LUISS BUSINESS SCHOOL
Divisione LUISS Guido Carli

Politiche e indicatori di qualità del Long-Term Care in Europa

Risultati del progetto ANCIEN, Assessing Needs of Care in European Nations

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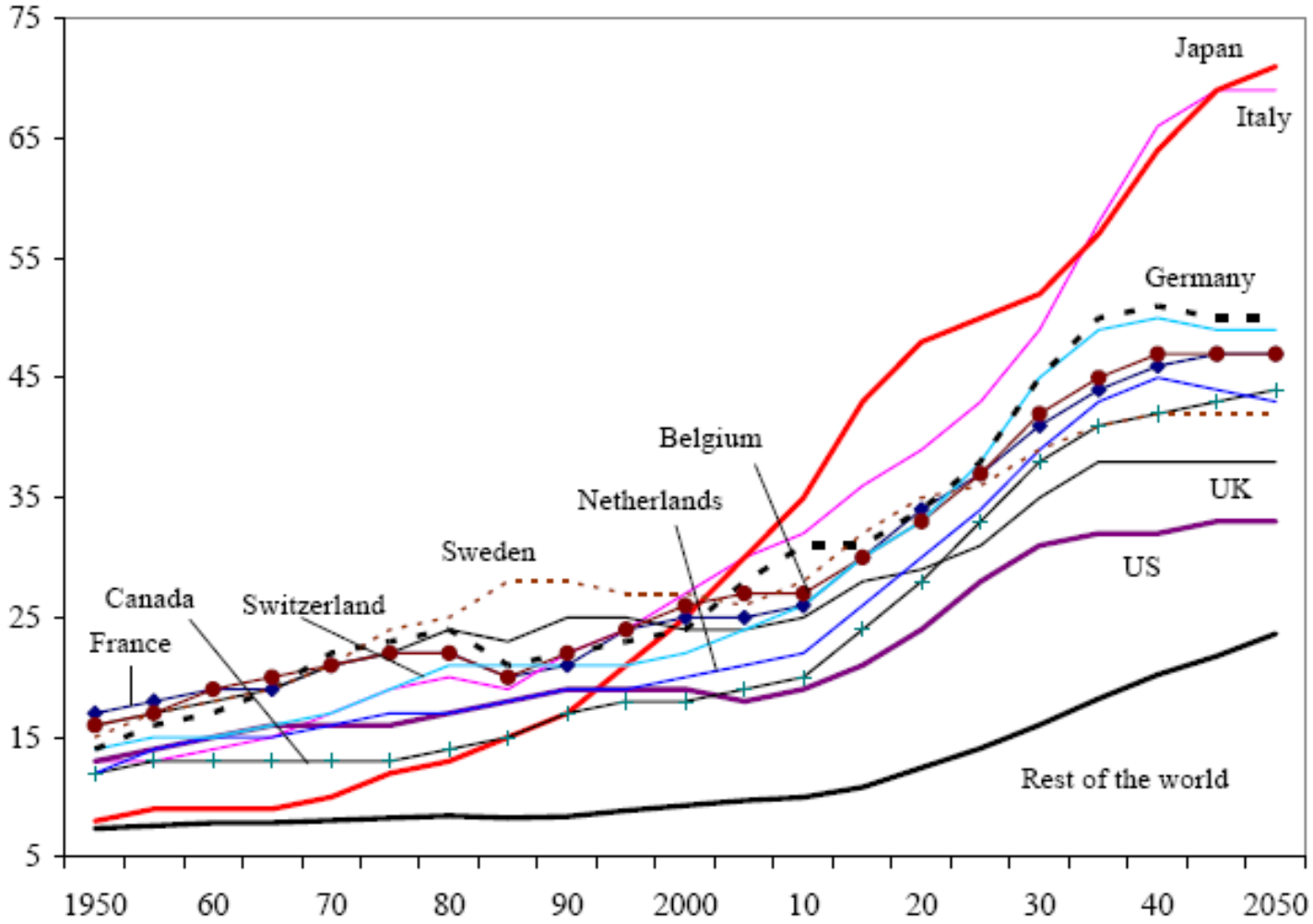
- Progetto FP7 di **44 mesi**, gennaio 2009-agosto 2012
- **20 partner**: 1. CEPS, Belgium (coordinatore) 2. CPB Netherlands Bureau for Economic Policy Analysis (scientific coordinator) 3. FPB, Federal Planning Bureau, Belgium (scientific coordinator) 4. DIW, Germany 5. NIDI - KNAW, the Netherlands 6. 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, EstoniaCoordinatori scientifici: Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis
- **2 domande di ricerca:**
  - Come evolverà il bisogno, la domanda , la fornitura e l'uso di LTC in Europa?
  - Quale sarà la performance dei sistemi LTC in Europa?

Linee di attività (Work Package)

1) Sistemi di erogazione del LTC in Europa (leader: IHS, Austria)
2) Stima dei bisogni di LTC in Europa (leader: NIDI, Olanda)
3) Assistenza formale e informale in Europa (leader: FEDEA, Spagna)
4) Tecnologie per il LTC (leader: CNR, Italia)
5) Qualità nel LTC (leader: LUISS, Italia)
6) Previsioni dell'uso di servizi di LTC (leader: FPB, Belgio)
7) Previsioni sulle performance dei sistemi di LTC europei (leader: CPB, Olanda)
8) Divulgazione dei risultati del progetto (leader: CEPS, Belgio)
9) Gestione del progetto (leader: CEPS, Belgio)

Figure I.1. Old-age dependency ratios are increasing sharply

(ratio of the population aged 65 years or over to the population aged 15-64, in percent)



Source: United Nations Population Division, *World Population Prospects: the 2004 Revision*.

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".

WP1: Sistemi di LTC

- Sviluppo di una tassonomia in base a due aspetti:
  - Organization/provision of care
  - Financing
- Identificazione di cluster di stati omogenei
- Inclusione dei 14 paesi europei di ANCIEN

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe,* ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

Metodo: analisi dell'organizzazione dei sistemi LTC

- **O1: Accessibility**
  - Means-tested access

    Value **1**: No means-tested access in both, FIC and HBC

    Value **0**: else
  - Entitlement

    Value 1: Entitlement in both, FIC and HBC

    Value 0: else
- **O2: Freedom of choice**
  - Availability of cash benefits

    Value **1**: Cash benefits in both, FIC and HBC

    Value **0**: else
  - Choice of providers

  (Can recipients choose the provider freely in FIC/HBC)

  Value **1**: Free provider choice in both, FIC and HBC

  Value **0**: else

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

Metodo: analisi dell'organizzazione dei sistemi LTC

- **O3: Technical depth**
  - **Quality assurance**

    (Quality assurance is mandatory OR not mandatory in FIC/HC/HNC)

    Note: If quality assurance is mandatory in HNC ➔ quality assurance is mandatory in HBC

    Value **1**: Mandatory quality assurance in both, FIC and HBC

    Value **0**: else

  - **Integration**

    (Quality of coordination BETWEEN LTC and other services is …)

    Value **1**: Rather good

    Value **0**: else

    Note: for no country the question was answered with "very good".

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

Sistemi LTC in base a organizzazione

Clusters	Countries in the clusters	Description	Values for overall typology
1	BEL	High accessibility High freedom of choice High technical depth	1
2	EST, SLO	High accessibility High freedom of choice Medium or low technical depth	2
3	DEN, SWE	High accessibility Medium or low freedom of choice High technical depth	2
4	BUL, CZE, FIN, FRA, HUN, NED, SVK	High accessibility Medium or low freedom of choice Medium or low technical depth	3
5	AUT, England	Medium or low accessibility High freedom of choice Medium or low technical depth	3
6	ESP, GER, ITA, LAT, LIT, POL, ROM	Medium or low accessibility Medium or low freedom of choice Medium or low technical depth	4

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

Fonte: IHS (Austria)

Finanziamento del LTC

- F1: Cost-sharing

  (Do formal care recipients have to pay cost-sharing for FIC/HC/HNC)

  Value **1**: Cost-sharing in FIC, no cost-sharing in HC and/or HNC

  Value **0**: else

- F2: Public expenditure for LTC as share of GDP

  Public spending is a measure for the generosity of a LTC-system. The more a country spends for LTC the more services/service capacity should be available. (Total spending on LTC is not available for all countries)

  Value **1**: Public expenditure for LTC as share of GDP 1% or higher

  Value **0**: Public expenditure for LTC as share of GDP below 1%

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe,* ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

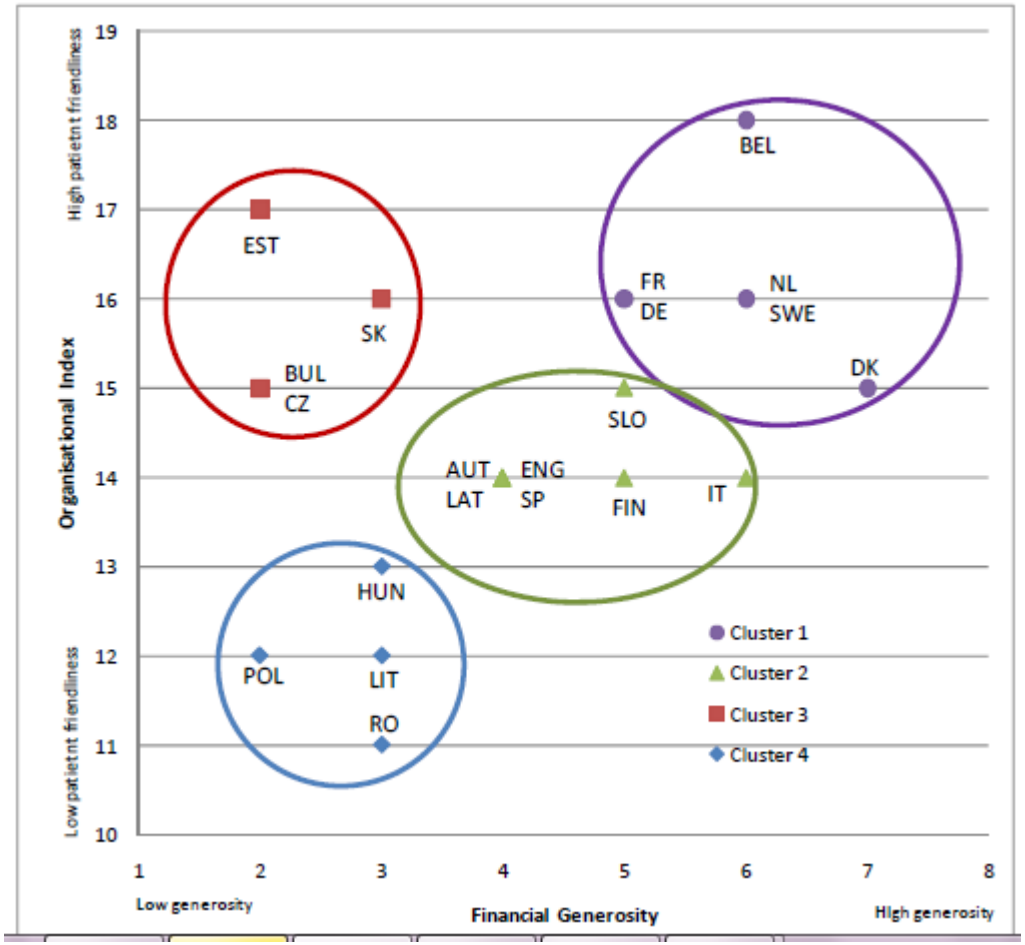
Paesi in base al finanziamento del LTC

- **Results**:

Cluster	Countries in the clusters	Description	Values for overall typology
1	BEL, DEN, FRA, ITA, SLO	High or medium public expenditures Not-widespread or medium private contributions	1
2	AUT, FIN, NED, SWE	High or medium public expenditures Widespread private contributions	2
3	ESP, GER, HUN, LAT, ROM, SVK, England	Low public expenditures Not-widespread or medium private contributions	3
4	BUL, CZE, EST, LIT, POL	Low public expenditures Widespread private contributions	4

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

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

Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czypionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 (www.ceps.eu).

Le dimensioni della qualità dell'assistenza

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?					
	Dimensions of Healthcare Performance				
Healthcare Needs	**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)

Dimensioni della qualità del LTC in ANCIEN

Effectiveness

1. *Effectiveness of care*: This key performance dimension refers to the extent to which the intervention produces the intended effects. Donabedian (1980) defines effectiveness as the expectation of a care to maximise patient welfare; 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

- Quality of care means safety of patients and providers. 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

- *Patient value responsiveness*: 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.

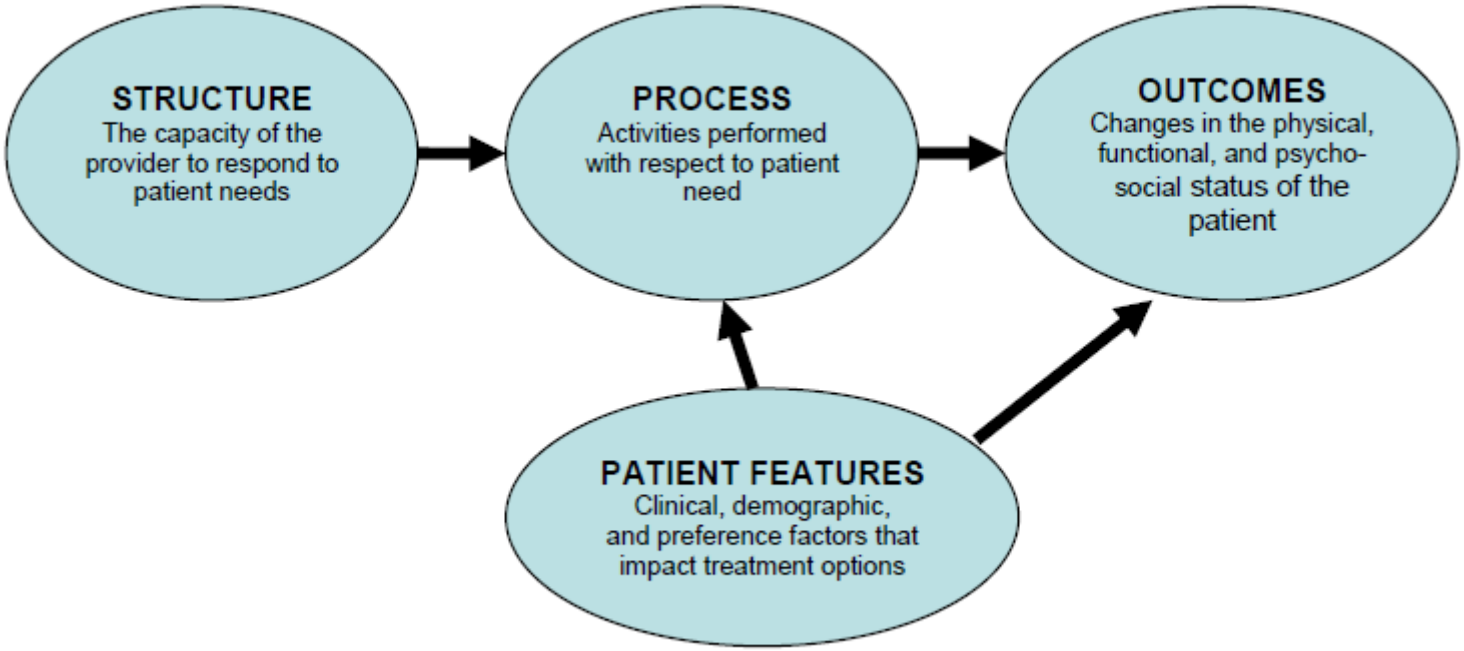
- *Acceptability*: How humanely and considerately the treatment is delivered.

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.

Dimensioni sistemiche

Figure 1.1 Donabedian's model



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

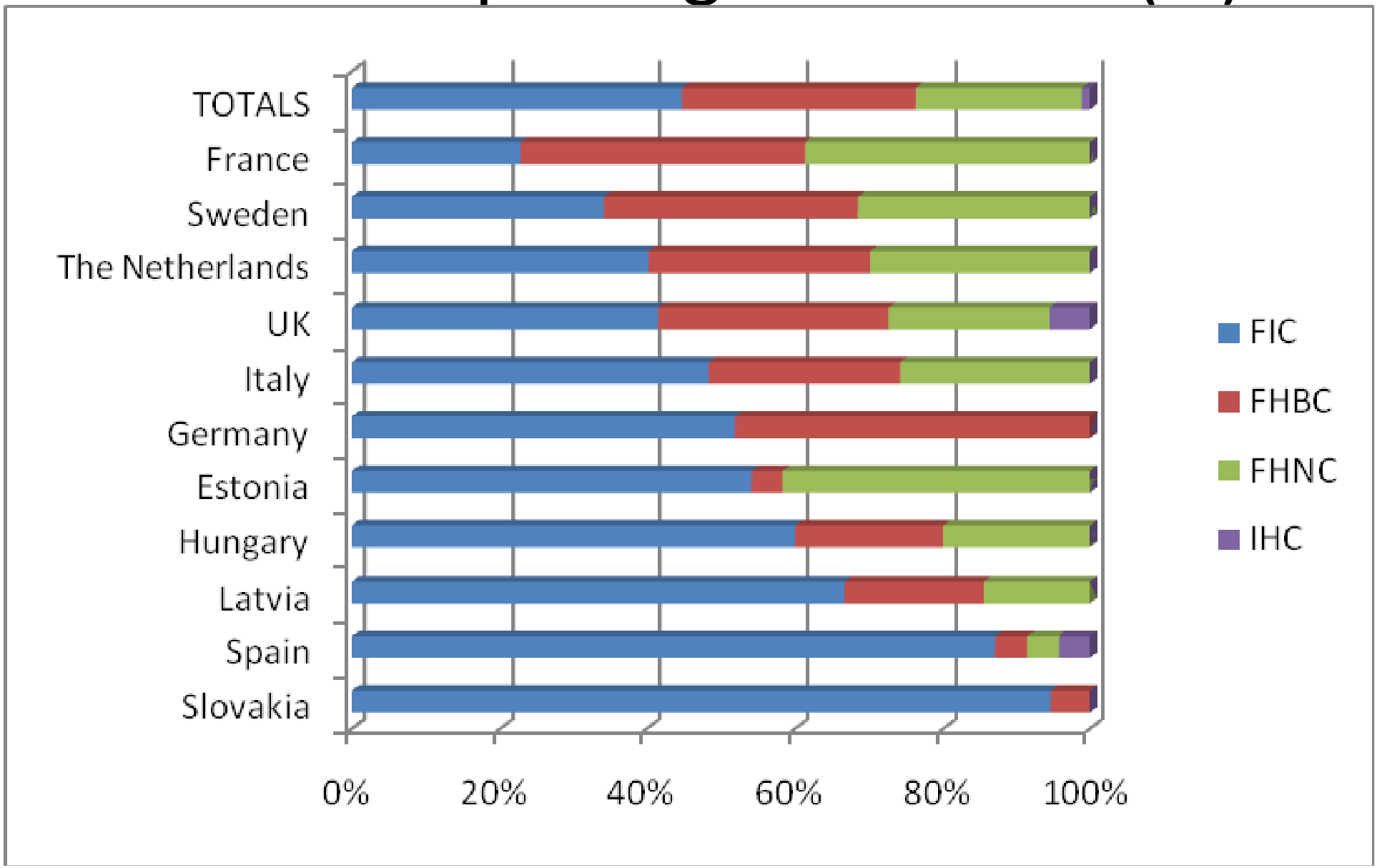
Tipi di indicatori di qualità

- Donabedian distingue indicatori di:
  - Input (risorse umane, strutturali, tecnologiche)
  - Process (attività)
  - Outcome (risultati, soddisfazione)
  - Un sistema di qualità pianifica azioni per gestire input-processi e outcome (plan), le mette in pratica (do), le controlla (check), e le migliora (act) (ruota di Deming)

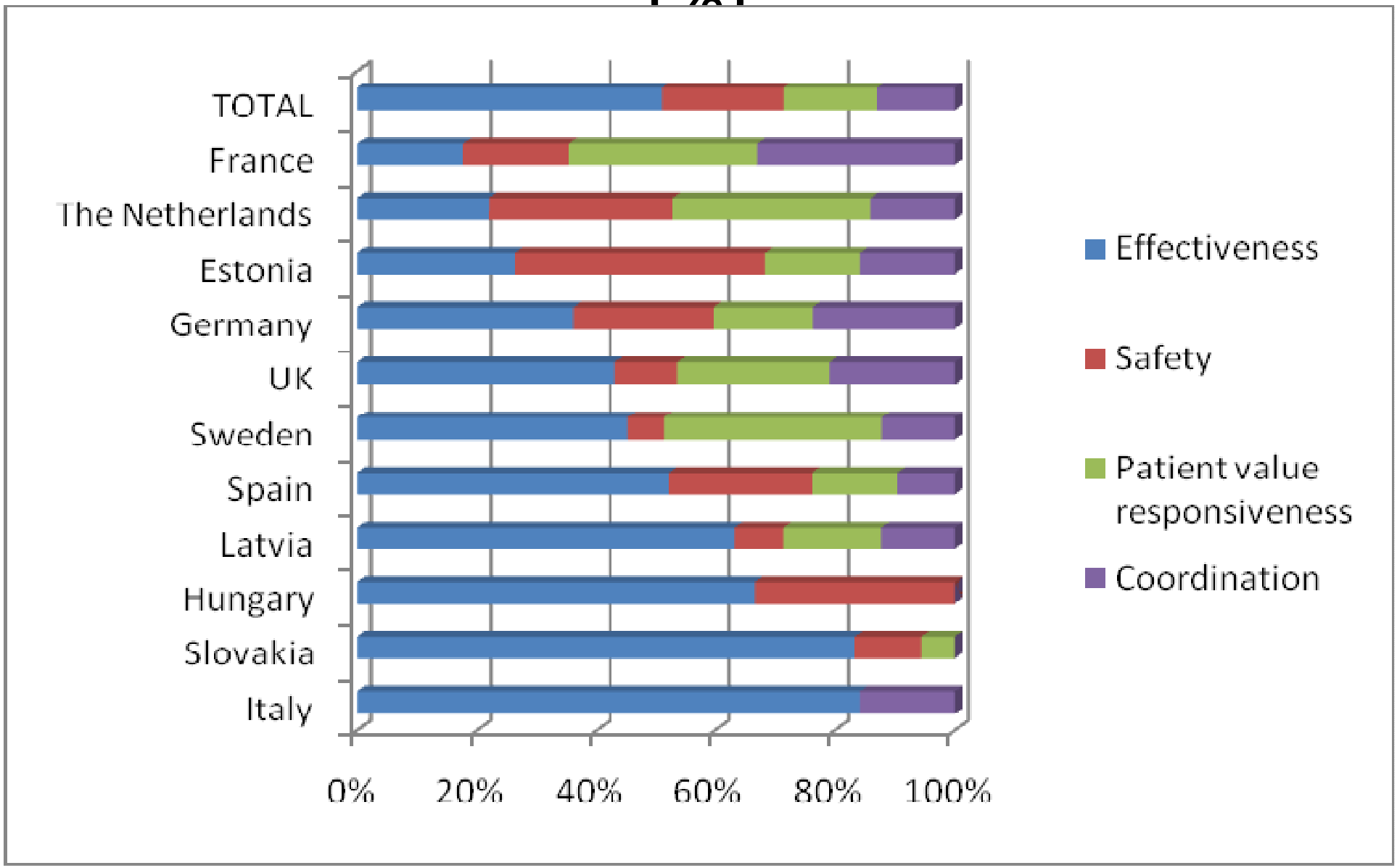
Questionario

- Domande su politiche (plan e do), indicatori di qualità (check) e azioni correttive (act) riguardanti:
  - 4 dimensioni della qualità: effectiveness, safety, patient-centredness, coordination
  - 4 tipi di assistenza: Formal Institutional Care (FIC), Formal Home Nursing Care (FHNC), Formal Home Based Care (FHBC), Informal Care.
- Categorizzazione degli indicatori di qualità nazionali in base a: input process outcome / tipo di assistenza / dimensione della qualità
- 15 paesi europei: Austria, Estonia, Finlandia, Francia, Germania, Ungheria, Italia, Lettonia, Olanda, Polonia, Slovacchia, Slovenia, Spagna, Svezia e Regno Unito.

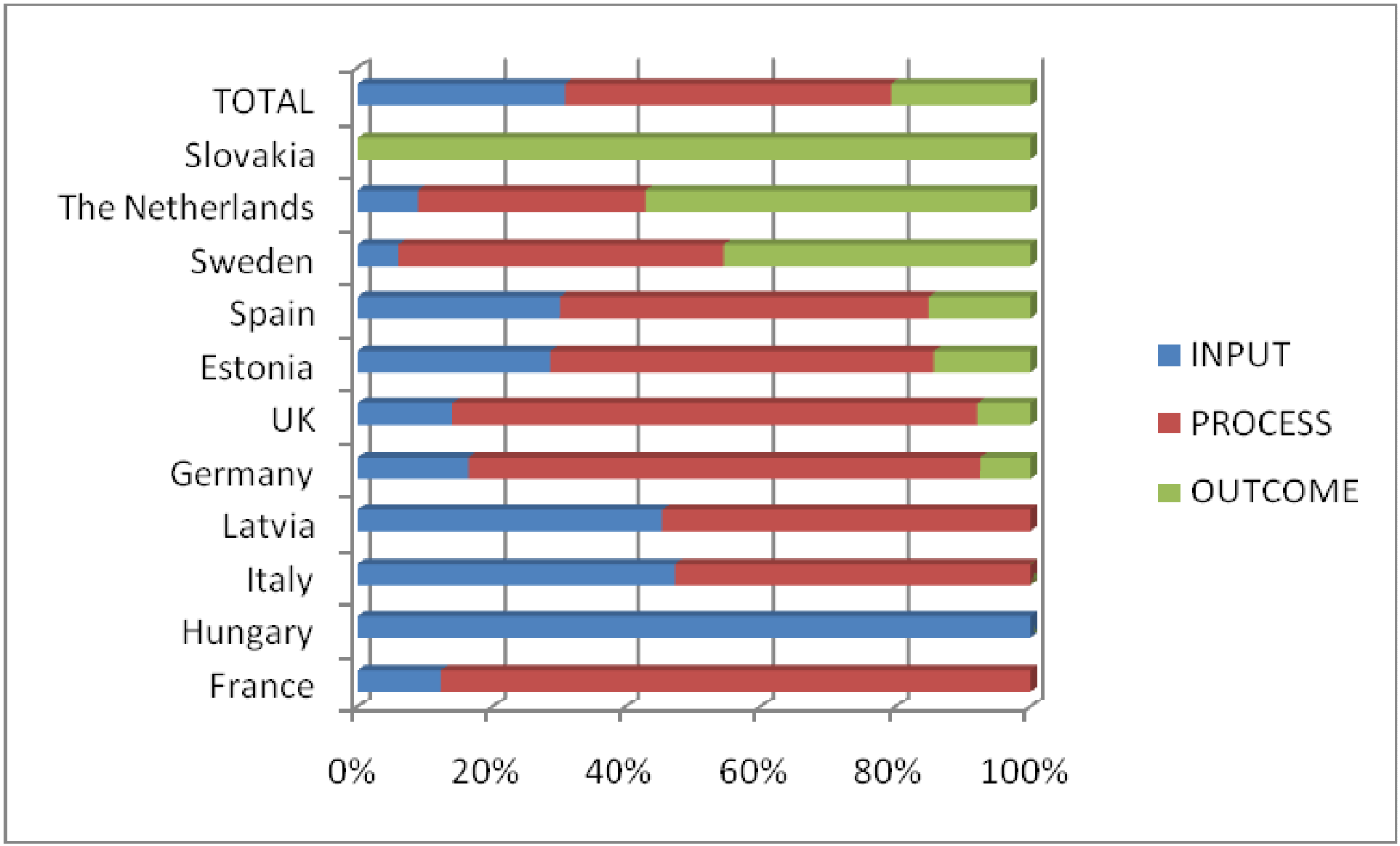
Indicatori per organizzazione (%)



Indicatori per dimensione di qualità (%)



Indicatori input-process-outcome (%)



Cluster in base alle politiche per la qualità

Cluster 1: 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.
Cluster 2: 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.
Cluster 3: Poland, Slovenia	Lack of quality policies and indicators
Cluster 4: 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.

Politiche

- Non sorprendentemente gli indicatori di qualità degli esiti e gli indicatori relativi all'informal care sono poco diffusi in Europa
- I paesi si distribuiscono su 4 cluster, di cui 2 basati su politiche di qualità legate alla formal care
- I Paesi con sistemi di LTC caratterizzati da ricorso a assistenza formale con alto finanziamento pubblico hanno coerentemente investito in politiche e indicatori di qualità su offerta formale
- I Paesi che ricorrono più alla compartecipazione privata e all'assistenza informale sono meno attrezzati sul piano della qualità

Integrazione

- *tempestività* delle cure*, continuità* delle cure, integrazione tra *assistenza primaria e secondaria* sono fattori che impattano sulla qualità.
  - Indicatori su coordinamento sono pochi
  - Le dimissioni ospedaliere sono problematiche

Trasparenza

	Paese														
	Austria	Estonia	Finland	France	Germany	Hungary	Italy	Latvia	Poland	Slovakia	Slovenia	Spain	Sweden	The Netherlands	UK
Visibilità Risultati qualità	X	X	X	X	V	V	X	V	X	X	X	X	V	V	V

- Olanda: dati pubblicati su base volontaria (nel 2008 circa il 50%)
- Slovacchia: dati saranno pubblicati dal 2013, secondo la nuova legge.
- UK: dati pubblicati fino al 2010,

Qualità dell'assistenza informale

- Interventi riguardano per lo più cash benefits, formazione/consulenza alle famiglie
- Best practices: network di municipi in Svezia (Mezzo); associazione "Mezzo" in Olanda per il supporto alle famiglie; programmi di formazione nazionali come "Caring with Confidence" in UK (ora interrotto).

Frequenza monitoraggio qualità

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

Competenze e organici

- Una formazione specifica sul LTC (oltre che tra i geriatri) si riscontra tra i MMG (10 paesi). L'Olanda dal 1990 ha corsi specifici per medici di RSA
- Un problema è la scarsità di infermieri. Best practice: la Germania sta investendo per attrarre nuovi studenti nei corsi infermieristici per la geriatria, e per attrarre infermieri da altri paesi.

Indicatori di qualità raccolti

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

Da notare…

- Circa il 40% degli indicatori FIC sono anche usati in FHBC. Più condivisione tra FIC e FHBC che tra FIC e FHNC: LTC è più sociale che sanitario.
- Indicatori FHBC e FHNC bilanciano efficacia e attenzione al paziente, mentre FIC punta solo su efficacia.
- Sicurezza e coordinamento sono misurati attraverso indicatori sia di processo sia di outcome.
- Attenzione al paziente riguarda sia processi sia outcome
- Indicatori di Input, Processo e Outcome sono equamente distribuiti tra le varie organizzazioni (20%-60%-20%). Golden rule?

Indicatori di outcome

Ne abbiamo raccolti 68, classificabili come:

- Indicatori di soddisfazione:
- Indicatori di condizione di salute: health conditions, functional abilities, behaviour, death
- Ospedalizzazioni e loro conseguenze
- Sicurezza: fall incidents, unintended weight loss, decubitus

- Poco diffusi (solo 7 paesi). Quelli di soddisfazione sono i più comparabili tra paesi.

Conclusioni

- Integrazione
- Monitoraggio
- Trasparenza
- Supporto all’assistenza informale
- Formazione specifica e organici
- Indicatori di outcome

Per informazioni su ANCIEN:

http://www.ancien-longtermcare.eu

Per scaricare i rapporti su qualità del LTC:

http://www.ceps.be/author/roberto-dandi

Grazie!