



WHITE PAPER

on
access to care
in Belgium



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Preamble

Belgium is considered a country with good social protection and a high-quality health service. However, for a series of particularly vulnerable groups, access to care is not always readily available, especially since some find themselves obliged to turn down or postpone care. Postponement is just one example of access difficulties. Other groups (such as those with a mental disability) also have problems, due to the insufficient medical support available in their facilities.

This White paper puts forward a number of operational recommendations to improve access to care for these groups.

It is the result of a long process, involving many health stakeholders, and of a joint initiative taken by Belgian healthcare representatives, National Institute for Health and Disability Insurance (NIHDI) and the health insurance funds, together with Médecins du Monde, one of the organisations providing medical assistance to the most vulnerable groups.

This process began with the drafting of a Green paper, analysing the situation regarding access to care in Belgium. It expressed the views of around thirty stakeholders from across the sector: healthcare professionals, field workers, patients, health insurance bodies, NIHDI, etc.

A series of round tables were then organised, at which more than 300 people from the sector met together to develop solutions to the problems highlighted in the Green paper. Following these round tables, the participants formulated many proposals. These can be grouped into 5 main priority areas for action, to make the health system more accessible:

1. Daring to implement a policy of inclusion
2. Strengthening existing measures
3. Investing more in prevention
4. Offering 'made-to-measure' care
5. Improving the information given to patients

Following discussions with the committee supporting this process, we felt it best to retain only one recommendation per area: that which we felt to be the greatest priority. These are the recommendations contained in this White paper.



Preamble

Our intention is to use the White paper to bring these issues to the attention of the political authorities. We hope that the various recommendations will feed into the development of health policies for the next 5 years and help to make our health system even more accessible.

We would like to take the opportunity to thank members of the Support Committee, contributors to the Green paper, moderators and participants at the round tables, staff members of both organisations and all those involved for bringing this process to completion.

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I. Daring to implement a policy of inclusion

1. Context/Issues

For people who are not covered by the health insurance system, various 'subsidiary' systems have been put in place. For example:

- Medical assistance for **persons without a legal residence** permit is paid for by the Public Social Welfare Centres (PSWC) via the Urgent Medical Aid system (UMA). This falls within the authority of the Federal Public Planning Service (PPS) for Social Integration. Procedures, however, vary from one PSWC to another and the conditions to be met are set in terms which are fairly vague and sometimes difficult to apply to certain groups such as 'in need' or 'main place of residence'. This lack of harmonisation between the practices of the various PSWCs creates many obstacles to access care: The decision as to whether or not to grant UMA can be somewhat arbitrary and results in inequalities and discrimination, inappropriate procedures, etc.
- For **asylum seekers**, healthcare is provided through a federal reception centre or a partner structure. Each partner, however, organises its own system autonomously. For the so-called '**no shows**' - asylum seekers living outside the reception centres - medical care is reimbursed by the 'Fedasil medical costs' unit, using a 'cost allowance form' system, whereby a form is given to the service provider for each service required. Medical care for asylum seekers living in a '**Local Reception Initiative**' (another type of reception facility organized at the local level in partnership with Fedasil) is reimbursed by the PSWCs.
- Financial responsibility for healthcare regarding **detained or interned persons** currently lies with the Federal Public Service (FPS) Justice. Once they enter the prison or detention centre, prisoners and detainees may no longer be covered by their healthcare insurance. The FPS Justice therefore pays for their medical care except in cases set out in the health insurance legislation. In these latter cases, NIHDI pays the costs out of a restricted budget. Once this budget has been completely used up, the costs are once again borne by the FPS Justice. Other situations may arise if the detainee is provisionally released for medical reasons, is provisionally released, is released on parole, is granted prison leave, is under electronic surveillance, etc. In these situations, the prisoner may have access to healthcare insurance if he is eligible.

I. Daring to implement a policy of inclusion

These differing rules and the cumbersome procedures associated with them have created many gaps in our social security safety net. Above all though they delay proper treatment of patients and cause much red tape for health-care providers. The patients falling under these subsidiary systems often find it even harder to access care because they are already subject to greater health risks and have other inherent difficulties such as language, past history, a different culture, multiple vulnerabilities, etc.

To tackle institutional exclusion, therefore, the various procedures used to provide medical aid to groups falling outside the healthcare insurance regime need to be harmonised as much as possible.

2. Recommendation: phased integration by target group

It is true that merging these subsidiary health systems into one sole standardised and computerised medical assistance system would prevent the discrimination resulting from the existing systems and would simplify reimbursement procedures for stakeholders (patients, providers and administrations). Nevertheless, we are calling for a phased approach, target group by target group.

- As discussed during the round tables on access to care, **we are calling for prisoners and detainees to be included in the healthcare insurance system.** There is no reason in principle why prisoners or detainees should be excluded from healthcare insurance.

Although it is legally and technically possible to change the legislation to give all prisoners and detainees access to healthcare insurance, a study should nevertheless be carried out. This study would have a number of objectives:

- to provide data on the future organisation of healthcare in prisons and detention centres
- to specify those points in the legislation which need to be amended, depending on the needs and problems identified
- to estimate the exact financial implications.
- For those receiving Urgent Medical Aid under the responsibility of the PSWC, the 'Mediprima' system which digitalizes the management of medical aid is an important step towards the harmonisation of practices and means less time spent on administration for the PSWCs.

I. Daring to implement a policy of inclusion

Mediprima also provides clear benefits for healthcare providers as it gives them clear information on reimbursed costs and a guarantee of payment by the State.

Although the Mediprima system is an important step towards simplifying procedures, individuals wishing to receive Urgent Medical Aid via the PSWC still have to carry out administrative formalities which can significantly delay the receipt of care (investigation into social circumstances, etc.). There are, moreover, considerable costs, especially staffing costs, involved in the use of these procedures.

We therefore suggest that our actions be targeted at various groups

- Initially, we suggest **automatic registration** with the Auxiliary Fund for Sickness & Invalidity Insurance (AFSII) of **people applying to a PSWC for a medical card** in the context of Mediprima (people without a legal residence permit, asylum seekers under the care of a PSWC, people seeking residence for medical reasons). This would be a **temporary** registration (e.g. 3 months) to allow time to check the conditions for PSWC involvement. If, after this three month period, it is found that the conditions for Urgent Medical Aid are met, the patient remains registered with AFSII (or with another insurer fully aware of the implications of such a choice) for the period of validity of the medical card. If the conditions are not met, the person ceases to be registered.
- For **homeless persons**, we suggest that if there are difficulties identifying the responsible PSWC, the PPS Social Integration should **designate a PSWC to take responsibility**, so that the homeless person is not disadvantaged.
- Finally, for **asylum seekers, including 'no shows' and those housed in local reception centres**, we suggest that the system described above for holders of medical cards should also apply.

II. Strengthening existing measures to facilitate access to care

1. Context/Issues

Universal protection against the risk of illness, financed according to each person's means, is one of the basic principles of health and disability insurance.

However, we are seeing worrying signs of inequality of health and access to healthcare. For example, 27% of people within the most vulnerable social group in society is not seeking medical care for financial reasons!

A number of factors increase the risk of financial difficulties in the access to healthcare:

- young household
- single-parent family
- low educational level
- low disposable income.

Also, households with the highest healthcare needs, and those reporting health problems, have a higher chance of postponing treatment for financial reasons.

Reforms have already been carried out to make care more easily affordable for people with financial difficulties:

- a ban on charging supplementary fees in rooms with 2 beds or shared wards
- extending application of the maximum invoice to patients with chronic condition status
- on 1 January 2014, the preferential regime was changed to a single system based on household income. From 2015, insurance funds may actively identify low-income households, and thus go a long way towards automatic granting of the preferential regime.

II. Strengthening existing measures to facilitate access to care

Without these measures to make healthcare more affordable, many families would fall into debt to pay for care, or would have to decide against care for themselves or their children. The care postponement rate, however, shows that there is still a need to continue seeking measures to ensure universal access.

2. Recommendation: across-the-board use of the third-party payment system

We recommend that:

- as set out in the law of 27 December 2012, there should be an obligation to apply the third-party payment system, as of 1 January 2015, to as many care services as possible (with priority given to general medical care and dentistry and, eventually, to all other out-patient sectors), for all patients with a chronically ill status, and for all patients eligible for the higher reimbursement rate.
- in the longer term, the third-party payment system should be extended to all out-patient services, and all patients, as in France, which has just announced extension of the third-party payment system to ambulatory care for all patients by 2017.

As well as making care more accessible to all patients, this extension of the third-party payment system will also greatly simplify administration for health-care providers.

Before this step can be taken, certain conditions must be met, particularly:

- it must be possible to check, on the spot, whether a patient is eligible for insurance
- electronic invoicing
- rapid reimbursement by health insurance funds
- simplified administrative procedures.

Some of these conditions have already been met, or will be in the near future.

Since this would be a major reform, 4 years would be a necessary but realistic time frame for achieving this goal.

III. Investing in prevention and health promotion

1. Context/Issues

All the studies carried out on health inequalities point clearly to the same conclusion: all other things being equal, when a person is of a low socio-economic status, his or her health tends to be worse and his life expectancy will be reduced. If we wish to make a drastic reduction in health inequalities, we must invest significantly in **prevention**, particularly prioritizing **pregnancy and infancy**, key life events in the build-up of social health inequalities.

A study¹ carried out by the Office of Birth and Childhood showed a significant relationship between the educational level of the mother and the period of breastfeeding, excess weight, dental decay and language development in the child. More women with a low level of education leave the maternity ward early on. They also tend to consult medical staff less often (17%) before conception than women with a higher level of education (38%)², when in fact, pre-natal consultations should play a vital part in medical and social protection during pregnancy for the poorest sections of society.

The current fragmentation of sexual and reproductive health (SRH) services is an obstacle to care, especially for vulnerable women who are unfamiliar with the health system or have not mastered the language. Different departments/services deal with different aspects of SRH. For example, a vulnerable pregnant woman may go to a pre-natal support centre. However, if there are complications, and for ultrasound scans, she needs to have access to a gynaecologist. She then gives birth at the hospital. Many of these departments and services are, moreover, extremely busy, and most SRH services have to be paid for, and are quite expensive.

Medical supervision of vulnerable pregnant women often begins rather late in pregnancy, which increases the risk of complications and/or death of the mother and/or child. The difficulty is to establish contact with the mother sufficiently early to monitor the pregnancy as early as possible and to carry out the necessary tests. There is currently no integrated SRH service package available in Belgium to the most vulnerable women.

¹ ONE report from the ONE database of medical and social data 2006-2007, 'health social inequalities in young children aged between 9 and 30 months', MC Mouroy, M Sommer, M Liegois, S Ndame Ebonge, 2009, p 143-157.

² Survey on the development of 1 year old children in the fields of health, support to and reception of parents, Study carried out for the ONE by Dedicated research, November 2012.

III. Invest in prevention and health promotion

Another vulnerable group which also requires particular attention in the area of health promotion is the group of people with high-risk behaviour, i.e. sex workers and drug users. The lifestyle and habits of these groups make them more vulnerable and more liable to develop certain infectious diseases (HIV, Hepatitis B/C, STDs, etc.). Hepatitis C is particularly widespread among drug users, who account for 80% of new cases³. It is however vital for public health to detect these infectious diseases at an early stage: this sort of epidemic cannot be kept in check if people are excluded from the health system or are not reached by prevention campaigns.

Prevention and health promotion work must therefore be stepped up to reduce health inequalities, and must be specifically geared to those groups which need it most, as part of an inter-sectoral and multi-disciplinary approach.

2. Main recommendations: a comprehensive approach to maternal/infant health and suitable preventive care for groups with high-risk behaviour

Ideally, any woman should have free access to help with any issues relating to her sexual and reproductive health: sex education, screening for and prevention of STDs, unwanted pregnancy or pregnancy monitoring, contraception or morning-after pill, sexual and/or domestic violence, fears about cancer, etc. Any woman should be able to obtain a direct response to her questions from medical, social, legal or psychology professionals, or should be redirected and accompanied to another department which can give her the help she needs.

Effective partnerships should be encouraged between the various bodies involved in SRH, such as the ONE, Kind en Gezin, family planning associations, maternities, general practitioners and health centres, but also with organisations working closely with vulnerable women, such as Aquarelle or Médecins du Monde. This should allow all women to have access to appropriate SRH provision.

³ Gerkens S, Martin N, Thiry N, Hulstaert F. Hépatite C : Dépistage et Prévention. Health Technology Assessment (HTA), Brussels: Belgian Health Care Knowledge Centre (KCE), 2012, KCE, Report 173 B. D/2012/10.273/02.

III. Invest in prevention and health promotion

In general, family planning organisations, for example, have very little contact with highly vulnerable groups such as the homeless, undocumented migrants, etc. These groups, moreover, are often unaware of the types of care on offer. Closer cooperation should thus be organised with grass-roots bodies, both for consultations and for advice on relationships and sexuality.

We recommend, therefore, that closer links and networks be set up between the various stakeholders involved in maternal and child health, to provide care packages as part of a comprehensive, non-fragmented approach to women's health. Agreement must therefore be reached in the Interministerial Conference, between the Communities/Regions and NIHDI, to set up **integrated health programmes** targeted at vulnerable women and households. These health programmes would cover, at least, the period from pre-conception until the child enters primary school.

For **groups involved in high-risk activities** (sex workers, drug users, etc.), it is vital that suitable **preventive care** be provided:

- early screening for sexually transmitted diseases and viral hepatitis
- vaccination against hepatitis B (HBV) and human papilloma virus (HPV)
- distribution of suitable preventive equipment: syringes, lubricants, condoms, sets of sterile injections, sniff kits, etc.
- improvements in access to opioid substitution treatments (awareness-raising among carers) and Naloxone (reimbursement)
- Designing of 'guidelines' to facilitate the detection and treatment of infectious diseases prevalent in more vulnerable groups (tuberculosis, HIV, Hepatitis C), but also addressing addictions (alcohol, tobacco, psychotropic substances, illegal drugs, etc), and mental health (anxio-depressive syndromes).

These groups should also be better informed of the risks and dangers linked to their actions: transmission of STDs, hepatitis, overdose management, etc. The information provided should be adapted so it is easily understood by the target-group (e.g. leaflets with translated pictograms).

Finally, prevention campaigns should be **proactive** i.e. should reach the target public where they live and socialise, through outreach work or by using mobile equipment.

These risk reduction programmes should be an integral part of the care on offer to these groups, and should be coordinated through the existing public care facilities (consultations, hospital emergency units, etc.).

IV. Offering 'made-to-measure' care to certain groups

1. Context/Issues

With regard to health, and particularly access to and accessibility of health services, particular attention must be paid to **so-called vulnerable people**. These groups (the homeless, newly-arrived immigrants, sex workers, drug users, etc.), in extremely precarious (material, social and psychological) situations, are often those most affected by major health inequalities. However, they are often excluded from care:

- 66% of patients attended by Médecins du Monde were not covered by social security, so had no access to the traditional health system
- 70 % are not registered with a doctor
- 36% admitted that they did not really know their rights, and were unfamiliar with the system as a whole⁴.

These groups don't access healthcare normally for a number of reasons: loss of social security coverage, lack of understanding of the system, loss of confidence in healthcare staff, inappropriate services on offer, lack of resources, etc.

Among the numerous, often overlapping, obstacles encountered by vulnerable groups, three will be mentioned here:

- **Medical barriers**

These various groups have ordinary health problems exacerbated by their living conditions, as well as specific health problems, which are both reasons for and the consequences of their current precarious circumstances and/or habits. Moreover, they often have both mental and physical problems. The care available is in many cases, therefore, not really suited to such individuals. There needs to be 'expertise' in this area.

⁴ Annual report by Médecins du Monde, 2012

IV. Offering 'made-to-measure' care to certain groups

- **Administrative barriers**

The Belgian health system is administratively extremely complex. It is not easy to gain access 'alone' to the care on offer, since the procedures are long and inflexible.

- **Barriers inherent to the individual (culture, language, etc.)**

People living in very precarious circumstances are also often partly responsible for their own state of exclusion. A bad experience with a healthcare professional may have broken the trust they had in the system. They will not then spontaneously seek treatment, and a proactive approach will be needed. Moreover, language and/or other cultural factors may affect access to care, and, above all, may determine how migrants are treated.

What these marginalised groups have in common is that they are all, to some extent, excluded from care, have only weak links with standard primary healthcare, and are also socially, medically and psychologically vulnerable.

Ad hoc measures are therefore needed, so that tailor-made care can be made available. The long-term objective of these structures is to return these individuals to the standard healthcare system.

2. Main recommendation: introduction of a low-threshold healthcare system in large towns

Given the circumstances described above, our proposal is **to set up, in all large towns, a low-threshold healthcare system. This system is also referred to as intermediate healthcare or 'line 0.5'**. This 'line 0.5' would be a **set of structures and/or services with a multidisciplinary, flexible and proactive approach**, where persons with no access to normal care may receive primary healthcare (including sexual and reproductive healthcare in all its aspects). Access conditions to such care would be non-discriminatory and respectful BUT the long-term objective would be to reintegrate the patient into the standard primary healthcare system.

- Multidisciplinary: the service provided must be multidisciplinary in order to address the whole range of the patient's problems.
- Flexible: the structure must adapt to the needs of the patient, and must have a low access threshold. It must, therefore, be able to ensure psychological and medical/social support, and must be affordable, while guaranteeing the confidentiality and non-judgmentalism required when dealing with highly vulnerable people.

IV. Offering 'made-to-measure' care to certain groups

- Proactive: the service provided must be mobile and outreaching. Increasing numbers of vulnerable people no longer trust the standard healthcare institutions. Mobile care can provide more possibilities outside an institutional setting, particularly when healthcare professionals, psychologists and social workers go to the places where patients live and socialise. A proactive approach will help reconstruct lost links with these groups and allow renewed referrals of these patients to other health professionals.
- Referral: 'line 0.5' should be a referral structure i.e. it should not replace standard healthcare. It should therefore be available for a specific period of time (which can be long) before referring the patient to the standard healthcare system. There would be medical structures, for example, for people with a drug addiction, which would take on and stabilise patients. However, once these patients are in a stable condition, they should be referred to the standard healthcare system.

This system should include a social service, a system of interpreters and/or cultural mediators and a guidance mechanism.

To ensure that vulnerable individuals accept medical care and complete their treatment, they will need support and advice. 'New professions' should therefore be considered within the healthcare system, such as psychological/social support workers, peer workers (contacts within the community who can spread prevention-related messages and help others find solutions to their problems), and network activators (who can activate and create links between the various institutions working with these individuals).

A psychological service and a strong emphasis on prevention are also needed to improve the care given to vulnerable groups, and to enhance their knowledge of the system (cf. the following point, 'health literacy').

Prevention and health promotion should be suited to the target public, using, particularly, risk-reduction strategies for persons with high-risk behaviours. For drug users, strategies could be opioid substitution treatments, syringe exchange programmes, access to Naloxone or lower-risk drug-use rooms. Sex workers could benefit from the distribution of condoms, STD screening or vaccination against hepatitis B and human papilloma virus.

Finally, there should be more intensive monitoring of these various ad hoc structures, so that they can work consistently as a network in a particular geographical area. Funding from NIHDl for these structures would depend on them being an integral part of the low-threshold healthcare system.

V. Improving patient information

The extent of line 0.5 would of course depend on the services currently offered by the primary healthcare system to vulnerable groups, and also on the geographical situation.

V. Improving patient information and understanding

1. Context/Issues

'Health literacy' is defined as *'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions'*. Poor literacy has negative effects on health outcomes, as well as on the quality and cost of healthcare. It is a risk factor for poor health, often caused by medical errors and an incomplete understanding of the disease and its treatments.⁵ There is also a clear correlation between low levels of health literacy and increased mortality rates.⁶

People with poor health literacy tend to be those with a low level of education or low income, elderly people as well as migrants and ethnic minorities (because of language and cultural differences).

For these vulnerable groups, low levels of health literacy often mean that they are unable to manage their health effectively, to have access to health services, to understand the information available or to make informed health choices.

⁵ Wolf, MS, Gazmararian, J.A., Baker, D.W (2005). Health literacy and functional health status among older adults. *Arch Intern Med*, 165, 1946-52.

⁶ Baker, D., Wolf, M, Feinglass, J, Thompson, J., Gazmararian, J and Huang J. (2007). Health literacy and mortality among elderly persons. *Arch Intern Med*, 167 (14), 1503-1509.

2. Main recommendation: creation of new professions (intercultural mediators and experts by experience) for the ambulatory care sector

To improve levels of health literacy, we must create **new professions in the ambulatory care sector**:

- In particular, **the use of intercultural mediators must be extended to primary healthcare**. For more than 15 years, hospitals have successfully employed intercultural mediators. They have had a wide variety of tasks: interpretation, accompanying, listening to and supporting patients, conflict resolution, defending the rights and interests of patients, or simply providing information to patients. We believe that this help should also be available to primary healthcare practitioners. The system would need to be flexible (without the need for a prior appointment), and easily accessible by the healthcare professional (e.g. via the internet).
- The PPS Social Integration hires individuals with personal experience of poverty to help improve the quality of public services. We recommend that this system of '**experts by experience**' be extended to the healthcare sector.

The development of these new professions will require suitable training programmes. Agreement will therefore need to be reached with the federated entities in the Interministerial Conference as to the content of such programmes.

List of abbreviations

Fedasil	Federal Agency for the reception of asylum seekers
HBV	Hepatitis B virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus

Further information



The Green paper, the proposals made during the round tables and the White paper are available:

- On the NIHDI website, www.inami.be. Go to “Publications”. Search for “livre blanc” and you’ll receive as a result the page “ Accès aux soins : nos recommandations pour un système de santé plus inclusif » where you’ll find the 2 documents
- On the Médecins du Monde website, www.medecinsdumonde.be. Go to ‘Publications > Dossiers’.

If you have further questions regarding the White paper, please e-mail us at rdq@inami.fgov.be.