Reform strategies in home care in Europe – What role for quality of services?

Virpi Timonen
Trinity College Dublin

For presentation at **Healthcare regulation and governance: How can we improve quality and safety in Ireland?**

Conference at University College Dublin

14 September 2012

Living Independently at Home –

Reforms in European Home Care

- Lead PIs: Kröger /**Finland**, Szebehely/**Sweden**, Vabø/**Norway**, Rostgaard/**Denmark**, Theobald/**Germany**, Gori/**Italy**, Österle/**Austria**, Glendinning/**England**, Timonen /**Ireland**
- National reports: www.sfi.dk/livindhome
- Journal articles: *Health and Social Care in the Community*, 2012, vol. 20, issue 3 – edited by T. Rostgaard, C. Glendinning and V. Timonen – I wish to acknowledge the contribution of my co-editors to today's presentation
- With thanks to the funder: Mission Recherche (MiRe), Ministry of Health, Youth and Sports; and National Solidarity Fund for Autonomy (CNSA), France

LIVINDHOME focus

- How have European countries responded to the growing need for formal home care?

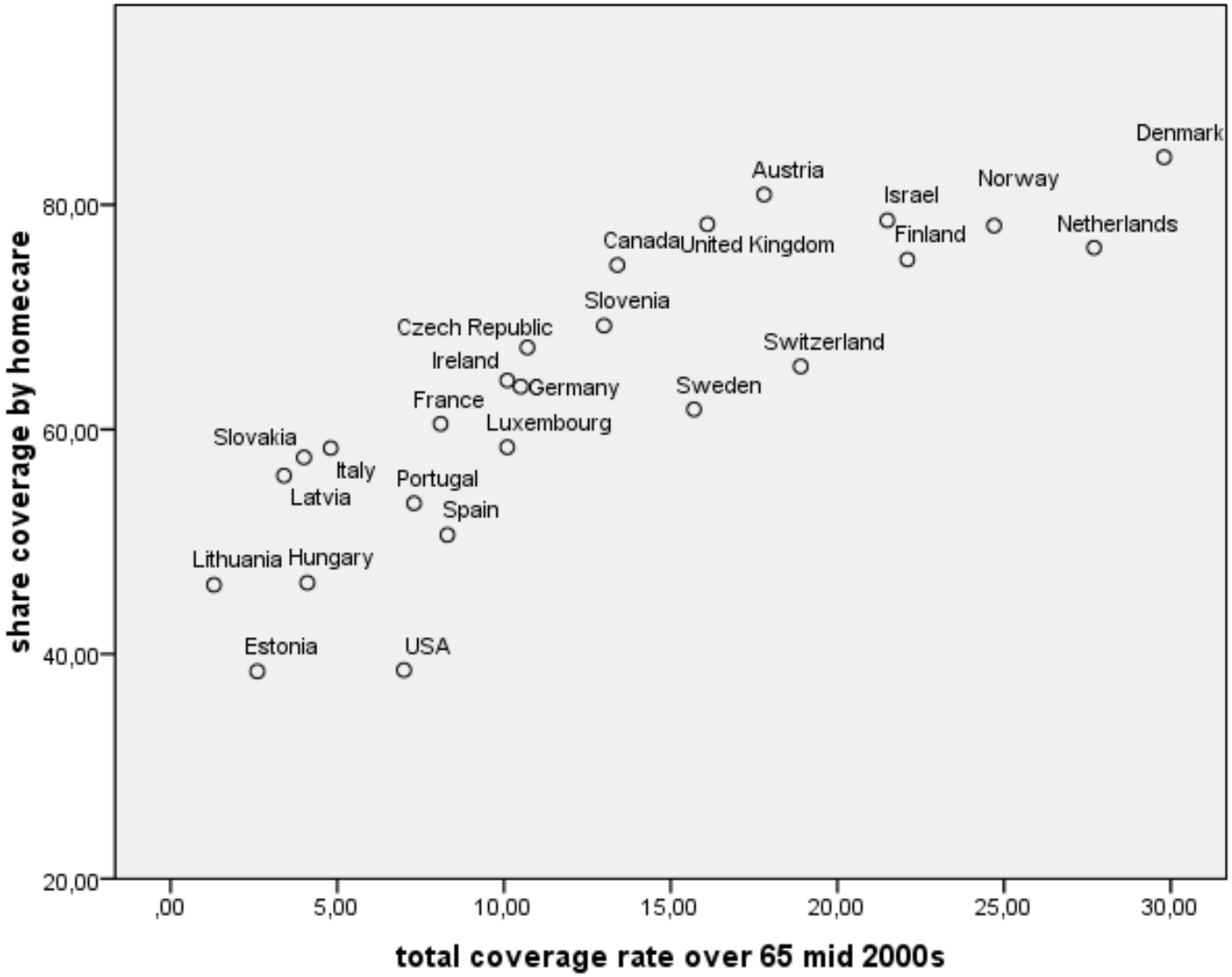
  Identifying drivers of change & responses with regard to the organisation, provision, & regulation of home care

Operational definition of home care

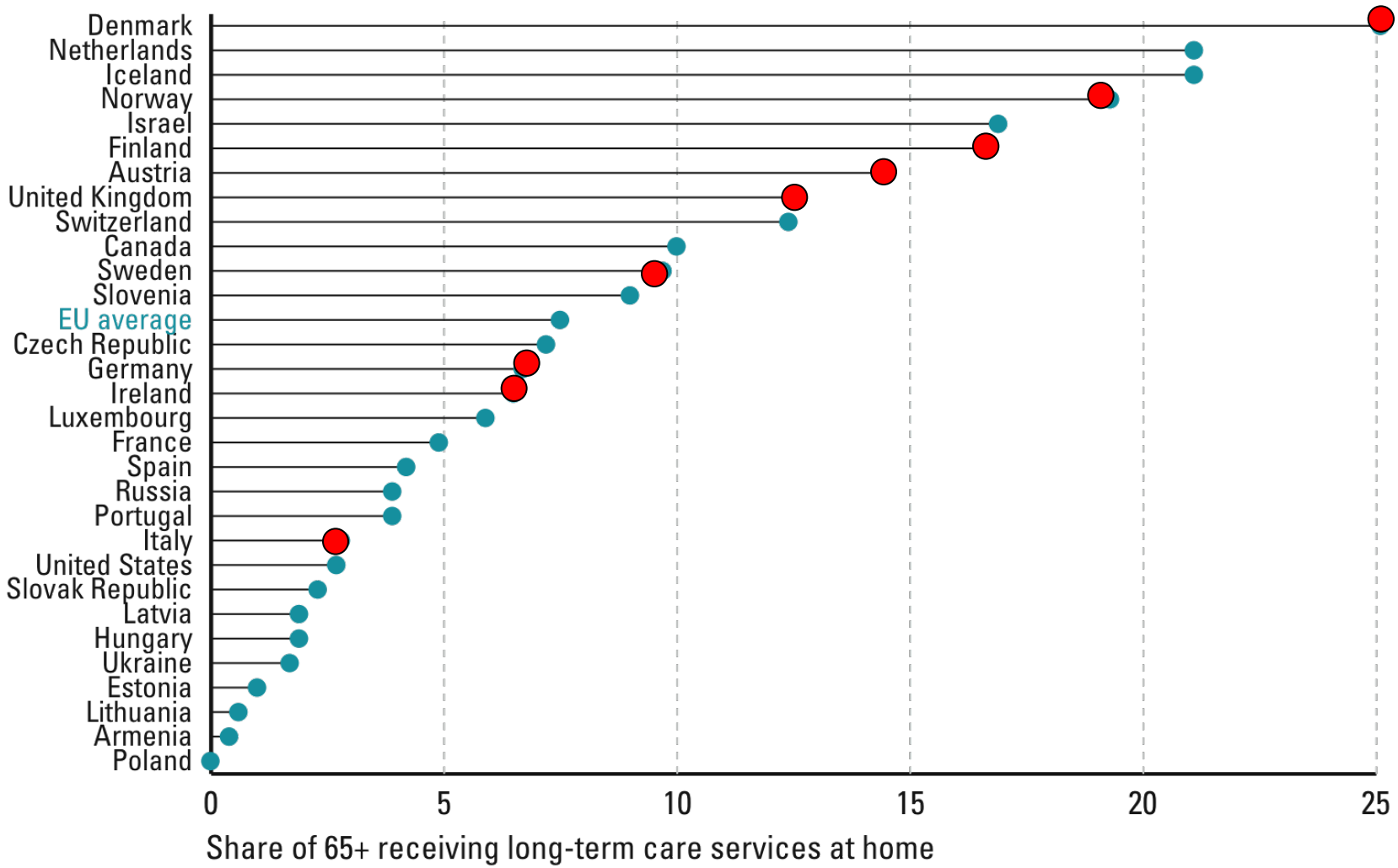
- Help with bodily and domestic tasks in the home of the care recipient
- Assistance with tasks such as cleaning, shopping, getting dressed, bathing, preparing and eating meals, companionship and participation in social activities
- Includes services as well as cash benefits
- Mainly provided for 65+, with 80+ having the highest probability of receiving services

40-90 % of all formal long-term care in OECD countries is home care

Overall coverage of long-term care / share of home care

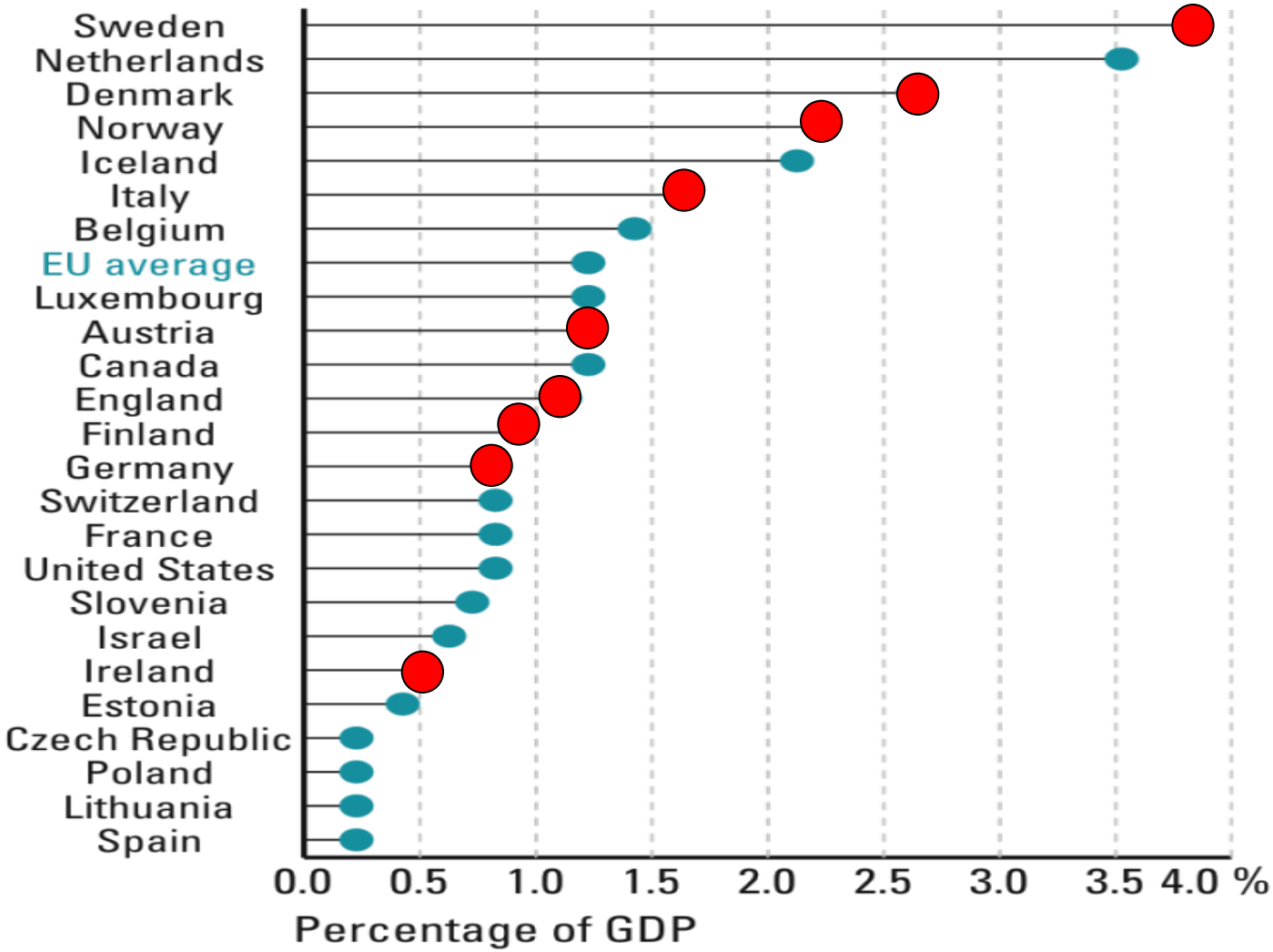


% of 65+ with home care services



Source: Huber et al, 2009

Expenditure on long-term care



Source: Huber et al. 2009, based on OECD, NOSOSCO , Eurostat and national sources.

Widely shared drivers of change

- **Socio-demographic change** (ageing, families, workforce)
- **Public expenditure projections** ("doubling of care costs within next decades") & concern with efficiency and cost-effectiveness
- **Individualism and consumerism**; personalisation and choice; concern with quality
- **Shifting assumptions** about welfare state boundaries and social rights

Challenges for reformers

1. Governance
2. Cost control & efficiency
3. User orientation
4. Regulation
5. Public vs. private realms
6. Effective workforce strategies
7. Quality
8. Equity and equality

Two ‘regimes’: path-dependency & change

Family-oriented welfare

- Austria, Germany ► corporatist response – new social rights
- Italy, Ireland ► expansion & innovation (cash-for-care), but limited central State role

Extensive formal services

- Denmark, England, Finland, Norway, Sweden
- Delivered by local authorities, central government regulation
- Reform strategies
  - Market and consumer mechanisms, including private providers
  - Targeting those with highest needs
  - Preventive approach / self-help / re-ablement

Differences overshadow commonalities

- Governments have become more active in this area because they need to be (seen to be) doing something about growing older populations;
- But they are also constrained by the perception of ballooning costs and limited public funds/fiscal crises

- Striking diversity in policy responses
- "Typical" trend – public funding, non-State provider organisations, family care integration

Dampening demand, widening welfare mix

- Steering policy responses in directions that dampen demand & draw on 'low-cost' sources of care (families, migrant workers, voluntary sector, older people themselves through private spending but also new directions like re-ablement, self-care)

- Resulting in inequalities in access and uneven/unknown quality (although massive inter-country differences persist in this respect)

Widely used strategies to reduce demand/contain costs/promote efficiency

- **Narrowing eligibility** through increased targeting – typically to 'highest needs', especially ADL difficulties – increasing frailty of recipients
- **Efficiency measures** (including both Taylorisation of care tasks & use of (basic) technology – e.g. bar codes)
- Introduction of **cash allowances**: expenditure becomes in principle more controllable e.g. value can be 'frozen' (Germany)
- **Embedding family and 'grey' care labour** into the long-term care architecture

Recruiting and retaining paid home care workers

- Common problem: efficiency and marketisation reforms can exacerbate challenges

- Responses include:
  - Training
  - Professionalisation & career paths
  - Attracting migrant workers

Improving quality of care

Structure Background checks, qualifications, training, staff/supervisors ratio

Process Documentation, Assessment, Monitoring of staff, Continuity, Feedback, Complaints processes

Outcomes Falls, Improvement/Decline in ability, Social engagement, Satisfaction with care

What constitutes quality for care recipients?

Time

Sufficient time to give and receive care

Unhurried care practice

Influence

Over content and timing of care

Over care provider

Continuity/ Continuum

of care

Approaches to quality

- Audit and accountability regimes (Norway)
- Registration and inspection (England)
- Functional integration (Austria, Germany)
- User feedback/surveys (Denmark, England, Finland, Sweden)
- No central state involvement (Italy)

Quality control in England

- All providers must register with the Care Quality Commission
- Must comply with 16 core national quality & safety standards
- Regular announced and unannounced inspections
- New unqualified staff must register for training within 6 months of taking up employment – since 2011, the new Qualifications and Training Framework allows for this in a flexible manner

….despite this, underfunding of home care services continues to be reflected in poor quality services (extremely short visits by care staff, uncertainty over timing of visits)

….and the 'mixed economy of purchasing' (increased choice of providers by cash-in-care recipients) will make quality control even more challenging (Glendinning 2012)

Quality control in Germany

- Care Recipients can choose between a cash-benefit or direct service delivery (private or not-for-profit provider)
- Only providers who introduce internal quality management practices accepted by insurance funds
- Focus on staff qualifications and ratios
- Recipients of cash benefits are visited by a nurse employed by the care insurance funds every 3 - 6 months to administer a universal questionnaire

Quality control in Denmark

- Local authorities are required by law to ensure that adequate home care is available flexibly for all who are assessed as needing care (24/7)
- Quality guidelines are outlined on an annual basis by the local government and vary substantially between municipalities – but this variation is known – **'quality through transparency'**
- Care recipient awarded specific tasks - Given some latitude to change care tasks
- They can choose between a public or private provider – or family member who is employed as a carer – **assumption of quality through choice**
- **Tension between individualisation/choice and standardisation**

Importance of institutions

- Differences in **historical traditions, values and structures** influence policy and practices – BUT these can be transcended / radically modified

- **Central government responsibility** for the overall provision and regulation of home care services is **essential** in securing adequate levels of provision; in safeguarding some aspects of quality; and in reducing inter-regional differences: ***this does not go all the way towards ensuring quality, but is an essential basic underpinning if quality is to be taken seriously***

‘Big’ things matter for quality…but so do ‘little’ things

- Whether care workers are reimbursed for time spent travelling between the homes of care recipients – impacts on recruitment, retention - and quality (UK Equality & Human Rights Commission, 2011)

- Striving for quality does not just involve adopting the use of distinct ‘instruments’ and ‘procedures’ – but calls for an integrated approach that is attuned to how **every** aspect of the home care system impacts on quality

Quality is closely interwoven with (new) tensions in care

- Central/local: Overall responsibility & variation
- Division of care work in the welfare mix
- Universalism: Changing perceptions of accessibility of home care services
- New demarcation line health/social care: medicalising needs and needs intervention
- Professionalisation/de-professionalisation
- Maintaining bureaucratic control while strengthening the service user's position
- **All of these influence quality**
- **Reform and regulation of all aspects of home care should be guided by a clear notion of what quality is – one that is ideally grounded in the outcomes that matter to care recipients**