Reorganisation of the primary healthcare in Flanders

Context and change process 2015-2019

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1. Background

The Flemish Coalition agreement and the policy memorandum of Minster Vandeurzen 2014-2019 describe a reform of the structures of the primary healthcare. In order to approach this reform with broad support, we propose a participative process with the sector, culminating in a primary care conference in the spring of 2017. At this conference, various working groups will announce their realistic and policy preparatory proposals. These proposals must culminate in new Flemish legislation that will redraw the primary healthcare landscape.
The scope of the primary care conference is the Flemish policy pertaining to primary care. This change process must also be in keeping with other reforms, both currently under way and still to be initiated, in particular: the expansion of the Flemish social protection, the development of a new organisation and financing model for elderly care, the implementation of the person-linked financing for persons with a handicap, the interjection of new powers pertaining to mental healthcare and the widening of the scope of the strategic care planning of hospitals.
We also take into account the change process around chronic illness that the federal government wishes to achieve in close consultation and coordination with the communities. The restructuring of the financing of the hospital sector and the exercising of healthcare professions (RD 78) are important reforms that take place at federal level and shall exercise a substantial influence on the organisation of primary care.
One should ensure at policy level that there is sufficient coordination between all these processes. The sector also has the important task of ensuring consistent input and information at the various consultation forums.

1.1 The Flemish Coalition Agreement 2014-2019

'The Government of Flanders is convinced that the development and reinforcement of primary care is crucial, especially given the increasing need for effective chronic care, care continuity, care for the elderly and mental healthcare. We want to start from our care facilities' strengths with their diversity of forms in which primary care providers operate.
This also implies that the individual patient/customer must be involved in the decisions involving his or her care and that we also recognise him or her as an expert in his or her condition or need for support. To reinforce this we will develop a charter that clearly defines the customer/patient's (collective) rights.
Various primary care network structures are currently in operation. In consultation with the stakeholders we shall work on an operational plan to strengthen, align, simplify and integrate primary care structures.
The sixth state reform creates the momentum for this challenge with the transfer of support for primary health professions and of the organisation of primary healthcare (General Practitioner Groups, Local Multidisciplinary Networks, Integrated Residential Care Services, palliative networks and palliative multidisciplinary teams).
Building further on the possibilities of the Flemish Parliament Act on Care Regions and the conclusions of the 2 primary healthcare conferences, we wish to bring together all care sectors at the regional city level and refine, in quantitative terms, the care objectives that are set at Flemish level (e.g. % reduction or % progress), promote their execution and protect the accessibility of the care available (detecting threatening over-supply or deficits in the care). Finally we want to stimulate at that level the dialogue between the various subsectors of healthcare and welfare in the care region. At the small-town level we will ensure that practical support and patient-oriented functions for primary care are included (support for local group operations, facilitation of multidisciplinary consultation, the provision of 24 hour cover etc.). To achieve this, we shall better structure the meso level. We will continue the Impulseo Fund's operations that provide incentives for newly qualified general practitioners and support for GPs and groups of GPs and examine how we can

improve them. We shall create a framework for organisational models for the practical implementation of primary care that could offer sustainable solutions for chronic care needs.

1.2 The Policy memorandum of minister Vandeurzen 2014-2019 *Streamlining regional consultation*

An accessible healthcare presupposes recognisability for the citizens. To magnify this, we restructure and simplify various network and consultation structures in primary care.We want to start from our care facilities' strengths with their diversity of forms in which primary care providers operate. Cooperation partnerships in primary healthcare, the palliative networks, LOGOs, the network structures that, with the state reform, are transferred to the Flemish Community such as the local multidisciplinary networks, the cooperation partnerships pertaining to palliative care, the multidisciplinary support teams for palliative care and the integrated services for home care shall be transformed into two structures with a reorientation of assignments in order to offer more customised care from a network. We shall study hereby the possible integration of the Consultation Platforms for Mental Healthcare.

- At regional city level[1] we want to integrate the various multidisciplinary cooperation structures into one structure so that the cooperation is simplified and the efficiency is increased. The coordination with the home care sector, the welfare sector and the hospital care will be linked to this. At this level, Flemish care objectives will be quantified.
- The practical supportive and patient-driven functions shall be included at the small-town level[2]. In addition, a framework shall be offered for cooperation models in the primary care in order to reinforce the quality of the chronic care.

In this way, the recognisability of these structures will be clearer for the citizen and for those needing care. The simplified structure will also lead to efficiency gains for care providers and the government, such as the reduction of the number of consultation moments.

This restructuring of primary care shall be prepared in joint consultation with the stakeholders, including representatives from the healthcare actors in primary care. The Flemish Patient forum shall be represented in the consultation. This process shall require an amendment to the Flemish Parliament Act pertaining to primary healthcare. The restructuring of the primary healthcare shall be prepared and confirmed during a new conference for primary care.

1.3 Definition primary care[3]:

- Refers to directly accessible, ambulant, generic care for non-specified health or welfare problems (or problems related thereto), whether of a physical, psychological or social nature.
- Forms, in principle, the first contact with professional care;

[1] The regional city level is often considered as the current level of the SELs and LOGOs that are divided into 15 units. These are, however, of unequal size.
[2] The small-town level is the level defined in the Flemish Parliament Act on Care Regions with 75,000 to 125,000 inhabitants
[3] Obv SAR WGG, Memorandum of Reflection Primary Care. Contribution arising from the Flemish conference on Primary healthcare, Brussels, 4 November 2010, p. 6-7.

- Can offer diagnostic, curative, revalidating and palliative care for the vast majority of the problems;

-Offers prevention for individuals and risk groups in the indigenous population;
- Takes into account the personal and social context of people;
- Ensures continuity of care over time and between care providers.
- Supports the informal care around the patient/customer

1.4 Short sketch of the conceptual framework around the future of care: evolution from acute and ad hoc care to integrated care and support

Considering the current social context with an increase in the number of persons with a sustained need for care, chronic illness and multi-morbidity (several chronic illnesses), we want, when organising the primary care, to start from a person-driven and integrated approach and no longer from an illness-driven approach. Placing persons with a care need at the centre means that care provider and care seeker enter into a mutual dialogue about the needs and objectives in the area of welfare and health. This also means that we must see primary care as a whole (including the broad welfare care, mental healthcare, specialised care, prevention) and perhaps even belonging to policy areas other than Welfare, Public health and Family (e.g. work, education, accommodation etc.).

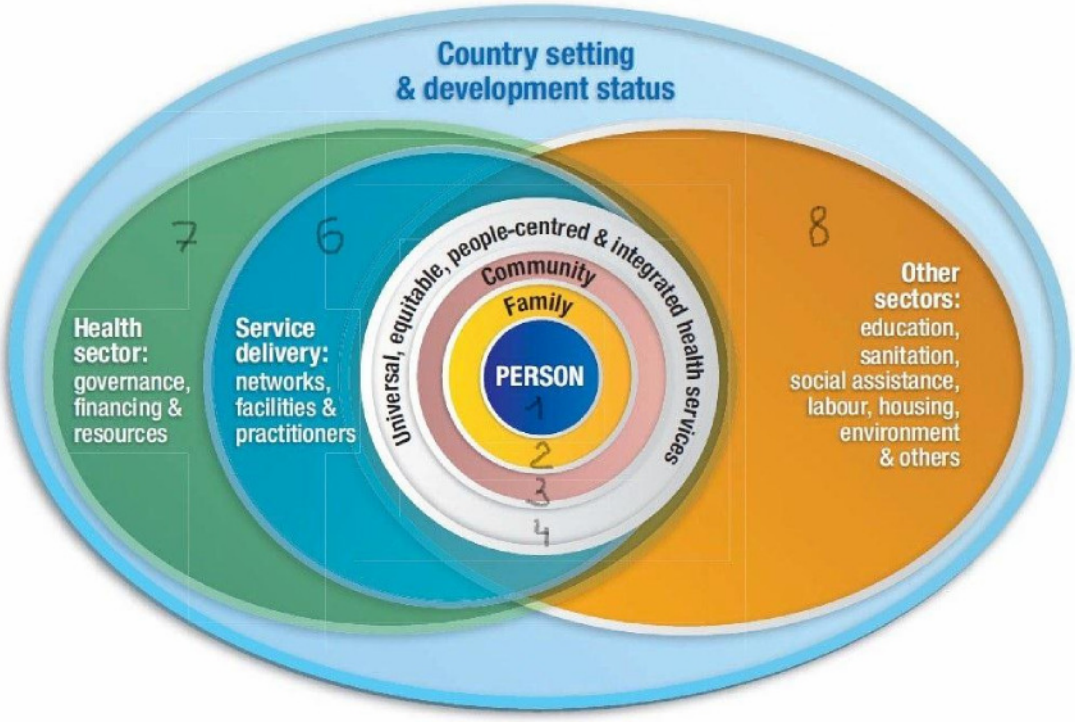
For the support of a person with a prolonged care need, we start from the **supportive model of the American Association on Mental Retardation** (AAMR) **and of the World Health Organisation[4].**

In these models, the client holds the central position and determines, if necessary in consultation with his informal and formal care providers, which support levels can make a contribution to his health, welfare and quality of life. According to the principle of complementarity and subsidiarity, the various support levels in this model build on each other and the support level grows in harmony with the need of the customer. The circle model also assumes that the customer can switch between various care forms as his needs evolve. This does not only demand a good assessment of the support needs but also an efficient data exchange between actors (with the approval of the customer). The drawing up of a care plan is necessary for a number of more complex situations.

The financing system and the excess scheme must allow easier switching between care forms, customised to the needs of the customer. The financing model must moreover contain incentives in order to allow care forms to cooperate, so that a supply of integrated care can be guaranteed.

[4] WHO global strategy on people-centred and integrated health services, interim report WHO/HIS/SDS/2015.6: conceptual framework for people-centred and integrated health services (pg 13)

Fig 1. Conceptual framework for people-centred and integrated health services



Circle 1 **self care**i.e. the care and the support that the person with a care need acquires himself. In order to maximise that self care, the person in need of care must have access to **aids to make home care possible**.

Circle 2 care and support that is offered by**informal caregivers** at home: family and/or friends

Circle 3 informal care by **volunteers** and **neighbourhood-driven** support. We see here an explicit role for the local authorities, civil society and the local care networks.

Circles 1 to 3 together form the primary social network and framework in the socialisation of the care. By this we mean, among other things, that the patient and his informal caregivers are given the necessary instruments and can receive the necessary support to make care possible. Socialisation also means that inclusion in society of persons with long-term care needs and persons with a handicap are made possible.

Circle 4 **professional care and support**: this includes care providers and care organisations that fall under federal responsibility: primary healthcare providers (general practitioners, home nursing, physiotherapists, etc.), general and university hospitals, rehabilitation services and clinics, and also services that fall under Flemish responsibility: centres for general welfare work, centres for mental healthcare, home care provisions[5] (services for family care and supplementary home care, services for logistic help, services for home minders, social work services by the health insurance, local service centres, regional service centres, centres for foster care, associations for users and informal caregivers), provisions for the elderly[6]

[5] These are provisions included in the Flemish Parliament Act on Residential and Home Care of 13 March 2009
[6] These are provisions included in the Flemish Parliament Act on Residential and Home Care of 13 March 2009

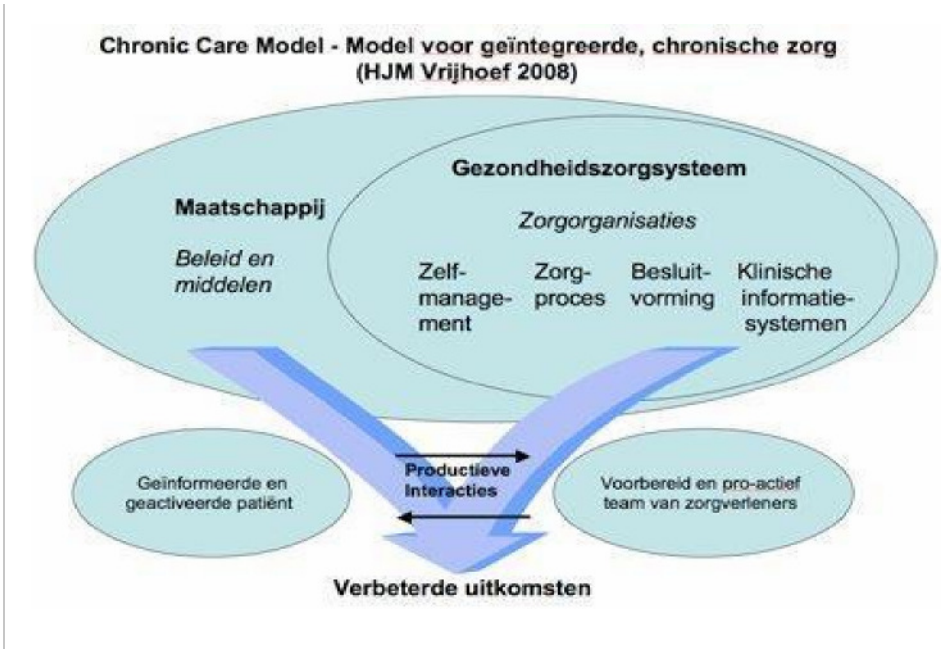
(day-care centres, centres for convalescence, centres for short stay, residential care centres, groups of assisted homes) and often facilities replacing the home environment (psychiatric care homes and protected living initiatives) ~), a number of rehabilitation initiatives (Sp services, centres for ambulant rehabilitation•••)[7].

The circle model should not be viewed as a mechanistic system, whereby the capabilities in a given circle are required to be completely exhausted before the next circle can be tapped into. Each plan is a highly individual exercise which seeks to establish what is desirable and feasible, in consideration of the wishes of the person with a disability and the resilience of all the circles.

In the WHO model, it also becomes clear how the formal and informal care organises itself in a network (no 6) and how the organisation of the care is subject to the policy followed and the available resources (no. 7). The model also illustrates how other areas of life such as education, employment, housing, environment etc. have an important impact on the health and well-being of the person (Health in all policies – no 8).

In addition to this circle model, which formulates a vision on care, there is also the **Chronic Care model by Wagner that offers a model for the organisation of healthcare**. In this model, the medical and non medical care is transformed from an acute, reactive care to a proactive, planned care. This model is based on a combination of effective care offered by a care team and is aimed at stimulating self-management. Empowerment of the person with a care need runs like a common thread through this model. The model itself is built up of columns of care: clinical information systems, decision-support and care processes, the column policy and resources and empowerment (of the care seeker) that runs through both these columns.

7 remark: The care for persons with a handicap and a great need for support, also if this takes place in a home replacing environment, takes place via specialised and professional care providers (the so-called step 2 of the person-linked financing system). Hereby, access is given to this care via an appropriate procedure and determined according to fixed criteria (cf. the Flemish Parliament Act on Person-linked Financing for Persons with a Handicap. For these reasons, this care is not taken into consideration and this care is allocated to a separate fifth circle in the AAMR model. Step 1 of the Flemish Parliament Act on Person-linked financing, the basis support budget, is, however, located in circles 1 to 4.



The **Strategic Advisory Council for Welfare, Health and Family** (SARWGG) of the Flemish Community stated in the Vision Memorandum "Socially Responsible Care" five important principles: quality, performance, justice, relevance and accessibility. An accessible and high quality care depends ultimately on the availability of the care offered.

1.5 Coordination between federal government and Flanders

Good coordination between the Flemish and federal level is crucial. This already took place before the 6th state reform but will become even more important because the powers for patients with chronic care needs are strongly intertwined between the federal and Flemish authorities.

The orientation memorandum 'Integrated vision on the care for the chronically sick in Belgium' of 2013 and adopted at the national conference Care for Chronically Sick of 28 November 2013 and the Inter-Ministerial Conference of 24 February 2014, contains six areas of action: multidisciplinary patient file, case management, multidisciplinary care, training and education, quality and evolution of the care and finally, making the actions operational and supporting and evaluating them. Twenty action points were defined in these areas. Quite a few of these action points are reflected in initiatives at the Flemish level

During this term of office, the conceptual process around chronic care at federal level will be continued in close cooperation with the communities and regions and prepared in an inter-administrative cell between the Federal public service Public health and the National Institute for Sickness and Invalidity Insurance. At the Inter-Ministerial conference of 30 March 2015, a common statement about chronic illness was approved by all the public authorities involved. The aim is to develop a common action plan and communal actions around chronic care. The communities and regions will be able to place their own accents in this. In the context of this plan a collective appeal will be launched for pilot projects in chronic care. Also with regard to the reforms of the hospital financing and the pilot projects in the context of the reduction of the length of stay, this shall be worked out in very close collaboration.

1.6 Policy concerning primary care in Flanders up to and including 2014

In 2004 the Flemish Parliament Act on Primary Care came into force. The Cooperation initiatives for Primary healthcare (SELs) were set up in 2008 by a Decision of the Government of Flanders. The Flemish Parliament Act on Care Regions (2008) and the Flemish Parliament Act on Residential and Home Care (2009) were adopted.

At the end of 2010 a primary healthcare conference was organised. A preparatory stage with various working groups was followed and culminated in reports from each working group and an umbrella synthesis report. The objective of the conference was twofold:

- to improve the quality of the primary healthcare for the patient through a better and more professional collaboration between the various care providers;
- to better guarantee the quality of life and work of the care providers by supporting and facilitating cooperation and by organising them in such a way that the administrative burden is reduced for all parties involved.

Following the example of this conference, considerable emphasis was placed on the development of ICT support for the primary care. Projects in the primary psychological care were also initiated, a Care Ambassador was named, a Cooperation Platform for Primary healthcare was created, thought was given to multidisciplinary cooperation partnerships at the level of practical implementation and the realisation grew that the supporting meso level needed restructuring.

On 7 December 2013, a symposium on primary healthcare took place, in which the current status of the policy in the matter was issued.

On 25 April 2014, the Government of Flanders adopted the Flemish Parliament Act concerning the organisation of the network for the sharing of data between the actors in healthcare. This Flemish Parliament Act refers to the sharing of data within primary care and within the secondary line and residential care. In this way, this Flemish Parliament Act makes a direct contribution to a more integrated and continuous care process.

The Sixth State Reform gives the possibility and opportunity for a thorough rethink about the reorganisation of the primary care, both in the area of structures and of content. The coalition agreement of the Government of Flanders and the policy memorandum 2014-2019 of Minister Vandeurzen both state that we want to put this into practice in consultation with the stakeholders in the field.

2. Change process 2014-2019

2.1 Reorganisation of the meso level in primary care

Basing ourselves on the vision developed on integrated care and support and the path that has already been taken, we can determine how the primary care meso level should function and which support it offers. By extension, the support of the policy level (macro level) will also be redefined.

If you are to undertake a change process that can rely on a sufficiently broad consensus, the necessary time must be devoted to developing models that are not only well-founded theoretically, but also withstand the test in practice (feasible, realistic).

For this, we are starting a preparatory stage in consultation with care providers and patients on the basis of working groups, with a clearly defined objective. We propose a contextual framework and a preparatory stage with 6 working groups, assisted by a steering committee and, where desirable, with an assessment by an scientific chamber of reflection. This stage will take place under external supervision.

2.2 Objectives and assignments of the 6 working groups and support by steering committee and academic chamber of reflection:

In order to restructure the meso level in a well founded way, it is vital to formulate clearly how we want to organise integrated care in Flanders, and how we truly want to place the patient/citizen at the centre of the care process. We must similarly determine which data are necessary in order to achieve this in a qualitative way in a specific area and which cross-compliance is necessary to mobilise the care providers for this. That is why, in addition to the working group targets and structure integration and region demarcation, four other working groups were started to operate in parallel. The 6 working groups were supervised by a steering committee.

Working group 1: "Targets and Structure Integration"

Objective Targets:
The allocation of clearly defined functions and concrete assignments and tasks, necessary for achieving an integrated care approach, at the levels that must support the level that puts it into practice.

The current levels are a small-town level of 60 units, the regional city level with 15 units and the macro level with 1 unit. The starting-point of this exercise is formed by a list of basic tasks validated by the Cooperation Platform for Primary Healthcare. For the allocation of the assignments and tasks, the aim is to achieve complementarity, the absence of overlap and to be as exhaustive as possible.

Objective Structure Integration:
Making a proposal for a supporting structure (structures?), based on the proposal for the 'Targets' exercise. The objective is to achieve the integrated care approach and efficiency gain, transparency and simplicity both for care providers and for citizens and care users.
For this, the working group fulfils the following assignments:

1. Determining to what degree the existing Flemish structures (SELs, GDTs, LMNs, HAKs, PN, PSV, MBE, LOGOs etc.) now provide an answer in content (so in the area of operations) to the assignments and tasks that were situated on a certain support level in the objective 'task integration'.
   Note: this exercise can show whether there are overlaps or gaps, in other words: functions, assignments and tasks that are either carried out by several structures or have not been adopted by any single structure.
2. Study to what degree the existing structures answer the proposal for support structure.
   Starting-point is budget neutrality.
3. Determine the conditions that must be achieved to be able to achieve the proposal of structure.
4. Drawing up a time line to set up the new structure in reality.

The working group formulates in consensus an opinion to the conference which, after political validation leads to amendments to the Flemish Parliament Act on Primary healthcare and possibly to the Flemish Parliament Act on Residential and Home Care. **Working group 2 "Geographic demarcation of the care regions"**

Objective:
Drawing up a proposal for care regions based on the results of working group 1. Hereby the following shall be taken into account:

a. The Flemish Parliament Act on Care Regions with its various levels (small-town, regional city, merger municipality, sub-level 1 and sub-level 2) are used as reference points for the demarcation;
b. Complete coverage of the Flemish territory;
c. Cube principle: a clear, non-territorial overlapping organisational structure whereby each smaller organisational territory must be a part of only one larger organisational territory;
d. Respect for municipality borders (and possibly also provincial borders);
e. Attention for suburbs.

This working group does not express any opinion about the content.
The starting-point here are the possibilities for cooperation within a model for integrated care.

The working group formulates in consensus an opinion to the conference which, after political validation leads to (possible) amendments to the Flemish Parliament Act on Care Regions.

Working group 3: "models for integrated care"

Objective:
The reorganisation of our primary care landscape must better address the need for a more person-directed and integrated approach of persons with a complex and long-term care complaint. For this, a Flemish model of integrated care will be developed, based on existing models, with an eye for the coordination with the federal project of integrated care for chronic diseases. All sub-aspects/columns of the desired Flemish model will be worked out in detail: self care and patient participation, informal care, professional care, (multidisciplinary) consultation, cooperation conditions, care continuity, care processes, care coordination, care continuity (multidisciplinary within primary care, outpatient and inpatient), support etc.

For this, the working group fulfils the following assignments:

1. Description of the desired Flemish model for integrated care.
2. The description of the current models of care provision in Flanders including test projects around integrated care.
3. Making the gap analysis between the current care provision model and the desired Flemish model of integrated care: cross-compliance that is necessary for a paradigm shift from an illness-driven to an objective-driven approach of care
4. The formulating of cross-compliance for achieving the desired Flemish model of integrated care.

Working group 4: "focus on the patient"

The central position of the patient/customer[8] and his environment is seen today as an obvious starting-point although in reality we often see that the care is still organised 'around' or 'over' the patient/customer.

Objective:

Working out a vision and scenario to give the citizen and the patient a leading role in the integrated care, in all aspects of that care in which that patient/customer must be involved.

For this, the working group fulfils the following assignments:

1. Determining the role of the citizen and patient in the strategy development process.
2. Establishing the working method to involve the citizen and patient structurally in the policy development process.
3. Formulating processes around
    a. a model or models of neighbourhood-driven care and the way in which the necessary actors can be involved in this.
    b. complaint consultancy and treatment at a level that rises above the practical execution level.
    c. the expansion and strengthening of the informal care and what conditions must be fulfilled for this.
    d. Access to primary care (this means taking into account the powers, primarily accessibility of care from a social-cultural perspective)
    e. Uniformly a transparent entrance to care

A representative from this working group shall be present in each of the other working groups, to secure the position of the patient/client in these working groups.

Working group 5: "Data sharing and Quality of care"

The principle of data sharing in care has now been anchored by act of parliament. There are various ICT initiatives to facilitate this, the necessity of it slowly but surely is reaching all care providers, support is facilitated and the campaigns concerning informed permission from the customer/patient are under way.

In addition, our thinking evolves, also with regard to primary care, towards more 'measurable' (output of) quality of care. The initiatives around this within the hospital landscape and the residential care centres have a trendsetting role in Flanders.

Objective:

Working out a model for evaluation of the quality of care within an integrated care approach.

For this, the working group fulfils the following assignments:

1. Stipulating the elements that determine the quality of care within an integrated care approach.
2. Stipulating quality indicators for all elements of quality of care within this integrated care approach.
3. Stipulating which data are necessary to be able to measure the quality indicators.

8 In the conferences around 'Smarter care for tomorrow' opt for using the terminology of client (and not patient/citizen/user) to indicate that this is about welfare and healthcare, and that this is not about the commercial term 'customer'. The term 'client' has not yet been accepted in the healthcare world. That explains the choice to use both side by side. Often initiatives are also directed at the broad population or at persons who are not yet ill. In such cases we shall rather talk about citizen.

4. Establish the conditions for gathering, analysing and reporting data from assignment 3.

Working group 6: "innovation and entrepreneurship in care"

Innovation and entrepreneurship remain in care little more than a slogan and too little

implemented with regard to the reality of the care provider. Furthermore, one should guard against a surfeit of pilot projects, demonstration projects and experimental gardens that, in retrospect, are seldom if ever implemented.

Objective:
Achieve solutions for rolling out those innovative and innovation projects in care that have been positively assessed.
For this, the working group fulfils the following assignments:

1. Drawing up an inventory of the results of innovation projects, experimental gardens, innovation projects and innovative technologies that already take place in Flanders and the degree of realisation/roll out on a large scale.
2. Based on this inventory, establish which projects that have not yet been rolled out are worthwhile to be rolled out on a large scale and which conditions must be fulfilled for this.
3. Based on an integrated care approach, we ascertain which other innovations (that are not yet included in assignment 1) can contribute to the realisation of this care approach and which conditions must be fulfilled for this.
4. Making proposals for initiatives to support the cooperation at the level of the practical execution in primary care, so that we can talk of integrated care.

The working group is in close contact with Flanders' Care and takes into account the implementations and assignments of the working group ICT of the Cooperation Platform for Primary Healthcare.

General remark: we do not choose for a separate mental health working group. We believe that mental healthcare is an integrated part of care and as a consequence assume that mental healthcare shall have a place in all working groups. We shall, as a consequence, ensure that a delegate is present from this sector in all working groups.

Composition of working groups

Chair: must have sufficient neutrality and preferably not be directly connected with one of the stakeholder organisations. The preference is for an independent scholar/academic

Members:

- One representative from each important stakeholder primary care organisation, provision, professional group;
- experts from the sector;
- agency

Stakeholders and involved parties (not limitative): SELs (cooperation initiatives primary healthcare), GDTs (Integrated services for home care), palliative networks and cooperation partnerships, palliative support teams, LMNs (local multidisciplinary networks), expertise centres dementia and maternity care (platforms) mental healthcare, LOGOs, professional associations for, e.g. general practitioners, chemists, dentists, home care nurses, physiotherapists etc., social welfare services of the national health insurance, Flemish Patient forum, informal care associations, hospital sector, services for family care and supplementary home care, local service centres, residential care centres, local managements (Association of Flemish Cities and Municipalities), Centres of General Welfare etc.

A balanced representative of the relevant stakeholders is of crucial importance to reach broadly sponsored proposals (consensus) within the working groups.

The members of the Cooperation Platform for Primary Healthcare and the organisations involved through the state reform but not yet included in the platform shall be invited to propose names.

Steering committee

A steering committee that consists, among other things, of chairs of the working groups, follows the activities of the working groups and ensures adjustment if this proves necessary. The steering committee also ensures coordination with other processes including the reform in elderly care and mental health care and the activities around chronic care at federal level.

A similar theme can arise in different working groups. The steering committee can decide in which working group this shall be developed further.

The objective of the steering committee is to have, at the end of the preparatory stage, a logically cohesive whole of measures to start the change process.

Within the steering committee, thought must be given simultaneously to all cross-compliance that shall be necessary to put the proposals of the working groups into practice. This concerns legislation, financial resources, consultation with other policy areas and policy levels, means of communications, possible project operation and so on.

Academic chamber of reflection

Group of academics that comment on the reports of the working groups and formulate an opinion.

2.3 Timing of the change process

The approach with working groups to prepare the primary healthcare conference shall be validated by the Cooperation Platform for Primary Healthcare of 25 February 2015. At that moment, the cooperation platform was asked to submit suggestions for participation in the various working groups.

The working groups shall complete their activities by October-November 2016.

The minister shall visit all the provinces with the proposals from the working groups. The broad field of action shall, in this way, be given the chance to reflect on the proposals of the working groups.

The restructuring and content orientation of the Primary Care in Flanders must come to fruition at a “conference Reorganisation of the primary care in Flanders” in the spring of 2017. This conference is the fermata of the preparatory process. During the conference, the models of reorganisation of the primary care and all conditions that are necessary shall be presented. The Cooperation Platform for Primary Healthcare of 25 February 2015 clearly indicated that they would reach effective decision-making following this conference.

After the conference, the actual change process shall start, for which several years and a thorough support from the policy level must be envisaged.

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List of abbreviations used and definition

Collaboration initiative Primary healthcare (SEL)

An SEL is a collaboration between care providers, primarily:

- the services for family care;
- the general practitioners;
- the local service centres;
- the public centres for social welfare;
- the residential care centres;
- the nurses and midwives;
- the social work services of the national health insurance, whether or not in collaboration with one or more regional service centres.

The other care providers, associations for informal carers and users and volunteer organisations that are active in the work area of an SEL, shall be invited to become a member of an SEL. By working together, these care providers wish to improve as much as possible their service and care provision around the patient. They take initiatives to coordinate their care provision to the needs of the patients in their region and enter into agreements to coordinate their care provision with each other. An SEL can also organise social and cultural education for the care providers and offer useful information.

Integrated service for home care (GDT)

A GDT is a healthcare provision that covers the whole patient care. A GDT does that, for example, via the practical organisation and support of the multidisciplinary consultation around a person in need of care. Only accredited SELS can be accredited as GDT.

Palliative Network/Palliative Cooperation partnership (PN/PSV)

A PN/PSV is a cooperation partnership around palliative care between various care providers and care provisions in a certain region. The network offers advice, information, support and coordination to all care providers that have to deal with palliative care. The aim of the collaboration is to build up the expertise of care providers about palliative care. This concerns, among other things, pain and symptom control, social and moral aspects, care for the next of kin etc.

The welfare services are supportive: the network helps the care provider in his assistance to a palliative patient, but does not assume his role.

In addition, a PN/PSV offers information to the citizen about the possibilities in palliative care. The networks increase the awareness among the population of the importance of palliative care.

The prime intention is to ensure that the patient can have a humane death in the environment where he wishes that to take place.

Multidisciplinary assistance team (MBE)

An MBE is a team with experts in palliative care. They offer support and help to other service providers that offer palliative care to their patients. The team works together with general practitioners and with other service providers, such as nurses, physiotherapists and psychologists. Although the support of other care providers is its primary task, the team can be directly deployed in the palliative care of a

patient.

An assistance team therefore has 2 primary assignments:

- give advice on palliative care to the care providers in primary care;
- provide psychological and moral support to the patient, the informal caregivers and possibly to the care providers of the primary care.

The MBEs are connected to the palliative cooperation partnerships. There, all palliative care providers in a certain region are represented.

Local Multidisciplinary Network (LMN)

The LMNs are pilot projects that are started up by the NSMDI for the support of so-called care pathways (ZT). The care pathways, also NSMDI projects, were started in 2009 and are aimed at 2 chronic diseases: diabetes type 2 and chronic kidney insufficiency. The care pathways aim at a better collaboration between general practitioner, specialist and other service providers involved (e.g. for diabetes: diabetes educators, podiatrists, dieticians, opticians etc.), and also an improvement in the quality of care provision. The general practitioner is the hub of the care pathway, while the specialist has a supporting (coaching) role. The patient should also have an active role within his care pathway (cf. empowerment through a better insight into the illness and care pathway, increased self-management). The general practitioner initiates the signing off of a care pathway contract between the general practitioner, specialist and patient. He then makes, in consultation with the patient, a care plan, in which further consultations are planned with the general practitioner and the specialist, and also consultations with other paramedics, technical examinations etc.

In 2009, the pilot project LMN was commenced, to promote the signing of care pathway contracts. An LMN must build up a local multidisciplinary network and support all actors that cooperate in the care pathway. An LMN is an initiative that is organised by a local GP group (HAK), preferably in collaboration with an integrated service for home care (GDT). A HAK (sometimes several HAKs) enter into an agreement with the National Institute for Sickness and Invalidity Insurance, through which a HAK receives resources enabling it to sign an employment contract with one or more care pathway promoters (ZTP), The ZTP, among other things, takes care of publicising the ZT in the region, the gathering of information about the operation of the LMN, the cataloguing of the partners in the region, organising meetings, administration, facilitating the provision of information and communications, reporting on tasks undertaken to the steering committee etc. The objectives and activities of an LMN, and also the working area and role of the ZTP, are also laid down in the agreements that are concluded by the National Institute for Sickness and Invalidity Insurance with the initiators of the LMN (HAK). Each LMN must also form a multidisciplinary steering committee, in which all medical and paramedical disciplines which participate in the care pathway must be represented. The GDT must also be represented in the steering committee, except when they expressly refuse.

Expertise centre for dementia

The expertise centres for dementia offer information and support to everybody confronted with dementia. There are many misunderstandings and prejudices about dementia. The expertise centres combat this by informing and making citizens and welfare workers aware of the problems. You can apply to such an expertise centre, for example, for answers to questions about dementia, about care provision for dementia etc. Furthermore, the expertise centres provide a permanent point of contact for everybody

confronted with dementia. Many of those directly involved do not dare to talk about it because they are ashamed or feel guilty. This reticence was partly the reason for founding the expertise centres.

Finally, the expertise centres gather together the information and expertise about dementia that is present in Flanders.

Expertise centre maternity care

The expertise centres offer:

- A documentation centre, with books and film material about pregnancy, birth, maternity time, breast feeing, raising children etc.
- An expert answer to your questions about maternity care, caring for the baby, the service provision connected with pregnancy and birth in the region etc.
- A wide range of maternity material
- Workshops and information sessions for pregnant women and young parents
- Training and refresher courses for professional care providers

The expertise centres for maternity care are a partner organisation of Child & Family.

General practitioner group (HAK)

A HAK is an association of practising, recognised general practitioners who exercise their professional activities within a specific working area, the GP zone. The GP zone is a connected geographic area of one or more municipalities, or part of a municipality in the larger agglomerations of Antwerp and Ghent.

Consultancy forum mental healthcare

The consultancy platforms group together the following provisions in mental healthcare:

- general hospitals that have a recognised psychiatric unit (PAAZ).
- psychiatric hospitals (PZ)
- psychiatric care homes (PVT)
- centres for mental healthcare (CGG)
- initiatives for Sheltered Housing (BW),
- provisions with a National Institute for Sickness and Invalidity Insurance convention that are responsible for organising a specific group of services within mental healthcare.

Cooperation partnership for local-regional healthcare consultation and organisation (Logo)

The Logos form geographically demarcated networks within which various organisations collaborate to implement the Flemish preventive medical policy (the six health objectives) at a local-regional level. Logos thus help to publicise within their working area the initiatives and methodologies that the Government of Flanders offers to promote, to protect or to maintain the health of the population.

Centre for General Welfare Work (CAW)

The CAW helps people with all their questions and problems relating to welfare (personal problems, financial, administrative, legal or material problems, problems in your family, friends, neighbourhood etc.). They also offer help to victims of violence and abuse, victims and those

involved in traffic accidents and crimes, and to offenders and their relatives. It wishes to offer support to those who are in difficulties and help them find their way. It wants to offer tranquillity to those who have lost it. It wants to strengthen people's potential. It wants

to assist people in making use of their basic rights. It wants to combat any form of exclusion. It fights for a humane and dignified life for everybody. It supports equal opportunities and aims for a harmonious society.

Additional powers after the 6th state reform

powers sixth state reform	budget 2015 (in euro)
Family benefit	3,620
FCUD	42
residential elderly care	1,868
Isolated G or SP services	102
Hospital infrastructure	0
Rehabilitation institutions	150
MAF	7
THAB	388
Mobility aids	57
Psychiatric care homes (PVT)	79
Initiatives for Sheltered Housing (IBW)	40
Consultancy forum mental healthcare	5
Prevention and primary help	47
operating costs FO and National Institute for Sickness and Invalidity Insurance	2
House of justice and primary help	42
Electronic ankle tagging	0
Youth protection	9
Total	**6,458**

Powers in health care

	financial contribution vaccination campaign	31/12/2014
	Preventive actions undertaken by the dental profession	31/12/2014
	ozone	31/12/2014
	Plan food-health	31/12/2014

Details of the agreed powers in healthcare

power cluster	theme	Transition period to:
Hospital policy	guidelines	31/12/2014
	categorical: Isolated (G and) SP services	31/12/2017
Elderly policy	Rest homes for the elderly (ROB)	31/12/2017
	Rest and Care Homes (RVT)	31/12/2017
	centres for day care	31/12/2017
	centres for short stay	31/12/2017
	Pricing policy	31/12/2014
	Assistance in help for the elderly (THAB)	31/12/2015
Mental healthcare	Psychiatric care hospitals (PVT)	31/12/2017
	Initiatives Sheltered Housing (IBW)	31/12/2017
	Consultancy forums mental healthcare	31/12/2014
Primary healthcare	General Practitioner Circles	31/12/2014
	Impulseo Fund	31/12/2014
	Local multidisciplinary networks	31/12/2015
	Palliative cooperation partnerships	31/12/2014
	Multidisciplinary palliative teams	31/12/2017
	GDT (integrated services for home care)	31/12/2015
	Consultation forum about the psychiatric patient in a home setting	31/12/2015
Recognition healthcare professions	Recognition healthcare professions	31/12/2015
Rehabilitation agreements	Centres for ambulant rehabilitation (CAR	31/12/2017
	Mental healthcare	31/12/2017
	others	31/12/2017

	specialised drug aid	31/12/2017
Prevention policy	Tobacco withdrawal	31/12/2015
	addiction fund: tobacco	31/12/2014
	addiction fund: drugs	31/12/2014
	Screening colorectal cancer	31/12/2014
	HPV vaccination	31/12/2014

Powers that will be discussed by the working groups and the primary care conference

Composition of the Cooperation Platform for Primary healthcare dated 09/02/2015

Cooperation Platform for Primary Healthcare	effective / alternate member	first name	surname
University of Ghent	effective	Jan	De Maeseneer
University of Ghent	alternate member	Bruno	Art
Catholic University of Leuven	effective	Bernard	Himpens
Catholic University of Leuven	alternate member	Dominique	Declerck
Catholic University of Leuven - LUCAS	effective	Chantal	Van Audenhove
Catholic University of Leuven - LUCAS BVR holding the appointment of the members of	alternate member	Evelien	Coppens
Academic Centre for General medical practice	effective	Jan	De Lepeleire
Academic Centre for General medical practice	alternate member	Frank	Buntinx
Axxon - Quality in physiotherapy vzw	effective	Dirk	Verleyen
Axxon - Quality in physiotherapy vzw	alternate member	Stefaan	Peeters
Flemish Agency for Care and Health	effective	Dirk	Dewolf
Flemish Agency for Care and Health	effective	Tom	Vermeire
Flemish Agency for Care and Health	effective	Bob	Ide
General Syndicate of Physicians of Belgium (ASGB)	effective	Reinier	Hueting
General Syndicate of Physicians of Belgium (ASGB)	alternate member	Michel	Creemers
Syndicate of Flemish General practitioners (SVH)	effective	Rufy	Baeke
Syndicate of Flemish General practitioners (SVH)	alternate member	Herman	Moeremans
Flemish Physicians Syndicate (VAS)	effective	Georges	Casteur
Flemish Physicians Syndicate (VAS)	alternate member	Hilde	Roels
SOM the federation of social companies vzw	effective	Anita	Cautaers
SOM the federation of social companies vzw	alternate member	Lieve	Van Den Bossche
Domus Medica	effective	Jozef	De Smedt
Domus Medica	alternate member	Peter	Dieleman
Jong Domus Medica	effective	Erika	Van Nuffel
Jong Domus Medica	alternate member	Gijs	Van Pottelbergh

House for Health	effective	Greta	De Geest
House for Health	alternate member	Tine	Dusauchoit
National Intermutualistic Committee	effective	Luc	Cools
National Intermutualistic Committee	alternate member	Bernard	Landtmeters
National Intermutualistic Committee	effective	Ivan	Van Der Meeren
National Intermutualistic Committee	alternate member	Jean-Pierr	Bronckaers
Minister Vendeurzen's Office	effective	Caroline	Verlinde
National Association of Catholic Flemish Nurses and Midwives (NVKVV)	effective	Ellen	De Wandeler
National Association of Catholic Flemish Nurses and Midwives (NVKVV)	alternate member	Kris	Vaneerdewegh
National Institute for Sickness and Invalidity Insurance (RIZIV)	effective	Ri	De Ridder
National Institute for Sickness and Invalidity Insurance (RIZIV)	alternate member	Jo	De Cock
SEL South-West Flanders	effective	Julie	Descamps
SEL TOM	alternate member	An	Nauwelaerts
SEL Hasselt	effective	Nele	van Meer
SEL Hasselt	alternate member	Kristel	Vanden Driessch
Strategic Advisory Council for Flemish Welfare, Health and Family Policy (SAR WGG)	effective	Gunter	Naets
Strategic Advisory Council for Flemish Welfare, Health and Family Policy (SAR WGG)	alternate member	Barbara	Krekels
Flemish Dispensing Chemists Network (VAN)	effective	Hilde	Deneyer
Flemish Dispensing Chemists Network (VAN)	alternate member	Dirk	Vos
Flemish Primary Care Forum (VELO)	effective	Christian	Devlies
Flemish Primary Care Forum (VELO)	alternate member	Laura	Picard
Association of Flemish Dentists	effective	Stefaan	Hanson
Association of Flemish Dentists	alternate member	Jean-Paul	Michiels
Flemish Professional association of Dentists	effective	Guido	Lysens
Flemish Professional association of Dentists	alternate member	Robert	Schockaert
Association of Services for Family Care of the Flemish Community	effective	Agnes	Bode
Association of Services for Family Care of the Flemish Community	alternate member	Robert	Geeraert

Flemish Network of associations where the poor take the word	effective	Griet	Briels
Flemish Network of associations where the poor take the word	alternate member	Frederic	Vanhauwaert
The Association of Flemish Cities and Municipalities (VVSG)	effective	Veerle	Cortebeeck
The Association of Flemish Cities and Municipalities (VVSG)	alternate member	Tine	De Vriendt
Flemish Professional association for Independent Nurses (ZBZV)	effective	Hugo	Baert
Flemish Professional association for Independent Nurses (ZBZV)	alternate member	Lucien	Speeckaert
Flemish Occupational therapists Association vzw	effective	Pierre	Seeuws
Flemish Occupational therapists Association vzw	alternate member	Jan	Lambrecht
Flemish Patient forum	effective	Ilse	Weeghmans
Flemish Patient forum	alternate member	Els	Meerbergen
Union of Flemish Midwives	effective	Kathleen	Vanholen
Flemish Organisation of Midwives	alternate member	Marlene	Reyns
Flemish Federation of Home Nursing Services	effective	Hendrik	Van Gansbeke
Flemish Federation of Home Nursing Services	alternate member	Jannie	Hespel
Carenet - elderly care	effective	Tarsi	Windey
Flemish Independent Care Network (VLOZO)	alternate member	Frank	Foucart
Carenet	effective	Johan	Pauwels
Icuro	alternate member	Vera	De Troyer
National Association of Socialist National Health Services	effective	Karin	Van Mossevelde
National Union of Liberal National Health Services	alternate member	Karin	Van Roy
National Union of Christian National Health Services	effective	Katrien	Van Kets
National Union of the Independent Healthcare Funds	alternate member	Annemie	Coeme
Flemish Association of Clinical Psychologists	effective	Koen	Lowet
Flemish Association of Clinical Psychologists	alternate member	Joeri	Calsius