Incentives from the authorities on quality improvement in Belgium

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Agenda

1. Belgian state structure
2. Quality on Flemish level
3. Quality on Federal (Belgian) level
4. What are the incentives for the hospitals?
5. Conclusion
1. Belgian state structure
1. Belgian state structure (2)

- **Federal level**
  - General hospitals/University hospitals
  - Programmation
  - Financing (Budget of Financial Means)

- **Regional level**
  - Revalidation hospitals
  - Recognition
  - Financing of infrastructure
  - Quality
2. Quality on flemish level

• History going back to 1997: “Decreet betreffende de integrale kwaliteitszorg in de verzorgingsvoorzieningen”

• Update in 2003 “Decreet betreffende de kwaliteit van de gezondheids- en welzijnsvoorzieningen”

• Basic elements: self-evaluation, quality manual, introduction of quality officer, role of the authorities, introduction of indicators (69 clinical indicators in 12 topics)
2. Quality on flemish level (2)

Update in 2012: three pillars defined

1. Accreditation – ISQUA accredited
2. Use of indicators
3. Role of authorities by use of inspection
A. Accreditation
A. Accreditation

• First hospitals started an accreditation cycle in 2010
• The Flemish authorities stated that before the end of 2017 a first cycle had to be completed (to avoid a general inspection by “Zorginspectie”)
• De facto not every hospital managed to be ready by the end of 2017 (although a wide majority got a positive accreditation result)
• Some of the early adopters already went through a second (and even third) cycle
B. Indicators
B. Indicators (2)

• Which indicators are used:
  • **Breast cancer**: diagnosis, treatment, survival and relative mortality risk (including multidisciplinary consult)
  • **Rectum cancer**: mortality post surgery, survival and relative mortality risk
  • **Patient experience**: patient friendly websites, patient experience measured by a uniform questionnaire developed by the VPP (Flemish Patient Platform)
  • **Hospital wide indicators**: re-admission, medication, hand hygiene, prevention of MRSA sepsis, patient identification, use of safe surgery checklist
C. Role of authorities

• In the past: global inspection of hospitals

• Thematic inspections
  • Internal medicine
  • Surgical medicine
  • Cardiology
  • Geriatrics
  • (Mother/child, oncology, psychiatry, dialysis)
D. How are hospitals involved

- Accreditation
  - On a voluntarily basis
  - No financial incentive from authorities
  - No global inspection by authorities
  - Recognition of hospitals unlimited

- All hospitals finally participated in an accreditation cycle
- Results had to be declared to the authorities
- What if not ready before the end of 2017?

- What in the future?
D. How are hospitals involved (2)

• Indicators
  - Supervised by a robust structure (VIP² = Flemish indicator project for patients and professionals)
  - Embedded in larger supervising structure (VIKZ = Flemish Institute for quality of care)
  - On a voluntarily basis
  - Support by authorities (4 data managers)
  - Publication of results on website [http://www.zorgkwaliteit.be](http://www.zorgkwaliteit.be)
  - Development groups hosted (mainly) by CMO’s
  - Some indicators are X-checked in the hospitals by hospital staff
D. How are hospitals involved (3)

- Inspection
  - Hospitals participate in the discussion about the reference framework
  - Obligatory for all hospitals
  - Unexpected visits by inspection team authorities
  - Results are publicly accessible

https://www.departementwvg.be/zorginspectie-inspectieverslagen-en-openbaarheid-verslagen-zorgtraject-internistische-pati%C3%ABnt
3. Quality on federal (Belgian) level

- 2007 – 2017: contract about patient safety (two periods of 5 years)

- 2018: start of Pay for Performance-program

- Minimal financial incentive:
  6 million Euro to divide over 100 hospitals
  (total budget for hospitals: 8 billion Euro)

<table>
<thead>
<tr>
<th>6,060,935 €</th>
<th>Totaal budget P4Q in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,212,187 €</td>
<td>Vast deel (20% van totaal budget-&gt; 11.884,19 €/ziekenhuis)</td>
</tr>
<tr>
<td>4,848,748 €</td>
<td>Variabel deel te verdelen over 102 ziekenhuizen, gebaseerd op de P4Q score en het aantal verantwoorde bedden</td>
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3. Quality on federal (Belgian) level (2)

- In budget of financial means are elements that (in)directly influence quality
- E.g.
  - Financing of oncological care
  - Financing of food-teams in hospital
  - Financial punishment for re-admission

- BUT: in globo this BFM is not made for specific quality amelioration
<table>
<thead>
<tr>
<th>Ziekenhuisbrede Indicatoren (55 punten)</th>
<th></th>
<th>Pathologiegebonden Indicatoren (25 punten)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structuur (35 punten)</strong></td>
<td><strong>Proces/resultaat (20 punten)</strong></td>
<td><strong>Proces (25 punten)</strong></td>
</tr>
<tr>
<td>ISQua accreditatie status op 1 maart 2018 (25 punten)</td>
<td>Patienterevaringen (20 punten)</td>
<td>Indicator antibioticum-profylaxis bij chirurgische interventies (10 punten)</td>
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<tr>
<td>Deelname aan niet-verplichte en kwaliteitsverhogende klinische registraties en/of verwerven van bepaalde kwaliteitslabels (5 punten)</td>
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<td>Implementatie van een patiënt securitymanagementsysteem: % notificatie van incidenten die correct gecodeerd worden doorgestuurd (5 punten)</td>
<td></td>
<td>Indicator (borst)kanker (15 punten)</td>
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</table>
3. Quality on federal (Belgian) level (3)

• Further challenges:
  • Updating yearly of the used indicators (e.g. introduction of head and neck oncology indicators in 2019)
  • How to deal with achievement vs. improvement
  • Closed budget: redistribution of limited resources
  • Where to find extra financial means to support this system
  • Do we have the best indicators to influence quality (in a desired direction)
4. What are the incentives for the hospitals

- Surely NOT financial (Flemish: no financing, Federal: less than 0,1 % of Budget of Financial Means)
- But: hospitals don’t want to lose a single euro!

- Transparency of results (Website, Open government policy)
- Benchmarking (internal competition between hospitals)
- Belief in quality improvement
5. Conclusion

- Quality (improvement) has been acquired as a concept
- The means to improve are also acquired
- Although the importance is recognized by everyone (authorities, hospitals, physicians), little investment is made by the authorities
- The major driving force is competition and public disclosure

- Perhaps whatever force is driving improvement of quality, the most important thing is that we improve!
Quality is everyone’s responsibility.

W. Edwards Deming

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