Interprofessional collaboration & financing at GP level to face primary care challenges in Belgium

A qualitative study – *European Forum for Primary Care*- Barcelona 19/09/2023

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Financing : NIHDI

Primary care crisis

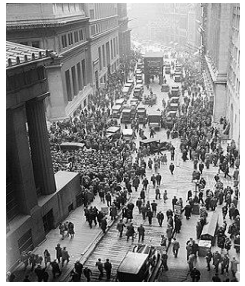
- International (8,2)
  - Increasing needs and more complex demands (1,2)
  - Needs at individual level : multimorbidity, pro-active management (4, 5)
  - Needs at organisational level
    - Broader range of services
    - Higher workforce capacity
    - Economies of scale (3)
  - Covid19 Crisis -> need for more patient oriented PC services (6,7)

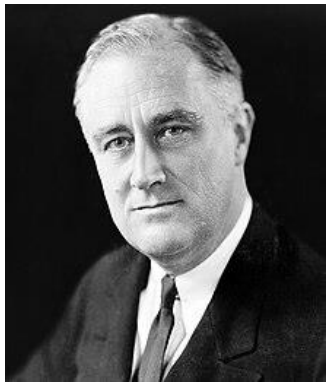
- Belgium situation
  - Freedom of choice for practices
  - Mainly solo and Fee-for-service (95%)
    - Other models : monodisciplinary, CHC's
    - capitation-fee (5%)
  - Decrease in overall amount of GP's workforce
    - Older GP's vs younger generations paradigm : work life balance (11)
    - Fixed quotas of overall physicians and GP's in particular
  - Bad indicators for chronic-condition follow-up (9, 10)

OECD 2020 calls for action (3) :

- ✓ Different practice organisations : teamwork & collaboration, prevention, care coordination
- ✓ Different payment schemes and non-financial incentives
- ✓ *"Efficency of PHC will furtherly depend on community-based teams"*

New-deal for GP's?





- June 2022 Ministry of health wishes to move (12)

Themes
A sufficient number and good distribution of (GP) practices
reducing unnecessary administrative workload
Better accessibility for patients
A new organisational model
New financial-mix

- Think-tank of GP representatives
- Steering committee : Universities-GP department and NIHDI
- 4 months, 2 monthly meetings
- Various questions :

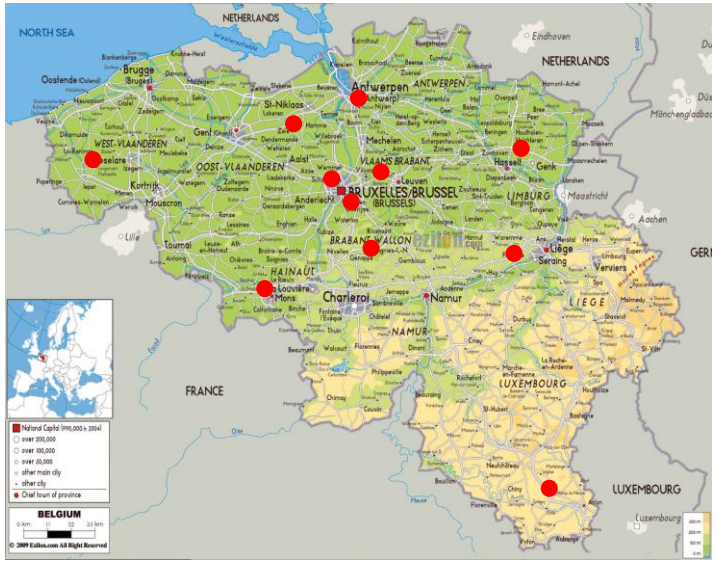
What is expected of a general practice? What care should be proposed?

How can we develop our relationship with the patient?

To achieve this, what professional profiles (including support staff) need to be present within the practice?

What alternative, mixed funding model (flat-rate and fee-for-service) should be put in place? How can we ensure that this funding model strikes the right balance between freedom and responsibility in the provision of care?

Methodology



- ✓ 2 connected research questions :
  - ✓ Who? What? How?
  - ✓ What financial mix?
- ✓ Focus group methodology : 2 rounds between September & December 2022
- ✓ Local quality evaluation groups (LQEG)
- ✓ 11 selected
  - ✓ Geographically (6 fl et 5 fr) ; rural/urban
  - ✓ Age of participants <40 years
  - ✓ Different organisational models
- ✓ 1 interviewer and 1 reporter
- ✓ Taping and quick-reports

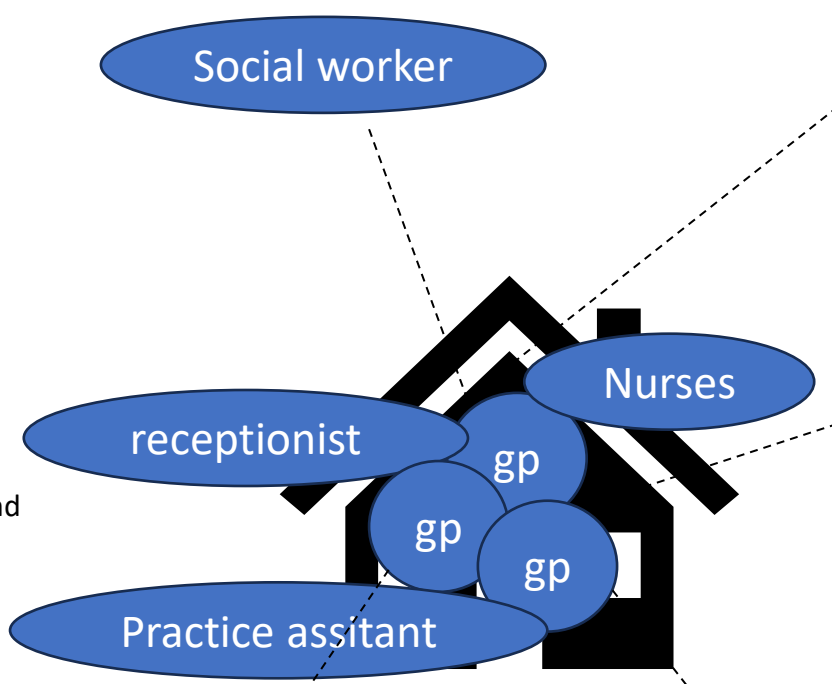
		FG 1 = 122	FG 2 = 110
Average age		45	44
Gender	Women	70	62
	Men	54	48
Urban/rural	Urban	21	18
	Rural	61	53
	Semi-rural	40	39
Practice	Solo	29	23
	Monodisciplinary network	12	3
	Monodisciplinary co-located	41	32
	Multidisciplinary FFS	24	40
	Multidisciplinary CF	17	12
Financial mix	FFS	105	98
	CF	17	12

Focus group 1 Who? What? How?

- 3 stories
  - #1 Clinical case : « *59-year-old-patient with COPD smoking stage 3, HTA, obesity, stabilized on treatment, sleep disorders, and anxiety + psychological & social context* »
  - #2 Typical day : « *60-year-old patient for a lower limb wound due to venous insufficiency; the influenza vaccine; follow-up of a shoulder tendonitis; a home visit for a 5-year-old child etc.* »
  - #3 Management : « *flu vaccination awareness campaign ; stock of "disposable" medical material ; human resources; computer equipment; physical activity group sessions for patients : etc.* »

Focus group 1 Who? What? How? : results

Who and what?



1. Secretariat
2. Triage and referral to the most appropriate care provider
3. Administrative tasks
4. Dispatching information
5. Supporting the logistical management of the building and care equipment

1. Triage and referral to the most appropriate care provider
2. Shared, protocol-based monitoring of patients with stable chronic pathologies, pregnancy, etc.
3. Organising care coordination
4. Support for palliative care and care planning
5. Writing practice guidelines
6. Quality improvement such as audits, Plan Do Check Act (PDCA)
7. Minimum social assessment in healthcare
8. Organisation of preventive activities for patients (e.g. flu vaccination campaign, colorectal cancer screening campaign, etc.)

6. Performing simple clinical procedures such as taking samples, measuring blood pressure, height and weight, simple wound care, point-of-care tests, NO ~~injections~~.
7. Supporting the GP/nurse in quality improvement actions.
8. Support the GP/nurse in organising preventive actions.

Outsourcing?

1. 'Specialization'
2. Freedom of choice

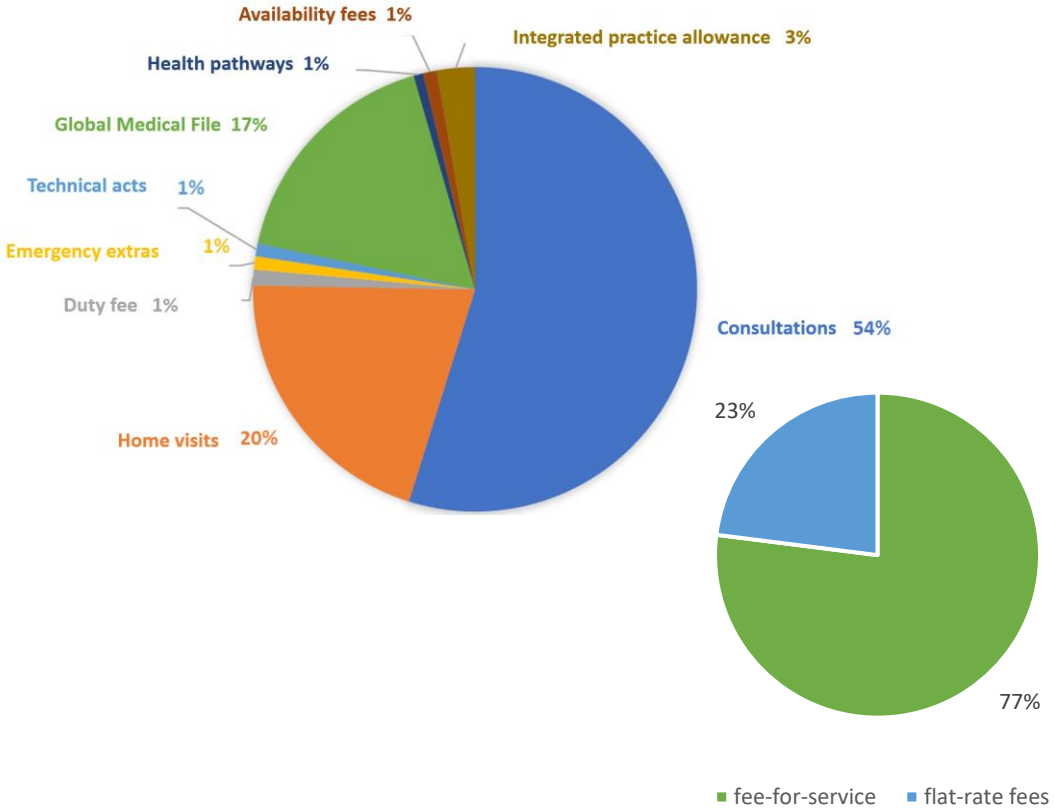
How?...insourcing & integrative tools:

- Shared EHR's
- work in accordance with the practice's internal guidelines and protocols,
- participation in coordination and care meetings,
- shared administrative and logistical management.
- description of each professional's tasks established at practice level.

+ Specific training

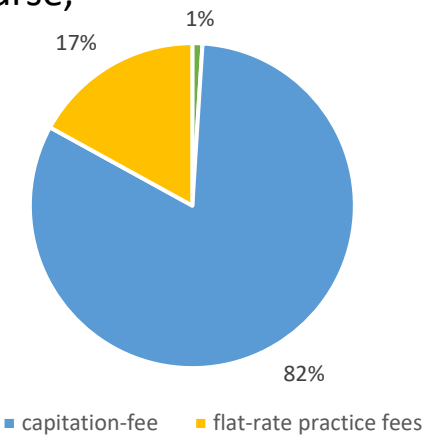
Focus group 2 What financial mix?

- General presentation of FFS and Capitation-fee incomes



Under the current Capitation-fee system, sources of funding :

- 82% from capitation fees
  - per registered patient
  - amount modulated by 40 patient parameters, which better reflects the differentiated workload (higher amount if patient is sicker)
  - if a minimum of 2 disciplines: GP and either Nurse, Physiotherapist or Nurse + Physiotherapist
  - compulsory accreditation and agreement
- 17% flat-rate funding based on practice
- small remuneration (1%) for technical procedures



1/ Based on your current experience, what do you think are the advantages and disadvantages of the different financing arrangements? What are the advantages and disadvantages of the current proportions?

2/ There are upcoming trends, in other countries, in the think tank, in the scientific literature : proactivity, complex consultations, social determinants of health, prevention campaigns, etc. thus more capitation and practice funding and less FFS funding. What is your perception on these trends?

Focus group 2 What financial mix? : results

Characteristics	Fee-for-service	Capitation-fee
Stimulating	(+) rewarding, autonomy, volume (-) complex situations	(+) flexibility, planification, complex situations (-) insufficient on current basis
Patient accessibility	(+/-) discussion on co-payment (-) risk of patient selection	(+) financial access (-) risk of patient selection and over-consumption
Continuity & availability	(+) availability on earning incentives	(-) reducing hour accessibility
Activities out-of-contact	(-) no recognition, difficult to delegate	(+) recognition, possible because flexible
Rational use	(-) risk of over-supply	(+) reduction of over-consumption (-) risk of under-supply
Administrative simplicity	(+) co-payment GP's choice (-) insufficient for complexity and variety of problems, to complex (codes)	(+) no codes, no invoicing (-) IN process to easy; OUT process to complex. To dependent on paying institutions

Quick-report based discussion and moving towards N-D practices

- RQ 1 Who?What?How?
  - ✓ Reasonably small scale structures
  - ✓Quite limited number of professionals : Gp's, nurses, receptionist &/or practice assistant
  - ✓Integrative tools such as : co-location, practices protocols, common EHR, care coordination, shared logistical management

- RQ 2 Financial mix?
  - ✓Heading towards different proportions of actual FFS
  - ✓Higher proportion of capitation-fee and practice financing

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