanings, scope and impact. This is particularly true for the area of social, health and long-term care services.

The general tendency towards market-oriented governance was based on the assumption that competition among private providers would increase efficiency and reduce prices against public service provision. While this might be true for network industries, there have always been critical voices when it comes to the procurement of social services of general interest, which has been seen by many as a de facto privation of public social services.

Procurement rules could impact negatively the quality of social services, but this also depends on national implementation. For instance, the introduction of procurement impacts differently systems with a previous public in-house provision than those with a long tradition of 'welfare mixes',

where private not-for-profit providers have always played an important role in social service provision.

In the first group (e.g. SE, UK), the introduction of a purchaser-provider split within public authorities or compulsory competitive tendering contributed to the emergence of:

- new stakeholders such as private for-profit providers,

- new procedures such as competitive tendering,

- related measures regarding contracting and quality assurance.

In the second group (e.g. DE, FR, the NL) the challenge was not about contracting services out to private providers, but to adapt the traditional system of grants and subsidies to a market where public, not-for-profit and for-profit providers interact on a level playing field.

In short, while in many countries the key question about relying on procurement had already been answered positively beforehand, in others it needed an explicit political decision to introduce **'markets for care'** through competition. Against this backdrop, issues of **market-oriented governance, choice** and **competition** were likely less well received in some EU Member States (e.g. FR, DE) due to the impression that regulations, which mostly came from the EU, tended to expand market-oriented governance to the area of 'social services of general interest', including long-term care.

Social services respond to vital human needs, contributing to non-discrimination, creating equal opportunities and jobs. Organisational and regulatory frameworks therefore should enhance their social cohesion role rather than hamper their efficiency and quality, e.g. by creating additional

transaction costs or by jeopardising continuity. It has been argued that, by applying EU rules on state aid and public procurement, public authorities would be able to increase efficiency and responsiveness to social purposes. However, few of those rules have been adapted to the specificities of social services of general interest.

In this context, procurement, commissioning and contracting are terms that are often used interchangeably, depending on countries, languages and perspective. In general, **procurement** is understood as the acquisition of goods or services (by public authorities) at the best possible value or cost (The Scottish Government, 2016).

"Procurement is the process by which a public body buys goods (e.g. books and computers), works (e.g. building roads, hospitals) and services (e.g. care services) from external suppliers." (The Scottish Government, 2016)

"Contracting means the process of awarding and specifying contracts, including ensuing contract management and monitoring of service delivery " (Welsh Assembly Government, 2010)

Procurement and contracting, however, mostly refer to single products and services, while it has turned out that social and in particular long-term care services are an array of interdependent services

that call for more complex and integrated processes to ensure seamless person-centred care (Addicott, 2014; Leichsenring et al., 2015).

Once public purchasers have reviewed their contract management, they might turn to an overall process of specifying, securing and monitoring services to meet people's needs at a strategic level – this process has been labelled **commissioning**, but in some contexts it is also called 'strategic purchasing', or simply 'planning and funding' (Newman et al., 2012; Smith et al., 2013; Addicott, 2014).

Some public authorities therefore may decide to not only procure LTC services, but that the procurement of those services "should be placed within the wider context of strategic commissioning" (The Scottish Government, 2016). Commissioning thus takes place on a superior, strategic level with the aim of providing analyses and evidence for needs, organisational and financial framework conditions as well as for related monitoring activities.

Indeed, in England, commissioning has thus been defined as "the process of specifying, securing and monitoring services to meet people's needs at a strategic level" (Audit Commission, 2003; IPC, 2008). Figure 3 depicts the distinction between procuring/contracting and commissioning by conceiving both as multi-layered processes, with commissioning as an overarching, comprehensive and strategic approach at systemic level.

"In the context of health and social care, 'commissioning' includes assessing needs, setting priorities, allocating resources, influencing providers, involving patients and the public, minimising transaction costs and managing financial risk." (Newman et al., 2012)

These management processes are underpinned by the classic **quality management cycle 'plan – do – check – improve'**, where the overall goal of both contract management and strategic commissioning is always to ensure compliance with requirements that have been agreed upon between the purchaser(s) and the provider(s). For instance, it is possible to procure home help and to contract a provider to deliver 10,000 hours of home help per year, but it would be necessary to commission a range of organisations to deliver integrated long-term care in a defined jurisdiction.

Commissioning can thus also be understood as contracting on a superior level, following the evaluation of managing single-service contracts.

Figure 3 From contracting to strategic commissioning

Improve

Plan

Commissioning

Needs analysis, strategy

Purchasing plan

Joint commissioning, integrated contract

Whole system analysis and improvement

Evaluation, re-organisation

Procuring Contracting

Tendering Contract

Monitoring compliance

Check

Strategic monitoring & review

Do
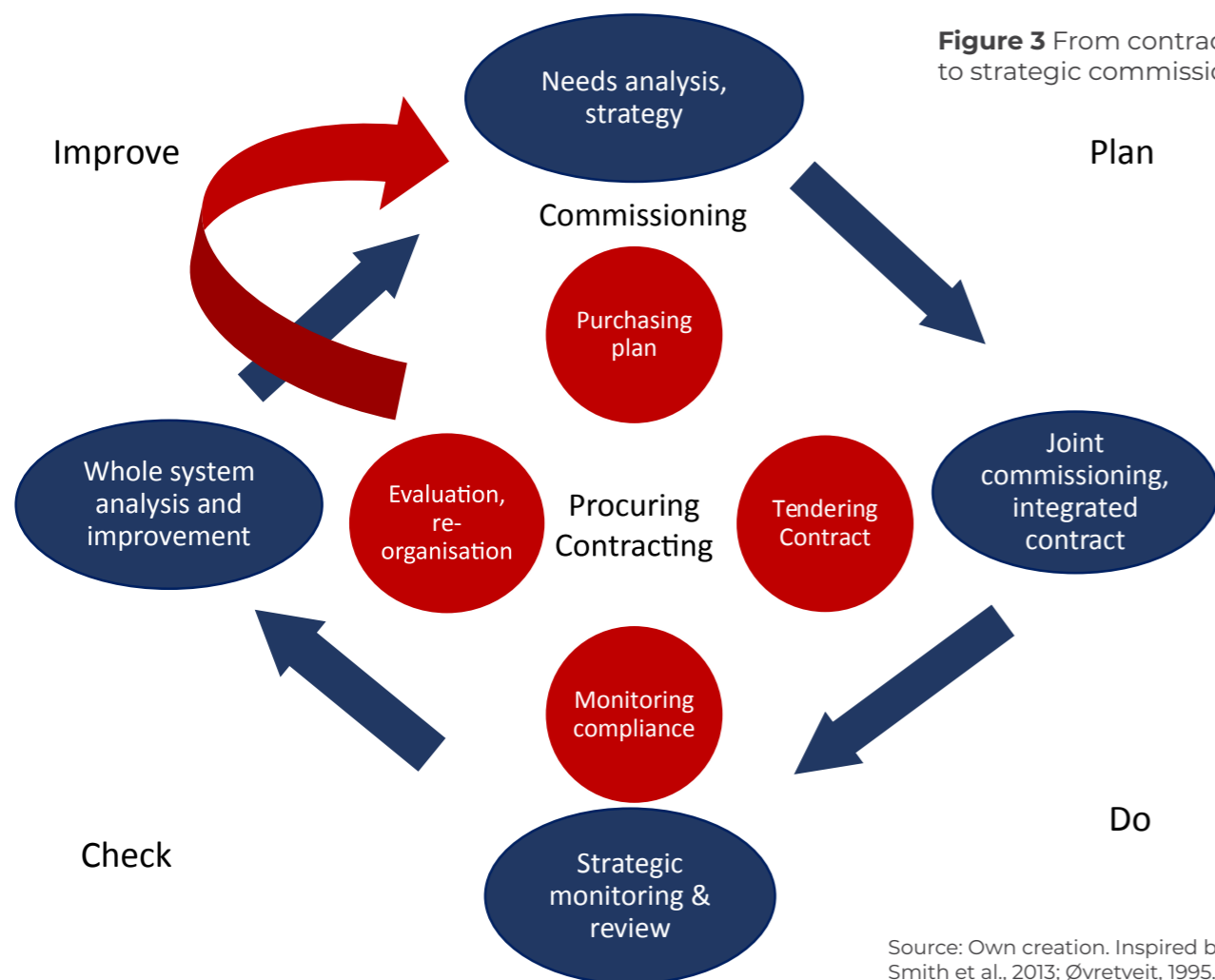
Source: Own creation. Inspired by IPC, 2014; Smith et al., 2013; Øvretveit, 1995.

Principles of New Public Management

New Public Management (NPM) is a conceptual framework that translates concepts of private-sector management related to efficiency and effectiveness into public administration.

In Anglo-Saxon countries this notion has been promoted to overcome bureaucratic and centralised administration.

In other countries, public sector reforms since the 1980s have been characterised by the introduction of market-oriented governance principles. This included, for instance, the split of public entities that had planned, funded, provided and managed services into separate units to purchase, to provide and to manage public services.

Public providers had to compete with (new) private organisations as service contracts became subject to compulsory competitive tendering. In a number of areas, for instance in telecommunication, public transport and waste management, these processes contributed to privatisation ('contracting-out') and thus to a reduction of public entities as providers. Theoretically, the role of public administration would be strengthened by procuring and steering, rather than by providing services and products.

With this objective in mind, the very same principles were also applied to the area of health and social care:

- purchaser-provider split: Planning, funding and purchasing of services are separated from 'provider units' of home care or residential care,
- compulsory competitive tendering: All accredited and authorised service providers are invited to tenders in which they are competing with each other; the purchaser selects on the basis of quality and price criteria,
- contracting: The purchaser negotiates with providers and establishes a contractual relationship for a limited period of time (e.g. after 3 years a new tendering process will be opened),
- performance management: Managers in public administration are shifting their attention from carrying out instructions to the implementation of political vision and goal-setting.

Although this approach met with very different national contexts and welfare traditions, it resulted in a rising share of private for-profit and not-for-profit providers of long-term care services across Europe (Marshall & Abresch, 2016).

1.3 The implementation of long-term care markets

Over recent decades, most countries in Europe have seen an increase of private provision and promoted access to new (private) providers due to explicit national policies that introduced New Public Management approaches and compliance with EU market rules. Purchaser-provider splits, compulsory competitive tendering and abandoning of traditional subsidised funding led to the establishment of 'long-term care markets'.

In long-term care markets, public authorities may fulfil at least three functions:

• service funders,
• purchasers,
• regulators or inspectors.

First, while the same authority may be both a funder or a purchaser, regulation and inspection are usually fulfilled by different agencies.

Second, for-profit and not-for-profit organisations are providers.

Third, there is a strengthened role for user organisations and interest groups.

As a result, the contracting of providers has gained in importance and can be implemented in different ways in relation to how providers are selected, which providers may access the 'market', at what 'price', and based on what 'quality criteria' of their service.

Implementation of long-term care markets may therefore take different forms:

- Public authorities may list all services they provide based on their legal statutory duties. This has been implemented in several countries, such as Germany or Finland. This could also be the starting point for an analysis of whether it would be more efficient and convenient to continue to have these services provided by public authorities or to procure them in the context of a competitive tender (see Box The 'make or buy' decision).

- Local, regional, and national authorities, based on their statutory duties, may define prices or quality criteria for services. This usually entails the definition of thresholds to regulate access to the market for potential providers. For instance, criteria related to accreditation, authorisation of operations, and requirements for reimbursement by public funds, as public authorities do in Sweden, France, Italy or Spain.

- Local or regional regulators may decide after a tendering process to contract several individual authorised and accredited providers and then negotiate price and quality criteria with each individual provider, as they do in Austria, Luxembourg or Italy.

- Public authorities may decide to privatise their public care homes and, following a tendering process, buy a defined number of places at negotiated prices from the provider(s) that won the tender, e.g. in Sweden, Austria and Spain.

- Public authorities with responsibility for LTC services could also agree to contract private providers to fill specific gaps in the 'chain of care', with related definitions of procedures and services at negotiated prices, as municipalities do in Sweden.

- Public authorities may also find that contracting individual services is not sufficient to ensure seamless LTC. They could then enter into a commissioning process with several providers that need to coordinate their services in the framework of defined structures and procedures to attain mutually agreed objectives. However, we do not have yet examples of such practice.

The 'make or buy' decision

It is unclear as to whether specific decisions to contract-out services have always been based on rational choice. For public authorities to base their decisions to contract out services on evidence, it would be useful to analyse whether the results of a service can be measured and to what degree there is scope for competition for service provision. Preker et al. (2000) provided a grid to support decision-making in public procurement in health care, but this has also been applied to social or long-term care (Rodrigues et al., 2014).

For example, the market for home care services may be competitive, particularly in large cities, but it might be challenging to monitor compliance with quality indicators due to the atomisation of the market with many providers providing these services.

Based on this logic, the public authority would need to develop initial quality assessment mechanisms, such as accreditation and licensing, as well as evaluation criteria for service delivery. Likewise, outcomes may depend on having a network of several providers alongside the continuum of care.

The same can be said of public authority provision, if publicly provided services have to abide by the same considerations of accreditation, licensing and quality.

Figure 4 The 'make or buy' decision

Source: Own creation, adapted from Preker et al., 2000; Rodrigues et al., 2014

1.4 Linking contracting and quality

While public authorities may decide to outsource or purchase LTC products and services from 'independent' private not-for-profit or for-profit providers, accountability for the service, and by implication its quality, still lie with the public authority.

> *"While public provision is shrinking, our role is to ensure the quality of the services"*

said a director of long-term care services at our annual seminar.

Indeed, with the outsourcing of long-term care, there is a need for a clearly defined framework of how to monitor and ensure the quality of these services. In the context of market-oriented governance this is a relatively feasible task when it is about a product, e.g. a security door. However, it is much more difficult for a service that aims to ensure that older adults are effectively integrated in their communities.

Quality has been defined as the appropriate delivery of a mutually agreed service or product (www.iso.org; see also ISO, 2010). When it comes to LTC it is paramount to agree with the relevant involved stakeholders on adequate structures and processes that are able to produce services that generate positive outcomes, such as improved quality of life for people with long-term support needs.

As a recent European Commission's report highlights:

> *"Market-oriented governance in long-term care (LTC) calls for special endeavours to assess, measure and control quality of services. The governance mechanisms at the national, regional and local levels also influence quality assurance, at times in conflicting ways, for the large number of important stakeholders: service users and families, care providers, local government and national regulators"* (Zigante & King, 2019, 7).

In recent decades we have seen a wide range of efforts addressing the challenge of measuring quality of LTC in terms of tools to measure and monitor quality as well as stakeholder involvement. In many countries we have seen the establishment of agencies dedicated to the monitoring of providers' compliance with rules and regulations. National and regional legislation also advanced authorisation and accreditation mechanisms, including the definition of quality indicators, even if these are often structural and process indicators that describe individual services and facilities (Nies et al., 2013).

Meanwhile, providers themselves have engaged in implementing either classical quality management (QM) systems (ISO 9000ff, EFQM) or adapted QM systems according to the needs of the LTC sector or their individual organisations. However, quality in LTC is not only dependent on the efforts of individual providers, but also on inter-organisational, inter-professional and inter-sectorial coordination. Neither the purchaser nor the user – in the context of market-oriented governance often conceived as 'customer' or 'client' – are buying a single 'product' but a range of services that the person using services needs so that they can improve their quality of life.

For instance, people with multimorbidity and reduced autonomy in their daily activities will need a package consisting of both health services (primary care, specialist care) as well as daily home care or participation in a day care centre, which is coordinated with their informal carer(s), and managed by a case manager who sits within formal care or in the public authority that granted this package of support. The quality of this arrangement does not only depend on the performance of each individual provider but on the interplay among them. This interplay - or relationship between the various providers involved - needs to be planned, delivered, regularly monitored and assessed, and continuously improved.
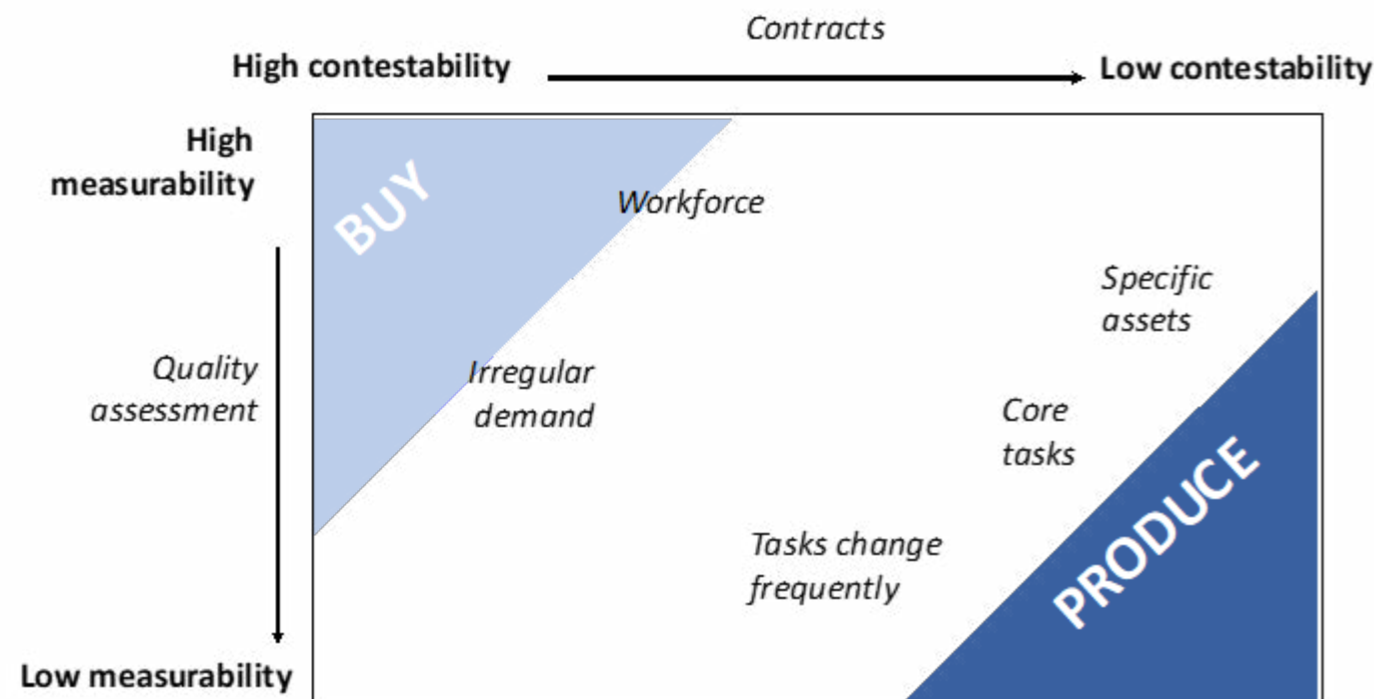
1.5 Bringing it all together: Linking contracting, pricing and quality in long-term care

Given the specific nature of long-term care, it is important to find ways to balance pricing and quality in contracting, at best by measuring **outcomes** in terms of user experience regarding their **improved quality of life**. For the purposes of this first chapter, we are particularly interested in how public authorities monitor and ensure quality through processes involving legal considerations on negotiation, monitoring and improvement of service contracts. This is basically achieved by following the classical

Quality Management Cycle
PLAN
DO
CHECK
IMPROVE

that has somehow been transposed into the commissioning cycle (see figure 3).

The commissioning cycle thus shows the way for monitoring and improving the quality of LTC if it is applied to the process of delivering person-centred care and the care continuum. Contractors and designated authorities responsible for inspection and quality assurance should therefore focus their activities on assessing results and outcomes of the interplay among care organisations.

In this study, we provide examples of such arrangements as provided by ESN Members. Moreover, we propose a number of recommendations stemming from latest studies and reports, e.g. regarding new ways of putting price-tags on LTC delivery based on performance indicators. In the future, rather than paying for or reimbursing individual services (based on the number of places/beds/clients, or by the number of hours or days), integrated LTC delivery could also be purchased as a **'bundle of services'** based

on defined outcome(s), such as reduced hospital admissions or individual examples of instances showing an improvement in the quality of life of persons using the services.

Several countries have already started to implement such models. For instance, 'bundled payments' have been facilitated in the Netherlands' health care system since 2007 (Struijs et al., 2013). This implies the definition of defined budgets for a specific 'bundle' of interventions, usually linked to a certain diagnosis, e.g. diabetes. In LTC, this could be compared to

> *Personal budgets: Beneficiaries are paid an amount of money to help with any social care and support they may have based on an assessment made by their local social services or competent authority. A care plan is agreed with the person to decide as to how the personal budget is managed.*

In personal budgets, the money can be paid as a direct payment to the person and is decided by local authority's social services (or the competent authority) after the needs assessment is done to work out the type of care and support the person needs, how much it would cost, and how much they may be able to afford themselves.

A **care plan** is agreed with the person, who could either manage the personal budget by themselves, have the money managed by the council, pay the money to care providers or choose a combination of these options.

Rather than being reimbursed a fee for individual lots (e.g. per hour), the involved organisations would get a lump-sum for the achievement of the outcomes that have been defined in the care plan. As people themselves become employers, other related quality issues arise, such as managing the people they employ to care for them, keeping records, doing background checks, and more generally checking the quality of the care provided.

2. Procurement and contracting in Europe

In this chapter, we will identify and analyse the different approaches to procurement, understood as per definition in chapter one as service purchasing and contracting, and the national implementation of relevant EU Directive(s) in the area of long-term care. In this context, it is necessary to briefly consider the concept of **'socially responsible procurement'** in LTC against other economic sectors. In trade, construction or manufacturing, socially responsible procurement means to embed goals such as the labour market and social inclusion of persons with disabilities and disadvantaged persons as well as other social clauses in tendering documents and awarding criteria.

This should naturally apply to procuring LTC services, where in addition to striving for decent working conditions and social inclusion, long-term care services should also attempt to attain specific 'social qualities', like improved quality of life for people using these services and their carers thanks to the **continuity of care** and service provision and improved coordination between services. Essentially, the **best price-quality ratio**, rather than just the most cost-effective option, should be at the centre of any contract awarded by the purchasing authorities.

2.1 How can EU procurement legislation contribute to quality long-term care?

__EU Directive 2014/24/EU of 26 February 2014__ on procurement regulates the leeway of Member States to define what they consider to be services of general economic interest and how those services should be organised and financed (Article 1.4 of the Directive). This means that governments have the choice on whether or not social services shall be procured from third parties or be provided by the state. Governments may also declare specific social services as 'non-economic services of general interest' and thus exclude them from the scope of the Directive.

If public authorities decide to organise social services as 'services of general economic interest', these need to be procured through public contracts.[1] This means that public authorities create a context which gives preference to 'buying' rather than 'making' LTC services (Rodrigues et al., 2013). We will examine here how the ensuing process of specifying, securing and monitoring services, also called commissioning, can be used to ensure quality in the delivery of LTC services in Europe. This process involves a broad range of activities ranging from **social planning** (individual, community and general needs assessment) to the **authorisation**, **accreditation** and **contracting** of (new) providers as well as **quality monitoring** and **assurance**.

1 There is an ongoing evaluation of state subsidy rules for health and social services of general economic interest with very weak participation of stakeholders; a final report is being envisaged for 2021 (https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/11835-Evaluation-of-State-aid-rules-for-health-and-social-services-of-general-economic-interest-and-SGEI-De-Minimis).

The following articles of the EU Public Procurement Directive 2014/24/EU are particularly important:

Article 1.4 reiterates that Member States have the freedom to define, in compliance with EU law, what they consider to be services of general economic interest and how those services should be organised and financed.

Only if and when contracting authorities choose to procure social and health services (listed in Annex XIV), and if the amount of the contract is equal or above €750,000, Member States must apply the rules set out in articles 74-77 of the Directive referring to social and other specific services.

Articles 74-77 specify the publication of notices, the scope of **reserved contracts** and the principles of awarding contracts, namely:

- quality,
- continuity,
- accessibility,
- affordability,
- availability,
- comprehensiveness of services,
- the specific needs of different categories of users, including disadvantaged and vulnerable groups,
- innovation,
- the involvement and empowerment of users.

Article 76.2 also specifies: "Member States may also provide that the choice of the service provider shall be made on the basis of the tender presenting the best price-quality ratio, taking into account quality and sustainability criteria for social services".

2.2 How has EU regulation impacted local procurement in long-term care?

Member States had to adopt this Directive by April 2016 but were given leeway to regulate practical matters in their national law (OECD/EU, 2016) or, according to national constitutions, at regional level. In some countries, e.g. Spain, regional legislation has not yet been fully adapted to the European directive and regions are still in the process of passing legislation to provide a legal framework for contracting **personal social services**. The European Commission has considered the transposition of the Directive as overall satisfactory but "will continue to closely monitor the implementation of the directives and evaluate the concrete experiences of national authorities and business with the current regime" (Breton, 2020).

Legislation and distribution of responsibilities

Long-term care and related legislation on procurement together with reforms in social services have been introduced in most countries over the past 15 years. These include, among others:

- 2006 Spanish Law to Promote Personal Autonomy and Care for Dependent People,
- Act on the System of Choice in the Public Sector in Sweden,
- 2014 Procurement Reform Act in Scotland (UK),
- 2016 Procurement Code in Italy.

The various pieces of legislation set out the responsibilities for procurement, planning, regulation, funding and quality assurance in long-term care, which are distributed across national, regional and local government levels. Not surprisingly, there is a tendency towards regulation, planning and funding at national level, but most administrative duties are actually shared within a system of multi-level governance. Procurement and contracting are mostly carried out at local level, together with funding and quality assurance. An exception happens in small countries, where all tasks from planning to quality assurance are carried out at national level.

Since a fundamental aim of the EU is to create a common market based on competition, equal treatment and transparency, it is desirable to know about contracts with sufficiently high value across Europe, in particular if this involves cross-border trade or service delivery.

To take account of the specific characteristics of social, health and education services, the 2014 EU public procurement directive provided a list of 'social and other specific services' where a 'light touch regime' applies to such services (e.g. home help services, training and social security services).

Public tenders of a lower value than €750,000 are not considered attractive in principle to enterprises from other Member States and therefore public buyers can conduct tendering under this threshold as they wish, according to national procurement regulations. For contracts over €750.000, national authorities must implement national legislation to regulate these procurement processes.

These national regulations can stipulate that quality of services provision is taken into account in the tendering process. This means that, based on previously defined quality criteria, public authority buyers can choose the provider that best meets qualitative criteria set out in the tender for the service in question (e.g. accessibility, continuity, or needs of the various categories of service users). States also have the possibility of banning the cost-only criteria in their national legislation on social service procurement (European Commission 2016).

Therefore, though the Directive is built on the principle of 'value for money', it focuses significantly on contracts being awarded on the basis of a combination of cost-related and non-cost-related factors.

In our questionnaire, we asked respondents how the EU public procurement Directive 2014/24/EU of 26 February 2014 affected contracting practices in their country in the area of LTC (Figure 5).

Figure 5 ESN members' views on impact of EU Directive on LTC procurement

- Legislative measures 33%
- Policy changes 19%
- Other effects 15%
- No effects at all 33%
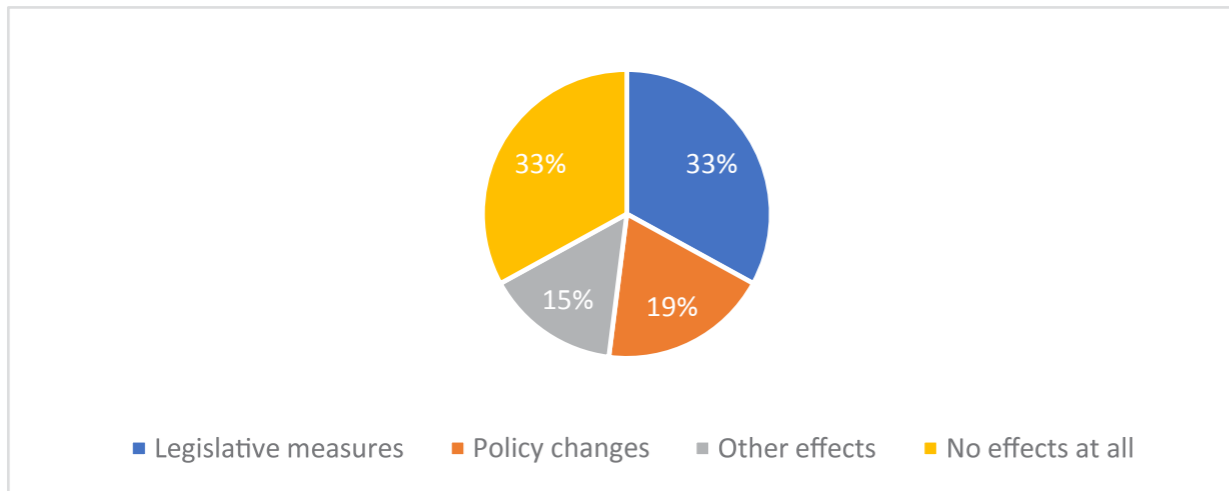
Source: ESN Questionnaire, Q14

While one third of respondents identified no effects at all, more than half of those who answered found related consequences in legislative measures as well as policy changes. For instance, Marc Geoff, Strategic Inspector at the Care Inspectorate in Scotland (UK), explained that "the transposition of the (EU) directive into national legislation improved flexibility to ensure service continuity".

In other instances, it was stated that the directive had actually been used to procure better quality services. "Providers may get a bonus if they fulfil the agreed quality criteria or targets", said Jukka Lindberg, Director of Social and Health Care in Hämeenlinna, Finland.

There have also been regions where no effect on quality has been experienced, and in some cases even a detrimental impact has been perceived, e.g. market concentration or a race towards 'the lowest price'. "The choice of contracts did not change in favour of quality criteria, actually it is still the lowest price that is mainly being considered", explained Ana Radulescu, from the Centre for Training and Assessment in Social Work (CFCECAS), Romania.

In Spain, the directive was transposed through law 19/2017 on public sector contracts, though each region has since been adapting this national legislation because health and social care is a regional competence. In the national transposition of the directive, long-term care services were left out. "The directive did not impact directly long-term care as these services were out of its application and therefore long-term care has a special regime within Spanish Public Procurement Law", highlighted Manuel Montero Rey, Head of the International Relations Service at IMSERSO, Spanish Institute for Older People and Social Services.

Nonetheless, the directive has impacted the way regional authorities deal with procurement processes. "Prior to the directive, the predominant criterion in the award of contracts in the regions was the lowest price. The directive has modified the culture of contracting, and social considerations are included in addition to price, both in specifications and in award criteria", argued a representative of the Regional Ministry of Social Rights and Welfare in Asturias, Spain.

This highlights how LTC services are contracted through differing practices not just between countries but also within countries. Regarding ways in which LTC services are contracted, competition between accredited providers was the most common mechanism, mentioned by 54% of respondents to the ESN questionnaire (Figure 6). However, this can be complemented by competitive tendering, or by choosing from a list of approved providers. In long-term care, an important criterion for awarding a contract has been 'continuity', which might have motivated some public authorities to apply a 'preferred supplier' scheme or reserve contracts.

In question 19 of the questionnaire, we enquired about the contracting process, and in their answers, 50% of respondents said that **best price-quality-ratio** is the key criterion for awarding contracts to providers of LTC services, followed by social clauses/social value (42%), and meeting needs (e.g. coverage of a defined target group, 35%). Only in a few cases (15%), there was emphasis on the 'best price' only or 'best quality' only criterion, but it is unclear how exactly the quality of services is being assessed or measured. A general approach is also that only accredited providers (those that have been previously authorised to deliver a service) get an 'operating licence' and may participate in tenders to receive public payments.

Figure 6 How LTC services are contracted in Member States
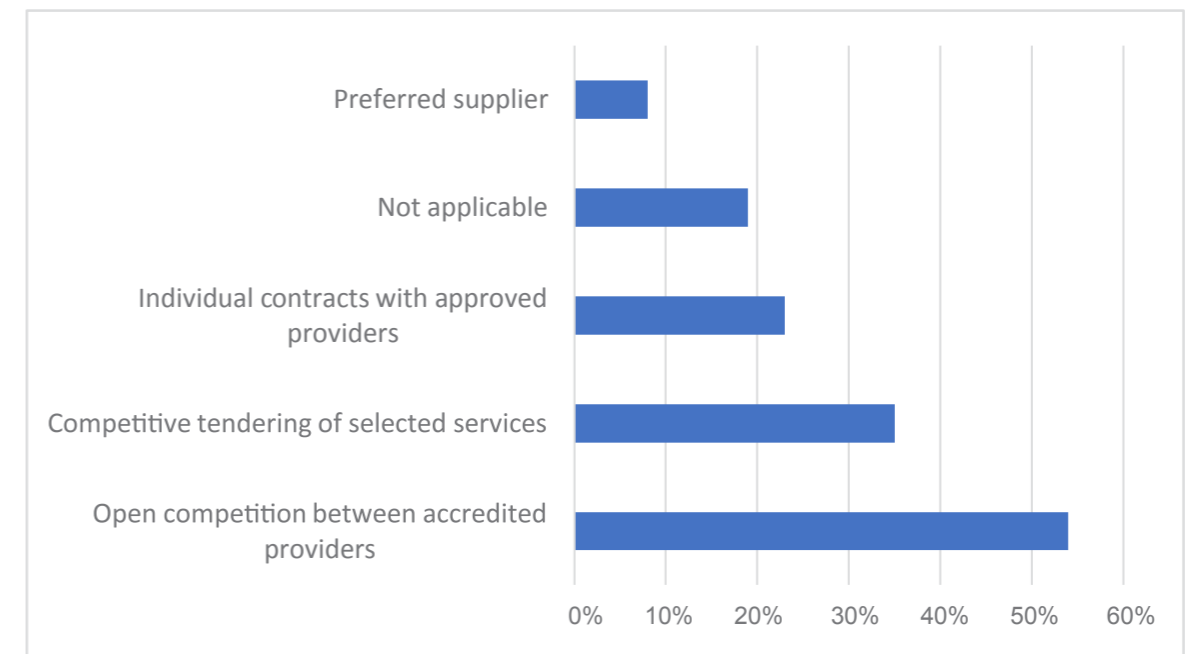
Source: ESN questionnaire, Q17 (multiple answers possible).

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Procurement in Practice: Hämeenlinna, Finland

The City of Hämeenlinna has many years of experience on how to include quality assurance and effectiveness in contracting processes.

> *"By effectiveness we mean that providers may get a bonus if they fulfil defined targets or quality criteria, but they may also be sanctioned in case of underachievement."*

Jukka Lindberg, Director of Social and Health Care, City of Hämeenlinna, Finland

In 2010, the city established a strategic commissioning unit that combines service procurement and quality. The unit applies a value-for-money approach by linking procurement, quality monitoring and strategic decisions about contracting-out, in-house provision and effectiveness of services in the Finnish quasi-market for long-term care.

This process entails the following tasks:

- collecting relevant knowledge and expertise to adapt the role and skills of the commissioning agency,
- developing user-based procurement practices,
- regulating quality assurance at several levels.

The most important challenge for this unit is to reach specified strategic goals by connecting a large range of elements and approaches as a purchaser. The unit is therefore involving all public departments who are dealing with funding and organising public services as well as all public and private (for-profit, not-for-profit) providers. The unit has become an important part of public administration, with related routine tasks and several long-term projects. For instance, the large scale of indicators needs to be constantly monitored and further developed.

Experience has shown that this development has paid off as there have been no legal issues with providers for a long time, and outcome also due to the establishment of strong local structures to facilitate a constant dialogue between all stakeholders involved. Procurement is not seen as an arm's length relationship anymore, but as a model that is moving towards a public-private-partnership agreed among all stakeholders.

Thanks to Jukka Lindberg, Director, Social and Health Care, City of Hämeenlinna, Finland.

Thinking of Putting into Practice …

- When preparing contracts, public authorities might have opted in the past for including clauses on sanctions in case the contract objectives were not met. However, as the example from Hämeenlinna shows, public authorities may adopt a more positive approach by rewarding providers with additional funding if they perform better than initially agreed. This is a way to incentivise providers to move beyond contractual agreements and to generate additional value.

- Map all stakeholders, to identify and involve all those who are relevant during the procurement process and jointly agree on strategic commissioning outcomes. Such stakeholders could include all public departments who are dealing with funding and organising public services, all public and private (for-profit, not-for-profit) providers of long-term care services, as well as, people using services, their families and informal carers.

2.3 How has procurement changed delivery of long-term care in Europe?

Societal and cultural traditions as well as economic and political pathways are shaping the way in which LTC and related individual and societal needs are being addressed and met in different countries. To identify typologies it is therefore necessary to select, describe and analyse a range of categories and indicators. For this, Esping-Andersen's seminal work on Liberal, Conservative and Social Democratic welfare regimes is often taken as a starting point (Esping-Andersen, 1990).

Further research has identified different 'care regimes' depending on the degree of public service provision, the mix of cash benefits and in-kind services, the role of informal carers (family responsibilities), coverage and funding issues or the specific mix of public, private, home and third sector provision of care. New Public Management and the rise of market-oriented provision have contributed to some dynamic changes of this mix in most countries.

Our questionnaire aimed at identifying current trends in European countries regarding these changes. Almost 30% of respondents reported an increase in provision from private for-profit providers in LTC over the past decade. Public provision only increased in Spain (following the 2006 Dependency and Autonomy Promotion Act) and Switzerland. Respondents explained how in some countries (e.g. FI, LT, IT), the share of not-for-profit providers increased, within a market that was already characterised by a steady growth of providers, as well as market consolidation and concentration of some of them. The original idea of market-oriented governance – to achieve lower prices and more user choice by competition – has thus been undermined in several countries due to the concentration of provision in some large providers.
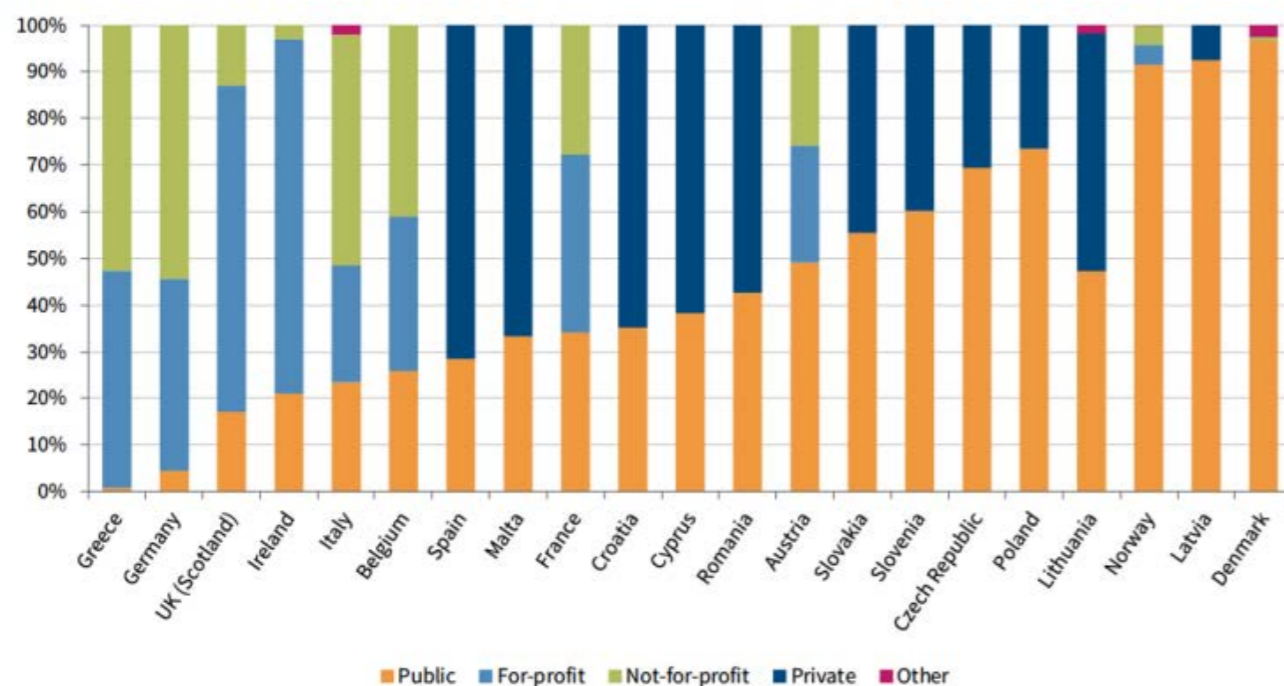
"In long-term care, there has been a huge increase of private for-profit provision during the last 15 years. At the same time, the number of private companies as providers has decreased dramatically. Instead, three to four large companies have taken over most of the market (...). Nonetheless, after this huge market concentration, there is now an increasing number of not-for-profit providers entering the LTC-markets."

Jukka Lindberg, Director of Social and Health Care, City of Hämeenlinna, Finland

A study conducted by Eurofound in 2017 concluded that the most significant growth in private residential care over the past decade took place in Romania, Slovenia and the Slovak Republic (though from a very low baseline). The largest share of private providers can however be observed in Ireland and the UK (Figure 7).

Among respondents to the ESN questionnaire, the market shares of different types of providers cover the entire range of variation, due in part to the fact that respondents reported not just on national but also on local and regional situations.

In residential care, estimates on the share of private for-profit providers range from 1% in Croatia to 80% in Ireland, but there are also huge differences within countries. For instance, in Spain according to data provided by respondents, the market share of for-profit providers in residential care ranges from 10% to 70% in the regions. However, at national level as a whole the picture is different. In Romania, 18% of care homes are run by private for-profit providers, 61% by not-for-profit organisations and only 20% by public authorities.

As for home care, Romanian not-for-profit organisations also hold the largest share of the market with more than 68%. The share of for-profit providers in home care accounts for 3% in Hungary compared to 80% in Spain.

Looking at the long-term care sector as a whole, we identified on average a market share of 42% for the public sector, 36% for the private for-profit sector, and 22% for the private not-for-profit sector. Similar market shares hold true for the home care sector, as per the responses to the questionnaire. Market access for new (private for-profit and not-for-profit) LTC providers has been generally regulated by authorisation, accreditation or licensing. In some cases, these mechanisms may be combined and request that providers comply with a number of requirements.

Procurement is generally well established in long-term care. Just one respondent to our questionnaire replied that, in their jurisdiction, LTC services are exclusively provided by public authorities 'in-house'. However, 37% reported that procurement is comprehensively established in long-term care in their countries (CH, ES, FR, HR, IE, IT, MT, SI, SE). A majority (56%) described various mixed models. For instance, in countries where the LTC system provides benefits in cash (incl. personal budgets), beneficiaries can choose between public and private providers, e.g. in BE, FI, ES, LV, HU, RO, PL, and Scotland in the UK. In order for individuals to employ their own carers or to choose their own providers, there is not a public procurement process. However, for these providers to be able to carry out those services, they may have undergone a procurement process. Likewise, specific care service packages may be also based on public procurement.

Figure 7 Market shares of different types of providers in residential care in selected Member States, around 2016
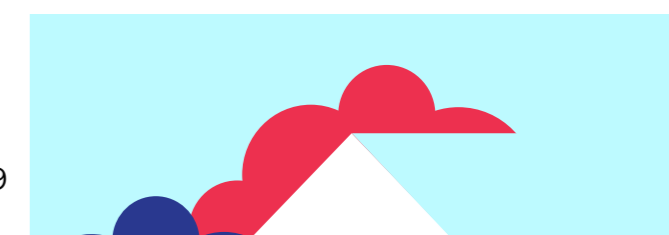

Source: Eurofound, 2017, 17.[2]

Note: 'Private' means both for-profit and not-for-profit as some countries do not distinguish between these two types of providers.

Respondents reported several reasons for moving from in-house production to procuring LTC services, but the most often quoted argument was the expectation of improved cost efficiency. Rising demand had also triggered the need for procuring services that were not available in-house, but there were also policy-driven goals such as "boosting competition between providers" or the intention to increase sustainability by specific social procurement. Finnish respondents also mentioned decreasing pressure on public budgets as an explicit goal by sharing investment between the public and private sectors. They did so through the implementation of a national strategy of deinstitutionalisation and innovation in housing and care.

Improved procurement has nonetheless triggered a number of **challenges** for public authorities and all stakeholders involved, according to respondents to the questionnaire. The majority of respondents identified as the biggest challenges both the **bureaucracy** of tendering procedures and the difficulties in **ensuring the quality of service delivery** (see table 1). Increasing bureaucracy does not only affect public administration but also the providers. In particular, smaller providers seem to be overwhelmed by documentation causing them to drop out of the market, which leads to a concentration of a few larger providers, particularly in sparsely populated areas.

It is interesting to note that 'rising prices' are an important issue in many countries. This would imply that one of the alleged key strengths of procurement and competition has turned out to be a major driver of costs.

With often legally complicated procedures in place, it is difficult to develop and implement **outcome-oriented procurement**. The challenge is therefore to appropriately use the opportunities of linking procurement with considerations of better quality not only within LTC and for individual users, but with a view to improving social quality by re-balancing the relationship between economic and social policy (van der Maesen & Walker, 2005). For instance, the Municipality of Avilés in Spain has embarked in a comprehensive initiative in public procurement linking expanding community-based services for older people with long-term needs support, and employment, local development and social inclusion (see section Procurement in Practice).

Table 1   Key challenges of procurement in LTC

Bureaucracy of tendering procedures	63%
Quality of service delivery	59%
Rising prices	44%
Continuity of provision	30%
Choice of providers	19%

Source: ESN questionnaire, Q16; n=27 (multiple answers possible).

Procurement in Practice: Avilés, Spain

Avilés is a small city in Northern Spain with a very high share of older people over 65 years of age (about 30%), many of whom live alone or in care homes. As the number of older people is expected to increase, so does the number of people in need of LTC, which may threaten the sustainability of the system. Therefore, the municipality of Avilés decided to expand its home support programme for older people to enable them to stay in their homes for as long as possible.

The municipality chose to use public procurement to extend its home support scheme. Since then, tender documents have specified as criteria that providers must ensure a typical way of life for people in need of care in their usual home environment and prevent unnecessary admissions to residential care.

The reasons for developing this initiative, which is currently in its consolidation phase, were twofold:

· to improve employment, especially of women,
· to improve quality of employment in the care sector.

To do so, the municipality defined quality indicators in providers' employment conditions, such as ensuring equal opportunities, and having these included in tender specifications and related scoring schemes.

The main aim of the initiative was to link the extension of care for older people in their homes with creating job opportunities for people with difficulties to access the job market.

The procurement process was underpinned by a number of quality indicators:

· facilitation of clients' permanence in their usual home environment,
· preventing unnecessary admission to care homes,
· facilitation of social integration in the neighbourhood,
· ensuring decent employment in the provision of long-term care.

With this way of procuring home support, it was expected that providers would be incentivised to establish secure employment in the sector and that more older people would remain in their own homes.

Implementation is monitored through several tools:

- user satisfaction regularly assessed through specific quality questionnaires,
- 24/7 help line to coordinate a rapid response to any issues in service provision,
- guide for provider organisations explaining how to collect and document defined quality indicators:

  - level of satisfaction,
  - number and type of users,
  - rate of use in relation to the sector's average,
  - staff turnover in relation to the sector's average,
  - coverage rate,
  - development and quality of employment contracts,
  - policies to implement corporate social responsibility,
  - extent of measures promoting employment for people with disabilities (at least 5% of staff with an assessed disability of 33%).

Following the implementation of this policy, LTC services currently employ 11% of staff with a disability and 89% of the newly employed home helpers come from groups with difficulties in accessing the labour market. The service contributes significantly to the maintenance of autonomy, wellbeing, and quality of life of 1,140 older people who mostly live alone.

With thanks to the Regional Ministry of Social Rights and Welfare of Asturias, Spain.

Thinking of Putting into Practice …

- Social clauses can be used to promote better working conditions for staff in care. Make sure that procurement units in social services departments are aware of the possibility to include social clauses in services tenders and contracts.

- Organise joint training sessions on social clauses for procurement and social services departments, so that they are aware of what can be achieved by making use of such clauses.

Socially responsible procurement cannot only contribute to ensuring the availability of a specific (social) service, it can also meet other social goals, such as creating job opportunities for people with difficulties to access the job market.

- When applying social clauses, check how the EU directive on public procurement has been transposed into your national legislation.

2.4 Challenges and opportunities of procurement in long-term care

Respondents to the ESN questionnaire provided comments and analyses in relation to procurement processes that have been grouped in challenges and opportunities in Table 2. Indeed, public authorities witnessed significant changes in their practice because both the growth of the LTC sector and the expansion of procurement procedures were taking place simultaneously. More importantly, applying procurement rules to an area in which 'quality' is still a shaky concept (see next chapter), has triggered some important lessons or at least insights for potential future strategies.

For instance, though the move to formal tendering processes replaced previously 'negotiated local arrangements', in some areas it became possible to refocus on fairer procurement procedures in the form of more sustainable terms and conditions for staff (as per the practice example in Aviles). Transparency, competition and public monitoring became increasingly enhanced, at best by an explicit focus on social clauses such as decent employment for groups with difficulties to access the labour market, and by involving different stakeholders in the development of goals and indicators.

Respondents mentioned other examples of new opportunities provided by procurement including the promotion of new care models, e.g. by taking advantage of technological innovation. Respondents also mentioned that "social entrepreneurship could be facilitated", and "coordination between administration and service providers" was improved, with increasing "opportunities for participation" of users and for co-production of relevant stakeholders "in the design and development of long-term care provision".
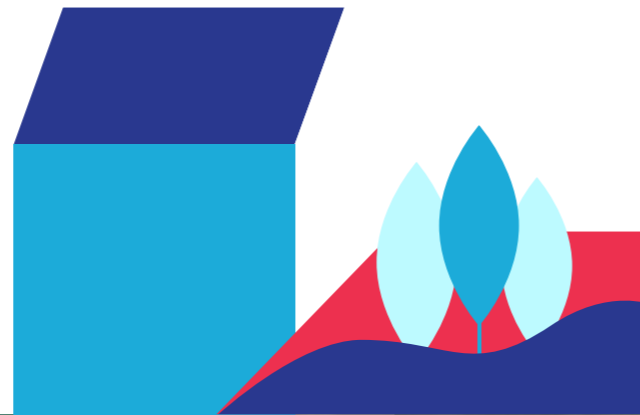
Table 2 Overview of responses on challenges and opportunities of long-term care procurement

Challenges	Opportunities
Difficulties in ensuring quality • evaluating the quality of services • monitoring and quality supervision costs • quality control	**Focus on quality** • The quasi-market arrangement also increases the quality of in-house public services
Focus on low price • The small number of companies that want to provide LTC services results in the acceptance of very low-priced service proposals • Procurement processes also lead to unsustainably low prices, which have detrimental effects on terms and conditions for staff and ultimately lead to workforce shortages, which limit supply • Tenders may be unrealistic in their price setting. This leads to situations where providers may promise more than they can deliver	**Generally improved services** • Contracting... • has led to better programmes • is also necessary because there are resources that **public administration does not have** (call centre, technology...) promotes modernisation by taking advantage of market innovations
Neglect of end-user • Procurement processes sometimes do not focus on outcomes for people who use services	**Focus on end-user** • There is a tendency to outcome-based dynamic procurement models linked to performance, as well as clear demands for good services from the end-users' point of view
Unbalanced quasi-markets • Lack of competition between suppliers • Tendency to concentration • The continuity of not-for-profit social organisations that have been providing services for decades is being endangered • Fragmentation of services	**Transparency** • Procurement may allow for a clearer focus on specifying requirements to meet the needs of people using the services • Tenders allow a transparent selection of the providers
Resistance to change • It is difficult to change the ways of working and to modify the rules of the game on which the market has traditionally been based	**Incentives for business development** • LTC as a market that develops entrepreneurship and opportunities for business development and job creation
Bureaucracy and transaction costs • LTC service providers do not have sometimes the staff to complete the tender documents and process requirements • Difficulty to achieve consensus among all suppliers and bidders	**Ensuring sustainability** • Procurement may help address the threats that affect the sustainability of the system and achieve the involvement of all actors
Lack of criteria for awarding contracts • Tenders do not always guarantee the choice of the best organisation in terms of reliability and ethical principles • Lack of criteria to find the best price-quality ratio	**Strengthening social criteria** • Use of public procurement including social clauses as tools that favour the implementation of social policies (socially responsible procurement)

Source: ESN questionnaire, Q20; n=26

In general, it seems that public authorities have found ways and strategies to deal with procurement by learning from practice and by improving communication with the stakeholders involved. Several respondents reported that the weight of the 'lowest price criterion' had been reduced in their local selection processes. One strategy to prioritise quality in the selection process has been to define the standard cost already in the tender document, so that bidders compete on quality only at a given cost.

Another area of learning has been to allow for continuity of service provision based on existing relationships with providers. For instance, in some Spanish regions it became clear that a change of providers would hamper continuity, particularly if there was a long tradition of cooperation with specific providers. This resulted in changing the 'culture of tendering', for instance through agreements (quota systems) with third sector organisations or cooperatives that support the social inclusion of people with disabilities, all by remaining compliant with the European directive and national legislation on procurement.

However, the situation varies across Europe. "Bureaucracy and procedures have become increasingly complex and there has been less and less differentiation between profit and not-for-profit organisations in the procurement of services. This has led to a higher weight of the price and less attention to the quality or social innovation in the organisations", explained Tobias Voltan, National Coordinator of the Italian National Council of Social Workers.

It should also be stressed that the emphasis on the lowest price was in many cases linked to austerity policies that led to an underinvestment in public social services following the 2008 financial crisis. This in turn impacted developments related to quality in public health and social services, and by extension long-term care.

Nonetheless, the authorities in regions and municipalities across Europe are now seizing the opportunity to learn from previous experiences. By applying the 'commissioning cycle' it has become evident that strategies of pure cost reduction resulted in unsustainable conditions of service provision. Therefore, they have started to review short-sighted strategies in favour of longer ones, more focused on commissioning for outcomes.

It remains to be seen what the result will be in the context of the ongoing Covid-19 crisis. As public authorities were starting to rebalance these two components of price and quality, the Covid-19 crisis hit care services. In many countries, in particular in Central and Eastern Europe, LTC services are also fragile and still suffer from unstable political support. However, there is evidence of newly developed local strategies **to monitor and guide long-term care towards quality indicators** with the aim of measuring improvement in people's outcomes and their quality of life.

In Catalonia (Spain), the regional government approved a **decree of quality of care**, according to which organisations that wish to be accredited as providers of public care social services must respond to the needs of users and provide them with an adequate quality of life. These include a user's register, a permanently updated individual care file, a charter of services, protocols detailing the actions that must be carried out to provide the service correctly and encourage the participation of users, as well as a referral mechanism in the event of termination of service to guarantee the continuum of care.

In Hämeenlinna (Finland), local authorities apply so-called **'strategic commissioning'** (or social planning) to ensure quality of services throughout the procurement process. The aim is to apply a value-for-money approach by linking procurement, quality monitoring and strategic decisions about contracting-out services. 'Strategic commissioning' takes place on a superior, strategic level, based on an analysis of needs and organisational and financial capacities. It also sets up monitoring activities that help to measure if a certain outcome has been achieved by the purchased services.

Strategic commissioning often comes into effect when a set of services is contracted out to achieve a common goal, such as improvements in people's quality of life when receiving long-term care. It has become an important part of Hämeenlinna's long-term care service procurement activities. Experience has shown is produces positive results. There have been no legal issues with care providers, due in part to the establishment of strong local structures to facilitate a constant dialogue between all stakeholders involved.

In France, tripartite **'multiannual contracts of objectives and resources'** signed by the County Council (public buyer of long term care), the care provider and the Regional Health Agency (public buyer of health care), determine quality goals that shall be reached during the execution of the contract. Those contract goals are determined based on a joint quality needs assessment by the three contractual partners. The compliance with the agreed quality goals is regularly monitored by the Regional Health Agency and the County Council, which fund and advise the contracted care service provider. The County Council funds long term daily care (i.e. food provision and cleaning) and the Regional Health Agency funds medical care (Agence Régionale de Santé, 2018).

In Ireland, complying with regulations is only one aspect care providers have to respect in order to demonstrate they are providing high quality care and support. They also have to show that they constantly strive for ongoing improvement in the quality of their services by using national standards to promote ongoing improvements that enhance the quality of life and rights of the people living in their services.

In the Netherlands, **quality of life** was put in the centre of the National Quality Framework, which includes quality and safety aspects such as person-centred care & support, wellbeing, safety of users, opportunities for learning and improvement as well as other conditions for good quality of care, such as performing leadership and governance, norms for staffing and efficient use of resources and information (Dutch Health Care Institute, 2017).

Figure 8 Integrated model for quality nursing home care in the Netherlands

Source: Dutch Health Care Institute, 2017

Commissioning in Practice: Outcome-Based Commissioning in Swindon (UK)

Programmed Performance Measures

Source: Marc Friedman, Director, Fiscal Policy Studies Institute (FPSI), Santa Fe, New Mexico, USA

Swindon's Adult Social Services have the duty to ensure sufficiency of care as well as a market management obligation for adults in need of care and support. Long-term care is provided mainly by private providers.

Swindon Borough Council buys approximately 10,400 hours of home care each week for approximately 700 older people. An additional 450 older people are supported by social services in residential and nursing homes.

When procuring services from providers, Swindon Borough Council defers to the methodology of Outcome-based Commissioning, developed by Mark Friedman (Friedman, M., 2009).

The purpose of using this methodology was to:

· establish a clear link between population outcomes for Swindon as a whole and performance measures for services delivered locally,
· use a simple framework where providers set performance measures within the framework set by social services,
· create a link between three elements of costumer outcomes: 1. Effort (how much is done), 2. Quality (how well is it done), and 3. Outcomes (whether anybody is better off).

An example outcome for the population was that older people can have a healthy and safe life. An example indicator for that is the proportion of older people living in residential care per 100,000 inhabitants. The performance of the provider would be measured around the three dimensions of Customer Outcome: 1. How much was done? 2. How well was it done? 3. Is anyone better off?

Swindon decided to apply the 'Outcome-based Commissioning' method on the contract with 'First City', a local lead provider for long-term care, working in collaboration with 15 partners who jointly support over 1,100 people living in the Borough.

The specifications of the contract were developed in engagement with providers:

· the involvement of local communities as well as the voluntary sector to support carers and those receiving care,
· the use and development of technology-based care,
· ongoing conversation with people receiving services about how the voluntary sector and the wider community can support them.

This allows Swindon to adapt services to the evolving needs of the users of social services.

With this method, positive outcomes can best be achieved if the public buyer and the provider enter a long-lasting partnership that allows for long-term planning on both sides as well as feedback loops and investment in quality, resulting in quality improvement over time. In Swindon, such long-lasting partnerships with lead providers are fostered by using multiannual contracts of 7 to 10 years. For instance, the contract with First City is for 10 years.

Achievements of outcome-based commissioning in long-term care in Swindon so far have been:

· delays in hospital admissions reduced and 50% of hospital beds were empty in April and May 2020,
· admission to nursing homes reduced by 10%,
· packages of care following hospital discharge were reduced.

With thanks to Sue Wald, Corporate Director of Adult Social Services, Health & Housing, Swindon Borough Council, UK.
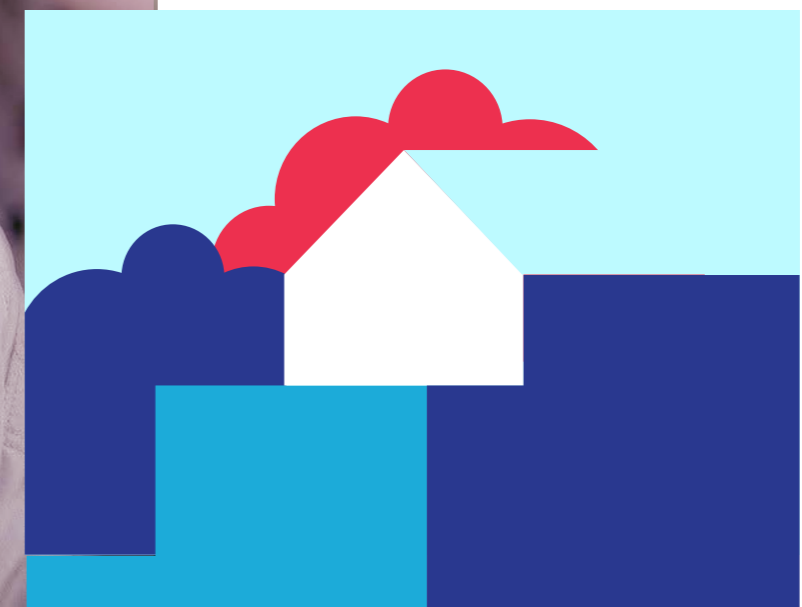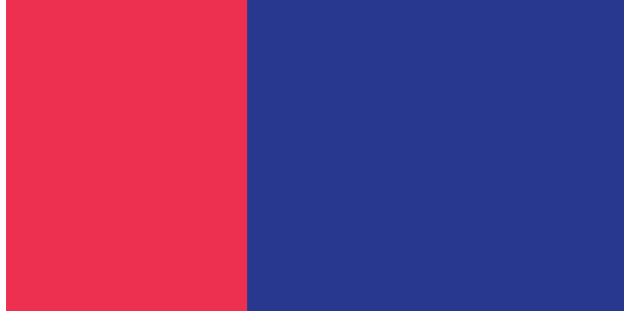
3. Ensuring quality in long-term care

The LTC sector is still struggling with definitions of quality (Cès & Coster, 2019; Zigante & King, 2019) and general standards in terms of professional roles, staffing levels, skills and grade mix, and other specifications that could serve as guidelines and requirements in tender specifications.

There has recently been a general trend to move away from structural and process standards to **outcome-oriented performance indicators** with a focus on quality of life (Malley et al., 2016). However, this trend often remains limited to theoretical concepts, while in practice providers have to deal with cumbersome bureaucratic processes that are still falling short of establishing continuous improvement indicators.

Our questionnaire therefore aimed to find out more about current developments regarding how public authorities have enshrined quality assurance and improvement processes in their own service provision, in procurement, and in contracting services out with external providers, as well as in monitoring and improvement of the services that they contract out.

3.1 What frameworks are used to ensure quality in long-term care?

In most European countries there are at least basic legal regulations to define quality of the various LTC services at national or regional levels as presented in earlier work by the European Social Network (ESN, 2020). Further efforts to monitor quality have been triggered by the general need to regulate access of (new) providers to the LTC market.

According to the answers to the ESN questionnaire, different national or regional laws regulating social services have defined general quality criteria, which are then detailed in specific requirements for individual services, such as home care, residential care, day-care, or telecare.

These criteria are used in accreditation, authorisation, licensing and quality management systems that providers are required to fulfil as a precondition to be allowed to deliver a service. Most legal frameworks also include a section on monitoring and quality assurance through inspections.

Based on the answers to the questionnaire, we can conclude that all countries have at least minimum standards on quality of care at national or regional levels, but their scope differs significantly from country to country.

This shows that there is an opportunity for mutual learning among European countries to find a common understanding regarding the definition of objectives and quality criteria in long-term care. There is ample space to discuss across regions and countries the strengths and weaknesses of different approaches to quality assurance and quality improvement.

Yet, in countries and regions with legal frameworks in place, emphasis is mostly placed on structural and process criteria such as 'staffing levels' and 'quality management'. Trends to include users' participation and satisfaction can nonetheless be observed. For instance, first steps towards outcome-oriented procurement have been implemented across localities as the examples in the previous section show. Standards and measures have also been identified with the introduction of national or regional care standards focused on the person's expectations of care (see section Quality in Practice below).

A majority of respondents reported that the existing criteria and requirements apply equally to all private and public providers. However, there are regions where public providers do not need a license to operate, while in other cases private providers may have certain restrictions. For instance, in Sweden they are not allowed to provide short-term and long-term residential care in the same facility, as this might lead to short-term residential care becoming permanent.

Table 3 Quality criteria of LTC covered by national or regional quality frameworks

Staffing levels and qualified workforce	73%
Quality management	69%
User satisfaction	62%
Service users covered	58%
The participation of users	54%
Number/Type of services	46%
Indicators on quality of life improvement	42%
Other	19%

Source: Q23, n=26 (multiple answers possible).
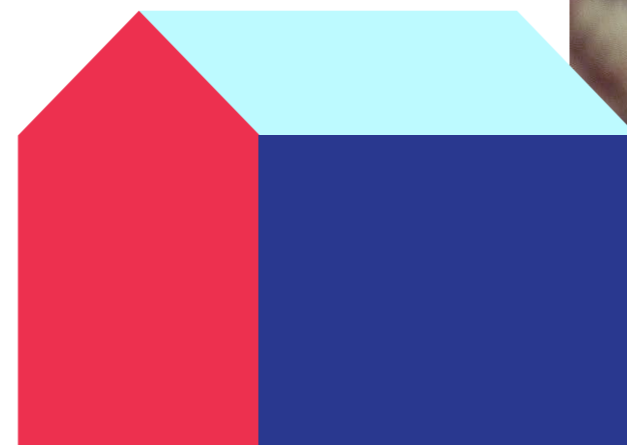
Quality in Practice: Health and Social Care Standards in Scotland, UK

The revised Scottish national health and social care standards came into force in April 2018. Their aim was to better define what people can expect when they use health, social care or social work services. These standards seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that their basic human rights are upheld. The aim is to drive improvement, promote flexibility and encourage innovation in how people are cared for and supported.

All services and support organisations are prompted to use the standards as a guideline for how to achieve high quality care, and as a basis of quality assurance. The standards were written from the perspective of people using services. This entailed an extensive engagement with service users and their representatives to focus items and indicators on outcomes and users' experiences.

The standards are used by ESN member the Care Inspectorate in relation to inspections, and registration, of care services. The standards are translated into quality frameworks for each type of service e.g. care homes or support at home. This is a lengthy process involving significant consultation with service providers and people who use services. A result of this process is the 2018 quality framework for care homes for older people.

Table 4 Quality indicators framework for older people care homes in Scotland (2018)

Key question 1: How well do we support people's wellbeing?

1.1. People experience compassion, dignity and respect

1.2. People get the most out of life

1.3. People's health benefits from their care and support

1.4. People are getting the right service for them

Key question 2: How good is our leadership?

2.1. Vision and values positively inform practice

2.2. Quality assurance and improvement is led well

2.3. Leaders collaborate to support people

2.4. Staff are led well

Key question 3: How good is our staff team?

3.1. Staff have been recruited well

3.2. Staff have the right knowledge, competence and development to care for and support people

3.3. Staffing levels and mix meet people's needs, with staff working well together

Key question 4: How good is our setting?

4.1. People experience high quality facilities

4.2. The setting promotes and enables people's independence

4.3. People can be connected and involved in the wider community

Key question 5: How well is our care and support planned?

5.1. Assessment and care planning reflects peoples' needs and wishes

5.2. Families and carers are involved

Key question 6: What is the overall capacity for improvement?

3.2 What mechanisms can be put in place to ensure quality assurance?

Based on legislation, there are various ways in which public authorities may ensure fulfilment of requirements and standards in LTC service provision. The mechanism mentioned by most respondents was regular inspection by a public agency; for instance, a care inspectorate that is somehow linked to national or regional ministries or departments. However, as there are so many providers, additional mechanisms have been developed including internal quality management, quality certification by a third party, or an evaluation in the case of a pilot project or a specific programme (see Table 5 for further information).

Care and service inspections have primarily an improvement function. Where areas for improvements are identified, care inspectorates usually follow a graduated approach to enforcement seeking to adopt the least restrictive action in bringing about the necessary improvements and outcomes for people. Enforcement of standards is a last resort and takes place after all collaborative efforts to improve have been unsuccessful. Indeed, enforcement is usually not within the remit of the care inspectorates, as it is generally the role of central, regional or local authorities.

Indeed, very few instances were reported of such situations. Our ESN member in the City of Hämeenlinna (FI) explained that if providers were unable to comply with requested improvements,

regional or local authorities have the prerogative to terminate the contract whilst Valvira, the Finnish quality assurance agency, may as a last resort terminate a licence. A similar approach is followed in Sweden where local authorities may terminate a contract, while the national inspectorate may withdraw a license as a last resort.

Similarly, in Latvia, the Ministry of Welfare may remove services or facilities from the register of social service providers if requests for improvement are not appropriately addressed, as our member at the welfare department of Riga City Council described. In general, very few situations have been reported where a service provider had to pay a penalty or lost their licence, as colleagues from Romania's centre for training and assessment in social work clarified. Hungary's Directorate General for Social Affairs and Child Protection reported only one case, in 2013, when a provider had to repay statutory funding to the Hungarian State Treasury.

Local authorities may also implement specific quality criteria in individual contracts. This is the case in domiciliary care, which is usually a local authority duty and, in several countries, there is not a quality framework for domiciliary care. For instance, in the City of Barcelona, quality criteria for domiciliary care are laid down in each individual contract with providers in line with the provisions included in Catalonia's regional Social Services Act. Barcelona County Council has developed a guide for quality of home care standards to support smaller municipalities efforts to establish quality standards in their contracting processes with providers.
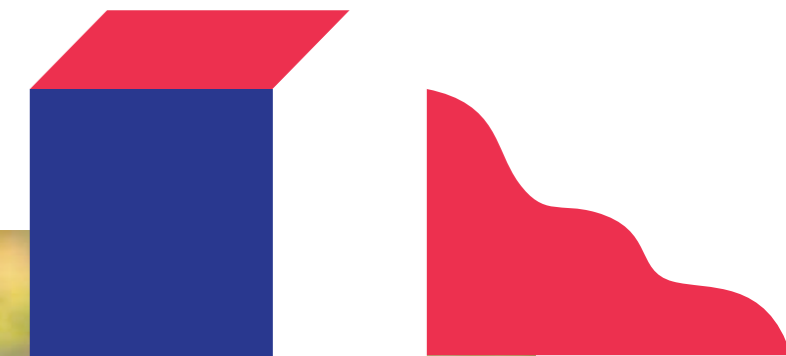
Table 5 Quality assurance mechanisms

Inspection by public agency (e.g. care inspectorate)	21
Satisfaction questionnaires	16
Internal quality management (self-assessment)	15
Complaint mechanisms	14
Public reporting (website)	10
Certification by third party (quality management system)	8
Outcomes based evaluations	8
Other, e.g. external evaluation	7

Source: ESN Questionnaire, Q27, n=26 (multiple answers possible).

Quality Inspection in Practice: Ireland

All services are required to be registered to operate, and services must comply with their conditions of registration. Where a provider is found to be in noncompliance with the regulatory requirements, the inspector assesses the risk as being low, medium or high. Where the risk is immediate, the provider will be informed and will be asked to address the risk before the end of the inspection. Where the risk is urgent, the provider will be required to address the issue within 24 hours. Following the inspection, providers are issued with the findings of the inspection in a written report and are required to submit a plan to address areas for improvement.

Where there is ongoing non-compliance, the chief inspector may take a number of escalating actions which can include:

- issuing a warning letter,
- attaching an additional restrictive condition to the registration of the centre,
- cancelling the registration of the centre which means the provider can no longer continue to operate the centre,
- the chief inspector may institute criminal proceedings.

During its inspections, HIQA, the Irish Quality inspection agency, is seeking assurance that the regulations are being adhered to. This means that inspectors try to make sure that older people who are receiving residential care:

- are safe,
- have their rights respected,
- are included in decisions about their care,
- are provided with care that matches their individual health and social needs,
- have a good quality of life.

Example questions included in the Guidance for the assessment of care homes for older people are:

- Has the registered provider established and maintained a Directory of Residents in a designated centre?
- Has the registered provider effected a contract of insurance against injury to residents?
- Has the registered provider provided an accessible and effective complaints procedure which includes an appeals procedure?
- Has the registered provider made each resident and their family aware of the complaints procedure as soon as is practicable after admission of the resident to the centre?
- Has the registered provider nominated person who is not involved in the matter the subject of the complaint to deal with complaints?
- Has the registered provider put in place any measures required for improvement in response to a complaint?
- Has the registered provider, in so far as is reasonably practical, ensured that a resident may communicate freely and in particular have access to:

  - information about current affairs and local matters,
  - radio, television, newspapers and other media,
  - telephone facilities, which may be accessed privately,
  - voluntary groups, community resources and events?

Further information can be found int the HIQA 2020 Guidance for the assessment of designated centres for older people (HIQA, 2020a).

Thinking of Putting into Practice ...

· Quality care is based on quality standards that should be developed and implemented in collaboration with providers. For authorities who would like to develop care standards, Ireland's Health & Information Quality Authority (HIQA) has prepared an online course, available **here**, which describes how national standards for health and social care settings are developed (HIQA, 2020b).

Monitoring the implementation of care standards is not about control but about a permanent dialogue between quality assurance agencies and providers. While providers need to be aware of existing quality standards, inspections and audits should help them with the application of these standards. Care Standard Authorities (CSA) should be transparent on what providers can expect from monitoring visits. HIQA has published a **number of documents** to help service providers prepare for monitoring visits (HIQA, 2020c).

· Quality standards should be defined in an extensive engagement with service users and their representatives and include a complaints mechanism which is available to all residents, and a follow-up process to any complaint.

· Care inspections were often halted during the Covid-19 pandemic. However, quality assurance agencies should implement ways to continue their activities and related visits while observing protection and social distancing measures

Table 6 Agencies responsible for quality assurance in selected countries

Country		Quality assurance agency and responsibilities
Belgium		• Brussels: IRISCARE (accreditation, inspection) • Wallonia: AVIQ - Agence pour une vie de qualité • Flanders: Agentschap Zorg en Gezondheid
Croatia		• Inspection of the Independent Sector for Supervision and Petitions at the Ministry of Labour, Pensions, Family and Social Policy
Finland		• Ministry of Social and Health Care Affairs (legislation, quality standards, guidance by information) • Institute of Health and Welfare (quality standards, national data-management, evaluation of state-financed development-projects) • VALVIRA – National Supervisory Authority of Welfare and Health (national supervision) • Regional State Administrative Agencies (regional supervision) • Municipalities (local supervision as procurer) • Provider units (reporting and self-assessment)
France		• Agence Régionale de Sante (control and inspection) • Cour des comptes (financial audits and control) • Inspection générale des Affaires sociales (inspection)
Ireland		• HIQA – Health Information and Quality Authority
Italy		• National Agency for Regional Health Services (analysis, monitoring, evaluation of health services) • Regional Agencies for Social and Health Services (accreditation and quality control at regional level)
Latvia		• Methodological Management and Control Department of the Ministry of Welfare (inspection, monitoring)
Malta		• SCSA – Social Care Standards Authority • Active Ageing Community Care • National Audit Office (financial audits and control)
Romania		• National Agency for Payments and Social Inspection
Scotland, UK		• The Care Inspectorate (registering and inspecting individual social care services in each of the 32 local authorities, supporting quality improvement)
Spain	Region of Madrid	• Autonomous community (periodic inspection and monitoring of implementation of quality standards)
	Region of Catalonia	• UCQEC – Quality Control Unit at municipal level (monitoring contracts) • CatSalut – Catalan Health Service (regional quality assurance regarding indicators included in contracts) • AQUAS – Agency of Health Quality and Assessment of Catalonia (monitoring framework, evaluation)
	Region of Asturias	• Inspection Services of the Regional Ministry of Social Rights and Welfare
Sweden		• National Inspectorate (accreditation and inspection)

Source: ESN Questionnaire, Q28

3.3 How can people using services be supported to participate in quality assurance in long-term care?

There has been an improvement across Europe in the involvement of people using services in quality assurance and feedback mechanisms, be it through satisfaction surveys or procedures to raise any issues or complaints. This is also facilitated by ombudspersons and regular inspections where users are able to express their preferences and expectations, or ad-hoc inspections in case of complaints.

Respondents to the ESN questionnaire reported on initiatives to involve people suing services and their families in:

- the design of care services (as illustrated in the example from Aviles, Spain),
- the assessment of the quality of care or services (as we saw in the example of the care quality standards framework in Scotland, UK),
- participation in functioning of residential care facilities (see the example below of Participation for Quality Assurance in Practice).

Quality standards may request that service providers involve people who use services and their carers and families in the planning and development of their services as well as delivery. Involvement is embedded throughout the quality frameworks that have been developed to support implementation of national standards.

Regulatory inspections of care providers' compliance with national standards may also include specific requests to assess users involvement, such as:

- pre-inspection questionnaires sent to care services for them to distribute to families, relatives, and service users,
- online questionnaires implemented within care homes,
- interviews with service users, families and relatives, and visitors,
- anonymised comments within inspection reports to reflect people's views.

Figure 10 provides an overview of mechanisms reported in the questionnaires to help ensure user participation in delivery of long-term care.

Figure 10 Involving users in quality assurance
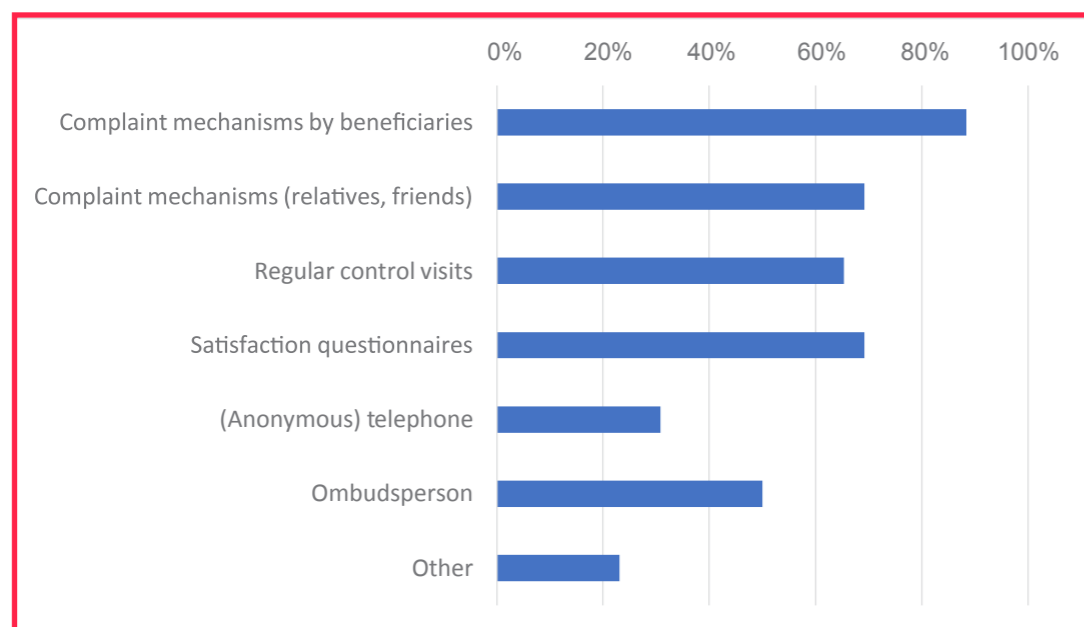
Source: ESN Survey, Q29 (multiple answers allowed).

Participation for Quality Assurance in Practice: Hungary

In Hungary, residential self-government or participation in decisions related to the functioning of the facility can be established if more than half of the residents request it. The aim is to provide an opportunity for active participation of residents in the life of the facility to contribute to its running and operations.

This body decides how it operates and lays down the regulations for this purpose. They determine, e.g., how often meetings are held, who is delegated to an advocacy forum to advocate on their behalf, how decisions are made, and distribution of responsibilities.

Its members are chosen by the residents, who may also elected a president amongst them. Meetings are only attended by the residents who discuss issues that affect them, satisfaction with care, relationships with carers and management. The decisions they make are then transferred to the manager in the facility.

The most relevant tasks of the self-government initiative are to promote:

- collaborative relationships with the managers and staff in residential facilities to improve the quality of care,
- participation in integration efforts,
- protection of residents' interests and rights,
- peer support,
- self-organising community activities, participating in organising and running programmes,
- external networking,
- collecting, discussing and forwarding the suggestions of the residents.

With thanks to Zsófia Szőnyi, Directorate-General for Social Affairs and Child Protection, Hungary.

3.4 How can we overcome the challenges in improving quality in long-term care?

Public authorities have engaged in addressing quality issues in long-term care, but there have been few concrete cases in which contracting was used to trigger quality improvement. This is due to a complicated mix of interests within and between contracting parties. On the one hand, public authorities would like to procure high quality services, but additional requirements may drive up their price. On the other hand, while providers also have an interest in decent quality provision, they often have to work with standard fees for individual services.

Therefore, some countries, particularly those where quality is still a relatively new concept, seem to have placed an emphasis on defining minimum standards, e.g. Italian regions have defined 'essential levels of service provision'. This process went hand in hand with the introduction of indicators measuring wellbeing and a review of out-of-date quality indicators (Q32).

These and other improvements that were recently introduced show some trends towards embedding health and social care standards in service delivery with a focus on human rights and the assessment of service users experience.

> *"Over the years, there has been a gradual introduction in some regions of indicators regarding people's wellbeing and above all a greater involvement of users and families in the assessment of services."*

Tobias Voltan, Italian National Council of Social Workers

Examples of developments combining contract management, quality develop¬ment and the involvement of relevant stakeholders can be found in several local authorities across Europe. At ESN we have implemented a learning process between public authorities with responsibility for social care and social services to address the challenges of procuring care and support with an increasing number of private providers, as we did at our annual seminar.

For instance, the City of Madrid has made progress in addressing potential resistance against quality assurance through a public-private partnership approach (see detailed example below).

In France, in addition to the care provider and County Council, Regional Health Agencies are also party to the contract ensuring that quality safeguards are included in the contract. Such tripartite 'multi-annual contracts of objectives and resources' are based on a shared quality aim by the three stakeholders involved: the buyers (the County Council and the Health Regional Agency) and the providers. Based on an assessment, they set the contract size and quality objectives to be met over a multiannual timeline (generally 5 years). The objectives, which are reviewed by the authorities every year, can include for instance improvements in the lives of people using the services, staff working conditions, including training for staff to respond better to the needs of people using services, as well as support for family members (Agence Régionale de Santé, 2018).

Quality Assurance in Practice: City of Madrid, Spain

Madrid City Council plans and designs services in-house and monitors the quality of services contracted out to external providers. LTC has been a particularly fast-growing sector with about 50 different, mostly private, organisations delivering various services to about 200,000 citizens. Advances have been made to ensure higher quality in contractual matters, advertising of tenders, transparency, inclusion of social clauses and the improvement of award criteria.

Madrid City Council is also convinced that assessing compliance with the involvement of the contracted providers and the participation of citizens is key to guarantee continuous improvement. Information obtained through the quality control system set up by the municipal Directorate General for Older People allows for a precise monitoring of the implementation of technical specifications defined in tender documents.

An important objective of the standards is that services are adapted to the expectations of older people with long-term support needs. It is therefore key to guarantee compliance with quality standards by all external providers. An important precondition is thus to establish a relationship of trust between the purchaser and the providers, including contractual definitions of quality.

A specific strength of this approach is to underpin municipal management, programming and re-programming, as contracts may be reformulated as they are monitored by the 'improvement group' of municipal experts in cooperation with providers.

User surveys are an important tool for monitoring not only user satisfaction but also compliance with objectives and the impact of services on people's quality of life. Users also contribute with suggestions for improvement that are merged with suggestions stemming from the municipal monitoring system.

Going from designing 'for' to designing 'with' is not an easy task, but it is a necessary strategy in providing services through a public-private partnership approach. Well-defined contracts are as important as the active involvement of the relevant stakeholders, including managing departments and service providers in a strategic alliance.

Madrid City Council argues that this approach has definitely changed service providers attitudes. While they had previously perceived increasing monitoring as a negative feature with an aim to sanction non-compliance, service providers are now considering each monitoring cycle as support towards improvement. A similar transformation has occurred within the council with professionals increasingly valuing the initiative. The mutually agreed importance attached to contracting and monitoring compliance is now considered an asset by all the stakeholders involved.

With thanks to Pilar Serrano Garijo, Social Affairs Department, Madrid City Council, Spain

Putting Quality First

In recent decades, we have seen a wide range of efforts addressing the challenge of measuring quality of care. In many countries, we have observed the establishment of agencies dedicated to the monitoring of providers' compliance with rules and regulations. National and regional legislation also advanced authorisation and accreditation mechanisms, including the definition of quality indicators, even if these are often process indicators that describe individual services and facilities rather than outcomes based.

Meanwhile, providers themselves have engaged in implementing either classical or adapted quality management processes according to the needs of the long-term care sector or their individual organisations. However, quality in care is not only dependent on the efforts of individual providers, but also on inter-organisational, inter-professional and inter-sectorial coordination. Neither the public authority as purchaser nor the user of services is buying a single 'product' but a range of services that the person or persons need so that they can improve their quality of life.

People with multiple needs will require a package consisting of both health services (primary care, specialist care), home care as well as participation in day care or an active participation centre, which may be coordinated with their informal carer(s) -if they have one, and managed by a case manager who sits within formal care or in the public authority that grants the support package. The quality of this arrangement depends on the performance of each individual provider as well as on the relationship among them. This relationship between the various providers involved needs to be publicly planned, regularly monitored and periodically assessed to ensure that it is continuously improved.

We examined how the process by which public authorities specify, secure and monitor services, also called commissioning, can be used to ensure quality in the delivery of care services across countries. This process involves a broad range of activities ranging from social planning (individual, community and general needs assessment) to the authorisation, accreditation and contracting of (new) providers as well as quality monitoring and assurance.

Given the specific nature of care, it is important to find ways to balance pricing and quality when public authorities contract services out, at best by measuring outcomes in terms of user experience regarding their improved quality of life. In this report, we have analysed how public authorities monitor and ensure quality through processes related to negotiation, monitoring and improvement of contracts.

This planning exercise should be complemented with ways of monitoring and improving the quality of the care delivered. Contractors and designated authorities responsible for inspection and quality assurance should focus their activities on assessing results and outcomes of the relationship among care organisations as well as the impact of those services on people's lives.

Throughout this report, we have presented practice examples as provided by ESN members and made recommendations on new ways of financing care delivery based on performance and outcome-based indicators. Rather than paying for or reimbursing individual services (based on the number of places/beds/clients, or by the number of hours or days), integrated care delivery could also be purchased as a package based on defined outcome(s), such as full or partial recovery, the possibility for people to better manage their conditions without the need to increase care, or delays in hospital or nursing home admissions.

Moving Forward: Proposals for Policy-Making in Long-Term Care

At EU Level

1. Supporting national authorities to end the institutionalisation of older people

The shared European values of human dignity, equality and the respect for human rights should guide the development of social care and social services which respect the integrity of the person. Older people prefer to stay at home and in their communities as long as possible.

The EU therefore needs to support the shift from institutional care to home and community care through supporting national authorities in the implementation of reforms in their care systems. One way this could happen is through ensuring that the future Recovery and Resilience Facility Funds (RRF) as well as the European Social Fund Plus (ESF+) help to prevent institutionalisation and promote reforms for the transition to community-based care.

2. Recasting the 2010 voluntary Quality Framework for Social Services

Across Europe, Member States are developing, commissioning, and procuring services for older people in different ways. To ensure that EU guidance is up to the task, the EU should recast the 2010 voluntary Quality Framework for Social Services, based on the principles of ensuring quality of care and outcomes for people using services.

Central to this recast should be a re-focus of the framework principles on the importance of outcome-based commissioning and procurement of social services guided by indicators that concentrate on the improvement in people's lives.

3. Guaranteeing the right to quality long-term care

Principle 18 of the European Pillar of Social Rights (EPSR) underpins the right of everyone to quality long-term care that is both accessible and affordable. The EU, through its EPSR action plan and through the future RRF and ESF+ should promote long-term care which is person-centred, community-based, integrated with health and social services, and aimed at maintaining and improving the quality of life of people using long-term care.

4. Recognising the importance of the workforce

Quality of social services and social care depends greatly on investment, how investment is made, and the importance given to the workforce. Staff in health and social care play a vital role in supporting those in need as we have seen during the current pandemic. Still there is a lack of skills and training for specific long-term care professionals, with significant differences in their status and standardisation across countries.

The sector is facing a significant under-investment, which has become exacerbated by the Covid-19 crisis and translates into poor working conditions and an enormous recruitment gap. Considering workforce mobility, economic development and the current health and social crises, these issues should be jointly tackled at national and European levels.

Programmes providing entry level training, supporting recruitment and retention, career progression and mutual recognition of qualifications would help address the shortage in the care workforce, which is an issue across Europe. The EPSR's action plan should include work with national governments on a social care and social services workforce strategy supporting those living in areas of disadvantage and younger people, since this could also support the work of the EU in combating poverty and investment in local communities promoting the care economy.

At National Level

1. Prioritising the implementation of principle 18 of the European Pillar of Social Rights

Evidence presented within this publication and ESN's ongoing work on the European Semester and the EPSR highlights a fragmentation between health care and social services that is, among other issues, hindering the implementation of community-based care for people with chronic conditions.

To overcome this fragmentation, there is a need to build policy coherence between the various levels of government, health and social care authorities and the many providers in the sector. Evidence has demonstrated the need for funding to invest in integrated community care models. Rebalancing care towards prevention, supporting older people to stay in their homes for as long as possible, and where it is not possible in community-based facilities, must be given priority by investing in integrated forms of support, which in turn should help develop the care economy.

2. Guaranteeing access to quality long-term care services

National authorities and decision-makers should ensure that everyone is able to access a range of quality long-term care services which meet their needs and adhere to minimum quality standards as set by Care Standard Authorities (CSA). These services should ensure adequate and equal coverage both in urban and rural areas.

In the provision of private services, public authorities need to ensure that there is not a strong market concentration, as it could be detrimental to competition and quality. The use of outcome-based procurement, social clauses and the definition of minimum quality standards should go hand in hand with appropriate mechanisms to ensure compliance with mutually agreed standards and outcomes.

3. Guaranteeing quality assurance of care

Care Standard Authorities (CSA) and similar agencies have become an important element of quality assurance in long-term care across Europe. There is a trend from mere inspections to quality improvement mechanisms that promote continuous improvement. This trend is advanced by CSAs that should have the resources to monitor services and work with providers to help them to improve the quality of care in an integrated manner.

Care standards should be implemented via a partnership approach allowing providers to improve their performance with the support needed to obtain better results. If providers do not meet the necessary levels of quality, CSAs should have the power to recommend measures, including ensuring that public authorities guarantee service continuity.

4. Progressing towards outcome-based commissioning and procurement of long-term care

Outcome-based commissioning and procurement puts the focus on the impact of the care, support and services provided to the person and how they may positively influence the person's quality of life. This approach places the person at the centre, helping to address their needs but also to fulfil their personal goals and priorities.

To advance towards such an approach, public authorities should progressively move from fee-for-service financing to financing that focuses services on positive results for the person. This involves consultation with all relevant stakeholders during the elaboration of the procurement process. The outcome-based model could also be further strengthened through the inclusion of social clauses related to staff employment or the involvement of people using services and their family in service design, delivery and assessment.

5. Recognising the importance of informal carers and the care workforce

Informal carers should be recognised as a vital stakeholder in long-term care sector. National authorities should support them through the provision of respite and safeguards against experiencing poverty; for example, by the provision of financial support and including them in national pension schemes.

Moreover, the rising demand for long-term care services requires more workers to enter the sector. Programmes providing entry level training, supporting recruitment and retention, career progression would help address the workforce shortage. If these are aimed at those living in areas of disadvantage and younger people, it could also support social inclusion and investment in local communities promoting the care economy.

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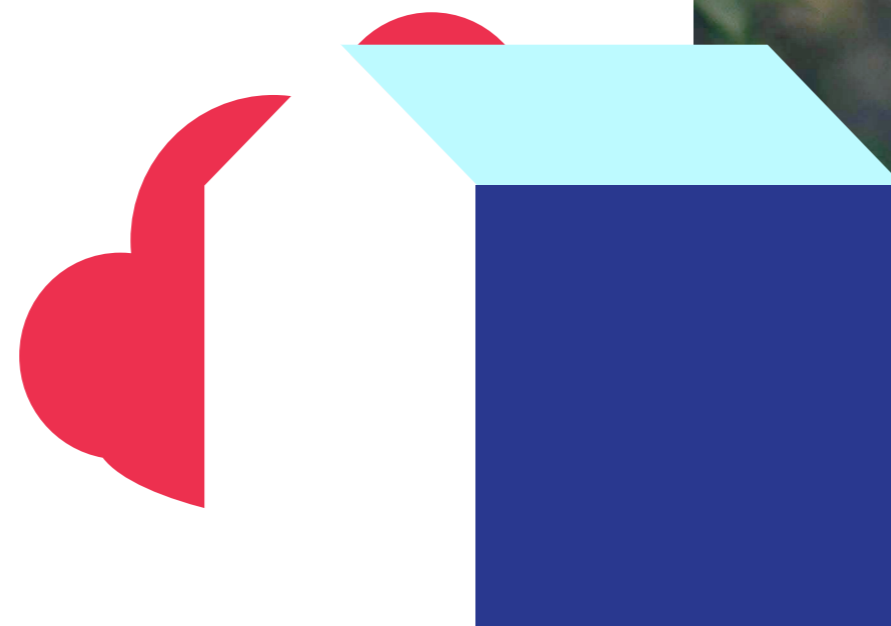
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