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RIZIV Report

The Belgian strategic plan for implementing health care innovations for chronic diseases: an overview of the key proposals for reform

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The Belgian chronic care system: 'as is'

The Belgian health care system is financed through the national, social security based, health insurance system. It is governed by the NIHDI, the National Institute for Health and Disability Insurance, one of the social security agencies under the responsibility of the Minister of Social Affairs.

The main characteristics of the national health care insurance system are:

- centralized rule setting and financing;
- reimbursement through 'mutualities' (membership organisations of social insures for health care reimbursement and sick leave coverage);
- free choice in access to care for patients to primary and secondary care; and
- a highly fragmented service delivery system, for example:
 - In primary care, that is to a large extent led by self-employed providers or by not for profit institutions;
 - Electronic medical records and information exchange that is not yet entirely implemented; and
 - Horizontal and vertical integration of service delivery that is not sufficiently developed.

Attempts have been made in the past to obtain more integrated approaches. About half of the population choose a GP to keep their medical record and integrated support services have been successfully developed in some areas (e.g. for palliative care). Other coordinating initiatives have been less successful since strategies have been too limited in terms of their scope of action, under-

financed, and lacking commitment from health professionals (especially GPs) to the necessary process of multidisciplinary collaboration.

A national plan for chronic ill people was issued and rather well financed in 2008, with emphasis on: better financial protection; better information to patients; socio-professional reintegration; and tailor-made programs for specific patient groups. Patient organisations entered the NIHDI as a new stakeholder with a consultative role, so raising concerns about the quality of care received by patients with chronic conditions. Other national plans were also issued (e.g. cancer, HIV and AIDS, etc.)

Integrated care programs

From 2009 onwards three specific integrated care programs were implemented on a national scale and covered by political agreement.

- In the field of long term care a national policy was fixed (after a period of about 5 years in the planning) of the so called ‘interministerial collaborative protocol’. This represented a strategy for new financial investment into long term care facilities to enable bottom up ‘care innovation’ initiatives that aimed to be more efficient in maintaining people’s autonomy and so postponing dependency. Whilst half of the budget for the initiative was later taken back for short term policy priorities, some 20 million euros was invested in two waves on such projects. The evaluation of the first wave of projects – based on a first enrolment of over 10,000 frail older people - showed the importance of targeted case management combined with a set of services that supported the older person and his informal carers. The evaluation process has enabled the effectiveness and cost-efficiency of case management to be assessed meaning that key lessons for effective care delivery have been used to focus the second wave of projects on the most effective interventions. The process will ultimately lead to the development of list of cost-effective interventions and services to be covered through social health insurance. Hence, the interministerial collaboration has made it possible to integrate health and social care services.
- In the realm of disease management programs, two ‘care trajectories’ – diabetes type II and chronic renal failure - were defined for patients at a certain stage of their disease, especially when management of the disease needs involvement of the specialist. The approach was inspired by Wagner’s Chronic Care Model and the programmes were initially negotiated between GPs, specialists and mutuality’s as a new scheme of ‘shared medical care’. The program was complimented with other supportive services such as patient education and self-care materials. The program is based on the development of an individual contract between the patient and his GP and specialist. Personal patient goals are identified on an individual basis. In order to support this program a national website was set up to provide service design recommendations, support materials were given to patient organisations, and GPs were commissioned to set up local multidisciplinary care centres where a ‘trajectory promoter’ supported the professionals to build up their collaboration. GPs committed themselves to transfer medical data to a central registry, which was a large success. The programme has been shown to improve the quality of the care process and the outcome results are promising, although not yet conclusive. Some 65.000 patients were enrolled.

- In the field of mental health care, local initiatives were allowed to launch projects on a territorial basis in order to replace hospital-based care by a range of community-based alternative services. Hospital beds have been closed and 19 projects are now running based upon community-based collaborations. Some central guidance is set in place and a national scientific evaluation program is running. The projects are politically covered by interministerial agreement similar to the innovation outlined in point 1 above, and the innovation process started off through a political shared statement on the policy to be developed in the field of mental health. The first wave of projects led to a close down of 750 beds and a yearly caseload of 6,300 patients.

Elaborating a national strategic plan on chronic conditions

Notwithstanding the importance of these three national programs it became clear that the challenge of chronic diseases, multimorbidity and ageing of the population (when combined with expected shortages in health care staffing and sustainability of the Insurance scheme) would need more intensified political actions. On an European level, Belgian EU presidency initiatives led to a reflection process, and consecutive actions including the EU summit on chronic diseases, 2014 (3-4/4). On a national level, the Minister of Public Health and Social Affairs launched a process to define a national plan for chronic care by the end of 2014, supported by interministerial departments. First the Federal Health Care Knowledge Centre (KCE) issued a position paper, published as report nr 190 on www.kce.be.

The national plan for chronic care proposes a root definition for chronic care in the Belgian context through an adaptation of Wagner's CCM and identified a set of key recommendations. These were submitted to stakeholder consultations in order to transform them into actions. The 20 actions that came out were published in a guidance note that was subsequently discussed at a national conference at the end of 2013. The Ministers then decided to further elaborate on this guidance note through extended stakeholder consultation and by setting in place a national coordinating structure with dedicated personnel in order to work systematically towards a large supported national action and implementation plan. The actions identified represent the necessary 'transformative' processes required to stimulate change towards better integration, better quality and more efficiency. Besides operational actions (like full electronic medical records, patient empowerment, case management, local support for multidisciplinary work) attention is also given to education and training, to quality assessment and to governance.