interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Quality assurance and quality management in LTC

National Report Switzerland

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1 Introduction

Switzerland cannot truly be said to have a national concept of long-term care (LTC) policies for older people. In August 2007 the federal government issued a report outlining its global strategy, as a response to a motion voted by Parliament 4 years earlier. The document put forward represents the results of the work of an interdepartmental group formed within the federal administration; representatives of interest groups, in particular associations of retired persons, were not associated with the preparation of the report. The paper deals with issues of mobility, housing, work, financial resources, social participation and health; it sets forth the main focuses of a strategy intended to integrate all aspects of the life of elders into a global perspective, both because it is interdisciplinary in nature and because it does not restrict itself to the field of direct competency of the federal level of government. However the federal government specifies that it intends to outline the contours of a strategy for a LTC policy for older people; it does not wish to "establish a plan of action" (Conseil fédéral suisse, 2007: 1).

Because of federalism and of the principle of subsidiarity, implementing LTC policies is primarily a responsibility which is devolved to the cantons, just like in the fields of education and health care. Cantons, as well as the federal government, are busy defining the main thrusts of their policy towards older people. For instance, the Geneva canton government presented its policy towards older people in 2005, Bern canton authorities carried out a similar task in 2007, and Fribourg and Valais cantons followed suit in 2008. 26 different policy papers on ageing and LTC issues are thus likely to be progressively written and debated over the next few years. 26 versions of policies will presumably be gradually implemented. Concepts put forward for parliamentary and public debate at the cantonal level are not limited to setting priorities for action. Their elaboration is also often an opportunity for reviewing recent policy implementation, for anticipating the needs of the older population of the canton and for initiating concrete measures considered necessary in the short or medium term.

Policies towards elders focus on generations who have reached retirement age, i.e. persons 65 and older. This group includes persons who are fully independent and in good health, persons who are dependant because of ill health and people who are frail, i.e. requiring help or losing their independence not because of specific medical diagnoses but because of frailty due to old age. While older people who are sick are taken care of by the health care system within the framework of federal legislation on health insurance (LAMal), the long-term care system is primarily focused on frail older people. Yet health insurance is not set up to wholly cover the needs of a long-term care clientele. Health insurance legislation does not specifically take long-term care into account. Thus older people in Switzerland are not covered by a branch of social insurance set up especially to cover the risk of long-term dependency in old age. As a result, in contrast with the health care system which rests on specific health insurance legislation (LAMal), long-term care does not have its own legal basis.

1.1 Long-term care in Switzerland: available data

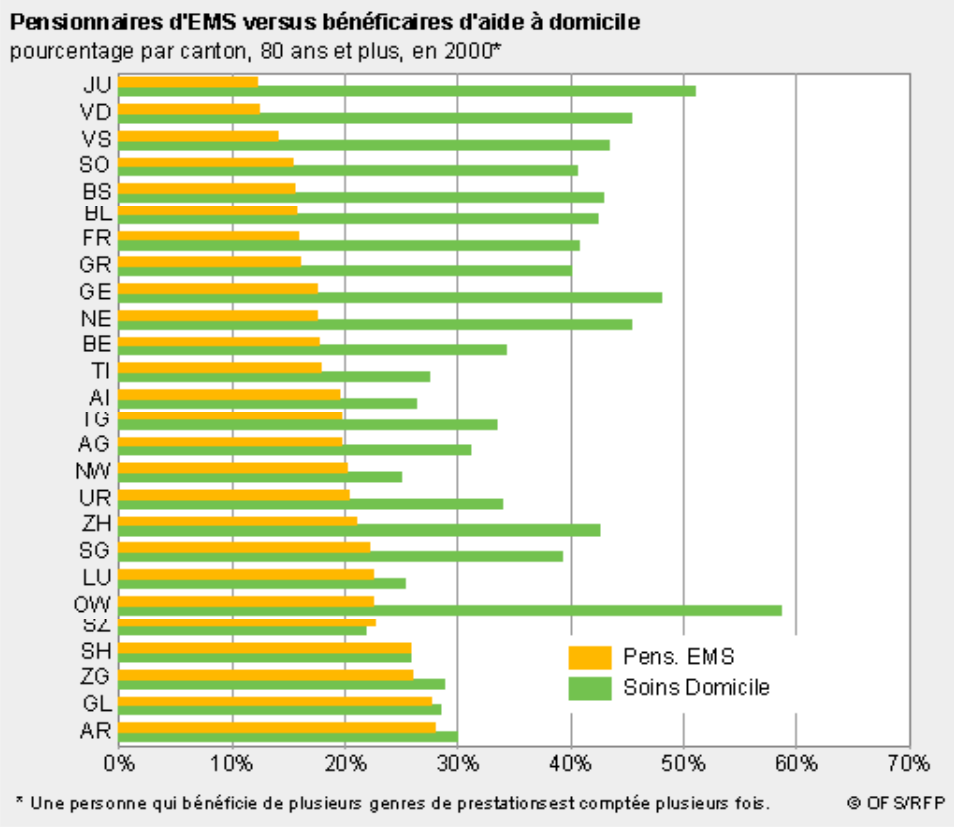
The Federal Statistical Office uses a relatively narrow and health-oriented definition of long-term care. In the perspective used by this Office, which is the main source of data at the national level, the long-term care sector includes specialised residential institutions for older people – i.e. nursing homes and care homes (in French: Etablissements médico-sociaux or EMS), Home health and home care services

(Services d'aide et de soins à domicile or SASD), intermediary structures such as sheltered housing, day care, short stay units in nursing homes, etc) and hospitals.[1] Nursing homes and home health/home care represent a clear majority of LTC.

When circumscribed by the definition outlined above, the value of services provided in the field of LTC en 2001 is CHF 6.5 billion, or 1.5% of GDP. It represents 14% of the global cost of health care, that is slightly more than the CHF 4.9 billion allocated the same year to drug purchases (Interpharma, 2004: 43). These costs are financed by health insurers, private households and state subsidies (Pellegrini et al, 2006).

At the national level, 12% of persons 65 and over use LTC services. Globally, 9% of Swiss residents aged 65 to 79 require LTC. This rate goes up to 48% when persons 80 and over are considered. However, important disparities between cantons exist in terms of use of nursing homes and home health/care services. Frequency of use for some types of services is two or three times higher in some cantons than others, as the figure below illustrates:

Figure 1 Proportion of LTC users at home or in residential care: differences between cantons



Source: Office fédéral de la statistique (2009) *Atlas de la vie après 50 ans.* <http://www.bfs.admin.ch/bfs/portal/fr/index/regionen/thematische_karten/atlas_de_la_vie_apres_50_ans/la_vie_en_institution/vivre_en_institution.html>. Consulté le 29 juin 2009.

[1] Hospitals are integrated into LTC statistics in three types of cases: specific rehabilitation care provided in hospital settings; hospital stays for nursing homes residents who temporarily require acute care; waiting periods in acute settings due to lack of places available in nursing homes.

The use of nursing homes is twice as frequent in central Switzerland (cantons Glaris, Argovie, Zug and Obwald) than in French speaking Switzerland (Vaud, Valais, Jura and Genève). For instance, canton Vaud has 143 nursing homes residents per 1000 inhabitants while the corresponding figure for canton Glaris is 342 / 1000 (Ruedin et al., 2006). On the contrary, recourse to home health/home care is much more frequent in French-speaking Switzerland than in the German-speaking part of the country. A ratio of one to two is found when comparing cantons Schwyz, Nidwald and Lucerne on the one hand, and Vaud, Valais, Jura and Genève on the other (Ruedin et al, 2006).

These differences, particularly marked for persons between 65 and 79 years of age, become slightly less strong after 80; this fact can partly be explained by cultural differences, French speaking cantons having explicitly based their policies on home health/care while Swiss German cantons have retained policies emphasizing the use of care homes as well as nursing homes as an option (Ruedin et al, 2006).

1.1.1 Nursing homes/residential care

According to a study carried out by the Federal Statistical Office in 2007, Switzerland has 1567 residential long-term care institutions for older people. 490 are public – i.e. belong to local authorities; 464 are private non-profits (owned by foundations, charitable organisations etc) and receive state (canton) subsidies; 613 are private and not subsidised (Office fédéral de la statistique, 2009: 1).

In 2001, the cost of nursing home care is CHF 5.6 billion. Each resident costs on average CHF 71,000 per year.

With their 78,000 residents, nursing homes cater primarily to the very old: 76% of residents are over 80, and most of them are women. On average, 20% of persons over 80 in Switzerland live in residential care, while only 2% of persons between 65 and 79 ans do (Pellegrini et al, 2006).

In European comparison, Switzerland has a particularly high rate of institutionalisation: out of 1,000 inhabitants of all ages, 12 live in an institution (Ruedin et al, 2006). Switzerland's position within the European context of residential care for older people is illustrated in Table 1.

Table 1 Services provided to older people: Switzerland and European countries in 2000

65+	*Share of older people in residential care (in %)*	*Share of older people using home care services (in %)*
Germany	5.0	3.0
Austria	4.7	3.0
Denmark	5.7	17.0
Spain	2.8	1.0
Finland	7.2	24.0
France	3.0	7.0
United Kingdom	5.1	13.0
Greece	0.5	-
Italy	2.0	1.3
Netherlands	10.0	8.0
Sweden	5.4	13.0
Switzerland	8.5	13.0

Source: Höpflinger/Hugentobler, 2006.

1.1.2 Home health/care services

In 2001, Switzerland had about 700 home health/care agencies or services (SASD) which are members of the national organisation of home health/care services (SPITEX).[2] Other organisations, notably Pro Senectute, which is a national organisation supporting older people, as well as other charities offer home care services in some cantons or areas, but not home health care covered by health insurance (Pellegrini et al, 2006).

As a national average, home health (nursing and personal care) activities by SASD agencies represent 0.8 hours per inhabitant and per year in 2002. Variations between cantons are quite marked and range from 0.4 hour per inhabitant in Zug to 1.4 hour in canton Vaud and Basel city. In most cantons, home health care represents 0.7 to 0.8 hours per inhabitant and per year. As far as home care activities are concerned, which focus on instrumental activities of daily living (IADL) they are slightly less intense. As a national average, they come to 0.7 hour per inhabitant and per year (2002). In that area also, inter-canton disparities are significant since they vary between 0.4 hour in Schwyz and 1.5 hour per inhabitant per year in canton Jura. In most cantons, we find figures close to 0.6 to 0.7 hour (Pellegrini et al, 2006).

At national level, in 2001, home health/care services provided nursing care and home care to 196'000 clients for a total cost of CHF 915 million,[3] i.e. CHF 4,700 per client (Pellegrini et al, 2006). In terms of total service time devoted to clients, the average time spent with each client per year is 61 hours. 7% of persons aged between 65 and 79 use home health/care services and this rate goes up to 27% for inhabitants 80 and over (Ruedin et al, 2006).

1.1.3 Analysing quality in long-term care

As was mentioned earlier, long-term care does not have a specific locus and definition within the Swiss social security system; it refers to services and institutions that are not planned and financed in an integrated manner. It developed without being supported by an explicit political will, at the margins of the social security system which only provides practical and financial to frail elders in an indirect fashion, i.e. through health insurance when frailty leads to illness, and/or financially though supplementary income benefits (in French: prestations complémentaires or PC), when frailty and dependency cause or worsen poverty (Despland, 2008). The proportion of costs covered by different purchasers is presented in Table 2.

Table 2 Costs* by purchaser in 2004 (in percentages)

Type of purchaser	*EMS*	*SASD*
Private households (incl. income supplements from "PC")	46.1	5.8
Direct subsidies by towns or cantons	10.0	32.0
Health or accident insurance	21.0	32.0
Social security (AVS, for SASD till 2008)	21.4	23.7
Private contributions/others	1.5	4.5

Sources: Weaver et al, 2008: 26.- Notes: * Total costs included for clients of all ages.

[2] In 2007, this figure is 639. Hone health/care agencies provide 12,000 full-time equivalent jobs, for a total of 204,700 clients, 74% of which are pensioners (OFS, 2009a).

[3] In 2007, this amount is CHF 1,209 million, i.e. 2% of health care costs (OFS, 2009a).

Health insurance covers approximately a fifth of the cost of care costs in nursing homes, and about a third of those provided by home health/care agencies. The proportion of the cost of care provided by nursing home and home health/care agencies and related to illness is thus estimated at 55-60% (Wächter/Stutz, 2007: 2).

Private households cover about half of the cost of services provided by nursing homes. The cost covered by households themselves relate to housing, food and social activities in the residential institution. In the field of home health/care, these aspects are not included as they relate to costs not incurred by care agencies but included in the older person's own household expenses. For this reason, the portion of costs directly covered by households is notably lower than in nursing homes.

Cantons and cities/towns cover 10% of costs of nursing homes through direct subsidies, and up to a third of costs of home health/care services. Public authorities also contribute through social security, in the form of old age disability benefit ("allocation pour impotent") and supplementary income benefit ("PC").

In short, it is realistic to suppose, that the fragmented character of the legal, financial and institutional bases of the long-term care system explains the fragmented nature of the quality promotion and control system which applies to it. When services provided to the frail older person are financed by health insurance (LAMal), quality control is linked to dispositions contained in the health insurance legislation and carried out by actors approved within the health insurance context. When services are paid for by private households – i.e. clients themselves, with or without financial support in the form of supplementary income benefits, quality control mostly depends upon arrangements made by providers themselves; these providers are primarily nursing homes (or care homes where they still exist) and home health/care services. These services and institutions are themselves subject to oversight by cantonal authorities, this oversight being founded on cantonal public health legislation. Three distinct levels of promotion of control can thus be identified, involving different concepts and different actors.

They can be described as follows:

- The quality control of services reimbursed by health insurance – this mostly concerns nursing care,
- The development of «total quality» systems conducted by private organisations focused on quality promotion in domains of activity which are not reimbursed by the health insurance, mainly services related to housing, food and activities in nursing homes, as well as home help (versus home health care) provided as support to IADL because of functional dependency (Weaver et al, 2008: 25),
- The control and oversight activities conducted by cantonal authorities.

The work of professional organisations (representing doctors, nurses or other therapists) which produce standards or codes of good practice in their specific fields, must be added to these activities. It will be briefly illustrated by an exemple taken from the nursing care.

Actions taken in the field of quality promotion and control at each of these levels and by these different actors are described below.

2 Quality control in the field of health care activities covered by health insurance (LAMal)

The parties to the quality insurance arrangements within the health care/LAMal field are national organisations of providers and health insurers. We outline their main organisations and practice below.

Three national organisations – CURAVIVA, SENESuisse and H+ – are charged with promoting the interests of nursing homes. The first is also the largest, 95% of nursing homes being members of CURAVIVA. SENESuisse is only present in the private nursing home field; finally H+, which represents acute care hospitals, has about 45 nursing homes as members.

Members of ASSASD/SPITEX, which is the national organisation for the home health/care field, deliver about 90 % of home health/care in Switzerland, the remainder being provided by independent visiting nurses and by for-profit agencies. 639 'local agencies' are grouped into 26 'cantonal associations' (2007), all members of ASSASD/SPITEX-Switzerland.

In 2005, there were 85 approved health insurers for compulsory basic health insurance (LAMal) in Switzerland. The four largest insure approximately half of the population of Switzerland (Interpharma, 2007: 63). Santésuisse is the national umbrella organisation of health insurers.

Care activities covered by health insurance are reimbursed on the basis of a legal ordinance (OPAS; art. 7 which defines activities covered, and art. 9 which defines billing modalities).

2.1 Legal framework

The law states that providers, insurers and competent authorities «make sure that care provided is appropriate and the quality of care is of a high level, while being as cost-effective as possible» (Art. 43, al. 6 LAMal). With a goal of «overseeing the implementation of dispositions (…) relative to the cost-efficient character and the quality of care provision», the law requires that health care providers give the Federal Statistical Office (which is a part of the central administration) the following data: "a) type of activity, infrastructure and equipment, legal status, b) staff data including training positions and their nature, c) number of patients and data on their characteristics, in anonymous form, d) type, volume and costs of services provided, e) costs, revenues and balance sheets, f) medical quality indicators" (Art. 22a, al.1 LAMal). With the goal of "guaranteeing quality or adequation of services reimbursed by basic health insurance», the law states that «the Federal government can mandate scientific systematic controls" and that it may "entrust their implementation to professional associations or to other institutions" (Art. 58, al. 1, 2 LAMal).

Health insurance legislation (LAMal) thus directly links principles concerning quality, the appropriate nature of services, and cost-effectiveness. But what, then, might be the nature of the link between these different goals? On this point, interpretations of the legal text are divergent. Some see these goals as complementing each other, whereas others find an opposition between the principle of guaranteeing quality services on the one hand, and the principles contained in the law which aim at raising the economic rationality of care provided on the other.

Analysts who favor the first interpretation see efficacy, appropriateness of care and cost-effectiveness as properties which are integral components of quality of care. This approach was used by Donabedian,

who added to them principles of acceptability, legitimacy and fairness when proposing an operational definition of quality (Donabedian, 1980, quoted in Haddad et al, 1997: 61).

The other type of interpretation views the notion of cost-effectiveness as requiring a specific approach based on the letter of the law. According to proponents of this view, health insurance law ties the reimbursement of services provided to three distinct conditions – i.e. "efficacy, appropriateness and cost-effectiveness" (Art. 32 LAMal), to show that the quality principle is very selective and only comes into play under very specific conditions. Firstly, the efficacy principle refers to the probability that a measure taken will lead to the expected therapeutic impact. Efficacy is thus a clinical – not an economic notion. When several therapeutic measures exist, the law mandates first to use the one which is likely to produce the best result, independently of price. Then, the law deems a measure is *efficacious* when it leads to restoring or ameliorating the health of the patient, or preventing a worsening of the patients' condition or general health status. The rule of appropriateness is related to the actual specific goal pursued by the treatment of a particular patient. It invites practitioners to choose between measures, the therapeutic impact of which has been evaluated for the condition being treated; the most *appropriate* for the specific patient must then be chosen, again without consideration to its cost. Only once efficacy and appropriateness have been established does the law raise the issue of the *cost-efficiency* of measures to be taken (it must be pointed out that a measure that has no efficacy or is not appropriate can never be considered cost-efficient). Finally, proponents of this interpretation remind us that the cost-efficiency rule can only be applied when several measures of the same efficacy and appropriateness are available, as cost-efficiency is relative and requires comparison according to the law. In their eyes, it is with regard to this three-level examination that quality control must be located. In this perspective, dispositions relative to quality control are meant to define the limits of the principle of cost-efficiency. They state, fundamentally, that the principle of cost-efficiency must be suspended if the least expensive measure which could be used does not allow the goals of quality set in the law and specified in its ordinances to be reached (Eugster, 2001: 18).

As we have just seen, health insurance includes two separate approaches of quality. When the principles of quality and cost-efficiency are viewed as complementary, quality is construed as a concrete «object», defined by specific attributes. One might say that this view is founded upon an ontological conception of quality, which holds similarities with the term quality as «neutral, passive, without known antonym»; Haddad and coll. attribute to Cicero the paternity of this meaning of the word (Haddad et al., 1997: 62). On the other hand, when two principles are opposed in the definition of quality, we are faced with a view of quality as defined by pre-existing norms. We may call this view a normative approach of the notion of quality.

An analysis of quality control mechanisms in place or in the process of being introduced tends to indicate that they are founded upon the view of insurers; as actors in the health care field, they are naturally more concerned about cost control than quality control; they may implicitly consider that care that is cost-efficient is of high quality. On the other hand, health care providers, when they wish to introduce quality standards, are more likely to refer to the second type of quality approach outlined above. However, standards are not seen as absolute limits below which the quality requirements set forth by law would no longer be fulfilled, but rather as average quality levels to be attained, given current financial constraints. As a result, the health care providers' approach cannot be used either to identify health care activities which do not correspond to the "high level of quality" required by lawmakers, although providers do use a normative conception of quality.

2.2 Control activities carried out by health insurers

Health insurers carry out "care controlling activities" which include, according to them, controls in the fields of cost-efficiency and quality. Their main goal is to verify whether service provision billed by the provider corresponds to the actual care needs of the patient. In this perspective, quality controls involve all aspects also necessary for cost-efficiency controls. Insurers check, among other things, that the objectives of the nursing or medical care provided are specifically formulated, as this is a precondition for evaluating whether the therapeutic measures used are appropriate.

The instruments which have mostly been put in place since the introduction of the current legislation on health insurance for evaluating the level of care needed are also used for evaluating quality, allegedly because they require collecting data on characteristics of patients of clients and their needs for care and help with activities of daily living. The main instruments used are BESA, PLAISIR and RAI, including its RUG function. BESA was originally developed by CURAVIVA. It is only used in German-speaking cantons. Inversely, the instrument called PLAISIR, developed by a Quebec private firm, has only been put into place in French-speaking cantons. Four cantons have chosen the RAI + RUG system, originally created in the USA. The figure below gives a synoptic view of the use of these various instruments for needs assessment. We may point out that cantons Bern, Fribourg and Ticino (Italian speaking) use instruments they devised themselves for their specific use, and that two cantons (Zürich and Argovie) use two different systems.

Table 3 Needs assessement instruments used in nursing homes, October 2008

System	*Number of care levels*	*Geographical distribution (canton initials)*
BESA	4	AI, AR, BL, LU, OW, NW, SG, SH, SZ, UR, VS, ZG, ZH
	12	AG, GL, GR, TG
RAI/RUG	44/12	AG, BS, SO, ZH
PLAISIR	8	GE, JU, NE, VD
Centralised system	10	BE
Own system	4	FR
	4	TI

Source: CURAVIVA.

It turns out that the various systems of needs assessment generate data which are not directly comparable. Legal changes which will follow the parliamentary adoption of some modifications in health insurance law during the summer of 2008 will necessitate changes in the instruments and systems used for determining levels of care. Any instrument used will have to produce 12 categories of care needs. Moreover, providers and systems operators will have to guarantee the comparability of data produced by the different instruments/evaluation system.

To date, the home health/care field only has one recommended, validated instrument for needs assessment. It is the RAI-Home care, which ASSASD/SPITEX encourages all its members to use. In time, it may lead to a clearer situation than in the nursing home field; however, providers in the field have not all switched over to RAI-Home care yet; many of them still use their own needs assessment scales or forms. Moreover, most health insurers have not formally approved this choice of instrument. In principle, they are favorable to the use of standard, homogeneous quality criteria, but they have not approved the concept of one single quality control system, which ASSASD/SPITEX wishes to introduce by

using data derived from RAI-Home care. For this reason, the quality standards proposed by AS-SASD/SPITEX have not been accepted by Santésuisse (the national organisation representing health insurers).

On the issue of care controlling, ASSASD/SPITEX has made an agreement with one large health insurer who also has formally promoted the use of RAI-HC as a single instrument for needs assessment. Both parties have agreed to ask home health/care providers to transmit to the health insurer the individual care plans which are elaborated on the basis of needs assessment and care activities offered – one of the tools provided by RAI-HC. The health insurer, who does not know the identity of the patient of his/her diagnosis for confidentiality reasons, then carries out a control of cost-efficiency/quality on the basis of documents received. The data does not enable the insurer to check the appropriate nature of care with regard to care needs. However, it allows the insurer to conduct spot checks to verify whether they seem coherent with accepted standards, and can lead him to react if care activities seem to fall outside usual practice (e.g. a bed bath given more than three times a day, etc.).

2.3 Quality control activities by health care providers

Each system of needs assessment can furnish data which can be used to devise indicators for the measurement of quality of care. CURAVIVA, who has decided to devise indicators for its members, convened a meeting of all concerned parties in late June 2009 in order to assess the specific needs of all its members, with a view to elaborating appropriate instrument. Its action is founded, indirectly, upon the recent legal requirement for hospitals which will have to use DRGs as a funding mechanism for acute care and which simultaneously mandates the introduction of quality indicators.

Just as BESA, PLAISIR et RAI+RUG for nursing homes, RAI-HC serves simultaneously as a systems of care needs assessment and as a quality control tool. On the basis of RAI-HC, ASSASD/SPITEX has identified 19 quality indicators, 15 of which stem from a list devised for use in the US and Canada (Rüesch et al., 2008).

The plan is to constitute groups of local agencies, e.g. on a regional basis for a limited aperiod of time, so that they can compare their scores on each indicator and jointly analyze the causes of observed differences. It must be noted that the goal of this benchmarking is not to introduce competition between local agencies about quality scores. Rather, the idea is to incite agencies to aim for an acceptable score (within a predefined range) for each item: comparisons will thus take place among types of items or indicators rather than between agencies. This type of quality control will not produce a ranking of agencies, but will highlight areas of practice in which an agency is especially good (or poor) in terms of care quality.

However, practical problems do arise. On the one hand, the question of adjusting scores to specific characteristics (e.g. how to compare agencies which have very different clienteles in terms of age) has not been completely mastered yet. On the other, the system of comparison requires that data from all agencies be stored and processed in one file. However, agencies use different types of software and data migration is not always possible. To date, 45 agencies use RAI-HC and compatible software enabling them to use the proposed system, out of 639 which could participate in the future.

This quality system's only goal is to make quality indicators visible and comparable. It enables agencies which participate in it to have detailed comparative information on the quality of are activities they produce. It does not however give them information on how to improve their performance, nor does it

propose specific measures. Managers of local agencies are responsible for defining and implementing quality improvement measures where expectations have not been reached.

3 Certification, accreditation and quality management

In 1964, Donabedian proposed an analysis of quality from the points of view of structures, processes and outcomes. When it focuses on structures, quality control deals with the level of resource allocation and its compatibility with desired objectives. When it focuses on processes, it looks at the ways activities are carried out; when outcomes – or results – are considered, the quality of the finished product must be assessed.

The controlling measures put into place by health insurers and the benchmarking based on a limited number of validated indicators also focus on care outcomes. In that sense they examine the results of the intervention. However, care activities not reimbursed by health insurance (LAMal) are not subjected to this kind of scrutiny. Their quality is mostly assessed at the levels of resources and processes, within the framework of quality management systems which set standards in these fields.

Health care providers have to meet minimum standards set by cantons, which verify them by means we will present in more detail in the next chapter. On the other hand, they are not forced to introduce quality management systems, which set their own standards, or to enter into certification processes; when they do, no specific system is imposed. Institutions enter into these processes freely, usually in order to increase the level of trust clients or patients award them. (Jaunin, 2006; 18) Because of the voluntary character of the process, estimating the proportion of institutions and agencies which enter into them is difficult. To our knowledge, there is no trustworthy general information on certification firms or agencies actives in the LTC field or about the range of quality management systems they propose.

The lack of specific directives or requirements stemming directly from the law (LAMal) further muddies the waters. Analysts agree that no single quality management system has taken the ascendancy at the national level, be it in the hospital, ambulatory care of long-term care fields (Shilling et al. 2001; Groupe de travail qualité de la FMH, 2008). This situation is widely viewed as unsatisfactory. «(…) this could potentially be expensive and time-consuming. Health care organisations would be dependent on various private and semi-private consulting firms and associations working in the health care business. Undoubtedly such an approach (which would renounce to implement any external peer-review system on national and/or cantonal level) would lead to a costly outcome for Swiss tax and health insurance payers» (Shilling et al. 2001: 160). In the same vein, the Management Committee of the Swiss Senate states in its letter to the Federal Government dated November 13th 2007: “Quality assurance according to the LAMal has a sizeable improvement potential and the Federal Government has not used its legal powers to the full in that regard” (cited by Groupe de travail qualité de la FMH, 2008: 238).

Some of the certification firms active in the long-term care field are accredited by the Swiss Accreditation Service (SAS). Like the certification of providers, accreditation of certification firms is voluntary. The SAS is linked to the State Secretariat for the Economy (SECO), and supported by the Federal Commission on Accreditation, which advises Federal authorities on such matters. The SAS role is to control certification organisations, and to accredit them in some cases. “Accreditation is proof that the organisation accredited is competent to carry out a specific clearly defined service, according to trustworthiness and quality standards required” (SAS,2004). The accreditation process takes place in three steps. First, SAS visits the offices of the organisation seeking accreditation. It checks on resources (infrastructure, in-

struments used, work processes, staff qualifications). Then, it verifies the ability of the organisation to impose the standards set in its certification system in the field, by an unannounced visit to an institution that has been certified. Finally it submits the reports that the certification firm gives to its clients to a critical examination. However, the SAS does not really evaluate the quality management system used by the certification organisations. If the SAS does not view the systems used as corresponding to its own standards, SAS will not initiate the accreditation process.

The bases upon which the work of the SAS rests are the international ISO standards which pertain specifically to certification organisations. As far as LTC is concerned, three standards are pertinent: ISO 17020, ISO 17021 and ISO 17021. The ISO 17020 standard states that "According to the internal rule of CEN[4]/CENELEC[5]" countries concerned (which include Switzerland) must put this standard into force. In November 2008, the European Union has recognized the conformity of the Swiss Accreditation system to European requirements. Since then SAS is a member of the European Cooperation for Accreditation (SAS, 2009).

The SAS keeps a list of certification organisations it has accredited.[6] Among these, we have identified six organisations active in the long-term care field. The data made available by SAS about each of them indicates the standards upon which the accreditation is founded. Some organisations describe the qualifications of their staff and publish the list of institutions they have certified on the web. Public information stemming from these presentations is shown in Table 4 below.

Table 4 Certification organisms active in the long-term care field and accredited by SAS, 2009

Organisations	*Standards*	*Nursing Homes certified*		*Home Health/care agencies certified*	
		German-speaking Switzerland	*French-speaking Switzerland*	*German-speaking Switzerland*	*French-speaking Switzerland*
SQS	ISO	20	25	5	5
ProCert	ISO, SPEQ, CertEMS	1	20	0	0
Concret AG	Method for appraising quality of care	2	0	0	0
Confidentia	Paths for quality	*n/a*	*n/a*	*n/a*	*n/a*
CIVEMS	Cantonal standards (VD)	0	all	0	0
sanaCERT	Normes sanaCERT	0	0	1	0

Source: own calculations from public data on Internet.

The ISO standards 900ff from the International Organisation for Standardisation are most commonly used. The ISO 9001 standard has been developed for industry, in coherence with the German (DIN) and European (EN) industrial standards. Initially introduced in 1987, it has been strongly developed since the

4 Comité européen de normalisation

5 Comité européen de normalisation éléctrotechnique

6 It can be consulted on the following web adress: www.seco.admin.ch/sas/akkreditiertestellen/index.html?lang=fr&

mid-90s (Jaunin, 2006a). It was first revised in 2000, then again in 2008. From the time of its first revision, it seems to have become more widely used in the health field. (Groupe de travail qualité de la FMH, 2008: 843). In Switzerland, the ISO standards are supported and developed by the Swiss Association for Quality Management Systems (SQS) and by ProCert, two leading organisations in the field of certification of institutions in the long-term care field.

SQS is active in many diverse fields. This organisation has about 150 employees in Switzerland, France and Italy, and operates quality control systems in about 60 nursing homes and home health/care agencies in Switzerland. Its influence is about evenly distributed between French-speaking and German-speaking Switzerland. SQS also certifies institutions on the basis of the EFQM model (European Foundation for Quality Management) which was funded in 1982 (Groupe de travail qualité de la FMH, 2008: 843). The EFQM model is considered part of the "total quality" systems. Although parallels with the ISO process do exist, total quality systems are viewed as having their own specific approach.

The number of employees of *ProCert* is unknown, but its activity in the nursing home field is sizable. ProCert works mostly with ISO standards, SPEC[7] and CertEMS[8] and certifies about 20 nursing homes in Switzerland. It is worth noting that CertEMS standards are recommended by the CLASS (French-speaking and Italian-speaking cantons); this may explain its strong presence in French Speaking cantons.

Beyond these two main organisations, we find three other firms worth mentioning: *Concret AG, Confidentia* and *sanaCERT*. *Concret* employs around 5 people. The firm uses a method of 'Appreciation of health care quality' (Concret, 2008), which it developed itself. This organisations mainly certifies hospitals and a few nursing homes in German-speaking Switzerland. *Confidenti*a uses a process based on the work of Rudolf Steiner called "Paths to quality". [9] Finally, the part played by *sanaCER*T must be seen as relatively marginal in the LTC field, since this organisation only certifies one home health/care agency and is mainly focused on acute care. *sanaCERT* was founded in Bern in 2001 and has developed its own quality control standards (Groupe de travail qualité de la FMH, 2008: 843).

The Vaud cantonal interservice team for nursing home oversight visits (CIVEMS)[10] is the only canton oversight organisation in the nursing home field which is accredited. Its work is discussed in the next chapter.

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7 Created by the Swiss agency for promotion and evaluation of quality in health and social institutions. It is based on ISO 9001 and adapted to the social field.

8 The CertEMS standard has been created by ProCert especially for nursing homes.

9 Wege zur Qualität. (S.D.). Audits et certifikation. (http://www.wegezurqualitaet.info/index.php?id=349). Page visited on 14th July 2009.

10 Canton de Vaud. (S.D.) Les contrôles de qualité. (http://www.vd.ch/fr/themes/sante-social/ems/quels-controles-fait-letat/les-controles-de-qualite/). Page visited on 14th July 2009.

4 Quality control by cantons

In Switzerland, cantons are responsible for devising and implementing policies of quality control in long-term care services. Cantonal legislations represent, in part, implementation legislations for federal law, in particular in the field of health insurance. In practice, cantons have grouped together into four regional «conferences», which function under the aegis of the Swiss conference or cantonal ministers of health and social services (CDS) (Achtermann/Berset, 2006). The regional conferences are the French and Italian-speaking cantons conference (*Conférence latine des affaires sanitaires et sociales* or CLASS)[11];The North-Western Switzerland conference (*Conférence des directeurs sanitaires de la Suisse du Nord-Ouest, or* GDK-NWCH).[12] The Eastern Switzerland and Lichtenstein conference (*Conference des directeurs sanitaires de Suisse orientale et de la principauté du Liechtenstein* (GDK-Ost)[13] and the Central Switzerland conference (*Conférence des directeurs des affaires sanitaires et sociales de Suisse centrale* or ZGSDK)[14]. These regional structures act as coordination forums which contribute to harmonizing cantonal arrangements and legislations in terms of implementation of federal legislation as well as cantonal public health laws and structures.

We will use, as a main example, the legislation and arrangements put in place in canton Vaud for quality control in LTC. This canton is part of the CLASS, created in 1981. We will compare and contrast it to dispositions existing in canton Neuchâtel – a smaller French-speaking canton - as well as in canton Zürich, a large German-speaking canton that includes the largest city in Switzerland.

4.1 Vaud example: cantonal quality control in nursing homes

In canton Vaud, the Department of health and social affairs (*Département de la santé et de l'action sociale or* DSAS) is in charge, among other structures, of nursing homes (EMS). Its activities in the field of quality control of nursing homes (as well as of home health/care agencies) are based on cantonal legislation.

4.1.1 Bases in cantonal laws

Control activities by DSAS are founded on the following legal bases: the Vaud cantonal law called '*Loi d'aide aux personnes recourant à l'action médicosociale* du 24 janvier 2006 *(LAPRAMS)'*, which deals with financial aid to people requiring health or social care, and on the '*Loi de la santé publique du 29 avril 1985' (LSP)* or public health law. The LAPRAMS sets as its goal "guaranteeing equal access to health and social care, at home and in residential care" (Article 1). The authority designated to implement is the DSAS, which "delegates to its services the mission to verify implementation of the law" (Article 4). Health and social care providers (at home or in residential care), as well as the Department of Health and Social Services, set the amounts of financial help allocated to beneficiaries by signing *rate agreements* (Article 5).

[11] Previously called CRASS or Conférence romande des affaires sanitaires et sociales. Includes the following cantons: Bern (French speaking), Fribourg, Jura, Neuchâtel, Tessin, Vaud, Valais.

[12] Includes cantons Argovie, Bern (German speaking), Basle-Land, Basle-City, Lucerne, Soleure.

[13] Includes (as well as Liechtenstein) cantons Appenzell (both parts), Glaris, Grisons, Saint-Gall, Schaffhouse, Thurgovie, Zurich.

[14] Includes cantons Lucerne, Nidwald, Obwald, Schwyz, Uri, Zoug.

Control and oversight of providers is within the purview of the DSAS. The law states: "Nursing homes and care homes are inspected by the Coordinated interservice team for nursing home oversight visits (CIVEMS), which must check the health and social care offered to persons who reside in the nursing homes, which may be visited at any time" (Article 7). The *Loi sur la santé publique* also states that: "The department can, at any time, take measure conducive to preventing or stopping actions which may endanger patient security and the protection of their fundamental rights" (Article 151). In case of poor results after inspections, five types of possible sanctions exist in the Article 151a of the *Loi de la santé publique*:[15] warning; fines ranging from CHF 500 to CHF 2,000; limitations to authorisations to run a nursing home; temporary of permanent suspension of the authorisation to run a nursing home; personalised withdrawal of the authorisation to manage a care home.[16]

4.1.2 Controls conducted by the Coordinated interservice team for nursing home oversight visits (CIVEMS)

With the goal of ensuring quality care in its nursing home, focusing on issues of dignity and security for persons living in residential care, cantonal authorities conduct nursing home inspections in nursing homes and in long-term care divisions of hospitals. The CIVEMS is the team in charge of these inspection visits, mandated by the LAPRAMS. Accredited by the Swiss Service for Accreditations,[17] it is a part of the administrations of 'social insurance and residential care' on the one hand, and of public health on the other; both these services belong to the DSAS. Periodical and unannounced visits are carried out in all institutions authorised to offer residential care. Two to three professional carry out these inspections: a nurse, a social worker and a dietician. If necessary, specific inspections can be conducted when complaints have been received; they may also take place following requests from administrative services.

Until 2008, quality inspections conducted by the CIVEMS were based on the checklist elaborated by the CRASS as a reference document. Six types of items were tested at the time: housing conditions, care concepts, organisation of residential life, infrastructures, resident's medical and nursing records and staffing. In 2007, 41 inspections were carried out; reports identifying unacceptable practices, standards not met or other violations were reported to oversight authorities in 13 cases (CIVEMS, 2008).

4.1.3 Introduction of a new evaluation instrument

Since the beginning of 2008, the DSAS has put into place a new inspection mechanism for nursing homes, and has thus moved away from the CLASS approach. CIVEMS inspectors use a new evaluation tool focused on the dignity and security of residents as primary concerns. To this end, staffing levels and restrictions of movement imposed on residents are specifically controlled. Administrative and management aspects feature less prominently, "as they are dealt with through audits related to quality assurance systems in place".[18]

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[15] These sanctions are also specified in the LAPRAMS, Article 39.

[16] *Loi sur la santé publique* (LSP) du 29 mai 1985, état au 01 janvier 2007. Canton de Vaud; *Loi d'aide aux personnes recourant à l'action médico-sociale* (LAPRAMS) du 24 janvier 2006, état au 01 mai 2006. Canton de Vaud.

[17] The CIVEMS decided to seek accreditation in 2002; this accreditation was renewed in 2006. It is viewed as a guarantee of the independance and impartiality of the CIVEMS.

[18] Voir le courrier: Canton de Vaud. Le chef du département de la santé et de l'action sociale, Inspection de la CIVEMS. 25 janvier 2008. En ligne

The new tool is based on five standards:[19]

- Dignity and privacy of the resident are preserved
- Safety is guaranteed and autonomy is encouraged
- Individual and group communication are respectful and valued
- The nursing home has individual records which describe care processes and enables inspectors to evaluate them. Care protocols and institutional directives are up to date and adapted to individual resident's needs.
- Legally mandated staffing levels are respected, including with regard to the professional qualifications required.

Each norm is detailed into specific indicators and sub-indicators, enabling quality to be evaluated in detail. The example below (Table 5)is directly taken from the evaluation tool:

Table 5 Item from the CIVEMS inspection tool ("Grille d'évaluation")

2.1	**An emergency call system can be reached by the resident; appropriate walking or other aids are proposed. The home environment is appropriate for his/her handicap.**	☐ reached ☐ partly reached ☐ not reached ☐ not observed
The resident ✓ Can reach an emergency call device wherever he/she may be in the building ✓ Wears clean eyeglasses ✓ Wears appropriate shoes ***The Nursing Home*** ✓ Offers rollators, walking sticks, wheelchairs, etc. ✓ Keeps all aides and devices in good, clean condition (walking sticks rubber ends, etc) ✓ Identifies and remedies dangers stemming from architectural barriers (e.g. access to stairs is secured) ***Staff*** ✓ Responds when the call system is used ✓ Checks that hearing aids function properly ✓ Checks dentures and/or teeth		

Source: Canton de Vaud. Civems. Contrôle qualité. La grille d'évaluation. S.D. En ligne <http://www.vd.ch/fr/themes/sante-social/ems/quels-controles-fait-letat/les-controles-de-qualite/>. Consulté le 29 juin 2009.

For each item, the CIVEMS has detailed instructions as to how to use the inspection instrument. For the items used above as an example, the instructions state:

- "When visiting bedrooms, inspectors verify that call systems are in place. If the condition of the resident no longer enables him/her to use the call system, this fact must be recorded in his/her record.

<http://209.85.129.132/search?q=cache:f4Q2lLpgg3UJ:www.vd.ch/fileadmin/user_upload/organisation/dsas/sash/Lettre_inspections_de_la_CIVEMS.pdf+inspection+de+la+CIVEMS+ems+vaudois+25+janiver+2008&cd=1&hl=fr&ct=clnk&gl=ch>. Consulté le 26 juin 2009.

[19] *Ibid*.

- Walking aids available to residents is clean, well kept and appropriate for their needs.
- The nursing home has identified risks derived from its infrastructure and has taken measures to circumvent them, e.g. gate in front of the staircase.
- Common spaces must be suitable for handicapped residents who live in the home, e.g. an elevator or wheelchair lift is present."[20]

Following the visit, a report and a final evaluation are written up, the same day and on the spot. Nursing homes are then classified according to three possible types of results and two categories:

a) The nursing home fulfills the standards set forth by the Department (more or less successfully). It then receives a written report and may ask for further explanations during the 2 weeks following the inspection. If results are less than very good, the institution receives advice as to how to better its scores. There are however no other actions taken until the next inspection.

b) The nursing home is not up to standards. Measures are then taken in order to enable the home to reach the required standards. Three situations may arise:

   - The nursing home does not meet standards in a general way. Global ameliorations are required, and another inspection will take place shortly. Inspection will be repeated until the required standards are reached.
   - The nursing home does not fulfill requirements in terms of staffing levels. Follow-up on this specific issue is mandated and it must quickly change its staffing levels. Follow up goes on until standards are reached.
   - The nursing home uses means to restrict the movements of residents. The CIVEMS will then impose a process of review of risk management A partnership exists between UNIGER,[21] the Alter Ego association,[22] and the CIVEMS. The nursing home will then be strongly encouraged to pursue staff training with the help of these partners. Again close follow-up will be out in place by the CIVEMS until required standards are reached.

In all these cases, if corrective action is not promptly taken, sanctions stated in the law are taken.

4.2 Neuchâtel example: cantonal quality control in nursing homes

In regional terms, canton Neuchâtel is part of the French and Italian-speaking regional conference as canton Vaud (CLASS). The Department of health and social services is responsible for oversight and quality control in nursing homes. Its role is defined by Neuchâtel cantonal legislation.

4.2.1 Cantonal laws pertaining to nursing home oversight

Two laws and two ordinances (or 'règlements') define the role of oversight authorities in canton Neuchâtel: the public health law, or *Loi sur la santé (LS)* dated Feb. 6th 1995, the law on specialised institutions for older people or *Loi sur les établissements spécialisés pour personnes âgées (LESPA)* dated March 21st 1972 and soon to be replaced by up-to-date legislation, the LESPA ordinance or *Règlement*

[20] Canton de Vaud. CIVEMS. Contrôle qualité. Le document explicatif des inspections. S.D. En ligne. <http://www.vd.ch/fr/themes/sante-social/ems/quels-controles-fait-letat/les-controles-de-qualite/>. Consulté le 29 juin 2009.

[21] Unité de recherche et d'intervention en gérontologie, Psychology Department, Lausanne University

[22] Association for the prevention of elder abuse.

d'exécution de la loi sur les établissements spécialisés pour personnes âgées dated August 21st 2002 as well as the ordinance on management and oversight of institutions or *Règlement sur l'autorisation d'exploitation et la surveillance des institutions* dated August 21st 2002 also.[23]

The public health law (LS) gives the canton's government (executive branch) the authority to designate the instance responsible for nursing home oversight. This instance is then charged with carrying out controls. The law specifies that if the institution does not provides quality care, its authorisation to function as a nursing home can be totally or partially suspended or withdrawn (Art. 81, 82). The ordinance - *Règlement sur l'autorisation d'exploitation et la surveillance des institutions* – specifies that in order to carry out its oversight function the Department ca relies on the *public health service* (Article 2). This instance is charged with "health planning, management of subsidies to all health care institutions (hospitals, nursing homes, home health/care agencies and other specialised services) as well as carrying out oversight of these institutions within the framework of their authorisations".[24] The ordinance enables the service to carry out unannounced inspections, just as in canton Vaud (Article 15).

4.2.2 Quality control activities carried ou by the public health Service

In Neuchâtel, quality control visits are conducted by nurses employed by the public health service. Just like in Vaud, after two years of using the CLASS (or CRASS as it was then known) checklist, Neuchâtel has decided to devise its own instrument. In 2005, he public health Service has set up a committee and mandated it to create new dispositions for quality control. Two tasks were conducted: a report was issued on oversight activities (*Surveillance du respect des exigences légales et réglementaires)* and another one pertaining to recommended criteria (*Critères de qualité recommandés)*. The latter is distributed to nursing home directors in order to guide them in self-evaluation of their institutions. The idea is to foster quality improvement, but no specific controls follow and no sanctions are taken. The public health service nurses intervene upon request from institutions to give advice and support in the quality improvement process. The first document, however, forms the basis of cantonal administration quality control activities.[25] This document, entitled «*Surveillance du respect des exigences légales et réglementaires»* sets forth 8 criteria:[26]

- Institutional characteristics;
- Accessibility;
- Information given to future residents before their move into the nursing home and upon their arrival. Among other things, information must specify how complaints will be handled internally and how residents will be encouraged to express themselves in case of problems;

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[23] *Loi de la santé (LS)* du 6 février 1995, état au 1er avril 2009. Canton de Neuchâtel; *Loi sur les établissements spécialisés pour personnes âgée (LESPA)* du 21 mars 1972, état au 1er janvier 2005. Canton de Neuchâtel; *Règlement d'exécution de la loi sur les établissements spécialisés pour personnes âgées* du 21 août 2002, état au 24 mai 2006. Canton de Neuchâtel; *Règlement sur l'autorisation d'exploitation et la surveillance des institutions* du 21 août 2002, état au 27 septembre 2006. Canton de Neuchâtel.

[24] Neuchâtel. Administration cantonale. Service de la santé publique. S.D. En ligne. <http://www.ne.ch/neat/site/jsp/rubrique/rubrique.jsp?CatId=1536>. Consulté le 30 juin 2009.

[25] Planification sanitaire. Rapport d'information du Conseil d'Etat au Grand Conseil concernant la planification sanitaire 2004-2008. Du 16 février 2009. (2009). Neuchâtel. Conseil d'Etat.

[26] Rapport de visite relatif aux établissements pour personnes âges. Surveillance du respect des exigences légales et réglementaires. (2007). République et canton de Neuchâtel: Service de la santé publique. Voir aussi: La santé publique dans le canton de Neuchâtel en 2007. (2008). Neuchâtel: Service de la santé publique.

- A «Care concept» part, laying out the values and care philosophy of the institution in terms of end of life care, social life, integration of relatives and friends and the professional perspective within which health and social care are embedded;
- A part devoted to « Respect for the dignity and intimacy of residents » referring to human rights and patients' rights;
- Residents' individual records;
- Staffing in terms of staff levels, training, hierarchical organisation as well as team work and collaboration;
- Infrastructure and environment, in terms of appropriate adaptation to safety and security requirements , as well as to specific needs of the resident population.

The document spells out each of these standards in similar fashion to the CIVEMS document presented above.

Oversight visits are announced. They take place in the form of interviews, observations and examination of documents. On this basis, the public health Service writes up a report. If necessary, quality improvements are requested from institutions who do not meet the standards set by the public health Service.

4.2.3 Quality controls in canton Jura

It is interesting to note that this small canton, temporarily lacking the appropriate oversight mechanisms, has mandated the Neuchâtel public health Service to carry out visit in institutions in the Jura. In 2007, five institutions have thus been visited by the Neuchâtel public health nurses using the Neuchâtel evaluation instrument.[27]

4.3 Example from canton Zurich: quality control in nursing homes

In regional terms, canton Zurich belong to the GDH-Ost (Eastern Switzerland conference). This conference has not specifically worked on cantonal quality controls in nursing homes. As opposed to CLASS, it has not elaborated any protocols for its members.

Just as for cantons Vaud and Neuchâtel, the policy in canton Zurich is founded upon cantonal legislation. The public health law defines the structure of control for nursing homes.[28] It states that each institution must have an oversight visit at least once a year and that a report must be issued. Hover, unlike in cantons Vaud and Neuchâtel, the oversight task is delegated to District Councils[29;30] and not carried out directly by the state.

The ordinance (*Règlement sur les contributions cantonales pour les homes de personnes âgée*s)[31] states the Department of Health (canton level) is responsible for quality assurance in nursing homes. Institutions not meeting cantonal standards can be subjected to cuts or to complete loss of cantonal subsidies.

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27 La santé publique dans le canton de Neuchâtel en 2007. (2008). Neuchâtel: Service de la santé publique.

28 Gesundheitsgesetz (GESG) vom 2. April 2007. Canton de Zurich.

29 Some Swiss cantons are subdivided into districts, which are comprised of a variable number of towns or villages.

30 Ibid.

31 Verordnung über die Staatsbeiträge für Altersheime vom 3. Dezember 1986.

Once more, the central role of cantonal legislation in the field of nursing home oversight can clearly be seen. This canton, however, uses more decentralised oversight mechanisms, which may lead to less homogeneity in quality control activities, each district setting up their control teams without central coordination by the canton.

4.4 Cantonal dispositions mirror the diversity of quality control methods in Switzerland

Comparing two French-speaking cantons, members of the same regional conference, we see that the basis for attributing oversight tasks is identical. Cantonal government defines oversight tasks and delegates them. However, while canton Vaud has set up a specific team for nursing home oversight (the CIVEMS), Neuchâtel uses state employees integrated into the public health service. Moreover, Vaud canton inspectors come from different professions (dietician, social worker and nurse) whereas in Neuchâtel we find nurses only. Finally, while the CLASS has produced an instrument for its members, we find that it is not necessarily used any more. The two French-speaking cantons examined have devised their own instruments since 2008 independently of intercantonal arrangements.

Canton Zurich presents a different configuration. While cantonal authorities do hold legal power for nursing home oversight, activities are delegated to district authorities who have to carry out controls in the field. It is difficult to have an idea of instruments used since arrangements are not centralised. We only know that controls must take place every year and that reports must be produced and turned over to cantonal authorities. Also, the regional conference GDK-Ost Schweiz has not specifically worked on the issue or produced materials for its members.

These three examples highlight the large degree of autonomy of each canton in matters of quality control in nursing homes. Central government has no authority in this field, and cantons vary widely in the arrangements they set up and in the degree of priority they afford to these issues. Some differences are likely linked to different political cultures and governmental organisations. Actions taken by regional conferences are limited in their impact, though they may act as incentives.

This inter-canton diversity is found in the entire field of quality control in LTC. Beyond legal bases for action and cantonal prerogatives, it is thus difficult to draw a complete picture of quality control in Switzerland. 26 systems would have to be described in order to compose a more precise pictures of the wide variety of arrangements found in this field.

5 Professional good practice: an example

Within the context of economy drives in canton Zurich in 2004, the Health Department tried to operationalise the concept of «high» quality found in the health insurance law (LAMal, art 43, al.6). With this goal, it took up the notion of four levels of care as defined by Fiechter and Meyer in 1981. These authors distinguish optimal care, appropriate care, safe care and dangerous care. (Fiechter/Meyer, 1981: 178). Authorities considered that care provided in canton hospitals was of an appropriate level. Yet, in their view, safe care was sufficient to fulfill the quality requirements of health insurance law. In the hope of reducing costs to canton taxpayers, they proposed to reduce quality of care to a ‘safe’ level. That meant, “for instance, responding less quickly to patient calls from their rooms, carrying out some basic care activities more quickly, or not providing a professional to speak to families at all times” (Gesundheit Direktion Kanton Zurich, 2004: 3).

The general level of quality would thus be directly above 'dangerous', - although institutions of professionals can be sued if they provide dangerous care as these can contribute to worsening the health status of the patient. This level of care is thus unanimously considered as insufficient.

Nursing staff opposed this reduction in care level, arguing that it would lead to an increase in professional risks and to a deterioration of the image of the nursing profession in the general public – as well as to a loss of meaning in care activities (AGGP, 2004: 1). The authors tried to define the contours of a "professional concept of quality". In this endeavor, they refered to quality in its 'absolute' sense (Haddad et al, 2007: 62) and equated quality with excellence.

This approach differs from that put forward by the professional association of nurses (ASI, 1989) who has chosen a relative approach to quality. In this view, quality of care is reached when care corresponds to the best possible standards in a given situation.

6 Cultural diversity as a feature of quality in LTC

The question of cultural diversity in LTC is not the subject of concerted specific or generalised efforts in Switzerland. It is however a topic of concern. A few specific projects can thus be outlined. It is worth noting that projects mentioned below are not explicitly integrated into policies pertaining to quality. They can however give an idea of current themes and concerns in this area.

The 'Age and Migration Forum' is an association which has chosen to deal specifically with issues affecting older migrants, whose health and financial situation is, on average, less favorable than that of their Swiss counterparts.[32] In 2005, the *Forum* launched a project called 'Migration Bus',[33] the leadership of which has been put in the hands of CURAVIVA. A bus drove around Switzerland between 2005 and 2007 with the goal of raising the consciousness of older people, of the public in general and of politicians about the issue of older migrants living in Switzerland. Today the *Forum* continues to be active in the field of bettering the living conditions and global situations of older migrants in terms of access to appropriate services in the fields of health and social care, at home or in residential institutions[34].

In the residential care field, cantons Bern, Zurich, Saint-Gall and Basel each have a nursing home which has set up a *Mediterranean Floor* or unit.[35] This type of arrangement was set up to cater for the large number of immigrants from Southern Europe (Italy, Spain and Portugal) who arrived as young workers in Switzerland in the 50s and 60s and are now reaching old age and gradually entering LTC institutions. The idea is to offer care within an environment fitting the cultural and daily life habits of these older immigrants (Däpp, 2006).

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[32] Forum national âge et migration. (S.D.) (http://www.alter-migration.ch/index.cfm?ID=1&l=fr). Page consultée le 6 juillet 2009.

[33] CURAVIVA. Mehr Verständnis für Migrantinnen und Migranten. (S.D.) (http://www.CURAVIVA.ch/index.cfm/70D310EC-B2C5-A8FA-19E38C13B581D0FF&cfidx816315&cftxf6f102076bdb5cb1-52817975-CEC6-4458-9C29AFF42AF38539/). Page consultée le 6 juillet 2009.

[34] Forum national âge et migration (2008).

[35] National Forum Alter und Migration (2008).

Since 2006, the Swiss Red Cross has set up a program aimed at combating racism and discrimination in health care institutions, i.e. in hospitals as well as in LTC. It offers training courses for health care workers, particularly in residential care institutions.[36] A brochure is also available (Kilcher et al, 2005) which gives concrete advice to institutions that wish to work on combating racism and discrimination.

6.1 Cultural diversity and quality promotion policies in the LTC field

The theme of cultural diversity is not specifically highlighted within quality control instruments in the LTC field. Given the diversity of cantonal policies conducted and instruments used it is hard to see how clear priorities in this field could be generalised. In instruments we studied, the question of cultural diversity is rarely specifically mentioned. However, some references to this issue are to be found in documents issued by CURAVIVA. The duty of nursing homes to respect the ethnic, cultural and religious identity of residents, and to promote an atmosphere of respect and equal treatment among all cultures are mentioned, as well as the necessity to find a balance between the respect due to different cultures and the requirements of community living in an institutional setting (Curaviva, 2005).

Beyond the CURAVIVA brochure, the very concept of cultural diversity or specificity is not usually present in the quality control instruments we examined. In general, we may state the cultural diversity is an integral part of LTC field because of the very varied cultural backgrounds of residents, clients and employees. We cannot however pretend that policies about quality promotion in LTC in Switzerland explicitly contain dispositions about cultural diversity. We are faced with a spotty, uneven landscape of actions and projects taking place in different agencies and institutions in different parts of the country.

7 Quality control in informal care and care provided by volunteers

It is fair to say that no national information exists on measures to control or improve the quality of care provided by informal carers, or by volunteers. While estimates based on the Swiss health Survey carried out in 2002 (Pellegrini, 2006) indicate that percentages as high as 11% of persons aged 65 to 79 and 30% of persons aged over 80 received care from family members who live with them – these figures not taking into account help and care received from informal carers external to the household - no specific measures exist to evaluate or promote the quality of care provided informally.

Associations or charities which train and place volunteers set their own recruitment and training standards. In residential care, institutions who are involved in quality management often must specify procedures through which they select and train volunteers. In specific fields such as dementia care and end-of-life care, associations such as the Alzheimer Association or professional structures promoting palliative care and end-of-life care have produced brochures and documents about the role of volunteer carers and they carry out training and promotion activities.

[36] Rassismus und Diskriminierung. (S.D.). (http://www.transkulturelle-kompetenz.ch/index2.php?m=7&tc=20). Page consultée le 7 juillet 2009.

We would however be hard pressed to describe global concepts or concerted actions in this field. No doubt greater attention will be paid to it in the future.

8 Conclusion

Quality control dispositions found in the field of long-term care are fragmented. We have highlighted three different levels. Outcome measures are mostly present in the area of care activities covered by health insurance; they are primarily defined and implemented by health insurers and health providers.

When services are not covered by health insurance, various certification organisations may be conducting external quality audits. This entire area lacks transparency, as individual providers are free to choose quality systems and certifications organisations use different approaches. However, certification activities by the SAS does provide useful information about the type of quality management systems used in the LTC field, the characteristics of organisations active in certification and institutions which have gone through certification processes. Yet these data are not representative of the whole of the field, as many certification firms are not prepared to meet SAS standards and are thus not accredited. Yet, they enable us to confirm that no one system of certification has achieved ascendancy at the national level.

Thirdly, we examined the oversight activities carried out by cantons, which are also based on heterogeneous legal bases and implementation arrangements. It is thus difficult to attain a global view of the field.

Several conceptions of quality, described in the literature, underpin quality control activities led by parties to the LTC field. Insurers seem to view cost-efficiency as a quality criterion, whereas a juridical view of this notion sees it, rather, as a protection mechanism against immoderate cost-cutting. Approaches of quality as a relative term, which must be defined as the attempt to narrow differences between an actual condition and a set standard, must also be contrasted to views which define quality as excellence.

9 Bases for the information contained in this report and bibliographical references

This report is partly based on four individual interviews as well as on the collaboration with our National Expert Panel (NEP).

Individual interviews were conducted with Ms Maja Mylaeus, head of quality for ASSASD/SPITEX (Bern, May 19th 2009); Mr Daniel Domeisen, head of quality at CURAVIVA (Bern, June 9th 2009); Dr Daniel Grob, Chief of medicine at the acute geriatric care clinic at Waid hospital in Zürich (Zürich, June 22nd 2009); Mr Rolf Straub, Head of the Chemistry, Biology and Health Department at SAS (Bern, July 10th 2009).

The NEP meeting took place in Lausanne on June 18th 2009. Dr Jean-François Bickel, sociologist at Fribourg University in the Department of Social Work and Social Policy; Dr Michel Blum, project manager at the Fribourg cantonal Department of social welfare; Dr Christophe Büla, chief of geriatric medicine at the University Hospital of Lausanne, Ms Karina Kassam, nursing consultant at the Swiss Patient Organisation. Dr Jean-Noël Du Pasquier, NEP member and independent health economist in Geneva, was interviewed individually in Lausanne on June 17th 2009.

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