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Mental health care delivery system reform in Belgium: The challenge of achieving deinstitutionalisation whilst addressing fragmentation of care at the same time

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ABSTRACT

Most mental health care delivery systems in welfare states currently face two major issues: deinstitutionalisation and fragmentation of care. Belgium is in the process of reforming its mental health care delivery system with the aim of simultaneously strengthening community care and improving integration of care. The new policy model attempts to strike a balance between hospitals and community services, and is based on networks of services. We carried out a content analysis of the policy blueprint for the reform and performed an ex-ante evaluation of its plan of operation, based on the current knowledge of mental health service networks. When we examined the policy's multiple aims, intermediate goals, suggested tools, and their articulation, we found that it was unclear how the new policy could achieve its goals. Indeed, deinstitutionalisation and integration of care require different network structures, and different modes of governance. Furthermore, most of the mechanisms contained within the new policy were not sufficiently detailed. Consequently, three major threats to the effectiveness of the reform were identified. These were: issues concerning the relationship between network structure and purpose, the continued influence of hospitals despite the goal of deinstitutionalisation, and the heterogeneity in the actual implementation of the new policy.

1. General background

The past few decades have seen most European countries reforming their mental health care delivery systems [1,2]. These reforms may have had two main aims [3,4]. The first is to completely deinstitutionalise mental health care delivery by providing community-based mental health services. Deinstitutionalisation was completed long ago in some countries (such as the United Kingdom and Italy) whilst in others (especially in Eastern Europe or in Japan) [3,5], the process is still ongoing. The second of these aims is to address the issue of fragmentation in health and social care delivery systems [6,7]. In most countries, care is delivered by a wide range of services without partnership working agreements aiming at continuity of care [8,9]. The issue of fragmentation is particularly relevant for severe and chronic mentally ill users with multiple, long-term, and complex needs [10–13]. Fragmentation also causes problems of coordination between different services. Various issues were subsequently attributed to this lack of integration, such as increased incidences of coercion and compulsory treatment, homelessness, unemployment, and increased pressure on carers and families [15–18].

Belgium is currently implementing a new phase of reform of its mental health care delivery system that aims to simultaneously address deinstitutionalisation and issues

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of fragmentation. The health care system in Belgium may be described as having three fundamental characteristics. The first is the principle of therapeutic freedom, which in practise means the freedom of users to choose their health providers, regardless of territorial or referral criteria. Compulsory health insurance covers most of the fee-for-service costs within this system. Secondly, the health care system mirrors the high level of fragmentation of the whole society. It is well known that Belgium is deeply divided into different linguistic communities. The coexistence of these communities has required many policy arrangements and reforms, which has resulted in a complex distribution of policy competences between the federal state and multiple federated entities, i.e. the three language communities and the three regions. Thirdly, in order to regulate this complex system, the traditional decision-making process for public policies is based on corporatism, which requires lengthy negotiation processes between different stakeholder groups [14]. As a result of this situation, the delivery of community care is largely organised and financed at the level of the federated entities, whilst in-patient services, including hospitals, fall mainly under the responsibility of the federal authority.

During previous phases of reform, some community settings were introduced into the Belgian mental health care delivery system. The process of deinstitutionalisation, however, was not complete. There were still 152 psychiatric beds for 100,000 inhabitants in 2008, the second highest number in Europe, according to the WHO [2]. Initiatives were also established to address the issue of fragmentation in the mental health care system. Particularly, the concept of *Care Networks* was introduced in the 'Hospitals Act' of 2008 [15]. This act allowed psychiatric hospitals to reallocate funds for long-term beds to networks with community-based services. This funding mechanism is at the core of the current phase of reform named 'Title 107', in reference to the title where this mechanism is suggested. The 'Title 107' reform proposal was described in a blueprint document entitled: "Guide towards a Better Mental Health care by Implementing Care Circuits and Networks" [16]. We carried out a content analysis of this document [17] in order to identify its programme theory, i.e. plan of operation [18]. This is therefore an interesting case study for looking at the ways in which these two aims can be addressed at the same time.

2. Materials and methods

The programme theory of the 'Title 107' reform was assessed through a content analysis of its policy formulation as described in the blueprint for the reform. Programme theory assessment is an essential preliminary step in the evaluation of health policies, providing the hypotheses to be tested in further impact evaluations [18]. As part of this content analysis, we identified the long-term aims and intermediate objectives of the reform. We also identified the tools, processes, and mechanisms being suggested in the blueprint with respect to achieving its aims and objectives. Finally, we identified and analysed the arguments used to support the reform, and the way in which goals and tools were articulated into a global programme theory [17]. The analysis of the programme theory of the reform made it possible to then identify ex-ante the potential threats to the effectiveness of the reform.

More specifically, we assessed the logic of the programme theory and compared the implicit configuration of the mental health service networks as suggested in the reform with the available evidence from the literature. Networks of services have often been identified as an effective way of overcoming the issue of care fragmentation in community-based care systems [19,20]. Although the literature on this topic is extensive, it is very heterogeneous, coming from separate research traditions, and little specific evidence is available [21]. On the one hand, health services research has investigated the concept of system integration, with specific attention to collaborative structures for health providers and to their capacity to provide continuity of care [13,19,22–35]. This type of study is, however, very dependent on contextual elements such as local policies and funding systems. On the other hand, organisational and management science has focused on inter-organisational networks as a specific type of organisation [36–41]. Although these studies are less influenced by contextual elements, they have focused mainly on private organisations, which differ from mental health services in terms of conditions for the emergence of networks, collective aims, and expected outcomes. The theoretical framework developed by Milward, Provan, and their colleagues is situated at the crossroads of organisational research and public mental health studies: it is developed on mental health-care service networks [19,20,35,42,43]. In order to avoid normative considerations from the two different traditions, this framework is based on a formal approach to networks, which are defined as a set of nodes and a set of ties representing some relationship between the nodes. This approach makes it possible to use this framework as a benchmark regardless of local policy contexts.

According to Milward et al., network effectiveness is influenced by a range of structural factors. They found that: (i) effectiveness is positively correlated with small groups of densely interconnected services, when these groups are connected to each other via a central agency [29,44]; (ii) centralisation facilitates coordination, whilst differentiation between services (i.e. diversity in care supply) is correlated with a low level of centralisation; and (iii) the density of connections between services tends to increase over time. Finally, these scholars, and others [31], concluded that density of ties and centralisation could not be maximised simultaneously [20,35,42,45,46].

In this study, we assessed the extent to which the network model suggested by the reform is consistent with these findings, thereby identifying possible threats to the effectiveness of the reform. We used the structure of the policy blueprint to divide the core elements of the programme theory into five sections: (i) the case for reform, (ii) goals and objectives, (iii) the new model, (iv) tools, and (v) issues regarding implementation and funding.