

Family Medicine in Belgium – practical solutions for South Africa.



Background

In December 2004, five representatives from family medicine departments in South Africa were invited to benchmark with ICHO, the family physicians' organization in Flanders, Belgium in the framework of the VLIR Own Initiatives program (2003). This experience and its meaning for practical solutions in the South African context are spelt out in a series of five articles. The first will give an overview of the country, its history and health system. The second article will concentrate on the Flemish model for training family physicians and the third will elaborate upon the educational system which is in place. In the fourth article, a particularly interesting concept, the learning plan, will be dealt with and in article five the evaluation system is discussed.

The purpose of this series is to stimulate debate in South Africa at a time where the new registrar training is imminent and ideas are still fluid. The essence of the debate should be to encourage good principles and practices experienced in other countries, to take root within a South African context.

Article 1

Family Medicine Training: Ideas from Belgium

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Introduction

'Huisaartskunde' or Family Practice is rooted in the history of Belgium and the evolution of its health-care system. Training and supervision is predominantly a private sector-university partnership with government incentives and regulation. The health system is private sector-driven with a

strong government-run social health insurance system. Whilst many things are not easily transferable to South Africa the lessons in Belgium in the structured interuniversity collaboration ie Interuniversitair Centrum voor Huisartsopleiding (ICHO), its relationship with stakeholders, its academic educational base of GPs

and the single common assessment are proving invaluable to South Africans.

Belgium, the country

Belgium is a small country (no bigger than twice the size of Gauteng) with 10.3 million people. It is at the "heart" of Western Europe not just geo-

graphically but also politically with European Union (EU) headquarters partly situated there and Belgium being very much part of the dynamic of the EU.¹

The country (with Brussels as capital), has evolved towards a federal parliamentary democracy model determined very much by historical language and religious affinities.

There are three communities. The Dutch-speaking Flemish in the north, the French-speaking Walloons in the south and since 1918 a small German-speaking community in the extreme east of the country. There are palpable language tensions which have created quite a fragmented system of government with five different levels of government but a remarkable attitude of "Belgian compromise".²

The Federal Government of Belgium is an amalgamation of community and regional governments which act with considerable independence. The system is quite complicated but Flemish governments and structures like Universities are quite autonomous as Flemish entities.³

The South Africans' visit was a really a visit to Flanders, the northern half of Belgium and to its major cities – Ghent, Antwerp, Leuven and Brussels. The hosts were the Flemish Universities with the support of the Belgian Government.

The family remains one of the basic values of Belgian society. Belgian society is based on solidarity where "the social security system works perfectly. Family benefit, pensions, medical insurance, unemployment benefit and paid leave are distributed to those who are eligible. The health care is among the best in the world and, according to a survey, almost 80% of Belgians consider their health to be good to very good."²

Belgian history

Flemish religio-political battles since the 15-16th Century and the spirit of

rebellion in Flanders have characterized their history of conflict with Spanish, Austrian and French rulers over the centuries. Flanders was part of the Netherlands but was separated and controlled by Catholic rulers over years resulting in Dutch/Flemish-speaking Flanders remaining Catholic with the Dutch-speaking people of The Netherlands being Protestant. This independence and strong civic tradition is a visible thread through Flemish society and even the Flemish Departments of Family Medicine. Religious and language differences seem to shape patient attitudes and the health system.



Belgium was formed as an independent state in 1831 with Leopold I as a significantly limited monarch. The country has become increasingly federalist since 1980 with three administrative regions: Flanders, Wallonia and Brussels. They are quite independent.¹ It is through the VLIR (Flemish Inter-University Council) financed by the Federal Minister for Development and International Cooperation that the ICHO-FaMEC project "Optimisation of post-graduate training in Southern Africa: a contribution to health for all" has been funded. The Flemish approach to South Africa was vociferously anti-apartheid and is now very supportive of South Africa and Africa.

Belgian economy and healthcare funding

Belgians have very different economic

circumstances from South Africans: per capita GDP of Belgium is \$27,932 whereas South Africa has per capita GDP of \$7,538. The similarities of percentage of GDP spend on health of Belgium (at 8.9%) and South Africa (at 8.6%) masks a different system of funding and distribution as well as the legacy of inequities in South Africa.⁴

As at 2002, for a population of 10,3m, Belgium has a life expectancy of 78.4yrs (for the total population) and child mortality of 6 per 1000 (under 5yrs) as compared to South Africa with its total population of 44,8m, life expectancy of 50.7yrs (for the total population) and child mortality of 86 per 1000 (under 5yrs).⁴

Belgium has a different system of health funding and health service distribution compared to South Africa. The mandatory Social Security or Social Health Insurance system is the predominant mechanism in Belgium (99% of the population is covered). In SA the prepaid 'medical aid' is the dominant private system (58% of total health expenditure) with a parallel public health system funded by taxation.⁵

There is no equivalent public health system in Belgium but the distribution of health services is fairly equitable throughout the country.

These funds are generated two-thirds from salary contributions and one-third from general taxation.⁶

The Rijkinstituut voor Ziekte en Invaliditeits Verzekering (RIZIV) is the body responsible for managing health and the budget through a process of committees involving stakeholders-the mutual health fund groupings and health providers. Management of the insurance funds is left to several mutual health funds (ziekenkas, ziekenfonds or mutualiteit). They hold and distribute the funds similar to medical aids except that most are not for profit and often linked to historical social formations.⁷ Delivery of services is through the private health system with

independent medical practices and mostly using fee-for-service payment.

Belgian medical system

Their health care is among the best and most modern in the world with 380 hospitals and more than 35000 doctors (including approximately 16000 GPs).⁸ Their tariffs or nomenclature are negotiated in a 'nomenclature or convention' between national mutual health fund associations and the professional associations. In Belgium they suffer similar dilemmas as in private health in SA with burgeoning hospital costs (using 30% of total health spend) and are subject to increasing controls.⁹

There are many tensions despite the good health system.

There is considerable exchange and contact amongst European countries as evidenced by a Serbian Government delegation meeting with Belgian government officials and facilitated by Jan De Maeseneer during the time of the South Africans' visit. Some of the Flemish universities work very closely with Netherlands Universities like Maastricht.

Belgian family doctors

In Belgium patients have a free choice of doctors and do switch around. There is fierce non-price competition (as prices are 'fixed') among physicians with initiatives afoot for selective managed care type contracts with some health providers.⁵ Prof. Jan De Maeseneer is part of a capitation initiative in his own group practice. It is only a few doctors that are exploring capitation (< 3%). There is a spectrum of GPs. As the South Africans noted 'they look just like our GPs back home'. Most GPs are in solus practice but many are beginning to form group practices. Most GPs work quite long hours (due to the implicit expectation by the public for long hours) and are now obliged to form voluntary regional groups and provide service to out-of-

hours patients as a group. They vary in size, frequency of calls and complexity. GP practice in groups is attractive to women and men not wanting to work an excessive amount of hours.

There is a profiling commission that provides regional groups with utilization information to review the practices in the regional groups; however the consequences of poor practice are left to the doctor groups.

The academics are predominantly GPs very grounded in their practices. Doctors get a monthly sum of money from government that contributes to the payment of the Trainee if they are



accredited as Trainers. Doctor numbers applying for traineeship are declining as the perception of the GP profession is that it is somehow inferior to other specialities. There are quotas for specialist training posts and much more competition for other specialties than for Family Medicine. Doctors see other specialisations as easier, easy to master, specific, more financially rewarding and with less hours.

Networking with ICHO

The Interuniversitair Centrum voor Huisartsen Opleiding (ICHO) was begun in 1984 as a cooperation between four Flemish university departments of general practice (Antwerp, Brussels, Gent and Leuven) for pragmatic organizational reasons: to pool scarce resources (material and people) for vocational training and also to be stronger in confronting the authorities and medical faculties. This

was made easier by personal relationships.

Internal deliberations in 1990 led to consensus and a plan in 1991 involving the faculties, most professional groups and the Flemish administration. This was not without fights and pressures even in subsequent years but the 'stubbornness of the GP departments, strongly united in ICHO, saved it'.¹⁰

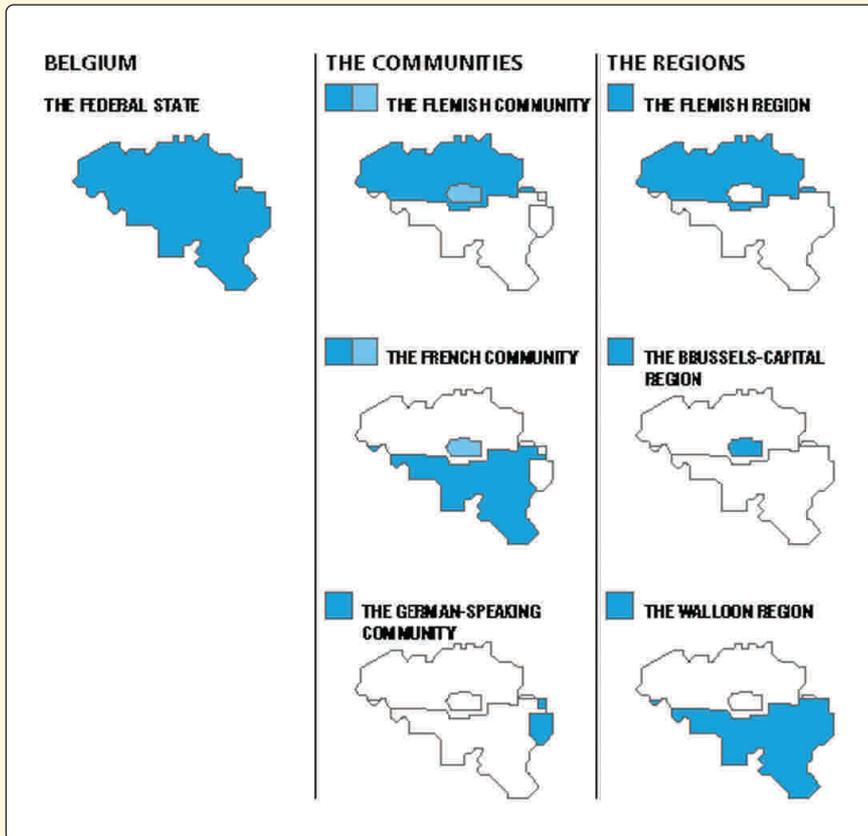
The Flemish Government took legislative steps in 1995 to make vocational training a post-graduate 'university degree' and provided resources for it. The four university departments worked out a legal contract with their respective universities about all aspects of the collaboration. What started out as gentlemen's agreement was translated into law.

Interaction with Service Providers

The present Director of ICHO states that 'The main aim of the ICHO (Interuniversity Center for Training of General Practitioners) is to train general practitioners. But the ICHO does not see being an institute for training as its sole purpose. It also wants to be a movement aimed at bringing the profession of general practitioner to a higher academic level, it is part of the interactive network that aims at improving the conditions of general practice'.⁹ The leadership of ICHO nurtures political relationships (despite being primarily academic) with involvement in various advisory committees of government and is also part of other negotiations like the capitation system and regulations regarding accreditation of electronic health record software. They are leaders 'addressing our interests', as stated by a trainee.

The ICHO collaboration in training

Students in undergraduate training in



Flanders go into Year 7, a kind of internship, as the first year of general practitioner (GP) training. This is done independently at the various university departments.⁹ The second and third year of GP training, ie Year 8 and 9, are organised by the interuniversity consortium: ICHO and ISHO (Interuniversitair Samewerkingsverband voor Huisartsenopleiding). Trainees get 'trainee jobs' with accredited GPs where most of their learning occurs one-to-one in a practice setting here they function as 'doctor assistants' or locums. A small group of highly trained part-time academic GPs from ICHO organize two-weekly afternoon seminars for Regional groups of trainees.

Structure of ICHO

ICHO is managed by two directors, a general director and an educationalist who is also the Educational Director. Together with the four Family Medicine Department Heads they act as a board. There are three secretaries for administration and two staff members:

one manages the two-weekly seminars programme. The other person is responsible for the development of the accredited GPs. These are the only full-time ICHO employees. The ICHO programme functions mostly through contracted part-time University GP appointments. These GP's are known as 'Staff Members'. They are then responsible for the practical training in ICHO. There is also a separate group within ICHO responsible for specialized educational programmes eg workshops on skills, internet sites etc and then another group in ICHO for the single exit assessment, thus making four divisions in ICHO : trainee, trainer, education and assessment.

According to a Staff Member there may be multiple 'bosses' but ICHO directs the trainee programme and the running is very smooth. The legal interuniversity contract is termed ISHO and has an academic oversight function but does not unduly interfere in practical decisions. There are many committees that are inter-university

and so the Universities generally feel completely involved.

ICHO training support

The Practice Trainers pool is constantly under review and uses a considerable amount of educational theoretical input managed closely by Sandrina Scholl, the Education Director.¹¹

The motivation for GPs to involve themselves as Practice Trainers is considered to be: financial and academic. The trend towards forming group practices has also helped this movement. The ICHO website at acts as an important and open portal of communication with Trainers and Trainees. The site contains useful support material with the ITOL as an added element of e-learning with restricted entry. ICHO also produces other educational materials.

History of FaMEC and ICHO

Flemish Family Physicians were instrumental in helping the Family Medicine Education Consortium (FaMEC) to develop as early as 1997 in a conference organized by the Flemish Departments of Family Medicine in Durban. FAMEC brings the 8 departments of Family Medicine in South Africa together – Pretoria, University of Limpopo, Witwatersrand, Bloemfontein, , Kwa-Zulu Natal, Walter Sisulu Medical School, Stellenbosch and Cape Town. This later facilitated the publication of "The Handbook of Family Medicine" in 2001 and the resuscitation of the South African Family Practice Journal. An application for VLIR funding in 2001/2002 led to a project "Optimisation of the vocational medical training in family medicine/primary health care in South-Africa: a contribution to the realisation of health for all" (Apr 2003) containing a set of objectives with indicators and verification.¹²

The developmental overall objective of the project is 'to contribute to a higher accessibility and quality of



family medicine/primary health care in South Africa, with special attention to underserved groups (rural areas, townships, remote areas, etc). A comprehensive system of family medicine/primary health care will contribute to a more cost-effective use of resources. The improved family medicine/primary health care service will be delivered in the framework of the district health system and according to the health care policy of province and country'.

The academic overall objective is 'to realise the social accountability of academic institutions by meeting the needs of the population, which special emphasis on underserved groups'.

The specific objectives of the project are:

1. To produce a better trained family physician operating in the framework of primary health care
2. To develop networking at the level of the training sites, institutional networking with government and universities and international networking.
 - a. Development of a network of decentralised training sites for family medicine/primary health care.
 - b. Institutional networking between training sites, institutions and FaMEC.
 - c. International networking at the level of the SADC-countries.
3. To strengthen the Family Medicine Education Consortium with a full-time coordinator/researcher, monitoring of sites and regular meetings of FAMEC.

There has been considerable progress in this project with the development of a core curriculum, the establishment of a formulated vocational training programme in South Africa and accreditation of vocational training by the HPCSA.

Conclusion

Despite the uniqueness of Belgium as a country, its health system and family practice there were many lessons learnt that need contextualizing in the African context. The collaboration and the networking of ICHO continue to inspire FaMEC. Its legal and organizational structure is worth emulating. The way in which ICHO relates to the GP population, its structuring of training and the supports it has put in place are worth modeling in the South African setting. The next article will explore the training model, supports for training as well as South African applications of the Belgian experience. ✨

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