How do Belgian hospitals make the transition to a new organization model?

Dr. Marc Geboers, Zorgnet Icuro
Zorgnet Icuro

- Flemish organisation representing care organisations
- Elderly care, mental health care, general hospitals
- 798 organisations
- 64 general hospitals (including all university hospitals (4))
- Staff taking care of hospitals: 10 persons (legal, financial, medical, IT)
Belgium

30,582 km²
11,409,077 inhabitants (2016)
Small country with a complex structure
Distribution of hospitals in Flanders

Legende
- campus ziekenhuis
opnameratio alle leeftijden gemiddelde 2009-2011
natural breaks (Jenks)
- 125.32 >= 148.25
- 148.25 >= 164.00
- 164.00 >= 180.92
- 180.92 >= 203.80
- 203.80 >= 238.31
Focus on CARE in Local care networks

Focus on Specialised Care in CLINICAL networks

Terminologie SAR = Zorg en Ondersteuning (Z & O)
Local care networks

- Target population
- Integrated care
- Defined region (proximity)
Clinical networks
Networking

1. Purpose
2. Tools
3. Networking
4. Programming “new style”
5. Locoregional clinical network
1. Purpose

**Care offer:** scientifically based
- according to demand
- quality
- accessible
- cost efficiency

**Care need:** expected evolution in
- demographics and pathology
- diagnostic and therapeutic tools
- medical technology

*Freedom of choice*
- patient
- care giver
2. Tools to adjust offer and need

A. Clinical network of hospitals
   - Each hospital has to participate in one clinical network of hospitals (including university hospitals)
   - 25 networks in Belgium – 400,000 to 500,000 patients in each network
   - Basic care available in each clinical network (each hospital?)
   - Development of supraregional functions not available in each clinical network

With:
   - Mutual agreement between hospitals on division of tasks
   - Concentrating functions
   - Referral of patients and continuity of care must be guaranteed
B. Federal programming
- Locoregional clinical network of hospitals
- Loco- and supraregional functions

C. Financing system
- BFM (budget of financial means):
- incentives to stimulate networking & eliminate obstacles
3. Networks

A. Locoregional vs. supraregional Functions

FUNCTION =
generic term referring to activities, equipment, medical-technical services, hospital departments, care programs,…

Locoregional function:
Function available in each locoregional network (not necessarily in each hospital)

Criteria:
- frequent care
- proximity is important
- urgent (at least until stabilisation of patient)
- less specialised expertise & less multidisciplinary teams
- no expensive infrastructure
- lower need for continuity
Supraregional functions:

These functions will be taken care of by a hospital called the “point of reference” (not available in every clinical network)
- Less than 25 in Belgium
- Less than 1 per 400 à 500.000 patients

Criteria:
- lower incidence
- very specialised expertise and multidisciplinar team
- expensive infrastructure
- higher need of continuity
B. Network of hospitals

1. *Locoregional clinical network*

   - Durable partnership
   - Each hospital (incl. university) is part of one and only one network (at least 2 hospitals per network)
   - One network covers an area of 400 à 500,000 patients (according to the real patient flow) -> 25 networks in Belgium (14 in Flanders)
   - Geographical continuity
   - Partial geographic overlap between areas is possible, eg. in metropolitan areas
2. Supraregional network

- Locoregional network chooses a point of reference, per supraregional function (maximum 2)

- Choice of point of reference in the interest of the patient
  - Quality
  - Geographical proximity (important in case of frequent care)
  - BUT: freedom of choice patient/care giver

- Agreement (eg. associations) between the locoregional network and the point of reference (advice to keep the amount of hospitals of reference per network as low as possible)
C. Governance of the network of hospitals

1. **Locoregional clinical network of hospitals**

   - Must be introduced in law
   - Juridical entity
   - Responsibilities given to the locoregional clinical network
     - All decisions taken at the level of the network have to be approved by the individual hospitals; responsibilities that are not allocated at the level of the network remain on the level of the hospital
   - Guarantee of a complete set of functions to the population
   - Agreements with the specialists
     - No obstacle for the network
     - No wrong incentives
     - Finally: common agreements for all functions of the network concerning financial, general en medical agreements
CMO in the network
- Responsible for a coherent medical strategy concerning the functions at the level of the network which have an impact on the individual hospitals
- Role of CMO is taken by existing CMO in one of the hospitals, by a new introduced CMO or a college of CMO’s
- CMO must coordinate the CMO’s of the individual hospitals
- Involved in the management of the network (CLINICAL network)

Specialists
- More responsibility
- More involved in management and operational steering of the network and the hospitals
4. Programmation “NEW STYLE”

Tool to make meet offer and need with the intention to have an efficient distribution of means: PROGRAMMATION

- **TRANSPARENT**
  - Process
  - Multiannual planning

- **SCIENTIFIC**
  - Studies
  - KCE
  - International examples

- **EVOLUTIVE**
  Regular evaluation -> integrating of evolutions in care, demography, needs of patient

- **PROACTIVE**
  In case of new technology, eg. via horizon scanning
Issues in programmation

• List of approximately 120 functions is defined

• Distribution in loco- or supraregional?

• Major discussion whether basic functions should be available in each hospital

• Global vision vs. decision per function

• Source of scientific evidence to decide
Current shortlist of priorities:

- Maternity
- Pediatrics
- ER
- Stroke (S2)
- Radiotherapy
- Low volume surgery oncology
5. Locoregional networks

Situation in Flanders:

Situation in Brussels and Wallonie is less well described
Strengths

- Hospitals leave (partially) competitive attitude
- Looking into opportunities on organising clinical work
- Looking into opportunities on logistics and supporting services
- All levels of stakeholders are talking with one another
- (boardmembers, executive layer, specialists, nurses,...)
Weaknesses

- It’s just a start
- Where’s the patient?
- The scope of the network is not ambitious enough
- Complexity of the country leading to different speed in implementation
- Too many uncertainties in legislation until now
- The promise of evidence based – but where exactly is the science?
Opportunities

- Good-will on the field
- At least there is moving something
- Start of a paradigm-shift
- All stakeholders are involved – mind-switch
Threats

• Stand-still due to complexity
• Focus on hospitals
• We forget it is all about the patient and care
• Scope of the government on savings without re-investment
• Lack of speed
Thank you for your attention.
Questions?

Dr. Marc Geboers
Zorgnet Icuro
Guimardstraat 1 – 1040 Brussel
+32 475/25.98.24
marc.geboers@zorgneticuro.be