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Policy instruments to promote good quality long-term care services

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Policy instruments to promote good quality long-term care services

Juliette Malley, Birgit Trukeschitz and Lisa Trigg

Abstract

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1 Introduction

In ageing societies it is not simply access to long-term care (LTC) that is important, but also its safety, effectiveness and responsiveness. This is not least because good quality LTC should help to maintain the health and functional status of people for longer, but also because poor quality care can cause serious harm and has the potential to be life-threatening. Indeed, concerns around the quality of LTC services are the second highest priority area for LTC reform across OECD countries, just behind the fiscal and financial sustainability of LTC systems (Colombo et al. 2011).

The political debates about ensuring the quality of LTC services are largely driven by three issues.

First, scandals around abuse and neglect arise frequently enough across OECD countries to ensure safety is a relatively constant political concern. Second, the effectiveness of LTC is of interest since OECD countries tend to invest a significant amount of public resources in LTC (Colombo et al. 2011).

Politicians are accountable to the public and need to demonstrate the value of these services to show that taxpayers' money has been spent wisely. Third, the responsiveness of services to their users is a concern – an issue that is linked to the lack of both information about the quality of providers' services and incentives to develop services that are right for users rather than easy for providers to deliver. Despite underlying similarities in problems experienced a variety of policy solutions are found across countries to promote quality.

The aim of this chapter is to describe and compare the policy instruments and approaches used by selected OECD countries to promote the quality of LTC services. Since the way in which each country promotes quality is inextricably linked with the overall design and features of the system, we have chosen to illustrate the policy options using six countries -- Australia, Austria, England, Finland, Japan and the United States of America (USA) -- whose LTC systems differ on a variety of characteristics.

These countries cover several continents and vary according to the degree to which the management of different aspects of the LTC system is centralised or decentralised, how the system is financed, the

eligibility criteria and the make-up of the LTC market in terms of private and public provision as shown in Table 1.

Table 1: Characteristics of national LTC systems

	Australia	Austria	England	Finland	Japan	United States
Degree of centralisation (policy, funding, provision)	Mainly centralised	Mixed	Mixed	Mainly decentralised	Mixed	Mixed
Source of financing	Tax-based	Tax-based	Tax-based	Tax-based	50% contributions; 50% government	Tax-based
Eligibility criteria	Universal	Universal LTC allowance; public support for LTC services means-tested	Public support for LTC means-tested; universal nursing care; universal benefits for disability	Universal coverage within a single system	Universal coverage within a single insurance system	Public support for LTC means-tested (Medicaid); universal for seniors (Medicare)
Type of providers	Mainly private, not-for-profit	Mixed, with private mainly not-for-profit	Mixed, mainly private, for-profit	Predominantly public, with private mainly not-for-profit	Mixed, with for-profit providers	Mainly private-for-profit

Adapted from Colombo et al (2011)

In discussing efforts to promote LTC quality in these six countries, we draw heavily on a number of recent publications. These include Wiener et al's (2007) study on approaches to quality improvement; the country chapters¹ included in Mor et al's (2014) book on regulation and quality assurance and the country reports from a special edition of EuroHealth on LTC quality². We also

¹ Australia (Gray et al. 2014) , Japan (Ikegami et al. 2014), Austria (Leichsenring et al. 2014a) , England (Malley et al. 2014) and the USA (Stevenson and Bramson 2014)

² Austria (Trukeschitz 2010), England (Malley 2010), Finland (Finne-Soveri et al. 2010) and the USA (Mor 2010)

make use of outputs from two Europe-wide research projects: the ANCIEN (Assessing Needs of Care in European Nations)³ and the Interlinks⁴ projects.

The chapter is organised as follows. The notion of quality in LTC can be understood and positioned in a number of different ways, so in section 2 we briefly set out the critical issues. Section 3 describes and maps the different instruments in place in the six OECD countries using a conceptual framework for evaluating policy instruments. We then discuss in section 4 the success and failure of these instruments, drawing on general economic and management theory, as well as evidence from implementing interventions within different LTC systems. The chapter concludes with observations and recommendations for future policy development in this area.

2 What is quality in long-term care services?

In defining the quality of LTC, it is useful to start with the carer-cared for relationship, which constitutes the basic caregiving unit. Understanding the nature of this relationship is critical to developing relevant measures of quality for LTC. Additionally, by focusing on the carer-cared for relationship we can usefully exclude aspects such as equity, efficiency and accessibility from our definition of quality since these only make sense at the aggregate service or system level, and may therefore be more usefully understood as aspects of performance (Reerink 1990).

Considering the nature of the care relationship, it is important to recognise that although some users of LTC may require specialist equipment and medical expertise, most care consists of help with activities related to daily living. Since most care is help with daily living, care is ongoing and is a prominent feature of the cared for person's everyday experience. Many of the activities are intimate tasks such as washing and dressing which require close collaboration between the carer and cared-for person, such that the 'consumer' of care is said to 'co-produce' his/her own care, even more than

³ Austria (Czypionka et al. 2012), Finland (Böckerman et al. 2011) and overviews of European countries (Dandi 2012; Dandi et al. 2012)

⁴ Finland (Hammar et al. 2010)

is the case for health care. These characteristics have two corollaries for developing relevant measures of LTC quality. First, measures of the quality of care need to reflect its relational and experiential character. This means that non-clinical aspects and aspects related to the process of caregiving, such as the behaviour of carers, the responsiveness of services and the cared-for person's quality of life, are just as important as clinical characteristics, such as the incidence of pressures sores or use of restraints, and end results (Malley and Fernández 2010). Second, the quality of care is not solely influenced by the care provider. Self-care abilities and the commitment of the care recipient also determine processes and outcomes (Trukeschitz 2011).

There are various frameworks for measuring LTC quality (for a review see Murakami and Colombo 2013b), which broadly fall into two approaches. Perhaps the best-known is the production process approach forwarded by Donabedian (1988), which distinguishes structural (input) from process and outcome indicators. Structural measures focus on aspects of the care environment, such as staff-to-patient ratios and room size, and do not capture the quality of the caring activity. By contrast, process measures focus on the way care is delivered and outcome measures on the results or impact of caring. Another approach, which is common among frameworks developed and adopted by policymakers, focuses on dimensions of quality, selecting those that have the greatest policy relevance. A good example of this is the OECD framework, which distinguishes (clinical) effectiveness and safety, patient-centeredness (including the experience of care), and care co-ordination and integration (Murakami and Colombo 2013b)⁵. While frameworks help to conceptualise quality for measurement, developing appropriate measures of quality, particularly those reflecting processes and outcomes, is far from straightforward. Measurement is plagued by barriers to data capture, reporting errors, and attribution of the effect of care. Although arcane, we must grapple with these issues since measurement and assessment is a central element of any quality promotion strategy.

⁵ In fact the OECD framework goes further melding the dimensions with the production process approach to identify key inputs (workforce, living environment and technologies) that the authors regard as 'instrumental for good care' (Murakami and Colombo 2013b: 48).

3 Types of policy instruments to promote good quality LTC services

Instruments to promote good quality LTC might do so *directly* by addressing specific quality-related concerns, or they might aim to influence quality in a more *indirect* way by matching needs to resources through assessment or redesigning (parts of) the LTC system. System-level redesigns, such as the introduction of consumer-directed care or marketisation, intend to change allocative and/or distributive LTC outcomes in general – the promotion of quality might be one of many goals. In this section, however, we focus on the description and analysis of instruments designed to directly affect LTC quality.

We describe these instruments in terms of two dimensions: the *type of intervention* and the *implementation characteristics*. Following Bemelmans-Videc (1998), we group them as one of three types: regulatory, economic or information-based instruments. In a more visual language, Bemelmans-Videc speaks of “sticks” (regulation), “carrots” (economic means) and “sermons” (information) to characterise the underlying aims of these interventions. By implementation characteristics, we refer to both the direction of implementation (‘top-down’ versus ‘bottom-up’) and the binding force of an instrument (‘high’ or ‘low’). Highlighting the direction of implementation and binding force helps to demonstrate the fact that not all instruments are developed by Government (‘top-down’) or consist solely of mandatory requirements (‘high’ binding force). As we show some are in fact developed by providers or by external stakeholder groups (‘bottom-up’).

3.1 Regulatory instruments

Regulatory instruments influence actors “by means of formulated rules and directives which mandate receivers to act in accordance with what is ordered in these rules and directives” (Bemelmans-Videc 1998: 10). According to Bemelmans-Videc, the defining property of regulation is an authoritative relationship. Most regulation of LTC services gains its authority through legislation

and there are generally powers (sometimes delegated to arms-length bodies⁶) to enforce compliance with the regulations. While such regulations are by definition implemented in a top-down fashion and have high binding force, regulation can also be implemented from the bottom-up or entered into voluntarily, through self-regulation. Commitments from self-regulation can be strong but by definition are not enforced by law.

The variation in regulatory instruments across six OECD countries is shown in Table 2, according to the implementation characteristics and three core elements of regulatory instruments described by Hood et al (1999). The first element is a method for setting standards, which we refer to as *directions*. Directions are designed to influence different parts of the production process. While the USA has a mix of structure-, process- and outcome-focused standards, Austrian and Japanese standards assess mainly structural aspects of quality, such as workforce requirements (e.g. qualifications and staffing ratios), the living environment (e.g. room size) and care technologies (such as care plans). By contrast, in Australia and England, standards focus on ‘outcomes’, although often these standards actually describe processes, such as plans and protocols, and may differ somewhat from an academic understanding of outcomes (Productivity Commission 2011; Malley et al. 2014).

The second element of regulatory instruments is a method of *surveillance* for detecting compliance with the directions. England, Australia, the USA and Austria use inspections, which involve on-site observation and frequently interviews with service users, relatives and staff, to uncover instances of noncompliance. By contrast, Japan and Finland use inspections primarily to follow up complaints and not as a form of surveillance. Instead both countries have ‘desk-based’ approaches to surveillance: Japan relies on auditing and Finland on performance reviews to survey quality. Data is gathered from records and documentary evidence, including forms of self-assessment; there are no site visits.

A method for *enforcing* compliance, should instances of noncompliance be detected, is the third element of regulation. Australia, England and the USA have a range of sanctions of varying severity

⁶ Arms-length bodies are administrative bodies that are not formally part of any government department, but are subject to ministerial direction and are usually financed by government.

to apply to providers that fail to meet standards. At the lower end are remedial action plans; while penalties, such as fines and termination of business, are reserved for more extreme cases or repeated failure to comply with standards. The range of sanctions is less diverse in Austria, Japan and Finland. However, in practice, there are often differences between what is available, the intentions of the system and the extent to which sanctions are used. Thus despite the range of available sanctions the Australian regulator operates more at the remedial end, trying to work with providers to find solutions, reflecting the dual orientation of the regulator towards assuring safety and quality improvement. By contrast in the USA, although the regulator is focused more on identifying and reporting noncompliance, sanctions are rarely applied in practice (Braithwaite et al. 2007).

Although the binding force of regulatory instruments is generally high and implementation top-down, there are examples where the character of regulation is more voluntary. This is particularly the case in Austria and Finland where the setting and implementation of regulations is devolved to lower levels of administration. In Finland, for example, there are national guidelines for standards and surveillance, but municipalities have a high degree of autonomy in how they are implemented within their own quality management systems, so guidelines at the national level have little force. Self-regulation is also common, with many countries having quite high usage of voluntary accreditation and certification schemes. These include the International Standards Organisation (ISO) system, and national schemes such as the National Quality Certification (NQC) which is popular in Austrian residential care and the Joint Commission Accreditation Programme in the USA. Additionally in Austria, as an example of bottom-up self-regulation, the main LTC non-profit providers have a document of understanding about the quality of domiciliary care services, which is a self-binding agreement.

The design variations discussed are illustrated in Table 2, but countries also differ in the target of the regulations. Thus the regulated entity in England and Australia is the provider; Japan and the USA focus on both providers and the workforce; and in Finland and Austria the workforce is regulated.

Regulation in all countries, except England, is much more developed for residential (and in particular nursing) homes. While many countries have directions and surveillance for home care agencies, standards are usually fewer and surveillance activity less frequent. It is only in England where home care agencies are subject to the same standards, surveillance and enforcement regime as care homes. However, countries are often aware of this difference in the intensity of regulation of residential and home care and, for example, recent legislation in Australia has narrowed the gap between the two regimes (Department of Social Services 2013).

Table 2: Summary of the forms of regulatory interventions to promote quality LTC services across selected OECD countries

Direction of implementation	Top-down		Bottom-up
	High	Low	High/low
Binding force			
Type of intervention			
Directions for LTC, providers, the workforce, or the rights of users and dependent people e.g. standards, targets, codes of conduct, charters	AUS, AUT, ENG, FIN, JPN, USA	AUT, FIN, JPN, USA (accreditation & certification)	AUT
Modes and rules for surveillance of commissioners, providers or the workforce e.g. inspection, audit, review	AUS, AUT, ENG, FIN, JPN, USA	AUT, FIN, JPN, USA (accreditation & certification)	
Rules and powers for enforcement of directions	AUS, AUT, ENG, FIN, JPN, USA		

Key: AUS Australia, AUT Austria, ENG England, FIN Finland, JPN Japan, USA America

3.2 Economic instruments

Economic instruments set incentives or disincentives to induce actors to change their behaviour.

Although most economic instruments aim to incentivise more efficient LTC provision, some are specifically designed to promote LTC quality. These economic instruments comprise at least two types of interventions. First, financial incentives, such as quality-related subsidies or reimbursement systems, reward providers for extra efforts in promoting quality. Second, economic incentives are used to increase competition based on the quality of LTC through, for example, setting quality-related criteria for selection of providers for public procurement. The expectation behind this policy is that market forces will lead to better performance and thus to higher quality LTC.

Financial incentives to improve LTC quality can be grouped into (i) quality-related subsidies, (ii) quality-related payment schemes or price regulation and (iii) quality-related procurement modes (see table 3). More generic approaches tie the eligibility of providers for public funding to the adoption of quality management systems. LTC providers need to implement at least some quality monitoring and quality improvement strategies to qualify for public funding, e.g. in Austria. On the other hand more sophisticated incentives reward providers for specific behaviour that is supposed to lead to LTC quality improvements such as their investment in staffing levels or in skill development. Across our six OECD countries different types of financial instruments are in place to incentivise providers to invest in such quality improvements.

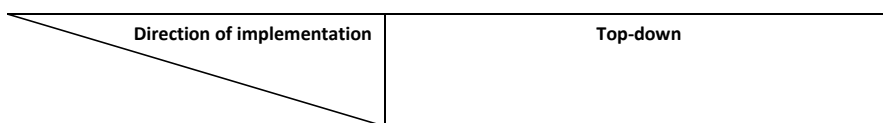
Quality-related subsidies can be found, for example, in England. Providers investing in staff can apply for workforce development funds from an independent organisation, Skills for Care, which receives funding from government to develop a better skilled care workforce. These funds are accessible to all eligible providers as they are not linked to a particular funding mode or provider-purchaser relationship.

Quality-related reimbursement intends to influence either the standards of staffing in particular or more generally the characteristics of LTC service provision. Examples in the first group of quality-

related reimbursements can be found in Japan and Australia. In Japan, additional reimbursement is available for providers that exceed the minimum standards of staffing in nursing homes. In Australia, the “Conditional Adjustment Payment” (CAP) encourages providers of residential care to improve corporate governance and financial management practices. The basic public reimbursement per resident is topped up (CAP) if workforce reforms are implemented (Department of Social Services 2013). The second type of quality-related reimbursement seeks to tie public means to certain LTC service characteristics. Different types of pay-for-performance (P4P) exist with the goal of encouraging ongoing improvements and rewarding high quality care. P4P is comparatively well-developed in Australia for care home and home care services. It is increasingly used in some parts of the USA and England, primarily in the care home sector. In England, both the criteria for a quality premium over and above the basic fee and the level of this premium vary between the local councils. Similar variations in programme characteristics are found across states in the USA (Briesacher et al. 2009; Werner et al. 2010; Allan and Forder 2012).

Public procurement can also be used to incentivise providers to focus on the quality of their services. The public purchaser can increase competition on quality by putting higher weights on predefined quality criteria and asking providers to compete on both price and quality. Examples of such schemes are found in some areas in England and include a ‘preferred supplier ranked list’, where the provider’s position on the list is determined through a quality assessment. In its extreme, public purchasers set both the price and output quantity (for example, care hours provided) and call for tenders on quality criteria only. An example for such quality-focused competitions are the tenders for stated-funded aged care packages for home and residential care in Australia (Davidson 2011; Department of Social Services 2014).

Table 3: Summary of the forms of economic instruments to promote quality LTC services across selected OECD countries



Type of intervention	
Quality-related subsidies e.g. for investments in quality infrastructure; for certifications; for projects aiming to improve quality	ENG (workforce development subsidies)
Quality-related price regulation, payment schemes e.g. P4P, mark-ups on reimbursement rates for over-fulfilment of standards	AUT (funding linked to adoption of QM schemes) JPN (mark-up on reimbursement) AUS (Conditional Adjustment Payment) ENG, USA (P4P – care homes) AUS (P4P – care homes & home care)
Quality-related public procurement e.g. quality criteria and their weights in public procurement	AUS (call for tenders on quality criteria only possible), ENG

Key: AUT Austria, AUS Australia, ENG England, FIN Finland, JPN Japan, USA America

3.3 Information-related instruments

Information instruments are implemented to influence the behaviour of actors “through the transfer of knowledge, the communication of reasoned argument, and persuasion” (Bemelmans-Videc 1998: 11). We interpret information in its broadest sense here and include four categories of information: education and knowledge management; quality management systems; public reporting; and feedback on quality from users, staff and other members of the public. The use of these types of

information instruments is illustrated in Table 4. Although the binding force of information instruments is usually relatively low, there are exceptions where they interact with regulatory or economic instruments.

In the six OECD countries, *education and knowledge management* involves a number of actors, many of whom are not formally part of government or operate at arms-length from government. For example, in England, the regulatory standards provide basic guidance on care processes, but these are supplemented by guidance on best practice from an arms-length body (the National Institute for Health and Clinical Excellence) and two independent, but partly government-funded, organisations (the Social Care Institute for Excellence, focusing on social care processes, and Skills for Care, focusing on the workforce). For residential care in Australia, education and knowledge management are more explicitly embedded in the regulatory system. The regulator has responsibility for the dissemination of best practice approaches alongside its inspection and audit role, which it fulfils by holding courses and conferences on continuous improvement and on achieving accreditation standards, as well as recognising good quality providers with Best Practice Awards on an annual basis.

Another source of information is advocacy groups which, in addition to campaigning for better care, are also active in defining, disseminating and educating providers on best practice, particularly in residential care. Although such groups are found in all countries they are particularly vocal in the USA, where several approaches for the redesign and improvement of residential care to achieve better quality of life outcomes have emerged under the banner of the 'culture change movement' (Rahman and Schnelle 2008).

Quality management systems and quality improvement tools – such as the generic ISO system or the care home-specific E-Qalin in Austria – are adopted by providers for a variety of reasons. Many of these tools (e.g. the ISO system) may be considered self-regulation (see section 3.1), however, they also act as information-related tools to increase providers' awareness and skills in monitoring and

improving the quality of LTC. Benchmarking is another way of using information to support quality improvement goals. In England, the popularity of benchmarking in public sector organisations and the availability of data on social care at the local government level has enabled the emergence of 'Adult Social Care Benchmarking Clubs'. These are often run by specialist benchmarking firms who assist local commissioners in sharing and comparing performance information, to identify opportunities to transfer learning for more effective commissioning and quality monitoring.

A more recent development is involving users of care and other members of the public in improving care provision. The *public reporting* of quality information aims to directly address the lack of information about quality in LTC markets, which undermines the ability of consumers to make effective choices about their care and creates market inefficiencies. Information on quality is available in three different forms (Fung et al. 2007). The first type is the publication of *right-to-know* information, where users are made aware of compliance with regulatory requirements and major provider failings. This is achieved by publicising the outcomes of regulatory inspections and reviews for residential care in Australia, and for residential and domiciliary care in England, Japan and the USA, with a focus on online information. In Austria only the part of the NQC assessment that covers structural indicators and management reports are accessible online. The second type, *targeted transparency*, consists of structured and formally-provided information that sheds light on provider quality. The most comprehensive example is Nursing Home Compare and Home Health Compare from the USA, which enable the comparison of care home and home health agencies on a range of quality indicators derived from the national minimum dataset for providers. There is a less-developed version in Finland (www.palveluvaaka.fi) and one in development in Australia (Department of Health and Ageing 2012). A more recent development is the emergence of a third type of information – *collaborative transparency policies* – where users and other stakeholders contribute to the production of published quality information. In other sectors, users and consumers are able to post reviews of products and services on the internet, for example, via sites such as TripAdvisor. In England, the government is actively supporting the development of similar feedback

and comparison sites for LTC providers (Trigg 2014). The end goal of these initiatives is to empower the users of care to make informed decisions in selecting providers, although the ability of the frailest users of care to act as consumers is questioned (Braithwaite et al. 2007; Eika 2009).

For instances of very poor care, there are usually more formal two-way channels for users, family and staff members to raise concerns about care received. Top-down regulations normally dictate that providers should have complaints processes in place and act as the first port of call for complainants. In Australia, England and in each state in the USA, there is a single independent body which deals with complaints that are not satisfactorily resolved at the provider (or commissioner in England) level; while local bodies are in place in Austria and Finland to resolve complaints. In Japan the escalation process is slightly different: complaints are made first to the care manager and then to the LTC insurer. In all countries there may also be a bottom-up element with providers developing complaints systems that go beyond regulatory requirements, for example to achieve certification, such as ISO.

Table 4: Summary of the forms of information interventions to promote quality LTC services across selected OECD countries

Direction of implementation	Top-down		Bottom-up
Binding force	High	Low	High/low
Type of intervention			
Education and knowledge management (excluding professional and clinical staff)	JPN	AUS, ENG, FIN, USA	AUT, AUS, ENG, FIN, USA
Quality management systems and improvement tools		AUT, JPN	FIN, USA, ENG
Public reporting			
Publication of inspection reports, compliance and sanctions	AUS, ENG, JPN, USA, AUT		

	(partial)		
Provider performance data	AUS, USA	FIN (partial)	FIN
Collaboratively produced information from stakeholders including users		ENG	AUS, ENG, USA
Complaints channels		AUS, AUT, ENG,	AUS, AUT, ENG,
		FIN, JPN, USA	FIN, JPN, USA

Key: AUT Austria, AUS Australia, ENG England, FIN Finland, JPN Japan, USA America

4 Critical assessment of policy instruments to promote good quality

LTC services

To assess the value of quality-promoting policy instruments it is necessary to view the instruments within a wider context. All quality-promoting instruments sit within a LTC governance regime, which structures the relationships between providers and their staff, government and service users. From the point of view of professionals and providers this might be described as the ‘external environment’. External environments will vary between countries and, where responsibilities are devolved to lower levels of administration, also within countries. It is therefore highly likely that similar policy instruments will have different effects depending on where they are implemented.

Provider characteristics will also be important in determining the chances of success of policy instruments. Factors such as the style and effectiveness of the leadership; the organisation’s vision, mission and strategy and the level of engagement of stakeholders in the process have been shown to be important in determining the success of change activities (see, for example, the model developed by Burke and Litwin 1992). Organisations may have very different goals to government and staff may be motivated by a range of factors, both altruistic and self-interested. It is therefore unlikely that the impact of each policy instrument will be uniform across providers or staff.

The implementation characteristics for each instrument, in particular the binding force, are therefore an important factor in understanding the impact of instruments. Where the binding force is low, we

must consider why providers or professionals would adopt the instrument; conversely, where the binding force is high, a more important consideration is whether providers and professionals react in adverse ways to the instrument.

The interaction between the different instruments, providers (and their staff) and the external environment is shown schematically in Figure 1. In the following sections we assess the effectiveness of regulatory, economic and information instruments paying attention to these relationships.

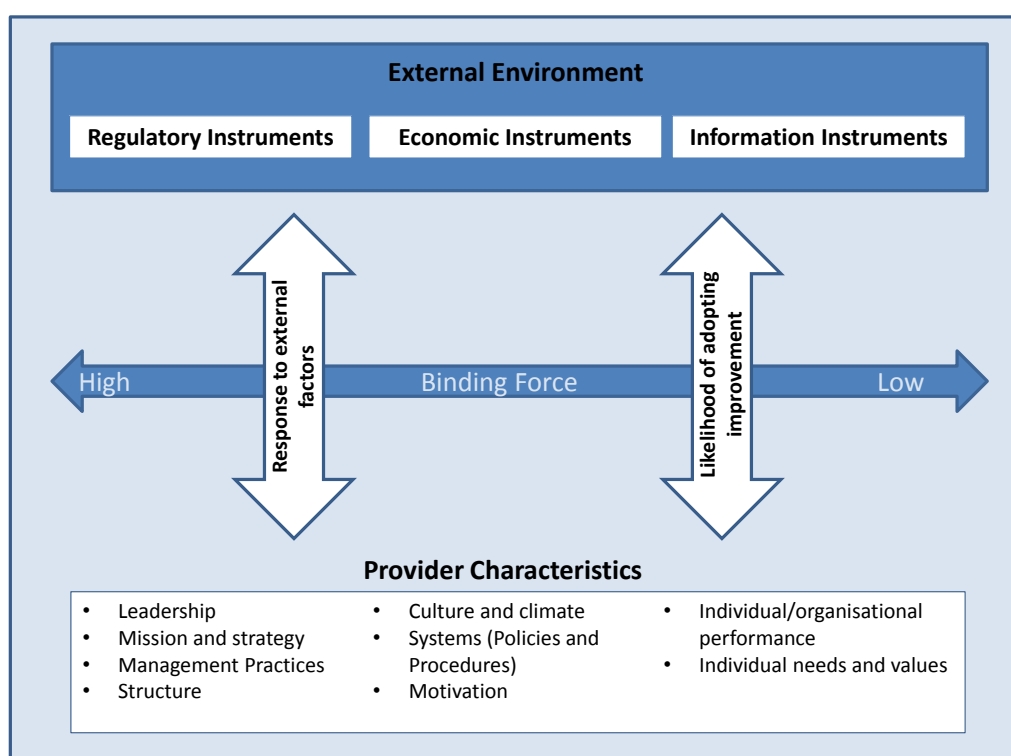


Figure 1: Key factors determining the likelihood of successful implementation or adoption of policies to promote formal LTC (Provider Characteristics are taken from the model developed by Burke-Litwin (1992))

4.1 Assessment of the regulatory context for LTC providers

The effectiveness of regulation is often considered through the lens of 'regulatory failure', describing situations in which the regulatory regime fails to have the desired effect. Causes of regulatory failure include resistance to the regulations, regulatory capture (where the regulated bend the regulations to meet their needs in place of the needs of those for whom the regulations were designed to

protect), ritual compliance (where organisations go through the motions of compliance), lack of data (reflecting the difficulty of measuring aspects of quality), and performance ambiguity (reflecting the multivalency of performance and quality) (Boyne et al. 2002).

Partly as a result of measurement problems and performance ambiguity there may be a lack of alignment between regulatory goals and the goals of other actors within the LTC system. For example, a regulatory system that focuses on, e.g. workforce characteristics and the use of care technologies, implicitly sets these structural requirements as system goals. This may be appropriate if the goal is, for example, to professionalise the workforce (see section 4.2). However, if the goal of policymakers and providers is to improve user outcomes, it is important to demonstrate how the structural standards specified promote user outcomes. Since where standards do not support the system goals and are not aligned with providers' goals they may be a barrier to achieving high quality care: providers may resist the regulations, perceiving them as burdensome and pointless; and poorly chosen indicators with no relationship to quality have broader system-wide effects such as distorting priorities and introducing inefficiencies.

Yet, evidence about the relationship between structural aspects of quality and user outcomes is in most cases either equivocal or absent. An exception in this regard is staff-to-patient ratios about which there is fairly compelling evidence from the US context. Studies have shown higher staffing levels to be positively associated with high quality care in nursing homes (at least when measured using clinically-oriented outcome indicators) (Spilsbury et al. 2011), fewer severe deficiency citations and an improvement in certain health conditions requiring intensive nursing care (Chen and Grabowski 2014). As a result of this lack of evidence and a concern to better reflect system goals, some countries have developed standards that focus on aspects of process or outcome quality.

However, process- and outcome-focused standards are generally much harder to define and measure than structural standards. Although some aspects, such as the use of restraints, may be monitored from care records, many, particularly those associated with quality of life outcomes,

require assessment either through observation or interview with the service user. It is unlikely to be by chance then that inspections are used in the USA, which has some process and outcome standards, and England and Australia that focus exclusively on outcome and process standards, since this method allows the inspector to observe practice and engage with service users.

Whilst inspections may allow for a more rounded assessment of quality and help to overcome the distortion and motivation problems associated with structurally-focused standards, it is an expensive and complicated activity, particularly when compared to a desk-based review or audit of documents. Inspectors need to be skilled in inspection methods and knowledgeable enough about care practice to judge compliance with consistency against what can be quite vaguely-specified standards.

Evidence from the USA which finds wide variations within and across states in the number of deficiency citations demonstrates the problem of inconsistency in interpretation of the regulations (Miller and Mor 2006). Data-based ways of surveying standards that do not involve inspections have been attempted, although unsuccessfully to date, in England due to difficulties collecting comparable data (see Malley et al. 2014). In the US inspections are run in parallel with a highly standardised and very detailed data collection and quarterly reporting scheme (Stevenson and Bramson 2014). It seems likely that process and outcome standards lead to higher surveillance costs and variability in the assessment of compliance with standards.

Enforcing regulation also raises challenges. Regulation scholars have proposed that regulators adopt a 'responsive regulation' approach to enforcement, which takes compliance through persuasion and education as its starting point (Ayres and Braithwaite 1992). Underpinning this approach is the recognition that providers are motivated by a wide range of factors. Penalties and deterrence activity assume that providers are largely self-interested, potentially inducing 'resistance' to the regulations and crowding out more 'knightly' altruistic motivations (Le Grand 2003). However, compliance through persuasion and education as a strategy on its own assumes that providers are largely knights, thus suffering conversely from problems of gaming and falsification where providers

are in fact self-interested 'knaves'. For this reason, enforcement strategies must incorporate strong sanctions and deterrence to deal with the self-interested knaves (Braithwaite et al. 2007).

In practice, in countries that follow the responsive regulation approach, achieving such a balance is a challenge. Whereas the USA regulator focuses, on paper at least, on detecting and enforcing compliance, the Australian regulator and its quality assessors explicitly have a dual quality improvement and enforcement role. Some commentators complain that this has led to a tension and blurring of roles, which undermines the regulator's effectiveness (Commonwealth of Australia 2007). Thus many countries seem to have come to the conclusion that regulation is not a silver bullet, but one part of the solution. Regulatory approaches based on controlling quality through inspection and enforcement need to be supported by other mechanisms, including self-regulation, quality management based on self-assessment or third-party certification (Leichsenring et al. 2014b), and data-based public reporting (Leone et al. 2014), all of which have gained importance in recent years.

4.2 Assessment of the regulatory context for LTC professionals and workers

The main aim of regulation aimed at the workforce is to ensure that workers have the right skills, experience and up-to-date knowledge. In countries, such as Finland, Austria and Japan, that heavily regulate the workforce, this is explicitly associated with the goal of professionalisation (see Leone et al. 2014). Japan is particularly interesting in this respect since care workers have distinct qualifications and, highly unusually compared to other countries, many obtain their qualifications following a four-year university programme. Commentators speculate that it is for this reason that care workers have a relatively high status and are paid above the minimum (Ikegami et al. 2014). Professionalisation may therefore be one important component of improving the status of care work, which is important for a growing industry already suffering from recruitment and retention problems (Fujisawa and Colombo 2009; Colombo et al. 2011).

However, a highly professionalised workforce is likely to be a more expensive workforce. More expensive workers, such as nurses, may be displaced by less expensive or unqualified workers, where substitution is possible. (Although this may not have negative consequences for the quality of care, see e.g. Chen and Grabowski 2014). Ikegami et al (2014) suggest that the reason nursing agencies in Japan have not expanded as fast as home helper agencies is because nurses are three times as expensive as care workers. Indeed in England there has been a debate for some time about introducing registration requirements for care workers, but one argument against this has been the effect this would have on the cost of care, which is already considered unaffordable for some people. There is a concern that, unable to afford the wages of professional care workers from home care agencies, people may turn in larger numbers to the grey 'unregulated' market. In the long-term substitution would affect demand for professionals, and would likely lead to low take-up of training by workers, thus undermining the goal of professionalisation.

Professionalisation of the workforce therefore requires strict regulation of roles for different professions and policing of the market to ensure there is not 'inappropriate' substitution. In this respect, one challenging issue that has emerged in many European countries, particularly those with certain types of care regimes (cash-for care regimes, substantial co-payments for home care services and an undersupply of home care services that oversee the dependent person for half a day and longer) and access to relatively cheap labour in Central and Eastern European countries, is a growth of (illegal) migrant care in private households (Österle and Bauer 2012). Many people hire unqualified immigrants although this practice is often illegal. For example, in Austria, to protect the goal of professionalisation and also to prevent dependent people from being sued for illegally employing migrant care workers, migrant care work was regularised in 2007 by introducing, among other things, some qualification requirements and restrictions around care tasks to be conducted by migrant care workers in private households (Österle and Bauer 2012; Trukeschitz and Schneider 2012). The problem was therefore resolved by creating a new type of care worker.

4.3 Assessment of economic incentives to improve the quality of LTC services

Although economic incentives are used across a number of countries, very little is written about the effectiveness of individual schemes in promoting quality, although one type of scheme, P4P, has received a lot of attention. The evidence for its effectiveness is limited and interpreting the findings is complicated by the diversity of ways in which P4P schemes have been implemented (Briesacher et al. 2009). Much of the debate about P4P is focused on the way providers (or staff) may react to such schemes and the potential for negative consequences.

A variety of negative consequences have been identified. There is the potential for providers to focus on the aspects of quality that are measured, and on which the additional payments are allocated, at the expense of other aspects of quality. There are also concerns about the accuracy of performance measures, where they are collected by providers, since they may seek to manipulate or game the data to get a higher payment. Independent collection of the data may not necessarily overcome this problem as agents of independent organisations may be susceptible to bribes or inducements, thus requiring additional layers of regulation to assure the standards of independent data collection organisations. Providers may also engage in 'cream-skimming', where they select people who are easier to care for to make their performance appear better. All of these adverse consequences have yet to be researched in the context of P4P schemes and more information about whether, and the circumstances under which, they occur is necessary for P4P schemes to be evaluated (Konetzka and Werner 2010).

A further issue with the use of P4P to reward 'good' performance is that it can redistribute funds from badly-performing providers to good providers. Commissioners generally have a set budget to use to pay for LTC services. Unless additional funds are identified and ring-fenced to finance P4P schemes, then funds for the scheme will be deducted from the general budget, thus reducing the money available to pay providers their basic fees. This in effect diverts money to good performers,

and could further undermine the ability of poor providers to improve, potentially hastening their exit from the market.

Finally, P4P mechanisms build on measurable LTC characteristics and aim to reward good quality LTC provision. This may be considered a good thing, since it improves market efficiency. However, particularly in the case of care homes, it may be viewed more negatively since relocation to a new home is a stressful event which potentially leads to poorer health outcomes and increased risk of mortality, although the evidence is equivocal (Jolley et al. 2011; Holder and Jolley 2012). A scheme that increased the number of care home providers exiting from the market may therefore, paradoxically, lead to worse outcomes for users.

4.4 Assessment of information tools to support LTC quality improvement

Underpinning the success of many information instruments, particularly quality management systems, is the rate of adoption by providers. It is perhaps for this reason that adoption of a quality management system is often embedded within regulations. For example, in Australia, providers have to show that their management processes and practices support continuous improvement to gain accreditation. Yet in the absence of a legislative imperative there is still extensive use of benchmarking, accreditation and associated quality management systems across countries. In addition, there are grass-roots movements, such as the culture change movement and the provider-led adoption of the resident assessment instrument (RAI) in Japan.

Many providers seem to participate in quality programmes to signal quality in a competitive market. Indeed, branding appears to be increasingly important, with institutions allied to culture change programmes using their care philosophy as a selling point. In England established companies from other sectors use their brand position when entering the LTC market. What is interesting is that even in countries with relatively low levels of service competition, such as Austria and Finland, there is still a desire on the part of providers to signal quality through participation in accreditation schemes. It is possible that this is a strategic response to what is in all countries a growing and evolving market,

with many countries increasingly allowing entry from private providers. This development may equally be rooted in care worker shortages and the attempts of providers to attract skilled care workers.

Nationwide quality certification systems, which are voluntary by nature, may have other benefits, helping to establish uniform quality standards and overcome fragmented quality regulation in a federalised system. An example is the development of the National Quality Certificate (NQC) for care homes in Austria. The development of the NQC is noteworthy since Austria is characterised by regional autonomy in standard-setting and currently focuses on structural indicators. The NQC defines nationwide standards and whilst recognising the predominance of structural indicators it also draws attention to both process and outcome indicators. Although there is room for improvement this example shows that uniform quality standards can evolve even in a decentralised governance system.

Other facets of the LTC system, particularly the regulatory environment, can thwart the adoption of some voluntary measures. In the USA, the emphasis of the culture change movement on quality of life is often in conflict with regulatory measures, which are preoccupied with minimising risk for users and can inadvertently sabotage improvement efforts. For example, the Eden Alternative model for residential care for older people involves developing more homelike and stimulating environments with, for example, soft furnishings and pets. The regulator itself has recognised the difficulties posed by its highly prescriptive requirements in environmental design, and training and information has been developed for providers to show them how to negotiate their way through regulatory requirements to implement culture change initiatives (Miller et al. 2010).

In addition to impeding quality-promoting efforts, regulations may be difficult to follow. Although standards are often intended to provide guidance to providers on how to deliver quality services, they may carry with them varying levels of clarity about what is required at an operational level to deliver the required level of quality or to improve quality over and above minimum standards. It is

common for other knowledge and education instruments to be developed by a variety of independent and government organisations to supplement standards. It may be challenging for providers, who may be small and lack resources to interpret and integrate information from a variety of sources. Organisations dedicated to supporting providers to change, such as the Quality Improvement Organisations in the USA or from the culture change movement, could be of value.

While many governments are developing public reporting schemes, their effects are generally poorly understood. In particular, the mechanism through which public reporting schemes have their effect is unclear. Berwick et al (2003) suggested that public reporting might have its effect through either a 'change' or 'selection' pathway. The change pathway works through market position or reputation, where providers are shamed into improving quality to ensure they remain competitive; whereas the selection pathway works through allowing people to make better choices about their care.

Interestingly, the evidence from the USA, and England to a lesser extent, provides more support for the change rather than the selection pathway. Thus Mukamel et al (2007) find that nursing homes in the USA examine their report cards to address failures. While there appears to be low awareness and usage of reports among users (Castle 2009; Commission for Social Care Inspection 2009; Office of Fair Trading 2011), reports may be used more widely by professionals and intermediaries in supporting older people to select providers (Shugarman and Brown 2006; Commission for Social Care Inspection 2009). Despite more evidence for the change pathway, new policies tend to emphasise the publication – usually online – of quality information to assist users to make choices, either consisting of data generated by providers and regulators (Australia) or reviews generated by users themselves (England).

Several issues have to be solved to ensure that publication of quality information can be used effectively to support decision-making. Users and their carers may not be using the quality information for valid reasons. All too often, LTC is a 'stress' purchase made under difficult circumstances. This is particularly the case for residential care where users are often seeking care following hospitalisation (Bebbington et al. 2001; Castle 2003). Several problems compound this

issue. The quality information available may not reflect what matters to service users, who may be more interested in the experiences of other users and carers; the user surveys in England and Finland are a step in this direction. Users of LTC have many difficulties interpreting data and quality information (Vaiana and McGlynn 2002; Gerteis et al. 2007) and older people and those with disabilities are the groups that are least likely to have access to the internet (Dutton and Blank 2011; Fox 2011). Overcoming these problems is critical for quality information to be of real value as an aid to consumer choice.

Leaving aside the issue of whether the intended audience for the information is capable and motivated to use it, publicly-reported quality information of all types may fail because of other implementation challenges. For example, user-produced reviews might be compromised by challenges in generating sufficient reviews, by whether reviews are genuine, and by issues associated with the confidentiality and anonymity of both users and staff (Trigg 2014). Issues around confidentiality and anonymity also hamper the effectiveness of complaints and whistle-blowing channels, with the fear of retribution or hostility seen to be a disincentive for the reporting of cases of abuse and neglect (Australian National Audit Office 2012; Healthwatch 2014); and better processes are seen as important (Cooper et al. 2008). In addition, the competitiveness of markets is important in determining the effectiveness of the public reporting of quality, as predicted by theory (Grabowski and Town 2011).

How quality is measured is also a challenge for public reporting. Information reporting systems can only report on certain aspects of quality and unreported aspects of quality may suffer at the expense of reported aspects. Although opinion in the USA based on the evidence from various studies is that public reporting has a modestly positive impact on the quality of care delivered (Konetzka and Werner 2010), research has been limited to the effect on clinical quality indicators. Aspects of quality of life and user experience were not assessed. As Netten and colleagues (2012) show, the relationship between quality of life outcomes for service users and other quality indicators may not be straightforward. They found that the care home providers with better star ratings, where the star

rating derived from inspection activity, were not necessarily always those with better quality of life outcomes for service users. In addition, although Werner et al (2009) found that unreported aspects of clinical quality improved in US nursing homes, the improvements were less than those for reported aspects, indicating that providers do focus on what is measured to some extent. The mix of indicators is also important to reduce the risk that providers will indulge in cream-skimming, as observed on an albeit limited basis by Mukamel et al (2009). Together these studies illustrate that, although a focus on certain aspects of quality may not completely crowd out improvement on other aspects of quality, high quality on one dimension does not necessarily lead to high quality on another dimension, and resources may become concentrated on the reported aspects of quality. Consequently the choice of indicators to report is important since a poorly chosen indicator can unfairly reward or penalise organisations, and may affect the efficiency of the market.

5 Conclusion

This chapter has illustrated the variation across countries in their efforts to promote LTC quality. We framed our analysis by distinguishing between regulatory, economic and information-related instruments. Even at this very general level, different policy styles could be identified, with countries relying more or less on information-related or economic tools in addition to regulatory approaches; putting different emphasis on regulating the workforce, providers or protecting consumers; and varying in the regulatory methods, degree of enforcement and types of standards employed. Some analysts have seen in the combinations of instruments adopted a certain degree of path dependence, with the direction of travel moving from regulatory controls, to the standardisation of care practices, and finally stimulating quality through market-based incentives and competition (Murakami and Colombo 2013a); while others see evolution in terms of selective borrowing and adaptation of elements from other regimes (Bode and Champetier 2012). Whichever explanation comes closest to the truth, it is certain that the degree of variation observed means there should be ample room for countries to draw upon and learn from the experiences of others.

However, learning from other countries' experiences is complicated by the variety of ways in which LTC systems are organised. For example, many of the information and economic instruments we identified work by increasing competition on quality and therefore rely on competitive markets for services. The competitiveness of markets varies, however, both within countries, due to differences in local conditions, and between countries, due to political choices over the extent of marketisation. It is therefore very likely that the effectiveness of instruments will vary according to the external environment or LTC system. Thus, although countries vary in their use of the spectrum of information and economic instruments available, suggesting that there is room for countries to develop their approaches to quality promotion, the effectiveness of these policies may be limited by the features of the LTC market. Some 'competition-based' policies, such as public reporting may have other benefits, such as promoting transparency and generating trust, but this is not always the case. When designing policies to promote quality it is important that governments, or other actors, consider the full range of tools at their disposal and analyse carefully the interdependencies between other aspects of governance and quality-promoting instruments.

The multiple types of instruments act in different ways upon providers and give policymakers a variety of tools to guide the behaviour of people and organisations within the LTC system. However, the impact of each type of instrument is unlikely to be uniform across providers. The complexities faced by organisations attempting to make either incremental improvements or transformational changes are described in an extensive body of literature on change management and organisational development (see, for example, Burnes 2009). As well as the motivation of the provider organisation and its staff, which we have considered here, the capacity of the organisation to respond will also be influenced strongly by characteristics such as the skills of its leadership, the structure of the organisation and its existing processes and systems. The predisposition of the provider to the adoption of innovations – whether technological or otherwise – will also influence how quickly and enthusiastically the provider adopts new ideas about the delivery of care (Rogers 2003). In addition

to the design features of the instruments, the characteristics and nuances of organisations are therefore important to consider when analysing the likely chances of success of instruments.

A further challenge for policymakers is the lack of evidence over the relative costs and benefits of quality-promoting instruments, which compromises their ability to make strategic decisions regarding which instruments to implement. For example, evidence about the effects of regulatory instruments is particularly weak, yet regulation is relied upon more extensively than other instruments (Murakami and Colombo 2013a). Equally, evidence about the value of instruments that focus on professionalising the workforce is poor. However, a number of countries choose this route to quality improvement despite the fact that investing in the workforce is likely to increase labour costs and therefore the overall cost of providing care, since labour costs are the vast majority of costs for organisations. Currently this choice seems to be informed more by the particular political and social history of a country than evidence as to the value of such an approach. Indeed such a policy would be difficult to sell to organisations struggling with cash flow or profitability issues, particularly since the cost premium cannot be offset by reducing staffing ratios – staff may be highly motivated and skilled, but that will not matter if they are unable to devote sufficient time to service users to ensure high quality care is provided. Interventions that facilitate immediate reductions in (or maintain) staffing costs are likely to be the most appealing for providers and cash-strapped governments, even if, in the long-run, their benefits are small in comparison to the benefits of investing in staff. Research providing an evidence base for the social and economic value of different types of instruments will be invaluable in this regard.

Measuring LTC quality adequately is a key issue for quality-promoting policies since the success of most instruments depends on reliable quality measurement. As we have shown many problems are associated with the choice of measure and how quality is measured. First, structural indicators, such as room size, staffing ratios, education levels, still dominate in the OECD countries. As making an informed choice between quality measures is far from trivial, it seems some public authorities stick to measuring what they are legally required to rather than investing in wholesale redesign of quality

measurement systems. While, a small number of countries have invested in the development of process and outcome indicators – to reflect the continuous and long-term nature of LTC by the way care is delivered (care processes) and how the care provided relates to the purpose of the intervention (care outcomes) – these systems are still a work-in-progress. Second, as the quality of LTC cannot be measured in every detail, public and private purchasers rely, to some extent, on the intrinsic motivation of the LTC provider. Quality assessments that come with what is perceived to be irrelevant data collection or too much burdensome paperwork for care workers might crowd out such intrinsic motivation, leading to undesired and unintended results. Finally, the choice of measures needs to reflect what is important to care recipients. While the service user's or care recipient's perspective is very important in other industries, it seems to be in its infancy in LTC as quality is often defined from an expert's perspective (providers, care workers, public authorities). As LTC can be considered as an experience good, user experience measures should have more importance in quality measurement frameworks. Although service user satisfaction surveys are quite common, they often do not measure the care recipient's quality of life. Measures such as ASCOT⁷ are leading the way in measuring quality of life in this area, but there needs to be more work to understand how experience measures can and should be used to direct or stimulate quality promotion.

Space did not permit us to expand upon two important aspects, which we mention here. The first is that a wide variety of actors were involved in quality promotion efforts within countries. Actors included public authorities at all levels of government from the local, through regional levels to the national as well as arms-length bodies and more independent organisations. However, the extent of involvement of these actors and the roles they perform differed between countries. Understanding the reasons for this variation as well as the consequences for the success of policies to promote quality would be an interesting and valuable direction for future research. The second area is quality of informal care. Given that LTC provided by family members and friends is still the most important

⁷ ASCOT (Adult Social Care Outcomes Toolkit) <http://www.pssru.ac.uk/ascot/> (derived 21 Nov. 2012)

resource for dependent people, policies to promote the quality of informal LTC could play a crucial role in improving LTC quality more generally. Interestingly, the political debates about LTC quality mainly address professional LTC provision. Informal care policies still primarily aim to support family members to care for their loved ones (Schneider et al. forthcoming) rather than enhance quality of informal care. Only a few countries have also developed programmes to assure the quality of informal care in private households. These home visit and counselling programmes differ in their design and coverage. More systematic analysis is needed to map different policy options for promoting quality of informal care and their impact on both maintaining the health and functional status and the quality of life of people in need of LTC.

Comment [m1]: NOTE FOR EDITOR: THIS REFERENCE IS TO A CHAPTER IN THE SAME BOOK. WE'RE NOT SURE HOW TO REFERENCE IT.

6 References

- Allan, S and Forder, J (2012). 'Care markets in England: Lessons from research. PSSRU discussion paper 2815'. Canterbury, Personal Social Services Research Unit, University of Kent.
- Australian National Audit Office. (2012). "Managing aged care complaints."
- Ayres, I and Braithwaite, J (1992). *Responsive regulation: Transcending the deregulation debate*, Oxford University Press, USA.
- Bebbington, A, Darton, R and Netten, A (2001). 'Care homes for older people. Vol. 2: Admissions, needs and outcomes', PSSRU.
- Bemelmans-Videc, M-L (1998). 'Introduction. Policy instrument choice and evaluation'. *Carrots, sticks & sermons : Policy instruments and their evaluation*. M.-L. Bemelmans-Videc, R. C. Rist and E. Vedung. New Brunswick, N.J., U.S.A., Transaction Publishers: 280 p.
- Bemelmans-Videc, M L, Rist, R C and Vedung, E (1998). *Carrots, sticks & sermons : Policy instruments and their evaluation*. New Brunswick, N.J., U.S.A., Transaction Publishers.
- Berwick, D M, James, B and Coye, M J (2003). 'Connections between quality measurement and improvement.' *Med Care* 41(1 Suppl): 130-38.
- Böckerman, P, Johansson, E and Saarni, S (2011). 'Institutionalisation and quality of life for elderly people in finland'. ENEPRI Research Report No. 92, August 2011.
- Bode, I and Champetier, B (2012). 'L'européanisation des régimes de care aux aînés. Apports d'une méthode ouverte de comparaison.' *Sociologie* 3.
- Boyne, G, Day, P and Walker, R (2002). 'The evaluation of public service inspection: A theoretical framework.' *Urban Studies* 39(7): 1197-1212.
- Braithwaite, J, Makkai, T and Braithwaite, V A (2007). *Regulating aged care: Ritualism and the new pyramid*. Cheltenham, Edward Elgar Publishing.
- Briesacher, B A, Field, T S, Baril, J and Gurwitz, J H (2009). 'Pay-for-performance in nursing homes.' *Health Care Financ Rev* 30(3): 1-13.
- Burke, W W and Litwin, G H (1992). 'A causal model of organizational performance and change.' *Journal of Management* 18(3): 523-545.
- Burnes, B (2009). *Managing change : A strategic approach to organisational dynamics*. Harlow, FT Prentice Hall.
- Castle, N G (2003). 'Searching for and selecting a nursing facility.' *Med Care Res Rev* 60(2): 223-247; discussion 248-252.

- Castle, N G (2009). 'Consumers' use of internet-based nursing home report cards.' *Jt Comm J Qual Patient Saf* 35(6): 316-323.
- Chen, M M and Grabowski, D C (2014). 'Intended and unintended consequences of minimum staffing standards for nursing homes.' *Health Economics: n/a-n/a*.
- Colombo, F, Llena-Nozal, A, Mercier, J and Tjadens, F (2011). 'Help wanted? Providing and paying for long-term care'. Paris, OECD Publishing.
- Commission for Social Care Inspection (2009). 'CSCI quality ratings: Market research report'. London, Commission for Social Care Inspection.
- Commonwealth of Australia (2007). 'Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian government subsidised residential aged care homes - final report'. Department of Health and Ageing. Canberra.
- Cooper, C, Selwood, A and Livingston, G (2008). 'The prevalence of elder abuse and neglect: A systematic review.' *Age and Ageing* 37(2): 151-160.
- Czypionka, T, Kraus, M and Kalmar, M (2012). 'Quality assurance policies and indicators for long-term care in the European Union. Country report: Austria. ENEPRI research report no. 105', ANCIEN.
- Dandi, R (2012). 'Quality assurance policies and indicators for long-term care in the European Union. ENEPRI policy brief no. 11', ENEPRI.
- Dandi, R, Casanova, G, Lillini, R, Volpe, M, De Belvis, A G, Avolio, M and Pelone, F (2012). 'Long-term care quality assurance policies in European countries. ENEPRI research report no. 111', ANCIEN.
- Davidson, B (2011). 'Contestability in human services markets. .' *The Journal of Australian Political Economy* 68: 213-239.
- Department of Health and Ageing (2012). 'Living longer. Living better. Aged care reform package April 2012'. Canberra, Commonwealth of Australia.
- Department of Social Services (2013). 'Report on the operation of the aged care act 1997. 2012-2013'. Canberra, Commonwealth of Australia.
- Department of Social Services (2014). 'Report on the operation of the aged care act 1997. 2013-2014'. Canberra, Commonwealth of Australia.
- Donabedian, A (1988). 'The quality of care. How can it be assessed?' *JAMA* 260(12): 1743-1748.
- Dutton, W and Blank, G (2011). 'Oxford internet survey 2011. Next generation users: The internet in Britain'. Oxford, Oxford Internet Institute.
- Eika, K H (2009). 'The challenge of obtaining quality care: Limited consumer sovereignty in human services.' *Feminist Economics* 15(1): 113-137.
- Finne-Soveri, H, Hammar, T and Noro, A (2010). 'Measuring the quality of long-term institutional care in Finland.' *Eurohealth* 16(2): 8-10.
- Fox, S (2011). 'Americans living with disability and their technology profile'. Washington DC, Pew Research Center's Internet & American Life Project
- Fujisawa, R and Colombo, F (2009). 'The long-term care workforce: Overview and strategies to adapt supply to a growing demand. Oecd health working papers, no. 44', OECD Publishing.
- Fung, A, Graham, M and Weil, D (2007). *Full disclosure : The perils and promise of transparency*. New York ; Cambridge, Cambridge University Press.
- Gerteis, M, Gerteis, J S, Newman, D and Koepke, C (2007). 'Testing consumers' comprehension of quality measures using alternative reporting formats.' *Health Care Financ Rev* 28(3): 31-45.
- Grabowski, D C and Town, R J (2011). 'Does information matter? Competition, quality, and the impact of nursing home report cards.' *Health services research* 46(6pt1): 1698-1719.
- Gray, L C, Cullen, D C and Lomas, H B (2014). 'Regulating long-term care quality in Australia'. *Regulating long-term care quality: An international comparison*. V. L. Mor, T.;Maresso, A. Cambridge, Cambridge University Press: 149-179.
- Hammar, T, Finne-Soveri, H, Mikkola, H-M, Noro, A and Hujanen, T (2010). 'Quality assurance and quality management in long-term care. National report Finland'. Helsinki, Interlinks.

- Healthwatch (2014). 'Suffering in silence. Listening to consumer experiences of the health and social care complaints system'. www.healthwatch.co.uk, Healthwatch England.
- Holder, J M and Jolley, D (2012). 'Forced relocation between nursing homes: Residents' health outcomes and potential moderators.' *Reviews in Clinical Gerontology* 22(04): 301-319.
- Hood, C, Scott, C, James, O, Jones, G and Travers, T (1999). *Regulation inside government. Wastewatchers, quality police, and sleaze-busters*. Oxford, Oxford University Press.
- Ikegami, N, Ishibashi, T and Amano, T (2014). 'Japan's long-term care regulations focused on structure - rationale and future prospects'. *Regulating long-term care quality: An international comparison*. V. Mor, T. Leone and A. Maresso. Cambridge, Cambridge University Press: 121-143.
- Jolley, D, Jefferys, P, Katona, C and Lennon, S (2011). 'Enforced relocation of older people when care homes close: A question of life and death?' *Age and Ageing* 40(5): 534-537.
- Konetzka, R T and Werner, R M (2010). 'Applying market-based reforms to long-term care.' *Health Affairs* 29(1): 74-80.
- Le Grand, J (2003). *Motivation, agency, and public policy: Of knights and knaves, pawns and queens*. Oxford Oxford University Press.
- Leichsenring, K, Hoffman, F, Schmidt, A, Rodrigues, R and Ruppe, G (2014a). 'Performance measurement in long-term care in austria'. *Regulating long-term care quality: An international comparison*. V. Mor, T. Leone and A. Maresso. Cambridge, Cambridge University Press: 33-66.
- Leichsenring, K, Winkelmann, J and Rodrigues, R (2014b). 'To make or to buy long-term care iii: Quality assurance to avoid market-failure'. *Policy Brief, November 2014*, European Centre.
- Leone, T, Maresso, A and Mor, V (2014). 'Regulating the quality of long-term care -- what have we learned?'. *Regulating the quality of long-term care quality: An international comparison*. V. Mor, T. Leone and A. Maresso. Cambridge, Cambridge University Press.
- Malley, J (2010). 'Measuring the quality of long-term care in England.' *Eurohealth* 16(2): 21-24.
- Malley, J and Fernández, J-L (2010). 'Measuring quality in social care services: Theory and practice.' *Annals of Public and Co-operative Economics* 81(4): 559-582.
- Malley, J, Holder, J, Dodgson, R and Booth, S (2014). 'Regulating the quality and safety of long-term care in England'. *Regulating long-term care quality: An international comparison*. V. Mor, T. Leone and A. Maresso. Cambridge, Cambridge University Press: 180-210.
- Miller, E A and Mor, V (2006). *Out of the shadows: Envisioning a brighter future for long-term care in america*, Brown University.
- Miller, S C, Miller, E A, Jung, H Y, Sterns, S, Clark, M and Mor, V (2010). 'Nursing home organizational change: The "culture change" movement as viewed by long-term care specialists.' *Medical Care Research and Review* 67(4 suppl): 65S-81S.
- Mor, V (2010). 'Public reporting of long-term care quality: The us experience.' *Eurohealth* 16(2): 14-17.
- Mor, V, Leone, T and Maresso, A (2014). *Regulating long-term care quality: An international comparison*. Cambridge, Cambridge University Press.
- Mukamel, D B, Ladd, H, Weimer, D L, Spector, W D and Zinn, J S (2009). 'Is there evidence of cream skimming among nursing homes following the publication of the nursing home compare report card?' *Gerontologist* 49(6): 793-802.
- Mukamel, D B, Spector, W D, Zinn, J S, Huang, L, Weimer, D L and Dozier, A (2007). 'Nursing homes' response to the nursing home compare report card.' *J Gerontol B Psychol Sci Soc Sci* 62(4): S218-225.
- Murakami, Y and Colombo, F (2013a). 'Regulation to improve quality in long-term care'. *A good life in old age? Monitoring and improving quality in long-term care*. O. E. Commission, OECD Health Policy Studies, OECD Publishing.
- Murakami, Y and Colombo, F (2013b). 'Why the quality of long-term care matters'. *A good life in old age? Monitoring and improving quality in long-term care*. O. E. Commission, OECD Health Policy Studies, OECD Publishing.

- Netten, A, Trukeschitz, B, Beadle-Brown, J, Forder, J, Towers, A-M and Welch, E (2012). 'Quality of life outcomes for residents and quality ratings of care homes: Is there a relationship?' *Age and Ageing*.
- Office of Fair Trading (2011). 'Evaluating the impact of the 2005 oft study into care homes for older people. Prepared for the office of fair trading by ghk', Office of Fair Trading.
- Österle, A and Bauer, G (2012). 'Home care in austria: The interplay of family orientation, cash-for-care and migrant care.' *Health and social care in the community* 20(3): 265-273.
- Productivity Commission (2011). 'Caring for older australians. Report no. 53, final inquiry report'. Canberra.
- Rahman, A N and Schnelle, J F (2008). 'The nursing home culture-change movement: Recent past, present, and future directions for research.' *The Gerontologist* 48(2): 142.
- Reerink, E (1990). 'Defining quality of care: Mission impossible?' *Quality Assurance in Health Care* 2(3/4): 197-202.
- Rogers, E M (2003). *Diffusion of innovations*. New York, Free Press.
- Schneider, U, Sundström, G, Johansson, L and Tortosa Chuliá, A (forthcoming). 'Policies to support informal care'. *Long-term care reforms in oecd countries: Successes and failures*. J. L. Fernández and C. Gori, Policy Press.
- Shugarman, L and Brown, J (2006). 'Nursing home selection: How do consumers choose? Volume i: Findings from focus groups of consumers and information intermediaries', Rand Corporation.
- Spilsbury, K, Hewitt, C, Stirk, L and Bowman, C (2011). 'The relationship between nurse staffing and quality of care in nursing homes: A systematic review.' *International Journal of Nursing Studies* 48(6): 732-750.
- Stevenson, D and Bramson, J (2014). 'Regulation of long-term care in the united states'. *Regulating long-term care quality: An international comparison*. V. Mor, T. Leone and A. Maresso. Cambridge, Cambridge University Press: 289-323.
- Trigg, L (2014). 'Using online reviews in social care.' *Social Policy & Administration* 48(3): 361-378.
- Trukeschitz, B (2010). 'Safeguarding good quality in long-term care: The austrian approach.' *Eurohealth* 16(2): 17-20.
- Trukeschitz, B (2011). 'Worauf es letztlich ankommt: Ergebnisqualität in der langzeitpflege und betreuung [quality of outcomes in long-term care].' *Kurswechsel* 26(4): 22-35.
- Trukeschitz, B and Schneider, U (2012). 'Long-term care financing in austria'. *Financing long term care in europe: Institutions, markets and models*. J. Costa-Font and C. Courbage. Basingstoke, Palgrave Macmillan: 187-212.
- Vaiana, M E and McGlynn, E A (2002). 'What cognitive science tells us about the design of reports for consumers.' *Med Care Res Rev* 59(1): 3-35.
- Werner, R M, Konezka, R T and Kruse, G B (2009). 'Impact of public reporting on unreported quality of care.' *Health services research* 44(2p1): 379-398.
- Werner, R M, Tamara Konezka, R and Liang, K (2010). 'State adoption of nursing home pay-for-performance.' *Medical Care Research and Review* 67(3): 364-377.
- Wiener, J M, Tilly, J, Howe, A, Doyle, C, Evans Cuellar, A, Campbell, J and Ikegami, N (2007). 'Quality assurance for long-term care: The experiences of England, australia, germany and japan'. Washington, DC, AARP,.