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The public gets what the public wants: experiences of public reporting in long-term care in Europe

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Introduction

Recent decades have witnessed an increasing reliance on market mechanisms for the delivery of long-term care (LTC). In a number of countries either users, or public commissioning authorities on their behalf, are responsible for choosing the providers that can best meet their care needs [1]. Those purchasing care need to consider the quality they might expect of the service before choosing a provider. In tandem with this, providers are required to increase the transparency of services they deliver to frail users who might have higher expectations in terms of quality, dignity and user-responsiveness. As a result, it has become paramount for all stakeholders to have access to measures of quality that are based on defined methods, valid indicators and adequate data collection.

According to Berwick and colleagues [2], having quality measurement tools in place could bring about quality improvement through two pathways, both based on the motivation of providers to increase their market share. The change or 'activation' pathway corresponds to quality management, where indicators are used internally by providers for monitoring and benchmarking with the aim to improve the organisation's performance. In the 'selection' pathway, users or purchasers of care reward better performing providers by choosing them over poor providers. In theory, making this information public to consumers and purchasers to inform choice, and for providers to compare their information should add an extra layer of incentives for providers to improve quality.

The public reporting of health and LTC has its roots in the United States (US), and for this reason much of the academic research is US-focused. In LTC, the Nursing Home Compare website was first piloted in 1998 and then launched nationally in 2002 by the Centers for Medicare and Medicaid Services (CMS) and features information and star ratings on quality aspects for all Medicare and/or Medicaid registered nursing homes. Public reporting of outcomes for home care was launched in 2003 via Home Health Compare [3]. There have been a number of US-based studies in LTC which have examined various aspects of public reporting, e.g., use by consumers and other stakeholders [4, 5] and the impact on quality improvement [6-8].

International comparative analysis of public reporting systems is scarce [9], limiting the opportunities to take a strategic view of developments in this field and to learn from best practice from other countries. Two studies in Europe have used web-based searches to compare quality reporting practices. The first, reviewed websites to gather and compare quality measurement and reporting practices for nursing homes across fourteen countries [10]. The second study also used a web search to identify and review 42 websites reporting the quality of health care across ten countries [11].

This paper provides a comparative overview of various approaches to public reporting in seven European countries, using in-depth information from key informants. Our hypothesis is that these countries with their different models of LTC provision and quality assurance also represent different stages of public reporting that range from early pilot projects over bottom-up processes to top-down regulations prescribed by national legislation. This scope of approaches will help to highlight the challenges involved in defining, developing and mainstreaming public reporting as a mechanism to improve quality through 'choice' and 'change'.

The first section describes the methods used to gather information and the sampling of countries; followed by a comparative description of different approaches to public reporting mechanisms. The impact of public reporting on the behaviour of users and purchasers, as well as on the reaction of providers to bring about improvements in quality is then analysed and discussed and conclusions and policy implications are drawn.

Methods

The study covers both established and pilot public reporting systems in seven European countries: Austria, England, Finland, Germany, the Netherlands, Spain (Catalonia) and Sweden. Established public reporting was defined as any initiative in which intra or inter-provider information on quality indicators is gathered on a systematic and regular basis, and made available to users, their families, purchasers of care (e.g. public commissioning bodies, health funds), other stakeholders (e.g. hospitals) or the general public. Pilot public reporting means that information is not yet gathered or displayed systematically and regularly.

Key informants in each country were identified and asked to gather information on public reporting systems using a survey template with the following dimensions: (i) aims, scope and coverage of existing public reporting systems, (ii) types of indicators, methods of data collection and their display, (iii) mechanisms incentivising quality improvements, and (iv) outcomes from the introduction of public reporting systems. The survey template was developed from a review of the theoretical underpinnings of public reporting in health and LTC and empirical studies, mostly from the United States. The first six countries were included as part of the European Care Across Borders Project (ECAB), with additional information on Sweden provided separately.

Sources of information included legal documents, published and grey literature, and websites. Based on key informants' responses and a parallel literature search, country profiles were produced. These were validated by the key informants after finalisation of the study. The process of gathering information through the survey template took place between July and November 2011 and January and March 2012 for Sweden, while the subsequent validation of country profiles took place between January and March 2012.

Results

(i) Approaches to public reporting in practice

The seven systems described here display a range of approaches to public reporting, as shown in Table 1. Four countries (England, Germany, the Netherlands and Sweden) have established public reporting mechanisms which cover all registered providers of both home care and residential care. In England and the Netherlands, the mechanism is managed by the regulatory bodies for both health and social care, the Care Quality Commission (CQC) and the Health Care Inspectorate (IGZ, *Inspectie voor de Gezondheidszorg*) respectively. The German

mechanism is managed by the Medical Boards of the Sickness and LTC insurers (MDK, *Medizinischer Dienst der Krankenversicherung*), an independent agency funded by the health insurers. In Sweden, the system is managed jointly by the National Board of Health and Welfare (*Socialstyrelsen*) and the Swedish Association of Local Authorities and Regions (SKL, *Sveriges Kommuner och Landsting*).

Finland, Austria and the Spanish region of Catalonia have pilot public reporting mechanisms, being voluntary and covering residential providers only. In Finland the system is administered by the National Institute for Health and Welfare (THL, *Terveystieteiden tutkimuskeskus*). In Austria, public reporting currently only providers with accredited quality management schemes may opt to participate in a quality audit, performed by a third party, to obtain a National Quality Certificate (NQZ, *Nationales Qualitätszertifikat*). In Catalonia, a number of nursing home providers participated in a one-off pilot in 2010 as part of a regional quality benchmarking conference.

Since 2005, care quality in the Netherlands has been assessed using the Quality Framework for Responsible Care, a set of indicators under ten different themes developed by IGZ with input from providers and users of health care and LTC. In 2008 the IGZ introduced the Consumer Quality Index (CQI), a collection of surveys of client experiences conducted face-to-face and by post with users, carers (where the user is cognitively impaired), and provider self-assessments [12]. Results from both inspections and the CQI are published on a website, *Choose Better* (<http://www.kiesbeter.nl/>), that has been maintained by the RIVM (National Institute for Public Health and the Environment), which was commissioned by the CVZ (the organisation which supervises the health insurers). The site was developed in collaboration with many other organisations in health care. From 2014 it will be managed by the Quality Institute (Kwaliteitsinstituut) which will be one branch of the Netherlands' Care Institute (Zorginstituut Nederland), a newly founded organisation that helps healthcare providers to improve quality.

In Sweden, provider quality is monitored against 28 separate indicators, including assessment of both clinical care and quality from the perspective of users. Socialstyrelsen and SKL work together to develop standards and produce reports [13]. Like the Netherlands, Sweden also has a dedicated website, *Older Guide*, designed specifically to support provider choice (<http://aldreguiden.socialstyrelsen.se>). This includes quality scores for providers of residential and day care facilities as well as home care.

In England, the CQC publishes the outcomes of inspections on its website (<http://www.cqc.org.uk>) for all registered providers of home care and residential facilities. The inspections are based on the Essential Standards of Safety and Quality, introduced in 2010. All providers are assessed against 16 of the 28 standards, with the CQC publishing whether or not the provider complied with each standard, or alternatively if improvements are necessary [14].

In Germany, specialist staff from the MDK have carried out regular inspections in all care home and home care organizations since the introduction of LTC insurance in 1995. Under LTC reforms in 2008, a specific scheme entitled 'transparency criteria' was introduced to complement the MDK's inspection guidelines and to make public reporting on quality information compulsory [15]. The transparency criteria contain 82 items for residential care and 49 items for home care and are gathered through annual inspections. For care homes, the scheme covers 35 items of nursing and medical care, 10 for care of residents with dementia, 10 for social and

everyday life support and 9 to assess housing, meals, housekeeping and personal hygiene. In tandem, voluntary user surveys are conducted for both residential and home care.

In Finland, the reporting of quality is centred on the use of the Minimum Data Set Resident Assessment Instrument (MDS-RAI). This tool, mainly focused on clinical process and outcome indicators, was developed in the United States and forms the backbone of quality reporting for US providers of LTC [16]. MDS-RAI was formally introduced in Finland in 2000, and is now used voluntarily by approximately one-third of residential and one-quarter of home care providers, although public reporting is limited to the former. While MDS-RAI data is only available to participating organisations, structural indicators for these organisations are available online.

In Austria, the results of inspections carried out by regional authorities are confidential. However, care home providers with internal quality management systems are eligible to apply for the NQZ, introduced as a pilot programme in 2008. Presently about 25 per cent of care homes advertise their certification through accredited quality management systems such as ISO 9001ff (www.iso.org), E-Qalin (www.e-qalin.net)^a or QaP (www.qap.at). Also following the legal acknowledgement of NQZ as an independent agency in 2013 the NQZ continues to be a voluntary certification mechanism for assessing internal quality management by means of structural and process criteria as well as by result-oriented performance indicators [17, 18].

In Catalonia, the Catalan Ministry of Health (*Departament de Salut*) gathers quality information for residential homes, with quality measurement restricted to indicators of clinical care. This information is published anonymously, i.e. individual results cannot be attributed to specific providers. The Centre of Results of the Catalan Health System (*Central de Resultats*) publishes the results of its evaluations so that providers can compare themselves with regional and sector averages and benchmark themselves against other providers. In 2010 however, 35 nursing homes made their quality performance results publicly available in a pilot experiment for public reporting at the *VIII Benchmarking Summit*, a regional conference organised for providers.

(ii) Collection of information

Among the countries involved in this study, three different methods to gather quality information can be distinguished: inspections as part of a legal quality assurance framework (sometimes based on a national quality framework); provider self-assessments in the context of internal quality management (often linked to audits by independent certification agencies); and surveys of user satisfaction, including service users, their families and carers and provider staff. In fact, these methods are often used in parallel, for instance, data and information gathered by a provider with an internal quality management system can be used during statutory inspections or in case of a third-party certification audit (e.g. Austria).

Inspections are the primary data collection tool in Germany and England. Germany has a long tradition of provider inspections carried out by its regional governments. In England, a brief experiment with a risk-based inspection model between 2010 and 2012 was abandoned in favour of annual inspections, but might be re-introduced in the future [19].

^a E-Qalin is also used in Luxembourg, Germany, the Czech Republic and Slovenia. In the latter country, adherent providers use a questionnaire to assess the satisfaction of users, families and staff; data are anonymously displayed to providers to compare performance with other care homes.

The data gathered are often supplemented by information from users and other stakeholders. In the Netherlands, data for the CQI are collected by a third party, supplemented by indicators collected by provider organisations themselves on a mandatory basis. In Finland, no tradition of regular inspections exists, perhaps due to predominance of public providers. Publicly available information is restricted to those care homes that collect data by means of the MDS-RAI.

In Austria, NQZ is partly based on information collected by care homes themselves through internal quality management systems. However, little is known about the quality of these data collection efforts and any tangible results. User surveys are carried out at the discretion of individual providers.

In Sweden, the information to be published on the Older Guide website is gathered through mandatory reports from care providers, and feedback from users of both residential and home care services. Providers are also required to provide clinical data for national quality registries for specific conditions (e.g. new cases of dementia) and processes (e.g. counselling to patients at end of life). The reported performance of providers allows municipalities to qualify for specific financial incentives. This is intended to promote cooperation between municipalities and county councils, and ultimately improve quality.

(iii) Quality indicators

In all countries studied, publicly reported information on quality includes criteria and indicators that extend beyond simple structural indicators of quality (e.g. staff ratios, room size), thus incorporating assessment of quality of life through internal and external auditing processes [20, 21]. Of the countries analysed here, only in Spain are the indicators still strongly linked to clinical processes and outcomes alone. In Finland, clinical indicators are supplemented by results of user satisfaction survey collected by local governments [22]. The CQI in the Netherlands draws explicitly on users' views, and also in Germany user experiences are assessed during MDK inspection. In England, where process and outcome indicators are deemed crucial to ensure user satisfaction and quality of life, regulatory standards have also increasingly focused on outcomes. In Sweden, quality indicators collected from providers, which mostly cover structure and process indicators (e.g. on users having a contact person) is supplemented by information from users mostly on their quality of life (e.g. feeling safe, able to influence care).

In Austria, there is great regional variation regarding the type and quality of data collected. The NQZ seeks to publicly provide some harmonised information without however prescribing a specific quality management system with which it is collected. Applicants for the NQZ are invited to make their performance transparent (e.g. online) by describing the quality of their structures and processes and measuring results through relevant performance indicators on residents, staff, leadership, social context and 'learning organisation'.

(iv) Display of information

Diversity of approaches to public reporting is reflected in the way in which quality information is displayed. Results for the CQI in the Netherlands are displayed in a star-rating format, with the rating reflecting how a particular provider compares to the mean score for all providers. They range from one star (poor) to five (good). In Finland, quality is shown as green-coloured bars, indicating a combination of percentages for achievement against structural indicators and scores out of five (high) for user satisfaction surveys. These are supplemented

by yes/no answers, e.g. regarding staff availability during evenings. In Sweden, scores for ten selected quality indicators, e.g. proportion of residents with updated care plans, percentage of falls and staff turnover, are provided for every care home, day-care centre and home care service at municipal level, with the national average shown for comparison purposes^b. In Germany, numeric scores are used to provide a grade of one to five for each of the quality criteria, excluding user surveys, and a composite grade is calculated from these. In contrast to other countries, lower scores represent higher quality [15]. In England, since 2010 quality has been shown using a combination of traffic light colours and ticks and crosses. Compliance with regulatory standards is now shown with a green tick, failure to comply with a red cross, and improvement required with a grey tick. This replaced a star rating system in place between 2008 and 2010 where inspectors assigned a star rating of zero for poor, up to three stars for outstanding performers.

The system in the Netherlands is the only one incorporating case weighting, although reliability of this method is contested, and presently only the CQI scores are publicly available [12]. Results are shown in relation to the average of all providers and not as absolute values, making comparisons over time impossible. In Germany, results of user surveys are also shown in relation to averages, albeit at the regional level.

All of the reporting already in place is published through websites. These are either purposely built to support consumer choice (Finland, the Netherlands and Sweden) or more simply published by the regulatory body (England) or the body overseeing providers (Germany). In the case of Finland, the internet is the only medium to access results, while in Austria and Germany information is visible in care homes too. Results of Catalan care homes participating in the pilot are available at the website of the Catalan Ministry of Health.

[Insert table 1 here]

Discussion

The aim of this article is to assess the extent to which the public reporting schemes studied have influenced i) user or purchaser behaviour – Berwick’s ‘selection’ pathway, and ii) improvements in quality by providers of LTC – the ‘activation’ or change pathway. Four of the seven countries mapped have established public reporting mechanisms. Nevertheless, evidence of their impact on user or purchaser behaviour and on quality is inconclusive.

Selection

To make informed choices, users need to have information on both the price and quality of the service they are purchasing. If providers have more information on the quality of their services than users, they may have an incentive to drive quality down to contain costs and compete on price. Public reporting of quality aims to correct this problem of *asymmetric information* [23]. Stevenson has identified three critical factors which are required to support the use of public reporting to support selection and this discussion considers each of these factors in turn: users need to be *aware* of reporting; they must trust the *validity* of information; and they must be able to *access, understand* and *act* on the information [24].

^b This has recently been changed and eleven indicators collected from users (e.g. on quality of life) are now publicly displayed in comparison with national averages (personal communication from national key informant).

Perhaps not surprisingly, *awareness* of the indicators that are published varies across different groups of intended end-users of public reporting mechanisms. Institutional purchasers of care, be it local authorities (England) or health insurers (the Netherlands), seem to be more aware of the indicators and base their purchasing or pricing decisions on them [25, 26]. Awareness is higher among professionals than among carers and users of care services. Over 95 per cent of council staff were aware of the star ratings previously used in England. For relatives of care home residents, awareness was at 45 per cent, and for residents themselves, only seven per cent [25]. Only 12 per cent of relatives in a US study said that they had referred to Nursing Home Compare to find a nursing home [4]. Use by professionals in the US is relatively low, with only a quarter of the hospital discharge planners in one qualitative study saying that they used websites (of any type) to find quality information [5]. This is despite heavy investment by CMS in promoting the Nursing Home Compare website [3]. In health care, awareness also is an issue [27], and patients are far more likely to turn to doctors or to family and friends for advice [28].

There are a number of factors which can impact on the *validity* of publicly reported quality. Evidence from health care highlights the potential for gaming and the manipulation of data [29, 30]. This is not mentioned as a concern in the countries covered despite reliance on self-assessed indicators, perhaps because publicly-reported data is often gathered from multiple sources, including inspections and user surveys (e.g. the Netherlands). The risk of inter-rater unreliability is nonetheless present and this has shown to be a relevant issue in the US context [31] and in assessing quality of life [32]. Observed standard deviation of ratings in nursing homes has been consistently low in Germany, which could suggest consistency in ratings used. The need to account for inter-rater reliability in inspections, self-assessment of quality and assessment of users' quality of life has so far been scantily discussed in Germany and in the other countries surveyed here [12]. Another prominent issue is the lack of risk adjustment on the majority of public reporting schemes, which could negatively impact the results of providers that have service users with higher needs [16, 33]. While the threat of gaming has not been widely discussed in this sector, other studies show that missing data can be assumed by consumers to indicate poor performance, and the credibility of the source of the data is also important [28, 34]. Providers in both Germany and the Netherlands have engaged in an on-going litigation process, questioning the validity and evidence-base of the indicators, which could undermine users' trust on the information made available [35].

As Table 1 shows, the internet is the preferred medium for displaying the information across the seven countries, accompanied in some cases by information on the site of individual providers. However, it is estimated that on average only 42% of people aged 55-74 in European countries access the internet regularly [36] and empirical research shows that disabled people are half as likely to access the internet as people without disabilities [37]. It is therefore questionable that the internet should be the sole medium to make this type of information available to older or disabled people.

The ability of consumers to understand quality indicators is a challenge consistently identified in the literature on both LTC and health care [3, 38-40], not least because the assessment of quality in LTC is far from straightforward due to its multidimensional nature, reaching from quality of care to other outcome dimensions such as quality of life [16]. How users experience quality is determined by the individuals' own set of values, being inextricably linked to the role of the user as co-producer of care [41]. Studies suggest that consumers will be more drawn to indicators which are easily understandable, such as client satisfaction [34] or the 'hotel' services of a nursing home [42] than they are to indicators regarding the quality of clinical care. Learning from

consumer behaviour in other areas also strongly suggests that public reporting should be tailored to the individual needs and preferences of users in order to support informed decision-making effectively [40].

Studies in health care consistently show that complex data presentation results in information not being understood, viewed as irrelevant and therefore not used effectively in decision-making [9, 27]. Despite this, most information providers base their design on 'common sense' [43]. There are however, a number of design features which affect users' ability to understand and to process information. Users are better able to understand indicators that are based on symbols and evaluative labels (such as 'poor' or 'excellent') which do not require them to 'drill down' for future information [20, 40, 44]. There are examples of indicators in the schemes surveyed which follow these rules, e.g., the use of ticks on the CQC reporting in England. However, the wide use of percentages and scores without easily understandable labels across the schemes suggests that many consumers may struggle to interpret the information.

The most important question regarding the selection pathway is whether consumers can act on the information – and whether they make different decisions based on it. Decision-making in LTC often occurs under stressful circumstances, with older users being particularly frail, often cognitively impaired and with a limited ability or propensity to change providers [45]. Research on the star rating scheme in England found that the ratings had a limited impact on consumer decision-making. Much more important sources were the advice of family and friends, social services, visits and chats with care staff, and feedback from other users and their relatives [25].

Evidence from the US shows that public reporting has minimal effect on occupancy rates of nursing homes [24] and consumers who are aware of Nursing Home Compare are less likely to use it to make informed decisions based on quality than they are to use it to research the location of nursing homes [4]. There is some evidence that quality information affected consumer choice of post-acute care facilities, but the overall effect was small [3]. Studies in health care reinforce these findings [9, 30].

Activation

The evidence from studies on health care is that there is a much greater likelihood of reporting stimulating internal quality improvement by providers than potential use by consumers and purchasers [9, 30]. The process of actually improving quality implies change, which can be a daunting and painful process, liable to elicit the resistance of those involved unless powerful incentives or motivations are in place [2]. In health care, it has been argued that the negative impact on a provider's reputation will be sufficient to stimulate quality improvement issues, regardless of the impact on market share [46, 47].

In England, while there has been improvement in reported quality since the introduction of the (now discontinued) star ratings in 2008, this is possibly part of a longer term trend in quality improvement [48]. In the Netherlands, quality indicator scores also improved since they have been made public, with the less-performing providers catching up, possibly by implementing quality improvements actions in response to the published results [49]. The same applies to Germany where it has been argued that, apart from aggregate improvements, individual ratings may have improved due to the increasing experience of organisations with these mechanisms, and due to a specific focus of staff and management on the indicators assessed by the MDK. However, direct comparisons over time have been made impossible also in Germany due to a modified assessment scheme in 2008 [50].

Experience from the US shows mixed results. Studies have shown a small positive effect [6], but mostly on clinical indicators [7, 51], and a recent study suggests that unreported components of quality may have been adversely affected [52]. Nonetheless, there is evidence that nursing homes have improved their quality, however, the impact is more pronounced in providers in more competitive markets [8].

Nevertheless the impact of public reporting on improving quality assessment in LTC as such should not be underestimated. Information gathered from the national key informants showed that the top-down approach to defining which dimensions or indicators should be publicly disclosed can bring about improvements and change the focus of quality measurement, e.g. by including measures of quality of life. In another example, the CQI resulted from the perceived need by the IGZ to introduce more objective quality measures.

The relative youth or even pilot stage of the mechanisms surveyed here is also liable to downplay their impact. Although a significant proportion of currently existing public reporting mechanisms in Europe is surveyed here [10], the current mapping of approaches to public reporting is not exhaustive in its coverage of countries. It is therefore possible that more successful experiences with public reporting have not been analysed.

Conclusions

The experience of countries mapped in this paper show that public reporting is far from becoming consolidated in LTC. This is despite an increased reliance on market mechanisms underpinned by a strong rhetoric of consumerism, as well as experience with public reporting mechanisms in health care.

A number of issues remain as challenges for the implementation of public reporting in Europe. First of all, local care markets are best characterised as monopolistic competition or oligopolies, with users generally choosing from a limited number of local providers. This market structure matters, for public reporting is likely to have a greater impact in more competitive markets.

Secondly, quality in LTC cannot always be reduced to individual care settings only, but depends on the inter-professional interaction between a range of organisations and settings across pathways of care. While quality management and improvement are certainly an important function of each individual organisation, ways to monitor and improve quality of care pathways need special attention[53]. The extent to which public reporting can contribute to integrated care remains nonetheless, disputable.

Thirdly, one important precondition for public reporting to be implemented and to bring about improved quality (the 'change pathway') is to enable staff and management of LTC services and facilities to understand the rationale for transparency, quality management and continuous improvement. This is difficult to achieve in a sector still characterised by high staff-turnover and low qualifications, where training does not always highlight that quality is not just achieved through correct use of acquired technical skills, but includes also internal and external communication, leadership and constant adaptation to changing environment.

There are nonetheless a number of ways through which the effectiveness of public reporting can be improved, namely by improving access, understanding, validity and actionability of indicators. Access to public reporting by users can be enhanced through improved health literacy, but also by engaging professionals to convey the information to users [54] and to help them understand publicly available quality indicators when selecting

providers. To this end information should be better adapted to their skill set using improved representation methods, namely by building on existing evidence on how to order and display information [55]. The public reporting mechanisms analysed in this paper, in particular those in the Netherlands and Germany, represent examples of how to involve users in the definition of indicators, reflecting on dimensions of quality that users perceive as important. More robust methods to account for case-mix and inter-rater reliability, both absent from most public reporting mechanism analysed here, would also contribute to improve the validity of indicators. Finally, it is likely that the decision by users to take-up LTC services would always be done under less than perfect circumstances. Even so, better engagement by professionals and the design of decision aids might enhance users' ability to act on available information.

Conflict of Interest

We are not aware of any relationships or support that could be perceived as conflict of interest.

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1 Table 1: Overview of Approaches to Public Reporting

Country	Responsibility for publishing quality information	Responsibility for the collection of data	Information displayed	Format	Method of collection	Coverage	Access
Austria	Bundesministerium für Arbeit, Soziales und Konsumentenschutz	<ul style="list-style-type: none"> Providers Independent quality organisations 	Themes (nr. of criteria in brackets): <ul style="list-style-type: none"> Residents (9), e.g., autonomy, communication, nursing care, palliative care Staff (7) Management (8) Social context (3) Learning organisation (3) Plus at least 10 related performance indicators 	Voluntary certification is awarded based on a weighted average of scores in indicators	Self-collected data as part of quality management systems, resident satisfaction survey, self-assessment report and audit by third party, certification	Residential care providers with quality management systems in place – rolled-out since 2013 following a pilot phase (2008-2012)	Future: selected results to be published
England	CQC	CQC	Essential Standards of Safety and Quality (28 standards in total, the following 16 apply to all providers, nr. in brackets): <ul style="list-style-type: none"> Involvement and Information (2) Personalised care, treatment and support (3) Safeguarding and Safety (5) Suitability of Staffing (3) Quality and Management (3) 	Compliance with essential standards is marked with a green tick (compliant), a red cross (not compliant) or a grey cross (improvement needed)	Inspections, supplemented by information from providers, and sources such as users, local involvement networks and whistle-blowers.	All registered providers of residential and domiciliary care	http://www.cqc.org.uk/
Finland	THL	THL	Indicators (residential care) <ul style="list-style-type: none"> Health condition of residents Residents' quality of life and care Staff (e.g. staff-ratios and qualifications) Housing, privacy. 	Percentages, scores out of five, and yes/no answers. Achievement of percentages and scores is shown using a green-coloured bar.	Use of Minimum Dataset – Resident Assessment Instrument. Data collected by qualified nurses.	Residential care only, restricted to providers who consent to have their information displayed	http://www.palveluvaaka.fi/
Germany	MDK	MDK	Residential care (82 items in total): <ul style="list-style-type: none"> Nursing and medical care Care of residents with dementia Social and everyday life support Housing, meals, housekeeping, personal hygiene Home care (49 items in total): <ul style="list-style-type: none"> Nursing care Activities prescribed by a physician Quality of organization and grade of service User survey 	Each element graded (1 = Excellent, 5 = failing), plus composite grade for each provider (not including user survey grade)	Inspections and user survey	Compulsory for all residential and home care providers	http://www.mdk.de/

Country	Responsibility for publishing quality information	Responsibility for the collection of data	Information displayed	Format	Method of collection	Coverage	Access
Netherlands	Health Care Inspectorate (IGZ) and CVZ (organisation supervising the health insurers)	RIVM (National Institute for Public Health and the Environment) From 2014: Kwaliteits-instituut	Kwaliteitskader Verantwoorde Zorg (Quality Framework for Responsible Care), incorporating the Consumer Quality Index: <ul style="list-style-type: none"> • Care (treatment)/life plan • Communication and information • Physical well-being • Safety care content • Domestic and living conditions • Participation and social handiness • Mental well-being • Safety living/residence • Sufficient and competent staff • Coherence in care 	Star ratings (1 = poor performer, 5= good performer) determined using the numeric score assigned to the provider. Displayed with the mean of all participating organisations for comparison.	Face-to-face interviews with a sample of nursing home residents; surveys with a sample of relatives representing residents with cognitive impairment; surveys with home care users	Compulsory for all residential and home care providers	http://www.kiesbeter.nl/
Spain (Catalonia)	Departament de Salut	Departament de Salut	<ul style="list-style-type: none"> • Accessibility (3 indicators) • Effectiveness (7 indicators), e.g. functional improvement after stroke, mortality rates • Cost-efficiency (4 indicators) 	Numerical indicators (e.g. percentage scores)	Self-collected clinical indicators	Pilot with 35 public nursing home providers	Not available
Sweden	Socialstyrelsen and Sveriges Kommuner och Landsting	Socialstyrelsen/ SKL	<p>Äldreguiden:</p> <p>All providers of residential, home and day care:</p> <ul style="list-style-type: none"> • Residents (clients) with an updated care plan (%) • Residents actively involved in the planning and implementation of their care plan (%) • Staff with adequate training (%) • Staff turnover (%) <p>For home care providers only:</p> <ul style="list-style-type: none"> • Procedure to prevent malnutrition implemented (yes/no) <p>For residential care providers only:</p> <ul style="list-style-type: none"> • Risk assessment for pressure ulcers, falls and malnutrition • Medications management • Facilities (e.g. private rooms) • Nutrition and meal planning 	Percentage achievement, shown with national average for comparison.		Compulsory for all residential, home and day care providers	http://aldreguiden.socialstyrelsen.se/