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Issue Note

Quality assurance mechanisms in long-term care homes: Evidence from abroad

Contributions: Christine Chan, Rosa Stalteri, Clémence Ongolo Zogo, Susan Law, Nathan Stall

Executive summary

Over twenty years ago, a World Health Organization report on long-term care¹ (LTC) referred to quality of care as the ‘weak link’ and noted the need for clearer quality assurance criteria and increased regulation.

¹ This is despite LTC quality receiving attention as early as the mid-1980s and quality improvement research gaining momentum in the early 90s. Most recently, LTC quality concerns have again been brought to the fore due to the disproportionate impact of the SARS-CoV-2 pandemic on Long-Term Care homes (LTCH).²

This paper is the first of two papers on quality with respect to LTCHs by CanCOVID. The first focuses on ***Quality assurance mechanisms in long-term care homes: Evidence from abroad***. The second focuses on how other jurisdictions adopted a mix of interventions to ensure quality of care in LTCHs, and what Canada can learn from these adoption processes. Thus, the first paper delves into the “What” and the second delves into the “How”.

This issue note answers the following question: **What are the interventions used in other countries to drive quality in long-term care homes, and how are these implemented in combination?**

There are many studies on LTC reforms and its impact on quality. Reforms are generally undertaken to plan for growing ageing populations and to curb rising LTC costs, and quality is often one among multiple goals. This literature describes quality assurance mechanisms in the following broad categories:

- Regulatory mechanisms;
- Economic mechanisms; and
- Information mechanisms.

Most countries use a mix of these mechanisms, although there are defining features in some jurisdictions that give one mechanism a greater emphasis over others, for example Australia is known for having a LTC regulator and mandatory accreditation but it also uses informational mechanisms. LTC reforms are fraught with complexity because of multiple structural and governance entities, numerous pieces of legislation often transversing health and social sectors, the large number and range of providers, and increasing complexity of resident care needs. For these reasons, reforms to structures and policies are typically formative and iterative: undone, re-done and re-reformed over time, as implementation is complex and fraught with difficulty.

The literature on LTC quality is concentrated on studies emerging from and about the Nordic countries and the Netherlands. The Netherlands and Denmark are often cited as exemplar LTC systems, and there is evidence that there is a level of satisfaction with LTC services there that is not observed in other jurisdictions.

The Netherlands, the world’s first country to establish a universal public LTC insurance system, holds many lessons for Canada in terms of its cycles of reforms and quality assurance mechanisms, and uses a mix of mechanisms:

- Regulatory mechanisms – for example, the Health [Inspectorate](#) is able to put LTCHs under supervision, direct strict controls and enforcement following facility inspection;
- Economic mechanisms – reforms in 2015 split up LTC benefits across three financing regimes incentivising different behaviours; and
- Informational mechanisms – publicly available information is available through the [Long-Term Care Monitor](#) and [Social Domain Monitor](#).

¹ Note also that while long-term care (LTC) in Europe typically refers to care provided in both long-term care homes (LTCHs) and in the home setting, in this report LTC is discussed with respect to only care provided in LTCHs.

Similarly, Denmark uses a mix of mechanisms:

- Regulatory mechanisms – central and municipal governments share quality-monitoring, and the Danish Patient Safety Authority conducts inspections with a high estimated risk to patient safety or in response to citizen concerns;
- Economic mechanisms – Denmark was one of the few countries (along with the Netherlands, Norway, and Sweden) to offer financial incentives to LTCHs to improve dementia management; and
- Informational mechanisms – a public website www.sundhedskvalitet.dk (Health quality) provides comparative information on LTCHs.

The commonalities between these two exemplar countries are as follows. Firstly, the locus of quality control is at a local-level: local-level stakeholders or municipalities operationalize quality standards, even if central and municipal levels share the quality-monitoring function, and even when national standards exist.

Secondly, both countries have a push to bolster home-based and community-based care over institutional care, and this push has resulted in intended as well as unintended positive and negative impacts on quality of LTCHs.

Thirdly, both countries have dignity as a core value underpinning their LTC systems. A common precondition for quality improvement reforms appears to be the establishment of basic values, rights, and responsibilities in the LTC sectors.

Establishing values at a systemic level is important because LTC reforms often have multiple objectives which can give rise to competing values such as resource or cost-efficiency versus quality of life, and contrasting objectives are difficult to integrate. The values may be cultural and a part of the country's values, and they are explicitly recognized in the LTC sector. Studies show that some countries embed LTC values in legislation; indeed, both Denmark and the Netherlands apply an expansive interpretation to dignity, as opposed to the North American understanding of dignity as simply independence of care: Denmark ran a “Dignity Billion” initiative in 2016² and its reablement philosophy has been entrenched in national legislation since 2015 and is applied in all regions of Denmark. The Netherlands also applies a reablement philosophy and is the only country in the world where LTCH medicine is a specific medical discipline; “elderly care physicians” in LTCHs have a stand-alone three-year training program.

Other countries including Sweden, Finland, Australia, Austria, Norway, Japan, and the UK are covered in this paper to provide cross-country comparisons across a variety of jurisdictions where similar quality mechanisms have been adopted although implemented in different ways and in different combinations. If there is a lesson for Canada from this, it is that complex problems call for complex solutions. A multi-pronged approach to driving LTCH quality is necessary – one underpinned by dignity as a core value, 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 which 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, it is advisable to take a formative and learning approach to introducing new, or modifying existing, quality assurance mechanisms in the Canadian context.

² A policy measure funded by 1 billion Danish kroner every year in which municipalities must formulate a dignity policy every four years and include aspects such as autonomy, quality, food and nutrition, and multidisciplinary care.

Introduction

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.³ 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 integration⁴ whereas European academics articulate different dimensions: availability, accessibility, affordability, person-centredness, comprehensiveness, continuous improvement, and outcome-orientation.⁵

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”⁶ and, as described above, it is acknowledged that quality itself is conceptualized differently by different jurisdictions and stakeholders.⁷

Note also that while long-term care (LTC) in Europe typically refers to care provided in both LTCHs and in the home setting, in this report LTC is discussed with respect to only care provided in LTCHs.

This paper uses Health Canada’s 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.⁸

In Canada, approximately 1.2% of older adults live in nursing homes.⁹ LTCHs are not publicly insured under the Canada Health Act.¹⁰ Governed at the provincial and territorial levels, differences in service range and cost coverage exist across the country. This gives rise to different definitions, scope, governance, and monitoring mechanisms of LTCHs across Canada. Unsurprisingly, there is great variation in quality of LTC services for older adults and sometimes, quality of services may not meet the expectations of the public, users, and their families.¹¹

Quality deficiency

Quality deficiency is a worldwide concern in LTCHs, and the SARS-CoV-2 pandemic triggered an awakening to the need for robust quality assurance mechanisms in this sector. Across OECD countries, around 40% of COVID-19 deaths have been in nursing homes despite the fact that under 1% of the population live in them.¹² Only about half of OECD countries had guidelines on infection control in nursing homes before the pandemic¹³; in many countries including Canada, many guidelines were issued on public health measures in LTCH over the past two years.¹⁴

Prior to the pandemic, evidence of quality problems emerged in Canada from a wide range of sources including reports by advocacy groups, media reports, findings from reviews, and quality-monitoring systems. Additionally, evidence on quality deficiencies has also come from the intersection with acute care (when LTC residents are transferred to the hospital), and from forensic medicine via investigations of causes of death towards end of life.¹⁵ Examples of inadequate care abound in the academic literature and media reports, and include inadequate housing, lack of staff assistance, poor social relationships, inadequate treatment of chronic pain, depression, bedsores, and inappropriate use of chemical or physical restraints.¹⁶ Despite the fact that LTCHs look after the sickest of patients, quality assessment and outcomes monitoring lags behind acute health care.¹⁷

Quality assessment using the Donabedian model

A recognized classification of quality assessment in health care is the Donabedian model, which describes structure-based, process-based, and outcomes-based approaches to assessing quality.¹⁸ Structure refers to resources and organization structure such as staffing and equipment; process refers to how care is delivered or care processes; and outcomes refers to impact on resident's health and functioning.

The model is most often used at the organizational level, however, it can be helpful to think about quality at a system level as well, considering this framework: structure, process, and outcome. Across the world, there is evidence that the type of indicators covered in LTC focuses more on structure and process than on outcomes, leaving consumers with limited information and an inability to differentiate between providers' level of quality.¹⁹ Some jurisdictions like the Netherlands recognize a need to shift to outcome aspects of quality²⁰ although this has been criticized since structure and process measures shed light on the nature and location of deficiencies in structure or process of care delivery.²¹

Additionally, there has been an international shift away from medical-centric and process measures to measures that focus on quality of life and person-centredness although operationalizing these concepts has been difficult²² as it is difficult to capture personal care experiences accurately.²³ 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.²⁴

The interlinked nature of care is also recognized in this model; indicators are often correlated and require assessors to have a whole-of-organization or whole-systems perspective. For example, bed sores can be considered a 'summary indicator' since it reveals multiple quality-of-care problems including malnutrition, dehydration, too little care time devoted to residents, incontinence, and physical restraint use – all factors that are known to increase risk of bed sores.²⁵

Methods

Literature review: A literature review was undertaken to identify information on quality in long-term care homes, searching for 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), Long-Term Care Responses to COVID-19 database, 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, and regulation. 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 perusing of reference lists of identified relevant reports and articles.

Search terms and inclusion criteria can be found in [Appendix 1](#).

Countries covered 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, like Canada, Sweden 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 and were interviewed to provide views on the current state of the evidence available on the topic. See [Appendix 2](#) for details on the key informants interviewed.

Limitations

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

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

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

Additionally, we have focused on quality assurance mechanisms in formal care and have not considered informal care (i.e. care provided by informal caregivers or carers 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^{26,27}. For further interest, CanCOVID is producing an accompanying 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 OCED countries*.

Findings

Classifying jurisdictions according to LTC quality assurance mechanisms

In the literature accessed for this report, quality assurance mechanisms are described within three broad categories: regulatory mechanisms, economic mechanisms, and informational mechanisms. This is depicted in Figure 1.

Quality assurance mechanisms
<ul style="list-style-type: none"> Regulatory mechanisms
<ul style="list-style-type: none"> Economic mechanisms
<ul style="list-style-type: none"> Informational mechanisms

Figure 1: Categorizing quality assurance mechanisms, based on *Policy instruments to promote good quality long-term care services*²⁸

Regulatory mechanisms seek to influence actors in the sector through formulated rules and directives which are mandatory. LTC is typically regulated through legislation and there are powers given to government, or delegated to arms-length entities, to enforce compliance.²⁹

Economic mechanisms use financial levers to incentivize actors in the sector to act or behave in particular ways and are usually used to incentivize more efficient care provision although some may also aim to drive quality.³⁰

Informational instruments use data to influence actors through transferring knowledge, communication and persuasion, and can include education, knowledge management, quality management systems, public reporting, and feedback on quality from residents and other stakeholders.³¹

These mechanisms are typically described as being either ‘hard’ or ‘soft’, for example, a hard mechanism would be inspection and enforcement and a softer mechanism would be relying on consumer choice and market forces.³²

Mechanisms, as shown in Figure 2, can also be described as ‘top-down’ as with a traditional paternalistic structure or ‘bottom-up’ with self-regulation being its extreme form³³ - commitments from self-regulation may be strong but are not legally enforceable.

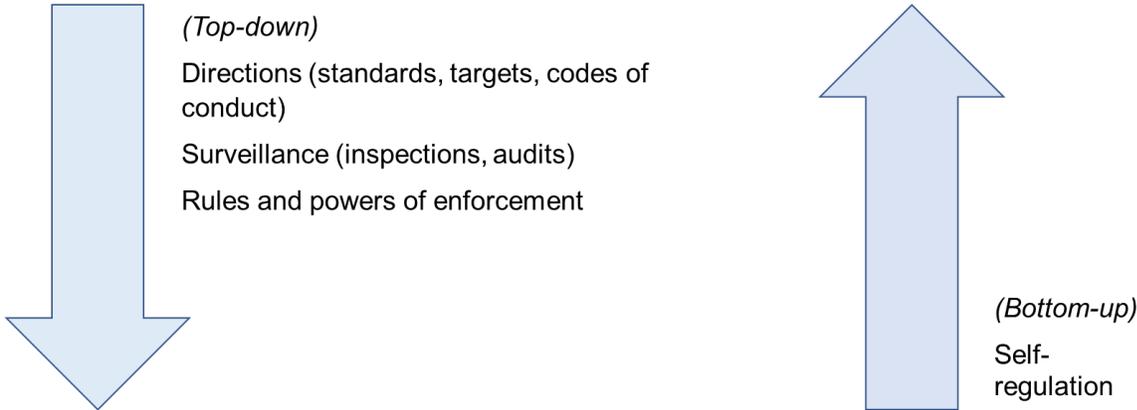


Figure 2: Examples of top-down and bottom-up approaches to quality assurance in LTCHs

Additionally, approaches to LTCH quality have also been categorized as professionalism-based, inspection-based, or data-measurement/public-reporting-based. Examples of approaches in selected jurisdictions are shown in Figure 3.

Jurisdiction	Type of LTCH quality-assurance system
Canada	Decentralized data-measurement/public-reporting based system (provincial/territorial responsibility)
US	Decentralized data-measurement/public-reporting based system (state government responsibility)
Sweden	Decentralized data-measurement/public-reporting based system (municipal level responsibility)
Norway	Decentralized inspection-based system (municipal level responsibility)
New Zealand	Centralized data-measurement/public-reporting based system (HealthCERT, a division of the Ministry of Health, certifies and designates audit agencies ³⁴)
Denmark	Decentralized inspection-based system (municipal level responsibility)
Netherlands	Decentralized inspection-based system (trend in moving from central government to municipal level responsibility)
Australia	Centralized inspection-based system (Aged Care Quality and Safety Commission, regulator)
England	Centralized inspection-based system (Care Quality Commission, regulator)

Jurisdiction	Type of LTCH quality-assurance system
Japan	Decentralized professionalism-based system (focus on professional organizations, particularly health professions, setting quality standards and self-regulation)

Figure 3: Categorization of LTCH quality-assurance approaches in selected jurisdictions, based on information sourced from *Review of International Systems for Long Term Care of Older People*³⁵

General observations about high quality LTC systems

Of all the jurisdictions listed in Figure 3, the evidence and available guidance repeatedly point to **Denmark**, the **Netherlands** and **Sweden** as having high-quality LTC systems.³⁶ All three, like Canada, embrace universal access as a principle for LTC provision. Denmark and Sweden are the closest in terms of similarity to Canada’s single payer system.

- Denmark’s LTC system is a national system (nearly all LTC is funded by general taxation) with entirely local/regional funding and local autonomy and heterogeneity in service delivery. LTC is organized by 98 municipalities, delivered by public and private providers, mainly free of charge, and financed through general taxation.
- Sweden is a universal system with primarily local/regional funding and local autonomy and heterogeneity in service delivery.
- The Netherlands was the first country to introduce a social insurance program for LTC services in 1968.³⁷

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 association between the choice of quality assurance regimes and welfare regimes.^{38,39}

There is evidence, however, showing that high-quality LTC systems involve comprehensive coverage systems requiring substantial investment. Denmark and Sweden have tax-based universal comprehensive coverage of LTC, spending more than 4% of GDP on LTC⁴⁰ and both fund LTC through federal grants and local taxes.⁴¹ The Netherlands has the most comprehensive LTC social insurance system in the OECD, spending 3.7% of GDP on LTC⁴², more than double the EU average. In comparison, Canada allocates 1.3% of GDP to LTC, under the OECD average of 1.7 percent, according to a 2020 report by a working group based at Queen’s University.⁴³ Canada spends less than Australia, which is described as being at the ‘bottom of the barrel’ for aged care spending.⁴⁴ The Queen’s University report estimates that recommended improvements, if implemented, will require a 67% increase in expenditure in Canada.

Mechanisms described in the literature are discussed in the next section.

1. Regulatory mechanisms

Literature is concentrated on regulatory mechanisms compared to other mechanisms.

England is an example of a centralized inspection-based system. It has one of the most developed private markets for LTC in Europe and there is a large variety of approaches to managing markets as well as assuring quality.⁴⁵ Prior to the early 2000s, individual health authorities were responsible for registering and inspecting LTCHs. Centralization reforms were implemented and in 2009, the Care Quality Commission (CQC) was established as a single, integrated regulator for England’s health and adult social care services including LTCHs. The CQC inspect and continually monitor information about LTCHs. Their qualified inspectors visit LTCHs to check that they are meeting the standards. They make unannounced inspections on a regular basis and at any time in response to concerns.

Australia similarly has a top-down inspection-based surveillance approach where there are on-site inspections and interviews with residents and staff to uncover instances of non-compliance.

Regulation in centralized regimes

The surveillance-based inspection systems in the UK and Australia contrast with inspection systems in countries like Finland, where inspections are conducted only in response to complaints (not as a normal course of surveillance) and compliance is gauged from performance reviews that do not involve site visits.⁴⁶ In Canada, there has been a similar system in Ontario where there was a move from a surveillance approach which required a proactive 'resident quality inspection (RQI) per year for each home, to a 'risk-based approach' which focused on complaints and critical-incidents inspections, in 2018.⁴⁷

Regulatory mechanisms are popular in response to scandals or concerns about the quality of LTC, but critics urge that unfortunately 'so much (LTCH) regulation is really a watered-down derivative of acute care curative model,'⁴⁸ and simplistic regulation based on acute care settings can actually take away residents' quality-of-life.⁴⁹ A large number of studies show that regulations are, by nature, blunt and crude instruments; they monitor what is measurable and may not monitor more meaningful processes and outcomes such as quality of care and care relationships.^{50,51} Worse, reactive regulations may generate more paperwork, perversely shift focus on standards and ratings away from actual care,⁵² and stifle innovation.^{53,54,55,56,57,58} There is evidence that regulations raise quality to a basic level but not beyond.⁵⁹ 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. Several studies emphasize the importance of flexible decision-making for care workers in providing quality care over rigidly prescribed rules: innovative models of care that allow flexibility in work arrangements are more likely to deliver person-centred care.⁶⁰ It appears that the key is to allow decentralization of regulatory mechanisms and local autonomy in the operationalization of regulations. The common challenge with this in all decentralized regimes is the inconsistency of service provisions from one geographical area to another, and across different demographic populations.⁶¹

Planned versus surprise inspections

Grey literature points to the benefits of surprise inspections. One of the open secrets in the LTCH sector is the pre-notification of what are supposed to be spot audits or surprise inspections. In both the US and Canada, anecdotal evidence suggests that some LTCHs know in advance when their inspections will take place. The New York Times investigation found that 70% of LTCHs increased their staff on the days of inspection, which would be atypical on other days.⁶² Experts from Denmark affirm the need for surprise inspections as well as planned inspections, highlighting that it is important to consider the spirit in which these inspections are carried out, and the objective of the inspections: is it to control and correct, or is it to promote learning and improvement – both planned and surprise inspections are essential and are carried out in Denmark.

Regulation in decentralized regimes

Another feature of Denmark's and the Netherlands' inspection-based systems is the devolution of responsibility for quality regulation. In Denmark, there are no LTC policies at the federal level.⁶³ Municipalities are responsible for LTCHs and finance LTC through block grants from the federal government, local taxes, and transfers from other local authorities. The municipalities are also responsible for licensing and quality monitoring, and inspection reports are publicly available. In the Netherlands, quality is the responsibility of providers, even though the Healthcare Inspectorate (IGZ) has a role as Supervisor. A number of mechanisms are used at the local provider level: periodic formal inspection of service providers by a representative of the health care system; providers themselves use internal quality control mechanisms to assess services since it is in their interest to present themselves as providing high quality services, given the competition among providers; and the law mandates that every service agency have a consumer council.

Notably, the Netherlands concurrently targets 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. The latter is an approach to quality of care that is based on professional norms and guidelines to steer the care delivery process, and is well established in acute-care settings, less so in LTCHs due to the lower qualification requirements of staff in LTCHs.⁶⁴

- 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 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.⁶⁵
- 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.⁶⁶

Despite this decentralized inspection-based system in the Netherlands, quality assurance is still a shared central government and municipal government responsibility, and the Inspectorate does still exercise its power to place LTCHs under supervision due to inadequate quality. The key message here is that there are multiple players at different levels of government responsible for regulating quality.

Accreditation

Self-regulation is common in the literature, with voluntary accreditation schemes operating in many countries such as the Joint Commission Accreditation Programme in the US, is a voluntary programme for all states.⁶⁷ Note that in addition to this, every state in the US must have a licensing and certification agency – as per federal regulations – that inspects facilities that have a contract with the federal government.⁶⁸ Voluntary accreditation is also in operation in Denmark⁶⁹, Switzerland⁷⁰, and in certain regions of Canada. In Ontario, Canada, where accreditation is voluntary, a study on the association between accreditation of LTCHs and safety found that of the five patient safety areas examined, only falls was significantly associated with accreditation and speculated that culture, incentives, and regulations (not examined in the study) are likely determinants of the impact of accreditation programmes.⁷¹

However, accreditation of LTCHs is mandatory in other countries. For example, in the Netherlands, accreditation is carried out by the Dutch Institute for Accreditation and is based on the following dimensions of care: client's perceptions, outcomes for informal care, service utilisation, care workers' qualifications and satisfactions, and clinical outcomes.⁷² Similarly, in Australia, accreditation is mandatory since LTCHs have to show that their management processes and practices support continuous improvement in order to gain accreditation.

Minimum standards

Some countries have developed minimum standards that focus on quality although enforcement is not compulsory in all countries. These standards are often key elements of evaluation criteria for authorization or certification to practice, and exist in the Netherlands, Australia, Austria, England, and the US.⁷³

Decentralization is a feature of the Denmark LTC system. Its quality assurance approach involves municipalities determining their quality standards for LTC on an annual basis, standards which are publicly available and used in tenders and audits. This approach allows flexibility and local diversity.⁷⁴

Similarly, in Norway's decentralized system, national regulations have been described as 'relatively unspecific.' The main regulatory instrument is the Municipal Health and Care Service Act, and municipalities have flexibility in operationalizing its tenets as the Act does not prescribe details on how

services should be organized. For example, the Act obliges LTCHs to have a physician, a registered nurse, and an administrator 'connected' to the LTCH but does not specify what that entails.⁷⁵ A study has posited that in countries where there is greater extent of private ownership of LTCHs, there tends to be more structured and detailed regulation schemes⁷⁶; this observation would appear to fit Norway, a country where most LTCHs are publicly owned.

Countries with professionalism-based approaches include Sweden, Switzerland, Japan, and Germany. Standards are negotiated between multiple parties involved in LTC with professional organizations and health professions taking an integral role in setting quality standards and self-regulation.^{77,78} Among the countries listed in this paper, only Sweden requires LTC nurses to have geriatric care training or to follow-up with such training when working in the LTC sector.⁷⁹

Worldwide, minimum standards are typically based on structure and inputs (number of staff, number of private beds, room size, safety features, training, etc.) and less on process- or outcome- quality indicators which are harder to measure. There has been some progress in shifting to process- and outcome- based evaluation in some jurisdictions. Centralized inspection-based systems like England and Australia focus exclusively on process- and outcome-quality standards which allows inspectors to observe and engage with LTCH residents. Such inspections are time- and labour-consuming activities, especially when compared to desk- or even phone- reviews (during pandemic times).

Many European countries have used minimum standards as a key tool to regulate and ensure quality in LTCHs. Finland, the Netherlands, and Germany are examples; in Germany, quality standards are used in annual inspections to assess LTCHs and 'care marks' are determined and made publicly accessible.⁸⁰ Again, these standards are mainly structure-based standards although efforts are continuing to identify process quality and disease management practice, and most recently infection control standards.

The Netherlands approached quality reform in a very intentional manner when they launched a quality framework in 2015 and the government made available EUR 2.1 billion to help LTCHs implement the framework.⁸¹ The reforms are considered the largest change since the LTC system came into force in 1968 were intended to reorientate the country's values to encourage family and local community networks to provide social services to older adults, to continue the shift from institutionalized to home settings, to decentralize home care to insurers and municipalities, and to facilitate 'efficiency cuts.'

Implementation of the 2015 reforms in the Netherlands remains its 'Achilles heel,' suffering administrative and technology problems. The new structure comprises three different schemes to meet LTC needs: LTCH, community nursing and personal care, and the rest of community and home care, each with its own implementing agencies, regulations, budgets, and target client population, making implementation challenging due to different incentives and the need to coordinate across different entities and processes.⁸² A national evaluation carried out in 2018 found that reforms are achieving some but not all goals as yet. Some goals that have been achieved include, for example, that most municipalities have set up community social care teams; and most people who apply for social support receive personalized support. However, still to be achieved include the following: independent client support (getting information and advice from an independent third party) is little known and therefore little used; and there is insufficient coordination between care providers and lack of clarity surrounding personal care since needs are now met by either insurers or municipalities, resulting in confusion in who provides what.⁸³

Apart from the already-mentioned worldwide shift from structure and process standards to outcome standards in quality measurement, there are two other shifts noted in the literature: a shift from organization- and profession-oriented measures to person-oriented measures, and an expansion from measuring only quality of care to quality of life.⁸⁴

Additionally, dementia has been singled out as a priority area in monitoring LTCH quality. Recent literature points to more countries paying attention to standards relating to dementia care; in England, the

National Institute for Health and Excellence (NICE) set out quality standards that state that residents living with dementia should be cared for by staff appropriately trained in dementia care.⁸⁵

Regulators

There have been calls in Canada for an independent regulator, 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. Additionally, experts suggest a Seniors' Ombudsman be established, to whom complaints can be made when standards are not met.⁸⁶

Enforcing compliance using a regulator is a mechanism used in Australia and there are a range of sanctions from remedial action plans at the lower end to fines and termination of LTCH at the other end; in practice, however, the Australian regulator (the Aged Care Quality and Safety Commission) operates at the lower remedial end, working with providers to find solutions. Similarly 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.⁸⁷

Requirement to have quality management systems

Germany, Australia, France and Spain require their LTCHs to use quality management systems as part of minimum standards, and these are implemented on an organizational level e.g. EFQM, ISO 9000, Total Quality Management (TQM) and Balanced Scorecard. Typically, the exact type of system is not mandated; in Finland, for example, LTCHs can use which system they would like but TQM and Balanced Scorecard are the most popular.⁸⁸ Austria requires LTCHs to implement quality improvement strategies to qualify for public funding.⁸⁹

2. Economic mechanisms

Most countries employ economic mechanisms to drive quality. In the Netherlands, economic mechanisms are used to reward as well as to penalize: subsidies are given or continued for quality improvement programs and punitive measures can take the form of loss of contracts or fines for non-compliance of quality standards. A positive use of this mechanism is the Dutch government's fund to financially support apprenticeships in the care sector. In this way, it stimulates initiatives aimed at increasing productivity, retaining employees, and attracting new employees.⁹⁰

A major initiative undertaken by the Danish government in 2016 was the Dignity Billion initiative, which obligates municipalities every year to adopt dignity policies in a collaborative manner with stakeholders including providers and relatives of older adults. The initiative is supported by an investment of 1 billion Danish kroner each year and municipalities must formulate and submit a dignity policy every four years addressing aspects including autonomy, quality, multidisciplinary care, food, and nutrition.⁹¹

In England, quality-related subsidies are given to providers who can apply for workforce development funds from Skills for Care, an organization that receives funding from government to upskill England's workforce. Japan provides additional reimbursement for providers in Japan who exceed minimum staffing standards.⁹²

Public procurement in Australia is another type of economic mechanism and takes the form of tenders for state-funded aged-care packages for LTCH where providers engage in quality-focused competitions to win the tenders. Providers in Australia can also access quality-related top-ups in the form of a "Conditional Adjustment Payment (CAP)"; they receive the CAP if they implement workforce reforms. Additionally, Australia runs a pay-for-performance (P4P) scheme whereby payments are linked to quality and efficiency. P4P schemes are comparatively well-developed in Australia for LTCHs and is increasingly being used in the US and England, however, there is little empirical evidence that P4P schemes increase quality.⁹³

Incentive grants from the national level to municipalities are another way Sweden has driven up quality. These grants are made available to municipalities to improve quality⁹⁴. Priority areas have included: better access to doctors, medication reviews, preventive work, dementia care, rehabilitation, diet and nutrition.

3. Informational mechanisms

In contrast to the Denmark and the Netherlands, Sweden has a comparatively light regulatory approach⁹⁵ and uses a data-measurement/public-reporting based system, which has a locus of control at the municipal level i.e. a decentralized system.

Quality indicators in Swedish LTCHs are tracked through a national monitoring system called “Open Comparisons” (Öppna jämförelser)⁹⁶. This system was launched in 2007 as a way to make it possible for anyone to compare the quality, costs and efficiency of services provided to older adults. There is a national website with comparable data from all municipalities and providers of LTCH as well as home care, both public and private. This transparency in reporting and comparisons is thought to have had a great impact and driver for improvement of quality in Sweden⁹⁷. As other experts have noted, “transparency is the path back to return to credibility and trust” and “lack of transparency is now viewed as something to hide, and worse still, as an admission of guilt”⁹⁸.

Examples of publicly viewable metrics are as follows:

- Share of older people living in LTCH who report that staff always or often have sufficient time to carry out their job;
- Waiting time for LTCH; and
- Assessment of food quality in LTCH.

Despite this national monitoring system, and the existence of a governmental watchdog, the Health and Social Care Inspectorate (IVO), Sweden has a long tradition of local self-determination and the responsibility for LTCHs rests at the municipal level⁹⁹ despite the existence of national-level bodies.

Another tool that has worked well in Sweden has been the clinical quality registers that include LTC residents. There is a Senior Alert register covering information on falls, pressure areas, and malnutrition, as well as a Dementia Registry and a Palliative Care Register. These data are publicly available through the aforementioned “Open Comparisons” system and allow academia to examine care delivered against clinical agreed standards¹⁰⁰.

The Netherlands also employs informational mechanisms to monitor quality, despite being primarily inspection-based. In the Netherlands, two ‘Monitors’ are publicly available: the Social Domain Monitor which contains information on outputs, costs and client satisfaction under the Social Support Act, and the Long-Term Care Monitor contains information on population, use, and accessibility among other aspects. Neither monitor covers information on actual quality of care (i.e. neither measures ‘outcome’ as per the Donabedian model).¹⁰¹

Australia, a system based on inspections and a regulator, also employs informational mechanisms to drive quality in LTCH. Education and knowledge management are explicitly embedded in the regulatory system and the regulator is responsible for disseminating best practice approaches together with its inspection and audit role. The regulator also facilitates knowledge exchange by organizing courses and conferences on continuous improvement and achieving accreditation standards and gives Best Practice Awards annually.¹⁰²

Other considerations

The literature notes other considerations relating to quality assurance mechanisms, as follows.

Dementia-specific quality assurance

Sweden is one of the few countries, along with Denmark, the Netherlands, and Norway, to offer financial incentives to LTCH to improve dementia management through uptake in dementia training. There is only limited evidence available related to quality assurance mechanisms specific to residents with dementia. Recommendations in literature point to the need for quality measures that matter to people with dementia, such as quality of life, personhood, and wellbeing. However, quality measures continue to emphasize service standards over personally meaningful outcomes.¹⁰³ This has major implications for Canada's LTCH system since 90% of LTC residents in Canada have some form of cognitive impairment and up to one third are living with severe cognitive impairment.¹⁰⁴

Quality-of-life measures

As previously noted in the *Minimum Standards* section, there is evidence that there is a worldwide shift in measuring only quality of care to also measuring quality of life, but progress has been slow. Experts point out that, too often, LTCHs are driven to use a quality-of-care scorecard that does not relate to what matters to the resident.¹⁰⁵

An increasing number of countries are using public reporting of LTC data to drive quality, with most using technical (care-related) or satisfaction measures but none successfully using resident-reported quality of life measures.¹⁰⁶

Some experts propose that resident and family experience and satisfaction are two key measures that should be adopted, and recommend moving away from provider-centric questions such as "How many chronic conditions do you have?", "How many prescription medications do you take?", and "What kind of assistance do you need for Activities for Daily Living?" to better person-centred quality-of-life questions such as "What gives you the most joy?", "Have you experienced any of that in this setting?", and "What gives you a sense of pride, purpose, and connection? Has this been encouraged or has this been taken away?", "When you moved here, what were your aspirations?", "Do you have hobbies? Do you get to do them here?", and "We don't tap into that, and that is what creates satisfaction".¹⁰⁷

Additionally, experts recommend quality measures that capture person-centred advance-care-planning, palliative and end-of-life experiences of residents, given that LTCHs are not 'just the resident's home but the home where they will die'¹⁰⁸.

Monitoring and evaluation approaches are often seen as a sure-fire way to drive quality, but the evidence reviewed in this paper shows that even 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. It appears that perversely the system has incentivized LTCH operators to 'improve their ratings, but not their quality.'¹⁰⁹ 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'; in fact, nursing homes that were rated five stars in the *Nursing Home Compare* were as nearly likely to fail in-person inspections as they were 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%¹¹⁰. This suggests that in public reporting systems, wholly relying on self-reporting is unwise and auditing of self-reported data by LTCH is crucial.

An interesting outlier is the framework used in England by its regulator, Care Quality Commission (CQC).¹¹¹ Researchers have noted that the CQC's quality assurance program does not use quality measures at

all; instead inspections take a holistic view of the service and inspectors consider if the service is safe, effective, caring, responsive (dimensions of health care quality as articulated by the Institute of Medicine) as well as whether the service is well-led and give a rating of outstanding, good, requires improvement or inadequate for each question.¹¹² Consequently, there is no systematic way to benchmark LTCHs nationally and the need for a minimum dataset has been recommended by experts.¹¹³

Residents' right to quality

While some might consider that the rights of LTCH residents can be implied from looking at the obligations of LTCH operators, the Dutch government prefers to give residents an enforceable right to quality of their own. This has been part of the shift from provider-centric to resident-centric care and the government has strengthened the position of residents in a number of ways including legislation. For example, the *Participation by Clients of Care Institutions Act* in the Netherlands mandates every healthcare organization to have a client council, gives client councils the right to advise management about the quality of care, and prescribes that the organization must ask for this advice.¹¹⁴ It is noted that this already exists in Ontario, Canada; the *Long-Term Care Homes Act 2007* states that every resident has the right to participate in Residents' Councils.¹¹⁵ However, the client councils in the Netherlands appear to have more legal rights including the right to have meetings with management about organization policy, and to request an investigation into mismanagement.¹¹⁶

Models of care and the wider cultural context

In addition to quality assurance mechanisms at a systems level, newer models of care based on innovations in technology, space, and notions of community have emerged as possible answers to quality deficiencies.¹¹⁷ These models are microcosms reflective of a wider culture change that is the transforming force driving quality and which is changing societies one geographic area at a time. To adopt a new model of care without pre-initiating wider culture change in the environment would be akin to renovating a granny-flat attached to a main house, without due attention to the house and surrounding environment, and because LTCHs are as much a social construct as it is a physical one, the social and cultural context of LTCHs needs shaping as the context can facilitate or impede quality improvement.

It is telling that the Danish White Paper outlining digital technologies for older adults, is entitled *A dignified elderly care in Denmark*¹¹⁸ while papers on this topic in Canada are entitled *Bringing home care into Ontario's digital health future*¹¹⁹ and *Realizing the full potential of virtual care in Ontario*.¹²⁰ The Danish begin conceptualization of innovation from a dignity viewpoint and the title of their white papers reflect the starting point for thinking about care for older adults: dignity. The Canadian papers are centred in the digitalized future and consider how to bring LTC into that future.

Denmark has a vision to integrate nursing homes into the community by creating public places that draw people into LTCH so they can interact with residents. The philosophy underpinning their approach is to 'add life to remaining years, rather than years to remaining life' and they do this through 'reablement programs' which are free of charge to Danish citizens. These proactively assess older adults' abilities to look after themselves and training to help them regain, retain, and build essential skills for independent living. Danish municipalities conduct annual home visits for all adults over the age of 75 to identify those at risk for frailty.¹²¹

Denmark's 'state-of-the-art nursing home' is a 75-room LTCH on the banks of the Aalborg River. As part of the wider vision of nursing care in Denmark to provide integration of sense stimulation, mobility, and social interaction, the Aalborg nursing home has achieved this using themed spaces such as common cooking areas, gardens, and a music room. Digital technologies contribute to increasing independence; for example, smart floor technology increases resident safety by illuminating bathroom lights upon the foot touching the floor.¹²²

A similar example exists in the Netherlands, notably the Dementia Village at Hogewey, in the Weesp, southeast of Amsterdam. The care home is a small, self-contained village where people living with

dementia can live relatively normal lives, moving freely between houses, shops, a theatre, gardens, restaurant, bar, and activity centre.¹²³

Other countries have come up with community-based alternatives to LTCHs such as the American-inspired Green House Project, which provides care in small, self-contained, family-style houses with a small number of residents.¹²⁴ Within Canada, there are also promising practices that could possibly be scaled up and that also could provide guidance to a greater focus on quality of life and the development of related measures as outlined in reports such as *Promising practices in long-term care: Ideas worth sharing*.¹²⁵

Leadership as an enabler

The SARS-CoV-2 pandemic has been a catalyst for LTC research. There has been rapid growth in the production of peer-reviewed and grey literature on how Canada can address deficiencies in quality of care at both systemic and facility levels. For example, in *Restoring trust: COVID-19 and the future of long-term care in Canada*, Estabrooks et al highlight the failure of considering LTC accreditation and regulation with a whole-systems perspective, with best-practices underpinning regulation. Despite heavy regulation, the system still lacks critical pieces of regulation on workforce standards and quality of work conditions, and these negatively impact quality of care and of life.¹²⁶ The paper highlights the inadequacy of leadership and management skills in the LTC sector, pointing to the need for transformational leadership.¹²⁷

Ultimately, operating an LTCH is a human-resource-intensive endeavour and good leadership is required to inspire and guide care workers onto a continual learning journey, and to involve relatives and informal carers appropriately in this process.

Involvement of the people who must produce the change is key, and in the complex social environment of LTCHs, it is ‘almost impossible to create a plan and expect it to be implemented’ – a learning process is needed, and we have to ‘learn our way into implementing it’ Indeed, literature shows that LTC reforms are often formative and iterative: undone, re-done and re-reformed over time due to changing political currents, difficulty in implementation, misalignment of incentives, and innovation.

Considerations in combining quality assurance mechanisms

This report has touched on a variety of quality mechanisms for selected countries. The major ones are shown in Figure 4.

Country	Quality assurance mechanisms discussed in this report
US	Regulator Voluntary accreditation Inspections Minimum Standards Regulator Pay-for-performance (P4P) Schemes Public reporting
Sweden	Health and Social Care Inspectorate Inspections

Country	Quality assurance mechanisms discussed in this report
	Professionalism-based mechanism Nurses working in LTC must have geriatric care training Financial incentives for dementia training National level inspectorate Public reporting
Denmark	Inspections Minimum standards Voluntary accreditation Economic mechanisms Public reporting Financial incentives for dementia training
Netherlands	Mandatory accreditation Minimum standards Health inspectorate Inspections Economic mechanisms Public reporting Financial incentives for dementia training Establishing values at systemic level Quality Framework
Australia	Regulator Mandatory accreditation Informational mechanisms Requirement for LTCHs to have quality management systems Pay-for-performance (P4P) Schemes

Figure 4. Quality mechanisms in selected countries discussed in this report

The question arises as to whether there is a natural or preferred order to implement the range of mechanisms necessary to assure quality in a nation’s LTCHs, or a whether there is an ideal mix of mechanisms.

In conversation with a Canadian expert, we are reminded that change is always profoundly contextual, and no one size fits all. Considering what interventions to implement to drive quality is a complex exercise. The unique political, cultural, and historical context needs to be carefully considered, together with the

level of trust. Governance mechanisms at national, regional, and local levels influence quality assurance, sometimes in conflicting ways for a wide range of stakeholders from residents to care providers to local and national government.¹²⁸ Implementation is difficult even in high trust environments like Denmark, where implementation of government directives and guidelines is carried out with willing compliance.

Intended and unintended consequences of quality assurance mechanisms need to be identified as much as possible. For example, because of reforms in the Netherlands, if an older person needs to be in a LTCH, they are now transferred from Wmo to Wlz care, which means transferred from the Social-Support-Act home care program to the Long-Term-Care-Act program. The Wlz care does not take into account the amount of care a person has previously received, and has a fixed budget, therefore, the effect of this transfer is that the waiting-older-person receiving less care at home than before – a phenomenon known in the Netherlands as the zorgval or ‘care trap.’¹²⁹

From Finland, we learned that even if there is the binding force of regulation, the resultant effect may be softer than anticipated. Finland, for example, has national guidelines for standards and surveillance but because municipalities have autonomy and flexibility in terms of how they implement quality monitoring systems, so in the end, the national level regulations have little actual force.¹³⁰

From Australia, we learned that Pay for Performance (P4P) schemes which use economic mechanisms to drive quality, can lead to negative consequences and providers can be perversely incentivized to select only healthier, low-risk patients (‘cream-skimming’). Additionally, if only certain measures are attached to the P4P schemes, those measures will tend to be targeted for improvement at the expense of other more important measures. In this way, mechanisms can be open to gaming and could potentially be harmful to residents.¹³¹

Conclusion

Quality improvement efforts in LTCHs will always involve a multi-objective multi-player and multi-strategy endeavour. The simultaneous pursuit of multiple objectives such as resource-efficiency, resident satisfaction, and better working arrangements, is challenging, given competing priorities, and will entail direct and indirect, intended and unintended consequences for all parties affected. Lessons from this review suggest that quality improvement in LTCHs could be advanced with greater transparency and acknowledgement of the intended and unintended positive and negative outcomes from efforts to change systems and processes. This implies that a precondition of any quality improvement mechanism must be a foundation of trust between the parties involved, as is well demonstrated by Denmark, known for having a high-trust society.

Findings from this review appear to indicate that a wise approach to quality assurance should be one that neither over-relies nor under-relies on certain mechanisms, but one that uses the output or performance from these mechanisms as signals to facilitate continual learning and continuous quality improvement in the LTCH system. Additionally, the worldwide move towards outcome measures and quality of life measures continues to gain momentum.

Adopting change in LTCHs is not easy to achieve¹³² and it is helpful to learn from experiences of comparable systems abroad (as well as within Canada) to understand what works, in what circumstances, how and why. This is the subject of part two of this report which discusses how other jurisdictions adopted the mix of interventions to ensure quality of LTCH, and what Canada can learn from these adoption processes.

Appendix 1: Search terms and inclusion criteria

Search terms and inclusion criteria are outlined below.

Definition of long-term care

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.¹³³

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 is 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”	Studies reporting system-level strategies or factors
“aged”	Published within the last two decades i.e. from 2002
“elderly”	
“quality”	English language articles
“review”	Focuses on quality or impact on quality of care in LTCHs
“reforms”	
“regulation”	

Appendix 2: Key informants interviewed

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, Bruyère Research Institute Concordia University Montreal
Denmark	
4.	Mrs. Louise Weikop Head of Quality and Innovation in the Municipality of Aalborg, Denmark

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