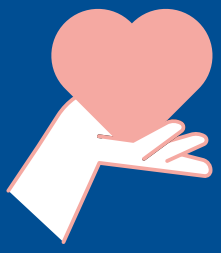
POLICY RECOMMENDATIONS



Based on the latest scientific knowledge and experience gained through six “Occupational Therapy in Primary Care" projects supported by the Dr Daniël De Coninck Fund

Occupational therapy has only a limited presence in primary care. Its contribution is mainly in secondary care and in institutions such as schools, rehabilitation and nursing homes, and residential homes. It makes a valuable contribution in these settings.

It could, however, add even more value in primary care than it currently does. Occupational therapy can significantly improve quality of life for people with a disability as well as those suffering from a range of illnesses.

Occupational therapy provides expertise in working alongside those needing care and assistance and those physically and socially supporting them. Its aim is to find methods and techniques to stabilise or reduce the effects of their acute or chronic illnesses and disabilities and enhance their autonomy and independence. This is done in collaboration with the person affected, their carer or those in their social environment, and it includes adaptations of the concrete environment, the use of various aids and other measures.

This **value** can be added in three ways:

- firstly, by preventing or delaying the need for admission to a residential institution;
- secondly through timely and preventive intervention where an illness or disability is approaching or worsening, in order to limit or slow its impacts and thus improve the person's quality of life;
- and thirdly, by improving or stabilising the quality of life for young or older people who already receive care at home for a chronic illness or disability.

The occupational therapist can assume various roles in both prevention and treatment, primarily offering advice, providing treatment (practicing the use of aids) and managing the person's care.

WHY NOW? WHAT IS THE URGENCY?

Our population is changing. An increasing proportion of the population are older people who are living far longer, healthier lives and remaining independent and active, but chronic or acute problems or disabilities do still occur, just as they do among younger people. Many of these people of all ages are able, willing or obliged to stay at home, and many of them wish to continue living independently. To ensure the best outcomes in this situation, the expertise of occupational therapists is increasingly needed in the home environment.

The occupational therapist mainly focuses on empowering clients so that they are able to live with their conditions or disabilities in the best possible way. The occupational therapist does this by working together with the person who needs care or support (in both prevention and treatment) to find ways of limiting the impacts of these conditions on activities of daily living. This can be done by carrying out tasks in different ways or adapting the living environment.

This expertise should be brought in an early stage, in primary care and not only in residential settings where people with an illness or disability find themselves after they have already lost their autonomy and independence. Doing this can offer two advantages. Timely introduction of adjustments to the living environment of these people and working alongside both clients and those close to them to find better ways of coping with their disabilities offers significant improvements in quality of life at home, often to the point where they are able to remain at home for the rest of their life.

PARADIGM SHIFTS

These calls for occupational therapists to have a stronger presence in primary care are fully in line with the paradigm shifts that are needed in our health and social care system. The first paradigm shift that is certainly applicable to those with a chronic illness or disability, is away from problem-oriented care and towards goal-oriented care. The focus here is on the life goals of the person needing care and support: which aspects of life matter most to them? This means moving away from a negative approach to health ("What is wrong?") and towards a positive approach based on the person's own goals (e.g. shopping or taking a train independently) and on improving opportunities to optimise a person's quality of life and participation in society.
The second paradigm shift is in the move from treatment towards prevention.

INTEGRATED AND MULTIDISCIPLINARY

It is often reiterated that care needs to become more multidisciplinary and integrated. So is the specific involvement of occupational therapists really necessary? Could the same contributions be made by general practitioners, home nurses, home carers, and physiotherapists etc, working together?
These professionals can certainly make a key contribution and they are essential partners for occupational therapists, but they are uniquely well placed to deliver their expertise in a systematic way: this encompasses supporting people and those close to them in ways that enable them to continue to function as well as possible in daily life, despite an illness or disability.

Occupational therapists do not work in isolation. They always work closely alongside the person requiring care and support, in their care and social context. As well as family carers, they collaborate with the professionals already mentioned and also with others, as well as those providing services in the areas of housing, work, education, training, leisure etc.
The starting point for an occupational therapist's activities is always the person's independence and social participation, seen from the perspective of the life goals that they set for themselves. This guarantees an integrated approach.

Training in occupational therapy

Occupational therapy is a relatively new discipline in Belgium; the subject has existed since 1959 and the first degree was awarded in 1962.
Since 1996, three-year Bachelor's courses have been offered in both Flanders and the French-speaking Community. There are eight higher education colleges currently providing training in Flanders and seven more in the French-speaking Community. A total of 875 new occupational therapists enter the profession each year, 575 in Flanders and 300 in the French-speaking Community.
In Flanders, an inter-university Master's in Occupational Therapy was created in the 2010-2011 academic year and 188 Master's Degrees in Occupational Therapy have been awarded since then. A number of occupational therapists have also obtained Ph.D qualifications in Health Sciences or Gerontology. It is now also possible to study for a Ph.D in Occupational Therapy.
Many aspects of training are different in Belgium's neighbouring countries: in some cases there is a four-year Bachelor's course with a Master's only, which may be an academic or a professional Master's, while in other countries it has been possible for many years to obtain a Ph.D in Occupational Therapy.

WHAT POLITICAL INITIATIVES ARE REQUIRED TO STRENGTHEN THE ROLE OF OCCUPATIONAL THERAPISTS IN PRIMARY CARE?

The answer to this question is complex, partly because the remits and funding for these areas are divided between federal, regional and local authorities (as well as their partners, such as educational establishments, members of health consultation bodies etc.). Some of the seven proposals set out below concern all levels of government, while others relate to regional or federal governments. Some obstacles need to be addressed between authorities, while others are missions for their partners.

1. Firstly, we must be aware at every level of government that, especially for people with a chronic illness or disability, **every facet of care is important**, not just the purely medical aspects. Thus, a person's well-being, quality of life, psycho-social aspects, activities of daily life and social participation are all important.
The starting-point must be the life goals of the person needing care and support, which requires a **paradigm shift towards 'goal-oriented care'**. It is for the person and those close to them to determine who supports them, so that they can make decisions on the basis of what they really need. Adequate time must be provided for this and the intervention to help them to express and define these life goals must be reimbursed.

2. It is essential, once again at all levels of government and in all sectors involved with care and well-being – to provide **public recognition** by the authorities and by experts in the field of care **the unique added value that occupational therapy and therapists are able to provide in primary care and in care at home.**

All professionals – general practitioners, rehabilitation doctors, nurses, care assistants and cleaning assistants, physiotherapists, social workers, and all the other medical, paramedical and care professionals – must be supported by government, their training, health insurers and the entire care system to recognise the expertise of occupational therapists. This is in the patient's best interests and it also enriches and informs their own area of work. Family carers should also be informed about this. It should be emphasised, without making any claim to exclusivity, that the holistic approach adopted by occupational therapists and their focus on the person's participation in society and life goals are particularly well suited to a role as care coordinator or manager in cases where there are particularly complex care needs.

3 If all government bodies and their partners are serious about openly recognising this fact, **budgetary reallocations and increases will be needed** in federal, regional and local budgets. So, how can this additional funding or human resources manpower for occupational therapists in primary care be mobilised? We note that more modest, intermediate phases are sometimes needed before full funding can be made available. A few points for consideration are set out below: The most obvious intermediate step in the current system is to increase the budget for the fees of occupational therapists in primary care. This measure could potentially be linked to the occupational therapists involved being associated with multidisciplinary primary care practices or networks, similar to the approach used for psychologists in primary care. A second possibility is to allocate 'tagged' or 'earmarked' occupational therapy funding to multidisciplinary primary care practices. A third intermediate option could be to transfer occupational therapy from secondary or tertiary care to primary care, as is being done in the 107 projects in mental health care (but these should be managed from primary care). A fourth interim possibility involves subsidising a project within a primary care zone, region or province to test the deployment of occupational therapy in primary care within a limited territory, as has been done in the "ZOPP" project aimed at developing support for self-help groups and patient representatives in Limburg.

4 In the short term, **the list of technical services** appended to the (federal) Royal Decree of 8 July 1996 on the professional title (etc.) of occupational therapists **must also be modified**. In addition to being extended, this list must be more focused on home care and prevention. A similar modification of the federal RIZIV/INAMI nomenclature could result from this, but more flat-rate funding might also be implemented. In principle, the occupational therapist always works as part of a multidisciplinary team, but it must still be considered whether occupational therapists should have opportunities to work independently.

5 Occupational therapists must also **be fully represented in decision-making bodies,** above all in federal bodies where decisions are taken on the nomenclature and technical services delivered by occupational therapists. They must also be represented at federal, regional and local levels: occupational therapists are

perfectly placed to negotiate the paradigm shift in care, from problem-oriented to goal-oriented and to introduce the broader perspective on health and well-being.

6 Taking a broader view, **a number of questions require urgent scientific research.** Qualitative and quantitative studies should be conducted on the efficacy and effectiveness of wider use of occupational therapy in primary care to treat acute and chronic diseases and disabilities. We are perfectly happy for our perspectives in this area to be tested by science, as long as this is not used an excuse to delay the required initial changes.

It is also necessary to consider whether appropriate human resources are available or can be mobilised. We are convinced that this is the case, but evidence is also required. Who could lead or coordinate this research? Such research would fit perfectly within the framework of research recently conducted by the KCE, the Belgian Health Care Knowledge Centre, on integrated care which, like the care described above, has both federal and regional aspects. The KCE could lead, or at least coordinate such research. Regional and local authorities, possibly in coordination with the federal government, must also verify, with support from the KCE if appropriate, whether the requirements relating to training set out in the Royal Decree of 8 July 1996 are still appropriate for the wider deployment of occupation therapists in primary care.

7 More generally, it should be noted that many problems could be avoided if our homes, towns and villages, work places, public spaces, public transport, leisure contexts, public institutions, signposting etc. were **compliant with the basic rules of Universal Design** and adapted to the needs of people with illnesses and disabilities as well as children and the elderly. This was not the purpose of the work that has resulted in this guide, but this has to be said because we and those we work for suffer so much as a result of inappropriate design, a problem that is much worse in Belgium than in our neighbouring countries.

IN SUMMARY:

1. **This project is part of the process of development towards a wide-ranging policy on health and well-being and the paradigm shifts that are required in healthcare today.**
2. **The added value resulting from the deployment of occupational therapists in primary care must be openly acknowledged.**
3. **This must lead to reallocation or increases in budgets accordingly. It is unlikely that a definitive solution will be found from the outset. A number of intermediate phases have therefore been suggested.**
4. **The list of technical services set out in the 1996 Royal Decree and the RIZIV/ INAMI nomenclature must be amended. An autonomous intervention by an occupational therapist must be possible in certain circumstances.**
5. **Occupational therapists must be represented on the main consultative and decision-making bodies.**
6. **Research must be conducted to evaluate the efficacy and effectiveness of occupational therapy in primary care and the required human resource planning so that occupational therapy can develop as envisaged here.**
7. **Our homes, towns and villages, workplaces and leisure facilities must be adapted for people with disabilities or medical conditions, and also for children and older people. The principles of Universal Design must be urgently adopted.**

Working as an occupational therapist

According to recent figures from the Federal Public Service Public Health, there are currently 14,433 occupational therapists registered in Belgium, almost as many as the number of GPs. Of this total, 10,896 (75.5%) of them live in the Flemish Region, 2,855 (20%) in the Walloon Region and 682 (4.5%) in the Brussels Capital Region. Master's degrees in occupational therapy are held by 188 of these 14,433 occupational therapists, but an unknown number of them hold master's degrees in other subjects such as gerontology, health promotion, health policy, public health etc.
The Occupational Therapy report by the Planning Committee for Health Care Professions mentions 10,622 'professionally active' occupational therapists: 8,019 (75.5%) in Flanders and 2,603 (24.5%) in the French Community. The number of these who work solely as employees is 9,362 (88%), while another 947 (9%) have mixed employee + self-employed status and 313 (3%) work solely in a self-employed capacity. Four sectors account for the lion's share of jobs in occupational therapy: hospitals and care homes account for just under one third each, care homes account for a quarter, and about 10% of them work in education. There is a single professional association in Flanders named 'Ergotherapie Vlaanderen' with 450 to 500 members, while the 'Union Professionelle des ergothérapeutes Belges francophones en germanophones (UPE)' has between 300 and 400 members. Together, these two organisations form 'Ergotherapie Belgium'.