3.4 Continuity of care

Continuity of care addresses "the extent to which healthcare for specified users, over time, is smoothly organised within and across providers, institutions and regions, and to which extent the entire disease trajectory is covered".[26]

Four aspects of continuity have been distinguished: **informational continuity** (the availability and use of data from prior events during current patient encounters), **relational continuity** (an ongoing relationship between patients and one or more providers), **management continuity** (the coherent delivery of care from different providers across different care settings) and **coordination of care** (the connection between different health providers over time to achieve a common objective).

Seven indicators have been selected that encompass these different aspects (see Table 5). Initiatives on integrated, people-centred care across various settings are also related to the continuity and coordination of care but are described in the section on patient centeredness care. Moreover, Initiatives on hospital at home are described in Box 8.

Box 8 – Hospital at home

Although there is no consensus on the definition of hospital at home (HAH), one may define it as "providing care in the patient's place of residence that would otherwise need to be delivered in an acute hospital".[34] An important element is the level of complexity of care, that is such that, without the possibility of HAH, the patient should necessarily be treated at the hospital.

This approach may fulfil a variety of needs and motives: address the lack of available hospital beds, an attempt to reduce healthcare costs, length of stay and/or the number of hospital admissions, or, from a demand perspective, a way to allow patients to remain within their own environment and respect their preferences - based on the assumption that patients generally prefer to stay at home.[34] Nevertheless, Belgium is in a situation of overall overcapacity of acute-care hospital beds, except for geriatric care beds.[35] Thus, the major challenges lie rather in ensuring continuity of care, bridging the current gap between primary and secondary care, and keeping people in the least complex environment that is clinically appropriate.[34]

In March 2017, the Minister of Social Affairs and Public Health launched twelve HAH pilot projects (five in Flanders, five in Wallonia and two in Brussels). They focus on home antibiotic therapy (eight projects) and other types of care, such as anti-tumour treatments (five projects, including two focussing on breast cancer) or haemato-oncological treatments (one project). The projects will involve 1300 patients and 35 hospitals, as well as home nursing services and GPs.[36]

Since July 2023, HAH is implemented on a more structural basis for patients who need antibiotic or oncological treatments.

Informational continuity in general practice

The global medical record (GMR) allows the general practitioner to gather information over time and centralise the medical data of his/her patients. This coverage has been growing over the years from 52.1% in 2010 to 83.3% in 2021. Differences can be observed by age group. Older insured people had a better coverage than young people, i.e. 93.2% for people aged 75 years and older versus less than 79.1% for people aged below 45 years in 2021. Differences can be observed between regions: in Flanders, 87.8% of the insured people had a GMR in 2021 while the coverage was 79.6 in Wallonia and 67.8% in Brussels. Differences along socioeconomic lines were small (see section 7.1).

Relational continuity with a general practitioner

The Usual Provider Continuity (UPC) index is the proportion of encounters with the "usual patient GP", i.e. the GP consulted most frequently by the patient over a two-year period.

Over the period 2020-2021, 60.3% of patients encountered their usual GP minimum three times out of four (UPC ≥ 0.75). This percentage was higher in Wallonia (68.0%) than Brussels (60.3%) and Flanders (56.4%) and was higher as well for the most vulnerable patients (patients 65 years old and over and lower socioeconomic groups, see section 7.1). A decreasing trend can be observed between 2011 and 2021, a bit more pronounced in Flanders than in other regions.

Management continuity between hospital and general practice

Despite the supposed advantage of having a contact with a GP within the week after hospital discharge, this was the case for only 43.5% of hospitalisations in patients aged 65 years and over in 2021. This proportion decreased regularly between 2010 (54.8%) and 2021 (43.5%). A lower proportion can be observed in Brussels (29.8%; compared to 45.2% in Flanders and 42.7% in Wallonia), in patients that do not receive long term care (i.e. 34.6% in patients that neither live in an institution nor receive nursing care at home), and in patients aged 65-74 years (33.7%). Differences by socioeconomic status are discussed in section 7.1.

A limitation of this indicator is that neither the reason for hospitalisation nor the length of the stay have been taken into account, although these factors influence the need of a GP contact after hospitalisation. It is also not possible to determine whether the contact with the GP results from a discharge plan proposed by the hospital or from an initiative of the patient himself. Moreover, the patient may have had a contact with another healthcare professional (e.g. specialist, home nurse, or nurse in nursing home).

Coordination in ambulatory care for people living with diabetes

To optimize care provided to people living with diabetes, several measures have been implemented by RIZIV – INAMI (diabetes passport, care trajectories for chronic diseases and convention for diabetes self-management).

After an increase from 2011 to 2019, the proportion of people under insulin registered in a diabetes care model slightly decreased in 2020 and 2021 (mainly via conventions). However. for patients using oral antidiabetics or non-insulin injectable solutions, the proportion of patients under a diabetes care model remained low (26.6% in 2021, half diabetes passport, half care trajectory) but increased between 2011 and 2019 and have remained stable since then. For both patient groups, the proportion was higher in Flanders and lower for patients in the residential sector. Differences along socioeconomic lines were small (see section 7.1).

Continuity of care is also a contributing factor to the effectiveness of the health system. Admissions for diabetes showed a decreasing trend over time (except in 2021, see QE-2), which is encouraging, even if the real impact of continuity of care on this outcome is difficult to estimate.

Patients with a reference pharmacist

Since 1 October 2017, a “reference pharmacist” service was introduced by RIZIV – INAMI for individuals going to a public pharmacy with a chronic disease (excluding persons in nursing homes or in homes for the elderly). This service consists of registering pharmaceutical delivered in the pharmaceutical (electronic) file; delivering a medication scheme for the patient and making sure other care practitioners have access to the patients’ medication scheme.

This indicator measures the uptake of the service among targeted individuals, i.e. patients who have been delivered at least 5 different active substances in a year, with 160 DDDs or more within the last 12 months for at least one of them.

The mean age of patients with a reference pharmacist is 67.6 years and the median 68 (in 2022); 56.4% of them are women; the proportion of patients benefitting from increased reimbursement is 27.5%.

The proportion of targeted patients that have a reference pharmacist has risen from 15.0% in 2017 to 38.7% in 2021. Flanders has a higher proportion (44.6% in 2021) than Brussels (31.6%) and Wallonia (29.9%). The trend is going up in all three regions.

Coordination in hospital care for cancer patients

Multidisciplinary team (MDT) meetings have been implemented in many countries as the predominant model of cancer management to ensure that all patients receive timely evidence-based diagnosis and treatment, and to ensure continuity between different care providers.

Since the introduction of specific nomenclature codes for the MDT in 2003, a rapid increase of its use has been noticed for all cancer types. Overall, 90.4% of cancer patients were discussed at the MDT in 2021 (compared to 52.5% in 2004 and 83.4% in 2012). Some variations in use of the MDT between types of cancer can be observed (highest in 2021 was breast cancer with 95.5%, lowest 75.6% for malignant melanoma of the skin and 67.5% for unknown primary sites and ill-defined cases), but differences were lower than in 2004.

An increasing use of the MDT was noticed for all three regions throughout the period 2004-2021. Moreover, initial (i.e. in 2004) marked regional variability in use of the MDT, with the highest results in Flanders, was clearly reduced in the more recent years. In 2021, cancer patients were only slightly more frequently discussed at the MDT in Flanders (91.6%), followed by Brussels (89.3%) and Wallonia (88.2%).

A limitation of this indicator is that, because it focuses on a specific category of diseases, it provides only a restricted picture of the intramural coordination of care.

Conclusion

Continuity of care indicators showed contrasting results. Coordination of care showed good results in primary care for people living with diabetes using insulin (measured as being registered in a diabetes care model) or within hospital setting for patients with cancer who need to be discussed in MDT meetings. Results were, however, disappointing for people living with diabetes who are not using insulin. It looks as if, for this patient population, the structure exists to promote coordination of care, but is hardly used. The other three indicators related to GPs and showed intermediate results: the use of a GMR was high among the population, relational continuity measured by the UPC index could be better even if this was relatively good among the most vulnerable patients (patients aged 65 and over and lower socioeconomic groups) and the occurrence of contacts after a hospitalisation of a patient aged 65 or more was still quite low.

This evaluation is hampered by two limitations: these few indicators only reflect a partial view of the multi-faceted concept of continuity of care, and a comparison with results from other countries is very difficult, due to the lack of international indicators, and hence data, in this dimension.

Table 5 – Quality: Indicators on continuity of care

(ID)	Indicator	Score	Belgium	Year	Flanders	Wallonia	Brussels	Source	EU-14 (mean)
Informational continuity in general practice									
QC-1	Coverage of global medical record (% of people who have a global medical record (GMR) with a general practitioner)	+	83.3	2021	87.8	79.6	**67.8**	IMA – AIM	-
Relational continuity in general practice									
QC-2	Usual Provider Continuity index ≥0.75 (% of patients with 3 or more contacts with GP in last 2 years)	-	60.3	2021	56.4	68.0	60.3	IMA – AIM	-
Management continuity between hospital and GP									
QC-3	GP encounter within 7 days after hospital discharge (% patients 65+)	-	43.5	2021	45.2	42.7	**29.8**	IMA – AIM	-
Coordination in ambulatory care									
QC-4	Diabetes follow-up within a convention/passport/care trajectory (% of people 18+ living with diabetes and under insulin)	-	86.0	2021	88.2	84.2	81.1	IMA – AIM	-
QC-5	Diabetes follow-up within a convention/passport/care trajectory (% of people 18+ living with diabetes and receiving only glucose-lowering drugs, excluding insulin)	ST	26.6	2021	32.8	**17.7**	**24.0**	IMA – AIM	-
QC-7	People with a reference pharmacist (% of people who should have a reference pharmacist)	+	38.7	2021	44.9	**29.9**	**31.6**	IMA – AIM	
Coordination in hospital care									
QC-6	Patients with cancer discussed at the multidisciplinary team meeting (% of patients with cancer)	↗	90.4	2021	91.6	88.2	89.3	BCR	-

Good (●), average (●) or poor (●) results, globally stable (ST), improving (+) or trend not evaluated (empty).
For contextual indicators (no evaluation): upwards trend (↗), stable trend (→), downwards trend (↘), no trend (C).