Unplanned care: achievements and challenges

Speech by Frank Vandenbroucke at the symposium for the Belgian Society of Emergency & Disaster Medicine, 31 May 2024, Ostend.

Ladies and gentlemen,

My sincere thanks. For an audience of emergency physicians, I can't help but start with this. Four years ago, you all found yourselves very much in the eye of the storm, with a tiny virus triggering an unprecedented health crisis, one in which you showed resilience, decisiveness, and flexibility in helping our population the best you possibly could. For this, you have my sincerest gratitude.

However, the **coronavirus** did more than that, causing our healthcare system to rapidly **transform, as well as innovate**. We witnessed unprecedented levels of collaboration and creativity – between healthcare providers and between levels of authority. We witnessed a shift towards population management, towards prevention at the population level and public health in the form of tracing, testing, and vaccination. We learned again that 'science and solidarity' are key to overcome such a crisis. A model based on science and solidarity is robust, resilient, and can weather a crisis. We should continue to invest in it.

However, we also need reform. While it has become somewhat of a cliché to say that our healthcare system is under pressure, this is also a reality, which is not likely to change in the coming years. Indeed, our ageing population will continue to impact our healthcare system. More people will require care, especially since many ageing patients now live with several health conditions simultaneously. These patients often require more specialized follow-up, requiring several healthcare providers to partner up and work together. At the same time, we are experiencing a wave of retirements among caregivers, with the new generation holding a distinctly different view when it comes to work-life balance.

And yes, **unplanned care is the proverbial canary in the coal mine**. When GPs introduce ‘patient stops’, emergency departments feel the impact. With the decline in available care staff, unplanned care has few alternatives but to step up a gear with the workforce available. If patients have to delay care because of scarcity, this can lead to acute or more serious health problems down the line.

In the field, I often read and hear two reactions to the widespread feeling of being overburdened and overstressed, both of which I believe are unhelpful. I think I can summarize the first reaction as: '**less of the same'**. This is essentially the view of disgruntled doctors, who mainly blame the problem on patients allegedly demanding too much, running to the GP or ER for all kinds of 'minor grievances'. According to these doctors, the crux of the issue is that they have become too accessible, even 'too cheap'. In short, demand needs to be reduced without altering the existing care provision. In other words, 'less of the same'. The second reaction may be summarized as: '**more of the same**'. This is the argument that hospitals and care providers should simply receive (much) more money, with increased health insurance budgets, all without bringing the organization and funding of the system itself into question.

The idea that healthcare is under pressure because it has become too accessible has no empirical basis. Obviously, we need to explain to patients when best to consult a physician and when they really shouldn't. And obviously, an attitude of 'good patientship’ is necessary and patients must be explained that it is necessary, presumably more so today than in the past. In my recent book, I call for concrete initiatives to both define and promote 'good patientship', building on a question I already submitted to Prof. Tom Goffin, chair of the Federal Commission of Patient Rights.

But 'less of the same' is definitely not a realistic recipe for future success. 'More of the same', on the other hand, won't work either, if only because, even with a lot more money, we still won't be able to find the people necessary to multiply the existing supply of care. So we will have to organize things differently, more efficiently. After all, the scarcity I just described is not just a matter of 'numbers' in terms of health care providers - it is also exacerbated by inefficiencies in the way care is provided, with too little collaboration, too little continuity, too little focus on people's resilience, too many administrative burdens, too little attention paid to prevention and, yes, some waste as well, …

What's needed is '**more of something else**', and that presupposes investment and reform. Needless to say, sharply reducing the growth rate of our health care budget, let alone cuts in healthcare spending, would constitute an incredibly bad idea. We do need a stable growth trajectory of collectively organized health care spending. But we also need reform: in addition to 'more money for health,' we also need '**more health for our money'**. Within the broad reform agenda that lays before us, unplanned care cannot, and should not, be forgotten.

Allow me to briefly and non-exhaustively zero in on reforms in the domain of unplanned care that are ongoing or in our agenda.

An important starting point was the opinion of the National Council on Urgent Medical Care (Nationale Raad voor Dringende Geneeskundige Hulpverlening), a council which is a true multidisciplinary collaborative platform for policy-making in urgent medical care. The council was deeply concerned about the structural underfunding of Urgent Medical Care. I took this advice very seriously, and negotiated a **tripling of the federal budget to €239.67 million**. This budget increase is not unconditional; on the contrary, it was linked to a necessary drive for quality through, among other things, accreditation standards of ambulances, as well as the structural establishment of Prehospital Intervention Teams. I don't need to tell you that **the PIT discussion** stirred up emotions, even among you, about the question: should the PIT be a hospital function, or should we be anchoring them in our system of Urgent Medical Care? I believe this was a somewhat unhelpful discussion, inspired in part by 'territorial rivalry', if I may use that expression. We must work together, especially in Urgent Medical Care, and that is exactly what you are doing. Collaboration between emergency physicians, emergency nurses and EMTs (emergency medical technician). Collaboration between hospitals and emergency care zones (hulpverleningszones). Collaboration between GPs and emergency physicians. Collaboration between EMTs and PIT nurses.

The real challenge is to ensure maximum quality. There was, and is, no discussion about the need for quality assurance, and this is now anchored in regulation. PIT nurses will need to be employed at least 80% of their time in emergency departments (spoeddiensten) and will be supervised by an emergency physician from a specialized emergency department (gespecialiseerde spoeddiensten). Where possible, PITs will be based at hospitals with specialized emergency departments. Where this is not optimal for reasons of geographical distance and driving times, a cooperation agreement with a specialized emergency department is mandatory.

There is still a lot of hard work to be done to implement this reform, especially in the areas of regulation and programming. How should we optimally deploy ambulances, PITs, MUGs, as well as first medical responders so that every patient in this country is guaranteed proper and speedy service in acute medical situations?

One reform that has been the focus of considerable effort, and of which you can be truly proud, is the rollout of the Belgian Incident Tracking System (BITS) - the electronic casualty list. This is a digital, flexible tool that allows us to track casualties from an incident site to a hospital. A tool with which we

can quickly help families or friends looking for loved ones, but also a tool that everyone within the care chain, as well as the disaster response chain, can use to rapidly obtain an overview of the type and extent of care still required. Several European member states are showing interest in BITS, with the Grand Duchy of Luxembourg even testing BITS as part of its medical chain. And BITS is not finished yet, with the team continuing to work on additional modules to make the tool even better and more powerful.

Ladies and gentlemen,

Investment and reform. Reform in the organization of care, committing to local provision where possible, concentration of care where needed. For your sector the discussion on the **major trauma centers** is particularly relevant in this respect. As recommended by the KCE (Belgian Health Care Knowledge Center) in its Report 281 of 2017, and by way of analogy with our neighbouring countries, it is appropriate to concentrate the treatment of major trauma in 'major trauma centers' (MTC) that have the required staff and infrastructure, as well as a sufficient level of activity to develop and maintain an adequate level of expertise.

I developed a set of Royal Decrees (RDs) that aim to structure care for patients with severe trauma – i.e. with an ISS (Injury Severity Score) greater than 15 – in integrated and hierarchically organized geographic networks built around a limited number of supra-regional reference centers. These draft Royal Decrees were developed in cooperation with representatives from professional and scientific societies (emergency medicine, surgery, orthopedics, anesthesia, intensive care, and interventional radiology).

The cornerstone of the trauma network is the 'MTC care program' for which structural accreditation standards are established in terms of medical and nursing staffing. Additionally, infrastructure requirements are defined. Estimates indicate that around 3,000 major traumas occur in Belgium. As suggested by the KCE report, a minimum activity level of 240 patients with an ISS (injury severity score) greater than 15 is required. This implies that a maximum of about 15 centers are needed in Belgium, with sufficient coverage to achieve an adequate geographical coverage across the country. For 'major trauma care' networks that group the nearest hospitals, MTCs act as the central reference point. Each hospital should be part of one single 'major trauma care' network. In terms of articulation on emergency medical care (EMC), it is envisaged that emergency physicians will accompany patients to the nearest MTC.

Unfortunately, as we know, this did not make it through the Council of Ministers, due to short-sighted resistance form certain quarters. We nevertheless decided to introduce mandatory registration for all hospitals of major trauma data, starting January 1, 2025, so that a national trauma register will become available. Incidentally, I did manage to get parliament to approve the amendment you requested to the Quality Act (Kwaliteitswet) concerning deep sedation by emergency physicians in critical situations, provided, of course, they are trained to do so. But, trust me, if I have the possibility, I will put this set of RDs on major trauma centers again on the agenda of the next government. Citizens should not be satisfied with suboptimal care.

Ladies and gentlemen,

The **reform** agenda for unplanned care must be pursued with urgency. This is something I don't think I need to convince you of. Every day, you face high workloads, a shortage of healthcare personnel, an ageing population, overburdened general practitioners, and social evolutions, such as the '24/7' society where people expect immediate solutions to their problems.

I sense concern within your discipline, but I also notice a great deal of drive to address this and turn challenges into a positive narrative.

As mentioned earlier, this reform agenda cannot be 'less of the same' or 'more of the same', rather 'more of something else' – the right care, by the right people, in the right place, and at the right time.

We must continue investing in **good triage** of unplanned care, which can provide patients with an appropriate response to their care needs. Over the past few years, I have been strongly committed to working closely with the Ministry of Interior Affairs on emergency call/dispatch centers, and have provided additional resources for this purpose. This work must be pursued, including the rollout of a (digital) platform allowing patients to easily perform their own self-triage. I also refer once more to the first steps I have taken to develop a concrete initiative for defining and promoting 'good patientship.'

We need to further review the **organization** of unplanned care in all its facets, with properly functioning primary care out of hours care centers (huisartsenwachtposten), basic and specialized emergency departments, and supra-regional care organisations, such as major trauma centers, as well as CBRN reference centers. With enough – not too many, but not too few – MUGS, PITs and ambulances via 112. With sufficient – but not too many – specialized emergency departments, and with focused and well-coordinated supra-regional structures in place. And with adequate attention paid to preparedness and crisis response.

Last but not least, the organisation of our GPs must not only be improved and reinforced so that they can see more patients, the regular organisation of care - both in primary and secondary care – must continue to provide **sufficient room of manoeuvre and time for 'unplanned care'**. For that reason, there is a crucial link between the necessary investment and reform in the organisation of our primary care and addressing the pressure you feel in your emergency departments. Room of manoeuvre and time for unplanned care in the primary sector is enhanced if its funding supports availability during ‘waiting times’, rather than merely the number of individual acts. Funding the organisation and availability of primary care is, in a general sense, also one of the guiding ideas of the New Deal for GPs which is now tested.

Ladies and gentlemen,

Time does not allow me to elaborate on the need for preparedness, on which we have been working hard both in Belgium and at the EU level. Yet, I would like to make one point in this respect.

The **changing world**, geopolitical instability, and **climate change** will also confront unplanned care with added and new challenges. There is conclusive evidence that climate change is having a significant impact on public health. This is especially true for emergency medicine, which will be affected by extreme weather events (floods, fires, and storms).

I know I'm preaching to the choir here, but if we want to safeguard both the future and the health of future generations, then we must urgently address the climate issue. And this applies across all policy areas and levels of authority.

I am therefore delighted that 'ensuring as healthy an environment as possible' is included as one of the three inter-federal health objectives upon which I recently reached an agreement with my fellow federal health ministers (in addition to the two other objectives of prolonging healthy life and reducing healthcare inequality).

These health goals should serve as an important compass for future coalition agreements. Personally, I'd like to take this a step further. Given the importance of the climate issue, and given the intertwining of climate (disasters) and health (crises), at the federal level the governance of public health and climate change should really fall under the same umbrella. It would certainly motivate me greatly to work in a coherent and integrated way on these shared challenges.

Ladies and gentlemen,

The challenges for unplanned care are manifold. If it were up to me, any future coalition agreement should pursue an ambitious investment and reform agenda in this domain. After all, unplanned care forms an integral part of the entire health care system. More than that, one could even argue that planned care survives thanks to the unplanned. As you may now, I recently published a book with ’10 frank questions’ on health care.[1] Maybe I should add an eleventh 'frank question' to my book: 'unplanned care: urgent in reform?' I hope that, at this point, I have already provided the answer to this question.

[1] *10 Franke Vragen aan Frank*, Marc Coenen in gesprek met Frank Vandenbroucke, Pelckmans, 2024.