Health Policy 121 (2017) 339–345

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

The 2016 proposal for the reorganisation of urgent care provision in Belgium: A political struggle to co-locate primary care providers and emergency departments☆,☆☆

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ARTICLE INFO

Article history:
Received 18 July 2016
Received in revised form 3 February 2017
Accepted 4 February 2017

Keywords:
Emergency medical services
Ambulatory care
Health services research
Health care reform
Utilization

ABSTRACT

Internationally the number of emergency department (ED) visits is on the rise while evidence suggests that a substantial proportion of these patients do not require emergency care but primary care. This paper presents the Belgian 2016 proposal for the reorganisation of urgent care provision and places it into its political context. The proposal focused on redesigning patient flow aiming to reduce inappropriate ED visits by improving guidance of patients through the system. Initially policymakers envisaged, as cornerstone of the reform, to roll-out as standard model the co-location of primary care centres and EDs. Yet, this was substantially toned down in the final policy decisions mainly because GPs strongly opposed this model (because of increased workload and loss of autonomy, hospital-centrism, etc.). In fact, the final compromise assures a great degree of autonomy for GPs in organising out-of-hours care. Therefore, improvements will depend on future developments in the field and continuous monitoring of (un-)intended effects is certainly indicated. This policy process makes clear how important it is to involve all relevant stakeholders as early as possible in the development of a reform proposal to take into account their concerns, to illustrate the benefits of the reform and ultimately to gain buy-in for the reform.

1. Introduction

In Belgium, as in most OECD-countries, the number of emergency department (ED) visits has continued to increase over recent years [1]. While the reasons for this increase are multifaceted, including both demand and supply side factors [1], a considerable proportion of patients at EDs are thought not to require emergency care and could potentially be treated by primary care providers [1,2]. Although there is no internationally accepted definition for these so-called 'inappropriate ED visits', numerous studies have reported the proportion of these visits to vary between 20% and 40% [3].

Belgian estimates for inappropriate ED visits are even higher, with reported proportions ranging from 40% to 56%

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

☆☆ This article has been made Open Access through funding by the European Observatory on Health Systems and Policies as part of its Health Systems and Policy Monitor (www.hspm.org), an innovative platform that provides a detailed description of health systems and provides up to date information on reforms and changes that are particularly policy relevant.

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http://dx.doi.org/10.1016/j.healthpol.2017.02.006

Box 1: Belgian macro-level governance of the healthcare budget.

The National Institute for Health and Disability Insurance (NIHDI) is responsible for the reimbursement of healthcare services and products. The NIHDI is composed of five departments, of which the healthcare department is responsible for the management of compulsory health insurance. The department is headed by the General Council and the Insurance Committee. In the General Council, representatives of the government and the sickness funds but also of employers, salaried employees and self-employed workers decide on general policy matters concerning health insurance and its budget. Within the healthcare department, various commissions composed of representatives of the sickness funds and providers negotiate on fees. For example, the National Commission of Sickness Funds and Providers, the so-called 'Medico-Mut', negotiates on physician fees. The negotiated fee or 'convention tariff' is settled in agreements (for physicians and dentists) and conventions (for other healthcare providers). The Medico-Mut is composed of an equal number of representatives of sickness funds and provider organisations. While the Medico-Mut was initially installed to negotiate the fee schedule (the nomenclature), it has – by lack of an alternative – progressively become the main locus of decision-making for a broad range of issues, including the organisational set-up of emergency care provision [9].

[4,5]. In addition, a high proportion of patients in Belgium visit the ED without a referral from a general practitioner (GP) or an ambulance (71% 'self-referrals') and only 23% of ED visits result in a hospital admission. These numbers indicate that a shift in health care provision from the ED to primary care might be desirable in Belgium as it could potentially reduce costs and improve appropriateness of care.

Several countries, including England [6], France [7], and Germany [8], are currently reviewing and reforming their urgent and emergency care systems, aiming (amongst others) to reduce the number of 'inappropriate' emergency visits. In this context, a 2016 reform proposal from Belgium is interesting because it has suggested to systematically introduce primary care providers co-located at hospital EDs.

This paper presents the Belgian proposal and places it into the context of previous attempts at curbing the growth in ED visits and the political context in Belgium. In addition, it describes the opposition to the proposal from stakeholders and the political processes that ultimately led to a compromise, which accepted the co-location of primary care providers at EDs only as one of various options for the organisation of urgent and emergency care. This political process can be understood only against the background of macro-level governance arrangements in the Belgian healthcare system, which give considerable negotiating power to the main stakeholders (insurers and providers) in determining the structures of the system (see text Box 1).

2. Problem context: previous reform measures were unable to curb the growth of ED visits

Since the beginning of the 2000s, Belgian policy makers have initiated three main reform measures in the field of urgent and emergency care (see Fig. 1). First, in 2003, a higher co-payment for self-referrals was introduced, which was intended to incentivize patients to visit their GP instead of the ED. As a result, patients who visited the ED in 2015 without a referral from their GP had to pay €20.21 instead of €4.50 when referred by their GP. However, the increased co-payments could not turn the tide of high self-referral rates and increasing ED use, as is evidenced by the continuous growth in ED use in Belgium, which is amongst the highest in OECD countries [1]. In addition, co-payments are hardly known to patients and do not seem to be important in patient choice of provider [10]. Furthermore, there is no legal obligation for hospitals to charge the co-payment.

Second, and also in 2003, Belgian authorities, i.e. the National Institute for Health and Disability Insurance (NIHDI) started to provide financial support to GP circles who would organise their on-call duties in 'out-of-hours GP posts'. Within a GP circle (n = 147 in 2014), local GPs work in collaboration to reach an agreement about the organisation of out-of-hours shifts for a specific geographic area. Funding for GP circles is mainly based on the number of inhabitants in the GP area where the circle operates [11]. GP circles can apply for additional funding to organise their on-call system in well-equipped GP posts (e.g. with secretary, car and driver for home visits) rather than via a local rotation system. In 2015, the NIHDI supported 70 GP posts covering 68% of the Belgian population with a total amount of €16 984 292. However, while the creation of GP posts may have contributed to improving working conditions of GPs (e.g. by reducing the number of nights and total time on duty during out-of-hours periods), their role in promoting the use of urgent primary care instead of EDs remains a matter of debate. The existence of out-of-hours GP posts is not well known to the general public and opening hours of GP posts are variable. By contrast, EDs are available 24/7 and they are more easily accessible because there are 139 EDs in the country but only 70 GP posts [12]. Furthermore, GP posts seem to attract another patient population than EDs (e.g. patients who want to avoid taking time off from work) [13,14].

Third, in 2008, a new telephone number (1733) was introduced to complement the European 112 emergency call number with the ultimate aim of guiding patients with primary care problems to primary care instead of the ED. In a first phase, the number 1733 has been implemented as an automatic connection to the GP on call. In a second phase (from 2016 onwards), the number will be tested as a telephone triage system in pilot regions. Depending on the results of a scheduled evaluation with regard to safety and impact on ED workloads, the phone number might be implemented nationwide. This evaluation is particularly important as there is a lack of international evidence about the effect of prehospital telephone triage systems on ED use [15].