



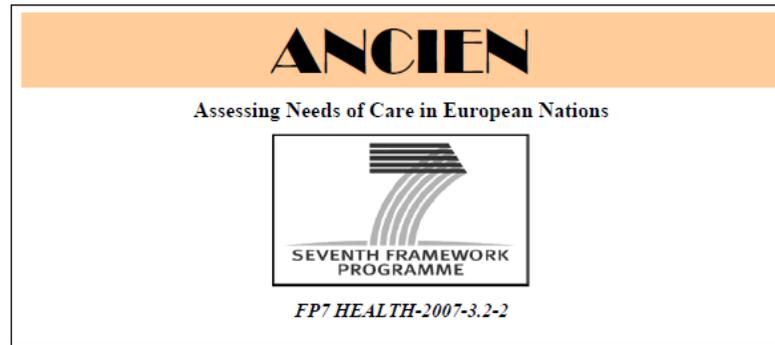
# LTC Quality Policies and Indicators in European Countries

*Results of the EU-funded project  
ANCIEN, Assessing Needs of Care in European Nations*

**Roberto Dandi**

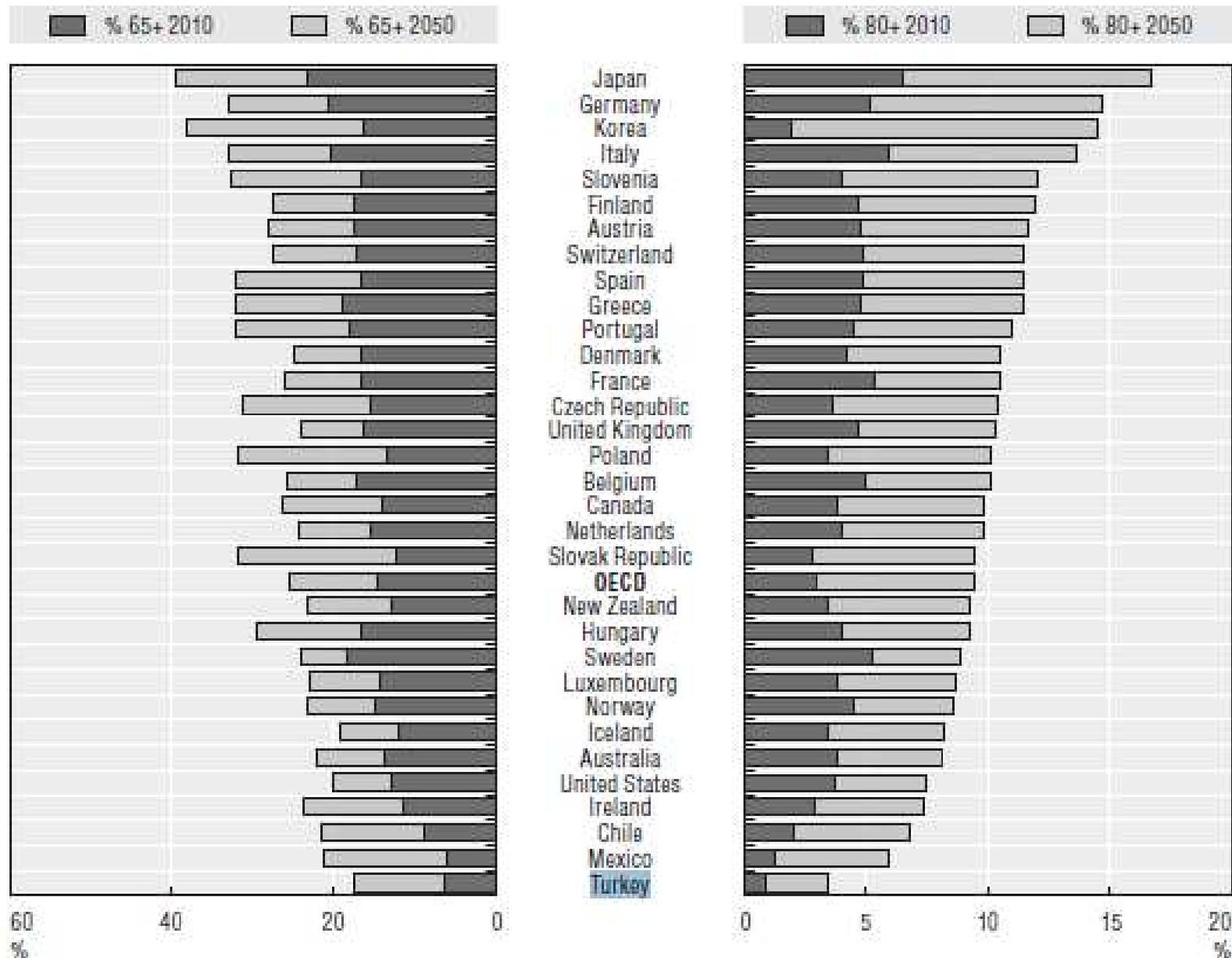
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Şişli Etfal Hastanesi, Istanbul, May 3 2012



- FP7 project, lasting 44 months, January 2009-August 2012
- **20 partners:** 1. CEPS, Belgium (coordinator) 2. CPB Netherlands Bureau for Economic Policy Analysis (scientific coordinator) 3. FPB, Federal Planning Bureau, Belgium (scientific coordinator) 4. DIW, Germany 5. NIDI - KNAW, the Netherlands 6. FEDEA, Spain 7. CNR, Italy 8. LUISS Business School, Italy 9. IHS, Austria 10. London School of Economics, United Kingdom 11. ISAE, Italy 12. CASE, Poland 13. IER, Slovenia 14. TARKI 15. ETLA, Finland 16. DAUPHINE-LEGOS, France 17. University of Stockholm, Sweden 18. Karolinska Institute, Sweden 19. SAS BIER, Slovakia 20. Praxis, Estonia  
Coordinatori scientifici: Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis
- **2 research questions:**
  - 1) How will need, demand, supply and use of LTC develop?
  - 2) How do different systems of LTC perform?

## The shares of the population aged over 65 and 80 years in the OECD will increase significantly by 2050



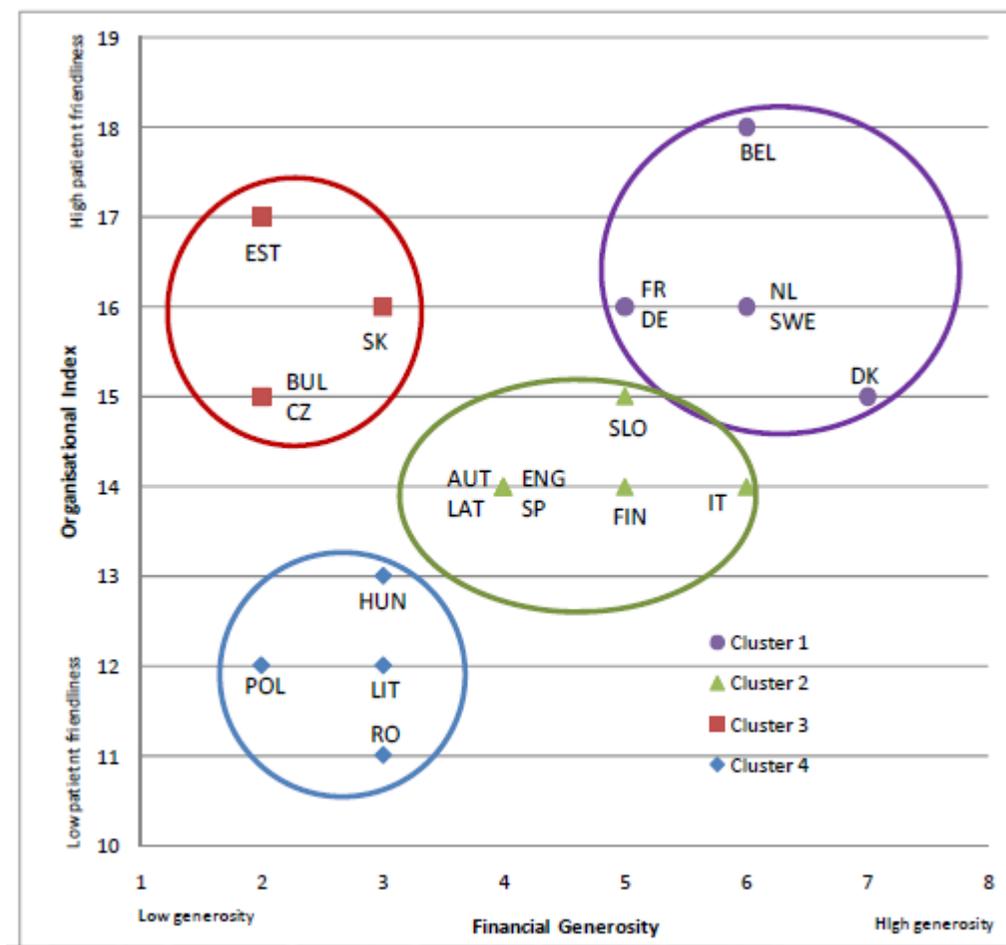
Source: OECD Labour Force and Demographic Database, 2010.

# Long Term Care

According to the World Health Organisation (2002) the goal of LTC is

“to ensure that an individual who is not fully capable of long-term self-care can maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity”.

## Tipi di sistemi LTC in EU in base all'organizzazione e al finanziamento pubblico (analisi WP1)



- Patient friendliness = means-testing, entitlements for services, availability of cash benefits, provider choice, quality assurance and integration of care.
- Financial generosity = % of LTC public expenditure on GDP, and presence or not of cost-sharing

# LTC quality dimensions

HEALTHCARE SYSTEM PERFORMANCE					
How does the healthcare system perform? What is the level of care across the range of patient care needs? What does this performance cost?					
<i>Dimensions of Healthcare Performance</i>					
<i>Healthcare Needs</i>	Quality			Access	Cost / Expenditure
	Effectiveness	Safety	Responsiveness / Patient-centeredness	Accessibility	
Staying healthy					
Getting better					
Living with illness or disability					
Coping with end-of-life					

Conceptual framework for Organization for Economic Cooperation and Development Health Care Quality Indicator (HCQI) Project (OECD ,2006)

# Effectiveness

1. *Achieving intended effects*: effectiveness refers to the extent to which the intervention produces the intended effects. The Council of Europe (1997) talks about increasing the chance to achieve desired results and avoid undesired results.
2. *Appropriateness*: As a performance dimension, this indicates the degree to which provided health care corresponds to the clinical needs, given the current best evidence. This dimension is most often presented as part of effectiveness.
3. *Competence of health system personnel*: This dimension assesses the degree to which health system personnel have the training, the professionalism and the abilities to assess, treat and communicate with their clients. This dimension, in terms of its assessment, is assumed to be included in effectiveness.

# Safety

## (of patients and workforce)

- The degree to which care processes **avoid, prevent and ameliorate adverse outcomes** or injuries that **stem from the process of care itself** (National Patient Safety Foundation, 2000).
- Safety is a dimension that is closely related to effectiveness, although distinct from it in its **emphasis on the prevention** of unintentional adverse events for patients.

# Patient value responsiveness

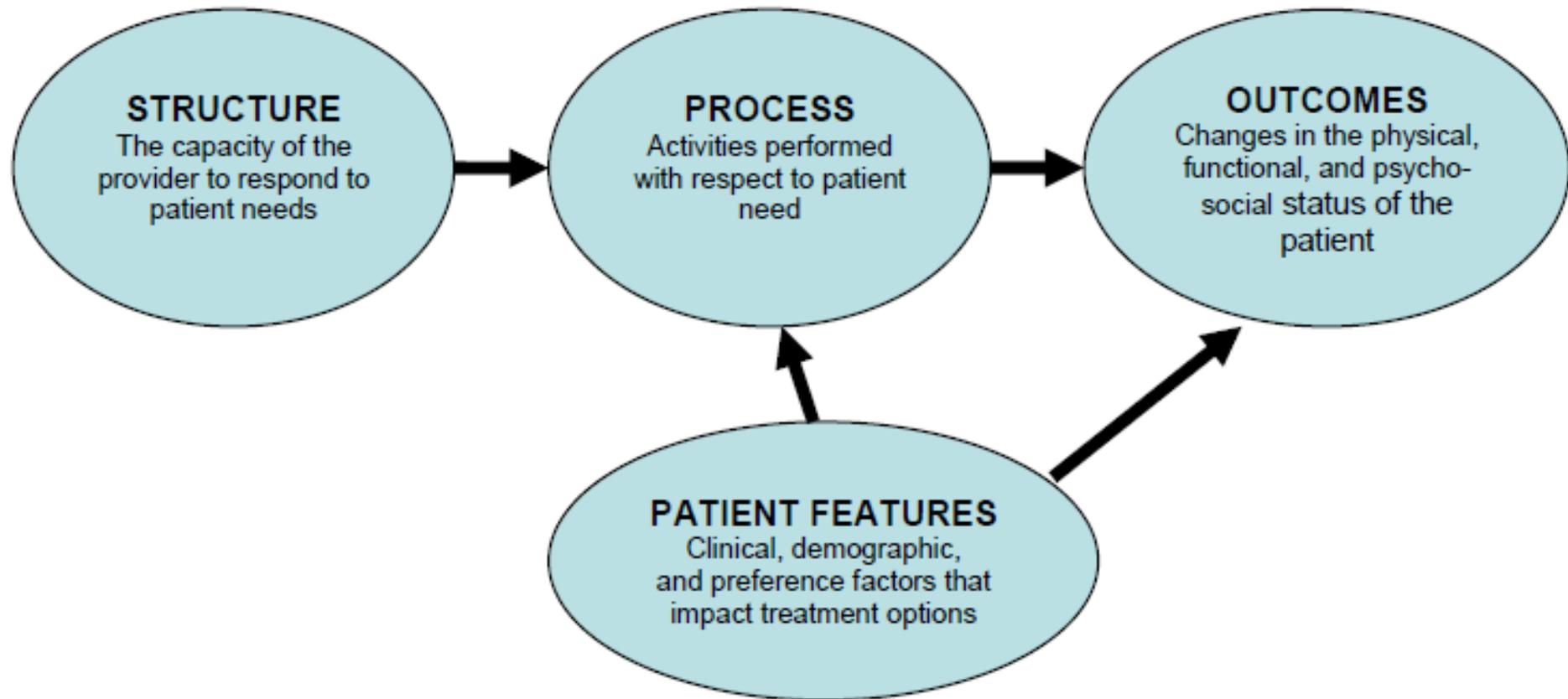
- **Achieving non-health related expectations:** Refers to how a system treats people to meet their legitimate non-health expectations (WHO, 2000) and their preferences and values: emotional well-being, personal development, self-determination, interpersonal relations, social inclusion and social networks.
- ***Satisfaction*:** How the treatment and the improvement in patient's health meets his/her expectations.
- ***Acceptability*:** How **humanely** and **considerately** the treatment is delivered.

# Coordination

- 1) **Timeliness** is a related concept that is used in several country frameworks and refers to the degree to which patients are able to obtain care promptly. It includes both timely access to care (people can get care when needed) and coordination of care (once under care, the system facilitates moving people across providers and through the stages of care).
- 2) **Continuity** addresses the extent to which health care for specified users, over time, is coordinated across providers and institutions.
- 3) **Integration** between primary and secondary care, and between health care and social care.

# System dimensions

*Figure 1.1 Donabedian's model*

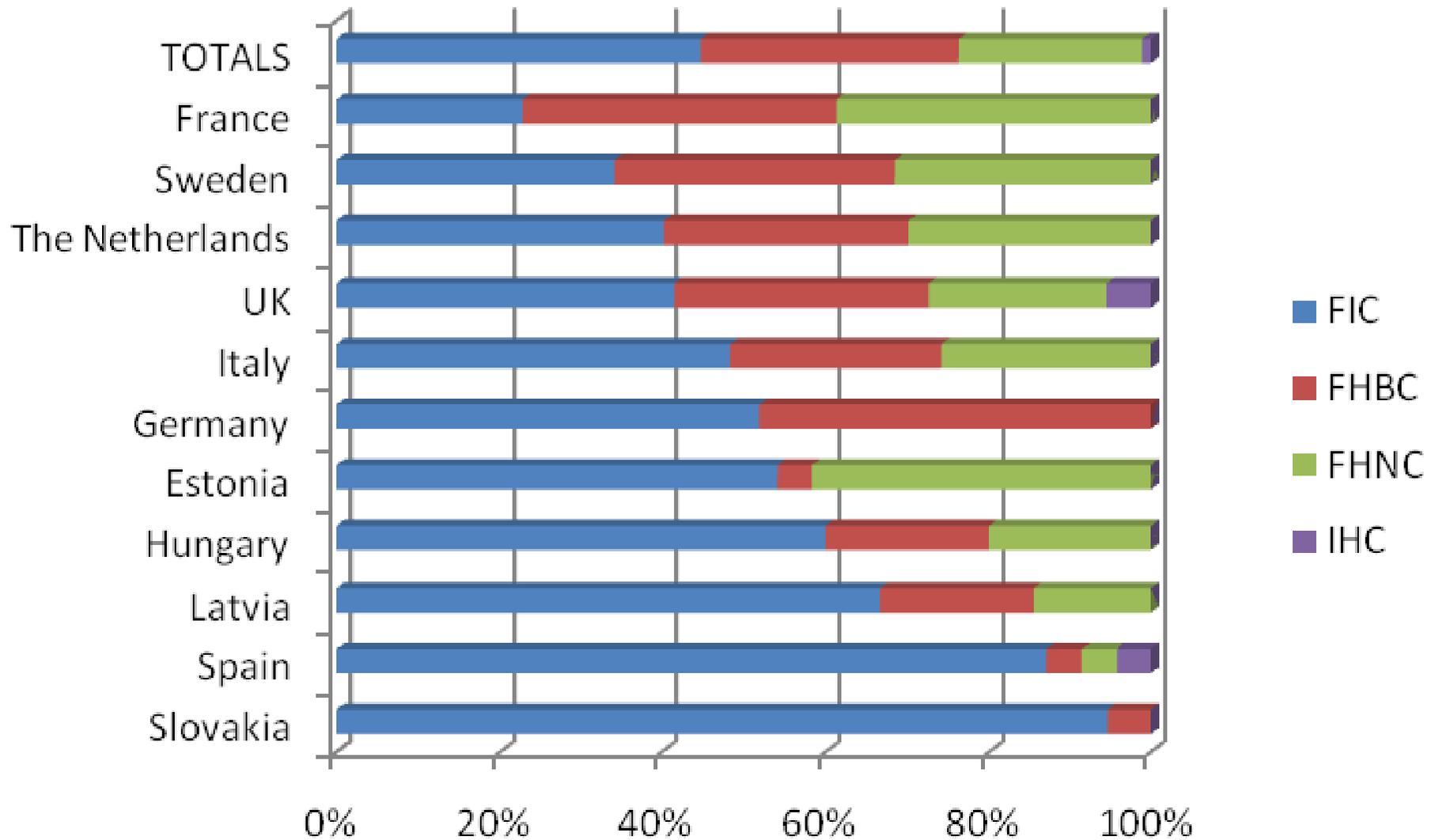


*Source:* Adapted from National Commission for Quality Long-Term Care, 2005.

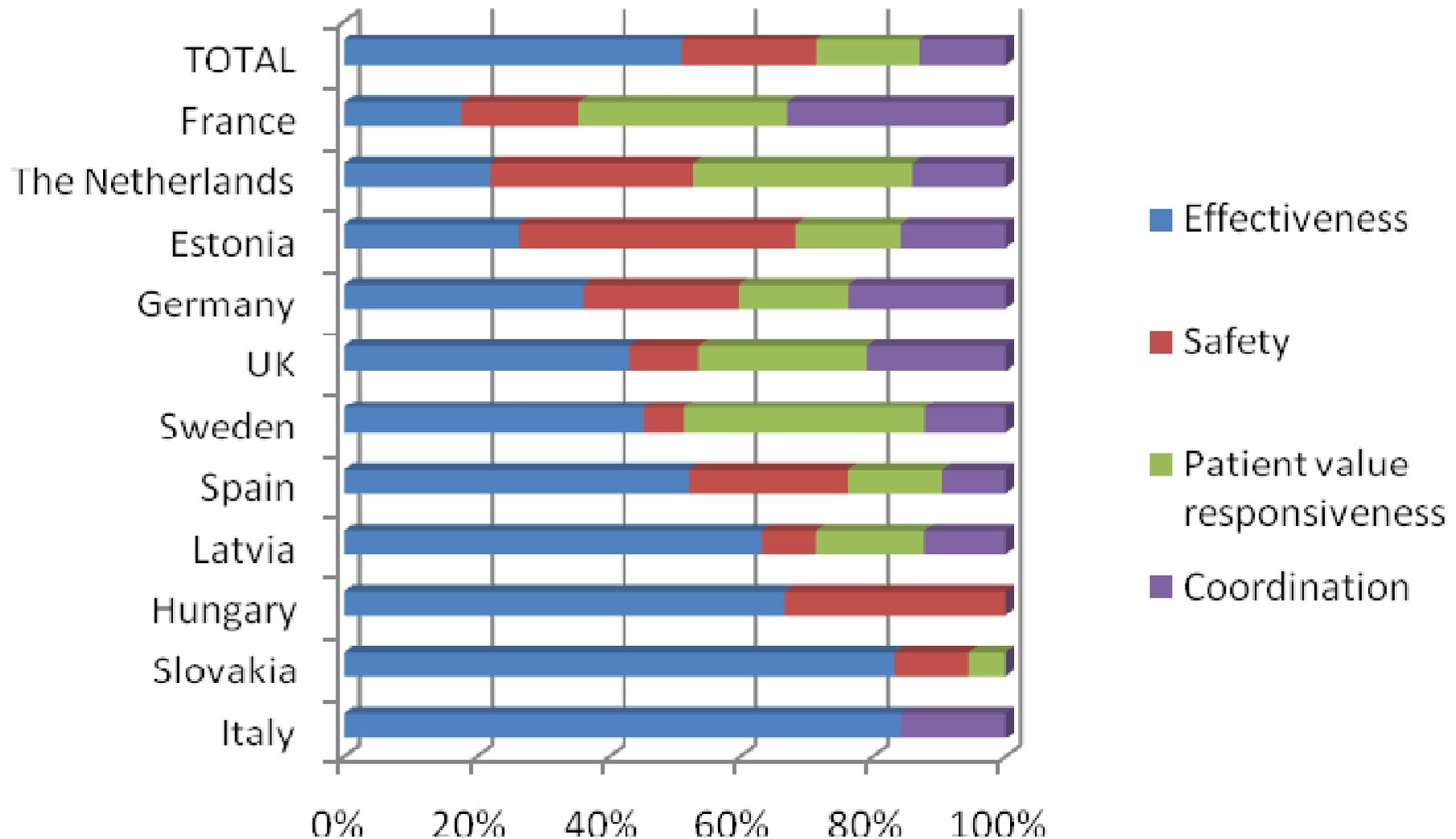
# ANCIEN questionnaire

- Questions on policies (plan e do), monitoring system (check) interventions (act) about:
  - 4 quality dimensions: effectiveness, safety, patient-centredness, coordination
  - 4 types of LTC: Formal Institutional Care (FIC), Formal Home Nursing Care (FHNC), Formal Home Based Care (FHBC), Informal Care.
  - 3 system dimensions: input-process-outcome
- 15 countries: Austria, Estonia, Finland, France, Germany, Hungaru, Italy, Latvia, The Netherlands, Poland, Slovakia, Slovenia, Spain, Sweden and United Kingdom.

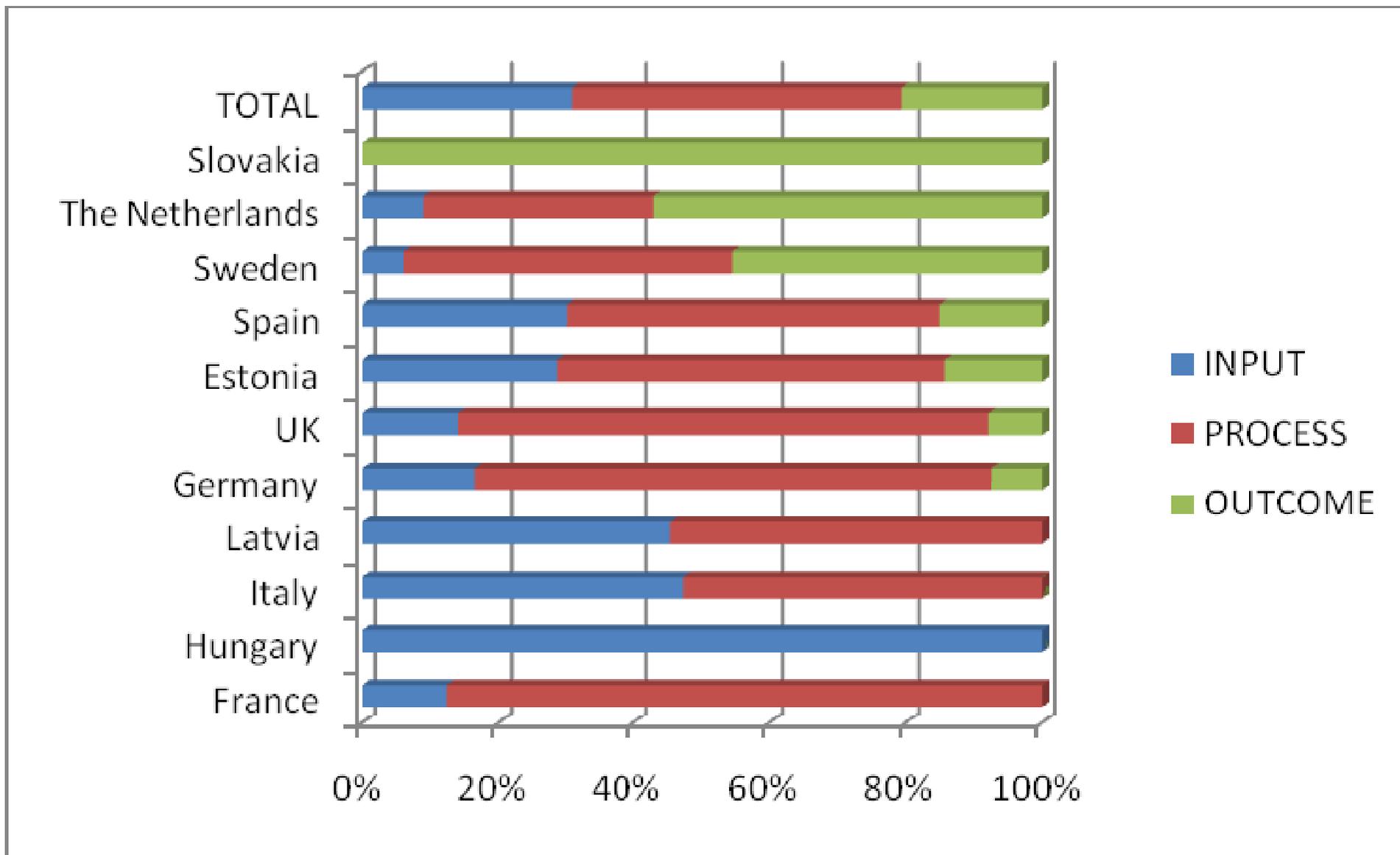
# Indicators by LTC type (%)



# Indicators by quality dimension (%)



# Indicators on input-process-outcome (%)



# Clusters based on LTC quality

<b>Cluster 1:</b> Estonia, France, Germany, Latvia, The Netherlands, Slovakia, United Kingdom	Quality policies about formal LTC, both residential and at home; outcome related policies and indicators; and guidelines about quality of LTC. Latvia actually belongs to cluster 1 but presents features of cluster 2 as well.
<b>Cluster 2:</b> Austria, Finland, Hungary, Spain, Sweden	Quality policies about formal LTC, as in cluster 1, but with a focus on monitoring quality of processes and quality of inputs rather than of outcomes. Some policy about quality of informal care is present.
<b>Cluster 3:</b> Poland, Slovenia	Lack of quality policies and indicators
<b>Cluster 4:</b> Italy	Quality policies and indicators about formal LTC; presence of guidelines about quality of LTC; lack of policies and indicators about responsiveness to patient needs.

# Tentative rankings

	Quality score (0-100)	Quality of care indices (0-100)			Eurobarometer quality (1-4)	
	- policies	Process	Outcome	Global quality	At home	Nursing homes
SE	96.9	53.2	62.8	58.0	2.9	2.9
FR	75.0				3.1	3.1
UK	71.9	85.4	68.3	76.8	2.8 (GB)	2.7 (GB)
LV	68.8				2.5	2.6
ES	64.1				2.8	2.7
NL	62.5	66.8	76.1	71.4	2.9	2.8
EE	56.3				2.5	2.4
FI	56.3				2.7	2.7
DE	56.3				2.9	2.8
SK	56.3				2.5	2.5
HU	50.0				2.5	2.6
IT	46.9				2.4	2.5
AT	43.8				2.9	2.8
SI	15.6				2.8	2.8
PL	12.5				2.4	2.3

Table 1: Quality indicators, sources: Ancien WP 5 data, as described by Dandi et al. (2012), and Eurobarometer 67.3

**Analyses by Georgia Casanova and Roberto Lillini**

- Not surprisingly outcome-based indicators and indicators for informal care are not diffused
- Countries form 4 clusters based on quality policies for LTC
- Countries with high use of formal care and financial generosity have coherently developed LTC quality policies and indicators for formal care
- Countries less financially generous (more private spending) and providing less services (high informal care use) have invested less on quality

# Integration

- *Key problem across countries.: timeliness, continuity of care, integration across levels of care*
  - Few indicators about integration
  - Low integration between LTC and acute care

# Transparency

	country														
	Austria	Estonia	Finland	France	Germany	Hungary	Italy	Latvia	Poland	Slovakia	Slovenia	Spain	Sweden	The Netherlands	UK
<b>Data available to the public?</b>	X	X	X	X	V	V	X	V	X	X	X	X	V	V	V

- The Netherlands: data publicized on a voluntary basis (in 2008 about 50%)
- Slovakia: data will be publicized in 2013, according to new law
- UK: data publicized until 2010

# Informal care support

- Most interventions are based on cash benefits, training/counselling of the family
- Best practices: municipalities network in Sweden; association “Mezzo” in The Netherlands for supporting families; national training programmes as “Caring with Confidence” in UK (now discontinued).

# Frequency of quality monitoring

	UK	5
	The Netherlands	1
	Sweden	na
	Spain	na
	Slovenia	3
	Slovakia	1
	Poland	na
	Latvia	5
	Italy	5
	Hungary	2
	Germany	3
	France	7
	Finland	na
	Estonia	1
	Austria	5
Frequenza monitoraggio		

# LTC workforce

- Specific training on LTC required for GPs (10 countries). Only The Netherlands has mandatory LTC classes for nursing homes physicians, since 1990
- Lack of nurses is a problem almost everywhere. Best practice: Germany is investing on attracting new students in geriatrics nursing classes, and for attracting nurses from abroad.

# Quality indicators collected

	FIC	FHBC	FHNC	IHC	Effect.	Safety	Resp.	Coord.	INPUT	PROCESSES	OUTCOME
FIC	<b>281</b>	101	64	6	141	70	56	60	59	161	58
FHBC	101	<b>198</b>	118	5	82	38	60	46	30	137	31
FHNC	64	118	<b>142</b>	5	54	20	44	32	21	94	27
IHC	6	5	5	<b>7</b>	2	0	0	5	0	6	1
Effectiveness	141	82	54	2	<b>182</b>	19	14	9	65	84	33
Safety	70	38	20	0	19	<b>78</b>	1	14	8	57	12
Responsiveness	56	60	44	0	14	1	<b>99</b>	2	4	68	27
Coordination	60	46	32	5	9	14	2	<b>88</b>	1	85	0
INPUT	59	30	21	0	65	8	4	1	<b>76</b>	1	0
PROCESS	161	137	94	6	84	57	68	85	1	<b>247</b>	0
OUTCOME	58	31	27	1	33	12	27	0	0	0	<b>68</b>

# To be noticed...

- About 40% FIC indicators are also used for FHBC. There are more shared indicators between FIC and FHBC than between FIC and FHNC: LTC is more “social care” than “health care”.
- FHBC and FHNC indicators balance between effectiveness and responsiveness, while FIC indicators are only focused on effectiveness.
- Safety and coordination are mostly process indicators.
- Input, Process and Outcome indicators are equally distributed across LTC types (20%-60%-20%). Golden rule?

# Outcome indicators

We collected 68 of them:

- Satisfaction indicators:
- Indicators about health conditions, functional abilities, behaviour, death
- Hospitalization and its consequences
- Safety effects: fall incidents, unintended weight loss, decubitus
  
- Not diffused (only in 7 countries).

# Conclusions

- Data, data, data: we need more standardized data to produce quality policies and care plans. Turkey has a young population and has time to organize this for future policies
- Integration: more communication, invest on more integrated communication technologies
- Monitoring: not just frequency, interventions based on monitoring results (plan-do-check-ACT)
- Transparency: recommended, it starts a virtuous cycle
- Informal care support: not just cash benefits, also services
- LTC workforce: invest on specific training and more nurses
- Outcome indicators: a national standard multidimensional assessment form should be adopted (Inter-RAI?)

More information:

ANCIEN project: <http://www.ancien-longtermcare.eu>

ANCIEN project quality reports: <http://www.ceps.be/>

CEPS Publications:

**Quality Assurance Indicators of Long-Term Care in European Countries**

04 April 2012

**Long-Term Care Quality Assurance Policies in the European Union**

08 March 2012

**The Influence of Technology on Long-Term Care Systems**

29 February 2012

**Quality Assurance Policies and Indicators for Long-Term Care in the European Union**

07 February 2012

teşekkür ederim!