

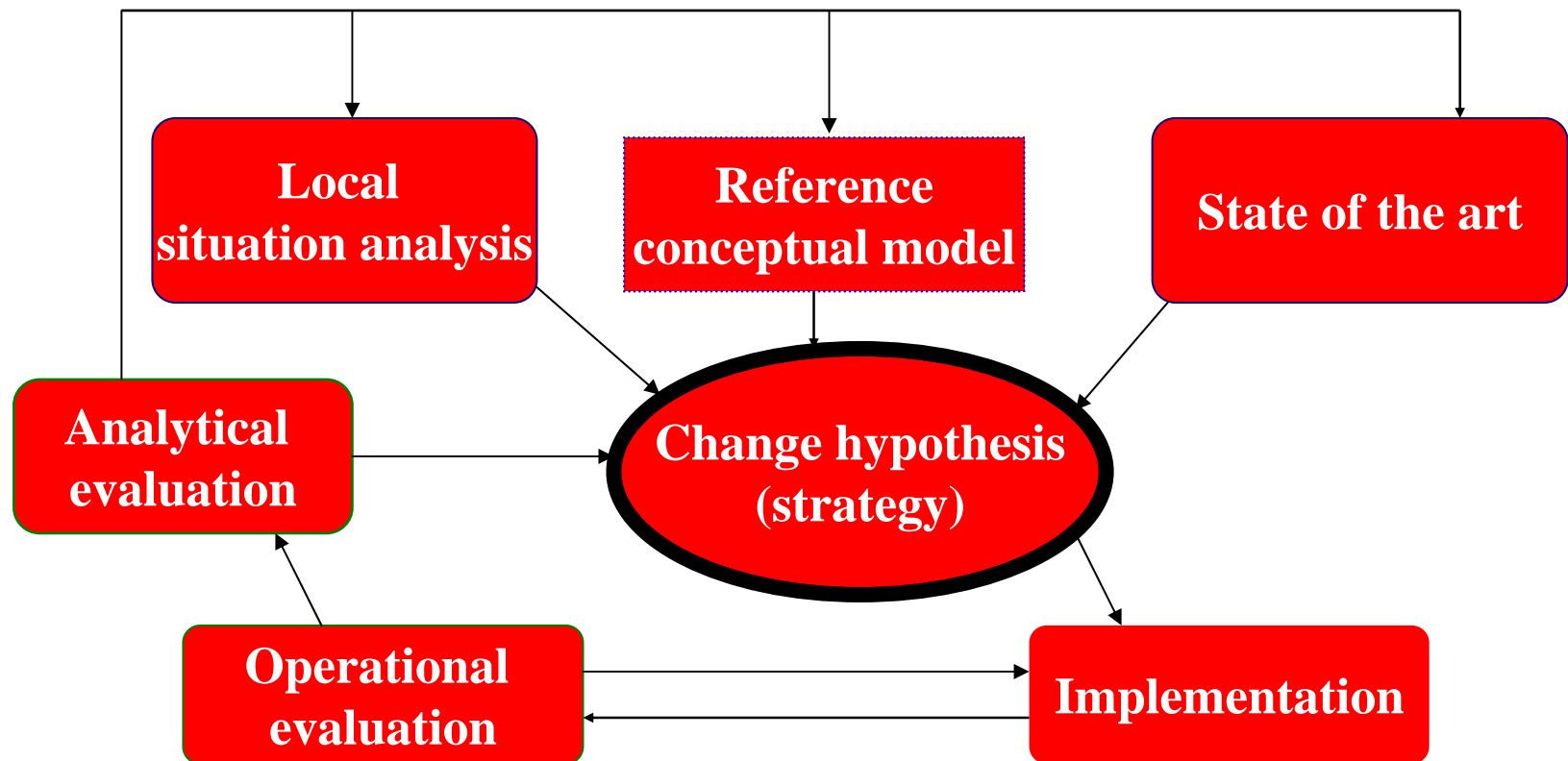


The Local Health Systems project in Belgium

Systemic responsibilities of public hospitals

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An action research pattern





Local situation analysis

Belgian health system 's weaknesses

- Bismarkian, demand side financing
- A professional bureaucracy (Mintzberg) with
 - Poor coordination between tiers
 - Multiple actors
 - Lack of evaluation of quality of care and quasi absence of corrective mechanisms
- Consequences :
 - patient 's follow up may be deficient
 - inefficiency

Project objectives: quality standards

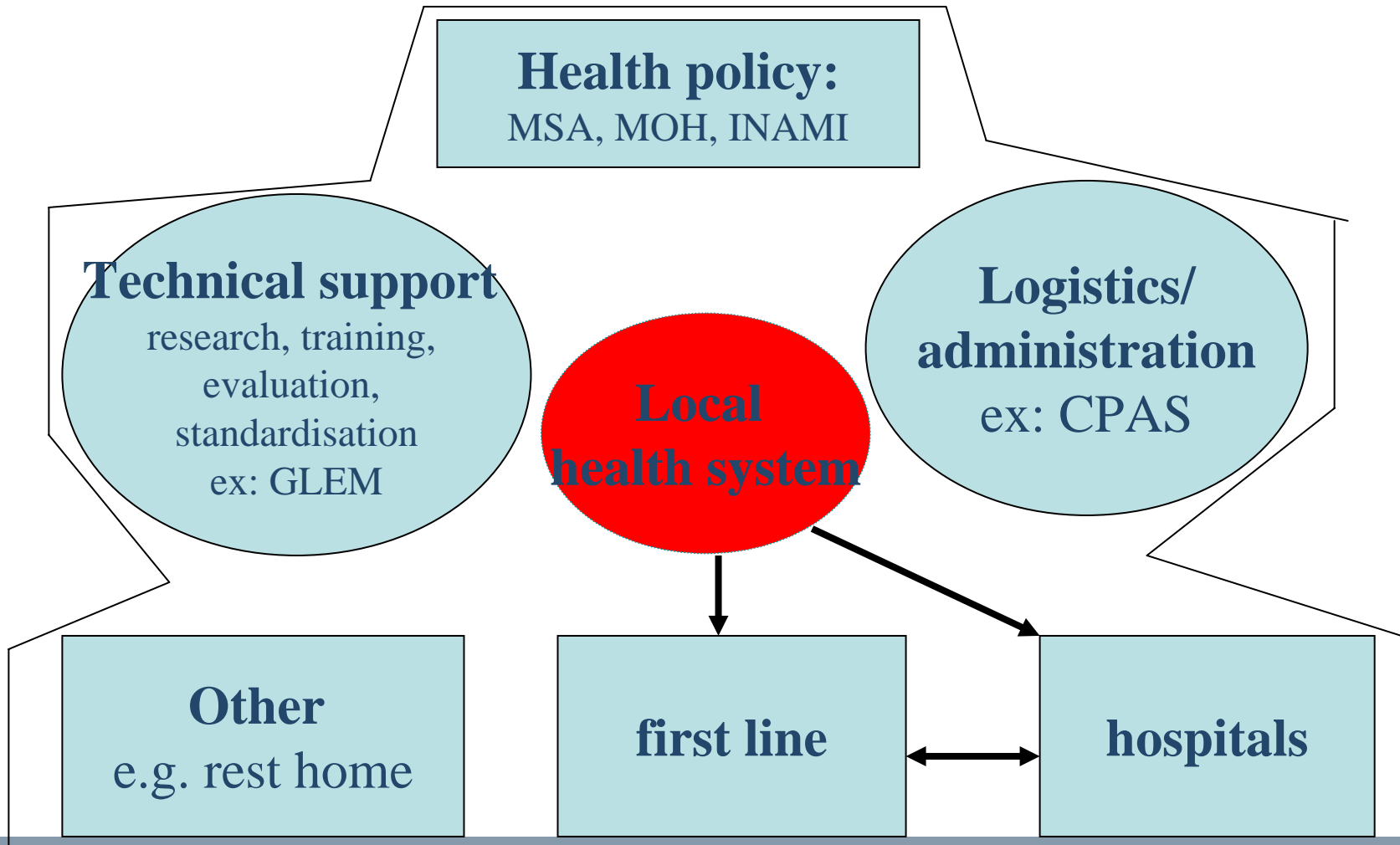
Improve care and system with defined criteria

Care: patient-centred care, continuity, efficiency, effectiveness

System:

- integration (no gaps, no deficiency, patients follow up by information, patient 's access to best tier/institution, optimal decentralisation of medical technology, first line as system 's entry point);
- strengthening first line
- integrated local health system model
- dissemination of reflexive methods

Change hypothesis: A bottom up strategy



Change hypothesis - project strategy



**volunteer professionals
of 1st & 2nd line
+
(initial) external technical assistance
=
middle line coordination**



- **since 1996 : Molière hospital, Brussels**
- **since 1995: St Vincentius hospital, Antwerp**
- **since 1999 : Malmedy hospital, Wallonia**

- + 3 short-lived experiences (2 to 4 years each, since 1994)
- + 1 failure (university teaching hospital)



- **Actors**

- 2 tiers are represented
- require sharing patients
- MDs. Later other professionals were involved

- **Organisation**

- technical support by ITM
- local coordination team (Brussels) or not (Antwerp):
meeting at least 1X/month
- group composed of representatives (Malmedy)



Implementation: local health system groups

- **Discussion of felt problems**
- **desk analysis**
- **interface flow process audit and (one way) service audit**
- **action research** led by subgroups to correct selected problems (identified by surveys, quantitative analysis, files analysis, direct observation)
- **intervision** (no supervision was used in the project)



- Negotiation between tiers/providers
- Design/dissemination of clinical guidelines, discharge cards
- Preparation of in-service training (e.g. sub-cutaneous drips)
- Patients sensibilisation
- Improvement of management control systems (e.g. access of GPs to computerised hospital files)
- reorganisation of hospital services (laboratory, radiology,...) and procedures
- reduction of hospitalisation needs



Implementation: examples of interventions

- Improve nurses patient communication in the hospital
- Evaluation of GPs' performances at the hospital
- Improve aid to decision of lab and radiology protocols for GPs
- Continuous training of GPs in manual skills
- In service training of GPs for terminal patients
- Standardisation of home pain treatments



- Problems:
 - All urgent X-rays demanded by GPs outside work hours had to be requested by the emergency ward → lost of clinical information and lost of GPs' names
 - Responses were dichotomised (urgent or not)
- Solution: 1 GP + 1 PH specialist investigate the ward organisation and propose solutions to improve its management



In-service training issues for GPs (insisting on manual skills)

- Objective: improving GPs' problem solving capacity
- Priorities identified in LHS practice
- Represent themes for seminars, local training groups and rotations for GPs accompanying patients



In-service training issues for GPs (insisting on manual skills)

- Pneumology: spirometry, peak flow, saturometry
- Cardio: reading ECG, mistakes of automatic diagnosis, demand of opinion for difficult ECG, cardio-respiratory reanimation
- Gastro entérology: placing a gastric catheter, ascit puncture



In-service training issues for GPs (insisting on manual skills)

- OB-GYN: cervix scrapping, IUD
- Urology: bladder catheter, cystocath, hormon implants
- Surgery: stitches, intra-articular punctures and injections; cast immobilizations, abces incision, postop catheter surveillance post-op catheter, ingrowing nail
- Dermato: dressing, removing superficial tumors
- Ophtalmo: removing foreign body, detection of cornea wound, glaucoma screening
- ORL: removing plug of earwas, epistaxis treatment, nasal tamponage



- action research project 's structure
- nested studies
 - direct observations,
 - surveys,
 - interviews,
- Exchange of experiences between different LHS

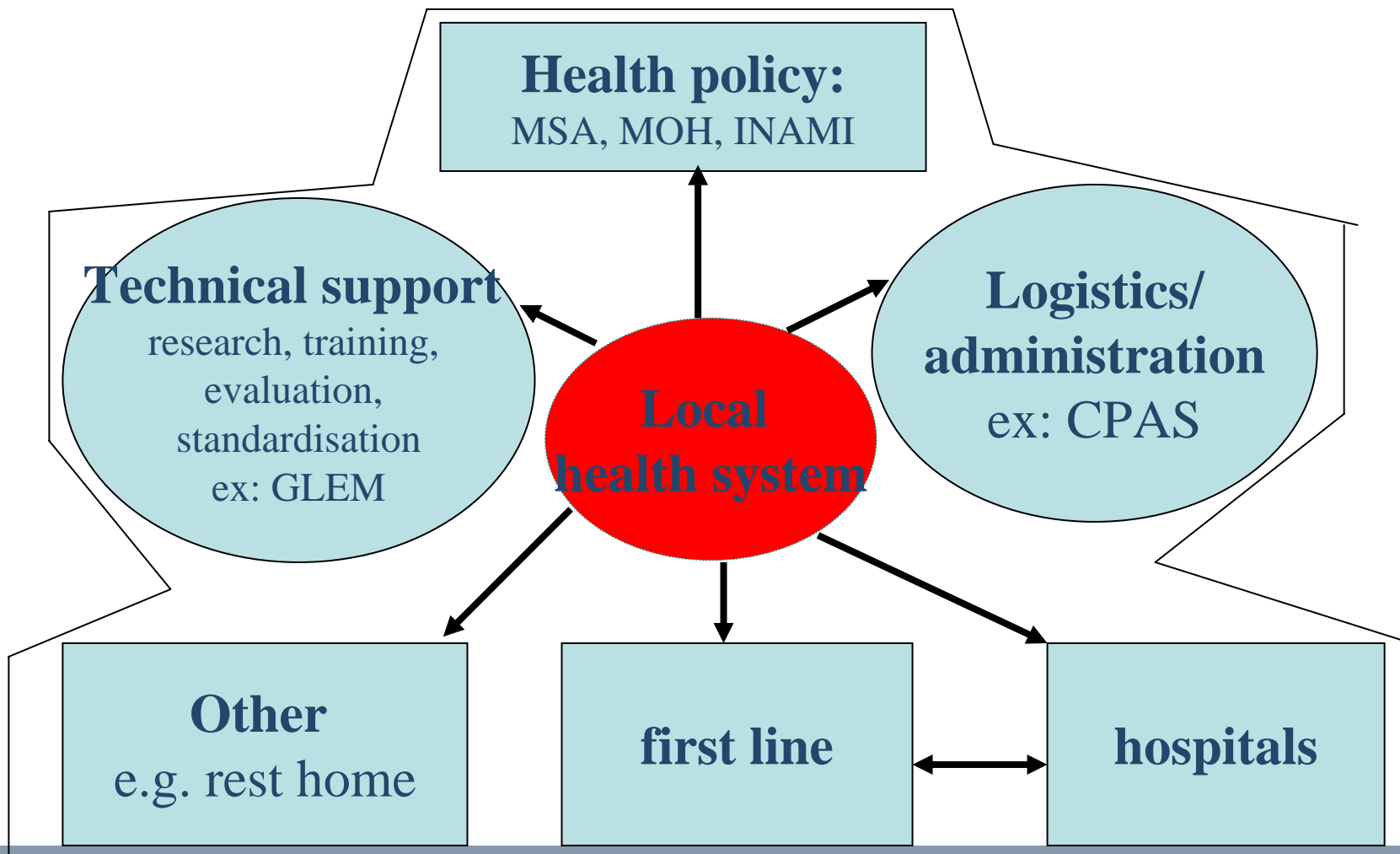


- Process
 - Technical assistance, training : ++
 - administrative support : +
 - Vertical integration and feedback to MOH: -
 - perception that process is slow and methodology not rigorous enough
- Outputs
 - Improvement of relationships between actors and of coordination between tiers
 - Improvement in care (for specific patients categories)
 - Efficiency improvement (with regard to diagnosis and treatment procedures)
 - « System » awareness amongst professional



- = possible approach for other professional bureaucracies (France, Germany, Switzerland, etc) ?
- select committed health professional as participants
- develop 1 LHS per hospital
- associate nurses and other professionals to doctors
- include organisation representatives
- start where it is easier (rural areas, places where friends are working, etc). Multiple referral patterns in urban areas is source of problems in LHS organisation
- proceed with an external technical assistance
- finance participation where possible

The future: dissemination and local extension





Conclusions – in cauda venenum

- In a context of health care commercialisation, bottom up strategies are needed to develop publicly oriented services
- These strategies are not only political. Technical realisations are complementary
- Academics should erase borders between health management and policy (as well as between policy and politics)
- Academics can increase the relevance of their research and teaching when they develop a practice in health care services
- Such practice need to aim at bringing changes if it is to be relevant for (policy and management) know-how development