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NURSING HOME FINANCE

IN ENGLAND AND
WITH FOCUS ON
SWITZERLAND

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*I certify that I have read and understood the rules and regulations of the LSE
regarding assessment procedures and formally declare that all work contained within
this document, with the exception of attributed references, is my own.*

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CHAPTER ONE:

Introduction

Between 1950 and 2050, the proportion of the population in OECD countries aged 65 and over will double. Between 1960 and 2040, the number of people in those countries aged 80 and over will triple. Because elderly people have higher rates of chronic illness, their needs for (expensive) long-term care are likely to increase in coming years. In Switzerland, the percentage of the population aged over 80 who live in long-term institutional care has jumped from 17.5% in 1970 to 21.8% in 1990. (Latzel, 1997) Of all Swiss residents aged over 85, 38% or 40,000 people live in stationary long-term care. Of those aged over 90, the percentage jumps to 42 percent. Clearly, as life expectancies increase, the number of people in long-term care may also increase, driving up costs. A corresponding demographic trend exacerbates the issue: fertility rates have dropped in OECD countries, decreasing the amount of future tax revenue and informal caregivers available to provide for the looming boom in long-term care needs and, correspondingly, financial costs.

As countries gear up to face a potential financial crisis, it behoves them to exchange ideas, thus learning from each others' experiences. Britain has been quite successful in its attempts to control costs in its healthcare sector, including its long-term care provision overall. In 1997, it spent only 6.8% of its GDP on healthcare - the second lowest percentage in the European Union. Despite this, Britain has amongst the highest nursing care (including expenditure on nursing homes) expenditure in the European Union, according to the World Health Organisation. Britain recently implemented reforms introducing innovative market-oriented mechanisms to improve the cost effectiveness and responsiveness of its long-term care provision. These reforms also involved a transfer of much funding and decision-making in long-term care planning from the central to local governments, with performance checks on local provision maintained by central bodies. There has also been a recent trend in Britain to encourage local governments to contract long-term care provision out to private bodies, thus implementing a 'mixed (public-private) economy of care'.

Switzerland spends a higher proportion of its GDP on healthcare than Britain: in 1997, it spent the second highest percentage in Western Europe at 10% of GDP. Much of this expenditure is by Switzerland's 109 non-profit, government-licensed, compulsory health insurance companies. In 1997, approximately 60% of healthcare expenditures came from public (including compulsory health insurance) resources, while 39% came from private sources.

This is in contrast to Britain's system, where 94% of healthcare expenses are borne by the public sector. Also in contrast to Britain, Switzerland has historically had a federalistic political system, with important responsibilities for healthcare and other social services balanced traditionally between: national government, insurance companies, cantons, private hospitals and physicians, hospital and health professional organisations, and municipal governments. Municipal governments and cantons are chiefly responsible for nursing home provision, with financing for the nursing part of care provided partly by insurance companies. Payments are subsidised by private supplementary insurance monies, social security, welfare, out-of-pocket payments, and/or by the municipality and/or the canton. Each canton and municipality has its own combination of these funding sources; thus, the Swiss financing methods of long-term care are somewhat more fractionated than are those of the UK. Britain's recent long-term care reforms can be seen to some extent as steps toward Switzerland's traditional method of financing and provision: emphasising local decision-making to increase responsiveness, and a pluralistic public-private economy of financing and provision.

In the face of looming, possibly unprecedented long-term care costs as the baby boom generation in OECD countries ages, an effective, responsive and equitable method of financing and provision is sought. Societies' search for a way that long-term nursing care can be affordable and available to all is crucial. Thus, this study's comparison of long-term nursing home care financing and organisation in Switzerland and England is topical and important. Although it will be considered officially by the Swiss authorities who funded it, decision makers in England and elsewhere will also find its analysis useful.

Research Methodology

This research was undertaken under the auspices of the Swiss Conference of the Cantonal Ministers of Public Health (SDK-CDS), the coordinating body between Switzerland's 26 cantons' health systems. The organisation tracks health system-related activities in the cantons, and makes recommendations in terms of health policy which the cantons consider but must not (always) heed.

Literature was collected on England's provision and financing of nursing homes from the library at the London School of Economics, from internet sites and from course materials. In Switzerland, literature was found at the library of a non-governmental organisation which pursues improvement in the livelihood of Switzerland's elderly, Pro Senectute, in

books available in Swiss Conference of the Cantonal Ministers of Public Health offices, and in government records. Information was also gleaned from interviews with and documents provided by cantonal health authorities. Because much evidence on the financing/provision of long-term nursing home care in the three cantons on which this study concentrates derives from interviews, and because in some cases, little documentation backing up those interviews was available, the cantonal explorations could not be perfectly uniform in their examinations. Instead, the issues topical in the eyes of the cantonal authorities, and the information that was available and deemed relevant by the researcher was included in this study.

CHAPTER TWO:

Financing Long-Term Residential Care

Introduction

Beveridge versus Bismarck Health Care Systems

Before launching into an explanation of long-term institutional - or nursing home - care financing in Switzerland and in England, it is useful to understand the theory behind the two divergent systems.

In either system, there is an interplay between three 'actors': the service users (here: the elderly), the service providers (here: nursing homes) and service financiers. Interaction between these three parties varies. The users pay for services either via social insurance or taxation. Financiers, which may be in the form of insurance companies or government, then secure provision of services for the users.

In 'Bismarck'-styled health care systems, thus named after the German chancellor during whose tenure the first laws of social insurance were instituted, compulsory social insurance ensures health care provision for the populace. This is the model which most closely resembles the Swiss system. The three actors are most clearly defined in this model, where health care financing is organised through compulsory social insurance. The state has an important role in the Bismarck model in regulating and organising the confluence of the three actors: services users, service providers and service financiers.

In England, as in the United Kingdom overall, health and social care provision aligns more with the Beveridge model. Under this model, financing is based in general taxation and services are provided mainly through publicly owned and run institutions, or by private institutions/practitioners run under contract with government financiers. (Kokko et al, 2000)

As Kokko et al point out, some current management theories argue that less state involvement in service provision may improve efficiency. This may explain England's recent shift toward a limited market in health care, spurred on by state contracting with health and social care practitioners.

Both the Bismarck and Beveridge models of service provision may ensure equity of access and provision throughout an entire populace. Although Switzerland's many insurance companies working with cantons and municipalities of variable affluence may seem to challenge functional ensurance of equity throughout the country, a system of balances works to remedy this pitfall. The UK's system of collecting health care funding via central taxation creates -- systematically - greater ease of ensuring equity. This does not in itself ensure *de facto* equity, however, as this study will later discuss.

Long-Term Nursing Home Financing: the Swiss Context

The Swiss system promotes equity and solidarity between generations as well as between income groups for nursing home care via various modes. As part of its social security scheme, dubbed AHV (*Alters und Hinterbliebenen Versicherung* or Old-age and Survivors Insurance), it does so by placing no ceilings on earning-related contributions to its social security and by ensuring that benefits in the highest bracket are merely twice those of the lowest. A system ensuring solidarity between regions is also in place on a cantonal (amongst municipalities) and on a national level, through its welfare scheme. (Segalman 1986)

All these systems ensuring 'separate but equal' treatment between regions make for challenging study of the Swiss nursing home care financing/provision system by an outsider. Switzerland's system is highly fractionated, with disparate sources of funding and regulatory bodies in every region. The division of health care and nursing home funding responsibilities between cantons, municipalities, the national government and a plethora of compulsory public and private governmentally regulated insurance schemes leaves an organic, detailed description of the system impossible though its structure can be described. The system's fractionated nature does allow for a truly locally accountable system that sustains remarkable equity within the national populace.

Contributing to nursing home costs are, sometimes, cantonal block payments to nursing homes (the proportion and composition varies by canton) and:

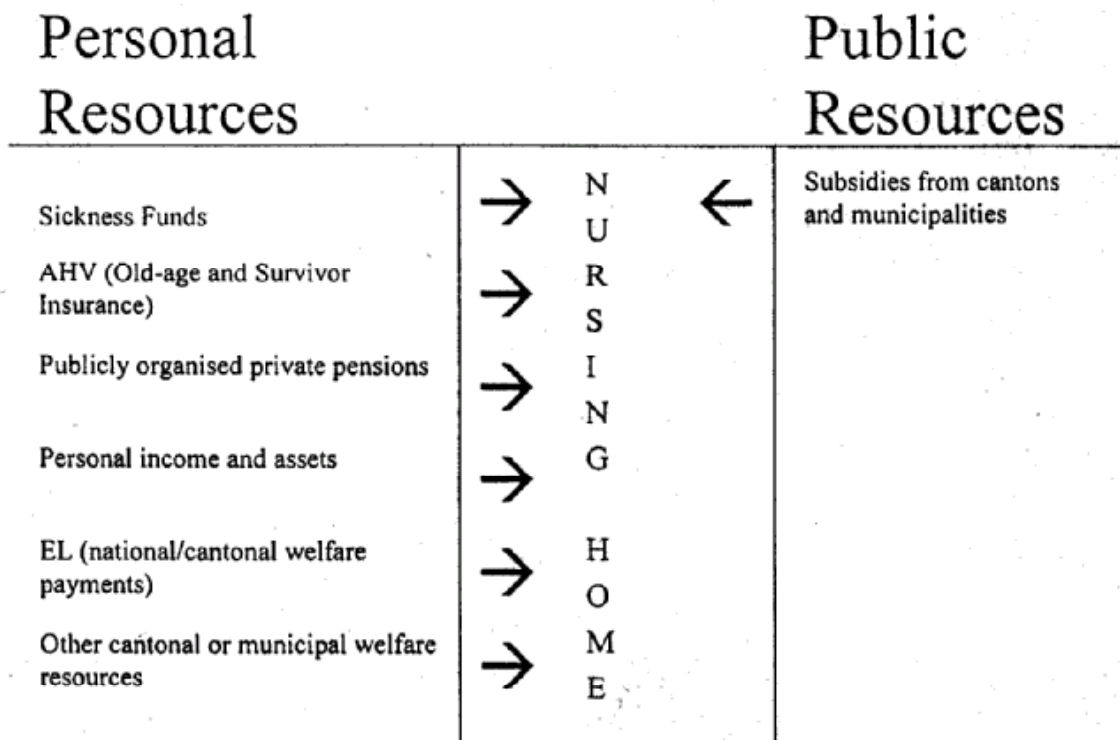
- compulsory sickness fund contributions (*Krankenversicherung*);
- AHV (*Alters und Hinterbliebenen Versicherung* or Old-age and Survivor Insurance);

- EL (*Ergaenzungsleistung* or welfare payments paid by the canton and federal government to the poor), which is complementary to AHV or IV (*Invaliden Versicherung* or Invalidity Insurance);
- social welfare payments for the very poor;
- in some cantons: AEL (*Ausserordentliche Ergaenzungsleistung* or Extra-Ordinary Welfare Payments), a source of cantonal funding for citizens with especial needs, such as those with expensive, chronic illness or especially small means;
- publicly organised private pensions; and
- private savings / assets.

Sickness funds (KVG) are legally obliged since 1996 (KLV 7a and b) to compensate for certain 'nursing-associated' -- not 'hotel' -- costs incurred during institutional nursing home care, though the proportion of nursing costs that is reimbursable depends on the canton.

Public and personal sources of finances for long-term residential care are shown graphically below:

FIGURE 2.1

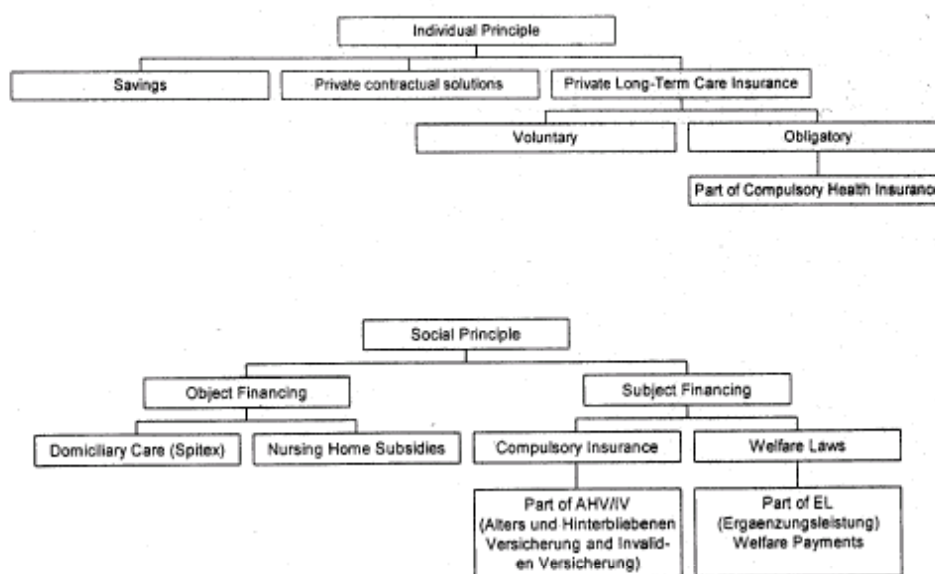


(Source: Huber Francois, 1997)

Though the 'personal' sources are comprised by funds not collected directly from government, all of the funding sources are regulated, and all insurance sources named are compulsory for every citizen. They will be described in greater detail in the next section.

The following diagram belies nursing home financing's ties to political theory. The theory behind the diagram is general, but in the text to follow it shall be applied to the case of Switzerland.

FIGURE 2.2



(Source: Eisen, 1992)

Funding of long-term residential nursing care is divided into two: the individual and social principles. Under the individual principle there are three sources of long-term funding: savings, private contractual solutions, such as privately organised pensions, and private nursing home insurance.

In Switzerland, there are few private long-term care insurance packages *per se* presently available, though the matter has been discussed as a more dominant potential source of nursing home funding for the future. Most obligatory sickness fund coverage packages date back to pre-1996, before sickness funds were required to fund the medical component of nursing home care.

Before then, sickness funds capped hospital and nursing home coverage at 720 days. Once this funding was used up, residents had to seek other modes of coverage for their long-term institutional care, or welfare funding from their municipality or canton. Thus, most sickness funds had,

and still have, supplementary nursing home coverage available in the form of 'nursing home cost insurance' (Pflegekostenversicherung) or 'nursing home pension insurance' (Pflegerentenversicherung). In the latter case, instead of covering all nursing home costs regardless of their magnitude, the insurance paid a predetermined periodic 'pension' in the case of a need for nursing care. (Zweifel, 1994) These forms of insurance still exist, although since 1996 the sickness funds must cover part of medical-related nursing home costs without a time limit, and so the importance of these supplementary insurance forms has diminished. The way that the amount compensated for by the sickness funds is tallied varies by canton. The situations in cantons St. Gallen, Basle City and Berne will be explained.

All residents of Switzerland must purchase coverage under one of the government-approved sickness insurance funds. Employers do not contribute to the premia, though some employers purchase insurance coverage in 'bulk' and thus can offer their employees better rates for more coverage. The unemployed or very poor are provided sickness insurance courtesy of their municipal government. No differentiation in premia between the elderly and youth or between gender is legal; there is a risk-compensation mechanism in place between insurance companies (sickness funds) which is intended to make up for this. (Law KVG Article 105) In fact, this compensates for only a part of the risk-related cost difference.

Object and Subject Financing

'Object' and 'subject' financing are terms widely used in German language literature which seem to have no perfect translation into English. 'Object' financing refers to funds directed toward institutions or people involved in the production of nursing home care. 'Subject' financing involves the support of the recipients of nursing care, and can come in the form of a subsidy for the patient, as a tax break for nursing care. Because subject financing has a direct correlation to the costs incurred on the nursing home, it theoretically encourages more cost effectiveness on the part of the nursing home than does object financing. Subject financing can also be used to fund private nursing homes cost effectively when it is in the form of a patient subsidy, allowing for free choice of home by the patient and thus allowing for of market competition between homes. Object financing by government, in contrast, presents an obstacle to private homes entering the market.

In England, the terms most similar to object and subject financing are 'block' and 'spot' payments. These, in addition to other forms of payment, will be explored in greater detail in the next section.

To continue on with the flow chart, subject payments may take on two forms: obligatory long-term care insurance, which encompasses AHV (Old-Age Survivor Insurance) and its government-funded complement for the needy, EL (*Ergaenzungsleistungen*) are also forms of subject financing. Obligatory, publicly organised insurance is desirable because it facilitates a pooling of risk by spreading it over the entire population.

If AHV/IV (IV is invalidity insurance, and it sometimes also is used toward long-term nursing care payments) in addition to sickness fund compensation and private pensions/assets are not sufficient to cover nursing home costs, then EL kicks in to cover the difference. EL (welfare) is funded mainly by the canton, but the canton receives 10-35% of EL costs from the national government. The minimum AHV monthly income was CHF 940 in 1994; its maximum was that amount, doubled. Welfare payment amounts vary by canton.

The Three Pillars of Funding for Old Age

Funding of life after pension - or life in old age -- was divided into three 'pillars' in 1963 by the Swiss parliament, when it stated that 'the insurance of our population against the progression of aging, death and invalidity is only successful once people, regardless of their situational and familial duties, are provided for under three pillars.' (Segalman, 1986) These three pillars remain the main sources of funding for long-term nursing home care in Switzerland. *The first is Old-Age and Survivor's Insurance (AHV), which is compulsory and which each employee contributes to until they are old enough to receive pensions. The second is publicly organised private pensions, which are compulsory since 1985 for all employees and employers. The third pillar is comprised of private savings and assets.* Between these three pillars, a sustainable income ought to be ensured for all Swiss into their later years. These three pillars also form an important part of nursing home funding.

Long-Term Nursing Home Financing: The English Context

The British (and thus also English) healthcare system operates under the Beveridge model and has until very recently delivered care to the needy and to the population generally in a more centralised fashion than does the Swiss system. This system is funded chiefly by taxes which are, for the most part, centrally levied and then distributed amongst the various health and social care provision and planning agencies. Interestingly, the 1990s have seen reforms shifting power, planning and regulation to the localities in England's health and social care systems, making the English system an

interesting case to compare to the Swiss system. The Swiss system has always been decentralised, deferring health and social care provision and financing to localities.

Social care as opposed to health care in England was historically delivered on a voluntary basis, through charities, families and private organisations. This means of delivering social care continued to some degree even after the UK's welfare reforms of the 1940s. Finally, the 1990s saw reforms make sweeping changes in the English method of financing and providing social care. (Knapp et al, 2001) Knapp enumerates the reform trends as follows:

- a massive transfer of funding from central to local government (and with it the responsibility to coordinate care purchasing);
- unprecedented rates of growth in independence sector services for older people;
- levelling-out and the beginnings of a reversal of the 50-year upward growth in nursing home provision;
- substantial contracting out of services for people with mental health problems and learning disabilities;
- changes to support arrangements for children, and the responsibilities of families;
- encouragements of devolved decision-making (including care management);
- development and elaboration of regulatory procedures;
- a sea change in local authority attitudes to, and sophistication of performance in, links with independent providers;
- a national debate and a Royal Commission on the financing of long-term care; and
- the introduction and rapid development of social care markets.

Thus, the system of relatively centralised planning in the UK is being replaced by a more factionated system of local authority purchasers and increasingly private providers of care.

This new situation increasingly bears resemblance to the contracting between cantonal and nursing home authorities that has long since existed in Switzerland. In Switzerland, each canton contains associations of nursing homes as well as of old age residential facilities and hospitals. These associations contract as a group with insurance company associations and with cantonal authorities, thus settling prices cooperatively. This system allows for cantonal planning and regulating of bed distribution and prices, while giving the homes a forum where they can demand higher compensation.

It is important and interesting to note that these negotiations take place between the respective nursing home / insurance company associations and either health authorities or social service authorities, depending on the canton. Both in Switzerland and in England, the status of nursing home care for the elderly as both a social service and a healthcare responsibility makes tracking its financing and its provision difficult.

Thus, financing of nursing home care can come from any of several sources in England. If a physician refers a patient to long-term nursing home care, it can be fully reimbursable by the National Health Service. Most of the time, however, a resident is assessed by a local authority-employed care manager, and a tailored 'care package' is devised for the patient, including provision and how costs will be covered, taking the resident's means into account. The local authorities are responsible for helping the resident meet his/her full costs of care. The localities have been responsible since 1993 for 'assessing the needs of the elderly', though they receive funding for this and for nursing home provision from the national government.

The UK social security system provides cash benefits designed to help with the additional costs encountered by people who require extra care and attention because of age or illness. (MISSOC 1999) The main such benefit in the UK is income support: a tax-financed, means-tested benefit which pays flat-rate premia to those with special needs, such as the elderly or disabled. People living in residential care or nursing homes can claim such support in addition to a special residential allowance. Again, this support is centrally funded from national welfare sources as part of a global budget, although its provision and financing is largely organised by the local authority. Allocations are made in the form of block grants, and are based on past expenditure as well as population, age structure, housing conditions and other factors in each local authority. For the first three years after this system was instituted in 1993, 85% of these funds had to be spent on the private sector. After the three years, the local authorities could spend the money at their discretion, as it was no longer earmarked for long-term care. (GAO/HEHS-1994-154)

Over the past 20 years, there has been a marked shift from long-term stays in NHS geriatric wards (where care of centrally funded and centrally regulated) into private or voluntary homes funded via income support. But it is unclear whether the expansion of community care services has been sufficient to offset the shift from NHS-funded geriatric ward stays to income support-funded private or voluntary nursing home residence. Frequently, fees paid by the local authority are not sufficient to meet placement costs, either because client assets are considered sufficient

without assistance, or because the care home charges fees above the local authority's limit. (Evandrou/Falkingham, 1998; Wittenberg et al, 1999)

Block and Spot Financing

Corollary to Switzerland's 'object' and 'subject' financing are 'block' and 'spot' financing in England. Forder et al (2001) describe five contract types: *spot*, *call-off*, *block*, *cost and volume*, and *grant*.

Spot contracts and *call-off contracts* are reimbursed on a per-case basis: prices are 'agreed in relation to individual units of service' and are made for each individual client. Call-off contracts differ from spot contracts in that call-off contracts set a price in advance and set it over a fixed period of time. Spot contracts set a price in advance, but then are reimbursed based on how much the individual client actually uses the service. Thus, prices over a set period can vary under spot contracts, but are fixed under call-off contracts. This sort of contract makes the provider responsible for providing a certain amount of care per unit reimbursed, and thus is corollary to 'subject' financing in Switzerland.

Block contracts are the corollary of 'object' financing in Switzerland. Here, payment goes to the institution in order to fund services provided to many users; Forder et al point out that if block contracts only offered services for a few clients, they would be similar to call-off contracts. Block contracts are 'characterised by payment being agreed in advance and made for a quantity of service regardless of whether that service is actually consumed by users'. (Forder et al, p. 6) Because under this sort of contract whether the service will not be consumed is not known, 'block' or 'object' financing is becoming less widespread in Switzerland and in England as both countries attempt to make providers more accountable, and more 'cost effective'.

Forder et al describe two further types of contract, neither of which are widely discussed as such in Switzerland: *Cost and volume* contracts involve an agreed-upon payment for a certain amount of supply, but additional payment is only made for service units beyond that level if they are actually consumed. The *grant* allocates a lump sum to a provider in return for a discrete number of clients expecting service in return.

Both Switzerland and England tend to employ a mixture of contracts types in their payment of nursing homes. Payment methods vary by canton and municipality in Switzerland and in England, though there has been a trend toward more 'accountable' financing by authorities in both places.

CHAPTER THREE:

Financing and Regulation of Nursing Homes in three Swiss Cantons: Basle City, St. Gallen and Berne

Introduction

The cantonal systems financing and providing long-term nursing care in Switzerland may serve to an outsider as evidence of Switzerland's prosperity, of its pure brand of democracy, and of its powers of innovation and organisation.

That Switzerland is able to maintain 26 semi-organic health services in and of themselves is not only a feat of organisation, but also is a sign of its prosperity, as each of these systems must fund its own bureaucracy. That each canton must deal with slightly variant demographic, economic and cultural situations shows not only the diversity of this country, but its powers to innovate. And yet the commonalities between the cantons are striking to an outsider - culturally and geographically, they do belong to a single nation - so that their variant and innovative ways of organising and funding long-term nursing care may serve as examples of the many ways in which nursing home care can be funded and delivered.

Basle City

Basle City is an unusual case in Switzerland. It is Switzerland's only canton that is also a city, and that is also largely run as a single municipality - several cantonal departments are also municipal departments, although the canton technically has three municipalities: Basle City, Riehen and Bettingen. Basle City's Bureau for Older Care (*Amt fuer Alterspflege*, which is a part of the canton's Health Department) is also that area's municipal authority.

Basle City is also an interesting case because, according to the Director of the Bureau for Older Care Renee Fasnacht, it is Switzerland's mostly densely populated canton by elderly people. This is a relevant issue for the cantonal government, as the canton's elderly population incurs inordinate costs on the working populace, causing local taxes and insurance premia to increase, and thereby driving the city's working population out of the city limits into the adjacent canton, Basle Country (*Basel Land*), where taxes and health insurance premia are lower.

Partly as a result of this problem, sickness funds contribute less to nursing homes in this canton than they do in others. (Nursing home associations negotiate with sickness funds to determine tariffs separately in each canton.) In Basle City, sickness funds compensate for 50% of 'nursing' (i.e. not hotel) costs.

Because some residents incur especially high costs, due to chronic or very expensively treatable diseases, the canton is considering compensating for such exceptional cases fully so as to keep insurance premia at affordable rates. The canton also is the only one to actively encourage domiciliary care by family members or neighbours, offering them daily stipends of from CHF 25 (10 pounds) in return for caring for their loved one at home. This is intended to delay entrance of the elderly into expensive institutional care.

The canton contributes 'block grants' or 'object financing' to homes in order to reduce their fixed costs, and thus, hopefully, tariffs. In addition to these, the canton contributes 'subject payments' or 'spot payments' on behalf of citizens with insufficient assets to cover nursing home costs.

Nursing home tariffs are calculated with regard to nursing care received separately from 'hotel' costs. The nursing-related tariffs are uniform across the canton, and apply to private, charitable as well as public homes. These nursing-need based tariffs will be, as of January 2002, based on the RAI/RUG system.¹ The Bureau for Older Care deems that system to be transparent and based on the needs of the patient. Tariffs in the RAI/RUG system are divided into 12 levels: patients are placed into one of these following an exhaustive questionnaire that determines their care needs.

A supposed advantage of this system is that, in addition to helping to determine tariffs based on the needs of the resident without a need for micro-costing, it can enable the Bureau to oversee quality in the homes. The RAI/RUG questionnaire enables homes to compile considerable statistics about constraints used in each home, falls, etc. - which can cumulatively serve as indicators of quality lapses in a home. Some Swiss academics, including Alfred Gebert, are critical of this approach to quality control. They claim that with the help of RAI/RUG statistical indicators, cantonal authorities can feel assured that quality checks are transpiring and thus that visits and other methods of cantonal supervision over homes may slacken.

As an additional check on quality, all homes must be licensed by the canton. Licensing involves a visit by cantonal health authorities to the home, fire hazard checks, and registration by home personnel.

The Bureau for Older Care also oversees bed utilisation, and thus takes note when one home has a long waiting list while another has empty beds. A home with many empty beds might indicate a quality problem, which the canton may then pursue and try to remedy. It also enables the Bureau to

¹ Please see Appendix I for an explanation of categorisation systems used to determine nursing home tariffs.

inform prospective home residents of where a bed is available at any given time. The Bureau then may track which parts of the city/canton have greater or lesser needs for nursing home beds.

Canton St. Gallen

According to the Director of the Department for Aged, Invalid and Domiciliary Care (a part of the Social Services Department) in St. Gallen, Mr. Kaspar Sprenger, that canton lends a great deal of independence to each of its 90 municipalities because Napoleon drew the borders of this canton arbitrarily more than 200 years ago. As a result of this, the municipalities do not 'culturally' mesh, and the canton has a tradition of allowing a great deal of autonomy to localities. The location of Switzerland's pre-eminent business university in the city of St. Gallen (the University of St. Gallen) may also have something to do with the local government's *laissez faire* philosophy.

As a result of this 'freedom', municipalities in St. Gallen are the chief organisers and funders of nursing homes. Since Jan. 1, 1999, there has been no more 'object financing' of nursing homes on a yearly basis. Since then, according to Sprenger, municipalities are the 'sole' overseers of care for their elderly. Homes receive a 20% payment to cover fixed costs when they are built, but this is a non-renewable cantonal subsidy. Aside from this, municipalities and citizens are responsible for their local nursing homes to a large degree; user charges have increased in this region in recent years due to rising nursing home costs and municipalities and sickness funds to keep their own costs in check.

The canton does contribute 'subject financing' toward nursing home costs in the form of 'Ausserordentliche Ergaenzungsleistung', a form of cantonally funded welfare which helps the needy acquire necessary nursing home care (or care for a handicap) that may not otherwise be affordable. The canton pays the difference between what each individual can afford given all their income and the price of the nursing home. This allows every resident of St. Gallen, according to Mr. Sprenger, to live 'without risk' of aging or handicap. Because of the nature of these subsidies, nursing home autonomy is not jeopardised.

The 'hands off' approach of the cantonal government does have drawbacks. Latzel (BSV, 1997) in his paper written on behalf of the Federal Social Insurance Office (*Bundesamt fuer Sozialversicherung*), is concerned about the lack of consistency amongst homes in this canton. There is, for example, no standard method of billing: some older care homes bill according to the medical and nursing needs of each patient, while some merely differentiate between 'independent living' (*Altersheim*)

facilities and nursing home facilities. There is also no standard method whereby homes can apply for welfare (*Hilflosenentschaedigung*) funding. Some homes bill according to each individual's means, and some don't. Latzel maintains that there should be in this canton, like there is in other cantons, canton-wide standards for billing.

The canton does oversee municipal demographics, and sometimes will advise a municipality to build a home. Municipalities plan sufficient homes for their populaces in regional groupings which are drawn up by the cantonal authorities; this way, each municipality must not have its own home for its own citizens, but can share costs and benefits with other municipalities in its region.

In addition to this financial and organisational autonomy, quality checks are left largely to the localities, as only private homes must be licensed by the canton. (Of St. Gallen's 140 homes, 55 are private.) In order to renew their license every two years, each private home must submit a written paper to the cantonal authorities explaining their philosophy in 20 pages. This paper must define what the home does, who it aims to serve, how many beds it has, and how the staff aims to achieve its goals. This paper takes the form of a contract between the home and the cantonal authorities, and is the canton's method of assuring quality that is sought 'from the ground'. Bi-annual visits by cantonal authorities serve to confirm nursing home quality. Latzel worries, however, that these visits cannot possibly transpire since there is only one employee working at 80% of full-time - who is meant to oversee St. Gallen's 129 nursing homes.

The canton also asserts that the local populace, or the loved ones of homes residents, are responsible for monitoring home quality - this is termed an 'individual check'. Finally, the canton is of the mindset that market forces monitor quality; if a home is of poor quality, then it will not be sought out by its local residents and will go out of business.

Swiss health policy professor Gebert argues that the quality control methods employed by canton St. Gallen minimize any real cantonal mandate for change in its homes. '...the potential for change due to cantonal quality controls is essentially minimized, such that the homes are immune to improvements affecting their quality.' (Gebert, 2001)

According to Sprenger, the sickness funds dispute this 'free market' approach to nursing home provision, since a free market is expensive. However, he maintains that a free market ensures higher quality.

In contrast to Basle City, where RAI/RUG is utilised to determine individual tariffs as well as to monitor quality, St. Gallen's philosophy maintains a clear separation between financing and quality checks. Partly due to this separation, RAI/RUG are not used to determine nursing-related tariffs in St. Gallen. Because RAI/RUG involve long, exhaustive

questionnaires for patients which are then compiled to acquire cumulative data on each homes and region's occupants, the canton also argues that RAI/RUG makes a nursing home 'feel like a hospital'. Several other articles, including 'Where's Gertrude?' in the Journal of the American Geriatrics Society (1997) and a recent article in Switzerland's FACTS magazine (2001) share this concern.

Instead of RAI/RUG, BESA is used to determine tariffs charged to compulsory sickness funds. Also based on individual patient needs, BESA is a relatively new system (developed as a successor to the system: BAK) which divides daily nursing home tariffs into 4 categories, where 4 is for the most ill and thus the most expensive patients.

Berne

As one of Switzerland's largest cantons, with 400 municipalities, the canton of Berne is a feat of close government over a diverse expanse. Forty-seven municipalities in Berne are French speaking while the rest speaks German; a large portion of the populace lives in rural, alpine areas - but Switzerland's capital city is also the capital of this sprawling, multifarious canton.

The cantonal government allows for limited flexibility of municipal organisation of nursing home care so that the diverse cultures and environments of Berne's many regions can be respected. Because the French speaking parts of canton Berne frequently prefer to use financing, quality-control and planning systems which are more in line with the French-speaking part of Switzerland, this flexibility has been a cornerstone of cantonal governance. It is not, however, necessarily a sign of a *laissez-faire* philosophy.

There are three types of nursing homes in Canton Berne: public homes, which receive funding from the canton and from sickness funds, private homes which receive money from sickness funds but not from government, and private homes which subsist solely from private or charitable funds.

Public homes receive government object financing based on a weighted system, which is calculated retrospectively according to the number of patients in the home and their medical needs. The costs of their medical treatment are divided into four reimbursable levels based on the BAK system, which is the precursor to the system used by St. Gallen: BESA. As of year 2003, Canton Berne hopes to allow its public homes to seek funding by using weights determined either by BESA or by RAI. The French-speaking municipalities prefer BESA and the German-speaking municipalities tend to prefer RAI; by leaving the system up to each home's discretion, the

cantonal government attempts to compromise between the conflicting desires of regional homes.

Funding for nursing homes is not only derived from cantonal monies, but is from a prospective funding 'pot' (*Leistungsausgleich*) financed half by the municipalities, and half by the canton. Each municipality contributes to the funding pool based on the size of their population and their wealth. Municipal contributions to the nursing home financing 'pot' are matched by cantonal funding, so that the composition of the cantonal nursing home budget is comprised 50% by municipal money. The contents of this account are then siphoned off to nursing homes according to their needs. This way, smaller or poorer municipalities do not bear a greater burden for nursing home funding. It also enables the canton to fund nursing homes canton-wide: so that if a citizen lives in one municipality but wants to live in another municipality's nursing home, the citizen is not imposing an extra burden on the neighbouring area's budget. This account also subsidises the home tariffs for individuals with insufficient personal means.

Canton Berne has an above-average proportion of elderly inhabitants who comprise quite a large burden on the region's health budget. The secretary general of Canton Berne's Department of Health and Welfare, Dr. Rudolf Gerber, demonstrated his diplomatic prowess when he informed this study's author (not Swiss) that this demographic trend is due to Canton Berne's relatively few foreign inhabitants. Foreigners in Switzerland tend, apparently, to be young and employed.

Quality control in Berne is conducted by requiring all nursing homes to be licensed. These licenses must be renewed when management changes. License applications must include a dossier of information, much like in St. Gallen, where homes must enumerate their goals, targeted market, personnel and their qualifications, responsible physician(s), ombudsman, pharmacist, building insurance, fire safety information and other information. In addition, Canton Berne has an ombudsman responsible for nursing home supervision. Concerned citizens can and do call this official to make inquiries or complains about nursing homes. These concerns are then pursued until a resolution is found. This ombudsman is also informed of empty nursing home beds canton-wide once yearly and is responsible for informing residents seeking nursing home care of those beds' existence. The canton also tracks yearly bed turnover in an effort to ensure that enough nursing home beds are available given cantonal demographics.

An additional quality indicator nursing homes may chose to use was developed in 1998 as part of a doctoral dissertation by a student at the University of Berne. 'Qualipro' consists of a set of questionnaires whose questions are developed specifically for: home residents, residents'

families, home personnel, administrative staff, doctors, sickness insurance funds, political overseers and educational institutions. The surveys are analysed systematically. Survey results then provide indicators of user satisfaction under the rubric of 'quality care'. Gebert notes that many of the questions posed by Qualipro are problematic because they do not discretely differentiate between opinion or perception of the answerer (*Einstellung*), and the concrete/factual state of their treatment.

CHAPTER FOUR:

Conclusion

As the proportion of the Swiss and English populations that is older increases, important and multifarious questions crop up. Both England and Switzerland are struggling to rise ahead of the tide: to create a foolproof system of nursing home financing that is both comfortable and affordable for their respective populaces. Such a system must be workable at various levels of government, by financiers and potential market entrants, by providers and by users.

In Switzerland, the government of late is concerned with containing costs without compromising provision quality or excluding any of its inhabitants from access to nursing care. The fragmented structure of financing, which allows for cantonal and even municipal variation in nursing home funding sources is a mixed blessing, as it permits variation and innovation, but may allow for differences in access to or provision quality of nursing home care for Swiss in different regions. There has been a tendency of late to seek more nation-wide policy-making with regard to nursing homes, without taking too much freedom to innovate from localities.

In particular, Swiss sickness funds have found loopholes in the 1996 national law requiring them to cover all medical-related nursing home costs. Sickness fund associations have negotiated deals where they pay various proportions of these costs. Such deals vary according to the canton and/or nursing home association. To some degree, localities have profited from the lack of legal clarity with regard to nursing home financing by sickness funds. Many localities, such as Basle City, have welcomed an opportunity to contribute to nursing home tariffs as a canton, for example, so as to keep insurance premia from rising inordinately. The law's elusiveness has lent the localities freedom to innovate and seek custom-made solutions according to regional tastes.

Germany recently introduced a form of mandatory long-term care insurance which covers nursing home care for all its inhabitants. Now even

the wealthiest in society are relieved from contributing to nursing home tariffs. The result: high insurance premia and ballooning costs.

Most Swiss policy-makers with whom the author spoke seem to favour continuing limited coverage of nursing home costs by insurance companies and the government, thus retaining a progressive financial system in Switzerland. In this case, the rich would continue to contribute significantly toward their nursing home costs, and the poor would be covered by sickness funds and welfare. The trick seems to be to create a national mandate where sickness funds contribute significantly to nursing home care *without* allowing for exorbitant coverage of the wealthy, and *without* driving insurance premia up to unaffordable heights. Methods of achieving this balance have been attempted and herein described: by allowing the canton to pay for the most expensive nursing home patients in order to keep insurance premia down, as has been suggested

Interestingly, while Switzerland recognises a need for limited national, uniform methods of funding (and containing) nursing home costs, particularly with regard to insurance fund contributions, the English government has sought local accountability and decentralised financing - and thus increased fractionation? - since its swath of reforms in the 1990s. It seems as though some national uniformity in nursing home financing could help to ensure solidarity and equal access to care to the Swiss. The English, meanwhile, are heading in the direction that the Swiss are in now: supporting local innovations in financing, even if at the social cost of potential increased user charges and a possibility of decreased access to care for all. (Evandrou et al, 1998)²

A common theme here has to do with the ideal balance in the spectrum between a free market and state involvement. Several insurance-based countries, such as Austria, Belgium, France and Germany, have recently pursued greater regulation in their health systems overall, requiring independent actors to use payment methods and incentives that encourage cost containment. National quality standards are also being pursued in several traditionally more de-centralised, insurance-based systems.

Kokko cites Maarse's paper (Kokko et al in Saltman, ed. 2000), where he recommends that states, rather than taking a *laissez faire* attitude, be active players in health care financing and planning. Part of the efforts and innovations by governments in Switzerland and England have to do with taking on this new role as arbiters of a limited internal market that is

² A systematic shift by the more centralised English system toward the Swiss, less centralised system, can be seen as tied to recent obscurities of the line between Bismarckian and Beveridge health care systems which Kokko et al refer to in their paper. (ed. Saltman et al, 2000)

organised and held in check (for quality, equity and affordability) by the state. Knapp notes in his paper (Knapp, Hardy, Forder, 2000) that commissioning arrangements in England between local authorities and caregivers seem to have incited improved choice, quality and cost-effectiveness of care. He also notes that national regulatory frameworks and tougher quality standards are being introduced to maintain uniform standards.

As populations age and demand for nursing home care increases, governments, markets and citizens seek an efficient method of funding such care that retains choice for citizens, high quality and affordability. Although there is certainly no 'ideal' method of nursing home financing, the innovations found in England and in Switzerland may be helpful in the search for the best balance between the various actors involved in nursing home financing.

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Appendix I

Categorisation Systems Used in Switzerland:

Assessing Medical Needs and Associated Costs of Nursing Home Residents

In the descriptions of cantonal nursing home financing systems, RAI/RUG, BAK and BESA are referred to as methods of categorising nursing home residents according to their nursing/medical needs. These systems are used in most Swiss cantons as a way of billing sickness funds transparently and according to medical costs per patient. Such a system has increased importance since 1996 and the new sickness fund laws; funds are now required to pay for patients' *medical-related* costs in hospitals and nursing homes.

In most of Switzerland, one of five such systems for categorising their nursing home residents and thus for billing sickness funds is used. The five include: BAK, BESA, LEP, RAI/RUG and PLAISIR.

LEP has so far not been adopted in any cantons. It was developed by The Research Group for Management in Public Health at Switzerland's pre-eminent business university, the University of St. Gallen, and is an information system which documents nursing home personnel's qualifications and patient population characteristics in addition to individual residents' care expenses.

The remaining four categorisation systems can be separated into two groups. BAK (*Bewohner/Arbeit/Kosten* or *Inhabitant/Work/Costs*) and its successor BESA (*BewohnerInnen- Einstufungs- und Abrechnungssystem* or *Inhabitant- Categorising- and Billing System*), are pragmatic, four-category instruments used mostly for billing purposes. They have to do with what *is supplied* to each patient. RAI/RUG and PLAISIR are both scientifically based and are more comprehensive in their scope: they deliver epidemiological information on home resident populations in addition to individual resident-associated medical costs. Philosophically, they pertain to *what is demanded* or *needed* by each patient.

The bases of BAK and BESA, according to Zuesli's article, are as follows:

- The costs of care for each of the system's four categories are tied to a proscribed set of care needs depending on the resident's medical profile.
- Nursing care costs are calculated in each category with regard to the degree of training required to deliver the necessary care.

Thus, costs per patient are carefully calculated with regard to the degree and intensity of nursing and medical care (supposed) needs. Neither BAK nor BESA, however, deliver much information with regard to nursing home care quality or indirect costs. These are basic systems used mostly for billing: by tabulating the severity of each patient's care needs and associated predicted costs.

RAI (Resident Assessment Instrument) is a systematic and comprehensive instrument which was developed in the US and which assigns patients into 12 categories according to their care needs and associated costs. RUG (Resident Utilization Groups), an instrument associated with RAI, assembles care quality and utilisation data. It delivers information such as the percentage of residents under restraints in each home in addition to epidemiological statistics: e.g. how many hip fractures are experienced by residents in each home. A high number of restraints and low number of hip injuries in a home might, for example, be a sign of high quality. A low number of residents under restraint but a high number of hip fractures may, correspondingly, be a sign of lax oversight and thus a lower quality of care. RUG's statistics are intended to aid authorities in monitoring such trends. RAI, as its counterpart, assembles considerable data on each patient's costs as well as personnel qualifications and associated costs.

Finally, PLAISIR, having been developed in French-speaking Canada, is used, in a slightly modified version, mainly in Switzerland's French-speaking regions. With PLAISIR, individual residents' care needs are tabulated and then aggregated in order to discern cumulative care unit costs and personnel demands. PLAISIR may thereby assist with nursing care unit planning / organisation. Its indicators may also indicate home- or region-wide epidemiological trends amongst home residents, and thereby may indicate optimal patient care approaches.