*Arch Public Health*
*2004, 62, 173-184*

# Options for a new procedure for determining care needs in Belgium: an initial exploration

by

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## Introduction

Broad consensus exists among Flemish care providers and policy-makers that the KATZ scale variables, which are widely used in Belgium, are not the ideal way of compiling a list of care needs or of preparing for care planning. However, deciding on a new and better procedure is not easy. One of the key tasks of the Qualidem project was to choose and support this procedure.

In recent years, a limited multidisciplinary reflection group has attempted to formulate the concepts underlying this choice and to compile a list of the most important options. This took place through monthly discussions based on a draft text. The knowledge and experiences of the first Qualidem project were drawn from extensively for both the draft text and for the adjustments, as well as the experiences of other groups described in the literature (1;2). In addition to the authors, the reflection group consisted of F. Falez, L. Delesie, J.P. Bronckaers, J. Pacolet and C. Swine. The text below is a description of the decisions and proposals made by this reflection group.

**Keywords:** primary health care, dementia, health care costs

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## I. General

### 1. What are care needs/dependency?

The question of what precisely are care needs is not easy to answer (3). Bradshaw stated that, broadly, four types of need can be described (4): felt need, as perceived by the patient/client; expressed need, as expressed by the patient/client; normative need, as defined/perceived by the professional; and comparative need: this is need as a function of what is accepted for comparable people in a comparative cultural and socio-economic situation.

We define care needs here as the need for formal and/or informal help in order to resolve a perceived problem, resulting from a disruption to health in the broad sense.

Huijsman (1990) describes care needs in the same context as "the consequence of a discrepancy between the actual situation and the desired situation, which is further influenced by the aspiration level of the person in question and the "mirror" in which the latter reflects the actual situation, i.e. the reference group situation (5).

Dependency can be defined as a situation in which the (elderly) person is no longer capable of carrying out everyday activities himself. The use of the term in different contexts causes confusion and leads to an ambiguous use of the term (6). Attempts to offset this are made, using adjectives such as "physical", "psychological" or "functional". The concept has chiefly been used in French-speaking countries. In Anglo-Saxon countries, the term "disability" is preferred. The most precise and least disputed definition is, "'Dependent elderly person' is understood to mean any elderly person who is suffering from a decline in his/her physical and psychological abilities and who finds it impossible to care for him/herself fully and who, as a result, must rely on a third person in order to accomplish everyday activities" (7;8).

A distinction can therefore be made between "doing instead of", "helping with" and "doing with supervision". These three levels imply assistance from a third party in order to perform the necessary acts and essential tasks in everyday life.

Van den Heuvel emphasises that dependency can come about in two ways: the person himself defines his situation as dependency (also known as subjective or "felt"); the people in the environment (professionals and volunteers) define the situation as dependency (known as

objective or "normative") (9). It is clear that whether or not dependency is present depends upon the person making the assessment.

## 2. Objective versus Subjective

The distinction is made above between subjective (felt) need and objective (normative) need. Objective (normative) is defined as need as it is assessed by the professional. How though can so-called "objectivity" be guaranteed? How objective is objective? Who ultimately determines what objective is? Experiences in the field and, particularly, conflicts about the assessment of care needs teach us that what is objective for one person is subjective for another. This is probably an area for endless discussion. One European project advocates abandoning these terms and using "evaluative" instead: the assessment is made following an evaluation which must be clearly described (10).

An evaluation means a comparison with previously defined criteria. Defining these criteria is a policy choice, based on ideological and pragmatic choices (financial resources, availability of personnel, etc.).

## 3. Deficit model versus competence model

In 2001 the WHO published a new classification: the International Classification of Functioning, Disability and Health, or ICF or ICIDH2 for short (11;12). This replaces the former classification of Impairment, Disabilities and Handicaps, known as the "Wood" classification (13). The aim is to produce a shift from the deficit model to the competence model, which is also assumed by Belgian policymakers (14). The basic premise is that the care must be based on an optimum participation in activities.

Care is then steered by the question of what is missing in order to allow the person to accomplish the maximum of activities or to participate in them. Attention is therefore targeted on rehabilitation. Under current Belgian legislation, the only incentive to rehabilitate someone is an ethically inspired exercise of one's profession. Financially – in both home care and residential care – the care provider is not rewarded for good work.

The question is therefore whether we want a registration of deficits and therefore of dependency, which concentrates on the care provider taking over functions (I were you), or a registration of care needs which concentrates on residual autonomy, focusing on help, encouragement,

etc. (I am encouraging you and helping you, where necessary, to wash yourself as much as possible), even if this leads to an – often temporary – longer period of care.

In fact, everyone has long agreed with a competence approach to dependency. The aim of care must be to use the competences a person still possesses and to maintain and further develop these competences.

The starting point is always measurement of a loss or a deficit. However, this should not automatically mean that the care to be provided is already established. For example, if a deficit is observed in the everyday activity of washing oneself, this does not automatically have to mean that hygienic care is provided, but it should lead to an examination of the kind of intervention that best responds in this specific case to the residual abilities of the person in need of care: material resources and adjustments or rehabilitation aid (e.g. learning to wash oneself following hemiplegia) or hygienic care by a professional or volunteer. Financing for the care should therefore be separated from purely providing the care.

The competence approach therefore implies that a goal is set and that attainment of it is regularly evaluated. Following the time of measurement of the loss or deficit, reflection must take place about the goal to be achieved through the care. The reflection is thus targeted at the patient's situation and at the attitude which the care provider thinks he should assume in his provision of help (remedying, rehabilitating or replacing).

Financing can be provided as a function of these objectives: during the period until evaluation of the objective, a budget or fixed sum can be allocated to the nurse or institution. The nurse therefore has no interest in providing a service every day, but will tend to encourage the patient to care for him/herself as much as possible so that, after some time, the nurse can restrict his/her intervention to a minimum.

Emphasising the capacities and competences of the patient requires some thinking ahead to the period during which the nurse will attempt to eliminate the existing deficit. The progress of the disorder/illness/loss, together with the period required for rehabilitation and recovery then becomes one episode. For example, the occurrence of a stroke plus the period required for rehabilitation and to re-acquire maximum independence.

This method therefore advocates an episode-based approach to care: this implies on the one hand a pro-active attitude to the commencement

of a care episode and, on the other hand, budget financing of the care episode.

### 4. Not able, not wanting to, not doing

The deficit model meets with questions about the distinction between not being able to (because of amputation), not (being able to) wanting to (because of depression) and not doing (because the nurse is coming anyway and can do it much better). The competence model will attempt to remunerate the nurse in such a way that an incentive exists to encourage the patient from the above example to wash him/herself, possibly after associated depression has been observed and treated.

What is being measured? What the patient does (performance) or what the care provider making the assessment assumes that the patient can still do (capacity)?

An establishment of performance is advocated: what a patient usually does, performs. The assessment should therefore not be made at one point in time, but over a longer period of time. It is therefore not advisable to subject an elderly person to a final assessment within the first few days of admission to an institution.

How should/can a scale/procedure prevent the reverse?

## II. If a scale is chosen

### 5. Scale and/or procedure?

A **scale** always implies that at least one item is used with two or more possible answer categories.
Only one answer can be chosen for each item. The answers per item are to be aggregated using fixed rules (addition, computer algorithm, etc.) into a global scale result. The global scale result is therefore an established fact, given the individual item answers.

A **procedure** is a formal method which uses a group of people to reach a decision. The method is thus known but the existing arrangements in this respect allow for a certain amount of freedom in decision-making. An exam deliberation is the prime example of a formal consultation procedure for making decisions. Scales may or may not therefore play a role in a procedure.

A procedure is indicated when the problem identified is so complex that a scale is insufficient. This complexity is the result of the possible contents of the scale items and of the processing algorithm into an aggregated score. An "exact" scale score, even if achieved in the most complicated way and with a reliable and valid scale, is always just an approximation of reality and therefore a vague indicator.

A consultation procedure, such as the Luxembourg "Evaluation and Orientation Cell" is a very difficult procedure for making a highly accurate decision for individual patients, for example about the number of minutes of care per week.

Do we want to make the allocation of financing dependent on the score on one scale (as is now the case) or on an assessment based on a multi-stage application of one or more scales or components of scales, which is called a "procedure"?

Do we want to work with scores from a limited number of "classical" indicators (of the KATZ and AGGIR types, etc.) or with a broader and more global inventory of problems (MDS/RAI, Pathos types, etc.), which leads to a care plan which is translated in one way or another into associated costs (cf. some US states, Luxembourg)?

The question can be asked as to whether it is in fact possible, based on one scale as is currently the case with the Katz scale, to assess the highly diverse complexity of care situations and, in addition, to make financing dependent on them.

We can imagine that limited financing requires a less extensive evaluation than extensive financing. For example, financing daily personal care requires less assessment than placement in an institution.

An instrument/procedure has two objectives: intended to plan the care (MDS/RAI, Aggir); intended to determine financing (Katz type, such as in Belgium); or a combination of both: financing and planning.

We choose the last option: planning and financing.

## 6. How are the vision and possibilities of the patient and his care environment taken into account?

The care situation and care needs are closely dependent on the socio-economic possibilities of the patient and on the strength in the broad sense of the volunteer care. Do we have to take these elements into account? How can we do this? What level of participation from the

patient/volunteer care can be envisaged? What responsibility can be given to the patient or his environment?

To put it negatively: through the use of the deficit model, the care providers (institutions, nurses, general practitioners, family and elderly services) will be under pressure from the patient and the care environment to certify a deficit because of the associated financial advantages. To put it positively: with application of the competence model, the patient/care environment would be encouraged to work in a way to achieve maximum rehabilitation and promote autonomy.

## III. If a team is chosen

### 7. External versus internal? Experts versus carers?

Within the context of a more complex procedure, at some point team consultation and a team decision can become necessary, preferably underpinned by registration of existing problems/possibilities. Should this team consist of an external group of evaluators (as in Luxembourg), of the care providers in question (as in many US states, based on the MDS/RAI) or of a combination of both?

In the Belgian system, the care providers themselves draw up the assessment of care needs/dependency and are subsequently monitored on this basis. An argument in favour of this can be that the ones who actually implement the care are also best at estimating the need for it. An argument against is that this can lead to a conflict of interest, both in home nursing and in the residential sector if financial consequences are attached to this evaluation.

The option is to do the assessment as a team, where patient carers, the patient him/herself or his/her personal representative and representatives of the financiers consult and make decisions jointly (cf. also below).

### 8. Retrospective monitoring versus consensus decision?

In this context, do we want a proposal from one or more care providers, monitored by an external inspector (such as the advising nurse or physician does now) or do we want a consensus decision by a group consisting of carers, patient representatives, plus an external representative of the financiers? If we choose retrospective monitoring, what information can/should be made available to the inspection body and at what point in the procedure/inspection? If we choose a consensus, should this

be reached in a meeting, by telephone consultation, e-mail consultation or a combination? Is remuneration envisaged for the team consultation?

Our proposal is to grant the representatives of the financiers systematic access to the consultation. They can choose whether to make use of this possibility. In addition, quality should be ensured through inspection, of the audit type, in the presence of representatives of the inspection bodies, preferably at inter-mutualist level. Inspection must be carried out with, not against, the personnel. The audit should consider quality parameters. Within certain basic standards, carers must be allowed the wisdom to deploy resources as they deem the most appropriate. In other words, a rigid system must evolve into a system with quality control and promotion. Within the context of quality control, use must be made of indicators to identify problems.

Curbing fraud will be dependent on the quality of the inspection and the nature/scope of the sanction. After all, inspection can only be efficient if a potentially strict sanction is attached to it.

### 9. Team at the beginning, middle or end of the care process?

A team meeting/decision requires much input in terms of people and resources.

At the beginning of the care process, a team makes it possible to adjust the care within the context of the competence model. The output is dependent on the options chosen. At key moments, a team offers fewer adjustment possibilities if deficits have already been acquired that could have been avoided.

The ideal time for a team meeting can be defined as the time when one or more of the parties involved feels that a decision has to be taken that has or could have major consequences for: relief; organisation of the care; the living situation (e.g. whether or not to admit to a rest home); the situation of the volunteer (e.g. taking leave without pay to provide relief) or major financial expenditure over a longer period.

## IV. Relating to the level of financing

### 10. Financing per individual or aggregated per service?

Do we want care financing in institutions to be allocated per individual patient or at an aggregated level per institution, taking into account

the case mix, the profile and the supply of the relevant institution? What about home care?

Three phases can be identified:

Phase 1: The deployment of professional nursing and caring staff (nurses, carers, home care and care for the elderly, occupational therapy) for a short period (under 3 months): payment per service.

Phase 2: The deployment of nursing/caring staff fewer than 6 times per week for a period of at least three months: Katz/Aggir pay classification with financing per individual as is now the case.

Phase 3: The deployment of nursing/caring staff more than 6 times per week for a minimum of three months: a more detailed evaluation should be made within a period of six weeks.

We propose two alternatives:

1. To begin with, every patient receives an extensive, multidisciplinary evaluation, including care planning. He/she is thus allocated a certain MDS/RAI category (n=44) for a certain period, after which a re-evaluation takes place.

   Every day, the current results for all patients are aggregated and an average is calculated per institution/service. Aggregation for the institutions takes place at institution level. For home care, aggregation takes place at the level of nursing practice.

   This financing is supplemented with fixed sum financing for patients who are in the evaluation phase, with a fixed sum to finance the evaluation itself.

   It is necessary to examine how this can/must be fitted into new and existing structures (GDT; SEL) and into the legislation of the various competent authorities.

   At fixed times, the financier allocates financing, based on the average data from the last x months, for a certain period, e.g. 6 to 24 months. This can be longer for more stable institutions and for institutions which posed no problems in the past.

2. Ditto as for 1, but only for part of the financing.

   The second part of the financing comes from institution-related basic financing according to the supply of the institution: what is the supply

of carers? What patient groups (possibly according to the RUG-III categories) are accepted? Of course, indicators have to be envisaged in order to monitor this supply in reality.

This financing is also supplemented with fixed sum financing for patients in the evaluation phase and with a fixed sum to finance the evaluation itself.

The financial consequences of audits must be institution-related.

### 11. Time: monitoring care needs – at what intervals?

In developing a new procedure, it is necessary to define at what intervals the care situation has to be re-evaluated and what consequences this can have. In order to ensure continuity of qualitative residential care, the management must keep medium and longer term planning in mind.

We prefer audits to take place every six months, year or 3 years depending on the extent of discussion in the work sphere. The financier determines the duration and makes this known after every consultation.

## V. Relating to continuity/competence

### 12. Location: same instrument in the home/institution?

The borders between home care, transmural (mixed home/residential) and residential care are becoming blurred. Moreover, it is important to develop a continuum of care, based on the actual care situation, the aspirations, possibilities and ambitions of the patient and his/her environment.

Do we have to continue the use of various instruments and various procedures between the various settings (such as the current Katz fixed nursing sum and Katz residential care), where results do not overlap, or should the selected scale/procedure guarantee continuity in the evaluation of care needs, apart from the setting in which it is applied? We opt for continuity and uniformity in the instruments used.

### 13. Organisations: same instrument for different wages?

It seems essential that evaluation of a patient for a certain care period should take place only once for all potentially involved care insurers (RIZIV, Flemish care insurance, etc.), so that no contradiction

can arise in the assessment of the same patient by different organisations (or by the same organisation for different objectives). We have to bear in mind that financing for various forms of care is governed by different authorities, e.g. nursing by the federal government, home care and care for the elderly by the regions. Transparency and unanimity in legislation are a necessity. This is a plea for homogeneous competence packages.

## VI. Relating to processes of change

**14. A change** is to be regarded and supervised as a process. Every time a change takes place, it can be expected that those involved will be uneasy about the repercussions for their own situation. Changes should be introduced gradually in every respect, with ample possibilities for adjustment during the transition period. We can envisage a trial phase for several years, during which financing initially takes place according to the old system, while the registrations and scoring for the new system are already compulsory (and can also be locally useful with a view to care planning) and simulations are created and communicated annually concerning the financial consequences of the new system for the various parties involved.

**15. A new system** should not be a means of economising, but of achieving a better distribution of available resources. In order to facilitate a consideration of content, it seems essential to agree early and officially that, during the transition period, no economising will take place and that the overall available mass remains constant or a previously arranged evolution will ensue.

If economising is unavoidable, this is best implemented before a new evaluation system becomes imperative.

## Acknowledgment

This work has been funded by RIZIV/INAMI 'Studie dementie/Etude de démence UB/1240'

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