Issue Note

High-quality long-term care homes: International approaches in implementing reforms

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Executive summary

The purpose of this report is to highlight key lessons for Canada in adopting quality assurance mechanisms to improve the quality of long-term care homes (LTCHs).

This report is the second of two papers by CanCOVID on the quality of long-term care. The first report focused on ***Quality assurance mechanisms in long-term care homes: Evidence from abroad***. This second report gives examples on how jurisdictions implemented a mix of interventions to ensure quality of care in LTCHs, and what Canada can learn from these implementation processes. Thus, the first paper covered the "what" question and the second will delve into the "how".

Note also that while long-term care (LTC) in European countries typically refers to care provided in both LTCHs and in the home setting, this report focuses only on institutional care.

Question

What can Canada learn from the way quality assurance mechanisms have been implemented abroad to improve quality of care in long-term care homes?

In reviewing the evidence for this report, we found no apparent association between the quality of LTCHs and quality assurance mechanisms. Quality assurance mechanisms are categorized in the literature as broadly falling under: regulatory mechanisms, economic mechanisms, and informational mechanisms. Existing evidence on LTC quality is skewed towards associations with financial expenditure and fiscal measures and this is driven by concerns worldwide over fiscal sustainability of LTC. In general, peer-reviewed research in quality of LTC settings lags behind research in quality of care in acute-care settings; therefore, this report on LTC quality has been heavily reliant on grey literature produced by policy and research institutes.

Overseas experience suggests that a multi-pronged approach to driving LTCH quality is necessary – one underpinned by dignity as a core value, one that is mindful of the place of LTCH within the wider health and social care sectors and its relationship with the informal care sector, and that considers both intended and unintended consequences of proposed mechanisms. Due to the observed cycles of reform, reform reversals, and re-reforms in jurisdictions around the world, assuming a more formative and learning approach when introducing new, or modifying existing, quality assurance mechanisms may be helpful in the Canadian context, bearing in mind the ten lessons presented in this report:

Lesson 1: Countries have taken advantage of policy windows to advance quality improvement in LTCH. Quality assurance regimes are shaped by a country's unique policy traditions. Policy legacies present not only constraints but can also have enabling effects and spark policy innovation. This can happen during major 'focusing' events which open a 'policy window' for bold governmental action. The SARS-CoV-2 pandemic and its impact on LTCHs is an example of a focusing event which did create a window of opportunity for policy innovation.

Lesson 2: Building of specialist capacity and capability in LTC clinical and managerial leadership is a core component of quality reforms. Foresight and leadership are necessary preconditions in launching a new quality assurance initiative or mechanism: expertise is needed in a wide range of areas not restricted to just LTCH specialization but in organizational development, quality management, and adult training as well. Alliances that span institutional

and geographic boundaries can contribute to building clinical and managerial leadership expertise within the LTC sector.

Lesson 3: Attention is paid to ensure the right incentives exist and are aligned with a country's quality assurance mechanism. The current worldwide shift from structure and process measures to outcomes measures must be accompanied by incentives that are aligned with objectives to improve quality. A relationship-centred orientation to quality assurance mechanisms can incentivize providers to improve quality on their own regardless of whether there is government oversight.

Lesson 4: National-level government involvement is common. Even countries with decentralized quality assurance systems have national governments which play an active role in regulating quality, particularly with respect to national legislation, standards, and inspection regimes.

Lesson 5: LTC quality regulators must be appropriately resourced. Much is expected of regulators yet some are hampered due to inadequate resourcing. It is important to consider the operational sustainability in terms of its capacity and capability when setting up an independent regulator to regulate quality of care in LTCHs, and to be aware of the limitations of regulators since harsher sanctions are rarely utilized in practice so effectual follow-through is essential.

Lesson 6: Public reporting must be understandable and inform decision-making. It is not enough to achieve accuracy and transparency of information; publicly available information must be understandable from a user's perspective and have practical value in decision-making. Evidence shows users may not be aware of the existence of public reporting, if they are then they may not understand the information, and despite having the information, make decisions based on factors other than or in addition to quality.

Lesson 7: Fiscal capacity is a fundamental requirement. Sustainable funding is necessary to support robust quality improvement mechanisms. All countries reviewed reported challenges with fiscal sustainability, and Canadian experts recommend attention be paid to the uneven fiscal capacity between levels of government and between provinces.

Lesson 8: Shifts to home care can result in unintended de-professionalizing of care provision. Shifts from institutional to informal and home-based care can have the unintended impact of reducing care expectations and lowering professionalism in the LTC sector.

Lesson 9: A community-development and whole-of-society approach to LTC needs is the way forward. Neighbourhood and community development have been a critical part of some countries' reform journies towards increasing quality of LTC, and evidence is building (but currently sparse) in terms of the impact of these on LTC quality.

Lesson 10: **LTC reforms reflect changing cultural norms and advanced jurisdictions are increasingly incorporating preventive LTC – services that aim to prolong independence and re-enable older adults to live well outside institutional care for as long as possible – in its purview**. LTC reforms can reflect shifting cultural values and the most advanced jurisdictions are incorporating preventive long-term care into its purview for action.

Definitions

Quality is a social construct and its perception differs from person to person. Quality of care depends on the nature and function of care, about which there is no universal consensus. [1] Therefore, a wide range of conceptualizations of LTC quality exist in the literature. For example, the Organisation for Economic Co-operation and Development (OECD) reports typically articulate quality of care as having these dimensions: effectiveness, safety, patient-centredness, care co-ordination, and integration[2] whereas European academics articulate different dimensions: availability, accessibility, affordability, person-centredness, comprehensiveness, continuous improvement, and outcome-orientation. [3]

Quality of care is commonly defined by national governments or national-level stakeholders who provide a framework for quality, which is then implemented at a local or regional level. Countries differ according to the degree to which monitoring of the framework is seen as a responsibility of the central government or a decentralized function of lower administrative structures.

Quality assurance in this paper is defined as "the activity of third parties to ensure and certify defined quality criteria from an external perspective"[4] and, as described above, it is acknowledged that quality itself is conceptualized differently by different jurisdictions and stakeholders. [5]

Long-term care (LTC) in Europe is typically used to describe both LTCHs and care provided in home settings (referred to a 'home care'). In this report, we focus on *long-term care homes (LTCHs).* This paper uses the Health Canada definition of LTCH: living accommodation for people who require on-site delivery of 24-hour, 7-days a week supervised care, including professional health services, personal care, and services such as meals, laundry, and housekeeping. [6]

Methods

Literature review: A literature review was undertaken to identify information on quality in long-term care homes, searching for systematic reviews in the first instance, then expanding to studies in the peer-reviewed and grey literature. Databases used included Cochrane, PROSPERO International prospective registry of systematic reviews, Centre for Reviews and Dissemination (UK), Health Systems Evidence Database, Epistemonikos, Agency for Healthcare Research & Quality Evidence-Based Reports, Evidence Synthesis Network, WHO COVID-19 Global Literature, TRIP, Google Scholar, and Canadian Foundation for Healthcare Improvement database.

Search terms and phrases included long-term care, nursing home, residential care, care home, aged, elderly, quality, reforms, review, regulation, implementation, and lessons. This approach was supplemented with information obtained by extensive grey literature searches which included national health and social care websites, key international reports including those produced by the OECD, the European Commission's European Social Policy Network, and the World Health Organization (WHO), articles recommended by experts, and reviewing reference lists of identified relevant reports and articles.

Search terms and inclusion criteria can be found in Appendix 1.

Countries included in this paper include Denmark and the Netherlands, two countries which stand out in the literature as having high-quality LTC systems. Other countries were selected based on similarity to the Canadian context – for example, Sweden, like Canada, has a decentralized data-measurement/public-reporting based system for LTC quality assurance – and countries were also selected as contrasts to the Canadian context, for example Australia and the UK are both centralized inspection-based systems.

Interviews: Key informants were selected on the basis of scientific expertise and/or health systems leadership in the domain of long-term care, as well as availability in the time available for the production of this report. They were interviewed to provide views on the current state of the evidence available on the topic and to clarify aspects of work they have published on this topic. See Appendix 2 for details on the key informants who were invited to provide comments.

Limitations

This paper has been produced with substantial reliance on grey literature, particularly reports by research and health organizations, and draws from peer-reviewed journal articles and informant interviews.

Given time constraints, it is not an exhaustive international review of implementation processes relating to quality assurance mechanisms in LTCHs and we do not strive to compare implementation processes in detail. Jurisdictions were selected based on relevance and include a range of contexts and mechanisms.

While quality assurance systems are typically designed across four levels (system, organizational, professional or carer, and resident) this paper is focused on system-level mechanisms.

Additionally, we have focused on quality assurance mechanisms in formal care and have not considered unpaid caregiving (informal care) i.e. unpaid care provided by informal or unpaid caregivers such as spouses/partners, other members of the household and other relatives, friends, neighbours, and others), though it is noted that informal care quality is one of the least researched areas in LTC literature. [7,8] See CanCOVID's upcoming report on engaging informal carers in long-term care: *Supports and interventions to integrate unpaid caregivers in long-term care and in the care of those aging in place among OECD countries.*

Findings

Government policy interventions in LTC in Europe and North America started about 30 years ago and have given rise to a variety of LTC systems. A policy legacy refers to public policy traditions within a country based on an established profile of strategies. [9] Policy legacies are one of the most influential forces determining the direction of future reforms. [10] The countries we focus on in this report cover a diverse range of policy legacies including the type of welfare regime that exists in a country. Using the classification of welfare regimes developed by Esping-Anderson, this report covers countries with[11]:

- Liberal welfare regimes such as Canada, the United Kingdom (UK), and Australia where benefits are means-tested, universal cash transfers are modest, and some social insurance schemes exist;

- Conservative welfare regimes such as Austria where there are status differentiation and social rights are related to status and class, and compulsory labour market insurance is common; and
- Social Democratic welfare regimes such as Denmark and the Netherlands, which provide many universal benefits since social rights are based on citizenship. [12]

In actuality, many countries are some form of hybrid of the above regimes, for example, the UK has been described as a 'liberal-social democratic' regime[13] and the Netherlands has been described as a 'democratic-conservative' regime. [14]

In a previous CanCOVID report, *Quality Assurance Mechanisms in Long-term Care Homes: Evidence from Abroad*, LTC quality assurance regimes were described as being either professionalism-based, inspection-based, or data-measurement/public-reporting-based and it was noted that, although there is evidence of association between health outcomes and welfare regimes (as evidence shows Scandinavian welfare regimes provide better health compared to other regimes), there is no evidence of an association between the choice of quality assurance regimes and welfare regimes. [15,16]

Policy legacies matter and policy windows present an opportunity

While underlying welfare regimes do not necessarily determine the mix of quality assurance mechanisms used in a country, policy legacies do, and legacies have both constraining but also enabling effects. Therefore, the legacies can create room for policy innovation despite apparent path dependency[1]. [17] This is consistent with Kingdon's 'policy window' framework which suggests that bold government action is more likely to happen during relatively short 'policy windows', when dramatic 'focusing events' bring a topic onto the policy agenda and direct public and political attention to particular policy problems. [18] The disproportionate impact of the SARS-CoV-2 pandemic on LTCHs[19] could be considered a focusing event opening a 'policy window' for government action.

Lesson 1: Countries have taken advantage of policy windows to advance quality improvement in LTCH. Quality assurance regimes are shaped by a country's unique policy traditions. Policy legacies present not only constraints but can also have enabling effects and spark policy innovation. This can happen during major 'focusing' events which open a 'policy window' for bold governmental action. The SARS-CoV-2 pandemic and its impact on LTCHs is an example of a focusing event which did create a window of opportunity for policy innovation.

An example of when a policy window was opportunistically used to effect major reform is the 2007 structural reform in Denmark which was described as the 'greatest public sector reform ever undertaken in Denmark'[20] and which set the course for future development of the Danish welfare regime and set a foundation for its LTC system. Five new regions replaced existing counties, and the number of municipalities fell from 271 to 98. The Berlingske Tidende newspaper's coverage of a public poll in support of this downsizing and of reform-friendly articles opened a policy window. A Danish politician, Rikke Hvilshøj, who opportunistically linked the three-level governmental structure with the high tax burden on the Danish people, together

[1] Path dependency is the tendency to develop in certain ways that are driven by historical patterns: what has happened in the past persists due to resistance to change.

with other policy entrepreneurs skillfully took advantage of the window to bring about the largest public sector reform in Denmark. [21]

Quality assurance is commonly a shared governmental responsibility and new mechanisms require new clinical and managerial skills

Most countries around the world,[22] including countries covered in this report have a decentralized system for quality assurance with multiple levels of government or entities responsible for regulating quality. Almost every country has struggled with the tension of national or federal involvement versus the desire for local autonomy at provincial or regional or municipal levels. Local autonomy is described in the literature as the authority of lower-level governments to make independent decisions about delivering services, and national-level governments are typically concerned about access to, and consistency of service standards, across geo-political jurisdictions within a country, and across different demographic populations. [23]. The two levels of government are often in a state of tension since both have interests, although different roles, in ensuring LTC service delivery to the population.

The Netherlands has been a system of decreasing the extent of national government responsibility for LTC as well as decentralizing responsibility to the municipal level. The Dutch experience of LTC reform is a part of a wider reform journey in that country – moving from a social insurance model to managed competition between private insurers – over the past 20 years following the integration of social private health insurance systems. The evidence examining this change has shown that it is possible to fundamentally change the underlying model of service and provision despite failures along the way. Earlier attempts at reform in the 1990s failed because of objection from insurers, employers, and clinicians, as well as due to changes in government. However, the original plans contained sub-reforms and overtime, those sub-reforms were gradually implemented, and these incremental changes opened the way to more fundamental changes to be introduced in 2006. [24,25]

The 2007 reform decentralized government responsibility in LTC with the introduction of the Social Support Act. It has been described in the literature as ‘the start of a contentious policy drama; a struggle between the national government and the municipalities’. [26]

LTC reforms in the Netherlands required new expertise and skills, and most municipalities anticipated this by embarking on internal restructuring initiatives, retraining staff, and hiring new staff with the necessary skills.

The Austrian experience also holds important lessons regarding the role of foresight and leadership in effecting reforms. Austria and Canada were countries which failed to prioritize the LTC sector early in the SARS-CoV-2 pandemic. [27] Similar to Canada, Austria did not have a wider ‘elder care system’ which encompassed LTCHs as part of a larger plan to address the needs of older adults and had no long-term care ‘system’. Instead, there are a number of measures at various governance levels that together consider long-term care needs of Austrians. The federal government oversees the universal allowance for LTC, and the provincial governments are responsible for LTC (in both LTCHs and in-home care). [28]

Over the years, the federal government has become more involved in LTC issues under its federal responsibility in consumer protection, even though the nine provinces are responsible for providing LTC services. When a universal allowance for long-term care was introduced in 1993,

the federal government and the nine provinces drew up an agreement, describing the services to be provided and quality standards. The two levels of government in collaboration with stakeholders including LTCHs themselves established a National Quality Certificate for Old Age and Nursing Homes (the 'NQZ'), which LTCHs can voluntarily apply for. The purpose of the national quality certificate was to 'make visible' quality assurance measures in LTCHs which go beyond what is legally required, and to create an incentive for quality improvement. [29]

This system was predicated on a pre-existing voluntary quality management system, E-Qalin, which was established around 2007 by stakeholders, providers, and researchers coming together to develop a quality management system in response to deficiencies in quality and inspection methods. The E-Qalin process trained managers as well as facilitators to carry out self-assessment and to implement continuous improvement processes in LTCHs.

Prior to the adoption of quality management in LTC in Austria, there existed a wider EU project called the European Quality Improvement and Innovative Learning (E-Qalin) from 2004 to 2007, involving 30 organizations from seven members states, where a working party was established in 2005 by the Austrian Ministry of Labour, Social Affairs and Consumer Protection and Federal Association of Old Age and Nursing Homes). [30]

As formally described in published studies, the EU project to establish a transnational quality system for LTCHs was initiated by the Austrian Institute for Training and Education in Public Health. [31] However, in a personal account by an academic observer at the time, the E-Qalin initiative was the result of a 'lucky encounter' between the President of the Austrian Federation of Care Home Managers, a director of the IBG (Institut für Bildung im Gesundheitswesen), and a private consulting institute. A multidisciplinary group of experts, including Dr. Leichsenring, bringing together gerontology, care home management, but also adult training, quality management and organizational development, convened to inspire this development.

There is some literature emphasizing the importance of both clinical and administrative leadership in LTCHs. In many countries, LTCHs are without general or specialist health professionals to provide clinical leadership within the nursing home, resulting in inferior medical care within LTCHs and a continuation of the perception that nursing homes are not attractive career-progressing settings for clinicians and managers to work in. [32] The lesson for Canada might be to consider forming a pan-Canadian alliance to develop nursing home capabilities – both clinical and managerial, as has been suggested by other international task forces.

Lesson 2: Building of specialist capacity and capability in LTC clinical and managerial leadership is a core component of quality reforms. Foresight and leadership are necessary preconditions in launching a new quality assurance initiative or mechanism: expertise is needed in a wide range of areas not restricted to just LTCH specialization but in organizational development, quality management, and adult training as well. Alliances that span institutional and geographic boundaries can contribute to building clinical and managerial leadership expertise within the LTC sector.

The pilot phase of the Austrian initiative that started in 2008 involved 14 LTCHs proposed by the provincial governments, all of which were awarded the NQZ. In 2011, the NQZ was given a legal basis and an NQZ organization was created. The NQZ is a voluntary certificate for LTCHs which prioritizes process and outcome quality. It is a 'positive incentive system'. LTCHs must have the following in place to apply for an NQZ: a quality management system, a self-

assessment process, a process that involves stakeholders, and a consumer satisfaction survey. [33]

Figure 1: The E-Qalin Framework

Table 2.3 *Overview of the E-Qalin model to assess and improve the quality of care homes in Austria*

Structures and Processes (66 criteria = 50 per cent)	Results (25 partial results assessed by key performance indicators = 50 per cent)
Five Perspectives	Five Perspectives
• Users, e.g. biographical approach, privacy, care process	• Users, e.g. quality of care, user satisfaction (quality of life)
• Staff, e.g. working time arrangements, cooperation, communication, incentives	• Staff, e.g. satisfaction with working conditions, staff-turnover
• Leadership, e.g. corporate policies, organization, financial management	• Leadership, e.g. economic viability, financing, costs
• Social context, e.g. relationships with families, partners, media	• Social accountability, e.g. satisfaction of family and friends, attractiveness as employer
• Learning organization, e.g. learning, transfer of knowledge, assessment	• Future orientation, e.g. sustainability, education and training

Source: *Regulating long-term care quality: An international comparison. p. 57.* [34]

The E-Qalin framework, shown in Figure 1 above, does not prescribe standards or key performance indicators; instead, LTCHs are supported to work with those key performance indicators that are most suited to their current status and that improve transparency. [35]

As mentioned, the E-Qalin initiative was seen as a successful initiative in Europe[36], and based on this, the Austrian Ministry for Social Affairs and Consumer Protection started the initiative to develop the NQZ. The NQZ was conceived as a tool for voluntary external certification of LTCHs who already have in place a recognized quality management system, and so the NQZ was to be a supplementary external audit to complement the self-assessment process at a national level. [37] As mentioned, the aim was to make visible the quality of care in LTCHs and provide incentives to drive up quality by sharing good practice and providing visibility for certified providers. In Austria, clients are free to choose between providers so the NQZ can improve providers' market position. In 2014, Mor et al reported that the NQZ was to be rolled out over the 'next few years' and enjoyed broad support including from most regional governments. Mor et al noted that the NQZ 'will remain on a voluntary basis as experience has shown that organizational improvement only works if management and staff are engaged in quality management, rather than perceiving it as yet another bureaucratic exercise to please funders, regulators, or purchasers. [38]

One region (Lower Austria) did attempt to make E-Qalin mandatory several years ago, but uptake was low since management perceived this as 'yet another bureaucratic burden' rather than an opportunity to improve.

Of the 900 LTCHs in Austria, about 300 use E-Qalin or another accredited quality management system, and only 54 LTCHs have been awarded the NQZ as of January 31, 2022. [39]

Dr. Leichsenring reported that it is a struggle to encourage LTCHs to sign up for NQZ as it is first and foremost, voluntary, and the benefits of the time-consuming process to the LTCHs may not be enough to motivate LTCHs. 'More funding would be needed, but also more incentives for care homes, and constant support for how to work with this system, and why it makes sense in terms of user and staff satisfaction'.

There is a strong association between incentives and uptake of quality improvement initiatives in the evidence reviewed. Within the field of quality improvement, there has been a shift from provider-centric ways of assessing quality to consumer-directed quality measures and to relationship-centred quality measures. Provider-centric quality is primarily concerned with what providers are interested in to assure themselves that they are providing safe quality care, but for some providers, such levels of quality represent the ceiling and limits their effort to strive beyond this ceiling. Critics of the existing system have described the rise of consumer-directed quality as a response to decades of care according to the dictates of providers with consumer views rarely sought. It can be spotted when providers treat residents as consumers and provide what some experts call 'are the pillows fluffed' indicators (also called 'cruise ship living' by others). Whereas with relationship-centred quality, the focus is on the resident as a unique individual and the relationships surrounding that resident with carers (both formal and informal). [40,41]

In a webinar presentation by Michael Wolfson, PhD in February 2022, Dr. Wolfson explained:

> "When we want to determine a program is working well, we would evaluate whether the structure is working well, are there processes in place and what are the outcomes? (Typically organizations) have a structure and processes, but no way of evaluating outcomes because they do not have the data. But even if LTCH providers may be aware of the quality of care, their incentives may not be necessarily aligned." [42]

Studies reviewed for this report contain quality measurement approaches that can be broadly categorized as being organization/provider-centric, consumer-directed, or relationship-centred. [43] Figure 2 shows the different orientations of quality measurement, presents examples of each type, and comments on the impact on quality through the presence of incentives.

Figure 2: Different orientations of quality measurement and corresponding incentivized behaviours

Orientation of quality measurement	Example of this in practice	Incentivized behaviours
Organization- or provider-centric quality measurement	Inspections by regulators in the UK and Australia to make sure residents are safe. The focus is on measures that are assessed by the regular, which are focused on the provider organization e.g. "please rate the cleanliness of the facility from 1 to 5."	The way governments pay providers can incentivize them to focus too much on organization-focused quality. There is evidence that regulations raise quality to a basic level but not beyond. [44] There is also evidence that providers can actually reduce their superior performance to meet a lower minimum level prescribed by regulations, thereby increasing apparent resource efficiency. [45] Furthermore, in the UK system, which passes or fails providers, there is no way of knowing if they had just 'scraped through'. [46]
Consumer-directed quality measurement	Provider-centric quality measurement becomes subservient to consumer-directed measures of quality. The most common type of consumer-directed measures are consumer or client satisfaction measures such as "how satisfied are you with the quality of care in this facility or home?" which some researchers say is "an unfortunate label because there is general confusion about what consumer satisfaction means and how to measure it, and most satisfaction measures are not based on areas of service considered important to consumers." [47]	Providers are incentivized to improve consumer-directed quality to attract potential residents. However, there is evidence that LTCH users often lack the ability to understand and interpret quality data, even when available publicly[48] and may focus on the superficial factors such as the foyer and the way the building looks[49]. There is also evidence that residents' satisfaction may not align with quality: 'quality riddles' exist when some residents may want more autonomy and may choose a lesser standard of care (and therefore a substandard of service)[50] e.g. a user may report that they are more pleased with the service from a less qualified carer not trained in dementia, than a more competent carer.
Relationship-centred quality measurement	Measuring person-centred care or relationship-centred care focuses on the needs of the person and the quality of their relationships and has been a response to counter reduction, medical-centric and commercialized ways of measuring quality. [51] An example would be: "Rate your satisfaction with the level of involvement your family and significant others are able to have, in making decisions about your care at this LTCH."	Providers are incentivized to improve quality on their own, without or regardless of government involvement. [52]

There has also been an international shift away from medical-centric and process measures to measures that focus on quality of life and person- and relationship-centredness although operationalizing these concepts has been difficult[53] as it is challenging to capture personal care experiences accurately. [54] Nevertheless, the Netherlands is one of the few OECD countries, along with England, which monitors residents' experiences in LTCHs such as through indicators on care plans, autonomy, and privacy. [55]

There are few studies on the impact of interest groups on the quality of LTCHs despite a large number of reports from interest and advocacy groups calling for quality of life measures, improved accountability, and new models of care. Although few studies have examined the role of interest groups in driving quality of LTCHs, a Danish LTC expert has indicated the importance of interest groups as a driver of quality in Denmark's LTC system. Ældre Sagen (Dan Age) is one of the key Danish interest groups – a non-profit organization with membership of almost a million people or 16% of the population. It is because of organizations like this that the LTC sector is continually kept on the radar as a priority for the country. [56]

Lesson 3: Attention is paid to ensure the right incentives exist and are aligned with a country's quality assurance mechanism. The current worldwide shift from structure and process measures to outcomes measures must be accompanied by incentives that are aligned with objectives to improve quality. A relationship-centred orientation to quality assurance mechanisms can incentivize providers to improve quality on their own regardless of whether there is government oversight.

Even decentralized regimes create room for national-level intervention

The most recent round of reforms in the Netherlands, which runs a decentralized inspection-based quality assurance system, took place in 2015, driven by austerity measures to safeguard financial sustainability and changing societal values. These reforms saw deinstitutionalization, further decentralization, and an increased focus on informal care provision. The reform was a continuation of the market-oriented reform philosophy that started in the 1980s to introduce regulated competition in the healthcare sector[57] and the impact of the reform on quality outcomes is not yet clear. [58]

In the Netherlands, quality monitoring is the responsibility of municipalities and local councils. The decentralized system concurrently targets the direct service level and focuses on providers as well as health professionals in its regulatory mechanisms, through two laws governing LTCH quality: (i) Law on quality in care organizations; and (ii) Law on professions in health care. [59]

- Regarding the first law, LTCHs are obliged to deliver quality care defined as effective, efficient, patient-centred, and attuned to the realistic needs of the patient. LTCHs have a degree of discretion to effect this and must have a quality system as well as submit an annual quality report to the Dutch Health Care Inspectorate (IGZ). The IGZ uses the information and determines a percentage of LTCHs to be inspected. If necessary, the Inspectorate can direct strict controls or further enforcement post-inspection. [60]
- Regarding the second law, the law specifies educational requirements for eight professions (physicians, dentists, pharmacists, clinical psychologists, psychotherapists, physiotherapists, midwives, and nurses). All practitioners of these

> professions have to be registered and residents can look up any provider in the register to check if they are qualified. Additionally, the law makes it a criminal offence for a professional to damage a client's health. [61]

Despite this decentralized system in the Netherlands, quality assurance is still a shared responsibility between central and municipal governments, and the IGZ – which monitors quality, safety, and accessibility. The IGZ is part of the Ministry of Health, reports directly to the Minister of Health, and has the authority to place LTCHs under supervision due to inadequate quality. In fact, in 2015, the IGZ placed 150 LTCHs under supervision due to poor quality. [62]

Similarly, the Swedish national government appointed the Health and Social Care Inspectorate (IVO) to conduct a large-scale inspection of LTCHs for quality and safety, during the SARS-CoV-2 pandemic, although known for its decentralized system for quality assurance. [63]

Lesson 4: National-level government involvement is common. Even countries with decentralized quality assurance systems have national governments which play an active role in regulating quality, particularly with respect to national legislation, standards, and inspection regimes.

Regulators must be set up properly to be effective

Calls for tougher regulation are common in times of crisis, and in Canada, there have been calls for an independent regulator at the national level, which should report not only to their own provincial government but to the federal government directly to enable high-performing provinces to learn from successes as well as detect poorer performing provinces. [64]

Australia is an interesting country to consider, for its similarity to Canada in terms of structure and failings. Both countries saw a disproportionate burden of deaths during the pandemic in LTCHs, and in both countries, hospital and physician care are fully covered by Medicare, which excludes LTC and home care. Both Australia and Canada have the same priorities in terms of LTC: care standards, staffing, and funding. [65]

The difference is that Australia has a regulator: the Australian Aged Care Quality and Safety Commission which regulates LTCHs and which has a statutory basis. The functions of the regulator are to:

- approve aged care providers to receive subsidies under the Aged Care Act;
- regulate providers through accrediting aged care services;
- conduct quality reviews;
- monitor quality of care;
- impose sanctions;
- handle complaints;
- undertake consumer engagement; and
- provide education. [66]

There has been disappointment with this regime, however. In its final report, the Australian Royal Commission into Aged Care Quality and Safety criticized the current regulatory arrangements as lacking effectiveness and too reliant on accreditation audits which are

inefficient and ineffective in addressing substandard care as well as having sanctioning arrangements which are ineffective. The Commission proposed new regulatory arrangements:

> "The current aged care system and its weak and ineffective regulatory arrangements did not arise by accident. The move to ritualistic regulation was a natural consequence of the Government's desire to restrain expenditure in aged care. In essence, having not provided enough funding for good quality care, the regulatory arrangements could only pay lip service to the requirement that the care that was provided be of high quality. We have proposed a new regulatory system that will be more rigorous and more vigilant." [67]

Like Australia, the UK has a centralized inspection-based quality assurance system. In the UK, the establishment of the regulator started with new legislation, the Care Standards Act 2000, which reformed the regulatory system for LTCHs in the UK, and which set up a new independent regulatory body was set up: the National Care Standards Commission (NCSC). Nine years later, the Care Quality Commission (CQC) was set up as a result of more new legislation, the Health and Social Care Act 2008, which merged three separate Commissions.

To replace these three Commissions, the CQC was created in shadow form on October 1, 2008, and began operating on April 1, 2009.

A key characteristic of the UK quality assurance regime is that the CQC is a single system regulating all health and social care and has the capability of regulating with perspective and a view of the whole system with all its links and interdependencies. [68]

In a blog article by The King's Fund, entitled *Are we expecting too much from the Care Quality Commission?,* the sheer number of organizations under the purview of the CQC was noted: more than 20,000 organizations in 40,000 locations[69] and concern by the CQC then Chair, Jo Williams about capacity. [70] Similarly in Australia, the independent regulator there has been found to be under-resourced, and lacking capacity and capability to perform its functions. [71]

Furthermore, research in this domain has raised doubt regarding the usefulness of CQC ratings. A study on the impact of CQC inspections in hospitals found that CQC inspections were not associated with improvements in quality of care at hospitals. [72] Another study found that during the first wave of the SARS-CoV-2 pandemic, CQC ratings were not associated with COVID-19 outbreaks or asymptomatic cases in LTCHs. [73]

In the UK, all LTCHs have to register with the CQC and meet minimum standards for quality and safety in areas including information, care, prevention of abuse, and staffing. The approach is risk-based in that regulation activity is targeted where needed. [74] The Commission inspects all local authority-run and privately-run LTCHs, using a set of National Minimum Standards that include air quality, food, and entertainment as well as enforcement powers. Unannounced inspections are made on a regular basis and in response to complaints. Although non-compliance sanctions are set out in legislation, only a very small proportion of LTCHs fail to meet standards or are sanctioned against non-compliance. [75]

Similarly, in Australia, there are a range of sanctions from remedial action plans at the lower end to fines and termination of LTCH licenses at the more severe end; in practice, however, the Australian regulator operates at the lower remedial end, working with providers to find solutions. Examples in other jurisdictions reflect a similar practice: in the US, which has regulation (a

function jointly undertaken by federal and state governments) focused on identifying and reporting noncompliance, sanctions are rarely applied in reality[76] and in Denmark, we are told that "very rarely the inspectors can shut a place down if they find the conduct poses an imminent danger to the citizens. That almost never happens though!". It appears that without effectual follow-through of sanctions, even the strictest regime is powerless to influence quality improvement.

Austrian experts noted that the international convention known as 'Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)' has been implemented by Commissions in many countries to ensure compliance including in the LTCH setting. However, while it can be a helpful instrument and necessary to prevent the worst cases of institutional abuse or neglect, poor levels of care can happen even in 'quality certified' LTCHs.

Lesson 5: LTC quality regulators must be appropriately resourced. Much is expected of regulators, yet some are hampered due to inadequate resourcing. It is important to consider the operational sustainability in terms of its capacity and capability when setting up an independent regulator to regulate quality of care in LTCHs, and to be aware of the limitations of regulators since harsher sanctions are rarely utilized in practice so effectual follow-through is essential.

Public reporting often holds more promise than it can deliver

Public reporting in LTC settings was first initiated more than two decades ago in the United States (US). For this reason, much of academic literature is US-focused and cross-country comparative studies on public reporting is scarce.

The US experience shows us that when there are survey and rating systems in place, actors can be perversely motivated to pursue ratings rather than meaningful increases in quality-of-life and quality-of-care satisfaction. The *Nursing Home Compare* (5-star rating system) in the US, run by a federal agency, Centers for Medicare & Medicaid Services (CMS), is an example of such a system. Studies note that there is uncertainty over whether the system actually improves quality of life or resident satisfaction. The system was introduced in 2008 and ratings are created starting with the grade from the in-person inspections and then awards bonus points for LTCHs which score well on two other aspects: staffing and quality of care. Authors have argued that the system has incentivized LTCH operators to 'improve their ratings, but not their quality'. [77] Investigative journalism by The New York Times found that the government rarely audits the nursing home's self-reported data, and some were 'incentivized to fudge their numbers.' Nursing homes that were rated five stars in the *Nursing Home Compare* were almost as likely to fail in-person inspections as to pass them. Another investigation by an analytics company compared self-reported LTCH data with actual hospital admissions data and found that half of nursing homes underreported potentially deadly pressure ulcers or bed sores by at least 50%. [78] This suggests that in public reporting systems, a reliance on self-reporting is unwise and auditing of self-reported data by LTCH is crucial.

A multi-country study found that awareness of publicly available information was typically higher among care providers than residents and their families; the internet was often used as the sole medium for disseminating results, restricting a sizeable proportion of stakeholders from accessing the information; and the ability of users to understand the quality indicators was

questionable. The authors emphasized that the most important question is whether users can act on the information and whether they would make different decisions based on it. [79]

In the UK, the regulator makes information on LTCHs publicly available on its website. However, only 15% of users are aware of the information with only 1% of users actually using the information displayed. [80] England recently discontinued a star-rating ranking LTCHs.

Similarly, an Austrian study found that contrary to expectations, competition and choice do not play a role in driving up quality since potential residents choose LTCHs based not only quality indicators but on other factors such as proximity to current location of residence or closeness to family members. [81] Similarly in the US, a study found that users of *Nursing Home Compare* are less likely to use it to make decisions based on quality than to research the location of nursing homes. [82]

Lesson 6: Public reporting must be understandable and inform decision-making. It is not enough to achieve accuracy and transparency of information; publicly available information must be understandable from a user's perspective and have practical value in decision-making. Evidence shows users may not be aware of the existence of public reporting, if they are then they may not understand the information, and despite having the information, make decisions based on factors other than or in addition to quality.

Fiscal challenges accompany accountability challenges

The preceding sections point to the need to be clear about points of accountability and where accountability lies, in relation to local-level or national-level governments, and the degree of public accountability and transparency built into the design of monitoring regimes. Apart from the challenge of being clear as to which body is accountable and responsible, and the extent of public accountability, there is another challenge that is universally experienced: fiscal sustainability.

All countries reviewed for this report facing fiscal challenges in sustaining LTCHs for their ageing populations. The Danish expert consulted also emphasized the importance of sustainable local financing as determinant of high quality LTCHs in Denmark. A European Commission report[83] described the expectation that:

> "…decentralisation will result in better value for money, because the municipalities operate on a local level and, it is assumed, they have more insight into what is needed. While the government decentralised some of the care homes, the decentralisation was accompanied by budget cuts. Older people are being encouraged to stay at home for longer – care at home can be provided with less budget than residence in a nursing home. Lastly, as mentioned above, the government aims for a more effective use of informal care, encouraging people first of all to involve their own social network in the provision of some care tasks. All in all, since 2015, the municipalities have struggled to find a balance between providing quality care and managing care budgets."

Canadian experts note that there is the accountability challenge together with the fiscal challenge in reforming LTC in Canada, and consideration needs to be given as to which level of government has sufficient fiscal capacity, given the reality of uneven fiscal capacity between government levels and between provinces in Canada. [84]

Lesson 7: Fiscal capacity is a fundamental requirement. Sustainable funding is necessary to support robust quality improvement mechanisms. All countries reviewed reported challenges with fiscal sustainability, and Canadian experts recommend attention be paid to the uneven fiscal capacity between levels of government and between provinces.

Shift from institutional to home care

In most decentralized jurisdictions, 'quality standards' were introduced to describe the amount of time and type of support older adults could receive, with much discretion given to social workers who can act within the politically influenced municipal framework. [85] However, the cultural and political shift towards informal care provision in home settings has altered public expectations for care delivery. For example, in Denmark, a historic trend of increasing professionalization in long-term care was observed until the recent focus on informal care and home care lowered care expectations. From 1994 to 2007, structural reform contributed to substantial changes that increased marketization, free-choice, and development of common terminology and standards in long term care provision. In 2012/2013, the Danish Elderly Commission recommended prevention, reablement, rehabilitation, and prioritizing the most needy. This cultural and political shift has led to the unintended deprofessionalizing of care in institutional settings as more and more informal and unpaid care is provided in home and community settings. There are many studies that have examined the impact of this higher burden on informal and unpaid caregivers, which is especially relevant for low formal care countries with high concentration of family caregivers such as Poland, Spain, Portugal, and Ireland. [86]

Similarly, in the Netherlands, due to the shift of the care burden to the informal sector, municipalities were confronted with the challenge of supporting informal caregivers, which led to new policy initiatives such as the 2015 reforms to support informal caregivers. [87] An example of this was that long term care for those who do not need 24-hour supervision is now assessed by district nurses, and is covered under the Health Insurance Act, which also includes support for informal caregivers, sheltered housing, and support for clients to organize their lives. [88]

Lesson 8: Shifts to home care can result in unintended de-professionalizing of care provision. Shifts from institutional to informal and home-based care can have the unintended impact of reducing care expectations and lowering professionalism in the LTC sector.

A community-development and whole-of-society approach to LTC needs

In Canada, there have been increasing calls for the integration of LTC into wider public health systems. A WHO report on Integrated Care called for the integration of LTC with other health and social systems to support person-centred approaches to provide care where and when it is needed. [89]

One of the ways LTC needs to be integrated is to ensure joint coordination of informal and formal care. A critical task that Dutch municipalities had to tackle was how to stimulate the complementary services of provider organizations who offered formal care and provider organizations that offered informal care. [90] Some municipalities organized 'neighbourhood teams' whereby several organizations – involved in formal and informal care – work together in a local team under the supervision of the municipality and a district nurse. With the overarching goal of smooth cooperation between providers of different levels of care, these teams aimed to:

- ensure cooperation between formal care organizations and informal care organizations whereby 'formal care should support informal care and not the other way around';
- ensure cooperation between municipalities and the formal care and informal care organizations whereby 'municipalities would be the coordinating point'; and
- ensure the municipalities work cooperatively with their populations and had a realistic understanding of their population's need of care, and their available social supports.

As one study concluded, "these types of cooperation are considered as indispensable in guaranteeing, and even increasing, the quality of LTC provisions." [91]

The existing evidence is sparse on the link between neighbourhood or community-development and its impact on LTC quality, although grey literature abounds in the promise of newer models of care which incorporate amenities and social assets of the surrounding neighbourhood.

Lesson 9: A community-development and whole-of-society approach to LTC needs is the way forward. Neighbourhood and community development have been a critical part of some countries' reform journey towards increasing quality of LTC, and evidence is building (but currently sparse) in terms of the impact of these on LTC quality.

Changing cultural norms include preventive LTC

Quality in LTC is a normative concept and reflects norms in social, professional, and personal lives and quality of life. While it might be tempting to borrow standards from acute health care settings, these do not necessarily meet the unique needs and norms of LTCH residents, their formal and informal caregivers. [92]

The Dutch LTC system has been described as unique, in that reforms have not been about only quality or cost-efficiency but driven from a normative place and cultural values on solidarity versus individual responsibility, and public versus personal responsibility. [93] As touched on above, the cultural value related to living independently as long as possible has underpinned the shift from institutional to home-based care. Additionally, local government is considered to be "best informed about the local situation and also best capable to deliver efficient, client-centred and integrated care at the local level because of its responsibility for various adjacent policy areas including housing, welfare programs, and local planning." [94] This is known as the subsidiarity principle – which is that social and political issues should be dealt with at the most local level, and an acceptance in society that municipalities are therefore best placed to know best the needs of their residents. [95]

A qualitative study with nine Dutch municipalities found that for the 2015 round of Dutch LTC reforms, municipalities perceived themselves to be prepared for changes and the assumption of new responsibilities in the short-term but underestimated the long-term challenges ahead of them such as the development of a 'participation society' – the notion that governments should empower individuals to take responsibility for their own lives and communities.[96]

The Dutch recognized the need to change attitudes towards LTC from being reactive to proactive: rather than 'being a government that merely responds to people's self-proclaimed healthcare needs', they recognized that 'municipalities would have to fulfil a more preventive role in the background' a role that emphasizes chronic disease management and integrated

care pathways across service settings. [97] This is part of a European movement towards integrated, preventive, and rehabilitative LTC. [98] For example, in Austria, specific interventions have included establishing multi-disciplinary hospital facilities and assessments for older people suffering multiple chronic conditions, and preventing and counselling home visits. [99]

Some Canadian advocates have expressly called for the need for a mental health promotion framework given the impacts on residents, staff, and family caregivers' mental health and wellbeing from the pandemic. [100]

Lesson 10: **LTC reforms reflect changing cultural norms and advanced jurisdictions are increasingly incorporating preventive LTC – services that aim to prolong independence and re-enable older adults to live well outside institutional care for as long as possible – in its purview**. LTC reforms can reflect shifting cultural values and the most advanced jurisdictions are incorporating preventive long-term care into its purview for action.

Conclusion

Lessons from abroad point to the need to understand the complexities of modifying existing policies and implementing new policies to improve quality of LTCHs. The policy traditions and cultural norms of a place drive major shifts such as the shift from formal institutionalized care to informal home-based care. Incentives need to be carefully considered and aligned to support and facilitate the delivery of policy objectives, even when the policy initiatives themselves are the right ones since good policies alone will not result in successful improvement. Critically, the specialist skills – in terms of leadership and management – that are required to maintain and drive increasing quality in LTCHs are a critical foundation to any new policies.

Canadian experts have made a number of proposals to improve quality of LTCH. Some have called for "new federal legislation for LTC to hold provinces and territories accountable to the national standards." [101] Others have recommended a Seniors Ombudsman[102] which could serve as a complementary measure to new legislation, and may provide greater accountability in the sector, and lead to the establishment of national-level family and residents' councils. There has also been a recommendation to establish an independent regulator.[103]

Still other experts propose that it may be possible to build onto existing arrangements to exploit the strengths and minimize the weaknesses of Canada's federal model. For example, given the limitations of fiscal transfers and accords to influence behaviour, some suggest adding a Long-Term Care Insurance plan onto the existing Old Age Security system. Shared responsibility between federal and provincial levels would be essential to designate providers as 'qualifying providers' and monitor quality according to national standards. [104] However, other experts raise concerns on the political feasibility of this recommendation and the considerable barriers in creating a new national insurance requiring the accreditation of, monitoring of continued accreditation of, qualifying providers, and the establishment of processing insurance claims systems at the national level, linked to provincial populations.

This report offers insights and lessons from other jurisdictions to contribute to this discourse on quality improvement efforts in LTCHs, which will always be a multi-player, multi-strategy endeavour especially in the Canadian context. The simultaneous pursuit of multiple objectives such as fiscal sustainability, resource-efficiency, resident satisfaction, and better working

arrangements, is challenging given competing priorities and will produce direct and indirect, intended, and unintended consequences for all parties affected.

The most advanced jurisdictions have built LTC systems with dignity as a core value, and their systems integrate LTC within the wider health and social care sectors as well as with the informal care sector. Observed cycles of reform, reform reversals, and re-reforms in jurisdictions around the world warn us that a formative and learning approach should be taken when introducing new, or modifying existing, quality assurance mechanisms in Canada, bearing in mind the ten lessons presented in this report.

Appendix 1: Search terms and inclusion criteria

Search terms and inclusion criteria are outlined below.

Definition of long-term care homes

In this report, we use Health Canada's definition of LTCH which describes LTCHs as living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. [105]

Note that in Europe, "long-term care" is used to describe both LTCHs and care provided in home settings (referred to a 'home care'). In this report, we focus on long-term care homes (LTCHs).

Care settings for long-term care services

The term LTCHs refers to nursing and residential care homes which provide accommodation and LTC as a package. This refers to specially designed institutions or hospital-like settings (e.g. nursing homes) where the predominant service component is LTC and the services are provided for people with moderate to severe functional restrictions.

LTC provided in home settings and home care are excluded from the scope of this paper.

In searching academic and grey literature, the following key search terms were used and the following inclusion criteria applied.

Key Search Terms	**Inclusion Criteria**
"Long-term care" or "Care home" or "Nursing home" or "Aged care" or "Residential care" "aged" "elderly" "quality" "review" "reforms" "regulation" "lessons" "implementation"	Studies reporting system-level strategies or factors Published within the last two decades i.e. from 2002 English language articles Focuses on quality or impact on quality of care in LTCHs

Appendix 2: Input from key informants

No.	Name
Canada	
1.	Dr. Colleen M. Flood PhD University of Ottawa Research Chair in Health Law & Policy
2.	Dr. Amy Hsu PhD Investigator at the Bruyère Research Institute uOttawa Brain and Mind-Bruyère Research Institute Chair in Primary Health Care in Dementia (2019-2024)
3.	Dr. James Conklin PhD Associate Professor, Applied Human Sciences Investigator, Bruyére Research Institute Concordia University Montreal
Denmark	
4.	Mrs. Louise Weikop Head of Quality and Innovation in the Municipality of Aalborg Denmark
5.	Professor Bent Greve PhD Department of Social Sciences and Business, Roskilde University, Denmark
Austria	
6.	Dr. Kai Leichsenring PhD Executive Director European Centre for Social Welfare Policy and Research, Austria

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