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The 2016 proposal for the reorganisation of urgent care provision in Belgium: A political struggle to co-locate primary care providers and emergency departments☆,☆☆

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ABSTRACT

Internationally the number of emergency department (ED) visits is on the rise while evidence suggests that a substantial proportion of these patients do not require emergency care but primary care. This paper presents the Belgian 2016 proposal for the reorganisation of urgent care provision and places it into its political context. The proposal focused on redesigning patient flow aiming to reduce inappropriate ED visits by improving guidance of patients through the system. Initially policymakers envisaged, as cornerstone of the reform, to roll-out as standard model the co-location of primary care centres and EDs. Yet, this was substantially toned down in the final policy decisions mainly because GPs strongly opposed this model (because of increased workload and loss of autonomy, hospital-centrism, etc.). In fact, the final compromise assures a great degree of autonomy for GPs in organising out-of-hours care. Therefore, improvements will depend on future developments in the field and continuous monitoring of (un-)intended effects is certainly indicated. This policy process makes clear how important it is to involve all relevant stakeholders as early as possible in the development of a reform proposal to take into account their concerns, to illustrate the benefits of the reform and ultimately to gain buy-in for the reform.

1. Introduction

In Belgium, as in most OECD-countries, the number of emergency department (ED) visits has continued to increase over recent years [1]. While the reasons for this increase are multifaceted, including both demand and supply side factors [1], a considerable proportion of patients at EDs are thought not to require emergency care and could potentially be treated by primary care providers [1,2]. Although there is no internationally accepted definition for these so-called 'inappropriate ED visits', numerous studies have reported the proportion of these visits to vary between 20% and 40% [3].

Belgian estimates for inappropriate ED visits are even higher, with reported proportions ranging from 40% to 56%

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Box 1: Belgian macro-level governance of the healthcare budget.

The National Institute for Health and Disability Insurance (NIHDI) is responsible for the reimbursement of healthcare services and products. The NIHDI is composed of five departments, of which the healthcare department is responsible for the management of compulsory health insurance. The department is headed by the General Council and the Insurance Committee. In the General Council, representatives of the government and the sickness funds but also of employers, salaried employees and self-employed workers decide on general policy matters concerning health insurance and its budget. Within the healthcare department, various commissions composed of representatives of the sickness funds and providers negotiate on fees. For example, the National Commission of Sickness Funds and Providers, the so-called 'Medico-Mut', negotiates on physician fees. The negotiated fee or 'convention tariff' is settled in agreements (for physicians and dentists) and conventions (for other healthcare providers). The Medico-Mut is composed of an equal number of representatives of sickness funds and provider organisations. While the Medico-Mut was initially installed to negotiate the fee schedule (the nomenclature), it has – by lack of an alternative – progressively become the main locus of decision-making for a broad range of issues, including the organisational set-up of emergency care provision [9].

[4,5]. In addition, a high proportion of patients in Belgium visit the ED without a referral from a general practitioner (GP) or an ambulance (71% 'self-referrals') and only 23% of ED visits result in a hospital admission. These numbers indicate that a shift in health care provision from the ED to primary care might be desirable in Belgium as it could potentially reduce costs and improve appropriateness of care.

Several countries, including England [6], France [7], and Germany [8], are currently reviewing and reforming their urgent and emergency care systems, aiming (amongst others) to reduce the number of 'inappropriate' emergency visits. In this context, a 2016 reform proposal from Belgium is interesting because it has suggested to systematically introduce primary care providers co-located at hospital EDs.

This paper presents the Belgian proposal and places it into the context of previous attempts at curbing the growth in ED visits and the political context in Belgium. In addition, it describes the opposition to the proposal from stakeholders and the political processes that ultimately led to a compromise, which accepted the co-location of primary care providers at EDs only as one of various options for the organisation of urgent and emergency care. This political process can be understood only against the background of macro-level governance arrangements in the Belgian healthcare system, which give considerable negotiating power to the main stakeholders (insurers and providers) in determining the structures of the system (see text Box 1).

2. Problem context: previous reform measures were unable to curb the growth of ED visits

Since the beginning of the 2000s, Belgian policy makers have initiated three main reform measures in the field of urgent and emergency care (see Fig. 1). First, in 2003, a higher co-payment for self-referrals was introduced, which was intended to incentivize patients to visit their GP instead of the ED. As a result, patients who visited the ED in 2015 without a referral from their GP had to pay €20.21 instead of €4.50 when referred by their GP. However, the increased co-payments could not turn the tide of high self-referral rates and increasing ED use, as is evidenced by the continuous growth in ED use in Belgium, which is amongst the highest in OECD countries [1]. In addition, co-payments are hardly known to patients and do not seem to be important in patient choice of provider [10]. Furthermore, there is no legal obligation for hospitals to charge the co-payment.

Second, and also in 2003, Belgian authorities, i.e. the National Institute for Health and Disability Insurance (NIHDI) started to provide financial support to GP circles who would organise their on-call duties in 'out-of-hours GP posts'. Within a GP circle (n = 147 in 2014), local GPs work in collaboration to reach an agreement about the organisation of out-of-hours shifts for a specific geographic area. Funding for GP circles is mainly based on the number of inhabitants in the GP area where the circle operates [11]. GP circles can apply for additional funding to organise their on-call system in well-equipped GP posts (e.g. with secretary, car and driver for home visits) rather than via a local rotation system. In 2015, the NIHDI supported 70 GP posts covering 68% of the Belgian population with a total amount of €16 984 292. However, while the creation of GP posts may have contributed to improving working conditions of GPs (e.g. by reducing the number of nights and total time on duty during out-of-hours periods), their role in promoting the use of urgent primary care instead of EDs remains a matter of debate. The existence of out-of-hours GP posts is not well known to the general public and opening hours of GP posts are variable. By contrast, EDs are available 24/7 and they are more easily accessible because there are 139 EDs in the country but only 70 GP posts [12]. Furthermore, GP posts seem to attract another patient population than EDs (e.g. patients who want to avoid taking time off from work) [13,14].

Third, in 2008, a new telephone number (1733) was introduced to complement the European 112 emergency call number with the ultimate aim of guiding patients with primary care problems to primary care instead of the ED. In a first phase, the number 1733 has been implemented as an automatic connection to the GP on call. In a second phase (from 2016 onwards), the number will be tested as a telephone triage system in pilot regions. Depending on the results of a scheduled evaluation with regard to safety and impact on ED workloads, the phone number might be implemented nationwide. This evaluation is particularly important as there is a lack of international evidence about the effect of prehospital telephone triage systems on ED use [15].

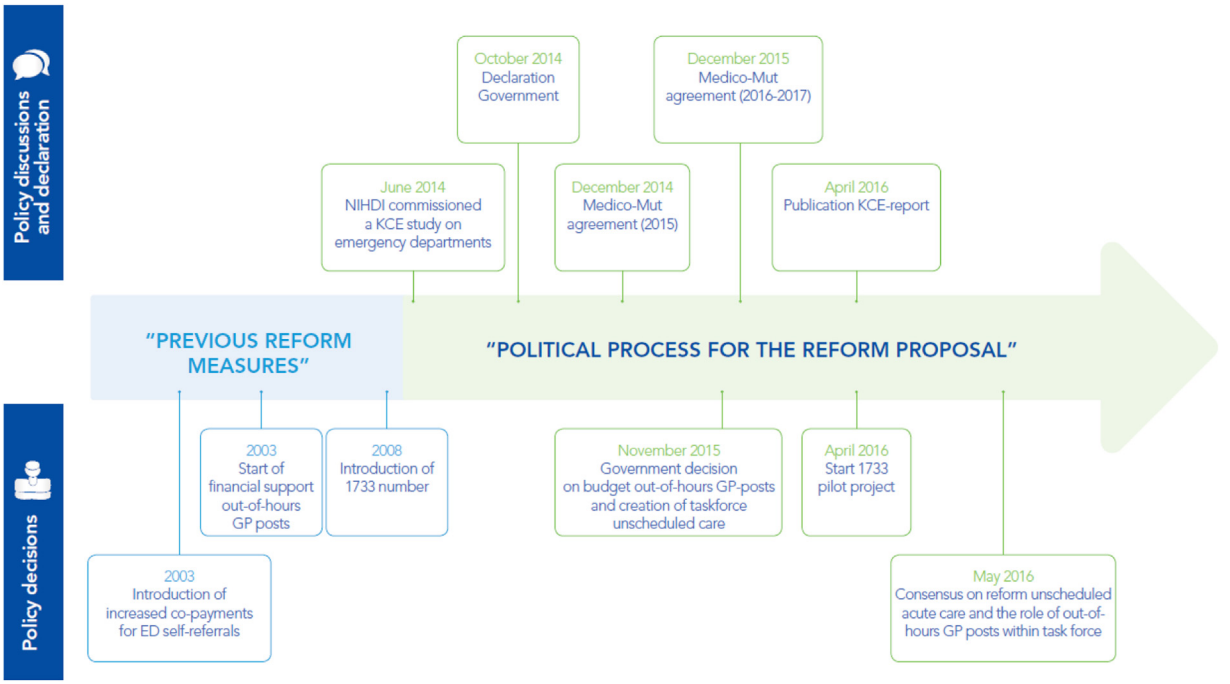

Fig. 1. Timeline policy process and discussions about urgent and emergency care.

3. Political context: harmonizing urgent care provision between out-of-hours GP posts and EDs rises to the agenda

Between 2014 and 2016, stakeholders in the health system increasingly perceived harmonization of urgent care provision between out-of-hours GP posts and EDs to be an urgent problem (see Fig. 1). In June 2014, in view of large investments in GP posts and in a context of continuously rising numbers of ED visits, the NIHDI commissioned the Belgian Healthcare Knowledge Centre (KCE) to carry out a study to evaluate the strengths and weaknesses of the Belgian organisation and payment of emergency care services. A few months later, in October 2014, a new Belgian government picked up the topic in its Declaration of Government. It stated that the organisation of the out-of-hours primary care system would be evaluated and that the number of inappropriate ED visits should be reduced.

Subsequently, the National Commission of Representatives of Physicians and Sickness Funds (called 'Medico-Mut') attempted to translate these aims into a specific plan. The Medico-Mut is primarily responsible for negotiating physician fees but it also approves applications for new out-of-hours GP posts (see text Box 1). It includes representatives of three physician unions as well as representatives of the sickness funds. In its agreement for the year 2015, the Medico-Mut mandated an ad-hoc working group with members of the Medico-Mut to develop a national framework for agreements between 'emergency departments' and 'out-of-hours GP posts' to better harmonize the use of these services. This framework was to be finalized by March 2015 and to be translated into local agreements between GP circles and EDs by the end of 2015. The plan was to make the existence of a local agreement between GP circles and EDs a prerequisite for receiving reimbursements for GP posts from 2016 onwards. However, stakeholders were unable to reach an agreement for a national framework by March 2015. In addition, hospital representatives complained that they were not included in negotiations concerning the national framework agreement and they blocked the development of a national framework. Consequently, negotiations ultimately ended in a deadlock.

Finally, the government stepped in at the end of 2015 to break this stand-still. It mandated the development and implementation of an integrated model for 'unscheduled acute care' aligning 'out-of-hours GP posts' and EDs to be completed by 2020. A task force with representatives of the Medico-Mut, GP posts/GP circles, hospitals, emergency physicians and the government was established. In parallel, the Belgian government decided to put the further development of out-of-hours GP posts on hold, increasing the pressure on stakeholders to reach an agreement about the future collaboration between GP posts and EDs. For 2016, the original budget for new GP posts of about 10 million was cut in half and the remaining €4.95 million were put on hold pending a revision of the existing funding principles.

These principles were later (see Fig. 1) specified by the Medico-Mut in its agreement for the years 2016–2017 in terms of four criteria. New GP posts would have to have:

1. "A collaboration agreement with an ED concerning the organisation of referrals, communication and service delivery (which implies that new GP posts were not able to apply for funding before April 2016);
2. Opening hours of at least 61 h (entire weekend from Friday evening until Monday morning);

3. A minimal (but unspecified) threshold for geographical and population coverage;
4. Declaration of costs that are in line with a national agreed cost structure" [16].

The content of future collaboration agreements between GP posts and EDs was to be specified by the newly established task force on acute unscheduled care by March 2016 with the aim of implementing effective collaborations by the end of 2017 for all GP posts. As a result of these deadlines, defining a framework for collaborations between GP posts and EDs was high up on the agenda when KCE published its report in April 2016. Furthermore, the minister had announced repeatedly that the report would form the basis for her reform of unscheduled care services, implying that the report would have considerable weight in the discussion.

4. The reform proposal of KCE: co-location of 24/7 GP posts and emergency departments

The KCE report made a wide range of recommendations concerning the organisation and financing of emergency care services based on an extensive analysis of the Belgian situation and experiences from other countries [12]. However, the most important recommendation was a suggested comprehensive reorganisation of patient flows in the case of unscheduled acute care, which aimed to reduce inappropriate ED visits by improving guidance of patients through the urgent and emergency care system (see Fig. 2).

According to the proposed model, patients would no longer have to choose between visiting a GP or going to the ED because 24/7 GP posts would be systematically co-located with EDs at hospitals. The GP post and the ED would share a common entry gate and a joint triage area coordinated by a GP. Triage would refer patients to the most appropriate provider, which – depending on the condition – would be (1) the regular GP in case of non-urgent conditions; (2) the co-located 24/7 GP service, where a higher co-payment would apply during office hours; or (3) the ED in case of urgent life-threatening conditions.

Guidance of patients would also be improved through the new urgent care hotline (1733), which would usually refer patients either to their regular GP or the 24/7 GP post, but which could also forward their call to the emergency hotline or refer patients directly to the ED (see Fig. 2). Furthermore, KCE recommended that a broad information campaign should accompany the introduction of the co-located 24/7 GP posts. Concerning practical implementation, the report suggested that the model could vary, e.g. 24/7 GP presence would not be required in regions with low caseloads and stand-alone GP posts might be appropriate in rural areas. In addition, the report proposed that GP posts at EDs would be staffed by a core team of GPs during office hours, while out-of-hours periods would be covered by GP circles on a rotation system as is currently the case for out-of-hours GP posts.

The suggested model implied a drastic reform in terms of opening hours and location of GP posts. In 2015, only 15 GP posts were located at ($n = 8$) or close to a hospital site (<150 meters; $n = 7$), while most GP posts were not and none truly integrated with an ED. In fact, 50 percent of GP posts were more than 1 km away from the nearest hospital site. In addition, existing out-of-hours GP posts were primarily funded to provide consultations and home visits during weekend days and bank holidays. They were not required to open during weekend nights and only 38 GP posts were open from Friday evening to Monday morning (between 59 and 61 h per weekend). Only seven GP posts were open during evenings on weekdays, of which only one was open during the night. In regions where GP posts are not open during (part of) out-of-hours, there is a fall-back on the traditional rotation system with GPs being on call (mostly in their private practices) to safeguard 24/7 GP availability for each geographical area.

5. Stakeholder positions and compromise

The publication of the KCE report coincided with the most heated negotiations in the task force on unscheduled acute care. The recommendations of the report were well received by the general media with public support of hospital representatives, patient organisations and to a certain extent emergency physicians [17,18]. However, they were heavily contested by physician unions and GPs in particular. While the minister's representatives defended the model in the task force, the opposition against it increased. Open letters and alternative models were published in specialised media and social media and some GP organisations even threatened with a strike. The strong opposition of all three physician unions can partly be explained by recent shifts in power balances. Physicians were, until recently, represented by two physician unions known to be dominated by medical specialists. Since 2014, a new physician union with a strong GP affiliation came into play as it acquired voting rights in the Medico-Mut. As a reaction and in an attempt to prevent a decrease in memberships, the two other physician unions took stronger position to defend the interests of GPs.

The main arguments of the opponents and proponents are listed in Table 1. Most importantly, GPs were afraid that the new model would increase their work load and reduce their autonomy to organise out-of-hours care in a way that suited their needs. In addition, they perceived the new model to constitute a shift away from traditional family practice to a model of hospital-based urgent primary care, possibly compromising the close relationship between patients and GPs.

Given these strong reactions it was politically not feasible to introduce the model proposed by KCE on a large scale. Without the support by the largest involved stakeholder group (i.e. the GPs) the reform was doomed to fail. Ultimately, the task force agreed on a compromise that was acceptable for the GPs. As a result, the proposed co-located GP post model is only one of many options as GP circles can continue to organise out-of-hours care at stand-alone GP posts, GP posts near the hospital, or GP posts adjacent to hospitals but with a separate entrance. In addition, the 24/7 opening requirement for GP posts was abandoned. Nevertheless, the task force decision was a small step in the direction of closer collaboration between GP posts and EDs as it included the obligation for GP posts to conclude agree-

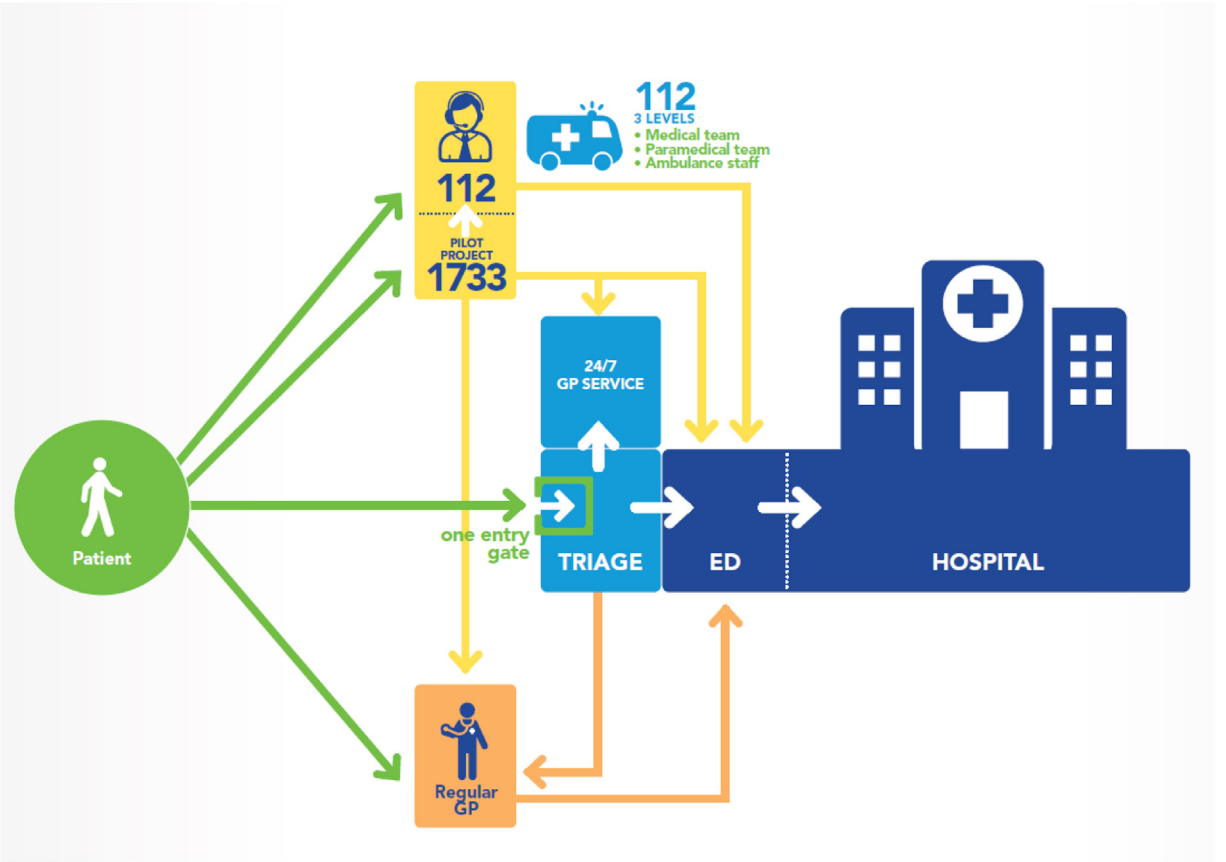

Fig. 2. Proposed model of the KCE for unscheduled acute care services.

ments (e.g. about patient referral; sharing equipment) with the local hospital. It also mentioned a further roll-out of 1733 telephone triage on the condition that the evaluation of the pilot projects was positive.

6. Discussion

A reform of the urgent and emergency care system is currently on the political agenda in several high-income countries. Most of these countries are still struggling to devise (or implement) an optimal care model to slow down the increase of ED visits and to guide patients to the most appropriate provider [1]. In this context, the Belgian reform proposal is interesting because it conceptualized a comprehensive urgent care model that could be expected to strike a balance between the (sometimes) conflicting objectives of achieving efficiency, quality, easy access, and freedom of choice, although the evidence is not clear cut. [19–24]

The KCE model was developed on the basis of experiences from other countries [19–24] but has several features that could be interesting also for other countries. First, it proposed the systematic introduction of 24/7 primary care services co-located with EDs. In the Netherlands, where co-located GP posts at EDs are most common [25], these are open almost exclusively during out-of-office hours periods. However, at least in Belgium, most (inappropriate) ED visits take place during normal office hours (e.g. 68% between 8 am and 7 pm) [12], which means that co-located GP posts restricted to out-of-hours periods have only limited potential to redirect patients to co-located primary care services. Second, the Belgian model proposed one common entrance gate for GP posts and the EDs with a joint triage area under supervision of GPs. Such a model has been implemented at some hospitals in the Netherlands and Switzerland, and it appears to be most efficient at guiding patients to the GP post and not to the ED [22,24]. At the same time, patients who visit the out-of-hours GP post can be easily transferred to the ED if they should require emergency care. Third, the model proposed by KCE included several safeguards to avoid that general primary care flow would shift towards GP posts at hospitals as it suggested that higher co-payments would apply at hospital GP posts during office hours and mandating that patients would have to go to community-based GPs for follow-up. The introduction of differentiated co-payments was proposed because it was assumed that they could potentially influence patient decisions when choosing between alternative forms of GP care (community-based GPs versus GP posts)—even if they had not been effective in steering patients away from EDs.

In other countries, where co-located GP posts integrated with EDs exist, e.g. in England [26], the Netherlands [22], and Switzerland [21,27], these have developed mostly on the basis of local initiatives. Probably, the Belgian experience of strong stakeholder opposition blocking the

Table 1
Main arguments of stakeholders concerning the co-location of GP posts and EDs.

Arguments of opponents[a]	Main arguments of the reform proposal that counterbalances the criticism	Alternatives proposed by opponents
Hospital centrism and ignoring the important role of primary care in public health delivery Main opponents: all three physician unions and GP academics	GPs retain autonomy and control: • Triage coordinated by a GP; • Tasks typically performed by a regular GP (e.g. follow-up appointments; coordinating care trajectories for chronic conditions) prohibited for 24/7 GP-posts; • Increased co-payment for self-referrals to GP posts during office hours; • Information campaigns to increase the awareness of each other's role in unscheduled care among the general public	• Introducing gatekeeping with compulsory referrals of GP or 112 dispatch centre to acquire ED access; • A nationwide introduction of a primary care telephone triage system that encourages the referral of non-urgent cases to GPs
Out-of-hours GP posts have the sole objective to increase attractiveness of the GP profession and not to alleviate pressure on EDs Main opponents: all three physician unions	International examples show: • Out-of-hours GP posts are often introduced to support a shift from the EDs to primary care; • GP posts co-located at the ED seem to be most successful	• GP circles should be free to organise out-of-hours care (e.g. staffing, location, opening hours); • Various models should be allowed, ranging from rotation systems to GP posts integrated with the ED
A 24/7 model cannot be combined with private GP practices Main opponents: all three physician unions	• No need to combine 24/7 GP posts with private practice; • GP posts to be staffed by a core team of GPs from 9 to 5; • Out-of-hours periods would be covered by a rotation system as currently in place for GP posts	/
Policy measures should target patient behaviour and not the already overburdened GP-workforce. Patients are responsible for inappropriate ED visits Main opponents: political debate (i.e. medical journalists and politicians)	• Increased co-payments can threaten financial accessibility for vulnerable groups • It is unrealistic to change the behaviour of patients through information campaigns	• Increased co-payments; • Information campaigns
GP circles are responsible – and not the Minister – for deciding about the most suitable care model for their geographical area Main opponents: all three physician unions	• Regional adjustments are possible, e.g. no 24/7 GP presence in case of low caseload at night or stand-alone GP posts in rural areas • Some standardisation is necessary to assure a coherent and comprehensive system nationwide	• GP circles can decide about how to organise out-of-hours care in their 140 areas

[a] This is based on an analysis of discussions in commissions of the Belgian Parliament [29], social media discussions, personal communications with the authors (confidential), minority reports published together with the KCE-report [30] and articles published [31–37] in specialised media (full list available upon request).

implementation of a national model for urgent and emergency care provision shows that it is particularly important to include (and convince) GPs already in the early planning stages of such a reform. At the same time, the outcome of the reform initiative confirms earlier evaluations of Belgian policy decisions which showed that evidence-based policy criteria are not met [28]. Indeed, policy decisions are dominated by expert opinion, political and ideological beliefs, lobbyist pressure, resource and financial issues rather than by clinical and economic evidence [9,28]. As such, also the final compromise on urgent care provision that has been reached in Belgium assures a great degree of autonomy for GPs in organising out-of-hours care. Therefore, improvements in guiding patients to the appropriate provider in the case of urgent acute needs, will depend on future developments in the field, i.e. on the number of co-located GP posts and the implementation of the compulsory agreements between GP posts and EDs.

7. Conclusions

The proposal for the reorganisation of urgent and emergency care services described in this paper has two main implications for policy makers. First, the proposed care model of introducing GP posts co-located with EDs could serve as an inspiration for reforms in other countries, even if implementation of the proposal was ultimately blocked in Belgium by opposition from GPs. Second, such a reform should make sure to gain support from GPs early on in the development of a specific reform proposal. If concerns of GPs (e.g. regarding professional autonomy and work load) had been taken into account more explicitly, it might have been possible to convince GPs of the benefits of collaboration with EDs for urgent care. Since one of the main objections against the reform proposal was the 24/7 presence of GPs, a more acceptable proposition could have been a co-located GP post during out-of-office hours only. Although this would not resolve a large part of the inappropriate ED use (i.e. during office hours), it could have increased the acceptability of the new organisational model. As relationships between GPs and ED physicians mature over time, a potential extension towards office hours could even be envisaged in the long run. With the current policy process, the future organisation of urgent and emergency care in Belgium remains uncertain as it largely depends on future local decisions of GP circles. Therefore,

continuous monitoring of (un-)intended effects is certainly indicated.

Conflict of interest

The authors declare that they have no competing interests.

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