

The evolution of the organization of homecare in Flanders, Wallonia and Brussels

by

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Abstract

Home care is defined as a health care provision aimed to keep patients at home, which is the place where the patient really lives. Key disciplines involved are informal care, general practice, nursing care, home help and social work in conjunction with Networks, service organizations and institutional care. In Flanders the coordination of home care is performed by 'Samenwerkingsinitiatieven in de Thuiszorg' while in Wallonia it is done by 'Centres de Coordination de Soins et Services a Domicile (CSSD)'. Identified problems are the coordination of care, multidisciplinary and the very complex Belgian legislation. The future will show if the new services will solve the identified problems.

Keywords: Home care services

Introduction

Home care¹ is defined as a health care provision aimed to keep patients at home, which is the place where the patient really lives. The aim is to contribute to the maintenance, the support and the recovery of

¹ Meshterms enclose 'Home care services' and 'home care nursing' but not 'Home Care'.

self-care and the care for carers by offering patient-adapted care. Therefore curative, preventive, palliative and social services can be provided and developed. Home care, as far as delivered by professionals, can consist of three elements (1): technical/technological care, physical and nursing (it is home care in the narrow sense) and treatment aimed at stabilizing and prevention of function loss and stabilizing social participation.

In this contribution we aim to describe the evolution of the organization of home care in Belgium in general and its evolution through the past decades. Detailed information can be found elsewhere (2-6). Recent laws and rules will cause important changes in the organization and functioning of home care in Belgium.

Who is involved?

The key disciplines that are generally involved are informal care, general practice, nursing care, home help and social work. Social care is delivered by the municipalities (OCMW/CPAS), the sickfunds and the centres for social work (Centra Algemeen Welzijn/CAW). Informal care by family members, neighbours and friends is of growing importance (4). Complex care situations require the input of disciplines such as occupational therapists, physiotherapists, pharmacists, speech therapists, services for meals on wheels, dentistry, hospital emergency department, and home health aides. New Belgian criteria for nurse assistants (zorgkundige/aide soignant) have been published (Belgisch Staatsblad (BS)/Moniteur Belge (MB) 1 sept 2001). Psychological help can be delivered by independent psychologists or by centres for mental health, recognized and financed by the regional governments. Some of these disciplines are organized as private practices (General practice), organizations (home help) or both (nursing care, pharmacists).

Networks and service organizations also are involved: palliative care networks and centres of expertise for dementia (www.dementia.be). Experiments are going on concerning specific care situations like psychiatric home care (7;8) and at home renal dialysis.

Home care pivots with institutional care for the most dependent patients. Residential care consists of home for the elderly and nursing homes, the latter taking care for the most dependent elderly. Most institutions in Belgium are mixed. In some cases a day care centre, short stay wards and service flats are organized. Nursing homes are obliged to have a collaboration with a hospital department for acute geriatric

care (G-service). For psychiatric patients psychiatric nursing homes and projects for sheltered housing are developed last years.

The history of home care during the last decades

Home care nursing is of all times (9). After World War II in the USA and later in Europe health care developed around technically specialized hospitals, hierarchically superior to all other health care services, also called the Flexner model (10). The health care system was legitimated by technical supremacy and hospitalization of acute patients.

But from the seventies changes occurred. Populations in Western Europe got older, there was a growing demand for humanization of medicine and the World Health Organization published the Alma Ata Declaration (11). One of the advices was that health care provision should become multidisciplinary and integrative and that a new balance should be achieved between professional care and lay responsibility. In Flanders a formal group of practitioners, members of the sickfunds and the government, put forward the principles of home care (12). In Flanders the organization of local GP groups UHAK, stressed the importance of professional, juridical and financial independence of GPs in home care teams (13). UHAK designed statutes for home care organizations (14). Within UHAK it was stressed that the GP should function at the centre of the team with good and loyal cooperation with specialists and other team members (15). VELO (Vlaams Eerstelijnsverleg), a multidisciplinary group nowadays tries to streamline the discussions concerning home care and its evolutions. The Flemish and Walloon communities have issued a first decree concerning the recognition and subsidy of services for the elderly, in 1985 and 1984 respectively.

1. In Flanders home care was regulated by two decrees: one dated 21/12/90 changed by one dd 07/04/98 that changed an earlier decree of 1983. Teams for home nursing and initiatives for home care (Samenwerkings Initiatieven Thuiszorg (SIT's)) were established per region. The latter has two main tasks: being a forum for consultation and cooperation and, by means of a coordinator, manage the care planning for patients. The plan for care or care plan therefore is an essential instrument. Three care plans for 1000 inhabitants can be registered. The financial support therefore is € 0.33 per inhabitant. In a region e.g. of 100,000 people 300 care plans can be managed. The subsidy is € 33,000 or € 110 for each care plan. If more care plans are managed, the amount per plan is even lower. The so called SITs are organizations at a local level where every discipline can participate.

A problem for the SITs is the cooperation with new structures like LOGO'S (network for prevention) and palliative care networks, that have a different regional responsibility (16). GPs and nurses can be chosen by the patient. Nurses are either independent either working in bigger services. These services tended to have close relations with sickfunds of the same ideological group, but last years these strings are less strong than before. The same is true for the home help organizations. Local services-centres (1/15000 inhabitants) exist ('Dienstencentrum')(BS 1992 08 20). They offer personal care, home help, technical support (alarmsystems), meals on wheels, networking and helping aids for mobility. Most of the local centres are developed by the local authorities (OCMW/CPAS). At the level of sickfunds regional service centres (also called 'thuiszorgcoördinatie centra) exist (1/100.000 inhabitants). Some of these elements are ruled by the decree for the elderly (Bejaardendecreet). New Flemish laws are also operational: 'Decreet zorgregio's' (BS/MB2003 06 02), 'Decreet Thuiszorg' (BS/MB 1998 09 05) and 'Kwaliteitsdecreet' (BS/MB 2003 11 10). The Flemish government approved a proposal concerning the organization of the basis healthcare and welfare services (Decreet Eerstelijnszorg en Samenwerking tussen zorgaanbieders, February 2004) which has been approved by the Flemish parliament. All these laws aim a better coordination between services.

2. Homecare in Wallonia is regulated by consecutive decrees. A cornerstone was the 'Picque' decree (BS/MB 4 8 1989). It regulates the development and functioning of coordination centers for home care called 'Centres de Coordination de Soins et Services à Domicile (CSSD)' or 'centres agréées'. The goal is to provide exclusive and coordinated home care and services. The coordination has to be done within three groups:

1. social service, nursing care and home help care
2. at least four disciplines out of nine (physiotherapy, occupational therapy, meals on wheels etc..)
3. general practitioners

The coordination centre keeps a 'coordination file'. Communication between the different providers is compulsory. The centers are financed by the local government. Depending on the real coordination tasks, the covered population, type of coordination and the number of interventions.

Three different groups developed recent years:

- the Catholic group (ASD=Aide et Soins à Domicile)

- the socialistic group (CSD= Centre de Services à Domicile)
- a multidisciplinary group working in the big urban areas (ACCOORD= Association de coordinateurs de soins et services à domicile situées en communauté française de Belgique). These groups were initiated by primary care workers long before the Picqué Decree. In certain regions more than twenty concertation groups exist.

The two first groups are employers and also called “intern co-ordinations” because they employ nurses, house helpers and sometimes, physiotherapists or language therapists. They also provide help advices, and sometimes meals at home. The last one, also called “external co-ordinations” organises collaboration between independent practitioners (G.P., nurses, farmacologists and physiotherapists) and other house helpers’ organisations.

Because of the financing system, these groups are in competition. General practitioners often are the coordinators of ACCOORD while the coordinators of “intern co-ordinations” are employees (social nurses or social helper). Therefore, the collaboration between independent practitioners and “intern co ordination” is difficult.

Nurses and home help work an integrated way within these groups. Within one region these three groups can be in function.

In 1998 in total 53 centers were approved. Half of them belong to the Accoord groep, the others to the ASD and CSD group.

The functioning and financing of these groups was refined by a new decree dating from 4.3 99 (BS/MB 18.6.99 2nd edition). Besides logistic support and rules concerning the staff, it rules the ways of cooperation, communication and arrangements between the different members. Twice a month a team is organized. The GP also is invited. The Decree supports three categories of coordination centres, depending on the number of handled files and availability of staff.

3. Home care in Brussels is very complex since federal, Flemish and Walloon rules are applicable. Flemish professionals feel difficulties caused by municipalities being adhered to Walloon regulations. This causes a weak support for SITs. Dutch speaking partners are assembled in BOT (Brussels Thuis Overleg). The french speaking municipalities work together with six coordination centres belonging to CSD, ASD and ACCOORD).

There are marked differences between the Flemish and the Walloon system of home care (10). In Flanders the cooperation between services

is the focus of organization, done at the level of the SIT. It has to be remembered that different umbrella organizations² are working at the same geographic area and have a political or ideological orientation. In one municipality therefore a lot of organizations operate in home care. In a lot of communities and cities the community social service (OCMW/CPAS) plays a role in the coordination and delivery of care. In Wallonia the coordination between disciplines is organized more within each umbrella organization, with one phonenumber etc., at the level of the CSSD. In one municipality therefore only a few organizations operate. A major problem is that not everywhere in Flanders a SIT exists as not everywhere in Wallonia a CSDS operates. The OCMW/CPAS play hardly a role.

Let's try to describe home care from the point of view of patients and GPs. In Flanders the patient has a free choice of whatever service he/she wants. For different patients the GP needs a cooperation with different umbrella organizations, independent nurses etc.. To overcome this, the coordination by a SIT is needed, causing major problems in municipalities lacking a SIT organization. The advantage for patients and GPs is the freedom of choice, the disadvantage for both is the chaos in the coordination of all these services. In Wallonia the patient just contacts one CSSD to get all services needed, except the GP service. A GP in Wallonia can work either with an "external coordination" or an "internal coordination". Freedom of choice for the patient is guaranteed. However, when the patient chooses an "intern coordination", that freedom of choice is quite limited.

In Wallonia the reverse situation exists compared to Flanders: the disadvantage is the limitation of freedom of choice but the advantage is a better coordination. From a public health point of view it has to be marked that in every municipality or geographic area, even in Wallonia, still a remarkably high number of organizations and services operate in a very competitive way. An illustration is the fact that in Flanders nine different services can be involved in the coordination of care for dementia patients (17). The question whether or not a religious and political split (*verzuiling*) still exist is complex. In Flanders there is no split in the sense everyone has the freedom to choose his own services and care

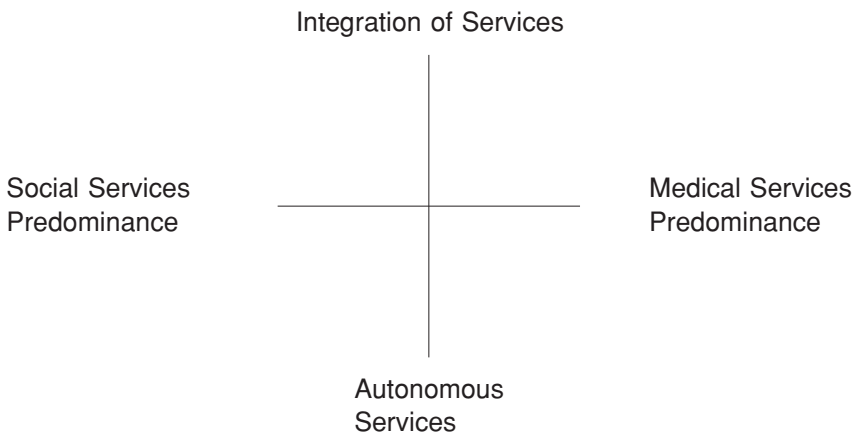
² In Belgium six sick funds are historically organized by political or religious inspiration: liberal, catholic, socialist, neutral, and free. Each sick fund has privileged relationships with nursing organizations, social services and home help organisations. This cluster is named in this text as 'umbrella organization'. This phenomenon is called '*verzuiling*' 'compartmentage' or religious and political split. For a certain geographic area, different umbrella organizations work competitive.

providers. A split still remains in the sense that every umbrella organization still operates at the same time at the same place in a competitive way. In Wallonia patient usually calls for services to organization from his own sick fund. However, this must be moderated in the facts. Independent nurses have the same number of patients as those working for intern coordinators. ASD-organisations exist for a longer time than than CSD and patients assured by the socialist sick fund can also call for help to ASD and vice versa.

What we described is in fact an oversimplification. First, we did not include all possible services and health care providers as described above. We limited the description to nursing care, social service, home help services and general practice. Secondly, in reality in all regions the organization of home care can be described as proposed by Meulemans (figure 1): a combination of two axes: one on the level of integration of services versus autonomy of services crossing an axis with a predominance of social versus medical (predominant) services. Thirdly, also in Flanders projects are going on aiming to coordinate better within an umbrella organization with sharing of logistic services (secretary, unique phone number). However it is not general; partly caused by lack of adapted financial incentives.

The field of home care is in full evolution. The new legislation will cause new situations which will be observed. Therefore this description has to be updated later on.

Fig. 1: A framework for the organization of home care by two axes (Meulemans H, 1990)



Identified Problems

Different authors tried to describe home care organization in Belgium(3;4;10;18). This is, contrary to some other countries, very complex and difficult for several reasons.

- At the level of the responsible administrations, no coordinated data exist. This is due to the very complex rules and financing procedures, involving nearly ten different administrations.
- Both federal and regional authorities are authorized at the same moment for the same area.
- Different disciplines, mostly acting for the same patient, are reimbursed or financed in a total different way. In most cases physicians and nurses are paid by a fee for service, reimbursed by the National Sickness and Disability Insurance (RIZIV/INAMI). The home help services instead are financed by the regional government (Flanders, Wallonia, Brussels Capital Region). Within one discipline, some actors are independent while others are employed. In the last case the organization they work fore is payed by a fee for service.
- For independent actors like general practitioners, pharmacists and a lot of nurses, only their total number is known. No figures are available about e.g. the number of hours a week they work. Therefore is it difficult to estimate what the workload and costs of these facilities are.
- In Flanders legislation on a new obligatory insurance recently was applicable: The “Vlaamse Zorgverzekering” (Flemish care insurance). This obligatory insurance for every citizen older than 25 years, partially reimburses some non-medical costs for people cared for at home. This service doesn’t exist in other parts of the country.
- Historically different trends developed in the northern, Dutch speaking part (Flanders) of the country and the southern, French speaking part (Wallonia).
For example the southern part has more institutions for the elderly. However they are smaller scaled and managed more by private contractors than in the North of the country.
- Structurally medical and paramedical services are organized and financed differently compared to social services. This hampers a good communication and coordination of care (19;20). Besides both sections handle different norms for quality of care. Therefore it is nearly impossible for practitioners and services to be in rule with both.

Several reports identified important problems. Meulemans and collaborators already in 1990 mentioned major problems concerning

coordination of care at the patients level (10). Functional integration will only be possible when the autonomous organizations are prepared to be complementary instead of concurrential. Essential instruments therefore are a coordinator (case manager), care plans, good instruments to quantify the need for care. Occupational therapists also need to be integrated.

According to De Maeseneer et alii, the conclusions are tending in the same direction (19). Case management started in the hospital has a positive impact on a successful home care process. The use of a care plan, multidisciplinary and support of the caregivers are essential instruments. They play for an independent, locally active case-manager. Coordination of care is needed and the SITs must be professionalized (20). The Qualidem group concluded that there is a major lack of coordination and continuity of care(21). Instruments used are deficient and the organization of care is cutted into bits (21). It is important to remind that the problems of coordination and lack of comprehensive care are a problem in other countries like Italy, Canada and Israël (22-27). It is striking however, that over a period of almost 15 years the same problems are detected without significant change or improvement.

The Future

In July 2002 a new structure is installed by the federal government (KB/AR dd 8 7 2002). It concerns the installation of Integrated Home Care Services (Geïntegreerde Diensten Thuiszorg (GDT)/Service Intégré de Soins à Domicile(SISD)). This structure coordinates all disciplines involved in the care for patients for a described geographical area. It stimulates multidisciplinary, complementary action instead of the development of concurrency, follow up of care plans and the use and implementation of instruments to asses the need for care. This has to be done in accordance with the structures already present and described earlier. Financial incentives were developed for multidisciplinary teams and meetings and the administrative handling of the follow up of the patient and his/her care plan. The federal government finances the GDT/SISD that are recognized by Flanders, Wallonia and Brussels.

The strengths of this new system are that by doing so the Belgian government overcomes the most important elements that are described earlier in this paper: lack of coordination and professionalization, the need for cooperation instead of competition. With respect of regulations in the Flanders and Wallonia, this system tries to get the best outcome with existing structures.

Possible problems can arise since Flanders has a small advantage in these regions where a SIT already functions. It is yet not clear whether these new structures will be able to generate good case managers. It is not clear too, what are the benefices that Walloon organization can take from this new system. Some practitioners argue that the regional organization fits remarkably well with areas the classical organizations operate while it ignores the Accoord group (28).

The major opportunity is to create strong networks of cooperating services without creating new ones.

The future of this system will largely depend on the flexibility of existing services and providers to cope with a situation where they lose some autonomy but can gain efficiency and a better outcome for their patients and clients.

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