Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

Organisation and payment of emergency care services in Belgium

Current situation and options for reform

KOEN VAN DEN HEEDE, CÉCILE DUBOIS, STEPHAN DEVRIESE, NATALIE BAIER, OLIVIER CAMALY, EVELINE DEPUIJDT, ALEXANDER GEISSLER, ANNELIES GHESQUIERE, SARAH MISPLON, WILM QUENTIN, CHRISTOPHE VAN LOON, CARINE VAN DE VOORDE

Study objective and approach

To explore the strengths, limitations and future challenges and recommend strategies for a more efficient organisation and payment system of emergency departments while access towards high-quality services is maintained

Mixed method design:

Qualitative study: interviews key informants

Analysis administrative databases and Belgian studies

Literature review + international comparison

Reform proposals

Reform proposal 1:

Rationalise the geographical spread and service offer of emergency departments

Reform proposal 2:

24/7 GP post on hospital sites

Reform proposal 3:

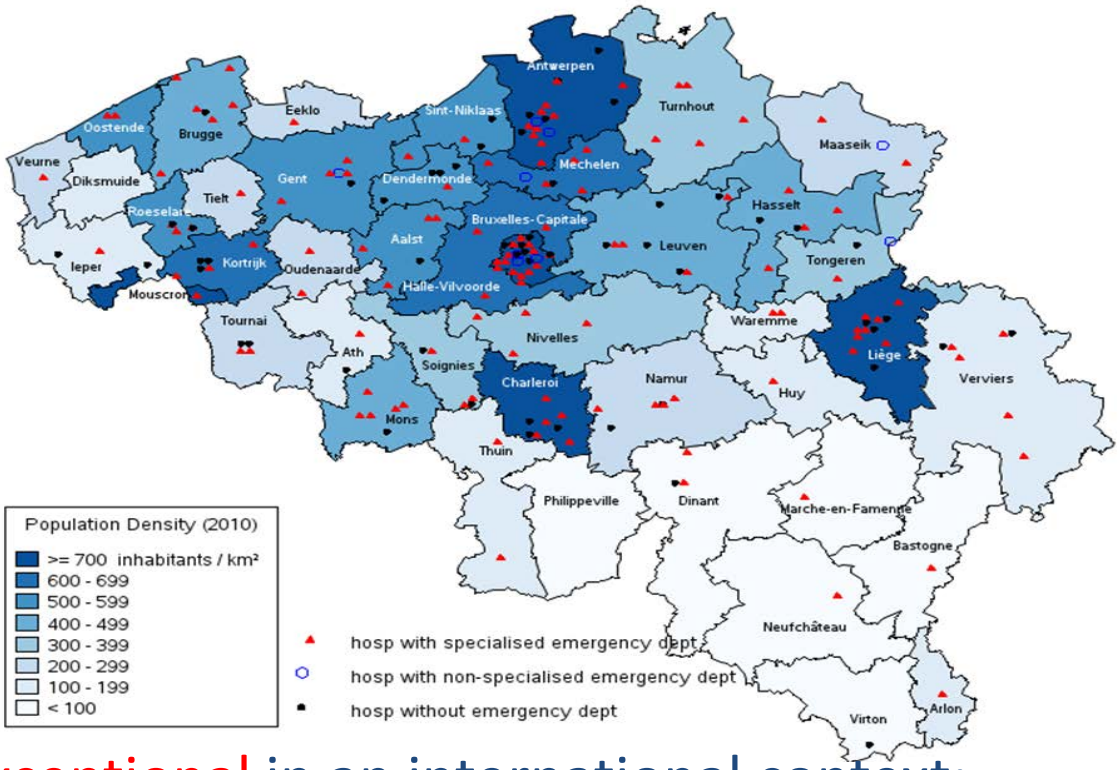
Fixed payment to guarantee a ’24/7 service of public interest’

Variable payment for activity

Reform proposal 4:

Harmonizing co-payment 24/ GP post and emergency department

Emergency departments (EDs)



Hospital level (n=102):

101 acute hospitals with a specialised ED

Hospital sites (n=198) with 139 EDs

131 specialised EDs
8 non-specialised EDs

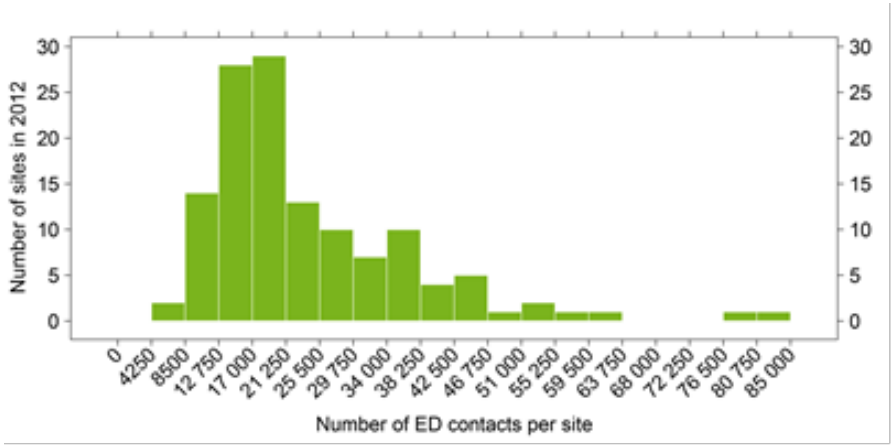
Exceptional in an international context:

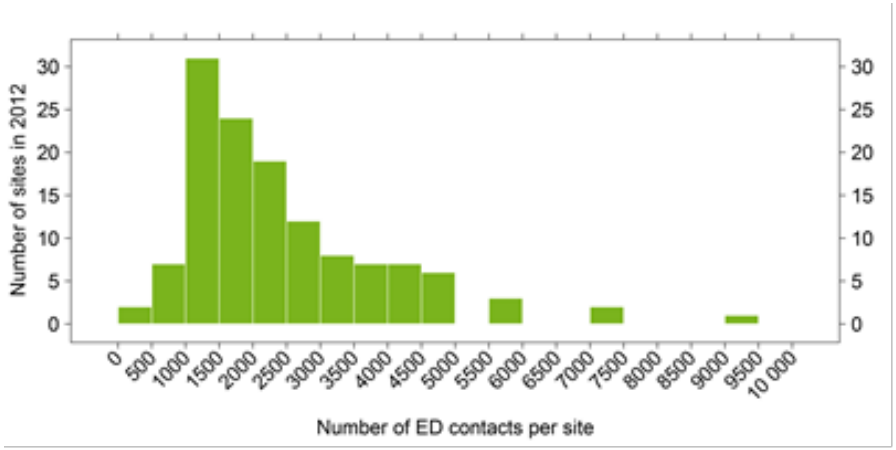
Proportion of acute hospitals with ED; high density; lack of reference EDs for time-critical conditions

Dispersion of the available budget and expertise

Low caseloads in many EDs

24-hour period	Arrival during night (0:00 – 7:59 AM)





- Economies of scale ≥ 20 000 ED contacts per year or 55 ED contacts per 24h
- 50% sites ≤ 55 ED contacts per 24h
- 50% sites ≤ 5.5 contacts per night

To the Minister of Social Affairs and Public Health

- **To rationalise the number and geographical spread and service offer of emergency departments and organised duty centres without limiting the access to high-quality healthcare services :**
  - **Programme the number of EDs based on scientific criteria (e.g. maximal travel time, minimal caseload):**
    - **Prioritize accessibility over minimal caseload**
  - **Stepwise implementation:**
    - **Closure of EDs from hospitals with several EDs**
    - **Additional ED closures in context of larger reform of the hospital landscape**
  - **Evaluate if and how many EDs should be recognised as a specialised reference ED for time-critical conditions (e.g. major trauma, stroke)**

Reform proposals

Reform proposal 1:

Rationalise the geographical spread and service offer of emergency departments

Reform proposal 2:

24/7 GP post on hospital sites

Reform proposal 3:

Fixed payment to guarantee a ’24/7 service of public interest’

Variable payment for activity

Reform proposal 4:

Harmonizing co-payment 24/ GP post and emergency department

Activity profile Belgian EDs

ED contacts increase

- From 3.0 (2009) to 3.2 million (2012)
- 290 per 1000 inhabitants (NL: 124/1000; EN: 271/1000; FR: 274/1000)
- Largest share of patients during office hours

Many patients could have been treated appropriately by a GP

- International estimates: 20%-40%, Belgian estimates are higher
- Other indirect indications: ambulatory ED contacts (77%); self-referrals (71%); low acuity levels

International practices and scientific evidence

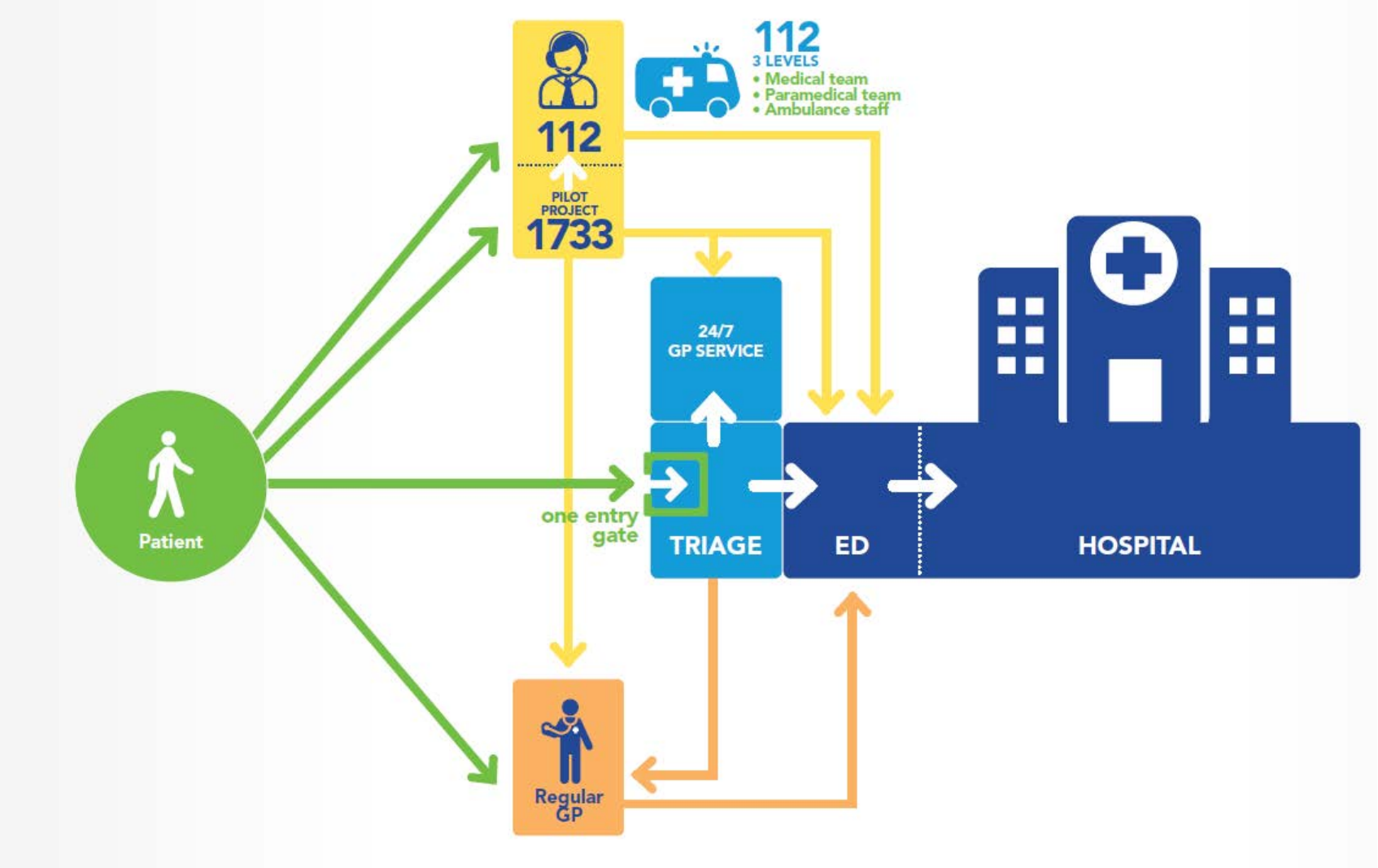
ED and GP post on one location

- Reduces ED contacts when there is one entry gate with triage function

Telephone triage

- Safe in 97% of cases
- Safety can be improved when operated by clinicians
- Risk to increase overall burden emergency care system

To the Minister of Social Affairs and Public Health



To the Minister of Social Affairs and Public Health

EDs and 24/7 GP post on one location:

- **One entry gate**
- **Clinical trained triage team supervised by a senior physician**
- **Financial and legal autonomous GP post organised by GP circle(s)**
- **Prohibition for the GP post to perform activities that belong to a regular GP (GMD-DMG, care trajectories, follow-up appointments)**

'Proof of concept' evaluation in a number of locations:

- **Compare results with evaluation of current landscape**

Exceptions to this model in areas without a hospital site nearby:

- **A well equipped and staffed GP post**

1733 implementation should depend on evaluation of current initiatives and prerequisites identified in literature (e.g. training level)

Reform proposals

Reform proposal 1:

Rationalise the geographical spread and service offer of emergency departments

Reform proposal 2:

24/7 GP post on hospital sites

Reform proposal 3:

Fixed payment to guarantee a '24/7 service of public interest'

Variable payment for activity

Reform proposal 4:

Harmonizing co-payment 24/ GP post and emergency department

Payment in numbers

Hospital budget (B2)

- Staffing: € 95.3 million (BFM-BMF 2013)

Physician fees

- A-fees: € 60.4 million(2013)
- C-fees: € 20.2 million (2013)
- On-duty fees: € 50.4 million (2013)

To the Minister of Social Affairs and Public Health

- **To implement a mixed payment system for EDs and GP posts which connects better with their role:**
  - **A fixed component for the ED and the GP post, respectively**
    - **Largest share**
    - **Sufficient to cover 24/7 duty of staff (medical, nursing, other)**
  - **For ED:**
    - **B2 budget, part of the A-fees and on duty fees**
    - **C-fees and remuneration technical fees not included**
    - **Several steps based on activity level EDs (unscheduled emergency admissions)**
  - **For 24/7 GP post:**
    - **On duty fee, part of the budget for fees and operational costs WP/PDG that move to the hospital sites**
    - **Based on historical ambulatory ED activity and activity WP/PDG**
    - **Including budget of triage team**
  - **A variable component**

To the Minister of Social Affairs and Public Health

- **Variable component:**
  - **Variable payment for ED and GP post respectively**
  - **A-fees per ED contact but lower than current A-fee**
  - **GP-fee per contact which is lower than current fee**

- **Sparsely populated areas: partial replacement of variable component by a higher fixed component**

To the Minister of Social Affairs and Public Health

- **To harmonize co-payment and third-party payer system ED and GP post:**
  - **One co-payment on the condition that patient follows triage advice**
  - **Higher than co-payment regular GP during office hours**

To RIZIV - INAMI

- Monitor C-fees

To FOD - SPF

- Monitor elective admissions via ED
- Evaluate impact telephone triage current initiatives
- Evaluate triage centres for unscheduled acute care

Colophon

- **Author(s): Koen Van den Heede (KCE), Cécile Dubois (KCE), Stephan Devriese (KCE), Natalie Baier (Technische Universität Berlin, Germany), Olivier Camaly (Möbius), Eveline Depuijdt (FOD Volksgezondheid – SPF Santé Publique), Alexander Geissler (Technische Universität Berlin, Germany), Annelies Ghesquiere (FOD Volksgezondheid – SPF Santé Publique), Sarah Misplon (Möbius), Wilm Quentin (Technische Universität Berlin, Germany), Christophe Van Loon (RIZIV – INAMI), Carine Van de Voorde (KCE)**
- **Publication date: 29 March 2016**
- **Domain: Health Services Research (HSR)**
- **MeSH: Emergency Medical Services; Emergency Service, Hospital; Health Care Reform; After-Hours Care**

Colophon

- **NLM Classification: WX 215**
- **Language: English**
- **Format: Adobe® PDF™ (A4)**
- **Legal depot: D/2012/10.273/24**
- **Copyright: KCE reports are published under a “by/nc/nd” Creative Commons Licence http://kce.fgov.be/content/about-copyrights-for-kce-reports.**

This document is available on the website of the Belgian Health Care Knowledge Centre.