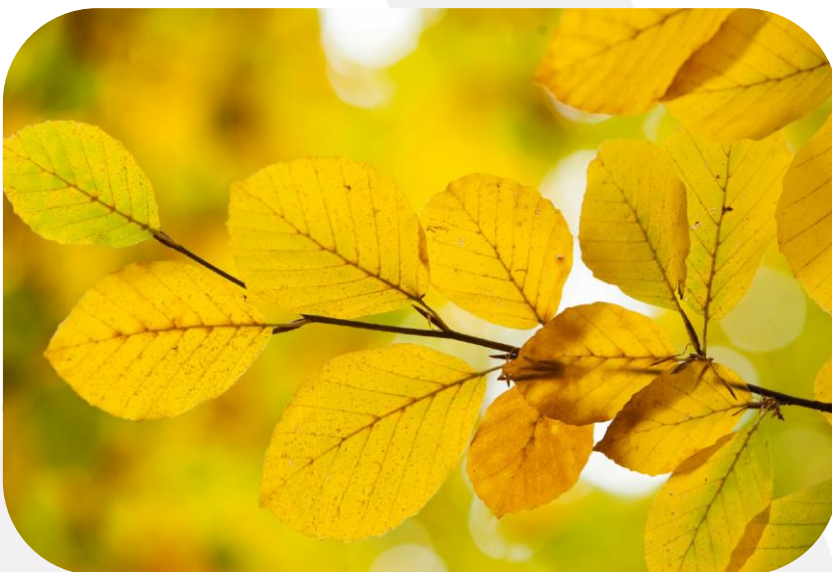


Approaches to the regulation and financing of home care services in four European countries

An evidence review



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Published by:

Health Research Board, Dublin
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Acknowledgements

The authors would like to thank Patricia Lee and Barry Murphy, Services for Older People, at the Department of Health for requesting this review. We would also like to thank Dr Jean Long of the HRB for commissioning us to complete the review. Many thanks to Dr Stephen Kinsella for his assistance in reviewing economic papers and giving his economic overview to this evidence review. We are also grateful to our peer reviewers, Dr Teija Hammar, Dr Kerry Allen and Dr Ricardo Rodrigues, for their helpful comments.

Acronyms and abbreviations

ADL	activities of daily living
CAK	Central Administration Office (the Netherlands)
CHPs	Community Health Partnerships (Scotland)
CIZ	Centre for Indication of Care (the Netherlands)
EU	European Union
GDP	gross domestic product
HRB	Health Research Board (Ireland)
HSE	Health Service Executive (Ireland)
IADL	instrumental activities of daily living
IGZ	Health Care Inspectorate (the Netherlands)
ISO	International Organization for Standardization
IVO	Health and Social Care Inspectorate (Sweden)
LTCI	Long-Term Care Insurance (Germany)
MDK	Medical Board of the Health Insurances/Medical Review Boards (Germany)
NBHW	National Board of Health and Welfare (Sweden)
NCSC	National Care Standards Committee (Scotland)
NHS	National Health Service (Scotland)
NPM	new public management
NZa	Dutch Healthcare Authority (the Netherlands)
OECD	Organisation for Economic Co-Operation and Development
PVG	Protection of Vulnerable Groups (Scotland)
QFRC	Quality Framework for Responsible Care (the Netherlands)
QMS	quality management system (Germany)
SCQF	Scottish Credit and Qualification Framework (Scotland)
SKL	Swedish Association for Local Authorities and Regions (Sweden)
SSSC	Scottish Social Services Council (Scotland)
SVQ	Scottish Vocational Qualification (Scotland)
UKHCA	United Kingdom Homecare Association
WHO	World Health Organization

Glossary

Activities of daily living (ADL): Functional tasks relating to personal care such as bathing, eating, toileting and dressing

Cash benefits: Government assistance in the form of cash that is transferred to a care recipient, family carer or informal carer to purchase care services

Domestic care: Support given to care recipients for instrumental activities of daily living, so they can live independently in their home

Formal care: Professional care paid for by recipients, family members or the State

In-kind benefits: State benefits given in the form of goods or services rather than money

Informal care: Unpaid care given to recipients by family members, friends or neighbours

Instrumental activities of daily living (IADL): Daily tasks such as cooking, shopping, driving and administering medication

Long-term care: A range of care services (i.e. home or residential care) needed by persons with physical or cognitive care needs, and who are dependent on help with ADL over a prolonged time period

Home care: Care provided to persons with physical or cognitive impairments for ADL or IADL in order for them to live independently in their own home. Home care can include domestic care, personal care, and home healthcare.

Home healthcare: Nursing and rehabilitative services given to persons in their home to assist with illnesses or conditions

Personal budget: An allocation of funding given to a care recipient through direct payments (as in Scotland) or through a voucher system (as in the Netherlands) allowing care users to choose personalized care services

Personal care: Care given to persons to assist with ADL

Social home care: Domestic and personal care that assists care recipients with ADL and IADL

Executive summary

Introduction

This evidence review describes approaches to the regulation and financing of formal home care services in four European countries. It looks at the evidence from four European countries, with the aim of describing regulatory measures, such as legislation, national standards, staff and provider accreditation, eligibility and needs assessment, financing of regulation, and the financing of formal home care services themselves. This will help to inform the debate around future consideration of approaches to formal home care regulation and financing in the Irish context.

Purpose

Home support services provided to older people in their own homes are not subject to statutory regulation in Ireland. An increasingly ageing population and the shift away from residential care towards keeping people in their homes have increased focus on the home care sector. With the proportion of many countries' old age population set to increase over the next number of decades, many governments are beginning to create sustainable and cost-efficient care measures for this demographic. The Department of Health in Ireland is currently undertaking work to develop a new statutory formal home care scheme for older people; this evidence review is part of the preparatory work undertaken to inform the regulation and financing of such a scheme.

The primary aim of the review is to describe evidence on the approaches to the regulation and financing of formal home care services, particularly for older people, in four countries – Germany, the Netherlands, Sweden, and Scotland.

Research questions

Three overarching research questions guided this evidence review, with a range of specific sub-questions to gain more understanding, within each one:

1. Describe the regulation of formal home care services in the selected countries.
 - a. Legislative or guidelines-based framework for formal home care services
 - b. National standards for formal home care services
 - c. Registration/licensing and/or accreditation of formal home care services and its process
 - d. Registration/licensing and/or accreditation of formal home care staff and its process
 - e. Home care provider and staff training requirements, competencies, and assessment
 - f. Inspections regime and routine monitoring (including performance indicators) for formal home care services with respect to the application of relevant national standards
 - g. Cost of regulation of formal home care services, and who funds the regulatory regime.

2. Describe the (staff and client) experiences of, and effectiveness of, regulation for formal home care in the selected countries.
 - a. Client experiences of regulation
 - b. Staff experiences of regulation
 - c. Baseline assessments at the introduction of regulation
 - d. Continuous monitoring of regulation
 - e. Reviews and evaluations of the effects of regulation.

3. Describe the approaches to assessing, financing and financial management of formal home care services in the selected countries.
 - a. Eligibility
 - b. Entitlement and basket of services,
 - c. Mix of funding mechanisms
 - d. Financial management
 - e. Does provision fall short of needs (rationing)?

Methods

The methods employed for this evidence review began with the undertaking of an initial scoping exercise to understand the scope of published materials pertaining to formal home care regulation and financing. This scoping review highlighted several large-scale European Commission, Organisation for Economic Co-operation and Development (OECD), and World Health Organization (WHO) projects on different aspects of formal home care service provision, particularly pertaining to older people. These results were supplemented with a comprehensive search of Medline and other health-oriented journal article/official databases, broader databases such as Google, the European Commission website, additional project websites, and subsequently some reference chasing and information gap filling. The information search was somewhat limited by a shortage of explicit evidence pertaining to the effects of regulation on formal home care services and, thus, not all research questions, particularly Question 2, could be answered comprehensively. The review was completed between July and December 2016.

Findings

Question 1 Regulation of formal home care

There are several similarities and differences, regarding how the four countries (selected for this review) regulate their formal home care sectors. All four countries fit the criteria of a 'framework type' of governance with an explicit national policy covering long-term care, including formal home care services; the overall provision of home care is decentralized to municipalities or regions. Thus, the national government has overall control of the vision for home care, but regional governments oversee the selection of home care services that will be publicly funded, administering how these services are delivered, setting prices including those of co-payments, and agreeing eligibility criteria. Support to keep people living in their own homes is the main principle underpinning home care policy in all four countries. There is a long tradition of regulated formal home care in the Netherlands and Scotland; whereas regulated formal home care was introduced later in Sweden and Germany. In the Netherlands and Germany home care is funded through compulsory insurance. Personalised

budgets or voucher systems are a feature of home care provision in all four countries. Such payment methods are intended to support the principle of user choice but they may also be a method of controlling costs, as indicated in the findings for Question 3.

Three (Germany, Netherlands, and Scotland) of the four countries have a clear national set of standards for home care services that are guided by legislative acts. In addition, the three countries have an independent inspectorate to assess quality standards. Only Sweden does not have explicit national quality standards, as standards are determined at individual municipal level. Quality standards have been determined by the regulator(s) in Germany, the Netherlands and Scotland; with care providers offering some input into quality standard development in Germany and patient organisations contributing to quality standard development in the Netherlands. In Scotland, a broad church of people and organisations (including the regulator) contributed to the development of Scottish standards for formal home care. Standards pertaining to home care services in Scotland and Sweden are also explicitly concerned with the protection of vulnerable persons.

To achieve accreditation, home care service providers in Germany and the Netherlands are expected to operate using a quality management system, such as ISO 9001, to guide their own in-house quality management, while also ensuring that staff are properly qualified and suitably remunerated. Annual audits are carried out by external bodies in Germany and the Netherlands to assess adherence to quality under the ISO standards, and accreditation is awarded if the audits meet the standards. Scotland and Sweden operate a national compulsory registration scheme. The Care Inspectorate in Scotland use nationally agreed standards to assess applicants as to their suitability as care providers for first registration and annual re-registration. In Sweden accreditation criteria are determined at municipal level which indicates that they may differ in each municipality.

Germany, the Netherlands and Scotland have minimum training criteria required for home care workers. The correlation between the levels of minimum staff training and common home care worker grades is relatively similar across the three countries. Sweden is perceived to have good levels of basic training for home care workers, however there is no regulated minimum training requirement.

As mentioned earlier, each country has developed quality/performance indicators related to their national quality standards, except in the case of Sweden where standards and quality are determined at individual municipal level. In Germany and Scotland random inspections are carried out on home care providers annually to ensure standards are adhered to, and in addition, specific complaints are investigated separately. The Netherlands monitor home care services via annual surveys and inspections are only carried out in response to specific complaints. In Sweden, both regular inspections and responses to specific complaints are carried out alongside monitoring via surveys conducted twice yearly. Transparency is a guiding principle in Germany, the Netherlands and Sweden, where they publish results of home care service quality inspections on publicly accessible websites, with the aim of facilitating informed choice for home care recipients. Germany, the Netherlands, and Scotland operate sanctions if quality standards are not adhered to. Conversely, in Sweden they operate a reward based-system to meet required standards.

In each country, regulatory bodies are or appear to be partly funded through contributions made by recipients of care via long-term care insurances, or by registration fees paid by care providers. The evidence available suggests that in Germany and the Netherlands regulation is paid for via the insurers (Germany) or through tax-funded municipalities (the Netherlands). In Sweden, each municipality relies on a self-regulation model and the evidence available suggests that the municipalities pay for this out of collected tax funds. Regulation by the Care Inspectorate in Scotland is funded through its annual grant, as well as monies accrued from registration fees for new providers and re-registration fees for existing providers.

Question 2 Measurement of the regulation of formal home care

There is a lack of relevant available evidence about experiences of regulation of the formal home care sector. Information that can be tenuously attributed to care recipient (client) and staff experiences of the regulation of home care services was gleaned from papers discussing reports on more generalized user and staff surveys. These surveys are typically undertaken annually or biennially; however, in Sweden, user satisfaction surveys are conducted twice a year. There was no evidence pertaining to care recipient's experiences of regulation of the formal home care sector rather the surveys assessed recipients' satisfaction with the services received and the majority of users were satisfied. Reported evidence suggests that care staff in particular have low satisfaction with their experiences of regulation in the formal home care sector, for example, home care staff reported that the minimum training requirements were high but the pay rate and working conditions did not meet minimum training requirements. We did not find any available evidence pertaining to baseline assessments, continuous monitoring and reviews and evaluation of the effects of formal home care regulation, as this type of appraisal of services does not appear to be undertaken, or if undertaken, does not appear to be published in English.

Question 3 Approach to financing home care

Germany and the Netherlands have long-established long-term care insurance schemes which have also facilitated the provision of formal home care services that have been subject to some change through recent reforms. The reforms have included revised needs assessments and eligibility entitlements alongside the introduction of increased or additional co-payments. Scotland and Sweden have a long-standing rights-oriented home care services sector, which are increasingly being rationed by stricter eligibility criteria and the introduction of fixed fee services and co-payments.

Need rather than the ability to pay for home care services is an underlying principle of all four countries formal home care provision. All four countries have formal needs assessment which contain documented eligibility criteria that allows a fair and comparative assessment as to the need for formal home care and the level of requirements in each geographical area. Recent reforms across all four countries have tightened up eligibility criteria to contain costs. Germany is particularly transparent about entitlements to home care benefits as they correspond to each care grade based on level of need. For the other three countries, the interpretation of the needs assessment with respect to services provided is not transparent in the published literature. All four countries encourage some level of informal care by close relatives to help fill the home care requirement; this is notable and transparent in the financial organisation of the German formal home care system. For example, the German

long-term care insurance charges more for childless adults, but allows for families to provide some of the formal home care requirements themselves and use the care-allowance for higher-level requirements.

The basket of formal home care services in the four countries include personal care and help with household tasks. Nursing care is included in the basket of services in Germany, the Netherlands and Scotland. Nursing care is provided through a separate assessment process in Sweden. Household tasks are handled differently in Scotland and the Netherlands. In Scotland, the recipient must pay for any housekeeping tasks if they earn over £16,000, while in the Netherlands, a cleaning company may be employed in a municipality to attend all household tasks required by older people in need. Sweden's basket of services includes emotional and social support. All four countries have an element of user choice as to how services are provided to address formal home care requirements, with services typically offered in kind or via personal cash budgets, direct payment, or voucher systems.

Each of the four countries has their own specific funding mechanisms and financial management system for formal home care provision. Germany and the Netherlands have commonalities in their funding systems as their formal home care is funded by a compulsory long-term insurance and co-payments, though the co-payments in Germany are higher than in the Netherlands. Formal home care in Scotland and Sweden is funded through national and local taxes with small co-payments for all services in Sweden and payment for household tasks by those who can afford to in Scotland. Of note, the four countries are increasing or introducing co-payments to fund the provision of home care services as well as tightening eligibility requirements in order to deal with increasing demand.

In general, the literature on the four countries reported that the supply of formal home care could meet the demand but their actions within the home care supply system indicate that countries have taken interventions to either restrict formal home care supply or fund additional demand. For example, Germany has increased the long-term insurance premium for childless couples, increased co-payments to 30% of the total formal home care costs, tightened the criteria for how much home care people can receive, and expects families to provide informal care where the formal home care service cannot meet the demand. The Netherlands has waiting lists and has reduced its needs-based service allocation by tightening access criteria. Scotland has increased the budget allocated to home care and asked citizens who can afford it to pay for home help. Sweden has also tightened criteria entitling its citizens to home care and allowing tax free credits for any private home care that tax payers pay for their elderly relatives.

Conclusion

There are several principles included in regulated home care such as standards, transparency, consultation, choice, equity, and sustainability. These principles are implemented through legislation, policy, strategy, service planning and financing.

Standards in home care are based on best practice which is generally agreed between stakeholders, and implemented through an accreditation, training, monitoring, and inspection process. Monitoring agencies also investigate complaints. Standards in formal

home care services use transparent performance indicators and public reporting in order to ensure that users can make an informed selection of home care provider.

Consultation is a major principle in regulated home care and is achieved through care recipients and other stakeholders having a voice in the development of standards. Care recipient's own needs assessment and care planning as well as surveys on user satisfaction help to facilitate the consultation process. In addition, most countries and their citizens explicitly agree that home care is preferable to residential care where possible. The wider approach of having a basket of services which individuals can select services to meet their needs rather than a one size fits all approach also enhances consultation and promotes user choice.

Patient choice is an ideal in many strategies and is implemented through choice of services, choice of funding approach (personal budget or service provision) and choice of provider. As already mentioned choice of provider is facilitated through access to publicly available quality reports.

Equity is another principle that runs through access to formal publicly funded home care and is implemented through standardized health needs assessment, services provision based on need and means adjusted payments.

Sustainability is approached in a very thorough manner in Germany and the Netherlands through compulsory long-term care insurance and means adjusted co-payments. In tax-based countries sustainability is introduced by increasing tax-based funding, raising the threshold for access to formal home care so that only people with the highest level needs are cared for, introducing or increasing co-payments, and charging full costs for services where people can afford to pay. Personal budgets are also used to control costs.

The foremost cost in home care is paying for trained carers. Nevertheless, controlling costs in formal home care can result in reduced pay for trained carers, reduced hours of care, or the use of untrained carers who will work for a lower hourly rate. The downside of personal budgets may be a lack of implementation of regulated standards and a lowering of the quality of care.

1 Introduction

This report presents the findings of a review of evidence carried out on behalf of the Evidence Centre in the Health Research Board (HRB) by a team comprising Dr Rachel A Kiersey and Mr Alan Coleman, with assistance in reviewing economic papers provided by Dr Stephen Kinsella. The evidence review was requested by the Department of Health (DoH) in Ireland. Evidence reviews are undertaken as part of a knowledge brokering service offered to policy-makers in the DoH by the Research Services Unit in the DoH in collaboration with the HRB Evidence Centre. The questions were set by DoH policy makers through an iterative process with the DoH Research Services Unit and the HRB Evidence Centre.

1.1 Purpose of evidence review

There has been an international shift away from institutional (residential) care towards a more community-led, home-focused care regime. The proportion of many countries' old age population is set to increase; the European Commission 2015 Ageing Report suggests that the demographic old-age dependency ratio is set to nearly double throughout the period 2013-2060.¹ Accordingly, many governments are beginning to create sustainable and cost-efficient care measures for this demographic. Formal home care and home support services provided to older people in their own homes are not subject to statutory regulation in Ireland. The Health Service Executive (HSE) has operational responsibility for planning, managing and delivering formal home and community-based services for older people. It is estimated that about 20% of the population aged 65 years and over receive some form of home or community-based support service annually from the State. This includes a formal home help service and formal home care packages for clients with more complex needs which, as well as additional home help hours, may include nursing and therapy services, short-stay residential care, day care and meals on wheels. Services are delivered either directly by HSE staff, or on its behalf by a combination of private and voluntary/not-for-profit providers.

This evidence review does not include a focus on evidence pertaining to informal care services as the Department of Health are not currently undertaking any work to regulate the informal home care sector. As such all references to home care throughout the evidence review, unless otherwise stated, should be taken to mean formal home care.

There is currently no statutory regulation in place for formal home care services in Ireland. This review looks at evidence from four European countries, with the aim of establishing an understanding of components on regulatory measures such as legislation, national standards, staff and provider accreditation, eligibility and needs assessment; the financing of regulation, and the financing of services. Establishing an understanding of formal home care regulation and financing in a selection of different countries will help to inform the debate around future consideration of approaches to this issue in the Irish context.

The primary aim of this review is to describe evidence on the approaches to the regulation and financing of formal home care services in four countries – Germany, the Netherlands, Sweden, and Scotland. The Department of Health in Ireland is currently undertaking work to develop a new statutory formal home care scheme for older people; this evidence review is

part of the preparatory work undertaken to inform the regulation and financing of such a scheme.

1.2 Research questions

Three central research questions guide the evidence review, each with specific sub-questions that are trying to gain a deeper understanding of the key components of the regulation and financing of formal home care services:

1. Describe the regulation of formal home care services in the selected countries.
 - a. Legislative or guidelines-based framework for home care services
 - b. National standards for home care services
 - c. Registration/licensing and/or accreditation of home care services and its process
 - d. Registration/licensing and/or accreditation of home care staff and its process
 - e. Home care provider and staff training requirements, competencies, and assessment
 - f. Inspections regime and routine monitoring (including performance indicators) for home care services with respect to the application of relevant national standards
 - g. Cost of regulation of home care services, and who funds the regulatory regime.

This first research question is primarily focused on describing aspects of the regulation of formal home care services in Germany, the Netherlands, Scotland, and Sweden.

2. Describe the (staff and client) experiences of, and effectiveness of, regulation for formal home care in the selected countries.
 - a. Client experiences of regulation
 - b. Staff experiences of regulation
 - c. Baseline assessments at the introduction of regulation
 - d. Continuous monitoring of regulation
 - e. Reviews and evaluations of the effects of regulation.

The second research question focuses on describing staff and client experiences of the regulation of the formal home care sector in the four case countries and the effect of such regulations on homecare.

3. Describe the approaches to assessing (eligibility, needs assessment and entitlement), financing and financial management of formal home care services in the selected countries.
 - a. Eligibility
 - b. Entitlement and basket of services,
 - c. Mix of funding mechanisms
 - d. Financial management
 - e. Does provision fall short of needs (rationing)?

The Department of Health want us to describe how each of the four countries, Germany, the Netherlands, Scotland, and Sweden approach the financial management of the formal home care sector.

1.3 Background

Since the 1980s and 1990s home care policy and service provision has been evolving across Europe, where it has increasingly been influenced by the backdrop of new public management ideology. The concept of new public management, which originated in the 1980s, aims to reform the public sector and public policy, including social welfare provision, using market-led principles to increase cost efficiency and legitimise the introduction of competition.² The decentralization of services and an increase in policy actors tend to be key characteristics of new public management.³ Competitive measures such as competitive tendering and contracting of services are also driving features of new public management.³

1.3.1 Definition of home care

Home care provision can differ considerably between countries. Therefore, it is important to establish what exactly is understood by use of the term home care, both in Ireland and internationally. There is no universal standardized definition of home care; nevertheless, Boerma and Genet⁴ have attempted to clarify an understanding of home care, which correlates with how home care is generally perceived across Europe:

‘Home care can be conceived of as any care provided behind someone’s front door or, more generally, referring to services enabling people to stay living in their home environment. In some countries, “someone’s front door” can include a home for the elderly. As regards the type of services, home care may refer to care given only by professionals or in combination with care given by a spouse or relative (personal care or housekeeping).’⁴

The Organisation for Economic Co-Operation and Development (OECD)⁵ has also attempted to clarify an understanding of what we mean by long-term care services at home:

‘[Home care] is provided to people with functional restrictions who mainly reside in their own home. It also applies to the use of institutions on a temporary basis to support continued living at home – such as in the case of community care and day-care centres and in the case of respite care. Home care also includes specially designed, “assisted or adapted living arrangements” for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control.’⁵

These definitions have helped guide this study when looking for international evidence on formal home care and long-term care. Nonetheless, this evidence review describes formal home care policy from four countries within the context that it is understood in Ireland. Home care in Ireland is typically understood as home help services, which include cleaning, cooking and other light household tasks that a person is unable to do themselves due to old age or disability. The scope of home help has subsequently developed to include more personal care assistance such as support with personal hygiene, washing, and dressing also.

1.3.2 Home care in Ireland

Irish long-term care policy has shifted towards providing care for the elderly in their own home rather than in institutions. However, there is an absence of national regulatory mechanisms in place to ensure that the highest level of quality is received within the formal home care sector.⁶⁻⁹ There is also a disparity in regulatory measures between private providers and public providers of formal home care services.¹⁰ This regulatory disparity has led to a number of issues within the Irish home care sector, such as high fees, varied quality among home care services and their standards, and poor working conditions for carers.¹¹

Government policy supporting older people to stay at home emerged in the 1960s in Ireland, with minor progression in home and community support services over the following four decades.⁶ Legislation and development of regulations have not yet caught up with contemporary social developments that have occurred in Irish society, such as an increase in home care funding since the 2000s.⁶ Ireland's governance approach to formal home care is described as a '*laissez-faire* type' by Genet *et al.*¹² This means that the Government plays a weak role in providing a national vision on formal home care. There is no national definition of eligibility and entitlements, and thus non-profit and private providers play a significant role in deciding the eligibility criteria for formal home care services.¹³

In 2005, the Irish Government first considered introducing policies that would allow for a financially sustainable long-term care service, and it established an Interdepartmental Working Group to advance policy development opportunities.⁶ The Working Group recommendations included producing specific national standard guidelines on the quality of home care and creating national guidelines on the eligibility criteria for formal home care services. The aim of these recommendations was to ensure uniformity on a national scale.⁶

Home care services in Ireland have traditionally focused on providing instrumental activities of daily living (IADL), which include housework such as cleaning and cooking as well as shopping tasks.⁸ With the proportion of elderly within the population increasing, formal home care in Ireland has expanded to include personal care, such as bathing and help with getting dressed.⁸ In 2015, 47,915 care recipients over the age of 65 received 10.4 million home help hours.¹⁴ A further 15,272 care recipients aged over 65 received a formal home care package.¹⁴ Therefore, formal home care provided to older people falls into two main categories: home help and home care packages.¹⁵ The Home Care Package Scheme was introduced in 2005 to offer a more personalized home care support service for older people when basic domestic and personal care was not sufficient, and a more enhanced level of care was also needed.^{6, 16} Both home help and home care services are delivered through the Health Service Executive (HSE) via the Home Care Package Scheme. Ireland's formal home care providers, similar to those in a number of other countries, are in the public, private and non-profit sectors.⁶ The HSE is the public body responsible for commissioning Home Care Packages, and employs a substantial proportion of social care staff as part of the Home Care Package Scheme introduced in 2005.^{8, 9, 15} The HSE is also responsible for issuing tenders for contracts to private services.

The main source of funds used to finance home care is from taxes via the General Fund, allocated to the Department of Health within each annual budget.^{6, 9} The allocated budget

amount is managed by the HSE on a national scale, with Local Health Offices given responsibility for the distribution of a budget on a local scale.^{6,9} Even with the increased diversity of service providers in the home care sector, 97% of formal care is publicly funded.¹⁶ However, there have been cuts to the funding of care services in recent years. In 2015, funding allocated for both home help and home care packages was €320 million, which represented an €11 million decrease on 2008, when the total spend on home care services was €331 million.¹⁵

1.3.3 International approaches

Across European jurisdictions, there are a range of long-term care models which are often developed in accordance with a jurisdiction's welfare regime and are dependent on the evolution of institutions over a long period of time.¹⁷ Models of long-term care range 'from highly integrated systems reliant on public provision with limited private alternatives to highly privatised systems where family is the key provider and the role of the public system is merely residual'.¹⁷ As Table 1 shows, there are four typologies into which some of the different long-term care regimes in European countries have been categorized.¹⁸ The Scandinavian countries as well as the Netherlands have a universal long-term care system and have the highest expenditure on long-term care in Europe.¹⁷

Genet *et al.*¹² defined three types of governance approaches to home care across European countries: 'framework', 'centralized' and 'laissez-faire'. The *framework* type of governance is the most common and can be seen in Nordic countries, Germany, England, the Netherlands, and Switzerland. This style of governance has a higher level of decentralized decision-making, with non-State actors having significant decision-making powers and a nation-wide home care vision. The *centralized* countries' national government plays the principal role in governing the home care sector and has a home care vision in place, including producing broad regulations. The *laissez-faire* approach, which can be seen in countries such as Bulgaria and Romania, as well as Ireland, usually has a weak government role and no vision for home care regulations, with eligibility criteria often set by voluntary and private providers.¹²

Funding of formal home care services varies considerably throughout each country, and depends on the type of care being provided: domestic help, home healthcare, personal care. National and local bodies involved in the financing of home care also vary, as public funding and spending responsibilities can be given to national, regional, local or a mix of authorities, depending on the country.¹² The source of home care funding typically comes from a number of different resources, which include taxation, insurance, co-payments or private donations.¹²

Table 1 Typologies of care in European countries

	Demand for care	Provision of informal care	Provision of formal care	Countries
Standard care mix	High	Medium/Low	Medium	Germany, Austria, France, United Kingdom
Universal-	Medium	Low	High	Sweden,

	Demand for care	Provision of informal care	Provision of formal care	Countries
Nordic				Denmark, The Netherlands
Family-based	High	High	Low	Spain, Italy, Portugal, Ireland, Greece
Transition	Medium	High	Medium/Low	Latvia, Poland, Hungary, Romania, Slovakia, Czech Republic

Source: Reproduced from Ilinca *et al.*, 2015¹⁸

There are three typical ways in which home care users contribute to their public formal home care services – free of charge, means-tested co-payments, or fixed co-payments. Certain European countries offer universal home care services, which means that home care services are free of charge for all citizens.¹² Payment types differ depending on whether service provision is from a health or social home care service.¹² When it comes to retrieving information on the financing of private providers, Genet *et al.*¹² point out that ‘little is known about the privately financed home care sector although this is the main provider of home care in many countries, especially in eastern Europe, Portugal and Greece’.¹²

1.4 Choice of countries

The authors undertook an initial scoping exercise to understand the extent of published materials pertaining to formal home care regulation. This highlighted several large-scale European, OECD, and World Health Organization (WHO) projects that have been undertaken on different aspects of home care service provision. Having considered these large-scale projects that were undertaken on myriad aspects of home care service provision, the authors decided to focus on European states only. While none of the projects are particularly focused on the regulation of formal home care services alone, some do observe regulation as part of the overall examination of countries formal home care services. The projects are:

- the EURHOMAP project – *Home Care Across Europe*
- the IBenC project – *Identifying best practices for care-dependent elderly by benchmarking costs and outcomes of community care*
- the INTERLINKS project
- ANCIEN – *Assessing Needs of Care in European Nations* project
- *Make or Buy – Long-term Care Services in Sweden: Lessons for Policy*
- the OECD reports *A Good Life in Old Age? Monitoring and improving quality in long-term care*, and *Help Wanted? Providing and Paying for Long-Term Care*
- the LIVINDHOME project – *Living independently at home – Reforms in home care in 9 European countries*.

The four countries were chosen as they display characteristics of each of the different dominant healthcare sector funding typologies across European states. This is illustrated in

Table 2 with information reproduced and modified from Mossialos *et al.*, 2016¹⁹ for Germany, the Netherlands, and Sweden, and from *OECD Reviews of Health Care Quality: United Kingdom 2016: Raising Standards*²⁰ for the information pertaining to Scotland. Each of the chosen countries also correspond with the retrieval of a high number of pertinent papers. For example, evidence relating to Germany was presented in at least 42 of the retrieved papers; at least 39 papers presented evidence relating to the Netherlands, and at least 31 papers presented evidence relating to Sweden. Evidence relating to Scotland was presented in less of the retrieved resources but was nonetheless chosen for its proximity and geographical similarity to Ireland.

Table 2 Healthcare system financing and private insurance role

Country	Government role	Public system financing	Voluntary private insurance role
Germany	Statutory health insurance system, with 124 competing SHI insurers (“sickness funds” in a national exchange); high income can opt out for private coverage.	National social health insurance system. Employer/employee earmarked payroll tax; general tax revenue	~11% opt out from statutory insurance and buy substitutive coverage. Some complementary (minor benefit exclusions from statutory scheme, co-payments) and supplementary coverage (improved amenities).
The Netherlands	Statutory health insurance system, with universally mandated private insurance (national exchange); government regulates and subsidizes insurance.	Private compulsory health insurance Earmarked payroll tax; community-rated insurance premiums; general tax revenue.	Private plans provide statutory benefits; 84% buy complementary coverage for benefits excluded from statutory package such as dental care, alternative medicine, physiotherapy, eyeglasses, contraceptives, and co-payments.

Country	Government role	Public system financing	Voluntary private insurance role
Scotland	National Health Service (NHS)	Tax-based public funding scheme. General tax revenue (includes employment-related insurance contributions)	Not applicable in the case of Scotland; health services in Scotland are government funded and almost entirely financed by taxation. ²⁰ Approximately 8.5% of people have voluntary private health insurance.
Sweden	National healthcare system. Regulation, supervision, and some funding by national government; responsibility for most financing and purchasing/provision devolved to county councils.	Tax-based public funding scheme. Mainly general tax revenue raised by county councils, some national tax revenue	~10% of all employed individuals aged 15–74 get supplementary coverage from employers for quicker access to specialists and elective treatment

Source: Modified from Mossialos *et al.*, 2016¹⁹ and OECD, 2016²⁰

1.5 Outline of review

The rest of the evidence review is set out as follows. Chapter 2 details the methodology employed to conduct the review. Chapter 3 answers Research Question 1 discussing the regulation of formal home care services in Germany, the Netherlands, Scotland and Sweden, each sub question is a section and there is a synthesis summary at the end of each. Chapter 4 answers Research Question 2 discussing the staff and client experiences of home care regulation as well as the effectiveness of home care regulation in these four countries. Chapter 5 answers Research Question 3 discussing the approaches to accessing and managing finances in the formal home care sector in the four countries, this information is presented describing each country separately with a synthesis at the end of the chapter. Chapter 6 concludes and summarizes the key themes emerging from the evidence review findings.

2 Methods

This evidence review took place within a six-month timeframe. To address the time constraints, the authors initially undertook a scoping exercise to understand the extent of published materials pertaining to home care regulation. The scoping exercise was also necessary to refine the search terminology that would be used to conduct the search proper. The scoping review highlighted several large-scale European, OECD, and WHO projects that have been undertaken on different aspects of home care service provision. None of these projects are particularly focused on the regulation of home care services alone; however, some do observe regulation as a part of the overall examination of countries' home care services. The scoping exercise highlighted a dearth of specific regulation-oriented material on home care, particularly in relation to evaluative or review-based texts. There are also relatively few fully costed economic evaluations.

The scoping exercise found that there were many policy reforms in the home care sector occurring in individual countries, many as a response to a myriad of factors but particularly weighted on an increasingly ageing population and financial constraints that have been subsequently compounded by the financial crisis in the late 2000s.

2.1 Search strategy

Following on from the scoping exercise, we selected appropriate search terminology to inform the comprehensive search. We were only concerned with retrieving results written in the English language as we did not have the facility or resources for translation services. Search terms included 'home care' and variations on same, such as 'home support', 'home help', 'domiciliary care'. Further terms associated with the specific research questions were added to the variant on home care to attempt to retrieve pertinent results. All the searches were run generally with the keywords and then again specifically with the keywords and country name(s).

For Questions 1 and 2 the date range was unrestricted. However, in many cases the pertinent material was more recently published, as many of the relevant home care policies providing the evidence for this review emerged from the mid-1990s onwards, or have been amended and/or reformed relatively recently. For the search strategy regarding Question 3 on costs and funding of home care, the date range was initially refined to 2009–2016. Nevertheless, additional ongoing searches to fill information gaps in our search were also carried out without any date restrictions, but rather very refined search term strings, to ensure that we were capturing all the relevant available evidence.

- For **Question 1** the words 'regulation', 'costs', 'funding', 'framework', 'legislation', 'standards', 'registration', 'guidelines', 'licensing', 'accreditation', 'training', 'inspection', 'indicators' and 'monitoring' were used in conjunction with the 'home care' variants, as were the words 'elderly' and 'aged', 'disability' and 'disabled', and relevant alternatives.
- For **Question 2** we searched for evidence using the keywords 'staff experience', 'client experience', 'effect*' 'baseline assessments', 'monitoring', 'evaluation',

‘review’, alongside the ‘home care’ and ‘regulation’ variants ‘elderly’ and ‘aged’, ‘disability’ and ‘disabled’, and relevant alternatives.

- For **Question 3** we searched for evidence using the keywords ‘costs’, ‘funding’, ‘regulation’, ‘management’, ‘eligibility’, ‘entitlement’, ‘basket of services’ alongside the ‘home care’ variants ‘elderly’ and ‘aged’, ‘disability’ and ‘disabled’, and relevant alternatives.

Refined searches, based on combinations of the keyword searches listed above, were undertaken across the databases Embase, CINAHL, PubMed (Medline), Web of Science, and the York – CRD Database. Additionally, several subject-specific journals that had provided suitable results in the database searches were further searched with several in-journal searches. The initial search before any screening took place yielded a total of 4,891 results; the intricacies of the search strategy are documented in Appendix A.

A search of a range of additional databases was employed. Broad-based tools Google, Google Scholar, and Social Care Online were systematically searched as far as they allow for it. The results of these searches were screened for suitability on an ongoing basis as the searches took place; the inclusion criteria in this case were for reports, papers, websites, and so on, that were focused on home care services, and that examined the regulation of these home care services in some capacity and answered some, or all, of the research questions in some capacity. As outlined above, several large-scale European, OECD and WHO projects that have been undertaken on different aspects of home care service provision were retrieved. Reference chasing was employed, as was a combination of reference chasing and additional searching to try and fill any gaps in the information that were preventing us from answering the research questions in a comprehensive manner. The European Commission website was also searched a number of times throughout the review; a valuable document was retrieved in October 2016 when the *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability* was published. The report provided good evidence to answer Research Question 3, for three of the countries. A list of some of the most pertinent large projects which inform this evidence review is set out in the Introduction chapter.

2.2 Screening

Following the removal of duplicate resources, of which there were 152, all remaining resources were screened by title and abstract by two reviewers. Following on from this, 4,588 records were excluded. Therefore, 139 records went forward for full text screening, and a further 21 records were excluded at this stage. An economic reviewer reviewed any pertinent economic papers, which resulted in an additional review of 26 papers (see section 2.4). Following data extraction and quality assessment undertaken on 118 papers, 82 more were excluded. Nevertheless, when writing up the findings, it was necessary to look for more information to answer some unanswered parts of questions. Consequently, an additional 38 documents were retrieved and these also underwent data extraction and quality assessment. Therefore, 74 quality-assessed and extracted papers were used to inform the evidence review findings. A flowchart which displays the search and screening process is set out in Appendix B.

2.3 Inclusion and exclusion criteria

Retrieved results were assessed as suitable if they were journal articles, reports, papers, websites, and so on, that were focused on home care services, or if they examined the regulation of these home care services in some capacity and answered some, or all, of the research questions in some capacity. Consequently, inclusion criteria for suitable texts were based on:

- Relevance in terms of reports/papers/websites, and so on, focused on home care services and describing aspects of the regulation of home care services
- Relevance in terms of reports/papers/websites, and so on, focused on home care services and evaluating and/or reviewing aspects of the regulation of home care services
- Relevance in terms of reports/papers/websites, and so on, focused on how home care services are accessed – eligibility, needs assessment and so on
- Relevance in terms of reports/papers/websites, and so on, focused on the financing and the financial management of home care services
- Published or written by an authoritative source.

Exclusion criteria were

- No examination of any aspect of home care regulation
- Not in English
- Not a text looking at aspects of home care regulation in Europe
- Not from a reputable source, (for example websites, blogs, online journals that are not peer reviewed, with limited information about them and untraceable authors).

2.4 Quality appraisal

A quality assessment was undertaken by two reviewers on all papers that met the inclusion criteria. Three different quality assessment tools were used for different types of papers:

1. A quality assessment tool for review, including systematic review, articles based on the McMaster University Health Evidence quality assessment tool²¹
2. An economic evaluation assessment tool²²
3. A quality assessment tool for reports, and other papers, adapted from and based on Glenton *et al.*²³ and Keane *et al.*²⁴

The questions used to guide each different quality assessment tool are presented in tables in Appendix C.

There were only four papers that could be categorized as review papers/systematic reviews. Three of the review papers were assessed as strong papers, and one was assessed as moderate.

The majority of papers used to inform this evidence review were descriptive texts which presented evidential information on how home care is regulated and/or financed. There was a dearth of papers which analyse or evaluate home care policy with regard to regulation. Nonetheless, the papers used were wholly appropriate to answer the questions posed by the DoH.

Following on from the initial application of inclusion criteria, screening, and quality assessment by the two reviewers, a third reviewer, economist Dr Stephen Kinsella, further assessed economic-oriented papers to ascertain their worth as economic evaluations. There were 26 papers that went through this stage. Each of the 26 studies discussed at least some of the funding details in their respective countries, and most posed well-defined questions to their respective data sources. In line with the Health Research Board's preference, it was proposed to use the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) checklist²⁵ for assessment of the economic papers. CHEERS is a reporting standard for economic evaluations of health interventions. Following an initial review of the papers, it transpired that none of the papers could be categorized as pure economic evaluations. Therefore, the CHEERS checklist was not an appropriate quality tool for assessment. Consequently, Dr Stephen Kinsella assessed the papers using the Drummond *et al.* (2015)²² checklist for assessing economic evaluations. This is a subset of the CHEERS method, but has fewer restrictions. The picture gleaned from the assessment of economic papers is one of a relatively understudied area from the perspective of health economic evaluation. There are, however, excellent descriptions of the funding models and service-level challenges of each funding model in many of the preambles of these 26 papers, and, where appropriate, these informed the present evidence review.

Official published papers, from authoritative sources, were quality assessed as far as they met the inclusion criteria, and were also assessed where appropriate using the third quality assessment tool. Outside of the aforementioned review and economic papers, the majority of papers were assessed using the third tool. Following assessment, 82 papers were excluded, either as not meeting the quality criteria, because they were weak papers, or they did not answer any of the research questions (while undergoing data extraction). We used 74 papers to answer the research questions during data extraction and analysis. Fifty-six of the papers were assessed as moderate and 18 were assessed as strong. The majority of the 74 papers were descriptive texts which presented evidential information on how home care is regulated and/or financed rather than papers interrogating or evaluating modes of home care regulation and/or financing. The table in Appendix D shows the breakdown of different types of papers and their assessed quality.

2.5 Data extraction and analysis

A data extraction form, see Appendix E, that mirrored the questions and sub-questions guiding the review was created to code the information from our included documents by research question. The data were analysed using a policy analysis approach. The analysis for the extraction process first involved reading and re-reading the data with all the research questions in mind. All relevant material extracted from the documents was coded to the corresponding sub-question, which it answered either tenuously (often), in part (more often), or completely (less often). Further descriptive analysis was undertaken on the extracted data to use the evidence to build a narrative that told the story of home care policy regulation and financing in the four countries. This was undertaken within the confines of providing evidence that is relevant to the Irish context as represented by the research questions posed.

The data extraction and analysis process helped to develop a clear picture emerging from the evidence. The data extraction process alongside the quality appraisal process also highlighted several papers that had made it through the full text screening phase. However, following quality appraisal and data extraction, they were deemed to be unsuitable for use to inform the evidence review. As stated in section 2.4, a further 82 papers were excluded as unsuitable for use following the quality appraisal and data extraction processes.

2.6 Limitations of this review

There is a shortage of explicit evidence pertaining to the regulation of formal home care services specifically. On the positive side, a lot of the large-scale European and other projects that examine home care service provision also tend to look at some aspects of regulation of the sector. Nevertheless, this does not detract from the fact that the evidence available is irregular at best. The irregularity of available evidence did not affect the retrieval of some good information answering Questions 1 and 3, which are concerned with the legislative, standardization side of the regulation of the formal home care sector, and the financial management and funding of home care/regulation of the sector. The irregularity of available information and evidence did result in an inability to adequately answer Question 2, which is concerned with outcomes of evaluations or reviews of the effect of regulation on home care services; this is mainly due to a lack of this level of evaluation being carried out on many aspects of the health and social care services generally. We also had difficulty finding up-to-date and explicitly relevant information on Sweden that was published in English. Therefore, for Sweden it was more difficult to write answers to all of the questions as comprehensively as for the other three countries.

The main body of the comprehensive search was unable to encapsulate all of the nuances of the specific research questions. Therefore, when writing up the findings after the initial screening, quality assessment and data extraction was complete, we found ourselves lacking pieces of information to answer certain sub-parts of certain questions. Consequently, we undertook very specific additional searches to fill in the information gaps pertaining to points in the research questions where information and evidence was lacking. This was to ensure that we had retrieved all pertinent papers. In many cases, employing these additional specific and intricately focused searches to fill in the information gaps proved successful and we managed to answer the questions more comprehensively. Nevertheless, it still proved difficult to answer many parts of Question 2 for all four countries, as information does not seem to be widely available in English.

3 Regulation of home care services in four countries

A regulated home care sector has been developing across most of the four countries reviewed due to an increasingly ageing population and growing recognition of the significance of providing formal home care services. In conjunction with this, increasing costs have also impacted on a need to clearly define legal parameters and frameworks to guide a home care sector that is meeting care needs and is fit for purpose. The emergence of *new public management* approaches to social welfare and care-oriented service provision has changed the landscape of home care governance in many of the four countries reviewed. Decentralization and deinstitutionalization have become overarching guiding concepts with services being managed and delivered at regional/local level with a higher-level policy supervision role emerging for national governments.

This chapter describes the regulation of the formal home care sector in Germany, the Netherlands, Scotland, and Sweden, and it highlights specific regulatory mechanisms used by these countries to ensure quality within the home care sector. We present evidence pertaining to regulation of formal home care in each country under the headings of legislation, national standards, staff and provider accreditation, staff training requirements, inspection and monitoring, and the costs of regulation.

3.1 Legislative or guidelines-based framework for home care services

Germany

Germany is described as having a framework type of governance for home care ‘characterized by a high level of decentralized decision-making and, at the same time, an explicit national vision on home care’.¹² The German welfare system traditionally operates on the principle of subsidiarity or shared care, wherein the non-profit sector, and/or the private family, has traditionally been the largest provider of welfare services such as home care.²⁶ The German social insurance system covers people in terms of sickness – health insurance; occupational accidents and disease – accident insurance; old age and disability – pension insurance; unemployment; and since the mid-1990s long-term care.²⁷ All social insurance legislation in Germany is formed under the foundation of the Code of Social Law. Home care is regulated by the Social Code SGB XI, which provides the regulatory framework guiding all statutory insurance schemes.²⁷ From a legislative perspective the Long-Term Care Act 1994 established and enshrined in law, within the existing social insurance system, a compulsory long-term care insurance scheme focused on detailing benefits and coverage for all people in need of long-term care. This Act, Sozialgesetzbuch (SGB) – Elftes Buch (XI) – Soziale Pflegeversicherung (Artikel 1 des Gesetzes vom 26 Mai 1994, BGBl. I S. 1014), also introduced quality assurance rules and standards for home care services.^{26, 28} The ethos behind the new long-term care act was to increase market-based provision, user choice, and competition²⁹ after an “oligopoly” of limited non-profit provision in the sector.²⁶ The focus of the Act was also to move away from dependence on residential care services to strengthen and promote both home care services and family-based care.³⁰ The statutory Long-Term Care Insurance (LTCI) scheme was introduced in 1995.^{27, 31} A newer care extension law, the Long-term Care Further Development Act – Pflege-

Weiterentwicklungsgesetz – was introduced in 2008; it includes a focus on improving the situation for family caregivers (informal care).^{13, 26, 32, 33}

The 1994–95 legislative and policy changes led to the establishment of the MDK (Medical Board of the Health Insurances or Medical Review Boards) which is a central body which operates needs assessments and quality assurance in long-term care including home care.²⁶ The MDK is operated jointly by the sickness funds – health insurance, and the LTCl.²⁷ The 2008 policy reforms increased the frequency of MDK inspections of home care providers from every couple of years to annually.² Mandatory social health insurance for the whole population has been in effect since 2009; access to long-term care services is by application only – via needs assessment; it is not automatically available.²⁷

The majority of provisions available within the German long-term care scheme also extends to people with disabilities, via the 2001 Federal Law on Rehabilitation and Participation of Disabled People (SGB IX).³⁰

State governments, Länder, have a role in capacity planning home care service provision with an onus on adequate supply, nevertheless, this is within a care market that is competitive in nature.²⁷ Competition is as much of a driver as capacity planning within the German home care markets.

The Netherlands

The Netherlands is also described as having a framework type of governance for home care, which has been traditionally characterized by the national government developing and overseeing an overarching framework within which municipalities and independent agencies can develop their own rules.¹² Consequently, the Ministry of Health, Welfare and Sport is charged with developing legislation and regulation, and supervising access, quality and efficiency within the long-term care sector, including home care.¹³ There has been a long tradition of home care service provision in the Netherlands; a national long-term care insurance scheme was in place from 1968 until relatively recently.^{13, 34} The Netherlands was the first country to develop a comprehensive long-term care insurance scheme, and did so within the framework of the Exceptional Medical Expenses Act (AWBZ) 1968.²⁹ From 2007 to 2015, municipalities had responsibility for regulating domestic aid whereas independent agencies were responsible for regulating home nursing and personal care services.¹² Since the 2015 Social Support (Wmo) Act, the municipalities are now also responsible for overseeing personal home care as well as home help services.³⁴

The Health Care Insurance Act, 2006 (Zvw) determined the services that should be included in the basic benefits package from each health insurer.³⁵ People pay an obligatory “own risk” premium to their health insurers to be covered for basic benefits.³⁵ The insurance cover enshrined in the Zvw is focused on short-term care related to the curing of an illness.³⁵ The AWBZ was a compulsory insurance which covered provision of care not included under the Zvw. Therefore, it typically covered long-term care such as home care for elderly and disabled people.³⁵

The Health Care Insurance Board, CVZ (College voor Zorgverzekeringen), has had responsibility for the implementation of the AWBZ, the management of the AWBZ fund and distribution of personal budgets to regional purchasing offices.^{13, 29} Regulation and supervision of the quality of care is managed by the Dutch Healthcare Inspectorate (IGZ – Inspectie voor de Gezondheidszorg).¹³ Local provision is administered by the Zorgkantoor local office.³⁵

The 2007 Dutch Social Support Act (Wmo) set out the general responsibilities of municipalities, including the requirement that every four years the municipalities must publish a vision for social support that includes a vision for domestic aid for home care.¹² Municipalities oversee decisions on eligibility for home care, the prices of services, and what services will be covered under public funding.¹² The goal of the Wmo is to facilitate everybody to participate in society, and live independently, regardless of illness or disability. Nevertheless, there is no mandatory entitlement to services.³⁵

The Dutch Healthcare Authority, NZa (Nederlandse Zorgautoriteit), is a public body that oversees the effective operation of the care market and sets the maximum prices for all long-term care tariffs including both personal care and home nursing.^{12, 13, 34} The NZa also safeguards compliance with care insurance laws and acts in an advisory capacity for the government.¹³ The Long-Term Care Act (Wlz) 2015 covers people with more serious illnesses and intensive care needs who need permanent supervision or 24-hour home care.³⁴

Other laws which are related to the governing of long-term care, including home care, are:³⁵

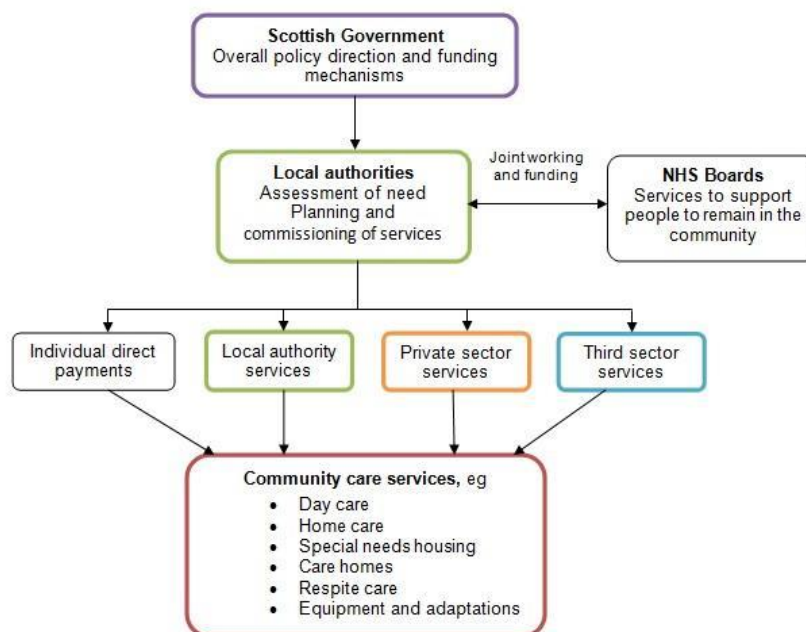
- The Care Institutions Accreditation Act, 2005 (WTZi), which covers licensing for all care providers and sets out rules for good governance. It also determines what and when profits may be distributed.
- The Medical Treatment Agreement Act, 1994 (WGBO), which mainly covers patient rights and regulates care agreements between care recipients and care providers
- The Healthcare Clients Complaints Act, 1995 (WKCZ), which upholds care recipients' right to make a complaint about their home care provision. Care providers must have a complaints procedure and a complaints committee. In very serious cases the complaint may be reported to the IGZ.³⁵

Reforms to the system which came into effect in January 2015 saw the AWBZ repealed and responsibility for the provision and regulation of home care decentralized to the municipal level.^{29, 34} The AWBZ has subsequently been replaced by the functions of several other acts: the Social Support Act (Wmo, 2015), the Health Insurance Act (Zvw, 2006), and the Long-Term Care Act (Wlz, 2015). Since the reforms, the local authorities, under the Wmo, oversee and regulate the provision of care and administer needs assessments for care services.³⁴ Domestic home help, however, was decentralized to the municipalities in 2007, a precursor to the wider reforms in 2015.³⁴ The general focus of the home care system as envisioned in the reforms is to work to encourage and enable people to stay in their homes and live independently, while also containing costs.³⁴

Scotland

Scotland has seen a clear shift in recent years in how it cares for its elderly, with current policy and legislation aimed at providing long-term care for elderly citizens in the home rather than in institutions.^{36, 37} A number of national policy initiatives have been implemented, seeking to integrate health and social care services in order to provide a partnered approach to providing a more inclusive social care plan for care recipients.³⁶ While current policy objectives have sought to increase the number of older people who need intensive care being supported at home, this has been at the expense of care recipients with less intensive needs.³⁷ Although there has been an overall increase in the total amount of home care hours received, there has been a steady decline since 2004 in the total number of people receiving care.³⁷ Recent legislative changes have allowed home care service users to take a more active role in the selection of care services that they feel best suit their needs.³⁷ This shift towards a more personalized approach to care services is described as the 'personalisation agenda'.³⁷

Figure 1, which is reproduced from Payne, 2011,³⁸ illustrates how long-term care and the affiliated services are managed and funded in Scotland. The Scottish Government plays a pivotal role in policy formulation and implementation, and also oversees the allocation of funding community care as well as the funding mechanisms utilized in financing these services.³⁸



Source: Payne, 2011³⁸

Figure 1 Home and community organization in Scotland

Local Authorities and NHS boards work together to ensure that people can have the choice to remain in their home. They assess the needs of potential care recipients and allocate the appropriate package of services to suit the care recipient's needs. This is done by allocating public services and commissioning the appropriate services from other sectors, such as the

local authority, private sector and third sector.³⁸ Some home care clients are also supported to create their own tailored personal home care package through receiving direct payments.

The Social Work (Scotland) Act 1968 was seen as a key piece of legislation which initiated the shift of care to the home and community; it still forms the basis of home and community care regulation.³⁸ In the 1968 Act, Local Authorities were given responsibility for assessing persons for social care and support and ensuring that those eligible received the necessary community and home support.³⁸ The NHS and Community Care Act 1990 devolved responsibility of home and community care, with Local Authorities in charge of long-term social care provisions and NHS local health boards given responsibility for the provision of healthcare to elderly persons.³⁹

The Regulation of Care (Scotland) Act 2001 established new regulatory mechanisms and a legal framework for the care sector. This included establishing new independent bodies to ensure the registration and inspection of care providers to improve national quality standards. The regulatory bodies also deal with complaints made about care providers.^{36, 39-41} Two new national regulatory bodies were formed in 2002 as a result of the Act, the Scottish Commission for the Regulation of Care and the Scottish Social Services Council (SSSC).⁴⁰ The primary aim of these independent bodies was to regulate the social services sector, including the regulation of social care workers and the education and training of the social services workforce.⁴⁰ In 2010, the Scottish Commission for the Regulation of Care was dissolved and a new body, the Care Inspectorate, was established under the Public Services Reform (Scotland) Act 2010; it has been regulating the care sector since April 2011.^{39, 41}

The remit of the SSSC was to regulate the workforce in the social care sector by ensuring the protection of home and community care service users and carers. The SSSC was established to certify the registration of persons working in the social care sector and to regulate the training and qualification of the appropriate workers.³⁶ In order to achieve their remit, five main responsibilities were delegated to the SSSC.⁴⁰ These were to:

1. Create a register of a range of different social services employees
2. Regulate the conduct of all members on the register
3. Regulate the education and training of social services employees
4. Undertake the role of the National Training Organisation for the Personal Social Services
5. Publish a range of codes of practice for all social service employees and organizations.⁴⁰

The Community Care and Health (Scotland) Act 2002 allowed for the creation of free personal and nursing care for elderly citizens at the point of delivery, as well as the establishment of regulatory procedures for the home care sector.^{36, 37} The introduction of free personal care for those aged over 65, regardless of income, was seen as an important development in Scottish home care policy and diverged from other home care policies elsewhere in the United Kingdom.³⁷

The Community Care (Direct Payments) (Scotland) Regulations 2003, which was amended in 2005, was an extension to the Community Care (Direct Payments) Act 1996. The 1996 Act put a duty on councils to ensure that almost all social care service users were able to receive

direct payments.^{36, 37} The National Health Service Reform (Scotland) Act 2004 introduced the development of Community Health Partnerships, which saw local authorities and NHS boards establish partnerships that aimed to produce a more integrated long-term care approach.³⁹

In 2011, the Scottish Government published *Reshaping Care for Older People*, a 10-year policy programme with the primary aim of creating a greater system of support to improve the independence and well-being of the elderly in their homes and to substantiate a shift in the focus of care away from an institutional setting.⁴²

The Social Care (Self-directed Support) (Scotland) Act 2013 has allowed clients to have more control and choice over the social care and support they can obtain.³⁷ The Act has made it compulsory for all Local Authorities to offer prospective service users four options:

1. A care recipient can receive a direct payment from the local authority.
2. A care recipient can choose a preferred care provider and the local authority will organize the required services.
3. The local authority can both choose and arrange the care provider and services for the care recipient.
4. A mix of all options above can be used.³⁷

Sweden

Sweden has a framework type of governance for home care; its vision for policy has been explicitly developed for home care.¹² Swedish home care policy has been centrally developed and is centrally regulated to be administered at municipal level.¹² Sweden has a universal approach to health and social services which affords citizens extensive coverage regardless of their income, as they are assessed based on their needs rather than their ability to pay.^{43, 44}

The Health and Medical Services Act (HMSA) was established in 1982, allowing for accessible universal healthcare to all citizens, which is prioritized on a needs basis.^{30, 45, 46} The HMSA regulates health authorities and health services to ensure that they provide equal and good quality treatment to all citizens.³⁰ The fundamental goal of the HMSA is to provide 'good health and health care for everyone, with equal access to health care, irrespective of age'.¹³ During a financial recession in Sweden in the 1990s, the Government implemented the 1992 Community Care Reforms, also known as the Ädel Reforms.^{13, 26, 45, 47} These reforms decentralized the provision of non-medical care for older and disabled people from regional governments (county councils) to local governments (municipalities).^{13, 48}

The Social Services Act 2001 (SSA) facilitates the provision of universal public services, such as home care, to all those in need of care, with priority being given to those who are deemed to be most in need. Municipalities are obliged to ensure that all citizens receive the care and support they need, and particularly to assist them to continue living at home as independently as possible.^{13, 30, 45, 46}

The SSA and HMSA are the two overarching pieces of legislation governing and regulating social and healthcare services for persons needing care in Sweden; there are also specific acts that are relevant to the care, including home care, of persons with a disability. For people with a functional impairment or disability that is not a result of old age, two pieces of legislation are relevant with regard to home care services. They are the 1993 Law regulating Support and Service to Persons with Certain Functional Disabilities (LSS) and the 1994 Assistance Benefit Act (LASS).^{30, 49} These acts are specific to people with a disability and both ensure that measures are put in place by local authorities/municipalities to guarantee that persons with specific and extensive impairments can live comfortably in 'good living conditions'.^{30, 49} There is a personal care assistance scheme under both acts which allows for care recipients to receive personal assistance with their daily living activities.^{30, 49}

Since the 1990s there has been a noted trend towards marketization of the Swedish social services, particularly in public care services for the elderly, with a consistent increase in privately funded eldercare.⁵⁰ The Swedish Government introduced the Act on System of Choice in the Public Sector (LOV) in 2009.⁵⁰ The Act introduced service vouchers for care recipients enabling them to choose from among public and for-profit providers who are operating in a competitive market.²⁶ The idea of the Act is to give service users, such as elderly home care users and their families, the opportunity to choose public services and to empower them to make their own decisions on the care services that suit them.⁵¹ Since 2010, it is mandatory for county councils to have a system of choice in the primary healthcare sector, in accordance with the LOV.⁵⁰

3.1.1 Synthesis of legislative or guidelines-based framework for home care services

There are several similarities and differences, regarding how the four countries (selected for this review) regulate their formal home care sectors. All four countries fit the criteria of a 'framework type' of governance with an explicit national policy covering long-term care, including formal home care services; the overall provision of home care is decentralized to municipalities or regions. Thus, the national government has overall control of the vision for home care, but regional governments oversee the selection of home care services that will be publicly funded, administering how these services are delivered, setting prices including those of co-payments, and agreeing eligibility criteria. Support to keep people living in their own homes is the main principle underpinning home care policy in all four countries. There is a long tradition of regulated formal home care in the Netherlands and Scotland; whereas regulated formal home care was introduced later in Sweden and Germany. In the Netherlands and Germany home care is funded through compulsory insurance. Personalised budgets or voucher systems are a feature of home care provision in all four countries. Such payment methods are intended to support the principle of user choice but they may also be a method of controlling costs, as indicated in the findings for Question 3.

3.2 National standards for home care services

Germany

There are quality standards inherent within the long-term care insurance (LTCI) law;³⁰ they are based on the principles and standards of quality that were agreed between the LTCI as a regulator and the federations of providers of care services, including home care services.^{29,}

⁵² The Act on Long-Term Care Insurance refers to three dimensions of quality: structure, process, and outcome.⁵³ These overarching criteria have been defined as follows:⁵⁴

1. Structural criteria related to the technical and educational competences of the chief nurse and other nursing staff, as well as basic criteria for running different types of long-term care facilities
2. Process criteria related to the services' self-description, the application of the nursing process, the documentation of services provided, and the collaboration with service users' family members, as well as with other professions or institutions
3. Outcome criteria related to service users' satisfaction with services received and the evaluation of care according to objectives stated in their care plans.⁵⁴

The quality standards are regulated by law at national level through the Act on Residential Homes (Heimgesetz) and the Act on Long-Term Care Insurance (SCB XI); home care is regulated by the Social Code SGB XI.⁵³ Other relevant legislation guiding quality standards in home care includes the Act on Health Care Insurance (SCB V) and the Social Assistance Act (SGB XII) for help in care.⁵³

More specific expert standards with respect to nursing care have also been developed.⁵⁴ To date, expert standards have been developed for the following:

- Pressure sore prevention in nursing care
- Discharge management in nursing care
- Pain management in nursing care
- Fall prevention in nursing care
- Promotion of urinary continence in nursing care
- Nursing care for people with chronic wounds
- Nutrition management for ensuring and promoting oral nutrition in nursing care.⁵⁴

The 2008 policy reforms which introduced annual inspections also developed a regulatory framework which defines specifically identified performance indicators.⁵⁵ The framework became operational in 2011 and the performance indicators are known as 'transparency criteria' based on items and questions taken from the general guideline for inspections by the MDK and agreed upon by the most important stakeholders: the contract holders/care providers, the MDK, and the LTCI funds.²⁹ The information gathered in this process is published on a publicly accessible website (www.pflegelotse.de).

The following table excerpt, Table 3 (the full table can be found in Appendix F), demonstrates examples of transparency criteria for home care as used in previous reports.⁵³

Table 3 Examples of transparency criteria for quality regulatory framework in Germany (excerpt)

Results of interviews with care recipients about their satisfaction
Expectations are taken into account.
Care contracts are concluded.
Agreed care services are carried out.
Working times are met.
Care is provided by the same person.
Motivation to activate care
Care provision according to wishes
Satisfaction with housekeeping
Care status (visits to the care recipients)
Care status appropriate
Documentation and care process (care documentation)
Collection of information on the health and care status of the recipient
Information concerning the biography of the recipient
Details concerning competencies, deficits, special problems of the recipient
Individual care goals are fixed.
Individual care measures are planned.
Documentation of measures carried out by external experts
Prophylaxis is taken into account.

Source: Schulz, 2012⁵³

For providers to receive authorization to operate in the home care market they have to meet certain structural standards. The structural standards include the following as some of the most important factors:

1. Competence of personnel: their training and ability to assess, treat, and communicate with the clients
2. Timeliness: timely access to care and coordination
3. Continuity: coordination.⁵³

Framework contracts agreed upon between the purchasers – funding agencies such as regional federations of LTCI funds, state (Länder) governments, and so on – and the home care providers regulate ‘quality standards as well as type of care, contents, and the extent of care tasks that a care home or home care agency must provide as well as financial reporting, personnel requirements and inspection regimes’.²⁹ The scope of the quality standards ranges from structural issues to client satisfaction and accountability.²⁸ The existing legislation sets out a general view of what quality/standards criteria should be included; however, additional standards develop via best practice, empirical evidence, and input from all the relevant stakeholders, such as service providers, home care clients, healthcare professionals, advocacy groups, and federal and state (Länder) governments.²⁸ A home care package/product may only be offered to clients if such products have been included in a care package defined by the purchasers and the providers in the framework contract.²⁹

The Netherlands

Measurable standards for the quality of care have been jointly developed by several stakeholders, including patient organizations and the IGZ (Health Care Inspectorate).¹³

These standards are used for assessment of services and benchmarking.^{13, 33} The development of quality standards came about following lengthy debates on the role of government in the quality of healthcare, legislatively beginning with the Quality Act, 1996 and followed over the next decade by the Quality Framework for Responsible Care.³³ The aim in the Netherlands is to set standards of good practice in conjunction with quality standards.³³ The IGZ focuses its work on specific aspects of the care sector, such as improving work processes and quality over time.³³ The NZa (Dutch Healthcare Authority) works to ensure that transparency on quality is paramount in order 'to regulate the impact of market approaches, based on competition, in home care services'.³³ Regional purchasing agencies clearly set out explicit standards for good practice and have strict 'procedures for monitoring and sanctioning home care organisations'.⁵⁶

Nies *et al.*³³ have described how many long-term, including home care, services are participating in a national benchmark scheme.³³ Areas covered within the benchmark include staff – quality of work; financial performance; client indicators – responsible care standards; service delivery; satisfaction of employees and quality outcomes – partly based on the Consumer Quality Index.³³

The Quality Framework for Responsible Care (QFRC) was developed in 2006, and launched in 2007, to be used by the nursing and caring sector; it has explicit standards for safe, effective, efficient, and client-centred home care.^{13, 28, 33, 46} The framework forms the basis for the Consumer Quality Index for home care (CQI – Home Care), which has been in effect since 2006,²⁸ and includes quality indicators that care providers themselves use to measure quality. Some of the measurable indicators (see table 4) within the framework for responsible care are measured by the care providers themselves, whereas those that are a part of the CQI are measured by independent agencies.³³ The results are used as a basis to improve care provision.³³ There are also quality criteria that have been developed for domestic help home care services.¹³ The CQI requires surveys of user experiences to be carried out, the results of which are publicly reported on the website www.kiesbeter.nl.^{28, 55} The Quality Framework for Responsible Care comprises 10 areas – themes – that are covered within the quality indicators, reflecting the structure, process and outcomes of care, and displaying a very user satisfaction-oriented approach to home care quality and standards.²⁸

1. Care/life plan
2. Communication and information
3. Physical well-being
4. Safety of care
5. Domestic and living conditions
6. Participation and autonomy
7. Mental well-being
8. Safety of living environment
9. Sufficient and competent personnel
10. Coherence in care.²⁸

The following table excerpt, Table 4, has been amended from the *Quality Framework Responsible Care 2007* and shows examples, only relating to home care, of the set of indicators for responsible care, by theme, including relevant CQI questions.⁵⁷

Table 4 Indicators for responsible care in the Netherlands (excerpt)

Theme 1	1. Care (treatment)/life plan
Indicator – CQ-I	1.1 The extent to which clients experience a good care plan and a good evaluation of that plan
CQ-Index questions	Have written agreements been made with you about the care you receive from the care institution? (What care, as of when, from whom, how often, on what days at what times, et cetera)
	Is your care dossier/file or log book used properly for the exchange of information? (e.g. by your GP or your relatives?)
	Have you had an evaluation talk over the past 12 months with someone from the care institution about how you feel about the care given?
	Have you got a regular contact that you can address at the care institution?
Indicator – CQ-I	1.2 The extent to which clients experience good participation and good consultation.
CQ-Index questions	How often do you participate in decisions about the content of the home care you receive?
	How often do you participate in fixing the times/days on which you receive your home care?
	How often do you participate in decisions about from whom you receive home care (which caregiver)?
	Is the care institution sufficiently open to your suggestions?
	How often does the care institution (the management or the Board) react adequately to your questions, suggestions or complaints?
	How often do your caregivers confer with you about what has got to be done?
	How often do your caregivers ask you if the care they give is up to your standards?
Theme 2	2. Communication and Information
Indicator – CQ-I	2.1 The extent to which clients experience good treatment.
CQ-Index questions	How often are caregivers willing to talk to you about matters that did not go well in your opinion?
	How often do caregivers respond to your questions well?
	Do the caregivers treat you in a polite manner?
	Do the caregivers listen to you attentively?

Source: Steering Committee Responsible Care, 2007⁵⁷

Scotland

The National Care Standards for the home care sector in Scotland were first published in 2002. There are 11 standards in total, all of which pertain to a care recipient's experiences of engaging with home care services⁴⁰ (see Table 5). The standards were developed by the National Care Standards Committee (NCSC) in conjunction with various working groups, which included service users, their families and carers, home care staff and service providers, Local Authorities, health and social care regulators, health boards and professional associations.⁴⁰ The standards are used by the independent regulatory body for the care sector, the Care Inspectorate, as a guidance tool when carrying out inspections and are not legally binding.³⁹

¹ CQ-I means client related indicators measured by an independent agency by means of consultation via the CQ-index

The National Care Standards apply to all registered home care providers and in turn ensure that all employees of these providers are suitably qualified and competent to undertake tasks in a professional manner that safeguards vulnerable persons needing care in the home.⁴⁰ Although the Scottish home care sector primarily provides services for elderly persons, services in the home are also given to children and young adults with disabilities, adults with learning or physical disabilities, adults dependent on alcohol or illegal substances and persons with HIV or AIDS.⁴⁰

Table 5 Scottish national care standards

Prior to using service		
1	Informing and deciding	You have all the information you need to help you decide about using the care service in your home.
2	The written agreement	You receive a written agreement which clearly defines how the service will meet your needs. It sets out the terms and conditions for receiving the service and arrangements for changing or ending the agreement.
3	Your personal plan	You can be confident that the service will meet your care needs and personal preferences. Staff will develop with you a personal plan that details your needs and preferences and sets out how they will be met, in a way that you find acceptable.
4	Management and staffing	You experience good quality care at home. This is provided by management and the care staff who have the skills and competence to carry out the tasks you require. The service operates in line with all applicable legal requirements and best practice guidelines.
Using the service		
5	Lifestyle – social, cultural and religious belief or faith	Your social, cultural and religious belief or faith are respected. You are able to live your life in keeping with these beliefs.
6	Eating well	If shopping for food or preparing meals is part of the service, you know that the food will be handled safely and meals will reflect your choices and special dietary needs (if any).
7	Keeping well – healthcare	You are confident that the service will get in touch with the healthcare services if you need them to.
8	Keeping well – medication	If your service includes help with taking your medication, the provider has arrangements in place for this to be done safely and in the way that suits you best.
9	Private life	Your rights to privacy are respected.
10	Supporting communication	You have help to use services and equipment for communication, if your first language is not English or if you have any other communication needs.
11	Expressing your views	You or your carer are encouraged to express your views on any aspects of the care service at any time.

Source: The Scottish Government, 2005⁴⁰

The standards were not only designed to equip independent regulators with the necessary tools to ensure that home care providers maintain high-quality care for clients, but also to ensure that care recipients, their family members and carers are well informed on necessary standards for home care providers and employees.⁴⁰

There are six main principles on which the standards are developed.^{40, 41} These are:

1. Dignity
2. Privacy
3. Choice
4. Safety
5. Realizing potential
6. Equality and diversity.^{40, 41}

The primary aim of these six principles is to ensure that all rights as a citizen are recognised within the 11 national standards.⁴⁰ Standards 1–4 are aimed at persons before they have decided to use a home care service, to ensure that they are well informed and equipped with the pertinent information to make an educated decision on a home care service.⁴⁰ Standards 5–11 are for care recipients availing of home care services, to ensure that the care recipient is comfortable and benefiting from high-quality care. These standards also provide care recipients and their family members with relevant information to ensure that they understand what is expected in a high-quality home care service and to recognise what is expected of the home care provider, as stated in the care recipients' written agreement and personal plan.⁴⁰

A review of the national standards took place recently, including a 12-week public consultation, from October 2016 to January 2017, on what they should be called in order to best represent their purpose.⁵⁸ The new standards are due to be published in April 2017, and are currently being referred to as the *National Health and Social Care Standards*.⁵⁸ The revised standards are human rights based, oriented around measurable user experience-type questions, and focus on five new principles^{59, 60}, which are:

1. Dignity and respect
2. Compassion
3. Be included
4. Responsive care
5. Support and well-being.^{59, 60}

Sweden

Sweden's legislation (HMSA, 1982 and SSA, 2001) requires local government to be responsible for and carry out the regulation of quality in social services. There are, however, no specific national standard guidelines to supervise the quality of formal home care.^{13, 30} The NBHW (National Board of Health and Welfare) has developed a number of guidelines related to elderly healthcare, such as palliative care, dementia care and heart disease, which can help guide professionals by providing up-to-date information on elderly healthcare.⁶¹ The report *OECD Reviews of Health Care Quality: Sweden 2013* suggests the need for some of these guidelines to include other areas outside of a hospital setting, such as social care services.⁶² The report notes that 'there is surprisingly little measurement of outcomes of long-term care services and few standards of care' in Sweden.⁶²

Examples of where the NBHW developed national guidelines to provide support for social care can be seen in the Swedish dementia guidelines and the *ProCare* guide.⁶² The dementia guidelines, which were published by the NBHW in 2010, cover areas of care such as informal care givers, living arrangements, prevention and medication.⁶² There are 157 items that explain how to deal with issues of dementia care. There are also 14 quality indicators that have been developed by the NBHW. The ProCare Group developed the ProCare guide, which is primarily aimed at elderly care, but can also be referred to by healthcare workers. The guide refers to the requirements needed in order to meet a service user's physical, psychological and social needs, and it includes quality requirements for geriatric health and personal care.⁶²

The Swedish Association of Local and District Health and Welfare established a way to measure the quality of care among home healthcare and home help services through a 'national system for public comparisons of quality (and cost and efficiency) in healthcare and services for disabled people'.¹³ The system requires all municipalities to register, with comparisons made in areas such as participation, accessibility and frequency of staff.¹³ The quality indicators used were developed by the Swedish Board of Health and Welfare and are based on a model designed by Stockholm County Council.⁶¹ Each indicator that is developed is required to be scientifically reliable, measurable and based on up-to-date evidence.⁶¹ The indicators are based on seven different themes:⁴⁶

1. Users' perception/satisfaction
2. Accessibility
3. Care for special needs
4. Risk prevention
5. Unsafe use of medicines
6. Staff and education
7. Costs.⁴⁶

The Better Life Initiative, which was implemented from 2010 to 2014, aimed to improve the overall quality of long-term care services through 'a top-down incentivized system' that rewards municipalities with performance bonuses.⁶³ The initiative was a partnership between the Swedish Government and the Swedish Association of Local Authorities and Regions, and it relied on a framework agreement between them. A framework agreement is a contract between different 'contracting authorities and one or more suppliers, the purpose of which is to establish the terms (for example, price and envisaged quantity) of the contracts to be awarded during a given period'.⁵⁰ There were five specific areas on which the initiative focused – coordinated health and social care, good dementia care, good palliative care, good drug treatment, and preventative approach.⁶³ The initiative achieved a number of successful outcomes in improving the quality of long-term care services, with a significant cultural shift seen in the long-term care workers' perspective towards the service user rather than the organization.⁶³

3.2.1 Synthesis of national standards for home care services

Three of the four countries have a clear national set of standards for home care services that are guided by legislative acts. In addition, the three countries have an independent inspectorate to assess quality standards. Only Sweden does not have explicit national quality standards, as standards are determined at individual municipal level. Quality standards have been determined by the regulator(s) in Germany, the Netherlands and Scotland; with care providers offering some input into quality standard development in Germany and patient organisations contributing to quality standard development in the Netherlands. In Scotland, a broad church of people and organisations (including the regulator) contributed to the development of Scottish standards for formal home care. Standards pertaining to home care services in Scotland and Sweden are also explicitly concerned with the protection of vulnerable persons.

3.3 Registration/licensing and/or accreditation of home care services and its process

Germany

Germany accredits home care providers through the LTCI (long-term care insurance) funds, with standards for home care being somewhat less strict than those for residential care.²⁸ Accreditation includes some of the criteria outlined in the discussion of standards in section 5.2 of this report. Accreditation is closely related to the structural quality standards, and as such requires that the home care services employ suitably qualified staff who are paid adequate wages, that expert standards are employed, and that a quality management system (QMS) is introduced.^{28, 53} The LTCI funds must also offer appropriate training courses in home care for family-based and voluntary carers.²⁸ States (Länder) via the regional branches of the LTCI funds undertake inspections of the structural criteria.²⁸

Quality management systems (QMSs) typically refer to generic certification models obtained through procedures and standardizations which are defined by the International Organization for Standardization (ISO).^{28, 33} Advancing the use of a quality management system is required for accreditation purposes; nevertheless, the type of QMS used is not specified.²⁸ Research has found that ISO 9001 is the most common QMS used by German home care services.⁵³ The ISO 9000 family of QMS standards is 'designed to help organizations ensure that they meet the needs of customers and other stakeholders while meeting statutory and regulatory requirements related to a product [or service]'.⁶⁴ ISO 9001 is the only quality standard that can be certified to. However, this certification is managed and issued by external bodies not the ISO; the ISO sets the standards.⁶⁵ There are eight quality management principles guiding ISO 9000 and ISO 9001 standards:⁶⁴

1. Customer focus
2. Leadership
3. Involvement of people
4. Process approach
5. System approach to management
6. Continual improvement

7. Factual approach to decision-making
8. Mutually beneficial supplier relationships

Services which sign up to the ISO 9001 QMS are typically subject to an annual audit conducted by an external auditor.^{30, 53}

The Netherlands

In the Netherlands, it is incumbent on home care providers to meet certain standards, ensure that care workers have appropriate qualifications and working conditions, apply defined instruments, and report on quality performance indicators to qualify for registration as a provider.^{28, 33}

The HKZ (harmonization of quality review in healthcare and welfare), is an accreditation scheme that covers home care services.^{28, 66} It is a combined initiative between healthcare providers, insurance companies and clients, with an aim to strive towards achieving good quality by adhering to quality management system certification, monitoring and reviews.⁶⁶ The HKZ encourages the use of ISO 9001 certification and employs it for quality management of home care services, which is recognised by the Dutch Board of Accreditation.⁶⁶ The expectation is that care providers have a systematic quality monitoring system in place that meets the ISO 9001 standards, in line with what is described for Germany above, and that is appropriate to meet the needs of those in receipt of services.⁶⁷

Scotland

In order for a home care service to operate in Scotland, it must be registered with the Care Inspectorate.^{41, 68} An organization or individual providing care to a person in their own home must register with the Care Inspectorate as a 'support service – care at home'.^{41, 68} The majority of registered providers (51%) are from the voluntary sector, with the private sector providing 34% of registered home care services and Local Authorities and NHS boards providing 15% of services.⁶⁸ The private sector is the biggest provider (49%) of stand-alone home care.⁶⁸ Home care that has been funded by the Local Authorities is often delivered by a provider in the voluntary/independent sector, with 37% of local authority-funded home care being provided by the voluntary/independent sector in 2015.⁴¹

The Care Inspectorate has produced a guide for newly registering care services, which outlines the step-by-step process a care service will go through in order to be registered and legally operate a care service for care recipients in a home or community setting.⁶⁹ The completion of an application form is required. The information provided in the completed application form enables the Care Inspectorate to assess the following:

1. The suitability of the applicant and whether they can provide an adequate care service
2. The suitability of the premises in providing care services
3. If the proposed care service has adequate provisions in place to uphold the health, independence, welfare, dignity, choice and privacy of care recipients who will use the service.⁶⁹

The application process includes answering questions on how applicants plan to regulate and evaluate their home care services in the future, and it also seeks information on how they plan to involve staff and service users in this process.⁶⁹

The final step in registering a care service is the assessment process, within which a financial assessment also takes place.⁶⁹ Applicants are assessed on the information they provide to support their application, together with information on the outcomes of meetings that have taken place with the Care Inspectorate.⁶⁹ Reference checks are also a part of the process.⁶⁹ A Protection of Vulnerable Groups (PVG) scheme record check is also carried out. In addition, checks are carried out on the people involved with managing the care organization, or in the case of an individual applicant, with managing the individual.⁶⁹

Sweden

In Sweden, registration is compulsory for home healthcare and home help service providers.¹³ There are no national accreditation criteria as accreditation is discretionarily used at municipal level and is subject to municipal requirements. For example, in the Norrtälje municipality, home care providers must be able to supply services in home care, home rehabilitation and basic home nursing in order to be accredited as a home care provider.²⁶ The OECD suggests that Sweden should introduce a national accreditation system for long-term care services, as it would be beneficial within the development of Sweden's inspectorate model, working alongside other quality assurance mechanisms to ensure that minimum standards are being upheld by long-term care providers.⁶²

The website of the Health and Social Care Inspectorate (IVO) states that it is responsible for issuing permits to private providers and for overseeing the related registers, under the Social Services Act, the LSS Act and the HMS Act.⁷⁰ The information available on the IVO website notes that it is illegal for any service provider to offer its services without a permit and that to do so can lead to prosecution.⁷⁰ It also notes that when a private social service provider makes an application for a permit a quality and safety assessment must be carried out before a permit can be granted, in order to ensure that the service and staff are of the highest competency.⁷⁰ Nevertheless, it is unclear whether the information provided on the website also extends to the sphere of home care services.

3.4 Registration/licensing and/or accreditation of home care staff and its process

With regard to Germany and the Netherlands, aspects of this question have been covered in the previous two sections; we found no additional specific information or evidence in English to explicitly answer this question. For both Germany and the Netherlands, accreditation at provider level necessitates that home care staff are suitably qualified and are paid adequate wages.^{28, 53, 33} We found no specific evidence, in English, to answer this question with regard to Sweden.

Scotland

The Care Inspectorate encourages all care providers to have comprehensive safe recruitment policies in place, which should background checks, references, and ensuring that employees are registered under the Protecting Vulnerable Groups scheme.⁶⁸ Home care workers must hold a relevant qualification or be working towards gaining one that relates to the work they do. There is an anticipated date of 1 January 2020 for all home care workers to be registered with the SSSC (Scottish Social Services Council). A manager who has taken up employment in a home care service must register with SSSC within six months and 15 days (90 hours) of post-registration training and learning throughout their registration period of three months.⁷¹ All supervisors in a care at home service must be registered with the SSSC by 30 June 2017. Supervisors who are new to the role after 30 June 2014 must register within a six-month period after taking up employment and they must complete 10 days (60 hours) of post-registration training and learning throughout their registration period of five years.

3.4.1 Synthesis of registration/licensing and/or accreditation of home care services and staff and its process

To achieve accreditation, home care service providers in Germany and the Netherlands are expected to operate using a quality management system, such as ISO 9001, to guide their own in-house quality management, while also ensuring that staff are properly qualified and suitably remunerated. Annual audits are carried out by external bodies in Germany and the Netherlands to assess adherence to quality under the ISO standards, and accreditation is awarded if the audits meet the standards. Scotland and Sweden operate a national compulsory registration scheme. The Care Inspectorate in Scotland use nationally agreed standards to assess applicants as to their suitability as care providers for first registration and annual re-registration. In Sweden accreditation criteria are determined at municipal level which indicates that they may differ in each municipality.

3.5 Home care provider and staff training requirements, competencies, and assessment

Germany

Since 2003, the qualification and training levels for home care staff have been set at a reasonably high level.⁷² Body-related care work requires between two and three years of professional training, there are also regional initiatives which aim to enhance qualification levels across the sector.^{28,73} There has been a notable increase in the number of those with qualifications working in the home care sector.⁷³ Typically, in German home care services, the professionals providing nursing care are qualified nurses; the professionals providing personal care are fully qualified nurses for the aged; the professionals providing domestic care are home helps, who require a training period ranging from three months to one year.³²

In order to target adequate provision of home care, and also attempt to regulate and formalize the black market care economy, unskilled mini-jobs (up to €450 per month), and

midi-jobs (up to €800 per month),⁷⁴ were introduced and now constitute a large part of the domestic/home help side of home care.^{74, 75} Mini-jobs are specific part-time employment contracts which dominate the market in relation to the provision of domestic services and are typically filled by women and migrant workers.^{74, 76} Bode and Chartrand⁷³ highlighted how migrant workers account for a large percentage of the home care workforce, often in a live-in capacity, and can be both informally and illegally engaged in such work.⁷³ Mini-jobs and midi-jobs have been developed to facilitate women and migrant workers to help to fill the provision gap, particularly pertaining to the more domestic task side of home care.^{74, 77} This is somewhat problematic, as it essentially legitimises lower levels of pay for predominantly women and migrant workers.

The Netherlands

There are formally established minimum criteria for the educational qualifications of home care professionals, and other workers, engaged in the provision of home care in the Netherlands. The Ministry of Health, Welfare and Sport has set out these minimum criteria (see Table 6), as outlined in the OECD report, *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care*.

Table 6 Long-term care workforce requirements in the Netherlands

National training available for LTC workers/minimum requirements in curriculum	Job title or category	Training content and duration
Yes	Care work assistant	Vocational Training Level 1: One year of training, no prior requirement. Mainly practice based.
Yes/national curriculum	Care work/social care work helper	Vocational Training Level 2: Aged at least 16 years, two years full-time assistant vocational education. Theory based.
Yes/national curriculum	Individual carer	Vocational Training Level 3: Requires preparatory intermediate vocational education (VMBO) or equivalent prior education (including diploma level 2); three years training.

Source: OECD/EU, 2013²⁸

Genet *et al.*,¹³ have also listed the different types of workers involved in Dutch home care and their corresponding training.

- Domestic workers – household work, daily shopping, and so on - no specific training
- Auxiliary helps/Care work assistant (level 1): household work - no training necessary but one-year vocational training is available for this role

- Home help/Care work/social care work helper (level 2): some personal caring tasks and sometimes household tasks - two years' vocational training
- Certified nursing assistants/Individual carer (level 3): caring work, some household tasks and drawing up and evaluating care plans; some nurse's aides help with basic nursing tasks (catheter; skin care) – three years vocational training
- Nurses (level 4): nursing, planning and coordination of care – three years' vocational training
- Nurses (level 5): (technical) nursing and supervision of other home care professionals – four years (higher) vocational training
- Nurse specialists (sometimes also called nurse practitioners; masters level): independent treatment and follow-up of specific (chronic) conditions, in some cases including drug prescriptions (this is being trialled) – academic education at masters level.^{13, 28, 32, 56}

There is an increasing presence of private for-profit organizations on the provider side of the home care services market.^{3, 12, 77} An example of this type of provision that has been somewhat lauded is the introduction and expansion of 'Buurtzorg' (care in the neighbourhood) during recent years. Buurtzorg is delivered locally via autonomous teams of community nurses and other highly trained carers who provide comprehensive home care, facilitated by using ICT applications to manage their work, thus reducing the need for office/administration overheads.⁶⁶ It has been extolled for reducing overhead costs, increasing home care staff efficiency, improving quality, and engendering high levels of satisfaction in both care recipients and staff.⁵² Results of the mandatory national quality of care assessment as reported by *The 'Make or Buy' Decision in Long-term Care: Lessons for Policy Final Project Report* have shown that Buurtzorg ranks number one in terms of user satisfaction with home care organizations.²⁹ In 2011, it was awarded a prize for best employer in the Netherlands among organizations with 6,000 employees or more.²⁹

Scotland

Home care is provided by three sectors: voluntary, private and local authority.^{36, 68} In general, the home care workforce had a low skill level, but this has begun to change in recent years.⁷¹ As stipulated in the National Care Standards, home care agents are required to have a specified number of suitably qualified staff working within their organization. The drive towards obtaining a relevant qualification is particularly seen in certain roles, such as managerial roles within the home care sector, as it is mandatory since 2014 for home care managers to be suitably qualified in order to be registered with the SSSC (Scottish Social Services Council).⁷⁸ To be suitably qualified, persons must be awarded a National Vocational Qualification, which in Scotland is referred to as an SVQ (Scottish Vocational Qualification). Alternatively, modern apprenticeships have also been developed for persons working in the home care sector who wish to remain working, for financial reasons, and wish to gain a qualification concurrently. The SVQ levels are ranked on the Scottish Credit and Qualification Framework.

The National Care Standards state that by 2008 at least 50% of personal care workers must have a suitable SVQ or a comparable qualification.⁷¹ For home care workers, a qualification in Social Services and Healthcare (SVQ Level 2, 3 and 4) and Care Services Leadership and

Management (SVQ Level 4) would be seen as the most suitable. The Social Services and Healthcare SVQ Level 2, 3 and 4 qualification can be gained through standard learning or can be attained through a modern apprenticeship.⁷⁹ As the SSSC requires all carers to have, or to be working towards, a formal qualification, the Social Services and Healthcare SVQ Level 2 qualification is designed for all support workers in the home and community care sector. While the Social Services and Healthcare SVQ Level 3 is for all carers in the home and community sector, it is also particularly aimed at carers in a supervisory role. The Social Services and Healthcare SVQ Level 3 and the Care Services Leadership and Management SVQ Level 4 are designed for management in the care sector, and are required in order to gain certification and recognition of the management skills necessary to run a home care service.⁷⁹ An additional requirement of the Care Inspectorate is the need for all home care employees to be suitably qualified and trained in hygiene and food safety.⁶⁸

Sweden

In Sweden, there are no specific national requirements or qualifications for persons working in public or private home care services.^{28, 63} Municipalities are in charge of the provision of care for care recipients with disabilities and the elderly; municipalities also purchase care for recipients from both private and public providers.²⁶ All home care staff are expected to be trained to a specific level, and there are specific educational programmes pertaining to care training.¹³ The SSA (Social Services Act) states that staff must be suitably trained or have suitable experience, and basic training levels are quite high.^{63, 80} The NBHW (National Board of Health and Welfare) recommends that basic care training and qualification for care workers 'be equivalent to a three-year secondary school healthcare programme'.⁶³ Care assistants are the most common type of home care worker, and they receive strong occupational training with both health and social care components.⁸⁰ The number of care workers with suitable qualifications or training increases by around 2% annually.⁸¹ In 2012, 75% of home care workers had attained a good basic care training qualification.⁸² Table 7 highlights the qualifications typical of staff involved in home care services.¹³

Table 7 Qualification requirements for home care staff – Sweden

Title	Qualification
Home Help Assistant	Three-year upper secondary school education
Personal/Care Assistant	Short course on role of personal assistants/three-year upper secondary school education
Home Help Officer	Three-year university education (i.e. in management and service assessment)
Assistant Nurse	Three-year upper secondary school education
Registered Nurse	Three-year university education/advanced level
Primary Nurse	Four-year university education/advanced level, as well as certificate in prescribing drugs from a limited list

Source: Genet *et al.*, 2013¹³

A clear need for more specialist nurses in elderly care in areas such as gerontology has been identified, with only 1.6% of nurses working in eldercare trained in this speciality.^{81, 83} There are a number of initiatives to help with the development and upskilling of care staff.^{63, 81} In 2011, a new government initiative called *Boost for Carers* was launched.⁸³ This four-year

education scheme is dedicated to improving overall competencies among long-term care sector employees who have no professional education.⁶³ The initiative was allocated SEK 1 billion by the Swedish Government.⁸³ Municipalities and training providers, who deliver courses in specialist areas such as gerontology nursing and geriatric care, were entitled to apply to receive a specialist grant from the initiative.⁸³ In 2013, a budget of SEK293.5 million was allocated for third level and high secondary level educational courses pertaining to long-term care .⁸³ Subsequently, the NBHW began to provide third-level training in leadership for managers working in the eldercare sector. Course fees are paid by the Government, whereas the municipalities pay for other expenses such as travel costs and temporary accommodation.⁸³

3.5.1 Synthesis and commonalities in staff training requirements

Germany, the Netherlands and Scotland have minimum training criteria required for home care workers. The correlation between the levels of minimum staff training and common home care worker grades is relatively similar across the three countries. Sweden is perceived to have good levels of basic training for home care workers, however there is no regulated minimum training requirement.

Table 8 shows that there are relative similarities in the types of training required to work as a home care/home help assistant across the four countries. Sweden has a longer basic training period, which corresponds with the perception of high levels of basic training.⁸⁰ Training in Scotland is attributed to a qualification level (SVQ) rather than duration of training time, which nevertheless is of a similar weighting to the other countries.

Table 8 Commonalities in staff training requirements across the four countries

Country	Home Help	Care/ Personal assistant	Nursing assistants	Nurse carers/ Specialists
Germany	0-3 months - 1 year	2–3 years	2– 3 years	3–3+ years
The Netherlands	0–1 year	2 years	3 years	4–4+ years
Scotland	SVQ Level 2	SVQ Level 3	SVQ Level 4	Nursing degree
Sweden	Three-year upper secondary school education	Three-year upper secondary school education – short course – three-year university course (for management role)	Three-year upper secondary school education	3–4-year degree

3.6 Inspection regime and routine monitoring (including performance indicators) for home care services with respect to the application of relevant national standards

Germany

Quality management and assurance is intrinsically linked in to the LTCI (long-term care insurance) law. The MDK (Medical Board of the Health Insurances) oversees the quality assurance procedure. Home care providers are obliged to undertake their own internal quality assurance in their agencies; the MDK examines whether the requirements have been fulfilled.³²¹³ The MDK previously operated a dual inspection role: the first was to respond to complaints by clients; the second was to carry out random examinations of care provision agencies without advance notice.^{13, 32, 72} This has subsequently been replaced by annual inspections by the MDK, alongside continuing to follow up on complaints pertaining to the quality of home care services.²⁷ The home care service is awarded a score based on the outcomes of the inspection. The score ranges from 1 (excellent) to 5 (insufficient).²⁷ The scores and results of these examinations are published as summary reports on the Care Guide website www.pflegelotse.de for public consumption.^{13, 26, 29} Data are also collected on waiting times for long-term care services.²⁸

The 2011 changes, which led to the increase in inspections of services (now annually), also introduced *transparency criteria*, as described in section 5.2. The transparency criteria are based on items and questions taken from the general guideline for inspections by the MDK, and are agreed upon by the most important stakeholders.²⁹ Quality inspections of non-residential facilities, including home care services, are based on the assessment of 49 criteria that cover four quality areas:²⁸

1. Nursing care services – 17 criteria
2. Medically prescribed nursing care services – 10 criteria
3. Service provision and organization – 10 criteria
4. Client interviews – 12 criteria.

Thirty-seven of these items are used as transparency criteria to inform the publicly available scores for services;²⁸ client interviews are not part of the transparency criteria and thus do not influence the final score.^{28, 84} Therefore, the 17 nursing care criteria, the 10 activities prescribed by the GP, and the 10 service organization quality criteria are used as transparency criteria.²⁹ Typically, the annual inspections are carried out by a team comprising a qualified community worker, a registered nurse and an administration employee.²⁸ The team looks at the quality of the basic and home nursing care received, and the quality of the home help domestic services; an evaluation of the care documentation is also undertaken.²⁸ During the unannounced inspections, which last between one and two days, the performance of the service is rated both in each individual area and as an overall grade.²⁹ The inspection team may provide advice on improving quality to the home care services.²⁸

There has been some criticism of the quality monitoring process as services have been identified as having a tendency to respond to the quality inspections by ‘focusing their quality assurance activities exclusively on those criteria that are controlled by the scheme’²⁹;

rather than focusing on overall good quality. A SWOT (strengths, weaknesses, opportunities, threats) analysis in the *'Make or Buy' Decision in Long-term Care: Lessons for Policy – Final Project Report*²⁹ highlights some issues with the transparency criteria mode of inspection and use of the results (see Figure 2). The dominant criticism of this rating system centres on two points. One, the emphasis on care documentation and service provision as opposed to focusing on outcomes;^{28, 29, 53} and two, that the overall score given is an unweighted average of all the criteria evaluated, which can lead to a service with very poor results in one area receiving an overall positive score.^{28, 29, 53} For example, the outcomes indicators that were recorded in home care quality assessments, only for formal home-based care, were the following:⁸⁵

- Care provision according to wishes
- Expectations are taken into account
- Satisfaction with housekeeping.⁸⁵

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Stakeholder involvement</i>: Transparency criteria were identified by involving relevant stakeholders • <i>Inter-organisational quality assurance</i>: The establishment of the MDK as a federal entity to carry out needs assessment and quality assurance (see also weaknesses) • <i>Standardisation</i>: Public reporting of individual organisations' performance is made available on a website 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Providers focus quality management on transparency criteria only • <i>Evidence-base</i>: Transparency criteria are not based on scientific evidence; reporting of unweighted measurements may lead to distortions • <i>Inter-organisational quality assurance</i>: The scheme does not sufficiently discriminate quality levels between providers (grades are hardly meaningful) • <i>Cost</i>: High costs and bureaucratic burden for intensive yearly inspections • <i>Applicability</i>: Reported demotivation of staff; little incentives for quality improvement • <i>Stakeholder involvement</i>: Little user involvement and no evidence about use of public reporting by users • <i>Other issues</i>: Problematic mixture of interests within the MDK: health insurers are responsible for both funding and quality monitoring
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Applicability and evidence-base</i>: A revision of the criteria has been announced in a mid-term perspective 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Other issues (governance)</i>: Duplication of quality assurance by new approaches of individual regions (Bavaria); further legal action by providers

Source: Rodrigues *et al.*, 2014²⁹

Figure 2 SWOT analysis of German transparency criteria quality assessments

Penalties incurred if quality requirements are not maintained can result in the termination of contracts by the LTCI.²⁷

The Netherlands

The Health Care Inspectorate (IGZ) is responsible for supervising the quality of services.^{12, 32} The quality programme for long-term care *Zorg voor beter* was launched in 2004. Standards were developed in collaboration with stakeholders in the care sector and by 2007 the *Quality Framework Responsible Care* was ready to be implemented. Oomkens, *et al.* (2016)⁵⁶ have explored how studies have shown that the introduction of quality-related registration processes and inspection services have aided the development of a home care market.⁵⁶

Home care providers are legally bound to have a policy in place that ensures appropriate, effective, efficient, patient-centred and needs-based care, and must have in place a quality system including systematic monitoring and annual reporting; annual reports are sent to the IGZ.^{13, 32, 33, 85} The annual reports and any complaints that arise within the ongoing monitoring process may lead to a further investigation by the IGZ. However, the IGZ does not act proactively in this regard, and only responds to information contained in the reports.^{12, 13, 32}

As outlined in section 5.2, the Quality Framework Responsible Care (QFRC) also encompasses the consumer quality index: CQI home care.⁸⁵ Surveys of care recipients' experiences are carried out using the CQI home care every two years.^{13, 32, 33} Because municipalities oversee the organization of domestic help provision, they are also obliged to evaluate their care recipients' experiences annually.^{13, 32} The results of the quality assessments are mandatorily made publicly available on the website www.kiesbeter.nl.^{13, 32, 52, 55} The QFRC allows the Board of Directors of the home care providers to review whether management is suitably in control of their quality and responsible care provision.³³ The quality committee, comprising members of the board, employees and representatives of care recipients, can discuss the results with management in respect of how they can be translated into quality policy and improvements in quality for the service.³³

A SWOT (strengths, weaknesses, opportunities, threats) analysis in the '*Make or Buy*' *Decision in Long-term Care: Lessons for Policy – Final Project Report*²⁹ highlighted some issues with the Netherlands' Quality Framework for Responsible Care (see Figure 3). Significant weaknesses highlighted in the analysis indicate that there is some uncertainty surrounding how the framework is related to the internal quality management. Of particular note is the fact that data collection is not routine; rather, it takes place over one 'measurement week'.²⁹

In 2012, the '*Kwaliteitsinstituut*' (Quality Institute) was established as a governmental body and was tasked with developing a framework for the measurement, monitoring and improvement of Dutch healthcare quality. It is focused on client and care staff perspectives as well as the perspectives of healthcare insurers.³² In addition, it is focused on strengthening quality standards in home care provision for all involved.^{28, 32}

<p>Strengths</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Public reporting of aggregated results by organisation • <i>Stakeholder involvement</i>: Indicators were developed by involving most relevant stakeholders; standardised questionnaires for users and their representatives • <i>Long-term care specificity</i>: Combination of organisational self-assessment and the assessment of user satisfaction • <i>Applicability</i>: Surveys are carried out by independent agencies • <i>Inter-organisational quality assurance</i>: incorporation of case-mix risk adjustment to facilitate comparison as well as ‘facility admission profiles’ and ‘agency intake profiles’, respectively • <i>Other issues</i>: Supported by large-scale improvement projects 	<p>Weaknesses</p> <ul style="list-style-type: none"> • <i>Standardisation</i>: Focus on selected indicators may incentivise providers to concentrate on those indicators only • <i>Evidence-base</i>: improving, but still restricted; furthermore, no evidence whether users’ choice is based on published data • <i>Applicability</i>: Unclear how the Framework is connected to internal quality management; data collection is not part of the routine in provider organisations, but takes place within one ‘measurement week’ • <i>Cost</i>: No information available, but resources for documentation and surveys are certainly considerable
<p>Opportunities</p> <ul style="list-style-type: none"> • <i>Inter-organisational quality assurance</i>: Benchmarking is being facilitated • <i>Stakeholder involvement</i>: The Framework has been continuously developed with providers and representatives of users, now coordinated by the new ‘Quality Institute’ 	<p>Threats</p> <ul style="list-style-type: none"> • <i>Other issues</i>: No further investment due to budgetary restrictions

Source: Rodrigues *et al.*, 2014²⁹

Figure 3 SWOT analysis of the Netherlands’ Quality Framework for Responsible Care

Scotland

The Care Inspectorate is an independent regulatory body which was created with the primary aim of inspecting care services in Scotland to ensure that they meet all requirements specified in law and in the National Care Standards.^{41, 68, 71} An inspection of home care services is carried out at least once every year by the Care Inspectorate.⁶⁸ The inspection reviews the standard of care provided by registered care services and whether there is an adequate level of beneficial outcomes for service users.⁶⁸ Home care services are assessed under four headings: ‘quality of care and support’, ‘quality of staffing’, ‘quality of environment’ and ‘quality of leadership and management’,^{41, 68} and they are awarded an appropriate grade, which is on a six-point scale from unsatisfactory (1) to excellent (6).⁴¹

The Care Inspectorate puts various protocols in place in cases where a care provider is not fully adhering to the care standards or is breaching regulations. If a care provider is seen to be deficient in certain areas during inspection, this is recorded in the inspection report and the manager of the service is expected to ensure that the issue is addressed.⁴¹ If the issues noted in the report are not addressed and there is a persistent or substantial failure to

address these concerns, the Care Inspectorate will place further conditions on the provider's registration.⁴¹

If the care provider fails to take the required actions highlighted in the inspection report, the Care Inspectorate will issue an '*improvement notice*'.⁴¹ The notice sets out the specific requirements needed in order to improve the care service as well as a timescale in which to make these improvements.⁴¹ If there is still no improvement following the issuing of an improvement notice, the Care Inspectorate can cancel the care provider's registration. It is also possible for the Care Inspectorate to take immediate action and cancel a care provider's registration, if a care recipient's life is perceived to be at risk.⁴¹

Sweden

The monitoring of quality in home care services is the responsibility of the State and Local Authorities, with government responsible for ensuring that the provision and organization of home care services is adequate and in line with regulatory criteria set out in the SSA (Social Services Act).⁵⁰ The SSA specifies that care services for older people must be of good quality that is improved on a regular basis, but does not identify how quality assurance should be carried out.⁵⁰ Local Authorities have autonomy in creating their own procedural mechanisms in quality management of their care services.⁵⁰ Erlandsson *et al.*⁵⁰ state that 'research reports and public investigations indicate, however, that local authorities' monitoring of eldercare, whether publicly or privately provided, often leaves a great deal to be desired'.⁵⁰

The National Board of Health and Welfare (NBHW) and the Health and Social Care Inspectorate (IVO) are two government agencies with a wide remit, including monitoring and evaluating social and healthcare services, supervising providers to ensure that they are operating in accordance with current legislation, and gathering and publishing reputable data.⁵⁰ While the IVO is in charge of issuing licences to private residential care providers, this is not the case for home care providers.⁵⁰ The NBHW is in charge of monitoring the quality and safety of care services in Sweden.^{13, 46} The NBHW works on a regional level and conducts evaluations, both organized and random inspections on home care services, as well as specially commissioned government assignments within the social and healthcare sector.⁴⁶ The NBHW also conducts investigations on its own; such investigations can be instigated by complaints or by certain concerns from persons such as care recipients and family carers or staff.^{46, 50}

Since 2007, the NBHW and the Swedish Association for Local Authorities and Regions have been commissioned to develop and undertake the monitoring of care services for the elderly.⁵⁰ This subsequently led to the creation of Open Comparisons, a national monitoring service for care services for the elderly.⁵⁰ The main aim of Open Comparisons is to enable people to compare and contrast the quality of different care services over time and between municipalities.⁵⁰ The data monitored by Open Comparisons comes from survey data, official statistics and national registers, with the NBHW carrying out two national surveys annually on care services for the elderly.⁵⁰ One survey focuses on the perception of service users on the quality of care provided to them, while the other looks at public and private care providers and Local Authorities.⁵⁰

Municipalities are obliged to collect this information in order to receive their national incentive grant to develop eldercare services. A further financial incentive is rewarded to municipalities that have raised the competency levels of their home care staff.²⁸ Prospective care service users and their family members can gather information on the quality of care services in their municipality from the Elderly Guide *Äldreguiden* website, which was developed by the National Board of Health and Welfare.^{28,46} Information from the Elderly Guide is gathered from the surveys produced by the Open Comparison monitoring service, with certain information sourced from register data.⁵⁰ The indicators used are based on seven different themes⁴⁶ which are listed in section 3.2 above. There is also an annual Open Comparisons Eldercare publication, which is primarily aimed at civil servants and politicians in Local Authorities.⁵⁰ This publication reports on the state of the eldercare sector at municipal level, with each local authority being rated from best to worst.⁵⁰ Data for the report are generally gathered from user satisfaction surveys and also include measures of costs and health conditions of the population.⁵⁰

The Swedish approach to monitoring in home care services primarily aims to ensure that the minimum quality standards are being met across the sector.⁶² The monitoring system has been criticised for being mainly reactive and focused on responding to complaints by care recipients.⁶² However, while Sweden may lack focused monitoring tools for long-term care, particularly home care, it does have a number of well-established registries related to elderly healthcare.²⁸ One of these, the Senior Alert registry, gathers specific information on elderly patients (e.g. falls, malnutrition and pressure sores).^{28,83} In addition, there is a palliative registry and a dementia registry, which also collect reliable data on older people.^{28,83}

3.6.1 Synthesis of inspection regime and routine monitoring for home care services

As mentioned earlier, each country has developed quality/performance indicators related to their national quality standards, except in the case of Sweden where standards and quality are determined at individual municipal level. In Germany and Scotland random inspections are carried out on home care providers annually to ensure standards are adhered to, and in addition, specific complaints are investigated separately. The Netherlands monitor home care services via annual surveys and inspections are only carried out in response to specific complaints. In Sweden, both regular inspections and responses to specific complaints are carried out alongside monitoring via surveys conducted twice yearly. Transparency is a guiding principle in Germany, the Netherlands and Sweden, where they publish results of home care service quality inspections on publicly accessible websites, with the aim of facilitating informed choice for home care recipients. Germany, the Netherlands, and Scotland operate sanctions if quality standards are not adhered to. Conversely, in Sweden they operate a reward based-system to meet required standards.

3.7 Cost of regulation of home care services and who funds the regulatory regime

Germany

When the LTCI (long-term care insurance) law came into being, as a specifically focused part of the existing social insurance system, it defined principles for the regulation and the expansion of the care sector.² Fundamentally, the sector's new approach was to respond to market principles and promote competition, value for money and improved quality in care services for users.² The change in the law opened up the market to both for-profit and non-profit providers of home care.²

The LTCI funds are key actors in the regulation of the care market, including the assessment of needs and the inspection of quality of care.²⁹ They set the prices for home care services and administer the payment of cash and in-kind benefits.²⁹ As discussed in section 3.6, the MDK (Medical Board of the Health Insurances) acting on behalf of the LTCI regulates the home care sector insofar as it monitors and evaluates the quality of providers' services, thus allowing them to continue being providers or not. The MDK is funded by the overarching statutory health insurers and also by the sickness funds, and it is organized at Länder level.^{28, 54}

At Länder level the states oversee the regulation of long-term care, including home care, and may also finance investments in home care agencies.²⁷ Actors on behalf of the purchasers and providers also have a vested insurance in the regulation of the sector, alongside the states, as they help to determine the quality standards during the contract negotiations.²⁷

With regard to regulation at local level, the 2008 policy reforms in long-term care saw funds being allocated to the creation of 400 new community care centres in at least 14 Länder, called Pflegestützpunkte.²⁶ The community care centres provide information, carry out needs assessments of clients, provide care management and counselling services, and provide information on available services in the neighbourhood.^{26, 75} The legal function of the community care centres is to establish networks and relationships with regional and community care providers in order to improve local care provision for those in need of home care within the community.²⁶

The Netherlands

We did not find any evidence that explicitly answered this question in terms of directly identifying the costs of regulation and who funds the regulatory regime. It is unclear who exactly pays for what in this regard. Nevertheless, there is some relevant evidence that indirectly influences potential answers to this question presented here.

The home care system is organized on the principle of regulated competition among providers of care services.¹³ The regulation that has been developed in this regard includes:¹³

- The introduction of cash benefits or personal care budgets that permit clients to contract their preferred providers
- The introduction of payment per type of service provided, instead of payment per type of client, which is not restricted to a certain number of hours¹³
- A separation of the financing schemes for nursing and personal care services from those for domestic help services. This allows commercial cleaning agencies to provide domestic services.
- The Dutch Healthcare Authority (NZa) established as a 'market watchdog' to safeguard access
- Quality and affordability in order to preserve competition
- The introduction of selective contracting and bargaining on price and quality, instead of the obligatory contracting of home care agencies by the regional purchasing offices.¹³

The Dutch system is predominantly publicly funded.⁸⁶ The NZa regulates the long-term care tariffs and monitors the conditions of competition. The NZa also sets maximum prices, where collective bargaining between purchasing agencies and providers is permitted, to determine the prices that they set.^{29, 34} Central government under the auspices of the Ministry of Health, Welfare and Sport and via the Dutch Healthcare Inspectorate (IGZ) are responsible for legislation, regulation and supervision on the quality side.⁸⁵

Scotland

The Scottish Government is responsible for commissioning the two independent regulatory bodies that are the sole regulators of the social care sector, including home care providers, in Scotland. The SSSC (Scottish Social Services Council) is funded through grant in aid and specific funds for special projects, both from the Scottish Government.⁸⁷ It also receives operational income from funding for practice learning, registration and other miscellaneous fees.⁸⁷ The SSSC received £13.9 million in grants and grant in aid from the Scottish Government in the 2014/2015 financial year.⁸⁷ The total operating income received by the SSSC was £3.9 million, with £1.6 million of this received through registration fees.⁸⁷ A total of £14.2 million was received in funding in the financial year 2014/2015.⁸⁷

The Care Inspectorate received £21.4 million from the 2014/2015 Scottish Government budget, which resulted in a total budget of £35.8 million when other financial income such as registration fees from newly registering care services, renewal registration fees and additional operating income is included.⁸⁸⁻⁹⁰ Registration fees for a home care organization depend on its size and whether it is newly registering or renewing its registration; fees can vary from £1,261 for a small (fewer than three employees) home care organization to £2,798 for a larger home care organization (15 or more employees). Annual renewal fees vary from £676 for a small organization to £2,255 for a larger organization.⁹¹

Sweden

The decentralization of long-term care, as well as Sweden's self-regulatory approach, has made it difficult to ascertain how much is spent on regulating home care services in Sweden. Each municipality manages the financing and provision of home care services,

develops its own regulatory procedures and establishes performance-based incentives to promote the highest quality by care service providers.⁶³

As outlined in section 3.1, the primary legislation that regulates long-term care is the SSA (Social Services Act), which includes a goal-oriented framework aimed at providing satisfactory care to citizens with care needs, such as the elderly, so that they can live independently.⁸² Any care recipient who is dissatisfied with the care they are provided with is entitled to make an appeal to the administrative court.

The Act on Public Procurement (LOU) 1992, amended in 2007, and the LOV Act 2009 provide national regulations and control the marketization of long-term care.⁸² Municipalities and county councils that outsource care services are required under the LOU Act 'to conduct competitive tendering using a confidential bidding process'. Since the introduction of the LOV Act in 2009, private providers have been permitted to enter the long-term care sector; in addition, marketization of the long-term care system has increased.⁶³

3.7.1 Synthesis of cost of regulation of home care services and who funds the regulatory regime

In each country, regulatory bodies are or appear to be partly funded through contributions made by recipients of care via long-term care insurances, or by registration fees paid by care providers. The evidence available suggests that in Germany and the Netherlands regulation is paid for via the insurers (Germany) or through tax-funded municipalities (the Netherlands). In Sweden, each municipality relies on a self-regulation model and the evidence available suggests that the municipalities pay for this out of collected tax funds. Regulation by the Care Inspectorate in Scotland is funded through its annual grant, as well as monies accrued from registration fees for new providers and re-registration fees for existing providers.

4 Staff and client experiences of, and effectiveness of, home care regulation in four countries

This chapter was expected to present the evidence on staff and client experiences of formal home care regulation and the effectiveness of home care regulation in Germany, the Netherlands, Scotland, and Sweden. However, there was a significant lack of available evidence to effectively answer the research questions guiding this chapter. We found some information that indirectly provided some evidence on client and staff experiences of regulation of the home care sector in the four countries. Nevertheless, there was no evidence found to effectively answer the questions guiding the final sections pertaining to baseline assessments, continuous monitoring, and reviews and evaluation.

4.1 Client experiences

There is a lack of available information in English to provide explicit evidence regarding client experiences of, and effectiveness of, home care regulation in any of the four countries. However, a very small piece of information was found in the review of evidence that could indirectly contribute to answering this question with respect to a minor aspect of home care regulation in Germany.

Germany

A paper by Theobald⁷² refers to the specific issue of regulation of migrant carers, whereby a legal care worker recruitment scheme was introduced in 2002 to hire workers from eastern European countries and regulate their employment situation as domestic carers to families with care-dependent members.⁷² This scheme became permanent in 2005.⁷² The regulations involved were concerned with 'regular working conditions or social security standards in Germany'.⁷² Research in relation to the scheme revealed that care recipients found the regulations involved too bureaucratic and as 'not corresponding to their own needs'.⁷²

4.2 Staff experiences

There is a lack of available information in English to provide explicit evidence regarding staff experiences of, and effectiveness of, home care regulation for any of the four countries. However, there is a small amount of information that was found in the review that could indirectly provide some evidence on staff experiences of the regulation of home care in Germany and the Netherlands; this information is presented here.

Germany

Evidence reported from a 2010 survey of care providers in Germany suggested that with regard to experiences of quality monitoring two thirds of home care service providers were dissatisfied with the paperwork, lack of focus on outcomes and arbitrariness of the audit carried out by the Medical Advisory Boards.^{9, 18} This led to plans to change the audit process and the underlying guidelines.^{28, 53}

The 2011 OECD report *Help Wanted? Providing and Paying for Long-Term Care*⁵ briefly describes home care regulations concerning the delivery of home care as often being a lot less detailed or strict than those for residential care. The report states that it is likely that home care workers have less representation and therefore do not have much of a voice in advocating for their needs.⁵ Wages and educational requirements are lower among home care workers compared to staff in residential care settings, even for those who do hold similar qualifications.⁵

The Netherlands

A study by Chen⁹² found that Dutch home care staff experienced a generous level of employment support and were facilitated to participate in a partnership approach to designing and organizing upskilling training programmes. Staff evaluation procedures allow for training needs to be recognized.⁹² Nevertheless, on the negative side, expectations surrounding training, knowledge, and skill development were perceived to be so high that they can cause demotivation.⁹² This is exemplified in this quote from the paper:

‘Two years ago, [my employer] asked me to do a new diploma, so I can do more complex care with people, like giving them medication. I had studied very hard to get the post-qualification level seven, but I was told a few days ago that it wasn’t enough, and I have to complete levels nine and ten in order to have promotion. I did everything and that is frustrating for me.’ (Dutch care worker)⁹²

Chen’s study also sheds light on the way that the organization of the Dutch home care system allows for a dichotomous situation to prevail, wherein expectations are high in terms of training and professional development but wages are getting lower because the cash benefits/personal budgets system allows care recipients to pay lower prices for their care.⁹² Consequently, this silences calls for wages to match qualifications (at a professional level) as there is potentially a pool of suitably qualified workers willing to work for less.⁹²

4.3 Synthesis of staff and client experiences of, and effectiveness of, home care regulation

There is a lack of relevant available evidence about experiences of regulation of the formal home care sector. Information that can be tenuously attributed to care recipient (client) and staff experiences of the regulation of home care services was gleaned from papers discussing reports on more generalized user and staff surveys. These surveys are typically undertaken annually or biennially; however, in Sweden, user satisfaction surveys are conducted twice a year. There was no evidence pertaining to care recipient’s experiences of regulation of the formal home care sector rather the surveys assessed recipients’ satisfaction with the services received and the majority of users were satisfied. Reported evidence suggests that care staff in particular have low satisfaction with their experiences of regulation in the formal home care sector, for example, home care staff reported that the minimum training requirements were high but the pay rate and working conditions did not meet minimum training requirements. We did not find any available evidence pertaining to baseline assessments, continuous monitoring and reviews and evaluation of the effects of formal home care regulation, as this type of appraisal of services does not appear to be undertaken, or if undertaken, does not appear to be published in English.

5 Approaches to accessing financing and financial management of home care services in four countries

This chapter details the evidence available to describe the four countries' approaches to assessing the eligibility of care recipients, the entitlements and basket of services available to care recipients, the financing mechanisms used to fund home care, and the financial management of home care services. The information is presented by country.

5.1 Germany

Since Germany initiated a long-term care insurance scheme in 1995, it has been oriented towards market principles in line with new public management ideology. As there is an existing culture of statutory health insurance people generally have an expectation that they must pay for services in this realm. The LTCI (long-term care insurance) is organized around the principle of individual responsibility which includes looking after the financial cost of the provision of some care expenses.

5.1.1 Eligibility/Needs assessment

Eligibility for benefits relating to home care is dependent on a recurrent inability to fulfil basic ADL (activities of daily living), and to some extent IADL (instrumental activities of daily living), for at least six months.¹³ People in need of care must have made at least six months of contributions to the LTCI prior to being eligible to avail of allowances.³⁴ Home care provision in Germany consists of ADL care with some IADL care, some basic nursing, and light supervision of basic medications.¹³

Home care is assessed by the MDK (Medical Board of the Health Insurances) from Pflegestützpunkte centres in locales that have them for the social LTCI, or an equivalent body for private LTCI,^{34, 75} by looking at needs for basic care regarding nutrition, mobility and hygiene, and household assistance – basic cleaning, food shopping, and cooking meals.³¹ Care advisers who carry out the assessments are staff members of the MDK; they analyse the need for care on the basis of an MDK report, then set up a plan for the provision of benefits and care-based social assistance.²⁸ When assessments are complete, a care level is assigned to the care user; the care level from 1995–2016 ranged from care level I (considerable need for care) to care level III (extreme need for care).^{31, 74} Corresponding payments and time allocations were issued according to the level of need.^{31, 74} For example:

- Care level I – a person requires at least 90 minutes of help every day of the week.
- Care level II – a person requires help three times a day, for at least 180 minutes, every day of the week
- Care level III – a person requires round-the-clock help every day and requires an average of at least 300 minutes of help every day of the week.⁹³

In 2016, new reforms to the LTCI redefined the previous three care levels based on physiological impairments; they will be replaced by five care grades based on physical, mental, and psychological disabilities.⁹³ The new assessment criteria will determine who is 'in need of care' by measuring impairments of independence or incapacitation in six areas, each of which carries a specific weighting:

1. Mobility
2. Cognitive and communicative abilities
3. Behaviour patterns and psychological problems
4. Level of self-sufficiency
5. Health restrictions, demands, and stress due to therapies
6. Structure of everyday life and social contacts.⁹³

The weighted scores will be added to a total result of between 0 and 100 points, where Care Grade 1 will be on the lower end of the spectrum, at 12.5 to 27 points, and indicates little impairment of independence.⁹³ At the top end of the spectrum, Care Grade 5, with 90 to 100 points, will reflect hardship cases. The time-allocated care levels are no longer relevant within these new criteria.⁹³ The need for care is assessed regularly, typically every six months, and assessors must evaluate whether reasonable care or measures have been provided.²⁸ This is also important regarding any change in the care level required.²⁸

5.1.2 Entitlement

The financial care allowances have been reformed in conjunction with the revision of care needs assessments, and from the beginning of 2017 will reflect the rates shown in Table 9. The new system is expected to be of greater benefit to those suffering from dementia⁹⁴ and to generally provide slightly higher payments to most care users.⁹³ Nevertheless, the new payments will result in an additional 0.2% increase in the contribution rate, starting January 2017.⁹³

Table 9 Monthly benefits per care level paid by the LTCI

Types of benefits	Care Grade 1	Care Grade 2	Care Grade 3	Care Grade 4	Care Grade 5
Care allowance	€125	€316	€545	€728	€901
Outpatient care: benefits in kind		€689	€1,298	€1,612	€1,995
Inpatient care: benefits in kind	€125	€770	€1,262	€1,775	€2,005

Source: Bäcker, 2016⁹³

The purpose of the cash allowances administered to those in need of care is for recipients to purchase their preferred mode of home care within the realm of what is available to them.²⁹ Those in need of care are offered a choice between cash benefits and in-kind services.²⁸ When a care recipient is approved for the benefits, they receive a notice of approval from the LTCI along with a list comparing the services and prices of the facilities in the area.²⁸ Regarding home care, people can receive cash benefits and pay for 'informal care', typically from family members, or they can avail of formal home care by using their cash benefits to purchase directly from the provider.³⁴ The organization of the system in this way allows the sector to continue to rely on the informal care sector, such as family members, to provide a large proportion of care needs.²⁹

5.1.3 Basket of services

The basket of services available to those in need of home care can be defined as a user-choice-oriented system.²⁶ Care recipients are able to choose their preferred provision in terms of cash or in-kind services from among a wide range of public, private/for-profit, and non-profit home care providers.^{26, 75} It may be possible for recipients to avail of a combination of in-kind services and cash allowances.²⁶ The amount of benefit received is measured in terms of the care grade assigned to the care recipient, as outlined in Table 9, and typically home care is expected to last for at least six months.³⁰

The Alzheimer Europe⁹⁵ website lists the kinds of specific services that are covered within home care in the LTCI:

- **Personal hygiene**, such as washing, showering and bathing, dental hygiene, combing, shaving, and assistance going to the toilet
- **Nutrition**, such as assistance with eating
- **Mobility**, such as assistance getting into and out of bed, standing up, going up and down stairs, and leaving and returning to one's home
- **Care of the home**, such as shopping, cooking, cleaning, washing pots, changing and washing clothes, and heating the home
- **Organized care**, such as respite care, day care, and night care
- **Various aids**, such as nursing aids and technical aids.⁹⁵

A 2011 report by Bode and Chartrand⁷³ referred to specific fixed prices for the various basket of service acts listed on the Alzheimer Europe website;⁹⁵ nevertheless, we found no such information in any other source available in English.

5.1.4 Mix of funding mechanisms

The statutory health insurance scheme is compulsory and includes coverage for social LTCI, as well as private LTCI for those with higher incomes. Social LTCI is available to all of those in need of care who are insured under the statutory health insurance scheme and thus is financed almost exclusively by the contributions they pay.⁷⁵ In the case of people who are unemployed, contributions to the LTCI are deducted from their unemployment insurance.⁷⁵ Private-sector home care services are available to all those in need of care who are insured with private health insurance companies; people with full-coverage private health insurance are also covered under the LTCI. The benefits are the same in both schemes: they cover basic provision and typically do not cover all requirements, thus there is an element of co-payments involved for care recipients.²⁸ OECD data referred to in the *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability: Volume 2 – Country Documents*³⁴ suggest that 25% of overall long-term care costs are co-payments, while Theobald and Szebehely⁸² have suggested that home care recipients may be co-financing approximately 33% of the home care costs themselves.⁸²

Figures from 2013 show that the total expenditure on health in Germany was 11.3% of GDP, with public spending representing 8.7% of GDP.³⁴ In 2012, the statutory social health insurance bore 57% of total health expenditure.³⁴ Other social insurance schemes bore 10.7% of expenditure, private health insurance - 9.3%, public authorities - 4.8%, and

employers - 4.3%,³⁴ while private, out-of-pocket payments covered by care recipients amounted to 12.9%.³⁴ Regarding long-term care explicitly,² public expenditure was 1.4% of GDP in 2013;³⁴ 69% of this was in-kind benefits and 31% was direct cash benefits.³⁴

In 2005, concerns about the financial sustainability of the LTCI led to a requirement for childless adults to pay an additional percentage of their income to the insurance scheme.⁹⁶ The rationale behind this was to offset the contributions that having children would have provided, in terms of the ability of adult children to provide care and of their additional contributions to the LTCI.⁹⁶ When introduced, the payment was an additional 0.25% of childless adults' income;⁹⁶ since January 2017, childless adults pay 2.8% of their overall income versus 2.55% for adults with children.⁹³

Genet *et al.*¹³ refer to the home care spending breakdown for Germany in 2007, when the overall home care spend amounted to €7.9 billion, which was an increase of 6.7% or €500 million on the previous year.¹³ The cause of the increase was attributed to medically oriented nursing.¹³ The breakdown otherwise was as follows:

- Public budget: €444 million
- Statutory health insurance institutions budget: €2.37 million
- The statutory long-term care insurance institutions budget: €2.8 million
- Private insurance institutions budget: €108 million
- Private households: €2.02 million.¹³

It is widely identified that long-term care insurance benefits are insufficient to cover home care costs fully and therefore co-payments are typically required to cover some of the costs.^{13, 75}

5.1.5 Financial management

The way the German LTCI system is organized facilitates the negotiation of both prices and contracts between the LTCI and local or regional representatives of the care providers.¹³ An individual contract is then drawn up between the care provider and the LTCI.¹³ The role of the Federal Ministry of Health is to set a price list for the different aspects of long-term care at home, particularly those tasks which are more specific to home care.¹³ Due to regional differences, prices can vary.¹³

Despite the universality and recognition of rights for support in old age inherent in the introduction of the LTCI scheme, the system remains based on limited insurance entitlements and is not designed to cover all the care needs of care recipients.⁷³ The care package is capped, benefits are assessed and awarded based on the three (soon to be five) care levels, and recipients must choose which aspects of their care package they wish to have covered by the LTCI payments.⁷³ The system remains reliant on co-payments to ensure adequate care provision.^{29, 30, 73, 75}

² There are no figures available that specifically identify costs of home care only.

Ongoing reforms to the LTCI system since it was introduced in 1995 have seen several additions to the criteria for contributions. The reforms have mostly been a response to deficits caused by weak growth rates for contributions.⁷⁵ In 2004, pensioners were required to contribute to the LTCI.⁵ In 2005, the higher rate of contribution for childless adults was introduced,⁵ and in 2008, contributions to the LTCI were made compulsory for those with higher incomes.⁵

5.1.6 Does provision fall short of needs (rationing)?

The reforms outlined in the previous section were a response to the weak growth rate of contributions to the LTCI, due mostly to contributions only being levied on income from gainful employment and the benefits derived from having been engaged in gainful employment (pensions, unemployment benefits).⁷⁵ The introduction of mini-jobs (up to €450 per month), and midi-jobs (up to €800 per month),⁷⁴ which account for a large part of the domestic task side of home care,⁷⁴ have had a negative effect on contributions to the LTCI, as the low wages necessitate a lower contribution rate to the LTCI.^{74, 75}

Criticism of the German LTCI and funding mix has suggested that the system design has an expectation that informal care networks will take up the greater part of care responsibility for older people in the community.² While a reliance on the informal care sector is not explicitly interwoven into the criteria for care eligibility, the way the system is structured bolsters the use of informal care, in the view of critics.² The fact that the payments are below the cost of resources, thus not meeting all the care needs of recipients, allows for informal care to flourish as it is typically cheaper to obtain.² It is often the case that the preferred cash option, although it is less money, is used to compensate family members for their informal care provision.² Tax deductions were introduced in order to attempt to reduce informal and grey-market activities and to create a regular market for household services.⁷² Nevertheless, Theobald⁷² refers to estimates from 2010 citing more than 90% of services within the private household as still being conducted on an undeclared basis.⁷²

The introduction of the LTCI essentially saw the German Government create an open market of long-term care.²⁶ Legislation, standards, and regulation allowed for contracts to be drawn up between the LTCI and for-profit providers.²⁶ These providers range from very small companies, approximately 10 employees, to much larger organizations, thus affecting the previous local authority level of planning in the LTC area.²⁶ Despite the local Länder having a role in terms of regulation, quality, inspection, and so on, the wider organization of care provision is essentially centralized.²⁶ Accordingly, choice can mean more bureaucracy and less of a personal touch.²⁶ Nevertheless, according to the literature, the provision of home care in Germany presently does not appear to fall short of needs.

5.2 The Netherlands

Long-term care in the Netherlands, including home care service provision, has been subject to some extensive reforms in recent years. In 2015 the AWBZ (Exceptional Medical Expenses Act), which had been operational since 1968, was essentially deconstructed and the main provisions from it affecting home care were restructured to be delivered under three alternative acts. They are the Long-Term Care Act (Wlz), which regulates residential care and home care for people with intensive care needs requiring 24-hour-per-day supervision; the Health Insurance Act (Zvw), which regulates home nursing care and personal care that is funded by health insurers; and the revised Social Support Act (Wmo), which covers domestic home help and other personal home care support services. These reforms are a response to increasing demand and cost containment measures and, like Germany and Sweden, are following a new public management ideology towards organizing home care services.⁹⁷

5.2.1 Eligibility/Needs assessment

Genet *et al.* (2013)¹³ illustrated how until 2015 eligibility was set for home care by the national government for main home care services in the Netherlands, whereas social home care, such as domestic help was set by municipal/regional governments.^{13, 98} Needs assessments for nursing and personal care was carried out by the CIZ (Centre for Indication of Care³) and its regional branches, with exact eligibility and assessment criteria decided upon within the boundaries of the governmental guidelines.^{13, 77, 99} Municipalities can contract the CIZ to carry out assessments for domestic help, and since 2015 for personal home care services too.¹³ However, since the reforms, the Wmo is mostly responsible for assessing eligibility for all home care services, home help and personal home care.^{32, 35} Those who are deemed to need care following their needs assessment can be aided by Regional Care Purchasing Offices in finding a suitable provider of nursing or personal home care.^{32, 35} The offices also manage waiting lists, if necessary, and inform the Central Administration Office (CAK) what the rates to pay contracted care providers are.¹³ It has been noted that those who are deemed eligible for domestic help and basic home (personal) care services are likely to be subject to more limited choice than before, due to many municipalities contracting a limited number of providers for these services.^{13, 32}

Eligibility is not contingent on income; all persons are entitled to apply to be needs assessed but not necessarily entitled to services.³² Seven criteria are used to aid the assessment.^{32, 100} These criteria relate to:

1. General health status
2. Limitations in functioning as a result of the disease/handicap
3. The home and living environment
4. Psychological and physical functioning
5. Social circumstances
6. Amount and duration of currently offered care
7. Best suitable client profile.^{32, 100}

³ Also known as Care Assessment Centre (Centrum Indicatiestelling Zorg)

Colombo *et al.*⁵ set out the needs assessment process for long-term care generally, as it was in 2011. This is depicted in Table 10.

Table 10 Long-term care needs assessment process in the Netherlands

Who can apply for care?	What is the assessment process?			Who is entitled to care?	
	Assessment tool	Criteria and range	Assessor and process	Care categories assigned following assessment	Eligible users
All ages	Nationally standard tool created by the Ministry of Health	Psycho-geriatric or physical limitations. Limitations assessed on a four-point scale.	Independent governmental agency (Centre for Care Assessment, CIZ)	No specific categories; there are four steps to determine eligibility to care.	Eligibility takes into account ADL limitations, alternative solutions (rehabilitation or home adaptation), and ability of family caregivers to provide support.

Source: Colombo *et al.*, 2011⁵

The outcomes of a needs assessment made by the CIZ are valid for a fixed period which corresponds to the level of need assessed;¹³ the care provider is expected to observe this fixed period.¹³ Care recipients with more serious needs, for example, chronic conditions such as dementia, can be assigned care based on their needs assessment for an indefinite period.¹³ If the care recipient's situation changes, the type of care they receive and the intensity of it can be modified within parameters set by the CIZ.¹³ Alternatively, the care recipient can be reassessed based on their changing needs.¹³ The providers of care have a duty of care to monitor the needs of their care recipients.^{13, 32}

5.2.2 Entitlement

Following the needs assessment, the provision of care can be received in kind or via a personal budget, where the care recipient buys their own care.³² Personal budgets are no longer received directly by care recipients. They now operate more like a voucher system, with funds paid directly to care providers by the municipalities on behalf of the care recipients; they also typically require some level of co-payment.^{34, 101} It is typically easier to select care providers when purchasing one's own care; nevertheless, personal budgets are typically set at a lower rate than in-kind care provision.^{5, 32} There are restrictions surrounding the concept of formal versus informal care. Da Roit¹⁰² has noted stricter eligibility criteria for those in need of care who live with another family member, as there is an expectation that the family member(s) will provide informal care.¹⁰² As Kok *et al.* have

stated, 'only if there is no informal caregiver or if the informal caregiver does not want to provide as many hours of care as is needed by the client, is the client entitled to formal care'.¹⁰³

The table in the previous section, Table 11, sets out the main factors relating to eligibility and entitlement to home care services in the Netherlands. There are no age restrictions on entitlement to long-term care benefits.⁵ Essentially, any person who thinks they are in need of home care services is entitled to apply for a needs assessment which will determine their eligibility to receive services and what type of services they may be entitled to.⁵ The needs assessment does not depend on income, but income-related co-payments (possibly means tested against capital resources since 2013) are typically required.¹⁰³ Accordingly, this means that people in need of care are not automatically entitled to specific types of help and there is a complexity surrounding how municipalities provide support, which is compounded by cost containment measures.¹⁰²

The municipalities operating under the Wmo are financed by taxes, making the services they administer dependent on available funds, as each council is given a budget to administer home care services from.³⁵ Da Roit has noted that municipalities are financially incentivized to contain the costs of home help services, as savings on the home help budget are transferable to fund other non-home care measures which the municipalities are financially responsible for administering.¹⁰² Undoubtedly, this also now applies to personal home care services since non-serious (intensive) home care needs are also administered by the municipalities. On the positive side of evidence pertaining to entitlement, the Netherlands has previously been lauded for low waiting times, low co-payments and the 'entitlement to a broad-based benefits package at an affordable premium for all citizens'.⁹⁸ Conversely, the less positive side of entitlement to home care in the Netherlands identifies that recent reforms, particularly related to the cost containment measures that Da Roit¹⁰² discusses, have included a substantial reduction of both coverage and entitlement 'to ensure the sustainability of the LTC system'.¹⁰⁴ Consequently, for the government to provide home care services in a cost-effective manner, coverage of services and entitlement to services will be reduced and co-payments will likely increase.

5.2.3 Basket of services

We found no specific breakdown of the minutiae of the basket of services provided in home care in the Netherlands. Until 2015, the basket of services was covered by the AWBZ delivering in-kind care benefits or personal budgets that allowed care recipients to purchase their own preferred home care service.³⁵ As outlined in section 3.1, the provision system was split in 2007, with the municipalities taking on full responsibility for administering domestic help home care services, and since 2015 all basic home care services, bar those for people with more intensive care needs, have been decentralized to municipal level.³⁴ Therefore, evidence pertaining to the basket of services available is less transparent in the available literature.

The Alzheimer Europe website has previously listed examples of the types of services available under the home care system in the Netherlands:¹⁰⁵

- Home nursing
 - Giving advice on how to cope with an illness
 - Dressing wounds
 - Administering medication
- Personal care
 - Assistance with dressing
 - Bathing
 - Personal hygiene
 - Eating and drinking
- Home help and housekeeping
 - Cleaning
 - Tidying
 - Preparing meals
- Day care
- Respite care
- Night care
- Assistive devices.¹⁰⁵

5.2.4 Mix of funding mechanisms

Until the recent reforms resulting in the decentralization of the home care sector, the ABWZ (Exceptional Medical Expenses Act) was funded by a combination of social security premiums, taxes and co-payments.^{3, 13, 32, 35} Domestic help home care, and now personal home care services, are funded by municipalities from their central budget alongside income-dependent co-payments.³² Public expenditure on long-term care for the elderly is high in the Netherlands, at 4.2 % of GDP in 2013.³⁴

The Central Administration Office (CAK) has had the responsibility of setting rates for co-payments that care recipients must pay and is also involved in the collection of co-payments, and paying care providers.^{13, 32} The personal budget system was introduced on a trial basis in 1995 and by 2001 it was available for anyone deemed eligible for home care to choose rather than in-kind home care.¹⁰² Nevertheless, the preference for personal budgets increased so much that it began to become unsustainable in the context of wider home care expenditure. Allocated budgets were no longer sufficient to cover costs for personal budgets.^{98, 102} So, according to Schut¹⁰³ and Da Roit,¹⁰⁷ personal budgets have been somewhat curtailed since 2012. In some cases, particularly with reference to domestic help services, the municipalities can decide if a personal budget will be issued or not.³⁴ Nonetheless, those care recipients that do still receive a personal budget for nursing or personal care must account for their expenses once or twice a year.^{13, 32}

The premium that people pay towards long-term care insurance is 9.65% of the income tax, with a maximum limit of €33,589.³⁴ There is also an income-dependent co-payment for adults which is dependent on circumstances; for example, whether the care recipient lives at home or in residential care, is under or over 65 years for age, or is single, married, or cohabiting.^{32, 34} Income-related co-payments covered 10% of total costs of long-term care in

2015.³⁴ Co-payments were first introduced in the 1990s as a means to somewhat restrict access to services and promote individual financial responsibility.¹⁰² Nevertheless, low-income earners have a right to social assistance if they cannot afford to pay for co-payments themselves.¹⁰² There is also an expectation that care recipients with lower incomes may be able to access free-of-charge informal care if it is available to them.¹⁰² Those with more money are free to access their additional formal home care via the market.¹⁰² The municipalities decide whether a co-payment is necessary for a service, and if so, the CAK determines the amount.³²

5.2.5 Financial management

Quasi-markets were introduced into the home care sector in the Netherlands, as part of several new public management-oriented principles,¹⁰² which allowed for a wave of mergers between non-profit providers and for-profit providers.⁵² The maximum prices for home care services are set by the NZa (Dutch Healthcare Authority) in the Netherlands. Costs are set after consideration of labour costs, productivity and overheads, and assessment of the level of expertise required; prices are index-linked.¹²

Home help services since 2007, and personal home care services since 2015, are financially managed under the Wmo (Social Support) Act) by the municipalities; local councils operate using monies from a non-ring-fenced budget⁴ which is also dependent on tax intake.^{5, 29} The municipalities also carry out the needs assessments. Therefore, they have a large influence on how the services are allocated. Consequently, this differs across regions, as decisions are at the behest of the individual municipalities within the government-set parameters.²⁹ The home help services are typically provided by 'private for-profit companies that tender for contracts with municipalities under the Wmo, while personal care services within the Personal Budgets scheme are provided by private non-profit home care organisations'.²⁹ As outlined in section 5.2.2, Da Roit¹⁰² noted that municipalities are financially incentivized to contain the costs of home help services, as savings on the home help budget are transferable to fund other non-home care measures which the municipalities are financially responsible for administering.¹⁰²

Other types of home care, particularly personal and nursing care for more intensive and serious long-term care needs, come under the Wlz (Long-Term Care Act) as administered via *Zorgkantoren* which are 31 regional care purchasing agencies that have been mandated to buy care with public funds.^{34, 98, 102} The insurance contributions paid into the Wlz are deposited into a Long-Term Care Fund and managed by the National Healthcare Institute, Zorginstituut Nederland (ZIN); 'the central government tops up the fund using public funds if these funds are too low'.³⁴ All tariffs related to all aspects of long-term care, including the different types of home care services, are regulated by the NZa, which sets the maximum prices and facilitates collective bargaining between purchasing agencies and providers in order to determine the prices that they set.^{34, 98} Umbrella organizations for home care providers are involved in negotiating labour agreements and tariffs.¹³ The *Joint Report on*

⁴ Non-ring-fenced for home care services; the budget is the general municipalities (local council) budget.

Health Care and Long-Term Care Systems and Fiscal Sustainability identified that 6.5% of total expenditure for the Wlz in 2016 would be for personal budgets.³⁴

5.2.6 Does provision fall short of needs (rationing)?

A study by Kok *et al.*,¹⁰³ which compares the costs and benefits of home care for the elderly versus residential care, notes the high costs for providing certain aspects of home care.¹⁰³ They highlight, for example, that the municipality bears the costs of cleaning in the elderly person's home, bears the costs of providing wheelchairs, mobility scooters and for home adaptations for elderly people living at home.¹⁰³ As municipalities do not pay for residential care, it is a financial disincentive for them to keep elderly people living at home, as they bear the brunt of all the incurred additional costs to do so.¹⁰³ Conversely, from an overall perspective, the State and the taxpayer are better off financially if elderly people remain in their homes.¹⁰³ Thus, Kok *et al.* concluded that home care is cheaper than residential care.¹⁰³

The recent reforms were enacted to make the long-term care sector, including home care, more financially sustainable.³⁴ The goal is to reduce the highest financial costs of long-term care while preserving high-quality service provision.³⁴ The reforms also aimed to engender a focus on individual responsibility and the preservation of independence as drivers of long-term care provision.³⁴ The three main aspects of the reform were:³⁴

1. Decentralization of home care services to municipalities
2. The introduction of a new long-term care Act (Wlz) to cover care for more vulnerable people
3. Transferring personal care from the repealed AWBZ (Exceptional Medical Expenses Act) to the Health Insurance Act (Zvw).³⁴

Therefore, the case appears to be that provision of home care in the Netherlands currently does not fall short of needs. Nevertheless, a caveat is necessary here as issues highlighted by Da Roit¹⁰² and Bakx,¹⁰⁴ and elaborated on in section 5.2.2, suggest that cost containment measures may well impact on provision in the future.

5.3 Scotland

Scotland has a predominately universal home care sector. Scotland has introduced several key regulatory mechanisms that have helped professionalize the sector and improve the overall quality standards in home care. The introduction of regulatory bodies such as the Care Inspectorate has led to improvements around accreditation, registration and qualifications for home care providers and their staff. Providers are required to register with the Care Inspectorate to legally provide care services. Home care workers are also required to have or to be working towards a qualification in order to work.

5.3.1 Eligibility/Needs assessment

Scottish Local Authorities are in charge of carrying out an *Assessment of Your Care Needs*, which is an assessment by a healthcare worker who establishes the specific needs of the potential care recipient and determines how these needs may be met.⁴¹ A care recipient may also require an assessment of their finances to determine whether and to what extent they are suitable for financial assistance.⁴¹ Local Authorities are funded by central government, and required to provide free personal home care services to citizens over the age of 65 who have been deemed in need following assessment.⁴¹ The Local Authorities' assessment determines what personal care services are required for the care recipient so as to maintain or maximize their well-being; in theory, there is no limit on the amount of care that a care recipient can receive.⁴¹

5.3.2 Entitlement

People over the age of 65 are entitled to receive free personal home care services if need is determined via assessment. Since 2002, a care recipient over the age of 65 with an income lower than £16,250, not including tangible assets, can also receive financial assistance for non-personal home help-type care such as help with shopping and housework.^{41,71}

5.3.3 Basket of services

The introduction of the *Reshaping Care for Older People* programme and the Change Fund initiative by the Scottish Government has aimed to commission more alternative services, such as preventative services.³⁶ An example of this is the collaboration of Local Authorities and NHS boards in order to provide special short-term home healthcare to care recipients to prevent them from being admitted or re-admitted to hospital and to provide them with the necessary skills and abilities to live an independent life at home with as little support as possible.³⁶

Home care services provided under the Free Personal and Nursing Care scheme are provided to care recipients and, depending on their needs, can include:

- **Personal hygiene** – bathing, shaving, oral hygiene and nail care
- **Personal assistance** – assisting care recipients to get in and out of bed, ensuring the correct use of medical devices and mechanical or manual aids, assisting with prostheses and dressings
- **Continence management** – toileting, catheter or stoma care, skin care and laundry and bed changing

- **Food preparation and dietary services** – assisting with meal preparation and special dietary needs
- **Equipment and adaptation** – supplying equipment and adapting the home of the client to help with immobility and to make tasks such as bathing, walking up and down stairs and general mobility around the care recipient's home easier
- **Simple medical treatment** – administering medication, applying creams and lotions, changing simple dressings, oxygen therapy.¹⁰⁶

Services that can be organized by a Local Authority but are subject to a fee, or income cap, include housework, laundry, shopping, out-of-home services such as day-care centres, and the cost of supplying food or prepared meals.¹⁰⁶

5.3.4 Mix of funding mechanisms

The majority of long-term care services are funded through taxation, from which the Scottish Government allocates budgetary spends in certain areas such as health and social care.³⁹ Due to the Community Health Partnerships, which see Local Authorities and NHS boards working together on this issue, the funding of long-term care is not channelled through a single funding body. In fact, due to the range of long-term care services provided that involve both health and social aspects to care, a range of services are funded jointly through both Local Authorities and health boards.³⁹ For example, Fife with a population of 363,460, has three separate Community Health Partnerships (CHPs) that are involved in operating and managing certain community and primary healthcare services. The partnership of NHS Fife and Fife Council had a combined social and healthcare expenditure of £759 million in the financial year 2009/10.¹⁰⁷

Personal home care is primarily State funded. While other health and social services are provided free of charge under certain policies and legislation (Community Care and Health (Scotland) Act 2002 and the Community Care and Health Act [Scotland] Act 2003), Local Authorities have responsibility over which other services are financed through the allocated budget given to them, which leaves how much a care recipient should co-pay towards their own healthcare and housekeeping at the Local Authorities' discretion.³⁹

5.3.5 Financial management

A commitment made by the Scottish Government's policy programme, *Reshaping Care for Older People*,⁴² has pledged to double the total social and healthcare budget assigned to home care services over the 10-year period in which the programme is implemented.⁴² As a result, there will be an overall increase from 6.7% to 13.5% in the total spend on home care services.⁴² In the *Reshaping Care for Older People* programme, it states:

'Assuming current service models remain the same, we will require an estimated annual increase in investment in health and social care services for older people of £1.1 billion by 2016 and £3.5 billion by 2031, a real increase of 24% and 74% respectively over 2007/08 levels.'⁴²

The 2015/2016 Scottish Draft Budget allocated £300 million to the Reshaping Care for Older People Change fund and the Integrated Care fund, in order 'to improve the way that public,

private and third sector organizations work in partnership to deliver health and social care services'.⁸⁸

According to the United Kingdom Home Care Association (UKHCA), the weighted average hourly rate paid by older people in Scotland was £13.68 in 2014.¹⁰⁸ Scottish Local Authorities funded 37 million home care hours in the 2014/2015 financial year.⁴¹ Local Authorities had a total gross expenditure of £732 million on home care services in the 2013/2014 financial year, which represented an increase of 3.1% when compared with the previous year.⁴¹

Since 2010/2011, there has been a year-on-year increase in the number of care recipients receiving direct payments from Local Authorities to purchase their own personal care and housekeeping services.⁴¹ In turn, there has been a yearly increase on Local Authorities' expenditure on direct payments, with £86 million being spent in 2014/2015.⁴¹ If looking specifically at care recipients aged 65 years or older, there were 2,420 people in this age bracket receiving direct payments at a cost of £22.8 million for Local Authorities in 2014/2015.¹⁰⁹

We found no evidence pertaining to privately funded home care in Scotland. However, an estimation by the UKHCA suggests that there were in the region of 2.8 million home care hours purchased privately by care recipients paying for their own care.⁴¹ The UKHCA estimated that private expenditure on home care services is in the region of £52 million annually.⁴¹

5.3.6 Does provision fall short of needs (rationing)?

Based on the available evidence, it appears that Scotland is not currently falling short of needs in home care provision. Nevertheless, Scottish Care has raised concerns about a few key issues surrounding the current state of the home care sector in Scotland. With demand for home care services rising annually, coupled with the shift in policy direction away from institutional care and towards home care, the prime area where there are shortcomings is in the financing and commissioning of public home care.³⁷ It is projected that a much higher proportion of the population will be in an older age bracket, with a 63% rise in the number of older people in Scotland by 2035.³⁶ The number of individuals aged 85 and over is expected to increase exponentially by 2035, with a projected growth of 147% in this age bracket.³⁶ An older population will ultimately need more preventative social and health services and not just services for intensive care needs. The complex needs of older people may put a heavier strain on financing and running adequate services in the long term, if issues and challenges are not dealt with in the short term.³⁶

Users of public home care services are seeking more home care hours; this is putting increased demand on service providers that receive limited funding from the Government budget.³⁷ Although the number of care recipients receiving intensive care support is increasing, there has been a decrease in demand from some rural or hard-to-reach locations.

There has been a reduction in the number of care recipients receiving fewer than 10 hours of care per week; this is due to an increasing policy focus on providing more care to those

with intensive care needs.³⁷ There are a number of issues pertaining to home care employees still arising within the sector, including zero hour contracts and wages under the minimum wage requirement, which ultimately impacts on recruiting and retaining suitable staff.³⁷

5.4 Sweden

Sweden relies on a self-regulatory model of home care service provision, allowing municipalities to fully oversee the provision of home care services; this makes it difficult to fully ascertain a true national picture of the home care sector. The evidence we found shows how the influence of *new public management* ideologies has led to an increase in the private and for-profit provision of home care. This ultimately indicates a shift away from Sweden's traditional universal social care system towards a market-led user choice model of home care.

5.4.1 Eligibility/Needs assessment

All permanent citizens that have care needs are eligible to apply for home care, with Local Authorities carrying out a needs assessment.³⁴ In recent years, with pressure on home care resources due to tighter budgets and more demand for services, needs assessment guidelines among municipalities have become stricter.¹¹⁰ The NBHW (National Board of Health and Welfare) was commissioned by the central government to develop a standardized needs assessment tool for municipalities.^{34, 28} The needs assessment tool was introduced in 2012 and is based on the International Classification of Functioning, Disability and Health (ICF) standard.³⁴ Table 12 is adapted from Colombo *et al.*⁵, with newer information pertaining to the assessment tool included.

Table 11 Long-term care needs assessment process in Sweden

Who can apply for care?	What is the assessment process?			Who is entitled to care?	
	Assessment tool	Criteria and range	Assessor and process	Care categories assigned following assessment	Eligible users
Thresholds for eligibility to care					
All ages	National standard tool created by the NBHW	N/A	Professionals employed by municipalities carry out the assessment	No specific categories	Benefits are at the discretion of the assessor

Source: Adapted from Colombo *et al.*⁵

In order to be assessed for home care services, a person must begin the process by filling out an application at a municipal department for eldercare.^{26, 28, 30} Following on from the

application, a municipal care manager will assess the needs of the person and evaluate if they are eligible for home care services, what services they are eligible for, and if so, how many hours they should receive in home care.^{26, 30, 43} A care manager from the local social welfare office will always assess prospective home care recipients, regardless of whether the service will be delivered from a public or private provider.⁴³ Care managers are only responsible for assessing the needs of persons for home help services, with care managers collaborating with the relevant health professionals in assessing the needs of persons requiring home nursing and rehabilitation services.²⁶ If a person is not satisfied with the decision made by the care manager, they are entitled to make an appeal to the administrative court.³⁴

Persons aged under 65 who have a functional impairment may also be eligible to receive assistance benefit under the LASS Act.¹¹¹ The assistance benefit gives financial support to persons with a severe disability to afford them the opportunity to have a personal assistant. If eligible for assistance benefit, the person is given a monthly stipend to the value of the number of hours they have been deemed eligible for.¹¹¹ There is no cap on the number of hours a person can receive, as those with severe impairments may need more than one assistant at a time. Persons with severe impairments are eligible to receive personal assistance 24 hours a day, if this allows them to live independently.¹¹¹ To receive personal assistance with daily living activities under the LSS and LASS acts, a person must have:

- An intellectual disability, autism or a condition resembling autism
- A significant and permanent intellectual impairment after brain damage in adulthood, due to an external force or a physical illness
- Have other extensive physical or mental impairments which are not related to normal ageing and result in difficulties in daily life.^{29, 49}

5.4.2 Entitlement

Sweden's universal social welfare system allows all citizens the right to publicly funded social care and support regardless of their financial situation, with public authorities given responsibility to ensure that they receive adequate support for their needs.^{43, 62} In order to be entitled to public home care services, prospective care recipients must have their needs assessed and a municipal care manager must approve the relevant care services.⁵¹ The amount of care a recipient can receive in cash benefits for home care services is determined from the needs assessment. Eligible persons are also entitled to personal assistance in their home, with payments made by the State.¹³ Table 13 illustrates the Swedish cash-for-care scheme and was adapted from Colombo *et al.*⁵

Table 12 Cash-for-care scheme in Sweden

Choice between in kind and cash?	Programmes	Eligibility	Tax free?	Benefit levels (monthly amounts)
Complementary cash and in-kind benefits	Attendance allowance	Minimum need of 17 hours per week	Yes	Estimated SEK3,000
	Assistance allowance	Aged over 65, activities of daily living requiring over 20 hours of help per week	Yes	Amount according to estimated hours of required assistance

Source: Colombo *et al.*⁵

Persons aged under 65 years with a functional impairment are entitled to 20 hours of State-funded home help per week under the LSS Act to assist with basic needs, mobility issues or help with a person who has an intellectual disability.¹¹¹ In order to be considered for personal assistance, the person must need support for certain activities of daily living such as bathing, dressing and eating, or they must need specialized assistance from someone who is knowledgeable about their functional impairment.¹¹¹ If the care recipient requires more than 20 hours of home help per week, the remaining fees will be paid for by the Social Insurance Administration.¹³ Those persons requiring more than 20 hours per week will also be entitled to assistance with other activities such as shopping or assistance during holidays.¹¹¹

Sweden also utilizes a voucher system, which entitles care recipients to a subsidy to spend on care services of their choice.²⁶ The entitlement to choose care through a voucher system increases competition among service providers and in turn encourages care services to provide efficient services of high standards.⁶²

While Sweden's eldercare services are largely financed and organized by public authorities, there has been an increase in private provision, with care recipients purchasing services directly from the market.⁴³ The increase in the market provision of home care services has in part been stimulated by the introduction of tax deductions for persons purchasing home care services since 2007.⁴³ There has been an increase in privately purchased home care services from persons who have less intensive care needs.⁴³ The increase in persons purchasing private home care services through the tax-reducing incentive, as well as the introduction of customer choice models in recent years, has ultimately brought further challenges to the universalism model.¹¹⁰ Persons within the higher income bracket who are looking for less intensive care services are incentivized away from publicly funded home care services.¹¹⁰ With regard to availing of private provision of home care services, the 'tax-subsidised household services reform', which was implemented in 2007, entitles taxpaying users of household care services to a 50% deduction on up to SEK100,000 (more than €11,000) of the person's expenditure on household services.^{30, 50, 81} There is no mandatory

needs assessment required from a local authority to avail of these services, allowing all persons who may want to benefit from such services the opportunity to claim the tax deduction.⁵⁰ Furthermore, the tax deduction applies to both personal care and domestic aid, as long as the service provider has a tax certificate.⁵⁰ The service providers are not regulated by either the State or Local Authorities.⁵⁰ Erlandsson *et al.*⁵⁰ explain that ‘in municipalities with a system of choice model, the credit halves the cost for the individual of the extra services that a private (but not public) provider may offer the home care user to “top up” the needs assessed home care’.⁵⁰

5.4.3 Basket of services

Publicly funded home care services can be provided by either public or private home care providers, with both requiring a needs assessment to determine eligibility. Care recipients are able to avail of care services through cash benefits or in-kind benefits, enabling them to choose the care provider and services that best suits their needs.³⁴ Sweden’s public and private home care providers supply a range of different services, which ultimately fall into three categories:

- **Practical assistance** – cleaning, laundry, cooking, delivery of pre-made meals, shopping
- **Personal care** – bathing, dressing, eating and drinking, assistance with mobility tasks
- **Emotional and social support** – preventing isolation, helping care recipients feel safe at home.^{30, 110}

In addition to these categories of services, other services that can be provided by public and private providers include home adaptations, meals on wheels services and home medical services.⁴³ These additional services vary in price and are fixed fee services, which means that a person’s financial situation is not taken into consideration when purchasing these services.¹³ Nevertheless, a maximum price for home care services across all municipalities was implemented in 1992.¹³ This means that while municipalities have full autonomy over fees for home care services, there is a maximum amount they can set for these services (approximately SEK1,780 – €180/185, in 2015).^{13, 19} For care recipients who are in need of practical assistance and personal care services but are unable to pay due to their financial situation, municipalities can reduce the cost or cancel the fee altogether.¹³

5.4.4 Mix of funding mechanisms

The long-term care system in Sweden is primarily financed through taxation, co-payments and other private contributions.^{5, 26, 34, 43, 112} Sweden has no private insurance for long-term care. Home help and home healthcare services are predominantly funded by municipal tax and State grants, with half of municipalities using county council tax to finance their home healthcare services.¹³ Municipalities, county councils and regions are in charge of their own tax, which in turn means they can levy their tax rates in order to fund specific activities.⁶¹ The tax is a percentage of the local residents’ income.⁶¹ Local tax rates among municipalities, county councils and regions average at 30% (20% to municipalities, 10% to county councils and regions).⁶¹

Co-payments for long-term care services are regulated through the Social Services Act, which ensures that there is no over-pricing for care recipients.³⁴ The Government sets an annual ceiling maximum fee of the amount that can be charged to care recipients.³⁴ Private contributions to publicly funded home care services are relatively low, with between 4% and 5% of expenditure coming from co-payments by care recipients.^{5,30} Co-payments depend on certain factors such as the care recipient's income, the care package and the municipality that they are resident in; there is a cap (approximately SEK1,780 – €180/185, in 2015)¹⁹ on the maximum amount a care recipient can pay.¹³

5.4.5 Financial management

Sweden's health and long-term care expenditure is one of the highest among OECD countries.^{26,28} In 2012, 3.7% of Sweden's GDP was spent on long-term care.³⁴ According to OECD projections, Sweden's expenditure on long-term care is expected to double by 2050, as the population ages.²⁸ The vast majority of benefits were in kind (96.4%) in 2012, whereas cash benefits resulted in only 3.6% of the overall benefits provided by the Swedish Government.³⁴ A total of 5.4% of the population over the age of 15 receive long-term care in kind and/or in cash benefits.³⁴ Furthermore, 49.7% of public in-kind expenditure is on long-term home care services.³⁴

Since the 1990s, Sweden, similar to other OECD countries, has reportedly failed to increase its expenditure and resources for elderly care in line with the increasing ageing population.¹¹⁰ There has been a reported decrease in expenditure on elderly care services in relation to the overall ageing population, with a 6% decrease in expenditure between 2000 and 2009.¹¹⁰ Nevertheless this is due to 'a complex interplay between decision-making at central and local levels' rather than a specific policy directive.¹¹⁰

The majority of expenditure on care for the elderly is funded from municipal tax, approximately 85%. The rest of expenditure is funded from national taxes (10%), with the smallest proportion (between 4% and 5%) funded by co-payments made by care recipients.^{30,44} There can be major discrepancies among municipalities on the levels of expenditure on eldercare, especially home care services for the elderly.⁴³ Although none of the eldercare services are means tested, care recipients' payments do depend on their income and the number of hours or services being provided.³⁰ However, since 2002 there has been a cap on the maximum amount of money an individual is required to pay for home care services that are provided through the publicly funded system; in 2015, it was approximately SEK1,780 (€180/185).^{19,110}

Municipalities are responsible for deciding how much the fees for home care should be, with many municipalities using fees as a tool to reduce demand for care that may not necessarily be for intensive care purposes and charging higher fees for a smaller number of care services.^{30,113} Locally elected politicians in each municipality decide on a number of financial and tax-related issues regarding elderly care services, such as setting the local tax levy and rates, deciding on budgets and creating guidelines and goals for services.¹¹⁰ It also must be noted that one in five home care recipients do not pay fees, as individuals in the lower income bracket are exempt from paying fees.^{30,34}

5.4.6 Does provision fall short of needs (rationing)?

Based on the available evidence, the provision of home care services in Sweden does not currently appear to fall short of needs. Sweden has a considerably well-developed, comprehensive long-term care model that on paper appears to be very accessible, due to Sweden's universal approach and high public spending on services.⁶³ Nevertheless, since the 1990s Sweden, similar to other OECD countries, has failed to increase its expenditure and resources for elderly care in line with the increasing ageing population.¹¹⁰ In fact, there has been a decrease in expenditure on elderly care services in relation to the overall ageing population, with a 6% decrease in absolute terms between 2000 and 2009.¹¹⁰ Budgetary constraints have contributed to many municipalities creating stricter eligibility criteria and more stringent guidelines for care managers who assess the care needs of potential care recipients.⁶³

The SSA (Social Services Act) states that home care providers must provide services to guarantee that all service users have a satisfactory standard of living. Leichsenring *et al.*²⁶ state that because there is no adequate definition of 'need', municipalities have a much higher level of independent autonomy over matters such as fixing local taxes and budgets, as well as guidelines on home care services. This results in municipalities differing in areas such as home care coverage and the degree of the provision of public and private home care providers.²⁶

The OECD has highlighted the need for establishing minimum qualification standards for long-term care employees.⁶² The lack of national standards in relation to targeted qualifications for workers in the long-term care sector poses a risk to the quality of these services, as it is left up to the discretion of the municipality on what, if any, training programme is established.⁶³ Furthermore, the OECD has also recommended that an accreditation system be implemented for long-term care providers in order to create minimum quality standards.⁶²

5.5 Synthesis of the findings in financing formal home care in the four countries

Germany and the Netherlands have long-established long-term care insurance schemes which have also facilitated the provision of formal home care services that have been subject to some change through recent reforms. The reforms have included revised needs assessments and eligibility entitlements alongside the introduction of increased or additional co-payments. Scotland and Sweden have a long-standing rights-oriented home care services sector, which are increasingly being rationed by stricter eligibility criteria and the introduction of fixed fee services and co-payments.

Need rather than the ability to pay for home care services is an underlying principle of all four countries formal home care provision. All four countries have formal needs assessment which contain documented eligibility criteria that allows a fair and comparative assessment as to the need for formal home care and the level of requirements in each geographical area. Recent reforms across all four countries have tightened up eligibility criteria to contain costs. Germany is particularly transparent about entitlements to home care benefits as they

correspond to each care grade based on level of need. For the other three countries, the interpretation of the needs assessment with respect to services provided is not transparent in the published literature. All four countries encourage some level of informal care by close relatives to help fill the home care requirement; this is notable and transparent in the financial organisation of the German formal home care system. For example, the German long-term care insurance charges more for single people, but allows payments for families to provide some of the formal home care requirements themselves.

The basket of formal home care services in the four countries include personal care and help with household tasks. Nursing care is included in the basket of services in Germany, the Netherlands and Scotland. Nursing care is provided through a separate assessment process in Sweden. Household tasks are handled differently in Scotland and the Netherlands. In Scotland, the recipient must pay for any housekeeping tasks if they earn over £16,000, while in the Netherlands, a cleaning company may be employed in a municipality to attend all household tasks required by older people in need. Sweden's basket of services includes emotional and social support. All four countries have an element of user choice as to how services are provided to address formal home care requirements, with services typically offered in kind or via personal cash budgets, direct payment, or voucher systems.

Each of the four countries has their own specific funding mechanisms and financial management system for formal home care provision. Germany and the Netherlands have commonalities in their funding systems as their formal home care is funded by a compulsory long-term insurance and co-payments, though the co-payments in Germany are higher than in the Netherlands. Formal home care in Scotland and Sweden is funded through national and local taxes with small co-payments for all services in Sweden and payment for household tasks by those who can afford to in Scotland. Of note, the four countries are increasing or introducing co-payments to fund the provision of home care services as well as tightening eligibility requirements in order to deal with increasing demand.

6 Conclusion

There are several principles included in regulated home care such as standards, transparency, consultation, choice, equity, and sustainability. These principles are implemented through legislation, policy, strategy, service planning and financing.

Standards in home care are based on best practice which is generally agreed between stakeholders, and implemented through an accreditation, training, monitoring, and inspection process. Monitoring agencies also investigate complaints. Standards in formal home care services use transparent performance indicators and public reporting in order to ensure that users can make an informed selection of home care provider.

Consultation is a major principle in regulated home care and is achieved through care recipients and other stakeholders having a voice in the development of standards. Care recipient's own needs assessment and care planning as well as surveys on user satisfaction help to facilitate the consultation process. In addition, most countries and their citizens explicitly agree that home care is preferable to residential care where possible. The wider approach of having a basket of services which individuals can select services to meet their needs rather than a one size fits all approach also enhances consultation and promotes user choice.

Patient choice is an ideal in many strategies and is implemented through choice of services, choice of funding approach (personal budget or service provision) and choice of provider. As already mentioned choice of provider is facilitated through access to publicly available quality reports.

Equity is another principle that runs through access to formal publicly funded home care and is implemented through standardized health needs assessment, services provision based on need and means adjusted payments.

Sustainability is approached in a very thorough manner in Germany and the Netherlands through compulsory long-term care insurance and means adjusted co-payments. In tax-based countries sustainability is introduced by increasing tax-based funding, raising the threshold for access to formal home care so that only people with the highest level needs are cared for, introducing or increasing co-payments, and charging full costs for services where people can afford to pay. Personal budgets are also used to control costs.

The foremost cost in home care is paying for trained carers. Nevertheless, controlling costs in formal home care can result in reduced pay for trained carers, reduced hours of care, or the use of untrained carers who will work for a lower hourly rate. The downside of personal budgets may be a lack of implementation of regulated standards and a lowering of the quality of care.

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Appendix A: Search strategy used to find articles

Database/Repository	Terms searched	Where	No. of (relevant) papers retrieved	Suitable papers (after screening)
PubMed				
	"home care"[All Fields] AND ("social control, formal"[MeSH Terms] OR ("social"[All Fields] AND "control"[All Fields] AND "formal"[All Fields]) OR "formal social control"[All Fields] OR "regulation"[All Fields]) AND English[lang] AND "aged"[MeSH Terms])	All fields	1,826	10
	"home care"[All Fields] AND (("social control, formal"[MeSH Terms] OR ("social"[All Fields] AND "control"[All Fields] AND "formal"[All Fields]) OR "formal social control"[All Fields] OR "regulation"[All Fields]) AND disability[All Fields]) AND ("humans"[MeSH Terms] AND English[lang])	All fields	141	10 (same 10 papers as previous)
	"home care"[All Fields] AND ("social control, formal"[MeSH Terms] OR ("social"[All Fields] AND "control"[All Fields] AND "formal"[All Fields]) OR "formal social control"[All Fields] OR "regulation"[All Fields]) AND ("loattrfull text"[sb] AND ("2009/01/01"[PDAT]: "2017/01/01"[PDAT]) AND English[lang] AND "aged"[MeSH Terms])	All fields	300	10 (same 10 papers as previous)
	Same search run with added separate economic terms for Question 3 : economic evaluation; cost benefit; cost effective; costs	All fields	0 No additional relevant papers	0 No additional relevant papers
	Same search run with added parameters and terms related to elderly; aged and/or disability added	All fields	0 No additional relevant papers	0 No additional relevant papers
	Same search run with variant terms for home care and additional search terms for Questions 1 and 2	All fields	0 No additional relevant papers	0 No additional relevant papers
The European Journal of Health Economics				
	"home care"	All fields	46	5
Health & Social Care in the Community				
	"home care" OR "home help" OR "home support" AND regulation	All fields	82	16
Embase				
	'home care services'/exp OR 'home care services' OR 'home support' AND older OR 'home help'/exp OR 'home	All fields	779	10

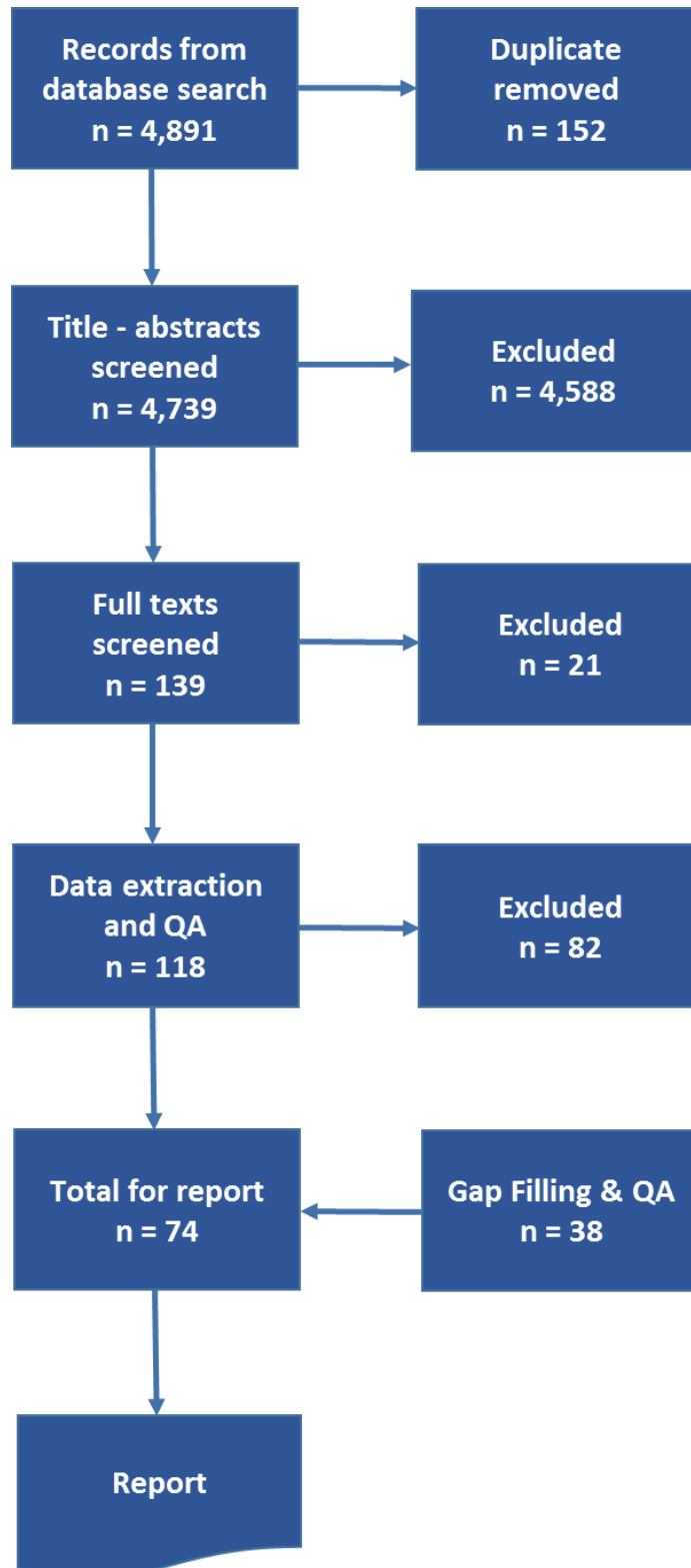
help' AND 'daily living'AND ([aged]/lim OR [very elderly]/lim) AND (2008:py OR 2009:py OR 2010:py OR 2011:py OR 2012:py OR 2013:py OR 2014:py OR 2015:py OR 2016:py)			
home AND care AND services AND costs AND 'daily living' AND [2009-2016]/		106	4
Same search, as directly above, run with added separate economic terms: economic evaluation; cost benefit; cost effective; costs		40	0
Same search run with added parameters and terms related to elderly; aged and/or disability added	All fields	0 No additional relevant papers	0 No additional relevant papers
Same search run with additional search terms for Questions 1 and 2	All fields	0 No additional relevant papers	0 No additional relevant papers
CINAHL			
"home care" regulation	All fields	14	4
"home help" legislation	All fields	735	3
Home care services AND funding OR financing OR economic cost Limited by: English, Research Articles, Peer Reviewed, Special interest – home health care, 2009 – 2015	All fields	494	18
York – CRD Database			
(home care services) OR (home support AND older) OR (home help AND daily living)	All fields	189	4
(home care services OR (home support) OR (home help AND daily living) AND disabled OR disability)	All fields	31	0
International Journal of Older People Nursing			
home care services regulation	All fields	48	1
Google/Social Care Online			
All keyword searches as documented below for the three research questions and variants on previous search terms	All fields	60	43
Total			118
Google and Google Scholar			
Reference chasing Gap filling – specific search terms related to gap filling need	All fields	38	38
Total			156

NB: For Question 1, the words 'regulation', 'costs', 'funding', 'framework', 'legislation', 'standards', 'registration', 'guidelines', 'costs', 'licensing', 'accreditation', 'training', 'inspection', 'indicators', and 'monitoring' were used in conjunction with the 'home care' variants, as were the words 'elderly and aged', 'disability and disabled', and relevant alternatives.

For Question 2 we searched for evidence using the keywords 'staff experience', 'client experience', 'effectiveness', 'baseline assessments', 'monitoring', 'evaluation', 'review', alongside the 'home care' and 'regulation' variants 'elderly' and 'aged', 'disability' and 'disabled', and relevant alternatives.

For Question 3, we searched for evidence using the keywords 'costs', 'funding', 'regulation', 'management', 'eligibility', 'entitlement', 'basket of services', alongside the 'home care' variants 'elderly and aged', 'disability and disabled' and relevant alternatives.

Appendix B: Flowchart of screening and selection process



Appendix C: Quality assessment tool questions

QA Tool 1 – Review of reviews, based on McMaster University²¹ Health Evidence quality assessment tool

Q	Question	Y/N
1	Clearly focused question – PICO?	
2	Provision of inclusion criteria?	
3	Comprehensive search strategy?	
4	Sufficient time period covered?	
5	Is included studies study design clearly identified?	
6	Was the methodological quality of the primary studies assessed?	
7	Are quality assessments transparent?	
8	Was it appropriate to combine the findings of results across studies?	
9	Were appropriate methods used for combining or comparing results across studies?	
10	Do the data support the author's interpretation?	

QA Tool 2 – Economic evaluation, based on Drummond, 2015²²

Q	Question	Y/N
1	Was a well-defined question posed in answerable form? 1.1 Did the study examine both costs and effects of the service(s) or programme(s)? 1.2 Did the study involve a comparison of alternatives? 1.3 Was a viewpoint for the analysis stated and was the study placed in any particular decision-making context?	
2	Was a comprehensive description of the competing alternatives given (i.e. can you tell who did what to whom, where, and how often)? 2.1 Were there any important alternatives omitted? 2.2 Was (should) a do-nothing alternative be considered?	
3	Was the effectiveness of the programme or services established? 3.1 Was this done through a randomised, controlled clinical trial? If so, did the trial protocol reflect what would happen in regular practice? 3.2 Was effectiveness established through an overview of clinical studies? 3.3 Were observational data or assumptions used to establish effectiveness? If so, what are the potential biases in results?	
4	Were all the important and relevant costs and consequences for each alternative identified? 4.1 Was the range wide enough for the research question at hand? 4.2 Did it cover all relevant viewpoints? (Possible viewpoints include the community or social viewpoint, and those of patients and third-party payers. Other viewpoints may also be relevant depending upon the particular analysis.) 4.3 Were the capital costs, as well as operating costs, included?	
5	Were costs and consequences measured accurately in appropriate physical units (e.g. hours of nursing time, number of physician visits, lost work days, gained life years)?	

	<p>5.1 Were any of the identified items omitted from measurement? If so, does this mean that they carried no weight in the subsequent analysis?</p> <p>5.2 Were there any special circumstances (e.g., joint use of resources) that made measurement difficult? Were these circumstances handled appropriately?</p>	
6	<p>Were the cost and consequences valued credibly?</p> <p>6.1 Were the sources of all values clearly identified? (Possible sources include market values, patient or client preferences and views, policy-makers' views and health professionals' judgements)</p> <p>6.2 Were market values employed for changes involving resources gained or depleted?</p> <p>6.3 Where market values were absent (e.g. volunteer labour), or market values did not reflect actual values (such as clinic space donated at a reduced rate), were adjustments made to approximate market values?</p> <p>6.4 Was the valuation of consequences appropriate for the question posed (i.e. has the appropriate type or types of analysis – cost-effectiveness, cost-benefit, cost-utility – been selected)?</p>	
7	<p>Were costs and consequences adjusted for differential timing?</p> <p>7.1 Were costs and consequences that occur in the future 'discounted' to their present values?</p> <p>7.2 Was there any justification given for the discount rate used?</p>	
8	<p>Was an incremental analysis of costs and consequences of alternatives performed?</p> <p>8.1 Were the additional (incremental) costs generated by one alternative over another compared to the additional effects, benefits, or utilities generated?</p>	
9	<p>Was allowance made for uncertainty in the estimates of costs and consequences?</p> <p>9.1 If data on costs and consequences were stochastic (randomly determined sequence of observations), were appropriate statistical analyses performed?</p> <p>9.2 If a sensitivity analysis was employed, was justification provided for the range of values (or for key study parameters)?</p> <p>9.3 Were the study results sensitive to changes in the values (within the assumed range for sensitivity analysis, or within the confidence interval around the ratio of costs to consequences)?</p>	
10	<p>Did the presentation and discussion of study results include all issues of concern to users?</p> <p>10.1 Were the conclusions of the analysis based on some overall index or ratio of costs to consequences (e.g. cost-effectiveness ratio)? If so, was the index interpreted intelligently or in a mechanistic fashion?</p> <p>10.2 Were the results compared with those of others who have investigated the same question? If so, were allowances made for potential differences in study methodology?</p> <p>10.3 Did the study discuss the generalizability of the results to other settings and patient/client groups?</p> <p>10.4 Did the study allude to, or take account of, other important factors in the choice or decision under consideration (e.g. distribution of costs and consequences, or relevant ethical issues)?</p> <p>10.5 Did the study discuss issues of implementation, such as the feasibility of adopting the 'preferred' programme given existing financial or other constraints, and whether any freed resources could be redeployed to other worthwhile</p>	

	programmes?	
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QA Tool 3 – Quality assessment for additional resources, based on an adaptation of Glenton *et al.*²³ and Keane *et al.*²⁴

Q	Question	Y/N
1	Was the purpose and/or research question stated clearly?	
2	Is the study context clearly described?	
3	Is the sampling method clearly described and appropriate for the research question?	
4	Is the method of data collection clearly described and appropriate to the research question?	
5	Is the method of analysis clearly described and appropriate to the research question?	
6	Are the claims made supported by sufficient evidence, i.e. did the data provide sufficient depth, detail and richness?	

Appendix D: Quality assessment table

Group	Type of quality assessment	Strength of document			Total
		Strong	Moderate	Weak	
Used	Review of reviews – QA 1	2	1	0	3
	Economic evaluations – QA 2	1	5	0	6
	Quality assessment – Tool 3	15	50	0	65
	Subtotal	18	56	0	74
Not-Used	Review of reviews – QA 1	1	0	0	1
	Economic evaluations – QA 2	1	4	7	12
	Quality assessment – Tool 3	1	48	20	69
	Subtotal	3	52	27	82
Total		21	108	27	156

Appendix E: Data extraction form

Document details

Author	Document name	Year

Data extraction reference

Q	Question	SQ	Sub-question
1	Describe the regulation of home care services in selected countries?	1.1	Legislative or guidelines-based framework for home care services
		1.2	National standards for home care services
		1.3	Registration/licensing and/or accreditation of home care services and its process
		1.4	Registration/licensing and/or accreditation of home care staff and its process
		1.5	Home care provider and staff training requirements, competencies and assessment
		1.6	Inspection regime and routine monitoring (including performance indicators) for home care services with respect to the application of relevant national standards
		1.7	Cost of regulation of home care services and who funds the regulatory regime
2	Describe the (staff and client) experiences of, and effectiveness of, home care regulation in selected countries?	2.1	Client experiences
		2.2	Staff experiences
		2.3	Baseline assessments
		2.4	Continuous monitoring
		2.5	Reviews and evaluations
3	Describe the approaches to accessing (eligibility, needs assessment and entitlement), financing and financial management of home care services in selected countries?	3.1	Eligibility
		3.2	Entitlement
		3.3	Basket of services
		3.4	Mix of funding mechanisms – Type of funding (e.g. tax (local or general), social insurance, private insurance, out of pocket payments and the role of co-payments) and mix of funding?
		3.5	Financial management
		3.6	Does provision fall short of needs (rationing)?

Appendix F: Transparency criteria – full table

Table 13 Examples of transparency criteria for quality regulatory framework in Germany

Results of interviews with care recipients about their satisfaction
Expectations are taken into account.
Care contracts are concluded.
Agreed care services are carried out.
Working times are met.
Care is provided by the same person.
Motivation to activate care
Care provision according to wishes
Satisfaction with housekeeping
Care status (visits to the care recipients)
Care status appropriate
Documentation and care process (care documentation)
Collection of information on the health and care status of the recipient
Information concerning the biography of the recipient
Details concerning competences, deficits, special problems of the recipient
Individual care goals are fixed.
Individual care measures are planned.
Documentation of measures carried out by external experts
Prophylaxes are taken into account.
Documentation of provided services
Continuous documentation
Personnel act adequately in urgent cases
Review of care outcomes and adjustments of goals and measures
Quality in the process and in outcomes
Activities to prevent pressure ulcer are adequate
Supply of nutrition and fluids is adequate.
Supply of incontinence products is adequate.
In-traction(servicing) of persons suffering from mental illnesses is adequate.
General information
Business premises existent
Team meetings possible
Personal documents non-accessible
Safe depositing of keys
Basic care theories
Vision/mission of care existent
Concept/model of care existent
Concept of care implemented
Personnel
Qualified nurse in charge existent
Qualification of nurse in charge adequate
Proxy person for qualified nurse in charge available
Share of qualified nurses adequate

Tasks and responsibilities are regulated.
Responsibilities of the qualified nurse in charge
Care process planning
Carrying out documentation of care activities
Manpower planning
Meetings/team meetings
Process organization
Review guaranteed
Assignment in accordance with qualification
Availability guaranteed
Quality management system
Internal quality management systems carried out
Further training takes place.
Further training planning
On-the-job-training takes place.
Implementation of hygiene standards
Care practice
Care carried out by qualified nurses
Care documentation system
Standardized
Completed

Source: Schulz, 2012⁵³

Appendix G: Indicators for responsible care in the Netherlands – full table

Table 14 Indicators for responsible care in the Netherlands – full table

Theme 1	1. Care (treatment)/life plan
Indicator – CQ-I⁵	1.1 The extent to which clients experience a good care plan and a good evaluation of that plan
CQ-Index questions	Have written agreements been made with you about the care you receive from the care institution? (What care, as of when, from whom, how often, on what days at what times, et cetera)
	Is your care dossier/file or log book used properly for the exchange of information? (e.g. by your GP or your relatives?)
	Have you had an evaluation talk over the past 12 months with someone from the care institution about how you feel about the care given?
	Have you got a regular contact that you can address at the care institution?
Indicator – CQ-I	1.2 The extent to which clients experience good participation and good consultation
CQ-Index questions	How often do you participate in decisions about the content of the home care you receive?
	How often do you participate in fixing the times/days on which you receive your home care?
	How often do you participate in decisions about from whom you receive home care (which caregiver)?
	Is the care institution sufficiently open to your suggestions?
	How often does the care institution (the management or the Board) react adequately to your questions, suggestions or complaints?
	How often do your caregivers confer with you about what has got to be done?
	How often do your caregivers ask you if the care they give is up to your standards?
Theme 2	2. Communication and information
Indicator – CQ-I	2.1 The extent to which clients experience good treatment
CQ-Index questions	How often are caregivers willing to talk to you about matters that did not go well in your opinion?
	How often do caregivers respond to your questions well?
	Do the caregivers treat you in a polite manner?
	Do the caregivers listen to you attentively?
Indicator – CQ-I	2.2 The extent to which clients experience good information
CQ-Index questions	Have you received enough information from the care institution about what it can do for you? (Possibilities in home care, the package of services,

⁵ CQ-I means client related indicators measured by an independent agency by means of consultation via the CQ-index

	et cetera)
	Have you received enough information from your care institution about your rights? (e.g. the right to participate in decisions about care and the right to complain)
	Have you received enough information from the care institution about what is expected from you? (The materials you are supposed to have in the house, your own contribution, et cetera)
	Have you received enough information about the clients' council? (Function, tasks, how to contact its members)
	Are the letters, brochures and flyers understandable to you?
	Do you know to whom you should go in the care institution with your questions, problems and complaints, if any?
Indicator – CQ-I	2.3 The extent to which clients experience good communication and they can easily reach staff by phone
CQ-Index questions	How often can the care institution easily be contacted by phone during the day from 9 to 5?
	How often can the care institution be easily contacted by phone outside office hours (in the evening, at night, during the weekend)?
	Do you know how and when your contact at the care institution or his/her substitute can be reached by phone?
	If it is impossible for you to reach your contact by phone and you leave a message, will you be called back within one working day?
Theme 3	3. Physical well-being
Indicator – CQ-I	3.1 The extent to which clients experience good physical care
CQ-Index questions	Do you receive your personal care (such as support with taking a shower/washing, getting dressed, combing your hair, et cetera) at times that you want that care to be given?
	Do you receive care in the way you want to receive it?
Theme 4	4. Care-related safety
Indicator – (CL)⁶ measured by care organization	4.1 The percentage of clients with decubitus stage 2 to stage 4 which started in the organizational unit (V&V) during the care period at home (ZT)
Indicator – (CL) measured by care organization	4.2b Percentage of clients with unintentional weight loss of more than three kilos over the previous month or more than six kilos over the previous six months
Indicator – (CL) measured by care organization	4.3 The percentage of clients that has been involved in a fall incident over the past 30 days

⁶ CL means care content indicators at client level measured by care organisations themselves

Indicator – (CL) measured by care organization	4.7a Percentage of clients that has urinary incontinence a couple of times per week or every day
Indicator – (CL) measured by care organization	4.7b The percentage of clients with incontinence on the day of/in the week of measuring in whose diagnosis a doctor or incontinence nurse was involved
Indicator – (CL) measured by care organization	4.8 The percentage of clients with a Foley catheter that was inserted more than two weeks ago
Indicator – (OL)⁷ measured by care organization	4.11 The organizational unit can prove that they have a demonstrable policy for the prevention of restricting measures concerning freedom of movement
Indicator – CQ-I	4.12 The extent to which clients experience adequate professionalism (and safety) in administering care
CQ-Index questions	Does the care institution observe the agreements related to care?
	Do the various caregivers coordinate the home care you receive well?
	Do the caregivers work professionally?
	Do the caregivers work independently? (Do they know what should be done?)
	Do the caregivers do the cleaning adequately?
	Are the caregivers competent in carrying out nursing activities (injecting, taking care of wounds and stomas)?
	Are caregivers well informed about your illness(es) or health problems?
	Do the caregivers work in the way that you want them to work?
	Do caregivers take into consideration whether or not you can do certain tasks yourself?
	Do your caregivers pay attention to changes in your health situation or do they tell you that they notice such changes?
	Do your caregivers pay attention to your correct use of medicines? (That you take the prescribed medicine at the correct time in the correct way)
	Are your complaints about your health taken seriously by your caregivers?
Theme 5	5. Domestic and living conditions
Indicator – CQ-I	5.3 The extent to which clients experience adequate privacy (and living accommodation)
CQ-Index questions	Is home care an infringement of your daily life because of the caregivers who come into your home (your privacy, the daily routine and activities)?
Theme 6	6. Participation and social handiness

⁷ OL means care content indicators at organizational level measured by care organizations themselves

Indicator – CQ-I	6.1 The extent to which clients experience adequate possibilities to spend the day and to participate in society.
CQ-Index questions	Is there any support from caregivers, volunteers or relatives if you want to go somewhere? (outside, visiting others, outings, activities, etc.)
	Does your caregiver offer you enough support in finding ways to spend the day, social contacts and activities?
	Does your caregiver offer you enough practical support in arranging practical matters as making phone calls, filling in forms, arranging aids or financial matters, etc.)
Indicator – CQ-I	6.2 The extent to which clients experience adequate independence/autonomy
CQ-Index questions	Can you manage daily life easily with home care?
	Can you decide how you want to spend the day?
	Can you go to bed and get up when you want to?
	Are the times at which you receive home care convenient to you?
	Can you do the things that matter to you?
	Can you go anywhere you like in the home?
	Can you go anywhere you like outside the home?
Theme 7	7. Mental well-being
Indicator – CQ-I	7.1 The extent to which clients experience adequate mental support
CQ-Index questions	Do you feel at home in your own apartment?
	How often do you worry about things?
	Do you feel lonely?
	Does your caregiver pay sufficient attention to how you are doing?
	Does your caregiver offer enough emotional support in conversations and is he/she a good listener?
Indicator – (CL) measured by care organization	7.2 The percentage of clients that have shown signs of depression over the past three days
Theme 8	8. Safety living/Residence
Indicator – CQ-I	8.1 The extent to which clients experience a safe living environment
CQ-Index questions	Do caregivers pay enough attention to your safety and the prevention of accidents in and around the home? (e.g. by watching out for loose mats/rugs on slippery floors)
	Do your caregivers point out to you the possibilities of adapting your home or the existence of certain aids?
	Do your caregivers pay attention to the sell-by date of food? (to prevent food poisoning)
	Has the care institution discussed with you what you should do in case of emergency? (Which telephone number you can dial, when and how you can raise the alarm, etc.)

Indicator – CQ-I	8.2 The extent to which clients experience staff to be adequately reliable
CQ-Index questions	Do caregivers stick to agreed tasks? (Does the work get done?)
	Do caregivers stick to the appointed times? (Do they come on time, don't they leave early?)
	Do caregivers deal with your confidential personal data and private matters respectfully?
	Do caregivers respectfully treat your belongings (furniture, crockery, clothing, etc.)?
	Can you fully trust your caregivers?
	Do you feel safe and at ease when caregivers are with you?
Indicator – (OL) measured by care organization	8.3 The organizational unit can prove that staff members working with transfer lifts have been instructed to do this.
Theme 9	9. Sufficient and competent staff
Indicator – CQ-I	9.1 The extent to which clients experience sufficient availability of staff (and continuity)
CQ-Index questions	How many different caregivers come into your apartment in one month? (Under normal conditions, outside the holiday period)
	What do you think about the number of different caregivers that come to help you?
	Are you informed in time about caregivers coming at other times than usual or if a caregiver is ill or on holiday?
	Are substitutes arranged well if your regular caregiver is ill or has a day off?
	Are the substitute caregivers well informed about the tasks/chores to be carried out?
	Do caregivers spend enough time on you?
	Is home care flexible in adapting the moments of care giving to your wishes? (Different time, another day)
Indicator – (OL) measured by care organization	9.4 The organizational unit can show that over the reported past year competencies of staff that carry out reserved or risky treatment have been tested (practical test) and found to be up to standard
Theme 10	10. Coherence in care
Indicator – CQ-I	10.1 The extent to which clients experience adequate coherence in care
CQ-Index questions	Do caregivers cooperate well with other disciplines such as the GP, specialists, physiotherapists, dieticians?

Source: Steering Committee Responsible Care, 2007⁵⁷