Dignity first – priorities in reform of care services (Sweden, 26-27 September 2013)

Long-term home care in Belgium – Challenges and innovations[1]

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1. Background - context

A proper understanding of home care and technologies use in home care needs a short description of Belgium health care and long-term care system, and some key changes under process.

General characteristics of Belgian health care system

The Belgian health care system is a pluralistic system: community dwelling frail elderly people's care is provided by a mix of private family practitioners and of others professional caregivers , many of them still working in solo, organisations with strong links with health insurers (mutualities) from different obedience (catholic, socialists, liberal), by municipalities, or purely private. It is mainly regulated and financed by two public authorities' levels, i.e. federal and regional. The federal Government is, among other things, responsible for the regulation and the financing of the compulsory health-disability insurance. The regional and community governments are, notably, responsible for other health matters. For long-term care, they are responsible for policies for elderly (including nursing home) and disability. The health system is primarily funded through social security contributions and taxation. Public sector funding as a percentage of total expenditure on health care fluctuates around 72%.

The Belgian health care system is based on the principles of **universal** and **equitable access** to care and **freedom of choice** (Corens 2007). Professional autonomy (mainly for medical profession) is also an important "driver" of the health care system.

Furthermore, most decisions in the health care system are the result of negotiation (consultation process) between key stakeholders of the system. With some variation, one can say that many of the reforms in the system have a strong "bottom-up" component (Schokkaert and Van de voorde 2010).

Evolution of primary care position

Apart consequences from political reforms (see below), series of interventions from federal and regional level aimed in the last years at giving a more central place to primary care within the general health care system. This include the creation of medical circles and the reorganisation of out-of-hours services in a context of GP

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shortage (Jonckheer et al. 2011); the implementation of a global medical file, managed by the GP (Gerkens 2013).

Attention to chronic care

Also, a progressively greater attention is given to chronic care. This has been translated into a large national plan named "*Priority to chronic patients*" which started in 2008.[2]

This plan has 4 major topics which includes more than 30 areas of action:

1. Recognise the patients with a chronic conditions (specific status);
2. Favour the access to information and simplify the administrative procedures;
3. Improve their integration in social and active life;
4. Improve the accessibility of health care (as financial accessibility than a broadening of the offer of health care).

Moreover, a recent position paper has identified 50 points of action for the reform of health care system (Paulus et al. 2012). This will culminate with a national conference by the end of this year 2013.

Finally, a major organisational reform is taking place on mental health care (with the aim of des-institutionalise the care to people with mental health problem).

Social care organisation at home in Belgium (short description)

Publicly funded social home care is based on 3 pillars:

- Services provided at home by accredited organisation through a "tutelary" system, which supports the provision of personal care services by allocating public funding to public and non-profit providers. Some examples are housework, home care, meals at home, social assistance, coordination of care services ... The regional authorities regulate the organisation of this services through, among others, a control of the accreditation conditions and the quality requirements (qualification of carers, social assessment, …);
- Voucher system (*titre-service*) has been established since 2001 at the federal level. Driven by the objective of generating employment, the service voucher is primarily aimed at supporting help with housework rather than personal care;
- Cash for care allowance (both federal and regional). Two major cash benefits are targeted at supporting services users' financial costs of nonmedical care-related expenses. At the federal level, the "Allowance for help to older people" (*Allocation pour l'aide aux personnes âgées* - APA) and the "Allowance for handicapped people" (*Allocations aux personnes handicapées*) provide financial support to older dependent persons. The level of the cash benefit varies with the level of dependency and the financial circumstances of the applicant. At the regional level, the Flemish Care Insurance is a separate Flemish long-term care insurance system (*Vlaamse zorgverkering*) that provides a universal monthly allowance to dependent people in Flanders (Degrave and Nyssens 2012).

[2] Cabinet de la vice-première ministre et ministre des Affaires Sociales et de la Santé Publique "Priorité aux maladies chroniques!" - Programme pour l'amélioration de la qualité de vie des personnes atteintes d'affections chroniques 2009-2010 -Propositions de Laurette Onkelinx, Ministre des Affaires sociales et de la Santé publique. Bruxelles; 2008. Available from: http://www.laurette-onkelinx.be/articles_docs/20080923_-_propositions_malades_chroniques_F.pdf AND Cabinet de la vice-première ministre et ministre des Affaires Sociales et de la Santé Publique Etat des lieux du programme maladies chroniques. Bruxelles; Mai 2012. Available from: http://www.lauretteonkelinx.be/production/content.php?ArticleId=91

Evolutions in long-term care: strengthening home care and political decentralisation

Over the past decade, a more diversified range of care services has become available, better tailored to the needs of care dependent older persons. The shift to providing care at home rather than in residential care facilities is striking: during the past decade the number nursing care by community dwelling older people has grown by more than 40% and the number of users of family care has grown by more than 20%, while the increase in residential care users amounts to less than 10% only. Despite what precedes and despite that, in Belgium, a significant and higher proportion of older people live in residential care than in other European countries (5.8% and 8.3% of the older population in Flanders and in Wallonia, respectively), the most recent estimations of needs in LTC plan on 23,500 extra beds (+18%) for institutionalised care when it is assumed that home care is expanded by 50% in the next 15 years (Degrave & Nyssens 2012).

To assist that shift from institutional to home care, Belgium has developed a national strategy. Since 2005, a memorandum of understanding between the federal state and the "federated" entities, acknowledged the need to develop alternative form of care in support to home care. This was operationalised in the form of a call for projects launched in 2009. To be eligible, projects had to propose services that (1) promote the autonomy of older people, reinforcing their capabilities of self-care; (2) provide alternatives to institutionalisation; (3) are based on multi-disciplinarity, and trans-murality; (4) provide care at a cost equal or lower to the average cost supported by the federal state for care in nursing homes. 66 projects were selected and started to provide services since 2010 to around 5,000 community dwelling older people (Onkelinx 2012). These projects provide the type of services that were not yet financed by the federal state such as: case management, ergotherapy, night (nursing) care, psycho-social support and day care centres.

This strategy takes place at a time of political reform. Indeed, the **6th political reform has recently been agreed. It will involve the transfer of some of the health related competencies from federal to federate entities (regions and communities)**.

As a result of this transfer, regulation, organisation and financing of home care for older person are distributed as follows:

- Financing of health care (i.e. nursing, medical, physio and some ergotherapy, …) services is done by the National Institute for Health and Disability Insurance (NIHDI). This remains the competency of federal entities;
- Financing of nursing homes will be done through federated entities (region or communities);
- Organisation of the coordination of care and cooperation between provider organisations will be the responsibility of federated entities (regions or communities);
- Support to the development of primary care will be the responsibility of federated entities;
- Social care at home is almost entirely the responsibility of federated entities (regions or communities).

This shift of responsibilities will obviously call for a new mode of cooperation between various states entities (federal authorities, regions, communities). This may be done through existing inter-ministerial conference.

2. Some key challenges in the current situation, the recent trends and innovative approaches in Belgium in relation to home care

In the context explained before, Belgium has to face a series of challenges, among which some are mentioned hereafter.

A move towards more home based elderly care: the challenge to keep a good access to necessary "classical" and new services by reshaping skill-mix, task delegation and new functions

The move from nursing to long-term home care increases the "pressure" on classical or new services at home: nursing care at home (including night care), services to support the stay at home (meals on wheels, housekeeping, …), medical care, day care centres, psychological support, ergotherapy, … .

This challenge needs to be tackled by taking into consideration the actual and possible future shortage in some professions (nurses, GP,…) and the risk of "low quality" jobs (underpaid, unstable jobs), particularly for social care services.

To confront the shortage of specific active workforce, there may be a progressive transfer from GP to nurses and from nurses to nurse aid:

- One important transfer from GP to nurses are the pilot projects being implemented to clarify the function of case-managers; another has been possible through the creation of care pathways;
- In the care to older persons, nurse aid play an increasing role compared to registered nurses. For example, in the alternative form of care projects presented here above, almost half of the equivalent full time invested in care is constituted by nurse aid.

A recent proposition of royal decree allows for example the financing, under supervision conditions, of nursing care activity which will be done by a nurse aid in the home care setting.

Coordination and integration in a context of freedom of choice and professional autonomy

In a "pluralistic" system where patient freedom and professional autonomy are central values, coordination becomes a complex issue. Over the past year, various structures focused on negotiation between providers covering defined geographical area have been created (i.e. SISD, SEL, RML, …). Others strategies (transmural care liaison nurses) or organisations (i.e. CCSSD in French speaking areas) have been created to increase coordination between institutional care and home care or between nursing and social care. This leads to a sort of "segmentation" of the coordination.

To overcome that while maintaining an equilibrium between various stakeholders in decision making, three issues are presently discussed as part of the reflection to improve chronic care in Belgium:

- Simplification or structures of negotiation covering a particular geographical area (SISD-SEL and RML): the proposal is to clarify and as much as possible to standardise roles and tasks from SEL/GDT and SISD as well as the level of MNL and RML. The various structures should be simple and complementary;
- Create synergies between actual organisations coordinating nursing and social care (i.e. CCSSD) and the emerging function of case manager;
- Progress in a contextualised definition of the function of case managers. Indeed, various forms of case management (CM) to care for frail older people are presently tested in Belgium. This strategy is indeed expected to be one of the

responses to overcome health care system weaknesses of caring for this population.

It is also important to mention that these 3 issues may be developed with different accents in the three region of the country, given their increased responsibilities in the organisation of the coordination.

Older persons and the informal caregivers' focused system

A third big challenge is to increase autonomy and give more voice to older people in need of care and their informal caregivers. This has to be considered in line with renewed concerns to ensure a health and social care system taking consideration preferences and demands of older persons and their informal caregivers.

Participation of these groups has already been sought through various strategies in the frame of chronic care (i.e. observatory of chronic diseases where patients have their representatives) or in nursing homes (i.e. where participation instances are compulsory).

Getting local evidence on cost-effectiveness of different interventions – P3 scientific evaluation

The national strategy presented before and aiming at reducing the risk of institutionalisation of frail older people is being evaluated. This evaluation aimed at answering to a series of research questions related to characteristics of the interventions, the beneficiaries, the association with outcomes and costs, and finally the explanatory theories. The goal of the evaluation was to find answers to the following questions: what are the interventions all about and how can we expect them to work? Who benefits from the intervention? Are interventions associated with changes in measurable outcomes? For which population? Under which circumstances? Through what mechanisms? What does the intervention cost? And finally, what are the consequences of the intervention on the cost of other services paid by NIHDI or by other funding sources?

3. What is the experience of your country regarding the use of technology in home care?

Economic policies are largely the responsibilities of the regions. For that reason, most policies to promote the use of technologies for home care are decided by the regions.

As a whole, promotion of technologies use in home care is still largely a bottom-up process with yet little intervention from public and regulation by the state. Most of regulation comes through the public financing of pilot projects (smart homes, telemedicine, and more largely all new TIC). One interesting and recent example is an initiative of Flanders, called "*Proeftuin Zorginnovatieruimte Vlaanderen*"[3], which support the creation of an innovation arena through a narrow collaboration between health care providers, researchers and industry in order to facilitate the creation of new process of care of new products for elderly care.

There is one notable exception to that, i.e. (1) the development of e-health (allowing circulation of information between all the stakeholders concerning care and/or status of the beneficiaries); and (2) the implementation of a common

[3] http://www.iwt.be/evenementen/infosessie-proeftuin-zorginnovatieruimte-vlaanderen-2012-2013

comprehensive geriatric assessment instrument (i.e. the BELRAI). Therefore, Belgium set up end 2012 an action plan for the period 2013-2018.[4]

4. How is the quality in the provision of services monitored in your country (e.g. quality registers)? Which information/indicators are being used?

Various initiatives and strategies are under development in Belgium to look at quality of long-term care. Once again, both federal and federated authorities assume the responsibility of some aspects of the quality management, particularly in the LTC.

Performance indicators for the Belgian health system

Following to the signature of the Tallin Charter in 2008, Belgium has recently realised its 2nd health system performance evaluation. In this context, Belgium has decided on a set of indicators to measure performance. These aim at measuring the quality of the system as a whole. Actually, there are still few indicators available for long-term care, particularly for LTC for elderly (Vrijens et al. 2012). The objective is naturally to improve this situation through the implementation of BelRAI in the concerned sector. Existing and expected indicators are available in the report 196B cited just before.

Main actual sources

Various databases are available and there is a tentative to move towards an integration of these into a meta-database (through e-health and "*banque carrefour*").

The main databases available are: (1) The IMA-database (health care consumption of services reimbursed by NIHDI); (2) the national health survey by interview; and (3) BelRAI data for older people benefiting from pilot projects.

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