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Improving Quality in Long-term Care

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IMPROVING QUALITY IN LONG-TERM CARE

Introduction

Population ageing is an issue affecting policymakers in industrialised countries all over the world. On average across OECD countries, there has been a large increase in the share of the elderly population in recent decades due to rising life expectancy and declining fertility rates. This development is projected to continue over the next decades. The rise in the share of the population aged 80+ years is especially large. Figure 1 illustrates the percentage of the population aged 80+ years projected for the year 2050 compared to the percentage in 2010.

It becomes obvious from Figure 1 that the share of the population aged 80+ years will more than double in many countries (Italy, Greece and the United Kingdom, for example) by 2050 versus 2010; and in some countries (e.g. Korea, New Zealand and Poland), this percentage will even more than triple. On average across OECD countries, the share is projected to increase from four percent in 2010 to ten percent in 2050. This demographic development poses many challenges to long-term care systems. Of course, an increasing share of the popula-

tion aged 80+ years does not necessarily imply an additional burden to long-term care systems, since the need for long-term care services depends on the health status of the elderly population. However, even according to an optimistic projection scenario – the so-called “cost-containment scenario”, long-term care expenditure as a share of GDP is projected to increase in the future. Figure 2 illustrates projected spending on long-term care as a percentage of GDP for the year 2060.

Figure 2 shows that on average across OECD countries, long-term care spending as a share of GDP will be twice as high in 2060 compared to the average value for the years 2006 to 2010 (1.6 percent compared to 0.8 percent). In some countries (for example, Turkey, Mexico and the Slovak Republic), the increase is even projected to be far more significant. Hence, it becomes evident that the increase in costs arising from population ageing will be considerable, even under optimistic assumptions.

Regulation of long-term care systems

In view of the growing need for long-term care services in the decades ahead, which is associated with significantly higher costs than in the past, improving the quality of long-term care services is becoming increasingly

Figure 1

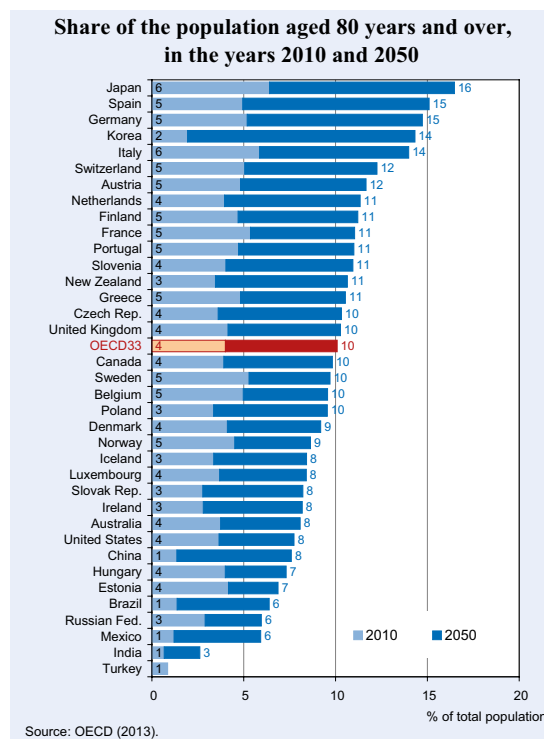
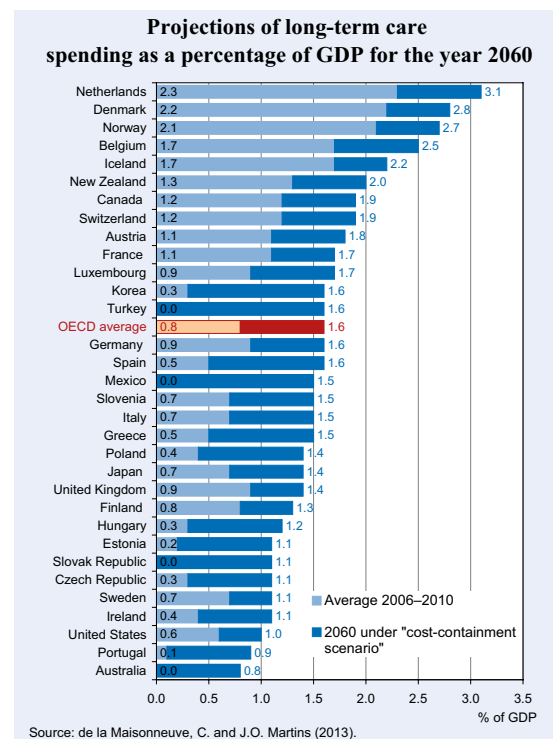


Figure 2



important (see OECD/European Commission 2013). In order to ensure that long-term care services offer a certain level of quality, long-term care systems are regulated. In all OECD countries, the central government determines the principles of regulation of long-term care systems. The three main objectives of regulation are to guide care providers on how to improve quality, to inform people needing long-term care services about the provision of certain care services and to provide information to regulators so that they can help to identify gaps. In many countries, decentralised bodies are responsible for the implementation of quality control.¹

The regulation of long-term care systems differs across countries. In general, nearly all OECD countries require long-term care institutions to be registered. This registration is conditional to the institution fulfilling certain minimum requirements. In addition, over two thirds of OECD countries require further quality standards for institutions. This kind of regulation is denoted by the term “accreditation”; and the main characteristic of accreditation is an evaluation process involving both an internal and an external review. During the internal review, care providers and institutions document their long-term care services, whereas during the external review, a governmental authority evaluates providers and institutions. In many countries (for example, France, Germany and Spain), accreditation is a precondition to accessing public funding.²

There are some common quality standards across OECD countries. One quality standard is a minimum ratio of long-term care workers to long-term care recipients. This ratio is used as a proxy for the safety and mobility of residents of long-term care institutions. There are also requirements that living environments have to fulfil in order to prevent accidents. Apart from measures that must be taken to ensure safety and mobility, further aspects have recently been taken into account in some countries. In the Netherlands, the United Kingdom and the United States, for example, the quality of life of residents and human dignity have been included; while in Ireland and the United States, individualised care planning processes and reporting systems for complaints have been added to the list of quality standards. In general, there is less regulation of home care and community-based care services than of long-term care institutions. There are, however, differences across countries. For example, in the Netherlands, care that is provided

outside of institutions is less strictly regulated than institutional care; whereas in Spain, accreditation is compulsory for any centre providing care services, which implies stricter requirements. The general purpose of regulating home and community care is to guarantee that the living environment is adapted to the needs of care recipients.

Inspections of care institutions and incentive schemes for care providers

In order to ensure that requirements with respect to quality standards in the long-term care system are met, inspections are carried out, which include paper-based inspections and on-site visits. In some countries, structured interviews with residents of long-term care institutions, family members and staff are required. The questions that are asked concern various aspects ranging from structural issues and satisfaction of care recipients to safeguarding resident rights. In many countries, inspections take place annually (e.g. Germany, Luxembourg and Portugal), but in some other countries, they are conducted at much larger time intervals of up to five to seven years (in France). In Finland and Sweden, inspections do not take place after a fixed time period, but upon request following complaints. Inspections are conducted by a team of inspectors in many countries (in the United States, for example, a multidisciplinary team of professionals is involved); in some other countries, however, inspections are carried out by a single person (e.g. Spain). Usually, an authorised accreditation body is responsible for training inspectors.

Another aspect that should be considered in the context of improving the quality of long-term care services is the incentive scheme for care providers. One measure to incentivise providers to enhance quality levels is public reporting. The purpose of public reporting is to increase transparency and provide information to care recipients. Requirements for public reporting differ across countries: in the United States, Germany and the Netherlands, for example, public reporting is compulsory; whereas in other countries (e.g. Finland and Spain), information is made available to the public on a voluntary basis. The frequency of reporting ranges from a few months (for example, in the United States) to one year (e.g. in Japan and Germany). The information provided includes aspects such as basic administrative information and inspection results. In general, there is a trend towards providing information about patient centredness (for example, meal choice, social activities) and clinical ef-

¹ See DICE Database (2014c) www.ifo.de/w/3BwDgiN6b for an overview of legislation concerning long-term care quality.

² See DICE Database (2014a) www.ifo.de/w/GrDVuXsy for an overview of regulation of long-term care providers.

fectiveness (e.g. rate of falls), rather than merely reporting on staffing and care environment (for example, beds and services). Another way of incentivising providers to improve the quality of their services is to introduce payment schemes based on performance. These schemes often combine public reporting with financial incentives and stimulate competition among care institutions with a view to improving quality. Such schemes have only been introduced in a few countries to date, and there has not yet been any systematic evaluation of the different schemes. According to OECD/European Commission (2013), preliminary evidence suggests that there is no direct causality between payment schemes based on performance and quality improvements. However, there could be positive “side-effects”: Since more information is made available to the public, the incentive for care providers to enhance the quality level may increase. One example of such schemes is the Value Incentive Programme in Korea, whereby the performance of each care provider is evaluated and the best ten percent of providers earn a financial reward. Similar incentive schemes also exist in the United States and Japan.³

Long-term care workforce requirements

An important factor influencing the quality of care is the long-term care workforce. Educational and training requirements for workers in long-term care institutions vary significantly across OECD countries. In the United States, for example, certified care workers need 75 hours of training; whereas in Japan, three years of experience are necessary to obtain an equivalent degree.⁴ Requirements for workers providing care services in institutions have been strengthened in some countries in recent years. In Sweden, for example, an education programme for care workers without any formal qualification has been started; and in Spain, every care worker is required to obtain a professional qualification by 2015. An aspect also taken into account by a number of training programmes is dementia care. For example, the Affordable Care Act in the United States requires specific training in caring for residents of long-term care institutions suffering from dementia; and in Ireland, care staff working with dementia patients can participate in specialist training programmes. Training requirements for workers providing care at home are often less strict than requirements for workers in institutions. In Austria,

for example, care workers in institutional settings need 1,600 hours of training, whereas only 400 hours are necessary for care workers in home settings. In general, workers providing care at home are often reported to lack the relevant qualifications. Due to preferences for care at home, however, according to OECD/European Commission (2013), it will become necessary to introduce higher quality standards in home settings. Another important issue is the training of long-term care workers after they have been employed. Continuous education is only compulsory for care workers in very few countries; in the United States, for example, 12 hours of continuing education must be completed every year. Generally, it is often the case that far more effort is put into ensuring that workers fulfil the conditions for being employed (no criminal history, for example) than into monitoring them after their employment. In many OECD countries, there is no process to monitor if a care worker commits a fault after being employed. Hence, post-employment workforce policies are decisive for improving the quality of long-term care services.

Conclusion

To conclude, it can be said that in recent years various measures have been taken to improve the quality of long-term care services in several countries. Given the growing importance of the issue of long-term care in the decades ahead, this topic looks set to remain a key policy focus area in the future.

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³ See DICE Database (2014b) www.ifo.de/w/3tNDYBZw for an overview of incentive schemes.

⁴ See DICE Database (2014d) www.ifo.de/w/nSynxQW9 for an overview of long-term care workforce requirements.