Neighbourhood Health Centres in Belgium

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Community Health Centres in Belgium

1. Historical developments
2. Illustration: Community Health Centre Botermarkt – Ledeberg
3. Assessment of Community Health Centres (KCE-report)
4. Future?
5. Epilogue
Historical developments

• May 68: medical students looking for a new orientation of their professional careers
• Social commitment and PHC orientation
• Underpinning principles: equity and access, bio-psycho-social model, interprofessional cooperation, quality health care
• Involvement of the community
• Citizen / patient empowerment
Problems for the development of Community Health Centres

- Fee-for-service
  R/1982: capitation (INAMI/RIZIV)
- Negative reaction by the traditional establishment
  R/Ongoing
- No training in interprofessional work
  R/curriculum change
- No links between health sector and other sectors (economy, housing)
  R/COPC
- “Care for the Poor”: risk for dualisation
  R/universal approach
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Four sets of reforms that reflect a convergence between the values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts. They include:

- **Universal coverage reforms** that ensure that health systems contribute to health equity, social justice and the end of exclusion
- **Service delivery reforms** that re-organize health services around people’s needs and expectations
- **Public policy reforms** that secure healthier communities
- **Leadership reforms**
Community Health Centre:

- Family Physicians; nurses; dieticians; health promoters; dentists; social workers; ...

- 5000 patients; 55 nationalities

- Capitation; no co-payment

- COPC-strategy
Figure 1 The PHC reforms necessary to refocus health systems towards health for all

UNIVERSAL COVERAGE REFORMS to improve health equity
Mixed capitation

- A patient-list system with a monthly fixed amount of money, paid by the insurance companies, covering family medicine, nursing care, [physiotherapy]
- System based on solidarity
- Additional payment systems:
  - fee for service
  - third party payment
  - provider oriented payment: e.g. “accreditation”, “impulseo”,...
  - practice oriented payment: e.g. EMR
Commitment:

• free access to service for patients on the list (for family medicine; nursing; (fysiotherapist) )

• patients are only allowed to contact providers from the health centre for family medicine, nursing care and [physiotherapy]
Patients on the list

From 55 different nationalities (107 nat. in Ledeberg)
Concentration of patients with specific care needs
The 19th century “belt” around Ghent
Figure 1 The PHC reforms necessary to refocus health systems towards health for all

UNIVERSAL COVERAGE REFORMS

to improve health equity

SERVICE DELIVERY REFORMS

to make health systems people-centred
Multidisciplinary team

- Family physicians
- Nurses
- Social work
- Health Promotion
- Dietician
- Administrative staff and receptionist
- Ancillary staff
- Dentists
- External health care workers: physiotherapists, psychologists
Family Physicians

- **During the day**
  - consultations 8.30-10.00 // 14.00-16.00 // 17.00-19.00
  - appointments
  - home visits

- **At night (from 19.30 until 08.00)**
  - Cooperation with other group practices and health centres in Ghent

- **During the week-end (Sat. 11.00 a.m. until mo 08.00 a.m.)**
  - Two “on call” GP-posts in Ghent
Nursing

- Working in the integrated capitation system
- Patients are obliged to utilise the health centre’s nursing team
- Tasks
  - injections
  - medication
  - blood pressure
  - health promotion
  - perspective: chronic disease management...
    e.g. diabetes clinic
  - wound dressing
  - ECG monitoring
  - blood sample taking
  - follow-up
  - immunisation and counseling
Social Work

• Problems situated on different domains of life
• Multiproblem cases
• Not (yet) reached by other social services
• Illegal residents
• On appointment or crisis intervention
• No waiting lists
Dietician

• Gives information about healthy food and counsels:
  – Patients with general dietary problems
  – Patients with gastro-intestinal problems
  – Patients with cardiovascular problems
  – Patients with diabetes
  – Patients with kidney-problems
  – Children with obesity
Reception and administration

• First contact of patients
• Organisation of the surgery
• Dispatching of incoming phone-calls
• Information to the patients
• General administration
• Handling of the capitation-system
Health promotion

• In the centre:
  – waiting room
  – leaflets
  – Call/recall: diabetes clinic, immunisation, breast cancer screening,…

• Targeted projects

• Working groups
Diabetes clinic

• Objectives:
  – Improving the care for diabetes type 2 patients through a structured multidisciplinary follow-up and health education
  – To help patients to cope with their condition ("empowerment")
  – Improve self-efficacy of patients
  – To tackle social inequalities in relation to chronic diseases
**Figure 1** The PHC reforms necessary to refocus health systems towards health for all

- **Universal Coverage Reforms**
  - to improve health equity

- **Service Delivery Reforms**
  - to make health systems people-centred

- **Public Policy Reforms**
  - to promote and protect the health of communities
Healthy life expectancy in Belgium

Socio-economic health differences

healthy life expectancy at age 25, men

Closing the gap in a generation

Health equity through action on the social determinants of health
Primary health care as a strategy for promoting health equity and intersectoral action

- Social Stratification
- Differential Vulnerability and Exposure
- Health Inequality
- Structural Determinants
Primary health care as a strategy for promoting health equity and intersectoral action

- **SOCIAL STRATIFICATION**
  - **DIFFERENTIAL VULNERABILITY AND EXPOSURE**
  - **HEALTH INEQUALITY**

**STRUCTURAL DETERMINANTS**

**PEOPLE**

**PHC-TEAM**
Primary health care as a strategy for promoting health equity and intersectoral action
COPC-project: children’s physical condition

- Consultation: problematic physical condition

• WGC Botermarkt
COPC-project: children’s physical condition

- Survey: children were two times longer in front of television and videogames, and had less physical activity compared to the Flemish youngsters.

WGC Botermarkt
COPC-project: children’s physical condition

- Community diagnosis: lack of playgrounds
COPC-project: children’s physical condition

- Intervention 1: construction of playgrounds
COPC-project: children’s physical condition

- Intervention 2: organisation of activities

WGC Botermarkt
COPC-project: children’s physical condition

- Evaluation:
  - ↓ street criminality
  - ↑ social cohesion
  - ↑ physical activity
“Towards Unity for Health”
Integration of personal and community health care

The promotion of primary health care since 1978 has had a profound political impact: it forced medical educators around the world to address the health needs of all people and it spurred the global recognition of family doctors as the primary medical providers of health care in the community. Yet, on the 30th anniversary of the Alma-Ata Declaration, disilluisionment with and failure to appreciate primary care’s contribution to health persist. The missing link in the translation of the principles of Alma-Ata from idealism to practical, at the expense of population health. The challenge of this balancing act is illustrated in the interchanged use of the terms “primary care”, which usually means care directed at individuals in the community, and “primary health care”, which usually means a population-directed approach to health. To simplify this discussion and to reduce confusion, we will use the term “personal care” instead of “primary care” and “community-oriented primary care” (panel) instead of “primary health care”.

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The Lancet 2008;372:871-2
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Comparison of 2 financing systems in PHC in Belgium

Lieven Annemans, Jean-Pierre Closon, Marie-Christine Closon, Isabelle Heymans, Raphaël Lagasse, Elise Mendes da Costa, Catherine Moureaux, Isabelle Roch.
Methods

• Literature search
  – Capitation
  – Quality indicators
• Data-analysis
  – 3 cohorts 2002-2004:
    • Capitation
    • Fee-for-service, matched
    • Fee-for-service, general population
  – Analysis:
    • Access
    • Costs
    • Quality
Results

The population in the capitation system is:
- Younger
- More socially deprived
- Morbidity at least comparable to the Belgian population
# Results: costs

<table>
<thead>
<tr>
<th></th>
<th>Cohorts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Capitation</td>
</tr>
<tr>
<td></td>
<td>mean</td>
</tr>
<tr>
<td>Primary care</td>
<td>216</td>
</tr>
<tr>
<td>Non primary care</td>
<td>1051</td>
</tr>
<tr>
<td>Total cost</td>
<td>1267</td>
</tr>
</tbody>
</table>
Results

- Quality:
  - Cohort “capitation”: better choice of antibiotic prescription
  - Cohort “capitation”: better performance for prevention and screening

- Efficiency:
  - Cohort “capitation”: more efficient
    - Prescription of antibiotics and anti-hypertensives
    - Follow-up of diabetes
  - No difference:
    - Asthma and COPD
Conclusions

Capitation:

- Total cost for INAMI/RIZIV: Equal
- Less expensive for patients and society (maximum bill)
- Quality better for the indicators under investigation
- Efficiency: better
- No risk selection

=> Development of capitation: OK
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Future?

- No out-of-pocket payments for PHC
- Need for gate-keeping
- Intersectoral action for health
Policies improving efficiency

“The government should strongly encourage patients to consult their general practitioner first as a general rule (except for emergencies) by not reimbursing medical expenses for patients not referred by their GP (gatekeeper).”

OECD economic surveys 2005 - Belgium, pag 68
Figure 1: The PHC reforms necessary to refocus health systems towards health for all.

- **Universal Coverage Reforms**
  - to improve health equity

- **Service Delivery Reforms**
  - to make health systems people-centred

- **Leadership Reforms**
  - to make health authorities more reliable

- **Public Policy Reforms**
  - to promote and protect the health of communities
Figure 1.10 How health systems are diverted from PHC core values

Health systems

Current trends
- Hospital-centrism
- Commercialization
- Fragmentation

Health equity
- Universal access to people-centred care
- Healthy communities

PHC Reform
PHC Reform
Figure 3.5 Primary care as a hub of coordination: networking within the community served and with outside partners\textsuperscript{173, 174}

Specialized care
- TB control centre
- Diabetes clinic

Diagnostic services
- CT Scan
- Cytology lab

Specialized prevention services
- Environmental health lab

Community mental health unit
- Referral for multi-drug resistance
- Referral for complications

Consultant support
- Traffic accident
- Placenta praevia
- Hernia

Emergency department
- Hospital

Maternity
- Surgery

Self-help group
- Liaison community health worker

Social services
- Alcoholism
- Gender violence

Women’s shelter
- Alcoholics anonymous

NGOs
- Cancer screening centre

Primary-care team: continuous, comprehensive, person-centred care
Community Health Centre: actual situation

- 90 health centres: 1,6% of population
- Federal (INAMI/RIZIV): (new) capitation
- Flemish community: no formal recognition; support for infrastructure (VIPA); projects
- French community: recognition for health promotion and specific functions
From Alma-Ata to Almaty: a new start for primary health care

On Oct 14, Now more than ever, the World Health Report for 2008, was launched at Almaty, a city formerly called Alma-Ata and well known for the 1978 WHO declaration on primary health care. Although many countries tried to put primary care into practice, the declaration’s goal of Health for All was not achieved. Will all countries now establish strong and efficient primary care as an integral component of their health systems? Is 2008 different from 1978?

The multiple interacting health problems that are intractable cannot be dealt with without a person-focused population-oriented approach. Vertically oriented and externally funded services interfere with the responsibility of the state to improve its own health services. The need for integration of health services by primary health care was emphasised by a workshop in May, 2008, in Geneva. The 15by2015 campaign (launched in March, 2008) ...
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Fifteen by 2015: strengthening primary health care in developing countries

Prof. J. De Maeseneer, MD, PhD; Prof. C. van Weel, MD, PhD; Prof. D. Egilman, MD, PhD; Prof. K. Mfenyana, MD; Prof. A. Kaufman, MD; Prof. N. Sewankambo, MD, PhD; Flinkenflögel M, MD
Zambia

- HIV prevalence rate: 16.5%
- PEPFAR: 150,000,000 US$
- Total government: 136,000,000 US$

• Total government; 136,000,000 US$
Vertical programs

• Create duplication
• Lead to inefficient facility utilisation
• May lead to gaps in patients with multiple co-morbidities
• Undermine government capacity
• Divert skilled health personnel from local health systems
Disease control activities should be integrated in health centers, which offer patient-centered care and should be designed and operated to strengthen health systems”.

Source: ¹ Unger JP, De Paepe P, Green A. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. Int J Health Plann Manage 2003;18:S27-S39

“The World Organisation of Family Doctors, (WONCA) in collaboration with Global Health through Education and Training and Service (GHETS), The Network: Towards Unity for Health, (The Network: TUFH) and the European Forum for Primary Care (EFPC) call upon funding organisations such as the Global Fund, the World Bank, the Bill and Melinda Gates Foundation, and the World Health Organisation, to assign to primary health care a pivotal role in the provision of their activities and to support its development in a systematic way. We propose that by 2015, 15% of the budgets of vertical disease oriented programmes like HIV/AIDS, Tuberculosis and Malaria, be invested in strengthening local primary health care systems and that this percentage would increase over time. Such an investment would improve developing nations’ capacity to address the vast majority of health problems through a generic, well structured comprehensive primary care system.”
Funding for primary health care in developing countries
Money from disease specific projects could be used to strengthen primary care

The World Health Organization's World Health Report 2007 deals with access to primary health care as an essential prerequisite for health. It acknowledges the importance of the Alma-Ata declaration of 1978, which called for integrated primary health care as a way to deal with major health problems in communities and for access to care as part of a comprehensive national health system. Yet the mission of Alma-Ata—to provide accessible, affordable, and sustainable primary health care for all—has been implemented only partially in developing countries. We have therefore instigated the "15by2015" campaign (www.15by2015.org), which proposes a funding mechanism for strengthening primary health care in developing countries.

In the accompanying analysis article, Gillam notes that most developing countries have failed to provide even basic primary healthcare packages. Weaknesses in primary healthcare services often result from a variety of forces, including economic crises and market reforms, which limit the range and coverage of services and thus their effect on health. On the positive side, between 1997 and 2002, financial support to improve health care in developing countries increased by about 26%, from $6.4bn (£3.3bn; €4.4m) to $8.1bn. However, most aid was allocated to disease specific projects (termed "vertical programming") rather than to broad based investments in health infrastructure, human resources, and community oriented primary healthcare services ("horizontal programming").

An example of vertical programming is the enormous donor response to the HIV epidemic. In 2006, although Zambia's entire Ministry of Health budget was only $136m, the President's Emergency Plan for AIDS Relief provided the country with an HIV targeted budget of $150m. This unbalanced distribution of health funding occurs across sub-Saharan Africa. Thus, although HIV positive patients receive free care, others with more routine diseases receive poor care and still have to pay. Salaries of healthcare providers working for donor funded vertical programmes are often more than double those of equally trained government workers in the fragile public health sector. This lures government workers to the higher paying vertical programmes and creates an internal "brain drain." But it is the underfunded primary care clinics and health centres that care for all diseases, including common illnesses such as diarrhoea, malnutrition, and respiratory tract infections, which take many more lives than HIV, tuberculosis, and malaria.

A new global strategy is needed to reinforce community focused primary health care in developing countries. This will require cooperation between ministries, universities, non-governmental organizations, and donors working on health to overcome severe resource constraints, including insufficient numbers of doctors, pharmacists, and other health personnel. Four international organizations—the World Organization of Family Doctors (www.globalfamilydoctor.com); Global Health through Education, Training and Service (www.ghets.org); the Network Towards Unity for Health (www.thenetworktuh.org); and the European Forum for Primary Care (www.euprimarycare.org)—have therefore set up the 15by2015 campaign to foster a better balance between vertical and horizontal aid. This campaign calls for major international donors to assign 15% of their vertical budgets by 2015 to strengthening horizontal primary healthcare systems so that all diseases can...
SIGN THE PETITION!
GO TO:
WWW.15BY2015.ORG
It’s time for change: YES, WE CAN!
Thank you!