Contracting for Quality

An ESN research study on the relationships between financer, regulator, planner, case-manager, provider and user in long-term care in Europe

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Who may contract whom?

Care as a social risk

Autonomy or dependency

Cash benefits or services?

Purchaser–
provider model

Social
planning and
subsidies

Accreditation
of providers

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ABOUT THE RESEARCH PROJECT

This research project was managed by ESN and carried out in collaboration with the European Centre for Social Welfare Policy & Research. It was one strand of ESN's work under its framework partnership agreement with the European Commission for the period 2008-10.

ABOUT ESN

The European Social Network (ESN) brings together people who are key to the design and delivery of local public social services across Europe to learn from each other and contribute their experience and expertise to building effective social policy and practice. Together with our Members we are determined to provide quality public social services to all and especially to help improve the lives of the most vulnerable in our societies across Europe.

ABOUT EUROPEAN CENTRE

The European Centre for Social Welfare Policy and Research is a UN-affiliated intergovernmental organisation concerned with all aspects of social welfare policy and research. Its core functions are:
- an international centre of applied social science and comparative empirical research on social policy and welfare
- an information and knowledge centre providing social science-supported social policy intelligence through a think-net
- a platform initiating future-oriented public policy debates on social welfare issues within the UN-European Region

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The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries.

To that effect, PROGRESS 2007-2013 (http://ec.europa.eu/social/main.jsp?catId=327&langId=en) aims to:

- provide analysis and policy advice on employment, social solidarity and gender equality policy areas;
- monitor and reporting on the implementation of EU legislation and policies in employment, social solidarity and gender equality policy areas;
- promote policy transfer, learning and support among Member States on EU objectives and priorities; and
- relay the views of the stakeholders and society at large.

The information contained in this report does not necessarily reflect the position or opinion of the European Commission.

Find out more about PROGRESS: www.ec.europa.eu/progress

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Workshop 1
Belgium (Flanders) and Sweden, 2 November 2009

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Powerpoints available at: http://www.esn-eu.org/pandp-cfq-workshops-be-se

Workshop 2
UK (England) and Germany, 3 November 2009

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Powerpoints available at: http://www.esn-eu.org/pandp-cfq-workshops-de-uk

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Powerpoints available at: http://www.esn-eu.org/commissioning-for-quality-working-group-members/index.htm

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INTRODUCTION

The complexity of the funding and regulatory structures of countries' care systems and the wide range of organisations carrying out the various roles identified in this study give rise to a web of interlocking relationships. These relationships – whether formal or informal – might be seen as 'contracts' and each has a potential impact on the quality of care that the system as a whole delivers, and hence on the quality of life of older people with care needs.

The demographic trend towards an older population (see table CFQ1) makes it all the more pressing to understand how these systems as a whole function and how they can be developed further to deliver better outcomes for older people with care needs.

Table CFQ1: Number of older persons with care needs (pure demographic ageing scenario in thousands (approx.))

	2007	2060	% increase
Belgium	455	978	115
Czech Rep	256	687	168
Germany	3201	6036	89
Spain	1728	4721	173
Sweden	312	639	105
UK	3094	6465	109
EU27	20705	44473.4	115

Source: EPC/ECFIN (2009), p158

Demographic ageing is going to have major implications for public expenditure on formal care services (the subject of this study) far beyond the present fiscal crisis affecting various countries in Europe:

> "The ageing of the population is expected to put pressure on resources demanded to provide long-term care services for the frail elderly and the ratio of long-term care expenditure to GDP is expected to rise in the future." (EPC/ECFIN, 2009)

The European Union's *2009 Ageing Report* outlines a number of scenarios for increases in long-term care expenditure (both on nursing care and social services) by 2060 in line with various scenarios. The moderate scenario (called 'AWG reference scenario') produces the figures below for the six study countries:

Table CFQ2: Forecast of public expenditure on long-term care, % of GDP (AWG reference scenario)

	2007	2060	% increase
Belgium	1.5	2.9	93
Czech Rep	0.2	0.7	178
Germany	0.9	2.4	153
Spain	0.5	1.4	166
Sweden	3.5	5.8	65
UK	0.8	1.3	60
EU27	1.2	2.4	94

Source: EPC/ECFIN (2009), p165

The rising pressure on public expenditure also makes it all the more important to promote a focus on quality of life as governments' attention inevitably shifts to looking at efficiency and economic performance. In light of the long-term ageing trend, several of the six study countries have recently begun reforms of their long-term care systems (Czech Republic, Spain, and Sweden). Whilst Germany was a forerunner with its 1995 insurance reform, the UK is also due to revise its funding arrangements for long-term care in the near future.

This study is not the first time that the European Social Network (ESN) has engaged with the challenge of long-term care. For a number of years, ESN has considered both funding and quality aspects, providing learning and exchange opportunities for its members, and having input into EU policy developments. ESN held a seminar on long-term care for older people in 2007, which led to the establishment, the following year, of an

ESN working group. Among the principal issues discussed by the group were:

- choice of care services for older people
- supporting older people to live 'unexceptional lives' (to borrow the words of group member Steve Wilds from the UK)
- the changing relationships of public authorities with independent care providers.

This group's work on the last issue is what inspired this study, although, in fact, all three issues re-surface through the pages of this report.

Members of the group had expressed concern about social attitudes to older people and to long-term care. Agnieszka Pierzchalska (Lower Silesia Region) brought out a wider problem about society's perception of social work and care in Poland: "In the immediate period after the fall of Communism, social services were perceived as a burden. Now attitudes are changing, things are getting better, but it is hard to raise the profile of social work and social care, to change people's attitudes towards services designed for the few." For Alexis Jay, Chief Social Work Inspector in Scotland, there was a broader issue about society's perception of older people as a burden: "We need to start moving away from talking about the 'demographic time-bomb' and seeing the benefits of people living longer and healthier lives."

The group had also highlighted the importance of local strategic planning and the steering role of local public social services. "I see the ULSS (local health and social service agency) as an important facilitator, shaping the care systems and building community capacity, facilitating networking and investing in cooperatives," emphasised Teresa Spaliviero from Veneto Region in Italy. Luc Kupers, chair of the Flemish association of

social directors, agreed: "While the public sector role in direct provision of services is shrinking, our new role is to ensure the availability of quality services."

Members of the group had stressed public accountability for externally provided services, arguing: "where a public duty is in part or in whole delegated to another organisation, it is still a public duty". In other words, while service delivery is outsourced (whether by tender or grant) to another organisation, accountability for the service (and by implication, its quality) should still lie with the public authority, most often at local level. The group also recognised that these contracts need to be well-managed so that older people get a better quality of service. While service delivery through external providers should be a welcome stimulus for improvements in quality, if not well-managed, it could have detrimental effects. The European Commission has recently underlined this point too: "Whether such reforms [privatisation] promote quality and efficiency depends on the incentives and notably the nature of contracts." (SPC/DG EMPL, 2009) This debate is an important background to the present study and its authors hope it will enrich this debate.

ESN had wanted to see quality not only in terms of internal quality management within a provider or in the relationship between financer and provider, but in terms of the whole system. The relationships in the system impact the quality of care, and so, the quality of life of older people. With this in mind, the study *Contracting for Quality* was based on the two key research questions:

1. How are markets regulated to improve the quality of care and quality of life for older people?
2. How are relationships between public authorities and (other) providers

managed to favour quality assurance and improvement?

In this study, 'quality of care' and 'quality of life' are not defined because of the variety of concepts and standards in place in the different countries. This study is about how relationships between different actors might incentivise improvements both in 'quality of care' and 'quality of life' as defined either in national legislation or by individual regulators and/or providers. Indicatively, 'quality of life' is used to refer to structural standards while 'quality of life' is used to refer to users' ability to continue living a relatively 'unexceptional' life in spite their care needs.

The key research questions could not be answered without first exploring in some detail the complex web of relationships in the long-term care sector in the study countries: Belgium (Flanders), Czech Republic, Germany, Spain, Sweden and the UK (England). These countries were selected because they represent different welfare traditions in Europe, in which it is hoped most European readers will find enough similarities (and indeed, differences) to help them reflect on their own country's long-term care system.

The main body of the report, then, is composed of six country profiles, each in four sections:

1. A general description of the country's social model and recent policy reforms
2. Identification of the organisations which play the various roles (regulator, financer, planner, case-manager, provider) in the care system
3. Description of how a person with care needs accesses the system and pays for the care s/he might require
4. Several examples of relationships (of different types) in the sector and how they might affect the quality of care provided.

This constitutes the basis for a comparative analysis of whether relationships might be described – however broadly – as constituting *contracts for quality*, in the sense of legal contracts containing financial incentives to deliver care against clearly defined standards.

In order to present relationships between organisations, it was felt necessary first to develop a working typology of the different roles played in a care system. One organisation may perform several of these roles and any one of the roles may be performed by several organisations:

- *Regulator*: any organisation, most probably a public authority, which decides who is able to provide a service on the basis of certain economic and qualitative criteria, which it may or may not set itself. This includes organisations accrediting and inspecting service providers, planners and case-managers.
- *Provider:* any organisation which provides a formal care service to older people, e.g. home care, residential care, day-care, nursing care etc.
- *Planner:* any organisation which evaluates the (likely) needs of a particular population (e.g. in a given geographical area) and develops a plan/strategy to ensure that those needs can be met.
- *Financer:* any organisation which transfers money to a planner, case-manager or provider within the care system. The word 'financer' seemed preferable on the grounds of its breadth to 'purchaser' or 'commissioner'.
- *Case-manager*: any organisation which assesses an individual's care needs, offers advice, helps someone access specific care and monitors his/her situation over time.

The central stakeholders in the system are, of course, the older person with care needs him/herself and his/her family and friends. S/he is referred to here by the term 'service user' or older person. S/he and his/her family might also take on various roles at different times, particularly as a (co-)financer, both from their own resources (pension, assets) and from other social benefits they may be entitled to due to their care needs (e.g. care allowance or vouchers). However, probably the most important role of the service user's family will be to provide (informal/unpaid) care. This study looks primarily at formal care services – it does not cover the various benefits and services set aside specifically for (informal/unpaid) carers.

METHODOLOGICAL NOTE

Following initial desk-based research, six country profiles were produced, but it was felt important to go further by trying to offer practice examples of contracts between financer and provider, as well as other types of relationships that might influence the quality of care. Questionnaires were sent out to some 30 municipalities with the aim of gathering a representative sample of the types of contracts. Although around half were returned, the responses were difficult to interpret and were not representative enough to draw conclusions about a whole country – their results have not been included in this report.

Subsequently, a different approach was taken: it was decided to bring together a financer and provider representative from each country, along with a country expert in a workshop. Three such research workshops were held, which paired the study countries so that we could more easily compare two care models at each meeting and so that the participants could learn about another country besides contributing their own knowledge to the study. The workshops on Belgium/Sweden and Germany/England were held in November 2009 and the workshop on Czech Republic/Spain was held in July 2010. This method proved most informative and the findings from the workshops are included in the country profiles.

These workshops further underlined the complexity of care systems and the diversity of organisations playing various roles in any given care system. It became obvious that to use a simple financer-provider-user triangle of relationships was to present an oversimplification of the reality in each country. Other important roles emerged from the workshops, which might have been conflated with the 'financer' role in early thinking about the research. These were regulator, planner and case-manager, all important enough to warrant discrete identification – and defined in the Introduction.

The workshops also showed that relationships based on formal legal contracts following competitive tenders were only one of the types of relationship that could be found. Others included *concessions*, in which accredited providers are paid via the person using the service, and the *subsidy model*, where providers had the initiative of applying for funding. Others do not even necessarily involve a transfer of money; for example, the planning role played by municipalities in some of the countries.

Given the context of the EU Single Market rules relating to competitive tendering, state aids and concessions, it was decided to add an additional short chapter that would seek to identify which relationships correspond to which set of rules in European law.

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BELGIUM: FLANDERS

1. Introduction and background

Belgium is a federal state in which the care system for older people is a shared responsibility between federal and regional (Flanders, Wallonia, Brussels-Capital) levels. The regions are responsible mainly for social welfare and social care services at home and in institutions, whilst the federal government is responsible for regulating the insurance system for health and medical care and unemployment – though it also has some competences in regulating nursing homes. There is some overlap in competences, meaning that providers and users of social services can expect to interact with both federal and regional authorities. This profile considers Flanders only; however federal laws and benefits described are applicable throughout the country.

In Flanders, two categories of services cover older people: home care (*thuiszorg*) and care for older people (*ouderenzorg*). Home care is not restricted by age, but can apply to older people needing help at home and ranges from help with household chores to home nursing. The aim of the whole range of home care services is for people to stay at home for as long as possible with supportive social networks around them. *Ouderenzorg* refers to care in "an environment that replaces their own home" and covers day-care centres, centres for short-term care and residential care. Each of the specific types of care or care settings within the two categories is described in legislation and service providers apply for authorisation to operate services. One of the conditions for authorisation is that the provider's intended services fit within the national and regional capacity programmes, for example defining the number of nursing home beds in a given area.
[OCMW-Gent presentation to CFQ research workshop 1]

This profile first seeks to identify which organisations play the key roles of regulator, financer, planner, case-manager and provider in Flanders. It then considers how the service user accesses care services and how s/he might pay for them. Lastly, it describes some of the relationships between organisations and considers their impact on the quality of care provided.

2. Identifying who plays what roles in the care system

The different roles (regulator, financer, planner, case-manager, provider) that are played in a care system are defined in the report's introduction.

The **regulators** of care services for older people are the National Institute of Health and Disability Insurance (RIZIV), the federal Ministry of Health and the Flemish Agency for Health and Care (VAZG). The RIZIV is the regulator of the insurance system: it negotiates annual conventions between health insurance funds and care providers, setting a uniform level of reimbursement for different types of services. Because social security in Belgium is paid by employee and employer, trade unions and employers' federations have powerful voices in RIZIV (RIZIV, 2010). The VAZG is an agency of the Flemish government which defines capacity programmes for different types of services and issues "preceding licences" (typically lasting five years) on the basis of the profile and identity of intended service users, economic analysis of the provider's business viability and its professional qualifications (CFQ research workshop 1).

The federal Ministry of Health plays a regulatory role for nursing homes (RVTs), whilst the regulation of non-nursing residential care lies with the regions (e.g. Flanders). There are special federal standards for RVTs, as follows:

- Care homes have to guarantee that residents are only accepted following a multidisciplinary assessment of needs
- Minimum of 25 places (*Flanders: only residential care centres with a capacity of less than 25 inhabitants can host older persons with physical disabilities or mental illness*)

- General structural conditions, accessibility, separation from hospital setting
- No more than four beds in one room (as of 1/1/2010 at least 50% single rooms, and remaining rooms with no more than two beds) – (*Flanders: maximum of two beds per room and these double rooms must not make up more than 10% of a care home's total capacity*)
- As of 1/1/2010: all rooms must have a bathroom and each room must have an area of at least 12m^2 (*Flanders: 16 m^2*) without bathroom
- For each resident there must be written documentation (assessment, personal care plan etc.)
- Staffing for every 30 residents: at least five registered nurses (FTE), one of which must be a matron; at least five therapists
- A Residents' Council must be established
- A contract between the resident and the provider must be signed
- A quality policy (quality management) must be defined (as of September 2006)

[Selected accreditation standards for old-age and nursing homes in Belgium Source: Arrêté royal fixant les normes pour l'agrément spécial comme maison de repos et de soins ou comme centre de soins de jour (21/9/2004).]

The main **institutional financers** are the insurance funds (*mutualiteits*) through RIZIV and the Flemish Health and Social Care Infrastructure Fund (VIPA). There is a split in financing in Flanders between infrastructure development and running costs of services. The RIZIV negotiates what providers can claim back from the insurance funds, with which people using services are insured. The VIPA provides subsidies and loan guarantees

to providers for buildings and renovation on a competitive basis and requires that (public and private) providers demonstrate demand for the services they wish to develop. However, only non-profit and public providers can apply for a grant/subsidy from VIPA; for-profit providers are restricted to applying for a loan guarantee (VIPA presentation to CFQ research workshop 1).

The Ministry of Economic Affairs, meanwhile, regulates the price charged to users, which tends to be around half of the total care costs per person. Municipalities and their attached public social welfare centres (OCMWs) may also decide to fund additional services which meet certain needs in their local area. The OCMWs (acting as social security agents) also help people who are not insured or whose insurance does not cover their care costs to pay for their care – particularly those on a low income.

The main **planners** for the development of social services (including for older people) are the VAZG and the OCMWs/municipalities via two separate processes. The VAZG reviews demand and supply of different types of services in Flanders annually and then gives permission to providers to increase their capacity to meet (projected) demand (Zorgnet Vlaanderen presentation to CFQ research workshop 1). Providers may apply to VIPA for a grant or a loan to help them do this. OCMWs and municipalities are required to develop a joint local social policy plan, which is agreed with local stakeholders and intended to establish a common direction and a basis for cooperation between the stakeholders. Each of the local social policy strategies (joint documents of the OCMW and the municipality) is developed in consultation with a wide range of organisations (OCMW-Gent presentation to CFQ research workshop 1).

The **case manager** role in Flanders is rather fragmented. Needs assessment can be carried out by a range of organisations using different assessment methods: insurance funds, family doctors, Cooperation Initiatives on Primary Care (SELs), Centres for General Wellbeing (CAW) and OCMWs (www.socialsecurity.be). This varies with each individual and may depend on which organisation they first ask for help and advice locally. In practice, family members are heavily involved in advocating on an older relative's behalf to help them access an appropriate service.

Insurance funds have networks with family doctors, nurses and OCMWs (local service centres). People have a free choice of family doctors, who have a very important role in helping people choose a nursing home (CFQ research workshop 1). An important advisory role is also played by OCMWs and municipalities; OCMW Ghent and the City of Ghent make a joint commitment in the Older People's Plan 2008-13 to "maximise access to social rights" (Stad Gent/OCMW Gent 2007). Municipal authorities aim to facilitate citizens' access to the different benefits and services available in Flanders, even where they do not directly manage them.
The SELs are a forum for consultation and cooperation and, by means of a coordinator, manage care planning for patients. All stakeholders involved in the care of the patient – professionals such as doctors and nurses, as well as informal care-givers – agree who should provide what care and when. These arrangements are laid down in a 'care plan', which is followed up by a defined case manager. The challenge for the SELs is to bring together a wide range of stakeholders: family doctors and nurses, who can be chosen by the client and are often working independently; home help providers tend to be non-profit organisations affiliated to political or religious groups; networks for

prevention or palliative care networks; and local service centres offering personal care, home help, technical support (alarm systems), meals-on-wheels etc. (Lepeleire et al., 2004).

Providers come from the public, non-profit and for-profit sectors. Flanders has around 65,000 beds in residential and nursing care (RVT) and there is strong regional variation in the weight of the respective sectors (Table BE1).

The greater dependency on OCMWs in Flanders is possibly indicative of its better economic situation, since OCMW services tend to cost more than other providers' services because of better pay, conditions and pensions. All providers have to register with the VAZG in order to provide services in Flanders and sign a convention with the RIZIV in order to be reimbursed by insurance funds for running costs of care services.

Table BE1: Market share by sector in long-term care provision in Belgian regions

	Flanders	Wallonia	Brussels
OCMW/CPAS	36 %	26 %	24 %
Not-for-profit	52 %	21 %	13 %
For-profit	12 %	52 %	62 %

Source: Zorgnet Vlaanderen (2009)

3. User: accessing the system, paying for services

Besides funding from the VIPA, VAZG and the RIZIV, significant funding is channelled through people using services. The federal care allowance (THAB) and Flemish care allowance permit people to buy home-help services, often using subsidised vouchers (SPF Social Security 2010*).*

In Flanders, as in the rest of Belgium, persons above the age of 65 with care needs are entitled to a federal care allowance (THAB) as a supplement to their pension or other income. This allowance is means-tested, taking account of income from pensions, employment, property and capital. The allowance has five categories according to the level of assessed care needs.

An application has to be made to the municipality where the person lives. The person (or their representative) receives a dossier containing one assessment form to be completed by a doctor and another which they complete themselves. They can request help

in completing the forms from various places, e.g. from their local OCMW or their own insurance fund. Once the federal government (Federal Public Service Social Security) receives the completed forms, the person is invited to a second medical interview with a government-appointed doctor, unless their needs can be proven on the basis of written evidence – often the case for anyone over 80 years old. [FPS Social Security, 2010]

Those who are not entitled to insurance pay-outs from a *mutualiteit* or whose insurance is not sufficient to cover their care costs are supported and advised by OCMWs, as agents of social security. In addition, a person having received a personal assistance budget (PAB) before the age of 65 (from the Flemish agency for persons with a disability) can continue to receive this after 65. [FPS Social Security, 2010]

Table BE2: Monthly and annualised maximum Belgian federal care allowance (THAB) in 2010

	Monthly	Annual
Category 1	€ 75.58	€ 906.91
Category 2	€ 288.49	€ 3,461.89
Category 3	€ 350.76	€ 4,209.10
Category 4	€ 413.01	€ 4,956.09
Category 5	€ 507.32	€ 6,087.86

Source: SPF Social Security (2010)

The Flemish government decided to introduce additional insurance in light of increased demographic change. A flat-rate benefit of 130€ per month (introduced in 2001 and funded by compulsory employer/employee contributions from the age of 26) is paid out by the Flemish region to fund non-medical care and support at home or in residential care. Residents of Flanders are required by law to sign up to this insurance scheme with one of the seven insurance funds from the age of 26. The VAZG accredits certain agencies as able to assess entitlement for this benefit: these include CAWs and OCMWs acting on behalf of the insurance funds. [VAZG webpage, Vlaams Zorgverzekering]

A voucher system was introduced in 2001, which allowed people to buy household and home-help (e.g. cleaning, laundry, shopping, gardening and tidying) services at a discounted rate. Registered service providers present the vouchers (bought for €7) to an accredited bank and receive €20.50 – in other words, the public subsidy is €13.50 per hour. This aimed to regulate the informal economy and almost 700,000 people had signed up by July 2008, using around 108 million vouchers (Henry et al., 2008: 144).

In order to keep home care services financially accessible, a system has been set up that fixes a price ceiling for care bills. This system limits the monthly cost of the personal contribution of the service user. The personal limit is derived from the financial situation of the service user; these ceilings are imposed by the Flemish government, which also covers any care costs beyond that ceiling. The price for accommodation, which has to be borne by the resident, is currently set at about €35 per day (CFQ research workshop 1).

A resident in a typical care home in Flanders would pay around 45% from his/her own resources (pension, benefits for people on a low income, Flemish non-health care insurance). Another 45% would then be covered by his/her insurance fund and the remainder by the OCMW (not only in its in-house homes) and from VIPA in terms of construction costs. A place in a care home might cost around 700€ a week (CFQ research workshop 1) .

4. Contracting for Quality: identifying relationships in the care system and their impact on quality

The complexity of the funding and regulatory structure and the wide range of organisations carrying out the various roles identified give rise to a web of interlocking relationships in the sector. These contracts – whether formal or informal – all have some potential impact on the quality of care that the system as a other. Here, we consider how the Flemish Fund for Social and Health Care Infrastructure (VIPA), the integrated home care services (GTH) and non-profit providers relate to other organisations in the care system, and what impact this has on quality.

Representatives of VIPA and *Zorgnet Vlaanderen* took part in CFQ research workshop 1 and outlined their organisations' relations with others in the system.

VIPA: relationships with care providers

[VIPA presentation to CFQ research workshop 1]

The Flemish Fund for Social and Health Care Infrastructure (VIPA) is a department of the Flemish Ministry for Welfare, Health and the Family. Its mission is "to develop initiatives and provide funding for a high-quality, accessible and affordable infrastructure for the provision of care and services." It provides grant-funding to a wide range of social and health services.

Care providers submit applications for funding at any time rather than in a response to a specific call for proposals. The application process comprises, first, the "strategic care plan" and, second, the "technical-financial plan". The "strategic care plan" covers:

- The provider's projects over the next ten years
- An environmental analysis
- Cooperation with local partners
- Profile of potential service users
- SWOT-analysis (Strengths, Weaknesses, Opportunities, Threats)

VIPA receives the plan and provides additional advice to the applicant, which has the option of revising the plan. If the plan is approved by VIPA (by a committee of experts and civil servants, then formally by the Minister) the applicant submits a "technical-financial plan", which comprises a business plan and architectural plans.

VIPA can subsidise up to 60% of the cost of the infrastructure project up to a maximum of €550 per square metre. For care homes, it funds a maximum of $65m^2$ per resident (includes all space, not just living space) – this means that developers can build more than this but VIPA will only fund up to $65m^2$. Funding is spread over twenty years.

There are two different types of funding – a grant/subsidy or a loan guarantee. Only OCMWs and non-profit providers can apply for a subsidy, not for-profit providers; all three can apply for a loan guarantee. The conditions of application for both are:

- The developer must be the builder and the operator
- The strategic care plan must be approved and fit into the VAZG's regional capacity programme
- The developer must own the land where the planned project will be built throughout the funding period (minimum 20 years)
- The project must not have received any public subsidies for the last 20 years

VIPA sets out to subsidise projects whose structural quality standards are above the defined minimum standards. For example, the VAZG requires a minimum of $16m^2$ living space per resident, whilst VIPA intends to fund around $25m^2$ living space per resident. In this way, it uses its financial weight to push up quality standards. It also requires high standards in accessibility, fire safety, energy-efficiency and checks on the developer's capacity to see the project through in terms of its procurement expertise and professionalism.

Relationships between planners, case-managers and providers: SELs

Federal law obliges OCMWs, private home care services, family doctors, care insurance funds, nursing services, local service centres and residential care centres to work together in "cooperation initiatives on primary care" (SELs). The main goal of this is the practical coordination of public and private care. An SEL can provide advice to people seeking services and also offers training for care providers in their network. SELs are organised at different levels, e.g. several in one city (Antwerp), or just one (Ghent) or a single SEL covering numerous smaller municipalities. SELs must be accredited by the VAZG and only accredited SELs can apply for accreditation as an "integrated home care service" (GTH), which works directly with users by providing advice and case management. The purpose is to improve quality of care through stakeholder cooperation. [VAZG webpage on SELs, 2010]

Zorgnet Vlaanderen: providers' relationships to regulator and financer

[Zorgnet Vlaanderen presentation to CFQ research workshop 1]

Zorgnet Vlaanderen is a network of health and social care organisations working in the Christian tradition. Its mission is to help its members develop quality, affordable and accessible care through cooperation and synergies. It acts as an employers' federation as well as a providers' association.

A care provider, such as a member of *Zorgnet Vlaanderen*, has to go through two processes of accreditation, one with the federal and one

with the regional government. The VAZG issues a "preliminary licence" to operate if a provider is able to show that its services fit into VAZG's capacity plan for a given municipality-area or area of several municipalities. The Flemish Ministry's Inspectorate inspects providers before they are given a "preliminary licence". The inspectorate has recently changed its policy from inspecting once in a six year period to a more selective process based on annual data input and issues raised by various actors in the care system, including users' complaints. There are also random unannounced inspections. At federal level, a provider has to be part of a convention with insurance funds negotiated through the RIZIV in order to receive reimbursement. This means that any provider can enter agreement through RIZIV and claim reimbursement for service users it attracts. A provider has to identify who its user group will be and can prioritise a particular profile of service user, e.g. saying that they will only take citizens of a local area. Referrals and admissions may come directly from the user or his/her family, the family doctor, the person's insurance fund, a hospital discharging a patient, the OCMW.

A user may influence quality development in the organisation providing care through its (compulsory) resident/client committee, via a register of complaints, via a free phone-service, where staff and users alike can lodge complaints or seek information. Every institution is required to have a manual of quality care, which covers issues such as person-centredness, efficiency and continuity of care. Providers will have the responsibility to produce self-evaluation reports from 2011.

5. Country Conclusions

Belgium's emerging long-term care system is insurance-based and supplemented by additional State (federal and regional) cash allowances for care. The roles of regulator and financer are distributed among various public agencies at different levels and the insurance sector. Planning is done at federal and regional level in terms of places in residential settings, and at local level by OCMWs and municipalities in terms of setting a framework for cooperation among local actors. Case-management lies with various local-level bodies and insurance funds; it largely depends on a user's first point of access into the system. The non-profit and public sectors both have a strong role and tradition as providers of care services, but the for-profit sector's share is growing, and is notably larger in Brussels and Wallonia than in Flanders.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?

In Belgium, there are at least two different markets for long-term care services. In the first, the health insurance system, providers' access to the market is governed by accreditation standards required by the health insurance regulator (RIZIV) and, in Flanders, by a government agency, the VAZG. There are few systemic incentives, other than supply and demand, to exceed the accreditation standards. The other "quasi-market" concerns mainly home care services, where an open market for providers has been created by means of subsidised vouchers, paid for in part by federal and regional cash allowances: private non-profit and commercial providers offer home help services (cleaning, washing, shopping etc.) at fixed prices to individuals who pay only about one third of the regular price per hour. There are concerns here about free entry into the market without accreditation for home-help services, let alone incentives for improving quality over time.

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

Quality assurance is based on self-assessment of providers and (rare) inspections (by VAZG) based on a restricted number of mainly structural quality indicators. There is hardly any incentive for providers to develop quality further. There seems to be a great reliance on providers themselves to be ambitious in raising their own standards through internal quality management systems. In this study, VIPA emerged as the only public authority with the financial weight to incentivise higher standards, but these only related to building standards. The agreement between VIPA and a provider to build or expand its infrastructure might be seen as a contract for quality. The softer steering role played by OCMWs at local level and by SELs at sub-regional level might also be understood as an informal and broad framework for improving quality among various stakeholders.

Notes:

Contracting for Quality

Country Profile:

Sweden

SWEDEN

1. Introduction and background

Sweden is a highly decentralised State, in which municipalities enjoy the greatest autonomy out of the six countries in this study. The three tiers of government (290 municipalities, 20 counties and the central government) have played different roles in care services for older people since the wide-ranging *Ädel reform* of 1992 (NBHW, 2007), which set out to address regional differences and the health/social divide:

- The central government aims to ensure that the principles governing care are the same throughout Sweden by issuing legislation (notably, the Social Services Act and the Health and Medical Act), e.g. setting a nationwide cap on user co-payments)
- County councils manage hospitals and out-patient care, although home health services can be transferred to the municipalities by mutual consent
- Municipalities are responsible for arranging social care for older people

The 1990s and 2000s saw outsourcing grow as a trend in Sweden, more than in their Nordic neighbours. Needs assessment and purchasing of services were separated from the actual provision of care services by splitting the respective departments within the municipal administration. The provider departments then had to compete on some contracts with private providers in a tender process run by their sister department in the municipality. Frequently, they lost the tender, due to higher wage costs. There were some savings as a result of outsourcing, but possibly to the detriment of quality. The aim to improve consumer choice through these reforms by diversifying service provision was not achieved, though, because one monopoly (municipality) was replaced by another (the private provider who had won the tender). [NBHW, 2007]

In 2009, a new Act on freedom of choice came into power, giving the municipalities an alternative to in-house provision or public procurement. In order to promote the new legislation, the Government has made available 280 million Swedish Kroner (SEK) or about €27m) for municipalities to study the introduction of freedom of choice models, for which more than 200 have applied (late 2009). On assessment of care needs, older people are given a voucher that entails the same payment per hour, regardless of the provider that is chosen, so that competition for customers is expected to be driven by quality of care services. Unlike the competitive tendering process, there is no monopoly in provision of care and certified providers are not guaranteed customers. The pool of available providers is defined by the municipality based on a certification process or by public procurement. [NBHW, 2007]

2. Identifying the actors and their roles

The different roles (regulator, financer, provider, planner, case-manager) that actors take in the formal care system for older people are defined in the report's Introduction. Municipalities in Sweden have traditionally combined all five roles as regulator, financer, planner and case-manager and provider to a large degree, though the counties and central government retain some regulatory powers. This is gradually changing as the provider role is increasingly shared with other actors, stimulated by outsourcing and customer choice reform.

The municipality's only obligation is to ensure that services are present to meet the needs of its population; it can decide how it does this. Since the freedom of choice reform, there are several options: first to provide services in-house, second to contract out services to private providers or third, to introduce a customer choice model; they can also use different models for different types of services. In the contracting-out and user-choice models, the municipality can set quality standards, prices and inspect providers. In the in-house model and for all services provided by the municipality, the National Board of Health and Welfare has been the joint monitoring body regarding health care and social services for older people since 2010, and the official national complaints body.

Taxes levied on the residents' income are the main source of revenue for municipalities, county councils and regions in Sweden, making up two-thirds of their revenues. On average, the local tax rate is 30%, split between the municipalities (20%) and the counties (10%). In order to compensate for differences in tax receipts, the State runs a system of equalisation that transfers revenues between municipalities and counties, according to their tax base and expenditure

(SKL website). Local taxation covers approximately 80% of the cost of caring for older people, with State grants (16%) and user co-payments (4%) (Ministry of Health and Social Affairs, 2007).

The Act on Social Services is not very specific about municipalities' role in **planning**. It states:

> "The social welfare committee shall make itself closely acquainted with the living conditions of older persons within its boundaries [...] The municipality shall plan its measures for older persons. In this planning, the municipality shall co-operate with the county council and with other public bodies and organisations."

It is also required to "establish special forms of accommodation" for dependent older people. It is common practice for municipalities to have a three or five year plan devised in consultation with older people's organisations, service managers, case managers and other interest groups. The new plan is based on an evaluation of the preceding plan, demographic data and economic forecasts.

Municipalities are the main **case-managers** for older people; irrespective of which model they are using (in-house, customer choice or public procurement). Needs assessment is carried out by a municipal care manager, who could consult with the older person's doctor or nurse and, of course, the family. Decisions regarding a move to residential care are often administered by a specialist care manager. The municipality then decides on the service level, eligibility criteria and range of services provided.

Like many European countries, Sweden has a long tradition of private non-profit organisations as **providers** of services. Some 20% of services for older people provided by private organisations are provided by non-profit providers, whilst most are provided by for-profit organisations, with a tendency to high market concentration among leading companies (CFQ research workshop 2)

Table SE1: Change in percentage of older people receiving care from private providers, by care setting, 2000-2008

	Home care	Residential care
2000	7%	11%
2007	11%	14%
2008	16%	15%

Source: SALAR (2009), National Board of Health and Welfare (2009).

Even though the municipalities' monopoly over care for older people has gradually been eroded due to contracting and customer choice, the share of non-public provision is still relatively small compared to other study countries as Table SE1 shows.

It is also worth noting that Swedish legislation does not make a distinction between for-profit and non-profit providers. Municipalities do not distinguish in tenders or authorisation procedures between for-profit and non-profit organisations. The main issue in Sweden is whether a service is delivered by a public authority or by another provider. There is, however, a political discussion over whether it is acceptable to make profit from publicly-funded service provision. Some think that as long as the quality of the service is good, it is not important. [ESN research workshop 1]

3. Users' financial contribution to services

Municipalities and counties can only charge users for services where specifically permitted to do so by law. Charging is permitted in care for older people but a non-profit principle means that "fees may not be higher than costs" (SALAR website). Although nursing and social care costs may be paid partly by the older person (service user?), the percentage of costs of care borne by users or their families is very small compared with other countries – approx. 4% in 2007 (SALAR, 2009) – due to the high taxation funding outlined above.

The relatively low caps imposed nationwide on a user's co-payments for residential care clearly contribute to this. Residents in special housing must pay rent, but this may be partially covered by a housing supplement, which covers up to 93% of the costs of rent. In 2009, the cap on users' co-payment for nursing and social care was 1,712 SEK monthly (about €166). Due to their (low) income, some 40% of the residents in special housing are exempted from co-payments for nursing and social care (but still have to pay 'hotel costs', i.e. rent and food). [ESN research workshop 1]

4. Understanding the relationships between actors and their impact on quality

Municipalities in Sweden had traditionally combined all five roles identified by this study. However, outsourcing and user-choice models are becoming more widespread and leading to the establishment of new types of relationships.

Relationships between the municipality and service providers – private or public – are governed by means of contracts. As already mentioned, in competitive tendering competition is limited to the tendering process, since the chosen provider enjoys a virtual monopoly for the duration of the contract. Whoever is awarded the contract, whether a private or municipal provider, will be the only responsible supplier for a defined area. These contracts usually cover a time-span of three years, although in smaller municipalities they may be extended to 8 or 10 years. If a provider later loses a contract, its care staff and buildings remain – only the management changes. The municipality, acting as the financer, specifies the needs and characteristics of the services to be provided and is also responsible for monitoring outcomes and quality.

The majority of those applying for tenders are private for-profit companies of Swedish origin. Whilst there were a great number of private companies in the early 1990s and their number continues to grow (170 companies providing care for older people in 2003, up from 120 in 1999, according to the National Board of Health and Welfare), the current trend is towards market concentration as smaller companies are bought out by larger ones or priced out of the market.

According to the National Board of Health and Welfare, in 1999, the four largest private providers had secured half of the contracted operations (Trydegård, 2004). Initial

competition based on price only and the quest for bigger market shares may have contributed to the concentration in private providers (Edebalk, 2008). Available information (Stolt and Jansson, 2006; Dagens, 2008; Meagher and Szebehely, 2009: 12) points to a highly concentrated market, where four firms play the biggest role: Attendo Care and Carema cover 45% each of the private elderly care market, while Aleris and Förenade Care share the remaining 10 per cent.

An evaluation of the competitive tendering process carried out by the National Board of Health and Welfare showed no significant differences in price and quality between private and public providers (Trydegård, 2004). Nevertheless, there are concerns that competitive tenders may be decided mainly on price rather than quality in some municipalities, e.g., "price is often given a weight of 60% or more, and the other quality criteria 40% or less" (Fröbel et al., 2006: 25). Municipalities are competing to attract the best private providers and are still developing their skills as purchasers and market-managers.

Consumer choice models are a more recent market mechanism now being tested, particularly in home-help services and community care (SALAR, 2009). Under these programmes only supplementary services offered by private providers have their price set freely by the market. These supplementary services are viewed as a way to increase the profitability of private providers (Meagher and Szebehely, 2009, quoting the Government Bill on consumer choice) while public providers are legally barred from providing these.

Among these supplementary services are "household services" (e.g. housekeeping, cooking, laundry) that are liable for a 50% tax deduction on their price (healthcare services are excluded from the scope of this scheme). This tax deduction could be an extra incentive for private providers to set up this kind of service, although the tax deduction may also be claimed by family members. For nursing and social care services, the municipality decides on the price per hour in order to contain costs – but some providers would not take part in tenders with too low a price because they could not provide good services at that rate.

The decentralisation of care for older people in Sweden has made it difficult to compare quality among providers. The National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions have agreed to establish a model that allows for comparison of care services (Swedish Ministry of Health and Social Affairs, 2007). Meagher and Szebehely (2009: 17) echoed the concerns regarding quality in privately provided care raised by a 2008 report from the Swedish National Audit Office. The report pointed out that:

- private- and publicly-provided care remain subject to different regulations, meaning that municipalities have fewer means to control outsourced services
- only staff employed by public providers have assured rights as "whistle-blowers"
- reporting of abuse by publicly-employed care workers must be directed at the elected authorities while in privately run facilities it is the managers or owners who receive these reports. However, municipalities can regulate this within the contract with the private provider.

The Act on Social Services makes clear that public authorities may procure services from private companies to provide services *on their behalf* – the implication is that these are still *public/municipal* services. It also specifies that "privately run activities that are financed using tax revenues must offer citizens services on the same conditions as those which apply to similar public services." (SALAR website) However, a municipality is free to decide what quality criteria it will require and how to structure the process of procurement.

The municipality of Nacka and the private for-profit provider Carema Care took part in the ESN workshop and outlined their relationships to different actors in the system.

Municipality of Nacka: Relationships with providers and users
[Nacka presentation to CFQ research workshop 1]

Nacka, an affluent municipality with a population of 88,000 south of Stockholm, was a forerunner of the current freedom of choice reform, when a former mayor became aware of the potential for utilising private provision to reduce the cost of public services. The thinking was that a greater range of services would offer better quality and overall reduce price to user. Essentially, Nacka's is a voucher-run system in which both municipal and private providers are reimbursed for what they provide. The philosophy is that users know how to choose the best for themselves: "We trust and respect the knowledge and ability of people, and their desire to assume responsibility." Public services were gradually converted to the user-choice model over the years – home-help in 1992, special housing for older people in 2001, day-care for older people in 2007.

Nacka municipality has a relationship with both its citizens as service users and providers as shown in the diagram above. In order to be authorised to provide services in Nacka, a provider must:

- state its commitment to paying taxes and social fees
- demonstrate its financial and staffing capacity;
- outline its professional skill including knowledge of applicable legislation
- be accessible
- have established routines for handling and reporting complaints
- accept municipal monitoring of its activities
- use the municipality´s ICT systems

The Municipal Council's Social Welfare Committee defines objectives and standards for providers and municipal staff evaluate and inspect providers against these.

The municipality assesses the users' needs and attaches to each individual a budget deemed sufficient to meet his/her needs. The user can then choose – often with the help of a relative or a social worker if s/he lacks cognitive ability – a provider from a catalogue 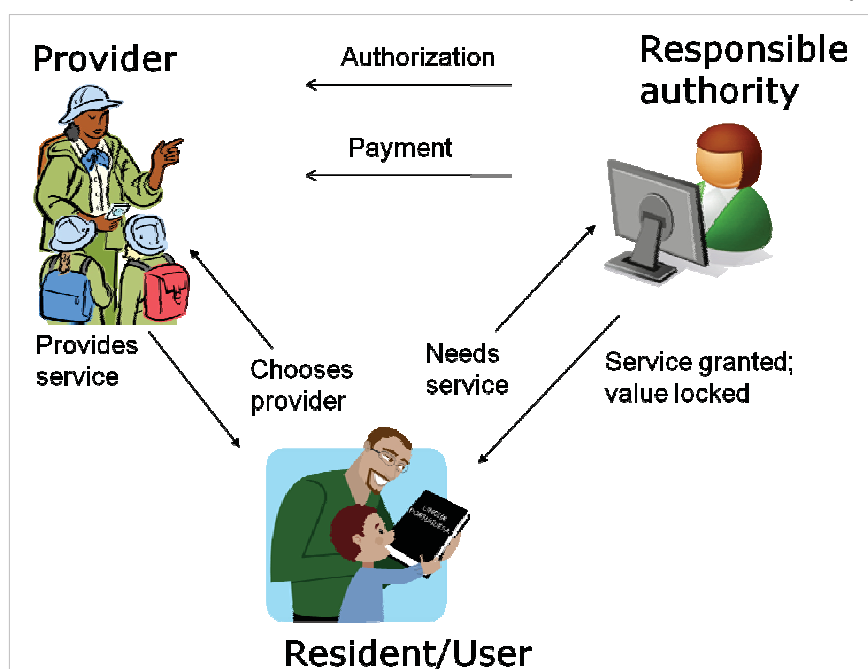and the provider receives the budget from the municipality. The user and provider have a contract between them, but the user has the right to change at any time. The idea behind this regulated market is that providers need to be of good quality in order to attract users and so receive payment from the municipality. A number of factors influence users' choice of providers according to another municipality working in this model:

- "Word of Mouth" – friends and neighbours
- Image of the provider
- Community-based local knowledge
- Coincidences
- Language skills
- Number of employees
- Capacity – evenings and weekends
- Variety of services

(Jönköping presentation to LTC working group, 2008)

If a provider is not good enough, people using its services will switch. Users can also complain to the municipality about poor service, and the municipality inspects services regularly and can rescind accreditation.

The County Administrative Board (Länsstyrelsen) is ultimately the responsible authority for ensuring that providers (private and municipalities) comply with regulations. Municipalities can also ask the National Board to investigate a complaint if this is within their own services. Besides complaints, there may be other signs that something is wrong inside an organisation, notably if it is not paying its social charges and taxes correctly.

Figure SE1. Relationships between municipality ('responsible authority'), resident/user and provider in Nacka.

Carema Care: Relationships with municipalities and users

[Carema presentation to CFQ research workshop 1]

Carema Care was founded in 1996 and had a turnover of €408m in 2008. Its vision is to "create the care of the future". It has around 10,000 employees (of whom around 42% work in care for older people) equivalent to 5,700 full-time posts and provides care to approximately 11,000 service users (of which 9,300 are older people). It is owned by Ambea, which in turn is 75%-owned by 3i. Care for older people accounts for 78% of its turnover in 132 units (though one of these is in Norway).

The process of setting up and delivering care services differs according to the method used by a municipality. In the case of **public procurement** (both in nursing homes and home care services), the municipality and provider negotiate the terms of the contract (defining care provision and payment). After this agreement, following their needs assessment by the municipality, users are referred to the providers. In the **freedom of choice** procedure, would-be providers evaluate the potential demand (demographics and health profile) before choosing to apply for authorization or application – unlike the tender process, providers are not guaranteed a certain demand or number of users. After being authorized to supply care services, a contract is signed with the municipality, setting the price per service (in principle the same for all providers) and other conditions for the provision of care. The municipality retains responsibility for needs assessment, but, rather than being referred to a provider, the user is entitled to a voucher. This is then used to acquire care services from a provider chosen from an authorised pool of providers, which are supposed to compete for custom on the basis of quality of service.

In the case of Carema, a business evaluation is conducted prior to setting up a nursing home in the area and applying for accreditation. After the agreement of operation is reached with the municipality, the Carema nursing home becomes one of the providers to which users can be referred by the municipality after the needs assessment. It chooses municipalities in which to apply for tenders or to seek accreditation according to political agenda, demography, the balance between price and quality in the tender specification, the availability of properties in which to deliver services and relations with local politicians and municipal staff.

It has its own in-house quality management tool called "Qualimax", which covers the following areas:

- Documentation: on a regular basis ensure that relatives and users participate
- Leadership: demonstrate good leadership and an effective workplace with help of key performance indicators
- Improvement: realise improvements by continuously monitoring key performance indicators for customer contact, routines and the values of co-workers. Measurement: determine the quality of care through routines for customer security and qualified staff

Carema works with the municipality (as financer/regulator) and the service user to try to improve quality. There are regular meetings with the municipality – they share knowledge and experience. There are surveys of users and their family and regular meetings with them both individually and through the "relatives' council".

5.   Country Conclusions

In this study, Sweden represents a Nordic welfare model that has fully embraced long-term care for older people as a pillar of the welfare state. Sweden has a long tradition of formal services, rather than cash benefits, with little means-testing and large-scale pubic provision. Indeed, Swedish municipalities combine the roles of financer, planner and case-manager as in the UK (as we shall see below) but may also fill the regulatory and – though this is gradually changing – provider roles. Some supervision is provided by the counties and the National Board of Health and Welfare, to ensure municipalities are fulfilling their duties in legislation.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?

In contrast to the Belgian model, there has traditionally been only a small (private) market in which older people themselves are direct purchasers of long-term care. However, this is changing as more and more municipalities decide to introduce user choice in social services, where they set the terms of accreditation, i.e. permission to operate in the market, and provide vouchers to users, who may then choose among several different providers – as in an insurance model. There is real potential for municipalities to regulate quasi-markets to improve the quality of care and quality of life for older people. It remains to be seen whether this kind of competition will trigger quality improvement and a competition based on quality or whether competitive strategies will become an obstacle to cooperation and coordination between providers and/or between them and the care system.

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

With the growth in outsourcing/public procurement by municipalities, the longstanding monopoly of public provision has been eroded as new private for-profit providers have succeeded in winning tenders against provider agencies within municipalities. Public procurement had until recently been based on a rationale that guaranteed a local monopoly (replacing the public monopoly) to providers who won the tender, denying users any choice among providers. Municipalities, nowadays, are able to choose between direct provision, public procurement and customer choice, each potentially giving rise to different types of contracts for quality with providers.

Notes:

Contracting for Quality

Country Profile:
Czech Republic

CZECH REPUBLIC

1. Introduction and background

The provision of care services during the years of centrally planned economy in the former Czechoslovakia was characterized by major centralisation of decisions, a public monopoly and the dominance of a medicalised institutional care model – the emphasis was on quantity as the main evaluation indicator (Marhánková, 2008).

The 1990s witnessed the emergence of non-profit organisations in the Czech Republic as providers, mostly of social care services at home, thus introducing new types of services, which had an enhanced focus on quality (Potucek *et al.*, 2006). The innovative character of these services was such that some, for instance personal social assistance or respite care, were provided without a proper legal basis, as they were not foreseen in the existing Social Security Act of 1988. Ad hoc subsidy programmes were therefore introduced by the Ministry of Labour and Social Affairs (MoLSA) to financially support Church and other care providers. The larger towns and cities were at this time rediscovering their civic role, there having been no local government in the Communist era. Some started to provide care services for older people and grants to NGO providers.

This model and the rather sporadic geographical coverage of social services continued until two policy reforms gradually signalled a change. The first was a state administration reform of 2001-03, which abolished districts and ushered in 14 regions alongside the 6,249 municipalities, all of which are classed as 'self-governing' in that they have elected bodies and their own administration. It also shifted responsibility for social care to the newly created regions and

to municipalities. It has also established a new category of municipalities "with delegated powers" (205 out of the 6,249) that carry out various tasks described in law on behalf of the State, including the distribution of the care allowance (see below). Municipalities may also exercise "independent competences" which can include the delivery of basic social care. [SMOCR presentation to CFQ research workshop 3]

The second policy reform was the Social Services Act 2006, which heralded profound changes. The Act attempts to channel money (the care allowance) through individuals to providers, rather than through providers to individuals. Service providers, regardless of their legal status (region, municipality, for-profit, non-profit) are now able to apply for financing from various sources: State, regional or municipal grants; own revenues (including contributions from their founder's budget); and co-financing by service users. The Act regulates all social services, not just care for older people. It describes both the type of service provided and the setting in which it is provided. The different settings are grouped into the following categories: "field-based services", "out-patient services" and "in-residence services". The most relevant social care services for older people are domiciliary services (115,000 service users), day-care centres (36,000 service users, homes for the elderly (41,100) and "special regime homes" where older people with severe dementia are housed (8,200). [MoLSA 2009]

2. Identifying who plays what roles in the care system

The different roles (regulator, financer, planner, case-manager, provider) that actors might play in the formal care system for older people are defined in the report's Introduction.

The **regulators** are the Ministry of Labour and Social Affairs and the regions, which enact the national law on registration and inspection of social services provided by municipalities and non-profit providers in their area. Registration is a necessary step for providers to be able to receive public financing, or to establish agreements with health insurance companies for reimbursement of costs. Monitoring of legal requirements is checked through inspections performed by MoLSA on services managed by the regions, and by the regions on services managed by non-profit and for-profit providers or municipalities (in 2008, around 300 inspections were performed overall – Matuška, 2009).

Regions can also establish (in-house) services themselves, which MoLSA inspects to assure some measure of independence. Finally MoLSA also inspects the five care institutions it manages directly and may establish more, which would not be subject to the regional accreditation process. There is not one single administrative body responsible for registering and inspecting providers; rather two levels of administration share this role.

In order to be registered, a provider must submit documentation (legal registration form, description of services provided, proof of ownership of setting for service provision) and fulfil certain criteria (qualified staff, no outstanding debts to social security, not declared bankrupt) as might be expected.

Providers must also abide by nationwide quality standards, including:

- the existence of a complaint management system (e.g. complaints must be "resolved" in a maximum of 28 days)
- the provision of sufficient information to prospective users
- prior agreement with the user on how the care services should be delivered
- existence of key-workers that are responsible for planning
- existence of a further training/educational plan for care staff (MoLSA, 2002)
- respect for the human rights of users (especially regarding the use of restraining measures, which should only be used in life-threatening situations after being approved by a medical doctor and consequently informing the legal representative of the user)

[MoLSA 2006; MoLSA 2002]

The **financers** of care services for older people are a mixture of State subsidies (34%), regional and municipal budgets (16%), users' co-payments (46%) and health insurance (4%). [MoLSA 2009].

According to the Social Services Act 2006, transfers to the regions are linked to the implementation of medium-term development plans for social services. The regions should apply to MoLSA for the subsidy, which is determined by the Ministry on the basis of:

- the region's own financial resources; the medium-term development plan
- the volume and value of care allowance payments to individuals
- the number of registered providers and their capacity

- the capacity of social services provision within health care institutions.

In reality, however, strategic service planning and the distribution of resources are disconnected. It is common practice that providers bid for grants directly from MoLSA and MoLSA asks the regions for their opinion. Special grants from MoLSA aim to support projects developed by NGOs with a nationwide impact or an innovative character (Pospísil/Rosenmayer, 2006). The State also funds MoLSA's own five institutions.

The new Social Services Act 2006 introduced a range of additional changes that were to impact the funding of social services. Although the state administration and social services reforms went some way to establishing a clear funding system for social services, the reality is that there are many different funding sources. Besides the care allowance, the onus is on providers to apply for grants from municipalities, regions, Ministries, foundations and international organisations. Each of these has a different timetable and application process and may require quality standards exceeding the national minima outlined above.

In 2004, the State transferred €41.9 million to municipalities to finance social care institutions whose management had been passed to them following the state administration reform. A further €158.1 million was spent by regions on institutions they had established and €0.86 million by municipalities for the same purpose. There was a much smaller level of subsidy to non-profit providers of around €43.42 million (MoLSA, 2005; European Central Bank).

The **planners** are the regions and the municipalities. According to the Act, only the regions are required to develop a medium-

term plan; this should be done in cooperation with municipalities, providers and user groups.

The regions should first "research needs of social services provision" to different groups of users and are also required to "monitor and evaluate fulfilment of social services development plans", and make reports to the Ministry. The municipalities are also obliged to "research needs in respect of social services provision" and "may prepare a medium-term plan of social services development in cooperation with a region", as well as with providers and users. If a municipality identifies a gap in service provision, it can either (if it has the available resources) set up or expand new services itself or invite (typically non-profit) providers to apply for a grant to develop in line with the municipality's plan.

As regards case-management, there is a serious implementation gap. The Social Services Act sees the **case-manager** role as shared among regions, municipalities and providers. All registered providers of services are required to offer "social counselling", which means providing "information to persons that contribute to resolving their adverse social situation"; this might include information about other services available. Municipalities and regions have a more specific obligation to "arrange for available information on possibilities and manners of social services provision in [their] territory." In practice, though, it is almost always the older person's family that must try to find a service; even in the case of hospital discharge following a fall, there is no formal transfer to another service.

The **providers** are regions, municipalities, non-profit providers and to a very small extent for-profit providers. Regions and municipalities are able to establish in-house services which they fund themselves or may provide grant funding to non-profit organisations. As can be seen from table CZ1, over 80% of registered social care providers are from the public sector.

Public:	
Region	52.8%
Municipality	30.7%
Not-for-profit	15%
For-profit	1.5%

Source: MoLSA (2009)

3. User: accessing the system, paying for services

Some services are provided free at point of use, e.g. social counselling and early intervention, whilst others require a co-payment, e.g. care homes, residential health care facilities and domiciliary care. In residential services users pay for board and lodging up to a limit to be fixed by law, but must be allowed to retain 15% of their income after paying for these expenses (Social Services Act 2006). Care costs will be covered by the attendance allowance, except in respite services (typical stay of one week), where costs with care will be limited to 75% of the amount of the attendance allowance (Social Services Act 2006).

Legislation has also set the maximum amount liable to be charged for domiciliary care. According to the Social Services Act (Division 5), the co-payments should be part of the agreement signed between the provider and the user and/or his/her family. Family members may be called on to contribute to the costs of care if the user's own income and assets are insufficient. Clients' payments (including pensions, care allowance and other State benefits) make up a large part of the funding sources for various services: 44% of the total cost of homes for the elderly; 22.9% of the total cost of domiciliary care (2008 figures, MoLSA 2009).

Table CZ2. Amounts of care allowance and number of recipients by level of care needs

	Monthly	Number of recipients
Level 1	2,000 CZK (74.41 EUR)	103,000
Level 2	4,000 CZK (148.82 EUR)	81,500
Level 3	8,000 CZK (297.63 EUR)	39,000
Level 4	12,000 CZK (409.24 EUR)	22,000

Source: MoLSA (2009) and European Central Bank.

Note: Exchange rate EUR/CZK in December 2008: 26.879.

The Social Services Act created the "care allowance", i.e. an individual cash benefit to finance the running costs of care provision per individual. This is a non means-tested allowance, the levels of which are set at four flat-rate levels according to the assessed need of care (the amounts differ according to age). Persons over the age of 65 make up 69% of care allowance claimants (MoLSA, 2009). The care allowance can be used to pay for informal care (e.g. spouse, daughter) and/or registered service providers. The former are not obliged to be registered, although they may choose to be listed with the social administration office if they wish their social and health insurance contributions to

be paid by the State (this is only possible for those caring for persons entitled to levels II to IV).

Assessment is made first by a social worker from a municipality "with delegated powers" or a region, based on a home visit. A doctor contracted by the State employment agency (also supervised by MoLSA) then reviews the paperwork and is responsible for assessing the applicant's health condition and ability to live independently, accounting for the ability to carry out (instrumental) activities of daily living and drawing on the findings of the social worker's assessment. While the applicant must provide information on who will arrange the necessary care, when submitting his/her application, the social worker is responsible for advising the applicant on the services that might be used. [MoLSA, 2009]

The assessment and the benefit levels are based only on care needs, not on the income and assets of the beneficiary. The municipalities with delegated powers are responsible for paying out the care allowance according to the Social Services Act. They should also "control whether the allowance is used for arranging assistance and whether a person granted the allowance is receiving the assistance corresponding to the determined dependence degree." (MoLSA, 2006)

When using formal care services, users' co-payments (e.g. board and lodging) are set on the basis of the user's income and assets, subject to limits set by the MoLSA. The care allowance can be used to pay for formal services at home or in residential settings regardless of the type of provider (public, non-profit or for-profit) or to pay for informal care. This is seen as the first step towards "choice" for service users to be made in the Czech Republic. In the case of formal service a user signs a contract with the provider, outlining the expected service and payment level.

Within a year of the introduction of the care allowance, it had become obvious that a lower than expected portion of the allowance was being used to pay for formal care (MoLSA, 2008) and lack of monitoring of use of the care allowance was already emerging as a problem. By an amendment to the Social Service Act, from 1 January 2010 onwards the care allowance for level I of care will be paid half in cash and half by voucher). The cash allowance can be a useful supplement to a household's income, as it compares well to the average monthly wage of around 15,000 CZK and the average pension of around 9,500 CZK. [CFQ research workshop 3]

In the future, it is expected that the care allowance will represent the largest source of financing long-term care (its extrapolated cost over a year is expected to be equivalent to 0.5% of GDP – MoLSA, 2009).

Table CZ3: Use of the care allowance by care level and status of provider, 2008

	Care level I	Care level II	Care level III	Care level IV
Informal carer	77%	77%	72%	59
Registered provider	17.5%	19.5%	23%	35
Unregistered provider or unknown information	5.5%	4.5%	5	6

Source: MoLSA (2009)

4. Understanding the relationships between actors and their impact on quality

There are different types of (formal and informal) relationships at work in the Czech system of care for older people and they have an impact on the quality of services. The transfer of responsibilities and resources for care to the regional and municipal authorities was *not* accompanied by the establishment of a purchaser-provider model, in which municipal and private providers could compete and gain access to the same funds. The ad hoc financing model that had developed in the 1990s to support innovative services provided by non-profit organisations became entrenched and the initiative continued to rest with providers to apply for grant funding (subsidies).

The new Social Services Act allows health insurance funds to establish agreements with providers of institutional care so that their clients with long-term care needs may move to residential care facilities, rather than staying in hospitals. These agreements ("Special Contracts" in the terminology used by MoLSA, 2008) stipulate the compensation for care that is provided by a new specialised group of professionals – the general social service nurses. However, only care provided by these professionals can be reimbursed by health insurance companies. By contrast, there is no purchasing or contracting as such in social care.

The municipality of Ostravá and the non-profit Church-based provider, Silesian Diacony, took part in a CFQ research workshop and outlined their relationships to different actors in the system.

City of Ostravá: relationships with providers
[SMOCR presentation to CFQ research workshop 3]

Ostravá is the Czech Republic's second city with over 300,000 inhabitants, of which 14% are over 65. Its 2009 expenditure (excluding investment costs) on social services was almost €43m – around 25% (€11m) was financed directly from the city budget (representing around 3.6% of the city budget), while the remaining 75% came from the county, Ministry, health insurance and the EU in 2009. Over half of the €43m went on services for older people, and most of that (82%) on homes for older people. The total budget for the city of Ostrava was €423m, of which €307m were current expenses. This means that 3.6% of total current expenses was spent on social services. It should be mentioned that additional funds from the city budget were spent on social benefits and employment policy. Some infrastructural projects were also realised that year and total expenditure on social services for 2009 came to 13% of the municipal budget.

The city sets store by community planning in collaboration with municipal districts, other providers and users of social services. It has developed a strategy for health and social policy and a concept for the quality of social services. On this basis, the municipality helps to develop a network of social services by establishing its own in-house services, but also by providing subsidies to non-profit providers in the city. However, there is still a gap in supply and some older people do not trust innovative – therefore, less familiar – types of services.

Table CZ4: Number of registered services by type and sector and persons using them in Ostravá

Service	In-house	External	Total	Users
Social counselling	0	4	4	1084
Domiciliary services	6	6	12	2497
Respite services	4	2	6	252
Day service centre	2	5	7	118
Homes for older people	7	7	14	1854
Homes with special arrangements	6	2	8	390
Social services provided in a hospital setting	1	0	1	150
Total	26	32	58	7179

Source: SMO CR presentation to CFQ research workshop 3

A little over half of the registered services in the city's area are external, the remainder being in-house. The reason for this is that before 1989, there were no services other than those of the State. After 1989, non-profit providers developed new services with the support of international grants and training. The city began to offer grants in an ad hoc way to support these organisations in the activities they were already carrying out. In 1990-95 there very few services; from 1996-2005 there was a significant expansion. In 2006, the new Social Services Act was introduced and it remains to be seen whether it will stimulate further supply to meet demand.

Nowadays in Ostravá, there is a grant system for external service providers. All the providers have to follow the same guidelines for the award of grants:
- the projects have to be in line with the city's priorities for social policy
- the projects have to commit to reporting on their implementation – performance and user numbers
- the provider has to be registered with the Region

Municipality and providers negotiate the price to charge the user, within the limits imposed by State regulations. The City of Ostravá supports and encourages all providers to implement all the changes required by law. Fulfilment of these changes requires a new approach to users, new management techniques, staff training, etc. The modernisation of services in the city is challenging, especially for residential institutions, but the city tries to offer support.

Silesian Diaconia: relationships with financers and users
[Silesian Diaconia presentation to CFQ research workshop 3]

Silesian Diaconia is a major non-profit NGO providing services in social and health care based on Christian values. Its vision statement reads: "Silesian Diaconia is an organisation with a high level of culture and qualitative accredited social services. It belongs to the substantial group of non-profit - making organisations within the Czech Republic and has a strong influence on the course of events in social fields". It has around 600 staff and 7,000 people use its services, all of whom have a contract with the provider. Its care services for older people include home care, residential homes, day care and respite care across the country.

Silesian Diaconia also has to be registered with the regional authority in every region in which it operates. This application is made in writing and the regional authority checks:

- Professional competence
- Hygiene standards
- Appropriate setting and fittings for service provision

Numerous documents have to be enclosed with the application:

1. Form "Data on registered social service", e.g. title, place of service provision, target group – with various attachments:
   - Description of social service implementation
   - Staffing *Organisational structure without names and work load* and nominal List of the Staff Members *Staff in direct care + manager of the particular social service*
   - Balance Sheet *Must be submitted at the primary registration – no more submission for the purpose of an update.*
2. Police record of staff members working in direct care
3. Certificates of professional competence of staff
4. Certificates of proprietary or other rights to the care setting
5. Decision on adoption of operational hygiene rules.

It should be noted that the region can also rescind accreditation for non-compliance.

The Silesian Diaconia has a relationship with numerous financers, as the financing system for social services in the Czech Republic is fragmented. The provider seeks funding on a rolling basis from public and international budgets as well as co-payments from service users. Silesian Diaconia seeks funding from, for example: regions, municipalities, MoLSA, various Czech and international foundations, private companies and of course the Church to which it is affiliated.

Besides inspections by the regional authorities, which are responsible for registration to assure minimum standards, legislation requires providers to have an internal quality management system. Silesian Diacony has developed a methodology for implementing certain standards and a team which coordinates the entire implementation process. This team works with service users in different service centres to develop the methodology. Silesian Diaconia's centres most often work with EFQM or ISO, but workshop participants estimated that only around 5% of services have one of these. The Diacony has become so specialised in quality assurance that it is now an accredited training institution.

Robust internal quality management systems bring benefits for user and provider. The Diacony tries to ensure that each user is aware of his/her rights and receives a personalised service. It is also good for staff that they have the opportunity to undertake training and build team-work. A higher quality service also tends to attract more service users and bring success in revenue generation.

5. Country Conclusions

In this study, the Czech Republic represents Central and Eastern Europe, where countries' welfare systems are still being built. This gives them a different starting point in confronting the challenge of demographic change and growing needs for care in old age. The Social Services Act 2006 can be seen as an attempt to create a common framework to replace disparate ad hoc initiatives launched after the fall of Communism.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?
The Czech Republic has mixed governance mechanisms that stretch from central planning to user purchasing – the initiative for developing services still seems to lie, in the main, with providers. If a non-profit provider wishes to develop services, it applies to public authorities and others for a grant to do so. There is market regulation in that the regions accredit and inspect social services, but there appears to be little systemic incentive to

surpass the national minimum standards, except that of winning grants over other applicants or attracting more service users – providers may have suffered from the trend to use the care allowance to support informal care rather than buy formal services. All providers are required to have an internal quality management system and some are still experimenting with different systems

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?
Cities and larger towns "with extended competences" are able to exert some pressure on providers to develop in line with the city's overall strategy, but this is more about capacity than quality. Because the initiative to develop services is so often taken by providers, the onus is rather on them to demonstrate to financers (including public authorities) their quality and capacity to improve.

Contracting for Quality

Country Profile:

Germany

GERMANY

1. Introduction and background

Germany is a federal State in which competences are divided between the Central State and the sixteen regions (*Länder*). Both the organisation of and entitlement to social services are regulated by several federal laws, e.g. concerning individual benefit amounts. Long-term care services are considered part of social services, and many of the rules applicable to all social services also apply to them. Long-term care has since 1995 been a branch of the health insurance system called "long-term care insurance" (LTCI) under a law called *Sozialgesetzbuch XI (SGB XI)*.

One of the aims of the reform was to stimulate the development of a home care market, notably in less prosperous cities. The LTCI covers a fixed level of care costs and plays a decisive role in regulating the care market, assesses individual care needs and inspects the quality of care provided (Arntz et al., 2007). The LTCI is not only intended for older persons but for anyone with a long-term condition, who requires assistance with defined daily activities. It is only intended to cover part of the costs of care, which leaves many people in need of additional social assistance.

The federal laws regulating social services apply to long-term care only in as far as additional costs of care or costs of living are concerned. With respect to the recipients of services, according to the *Sozialgesetzbuch XII* (social assistance law) additional assessments and inspections are possible. The amount paid to social-assistance recipients depends on individual need and may vary regionally.

Local long-term care planning is nowadays mostly concerned with creating (economic or other) incentives or disincentives for providers to set up certain types of services in given areas. There is also a role for municipalities in creating a community suited for people needing long-term care, e.g. by fostering household services and social activities. Before the introduction of the LTCI in 1995, municipalities held the primary planning role in their local area.

*With special thanks to Heike Hoffer of Deutscher Verein in Germany for her input into this country profile.

2.   Identifying who plays what roles in the care system

The different roles (regulator, financer, provider, planner, case-manager) that actors might take in the formal care system for older people are defined in the report's Introduction.

The principal **regulators** are the umbrella body of the health insurance funds (GKV) and the Medical Service of the Health Insurance Funds (MDK), a joint agency of the LTCIFs. There is a framework contract on quality standards between the GKV and the umbrella organisations of providers – i.e. quality standards are negotiated between the insurers and providers at federal level. In some cases, these standards have to be approved by the federal government (Ministry of Health) The MDK is an intermediate public agency (indirect state administration), one of whose roles is on behalf of the LTCIFs to ensure compliance with agreed quality standards by carrying out inspections. The MDK represents the professional (nursing) point of view in negotiations on quality standards between LTCIFs and providers.

Registration of providers occurs through a "provision contract" (*Versorgungsvertrag*) negotiated between a service provider and the regional (i.e. *Land*) federation of the LTCIFs. This is necessary step in order for a provider to receive reimbursement for its clients through their specific insurance fund. In signing a provision contract, a provider agrees to:

- guarantee delivery of services (home care and home help) 24 hours and seven days a week – but has no guarantee that any clients will be referred
- not deny services to any insured person
- cooperate with other providers, in particular with emergency services
- foster efficient and economically viable services

- indicate a catchment area of a specific district or town
- comply with quality assurance mechanisms (defined at federal level) and be subject to quality inspection by the MDK
- make sure that all services are provided under supervision of a registered health care professional
- have at least three employees (full-time equivalent, including managers)
- sign a care contract with each service user.

As some funding comes through the social assistance regime, service providers must also have agreements with its agencies, notably with municipal *Sozialämter*. Some *Sozialämter* may choose to come together in a certain district or region in a more or less formal way and negotiate collectively with both providers and the insurance funds.

There are three inspection regimes in Germany: the MDK inspects on the basis of federal or contractual standards; municipalities inspect as contractual partners in paying social assistance, and local/regional inspectorates do so on the basis of regional laws (*Landesheimgesetze)*. The MDK carries out inspections of all providers of residential and community care. There are concerns that these parallel structures are an inefficient use of resources (CFQ research workshop 2). From December 2009, the inspection reports have been transformed into so-called 'transparency reports' and made publicly available on the internet. As of 2011, there will be an annual MDK inspection of both residential and home care providers.

The main institutional **financers** in long-term care are the LTCIFs (care-related costs) and the municipalities (additional care costs and social assistance, e.g. for housing costs). The regions provide grants for investments

(though the legal basis for this is rather vague) and can thus influence service development. Investment costs can also be charged to the users of a service separately to ongoing care costs (CFQ research workshop 2). The LTCI is funded by combined employer/employee contributions worth 1.95% of an employee's gross salary (2.2% for employees without children). "Provision contracts" (see below) set the reimbursement rates, which care providers claim from the relevant LTCIF for each service user.

The municipality (specifically, its social assistance agency – *Sozialamt*) supplements the funding available through the LTCI for anyone who is not insured, on a low income, or whose insurance does not cover the cost of the care they have been assessed as needing. The *Sozialämter* contribute a significant part of their social assistance budgets to subsidising long-term care, particularly by paying nursing home fees for residents on a low income.

There has been no formal **planner** in the German system since 1995, before which time the municipalities held this role. The system is very much driven by a process of supply and demand, in that home care and residential care providers enter the market (on the basis of quality standards) and compete for clients, whose costs are reimbursed through their LTCIF. [CFQ research workshop 2]

Only where there are not sufficient care providers ("*Unterversorgung*"), are the LTCIFs and the regions (because they are responsible for care infrastructure, seeing Section 9 of SGB XI) obliged to take action to ensure adequate provision for all citizens. However, there are no clear rules on how this is to be done: LTCIFs may set up their own providers (but rarely do so), the regions may use grants to incentivise providers and the

municipalities may set up their own providers as well (but only where there are no other providers willing to set up a business). [CFQ research workshop 2]

However, there is currently no general shortage of providers even if there are concerns about a lack of providers with certain areas of specialisation (such as dementia care) or that in some regions there has been a shift towards residential rather than home care, despite political support for the opposite trend (i.e. towards looking after more people in their own home).

The **case manager** role is shared among several bodies in Germany. Needs assessment is carried out by the MDK's doctors and specialist nurses (*Pflegegutachter*) against four levels of dependency from 0 to III. This needs assessment is based on the activities of daily living time-frame and the assessment is the same in all the German *Länder*. This most often happens either at home or in a hospital prior to discharge.

The LTCIFs are required by law to establish advice services for people receiving benefits from the LTCI (*Pflegeberatung*). Here they get information and advice on what benefits they are entitled to, are supported in making use of them and receive information about other types of assistance. Also, the LTCIF's care advice service should set up an "individual care plan" (*Versorgungsplan*) for each client. In practice, advice services work well for some LTCIFs, in particular those that have a strong network of service points. For other LTCIFs these services can be offered/delivered only by telephone and are potentially less effective.

A recent reform gave regions (*Länder*) the option to make compulsory the establishment of single access points (variously called

Pflegestützpunkte, Leitstelle Älterwerden, Seniorenbüros), typically, one per 30,000 inhabitants. However, because such access points are meant to include many actors (under the lead of the LTCIFs), their organisational structure and effectiveness varies greatly. Some municipalities and regions had already set up structures like this and converted them into what the law required.[1] In many regions, such single access points are run or subsidised by public authorities in cooperation either with other public authorities or with non-profit providers, or may even be sponsored by private firms. [CFQ research workshop 2]

Given the prevailing market-led nature of relationships and the shift of responsibilities and resources to the LTCI, activities of municipalities and *Länder are* very much dependent on political initiatives to establish systematic planning and coordinating activities. However, as such activities and choices depend on available resources, regional differences are growing.

Table DE1: LTCI-funded market share by type of provider and care setting

	Community care	Residential care
Municipality	2%	7%
Not-for-profit	41%	55%
For-profit	47%	38%

Source: Statistisches Bundesamt (2007) Pflegestatistik 2005.

The **providers** have traditionally been large non-profit organisations (*Wohlfahrtsverbände*), namely *Caritas* (affiliated to the Catholic Church), *Diakonie* (affiliated to the Protestant Church), *Arbeiterwohlfahrt (*affiliated to the Social Democratic Party – SPD), *Deutsches Rotes Kreuz, Paritätischer Wohlfahrtsverband* and *Zentralwohlfahrtsstelle der Juden in Deutschland*. They had a longstanding relationship with the municipal *Sozialämter*, based on trust, social planning and subsidies, which included coverage of losses at the end of the year. Indeed, the German corporatist governance model had resulted in the delegation of service provision to the third sector "which [had] led to common planning, the acknowledgement of the non-profits' special professional rationales, and high rates of service refunding" (Bode, 2003). Municipalities have had little or no involvement in direct service provision of care for older people even before 1995. Since the introduction of the LTCI in 1995, there has been growth in for-profit provision too, both in residential and home care.

Among the 11,500 home care providers, 70% probably have fewer than 50 clients – there is a trend of market consolidation in this area, with some of the insurance companies buying up the small providers.

3. User: accessing the system, paying for services

Germany channels much of its funding for long-term care through individual persons via their insurance funds. The benefits from the LTCI are not means-tested – the user must merely be insured with the LTCI for more than 2 years and submit an application for care needs, which is then assessed. For people drawing on the LTCI, there are four funding types – cash benefits (*Pflegegeld*), benefits in kind (*Pflegesachleistung*), social assistance (*Hilfe zur Pflege*) via the municipality's *Sozialamt* and his/her own income and assets. Some regions have a care housing benefit, an extra financial contribution to housing costs in residential care.

There are minimal controls on how cash benefits are spent, though there are biannual visits by home care providers, who report back to the LTCIF on whether the care is appropriate. The *Pflegesachleistung* operates in a similar way to a voucher and can be used only for services authorised by the MDK. Services can also be combined with cash benefits, e.g. 50% cash and 50% services. In nominal terms, services are worth more than cash benefits (see Table DE2), though cash benefits are cheaper for the LTCI system to administer than services are to arrange. Although in-kind benefits are worth double the amount of the cash benefit, more than 70% of those entitled choose cash-benefits or a combination of cash and in-kind services (see Rothgang, 2010). However, this trend may now be in reverse, either because fewer and fewer women (or indeed men) are willing to leave the workforce to fulfil a caring role, or simply because they live too far away, making the use of cash benefits in caring for relatives impractical.

Table DE2: LTCI benefits by level of dependency and type of benefit, 2009

Type of benefit	Level of individual assessed care needs[1]			
	Level 1	Level 2	Level 3	Hardship
In-kind benefits for community care (per month)	€420	€980	€1,470	€1,918
Cash benefits (per month)	€215	€ 420	€675	
In-kind benefits for residential care (per month)	€1,023	€ 1,279	€1,470	€1,750
Supplement for exceptional care demand (e.g. dementia)	max. €2,400	max. €2,400	max. €2,400	
Contribution to pension insurance of the informal carer	€133.73 (West) €113.30 (East)	€267.46 (West) €226.59 (East)	€401.18 (West) €339.89 (East)	

Source: BMG (2009) Facts and figures on LTC Insurance. Berlin: BMG.- (1) Individual care needs are assessed by an expert of the MDK (medical doctor or registered nurse).

Municipalities are entitled to supplement the funding of services, and provide cash benefits. The criterion for a municipality to fund services is that the MDK has made a care (needs) assessment that the person therefore needs assistance. Only where the benefits from the LTCI do not cover all care needs will the social assistance supplement them. This includes special care services: care services for people with care needs below the threshold for receiving LTCI benefits as well as the need to pay for housing, food and investment costs (these being typical out-of-pocket payments) in residential care. Indeed, covering investment costs (i.e. the cost of building the home and setting up a business), on behalf of nursing home residents can be a significant financial burden for municipalities.

Entitlement to social assistance, unlike LTCI payments, depends on a means test which takes a person's income and assets into account. Compared to the "general" social assistance for jobless people who cannot work more than 3 hours per day (*Sozialhilfe*), the care-related social assistance (*Hilfe zur Pflege*) allows the recipient to keep a greater share of his/her income and assets. A person with income and assets above a certain threshold first needs to use this money to pay for care, before s/he may receive social assistance. The rules for means-testing are generally the same across the country, but the calculation varies slightly according to the cost of housing.

Service users either arrange services themselves or with the help of LTCIFs' or municipalities' advice centres. They will be advised by the LTCIF on whether home care or residential care would better meet their needs. In the area of home care, though most providers have very few clients, supply is exceeding demand in most parts of the

country, even though there is said to be a shortage of specialist services in some areas.

Since the last LTCI reform in 2008, LTCIFs have set up internet sites that allow users to search for services according to certain criteria (e.g. post code). Since December 2009, these websites also make available transparency reports for every provider that has been inspected since the summer of 2009. Also, the LTCIF counselling services (within and outside of single access points) are required to have lists of providers including services offered and prices available (*Vergleichslisten*). The single access points are meant to play an increasing role in supplying information on providers and supporting users in their decision-making process. Word-of-mouth is very important in people's choice of provider, as are the LTCI and municipal advice centres, which have to be well-informed about services in their local area. Hospitals and family doctors also tend to recommend providers they work with regularly.

The assessment based on dependency levels has created some counterproductive incentives in the system. For instance, if a resident with level-3 needs in a nursing home dies, there is an incentive to attract another person with level-3 dependency because they represent a higher level of funding. There is potentially also an incentive to let a person's condition deteriorate in order to re-assess him/her as level-3 dependency. The policies of 'home care first' (*ambulant vor stationär*) and 'rehabilitation first' (*Reha vor Pflege*) present in the SGB XI are widely thought of as political commitments, not significantly backed up in practice (CFQ research workshop 2). Attempts were made to increase payment rates for home care and reduce rates for residential care, but the latter was resisted by the residential care lobby (CFQ research workshop 2).

4.   Understanding the relationships between actors and their impact on quality

With the introduction of the LTCI in 1995 the German government intended to introduce an open market and facilitate competition between providers, so fostering innovation. Before 1995, almost all community care services had been provided by third-sector organisations, with representatives of the welfare associations (umbrella organisations) on the basis of municipal planning and subsidies. With the introduction of market mechanisms in 1995, relationships between the new purchaser (LTCIFs), co-funders (municipalities) and providers changed radically, calling for new forms of contract between them.

The **provision contracts** (*Versorgungsvertrag* – Section 72 SGB XI) between the regional federation of LTCIFs and the provider basically represent an authorisation to provide care services and receive reimbursement from a given client's own LTCIF. The **framework contracts** (*Rahmenverträge* – Section 75 SGB XI) between the same parties concern the content of services, financial reporting, personnel requirements and inspection regimes. The overall purpose of the framework contract is "to ensure an effective and efficient care provision for insured persons". The *Sozialämter* participate as social assistance agencies through various district-level or regional federations in these negotiations and are signatories to the contracts too. The **reimbursement agreements** (*Vergütungsvereinbarungen* – Section 82 SGB XI) between each individual provider and regional federation of LTCIFs cover payment levels for different types of services (see section below on home care providers for further details on these contracts.)

Contracts between providers and users (both in residential and home care) are governed by the newly established *Wohn- und Betreuungsvertragsgesetz* of October 2009. It is meant to be a consumer protection law in the area of combined care and housing services. While it does not contain any general "quality standards", it does place a number of obligations on the provider (e.g. about the form and content of the care contract), user rights and – specifically – the right of the user to demand a reduction in the agreed price when the service is not up to either care quality standards or individually agreed "standards".

The intention is to increase quality by establishing structural and organisational minimum criteria (e.g. staff quotas and qualifications), which would support the quality of services and by obliging the providers to adhere to certain quality standards, e.g. internal quality management and so-called "expert standards" of care, mainly related to nursing science and approved by the Federal Ministry of Health.

The municipality of Dortmund and an consultancy to small for-profit providers took part in a CFQ research workshop and outlined their relationships to different actors in the system.

City of Dortmund (*Sozialamt*): relationships with citizens, providers and LTCIFs

[Dortmund presentation to CFQ research workshop 2]

The City of Dortmund is a signatory to some 35,000 contracts within its area. As a social assistance agency, its consent is required for the provision contracts between the LTCIFs and the providers - otherwise providers would not be able to reclaim running costs for users co-funded by social security through the *Sozialamt*.

Municipalities have a right to inspect services they (co-)fund as social assistance agencies, and – in some *Länder* – a duty to inspect nursing homes (sometimes also home care services) through local inspection services (*Heimaufsicht*). In some *Länder*, the *Heimaufsicht* is managed by the region. The City of Dortmund has three special inspectors for nursing homes (*Heimaufsicht*) to ensure adherence to the quality standards required by law. On its own initiative, it also employs four inspectors (trained nurses and social workers with specialist training) in the area of home care.

As there is no longer a strong social planning role in long-term care for municipalities, cities like Dortmund have to look for softer ways of influencing supply of care services in their area, e.g. by:

- Publishing regular demographic and market reports and using this to advise home care providers and nursing home developers about over- or under-supply in specific districts.
- Advising developers on the location of a new nursing home
- Organising a forum for older people that raises awareness in the community and among care providers of the municipality's role

- Supporting a committee of older people with a special advisory role to the city council.

In addition, city councillors may speak out on the basis of the reports, talking about gaps in supply or poor quality services, so influencing LTCIF and providers through the public sphere.

When it comes to the quality of care, the City of Dortmund also looks for ways to exert an influence:

- If people complain to the City's Seniorenbüros about poor quality, they contact the local offices of the care insurance or their in-house inspectors to take further action
- In nursing homes: the Sozialamt's inspectors offer advice, issue sanctions and can close down a nursing home in case of serious failings
- Home care services used by clients for whom the City's Sozialamt pays: if inspectors receive negative feedback, they visit the clients and review care documentation and staffing standards.

The City Council sees itself as having a notional contract with its citizens to help them find the right type of care and support through the LTCI. For this reason it has established *Seniorenbüros* around the city in cooperation with a local NGO – also on the basis of a contract. These offer a case management service for older people needing help and are networked with home care providers, police, hospitals, family doctors and housing providers in their district of the city. The municipality also aims to develop volunteering and meeting places for older people through their NGO partners.

Home care providers: relationships with financer and regulator

[BAAS Lünen presentation to CFQ research workshop 2]

A provider has relationships with at least four different actors. First, it must seek a provision contract with the regional federation of the LTCIFs and municipalities in the area. This covers the type, content and volume of services. The provider must satisfy a number of criteria in order to get this contract; it must:

- be legally established and financially sound
- have employed a managing nurse to oversee the nursing process
- have the capacity to provide 24-hour care

The provider must also commit to:

- accept every application for care by an insured person
- not request additional payment
- establish a contract (including payment agreement) with every service user

The framework contract is negotiated and agreed at the same time as the provision contract between the same actors (though possibly represented through different bodies). It covers a number of other issues:

- The general context of care including cost absorption and billing issues
- Concepts and guidelines for efficient and effective staffing and other structural criteria
- Assessment and control of necessity and duration of care
- Access of inspectors (MDK or other)
- Criteria for economic assessments
- Criteria for catchment areas

A subsequent "payment arrangement contract" is based on the preceding contracts and agreed between the same parties. It is here that the exact reimbursement and user charging rates are set out. Each type of service has a certain number of points, which are worth around 0.04€. A complete process of getting someone out of bed, helping them wash and eat would be worth around 16€. A provider might negotiate well so that a point is worth 0.041EUR.

The provider itself has to consider in which local area it wants to offer its services. The main factors influencing this decision are:

- the demographic structure of the area
- population density and ease of access within the catchment area
- existing contact with health-care-providers (family doctors, hospitals, pharmacies) or municipality as a potential source of referrals
- whether there is a gap in supply of specialist services, e.g. psychiatric care
- cooperation with the local housing associations and landlords
- opportunity to take over a competitor (established access to local market)
- expansion opportunities in surrounding areas

Service provision in different cities is possible, though a further series of contracts would then have to be signed.

Providers and inspectors (MDK, municipality, region)

Providers are required by their LTCI contracts to allow access to their services for inspection visits by the MDK and municipal or regional authorities. Providers are legally bound to work on the basis of nationally defined nursing quality standards, which cover: decubitus prophylaxis; management of patient transfers between hospital, residential care and home care; management of chronic pain; fall prophylaxis; wound treatment. Providers have to accept inspections conducted by MDK-inspectors on an annual basis from 2010. The results of the inspections will be made public in a special transparency report. In addition to external standards, providers are also legally bound to establish an internal quality management system, e.g. ISO, TQM etc.

Quality efforts are intended to focus on outcomes for service users. This is done by giving outcomes and user survey results a greater profile in the transparency reports. Impressions of quality often concern care staff who visit a person in their own home: their punctuality and politeness, and a user's feeling of wellbeing during and after the visit.

A key topic of recent debates has been the public availability of inspection reports. An agreement was put in place after intense debates (see, for instance, BAGFW, 2008) in 2009 between the federations of private non-profit (BAGFW) and for-profit (BPASD) providers and the federation of LTCI funds (*GKV-Spitzenverband*). In future, all providers (of residential and community care) inspected by the MDK will publish the results of ratings in relation to 49 criteria covering nursing care, health care and organisational issues, as well as a satisfaction survey of users.

Most criteria already existed before as part of the inspections, but some were added for the purpose of developing transparency reports. These are mainly structural and process indicators, e.g. whether:

- the biographical background of residents suffering from dementia is being considered
- medicines are provided according to the family doctor's prescription
- a complaints system has been put in place.

Residents are asked to assess twelve items including whether staff are "polite and friendly". The idea behind this regulation is to facilitate informed choice – apart from quality management systems and respective certifications (ISO 9000, EFQM, etc.) used by organisations – and comparisons of facilities and services by (potential) service users.

Quality, especially quality of life of residents of nursing homes, is further influenced by resident councils and resident representatives ("ombudspersons"). Residents' Councils have (according to the applicable *Landesheimgesetz*) a number of information and co-determination rights, e.g. to obtain information on the financial situation of the nursing home or to co-determine the interior decoration of communal spaces. Where a residents' council cannot be set up (e.g. because most residents suffer from severe dementia), most regional laws provide for an external ombudsperson to represent the residents. Also, some regional laws impose a specific quality standard regarding community involvement and social inclusion

5. Country Conclusions

The extension of Germany's health insurance system in 1995 to incorporate a pillar on long-term care insurance radically altered the landscape and relationships at local level. Past relationships based on social planning and public subsidy between municipalities and private non-profit providers were gradually replaced by more formal contracts between insurance funds and providers, including new non-profit providers. Among the study countries, Germany was the first to introduce a reform, which channels publicly regulated funding through individual users, a trend which others in the study have since followed.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?

Access to the market in Germany is controlled by the MDK, a semi-public agency to which all the health insurance funds are affiliated. The MDK accredits services, which then seek to attract users, whose insurance funds reimburse the cost of their care. In this system, competitive tendering does not play a role, as each provider which fulfils the accreditation criteria is entitled to a "provision contract". It is then a matter of supply and demand whether a provider will survive in an increasingly competitive care-market. The MDK will inspect services annually from 2010 on the basis of 49 quality criteria and make the results public. This is an additional measure of market regulation, but it remains to be seen whether better information for 'consumers' really improves the quality of care for older people.

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

Since 1995, the role of municipal *Sozialämter* has reduced in scope to being that of case-manager for persons on a low income and a secondary inspector of residential and nursing homes. *Sozialämter* have little say in the contracts between insurance funds and providers in their area, though they must give their consent. Public authorities' relationships with providers and other organisations are most similar to Belgium's in this study, though in Belgium OCMWs and municipalities have a duty to plan and coordinate service provision in their area – a matter of local political decision in Germany. The *Länder*, be it as co-financers of care infrastructure or regulators also have limited to drive quality improvement, as the decision to have an open market of providers with regionally regulated prices does not provide/create any incentives beyond survival in the market.

Contracting for Quality

Country Profile: United Kingdom: England

UNITED KINGDOM: ENGLAND

1. Introduction and background

The United Kingdom has been a centralised State until recently, though with a strong role for municipalities in social care. Powers over health and social policy have been devolved to new administrations in Scotland, Wales and Northern Ireland since 2001 with a consequential rise in differences between the nations – this profile focuses on England only.

The United Kingdom, England in particular, has been a forerunner in introducing business-like management tools in the context of privatisation policies since the 1980s (Taylor-Gooby and Mitton, 2008). The NHS and Community Care Act of 1990 established a trend towards outsourcing of traditional residential and nursing homes and home care from municipalities to the so-called 'independent' sector of for-profit and non-profit providers. For example, by March 2008 the private (for-profit) and voluntary (non-profit) sectors were delivering 92% of all places in residential care and nursing homes and the market was showing a trend towards concentration (CSCI, 2009, p49).

In the area of home care, the proportion of hours contracted in this way has also been rising rapidly, while the number of households receiving council-funded home care has been falling (due to targeting and rationing). Between 2004 and 2008, there was significant growth in the number of home care providers registered with CSCI from 1800 to nearly 5000. Most of that growth came from a tripling of the number of registered private for-profit providers – from 1300 to 3700. Municipal and non-profit agencies also grew over the same period, but more slowly and from a lower base. [CSCI, 2009, p55].

Over the past 20 years a new structure of provision has therefore emerged, with municipalities acting as purchasers of

services from the independent sector (i.e. non-profit and for-profit providers). Since 1997, when Labour came to power, this approach has been modified by adding a focus on quality assurance and user orientation. Legislation included the Care Standards Act 2000, which introduced national minimum standards for all care providers, whether in the public or independent sectors. Other pieces of legislation introduced the possibility of direct payments for users (currently around 7% of expenditure), and programmes such as Best Value and then Comprehensive Performance assessments in relation to local councils' performance, both overall and in relation to social care (Kirkpatrick, 2006; Netten et al., 2005). These initiatives were the Labour Government's response to the previous Conservative Government's policy of outsourcing and putting council services out to competitive tender, and were designed to provide incentives for improved performance without requiring outsourcing (though some still occurred).

Today, the care market for older people is defined by a high degree of tender-based contracting and high regulation and direction by public bodies, notably the Care Quality Commission (CQC), which registers and inspects all service providers and also assesses the performance of municipalities. The 152 municipalities in England with "Adult Social Services Responsibilities" also regulate and part-finance the market in their local area - they assess social care needs and commission services for different user groups.

(Not all municipalities have these responsibilities because of the two-tier system of local government in some areas.)

2. Identifying who plays what roles in the care system

The different roles (regulator, financer, provider, planner, case-manager) that actors might take in the formal care system for older people are defined in the report's Introduction.

The main **regulator** in England is the Care Quality Commission: it assesses municipalities' performance as 'commissioners' (i.e. planners and financers) and registers and inspects care providers (care homes providing personal or nursing care, adult placement schemes, home care agencies) to check whether they (continue to) meet the standards required, which are grouped as follows:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management.

For a full list of outcomes, please see Annex UK1. Each group contains a number of outcomes, e.g. Involvement and Information has three:

- Outcome 1: Respecting and involving people who use services
- Outcome 2: Consent to care and treatment
- Outcome 3: Fees

Service providers must also complete a self-assessed 'Annual Quality Assurance Assessment' (AQAA) for the CQC and submit with it a data set concerning their services (CQC, 2009).

The frequency of care home inspections depends on the most recent CQC score: care homes rated "excellent" are inspected every three years, "good" at least every two years, "adequate" at least once a year and "poor" homes at least twice a year. There may also be random unannounced inspections of any care home. The Star Rating Assessment Tool is used in the UK to inform the public about the outcomes of inspections and the quality of institutions. On the CQC website, people can search for care homes in their area and find out about their quality ratings. The principle is that the CQC and the municipality will support the provider's efforts to improve, before taking other measures.

Municipalities should also be seen as **regulators**, in that they have some autonomy in shaping and influencing the care market in their area, being able to set prices and define conditions of access to services on the basis of individual needs assessment. They may also define values and set standards above and beyond those required by the CQC (see for examples the examples of Surrey County Council and Stoke on Trent Borough Council below).

The roles of **institutional financer**, **planner** and **case-manager** in England and across the UK all lie with municipalities, though many service providers, especially in the independent sector draw in substantial private financing by users (for all or part of the costs). All providers must, however, be registered with the Care Quality Commission. For self-funding users, there is no case management or assessment by municipal social workers, though the right to assessment exists for everyone (CFQ research workshop 1).

Figure UK1. Local authority commissioning cycle showing (from top-left) needs analysis, service planning, procurement and review. Source: Surrey County Council.

As **financer**, a municipality gathers money from a local property tax (Council Tax), a central government grant and from users' co-payments. Their monopsony purchasing power is significant and most home, residential and nursing care is now provided principally by the independent sector, either under contract from municipalities as "commissioner" or directly from individuals, so-called "self-funders". The proportions in each category vary regionally, with some councils in the south east of England commissioning under 20% of all care home places purchased (CFQ research workshop 2). Local NHS Trusts (PCTs) [2] also act as financers of services for older people, particularly as regards medical conditions – but the boundary between what the NHS and the municipality should pay for is often unclear and the subject of some negotiation.

As **planner**, municipalities have a duty to assess the needs of the population and to ensure that care and support is available to meet those needs. They apply eligibility criteria according to the available resources – some three-quarters of all councils most now only fund services for older and disabled people with "critical" or "substantial" needs, as defined in Government guidance. They work closely with the primary care trusts (PCTs) in order to meet health and care needs in a coordinated way.

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[2] As this report went to print, the UK coalition government was introducing a policy to replace PCTs with GP-led consortia that would commission health care on behalf of patients.

The concept of "**commissioning**" (see figure UK1) is central to a municipality's roles as planner and financer. The Department of Health defines it as "the process used by local authorities and NHS bodies to arrange services for their local population. It is the process of translating local aspirations and assessed needs, by specifying and procuring services for the local population, into services for people that use them." (Department of Health Archive Website, 2010)

Municipalities are also **case-managers**, at least for the people whom they fund, most probably those with severe or substantial needs. A social worker employed by the municipality will carry out an assessment of a person's needs, whether at home or in hospital following medical treatment. The social worker will then advise him/her or his/her relative/carer on what services could

be provided at home or through residential care, and how these might be funded.

Providers are today by and large from the independent sector, i.e. non-profit and for-profit providers. For most social care services, a provider needs to be registered with the Care Quality Commission in order to provide either domiciliary or residential care services to older people. It can then seek to attract self-funding users or residents, spot placements by municipalities or win a block contract through a competitive tender.

It is worth noting here that England has the highest degree of independent provision under contract from municipalities. Many Scottish and Welsh municipalities and their Labour-voting populations have an historic attachment to publicly provided services.

Table UK1: Market share by setting in England; Scotland for comparison.

	England		Scotland
	Residential places	Home Care Agencies	Registered care services
Municipality	6.5%	14%	20%
Not-for-profit	13%	8%	22%
For-profit	79%	75%	58%

Note: NHS and other providers mean figures do not total 100%.

Source: CSCI, 2009: 58

3.   User: accessing the system, paying for services

Besides funding from the municipalities and PCTs, service users in residential settings in particular contribute significantly to the cost of their care. A non-means-tested attendance allowance is available through central government to help older people pay for their care. There is no specific care insurance in the UK as in Belgium or Germany; rather there is general taxation (income tax, VAT, etc) and a National Insurance (payroll tax) scheme. The central government distributes resources to the devolved administrations and, in England, directly to municipalities. In

addition, municipalities raise funds from local property and business taxes.

There is an "attendance allowance" for persons over 65, which is managed by the Department of Work and Pensions (DWP). It is worth £71.40 per week (for care throughout the day and night) or £41.80 (for frequent personal care and care in the day or night only). This allowance is not means-tested and national insurance contributions are not required to qualify for it. Applications are made in writing to the DWP citing any relevant

health or care conditions and providing references from the family doctor; a separate medical examination may follow, but is often not required. The attendance allowance is mostly used for care at home and can only be claimed for residential care, if a person is entirely self-funding (i.e. not receiving financial support from their local council). [Directgov website]

In England, health and social care are funded differently. Funding for health care comes from central government, whereas social care funding comes from a combination of local taxation and central government grants to municipalities – user charges are set by municipalities. From the point of view of the service user, health care is free at the point of use, whereas social care is means-tested. In addition, different rules apply to residential and community care. Detailed charging policy is largely at the discretion of individual municipalities as regards home care, while residential services are subject to a nationwide charging regime.

Just over half (56.6%) of the residential care market is made up of "self-funders", i.e. people who (or whose families) are paying in full their care and hotel costs in residential care. There is a marked North/South divide here: in the North of England, the ratio of council-supported residents to self-funders is 76:24 versus 43:57 in the South (CFQ research workshop 2). When someone's

assets are worth over £23,250, they pay the whole cost of care, until the value of their assets falls below that threshold.

Any older person who owns their own home would therefore – if they had no spouse or dependents living there – probably have to sell it in order to fund their stay in a care home. This means that the council's influence on the market is reduced. Numerous residential homes also charge all residents a top-up fee in addition to what the Council pays. The municipality must ensure that a person in residential care is left with at least £22.30 per week for personal spending. [CFQ research workshop 2]

Charging for home care is decided locally by municipalities on the basis of available resources. The only national rule is that it should be fair and that no-one on a low income should pay more than they can afford. In practice, everyone pays something towards the cost of care at home. What this means is that the fees set by municipalities in England are highly variable, and the trend is for charges to rise, sometimes substantially, as municipalities struggle to balance demand and resources. By contrast, there is a national charging scheme for residential care. The purchasing pressure exerted by municipalities means that, in many cases, self-funders are subsidising council-funded places in care homes. [CFQ research workshop 2]

4. Understanding the relationships between actors and their impact on quality

The existing funding and regulatory structure involves a range of organisations carrying out the various roles identified above. England has increasingly moved towards a structure of contract-based relationships following competitive tenders organised by municipalities. There is good and bad commissioning practice and municipalities are learning by experience about what effect this has on the quality of care in the local area (CFQ research workshop 2). Unlike in other countries, municipalities themselves are assessed in their role as commissioner – i.e. planner and financer of services for a given area.

The public regulator, the Care Quality Commission, seeks to ensure compliance with government-set quality standards through its registration and inspection processes. Municipalities, acting as financers (via competitive tendering) can potentially require providers they work with to meet additional standards, e.g. in order to meet specific local needs, in particular by means of tendering processes. In general, such quality specifications focus mainly on room size, training and consistency of staff, safety and hygiene, communication with and treatment of clients, expertise, and reliability, i.e. on structural and process quality specifications, rather than on outcome measures.

On the other hand, tenders could be set up so that price is prioritised over quality or the tender specifications could be so specific as to make it difficult for a provider to innovate. Pay and conditions in the private sector are not as good as in the public sector. Providers were reported as complaining about shortcomings regarding, in particular, their lack of involvement "in care-planning and review" (Forder et al., 2001: 4).

Notably, innovative providers that do not comply with standardised services but may nonetheless try, for instance, to promote self-care in order to help clients regain their independence are discouraged.

Relationships between financers and providers are still quite variable, depending on local history and personalities. At best, municipalities discuss future market needs and requirements with a range of potential and actual providers in general terms and draw on the knowledge and expertise of providers, whilst elsewhere relations remain quite adversarial and focused on annual fee negotiations (CFQ research workshop 2). There are still municipalities whose in-house home care services have preferential treatment and whose staff enjoy better terms and conditions than those employed by independent providers commissioned by the authority (Banks, 2007).

Here, we consider how municipalities, Surrey County Council and Stoke-on-Trent Borough Council (as financer, planner and case-manager) and Ideal Care Homes (a provider) manage their contracts with others in the system and what impact this has on the quality of care. Surrey County Council and Ideal Care Homes took part in the CFQ research workshop 2, England/Germany on 3 November 2009.

Surrey County Council: relationships with users and providers

[Surrey County Council presentation to CFQ research workshop 2]

Surrey County Council has made a decision to outsource the provision of some home care and residential care services, which has also led to the outsourcing of ancillary services such as respite and day services. The historical decisions relating to the outsourcing of these services were largely driven by central government, which had advised that only 15% of home care services should be provided by municipalities directly, whilst the remaining 85% should be supplied via the independent sector.

There are differences in contracting arrangements according to the type of service. Nursing care is largely procured through 'spot contracts', i.e. one-off contracts for a particular service user; residential care through 'block contracts'; and home care through *framework contracts*.

In the tender process for block contracts, a provider is asked to complete a Pre-Qualification Questionnaire (PQQ), which is a document that sets out the minimum standards required to provide the service in question. Once successfully short-listed, providers are asked to respond to set questions relating to their proposal, which enable Surrey County Council to take a fair and robust approach towards evaluation and determining which offer demonstrates the best value for money. Quality is of significant importance and generally tenders are evaluated on a 60/40 basis with 60% relating to Quality and 40% price. References are requested from people already using the provider's services, site visits are conducted and presentations made where appropriate. For spot contracts, providers wishing to supply services need to sign up to a Pre-

Placement Contract, which is a legally binding agreement that ensures the required standards of service will be met. In order to secure a Pre-Placement Contract, providers must meet the criteria of Pre-Approval Checks. Where CQC star ratings apply, it is expected that a provider will have attained a minimum rating of 1 (where 0 is poor, 1 is adequate, 2 is good, 3 is excellent). With spot purchasing, the contract ends if the service user to whom it relates dies, whereas with a block contract, there is an incentive for the provider to find a replacement person with similar needs.

In home care, there is a framework contract, whereby providers have some certainty that they will be contracted for a certain volume of hours in a given geographical area. The contract does not, however, commit the Council to guarantee these hours and is flexible enough to help it deliver on the government's agenda for more personalised social services.

Surrey County Council also works with providers in other ways. It part-funds the activities of the Surrey Care Association (SCA), which helps to coordinate training activities for care workers and ensure that providers are up-to-date with the standards required by the CQC and the County Council. The SCA also employs consultants who lead a programme called the Surrey Care Advice Service, which actively works with 0-rated providers to help them improve their star rating – there is a duty to help providers achieve a one-star rating. A budget of €0.8m per year is set aside to train providers.

Provider performance is reviewed by a Procurement Team and ongoing quality improvements are reviewed with providers as part of the Contract Management and Supplier Relationship Management processes. The contracts are still input and

process-based, but there is a plan to move towards outcome-based monitoring. The County Council has recently piloted a quality monitoring process for home care that it is expected to build the foundations for county-wide quality monitoring.

Surrey County Council's relationships with service users are based on a commitment that "every person will experience a person-centred approach to accessing support" in line with government policy on personalisation. Currently, there is a trial of individual budgets in one part of Surrey which enables individuals to purchase their own care; however, the County Council still sources care on behalf of individuals across the rest of the county. Council-funded service users currently access services through their Care Manager, but this may change in future as more people have the choice to use an individual budget; they may then go directly to the provider or through the Council's in-house brokerage team (made up of social workers). The Council's social workers will in any case continue to act as advocates and advisors for users of both home/residential and nursing care, besides carrying out the required needs assessment.

Stoke-on-Trent Borough Council: relationships with providers
[Stoke-on-Trent presentation to LTC working group, 2008]

The Borough Council purchases approximately 9,000 hours of home care per week from the independent sector. The latest call for tenders was published in 2007 with the aim of contracting the winning bid for a period of about three years, with an option to extend for a further three years. The tender document has more than 100 pages in which applicants are asked for detailed responses to demonstrate their capacity and capability,

including CQC inspection reports, results of user surveys, mission statement, recruitment and training plans etc.

Tenders are marked by allocating points (0-5) to each criterion. The scores are then multiplied by the relevant weighting to calculate the total score: for instance, expertise and experience of the organisation in the provision of high quality care (weighting 2), mobilisation plan (weighting 3), development plan (weighting 3), understanding of and ability to implement and monitor outcome based care plans (weighting 4), ability to provide timely and accurate monitoring information (weighting 2), and presentation (weighting 3). The total score is evaluated in conjunction with the tendered hourly rate to determine which tenders are the most economically advantageous.

The agreed price to be paid includes an element linked to the achievement of performance standards. For each hour of care undertaken 90% of the provider's hourly rate is paid. The remaining 10% is paid based on weighted performance indicators such as punctuality, outcomes achieved and the consistency of the carer visiting a particular person.

Ideal Care Homes: relationships with municipality and service users
[IdealCareHomes presentation to CFQ research workshop 2]

With the population of 85-and-overs set to more than double over the next 25 years, care homes are a growth market. Laing & Buisson estimate a required increase of 2,400 beds per year between 2006 and 2016 to meet demographic demand (CFQ research workshop 2). Ideal Care Homes sets out to offer purpose-built facilities, a high-quality and personalised service, and to be affordable, not requiring top-up fees from users who are

already receiving public funding through a municipality. It is a business group whose different partners are collectively equipped to deliver a project from design through build to full operation as a care home. Ideal Care Homes has developed its own business tool called "Big Map" which shows existing care home capacity and population of older people in a given area. It also considers potential competitors, municipality's fee policies and the availability of land and its cost. The company notices big differences in payment practices between municipalities: some set their own additional standards and pay more for those, whereas others rely on a higher CQC-rating to fund them.

Table UK2: Ideal Care Homes' assessment of the care market in a medium-size English city (=zone area)

Zone area	Pop.	Over-75s	(Estimated) demand*	Ensuite residential care beds	Ensuite care beds	Over/under-supply of care beds
UK	62,667,810	4,671,765	343,842	101,064	222,728	121,114
Zone area	273,654	23,712	1,745	736	1,390	355
Competition in zone area						
	Nursing			**Residential**		
	For-profit	Non-profit	Total	For-profit	Non-profit	Total
No of Homes	22	10	32	14	71	85
No of beds	751	269	1020	305	1247	1552
Average size	34.14	26.9	31.88	21.79	17.56	18.26

*Demand = 7.36% of population over 75.

Source: Greaves, M. (2009)

5.   Country Conclusions

England's long-term care system for older people is based on regulation by a central agency (CQC) and commissioning (i.e. planning, financing and case-management) by municipal social workers. Private providers have come to play an ever more important role in care provision as government guidance since the 1980s has steered municipalities to introduce competitive tendering in social services, including long-term care for older people.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?

There are two overlapping markets in England (the private care market and the local authority-funded quasi-market). In the private care market, (better-off) older people pay for their home care or residential/nursing home places themselves; providers' entry into this market is regulated by the CQC. Inspections can be up to every six months and the CQC publishes all inspection reports online (with an easy-to-follow star-rating system). Here, the regulation (arguably) establishes an incentive to improve the quality of care because the performance information of a given care home is publicly reported online. It remains to be seen whether this transparency, also being pursued in Germany, will have the desired effect of improving quality, or whether stronger incentives will be needed.

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

These relationships are especially important at local level in the publicly co-funded care market. In this other – albeit overlapping – quasi-market, older people (on a lower income) arrange their care with the help of their local council's (i.e. municipality's) social workers (acting as case-manager). Municipalities here are an additional local gate-keeper alongside the Care Quality Commission centrally, in that they have agreements with certain providers for users whose care they fund. As in Sweden, UK municipalities can set their own standards and have the freedom to pay more for higher quality, e.g. a better CQC star-rating, or standards of their own – see the examples of Stoke-on-Trent, Surrey and, from the provider perspective, Ideal Care Homes. Several of these examples could qualify as contracts for quality.

Annex UK1: List of Outcomes for health and adult social care providers in England

Care Quality Commission (2010) *Guidance about Compliance: Essential Standards of Quality and Safety.* London: Care Quality Commission. Web reference: http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf

Involvement and information
Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to care and treatment
Outcome 3: Fees

Personalised care, treatment and support
Outcome 4: Care and welfare of people who use services
Outcome 5: Meeting nutritional needs
Outcome 6: Cooperating with other providers

Safeguarding and safety
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 9: Management of medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability and suitability of equipment

Suitability of staffing
Outcome 12: Requirements relating to workers
Outcome 13: Staffing
Outcome 14: Supporting workers

Quality and management
Outcome 15: Statement of purpose
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 18: Notification of death of a person who uses services
Outcome 19: Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
Outcome 20: Notification of other incidents
Outcome 21: Records

Suitability of management
Outcome 22: Requirements where the service provider is an individual or partnership
Outcome 23: Requirement where the service provider is a body other than a partnership
Outcome 24: Requirements relating to registered managers
Outcome 25: Registered person: training
Outcome 26: Financial position
Outcome 27: Notifications – notice of absence
Outcome 28: Notifications – notice of changes

Contracting for Quality

Country
Profile:

Spain

SPAIN

1. Introduction and background

According to the Spanish Constitution approved in 1978, the "State is organised territorially into municipalities, provinces and any Autonomous Communities that may be constituted" (Article 137). This paved the way for provinces and municipalities to take the legal initiative to constitute Autonomous Communities (CCAA) and by 1995 the Statutes of 17 CCAAs had been approved.

Regarding long-term care services for the elderly the distribution of competences is as follows:

- The (Central) State is responsible for establishing a common framework of reference: establishing standards for the assessment of long-term care needs; and ensuring equal access rights for all citizens, regardless of their residence (namely by setting minimum benefit levels for older people with long-term care needs and nationwide limits on co-payments; and by addressing inequalities among CCAAs through differentiated transfers)
- The CCAAs are responsible for the assessment of people's needs and for delivering the care allowance under the law. They are also responsible for broader social welfare provision in their territories by issuing specific legislation within the limits set by the national framework legislation
- The Municipalities (*Ayuntamientos*) may have competences in the provision of social services and the promotion of social inclusion, according to the

legislation approved by their respective CCAA.

This has given rise to a highly decentralised and complex system, which "makes it difficult to design transversal institutional responses aimed at meeting needs" (Torres, 2006: 16) and resulted in regional asymmetries in both the availability of care and regulations.

December 2006 witnessed the approval of law 39/2006, the "Law on Promotion of Personal Autonomy and Care for Dependent Persons" (LAAD) that for the first time established long-term care as a citizens' right in Spain. It is destined to meet the needs of as many as 1.3m people by 2015, with wider impacts on their families (MSPS 2008, National Strategy Report 2008-10). This right is to be fulfilled by the System of Autonomy and Dependency Care (SAAD) that brings together public and private service providers within the above-stated division of competences between the State, CCAA and Municipalities (MSPS 2008). The types of services available within the SAAD are: preventive; tele-care; home help; personal assistants; day centres for older people; night centres (short-stay residential); residential care for older people (MSPS 2008).

The SAAD is to be implemented in phases between 2007 and 2014, starting with those with higher dependency levels. As of July 2008, almost 540,000 people had been assessed as dependent, and over 325,000 were receiving the care allowance at high or severe levels (MSPS 2008).

Table ES1: Usage of care allowance by service type (1 July 2009)

Benefit	Percentage in total benefits*
Prevention and rehabilitation	0.3%
Tele-assistance	3.8%
Domiciliary care	6.5%
Day/night centres	3.4%
Institutional (residential) care	12.5%
Earmarked (cash) benefit for purchasing of services	4.1%
Support for family carers (cash)	32.5%
Personal assistant (cash)	0.1%
Unspecified benefit	36.8%
Total	100% (621,336 beneficiaries**)

Source: IMSERSO

*Notes: *Some beneficiaries may have been entitled to more than one benefit;*

***Includes all recipients, not only those over 65 years old.*

The LAAD is in the middle phase of its implementation nearly 4 years since it came into force. The LAAD is being implemented at different rates by the various CCAAs according to their various starting points (in terms of infrastructure and funding) and their political situation. According to a recent report published by the national association of managers of social services it seems that the system has entered a phase of impasse based on the fact that an increasing number of applications is being received and the waiting list for granting allowances or delivering services is lengthening. The rate of implementation of the law can be measured in terms of the number of inhabitants per 1,000 who have received benefits or services under the LAAD. The best performing regions according to data gathered by the association are Cantabria, La Rioja and Andalucía, whilst the poorer performing regions are the Canary Islands, the autonomous community of Valencia, Madrid and the Balearic Islands. However, there are no official government data and these data are from an independent source. It should be considered that regions have different starting points as regards the level of development of service infrastructure. (*Asociación Estatal de Directoras y Gerentes de Servicios Sociales*, 2010)

Given the highly regionalised nature of Spain, this profile will mention Andalucía and Madrid regions as examples, where required to demonstrate how the system works.

2. Identifying who plays what roles in the care system

The different roles (regulator, financer, provider, planner, case-manager) that actors might take in the formal care system for older people (and indeed all dependent persons under the LAAD) are defined in the report's Introduction.

The **regulators** are the SAAD Territorial Council, where central, regional and local government is represented; the Central State (especially IMSERSO); and the individual Autonomous Communities (CCAAs). The CCAAs have numerous duties under the dependency law, notably:

- "creating and updating the registry of centres and services, facilitating the necessary accreditation in order to guarantee compliance with the quality requirements and standards"
- "inspecting and, where applicable, applying sanctions for non-compliance regarding the quality requirements and standards of centres and services and regarding beneficiaries' rights"

In light of the considerable regional differences between the CCAAs, the Territorial Council of the SAAD aims to negotiate common minimum standards for accreditation of services; this does not prevent the CCAAs from supplementing these with additional requirements. It also produces best practice guides and service charters and seeks to facilitate comparison across regions. Residential centres are required by the dependency law to have "internal regulations governing organisation and functioning, including a quality management system".

The services that constitute the SAAD can be supplied by public providers (the CCAAs themselves, the Municipalities, or institutions set up by the Central Government) or accredited private providers that have signed agreements or contracts with the CCAA to provide care. The Territorial Council of the SAAD (representing all the Autonomous Communities) has agreed a common set of accreditation criteria, but the CCAAs may require higher standards for accreditation. This means that private providers must comply with the (potentially different) rules of each CCAA where they provide care. The CCAAs also have autonomy in defining their own rules regarding co-payments from beneficiaries, although these co-payments are subject to nationwide caps established by the Central Government.

Table ES2: Structural conditions in residential centres for dependent older persons.

	Spain (minimum)	Andalucía	Madrid
Maximum number of residents per room	Depends on a forthcoming decision	Two persons per room; 10% of rooms must be singles	6 persons
Dimensions of the rooms	Depends on a forthcoming decision	Singles: 12m^2 Doubles: 18m^2	5.5m^2 per person or 7.5m^2 for a person using a wheelchair
Number of bathrooms	Depends on a forthcoming decision	1 bathroom for every 2 rooms	1 bathroom for 6 people

N.B.: the standards for Madrid region are due for revision very soon and new minimum standards for the whole of Spain are currently being negotiated within the SAAD Territorial Council. *Source: IMSERSO/CFQ research workshop 3*

Currently, two systems of accreditation are in operation, one that predated the 2006 dependency law, the other postdating it. Until now, very few Autonomous Communities (Andalucía, Cantabria) have developed accreditation systems based on common criteria in line with the 2006 legislation. Most CCAAs refer directly to the rules existing prior to the legislation with some minimal adaptation to the new common criteria (CFQ research workshop 3, 2010). Before the legislation there was already regional variation as each CCAA was exclusively responsible for accreditation in its own territory (Ariza et al., 2008).

Standards currently being developed by the Territorial Council should go some way to overcome this. They will cover three areas: structural resources and equipment; human resources (staff ratios and training); documentation and information, including a quality management plan. With respect to human resources, it is planned that by 2015 (year by which the implementation of the Law should be completed) 70% of non-graduated staff will have a professional qualification and by 2011 the stipulated carer:resident ratio will also have been reached.[3] Furthermore,

providers have to abide by municipal rules in relation to building standards, e.g. accessibility, fire safety, emergency exits.

The institutional **financers** of care for older people in Spain are the central State, the Autonomous regions and the municipalities. The State and CCAAs are responsible for providing public funding to the SAAD. The State transfers to the CCAAs a minimum amount per care level and per beneficiary (in 2008, the State has €871m for this transfer, up from €400m in 2007) (MSPS, 2008). Further transfers are channelled from the State to the CCAAs as part of service development agreements/plans signed between the State and each CCAA to improve available care services (in 2008 the State transferred a total of €241m, up from €220m in 2007) (MSPS, 2008), which the CCAA may then supplement. Following initial years of spending growth, there are now concerns that central government subsidies are falling as a result of Spain's deteriorating financial situation (El País, 2010). Whilst the CCAAs regulate the services, the financing is shared equally by central and regional governments. On top of this, each CCAA can establish its own rules on co-payment by service users in line with national guidance from the Territorial Council.

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[3]This is supposed to be the average between the minimum and maximum ratios stipulated, e.g. 0.41 to 0.54 workers per user of a residential care home for the elderly (MSPS, 2008: 84).

The **planners** are in the main the CCAAs, which should "[plan, coordinate, and manage], in the scope of their territories, the services for the promotion of personal autonomy and care for dependent persons". They are also required to draw up "plans for the prevention of situations of dependency", which assess and seek to mitigate the risks of dependency in old age. These plans will have to be carried out in compliance with the criteria, recommendations and minimum conditions set by the Territorial Council, having constituted a working group for this purpose.

The **case-managers** are not identified by the law at State level, rather it is the CCAAs' responsibility to "determine the bodies for assessing the situation of dependency, which shall issue a report on the degree and level of dependency, specifying the care that the person may require" (LAAD). It is worth noting, though, that these bodies must be public authorities, not private bodies. The Territorial Council of the SAAD is meant to create some common conditions in relation to these bodies. In CCAA Andalucia the relevant body is the Assessment Service (composed of qualified professionals from health and social services) of each of the eight Provincial

Delegations for Equality and Social Welfare. In CCAA Madrid, the relevant body is the Department of Coordination of Dependency (within the Regional Ministry of Family and Social Affairs).

The **providers** are a mixture of public, non-profit and for-profit organisations. For institutional (residential) care and day/night centres, available data confirm the importance of private providers in the Spanish context, compensating for the limited availability of capacity in public care facilities. Whilst still predominant in institutional care, the share of privately provided places whose price is set by the market has dwindled in favour of an increased share of places that are regulated by agreements established with CCAAs through competitive tendering processes. Private providers that have not signed agreements with the CCAA – and are thus not part of the SAAD – must nevertheless be accredited in order to provide care. Service users may resort to private providers outside the SAAD, but will be charged a "market price" (in principle higher than subsidised services). Over half of the residential care market lies with these private providers in Spain (see table ES3).

Table ES3: Distribution of places in residential care according to sector, 2008

	Spain	Andalucía	Madrid
Public	23.3%	13.6%	20.3%
Private provision by agreement with CCAA	23.9%	30.2%	26.2%
Private provision without CCAA agreement	52.8%	56.2%	53.5%

Source: IMSERSO/CFQ research workshop 3

3.   User: accessing the system, paying for services

The LAAD established an individual's right to a service, promoting autonomy for persons assessed as being dependent. This puts the user at least nominally at the centre of the system. It means that a large portion of funding for service provision is channelled through people assessed as having a given level of dependency. Access to benefits is based on the level of care needs, linked to ability to carry out activities of daily living (ADL). There are three grades of dependency and two levels within each (IMSERSO website):

- Grade I (moderate) – help at least once a day
- Grade II (severe) – help 2-3 times a day but does not need a permanent carer
- Grade III (major) – help several times a day and needs a carer to be there continuously

The assessment standards are set by the Central Government, which approved the scale for assessing the situation of dependency, based on an agreement reached by the SAAD Territorial Council. The assessment itself is carried out by the CCAA or an institution appointed by the CCAA, based on countrywide criteria developed by the SAAD Territorial Council. The assessment is carried out by a qualified worker, based on information on the health status of the claimant and on his/her living conditions and environment. The CCAA is responsible for evaluating the claimant's dependency level and its social services must establish an individual care plan (*PIA: Programa individual de atención*) based on the cash allowances or services to which the user is entitled.

Table ES4: Rules on co-payments for care services under the LAAD

In-kind benefit	Co-payment	Exemptions and added co-payments
Home care	Between 10 and 65% of their income and assets, without exceeding 65% of the reference indicator	If a person's income and assets are lower than IPREM (see note 1), the beneficiary will not participate in the cost of home services
Day/night care centre		If the service of the Day/Night centre implies transport or board, these percentages may be higher.
Institutional (residential) care	Between 70% and 90% of their income and assets, without exceeding 90% of the reference indicator	Beneficiary must pay for "board and lodging" (See note 2). The beneficiary is guaranteed a minimum amount for personal expenses.

Source: Adapted from Celdrán et al. (2009) p 39.

Notes: (1) IPREM is a cost of living reference point used in public services and benefits. CCAAs may also set a different reference point. In 2008, the monthly value of the IPREM was €516.90. (2) Social assistance covers these costs if income is insufficient.

Table ES5: Maximum amounts of the cash allowances for 2010

	Value of services to be purchased	Support payment for care by the family*	Payment to employ a personal assistant
Grade III.2	833.96	520.69 (683.18)	833.96
Grade III.1	625.47	416.98 (579.47)	625.47
Grade II.2	462.18	337.25 (324.98)	Not permitted
Grade II.1	401.20	300.90 (463.49)	Not permitted
Grade I	Not permitted	Not permitted	Not permitted

This figure includes a social security contribution of 162.49€ for the carer

Source: Royal Decree 374/2010.

Web Reference: http://www.boe.es/aeboe/consultas/bases_datos/doc.php?id=BOE-A-2010-5040

The default position according to the law is that the person receives benefits in kind, i.e. services, to promote their autonomy and manage their dependency. Exceptionally, they may also receive a cash allowance, which can be used in one of three ways: (i) to arrange and pay for their own services; (ii) to financially support care by their family; (iii) to hire a personal assistant. In the second case, the allowance consists of an amount of money paid by the state plus coverage of the carer's social security contributions.

The LAAD states that priority access is to be given to those with higher care needs and lower financial resources. Indeed, a principle enshrined in the law is that "no citizen shall be left out of the System for failing to have economic resources." When receiving services, beneficiaries must make a financial contribution (*copago*) to the cost of care. The SAAD Territorial Council is responsible for setting user contribution criteria, within which the CCAAs can set their own rules. This financial contribution is calculated as a percentage of the user's income and assets[4] (taking into account as well the reference costs of services provided).

If the CCAA is unable to provide a service to meet a person's needs, the person may receive a cash allowance (up to a maximum indicated in table ES5). The beneficiary shall receive the maximum amount if their income is less than the IPREM (see note 1 in the table ES4). Certain minimum amounts are also guaranteed – at least 40% of the allowance for personal assistance and at least 75% for a dependent person purchasing services delivered in their own home (Celdrán et al., 2009).

It is worth noting that out of the 723,389 recipients of SAAD benefits, almost 57% are receiving cash benefits (50% used for family care, nearly 7% for purchasing services and a small sum for personal assistants. The remainder of funding for in-kind benefits goes mainly to residential care (16%), home care and tele-care (both 11%). (IMSERSO website, Personas Beneficiarias y Prestaciones)

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[4] Calculated according to the service user's pension and a percentage of his/her assets (depending on age).

4. Understanding the relationships between actors and their impact on quality

There are different types of (formal and informal) relationships at work in the Spanish system for the promotion of autonomy and care for dependency. Relationships between different services, notably health and social care have an impact on quality in their own right. Besides identifying the actors and the relationships between them in elderly care, this report is also interested in seeing how actors exert pressure on one another to improve the quality of care. Here, we look at the relationships of two organisations that participated in CFQ research workshop 3 (Madrid City Council and ASISPA) to other actors in the system and consider their impact on the quality of care.

It is first worth noting some legal background to the structure of relationships. The services may be arranged by the CCAAs either by direct provision to the user or by different types of contract (public service management, agreement between the public and private sector to share services) which are usually governed by competitive tendering under Law 30/2007. A CCAA such as Madrid or Andalucía may provide care to older people who have been assessed as being in need of care through several arrangements[5]:

- Institutions that are directly managed and owned by the CCAA;
- Places in institutions that are owned by the CCAA, but whose management was delegated to private companies through an administrative concession (concesión administrativa);
- Places in institutions owned and managed by the municipalities that have established agreements with the CCAA;

- Places in institutions owned and managed by private providers that have established a contract with the CCAA through a competitive tendering process.

The law itself stresses the integrated and coordinated nature of the services within the SAAD in its Article 6: "The System is configured as a network for public use that integrates on a coordinated basis both public and private centres and services."

Madrid City Council: relationships with providers and users
[Madrid presentation to CFQ research workshop 3]

Madrid has 3.3m inhabitants, of which almost 1 in 5 are over 65 and 5.6% over 80. The city council's key duties are to direct, plan and evaluate programmes to improve the well-being of older people in the city, with the intention of helping them live in their own home for as long as possible. It also aims to promote the social participation of older people, especially through day centres. The department for elderly care has an annual budget of €240m and 75 staff, plus 560 social workers across the 21 city districts.

The City Council plans and designs services in-house and provides quality monitoring of services provided under contract. A major tele-care service is contracted out and covers 92,000 homes. Other major contracted services include home care (54,000 users), meals-on-wheels (1,700 users), day-care centres (7,000 users) and residential homes (190 users). The number of people in residential homes is so low because the figure given is only for those homes built by the City Council; many others exist in the area of the

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[5] Information available (in Spanish) at:
http://www.madrid.org/cs/Satellite?cid=116435205590 2&language=es&pagename=PMAY%2FPage%2FPM AY_pintarContenidoFinal

city and are regulated by the Region of Madrid.

The model commonly used for elderly care is that the City Council builds the infrastructure (e.g. day-care centres) and tenders for the running of the service. In tendering, it has to abide by a 2002 State law which regulates procedures according to value of the contract:

- Under €18,000 – no tender required
- Between €18,000 and €60,000 – at least three organisations must compete in a tender
- Over €60,000 – a formal public tender open to all.

Most contracts are of two years' duration, and are often extended by two years.

The City Council sets out a number of requirements:

- The applicant has to be solvent and have technical competence (proved through quality certificates and references from other public authorities for the provision of similar services)
- The application has to have a clear and coherent plan for realising the contract
- It has to have certain technical standards for staffing, working time, fittings, training and quality management
- It has to be economically competitive

The first two criteria together are worth 45%, the third is worth 35% and the fourth 20%. The contract contains a description of the service, its objectives and how it is controlled. Innovations in care processes and improved quality beyond the specifications of the contract deserve a higher mark in the evaluation of the proposal.

The financer works with the provider to improve the quality of services through continuous monitoring, both by working with managers in provider organisations and through independent surveys of users. Surveys of a representative sample of users are carried out by a contracted consultancy company; the results are made public and providers and local politicians informed. Monitoring is intended to be supportive and to be the basis for advice and training.

This means that a relationship of trust has to be established between financer and provider, in which quality is part of the contract. However, in extreme cases, there is the potential for a financial penalty and no reference will be provided. Termination of a contract has not happened yet, though if it did, the failed provider would be obliged to continue to supply services until a new provider could be found. The city administration also aims to improve its own performance, making its administrative procedures and contract management more flexible. There is some healthy competition among the providers in the city from both the for-profit and non-profit sectors.

People wanting to access services can do so through the City's district social services centres. A municipal social worker can help someone to apply for the care benefits from the CCAA by helping them fill out the required forms. The CCAA's multidisciplinary team then carries out a formal needs assessment against nationwide common criteria based on a bio-psycho-social scale. Generally, the user wants to continue receiving the same service they received before the SAAD care allowance was introduced. Where users are receiving financial support from the City's social security services, the City itself signs a contract on their behalf with the provider. There are a number of ways in which individual users can influence quality through suggestions and complaints systems operated by providers and the City Council. There is

also a Council of Older People, which can influence service development and design.

ASISPA: relationships with financers and users

[ASISPA presentation to CFQ research workshop 3]

ASISPA was established in 1980 with the idea of providing comprehensive care for older people, comprising tele-care, home care, day care and nursing homes. Its vision is to be "an organisation benchmarked for its quality, warmth and innovation in the provision of services in both prevention and attention to dependency". Their values are: respect for individuality and right to difference; professional competence; warmth and closeness; team work; initiative; transparency; commitment to organisational goals; continuously-improving management and the performance of the system. The size of the organisation has grown significantly over the last twenty years, from providing services to just 2,100 people in 1990 to 132,000 in 2009.

ASISPA chooses to participate in public tenders where they believe the financer trusts their operating model and shows sensitivity and consistency in its approach to public services. ASISPA must also be confident that a comprehensive care model can be implemented and that providing the services will be economically viable.

This provider works differently with city councils depending on their commitment to quality monitoring and development. There are regular meetings between professionals on both sides, where they discuss specific cases, exchange results of user surveys and share information about quality indicators. Besides responding to its expectations and specifications, ASISPA also attempts to anticipate the needs of the public administration and propose creative new solutions.

A user can access ASISPA's services in various ways depending on his/her circumstances:

1. A private user accesses the service directly and pays for it in full (contract between ASISPA and user).
2. A user who is seeking financial support through the city council may be referred to ASISPA (contract between City and user on the one hand and between City and ASISPA on the other).

ASISPA establishes an individualised care plan with each older person and there are interviews and follow-up meetings with him/her and his/her family.

Internal quality management systems are usually highly valued in tender specifications. ISO and EFQM are widespread as is UNE 158:000 which is specific to Spain and was introduced in the wake of the LAAD. Its aim was to set minimum quality standards for organisations providing social services related to the care system, as well as to comply with certain criteria of technical and economic solvency (experience, previous contract…etc). ASISPA's centres and services hold various certificates, including ISO 9001 and EFQM, which it uses across the whole organisation. Internal quality management is especially important to ASISPA in fulfilling its duty "to guard the quality and warmth for older people or those in a situation of dependency."

5.   Country Conclusions

Spain's is still a nascent system of care for all dependent persons, including older people. It aspires to be the fourth pillar of the country's social security system (alongside health, education, welfare). Spanish people are very keen for the dependency law (LAAD) to be enacted quickly, but this depends on coordination between the State and the Autonomous Communities. The system is still being built, but there are growing concerns that over a decline in central government grants to local and regional authorities following initial year-on-year growth in investment in the new system following the 2006 reform.

Research Question 1: how are markets regulated to improve the quality of care and quality of life for older people?

As in the other study countries, access to the market is controlled by accreditation against certain standards, on which agreement is currently being sought at national level. Even as the Territorial Council of the dependency system (SAAD) strives for these common criteria for provider accreditation (and means-testing), some Regions (responsible for the accreditation process regionally) seem likely to go beyond the countrywide minima required. This is quite different, for example, from the Czech Republic, where the standards are, at least on paper, uniform across the country, but is more similar to the UK nations' four different regulatory regimes.

Research question 2: how are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

In many ways, it remains to be seen how the relationships within this system between financer, regulator, planner, case-manager, provider and user will take shape over the years ahead, to establish 'contracts for quality' and truly become a system for the promotion of personal autonomy. The relationships and contracts ingrained in the preceding system are gradually being redrawn at local and regional level as new requirements emerge, and as users themselves have greater opportunities to purchase services directly or to support a family member to care for them.

Contracting for Quality

EU Policy Context

EU POLICY CONTEXT

Contracting (for quality) in practice may bring a given contract or relationship into the field of application of European single market rules on public procurement or state aid.6 These rules could apply to numerous examples of the relationships between financer and provider described in the country profiles. In EU law, there are currently three sets of rules that could apply to long-term care services for older people as part of the group of services known at EU-level as "Social Services of General Interest" (SSGIs):

- public procurement
- state aid (public service compensation)
- freedom of establishment

Two categories of SSGIs are identified by the European Commission (European Commission, 2006):

- statutory and complementary social security schemes
- other essential services provided directly to the person

"**Public procurement** rules [do] only apply if the public authority opts to externalise the service provision by entrusting it to a third party against remuneration," according to the European Commission (FAQ public procurement, 2007). Two types of public procurement exist:

1. **Public service contracts**, in which "the public authority pays the service provider a fixed remuneration."
2. **Service concessions**, in which "the remuneration consists in the right of the concessionaire [or several concessionaires, i.e. providers] to economically exploit the service".

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6 The following is based on the authors' own understanding of the application of EU rules and in no way constitutes legal advice or opinion. It relies heavily on the European Commission FAQs on public procurement and state aid. As this report went to print, the Commission was about to publish new guidance.

Examples of **public service contracts** in this study could include:

- Surrey County Council's block contracts for residential care and framework contracts for home care
- Madrid City Council's contracts for tele-care and home care, among others

An exception is made in the relevant directive (2008/18/EC), where public authorities provide a service in-house but establish a legally independent entity to do so (there are no examples of this in the present study).

Examples of **service concessions** in this study could include:

- Germany's long-term care insurance system, in which the government (via the MDK) permits providers to provide care and receive reimbursement from their own LTC insurance fund, municipal *Sozialamt* and a user's own income and assets
- Spain's dependency and autonomy system, in which regions (CCAAs) accredit providers to provide care and to receive payment taken (at least in part) from cash allowances or vouchers issued by the regions following a needs assessment
- Czech Republic's care allowance model, in which the regions accredit providers to provide care and to receive payment taken (at least in part) from cash allowances or vouchers issued by the regions following a needs assessment
- Belgium's long-term care insurance model, in which a national agency (NIHDI) permits providers to provide care and receive reimbursement from their own LTC insurance fund, municipal OCMW and a user's own income and assets.

In the case of these two types of **public procurement** the public authority (as financer) has a number of duties that derive from EU law besides those (relating to quality standards) deriving from national or regional legislation:

- To ensure adequate publicity of its intention to conclude a public contract so that all potential bidders (Europe-wide) have the opportunity to express interest
- To provide all the applicants invited to submit a bid with the same information throughout the process so that they are on an equal footing

These duties derive from the principles of transparency and non-discrimination of the public procurement directive (2008/18/EC), which regulates procedures for public authorities purchasing certain types of goods or services. In addition, services above a certain threshold must abide by certain technical criteria and publish the results of the tender. A more stringent procedure applies to other types of services.

The application of the public procurement directive to social services has given rise to a number of concerns both for financers (i.e. public authorities) and providers from all sectors. Some of these concerns relate to the quality of the service, e.g.:

- the degree of personalisation possible, where services may be precisely described
- the opportunity to address multiple needs
- the freedom to adapt services to changing needs and circumstances during the lifetime of the contract
- users' freedom of choice of provider, where a large contract with one provider exists

- the possibility to stipulate the need for local knowledge in a tender in a European market

Other concerns relate more to legal and process aspects, e.g.

- the possibility to negotiate terms during the selection process
- the degree of application of the rules to inter-municipal cooperation

The Commission responds to these issues in its FAQ on public procurement. In terms of contracting for quality, the main message appears to be that it is perfectly possible to require quality standards (certainly many of those required by national/regional legislation in the study countries), as long as each potential bidder has the same information and opportunity to express interest. At times, it seems that concerns about the application of public procurement rules are conflated by stakeholders with those about the outsourcing of public services (notably to private for-profit companies, as outlined in some of the country profiles above) regarding the motivation to reduce cost through outsourcing rather than to improve quality.

State aid rules also apply to social services of general interest, as European law regards these as an economic activity, i.e. "offering goods and/or services on a given market" – Thus a grant (or '**public service compensation**') given by a public authority to a service provider for SSGI is subject to state aid rules.

Instances of public subsidy to private 'undertakings' engaged in an economic activity is seen as state aid (FAQ state aid), unless it is under the threshold of 200,000€ over three years. State aid "in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings… in so far as it affects trade between Member States, shall be incompatible with the internal market." (Art

107, TFEU) The Commission, and to a lesser extent Council, have various courses of legal action in order to require that state aids be abolished.

The European Commission recognises that certain forms and levels of subsidy are permitted. Based on existing case-law, it says that public authorities can allocate a subsidy or tax benefit as well as an "exclusive or special right" to a service provider, as long as such assistance does not exceed what is economically necessary to assure the service is provided (FAQ state aid). The Commission also advises that a public authority may finance a pilot initiative up to the 200,000€ threshold over three years (FAQ state aid). Public authorities can, it appears, financially support certain providers to fulfil clearly defined tasks, as long as the subsidy/state aid is only used to those pre-defined tasks.

The *Altmark criteria*, based on the case of the same name, are a set of four cumulative criteria, which exclude any public subsidy that meets all four criteria from being state aid. These are described in the FAQ on state aid as follows:

- "First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined.
- "Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner.
- "Third, the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit.
- "Finally, where the undertaking which is to discharge public service

obligations, in a specific case, is not chosen pursuant to a public procurement procedure which would allow for the selection of the bidder capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well run and adequately equipped, would have incurred."

If all four criteria are met, then a public subsidy to a private provider of SSGI is permitted as a 'public service compensation'. If any of the criteria is not met, then the public subsidy is seen as State aid, and could therefore be subject to legal action by the European Commission.

Because it is a matter of legal opinion whether these conditions are met, it is difficult for the authors to do more than say that the following types of relationships outlined in the country profiles may constitute a 'public service compensation':

- The grant funding given to providers to establish or develop services by the Flemish agency VIPA in Belgium.
- The grant funding given to providers by the Ministry of Labour and Social Affairs and the regions in the Czech Republic.

Here again, concerns have been expressed at the possible detrimental influence on quality of the state aid rules, and indeed the burden of legal consideration they place on public authorities and providers, including for example:

- The possibility to exclude non-profit providers from the scope of the rules on the grounds that they are not economic services
- A public authority's freedom to finance a pilot initiative, e.g. for innovative services, when it does not yet wish to

engage in public procurement, nor to provide the service in-house.

- The possibility of distributing vouchers to users in order that they purchase care services directly

The FAQ on state aid responds to these points. It is interesting to note that the response on the issue of vouchers (or, presumably, cash benefits) for service provision is that this is only permitted, where "such aid is granted without discrimination to the origin of the products or services concerned." This is, perhaps, at odds with the accreditation criteria established in the study countries here, in all of which there is some form of voucher or cash benefit to enable users to purchase care. There also appears to be some cross-over in the application of rules on service concession and state aid to voucher systems. Concerns about state aid rules have also, at times, been conflated by stakeholders with concerns about undermining the long-standing relationships of trust (e.g. as described in Germany) between public authorities as financers and large, in some cases, multi-national, private non-profit welfare providers.

Discussions about SSGI and the extent to which the public procurement directive and state aid rules should apply is ongoing, notably through the biennial SSGI Forum and the ongoing process of collecting questions, on which the Commission issues advice. The discussions are at times, rather heated, and some argue passionately that no 'social' service should be seen as 'economic'. Some also argue, in a similar vein, that for-profit providers alone should not be treated as economic services. The Commission (drawing on rulings of the European Court of Justice) meanwhile maintains that neither argument is valid because social services are almost always (perhaps with the exception of planning and case-management) provided for 'remuneration' and therefore economic in

nature. The very term 'social services of general interest' seems to have been invented as an umbrella term for a group of services to which these rules *should not apply.*

Studies on the impact of these rules on SSGI, especially on whether they harm quality are few and far between, at least at European level – as evinced by an SSGI study (2010) financed by the European Commission:

"In general, it proved difficult to find supporting evidence when documenting the impact and consequences of the application of EU rules."

The report goes on to say that the experts and persons interviewed were often not aware of the EU rules and that the term SSGI is not widely recognised in legislation or political debate. By the same token, there have to date been very few cases brought before the European Court of Justice pertaining to SSGI. That said, the same SSGI study noted:

"Several public authorities – mainly local authorities – which are most often in charge of social services – and service providers active in the social field have reported difficulties in understanding and applying the relevant EU rules."

Misconceptions that these rules are intended to liberalise, privatise or deregulate the sector are also not uncommon, according to the report.

The latest European Treaty, the Treaty of Lisbon, includes a protocol on services of general economic interest (including SSGI), which underlines:

- "the essential role and the wide discretion of national, regional and local authorities in providing, commissioning and organising services of general economic interest as closely as possible to the needs of the users;
- "the diversity between various services of general economic interest and the

differences in the needs and preferences of users that may result from different geographical, social or cultural situations;

- "a high level of quality, safety and affordability, equal treatment and the promotion of universal access and of user rights."

The authors do not wish to express an opinion on this debate – this has not been the focus of this study, and there is not the space to do it justice. However, the study does try to shed some light on the myriad financial and other relationships and contracts which underlie the delivery of a care service to an older person. What emerges is, in every country, a diversity of relationships and funding arrangements, to which EU rules on public procurement and state aid do seem, prima facie, to apply. The ongoing challenge for European legislators is to understand the complexity of the sector as it is today and to facilitate all the organisations involved, but notably the financers, providers and users to engage in contracting for quality. The authors hope that this study will be a significant contribution to that understanding.

The European Union provides a valuable framework for mutual learning and comparative research in the framework of the open method of coordination on social protection and social inclusion. This framework is currently in the process of revision in light of the Europe 2020 Strategy and the recently published flagship initiative, the European Platform against Poverty and Social Exclusion.

The EU Social Protection Committee (composed of Member State civil servants) has recently published a voluntary quality framework for social services, which aims to be a general reference point for public authorities developing tools for the evaluation and improvement of social services, including those provided under the scope of European legislation outlined above. This document can be interpreted as a further step of EU institutions for complementing the debate on SSGI quasi-markets and competition rules by considerations on quality and national differences according to path-dependent developments of social services.

Even if it did not discuss at length the legal issues regarding the application of EU rules, the authors hope that the present study does usefully contribute to these latest developments by bringing together two strands of debate at European level: the regulation and financing of (quasi-)markets for SSGI in long-term care on the one hand and the improvement of quality of SSGI on the other.

Contracting for Quality

Comparative conclusions

COMPARATIVE CONCLUSIONS

The study 'Contracting for Quality' was about how markets are regulated to improve the quality of care and quality of life for dependent older people, and how relationships between public authorities and (other) providers are managed to favour quality assurance and improvement in long-term care.

It has become evident from this study that there are no simple answers to these questions. Depending on national models of planning and delivering social and health care, the roles of different stakeholders and, in particular, the role of users influence the implementation of seemingly similar concepts. For instance, market-orientation does not necessarily mean competitive tendering, neither does user choice necessarily ensure pre-defined quality.

Although the 'New Public Management' paradigm has become entrenched in the area of long-term care, competitive tendering is not a widespread phenomenon in the study countries. 'Contracts' and the process of 'contracting' have taken on rather different forms than just a legal document to describe requirements and compensations between a financer and a provider. Long-term care services have only just started to develop criteria and indicators to define, assess and improve quality, in particular when it comes to quality of life (Nies et al, 2010).

In order to respond to the key research questions, this chapter will draw conclusions from and comment on the six country profiles of Belgium (Flanders), Czech Republic, Germany, Spain, Sweden and the UK (England). These profiles have, first, outlined each country's social model and recent policy reforms. Secondly, they presented a picture of the organisations performing particular roles (financer, regulator, planner, case-manager and provider) and outlined the relationships between them. Thirdly, the role of the users with care needs, how they access the care system and what they contribute out of their income and assets to pay for care, was explained. Finally, examples of 'contracts' were given that offer an insight into various methods and tools for assessing and improving the quality of services. This comparative chapter will follow a similar structure.

1. Social models and recent policy reforms

The modernisation of social and health care services over the past two decades, in particular those for older people, was driven largely by the idea that market-mechanisms, competition and user choice were to be expanded with the aim of increasing capacity and improving quality. The so-called 'New Public Management' paradigm (i.e. performance management based on private sector ideas of effectiveness and efficiency) was thus applied to an area that had been characterised by traditions of welfare ('poor law'), subsidised non-profit provision or a monopoly of public provision. This also had implications for a target group that had for a long time been considered as mere 'recipients' of welfare services, rather than 'clients' or 'customers'.

The impact of this new paradigm on existing structures and relationships between stakeholders has been as divergent as the types of welfare regimes and public policy traditions to be found in the study countries. Indeed, the implementation of 'New Public Management' was influenced by national ideological cleavages, by historic changes such as the transformation of formerly Socialist countries, and by supra-national influences such as EU single market rules and globalisation trends.

These contextual changes have created new roles for existing stakeholders, new types of stakeholders and new relationships between them. The changing patterns of regulation, financing, planning, provision and case-management were experienced by all stakeholders as a major challenge. For example, the concept of splitting purchaser and provider roles was more pervasive in countries where social and health services had been delivered mainly by public providers (e.g. **Sweden**, **UK**). New private providers –

non-profit or for-profit – entered the market by being more competitive in tendering relative to the newly formed public provider units with their legacy of higher wages and overheads.

However, even in countries where private non-profit organisations had a long tradition as service providers (e.g. **Germany**), relationships formerly based on mutual trust and subsidies became formalised through contracts and fixed prices. Rather than creating a 'real' market in which supply and demand regulate prices, the State still intervenes as a regulator (e.g. of price and quality) in so-called 'quasi-markets'. Furthermore, different levels of government continue to control the entry of new providers by means of accreditation, to define quality standards and to inspect providers' adherence to the standards. Providers may thus face a variety of regulatory regimes and quality requirements depending on their area of activity (e.g. **Belgium**, **Germany**, **UK**).

Service users have been perceived by the market model as well-informed customers capable of articulating their needs and preferences and of choosing between providers (e.g. **Sweden**, **Germany**). Government schemes increase service users' purchasing power (e.g. **Spain's** dependency law; **Czech Republic**'s care allowance) with the aim of stimulating new solutions to meet unmet demand and ensure that complaint mechanisms are in place, so protecting people from exploitation or abuse by unscrupulous providers.

The business model of modernisation also incorporates ideas from organisational quality management, notably in relation to governance, transparency, documentation and efficiency of resource utilisation. The risk connected with this approach lies in assessing

services and products exclusively on the basis of these criteria. In the area of personal social services these results may run contrary to those deriving from the application of normative quality criteria based on users' quality of life, harder to measure though they are. The question is whether it is possible to combine elements of both.

When it comes to long-term care for older people, these patterns become even more complex with regard to the way in which policies have been conceived and implemented in the study countries. In general, age-related dependency has only been acknowledged as a social risk during the past 20-30 years and many of the study countries are still in the process of embedding relatively recent reforms.

Key challenges concern the coordination of social and health policies, equal access to services as well as issues of growth in supply and, crucially, quality assurance. Serious

concerns about the long-term sustainability of the sector in terms of financing and human resources are also ever present. Furthermore, there are significant cultural, political and legal differences regarding societal and private responsibilities for long-term care. Indeed, most care for older people is still provided by informal carers within family settings (see Triantafillou et al, 2010; HM Government, 2008). Boundaries between paid and unpaid informal care have started to become blurred, as evinced by the care allowances introduced in the **Czech Republic** and **Spain**.

Considering the long-term trends and more recent reforms described above, the complex and heterogeneous picture that emerges from the six country profiles is unsurprising. In the following section, the organisations playing the different roles are identified.

2. Identifying who plays what roles in the care system

There are many traditional and new stakeholders in the provision of long-term care services for older people. Table CFQ1 provides an overview of their different roles in regulating, financing, planning, case-managing and delivering long-term care in the study countries.

As governments have reformed long-term care policies to stimulate and regulate the market, new public institutions (regulators and planners) have come into existence:

- In **Germany**, with the introduction of the LTC Insurance, new branch offices of the LTCIFs came into existence as well as the MDK with competences for individual needs assessment and regulatory competences for contracting and inspecting all service providers.
- Also in the **UK**, LTC became more closely attached to the health system, e.g. by the creation of the Care Quality Commission with regulatory competences in the field of registration and inspection. Still, local authorities have maintained a strong position in social care with respect to financing, planning and purchasing.
- In **Spain**, the ongoing implementation of the LAAD gives an important role to the Autonomous Communities. The Territorial Council (assembly of Autonomous Communities and Central State) is elaborating new country-wide quality standards. At local and regional level, new institutions are coming into being in order to ensure the implementation of the new law.

- In **Sweden**, decentralisation policies and 'New Public Management' approaches in long-term care led to new responsibilities for municipalities and the introduction of a market-oriented terminology and organisation, e.g. by separating planning, case-management and financing from service provision.

The most visible new stakeholders are private for-profit providers (see table CFQ2), which have appeared in the market due to relatively low entry thresholds (**Germany**, **Belgium**, **UK**) and/or due to competitive advantages in tendering processes (**Sweden**, **UK**). Still, their legal status as for-profit organisations hides a variety of different types of organisation, from large companies with multinational owners present in several countries (e.g. **UK**, **Sweden**) to small and medium size enterprises (e.g. **Germany**). In the **Czech Republic**, private for-profit providers have not yet entered the market, possibly also due to uncertainties concerning the general regulatory framework. Both in **Sweden** and in the **Czech Republic** (though for different reasons), the emergence of non-profit organisations as providers of services is a relatively new development over the past 20 years – with respective challenges for regulators to create 'equal opportunities' in relation to market access and service continuity.

Table CFQ1a
Overview of different stakeholders' roles as regulator, financer, planner, case-manager and provider in the study countries

Role of stakeholder	Belgium	Czech Republic	Germany	UK	Spain	Sweden
Regulator	Federal Social Health Insurance and Regional Governments - Flemish Agency for Health and Care (VAZG)	Ministry of Labour and Social Affairs	Federal Ministry of Health; Long-term care insurance and regional branches; Regional governments (inspection)	Department of Health; Care Quality Commission (CQC)	Central State; Autonomous Communities	Central State (framework legislation); Municipalities; Counties (health care)
Institutional financer	Insurance funds; Flemish Health and Social Care Infrastructure Fund (VIPA); Flemish Agency for Health and Care (VAZG)	State subsidies, regional and municipal budgets (grants), health insurance	Long-term care insurance; Local Social Assistance funds	Municipalities; Local NHS Trusts	Central State; Autonomous Communities	Municipalities
Planner	Local Social Welfare Centres (OCMW); VAZG	Regions, Municipalities	None (regions)	Municipalities; Primary Care Trusts (PCTs) *[about to replaced by GP-led consortia in 2011]*	Autonomous Communities	Municipalities

Please refer to country profiles for further details.

Role of stakeholder	Belgium	Czech Republic	Germany	UK	Spain	Sweden
Case manager	Local multi-stakeholder cooperation initiatives; OCMWs	Undefined ('Social counselling' by regions, municipalities and providers)	Municipalities; LTC Insurance Funds ('care counselling')	Municipalities	Undefined (Autonomous Communities)	Municipalities
Provider	Public – non-profit (esp. Flanders) – for profit (esp. Wallonia, Brussels)	Public – non-profit – (almost no for-profit)	Public – non-profit (important) – for profit (increasing)	Public – non-profit – for profit (esp. care homes)	Public – non-profit – for profit	Public (municipalities) – non-profit – for-profit (care homes)
Users as purchasers	*Co-funding; national and regional attendance allowances; subsidised home help vouchers*	*Co-funding (LTC allowance)*	*Co-funding (LTC Insurance)*	*Co-funding (direct payments for small group; attendance allowance)*	*Co-funding (LTC allowance)*	*Small co-funding*

Please refer to country profiles for further details.

What is striking in Table CFQ1 is the variety of organisations performing these roles, the different sectors (public, non-profit and for-profit) involved and – for public sector organisations – the different levels of administration (local, county, regional, central) from which they come. What must also be appreciated is that a single role may be played by many organisations or that one organisation may fulfil numerous roles. This characteristic of the long-term care sector is at the heart of difficulties in clearly defining expectations, strategies and accountability.

Table CFQ2 shows the approximate market share of different types of providers, using the example of residential care. In the **UK (England)**, private providers are now running the largest share of care homes and going through a consolidation process, in which the five largest companies dominate the market. In a relatively small market in **Spain**, for-profit providers have increasingly gained ground, and they are playing an active role in the extension of care services. In **Germany,** too, for-profit providers (though typically smaller companies) have increased their market share over the past 15 years, notably in the

home-care sector. Both in the **Czech Republic** and **Sweden**, home-care services have also seen the emergence of specialised non-profit providers. These trends can be expected to continue.

The emergence of new actors and organisational structures has significantly changed the landscape of the sector. In **Germany**, for instance, private non-profit organisations had a long tradition as almost monopolistic providers and a relationship with public financers based on trust; these relationships have gradually been replaced by contracts, rigid service pricing and the definition of market access rules. In other countries (e.g. **England**, **Sweden**) the balance of provision has been shifting from the public to the private (for-profit) sector. This shift in the welfare mix has called for new criteria and mechanisms to ensure quality and to define access rules. Only in exceptional cases, however, have governance mechanisms come to be based on formal legal contracts between a single financer and a single provider, in which intended service outcomes are clearly defined.

Table CFQ2
Approximate market shares of different providers of residential care in the study countries

	Public	Private non-profit	Private for-profit
Belgium (Flanders)	36%	52%	12%
Czech Republic	83%	15%	2%
Germany	7%	55%	38%
UK (England)	7%	13%	79%
Spain	23%	24%	53%
Sweden	85%	-	15%

For sources and dates, see relevant country profiles.

3. The role of users: accessing the system, paying for services

Older people in need of care have been attributed cash benefits to pay for care in all selected countries (Table CFQ3), with the exception of **Sweden**. However, the benefits identified are only intended to cover part of the real cost of services required to satisfy individual care needs. The role of users as purchasers of formal care is still in the early stages of development in the study countries. Older people in need of care (and their carers) tend to opt for home-care for as long as possible, only moving to care or nursing homes when it becomes clear that no alternative remains, or perhaps if family members live a long way away.

As a consequence, care homes, for instance in **Germany** and the **UK**, have reported occupancy rates below 90% (Berschneider/Schulte, 2008; Laing & Buisson, 2010). Investment and expenditure in this setting nonetheless remains far home-care. Given the potentially high cost of residential care, it is unsurprising that users should try to optimise their purchasing power in home-care through the 'black market' (e.g. by employing migrant carers) and/or by using

care allowances to pay family members for their support (**Czech Republic, Spain**). In order to counteract a growth in private solutions of this type, cash benefit schemes have in-built incentives for choosing formal care services, whether at home or in residential setting:

- In **Germany**, if beneficiaries opt for in-kind services the nominal amount stipulated for these is worth more than double the amount of the cash benefit – notwithstanding, more than 70% choose cash-benefits or a combination of cash and in-kind services, rather than in-kind services only (see Rothgang, 2010).
- Also **Spain** and the **Czech Republic** are both seeing a trend for people entitled to LTC benefits to choose cash benefits over services, meaning that they are not achieving one of their political aim of stimulating new supply. In the **Czech Republic**, the LTC allowance for people with less intensive care needs (level I) is now being paid partially in cash and partially in kind.

Table CFQ3. Minimum and maximum amount of cash benefits for LTC in selected countries (2009, 2010)

	Minimum allowance per month	Maximum allowance per month
Belgium (Flanders)	€75.78 (means-tested) + €130	€507.32 (means-tested) + €130
Belgium (Wallonia)	€75.78 (means-tested)	€507.32 (means-tested)
Czech Republic	€74.41	€409.24
Germany	€215.00	€1918 (€2400 in exceptional cases)
UK	€212.00	€362.00
Spain	€300.90	€833.96
Sweden	Subsidised services, service vouchers	Subsidised services, service vouchers

For sources, please refer to country profiles.

In spite of significant improvements in purchasing power through the cash benefits described above, older people (and their families) are still co-funding formal services to a large extent through means-tested payments out of their own income and assets. Even with the new cash benefits, the service user and his/her family face a number of disadvantages as 'consumers' in the care market. Apart from limited purchasing power, lack of information and health-related constraints such as dementia, these new 'consumers' may also not find the types of services in the market that they would like to buy. Care counselling, case management and one-stop information centres, as well as compulsory visits by formal services to the homes of recipients (e.g. **Germany**) have been introduced to fill the information gap for users and carers. These intermediary roles are conceived in various ways: as independent counselling centres, as advocates for the user or the carer or even as gate-keepers.

Furthermore, the 'informal' or unpaid care workforce of family members still provides more than 80% of care even in countries with more developed long-term care systems (see Triantafillou et al, 2010; Nies et al, 2010). Although it is tempting to see users and family carers as a single stakeholder, their interests may not always lead to the same choice of care – e.g. residential care or home-care. The use of care allowances to pay migrant carers, possibly on the black market, is becoming more and more common as families seek cost-effective and convenient solutions (**Germany, Spain**; see Di Santo/Ceruzzi, 2010). Though a number of measures have been introduced to improve the status of carers, the division between formal and informal care continues to be a challenge for emerging long-term care systems, in particular concerning information, support and quality assurance (see Triantafillou et al, 2010; Nies et al, 2010).

4. Improve the quality of care and quality of life for older people

As the relationships between public authorities and other stakeholders form one aspect of market regulation, the two principal research questions of this study are closely related:

1. How are markets regulated to improve the quality of care and quality of life for older people?
2. How are relationships between public authorities and (other) providers are managed to favour quality assurance and improvement?

As we have seen in the six study countries, both market regulation and long-term care for older people are still developing. Market mechanisms have been introduced in all

countries, regardless of welfare traditions or regimes. However, these legacies have powerfully influenced national and local adaptations.

The **UK (England)** has usually been described as the most advanced country with respect to market regulation. Indeed, the privatisation of long-term care provision in community care, and even more so in residential care, has been almost total. This development comes with quite detailed national regulation of quality criteria, and a strong role for local authorities in defining prices, quantities and terms through commissioning. Theoretically, public purchasing decisions should be neutral with

regard to ownership or legal status. An important feature in the **UK** will also be the future funding settlement for long-term care (Dilnot Commission) – it remains to be seen to what extent a reform may address the fact that 44% of residents in care homes cover their own costs from private assets.

Germany has a relatively low threshold for providers entering the market, but the balance of power in defining prices and quality standards lies largely with the regulator and financer. Under this system, providers must usually accept the prices (e.g. daily rates or block grants) defined by the financer, even if they are able to calculate different real prices and costs. Similar developments as in **England** are related to an expansion of private for-profit chains, in particular in residential care. In contrast to their English counterparts, German municipalities have lost virtually all power as a planner and financer, as purchasing power lies with care insurance companies and private investors are able to decide to construct care homes or services with little local municipal control. While the relatively low threshold for entering the care market has certainly contributed to a steep rise of supply – both in community care and in residential care – ongoing debates show that the market might need much more regulation in terms of transparency, quality assurance, planning and case management.

Sweden has seen a trend towards increased competitive tendering, but municipalities today have the choice of three routes: tendering; user choice model; or in-house provision. There are strict regulations concerning prices and staff tenure in the case of external provision. Altogether, the market share of the non-public sector is only around 15%. As in **England** and **Germany**, there is a tendency towards concentration of care chains. However, choice for users will only slowly gain ground with the new 'freedom of choice'

regulations, while prices remain highly regulated and capped. The advantage of the Swedish experience is that formal care services are already highly developed and accepted by society.

The **Czech Republic** has increased the purchasing power of consumers, but formal services do not seem to be as attractive as paying informal or family carers. With its shift towards care allowances, it is on a similar track to **Spain** – though Spain's recent law was specific to long-term care, and the **Czech** Social Services Act covers all services. Despite the emerging role since the 1990s of private non-profit organisations as providers, traditional social service provision remains concentrated in the public sector, while the share of commercial providers is very small. Whereas the **Czech Republic** has uniform standards across the country, Spain's regions (autonomous communities) supplement national standards with their own, creating significant disparities. **Spain** and the **Czech Republic** might thus follow the **German** pathway, with an expansion of care services but with more severe financing difficulties in the absence of ear-marked funds or an insurance system.

Belgium (Flanders) is a special case, as it has complemented a system based on rigorous contracts and (regional) social planning in the area of health and long-term care services with an open market for home-help services, based on low entry thresholds and regulated prices that come with significant subsidies for users. This strategy boosted supply (and regular employment) as well as demand for home help vouchers and seemingly reduced the emergence of a 'black market' of care. However, relationships between 'traditional' providers of home care and the new providers of home help have given rise to a fierce debate about training

standards for new providers and measures to improve coordination.

Individual providers have developed various strategies to cope with regulatory conditions, the contents of which they have been able to influence only in a very restricted way. First, to fulfil the legal requirements and increase their own competitiveness, many providers have introduced internal quality management systems. As the examples show, both internally developed QM systems (e.g. Carema in **Sweden**) and classical tools such as ISO 9001 or EFQM are being adopted; some providers have even implemented several systems in different service units (e.g. ASISPA in Spain or the Silesian Diaconia in the **Czech Republic**). Secondly, alongside other quality indicators, user satisfaction surveys are often used to assess service quality. Thirdly, inspection mechanisms are applied in all countries, though with varying frequency and methodology, e.g. the **Flemish** Ministry's Inspectorate used to inspect care homes only once in a six year period, but has now changed its policy to a yearly inspection. In **Germany**, each care home will be inspected by the MDK once a year from 2011 onwards. In the **UK**, there is a tendency towards self-assessment (annual reporting), while external inspections will be made dependent on performance.

There are often overlapping sets of quality criteria set by different levels of government (local and national in the **UK**; national and regional in **Belgium, Spain, Germany**) and there are often different regimes for home and residential care. Criteria still tend to be structural or clinical, and only the most recent developments in **England** show an orientation towards outcomes for users/residents, though there is widespread awareness that this

approach should be developed. This has been underpinned by the creation or enhancement of regulatory bodies, e.g. the Care Quality Commission (CQC) in the **UK** or the new transparency policy in **Germany** – both aim to provide better information to potential users/residents choosing between providers. In **Spain**, CCAAs are free to define quality critieria exceeding those agreed centrally; which may result in a perpetuation of pre-existing regional differences. For providers that try to supply services nationwide, this calls for ample flexibility. In consequence, providers examine tender documents and accreditation regimes thoroughly before deciding whether it is worthwhile applying.

Despite their increasing roles as co-funders of services, users are still relatively weak in influencing quality criteria compared with providers, financers or particular professions, such as doctors or nursing scientists. This may explain the underdevelopment (so far) of 'quality of life' measures. Progress has been made in establishing councils of older people (e.g. Madrid, Dortmund) as consultative bodies for local policy-making and, there, major representative organisations (statutory or charitable) are making headway.

Users (and carers, on their behalf) often have recourse to complaints procedures offered by providers or to an external regulator or ombudsman; however, there may be questions over the take-up of such facilities. Satisfaction surveys are also a common tool among the practice examples provided here (Madrid City Council, Ideal Care Homes). There is no doubt that much more could be done to consult older people and their carers systematically about quality standards (notably outcomes) and whether they are being achieved.

5. Conclusions

The country profiles present various examples of organisations' relationships with each other in the long-term care sector and analyse their impact on quality. To present frank assessment, very few of these relationships can be argued to be 'contracts for quality' in the sense of legal contracts containing financial incentives to deliver clearly defined quality care. The two that come closest are:

- The relationship between the Flemish Health and Social Care Infrastructure Fund (VIPA) as financer and any provider applying for funding: VIPA incentivises providers to deliver structural standards beyond the minimum federal requirements – even if the quality criteria are only structural (**Belgium**).
- The relationship between Stoke-on-Trent Borough Council as financer and any provider winning a competitive tender in the borough: the Council only pays the full hourly rate to providers which meet certain quality standards, e.g. on consistency and punctuality of staff visiting an older person at home (**UK: England**).

Even these examples of good practice do not necessarily provide incentives for continuous improvement based on older people's quality of life. However, it is difficult to assess whether this means that such contracts are not common practice in the study countries or that a study of this limited scale was not able to locate them.

There are nevertheless other tools and systemic incentives for assuring an agreed level of quality in regulated quasi-markets:

- **Accreditation** of providers, with requirements that certain minimum standards be met is present in all the countries and, in some cases (**Belgium, Germany**), there are

several levels of accreditation by different public authorities.

- **Inspections and general quality reporting** to monitor performance of providers are also foreseen in most countries.
- **Providers' own commitment** to drive up quality and therefore win contracts or attract service users is paramount: all the providers in this study showed real corporate commitment to quality care.
- The **power of a quasi-market** in producing a competitive environment for attracting funding, both from individual service users and from institutional financers – the concept here is that better providers (even charging more money) will attract more 'business' and therefore be more successful.
- **Transparency** of the quality of different providers/services is also seen as an additional tool (linked to the quasi-market) for improving quality, i.e. if service users as 'customers' are able to make informed choice about providers through, for instance, the Internet, they will choose higher-quality providers.

These market-based tools do, however, raise questions over the affordability of higher-quality service provision to older people and their families, especially those on a lower income. There may also be questions over the development of the market in rural areas – i.e. whether limited demand is capable of stimulating a sufficient number of providers to compete with each other and thus drive up quality. As has also been seen in several countries, there has been a significant concentration of private for-profit providers, notably in the residential sector.

In conclusion, a wide range of policies to influence and improve the quality of services are in place, but it seems that, as long as such measures are not directly linked to financial incentives, it will be difficult to convince all providers that quality management is more than just a matter of satisfying the inspector once a year. Measures to define, assess and control quality tend to focus on individual organisations, agencies or services, rather than looking across the system, notably across the health and social care divide. Quality indicators that serve to improve inter-agency working, case management and interfaces along the 'chain of care' (including informal care and health care organisations) remain to be developed.

For the future, this implies a range of policy and governance challenges for all stakeholders:

For **regulators**, the development of more outcome-oriented (quality of life) assessments may be a pathway to further incentivise continuous improvements in care organisations, accompanied by a supportive rather than punitive model of inspection. However, these strategies will have to be underpinned by greater investment in training and clearer career structures in long-term care. Finally, a dialogue between all stakeholders has to be established, to mutually agree upon quality criteria and respective costs, and the voice of users significantly strengthened.

For **financers**, more developed thinking in terms of 'care chains' and care coordination is needed to respond to users' real needs – 'care trusts', more joint training and financial incentives for coordination in care provision may help to bridge the divide between health and social care. This might also make it

possible to address the 'quality-cost chasm', i.e. the definition of quality criteria by one agency and the decision on budgets and prices by another agency.

While social **planning** seems to have lost ground due to market-oriented governance mechanisms, there are the first signs of a revival due to the crisis of public expenditures. Rather than reducing public spending in general (e.g. 20% less for all), it will be necessary to look for 'intelligent reductions' to make efficiency gains. In order to do so, new investment may be need in the short term to strengthen planners such as regional and local authorities in their role.

For **providers,** which in most countries have witnessed greater demands for compliance, it has not always been easy to adapt to changing criteria and indicators – often without being clear about the objective of regulations that have been experienced as purely bureaucratic. The question is how different types of providers (public, non-profit, for-profit) – now grown more accustomed to competition – will be able to find common ground and join forces in the interests of users. The already fragmented sector of long-term care is at high risk of becoming more fragmented, rather than better coordinated.

One of the key mechanisms for promoting care coordination and 'guiding the user through the system' has been **case-management**. However, this is one of the weak points of current regimes in Europe. As in planning, it will be an important task for municipalities – and perhaps other stakeholders – for the next few years, to address the issue of case management, and so the questions of skills, training and status for case-managers, to ensure coordination and quality of care across individual providers.

Finally, Europe will face new generations of (potential) **users** of long-term care services over the next two decades: ourselves. We (and our families) will have higher expectations, be better educated and better informed. More and more of us will gain experience of the care system as we or our relatives need care. This may potentially mobilise us to take part in a serious dialogue not only about the development of standards based on quality of life (and so, on the outcomes resulting from care interventions) but also about the sustainable financing of long-term care.
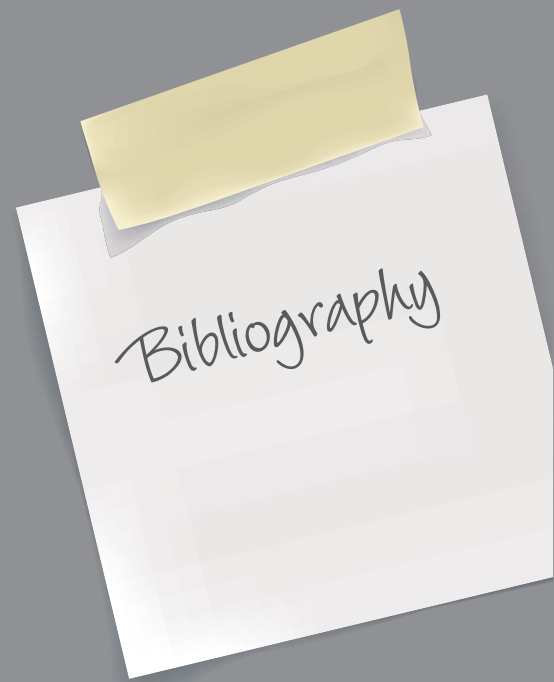
A repeat of this study in as little as five years' time would doubtless reveal further developments in regulation, financing, planning, case-management and provision in the long-term care sector. Whether this will lead to improvements in the quality of care and quality of life of older people needing care, only time will tell.

Notes:

Contracting
for Quality

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Notes:

READING GUIDE

The authors hope that you will be able to easily navigate through this study using the Introduction and the table of contents.

Although we hope you will read the whole report, if you are interested in any of the following, here are some suggestions about what to look for:

- *long-term care policy and systems*, i.e. how things are organised in a given country, you can read sections 1-3 of each or any country profile
- *long-term care in practice*, i.e. how things work in a particular organisation often at local or regional level, you can read section 4 of each or any country profile
- how *service users access and pay for the care they receive*, you can read section 3 of each or any country profile
- data relating to the *cost of care* and the *care market*, you can look at the relevant tables in each country profile
- the analysis that is based on the *key research questions*, you can read the key findings, section 5 of the country profiles and the comparative analysis chapter.

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HOW CAN I USE THIS REPORT?

This report is clearly intended to be informative, but also thought-provoking. You may want to reflect further on your organisation's role(s) in your country's long-term care system, by asking yourself any or all of the following questions:

- Which of the five roles identified in this report does your organisation play?
- If your organisation plays several roles, what are the advantages and disadvantages of combining these roles in one organisation?
- Which organisations play the other roles identified in this report in your country?
- What is the nature of your organisation's relationship with these other organisations?
- Do you think that any of the relationships your organisation has with others in the system is a 'contract for quality', i.e. how does this relationship improve the quality of care and quality of life of an older person?
- Have you or a family member used care services for older people in your country? What was your/their experience of accessing and paying for those services? How well was the assessment of needs and ongoing case-management organised?

The study's authors will be pleased to consider invitations to present its results in various settings and are able to do so in English, French, German, Italian, Portuguese or Spanish.

This ESN research report looks at the changing relationships between regulator, financer, planner, provider, case-manager and user in long-term care for older people.

The formal and informal contracts between organisations from the public, non-profit, for-profit and insurance sectors performing these roles form a complex web of relationships in the care sector for older people. They all have a significant impact on the quality of care which every older person in Europe receives.

This report sets out to map these relationships and assess their impact on the quality of care in Belgium (Flanders), Germany, Sweden, UK (England), the Czech Republic and Spain.