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Incentivising quality improvement in Belgian hospitals

Belgium is a small country in Western Europe with a complicated state structure. When it comes to legislative and governance authority over Belgian hospitals, both the federal level of government and the regional level have significant, and at times overlapping, responsibility.

For example, the federal level finances the system while the regional level finances infrastructure. Both levels of government play a role in medical services and the delivery of care. And while quality in Belgian hospitals is the responsibility of regional governments, the federal government involves itself in financing hospital quality initiatives.

An integrated quality improvement system in Belgium's Flemish region has been developed and is built on three complementary pillars: ISQUA-accredited accreditation, use of indicators and supervision by means of an inspection tool.

All Flemish hospitals are involved in an accreditation process, and about 70% of these hospitals have acquired a positive accreditation status.

All Flemish hospitals participate in VIP² (Flemish Indicator Project for Professionals). Flemish hospital results are tracked and published on the public website, Quality of care – Zorgkwaliteit. The Flemish Ministry of Healthcare has developed a system of thematic inspection in such areas as internal medicine, surgical medicine, geriatrics and cardiology, for example. The reports of these inspections are also made public.

Accreditation and participation in VIP² are on a voluntarily basis. There are no financial incentive for Flemish hospitals to participate. The cost of a first accreditation in a medium-sized hospital can cost as much as 1 million euros and is paid entirely by the hospital. Concerning the indicator project, there is a small financial contribution from the government, which is equivalent to the cost of two full-time data managers.

Indicators are developed together with the hospitals, and the results are made public. Inspection against the indicators is obligatory and is performed unannounced.

Recently at the federal level a first step has been made toward a pay for quality system. One hundred hospitals will be assessed against a limited number of indicators. Limited funding has been dedicated to this project: 6 million euros (on a global budget of 8 billion euro).

The incentive for the hospitals to participate in these quality projects is

certainly not financial. Little money can be gained by the hospitals.

The publication of hospital results is the primary incentive for hospital participation—and of course a strong belief in quality improvement.

Quality improvement as a concept has taken hold, in Belgium, together with the tools used to evaluate and report.

Governments have invested little money in these projects and speculate on the power of public access and competition between hospitals as a key driving force for quality improvement.

Perhaps it is not important which incentive you choose as long as the on-going journey toward quality improvement is the final goal.

Dr Marc Geboers will talk about incentivising quality during Concurrent Session 2.5 'From projects to scalable solutions: sustainability in integrated care' at 11:00am on Thursday 11 October 2018 during day 2 of the World Hospital Congress.