Long-term care financing: lessons for low- and middle-income settings

Brief 7. Promoting quality and value in long-term care

Key messages

– The COVID-19 pandemic exposed long-standing quality and safety problems in long-term care (LTC) institutions that resulted in shockingly high rates of preventable mortality among vulnerable older persons.

– A fundamental prerequisite in delivering, monitoring and financing LTC services is to build systems that set forth quality principles and standards that apply across the broad range of LTC delivery settings.

– Investing in strong quality assurance frameworks is essential to deliver, monitor and pay for quality LTC; this includes developing and implementing accreditation and regulatory systems for institutions and community care providers.

– Collecting and monitoring data about quality from all LTC providers in institutions and communities can guide improvement strategies. A shift is underway from measuring adverse outcomes towards quality metrics that measure well-being and quality of life.

– To promote quality, some countries have linked higher payments to quality outcomes; however, the impact of paying for quality in health and LTC is inconclusive, and further evaluation is needed.

– Beyond linking payments to quality outcomes, countries use a range of other purchasing strategies that employ financial incentives to improve quality in long-term care, but evaluations of their impact are lacking.

– Improving the quality of care for older adults starts with the formal participation of older persons in biomedical research, which underpins clinical guidelines and payment systems.

– Low- and middle-income settings can learn from the experiences and mistakes made in more developed settings and invest early in strong quality and regulatory systems for LTC, including focusing on quality metrics that measure desired outcomes, such as quality of life.
 Ensuring quality in long-term care (LTC) was problematic before the pandemic. The Organisation for Economic Co-operation and Development (OECD) monitors data about safety in nursing homes, measured as the incidence of infections acquired within a health care or LTC facility that are resistant to antibiotics and antifungals and therefore not easily treated. In the USA, it is estimated that one nursing home resident in 43 contracts at least one health care–associated infection every day (3). Other safety considerations include polypharmacy and overprescribing. Countries that report to the OECD describe that more than half of adults aged 75 and older are prescribed at least five medications; in addition, the use of benzodiazepines – typically prescribed for sedation, anxiety and depression – was described as chronic; in 2021, they were prescribed for an average of 44 older adults per 1,000, despite recommendations against their use in this population due to dangerous side effects (4). Wide variations in use could be attributed in part to reimbursement and prescription policies. Much less information is available about quality in home- and community-based LTC settings due in part to fewer regulations and weak quality monitoring and information systems.

A fundamental prerequisite in delivering, monitoring and financing long-term care services is to build strong systems that set forth quality principles and standards that apply across the broad range of delivery settings

Quality in LTC promotes equitable and person-centred care that respects individual preferences and responds to a range of important needs, including health, behavioural and social care; safety; quality of life; and autonomy. Systems to continually improve quality across LTC settings can encompass a broad range of activities. These may include, for example, strengthening the models for delivery systems; ensuring appropriate numbers and qualifications for the LTC workforce; promoting transparency in the financing and ownership of institutions; ensuring sufficient and sustainable financing; building quality assurance systems that include regulation and ombudsperson programmes, quality measurement, monitoring and improvement programmes and comprehensive information systems; and enabling beneficiaries to choose their care provider (5). This brief focuses on a few issues important to low- and middle-income countries (LMICs), in recognition that the maturity of an LTC system is a key factor in
how countries determine the kinds of strategies implemented to improve quality (6). In acknowledgement that LTC strategies for workforce recruitment and retention are numerous and critical, these topics are covered separately.

A number of countries have set forth strategies for assuring and regulating the quality of LTC services across all settings (7). Germany has established its Long-Term Care Insurance Act, which provides a framework of requirements that apply to all LTC providers in residential and community settings. Such requirements include physical structural quality, workforce qualifications, and internal quality management systems that may include guidelines for treating specific health problems and monitoring outcomes. The framework also defines the roles and responsibilities of stakeholders, including the role of government at different administrative levels. In Luxembourg, the LTC quality framework is legally binding and applies to all care providers – whether formal or informal. The main body responsible for quality control is the independent State Office for Assessment and Monitoring of the long-term care insurance. In Portugal, the National Network of Integrated Continued Care specifies the legally mandated requirements for all LTC services, whether in health or social care settings, in institutions or communities, or provided by public or private organizations. In other settings in Europe, quality in LTC is covered under existing regulatory frameworks for health or social care.

**Strengthening quality assurance frameworks is fundamental to deliver, monitor and pay for quality long-term care, including accreditation and regulatory systems for institutions and community care providers**

Quality assurance frameworks recognize that investments are needed to strengthen the standards that provide a foundation for delivering LTC. Investments need to be similar to those in the health sector, including developing and implementing standards for system inputs and for infrastructure. Implementation encompasses regulating the qualifications and numbers of care providers and professionals, and standards to protect older persons.

The majority of OECD countries set minimum standards for licensing and accreditation for LTC institutions (8). The Joint Commission International Accreditation Standards for LTC include those focused on residents’ safety, access to and the quality of care, as well as organizational standards for staffing and governance (Box 1) (9). Setting and enforcing such standards is particularly important in LMICs to ensure that older people are safe and protected, given that poor quality care can be harmful (10).

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**Box 1. Domains of quality: the Joint Commission International Accreditation Standards for Long-Term Care, 2023 (9)**

Section 1. Accreditation participation requirements
- Patient safety goals
- Access to care and continuity of care
- Resident-centred care
- Assessments of residents
- Care of residents
- Medication management and use

Section 2. Health care organization and management standards
- Quality improvement and resident safety
- Prevention and control of infections
- Governance, leadership and direction
- Facility management and safety
- Staff qualifications and education
- Management of information
The enforcement of quality standards requires regulatory institutions and sanctions. Mandatory certification of quality or accreditation can be used as a prerequisite for obtaining a practice license and for LTC facilities to be eligible for public payments or insurance reimbursements. Facilities found to be in violation of regulatory standards could face withdrawal of accreditation, loss of public payments, fines or even closure, depending on the nature and persistence of the violation (7, 11). In Australia, regulators strive to encourage both safety and quality improvements, and they take the approach of working with providers to find solutions to problems identified (12).

Requirements for home care services vary widely across high-income settings. Some countries have developed sets of standards or use a registration process, while others use accreditation. Registration of home care service providers can be used to ensure there are a minimum number of qualified human resources and sufficient financial resources. In England, the Care Quality Commission carries out comprehensive inspections of newly registered LTC service providers to evaluate their safety, effectiveness, the care provided, and their responsiveness and leadership (13). In Luxembourg, LTC providers working in community care and residential care must follow an accreditation process in order to obtain authorization to practise in the sector, and there are standards for staff qualifications and for infrastructure. In Lithuania, social service providers are required to obtain a license and meet staffing and care standards, and LTC providers in the health sector must be accredited by the State Health Care Accreditation Agency and obtain a license to practise (7).

**Collecting data about quality from all long-term care providers in institutions and communities – while challenging – can support monitoring and guide improvement strategies; a shift is underway from using quality metrics focusing on adverse outcomes towards those that measure well-being and quality of life**

Measuring quality in LTC is a long-standing challenge, given the diversity of providers and institutions involved in care provision and the range of outcomes desired. The quality assurance and regulatory processes involve setting measures and standards, with minimum requirements for inputs to LTC services. Many of the quality standards are structural – such as those for human resources – and some are related to processes and outcomes. In some settings, countries mandate reporting about these standard requirements. As such, information about structural quality indicators may be more easily collected and monitored.

Measuring process, quality and outcomes for LTC delivered in the community and at home remains challenging, and many metrics focus on disease groups or adverse outcomes (14). For LTC residential institutions, quality indicators typically focus on the incidence of specific adverse events, such as falls, pressure ulcers, the use of safety restraints, involuntary weight loss, problems with medication or drug-resistant infections (7). Efforts are also being made to shift from negative quality metrics towards those that take a more positive view of ageing and desired outcomes in the care of older people, including well-being, quality of life and having the right to care. For example, quality of life measures can include mobility, the ability for self-care, being able to carry out usual activities, having social relationships, the
environment, personal cleanliness and comfort, nutrition, the provision of clean and comfortable accommodation, control over daily life, having an occupation and dignity (15).

Some high-income countries make data about price and quality measures for LTC available to health care providers and the public. In Germany, insurance funds are mandated to audit quality in LTC facilities (mainly on processes and outcomes) at least once a year, and results are publicly available (7). In some cases, publishing data about prices and quality is part of a programme to encourage individual choice. In Australia’s home care programme, for example, the LTC pricing schedule must be published on the government’s My Aged Care website and include the basic daily fee, care management costs and approximate hours of service available within each package level for common home care services (e.g. personal care, care by a registered nurse, assistance with cleaning and household tasks) (16). The pricing schedule must also include other costs, such as staff travel reimbursement, and any extra costs involved in obtaining services from other providers. However, studies are inconclusive as to whether making cost and quality information publicly available affects utilization and patient outcomes (17).

To promote care quality, some countries have linked higher payments to quality outcomes; however, the impact of paying for quality in health and long-term care is inconclusive, and further evaluation is needed

Salary and fee-for-service payments are usually the basis for provider reimbursement for LTC delivered at home, and per diems are typically used for LTC institutions (18). Such payment methods tend to promote higher volumes of services rather than quality and optimal health outcomes. Some initiatives are underway to use payment mechanisms to promote quality. The most common include pay-for-performance schemes that provide rewards for attaining specific quality objectives or apply penalties for not attaining them. This may include pay-for-coordination payments in which providers receive additional incentives for collaborating and coordinating care, activities that are critical for chronic disease management, particularly for patients with multimorbidity. However, rigorous evidence and documentation of the effects of such mechanisms on quality are lacking, particularly for LTC services and in LMICs (19). Challenges to implementation include measuring quality accurately enough to link to payments, ensuring timely reporting and adjusting for health and socioeconomic risks across different beneficiary groups (20, 21).

Payment mechanisms to encourage strong coordination and integrated care have emerged as strategies to provide financial incentives for better quality health care and LTC. Several payment models include shared savings and shared risks that apply activity-based payments to established benchmarks for a set of services that can include health and social care, typically across networks of providers. Providers can share in the savings if they are efficient in reducing expenditures below benchmark levels and meet quality targets. Accountable care organizations in the USA are one example of these strategies. Under shared-risk models, providers are accountable for overspending if their costs exceed the benchmark. A scoping review that included eight shared-risk and shared-savings models found evidence of
improved process outcomes for disease-specific management and control indicators; however such evidence ranged from moderate to low levels of certainty, and there was low certainty about improvements to health outcomes and continuity of care (22). These models stress the importance of broader aspects of service delivery in conjunction with purchasing, including the implementation of care coordination and patient management strategies. However, evaluations of impact are needed to determine their effect on quality, particularly in LMICs and for LTC services.

**Beyond linking payments to quality outcomes, countries use a range of other purchasing strategies that employ financial incentives to improve quality in long-term care, but evaluations of their impact are lacking**

Beyond strategies that link payments to quality and outcomes in health and LTC, countries have used a wide range of other purchasing instruments that use financial incentives to promote quality. For example, in recognition of the limitations of Australia’s fee-for-service system for beneficiaries requiring complex LTC, the national government allocated funding to provide additional resources to general practitioners to encourage them to coordinate care for older patients – from acute care to LTC – and to encourage older patients to enrol with one of these practices. Since 2020, patients aged 70 years and older have been eligible to enrol with a single, accredited general practitioner. The aim of the programme is to improve the continuity of care, improve health outcomes and reduce spending (18).

Netherlands (Kingdom of the) provides additional lump-sum funding to nursing homes to encourage quality improvements. Regional purchasing offices distribute these funds across providers based on their mandatory quality plans. Sweden has made use of financial incentives to foster better performance through conditional budget transfers. These transfers are designed to encourage improved provider performance by incentivizing competition among providers, encouraging users to choose across providers, and ensuring that municipalities deliver value and quality (18).

In countries with developed LTC systems, service prices are mostly set unilaterally by the purchaser or through collective negotiations between purchasers and providers. These methods have the potential to reduce price discrimination in LTC services and thus reduce variations in prices for the same services that are not linked to quality or production. This can promote affordability and equity in comparison with systems in which prices are determined through market-based mechanisms. However, the advantages of unilateral price setting may be offset if there are differences in the level of administration and if local authorities set prices depending on the availability of resources. For example, subnational governments in France, Spain and Sweden play an important role in setting public payer prices for LTC personal and social care services for older persons, resulting in substantial price variation within each country that does not necessarily reflect differences in quality, the costs of production or local wages (18).

Some countries adjust prices for LTC services to ensure that public payers cover care that meets minimum quality standards, for example by ensuring fair payment for quality care in remote or rural areas. To recognize cost differences among providers, prices can be adjusted for geographical location, the degree of dependency of beneficiaries and the type and
length of the home care service. Australia, Netherlands (Kingdom of the) and the USA, adjust prices for facilities in rural areas. Outlier payments are made to ensure quality in meeting additional care needs, including for oxygen and enteral feeding (Australia), palliative care (Australia, France), short and long stays (France), and specific conditions, such as dementia (Australia) or Huntington’s disease (Netherlands (Kingdom of the)). In Australia, supplemental support is provided to ensure there are services in indigenous communities (18).

In Japan, the fees and conditions for billing have been revised to align with policy goals pertaining to access and quality. For example, bonus payments are provided to home care agencies that employ workers with more experience. In Netherlands (Kingdom of the), an additional payout can be made to compensate providers for nursing home care or to substitute round-the-clock home care in relatively expensive areas if the regional budgets are not sufficient (e.g. because of high turnover in personnel in urban regions) (18).

**Improving the quality of care for older adults starts with formal participation of older persons in biomedical research, which underpins clinical guidelines and payment mechanisms for quality**

Care protocols and pathways, informed by biomedical research, are critical for the management and referral of LTC beneficiaries. Biomedical research underpins clinical care. Clinical trials to evaluate medical products commonly exclude the very populations for which they are frequently intended: older adults and those with multiple medical conditions (23). This is an important omission, given that ageing can affect how medicines work. For example, older patients commonly experience reduced liver and kidney function, which affects the way medicines are absorbed, distributed through and removed from the body, possibly resulting in severe side effects.

Basic biomedical research informs clinical practice guidelines, some of which may be inappropriate for patients with multiple morbidities, and these, in turn, may also be used for developing quality metrics and payment systems. Many practice guidelines are disease-specific and may not be appropriate for patients with multiple conditions. Training for physicians and other health care providers typically follows the same model: focusing on treating specific, discrete diseases. Thus, a health care provider developing a care plan for an older person with a combination of different conditions – for example, depression, chronic obstructive pulmonary disease and arthritis – often does so in the absence of complete information and the right incentives to ensure quality. Given that older age is a risk factor for multimorbidity, the traditional inclusion and exclusion criteria for older adults in clinical trials should be reconsidered in cases in which no clinical justification exists. In the interim, countries can strengthen postmarketing studies of existing medicines and care approaches by evaluating their use in older populations and across diverse LTC settings.
Implications for low- and middle-income countries

The COVID-19 pandemic exposed long-standing problems with quality and safety in LTC. The most vulnerable members of communities – frail older persons in residential settings – faced unacceptably high, preventable mortality in settings that did not meet fundamental safety and quality standards. A necessary prerequisite for LMICs is to build strong systems that set forth quality principles and standards that will apply across the broad range of LTC delivery settings. In particular, attention needs to be paid to quality assurance frameworks, including accreditation and regulatory systems for institutions and community care providers. Collecting data about quality from all LTC providers in institutions and communities can support quality monitoring and guide improvement strategies. While many countries have also invested in making information about quality available to the public, it is unclear whether such strategies impact choice or quality outcomes. High-income countries have also used a range of financial incentives to promote quality. These include payment methods that are linked to quality outcomes as well as a wide range of purchasing strategies that use financial incentives to promote quality. However, further evaluations are needed to determine their impact on LTC quality and outcomes particularly in LMICs. Including older adults in biomedical research can support the development of relevant clinical guidance and quality metrics. LMICs can learn from the experiences and mistakes made in more developed settings and invest early in strong quality and regulatory systems for LTC.

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