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**Quality Assurance for Long-Term Care:
The Experiences of England, Australia,
Germany and Japan**

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The Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group of AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

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FOREWORD

When older people with disabilities and their families reach the point when they must find professional services to deal with long-term care needs, questions about the quality of those services invariably arise. News stories about substandard care in nursing homes, assisted living, or home care services reinforce public concerns and increase pressure for governments to take action to ensure a decent level of quality services. These concerns have not been assuaged in the United States although it has a very extensive system for regulating and gathering data about the quality of services, particularly in nursing homes.

This report documents the fact that concerns about the quality of long-term care services are not confined to the United States. The four countries examined in the report—England, Australia, Germany, and Japan—have differing systems for public financing and very different systems for regulating and monitoring the quality of long-term care services, but all are looking for ways to improve quality as they face the prospect of increasing demand for such services in their aging societies.

Joshua M. Wiener, Ph.D., of RTI International, has assembled an impressive group of researchers to provide detailed insights into the demands for long-term care, the public and private systems for financing such services, and the public efforts to regulate and improve quality in each of the study countries. The summary report uses the detailed country descriptions to describe similarities and differences among the four study countries and with the United States. While outcomes data do not exist to definitively say which approaches are most effective, the comparisons clarify important issues for policy and practice as well as describe alternative approaches that may be useful to decision makers in the United States and other developed countries as they seek to improve their long-term care systems.

The Public Policy Institute offers this report as part of an ongoing series of reports on quality in long-term care in the hope that policy decision makers, practitioners, and consumers will better understand the variety of ways to address quality that are used in different countries. Such an understanding could be increasingly important as developed countries address the common issues involved with improving the quality of their rapidly changing systems of long-term care delivery and financing.

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Executive Summary

Background

Concern about poor quality of care by nursing homes and other long-term care providers in the United States is longstanding. Despite improvements in nursing home care following the passage of additional regulatory requirements in the Omnibus Budget Reconciliation of 1987, signs of poor-quality care in nursing facilities and problematic government oversight persist. The Administration on Aging's national ombudsman reporting system received more than 192,000 complaints in 2004 concerning quality of care, quality of life, and resident rights in nursing homes.

One of the key policy rationales for expanding home and community-based services is that these services provide a better quality of life than found in nursing homes. However, little is known about the quality of home and community-based services, even though increasing numbers of people are receiving paid care in those settings. People who use home care typically report high levels of satisfaction, but the ability to measure and ensure the quality of care in a home or community setting is at a fairly early level of development compared with nursing home care. Recent newspaper accounts of poor quality of care in assisted living facilities have increased concern about the care provided in those settings.

The United States is not alone in its unease about inadequate care for people with disabilities. Other countries are working to assure the quality of long-term care provided to their citizens. The following report compares these efforts in four developed countries—England, Australia, Germany, and Japan.

Purposes

The purposes of this report are to:

- Examine the extent to which the perceived types and causes of quality problems in long-term care services differ in the four countries studied;
- Describe varying philosophies and strategies for monitoring and improving the quality of long-term care and how they are implemented in these countries;
- Compare the monitoring and enforcement strategies that these countries employ for long-term care settings and services;
- Explore options beyond inspection and enforcement that these countries use to improve long-term care services; and
- Discuss the implications of the experiences in England, Australia, Germany, Japan, and the United States for these and other countries seeking to improve the quality of long-term care services.

Methods

The four countries in this study were chosen for comparison with the United States because they had made major changes to their long-term care financing systems, which raised the public policy salience of long-term care quality, or because they had recently made changes to their long-term care quality assurance systems. Information for this study was collected from four sources:

- Published and unpublished literature available from journals, government documents, Web sites, and other sources were reviewed. Web sites were monitored until the completion of the project.
- In-person and telephone interviews were conducted with government officials, researchers, and provider and consumer groups in each country during the summer and fall of 2004. These interviews were conducted using an open-ended, structured protocol.
- The country reports were written by nationals from that country or experts who had written previously on long-term care in that country. Thus, they were able to bring their previous expertise to bear on this topic.
- Long-term care experts in each country reviewed the country reports for accuracy.

Principal Findings

The four countries have both similarities and differences with each other and with the United States regarding the ways they assure quality in long-term care. Each country has a different culture that characterizes its approach to regulation and quality assurance.

- Quality assurance for long-term care is a significant focus of the Labour Government in England. Regulation is a critical component of the government's "third way" approach, providing a way to influence the behavior of providers between the laissez-faire of unbridled markets and direct public ownership. England is probably most like the United States in its emphasis on regulation to enforce compliance with national standards for nursing homes, while allowing localities to impose additional quality standards. The regulatory agency, which is a quasi-governmental agency, is aggressively reforming the inspection process with the goal of making the system more client- and outcome-oriented. In addition, England has a conscious national strategy for regulating and improving the workforce in all long-term care settings and for disseminating best practices.
- The Australian system for quality assurance relies heavily on consultation and collaboration between the industry and governmental and quasi-governmental officials. Inspections of residential care are carried out by a quasi-governmental accrediting agency, but approving providers to receive federal funds and enforcement of quality standards remains a fully governmental responsibility. The Australian quality standards for residential care settings are very broad and non-specific to allow providers considerable latitude in demonstrating how they achieve quality goals.

Quality assurance for home and community-based care is more decentralized and has been implemented only recently.

- Germany's approach relies on sickness funds to negotiate quality standards during the bargaining process over contracts with providers of institutional and home care services. Sickness funds are nonprofit organizations, heavily regulated by the government, which administer the long-term care insurance program. These contracts articulate general expectations around provider quality as well as the structures and processes that providers should have in place to monitor and improve quality. German states (Länder) also regulate nursing homes. Developing a consensus between providers and payers is important to this process, but consumers are not much involved.
- Japan recently started a public long-term care insurance program, increasing its resources to improve the quality of institutional and home care services as opposed to simply policing providers. Although formal quality assurance mechanisms are now more prominent, the Japanese system relies heavily on training and certification to develop the skills of long-term care workers, on social networks and regular communications from the government and among providers to motivate and disseminate best practices, and on "care managers" to help clients and to assure quality. In addition, new competition among providers, especially home and community-based services agencies, gives consumers a voice in quality assurance through greater choice in providers.

In addition to inspections, all of the countries use other strategies to improve quality, such as competition among providers, education, and training, and providing consumer information. Perhaps surprisingly, the United States has a number of quality assurance mechanisms that other countries do not have, including quantitative quality measures that are posted on the Internet for each nursing facility.

Comparative Analyses of Similarities and Differences

This research examined the quality assurance systems in four developed countries—England, Australia, Germany, and Japan—as a way of identifying approaches to improve the quality of long-term care. The approaches taken in the four countries and the United States represent a range of financing and delivery systems and use a variety of strategies to assure the quality of institutional and home and community services.

Country Similarities

The four countries in this study and the United States have a number of similarities in their quality assurance systems. First, long-term care quality assurance is on the political agenda in all of the countries, in part because of the substantial public funds allocated to these services and the heavy reliance of long-term care providers on public funding. As the populations in these countries age, the focus on long-term care, in general, and the quality of care, in particular, will likely increase.

Second, all of the countries rely, at least in part, on inspection and regulation of long-term care providers to assure quality. Reflecting the relative allocation of funding resources and perhaps the greater vulnerability of people in institutions, all four countries and the United States devote far greater resources to monitoring nursing homes and other institutional providers than they devote to home care and other community services. Strikingly, although the frequency of inspections seems to be increasing in most of the countries studied, all of the countries inspect nursing homes and other providers far less frequently than is the case in the United States.

All four countries and the United States are working to reform their quality assurance systems. Critics of the existing systems argue that the current inspection processes are too structure- and process-oriented, not focused enough on outcomes, subject to variation in application across surveyors, and not adequately reflective of the experience of service users.

Third, all of the countries rely to some extent on strategies other than direct inspection of facilities and agencies to assure quality of care. Many of these initiatives involve registering, regulating, and training the long-term care workforce. In none of the four countries, however, are there “culture change” initiatives, such as Green House Nursing Homes or the Eden Alternative in the United States, which seek to improve quality by changing organizational norms and values.

Country Differences

Despite some similarities across the countries, major differences remain across England, Australia, Germany, and Japan in how they each assure the quality of long-term care. First, the underlying philosophies of quality assurance vary across the countries, which affects how each country structures its standards, inspections, and enforcement. Second, the countries involved in this study vary in how they finance long-term care services. Third, countries vary in how strongly they separate payers from quality regulators as a way of addressing the potential conflicts of interest between those two functions. Fourth, interest in private accreditation in addition to (rather than in substitution for) government regulation is growing in Germany and especially in Japan, but not in England and Australia. Fifth, Japan appears to be the only country to have developed special approaches to assure the quality of care in facilities for people with dementia.

Conclusions: Implications for the United States and Other Countries

Without systematic cross-country quantitative data, it is impossible to objectively assess differences in the quality of care and make judgments about which quality assurance system is best or which aspect of quality assurance is most effective in improving the care received by older people with disabilities. In this respect, the United States has taken more steps to increase data collection on health and long-term care quality than any other country. For example, none of the four other countries collects anywhere near as much resident- and patient-specific functional and health data as does the United States.

Although none of the countries studied have solved the problems of quality in long-term care, the United States and other countries can fruitfully learn from the quality initiatives undertaken in each nation. The following issues emerged from the four study countries with policy implications for the United States and other countries.

- The financing of long-term care makes a difference in the quality of care, but not simply along public versus private lines. For example, the implementation of the public long-term care insurance program in Japan greatly expanded the supply of home care providers, which allows for more competition for consumers based on quality; however, under the insurance program, demand for nursing home care increased more than supply, resulting in waiting lists that reduce facility incentives to compete for consumers by providing higher quality care. The key strategy should be to structure the financing system so that it supports improved quality.
- Inspection and regulation are the cornerstones of quality assurance for long-term care in the four countries and the United States. A major tension exists in all of the countries regarding the extent to which inspectors consult rather than police. Dissatisfaction with traditional inspection is leading to new approaches. For example, Australia uses very general standards in order to focus on broad issues of facility quality rather than compliance with detailed regulations. England recently moved away from yearly inspections for all providers to a system that pegs the frequency of inspections to provider performance in order to free resources to monitor poorly performing providers. Japan requires third-party reviews for some providers. Creating ways to encourage and reward high performance as well as penalize poor performance is an area that is likely to receive more attention in all countries.
- Countries are looking for ways to supplement regulation by providing more information to consumers, providing training of the workforce, funding demonstration projects, and disseminating promising practices. All of the countries except for Germany place at least some quality information about individual providers on the Internet, although there is great variation in how consumer-friendly the information is. Staffing is recognized as a problem in all countries featured in this report as well as the United States. The governments of England and Japan, in particular, play a strong role in the training and regulation of the direct care workforce. Germany and England have developed practice protocols and funded demonstrations. Use of private accreditation to supplement regulation in Germany and Japan has been limited.
- All of the countries are shifting their delivery systems to encourage more consumer choice and more home and community services to address the quality of life issues that are often neglected in institutional settings. But these goals are accomplished in very different ways. For example, Germany's cash benefit option generally supports family caregiving and relies on the commitment of families rather than regulatory oversight to assure quality care. Japan's exclusive financing of agency-provided services was designed to liberate women from the burdens of family caregiving and relies heavily on training to assure quality. The expansion of home and community-based services provides more choices for consumers and may increase competition based on quality.

Quality Assurance for Long-Term Care: The Experiences of England, Australia, Germany, and Japan

Concern about poor quality of care by nursing homes and other long-term care providers in the United States is longstanding (New York State Moreland Act Commission, 1975; U.S. Senate Special Committee on Aging, 1974; Wiener, 1981). Despite some improvements in nursing home care following the enactment of new federal regulatory requirements in the Nursing Home Reform Act in 1987 (Fries et al., 1997; Hawes et al., 1997; Phillips et al., 1996, 1997; Zhang and Grabowski, 2004), signs of poor-quality care in nursing facilities and problematic government oversight continue (Institute of Medicine, 2001; U.S. Government Accountability Office, 2002, 2003, 2005). The Administration on Aging's national ombudsman reporting system received more than 192,000 complaints in 2004 concerning quality of care, quality of life, and resident rights in nursing homes (Administration on Aging, 2005).

One of the key policy rationales for expanding home and community-based services is that the quality of life for beneficiaries is usually better than in nursing homes. However, little is known about the quality of home and community services, even though increasing numbers of people are receiving paid care in those settings. Although people who use home care typically report high levels of satisfaction, the ability to measure and ensure the quality of care in home and community settings is at a fairly early level of development compared with nursing home care (Geron et al., 2000; Kane and Huck, 2000; Montgomery and Kosloski, 1995). Newspaper accounts of poor quality of care in assisted living facilities have increased concern about the care provided in those settings (Appleby, 2004; McCoy, 2004; McCoy and Appleby, 2004).

The United States is not alone in its unease about inadequate care for people with disabilities (Organisation for Economic Co-operation and Development, 2005a). Other countries are working to assure the quality of long-term care provided to their citizens, even though they use different approaches and build on different national traditions in their systems to promote quality. This study examines quality assurance systems for long-term care in four countries—England,¹ Australia, Germany and Japan—with the goal of analyzing how other countries help ensure that older people and younger people with disabilities receive quality care. Reviewing the efforts of other countries with different experiences with long-term care can inform the development of quality assurance policies in the United States as well as in other countries that are seeking to improve the quality of long-term care services.

The study has two main limitations. First, it focuses on variations in quality assurance systems rather than differences in quality of care outcomes. Very limited quantitative data are available to measure the quality of care across the four countries. As a result, this study cannot objectively evaluate whether certain features of quality assurance systems result in better quality of care outcomes. Second, the study does not address long-term care for people with developmental disabilities or mental health conditions.

Purposes

The purposes of this report are to:

- Examine the extent to which the perceived types and causes of quality problems in long-term care services differ from country to country;

- Describe varying philosophies and strategies for monitoring and improving the quality of long-term care and how they are implemented in different countries;
- Compare the monitoring and enforcement strategies that different countries employ for long-term care settings and services;
- Explore options beyond inspection and enforcement that different countries use to improve long-term care services; and
- Discuss the implications of the experiences in England, Australia, Germany, Japan, and the United States for these and other countries seeking to improve the quality of long-term care services.

Methodology

The four countries in this study were chosen because they had made major changes to their long-term care financing systems, which raised the public policy salience of long-term care quality, or because they had recently changed their long-term care quality assurance systems. They also represent a range of approaches to quality assurance.

The four research questions for each country are as follows:

- What is the perceived quality of care in each country and what does each country consider to be the underlying causes of quality problems?
- What is the overall philosophy of quality assurance in each country?
- How are long-term care providers inspected and regulated for quality of care?
- What other strategies (e.g., training the workforce, providing consumer information, and increasing competition) are used to assure quality?

Information on these research questions was collected from three major sources:

- Published and unpublished literature available from journals, government documents, Web sites, and other sources were reviewed. Web sites were monitored until the completion of the project.
- In-person and telephone interviews were conducted with government officials, researchers, and provider and consumer groups in each country during the summer and fall of 2004. These interviews were conducted using an open-ended, structured protocol.
- The country reports were written by nationals from that country or experts who had written previously on long-term care in that country. Thus, they were able to bring their previous expertise to bear on this topic.
- Other long-term care experts in each country reviewed for accuracy each of the country reports.

Cross-country comparisons are reported in the sections that follow; detailed descriptions and analyses of the long-term care quality assurance systems in England, Australia, Germany, and Japan are included in the appendices. Although not a major focus of the report, comparisons to the United States will be made when especially appropriate.

Overview

Despite important differences in population characteristics, England, Australia, Germany, and Japan are all aging rapidly, with Japan already being one of the oldest nations in the world (see table 1) (Organisation for Economic Co-operation and Development, 2005b). The percentage of the population that is age 65 or older is currently higher in all of the countries in this study than in the United States. By 2020, approximately a fifth of the population in Australia, England, and Germany will be age 65 or older; by that date, more than a quarter of the population in Japan will be age 65 or older.

Table 1. Percentage of the Population Age 65 or Older in 2005 and 2020

	Australia	England	Germany	Japan	United States
Percent of the population age 65+ in 2005	12.9	16.0	18.9	19.9	12.4
Percent of the population age 65+ in 2020	18.0	19.2	21.7	27.8	14.5

Source: Organisation for Economic Co-operation and Development, 2005b; United Kingdom Government Actuary Department, 2004.

The four study countries have both similarities to and differences with the United States (see table 2). In the United States, the popular view is that the quality of care in nursing homes is fair to poor (with exceptions) and many people say that they would rather die than live in a nursing home (AARP, 2003; Mattimore et al., 1997). Although there is variation across states, the quality assurance system is dominated by an adversarial, regulatory system (Wiener and Brown, 2005). In order to receive Medicare and Medicaid reimbursement, nursing homes and home health agencies must meet federal quality standards. Nursing homes are also licensed by the states as are home health agencies in some states. Inspections of nursing homes and home health agencies are performed about once a year by the states on behalf of the federal government. Enforcement options include suspending admissions and decertification from participation in the Medicare and Medicaid program, but the most common remedy is for the facility to devise a “plan of correction.” Quality regulation for nonmedical home care and residential care facilities, such as assisted living facilities, is the responsibility of the states. In general, these services are more lightly regulated than nursing homes. Over the last 10 years, however, regulation of residential care facilities has increased.

The federal government is interested in promoting nonregulatory approaches to quality assurance. The United States collects a great deal of resident-specific health and functional data on nursing home residents and home health patients, which the government uses to create quantitative quality measures that are posted on the Internet for each facility or agency. Summary findings of the inspections are also posted on the Internet, but facilities are not rated according to a numerical scale or other ranking system. Similar data are not available for nonmedical home and community services. In addition, although not actively promoted by the

government, quality initiatives that change the organizational culture of nursing homes to make them more home-like are popular among consumer advocates and some providers.

The four study countries vary greatly in how they finance long-term care. Like the United States, England finances care primarily through means-tested programs, limiting government aid to people who are poor or become poor through the use of expensive long-term care services.ⁱⁱ Japanⁱⁱⁱ and Germany,^{iv} the two oldest countries in terms of population, primarily finance long-term care through social insurance programs (*Kaigo Hoken* in Japan and *Soziale Pflegeversicherung* in Germany) that provide services to all older people who meet the functional disability tests. Australia falls in between these two approaches, with services provided largely on a sliding fee scale according to disability level and ability to pay.^v

Compared with the United States, nonprofit organizations play a much larger role in providing long-term care services in the four countries. The role of nonprofit organizations varies between nursing homes and home and community-based services.

Quality assurance for long-term care is a significant focus of the Labour Government in England. Regulation is a critical component of the government's "third way" approach, providing a way to influence the behavior of providers between the laissez-faire of unbridled markets and direct public ownership. England is probably most like the United States in its emphasis on regulation to police compliance with national standards, while allowing localities to impose additional quality standards. The regulatory agency, which is a quasi-governmental agency, is aggressively reforming the inspection process to make the system more client- and outcome-oriented. In addition, England has a conscious national strategy for regulating and improving the workforce and for disseminating best practices.

The Australian system for quality assurance relies heavily on consultation and collaboration between the industry and governmental and quasi-governmental officials. Inspections of residential care are carried out by a quasi-governmental agency, but approving providers to receive federal funds and enforcing quality standards remain fully governmental responsibilities. The Australian quality standards for institutional care are broad and non-specific to allow providers considerable latitude to demonstrate how they achieve quality goals. Quality assurance for home and community-based care is more decentralized and only recently implemented.

Germany's approach relies on sickness funds to negotiate quality standards during the bargaining process over contracts with providers. Sickness funds are nonprofit organizations heavily regulated by the government that administer the long-term care insurance program. These contracts articulate general expectations about provider quality as well as the structures and processes that providers should have in place to monitor and improve quality. In addition to negotiated standards used by the sickness funds, German states (Länder) also regulate nursing homes. Developing a consensus between providers and payers is important to this process, but consumers are not much involved.

Japan recently started a public long-term care insurance program, increasing its resources to improve the quality of services as opposed to simply policing providers. Although formal quality assurance mechanisms are now more prominent, the Japanese system relies heavily on training and certification to develop the skills of long-term care workers, on social networks and regular communications from the government and among providers to motivate and disseminate best practices, and on "care managers" to help clients and to ensure quality. In addition, new

competition among providers, especially among home and community-based services agencies, gives consumers a voice in quality assurance.

Table 2. Overview of Long-Term Care Quality Assurance Systems in England, Australia, Germany, Japan, and the United States

	England	Australia	Germany	Japan	United States
Rank order of countries by percentage of population age 65 or older (low to high)	3	2	4	5	1
Dominant long-term care financing system	Means-testing	Sliding scale	Social insurance	Social insurance	Means-testing
Extent to which quality is perceived as a problem	High	Low	Medium	Low	High for nursing homes, low for HCBS*
Overall approach	Regulation (undergoing reform)	Consultation and collaboration	Enforcement of contracts and consultation	Regulation, group processes and workforce training	Regulation (and consumer information)
National or subnational responsibility for quality assurance	National	National for institutions, shared national and state/territories for HCBS*	Sickness funds dominate, but Länder (states) license nursing homes	National standards for nursing homes, prefectures perform inspections	National standards for nursing homes and home health with state inspections; state standards and inspections for HCBS
Separation of quality assurance from payers	Yes	Yes for institutions, no for HCBS*	No	No	No requirement, but health departments, which inspect nursing homes and home health agencies, are typically separate from Medicaid
Use of private third-party evaluation	No	No	Voluntary accreditation used by small percentage of nursing homes	Third-party evaluation required for group home for dementia care	Voluntary accreditation used by small percentage of nursing homes and assisted living residences
Use of quasi-governmental agencies	Yes	Yes	No	No	No
Institutions					
Inspection frequency	Varies by quality, at least once every 3 years	Varies by quality, most once every 3 years	Varies by sickness funds, some not yet inspected	Annually, but on-site inspection only every other year	Annually
Detail of standards	Medium	Low	Varies	High	High
Use of strong enforcement, such as freezing admissions	Infrequent	Infrequent	Infrequent	Infrequent	Infrequent

	England	Australia	Germany	Japan	United States
Home care regulation	Recent, but same framework as institutions; consumer-directed care and assisted living excluded	Recent, but regular	Low priority for sickness funds	Almost nonexistent for home care, regulation for assisted living and Alzheimer's group homes	Varies by state, but much less than nursing homes
Alternative strategies to assure quality	Regulation of workforce, dissemination of best practices, inspection results on Internet	Education of providers, inspection results on Internet but not consumer friendly	Development of protocols, workforce training, demonstrations, no data on Internet	Care managers, workforce training and focus, some information on Internet	Inspection results and resident/patient quality indicators on Internet for nursing homes and home health agencies
Detailed health and functional data collected and used for quality indicators	No	Data collected for reimbursement of institutions but not used for quality indicators	No	No	Yes for nursing home residents and home health patients; limited data for HCBS* users

*HCBS = home and community-based services.

Long-Term Care Quality as a Policy Issue

The quality of long-term care services is perceived to be a problem in all four countries, although this view does not appear to have the same intensity that it has in the United States (with, perhaps, the exception of England).

- As in the United States, media attention about poor quality care is a major part of the political dynamic on this issue.
- The implementation of public long-term care insurance programs and the subsequent infusion of substantial new funding for long-term care in Germany and Japan has focused attention on the quality of care being purchased with public funds.
- Underlying causes of poor care are thought to include low reimbursement rates, lack of staff and inadequate training, and ageism and minimalist goals for long-term care.

In England, long-term care quality is widely viewed as a significant problem by major stakeholders, including government officials as well as provider and consumer groups. These problems are a major focus of print and television media, which regularly publish stories on inadequate care (e.g., Barclay, 2003; Lyon, 2003). In 2004, the House of Commons conducted hearings on abuse and neglect of older people receiving social care (House of Commons Health Committee, 2004). Studies have found improperly documented prescriptions (Osborne et al., 2003), unsafe administration of drugs (Batty, 2004), and the failure by care homes (nursing homes and certain other residential facilities) to meet the national quality standards (Dalley et al., 2004). Some observers believe that people with Alzheimer's disease, people who developed disabilities when younger, and people who need complex medical care often receive poor quality care. Although a majority of home care clients report being satisfied with their care, complaints

about worker unreliability and theft are common (Netten et al., 2004) and satisfaction levels appear to be lower than in the United States (Khatutsky, Anderson, and Wiener, 2006).

Although quality in Australia is generally perceived to be fairly good, the politics of quality of care play out in the national parliament in an episodic and contentious manner. The debate on quality of care at the national level often centers on incidents of poor quality of care in homes that have been approved as meeting the quality standards. These failures lead to claims by the opposition that the system is ineffective and that the government has failed to protect the wellbeing of vulnerable older people. The quasi-governmental inspection agency, however, argues that its quality assurance system uncovers most problems.

Officials in Germany are increasingly concerned about quality of care, given the large sums of money being spent on long-term care. However, Germany has no mechanism to routinely collect or provide systematic quality of care data to providers, policy makers, or consumers. The sickness funds have medical offices in each of the Länder (states), which conduct scheduled and complaint-generated reviews of nursing home and home care. This information is reported at the federal level in aggregate form only (Federal Medical Office of the Sickness Funds, 2004). Nursing homes, particularly the large ones, generally fare well in the structural aspects of care, but they often fall below standards when resident care is reviewed. In 2004 reviews of client care, 17 percent of residents received care that was considered to be below minimum standards. Higher rates of problems were found with nutrition and hydration, continence care, bedsores prevention, and care for people with dementia. Nine percent of nursing home residents had inappropriate restraints applied. In 9 percent of agency-provided home care cases, care was considered to be below minimum standards. Most institutional and home care agency problems appear to persist when reassessments occur.

Historically, Japanese public administration has not emphasized quality assurance in the delivery of public services, beyond ensuring compliance with basic legal, administrative, and financial rules. However, the quality of long-term care is a significant public policy issue because of concerns about frail older people. Traditionally, public attention has particularly focused on the poor conditions in many hospitals, which, up until passage of the public insurance program, provided the bulk of institutional long-term care to older people (Campbell and Ikegami, 1998). The use of restraints, which according to some specialists visiting from other countries was unusually common in Japan, was also a matter of concern. The Ministry of Health and Welfare declared restraints illegal at the start of the long-term care insurance program and launched an intensive “zero restraints” campaign. In contrast, home and community services appear to be well regarded by clients, families, and academic experts, despite some complaints about care managers and home helpers. Overall, apart from hospital-based care, long-term care seems to be viewed more positively by the general public in Japan than in the United States.

Overall Strategies for Assuring Long-Term Care Quality

As in the United States, the four countries in this study rely mostly on inspection of long-term care providers to assure quality. Australia, England, Germany, and Japan share responsibility for long-term care regulation among various levels of government and each nation focuses much more of its attention on institutional providers than those cared for in the home or in the community. Given the potential conflict of interest between the government’s desire to control

public costs and its obligation to improve quality, these four countries have adopted different strategies governing how these two functions interact.

Each country has a different philosophy of quality assurance, which is most pronounced in how it addresses institutional providers:

- England's system is characterized by a strong and quite adversarial regulatory approach, albeit one that is trying to make inspections more oriented toward outcomes, more focused on important issues, and more inclusive of users.
- Australia relies on a consultative relationship between providers and regulators. Education rather than directive regulation is a major focus of the government's activities. Regulations are, as a matter of principle, very broad and not specific.
- Germany relies heavily on the enforcement of contracts between providers and sickness funds as the principal strategy for quality assurance. These contracts cover broad categories of providers and are not individualized for specific providers.
- Japan places more emphasis on worker training and informal mechanisms to assure quality. Japan is also experimenting with third-party evaluation in addition to government regulation.

Until 2002, England regulated long-term care through approximately 230 local and regional health authorities. The Care Standards Act of 2000 transferred authority for quality assurance to the central government, which sponsors three semi-autonomous organizations to address quality issues in social care. Part of the goal in creating these three entities was to “long arm” the relationship between the payers and regulators, reducing potential conflicts of interest. The Commission for Social Care Inspection regulates a broad range of long-term care and other social service providers. Its primary activity is to inspect services against the National Minimum Standards. Regulation is perceived as central to the Labour Government's “third way” approach to achieving public objectives without direct public ownership. Despite this change, local authorities remain involved in quality assurance through their contracts with providers, and they often set their own quality standards. In addition, the Commission for Social Care Inspection does assessments of local authority social service departments, provides policy analysis and comments on social care issues, and works with other health and social care agencies. The General Social Care Commission regulates the social care workforce, and the Social Care Institute for Excellence disseminates information on best practices in social care.

In Australia, the Aged Care Act of 1997 established the quasi-governmental Aged Care Standards and Accreditation Agency to accredit residential long-term care facilities using a single set of care standards for nursing homes and hostels (similar to assisted living) and required the Department of Health and Ageing to certify compliance with separate standards for buildings. All operators of residential care services (nursing homes and hostels) must be approved providers under the Aged Care Act. Although Australians use the term “accreditation,” it has a very different meaning than in the United States and does not denote a private sector alternative to standard regulation. All agencies that deliver service packages as alternatives to residential care must meet accreditation standards. In contrast to facility-based care, agreement on national standards for home care is recent, and national standards for residential services for younger people with disabilities still do not exist. In general, consultation and collaboration

between the inspecting agency and providers characterizes the quality assurance system. The Aged Care Standards and Accreditation Agency also has an active program of provider education.

Germany's quality assurance system splits responsibility between providers and sickness funds, with the Länder (states) playing a residual role in regulation. The 2001 Long-Term Care Quality Assurance Law states that long-term care providers are responsible for quality outcomes and for operating quality assurance mechanisms. The law requires each provider to have a formal, internal system that focuses on continuous quality improvement. The sickness funds must ensure, through their contracts with providers, that beneficiaries have access to quality care. Sickness funds, however, are required to contract with all providers that meet the minimum requirements, thus limiting their leverage with providers. In setting quality standards, coalitions of sickness funds negotiate with coalitions of providers; consumers are not involved. Consensus among the negotiating parties is critical to the adoption and implementation of any initiatives. In addition to sickness fund oversight of home care agency and nursing home quality, the Länder license and certify nursing homes, providing some "double" regulation. Quality assurance is achieved largely through enforcement of sickness fund contracts rather than enforcement of regulations specific to each Land. At this point, the frequency of inspections varies greatly across sickness funds. Within Germany, third-party accreditation, practice protocols, and upgrading worker training requirements have received some attention.

In Japan, regulation of long-term care is shared by all three levels of government—national, prefectural (i.e., states), and municipal. The national government makes policy, including issuing detailed standards, and provides active oversight of local programs. Prefectural governments license providers and inspect institutions. Municipal governments are on the front line; they plan and administer health and welfare programs for older people, and they are the insurance carrier for the public long-term care insurance program. For nursing homes, inspections are rather formalistic and paperwork-oriented; formal ongoing regulation of home and community-based services is minimal. Informal processes are important in Japan, with government officials routinely exhorting providers to improve quality. Competition and consumer choice appear to play important roles in home and community services, although excess demand for nursing home care limits competition in that sector. Care managers are also important quality monitors on behalf of individual clients, although they do not have a formal role in the quality assurance system.

Inspections of Long-Term Care Providers

In all four countries, inspections of facilities and agencies are critical components of government approaches to assuring the quality of long-term care.

- Inspections of institutional care have the longest history; inspections of home and community services have begun recently and are a much lower priority.
- All of the countries inspect institutional providers much less frequently than in the United States, which partly reflects perceptions of the level of problems and partly is a concession to resources available.

- In all of the countries, the inspection standards and processes have received more attention than the enforcement mechanisms.

England

The National Minimum Standards, which are issued by the Department of Health, establish the basic expectations for providers of social and health care services. There are 38 standards for care homes (nursing homes and certain other residential facilities) for older people and 43 standards for care homes for adults age 18 to 65. There are 27 standards for domiciliary care agencies (i.e., home care) and 18 for nursing agencies. Consumer-directed care (known as “direct payments”) and assisted living facilities (known as “extra care facilities”) are not included in the regulatory framework. The National Minimum Standards address the following issues: privacy and dignity; service users’ choice and control over their own lives; how cultural, social, spiritual, and education needs are met; health and well-being; the quality of the physical environment; and protection from harm and abuse. The standards are like a code of practice. When the Commission for Social Care Inspection makes decisions about services (e.g., whether to grant or refuse registration), it must consider the standards, along with any other relevant factors.

Effective April 2006, a number of changes in the regulatory process were announced. The Commission for Social Care Inspection may now inspect any adult social care service at any time as long as every service is inspected at least once every three years (Commission for Social Care Inspection, 2006). Previously, regulations required two inspections a year, although more inspections could be done if there were complaints. The new system includes “key inspections,” which are detailed unannounced inspections; “random inspections,” which are short, targeted inspections; and “themed inspections,” which address specific issues, such as medication management. The Commission supports “lighter touch inspections” for the best quality providers as part of its effort to make the process more “proportionate” (Commission for Social Care Inspection, 2005). The Commission believes that this new policy will allow them to concentrate resources on poor quality facilities. Some consumer groups, such as Age Concern and Help the Aged, fear that reducing inspections will not provide enough oversight for providers whose quality of care might change for the worse.

The inspections usually last between one and five days, depending on the size and nature of the service and the issues that arise during the inspection. In care homes, inspectors are supposed to speak with residents. Inspectors also talk with key staff and check care plans, along with other relevant documents such as staff records, accident books, fire safety books, medication administration, health and safety logs, and the way in which service users’ finances are managed. Inspectors are also supposed to speak with domiciliary care clients, but the geographic dispersion of such clients makes that very difficult.

After the inspection, initial findings are discussed with the provider, who has an opportunity to respond to issues or concerns raised. The inspector will point out any regulations that are not being met and will also make recommendations; although not legally required, these suggested improvements enable the provider to meet best practices. Providers are given a short questionnaire to rate the inspection process. Care homes and domiciliary care agencies receive a draft report within 28 days of the inspection and have 28 days to respond, after which time the report is finalized.

When failure to meet the National Minimum Standards is serious, enforcement action is taken—for example, issuing a statutory notification requiring changes within a specified time frame or canceling the home's registration. Limiting admissions until corrections are made and levying fines are possible remedies, but these sanctions are rarely imposed. If a problem poses serious risks to clients, the Commission can obtain a court order to immediately close the agency or facility or take over its management. Certain actions, such as obstructing an inspector or providing false information, are criminal offenses. The goal, however, is to improve care rather than to close down providers.

In the view of the Commission for Social Care Inspection, the existing regulatory system is improving the quality of care homes and domiciliary care agencies. Even so, observers have a number of criticisms of the current system, many of which the Commission agrees with and is committed to addressing. These criticisms include the following: (1) the standards are too process-oriented and do not address outcomes; (2) the views of residents are not well integrated into the standard setting or inspection processes; (3) the standards are rigidly applied; and (4) the complaint system is ineffective because people are afraid that they will be treated poorly if they complain.

Australia

In Australia, residential care facilities (nursing homes and hostels) must meet two sets of standards—those related to the certification of the buildings and environment and the accreditation of care standards. The certification process is administered by the federal Department of Health and Ageing, and homes cannot charge residents a special capital replacement fee or receive federal payments for residents who cannot afford these charges unless they have certification. Certification does not mean that a home will automatically meet the accreditation standard covering physical environment and safe systems.

Accreditation is equivalent to a combination of licensing and certification of nursing facilities in the United States. A single quasi-governmental body, the Aged Care Standards and Accreditation Agency, Ltd., undertakes the process of accreditation. Unlike the Joint Commission on the Accreditation of Healthcare Organizations in the United States, the Aged Care Standards and Accreditation Agency was established as a government-owned company that reports to the minister responsible for aged care. Moreover, the head of the Agency is appointed by the government minister, not by the organization's board or members. Although the Agency inspects providers, it is the government that decides whether to accredit them. In addition, the government, not the Agency, is responsible for all enforcement actions associated with accreditation. Although the Aged Care Standards and Accreditation Agency receives government grants, the major part of its funding comes from fees paid by providers, but these fees are set by the government. Public facilities (less than 10 percent of all facilities) are subject to state as well as national regulation. Local governments do not have a role in regulating long-term care quality.

The accreditation standards address management systems; staffing and organizational development; health and personal care; resident lifestyle; and physical environment and safety systems. Each of the four standards includes a statement of a principle, the intention of the standard, a set of indicators, and expected outcomes. In total, there are 44 indicators and associated expected outcomes. The standards are general statements; they do not provide a checklist, and they do not tell providers how to meet expected outcomes. Moreover, the standards are not measurement tools, but rather each standard provides a framework around

which the accreditation agency builds evidence to determine whether a home is complying. Considerable flexibility is used to apply the standards, and not all providers respond to the standards in the same way. An accreditation guide for providers and a handbook for assessors provide advice on expected performance and opportunities, which providers can use to demonstrate that they have achieved specific outcomes.

The standards call attention to the special needs of different populations, including people with dementia and other cognitive impairments, people from linguistically diverse backgrounds, indigenous Australians, and people living in remote areas. For example, under the health and personal care standard, identification and effective management of memory loss and challenging behavior are specifically mentioned. The resident lifestyle standard includes an indicator that calls for the individual's interests, customs, beliefs, and cultural and ethnic backgrounds to be valued and fostered. The same standards apply to all homes. Separate standards for homes that provide care for special needs groups have not been issued, in part, because most members of these special populations reside in "mainstream" homes.

The accreditation standards do not set ratios for nursing staff to residents. As with the regulations for Medicare and Medicaid in the United States, the standard for human resource management requires sufficient skilled and qualified staff to ensure that services are delivered in accordance with both the standards and the residential care service's philosophy and objectives. The standard for regulatory compliance requires staffing to be in accordance with legislation and regulation of nursing practice, particularly in relation to medication management and technical nursing procedures.

The standards raise a number of issues. First, some observers question whether it is appropriate to have the same quality assurance system for the whole range of dependencies found among residents, from relatively independent residents in hostels to completely dependent residents who need a high level of skilled nursing care in nursing homes. A related question is whether the current system detects variations in quality of care for residents with dementia as well as it does for cognitively intact residents. Second, the lack of specificity in the standards used in the Australian accreditation system leaves them open to provider interpretation to determine how they have addressed the standards as well as to assessor interpretation to establish whether the standards have been met. Third, the broadness of the standards also makes it difficult to develop quantitative measures of quality.

Nonetheless, the consensus opinion in Australia is that these broad standards are better than more specific standards because they allow inspectors and providers to focus on the broad issues rather than to get bogged down in less important details. Moreover, the general nature of the standards forces assessors to engage in a dialogue with providers and users to establish whether and how the expected outcomes have been achieved. In the course of this dialogue, all parties must be assured that all relevant information has been presented and any differences in views about compliance must be resolved.

The accreditation process for quality of care occurs in three steps. First, the home completes a self-assessment about how it is meeting the standards and submits the assessment to the accreditation agency. Second, quality assessors conduct a desk audit of the self-assessment information and then conduct an on-site assessment. During this audit, the assessors review documentation; speak with residents, relatives, staff, and other relevant professionals (such as doctors or pharmacists); and observe the environment and practices of the home. The assessors

may provide verbal advice to the home. Third, a staff member from the Agency outside the audit team decides whether the facility should be accredited and for how long. No numeric score is officially used to determine whether a home will be accredited, but meeting 40 of the 44 standards is an informal benchmark.

One issue surrounding this inspection system is that facilities receive warning of on-site assessments, although unannounced spot checks may be used at facilities with a history of noncompliance or against whom a serious complaint has been filed or when a change of ownership occurs. In 2003–04, only 14 percent of all follow-up visits were unannounced spot checks (Aged Care Standards and Accreditation Agency, Ltd., 2004). Another issue is that the assessors are said to focus too much on documentation at the expense of examining outcomes of care.

The accreditation agency may grant full accreditation for three years or for a shorter period if not all standards are met. The vast majority of homes, 94 percent in 2002–03 and 90 percent in 2003–04, were given three years' accreditation (Hogan, 2004). To be accredited for three years, homes must have no history of noncompliance, must have met most or all of the standards, and must satisfactorily demonstrate evidence of undertaking continuous improvement.

The Department of Health and Ageing carries out the enforcement functions. Two levels of action are available: (1) existing accreditation can be revoked or shortened in length; and (2) sanctions can be imposed that include suspension of admissions or closure of the home. Very few homes have been forced to close, and the aim of the accreditation process is to minimize the risk of having to impose sanctions. Fines are not part of the enforcement system in Australia and have not been seriously discussed as an option.

Government-funded home and community care providers must meet standards, and their clients are asked questions about quality. Inspections of home and community services have been instituted only recently. Providers are subject to meeting 27 standards, with each standard stated as an expected consumer outcome. The standards and the instrument used are designed to assess the quality of services against the national standards and to provide a nationally consistent methodology. States and territories implement the instrument by conducting a joint assessment with the provider or by verifying the outcome of a provider's self assessment. Australia also relies on consumer surveys to help assure the quality of home and community care. A mailed survey is used for most consumers. However, face-to-face interviews or focus groups are often used with non-English speaking clients and indigenous clients. All methods seek information in three areas: (1) consumers' experience of service provision, (2) respect for clients' rights and receipt of information about them, and (3) satisfaction with services. No comprehensive data are available on the extent to which these services meet the national standards.

Germany

The German system relies on enforcement of contractual provisions between payers and providers of nursing home and home care services to ensure quality. The 2001 Long-Term Care Quality Assurance Law introduced the concept of quality contracts between sickness funds and providers. The federal standards that govern the quality contracts are relatively general because details are determined by negotiations between the sickness funds and providers. Sickness funds have separate service and quality contracts so they can review providers' quality when negotiating rates, which creates an opportunity to incorporate quality measures into rate

negotiations in a more systematic fashion than was previously possible. Every two years, providers must demonstrate to sickness funds that they have quality assurance mechanisms in place and that they have delivered services in accordance with the service and quality contracts. Implementation of these “proofs” of services and quality assurance mechanisms has been slow.

The 2001 quality law also made a range of sanctions available to sickness funds when quality problems are discovered, such as temporary reductions in payment rates, refunds of payment, and temporary bans on client admissions. However, experts say that these sanctions are rarely imposed.

Another part of the 2001 law clarifies that the medical offices of the sickness funds have the authority to conduct inspections, which may be unannounced and may occur at night. The federally designed inspection instruments, which medical offices use, address structure, process, and outcome measures of quality. The medical offices portray their roles as consultative, viewing the role of external quality inspection as limited to a supportive function that points providers toward areas of potential improvement. The intensity of the medical office review effort varies considerably. In some Länder, inspections are conducted only as the result of consumer complaints, so provider inspection rates are low. In other Länder, inspections are conducted on a regular basis as well as in response to complaints.

One concern about these quality instruments is that no public data are available on their validity or reliability. Common data reporting is not required for these inspections. At best, the German federal medical office consolidates assessment data from medical offices and prepares ad hoc summaries. Data on individual providers are not publicly available.

In addition to sickness fund quality assurance, nursing homes may be licensed by the Länder. This licensing involves annual, onsite inspections. Some experts and industry representatives consider the “double” oversight by sickness fund medical offices and local nursing home authorities to be redundant. In response to provider complaints, Länder, municipalities, and sickness funds have increased their cooperation in monitoring nursing homes. In 2003, 46 percent of sickness fund medical office reviews were conducted jointly with representatives of Land nursing home authorities (Federal Medical Office of the Sickness Funds, 2004).

Quality assurance in institutional settings is considered a higher priority than quality assurance in home and community settings (Federal Medical Office of the Sickness Funds, 2004). Although sickness funds help assure quality for home care agencies through contractual requirements, the Länder and local governments do not oversee these providers directly. Sickness funds may cut payments or exclude agencies entirely if services are not delivered as agreed or if quality problems are detected, but these remedies are seldom used.

Special provisions exist for long-term care insurance beneficiaries who choose cash benefits. Everyone selecting cash receives semiannual “control” visits from an agency provider to confirm that beneficiaries are receiving care. The format of these control visits has been agreed on by the major sickness funds and provider associations. Because caregivers are almost always family members, however, enforcement actions are rarely taken (Wiener, Tilly, and Cuellar, 2003).

Japan

In general, nursing homes are attentive to guidance from the national Ministry of Health, Labor, and Welfare. The national government issues highly detailed structural requirements for facilities and staffing for nursing homes, which vary by the number of beds. These requirements include a minimum number of direct care (nurses and nurse aides) and support staff, a minimum amount of space per bed in rooms, and required equipment. Beyond that, a new or rebuilt nursing home must meet more detailed and rigorous specifications for construction.

Inspections of institutions are carried out by prefectural governments (sometimes accompanied by municipal officials). In principle, inspections are annual; however, in practice, this requirement is met in alternate years by submission of documentation rather than in-person inspections unless serious problems are identified. The inspections concentrate on the physical plant, staffing levels, financial management, and accuracy of reports. The only sanction employed is a reduction in payments from the long-term care insurance program of up to 30 percent for periods of inadequate staffing, although, in principle, the license can be revoked.

The fastest growing provider groups are residential care facilities, which resemble assisted living facilities in the United States. One type of residential care facility—Alzheimer’s Group Homes—usually serves five to nine people with dementia in private rooms. Long-term care insurance expanded the government’s role because the facilities must be licensed to receive reimbursement for coverage of the “care” portion of their services. Licensing involves an initial approval process and a degree of continued oversight, but regulation of staffing, required equipment, space, and other factors are not as strict as for institutions.

The government has devised several special methods of assuring quality for the Alzheimer’s Group Homes. First, special guidelines encourage interaction among families of residents, the community, and local networks of providers, and training for staff and owners. Second, the government helped create a trade association of Alzheimer’s Group Home operators and pushed it to work on quality issues, funding, materials on good practice, and self-evaluation. Third, in 2002, the government mandated that all group homes undergo an outside assessment of quality of care by qualified local evaluators, making them the only type of facility for which nongovernment evaluation is mandatory. However, prefectural or municipal officials do not appear to pay much attention to these third-party evaluations.

Initially, prefectures were given the added responsibility for licensing home care agencies, but this role is being transferred to municipalities. Home care agencies must file an application showing that they meet minimal standards of qualified staff and financial stability. No systematic procedures exist for renewing or revoking licenses, although such provisions are under discussion. As a result, providers need not worry much about quality enforcement unless a complaint is filed.

Alternative Approaches to Quality Assurance

In addition to inspections and enforcement, the four countries in this study use a variety of alternative approaches to quality assurance. To varying degrees, government policies promote training and regulation of direct care workers, education of providers, increased consumer

information, dissemination of “best” or “promising” practices, competition, and private accreditation or evaluation.

- England has the most conscious strategy of using alternative approaches to quality assurance, with relatively new organizations focusing on the workforce and disseminating best practices. Although lacking quantitative measures, England’s Commission for Social Care Inspection posts nontechnical inspection reports on its Web site.
- Consistent with its consultative philosophy, Australia focuses on educating providers.
- Germany has focused on improving the workforce, developing care protocols, and funding a variety of demonstration programs, including new models of dementia care and case management.
- With the implementation of the Japanese social insurance program, providers began to compete for consumers, although waiting lists for nursing home care have limited the quality impact. A substantial amount of attention has focused on improving the workforce. Japan is experimenting with private accreditation in addition to government-sponsored inspections, although these evaluations do not appear to have had much impact.

England

The Labour Government’s quality assurance strategy addresses the workforce, dissemination of best practices, and consumer information. The General Social Care Council was established in 2002 to regulate and promote the social care workforce. The Council employs a three-pronged approach to improving the workforce. First, it established “codes of practice,” setting out the proper conduct and practice for all social care workers and their employers. Second, in 2003, the Council began a system of registration for social care workers, who must meet certain qualifications and competence standards, pass a criminal records check, and undergo a review of their employment record. The Council is also responsible for disciplining social care workers, when necessary. To upgrade the skills of direct care workers, the Care Standards Act set a target that half of the workers in each agency and facility would meet the National Vocational Qualification-2 standards, which is a general rating of occupational competency. Given the large number of direct care workers and the substantial turnover rate, this goal was thought to be reachable. Third, the Council approves courses in social work training and monitors their quality. To improve the training of social workers, the government is funding a new three-year social work degree.

The Care Standards Act of 2000 also established a Protection of Vulnerable Adults list, which compiles the names of people judged to be unsuitable to work in the care sector (Ladyman, 2004). Although the situation appears to be improving, employers and users of Direct Payments (consumer-directed payments) have complained about the high cost and bureaucratic delays of conducting a Criminal Records Bureau check. Some observers criticize the Protection of Vulnerable Adults list as casting too broad a net, one that includes people against whom problems are alleged but not proven. Individuals can appeal their placement on the list, but they bear the burden of proof as to why they should be removed.

The Social Care Institute for Excellence was established to raise the standard of social care services, improve consistency in delivery across the social care sector, and promote the adoption of best practices. The premise of the Institute is that many good practices exist, but most providers are not aware of them. The Institute has three main activities: commissioning literature reviews; conducting surveys to determine what providers and users think is best practice; and translating information and research into protocols, guides, and other tools for practice. The Institute disseminates this and other information, largely through the electronic library on its Web site.

The government also posts inspection reports for both care homes and home care agencies (along with many other services) on its Web site. The reports are about 20 pages long, are written in nontechnical language, and include a two-page summary of findings. The reports are impressionistic and do not generally include quantitative measures as evidence, although individual standards receive a rating between one and four (but not an overall rating). In 2006, the Commission for Social Care Inspection announced that it would issue overall ratings in the future.

Australia

With the exception of educating providers and consumers, Australia has not pursued alternative strategies of quality assurance. The accreditation agency's educational activities and materials include events promoting better practice, publications relevant to accreditation such as pocket guides to standards, education packages on documentation and measurement, and presentations on continuous quality improvement presentations for use with facility staff. The dual role of monitor and educator is considered problematic and has had a mixed reaction from the industry. Some providers are reluctant to engage in Aged Care Standards and Accreditation Agency-sponsored education, fearing that it will have regulatory consequences. The Agency contends that the critics of its better practice events are industry bodies that provide education programs that compete with those provided by the Agency.

Other organizations have initiatives designed to promote quality care. Typical of the general activities are the annual conferences held by industry bodies and professional associations. Newsletters and awards schemes run by these industry bodies also raise quality of care awareness by disseminating and acknowledging best practices.

The Aged Care Standards and Accreditation Agency operates a consumer education program, which includes a magazine for residents of aged care homes and seminars for residents, relatives, and the general community. The Agency produces brochures that inform residents of their rights and the quality of care they should expect to receive. These brochures are distributed to all residents in aged care homes. The Agency also reaches prospective residents and their informal caregivers through advertising in a popular listing of aged care facilities that is distributed free of charge.

The Aged Care Standards and Accreditation Agency provides quality of care information to consumers primarily by making the accreditation reports on facilities publicly available. These reports are lengthy and written in formal and, at times, technical language. Thus, they do not provide user-friendly information to consumers.

Germany

Germany is pursuing strategies to assure quality in home care agencies and nursing homes, which include private accreditation, worker training, practice protocols, and a modest number of demonstration programs, a third of which focus on dementia care. Privately sponsored accreditation efforts reportedly have increased among some provider associations. However, accreditation is not common; data from medical office quality inspections show that only 5 percent of the nursing homes and 4 percent of home care agencies were accredited in 2003 (Federal Medical Office of the Sickness Funds, 2004). Many experts do not consider accreditation effective because the standards and the sophistication of the monitoring agencies vary, making comparisons across providers difficult. In addition, many of the accreditation standards are generic and not specific to long-term care. Furthermore, few of the standards are thought to be rigorous and evidence-based. Others, mainly providers, argue that accreditation should substitute for routine reviews by the medical office of the sickness funds.

A 2000 education reform law, implemented in 2003, created uniform national standards for elder care workers, including geriatric nurses and home care aides. The law requires three years of training for elder care workers, making it closely resemble training for nurses. In addition, several universities have developed voluntary management training programs for long-term care. The worker training law received considerable support as a way to raise the status of the elder care profession over the long run. However, some observers argued that the evidence-based science in long-term caregiving is lacking, implying that training may not be effective without such evidence (Roth, 2004).

Because the medical offices have detected problematic patterns for client outcomes, they have developed best practice protocols. The federal medical office of the sickness funds works with other experts to develop care standards through a consensus process. The standards include suggestions to providers and are meant to be educational and consultative. Once consensus is reached, a standard becomes the focal point of an education and publicity campaign. The medical office then announces that care in this area will be the special focus in upcoming inspections. Other institutions and expert groups have developed best practices and guidelines, some with federal funding.

Implementation of these protocols faces numerous barriers. Although several standards have been completed, many providers and their industry associations are not aware of these efforts, and the dissemination campaigns are considered to be time consuming and expensive. Länder and municipalities seldom assist in the dissemination efforts. In addition, many providers believe that the standards are difficult to implement in practice because of staff and management training levels. Although some experts felt a need for uniform standards of care, others disagreed and were comfortable having protocols developed by multiple sources. Still others lamented the variation in scientific rigor across protocols (Roth, 2004).

Consumers do not receive, nor have consumer groups systematically voiced much interest in, comparative quality information about providers. Local consumer offices supported by the government address a number of consumer issues; some of these offices have developed expertise in long-term care.

The federal government also fosters experimentation in care delivery and quality assurance. The 2001 legislation specifically authorized systematic research and demonstration initiatives. These

efforts involve research networks of universities and providers—for example, testing a program that combines cash benefits with case management or developing care models for people with dementia. Other federally funded efforts are more modest. The government has funded roughly 600 local model programs since 1991, which range from promoting particular facility types to developing continuing education programs. A third of the model programs have been specifically targeted to dementia care.

Japan

In addition to regulation, Japan is pursuing a number of alternative strategies to improve quality of care, including competition among providers, private accreditation (third-party evaluation) and certification, and workforce training. Prior to the introduction of the public long-term care insurance program, providers were heavily dependent on referrals by the municipal government. In theory, *Kaigo Hoken*, the Japanese social insurance program for long-term care, fundamentally changed these arrangements by giving service choices to the consumer and requiring providers to compete on quality. Some observers, however, question whether the situation has changed all that much. First, providers continue to be embedded in fairly dense, formal and informal networks of government officials, which limit their autonomy. Second, increased demand for nursing home care as a result of public insurance has resulted in a shortage of beds and long waiting lists. As a result, facilities do not have to compete to fill their beds. Competition is reportedly much more common among home care agencies.

The national government recommends but does not require third-party evaluations of long-term care providers (with the exception of Alzheimer's Group Homes), and prefectures vary in how much they encourage them. The business of third-party evaluation is quite competitive on the basis of price and convenience because of the large number of approved evaluators. In Tokyo and many other prefectures, the results of the evaluations are posted on the Internet to help consumers choose providers. However, local officials do not use the reports, relying instead on formal inspections and complaints. The main value of the process may lie in what providers learn from the evaluation. In the future, the government plans to develop a system of third-party evaluations of long-term care agencies and facilities, with a regular schedule for posting the results on the Internet in standardized form.

The government has promoted improvements in the long-term care workforce. It created two new officially recognized job categories: Certified Social Welfare Specialist and Certified Care Worker. The first designation is roughly equivalent to a social worker in the United States. The second designation, however, has been attractive to people in the field as a marker for expertise in caregiving. As in many other fields in Japan, official certification is attained by passing a government examination or by graduating from a prescribed training program. To take the care worker exam, one must have either three years' experience in a caregiving job (usually a home helper or a nurse's aide in an institution) or a high school degree with a welfare major. A lower-level certification system is used to qualify workers as a Home Helper First or Second Grade and uses a combination of experience and training. Such efforts have been one factor in a substantial improvement in the visibility and image of caregiving as a profession.

The profession of care manager was created to fill the role that municipal officials held under the old system—deciding on services and monitoring care. Long-term care insurance enrollees can manage their own care if they want, but the services of a care manager are free and the vast majority of beneficiaries use them. The cost of the care manager does not count against the

disability-determined expenditure ceiling for services. Individuals can choose their own care managers. The care manager is supposed to represent the interests of the client, but he or she usually is employed by a provider. All institutional care providers must employ at least one qualified care manager, and many community care providers are dually registered as care manager agencies.

Given the need for a great many care managers and the shortage of social workers, training and expertise requirements are modest—five years' experience in a related field, passage of an exam, and roughly four days of training. The qualifying exam is extremely popular, with more than 337,000 persons passing it by the end of 2004. However, care managers generally see themselves as underpaid and overworked. A recent government review argued that care management needs systematic reform to improve quality, including reduced case loads, more mandatory training, and stricter standards for recertification as well as greater enforcement of these standards.

Comparative Analyses of Similarities and Differences

This research examined the quality assurance systems in four developed countries—England, Australia, Germany, and Japan—as a way of identifying alternative approaches for improving the quality of long-term care. As described above, the approaches taken in the four countries represent a range of financing and delivery systems and use a variety of strategies to assure the quality of institutional and home and community services. The four countries have both similarities and differences in their approaches that can offer a number of possible ideas to strengthen quality assurance in the United States. In addition, the four countries may consider adopting aspects of the system used in the United States, because the United States uses a number of quality assurance mechanisms that they do not.

Country Similarities

The four countries in this study and the United States have a number of similarities in their quality assurance systems. First, quality assurance for long-term care is on the political agenda in all of the countries, in part because of the substantial public funds allocated to these services and the heavy reliance of long-term care providers on public funding. Germany and Japan, in particular, have made financing changes that substantially increased public funding for long-term care, raising a fiduciary responsibility on the part of the government to ensure that the funds are well spent. In addition, newspapers, television, and other media periodically run stories about poor quality of care in long-term care in all of the countries studied, which motivates government action, albeit sporadically. As the populations in these countries age, the public policy focus on long-term care in general and on quality of care in particular will likely increase. Poor quality in long-term care is commonly attributed to low government reimbursement rates, inadequacies of the workforce, and ageism.

Second, the four study countries and the United States all rely, at least in part, on inspection and regulation of long-term care providers to assure quality. Although subnational government entities play a role in all of the countries, quality assurance is predominantly a national government responsibility. Reflecting funding limitations, the greater difficulty with monitoring quality in home and community settings, and perhaps the greater vulnerability of people in institutions, all four countries and the United States devote far greater resources to monitoring nursing homes and other institutional providers than they devote to home care and other

community services. Indeed, in Australia and England the regulation of home and community services is very new; in Japan and Germany, it hardly exists at all. Where consumer-directed home care exists, it is outside the regulatory framework (in England) or subject to fairly minimal oversight (Germany). Given the variation in nomenclature, it is difficult to assess how quality issues in assisted living facilities are addressed. Assisted living appears to be included in the general regulation in Australia (i.e., hostels). But such facilities are excluded from regulation in England (i.e., extra care facilities, although many care homes serve people with relatively minimal disabilities) and in Germany. In Japan, however, these facilities are subject to special regulation if they serve people with Alzheimer's disease (i.e., Alzheimer's Group Homes). All of the countries are planning greater oversight of home and community services.

Strikingly, although the frequency of inspections generally seems to be increasing, all of the countries inspect nursing homes and other providers far less frequently than does the United States. Although England previously had a more frequent inspection schedule than the United States, it recently changed to a system that allows up to three years between inspections for high quality facilities. Australia has a system that links the inspection cycle to facility performance during the survey; the vast majority of facilities, however, are inspected only once every three years. Inspection frequency in Germany varies by sickness fund, and some facilities have never been inspected under the new system. Japan does an in-person inspection only once every other year, although documentation must be submitted annually. In contrast, nursing homes in the United States must be inspected annually (technically, every nursing home must be surveyed no less frequently than every 15 months, and the statewide average interval for these surveys must not exceed 12 months). In general, neither the four countries nor the United States make much use of the relatively limited range of enforcement mechanisms available to regulators.

All four countries and the United States are working to reform their inspection systems. Critics of the existing systems argue that the current inspection processes are too structure- and process-oriented, not focused enough on outcomes, subject to variation in application across surveyors, and inadequately reflective of consumer experience. Although England, Germany, and Japan are moving in the direction of making their regulations more specific, Australia's standards are deliberately very broad and general. The consensus opinion in Australia is that general standards allow facilities greater flexibility to determine how they meet the standards, allowing greater focus on the more important goals.

Third, all of the countries rely, at least to some extent, on strategies other than direct inspection of facilities and agencies to improve quality of care. Many of these initiatives involve registering, regulating, and training the long-term care workforce. For example, England is requiring that half of its direct care workers meet the requirements of the National Vocational Qualification-2 (NVQ-2), which is a level in the national competency assessment system. Care protocols and best practices are created and disseminated in all of the countries, but they are particularly prevalent in England, Australia, and Germany. England, Australia, Japan, and the United States provide consumers with information about the quality of individual long-term care providers and post it on the Internet. With the exception of England and the United States, however, these reports are often long, technical, and not user-friendly, limiting their usefulness to consumers. Competition among providers plays a role in quality assurance, but it is a conscious strategy in the Japanese home care market, in which services expanded greatly after the introduction of the social insurance program for long-term care, and in England, which has seen the transformation of long-term care from a heavily publicly operated system to one dominated by private, for-profit organizations.

Some quality assurance mechanisms that exist in the United States are absent in the other four countries. First, the other countries do not collect anywhere near as much resident- and patient-specific functional and health data as does the United States. The data are collected through assessment instruments for nursing home residents and for home health agency clients whose services are publicly funded. Only the United States produces quantitative quality indicators and makes them widely available to the consumer. Second, a “culture change” movement is not evident in any of the four countries, and there is a lack of knowledge about such initiatives as Green House Nursing Homes or the Eden Alternative in the United States that seek to improve quality by changing the organizational culture of nursing homes. Third, only in the United States does an ombudsman program exist to provide a mechanism to receive and investigate complaints outside of the regulatory system and to advocate for quality improvement. Fourth, linking reimbursement to quality of care is not being discussed in any of the countries as seriously as it is in the United States, nor is it part of the debate about “pay for performance.”

Country Differences

Despite some similarities across the countries, major differences exist among the four study countries and the United States in how they assure the quality of long-term care. First, the underlying philosophies of quality assurance vary across the countries, which affects how each country structures its standards, inspections, and enforcement. The United States has the most adversarial system, relying on enforcement of regulatory standards. In England, regulation of the private sector is a key part of the Labour Government’s “third way” approach to addressing social problems without resorting to either public ownership or an unfettered free market. Although government officials admit that they have a long way to go, regulation is the primary tool being used to transform providers to make them more outcome- and user-oriented. Australia has a much more collaborative and consultative approach to quality assurance, with relationships between providers and regulators being far more cordial than in the United States or the other countries. Germany’s approach relies heavily on the enforcement of contracts between the sickness funds and providers to ensure quality of care. This approach is different from other countries that approach quality assurance mostly through licensure, which limits what can be demanded of facilities to established minimum standards. In contracts, payers theoretically can set high standards if they choose, although in Germany it is hard for sickness funds to selectively contract with only high quality providers. In Japan, inspections are strongly focused on structure and process rather than outcomes, with much of the focus being placed on maintaining staffing levels and a high quality workforce.

Second, the countries involved in this study vary in how they finance long-term care services. Over the past decade, Germany and Japan have implemented social insurance programs that provide near-universal coverage to older people with disabilities. England and the United States provide public funding on a means-tested basis, so that only the poor or people who have become poor because of the high cost of long-term care receive public subsidies. Australia’s system is somewhat in between—offering universal eligibility for services but a sliding scale of payments according to ability to pay. The implementation of social insurance has increased consumer choices, including in Germany where consumers can choose between cash benefits and agency-provided services for home care. In Japan, the implementation of social insurance has been a factor in the rapid expansion of home and community-based services.

Third, countries vary in how strongly they separate payers from quality regulators as a way to avoid potential conflicts of interest between those two functions. It is widely believed that giving payers too strong a hand in decisions about quality will have adverse consequences because of the trade-off between quality and cost. In England and Australia, the organizational structure puts some distance between these two functions. In England, responsibility for quality assurance for social care was recently transferred from local authorities, who are the principal payers, to the central government—and within the central government, to a quasi-governmental commission, the Commission for Social Care Inspection. In Australia, quality assurance for institutional care is the responsibility of a quasi-governmental agency at the federal level, the Aged Care Standards and Accreditation Agency. In Japan and Germany, however, financing and quality assurance are located within the same agencies. In the United States, states differ in the degree to which they separate the financing and inspection functions by placing them in separate agencies.

Fourth, interest in accreditation and private evaluations of quality appears to be increasing somewhat in Germany, Japan, and the United States, where such measures are used in addition to, rather than as substitution for, government regulation. Indeed, Japan requires that Alzheimer's Group Homes obtain third-party evaluations, and the results of these evaluations are posted on the Internet (although, reportedly, not much used by government officials for quality assurance). Although widely discussed in Germany, few nursing homes obtain private accreditation. The German and Japanese governments promote accreditation as a way to further focus facilities on quality of care. Private accreditation remains a voluntary approach in the United States with low rates of use.

Fifth, Japan is the only country to have developed special approaches on a nationwide basis to assure quality of care in facilities for people with dementia. The fact that people with Alzheimer's disease usually cannot advocate for themselves and that many providers have limited professional staffing makes quality assurance measures essential. Japan has developed special guidelines for these homes, funded a trade association that focuses on quality issues, and mandated third-party evaluations in addition to government regulation. About 30 states in the United States regulate special care units for people with dementia in nursing homes, primarily by requiring those homes to disclose the special services they offer to consumers. Forty-four states have specific regulatory provisions for assisted living or residential care facilities serving people with dementia (Mollica and Johnson-Lamarche, 2005). Few states have special licensure requirements for these homes.

Conclusions: Implications for the United States and Other Countries

Without systematic cross-country quantitative data, it is impossible to objectively assess differences in quality of care and make judgments about which quality assurance system is best or which aspect of quality assurance is most effective in improving the care received by older people with disabilities. In this respect, the United States has taken more steps to increase data collection on health and long-term care quality than any other country. International efforts are underway to extend and standardize data collection on health and functional outcomes for the beneficiaries of long-term care services (see www.interRAI.org), achieved largely by building on the pioneering work done in the United States. But efforts to measure quality outcomes are in an early stage and do not yet provide a sound basis for making judgments about the relative merits of one country's approach to quality assurance compared with another. In the absence of such

comparative outcomes data, the following issues in the four study countries have implications for policies under discussion in the United States and other countries.

Public versus Private Financing of Long-Term Care

In the United States and England, funding of most long-term care services is seen as a private responsibility, with means-tested welfare programs serving as a safety net for those who cannot afford services. In the United States, some observers view privately funded options like assisted living as providing a better quality of life for residents than the largely publicly funded nursing homes. Assisted living providers in the United States sometimes resist more public funding for long-term care services out of the fear that reliance on public funds would bring additional regulation but without adequate funding levels to provide quality services.

In Germany and Japan, however, the recent increase in public funding for long-term care through social insurance programs has been associated with increased use of services, consumer choice, and quality improvements. At least for home care, increased public funding for services has been associated with some increase in competition among providers. Understanding the ways in which public and private funding can best promote quality services, along with increased consumer choice and control, is one area in which these countries might fruitfully learn from one another.

The Role of Inspection and Regulation

For nursing homes, at least, U.S. regulatory standards appear to be more detailed than standards in the other countries and address many specific minimum standards. The United States monitors facilities far more frequently than the other countries (with the possible exception of England) and has a broader array of enforcement mechanisms. But quality problems persist in the United States, and many providers do not feel that the improvements achieved are commensurate with the level of effort and cost imposed by the regulatory system. To some extent, this feeling may be due to the fact that the United States—through its long-term care ombudsman program, data collection and reporting systems, and other programs—may have a better method of finding and reporting problems than do the other countries. However, a recent General Accountability Office (2005) study found that state nursing home inspectors tended to underreport serious problems.

In every country in this study and the United States, providers complain about the time and expense involved in regulation as well as the paperwork nature of many of the requirements that seem unrelated to quality outcomes. Some of these complaints may be dismissed as the natural reluctance to accept additional work requirements and to regulation in general. But some approaches used by the countries in this study may warrant further examination if better ways can be found to assure the protection of residents. For example, Australia's experience in using fewer and more general standards may focus more on the big picture rather than immerse regulators and providers in details that are not relevant to quality of care. England's recent move away from yearly inspections for all providers to a system that pegs the frequency of inspections to provider performance may provide a way to more effectively focus monitoring efforts on poorly performing providers and on specific areas of poor performance. A key issue is how to identify problems in the interim period if performance deteriorates.

Basic Philosophy: Adversarial versus Collaborative Approaches

Although it varies across states, the United States has the most adversarial approach to quality assurance for nursing homes; that is, the emphasis of the quality assurance system is the enforcement of regulations through penalties for noncompliance (U.S. Department of Health and Human Services, Office of the Inspector General, 2003). In sharp contrast, the Australian system emphasizes a more collaborative approach in which the regulating agency serves more as a consultant and coach to encourage better performance than as an enforcer. Although penalties can be imposed for consistently poor performance, they are rarely used. Instead, the Australian system builds in some recognition for top performers.

Critics of the adversarial system argue that it cultivates a “gotcha” mentality in which inspectors go out of their way to find areas of noncompliance, even when the quality of care is not affected. In their view, high quality is not noted or rewarded. Critics of a consultation approach argue that it encourages too close a relationship between the provider and the regulator so that quality problems may be ignored. Creating ways to encourage and reward high performance, as well as ways to penalize poor performance that endangers consumers, is an area that is likely to receive more attention in all countries as they seek to improve their quality assurance systems.

Supplements to Regulation

Countries are looking for ways to supplement regulation by providing more information to consumers, increasing staff training, funding demonstration projects, and disseminating promising practices. All of the countries except for Germany place at least some quality information about individual providers on the Internet, although there is great variation in how consumer-friendly the information is. Staffing was recognized as a problem in all countries featured in this report as well as in the United States. In general, governments in the study countries play a more active role in providing training or ensuring that workers are trained. England, in particular, seems to have a more systematic approach to recruiting, retaining, and training the long-term care workforce than does the United States. Wages and benefits are generally lower in the United States, and staff turnover rates are much higher. Germany and England have developed practice protocols and funded demonstrations to improve quality. While there is interest in private accreditation to supplement regulation in Germany and Japan, its role in quality assurance is limited.

Changing Systems, Changing Issues

The long-term care systems in all four of the countries featured in this report have been undergoing major systemic changes. All have taken steps to encourage more consumer choice and more home and community-based services. But these goals are accomplished in very different ways. For example, Germany’s cash benefit option has generally been used to support family caregiving and relies on the commitment of families rather than regulatory oversight to assure quality care. Japan’s exclusive financing of agency-provided services was specifically designed to liberate women from the burdens of family caregiving and relies heavily on training to assure quality.

In addition, policy decisions about one type of long-term service have implications for other types of services as well. Providing more home and community services means that people with higher levels of disability are living in communities, which may improve the quality of their lives

but also creates new challenges in assuring quality services. Enabling people with disabilities to live in the community longer also means that the disability levels among the individuals who do enter institutions may be going up. Changes in healthcare delivery also affect the long-term care system. For example, the United States has done more than other countries to medicalize nursing home services, partly by shifting more hospital patients to nursing homes for post-acute and end-of-life care. An important policy question is whether quality of life factors, such as autonomy, dignity, individuality, comfort, meaningful activity and relationships, sense of security, and spiritual well-being, can be adequately balanced with the increasingly medical environment of American nursing homes. Some providers, particularly in the assisted living industry, have looked to European countries for models that are perceived to do a better job in addressing such quality of life issues in long-term residential care. An important hypothesis is that there may be trade-offs between some regulatory requirements regarding quality of care and quality of life, especially around issues of safety (Kane, 2001, 2003).

Closing Thoughts

With the worldwide aging of the population, long-term care will inevitably command a higher place on the public policy agenda over time. This study attempts to look beyond the borders of the United States to gain new perspectives and approaches to assuring the quality of long-term care that we all want for ourselves and our families. Developed countries have much to learn from each other as they plan to meet the future health and long-term care needs of their aging populations.

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Endnotes

ⁱ Because the four constituent countries of the United Kingdom organize their long-term care systems differently, this study focuses on England, which has the largest population in the United Kingdom.

ⁱⁱ England's means-tested long-term care services are designed and administered by localities. Funding is limited and comes in the form of grants from the central government, as well as local taxes and user charges. Although the central government provides a great deal of policy leadership, local authorities have considerable autonomy in how they organize and finance long-term care services. In a recent development, nursing services provided in institutions are now provided without a means test and are financed through the National Health Service.

Historically, residential care homes and home care providers were predominantly owned and operated by local government. Over the last 25 years, however, ownership has shifted to the private sector. Residential facilities are now overwhelmingly for-profit organizations; for-profit organizations do not play as big a role in home care, but they are still major sources of care.

ⁱⁱⁱ Japan has mandatory public long-term care insurance (*Kaigo Hoken*), which was implemented in 2000. The program is financed by a combination of general tax revenues and premiums. Under *Kaigo Hoken*, everyone age 65 and older and certain people age 40 and older are eligible for assistance based on an objective test of functional impairment. Individuals are placed in one of six disability levels, which provide varying capped levels of assistance. Low-income people with disabilities rely on social assistance programs to pay their portion of cost sharing. Consumers can choose between institutional and community-based care. The insurance program is administered by the municipalities, under direction of the central government. All nursing homes and most home care providers are nonprofit organizations.

^{iv} In 1995, Germany implemented a universal, social insurance program for long-term care (*Soziale Pflegeversicherung*). This program serves people of all ages who have moderate to severe disabilities expected to last six months or longer. Funded by mandatory payroll and pensioner premiums, the program covers nonskilled home care and institutional care. Program benefits vary by three levels of disability and are capped. Beneficiaries choosing noninstitutional care may receive their benefits in the form of cash or agency services. Program beneficiaries pay institutional room and board costs and other uncovered services out of pocket, or they rely on means-tested social welfare programs to pay these expenses. The long-term care insurance program is administered by competing sickness funds, which are nonprofit, nongovernmental organizations heavily regulated by the government. These funds contract with providers to deliver long-term care services. More than half of all nursing homes and home care agencies are operated by nonprofit organizations.

^v In Australia, responsibility for long-term care programs is divided between the national and state levels of government. The federal government finances residential care for frail older people and the state and territorial governments are responsible for residential services for younger people with disabilities. Means testing is applied only after clients are admitted to services to calculate user charges, not to exclude people from receipt of services. Most residents pay only the basic level of fees, which are linked to the government-provided Age Pension. Responsibility for community care for all age groups is shared between the two levels of government, and the programs pay for a wide range of services. Home and community care has a capped budget and access to services depends on availability of services and assessment of client needs. While fees for noninstitutional services are income-tested fees, most participants pay only nominal fees. Most institutional and home and community service providers are nonprofit organizations.

Appendix A

Quality Assurance for Long-Term Care: The Experience of England

In recent years, the national governments in the United Kingdom—England, Wales, Scotland, and Northern Ireland, Wales, and Scotland—have taken over responsibility for quality assurance. While the national systems have many similarities, this report focuses on the quality assurance system in England.

Quality assurance for long-term care is a significant focus of the Labour Government. Regulation is a critical component of the government’s “third way” approach, between the laissez-faire of unbridled markets and direct public ownership. Regulation provides a way of influencing the behavior of private providers without requiring direct public ownership. The regulatory agency is aggressively reforming the inspection process to make the system more client- and outcome-oriented. In addition to regulating providers, national quasi-governmental agencies regulate and train the workforce and disseminate best practices. The responsible bureaucratic structures for quality assurance have been repeatedly reorganized in recent years, somewhat diverting attention away from the reform agenda.

Background

Relative to the United States, a higher percentage of the population in the England is elderly. In 2005, an estimated 16.0 percent of the population of England was age 65 or older; in 2020, the older population is projected to increase to 19.2 percent of the population (United Kingdom Government Actuary Department, 2004).

Long-term care in England is financed primarily through means-tested programs administered by local authorities (i.e., county, municipal, and submunicipal governments). Funding for these means-tested local government services comes mainly from a general purpose grant from the central government, but local taxation and user charges also play a role in funding services (Organisation for Economic Co-operation and Development, 2005b). The central government provides substantial policy direction and leadership, but local authorities have considerable discretion in how they organize long-term care. Long-term care is primarily funded through appropriated programs rather than as open-ended entitlements.

Health services, including some associated with long-term care, are provided by the National Health Service (NHS), which is funded through general taxation. To ensure access, services are provided free at the point of service with no means test. The NHS provides community nursing and therapy services. Since 2002, the NHS has been responsible for the cost of nursing care provided in private care homes with nursing, which is also provided without a means test. Encouraging coordination between acute and long-term care services has been a major policy focus of the government in recent years.

Historically, care homes (nursing homes and certain other residential facilities) and home care providers were predominantly owned and operated by local authorities. Over the last 25 years, however, the long-term care industry has grown dramatically and ownership is now overwhelmingly held by the private sector. A major consequence of this change is that the government is now primarily a purchaser of services rather than a direct provider of care. In May 2003, 29,890 care homes provided 577,301 beds (Laing and Buisson, 2005). A total of 92

percent of all care homes were owned by nonprofit or for-profit organizations; only 8 percent of care homes were owned by local authorities. Chains play a relatively small role in the care home industry. The legal distinction between nursing homes and care homes was eliminated in 2002; some care homes now provide nursing care and some do not.

Through its means-tested programs, England funds a wide range of home and community-based services. One of the goals of the Community Care Act of 1990 in consolidating responsibility for long-term care at the local level was to highlight the trade-off between institutional care and home and community-based services in a single level of government (Wiener and Cuellar, 1999). Compared with residential care, the market for home and community-based services (known as domiciliary care) is relatively immature, although the independent sector has been growing rapidly in recent years. Approximately 60 percent of home care is provided by nonprofit and for-profit agencies (Commission for Social Care Inspection, 2005c). Although not widely used, local governments are required to offer consumer-directed services (known as direct payments) to younger people and older people with disabilities (Wiener, Tilly, and Cuellar, 2003).

A 2005 Department of Health “green paper” on social care articulated a long-term vision for the next 10 to 15 years in which people with disabilities have more choices and control over their lives (Department of Health, 2005). The report highlighted the need for high quality, person-centered services designed to maintain the independence of people with disabilities and to achieve clear outcomes.

Perception of Quality Problems

Quality of care in long-term care is widely viewed as a significant problem by major stakeholders, including government officials and provider and consumer groups. These problems are a major focus of print and television media, which regularly publish or air exposes of poor care (e.g., Barclay, 2003; Lyon, 2003). The House of Commons conducted hearings in 2004 on the abuse and neglect of older people receiving social (non-medical assistance) care (House of Commons Health Committee, 2004). Some observers believe that the quality of care is often poor for people with Alzheimer’s disease, people who developed disabilities when younger, and people who need complex medical care.

Care Homes

The quality of care in care homes has received particular attention in recent years. In 2004, the main regulatory body for care homes reported that 55 percent of facilities failed to safely administer drugs to residents (Batty, 2004). In a 2002–03 study, only 68 percent of care homes for older people met at least 50 percent of the National Minimum Standards established by the Care Standards Act of 2000; only 60 percent met the quality of life standards (Dalley et al., 2004). In the same analysis, 14 percent of homes for older people did not meet at least 20 percent of the standards. Despite these problems, in one study, 79 percent of care home residents reported that they would recommend the facility to their friends (Office of Fair Trading, 2005).

Home Care

In general, home care users appear somewhat satisfied, although their ratings are not as high as found in some studies in the United States. In England, 57 to 60 percent of home care

respondents said that they were “very” or “extremely” satisfied (Netten et al., 2004a), compared to 78 percent of Medicaid home care users in the United States who were “very happy” (Khatutsky, Anderson, and Wiener, 2006). Frequent complaints include stealing, neglect, and poor reliability of staff in terms of when they show up, how long they stay, and what they do. In one study, less than half of home care consumers reported that workers always came on time (Netten et al., 2004a).

Causes of Quality Problems

Aside from limitations in the regulatory system, poor quality care is often attributed to three interrelated factors: ageism, low levels of funding, and a poorly trained workforce that is in short supply.

First, many experts believe that ageism—discrimination against older people—is a particular problem in England (Robinson, 2002a). For example, unlike the United States where Medicare gives older people a relatively privileged position relative to the rest of the population in terms of universal health insurance coverage, the United Kingdom has a long history of providing fewer health services to older people than to younger people with similar diseases (Aaron and Schwartz, 1984). As one observer put it, “Older people face the attitude that what is wrong with them is not a disability; it is ‘just old age.’” One advocate for older people stated,

Older people are one of the most discriminated against groups in our society. There is a lack of funding, a lack of valuing and a lack of desire on the part of society to be associated with them. Older people lack status; they are not seen as interesting or exciting or sexy. For example, the average cost of care packages for older people is half what is spent on younger persons. The fact that residential care is means-tested feeds into the stigma of old age.

Second, many providers and other observers argue that reimbursement rates for providers are too low to provide high quality care (Wanless, 2006). For example, as a result of funding pressures, home care is being provided in smaller increments of time, which arguably forces workers to cut corners and rush to complete their tasks. In addition, travel time for home care workers generally is not reimbursed.

Reimbursement rates are determined by local authorities through contractual arrangements with providers, with little guidance from the federal government. The central government maintains that they have provided local authorities with substantial increases in funding to allow them to expand services and provide quality care. Local authorities argue that funding is not sufficient and that many mandates and additional responsibilities have come with the larger grants.

Third, social care workers are generally low paid and unskilled, and they have high turnover rates (although turnover rates appear to be lower than in the United States). Recruitment is difficult, especially in areas with low unemployment (Robinson, 2002b). In at least one study, home care satisfaction was lower in areas that also experienced low general unemployment (Netten et al., 2004a). Wages for social care workers are lower than salary levels in the NHS, which creates recruitment problems. The lack of a career ladder for most social care workers is another barrier to recruitment and retention. An increasing number of long-term care workers are foreign-born and -trained professionals, which has resulted in reports of racial discrimination (Allan and Larsen, 2003; Redfoot and Houser, 2005).

Overview of Quality Assurance System

The current organizational framework for quality assurance for social care is very recent and has undergone a substantial amount of bureaucratic reorganization over the last several years. Until 2002, regulating the quality of long-term care was the responsibility of approximately 230 local and regional health authorities. The lack of meaningful national standards created great geographic variation in how social care providers were regulated. In 1998, the Labour Government released its white paper, “Modernising Social Services,” which outlined major changes in quality assurance for social care. These changes were enacted in the Care Standards Act of 2000, and have been accompanied by a large increase in spending on social care regulation (Netten et al., 2004b).

The Care Standards Act transferred authority for quality assurance from local authorities to the central government and established the National Care Standards Commission, which had the responsibility to inspect home care agencies, care homes, and a wide range of other social care providers. It also established the General Social Care Commission, which regulates the social care workforce, and the Social Care Institute for Excellence, which disseminates information on best practices in social care. In 2004, the National Care Standards Commission was replaced by the Commission for Social Care Inspection. All three of these organizations are semiautonomous organizations outside of the normal government structure. In 2005, the government announced that it would merge the Commission for Social Care Inspection with the Commission for Health Care Audit and Inspection, which regulates health care providers. The Commission for Social Care Inspection has opposed the merger, arguing that the resulting organization will be too large, too unwieldy, and too medically oriented.

The Commission for Social Care Inspection has control over the bulk of the regulatory apparatus for long-term care as well as most other social care providers (Commission for Social Care Inspection, undated). Thus, its responsibilities include oversight of providers of services for children and younger adults as well as older people. Its primary activity is to inspect services against the National Minimum Standards. The Commission inspects more than 40,000 social care services, including care homes, home care agencies, children’s homes, adoption agencies, foster homes, and facilities for people with developmental disabilities. The Commission has the power to close down a provider when it finds a serious risk to the clients. In addition, the Commission does assessments of local authority social service departments, provides policy analysis and comment on social care issues, and works with other health and social care agencies.

Part of the goal of creating these quasi-governmental entities was to “long arm” the relationship between the payers (i.e., the local authorities and the NHS) and the quality regulators. Moreover, for the first time, care homes operated by local authorities are subject to independent quality monitoring. Despite this change, local authorities remain involved in quality assurance through their contracts with providers; local authorities often set quality standards in addition to those set by the national government. To some extent, providers feel that they are subject to double regulation, and larger providers may have to adjust to the different requirements of several local authorities.

Regulation of publicly funded services is a philosophically important component of New Labour’s “third way.” Regulation seeks to enhance the “steering” rather than “rowing” capacity of the central government (Osborne and Gaebler, 1992). With respect to long-term care services,

regulation provides a way to control the quality of care without having to directly operate the services. Importantly, regulation is seen as a means to achieve accountability and mitigate the negative aspects of both the privatization of providers and the direct provision of care by public agencies. As the 1998 Labour Government white paper on social services put it,

The last Government's devotion to privatization put dogma before users' interests, and threatened a fragmentation of vital services. But it is also true that the near-monopoly local authority provision that used to be a feature of social care led to a "one size fits all" approach where users were expected to accommodate themselves to the services that existed. Our third way for social care moves the focus away from who provides the care and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families (Department of Health, 1998, p.4).

Regulation of Residential Care and Home Care

Although the standards are different, care homes and home care are regulated and inspected in the same way. Inspections of care homes have occurred since the mid-1980s, but registration and inspection of home care is new, only beginning in 2003. Direct payments and supported living (i.e., assisted living facilities) are strongly encouraged by the central government, but they are outside of the existing regulatory framework.

Regulatory Process

National Minimum Standards, which are issued by the Department of Health, establish the expectations of those providing social and health care services with the aim of ensuring adequate quality of care. There are 38 standards for care homes for older people and 43 standards for care homes for adults age 18–65; there are 27 standards for domiciliary care agencies and 18 standards for nursing agencies. The National Minimum Standards address issues of privacy and dignity; service users' choice and control over their own lives; cultural and social, spiritual, and education needs; health and well-being; the quality of the physical environment; the quality of the physical environment; and protection from harm and abuse—physical, emotional, financial, or sexual. The National Minimum Standards are like a code of practice. In addition, providers must comply with regulations. When the Commission for Social Care Inspection makes decisions about services (e.g., whether to grant or refuse registration), it must take the standards into account, along with any other relevant factors.

Effective April 2006, a number of changes in the regulatory process were announced. The Commission for Social Care Inspection may now inspect any adult social care service, including care homes and home care agencies, at any time, as long as every service is inspected at least once every three years (Commission for Social Care Inspection, 2006). Previously, regulations required two inspections a year, although more inspections could be conducted if there were complaints. The Commission supports "lighter touch inspections" for the best quality providers as part of its effort to make the process more "proportionate" (Commission for Social Care Inspection, 2004). The Commission believes that this new policy will allow them to concentrate resources on poor quality facilities. Some consumer groups, such as Age Concern and Help the Aged, fear that reducing inspections will not provide enough oversight for providers whose quality of care might change for the worse between inspections.

The new system will include the following three types of inspections:

- *Key inspections* are comprehensive, unannounced inspections. The results of these inspections will be used to determine the period of time between inspections. During an annual service review, which will occur at the one-year anniversary of the first key inspection, information about the service will be examined to assess whether additional action is needed.
- *Random inspections* are short, targeted inspections, usually to address specific issues with a service. In addition, a number of random inspections will be conducted without a specific reason for the inspection.
- *Thematic inspections* are inspections that address specific national or regional issues, such as medication management or nutrition.

Most inspectors are experienced social care, education, or health care workers (Commission for Social Care Inspection, undated). Many have either a background in nursing or social work or hold another professional degree. They are trained in inspection and work to an established code of conduct. Although opinions differ, providers view an inspector as being more of a policeman than a consultant. Starting in 2006, some people who use social care services joined the inspector team as “experts by experience.”

The inspection usually lasts between one and five days depending on the size and nature of the service and the issues that arise. In care homes, inspectors are supposed to speak to at least 10 percent of service users; in small homes offering care to fewer than four people, all residents will be interviewed. The Commission is examining ways to increase the input of service users. Inspectors check care plans, other relevant documents such as staff records, accident books, fire books, the way service users’ finances are managed, medication administration, and health and safety logs, as well as speak to key staff. Inspectors are also supposed to talk with home care clients, but their geographic dispersion makes that difficult.

Compliance with the standards is measured on a four-point scale: 4—standard exceeded (commendable), 3—standard met (no shortfalls), 2—standard almost met (minor shortfalls), and 1—standard not met (major shortfalls). Although no summary numerical judgment about the facility or service was made through 2006, the Commission will begin making these judgments in mid-2007. The Commission is currently exploring the technical issues of the new rating system, which will help inform how often to inspect the service.

After the inspection, initial findings are discussed with the provider, who has an opportunity to respond to issues or concerns raised. The inspector will point out any regulations that are not being met. The inspectors will also make recommendations that, although not legally required, are seen as suggested improvements to meet best practices. Providers are given a short questionnaire about how the inspection process was conducted. Care homes and home care agencies receive a draft report within 28 days of the inspection and have 28 days to respond, after which time the report is finalized. Under the new regulations, providers must produce a plan explaining how they will improve services, which will be monitored by the Commission unless the provider’s services are rated as excellent or good.

When failure to meet the National Minimum Standards is serious, enforcement action is taken—for example, issuing a statutory notification requiring changes within a specified time frame or canceling the registration of the home. Limiting admissions until corrections are made and levying fines are possible, but these sanctions are rarely imposed. In the event of a serious risk to clients, the Commission can ask a court to immediately close the agency or facility or to take over its management. Certain actions, such as obstruction of an inspector or providing false information, are criminal offenses. The goal, however, is to improve care rather than to close down providers.

The recent changes in regulations also require providers to produce an Annual Quality Assurance Assessment. This assessment program is currently under development by the Commission.

Issues in the Current Regulatory System

In the view of the Commission for Social Care Inspection, the existing regulatory system is improving the quality of care homes and home care agencies. However, observers offer a number of criticisms of the current system. The Commission agrees with many of the criticisms and is committed to addressing them. These criticisms include the following:

First, according to many observers, the standards are too paperwork- and process-oriented, and are not focused on the outcomes for the users (Better Regulation Task Force, 2004). English standards do not require longitudinal data on the health and functional conditions of residents and home care patients similar to the Minimum Data Set (MDS) for nursing home residents or the Outcomes and Assessment Information Set (OASIS) for home health patients required in the United States. As a result, quantitative outcome measures cannot be calculated. In addition, some observers argue that the current regulations are too risk adverse, taking away people's choices (Better Regulation Task Force, 2004). The Commission for Social Care Inspection intends to focus on a fewer number of standards that are particularly important to quality outcomes.

Second, the views of service users are not well integrated into the standard setting or inspection processes (Commission for Social Care Inspection, 2005a). As a high level Commission official put it, "Our aim is to put the people who use social care first. Their views, their life experiences will drive the way we inspect and regulate all services in England. We want to be responsive to people's needs" (Commission for Social Care Inspection, 2005b).

Third, critics of the regulatory process contend that the rigid application of the standards is driving out innovation and nonstandard provision of services. Proving compliance with the standards depends heavily on producing policies and manuals, which are viewed by critics as largely irrelevant to the provision of care. Inspectors are criticized for having a "tic box" approach to regulation, in which inspectors check off whether certain written policies exist without assessing whether they are having the desired effect. The Commission's initiatives to involve service users are part of its response to this criticism.

Fourth, the complaint system is considered ineffective (Office of Fair Trading, 2005). Reportedly, users of the system do not want to complain because they are afraid of losing the services they have or being treated badly in a care home. The Commission is reviewing its complaint procedures to create a more open and transparent system.

Alternative Strategies for Quality Assurance

While the government's quality assurance strategy depends heavily on direct regulation of agencies and facilities, they also focus on strategies that address the workforce, dissemination of best practices, and consumer information.

The Workforce: General Social Care Council and Skills for Care, Ltd.

The General Social Care Council was established in 2002 to regulate and promote the social care workforce. Approximately 1.2 million people work for 23,000 social care employers; nurses and other health care professionals are regulated separately (General Social Care Council, 2004). The General Social Care Council has established a three-pronged approach to improving the workforce.

First, the General Social Care Council established "codes of practice" setting out the proper conduct and practice of all social care workers and their employers (General Social Care Council, 2002). Since the release of the coded of practice, the General Social Care Commission has distributed more than 1 million copies of the codes, which are available in 30 languages.

Second, in 2003, the Council started phasing in a system of registration for social care workers, beginning with social workers. Registered workers will have to meet certain qualifications and competence standards, as well as pass a criminal records check and a review of their employment record to ensure that they are competent, reliable, and honest. At this point, education and training qualifications are taken as evidence of competence. The General Social Care Council is responsible for disciplining social care workers, when necessary.

As part of this registration, the General Social Care Council is also setting standards for social care workers. The goal is that half of all social care workers will meet the National Vocational Qualification level-2 (NVQ-2) by the end of 2006; managers are supposed to meet the NVQ-4 or equivalent in both management and care. The National Vocational Qualification is a system of national job standards emphasizing on the job training. The system relies mostly on assessments by supervisors rather than exams to determine qualifications. Although some observers have expressed skepticism about the utility of National Vocational Qualifications, the standards are well established in the English occupational system.

Third, the General Social Care Council approves courses in social work training and monitors their quality. To improve the training of social workers, the government is funding a new three-year social work degree. The Council also manages a system of grants for social work students.

Skills for Care, formerly the Training Organization for Personal Social Services, is the workforce development council, which works to ensure that social care training is provided. Skills for Care is responsible for the overall coherence of social care training and workforce planning (Training Organization for Personal Social Services, 2003). It is led by networks of providers, service users, training interests, and worker associations. Training is generally offered by local authorities and provider organizations. High turnover rates make reaching training goals difficult.

The Care Standards Act of 2000 also established a Protection of Vulnerable Adults list, which includes the names of people judged unsuitable to work with vulnerable adults in the care sector

(Ladyman, 2004). Although the situation is improving, employers and users of Direct Payments (consumer-directed payments) have complained about the high cost and bureaucratic delays of conducting a Criminal Records Bureau check. Some observers criticize the Protection of Vulnerable Adults list for casting too broad a net, one that includes people with alleged but not proven problems. Individuals can appeal their placement on the list, but they bear the burden of proof.

Promoting Good Practice: Social Care Institute for Excellence

The purpose of the Social Care Institute for Excellence is to raise the standard of social care services, improve consistency in delivery across the social care sector, and promote the adoption of best practices. The premise is that many good practices exist but are not widely known by social care providers. To increase the knowledge by providers about good practices, the Social Care Institute for Excellence engages in four main activities. First, it commissions knowledge reviews, including systematic reviews of the literature. Second, it conducts practice surveys to determine what providers and users think is best practice. Third, it translates information and research into protocols, guides, and other tools for practice. Fourth, it disseminates information, largely through its Web site and electronic library for social care (<http://www.sciek-socialcareonline.org.uk>).

Consumer Information: Posting Inspections on the Internet

To make the social care market more effective, the Commission for Social Care Inspection posts inspection reports for both care homes and home care agencies (along with many other services) on its Web site (http://www.csci.org.uk/find_a_care_service/how_to_find_inspection_reports.htm). The reports are about 20 pages long and are written in nontechnical language. Each report includes a two-page summary of findings. The reports are impressionistic and do not generally include quantitative measures as evidence, although, as noted above, individual standards receive a one-to-four point rating.

Conclusions

The English quality assurance system for long-term care has several distinctive characteristics, which include the following:

- Reforming quality assurance for social services, including social care, is a relatively high priority for the government. Regulation is perceived as a key part of the Labour Government's "third way" approach to achieve public objectives without direct public ownership. Relative to other countries in this report, the English strategy for quality assurance is quite comprehensive.
- The quality assurance system is recent and rapidly changing. The repeated reorganizations of the administrative structures have created some confusion and numerous changes in leadership.
- Compared with the previous system of quality assurance, one of the major features of the new system is the separation of responsibilities for quality assurance and

financing. As a result, responsibility for quality assurance has moved from the local authorities to the central government.

- The regulatory system is basically the same for residential facilities and home care agencies. Consumer-directed home care and assisted living facilities are outside of the existing regulatory framework. England has only recently moved to a system in which the frequency of inspection is linked to its performance on the inspection. The regulatory standards are relatively general. Providers' compliance with the individual standards is rated on a scale of one to four; a summary rating will be provided in the future. Enforcement is achieved mostly through prodding providers to improve; fines, freezes on admissions, and delicensing are available as sanctions, but they are rarely used.
- Critiques of the regulatory system, which the Commission for Social Care Inspection is committed to addressing, include the following:
 - The standards are too paperwork oriented;
 - Inspectors vary in how they apply the standards;
 - The regulatory process stifles innovation; and
 - The perspectives of users are not adequately integrated into the standards or the inspection process.

In addition to inspections of facilities, England is developing a number of other strategies to improve the quality of care of long-term care providers, including the following:

- The General Social Care Commission is registering and beginning to regulate the social care workforce.
- The Social Care Institute for Excellence is developing and disseminating information on good practice in social care.
- The Commission for Social Care Inspection is increasing the amount of information available to consumers by posting easy-to-read inspection reports on its Web site.
- However, England does not collect client functional data or health information on a consistent basis, which would allow the creation of quality indicators similar to those available on the U.S. Centers for Medicare and Medicaid Services Web site.
- Providers have not demonstrated much interest in industry-initiated culture change initiatives, such as the Eden Alternative or Green House nursing homes in the United States.

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Appendix B

Quality Assurance for Long-Term Care: The Experience of Australia

The Australian system for quality assurance relies heavily on consultation and collaboration between the industry and government and quasi-governmental officials. Quality assurance in institutional care is carried out by a quasi-governmental accrediting agency, but approving providers to receive federal funds and enforcing quality standards remain fully governmental responsibilities. Accreditation has a very different meaning in Australia than it does in the United States, where accreditation refers to quality inspections by private organizations that are separate from the government. In Australia, a quasi-governmental agency, the Aged Care Standards and Accreditation Agency, establishes standards and monitors performance.

The Australian quality standards for institutional care are very broad and non-specific, which gives providers considerable latitude to demonstrate how they achieve quality goals. As a result, Australian officials believe that much more attention is paid to the more important issues of quality than there would be if inspections were conducted using narrower criteria. In carrying out their monitoring role, the inspectors from the quasi-governmental accrediting agency also act as consultants to promote quality of care. Quality assurance for home and community care is more decentralized and only recently implemented, but it includes a strong consumer component. Provider education is the principal strategy being pursued to supplement the inspections.

Background

Of the four countries in this study, Australia has the lowest percent of the population that is age 65 or older; however, starting around 2010, the aging of the baby boom generation will sharply increase the proportion of the population that is elderly. In 2005, an estimated 12.9 percent of the Australian population was age 65 and older; by 2020, the older population is projected to account for 18.0 percent of the population (Organisation for Economic Co-operation and Development, 2005).

Australia is a federation, consisting of the Commonwealth (federal) government, six state governments and two territories. Responsibility for financing and monitoring long-term care is divided between the two levels of government. The federal government is responsible for institutional care for the frail aged, and the state and territory governments are responsible for supported accommodation services for younger people with disabilities. Federal and state governments share responsibility for programs of home and community services for clients of all age groups.

The Aged Care Act of 1997 brought together nursing homes and hostels—a form of congregate housing akin to assisted living, which is eligible for federal reimbursement—into a single system of residential care. The two levels of care were relabeled high care and low care. In Australia, the terms residential care and aged care homes refer to both nursing home and assisted living facility care. The Aged Care Act covers institutional care services for the frail aged and two programs that provide home and community services as alternatives to residential care: Community Aged Care Packages and Extended Care at Home Packages.

The system is complicated and different needs-based assessment processes apply to residential care and community care. Means-testing is applied only after clients are admitted to services to

calculate user charges, not to exclude people from receipt of services. As a result, all institutions serve individuals across a range of incomes, and all must make places available to those who are fully subsidized by government. Most residents pay only the basic level of fees that are linked to the Age Pension. Of the small minority of residents who pay the full or near full cost of their care, only a portion opt for “extra services” homes that charge premium fees for higher standard accommodations and services. Serving clients across a range of incomes in the same facility is widely regarded as moderating variations in quality based on capacity to pay.

The Home and Community Care (HACC) program is administered and funded jointly by the Commonwealth and state and territory governments. HACC provides a wide range of home and community care services encompassing both nursing and allied health services, and nonmedical or social care services. HACC covers all age groups, and more than 75 percent of clients are age 65 or over (Australian Institute of Health and Welfare, 2005, 179). The HACC program has a capped budget, and access to services depends on availability of services and assessment of client need. Although users pay income-related fees, the great majority of users pay only nominal fees, and income testing is not used to exclude clients from accessing services.

The Commonwealth State Disability Agreement (CSDA) funds services for younger people with disabilities. The federal government is responsible for education, training, and employment services; state and territory governments are responsible for long-term care and accommodation support services. Accommodation support services include a range of residential care with varying levels of care and supervision, services to enable individuals with disabilities to remain in their own homes, and assistance in finding suitable housing in the public, private, and not-for-profit sectors.

About 75 percent of public expenditures for long-term care for the aged are for residential care, but most users receive care in the community (Australian Institute of Health and Welfare, 2005). The balance of funding of long-term care is approximately 75 percent from public sources and 25 percent from user payments. A substantial part of user payments are derived from Age, Veterans’, or Disability Pensions, and thus are effectively transfer payments from public sources. To ensure affordability, user payments are set in relation to the Age Pension.

About two-thirds of all nursing home and hostel beds are in the not-for-profit sector, while for-profit operators account for just over 25 percent of beds, and the balance are in the public sector (Hogan, 2004b). Almost all home and community-based services providers are not-for-profit or local government agencies.

Access to acute care in public hospitals is provided free of charge under Australia’s universal health insurance program, Medicare, which also provides free or near free primary and specialist medical care. Private health insurance covers most, but not all, of the cost of care in private hospitals. Private health insurance also enables the choice of doctors for insured patients who elect to be treated as private patients in public hospitals. Private health insurance is heavily subsidized, but no insurance coverage is available for long-term care.

Perceptions of Quality Problems

Although in need of improvement, the quality of care in long-term care is generally perceived to be fairly good by Australians. Nonetheless, the politics of quality of care as played out

episodically in the national parliament are characterized by considerable conflict. Debate on quality of care at this level is precipitated mainly by incidents of poor quality of care in homes that have been accredited, leading to claims by the opposition that the system is ineffective and that the government has failed to protect the wellbeing of vulnerable older people. However, defenders of the system point out that accreditation and its follow-up processes are responsible for uncovering most of the problem cases. Although these incidents are not common, they can assume a high profile, which is fueled by media attention to the alleged scandals.

Aside from issues of the regulatory system, a number of factors are thought to cause inadequate care, including the following four issues: (1) lack of funding, (2) lack of staff, (3) few financial incentives, and (4) failure to serve younger people with severe disabilities.

First, lack of funding is usually cited as the cause of problems in the aged care sector. However, the 2004 Review of Pricing Arrangements in Residential Aged Care concluded that the industry was financially viable and that further improvements could come from efficiency gains rather than additional funding (Hogan, 2004a). Although these conclusions were not widely endorsed by the industry, providers recognize that management factors have significant effects on the ways in which resources are used and, hence, the quality of care.

Second, lack of staff of all types, particularly skilled staff, is often cited by the industry as a contributor to inadequate quality of care (Australian Nursing Federation, 2004). Although having more highly skilled staff available to care for dependent residents might be expected to result in better care, Australian research indicates that the relationship between staffing levels and quality is more complex (Pearson et al., 1990). Annual staff turnover is thought to be high; however, at a quarter of personal care assistants and close to one in five nurses, turnover rates are far lower than in the United States (Richardson and Martin, 2004).

Third, some industry representatives believe that there are few financial incentives to provide high quality care. Apart from the relatively few extra services homes, facilities cannot charge higher fees for delivery of higher quality services. The lack of strong demand for more extra services facilities suggests that potential residents and their families are satisfied with the general standard of care provided at other homes. Moreover, because the supply of places in aged care homes is strictly controlled by the federal government, admission usually occurs under conditions that constrain choice and competition. Although in theory no individual is forced to enter a home against his or her wishes, most have to make a choice from a limited number of vacancies available in their local area at any one time (Howe and Rosewarne, 2002). The risk of increasing the bed supply is that demand could simply expand to fill the available beds, resulting in considerable cost to taxpayers, little increase in consumer choice, and no guarantee of improvements in quality.

Fourth, institutional aged care is recognized as not providing an appropriate care setting for younger people with severe disabilities, such as acquired brain injury or early onset neurological conditions. The majority of these clients are served in facilities that fall under the CSDA, but some 5,000 residents in aged care homes are between 50 and 70 years old, and around 1,000 are under 50 years old. These individuals are in aged care homes mainly due to the shortage of alternative accommodations. Particularly in nonmetropolitan areas, the only option to locate younger people with disabilities in residential care close to their families may be an aged care home.

Overview of Quality Assurance System

The 1997 Act established the independent Aged Care Standards and Accreditation Agency (ACSAA), which took over responsibility for standards monitoring that previously had been conducted by the federal Department of Health and Ageing. The Aged Care Act created a single set of standards for accreditation of nursing homes and hostels, replacing two previously separate sets of standards, and established additional standards for certification of buildings. All operators of institutional care facilities and all agencies that deliver care packages as alternatives to institutional care must be Approved Providers under the Aged Care Act.

The 1985 HACC Act governs care services delivered in home and community settings. Although HACC serves individuals living in congregate housing, such as boarding houses, and may provide short-term nursing care to residents of low care facilities, those in institutional care are otherwise excluded. Although the first steps toward developing standards in community care were initiated in the late 1980s, the development of a national quality assurance system has been slow. The majority of users of community care are less dependent and less vulnerable than those in institutional care, and their wellbeing is mediated by a much wider array of factors outside the care program than is the case for those in nursing homes and hostels. In addition, although the federal government has sole responsibility for residential care, the division of responsibility for HACC between the federal and state governments has resulted in protracted negotiations on many aspects of the program, including standards.

No national standards govern accommodation services operating under the CSDA or other forms of housing, such as boarding houses, in which some clients of other CSDA services live. Nor are there any national standards for community disability services, but because many of the providers of community support under the CSDA are also approved providers in HACC, their roles in CSDA services are influenced by the HACC standards.

Regulation of Institutional Care

The Aged Care Act 1997 created a two-part quality assurance process that provides for (1) certification of buildings and environment; and (2) accreditation of care standards. Certification and accreditation are both necessary to receive federal funding, but they are managed through separate processes. The process of approval of entities to operate as providers under the Aged Care Act 1997 is a third distinct process. The process by which a facility becomes an Approved Provider under the Aged Care Act is managed entirely by the Department of Health and Ageing rather than by the ACSAA. Failing the accreditation standards can be grounds for the Minister to revoke the approved provider status.

Certification

Certification was introduced in 1997 to improve the standard of buildings in which institutional care is provided. The certification process is administered by the federal Department of Health and Ageing. A 10-year plan for certification was established in 1999, with targeted progressive improvements to achieve targets for fire safety by 2003 and for privacy and space by 2008. This timetable has generated a substantial level of upgrading old facilities and constructing new facilities.

Although certification is not technically required for a home to continue operating and for residents to receive care benefits, certification is mandatory for homes to levy accommodation charges (i.e., the room component of room and board) on residents and to receive federal “concessional” payments for residents with low incomes who cannot make the accommodation payments. Certification for these purposes is independent of accreditation and does not mean that a home will automatically meet the accreditation standard covering physical environment and safe systems.

Accreditation

Accreditation regulates the care provided in institutional facilities. The accreditation process is the responsibility of a single quasi-governmental body, the ACSAA.^{vi} The Agency was established as an independent company but with a sole shareholder, the federal Minister for Ageing, and it operates under contract to the federal Department of Health and Ageing. Although the Agency receives government grants, just over half of its funding comes from fees paid by providers, but these fees are set by the government. The Agency is not a membership organization, and the head of the Agency is appointed by the Minister, not by providers or the board. Thus, although this arrangement creates a very limited distance between payers and quality regulators, the Agency is not an autonomous organization like the Joint Commission for Healthcare Organizations in the United States or the Australian Council of Healthcare Standards. State governments only regulate the homes they operate, and these homes are also subject to the federal standards because residents receive federal funding. Local governments do not have a role in the regulation of quality of care in long-term care services.

Accreditation Standards

The accreditation standards cover four areas: (1) management systems, staffing, and organizational development; (2) health and personal care; (3) resident lifestyle; and (4) physical environment and safety. Each standard consists of a statement of a principle and the intention of the standard, a set of indicators, and expected outcomes. In total, there are 44 indicators and associated expected outcomes. The standards and the associated indicators and expected outcomes are general statements; they do not constitute a checklist, and they do not tell providers how to meet expected outcomes. Furthermore, the standards are not measurement tools, but rather a framework around which the Agency builds evidence to determine whether a home complies with each standard. The standards aim to ensure quality of care, and they are a necessary but not sufficient condition for achieving quality of life for residents.

The same set of standards apply to all institutional care homes, but considerable flexibility is used to apply them in recognition of the fact that not all providers respond to the standards in the same way. Providers have considerable leeway in how they achieve the standards. An accreditation guide for providers and a handbook for assessors provide advice on expected performance and opportunities, which providers can use to demonstrate that they have achieved each outcome (ACSAA, 2001a, 2001b).

The standards call for attention to the special needs of different populations, including people with dementia and other cognitive impairments, people from culturally and linguistically diverse backgrounds, indigenous Australians, and those living in remote areas. For example, under the Health and Personal Care Standard, identification and effective management of memory loss and challenging behaviors are specifically mentioned, and the Resident Lifestyle Standard includes

an indicator that calls for the individual's interests, customs, beliefs, and cultural and ethnic background to be valued and fostered. These standards apply to all homes, and no separate standards apply to homes that cater specifically to special needs groups, in part because most members of these populations are in "mainstream" homes.

The accreditation standards do not set ratios for nursing or other staff to residents. As with the regulations for Medicare and Medicaid in the United States, the standard for human resource management requires that skilled and qualified staff be sufficient to ensure that services are delivered in accordance with the standards and the residential care facility's philosophy and objectives. The standard for regulatory compliance requires staffing to be in accordance with separate legislation and regulation of nursing practice, particularly in relation to the management of medication and technical nursing procedures.

The standards raise a number of issues. First, some observers question whether it is appropriate to have the same quality assurance system for the whole range of dependencies found among residents, from relatively independent residents in hostels to completely dependent residents who need a high level of skilled nursing care in nursing homes. A related question is whether the current system detects variations in quality of care for residents with dementia as well as it does for residents without dementia.

Second, the breadth of the standards used in the Australian accreditation system leaves them open to providers to interpret how they have addressed the standards, as well as to assessors to establish whether the standards have been met. While the Agency provides reliability training for assessors to ensure that the same process is followed throughout Australia, providers have raised concerns about variations in the ways in which assessors apply the standards. However, at least one study argued that the standards were more reliable precisely because they were broad, subjective, and undefined in regard to protocols (Braithwaite, 1998). Rather than using a rule book to check long lists of highly specific standards, the general nature of the standards encourages Australian assessors to engage in a dialogue with providers and users to establish whether and how the expected outcomes have been achieved. In the course of this dialogue, all parties must be assured that all relevant information has been presented and any differences in views about compliance must be resolved.

Braithwaite (1998) argued that the pursuit of more specific standards could undermine the reliability of the accreditation process as a whole: assessors would lose sight of the "forest" of quality of care because they would be focused on too many and separate "trees" of specific regulations. A trade-off may exist between broad standards that allow for greater in-depth investigation compared with more specific standards that can be rated on the basis of relatively superficial inspection. This is not to say that homes do not use specific and quantifiable measures to provide evidence of the quality of care they deliver, but such measures are not formally required as part of the standards monitoring system. The broad brush approach thus lacks systematic, quantifiable indicators that could be used to compare facilities or to provide benchmarks for the whole system to track changes over time.

Third, a debated issue is whether the standards represent the minimum quality of care that has to be provided to gain accreditation, or whether the standard to be achieved demands a level of good practice that delivers a higher quality of care. Those in the field who argue that the standards are a minimum see the accreditation system as providing little incentive for providers to improve quality above the lowest common denominator. This view is, however, countered by

the serious approach that the industry has taken to address the standards. Accreditation outcomes are common knowledge, creating not only peer pressure to meet all the standards but also an element of competition for recognition as a provider of outstanding quality care.

Accreditation Process

Four broad steps are used in the accreditation of quality of care. First, homes complete a self-assessment to demonstrate how the facility is meeting the standards and submit it to the Agency. Second, quality assessors perform a desk audit of the self-assessment information and then conduct an on-site assessment. The desk audit reviews the self-assessment information to determine whether the information available complies with reporting standards. Desk audits allow assessors to check whether additional information will be needed and to decide whether to proceed to a site visit. A decision not to conduct a site visit does not mean that a home has been accredited automatically or that it has failed accreditation, but rather that there will be a delay until all information is in order for a site visit to proceed.

Third, assessors visit each facility to conduct an on-site assessment. A high proportion of the assessors are registered nurses who have experience in aged care. Assessors usually work in pairs or a team of three that includes one member with a nursing background, but there are no rules about the disciplines to be represented. Assessors who are not nurses come from a range of backgrounds, with the most common being management and administrative positions in the health and human services sector. During the site visit, the assessors review documentation; speak with staff, residents, relatives, and relevant professionals; and observe the environment and practices of the home. The assessors may provide verbal advice to the home.

Providers receive advance warning of the assessors' visits for the site audit, but unannounced spot checks may be used at facilities with a history of noncompliance or against whom a serious complaint has been filed or when a change of ownership has occurred. In 2003–04, 14 percent of all follow-up visits were spot checks (ACSAA, 2004). Some providers see unscheduled visits as unwarranted intrusions, but many other interested parties, particularly consumer advocacy groups, see them as the only way of ensuring that the quality of care normally provided is the same as that which assessors see on their scheduled visits. Calls for more spot checks have been resisted by the Agency and government as well as by the industry.

A common criticism is that the assessors focus too much on documentation to demonstrate that systems are in place, rather than looking directly at actual care practices and the outcomes that result (Australian Nursing Federation, 2004). Although viewing documentation is only one of the methods used by assessors, providers argue that they have to produce the “right words” in documentation even though doing so may not necessarily have any impact on the actual quality of care being delivered. Providers argue that the amount of time taken to complete desk work is time that could have been better spent attending to residents. The Agency acknowledges that the attempt to produce the best evidence that standards are being met may be leading to over-documentation of care processes and systems. In response, a national framework for documentation was issued in 2005 to streamline and standardize documentation (Commonwealth of Australia, 2005).

In the fourth step, the assessors prepare a detailed report following a standard format, and a staff member from the Agency outside the audit team decides whether the facility should be accredited and for how long. Meeting 40 of the 44 standards is an informal benchmark for

accreditation. Based on these reports, the level of noncompliance with the standards is relatively low (Hogan, 2004a). Decisions are “merit-based”—that is, they take into account all the facts of the particular case, and no strictly numeric or quantitative equation translates compliance with a given number of standards into accreditation. The Agency makes its decisions publicly available along with a copy of the assessors’ full report.

Meeting 40 of the 44 standards is an informal benchmark for full accreditation for at least three years. A serious breach on only one standard, however, may mean that accreditation is given for only one year and that the facility will be subject to remedial action. In other circumstances, three years’ accreditation will be granted when it is evident that a small number of standards not met at the time of the site visit are being addressed and will be met in a short time. Completing building renovation, installing new equipment, or having staff complete training are cases in point. Where there may be a longer time lag until a small number of outstanding standards are met, accreditation may be granted for a shorter period. Only two homes were not accredited in 2002–03 and fully 90 percent of homes that were accredited were compliant in all 44 standards, and another 5 percent were compliant in all but one standard. Ninety-two percent were granted at least three years’ accreditation, another 5 percent were given accreditation for two years, and the remainder, including some new homes just starting operation, were accredited for a shorter period (Hogan, 2004a).

Accreditation assessment also recognizes a small number of homes—less than 15 nationwide—for achieving outstanding levels of quality. Although the industry supports such recognition of excellence, some people are critical of the lack of any other differentiation of quality, which ranges from homes that just barely achieve accreditation to those that are close to receiving merit awards.

Enforcement

To the extent that accreditation assessors in Australia are police officers, they also can be seen as detectives who collect evidence. But their role is clearly separated from the enforcement functions that are carried out by the Department of Health and Ageing under the authority of the Minister for Ageing.

Three levels of enforcement action are available under the Aged Care Act accreditation process. When a home does not comply with the standards and does not improve as a result of support visits and other advisory action by the Agency, its accreditation can be revoked or shortened in time. The next level of action includes such sanctions as suspension of admissions so that the home suffers vacancies and a consequent loss of income. If the home does not improve quality of care as the sanctions require, the home can be closed. In the event of closure, the bed licenses are rescinded so that the provider cannot gain by selling the licenses, which command a high price. Very few homes have been forced to close, but even isolated instances have a significant effect on the residents who have to be relocated and on their families. The aim of the accreditation process is to minimize the risk of having to impose sanctions rather than “catch and close down.” If the provider does not agree with the decisions being made, it has a number of avenues of appeal throughout the accreditation process. Fines are not part of the enforcement system in Australia and have not been raised as an option.

Regulation of Home and Community-Based Services

The HACC standards package consists of the National Standards Instrument and Guidelines and a Consumer Survey Instrument and Guidelines (Home and Community Care, 1998a, 1998b). The Standards Instrument establishes seven objectives. Under these objectives are 27 standards each of which is stated as an expected consumer outcome.

The standards instrument is designed to measure the quality of services against the national standards and to provide a nationally consistent method to evaluate and monitor the quality of service provision. States and territories agreed to implement the instrument using one of two methods. The *joint assessment method* allows service providers to supply answers against the performance information. The ratings and provider appraisal summary form are then completed in conjunction with the visiting assessor, who is appointed by the state department administering the program. The *self-assessment and verification method* enables the service provider to complete the standards instrument, including their ratings, transfer this information to the appraisal summary form, and complete an action plan. The appraisal is then discussed and verified by a visiting assessor.

The consumer survey instrument and guidelines run parallel to the standards instrument. Slightly different formats are available for providers that deliver different types or mixes of services. Although a mailed version is most widely used, a telephone interview version is also provided. Face-to-face interviews are generally viewed as the most appropriate method to obtain feedback from non-English speaking and indigenous clients, and provisions are made to use focus groups with these clients. All methods include questions that seek information on three areas: (1) consumers' experience of service provision, (2) respect for clients' rights and receipt of information, and (3) satisfaction with services. The survey also collects basic information on client characteristics.

Although standards for HACC providers were developed in the early 1990s, formal monitoring only began in 2001. All jurisdictions had reported to the Commonwealth by 2003, but they failed to reach an agreement on the release of these findings. All HACC services have had the benefit of undergoing the appraisal process and have received feedback on their performance, but no comprehensive data are publicly available on the extent to which HACC services meet the national standards.

Alternative Strategies for Quality Assurance

With the exception of provider education and, to a limited extent, consumer education, Australia has not pursued alternative strategies of quality assurance. Although it gathers substantial amounts of resident functional data for its reimbursement system, the Department of Health and Ageing has not used that data to develop quality indicators that could link care outcomes and client characteristics.

Education

The philosophy of the Agency is that quality of care can best be improved through accreditation and education. In the Agency's view, each role supports the other, and its education role makes the Agency more effective than it would be if it were limited to an auditing or policing role. The

main means by which the Agency's consultancy role is implemented is through the activities of its Education Division, which operates alongside the Accreditation Division. Educational activities include Better Practice events that feature presentations by providers, publications relevant to accreditation (such as pocket guides to standards), education packages on documentation and measurement, and continuous improvement presentations for use with facility staff. The dual role of monitor and educator is considered by some providers to be problematic and has drawn a mixed reaction from the industry. Although some providers say they are reluctant to engage in Agency-sponsored education for fear that it will have regulatory consequences (although the same might apply to nonparticipation), the Better Practice events are oversubscribed and are highly regarded not only by providers but also by academics and professional associations. The Agency identifies the greatest critics of its Better Practice events as industry bodies that provide education programs themselves and see the Agency as a competitor to their commercial interests.

In addition to the educational activities undertaken by the Agency, a wide range of ongoing education initiatives are pursued by other organizations to promote quality of care. Typical activities include the annual conferences held by industry bodies and professional associations. Newsletters and awards schemes run by these industry bodies also raise quality of care by motivating providers and describing and disseminating best practices.

Increasing Consumer Information

The Agency operates a consumer education program funded by the federal government. This program includes publication of a magazine for residents of aged care homes and seminars for residents, relatives, and the general community. Homes are required to provide residents with opportunities to participate in decision making and control of their care. Although resident committees provide a common means to address the standard covering this area, not all homes have such committees, and the effectiveness of committees is variable (Wilson and Kirby, 2005).

The Agency also produces brochures that inform residents of their rights and the quality of care they should receive and distributes them to all residents in aged care homes. The Agency reaches prospective residents and their carers by advertising in a popular listing of aged care facilities that is produced by a not-for-profit publisher. It is distributed free of charge and also is available online (<http://www.dpsguide.com.au>).

The main means by which the Agency provides quality of care information to consumers is through making the accreditation reports on facilities publicly available via the Internet or in hard copy, on request. These reports are lengthy and written in formal and, at times, technical language; as such, they do not provide user-friendly information to actual or potential consumers and the community at large.

Summary

The Australian quality assurance system for long-term care has several distinctive characteristics, which include the following:

- The overall ethos of the system is consultation and collaboration between the regulating agency and providers and includes consumer involvement. Australia

appears to lack much of the adversarial relationship that exists between regulators and providers in the United States. The less confrontational relationship in Australia may be due to the overwhelming dominance of not-for-profit providers in Australia; for-profit institutional care providers account for just 25 percent of the market for institutional care and they are almost entirely absent from home and community-based services.

- At least for institutional care, government payments are separated from regulatory functions. The main regulatory body, the Aged Care Standards and Accreditation Agency, is an independent not-for-profit organization, operating at arm's length from but still reporting to the federal government. This separation reduces the potential conflict of interest between paying for care and improving quality of care. Enforcement, however, remains the responsibility of the federal government.
- The institutional care standards are very broad and non-specific, giving discretion both to providers to prove their compliance and to assessors to determine whether the facility meets the standards. The standards are broad as a policy preference and are meant to focus attention on the big issues of quality of care. This approach arguably allows for more depth in the exploration of the meaning of quality of care and how it is achieved in each home than might be possible with only shallow investigation of more specific standards.
- In line with the relatively greater trust of providers in Australia compared with the United States, residential care facilities in Australia are usually inspected only once every three years compared with once every year in the United States.
- Home care regulation is a joint federal-state responsibility and has been implemented only recently. While the federal and state governments have been slow to agree on how quality of community care should be assessed, providers and consumers have accepted the process with little difficulty. Serious shortcomings in quality of care have been extremely rare, and the quality assurance process for community care has been far less contentious than for institutional care.
- The Aged Care Standards and Accreditation Agency sees itself as having both monitoring and education and consultation roles. It provides informal consultation to facilities as part of the assessment process and sponsors numerous educational activities that are conducted separately from its regulatory functions. Apart from the Agency, a number of other bodies provide educational activities aiming to improve standards.

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Appendix B Endnote

^{vi} Extensive information on all aspects of the operation of the Agency is available from its Web site (<http://www.accreditation.aust.com>).

Appendix C

Quality Assurance for Long-Term Care: The Experience of Germany

Unlike other countries, Germany places a strong emphasis on using contracts between sickness funds and providers for quality assurance in long-term care. These contracts articulate general expectations about provider quality and about structures and processes that providers should have in place to monitor and improve quality. The contracts serve as tools to enforce quality. In addition, a common theme among policy makers is that government oversight of quality will never be adequate and that providers must take a proactive role in the management and improvement of their own quality of care. Debates often center on whether financing and local expertise are sufficient to enable high quality services and oversight.

Background

Germany has one of the oldest populations in Europe. In 2005, an estimated 18.3 percent of the German population was age 65 and older; in 2020, the older population is projected to account for 21.7 percent of the population (Organisation for Economic Co-operation and Development, 2005).

In 1995, Germany implemented a universal social insurance program for long-term care covering people of all ages who need an established minimum level of assistance because of a disability expected to last six months or longer (Cuellar and Wiener, 2000; Wiener and Cuellar, 1999). The social insurance program largely, but not completely, replaced the previous means-tested system. Funded by mandatory payroll and pensioner contributions, the program covers either nonskilled home care or the non-room and board portion of institutional care. Benefits per person are capped and vary by three levels of disability. Uncovered services are paid out of pocket or by means-tested social welfare programs. Maximum benefit levels have not increased since the program began.

During 2004, 2 million beneficiaries received either home care or institutional services through the long-term care insurance program (Federal Ministry of Health and Social Welfare, 2006). The program served approximately 8.6 percent of the total population over age 60. Given a choice between home and institutional care, more than two-thirds of beneficiaries chose home care.

People selecting home care have the option of receiving agency-provided services, a cash benefit, or a combination of the two. Approximately 83 percent of home care beneficiaries choose full or partial cash benefits. Although this proportion is still high, it reflects a gradual decline over time in favor of agency-provided services (Federal Ministry of Health and Social Welfare, 2004).

The long-term care insurance program is administered by “sickness funds,” which are nonprofit organizations heavily regulated by the government.^{vii} Sickness funds contract with providers to deliver long-term care services. In 2003, 9,499 institutions and 12,216 home care agencies had contracts with sickness funds to provide long-term care services (Federal Medical Office of Sickness Funds, 2004).

Nonprofit nursing homes and home care agencies are more prominent in Germany than in the United States. Less than half of nursing homes are for-profit providers (36 percent), while 56 percent are nonprofit providers and 8 percent are publicly owned. In contrast, just over half of home care providers are run by for-profit providers (52 percent), another 46 percent are run by nonprofit organizations, and only 2 percent are publicly operated (Federal Medical Office of Sickness Funds, 2004). The providers of nonskilled home care overlap considerably with home health care agencies.

Approximately half of program expenditures are for home and community-based services and about a half are for institutional care (Federal Ministry of Health and Social Welfare, 2004). Expenditures have increased slowly since the inception of the program, helped by the fact that the maximum long-term care benefits have not increased over time. However, revenues have been flat. As a result, outlays are gradually outpacing program income.

Acute care is administered by the health care sickness funds and is financed by separate mandatory payroll and pensioner contributions. Unlike nonskilled home care, home health falls under the auspices of the acute care program. Individuals must choose the same affiliated sickness funds for both acute and long-term care.

Perception of Quality Problems

As expected, long-term care expenditures increased significantly with the implementation of the long-term care insurance program. This expenditure growth increased the saliency of long-term care quality issues, especially after the initial implementation phase. Given the large sums of money being spent on long-term care, officials are increasingly concerned about the quality of care being provided.

Currently, no mechanism exists to routinely collect quality information. As a result, no comprehensive or even representative picture of long-term care quality across the country is available. In part, this lack of information is due to the fact that inspections and consumer surveys are not routinely conducted in all Länder (states). When data are collected, they are not made available more broadly, either to consumers or to researchers, and are not reported on a provider-specific or even Land-specific level.

A 2003 federal report on the quality of long-term care summarizes results from scheduled and complaint-generated reviews of home care and nursing home providers (Federal Medical Office of the Sickness Funds, 2004). Given that a majority of reviews resulted from complaints, the following data are likely to be biased toward a problematic picture of care providers. However, the data are useful in providing a sense of the type and volume of quality problems.

Nursing homes, particularly the large ones, generally fared well when structural aspects of care were measured, but they often fell below standards when resident care was reviewed. Among the structural measures examined were whether nursing homes had a defined model of care, a description of care processes, internal communication channels, and a quality assurance system; 83 percent of facilities met this standard. Seventy-six percent of nursing homes had implemented at least some of these quality management measures. In most cases, staffing levels were considered to be adequate (82 percent). However, 11 percent of providers could not provide complete documentation of care, and only 54 percent of facilities conducted their own audits of

care. Fifty-one percent of nursing homes documented the capabilities of each resident, a step viewed as necessary to promoting independence. Eighty-eight percent of homes offered social support services and made residents aware of them, but 33 percent did not have social support services for certain subsets of residents, such as those who were not mobile or who had dementia.

Consumer satisfaction rates exceeded 90 percent across a number of categories. Despite high levels of reported consumer satisfaction, the report noted a number of problems. In 17 percent of client cases reviewed, care was considered to be below minimum standards. Problems with nutrition and hydration were found in 41 percent of cases, in 20 percent of cases with continence care, in 43 percent of cases with bed sore prevention, and in 30 percent of cases with appropriate care for people with dementia. Nine percent of nursing home residents had inappropriate restraints applied.

In contrast to nursing homes, only 68 percent of home care agencies had adequate structural quality assurance mechanisms, while 71 percent of agencies had implemented at least some quality management measures. Smaller agencies tended to have worse scores than larger ones.

Staffing levels for direct care personnel and management were considered adequate for most agencies, as were opportunities for further employee training. However, 60 percent of agencies had deficiencies with complete documentation of care, and only 52 percent conducted their own audits of care provided by their staff.

The home care agency reviews showed that more than 90 percent of consumers and families interviewed were satisfied with their home care services. However, care reviews showed that in 9 percent of client cases, care was considered to be below minimum standards. A widespread care problem involved agencies treating individuals as passive objects, which tended to lead to more disability. In only 39 percent of cases were individuals' capabilities and deficits noted by their home care agencies, a lower level than among nursing homes.

The report also documented the persistence of many quality problems within agencies and nursing homes. Despite some improvements, most problems appear to persist when agencies and nursing homes are reassessed in follow-up reviews.

Quality Assurance Overview

Sickness funds oversee the quality of long-term care through their contracts with nursing homes and home care agencies, while the Länder (states) license nursing homes. In Germany, no national oversight, certification, or accreditation of providers currently exists. There is considerable debate over whether quality (meaning outcomes) and quality assurance (meaning structures and processes) should be monitored primarily by providers or by outside entities. In terms of care delivery, the fact that providers are primarily responsible for quality assurance presumes a level of training and expertise in quality management that many observers feel is not warranted, particularly in home care agencies. For external involvement, the question remains whether that entity should be federally designated or be an entity of the provider's choice.

Reforms to improve quality are hampered by the fact that financing for the long-term care system has gradually tightened because cost outlays have grown with more beneficiaries but revenues have leveled. Providers argue more funding is needed to improve quality and fewer resources should be spent on "unnecessary" quality regulation. Similarly, Länder have blocked

new quality measures out of cost concerns. Other observers attribute ongoing quality problems less to the lack of funds than to a lack of appropriate quality management and a lack of oversight of quality at all levels (payer, providers, and consumer). These observers argue that more could be done with the available resources.

Germany's 2001 Long-Term Care Quality Assurance Law states that providers are primarily responsible for quality outcomes and for quality assurance mechanisms, and each nursing home and home care provider must have a formal, internal system that focuses on continuous quality improvement. This assurance system should involve all employees and address structure, process, and outcomes.

The sickness funds, which administer the long-term care insurance program, must ensure that beneficiaries have access to quality care, consistent with contemporary care standards, through their contracts with providers (Long-Term Care Law (SGB XI) paragraph 69). Sickness funds, however, must contract with all providers that meet the minimum requirements, thus limiting their leverage with providers. This requirement reduces the providers' incentive to compete on quality, although once they contract with sickness funds, they must still compete to attract consumers. In setting quality standards, coalitions of sickness funds negotiate with coalitions of providers; consumers are not involved. Consensus among the negotiating parties is critical to the adoption and implementation of any initiatives.

Sickness Fund Quality Assurance for Nursing Homes and Home Care Agencies

Two federal documents guide long-term care provider quality. Sickness funds, key provider associations, and social assistance programs at the national level must agree on general quality assurance standards. Setting standards through negotiations among interested parties under the auspices of a nongovernmental body is somewhat analogous to way that standards are set by accrediting bodies in the United States (for example, where Medicare relies on the Joint Commission on Accreditation of Healthcare Organizations to accredit hospitals). In Germany, the self-governance authority is broader because it includes quality, administration, and oversight based on a provider-payer consensus process. These groups developed principles and measures in 1996; however, despite passage of the 2001 Long-Term Care Quality Assurance Law, they have not revised them since. The lack of revisions is due to providers' and social assistance programs' fears that the cost of care might increase.

The 2001 Long-Term Care Quality Assurance Law introduced the concept of quality contracts between sickness funds and providers. Federal standards do not contain detailed guidelines for the contracts, which are implemented at the Land level as "service and quality" contracts between providers and sickness funds and are negotiated primarily through collective bargaining contract negotiations. These "service and quality contracts" were to be signed by all providers by January 1, 2004, but compliance has not occurred consistently in all Länder.

Separate contracts for services and quality allow sickness funds to review providers' quality when negotiating rates, creating an opportunity to incorporate quality measures into rate negotiations in a more systematic fashion than was previously possible. This unique structure relies on enforcement of contractual provisions between payers and providers to ensure quality.

Every two years, providers must demonstrate to sickness funds that they have quality assurance mechanisms in place and that they have delivered services in accordance with the service and quality contracts. These “proofs” of services and quality assurance mechanisms have been implemented very slowly. The 2001 quality law also made a range of sanctions available to sickness funds when quality problems are discovered, such as temporary reductions in payment rates, refunds of payment, and temporary bans on client admissions. However, experts say that these sanctions are rarely imposed.

Another part of the 2001 law clarifies that the medical offices of the sickness funds have the authority to conduct inspections, which may be unannounced and may occur at night. Quality assurance in institutional settings is considered a higher priority than quality assurance in home and community settings (Federal Medical Office of the Sickness Funds, 2004). From 1996 through 2003, only half of all home care agencies and 62 percent of nursing homes had ever been inspected by the sickness funds.

The intensity of the medical office review effort varies considerably across the Länder. In some Länder, inspections are conducted only as the result of consumer complaints, so inspection rates are low. In other Länder, inspections are conducted on a regular basis as well as in response to complaints.

Because the medical offices are arms of the sickness funds, payers have a strong role in quality assurance, creating a possible conflict of interest between cost control and quality improvement. The medical offices portray their roles as consultative, viewing the role of external quality inspection as limited to a supportive function that points providers toward areas of potential improvement.

The federally designed inspection instruments used by the medical offices address structure, process, and outcome measures of quality. No public data are available on the validity or reliability of the instruments, nor are there any common data reporting requirements for these inspections. At best, the German federal medical office consolidates assessment data from medical offices in the Länder and prepares ad hoc summaries.

Quality Assurance for Institutional Care

In addition to sickness fund quality assurance, nursing homes may be licensed by the Länder and municipalities, which entails annual, on-site inspections. Some experts consider the “double” oversight by sickness funds’ medical offices and local nursing home authorities to be redundant. In response to these provider complaints, Länder and municipalities have exercised greater cooperation with sickness funds in monitoring nursing homes. In 2003, 46 percent of medical office reviews were conducted jointly with representatives of Länder nursing home authorities.^{viii}

Land and municipal nursing home authorities tend to focus on minimum standards for personnel, safety, and building codes. In general, researchers and officials consider medical office inspections to be more useful because they are more frequently conducted by long-term care experts who can assess client outcomes. Inspections by the nursing home authorities are supposed to occur annually but generally do not occur that frequently.

No national, agreed-upon minimum staffing level for nursing homes has been established. Considerable efforts have been made, however, to agree on a resident assessment instrument to

determine the relative illness severity of a home's residents that would be used to establish the necessary minimum staffing levels and staff skill mix. These personnel standards have yet to be implemented, although some Länder have established their own personnel calculation systems.

Widely varying staffing levels among nursing homes have hindered efforts to set minimum staffing standards. Only recently have systematic baseline data been collected that document comparative staffing, skill mix, and disability levels in nursing homes (Roth, 2004). Among 27 nursing homes studied in Nordrhein-Westfalen, staffing ratios ranged from 1.7 residents to 1 staff member to more than 4 residents to 1 staff member with little correlation to resident case mix (Wingenfeld and Schnabel, 2002).

To assist payers and consumers, the quality assurance law requires a formal comparison of nursing homes according to quality, quality assurance systems, and prices (Long-Term Care Law (SGB XI) paragraph 92a). Sickness funds were to compile these comparisons and use them to negotiate service and quality contracts and reimbursement rates. This information was also to be provided to consumers to help them choose providers (Long-Term Care Law (SGB XI) paragraph 7). These data have not been collected and reported, however, because the Bundesrat, one of the national legislative houses, has vetoed the process.

The 2001 law further intended to empower nursing home consumers by allowing consumers or family members to participate in nursing home advisory boards and contract negotiations (Third Law Modifying the Nursing Home Oversight Law, November 5, 2001). This participation appears to be relatively uncommon and these initiatives are not considered effective by many observers.

Quality Assurance for Home Care

Although sickness funds help assure quality for home care agencies through contractual requirements, the Land and local governments do not oversee these providers directly. Sickness funds may cut payments or exclude agencies entirely if services are not delivered as agreed or if quality problems are detected. However, such sanctions are seldom imposed.

In home care, special provisions are made for long-term care insurance beneficiaries who choose the cash benefit. Everyone selecting cash benefits receives regular—generally every six months—“control” visits from a home care agency to confirm that care is in place. The format of these control visits has been agreed on by the major sickness funds and provider associations. However, because caregivers are almost always family members, actions are very rarely taken because it is thought inappropriate to interfere in family relationships (Wiener, Tilly, and Cuellar, 2003). Because there are no restrictions on how the cash benefit is used, some observers argue that this enormous flexibility increases consumer satisfaction. However, the degree to which flexibility correlates with satisfaction has not been systematically studied.

Alternative Strategies

In addition to regulation, Germany is pursuing a number of alternative strategies to assure quality in home care agencies and nursing homes.

Accreditation

Privately sponsored accreditation efforts reportedly have spread among some providers. Certain provider associations have agreed to particular certification procedures, but outside accreditation is not very common thus far. Data from 2003 medical office quality inspections show that only 5 percent of the nursing homes and 4 percent of home care agencies had such certification (Federal Medical Office of the Sickness Funds, 2004).

Many experts do not consider outside certification effective because the standards and the sophistication of the monitoring agencies vary, making comparisons difficult. In addition, many of the certifications are generic and not specific to long-term care. Furthermore, few of the standards are thought to be rigorous and empirically based. Other experts, mainly providers, feel that such certifications should be able to substitute for routine medical office reviews.

Worker Training

A 2000 education reform law, implemented in 2003, is designed to address problems of disparate training and licensing requirements for home care workers across the Länder (Law Regarding Practitioners of Elder Care (Elder Care Law), 2000).^{ix} The reform law makes education requirements for elder care workers, who are roughly equivalent to geriatric nurses and home care aides, uniform across the country. The law requires three years of training for elder care nurses, making it closely resemble training required for nurses. In addition, several universities have developed voluntary management training programs for long-term care workers.

The worker training law received considerable support as a way to raise the status of the elder care profession over the long run and to elevate interest in training programs. The intent of the law was to prepare nurses in home care agencies to take on roles in management, quality assurance, and care coordination, and to prepare home care aides for direct care to consumers (Theobald, 2004). However, some observers argued that the evidence-based science in long-term caregiving is lacking (Roth, 2004). The implication is that, without such evidence, training may not be effective. In addition, some observers felt gerontological competencies are still underemphasized in the training provided to aides (Theobald, 2004).

Practice Protocols

As the medical offices have detected problematic patterns for client outcomes, they have developed several best practice protocols (e.g., prevention of bed sores). The Federal Medical Office of the Sickness Funds works with other experts to develop care standards through a consensus process. The standards include suggestions to providers and are meant to be educational and consultative. Once consensus is reached, the standard becomes the focal point of an education and publicity campaign. The medical office then announces that care in this area will be an area of special focus in upcoming inspections.

Other institutions and expert groups have developed best practices and guidelines, some with federal funding. Several standards have been completed, but many providers and their associations were not aware of these efforts, and the dissemination campaigns are considered to be very time-consuming and expensive. Länder and municipalities seldom assist in the dissemination efforts. In addition, given staff and management training levels, many providers believe that the standards are difficult to implement.

According to some observers, best practice guidelines have been developed and disseminated in an unsystematic fashion. Although some experts believe that uniform standards of care are needed, others disagreed. Still others lamented that the scientific rigor varies enormously across best practices (Roth, 2004). These best practice recommendations, whether issued by the medical offices or other parties, have no force of law, and providers are not required to adopt them, a limitation considered problematic by some. Furthermore, beneficiaries have no right to any particular standard of care.

Consumer Input and Information

The lack of consumer activism, at the broad political level and at the individual provider level, contributes to inertia in quality improvement. Consumers have played a limited role in policy debates in part because they lack a meaningful political organization through which to articulate and voice their concerns. Many prominent academic researchers and professionals are sensitive to consumer needs and consumer perspectives on quality, but they cannot substitute fully for a direct consumer voice (Bundeskonferenz zur Qualitätssicherung im Gesundheits- und Pflégewesen [Federal Discussion Group on Quality Assurance in Health and Long-Term Care], 2004). As a result, payer and provider associations largely have been able to skirt the issue of improving information and transparency on quality.

Consumers do not receive, nor have consumer groups systematically voiced an interest in, comparative quality information about providers. Local consumer offices, supported by the government, address a number of issues; some of the offices have developed an expertise in long-term care. Consumers are not completely voiceless, however, because their complaints lead to medical office reviews. Furthermore, individual advocates have become more vocal,^x but no major consumer movement has developed. Separately, the media have reported on a number of nursing home “scandals” related to poor quality.

At the same time, little hard evidence suggests that consumers are dissatisfied. As noted above, consumer satisfaction reported in the medical office reviews for both nursing homes and home care agencies is very high (Federal Medical Office of the Sickness Funds, 2004). Many observers do not find these figures credible, particularly in light of the many problems detected when the same consumers were assessed for problems of bedsores, hydration, and nutrition. A separate, empirical, observational study of nursing homes found the care to be driven by cost and efficiency concerns rather than consumer preferences or abilities (Wingenfeld and Schnabel, 2002). Some attribute the high rates of satisfaction to poor measures, while others attribute them to consumer reluctance to express their true concerns. Such patterns of high satisfaction rates have been observed in other countries as well (Geron et al., 2000).

Research and Demonstration Projects

The federal government has funded a number of demonstration projects. The 2001 legislation specifically authorized systematic research and demonstration initiatives. For example, one project is a multiyear research network of universities and providers to develop diagnosis and care models for people with dementia. Another project involves testing cash benefits combined with case management. Separately, the government has funded roughly 600 local model programs since 1991, including efforts to promote particular facilities, such as hospices; to improve coordination between acute and long-term care providers; and to develop continuing

education programs for home health workers and physicians. A third of the model programs have focused on dementia care.

Summary

The German long-term care quality assurance system has several distinctive characteristics, which include the following:

- The quality assurance system is just now catching up with the change in financing that occurred a decade ago. Increasing responsibilities are being placed on sickness funds to monitor and regulate nursing home and home care, but local and state authorities continue to play a role in regulating nursing homes, leading to charges of redundant regulation. Because quality assurance has been integrated into the sickness funds, much of the quality assurance activities now revolve around specifying quality requirements in contracts and then enforcing the contract. Unlike in some countries, the role of payers is not institutionally separated from quality assurance, raising concern about potential conflicts of interest. The slowly deteriorating financial situation for the long-term care insurance program is making it difficult to implement quality changes that will increase costs.
- Partly because the involvement of payers is recent, inspections of nursing homes and home care agencies by sickness funds are much less frequent than in the United States, and the frequency varies across sickness funds. Inspections by Länder and municipalities are supposed to occur annually, but they often do not occur that frequently. Providers have strongly resisted additional regulation, which they view as unnecessary, burdensome, and costly.
- Providers are required to have continuous quality improvement systems, and the regulatory standards place substantial emphasis on providers' quality assurance systems to maintain quality.
- Regulation of home care is a lower priority and is less well developed than for nursing homes. For the large majority of home care beneficiaries choosing cash benefits and receiving care from informal caregivers, periodic "control" visits are conducted by home care agencies to ensure that care is being provided, but the monitoring and enforcement philosophy is noninterventionist.
- With the exception of increased education for elder care workers and the development of practice protocols, alternative strategies for quality assurance are not receiving much attention. Importantly, consumers are not well organized politically and consumer-friendly, reliable, and valid data on which to compare providers are not available. Consumers are not part of the ongoing negotiations between providers and sickness funds.

Although many stakeholders expressed optimism that the concepts of quality assurance had been absorbed into the everyday long-term care dialogue, others were concerned that these concepts had not been made operational, especially with empirically based standards and consistent procedures (Roth, 2004). Furthermore, little research has been done to establish what structural or procedural aspects of quality are associated causally with poor or good outcomes.

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Appendix C Endnotes

^{vii} A small minority of upper-income Germans receive their long-term care through private insurance.

^{viii} Forty-nine percent were conducted solely by the medical offices. Another 12 percent were conducted along with provider association representatives, 12 percent with health safety program representatives, 3 percent with social assistance program representatives, and 9 percent with other outside representatives. Responses do not sum to 100 percent because of multiple possible answers.

^{ix} Although the law passed in 2000, implementation of the law was delayed when two Länder blocked the implementing regulations, citing Länder rights over federal rights in matters of education and training programs. However, in late 2002 the German high court ruled in the federal government's favor and most provisions will be implemented mid-2003 (Law Regarding Practitioners of Elder Care (Elder Care Law), 2000).

^x Claus Fussek is an example. He has organized a series of "Münchner Forums to Improve the Situation of the Disabled Elderly in Germany," which are now routinely attended by the Bavarian social ministry, and has received considerable press coverage. His focus is primarily on problems in nursing homes, but also in home care. He also participates in the Federal Roundtable on Long-Term Care.

Appendix D

Quality Assurance for Long-Term Care: The Experience of Japan

Japan recently started a public long-term care insurance program, increasing its resources to improve the quality of services as opposed to simply policing providers. Although formal quality assurance mechanisms are now more prominent, the Japanese system relies heavily on training and certification to develop the skills of long-term care workers, on social networks and regular communication from government and among providers to motivate and disseminate best practices, and on the new role of “care managers” to help clients and to assure quality. In addition, new competition among providers, especially home and community-based services agencies, gives consumers a voice in quality assurance through the choices they make in providers.

Background

Japan is a rapidly aging society and is already one of the oldest nations in the world. In 2005, an estimated 19.9 percent of the Japanese population was age 65 or older; in 2020, the older population is projected to account for 27.8 percent of the population (Organisation for Economic Co-operation and Development, 2005). How to address the problems of an aging society has been a major policy issue for more than three decades.

Public universal long-term care insurance (*Kaigo Hoken*) was passed in 1997 and implemented in 2000 (Campbell and Ikegami, 2003). The public long-term care insurance system largely replaced a system of means-tested and appropriated services. Under *Kaigo Hoken*, everyone age 65 or older (and those age 40 or older with an “aging-related” condition), regardless of income and assets and whether family care is available, is eligible for assistance based on an objective test of activities of daily living. Individuals are placed in one of six disability levels, which provide from \$600 to \$3,500 per month in services. No cash allowance or subsidization of care by relatives is offered. Consumers can choose between institutional and community-based care. Although most providers are nonprofit, for-profit companies are allowed in community-based services.

As of December 2004, about 4.2 million older people (16 percent of the age 65 or over population) were certified as being eligible for the program.^{xi} Approximately 76 percent of insurance clients were in home and community-based care and 24 percent were in institutional settings, while the spending was divided 49 percent for community services and 51 percent for institutional care. A relatively unique characteristic of the Japanese long-term care system is that a substantial, although declining, portion of the institutional care is provided by hospitals for older people, most of which were not designed for long-term care. These hospital costs are paid under the acute care insurance program.

Expenditures on long-term care insurance beneficiaries in 2004 amounted to about \$42 billion U.S. dollars or 1.2 percent of the Japan’s gross domestic product (GDP). Future expenditures are estimated to rise to \$70 billion and 1.5 percent of the GDP in 2010 (*Asahi Shinbun*, 2005). The additional long-term care costs under health insurance add at least another 0.2 percent of GDP.^{xii} *Kaigo Hoken* expenditures were within budget for its first three-year fiscal period; premiums rose about 20 percent (around 7 percent per year) for the second three-year fiscal period.

Some deficits are now appearing, and the government is considering ways to achieve fiscal balance.

Japan has universal and comprehensive health insurance, including coverage of prescription drugs. Insurance is provided by various carriers based on occupation or residence, but it includes substantial regulation and subsidies from general revenues to assure equity. People over age 70 are assessed lower copayments than are younger people (Ikegami and Campbell, 2004).

Perceptions of Quality Problems

Historically, Japanese public administration has not emphasized quality assurance in the delivery of public services, beyond ensuring compliance with basic legal, administrative, and financial rules. Intensified public awareness of frail older people that coincided with the initiation of *Kaigo Hoken* has resulted in quality assurance being mentioned more often in connection with long-term care than in other policy sectors. Expanding the quantity of long-term care and the money spent on it through the public long-term care insurance program has raised concerns about quality of care. In fact, “from quantity to quality” was an explicit goal of the 2005 revisions of the public insurance law.

One aspect of long-term care quality that drew public attention in the past was the poor conditions in many of the hospitals that provided long-term care to older people (Campbell and Ikegami, 1998). Older patients were housed in multibed rooms and kept in bed with no activities, not even television. It was widely alleged that older patients were overtreated, particularly with prescription drugs, as hospitals sought to make money.

Another earlier quality issue was the lack of activity for many older people with disabilities. In the mid-1980s, a series of reports from the Ministry of Health and Welfare criticized the quality of care for older people in Japan, pointing out that the category of “bedridden” (*netakiri*) elderly—meaning people who spent nearly all their time in bed—was not used in other industrialized countries. In 1986, an estimated 600,000 elderly (5 percent of the population age 65 or older) were bedridden, 60 percent of them in hospitals or nursing homes (Ministry of Health and Welfare, 1989). The large numbers of bedridden older people were blamed mostly on structural factors (understaffed institutions, little attention to rehabilitation) but also on staff attitudes. The Ministry called for more spending to improve services but put most of its energy into the “zero bedridden” movement (*netakiri zero undou*), which was a public relations campaign aimed at changing ways of thinking about quality of care (Yamanoi, 1993).

More recently, the use of restraints in nursing homes has become a matter of concern. The Ministry of Health and Welfare declared restraints illegal at the start of the long-term care insurance program and launched an intensive “zero restraints” campaign. This campaign was mainly conducted through education and exhortation, not direct enforcement of regulations. In 2004, the Ministry of Health and Welfare signaled attention to the restraints problem by announcing a major nationwide survey of 12,000 facilities to assess its prevalence (*Asahi/International Herald Tribune*, 2004).

As in other countries, the media occasionally report cases of poor care in nursing homes. However, such coverage is quite different in tone from the media’s coverage of poorly performed operations and other mishaps in acute care. Nursing homes retain something of a halo

in the eye of reporters and the public, and cases of poor care are not portrayed as an indictment of the entire industry.

Quality Assurance Overview

Regulation and inspection of long-term care is shared by all three levels of government—national, prefectural (i.e., similar to state government in the United States), and municipal. The national government recently completed a comprehensive review of the public long-term care insurance program that focused on ways to improve quality of care.

Basic Quality Assurance Structure

The national government (i.e., the Ministry of Health, Labor, and Welfare) makes policy, including detailed standards in some fields, and provides active oversight of local programs. Prefectural governments license providers and inspect institutions. Municipal governments are on the front line; they plan and administer health and welfare programs for older people, and they are the insurance carriers for the long-term care insurance program. The influence of a mayor or a municipal old-age health and welfare office on long-term care quality is informal and hard to measure, but this influence is often thought to be substantial.

To address the division of responsibilities, Japan has a very high level of intergovernmental communication, particularly with regard to high-priority programs like the long-term care insurance program. For example, the director of the Health and Welfare Bureau for the Elderly convenes regular meetings of prefectural and municipal officials in charge of old-age programs to report on quality and other issues and to exhort them to push for improvement. Similar meetings are held at the prefectural level.

Many nongovernmental organizations also play a role in quality assurance. For example, Social Welfare Councils (*Shakai Fukushi Kyougikai*) have long directly operated many services and represented other not-for-profit providers. Most important are the networks of providers that meet to discuss mutual problems and propose new ideas, with quality often a major concern.

Consumer organizations do not appear to be important in maintaining the quality of long-term care for older people. The many watchdog groups that monitor nursing homes in the United States have no counterparts in Japan.

The Fifth Year Review

The original public long-term care insurance legislation called for a financial review every three years to adjust the fee schedule and contribution rates and for a comprehensive review in the fifth year of the program. The Fifth Year Review proposals were incorporated into amendments to the *Kaigo Hoken* law; the amendments were debated and then passed by the legislature in 2005.

The main theme for the review was ensuring fiscal sustainability, but a second goal was to shift attention “from quantity to quality.” Official thinking is well documented in an internal policy memorandum, which includes a section on “Ensuring and Improving Service Quality.”^{xiii} The recommendations for “ensuring and improving service quality” in the Fifth Year Review include strengthening evaluation and regulation, but they go well beyond such traditional quality-control techniques. First, one goal is to make programs more natural and less bureaucratic. This goal

would be met through “unit care” in institutions and local centers to deliver home and community-based care. The assumption is that quality means approximating what people would experience in their families or neighborhoods. Second, human resources are thought to be central to quality, meaning attitudes and understanding of staff at all levels as well as specific skills. In general, performance by individuals is the key to Japanese thinking about quality. Efforts to improve the quality of services concentrate on selection processes, training, and involvement in group activities to improve the motivations and capabilities of professionals and other workers.

Regulation and Inspection of Institutional Care

The number of long-term care patients in hospitals has dwindled but not disappeared since the advent of national long-term care insurance. Most of the older people remaining in hospitals are in chronic care beds, and most of these are in hospitals that only provide long-term care for older people. The national government issues detailed regulations for all types of hospitals. Close attention is paid to physical facilities and staffing levels. Hospitals are inspected every several years by prefectural officials. Despite the detailed regulations, oversight generally is not very intrusive except for major incidents, such as fatal medical errors or outbreaks of infection.

In general, nursing homes are attentive to guidance from the Ministry of Health, Labor, and Welfare. The national government issues highly detailed structural requirements for facilities and staffing for nursing homes, which vary by the number of beds in a facility. These requirements include a minimum number of direct care workers (nurses and nurse’s aides) and support staff, the amount of space per bed in rooms, and required equipment. Beyond that, new or rebuilt nursing homes must meet more detailed and rigorous specifications for new construction, such as the recent requirement that all rooms be private. In addition, the national government gives informal advice that builders find hard (but not impossible) to ignore.

Inspections (*kansa*) of institutions are conducted by prefectural governments, who have the authority to license facilities. In principle, inspections are annual, but in practice, the requirement is met every other year by submission of documentation rather than in-person inspections unless some serious problem is identified. The in-person inspections are scheduled in advance and are carried out by prefectural officials (sometimes accompanied by municipal officials). The inspections concentrate on physical plant, staffing levels, financial management, and accuracy of reports. Although the facility’s license could be revoked for periods of inadequate staffing, the only sanction employed is a reduction in payments from the long-term care insurance program of up to 30 percent. As part of the Fifth Year Review, the Ministry proposed periodic renewals of the license for long-term care insurance providers, as well as cancellation of the license for improper behavior, thus formalizing a mode of supervision that previously had been carried out primarily through consultations.

Quasi-Institutional Care

The fastest-growing elements of long-term care in Japan are residential care facilities, which are roughly the equivalent of assisted living in the United States, and Alzheimer’s Group Homes. Both types of facilities are specifically recognized under the long-term care insurance program, but insurance covers only the “care” portion of costs (by a fixed monthly fee depending on the assessed level of need); other costs, including room and board, are paid out of pocket at market rates.

Private sector developers became interested in older people some 25 years ago. For-profit companies were precluded from opening nursing homes, and so they built assisted living–type facilities called “fee-paying old-age homes” (*yuuryou roujin houmu*). Most were quite luxurious with high initial payments. The government first got involved in limited regulation of these facilities after some financial scandals. Long-term care insurance expanded the government’s role, and these facilities must now be licensed for coverage of the “care” portion of their services. Licensing establishes an initial approval process and a degree of continued oversight, but regulation of staffing, required equipment, space, and other factors are not as strict as for institutions.

Perhaps the most notable development in long-term care service delivery since the initiation of *Kaigo Hoken* has been the explosive growth of Alzheimer’s Group Homes (*Ninchishou Taiougata Kyoudou Seikatsu Kaigo*), which serve people with dementia. These residential facilities typically include five to nine small private rooms plus a big common room with kitchen facilities and often some outdoor space. They typically have eight staff, mostly part time, only one of whom needs any kind of license. There were 41 Alzheimer’s Group Homes in 1997, but well over 5,000 facilities by early 2005 (*Asahi Shinbun*, 2005b). The rapid growth is due, in part, to the restriction of institutional care to nonprofit organizations, while for-profit entrepreneurs can operate Alzheimer’s Group Homes.

The government has come up with several devices for quality assurance beyond routine checks. First, special guidelines to encourage interaction with families, the community, and local networks of providers, and training for staff and owners have been developed. Second, the government helped to create a trade association of Alzheimer’s Group Home operators and pushed it to work on quality issues, funding, materials on good practice, and self-evaluation.

Third, in 2002 the Ministry mandated that all Alzheimer’s Group Homes undergo an outside assessment of quality of care by qualified evaluators, making them the only type of facility for which nongovernment evaluation is mandatory. Rather than drawing on specialized evaluation experts or agencies, the Ministry decided that prefectures should recruit evaluators from among people in the long-term care field in the same geographic area—people who speak with the same accent as the staff in the home—so they could tell how well the home was fitting into local culture. Evaluators are paid a small stipend and expenses, which are borne by the home being evaluated (regarded as a nontrivial expense by some). All of the reports may be accessed from a single national Web page, which is part of the big Ministry of Health, Labor, and Welfare–supported Web site.

Prefectural or municipal officials do not appear to pay much attention to these third-party evaluations, except to ask whether they have been completed. From an official point of view, the annual government examinations are far more important because they identify breaches in the law or official regulations. The softer information from third-party evaluations does not provide much reason for intervention—especially because an “unsatisfactory” score on even one item is rare.

Home and Community-Based Care

Although the national government started supporting home helpers in the early 1960s, formal community-based care was largely restricted to “live-alone” (*hitorigurashi*) older people,

reflecting the assumption that care by children was the norm. Only well into the 1990s, when home care services had become more widespread, was much public concern expressed about the quality rather than quantity of services available. Municipal governments were supposed to be responsible, but they did not exert much formal authority over services in an increasingly fragmented system (Adachi, Lubben, and Tsukada, 1996). To help consumers navigate the long-term care system, nearly all beneficiaries use care managers, whose fees are covered by the long-term care insurance program without a copayments.

Services

Initially, prefectures were given the new responsibility of licensing home care providers, but this role is being transferred to municipalities. A commercial or not-for-profit services agency must file an application showing that it meets minimal standards of qualified staff and financial stability. No systematic review procedures exist for renewing or revoking licenses, although such provisions are under discussion. The revocations that have occurred are due to fraud. Therefore, unless a complaint is filed, providers need not worry much about quality enforcement.

All municipalities must maintain and publicize “windows” for complaints about welfare facilities and services. These windows are often not specialized by target population or services. Typically, there is a window in the municipal office and in the insurance office. In one ward of Tokyo, the most common complaints reportedly were about home helpers—for example, they do not listen, they do not work hard, they do not stay the whole time—and care managers. Relatively few complaints were about nursing homes, and these grievances usually involved a family member complaining about staff attitudes. The officials usually follow up complaints immediately by telephone—or with a visit in a small minority of the cases—and they claim that most problems are easily resolved.

Care Managers

The position of care manager is a new quasi-profession, created by the long-term care insurance program to fill the role that municipal officials held under the old system—that is, deciding on services and monitoring care. Long-term care insurance enrollees can manage their own care if they want, but the services of a care manager are free to consumers and the vast majority of beneficiaries use them. The cost of the care managers do not count against the individual’s monthly expenditure cap. All institutional care providers must employ at least one qualified care manager, and many community care providers are dually registered as care manager agencies (*Kyotaku Kaigo Shien Jigyousha*). Given the need for a great many care managers and the shortage of social workers, training and expertise requirements are modest—five years’ experience in a related field, passage of an exam, and roughly four days of training. The qualifying exam is extremely popular, with more than 337,000 people passing the exam by the end of 2004.⁴

The quality of care managers has been a concern since the long-term care insurance program started. Reportedly, care managers often see themselves as underpaid and overworked, complain about their jobs, and have low morale, which may be partly due to an ambiguity of their role. The care manager is supposed to represent the interests of the client, but most often he or she is employed by and accountable to a provider. Although many care managers went into the field because they wanted to do counseling, they spend most of their time with detailed accounting of use of services and copayments.

The Ministry of Health, Labor, and Welfare, local officials, activists, and academic experts have put a lot of energy into trying to improve the performance and morale of care managers, who are seen as a key to high quality services. As often is the case in Japan, the initial means for improvement were training and group process. Many books, brochures, and trade journal articles were produced, and care managers attended lectures and meetings to share their experiences and work on problems together.

The Fifth Year Review argued that care management is in need of systematic reform to improve quality (*Asahi Shinbun*, 2004). The reform mandated that caseloads be reduced from 50 to 30 clients and fees raised, that previously voluntary training activities be made mandatory, that the role of care managers be differentiated from the role of service providers, that improper behavior be more clearly defined, and that recertification be required and stricter punishments be enforced. In effect, this approach tries to make the care manager more responsible for quality control in individual cases by increasing training, improving working conditions, and providing rewards and penalties to change behavior.

Alternative Strategies for Quality Control

In addition to regulation, Japan is pursuing a number of alternative strategies to improve quality of care. These strategies include the following: competition, third-party evaluations, workforce quality, and local centers.

Competition

Before the introduction of the long-term care insurance program, nursing homes were totally dependent on the municipal government for funding and for referrals. Similarly, home and community-based services were financed by the municipality and usually were provided under contract with not-for-profit organizations, often the local Social Welfare Council that had long and intimate ties to the municipal government. Municipal officials thus had a formal oversight role in long-term care that in many cases broadened to a paternalistic sense of responsibility. As long as the rules were followed, oversight was rather undemanding. These arrangements did not provide much in the way of positive mechanisms for quality assurance.

The long-term care insurance program was expected to fundamentally change these relationships because service choices and funds were given to consumers rather than to the local government. In theory, facilities and agencies would now compete based on quality. But, according to some observers, it is questionable whether the old vertical relationship has eroded all that much for two reasons. First, municipalities have a generalized responsibility for the quality and quantity of services, and in the rather deferential culture of the Japanese welfare agencies, local officials are likely to be respected. Perhaps most important, nursing homes are still embedded in fairly dense, informal or semiformal networks of people and institutions concerned with old-age care, and the local government is much involved. These factors inhibit the exercise of consumer autonomy, at least to some extent.

Second, although the use of community care has increased, the long-term care insurance program also brought unexpected demand for institutional care because it offered care to all older people regardless of income at much lower out-of-pocket cost, well outstripping the number of beds (Campbell and Campbell, 2003). Concerns about a “shortage” of beds and long waiting lists

diminish the competition that could provide incentives for quality. In addition, nursing homes do not really have much control over admissions because the Ministry responded to high demand by requiring that facilities prioritize admission by considering income and availability of family care, the same criteria used in the early “placement system” days. Supply is constrained because 75 percent of construction funds are from public sources, which are limited.

Since the advent of long-term care insurance, the situation of home and community-based care has changed more dramatically than for nursing homes. Traditional providers like the Social Welfare Councils have kept their business better than many expected, but most of the rapid expansion of clients has gone to new, for-profit agencies. Coupled with the fact that formal oversight is much less strict than for institutions, home and community-based service providers are much more autonomous from top-down influence regarding quality or anything else.

Few Japanese older people and their families are truly aggressive consumers; however, according to some experts, many consumers try a number of agencies before finding one they like, and people seem willing to complain and to fire care managers or service providers. Certainly, community-based care agencies are very conscious of the need to compete for customers through active marketing and, because prices are fixed, through appeals based on quality of care.

Third-Party Evaluation

The biggest innovation in formal quality control in Japanese public administration is “third-party evaluation” (*daisansha houka*). Site visits and other inspections are carried out by nongovernmental organizations, including trade associations, not-for-profit evaluation organizations, or individual experts recruited by the government. These third-party evaluations are similar to “report cards” in other countries, but there is no pass-fail rating system as with accreditation. In the long-term care field, the Ministry of Health, Labor, and Welfare strongly urges but does not require third-party evaluations, and prefectures vary in how heavily they encourage them. Providers pick their own evaluators, and the business is quite competitive on the basis of price and convenience. In Tokyo and many other prefectures, the results of the evaluations are posted on the Internet to help consumers choose providers. Local officials do not use the reports much, relying instead on formal inspections and complaints. The main value of the process may lie in what the staff of the provider learn from the evaluation.

As part of the Fifth Year Review, the government also called for a systemization of third-party evaluations of long-term care agencies and facilities, including a regular schedule for posting the results on the Internet in standardized form. Responsibility for this system of evaluations is lodged with the prefectures. The Ministry of Health, Labor, and Welfare is initiating a model project to develop procedures for evaluations.

Workforce

Informal observation over a period of years by the authors suggests that basic quality of care for residents of Japanese nursing homes has been good overall, despite many obvious deficiencies, such as overuse of restraints and multibed rooms. The main reason appears to be the quality of staff—nurse aides are older and more experienced than in the United States, they are better paid, their turnover rate is far lower, and they are more integrated into the caregiving mission of the

institution through training and customs that amount to participatory management (e.g., the daily morning meeting, in which aides do much of the talking about the residents).

The government has promoted improvements in the long-term care workforce. In 1988, the Ministry of Health and Welfare created two new official certifications in the welfare field: Certified Social Welfare Specialist (*shakai fukushishi*) and Certified Care Worker (*kaigo fukushishi*). As in many other fields, official certifications are attained by passing a government examination or by graduating from a prescribed training program. The first designation is roughly equivalent to a social worker in the United States, but until recently few positions were available for which this status had a major advantage over the Certified Care Worker designation. The Certified Care Worker designation, however, has been attractive to people in the field as a marker for expertise in caregiving.

The examination for Certified Care Worker has an academic and a practical part and is given once a year in several locations for a fee of about \$100. To take the exam, applicants must have either three years of experience in a caregiving job (usually a home helper or a nurse's aide in an institution) or a high school degree with a welfare major. Officials looking to upgrade quality think first of adding more advanced topics to the examination. A lower level certification system qualifies workers as a Home Helper First or Second Grade and uses a combination of experience and training. Such efforts have been one factor in a substantial improvement in the visibility and image of caregiving as a profession.

Another example of this changing status is the rapid growth of university departments offering four-year degrees in social work or related fields. Many graduates of these programs, along with graduates of other two- or four-year college programs, have taken basic-level jobs as home helpers or nurse aides. For this and other reasons, levels of training are typically higher than in the United States.

The Fifth Year Review stressed enhanced expertise and specialization of long-term care staff, including family doctors and nurses, particularly in the care of people with dementia. Moreover, directors and administrative staff of institutions and agencies are said to need more training and testing in both service delivery and general management. The review notes that home helpers are the key to high quality community-based services. However, it pointed out that an increasing proportion of home helpers are not regular staff; some have only one or two clients and go directly from their homes and return, which makes information and skill upgrading difficult. In general, the report argued that personnel management standards were at a low level in the long-term care field and that rapid improvement is a high priority.

Local Centers

As part of the Fifth Year Review, the Ministry proposed a major change in service delivery by creating "local comprehensive support centers" at the neighborhood level. These centers would be sufficiently integrated into local society to have a real grasp of the situations of the elderly population and could easily intervene to correct poor caregiving, protect human rights, or improve people's physical or mental functioning. The idea reflects a perception that long-term care programs are too fragmented and remote from people's lives.

Summary

The Japanese system of quality assurance has several distinctive characteristics:

- An important contextual difference from the United States is that long-term care is viewed rather positively by the general public. Media reporting is virtually the opposite of that in the United States, where stories about nursing homes (and increasingly assisted living) are generally about poor quality care, scandals, and loneliness. Japanese media run negative and positive stories about long-term care, although they rarely report anything positive about the medical care system.
- Responsibility for inspections is divided across the national, prefectural, and municipal governments. For nursing homes, inspections are often rather formalistic and paperwork oriented, although specific standards for staffing are carefully monitored. With the exception of reductions in payments for understaffing in nursing homes, significant penalties are rarely imposed. In-person inspections usually take place only once every other year. Limited reliable and systematic data are collected, and it is hard to assess whether the process is effective. Evaluations of Alzheimer's Group Homes are probably more effective, mainly because they seem more targeted and less routine than other evaluation methods. In addition, the effort has a high government priority and is carried out with some enthusiasm. Formal ongoing regulation of home and community-based services is minimal, with the system largely depending on care managers and consumer choice to monitor care.
- Alternative or informal processes of quality assurance are important in Japan. Government officials routinely exhort providers to improve quality, and numerous opportunities are available for additional training. Indeed, the professional training of workers is a major emphasis in the Japanese quality assurance system. Competition and consumer choice in community-based care appear to play important roles. On the nursing home side, however, excess demand and a shortage of beds limit the ability of consumers to choose facilities based on quality. Although there has been a major push toward third-party evaluations by private organizations in addition to government inspections, providers choose their review agency, which creates a conflict of interest, and inspections do not appear to be very rigorous.

The Fifth Year Review of the long-term care insurance program identified a number of areas for improvement but also pointed out that this big new program generally had been well implemented and had come to be accepted as normal and appropriate social policy by the Japanese population. The review's theme of "from quantity to quality" represents a transition to a more mature program rather than a response to a big upsurge of quality problems.

Appendix D References

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Appendix D Endnotes

^{xi} Current official statistics are available at http://www.dbtk.mhlw.go.jp/toukei/kouhyo/indexkk_5_46.html.

^{xii} Estimated from the Ministry of Health, Labor, and Welfare statistics on patient numbers.

^{xiii} See www.mhlw.go.jp/topics/kaigo/osirase/tp040922-1.html; also see *Asahi Shinbun*, (2005 a and b).

⁴ See www.mhlw.go.jp/houdou/2004/12/h1227-4.html.