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Inequalities in access to healthcare in Belgium

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Inequalities in access to healthcare in Belgium

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Executive summary

Access to healthcare in Belgium is, for the population as a whole, relatively good. However, there are large disparities in access between socio-economic groups ([1]). While in 2017, 2% of the adult population, self-reported unmet needs for medical care for financial reasons (and 3.5% for dental care), this number varied from 6.7% for persons in the lowest income quintile, 2.1% in the second quintile, and low to zero from the third quintile onwards. This gap between the poorest and richest quintiles is among the most pronounced in the European Union. Furthermore, a significant deterioration of the situation of persons in the lowest income quintile is observed between 2011 and 2017, while no significant difference is observed in other quintile categories. Unmet healthcare needs are thus mainly encountered by the least well-off.

Little is known concerning the characteristics of those with access problems, and there is no clear insight into factors that may explain these inequalities, and the increasing trend over time. Our study intends to help fill this gap. It is guided by the following research questions:

1) *How serious are the financial difficulties in accessing healthcare in Belgium? How have they evolved over the period 2011-2017?*
2) *Who is most at risk of unmet needs for healthcare, and of experiencing healthcare as a financial burden? What are the determinants of unmet needs for healthcare?*
3) *For which healthcare services and products are the barriers to access highest?*
4) *Which factors within the healthcare system can lead to difficulties in accessing healthcare and help to explain how these difficulties have evolved over the period 2011-2017*?

Our research, commissioned by the Belgian National Institute for Disability Insurance (NIHDI), focuses on inpatient and outpatient curative care provided by health professionals. The analysis relates to the population legally resident in Belgium, apart from people residing in collective facilities (e.g. prisons, nursing homes). Thus, our study does not consider some of the groups with the most serious difficulties in accessing healthcare, in particular persons not officially resident in Belgium, such as undocumented migrants or homeless people.

To answer the research questions, we analysed data from different sources. First, we explored the available literature, which is often grey literature, such as reports drafted by governments and stakeholders. Second, we analysed secondary data (from the EU-SILC survey), related to self-reported unmet needs for medical and dental care. Thirdly, we carried out and analysed 13

1. This report uses 2011 and 2017 microdata of the European Union Statistics on Income and Living Conditions (EU-SILC), provided to the OSE by Eurostat in November 2019. The Belgian statistical office, Statbel, informed us (e-mail exchange of 13/07/2020) that there have recently been minor corrections to the 2017 data (not made official yet). However, these corrections would have only marginally impacted the results of our statistical analysis. In addition, the data for Belgium for 2016, 2017 and 2018 that are available online on the Eurostat website (consulted on 10/07/2020), have recently been changed. The data for 2017 no longer correspond to those provided to us in November 2019, nor to the corrected data provided by Statbel on 13 July. We therefore do not refer to the data available on the EUROSTAT website.

semi-structured interviews with social and health workers in services providing support to patients and to people in a precarious situation, as well as a group interview with people with a chronic illness. Interviews were carried out in Antwerp, Brussels and Charleroi in the period May-September 2019.

The results of the statistical analysis broken down by individual socio-economic characteristics show the differences between socio-economic groups. Unmet needs are high among persons with no or low working activity (except for students and retirees): the unemployed (7.6% for medical care and 11.6% for dental care), the disabled (9.8% and 13.8%) or in households with low levels of working activity (9.9% and 14.1%). The highest proportion of unmet needs for medical care is observed for persons who report they were in arrears on utility and/or housing bills: 22.8%. Furthermore, for the group in arrears the situation significantly deteriorated since 2011.

After adjusting for other factors potentially influencing unmet needs (such as income, or needs factors), females are more likely to report unmet needs for medical and dental care. Married status was a protective factor compared to single status for dental care. The elderly, students and self-employed are less likely to declare unmet medical needs.

After adjusting for other factors (such as health need factors), income remains a significant factor of unmet need. Housing tenure status is significantly associated with unmet needs and there is a significant increase in unmet needs for tenants between 2011 and 2017. In 2017, another category, homeowners with a mortgage, is also at a higher risk of unmet needs than homeowners without.

Unmet needs for medical care are also more frequent among persons who are supposedly most in need of healthcare, that is people with a bad self-perceived health status and people with functional limitations. After adjusting for other factors, people who self-perceived their health as bad or fair are at higher risk of unmet needs than those reporting good health. This observation raises the issue of the reduced accessibility of healthcare for those who are the most in need. By contrast, an important positive change is observed for people with chronic diseases. This factor is no longer associated with unmet medical needs in 2017 (after adjustment), while it was in 2011.

Significant regional differences can be observed. In 2017 the share of persons who self-report unmet needs is significantly higher in Wallonia (3.1%) and Brussels (4.3%) than in Flanders (1%). Since 2011, the percentage has remained stable in Flanders while a significant increase is observed in Wallonia. In Brussels, a slight increase is observed but it remains insignificant. After adjusting for other factors —such as predisposing socio-economic and demographic factors, income and health need factors — the difference between regions remains significant in 2017.

Our study identified the following access hurdles to healthcare:

1) People who are not covered for healthcare face the most serious access problems. These include: people who have not paid their social contributions, in particular among the self-employed; those who failed to take the necessary administrative action to be covered, and those who have been deleted from the population register while they still live in Belgium.

While the number of people officially residing in Belgium but not covered for healthcare is estimated at 1% of the population, no reliable data are available.

2) Up-front payments are a major hurdle for access to all types of ambulatory healthcare.
3) Coverage for hospital care is low in Belgium compared with other EU countries. High advance payments and out-of-pocket (OOP) expenses were reported for patients hospitalised in shared wards, including for those qualifying for increased reimbursement (IR) ([2]). In particular, long stays and specific costly health material (e.g. prostheses) may lead to important affordability issues. Furthermore, hospitals and doctors reduce access to healthcare for patients with payment arrears.
4) User charges for physiotherapy, dental care and medicines are often difficult to afford, as is the case in many EU countries.
5) Patients living in precarious situations are not aware of the differences in status between contracted and not-contracted doctors, and are often not aware of the consequences of the paper they sign on admission to hospital, asking to be hospitalised in a single room.
6) Increased reimbursement status is an important measure to help low-income people to afford healthcare. Nevertheless, there are various issues with this status: firstly, non-take-up of the IR status for people not automatically granted the status; secondly, persons just above the threshold for IR status lose many important benefits, while their financial resources are not significantly higher; thirdly, the remaining user charges are still relatively high for some types of healthcare, including for hospital care, medical devices and medicines.
7) The Public Centres for Social Welfare (CPAS/OCMW), organised at municipal level, play a crucial role in providing financial support for healthcare costs for the least well-off patients. However, there are substantial differences in policies between municipalities. The diversity in approaches may be an additional hurdle for patients, for instance, when moving from one municipality to another and thus lead to geographic inequalities in access to healthcare for the least well-off.
8) The complexity at all levels of the healthcare system is an important hurdle to access care. This includes, among other things: the administrative procedures to obtain coverage and the exemptions on paying contributions; entitlement to increased reimbursement, the choice of a contracted healthcare provider, the right to the third-party payment system, the care trajectory and referral procedures which must be followed to benefit from reduced user charges, access to support from the CPAS/OCMW.

Our study did not identify obvious changes in the healthcare system that could help to explain the deterioration in access to care for vulnerable groups. On the contrary, several measures were implemented in that same period to improve access to healthcare. We therefore hypothesise that a deterioration of the household budget, available after deduction of the costs of other essential goods and services, of some vulnerable groups may explain these trends.

2. Some categories of insured persons, on a low income, pay lower user charges, based on a status called 'increased reimbursement'.

Other research indeed found that the number of persons at risk of poverty has increased since 2011 and that households on the lowest incomes and with very low work-intensity were left behind in the overall increase in household income (FPS 2019). The high proportion and significant increase in unmet needs for medical care among persons in arrears on their utility and/or housing bills, and the significant increase in unmet needs for tenants, also point in this direction.

Our findings show that the health insurance system is not equipped to adequately address these growing problems and thus to protect vulnerable people from access issues.

In light of these results, the authors of the report invite stakeholders to engage in an in-depth discussion on how to move forward towards universal health coverage. An open discussion would be warranted on the very design of the system for ensuring access to healthcare and on the financial burden on patients. In the context of the health and economic crisis, the need of such debate becomes even more urgent, considering the high risk of unmet healthcare needs for so many people who incurred a sudden significant drop of their income. Ensuring equal access to healthcare and protecting patients from excessive out-of-pocket payments should be the main goals of the compulsory health insurance system, not only in principle but also in practice.

Introduction: ambitions and scope ([3]) ([4])

Access to healthcare in Belgium is, for the population as a whole, relatively good. Nevertheless, there are large disparities in access between socio-economic groups (NIHDI 2014; Demarest 2015; Van Roy and Willems 2017; Buffel and Nicaise 2018; NIHDI and POD/SPP 2018; Devos *et al.* 2019a; Solidaris 2019).

In 2017, while in the highest income quintile ([5]), almost nobody reported a lack of access to the necessary medical care for financial reasons ([6]), this figure was 6.7% for the population in the lowest income quintile ([7]). Among the households with an income below the poverty line (60% of the median income), almost one in three reported that the costs of medical care are a significant financial burden for them ([8]).

What is more, according to the same European Union (EU) survey, inequalities in access to care between socio-economic groups are increasing: while for the EU as a whole the number of people reporting unmet needs for medical care in the lowest income quintile fell from 6.1% in 2011 to 3.3% in 2017, this number increased in Belgium from 4.8 to 6.9% in that same period. In its assessment of the economic and social situation in Belgium, the European Commission noted that "*the gap between the poorest and richest quintiles is the most pronounced of all western European countries*" (European Commission 2019a). Only Greece and Latvia show a bigger gap in 2017 (OECD/European Observatory on Health Systems and Policies 2019).

Little is known about the characteristics of the people with access problems, and there is no clear insight into factors that may explain these inequalities, in particular the increasing trend over time. Difficulties in access may be due to financial hurdles, but other factors too may affect access, such as: availability and proximity of healthcare services; access to information; acceptability of healthcare; health literacy etc. Furthermore, increases in unmet needs for healthcare may not only be due to changes in the healthcare system, but also to a possible deterioration in the available household budget of the low-income population and increasing costs of other essential goods and services. Finally, increasing (self-perceived) health needs may also contribute to an increase in unmet needs for healthcare.

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3. This report uses 2011 and 2017 microdata, provided to the OSE by Eurostat in November 2019. The Belgian statistical office, Statbel, informed us (e-mail exchange of 13/07/2020) that there have recently been minor corrections to the 2017 data (not made official yet). However, these corrections would have only marginally impacted the results of our statistical analysis. In addition, the data for Belgium for 2016, 2017 and 2018 that are available online on the Eurostat website (consulted on 10/07/2020), have recently been changed. The data for 2017 no longer correspond to those provided to us in November 2019, nor to the corrected data provided by Statbel on 13 July. We therefore do not refer to the data available on the EUROSTAT website.
4. We wish to thank our interviewees for their time and for sharing their field experience with us, without whom this research would not have been possible. We also thank Carine Vande Voorde, Nicolas Bouckaert, Rudi Van Dam, Ri De Ridder, Laurence Kohn, Stefaan Demarest, Bart Vanhercke, Déborah Flusin and staff members of many NIHDI services for their help and valuable feedback on earlier drafts of this report.
5. The 20% of the population with the highest income.
6. Over the past twelve months.
7. European Union Statistics on Income and Living Conditions (EU-SILC), [hlth_silc_08].
8. EU-SILC, [ilc_hch01].

Our study intends to help fill this gap in the knowledge. We do not aim to provide an exhaustive list of factors explaining the inequalities or the increasing trends. Nor do we aim to highlight causal relationships between access hurdles and unmet needs. We wish, however, to identify and describe the various affordability issues linked to features of the Belgian healthcare system that may contribute to social inequalities in access to healthcare. We furthermore look at developments in the health and social care system that may possibly contribute to the increasing trend.

Our research focuses on the potential factors explaining unmet needs and affecting the affordability of healthcare within the health system. We do not, therefore, consider factors outside the health system, such as trends in income, in expenditure on basic goods and services, or social policies beyond the health sector. We are nevertheless fully aware that there may be important factors, outside the healthcare system, potentially explaining trends in unmet needs for healthcare.

Problems with affordability of health care have two major negative consequences: first, unmet health care needs and second, financial hardship due to the use of expensive health services for patients. Our research concerns primarily access to health care. Our approach does not allow to assess the financial impact of health care costs on household budgets, nor the effectiveness of tools to protect households from the risk of impoverishment due to health care costs ([9]).

Our analysis focuses on the population legally resident in Belgium, apart from people residing in collective facilities (e.g. prisoners, people in long-term care homes, or in centres for asylum seekers).

Thus, our study does not consider some of the groups with the most serious difficulties in accessing healthcare, in particular persons not officially resident in Belgium, such as undocumented migrants or homeless people. Access problems for these vulnerable groups have been analysed in the Green Paper on the accessibility of healthcare in Belgium, published in 2014 on the occasion of the 50th anniversary of the Belgian health insurance system (NIHDI 2014). An analysis of the problems faced by some specific groups in accessing healthcare has also been carried out by the Belgian Healthcare Knowledge Centre (KCE): undocumented migrants; prisoners and asylum seekers (Roberfroid *et al.* 2015; Mistiaen *et al.* 2017; Dauvrin *et al.* 2019). Access issues of these groups are also analysed by other actors (e.g. Médecins du Monde, 2019).

As revealed by the EU-SILC data, problems in accessing healthcare are not limited to these particularly vulnerable groups. People who, in principle, are entitled to coverage by the Belgian compulsory health insurance system may still have difficulties accessing the necessary healthcare. In our study we seek to investigate the problems faced by these population groups.

Our research focuses on inpatient and outpatient care provided by health professionals, as well as prescribed pharmaceuticals and medical devices. We do not investigate the access to and use of preventive care, long-term care services in residential settings and home care not provided by health professionals.

9. Such as the Maximum Billing system, see Box 19.

When relevant, we will point to the impact of unmet needs for healthcare on health. We will not, however, look at the impact of socio-economic inequalities on health. While access to healthcare has an impact on health, other socio-economic determinants may have an even more important impact (WHO 2019).

We formulated the following research questions:

1) *How serious are the financial difficulties in accessing healthcare in Belgium? How have these evolved over the period 2011-2017?*
2) *Who is most at risk of unmet needs for healthcare, and of experiencing healthcare as a financial burden? What are the determinants of unmet needs for healthcare?*
3) *For which healthcare services and products are barriers to access highest?*
4) *Which factors within the healthcare system can lead to difficulties in accessing healthcare and help to explain their evolution over the period 2011-2017?*

To answer the research questions, we analysed data from different sources.

First, we carried out desk research, in order to understand the features of the Belgian healthcare system relevant to access to healthcare, and to explore the available literature. Second, we analysed secondary data from the EU-SILC survey, focusing on the data on self-reported unmet needs. Thirdly, we carried out and analysed semi-structured interviews with social and health workers from services providing support to patients and to people in a precarious situation, as well as a group interview with people with a chronic illness.

We carried out our research at the request of the Belgian National Institute for Health and Disability Insurance (NIHDI).

In this report, we first present the theoretical background on access to healthcare (Chapter 1), next we explain the different methods we used (Chapter 2). Chapter 3 presents the results of literature on the performance of Belgium with regard to access to care compared to other EU countries. Chapter 4 presents the identification of the profile of people who declared unmet needs for medical and dental care, based on the EU-SILC micro data and the determinants of unmet needs. In the next chapter (Chapter 5), we present the hurdles for access to healthcare in Belgium reported by the interviewees. In Chapter 6, we discuss our findings, present a series of policy recommendations and conclude.

Chapter 1. Theoretical background on access to healthcare

1.1 Universality and equity

The European Pillar of Social Rights, proclaimed by the EU institutions in 2017 ([10]), states that "*everyone has the right to timely access to affordable, preventive and curative healthcare of good quality*" (Tajani *et al.* 2017) ([11]). The Council of the EU defined the common values of health systems as follows (Council of the European Union 2006): "*Universality means that no one is barred access to healthcare; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay.*"

Universal health coverage refers to the objective of ensuring access to effective health services to everyone when needed without risking financial hardship (Thomson *et al.* 2019). The underlying principle is horizontal equity: equal access for similar healthcare needs ([12]). Different interpretations have been given to this concept. For van Doorslaer, other individual characteristics such as income, geographic location, gender, age, and social status should not influence healthcare utilization (especially income) (van Doorslaer *et al.* 2000). According to these authors, equitable access to healthcare would yield equal healthcare utilization for equal healthcare needs. However, healthcare systems generally allow the consideration of individual preferences and thus unequal use of health services for a given level of need (Schokkaert and Van de Voorde 2014). Additionally, given the limited resources in healthcare, efficiency of health services is important in ensuring access to healthcare. Equitable access to healthcare thus includes "ensuring that the resources required to deliver relevant, appropriate and cost-effective health services are as closely matched to need as possible" (EXPH 2016).

1.2 Factors influencing access to healthcare

Penchansky defines the concept of access as "*the degree of "fit" between the clients and the system*" (Penchansky and Thomas 1981). Conceptual frameworks differ according to authors (Penchansky and Thomas 1981; Evans *et al.* 2013; Levesque *et al.* 2013). Access to healthcare is a complex notion with various dimensions.

Figure 1 shows the different types of factors influencing access to healthcare. Moving toward universal health coverage requires good performance on availability, affordability and acceptability of health care. These three dimensions are closely interrelated.

Availability refers to the ease of accessing good quality health services, in good time, with, in particular, sufficiently well-trained healthcare professionals to meet the population's needs for

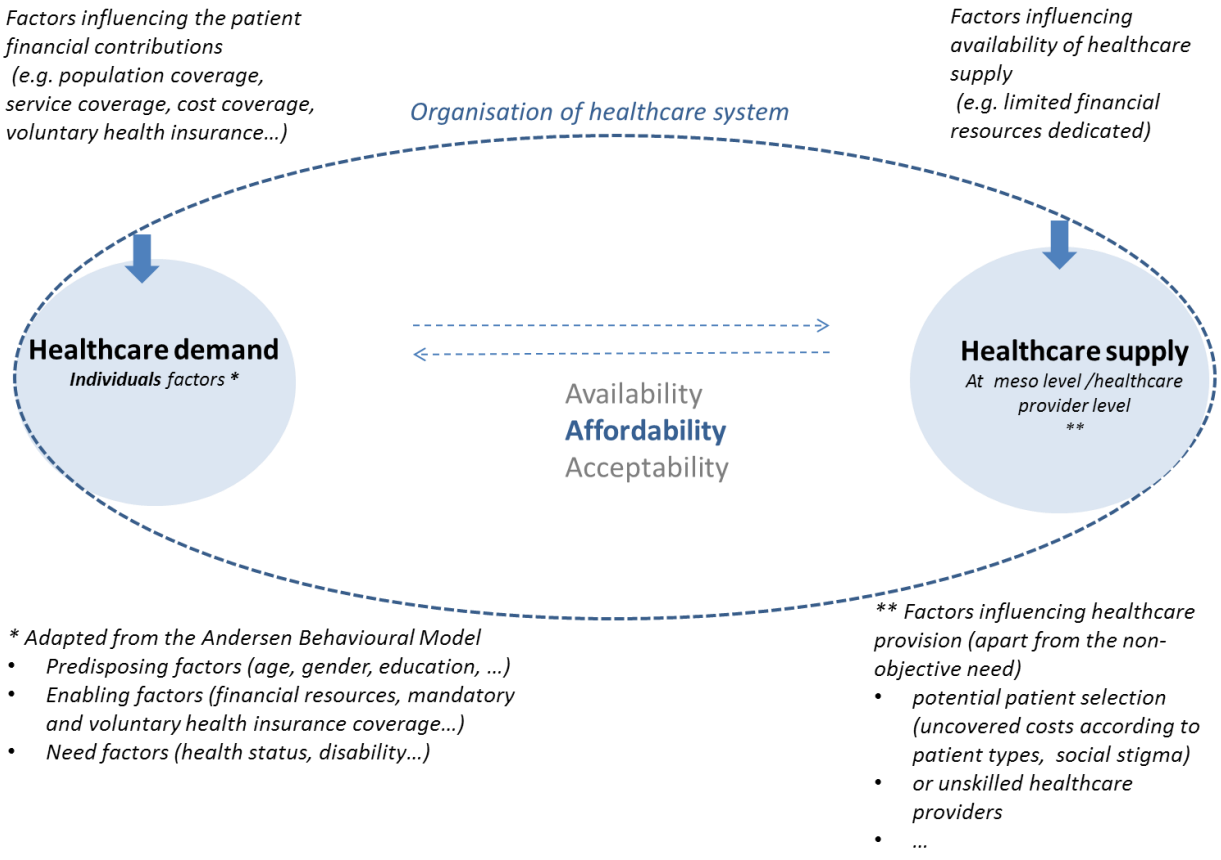
10. The European Pillar of Social Rights has been proclaimed by the European Parliament, the Council and the European Commission at the Social Summit for Fair Jobs and Growth on 17 November 2017.
11. Principle 16 – "Healthcare" (https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en) (latest consulted on 16/06/2020).
12. As opposed to vertical equity, which refers to different treatment of different healthcare needs.

healthcare. It includes considerations concerning the organisational aspects of healthcare delivery, such as opening hours and appointment systems.

Affordability relates to *people's ability to pay for services without financial hardship*. Affordability depends greatly on coverage decisions (Busse *et al.* 2007), which determine out-of-pocket (OOP) expenses. However, this dimension refers not only to the financial contribution of patients. Other factors may be non-healthcare related costs (e.g. travel costs or informal care) or the opportunity costs of accessing health services (e.g. time spent away from work). This dimension is the focus of our research.

Acceptability relates to the willingness to seek healthcare services. Acceptability is influenced by individual perceptions of the quality of healthcare services and various subjective considerations related to cultural expectations, religious orientations, etc. To be acceptable, care provision needs to meet the expectations and particular needs of various groups in society, such as the socio-economically disadvantaged, women, older people, etc. Levesque provides more detailed upstream aspects of acceptability. He includes approachability, which refers to the ability to identify healthcare services that can be reached and the ability to perceive health needs, which is determined by e.g. health literacy or beliefs (Levesque *et al.* 2013).

Figure 1: Factors influencing access to healthcare



Source: authors' own elaboration.

Within the healthcare sector, barriers or facilitators for access can operate at three levels: 1) at macro level (the healthcare system), 2) at meso level (healthcare providers and payers) and 3) at micro level (individual behaviour ofpatients or healthcare professionals). We will discuss these different levels below. Outside the healthcare sector, social policies or other public policies may also strongly influence access to healthcare, but this matter is outside the scope of this study.

At **macro level**, various factors influence both healthcare demand and supply:

Healthcare supply is influenced by a set of factors, such as the level of financial resources allocated to the healthcare sector or regulations on access to the health professions.

On the *demand side*, the level of the patients' financial contribution, OOP expenses, is determined by various factors, such as the criteria to be met in order to qualify for health insurance, the range of health services and products covered by the compulsory or voluntary health insurance and the share of the cost covered by the healthcare system. This is shown in Figure 2. The different types of OOP expenses are listed in Box 1.

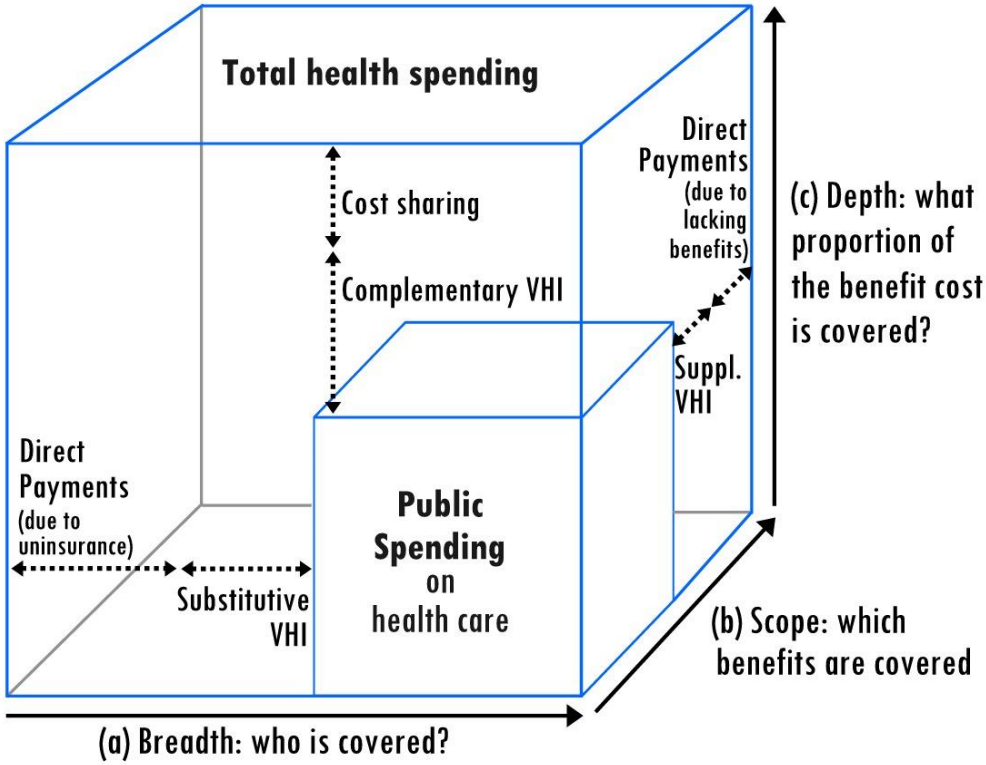
Box 1: Different types of out-of-pocket expenses

OOP expenses include:

1) direct payments: payments for goods or services that are not covered by any form of third-party payment;
2) cost-sharing (user charges): a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of the healthcare received;
3) fee supplements: payments due on top of the regulatory defined user charges, for healthcare provided by health providers who are free to set their tariffs;
4) informal payments: unofficial (under-the-table) payments for health goods or services.

Source: authors' elaboration based on (Rechel *et al.* 2010).

Figure 2: Three dimensions determining the level of out-of-pocket spending



Source: (Rice *et al.* 2018), adapted from (Busse and Schlette 2007).

At **meso level**, healthcare providers and other organisations in the healthcare sector may also impede (or facilitate) access to healthcare, for instance, by introducing discrimination measures (e.g. patient selection due to social stigma) or may affect the quality of healthcare, for instance by recruiting low-skilled healthcare professionals.

At **micro level**, individual behaviour is determined by various factors. We use the Andersen Behavioural model, a theoretical framework which was primarily developed to understand healthcare utilisation (Andersen 1995). Three categories of factors are identified that may impede or foster healthcare take-up: predisposing characteristics, enabling resources and needs. In this model, different levels are identified, as are individual and local contextual characteristics, and healthcare supply characteristics.

- "Predisposing characteristics" include individual characteristics that are likely to influence the need for health services (e.g. demographic factors such as age, gender) and social-economic factors that may impact on health or influence the ability to cope with health problems, such as education, occupation or social interactions, health beliefs, psychological characteristics.
- "Enabling resources" include characteristics at the community level related to the availability of healthcare supply and the organization of services. At the individual level, they include factors likely to influence the affordability of healthcare services, such as income and health insurance coverage.

- "Need" factors may differ between self-perceived health needs and medical judgement. The medical judgement may however also be influenced by subjective components and may vary over time with medical progress ([13]).

Inequity in access exists when issues other than need-related factors influence healthcare access, particularly enabling factors such as income. Andersen introduced the concept of 'mutability' to this discussion on how to enhance equity; factors are mutable to varying degrees (e.g. enabling resources can change from low to high).

Additionally, health professionals may also facilitate or impede access to healthcare at a micro level by favourable or inadequate behaviour, in particular by adapting their clinical practice to the expectations or specific needs of individuals (e.g. providing sufficient explanations when required).

Achievement of universal health coverage may be seriously hampered by affordability issues. Smith *et al.* (ICF 2018) propose a hierarchical classification of the three dimensions of access to healthcare: availability and affordability should be achieved before acceptability can be assessed (ICF 2018). Affordability issues have two major adverse effects: first, unmet needs for healthcare and second, financial hardship when people use health services and then have to pay for them. The study mainly focuses on identifying affordability issues and on their impact on access. Some consequences for the household budget have been described but were not covered by our research questions. However, despite its potential major impact on many domains of well-being (ability to meet basic needs, health, social, psychological, etc.), financial hardship is not assessed in depth in the study. For this, a quantitative analysis would be required, with access to several micro databases (Thomson *et al.* 2019).

1.3 Definition of healthcare need

In our research, we analyse data on self-reported unmet needs for healthcare. The main difficulty when using self-reported unmet needs is that the need for healthcare cannot be objectively measured. The perceptions of need can vary between the individual and the doctor, since, for example, the dividing-line between a potentially beneficial treatment and the absence of adequate treatment can be blurred (e.g. in a case of low benefits considering the resources required, or because of excessive marketing for ineffective treatments). However, it is possible to distinguish between an individual's decision not to seek care and the lack of an adequate response from the healthcare system.

Different definitions have been given of health needs:
Health need has been defined as "the ability to benefit from healthcare" (EXPH 2017)

- From the individual point of view, the notion refers to perceived health need, which can have two possible consequences:
  - The perceived health need may not lead to a (total or partial) expressed demand for healthcare (totally or partially).

13. For reasons of clarity we will use the concept of "health needs" in our analysis, since we also discuss other basic needs such as needs for housing and food.

- The perceived health need may lead to a decision to seek healthcare and healthcare may be provided or not.

Hence, there is a potential two-fold distortion between the objective (medically defined) need for healthcare and the individual's self-perceived health need:

- The individual may underestimate his health need, i.e. potential treatments exist but the individual does not perceive his health need and thus his need for healthcare.
- On the supply side, for a given self-perceived health need, there may be no existing/adequate treatment; the individual's health status does not allow him to receive the treatment because it is expected to be ineffective (e.g. because of co-morbidities), or the doctor is not able to identify objective need given e.g. difficult communication with the patient, vague description of symptoms, etc. In some cases, it may be difficult to determine how beneficial a treatment is likely to be.

Hence, the concept of need can be defined from two perspectives: individual and medical (as expressed in the clinical judgement). Since information on healthcare needs from the medical perspective is not available for the whole population, one pragmatic approach to measuring needs for healthcare is to ask individuals whether they identified a health need ([14]). The notion of 'self-reported unmet healthcare needs' refers to the fact that no care was received when a need was self-perceived.

Figure 3 presents the different possible situations leading to self-reported unmet healthcare needs: individual health need (self-perceived or not), medical evidence (objective need or not) ([15]) and healthcare utilisation (utilisation or not). Self-reported unmet healthcare needs exist when individuals identify a health need but do not obtain healthcare. This may exist in two main scenarios:

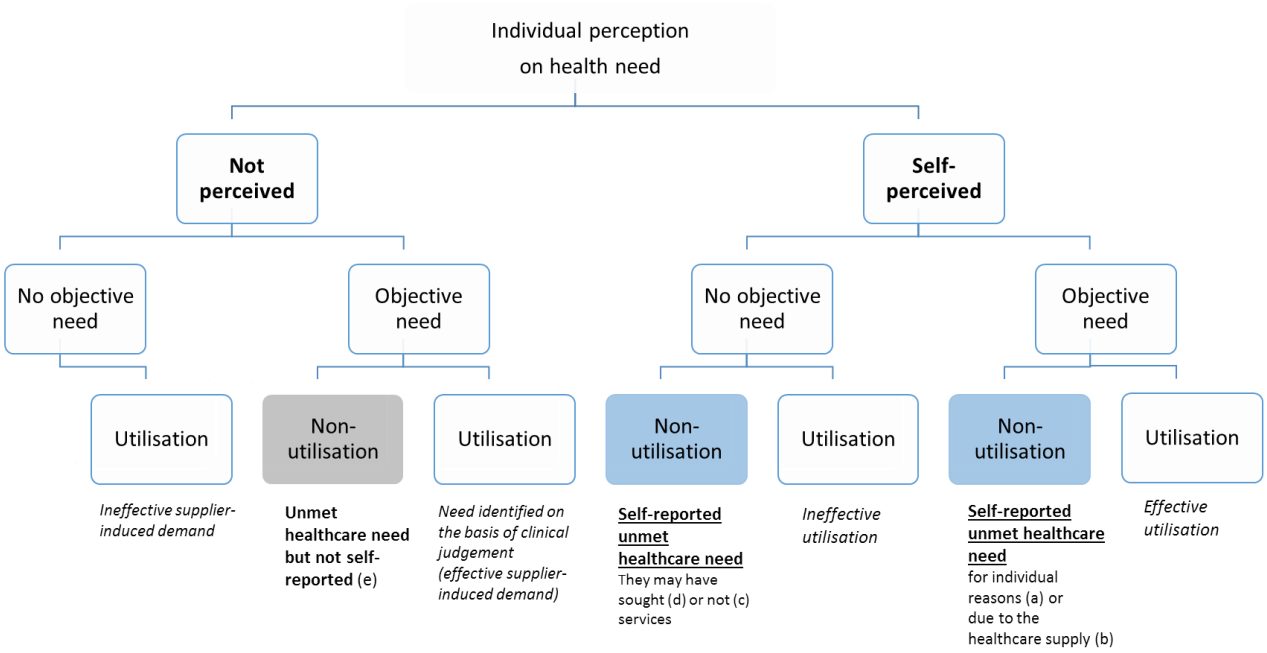
- Individuals identify a health need but deliberately do not seek healthcare due to financial or other individual constraints:
  - although an adequate treatment exists (a),
  - while no adequate treatment for the health problem exists, based on clinical judgment (c).
- Individuals identify a need and seek care but do not receive it:
  - because there is no objective need (d) (in this case, not all individuals would report unmet needs if health providers informed them properly about the absence of an appropriate treatment).
  - for reasons linked to healthcare supply such as underdiagnosis, or discrimination (b) while there is an objective need.

Hence, the self-reported unmet needs measured include objective unmet healthcare needs (a) and (b), but also self-perceived needs although there is no objective need based on clinical

14. Apart from in epidemiolocal research studies, where needs for healthcare are assessed according to clinical judgement.
15. It should be noted that 'objective medical need based on a clinical judgement' is a theoretical concept. In reality, medical evidence is not always univocal and the state of medical science is developing continuously.

judgment (c) and (d). Objective needs that are not self-perceived are not included in the measurement (e) while this may be more frequent among vulnerable populations (Warin 2011).

Figure 3: Overview of the link between individual perception on health need and self-reported unmet healthcare need



Source: authors' own elaboration, adapted from (Warin 2011).

Chapter 2. Methodology

Access to healthcare is not univocally defined from a theoretical point of view (McIntyre *et al.* 2009). The three main dimensions of access (see 1.2) are highly intertwined while a great range of factors at macro, meso and micro levels play a role. To study financial access, we therefore opted for mixed methods research which allows us to draw on the potential strengths of both the qualitative and quantitative methods (Kohn and Christiaens 2012; Queirós *et al.* 2017). Qualitative work is essential as a complement to quantitative work, to explore financial barriers to access: "*Often qualitative and quantitative data can be fruitfully combined as they mostly elucidate complementary aspects of the same phenomenon*" (Patton 1999).

To understand the extent of access issues in Belgium compared to other EU countries, we first carried out an overall descriptive cross-country analysis of different dimensions of access to healthcare. This analysis draws on available secondary statistical data and literature.

Secondly, to identify the profile of people facing unmet needs for healthcare in Belgium, we performed an in-depth statistical analysis of microdata on self-reported unmet needs for medical and dental care, drawing on the EU-SILC data on self-reported unmet needs for medical and dental care.

Thirdly, to provide an overview of the variety of issues related to financial access to healthcare and financial hardship resulting from healthcare take-up, we carried out and analysed 13 semi-structured interviews with social and health workers active in services providing support to people in a precarious situation, as well as a group interview with people with a chronic illness.

2.1 Statistical analysis of data on self-reported unmet needs for healthcare

Since data on objective health needs (the ability to benefit from healthcare) and barriers affecting access to healthcare are difficult to collect, the proxy commonly used to study access to healthcare is self-reported unmet needs for healthcare, *i.e. "whether they were unable to obtain care or treatment when they believed it to be medically necessary"* (EXPH 2016).

2.1.1 The EU-Statistics on Income and Living Conditions (SILC)

We used the EU-SILC data. This survey ([16]) is currently implemented in 28 European Union countries, as well as Iceland, Norway, Switzerland and Turkey. Belgium was included from the start (2004).

The survey mainly focuses on income, mostly at individual level (some household income components are included). Additional information is collected on poverty, social exclusion, housing, labour, education and health. The reference population is: "*all private households and their current members residing in the territory of the countries at the time of data collection*"

16. Information retrieved from: https://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:EU_statistics_on_income_and_living_conditions_(EU-SILC) (latest consulted on 16/06/2020) https://ec.europa.eu/eurostat/web/income-and-living-conditions/overview (latest consulted on 16/06/2020).

([17]). Persons living in collective or institutional households, children under 16 and people not officially residing in the country are excluded. A representative sample of private households is surveyed. All household members aged 16 and above are interviewed (face-to-face interviews). A quarter of the sample is replaced each year. In Belgium, a two-stage sample is drawn. First, 275 Belgian municipalities are selected randomly (no changes since 2004). Then, based on the National Register, in each of these municipalities a number of households are selected, also randomly ([18]). In 2017, 11,281 individuals from 6,053 households were surveyed in Belgium.

Some groups who are likely to have higher levels of unmet needs for healthcare than the general population, such as those living in institutions (health and social care residential facilities, prisoners), homeless people, undocumented migrants, are thus not included in the survey.

2.1.2 The question on unmet needs for medical and dental care in the EU-SILC survey

The question on self-reported unmet needs for medical care in the EU-SILC questionnaire, translated into English is presented in Box 2. For the original Dutch and the French version: see Annex II.

17. Household is defined as a housekeeping unit or, operationally, as a social unit having common arrangements; sharing household expenses or daily needs; in a shared common residence period. It includes either one person living alone or a group of people who live together in the same dwelling with common housekeeping.
18. This Register includes all private households and their current members residing on the territory and is updated twice a month.

Box 2: The question on self-reported unmet needs for medical care in the EU-SILC questionnaire

"Was there any time during the past 12 months when you really needed a medical examination or treatment, but did not?

1. *Yes, there was at least one occasion*
2. *No, there was no occasion"*

The question refers to medical examination or treatment provided by physicians, including general practitioners as well as surgeons, gynaecologists and other specialists. It thus refers to care provided by medical doctors, not to care provided by other health professionals, or to prescribed drugs ([19]).

"What was the main reason for not having a medical examination or treatment?

It includes the following reply categories:

"1. Could not afford to (too expensive or not covered by the insurance fund)

2. *Too far to travel / no means of transportation*
3. *Waiting list / don't have the referral lettre*
4. *Could not take time because of work, care for children or for others*
5. *Fear of doctor, hospitals, examination, treatment*
6. *Wanted to wait and see if problem got better on its own*
7. *Didn't know any good dentist*
8. *Other reason"*

Source: Eurostat website, https://ec.europa.eu/eurostat/fr/web/income-and-living-conditions/quality/questionnaires (latest consulted on 16/06/2020).

A break in the time series in the indicator on unmet needs for medical examination in Belgium occurred in 2011, due to changes in the structure of the questions. Before 2011, the question first identified people who had medical needs in the past twelve months, and then, among these people, those with unmet healthcare needs. Since 2011, these two parts are combined in one single question, on existing medical need and unmet need, in order to be better aligned with the EU standard question.

It should be noted that this question is put at the individual level, and thus relates to the unmet needs of the interviewed adult. This contrasts with some other surveys, such as the Belgian Health Interview Survey (HIS) ([20]), where unmet needs are reported at the household level.

19. "*Medical care refers to individual health care services (medical examination or treatment) provided by or under direct supervision of medical doctors (general and specialist medical practitioners), traditional and complementary medical professionals (ISCO-08 code 2230) or equivalent professions according to national health care systems. Included: medical mental health care; prevention if perceived by respondents as important. For example, a national health care system guaranties regular preventive medical check-ups but the respondent is not able to make an appointment and perceives the situation as jeopardizing his/her health. Excluded: self-medication (taking prescribed or non-prescribed drugs); dental care.*" (codebook individual questionnaire 16 years and more 2016, methodological guidelines and description of EU-SILC target variables https://circabc.europa.eu/sd/a/165c80b9-5631-4f5b-b847-29c638715c0e/DOCSILC065%20operation%202016%20VERSION%2022-05-2017.pdf) (latest consulted on 16/06/2020).
20. The Health Interview Survey is organised every 4-5 years by Sciensano and collects data from about 10,000 persons in Belgium.

The indicator makes it possible to estimate the proportion of persons experiencing at least one need that was not satisfied over the twelve-month period. The question does not make it possible to calculate the number of episodes of unmet needs (EXPH 2017).

2.1.3 Variables used in the quantitative analysis

We use Andersen's conceptual model (see Section 1.2). This theoretical model provides a list of the different components that are likely to impact healthcare utilisation. However, this model does not explain the complex underlying mechanisms or show the extent to which factors affect healthcare utilization. Hence, this model should be used with caution in statistical analysis since it may be difficult to apply. It may be difficult to disentangle possible interactions between the different factors (Babitsch *et al.* 2012). Although it is designed to analyse healthcare utilization, we assume that is also suited to analysing the determinants of self-reported unmet healthcare needs. Indeed, the advantage of this model is that it allows us to classify the potential factors likely to also influence non-utilisation of healthcare.

We analysed variables from the EU-SILC questionnaire in two ways, first at a descriptive level and second in a regression analysis. The variables tested in the regression analysis are presented in Annex III Tables of variables used in the quantitative analysis of EU-SILC data

Table 2, Table 3 and Table 4 of Annex III. Sometimes, information relates to the characteristics of the household (indicated in the tables in Annex III with (a)). However, the analysis is always performed at individual level.

2.1.4 Statistical analysis

The 2011 and 2017 releases of the EU-SILC data were used to perform the analysis. To process the data, Stata 16 version was used.

The sample design was taken into account in calculations by using the Stata do file from Goedemé (to build the EU-SILC sample design variables, primary sampling unit and primary strata) (Goedemé 2013; Goedemé and Zardo Trindade 2016). In the analysis, the survey design characteristics were taken into account by using svyset and prefix svy commands.

Univariate logistic regression was carried out to test unadjusted differences of probability of unmet needs. The multivariate logistic regression was carried out to identify the factors associated with the probability of unmet medical needs/financial burden by estimating the simultaneous effects of multiple factors potentially influencing the unmet need (dichotomous variable: 0 for no unmet needs and 1 for self-reported unmet needs). The statistical analysis is performed in two steps: first, each factor is individually tested (univariate) and is selected at $p<0.1$ level of significance. Second, the multivariate analysis is built by adding iteratively one factor and the significance using the P-value from the Wald Test ([21]).

21. For complex survey data, p-values are calculated using the Wald test (the likelihood-ratio test is not relevant in this case).

2.2 Semi-structured interviews

To describe the various access issues, and in order to better understand the multitude of mechanisms leading to unmet needs and healthcare-related financial hardship, we carried out semi-structured face-to-face interviews with social and health workers from services providing support to patients and to people in a precarious situation.

2.2.1 Selection of interviewees

We opted to interview mainly fieldworkers as first-hand witnesses. They can provide direct information on the target population, can clearly formulate the issues and describe the situation of clients or patients. We invited them to provide us, as far as possible, with concrete examples of the topics of discussion, of clients/patients with whom they are in direct contact. This enabled us to collect data on specific individual cases.

We did consider interviewing patients in vulnerable situations, but for methodological reasons and due to time constraints this option was not retained ([22]) (Hearne and Murphy 2019). We nevertheless conducted one interview with a group of patients with chronic conditions, organised in a patient-advocacy group, during their three-monthly meeting.

We selected the professionals interviewed according to the following criteria:

- First, three geographical areas were selected: Antwerp, Brussels and Charleroi. This allowed coverage of the different regions in Belgium, while focusing on areas with high concentrations of poverty and deprivation ([23]). Practical criteria also played a role in selecting areas that are easily reachable by public transport.
- Second, within these areas, we selected organisations in direct contact with vulnerable populations, providing health and social care services. These included hospitals, birth and childcare offices, community primary care centres, sickness funds and Public Centres for Social Welfare (CPAS/OCMW).
- Third, within each organisation we selected professionals who are in direct contact with people in a precarious situation who may have problems affording healthcare. This included health professionals (in particular general practitioners) and social workers.

We carried out 13 semi-structured interviews ([24]).

22. Issues include the identification of people with unmet needs for healthcare; the establishment of a relationship of trust with people in a precarious situation and making an appointment. This approach would furthermore require far more interviewees, since each case is particular.
23. In 2017, the average net taxable income per inhabitant in Belgium amounted to 18,331 euros. Per capita income in Flanders is 7% above the national average, in Wallonia it is 6% below the Belgian figure, while in Brussels it is on average 22% less on an annual basis. In the municipality of Antwerp, it is however 12% below the national average, which is among the lowest scores of the municipalities in Flanders. In Charleroi, it is 27% below the national average, which is one of the lowest scores in Wallonia. https://statbel.fgov.be/fr/themes/menages/revenus-fiscaux (latest consulted on 02/03/2020).
24. We contacted 15 organisations. Two of them did not respond to our request.

2.2.2 Semi-structured interviews

All interviews were carried out in the period May-September 2019. An interview grid was drawn up and adapted for each interview according to organisation visited. The interview grid was first elaborated based on literature. The following topics were included:

- Presentation of the organisation, the service and the professionals interviewed;
- Description of the profiles of the persons who have difficulties to access healthcare;
- Healthcare coverage problems;
- For the persons with healthcare coverage:
  - Description of the financial difficulties for inpatient care and post-treatment after hospitalisation;
  - Description of the difficulties for outpatient care (for chronic patient or not),
- Strategies adopted by patients to cope with financial hurdles or difficulties;
- CPAS/OCMW intervention for out-pocket expenses;
- The role of the sickeness funds in solving administrative and affordability issues;
- Suggestions for solutions and recommendations.

The interviews lasted between one and two hours and most of them were carried out by two researchers (or, if not possible, by one researcher). The number of participants in an interview was variable: between one and five interviewees. The participants in an interview were usually from the same profession (social workers or doctors); 14 patients took part in the group interview with the chronically ill patients. To ensure the anonymity of the interviewees, no names of persons or organizations are mentioned in the report.

The interviews were all recorded and fully transcribed. Interviewees sometimes provided additional information after the interview (e.g. examples of patient cases or hospitalisation invoices) and this was also included in the qualitative data analysed.

2.2.3 Thematic analysis

To process our data, we encoded the interviews using Nvivo 12 plus. The encoding was performed by two researchers (SC and RB) using an iterative process. A first encoding was performed by a researcher, then discussed and adapted in Nvivo. We then carried out a thematic analysis of the data (Braun and Clarke 2006).

Chapter 3. Access to healthcare in Belgium: a review of literature

In this chapter, we discuss the findings of existing studies on access to healthcare in Belgium. We first present some main data on self-reported unmet needs for healthcare (Section 3.1): Belgium in comparison to other EU countries (Section 3.1.1) and the results of existing surveys in Belgium (Section 3.1.2). Next, we present data on Belgium's performance compared to other European countries, on different aspects related to OOP expenses (Section 3.2). This includes population coverage of healthcare (Section 3.2.1), the importance of OOP expenses (Section 3.2.2) and the financial burden of OOP (Section 3.2.3).

3.1 Self-reported unmet needs for healthcare

The most common approach to monitoring inequalities in access to healthcare is through a proxy indicator on the self-reported unmet needs for medical care. There may be substantial differences between surveys in the share of the population reporting unmet needs. These differences can reflect the different ways in which the surveys are designed. The unit surveyed may be an individual or a household, the question may focus on care provided by physicians only, or include healthcare provided by other health professionals, and may or may not also cover medicines and medical devices. Also, the way in which the question is formulated may result in different outcomes.

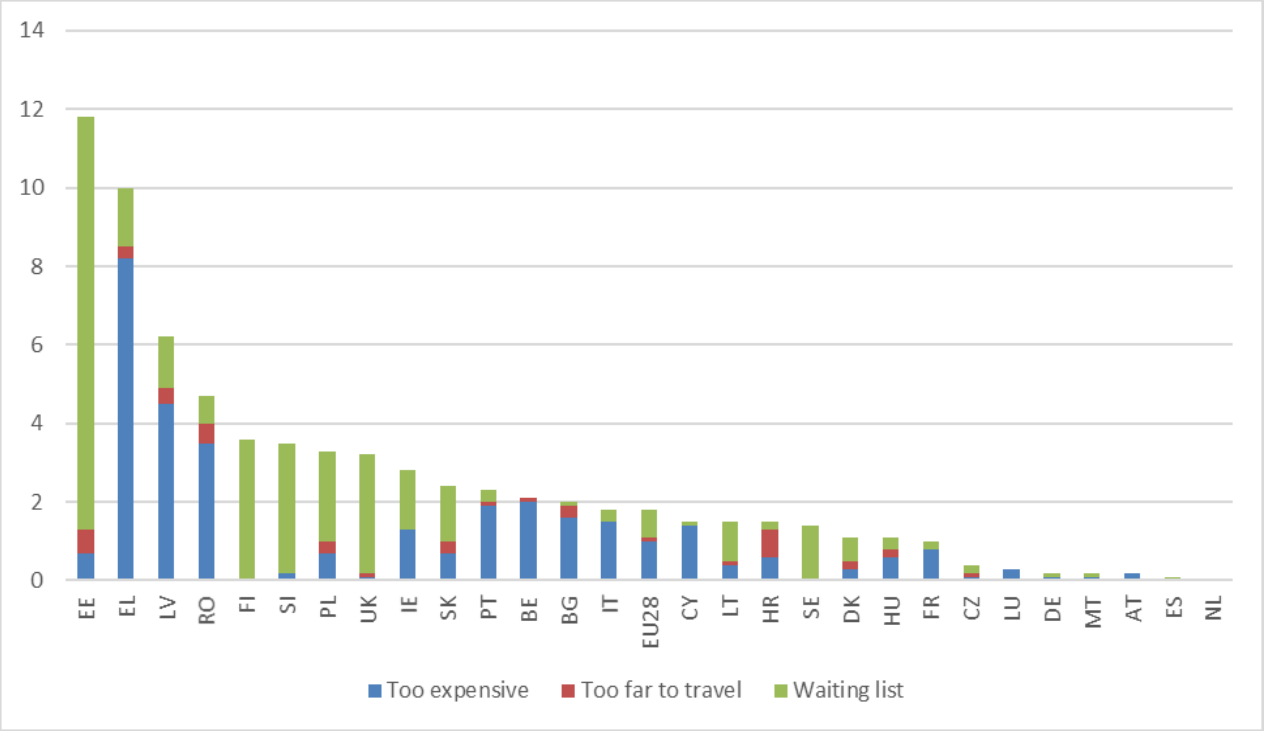
3.1.1 Belgium compared to other EU countries

In this section we discuss cross-country comparisons of self-reported unmet needs for healthcare, based on different data sources ([25]).

Figure 4 shows the percentage of self-reported unmet medical needs according to the main reasons cited, based on the EU-SILC survey data 2017. In Belgium, cost is the most important factor impeding effective access to healthcare.

25. The cross-country comparisons should be interpreted with caution (European Commission 2016; Baeten *et al.* 2018; Eurofound 2019; OECD 2019b). Major efforts have nevertheless been made during the last decade to better align the questions in the different Member States. Breaks in time series at country level are well documented. Despite this, there may still be differences in the design of the survey, such as the wording or translation of the question, questions formulated in one step or two steps. Furthermore, issues such as cultural biases, non-response rate among vulnerable groups may also impact cross-country comparability. Diverging trends between countries over time and trends in gaps in unmet needs between socio-economic groups within countries do nevertheless provide important indications of access issues.

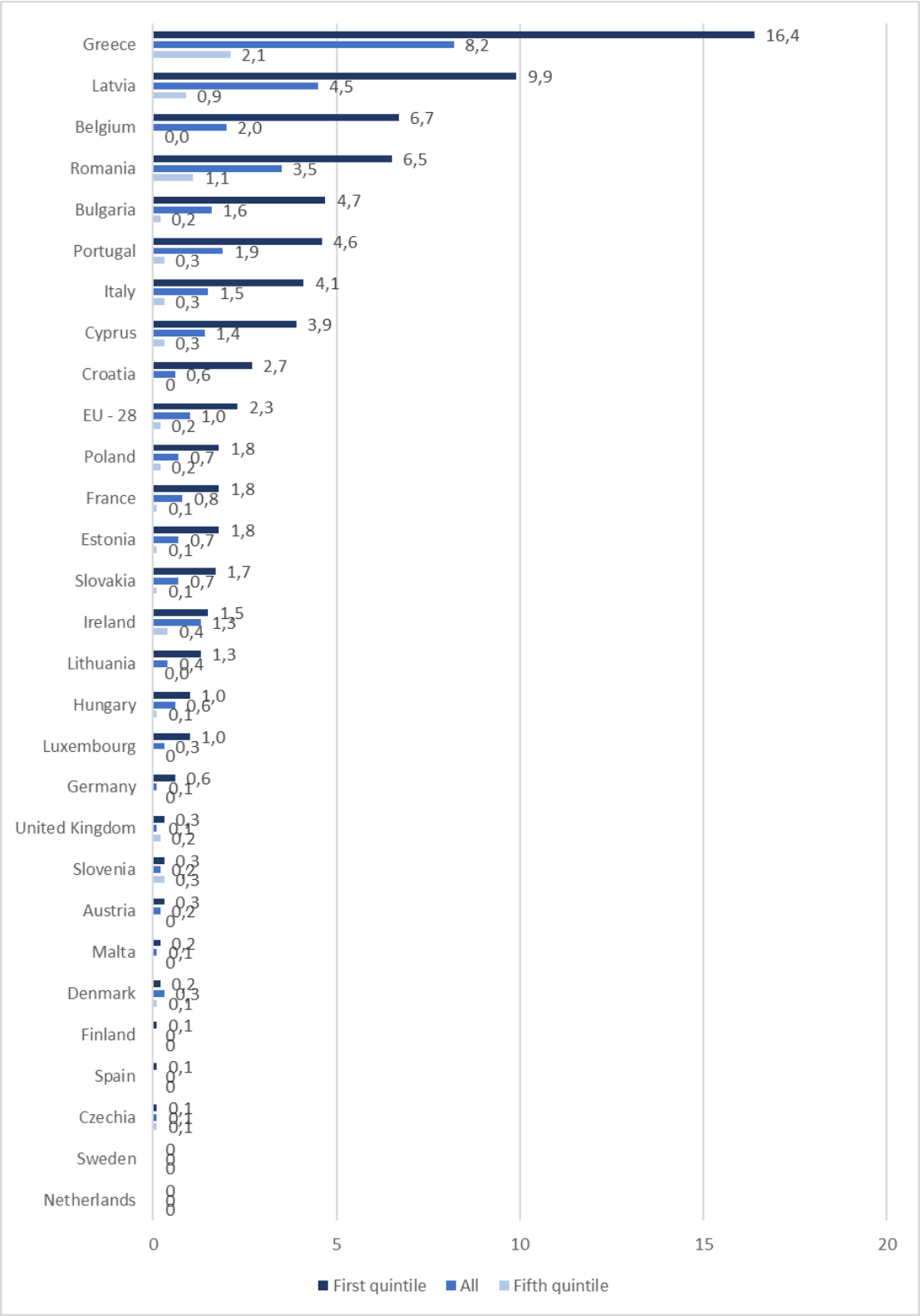
Figure 4: Percentage of persons who self-reported unmet needs for medical examination or treatment, 2017: main reasons



Source: Eurostat, EU-SILC 2017, [hlth_silc_08].

Figure 5 shows the percentage of persons declaring unmet needs for medical examination or treatment for financial reasons in 2017, per income quintile. While, for the population as a whole, the percentage of unmet medical needs for financial reasons remains, at 2%, relatively low in 2017, it is among the highest figure in the EU for the first income quintile: Belgium has the third highest percentage of persons with unmet needs for medical examination or treatment due to cost (6.7%), after Greece and Latvia.

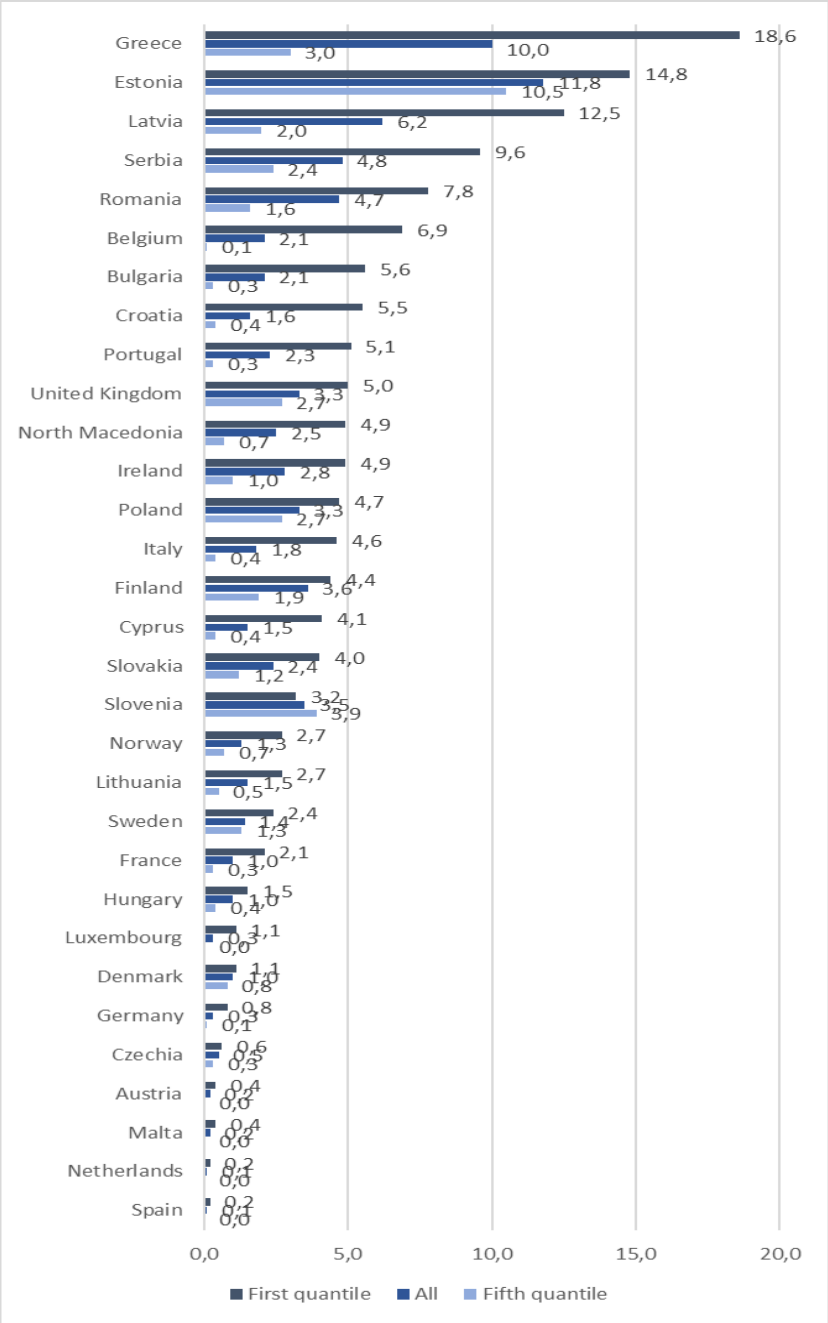
Figure 5: Percentage of persons declaring unmet needs for medical examination or treatment for financial reasons and income quintile, 2017



Source: Eurostat, EU-SILC 2017, [hlth_silc_08].

If we include the two other main reasons for unmet medical needs, waiting lists and distance, Belgium's ranking is slightly better. Nevertheless, the proportion of persons declaring unmet needs for medical examination or treatment in the first income quintile group, in 2017, is still, at 6.9%, high, compared to other EU countries.

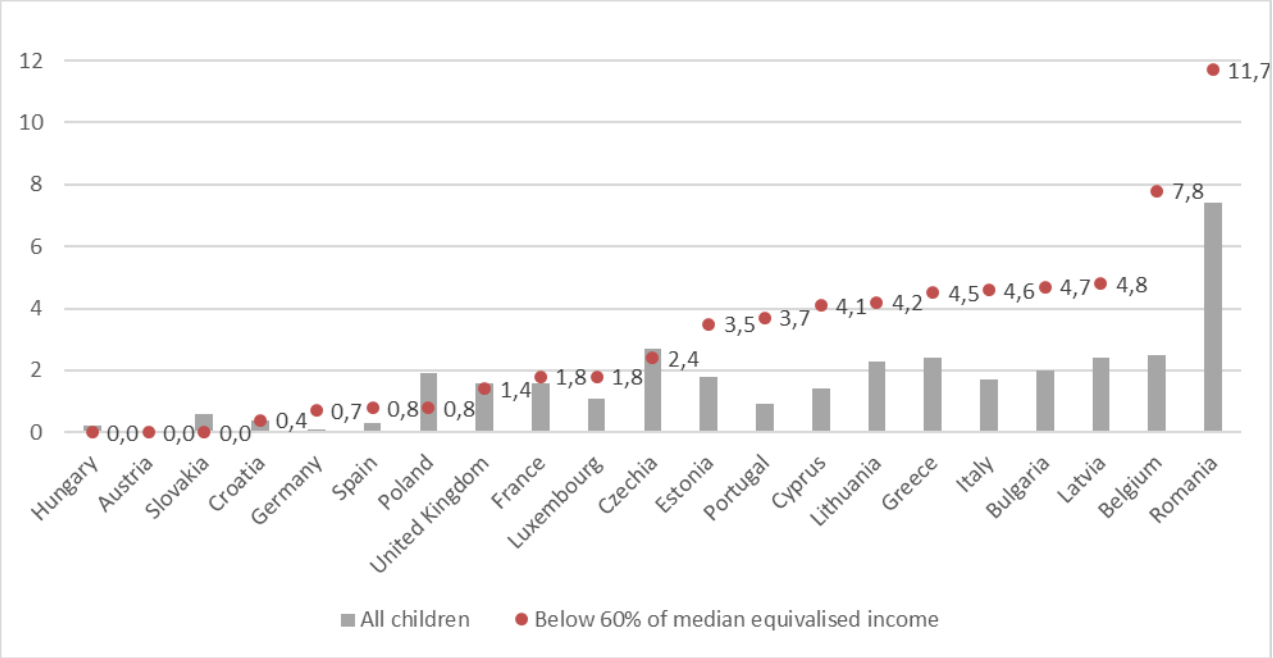
Figure 6: Percentage of persons declaring unmet needs for medical examination for financial reason or waiting list or too far to travel and income quintile, 2017



Source: Eurostat, EU-SILC 2017, [hlth_silc_08].

Figure 7 shows the percentage of children living in households with at least one child suffering from unmet medical needs, broken down by poverty status. In Belgium, in 2.5% of households there was at least one child suffering from unmet medical needs. Among the children living in households below the poverty line, the unmet needs, at 7.8%, are second highest among the EU countries for which data are available. Only Romania scores worse.

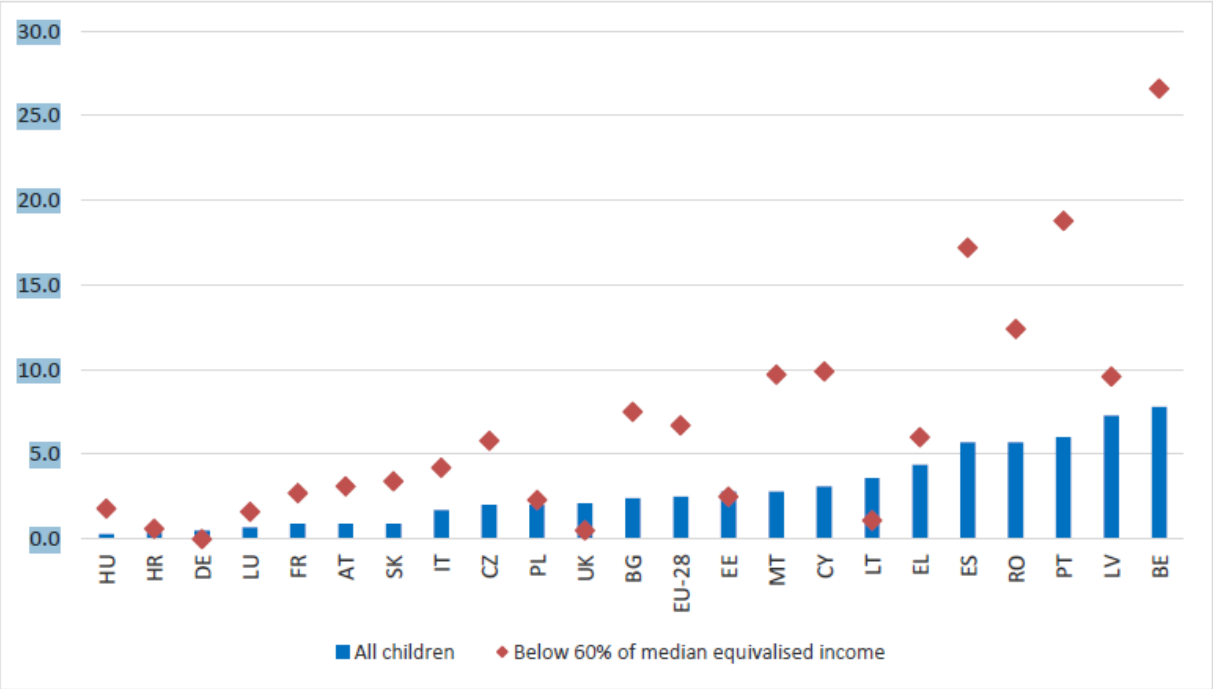
Figure 7: Percentage of children living in households declaring unmet medical needs for at least one child, all children and children at-risk-of poverty, 2017



Note: the sample size is too small to provide reliable information in DK, IE, FI, NL, SE and SI.
Source: Eurostat, EU-SILC 2017, Table ilc_hch14 (Frazer *et al.* 2020).

For dental care (Figure 8), the proportion of children living in a household with at least one unmet need for at least one child is 7.8%, while the EU average is 2.5% (Frazer *et al.* 2020). The score for Belgium is highest among the EU countries for which data are available. For low-income households, the proportion is much higher than for other countries (26.6%).

Figure 8: Percentage of children living in households declaring unmet dental needs for at least one child, all children and children at-risk-of poverty, 2017

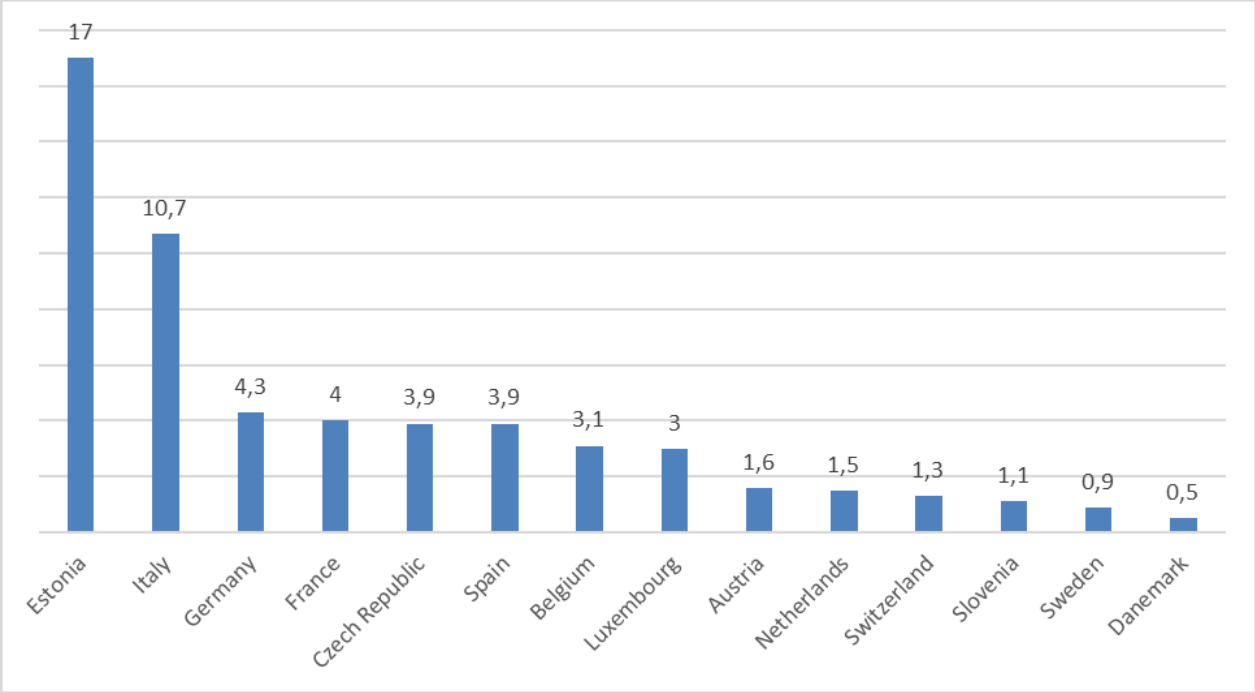


Note: the sample size is too small to provide reliable information in DK, IE, FI, NL, SE and SI ([26]).
Source: Eurostat, EU-SILC 2017, Table ilc_hc14. (Frazer *et al.* 2020).

Figure 9 shows the percentage of unmet medical needs for financial reasons among the population aged 50 years and older, based on data collected in 2013 for the Survey of Health, Ageing and Retirement in Europe (SHARE). 3.1% of the respondents self-reported unmet medical needs for financial reasons in Belgium (Krůtilová 2016b) ([27]). Belgium is thus in the middle group of the EU countries included in the survey.

26. No further information is provided to explain why those countries are excluded while Belgium is included.
27. Share 5th wave (2013), *"Was there a time in the past twelve months when you needed to see a doctor but could not because of cost?".* http://www.shareproject.org/fileadmin/pdf_questionnaire_wave_5/SHARE_paperversion_5_4_10_en_GB.pdf (latest consulted on 22/06/2020).

Figure 9: Self-reported unmet medical needs for financial reasons among the population aged 50 years and older, 2013 (%)



Source: based on data available in (Krůtilová 2016a).

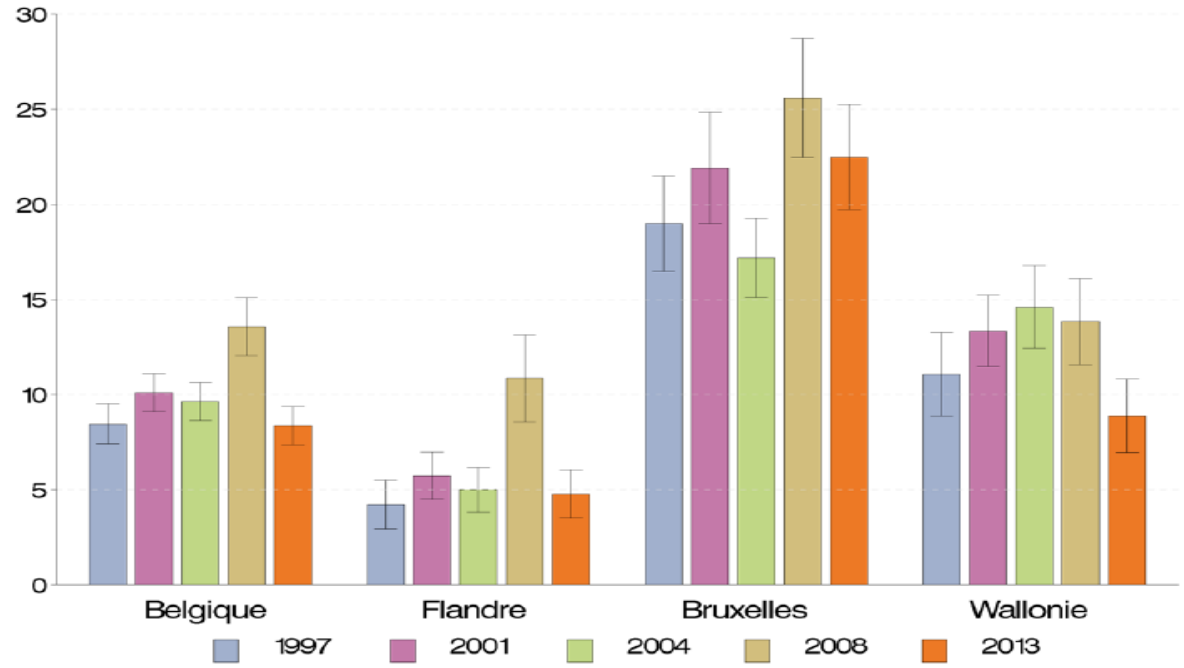
3.1.2 National surveys

In the national Health interview survey (HIS), in 2013, 8% of households declared that one or more household members needed healthcare in the past twelve months but did not have access to this as they could not afford it ([28], [29]). The question relates to one of more of the following types of healthcare: medical care; dental care; mental healthcare; glasses and/or prescribed medicines.

The percentage of households in which members had unmet healthcare needs for financial reasons increased significantly in 2008 and then slightly decreased in 2013 in the three regions (Figure 10). The highest percentage is observed in the Brussels region (22%), 9% in Wallonia and 5% in Flanders (20).

28. *"Sometimes people have problems in getting medical care when they need it. Using the next questions we would like to check to what extent your household was confronted with problems like this during past 12 months. Was there any time when someone in the family needed the following kinds of care, but could not afford it?".* https://his.wiv-isp.be/SitePages/Questionnaires.aspx (latest consulted on 22/06/2020).
29. These percentages are substantially higher than those from the EU-SILC survey. One of the main explanations for this is the way in which unmet needs are counted. In EU-SILC, only unmet needs of the interviewee are counted, while in the HIS unmet needs for all household members are counted, i.e. if only one member had unmet needs while the other members had none, unmet need is recorded for the whole household with no distinction between members.

Figure 10: Percentage of households which could not afford the healthcare they needed



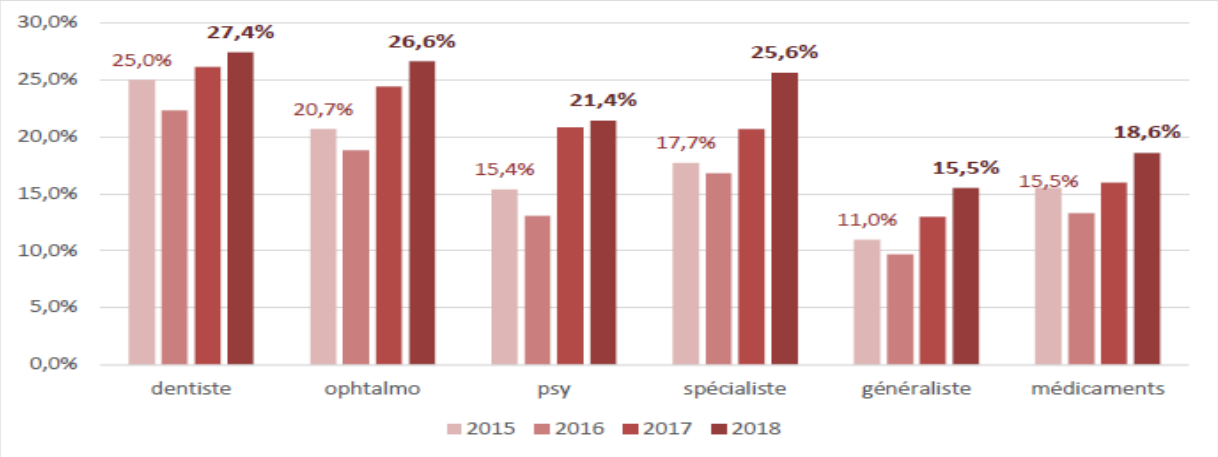
Source: (Demarest 2015).

In 2013, among households with a low income (first quintile), 17% of households declared that they could not afford healthcare at least once over the past twelve months. The same was true for 4% of households in the highest income quintile.

The sickness fund group Solidaris surveyed self-reported unmet needs among its members in Wallonia and the Brussels region between 2015 and 2018 ([30]) (Solidaris 2019). Between 2015 and 2018, a substantial increase can be observed for specialist care (Figure 11). In 2018, 27.4% of persons declared unmet needs for dental care for financial reason, 25.6% for specialist care, 18.6% for medicine and 15.5% for general practitioner care.

30. *« Au cours des 12 derniers mois, j'ai dû renoncer (à aller chez dentiste/ophtalmologiste/médecin spécialiste/ médecin généraliste/psychologue, à acheter des médicaments) pour des raisons financières ».* https://www.institut-solidaris.be/index.php/lereportdesoinsdesante/ (latest consulted on 22/06/2020).

Figure 11: Percentage of individuals failing to seek healthcare for financial reasons between 2015 and 2018



Source: (Solidaris 2019).

3.2 Out-of-pocket expenses: Belgium compared to other European countries

As explained in Section 1.2, the level of the patients' financial contribution, OOP expenses, is determined by three factors: 1) whether the individual is covered by the health system 2) the range of health services and products covered by the health system (the benefit package) and 3) the share of the cost covered by the healthcare system. Box 3 explains some of the basic features of the Belgian healthcare system relevant for understanding access issues.

In this section we will look at how Belgium performs with regard to OOP expenditures, compared to other European countries.

Box 3: Basic features of the Belgian compulsory health insurance system relevant for access

Belgium has a compulsory national health insurance system. Each individual must join a sickness fund and fulfill the requirements with regard to payment of social contributions (for further details see Box 4). Healthcare delivery is mostly private, from independent medical practices. The patient has a large freedom to choose a healthcare provider. Remuneration is predominantly based on fee-for-service payment. Hospitals are public or not-for-profit private. Hospital budgets are calculated based on a series of parameters, which are the same for all hospitals, irrespective of their legal status. They cover accommodation costs and costs for nursing care. Medical care in hospital is funded on a fee-for-service basis.

Although the compulsory health insurance system covers a broad range of health services and products, user charges apply for most benefits covered. The amount of the user charges depends on the insurance status of the insured person: ordinarily insured person or a beneficiary entitled to an increased reimbursement (see Box 6). Non-contracted health providers may charge fee supplements (see Box 8).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

3.2.1 Population coverage

The rules that apply in Belgium to be covered for healthcare, are described in Box 4.

Box 4: Rules for coverage for healthcare in Belgium

To be covered for healthcare in Belgium, each individual must join a sickness fund and fulfill the requirements with regard to payment of social contributions. The compulsory health insurance system covers both active and non-active people (as titleholders), as well as their dependents. Those on a replacement income may be exempted from paying social contributions. Dependent children and the spouse of the entitled person living in the same place of residence are covered based on their relationship with the titleholder (as dependents).

While for employees, social contributions are automatically deducted from their salary, the self-employed have to take action themselves to be covered for healthcare. They must join a social insurance fund before the start of their activity. Failing this, after a formal notice giving a period of 30 additional days, they are automatically affiliated with the National Auxiliary Fund for the self-employed ([31]). They must pay income-based social contributions and have to join a sickness/health insurance fund. People officially residing in Belgium who do not qualify for the status of titleholder or dependent (with no or insufficient income from professional activity), can be covered if they pay personal contributions ([32]). These contributions are income-related and range from 0 € for those with an income below the level of the subsistence minimum to nearly 248 € per month for the highest incomes.

In principle, only persons officially registered in Belgium ([33]) can join a sickness fund. Homeless people may join a sickness fund and qualify for health coverage if they are registered at a reference address, often at a Public Centre for Social Welfare (CPAS/OCMW) ([34]).

31. This is the social insurance fund of the national institute of social insurances of the self-employed (INASTI).
32. People with the status of titleholder or dependent, but who have not contributed enough, can keep their status by paying additional contributions.
33. Or, in some cases, in another country, such as frontier workers or pensioners abroad.
34. For a full explanation of this measure, see section 5.4.3.

Membership of the sickness fund begins as soon as the administrative requirements are fulfilled; the person is covered for healthcare from the first day of the three-months term in which the contribution requirements are fulfilled. The entitlement remains valid each time at least for a full calendar year. The entitlement ends if the entitled person did not comply with the requirements in the reference year, two years earlier. Thus, persons who had insufficient income or paid insufficient social security contributions for a temporary period (e.g. in the case of part-time agency work or suspension of unemployment benefits ([35]), can (temporarily) be removed from the health insurance regime two years later.

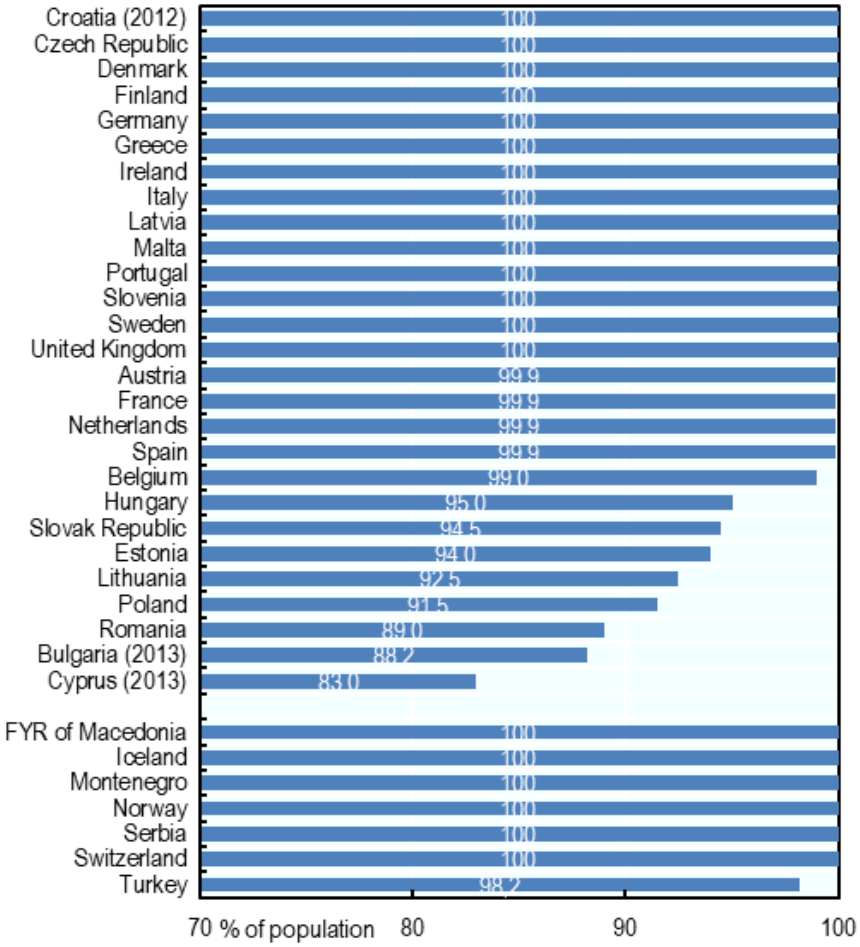
People who have lost their coverage for health insurance for less than 2 years must not re-join a fund, but must have their situation 'regularised', i.e. brought back into order. This may be conditional upon payment of the social contributions due for the reference year. People who have lost their entitlement for more than two years have to re-register with the sickness fund and a trial period of 6 months applies in principle. Several categories of persons are nevertheless exempt from the trial period, such as people on a subsistence minimum income or an equivalent income.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

In 2016, 99% of the population was compulsorily covered for a core set of services in Belgium (see Figure 12). This is the lowest coverage rate of Western European countries: in most of them 100% or 99.9% of the population is covered. These data should nevertheless be interpreted with caution. The population not covered may include people covered by private schemes, such as people working for international organisations or those covered in another EU country, for instance posted workers, as well as people not covered by any scheme. The latter have to pay the full costs of healthcare themselves. Furthermore, these data for Belgium only include part of the non-covered population. For a critical discussion of the estimated number of people not covered in Belgium, we refer to Section 6.1.5.1.

35. And if they have not paid a top-up for the contributions due.

Figure 12: Population coverage for a core set of services, 2016 (or nearest year)



Note: This includes public coverage and primary private health coverage. Data for Luxembourg is not available.
Source: OECD Health Statistics 2018; European Observatory Health Systems in Transition (HiT) Series for non-OECD countries, in (OECD and European Union 2018).

3.2.2 The importance of out-of-pocket expenses

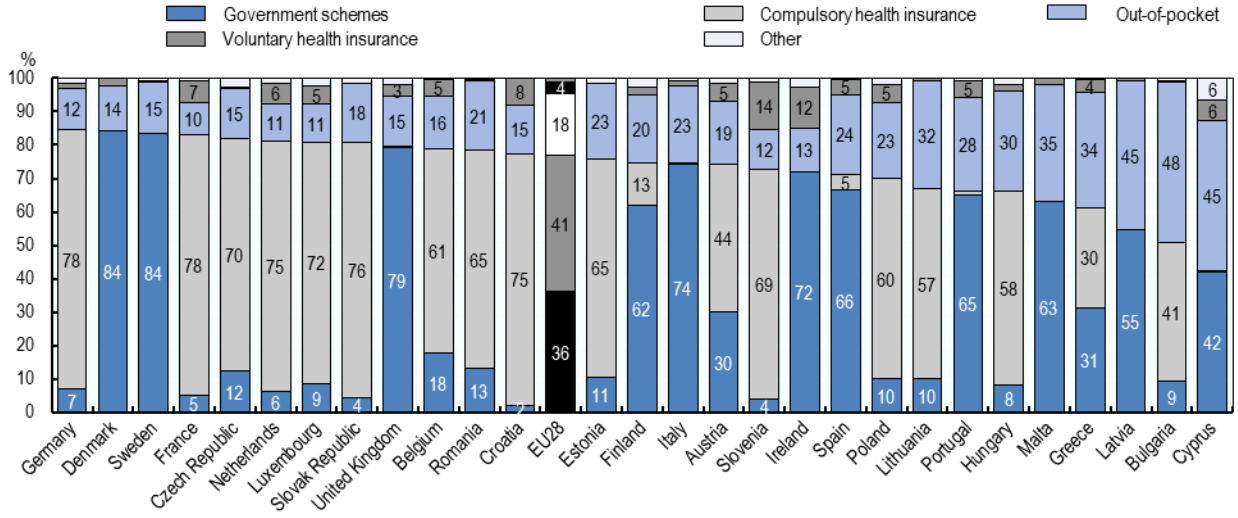
As explained above, out-of-pocket expenses include direct payments for goods or services that are not covered by any form of third-party payment; cost-sharing or user charges for healthcare that is covered by the public system and fee supplements due on top of the regulatory defined user charges, for healthcare provided by health providers who are free to set their tariffs ([36]). The basic rules on user charges in Belgium are explained in

36. In principle it also includes unofficial (under-the-table) payments for health goods or services, but these are, by definition, not included in the official statistics. There are no indications that they would be important in Belgium.

Box 3 and for the rules on reduced user charges for vulnerable groups we refer to Box 6. For the rules on fee supplements, see Box 8.

Figure 13 shows total health expenditure broken down into the various types of financing in European countries ([37]). OOP spending represented 16% of total health expenditure in Belgium in 2016. Of the EU 28 countries, Belgium ranks 12th (ranking from the lowest share of OOP spending in health expenditure) (OECD and European Union 2018) ([38]).

Figure 13: Health expenditure by type of financing, 2016 (or nearest year)

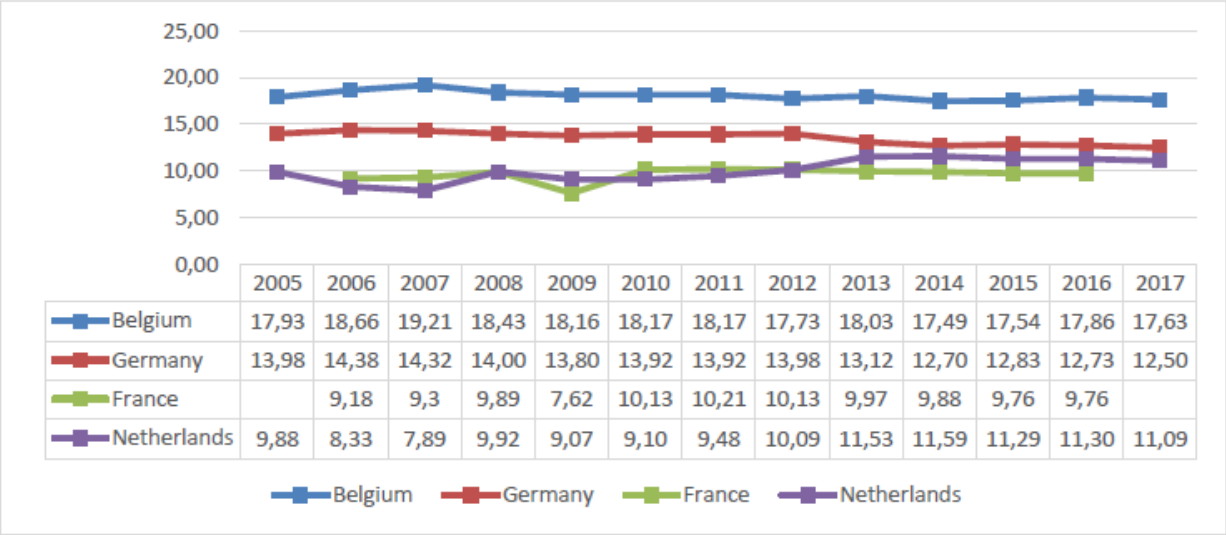


Note: Countries are ranked by government figures and compulsory health insurance as a share of current health expenditure.
Source: OECD Health Statistics 2018; Eurostat Database; WHO Global Health Expenditure Database in (OECD and European Union 2018) ([39]).

At aggregate level, the share of healthcare expenditure, paid by patients in Belgium is estimated at 17.6% of total health expenditure (8 billion € in 2017), i.e. 704 € per inhabitant on average in 2017 (FPS 2019). Figure 14 shows the percentage of OOP payments in the total healthcare expenditure for Belgium and its neighbouring countries from 2005 to 2017. The share of OOP expenditure is relatively high in Belgium compared to the neighbouring countries (12.5% for Germany, 11.1% for Netherlands). Yet, due to comparability problems, caution is required when interpreting these data (FPS 2019) ([40]).

37. *"Out-of-pocket payments are expenditure borne directly by patients, which can take the form of cost-sharing of services included in the publicly defined benefit package, as well as direct purchases of goods and services."* (OECD and European Union 2018).
38. We included the UK among the EU countries, as the data are from before Brexit.
39. "*Data are jointly collected by OECD, Eurostat and WHO, and comply with internationally standardised definitions of health spending provided under the System of Health Accounts (SHA 2011) framework.*" (OECD and European Union 2018).
40. In the SHA, OOPs are a residual category and may cover different payments for different countries.

Figure 14: Percentage of out-of-pocket expenditure as a share of total health expenditure, Belgium and its neighbouring countries, 2005-2017



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belgium	17,93	18,66	19,21	18,43	18,16	18,17	18,17	17,73	18,03	17,49	17,54	17,86	17,63
Germany	13,98	14,38	14,32	14,00	13,80	13,92	13,92	13,98	13,12	12,70	12,83	12,73	12,50
France		9,18	9,3	9,89	7,62	10,13	10,21	10,13	9,97	9,88	9,76	9,76	
Netherlands	9,88	8,33	7,89	9,92	9,07	9,10	9,48	10,09	11,53	11,59	11,29	11,30	11,09

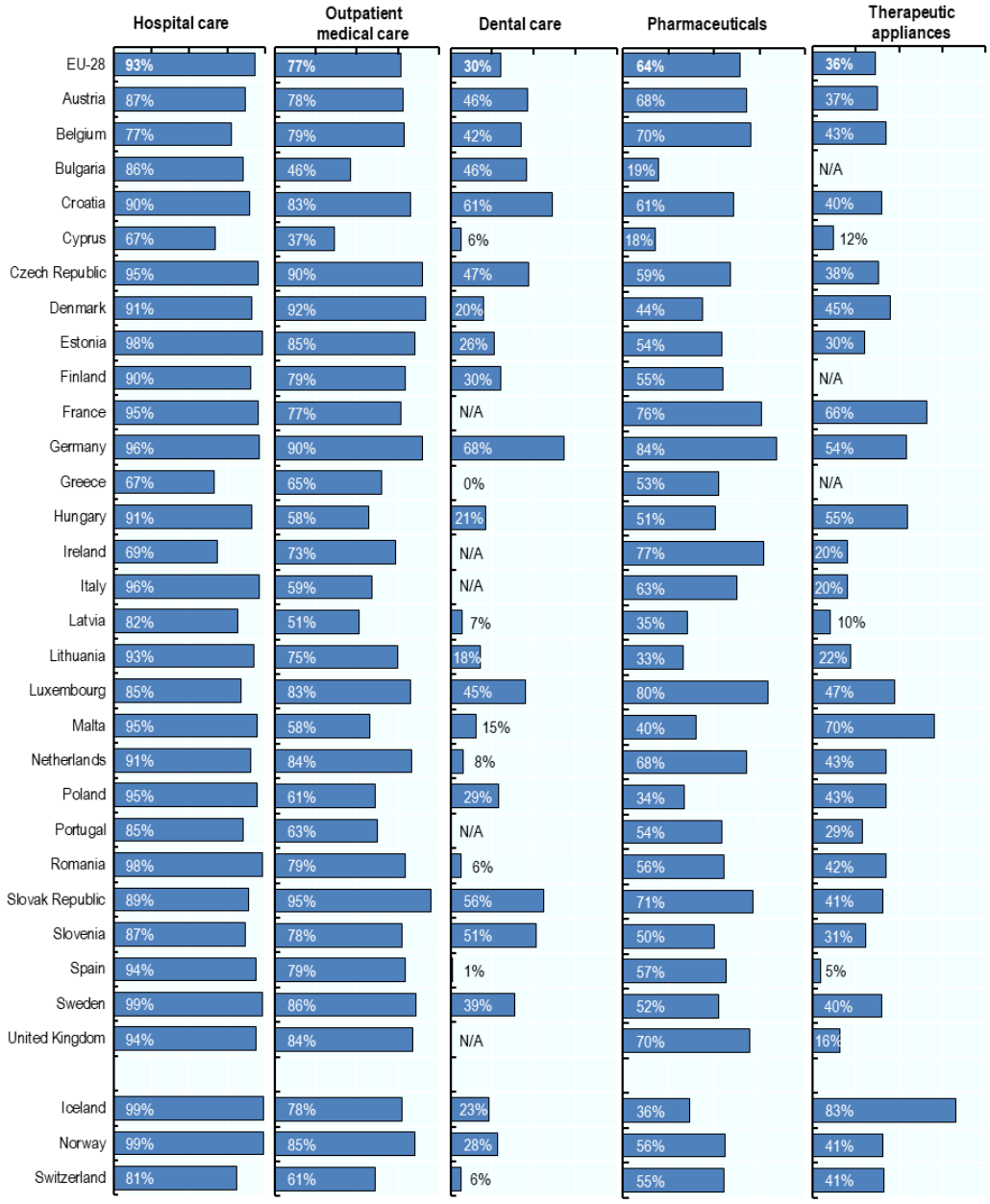
Source: Eurostat – SHA in (FPS 2019).

shows the share of government and compulsory health insurance in total health spending per type of services and goods. Compulsory coverage for outpatient medical care, pharmaceuticals and therapeutic appliances is slightly higher in Belgium than the EU average. However, most neighboring countries have better coverage for most of these health services and goods. For dental care coverage in Belgium is higher than the EU average (42% of the costs covered in Belgium, compared to 30% for the EU as a whole). Importantly, cost coverage for hospital care is low in Belgium compared with other EU countries. It amounted to 77% of the total hospitalisation cost in 2016 ([41]), while, in the EU as a whole, an average of 93% of the costs of hospital care is covered. The remaining 23% of hospitalisation costs in Belgium are partially covered by voluntary and private health insurance. Nevertheless, more than half of this amount comes from OOPs (OECD, 2019b). Among the EU countries, the mandatory coverage of hospitalisation costs is only lower in Greece, Ireland and Cyprus.

41. In 2017, the percentage covered in Belgium was 76%, which is even slightly lower (OECD 2019a).

Figure 15: Healthcare coverage for selected goods and services, 2016

Government and compulsory insurance spending as proportion of total health spending by type of service

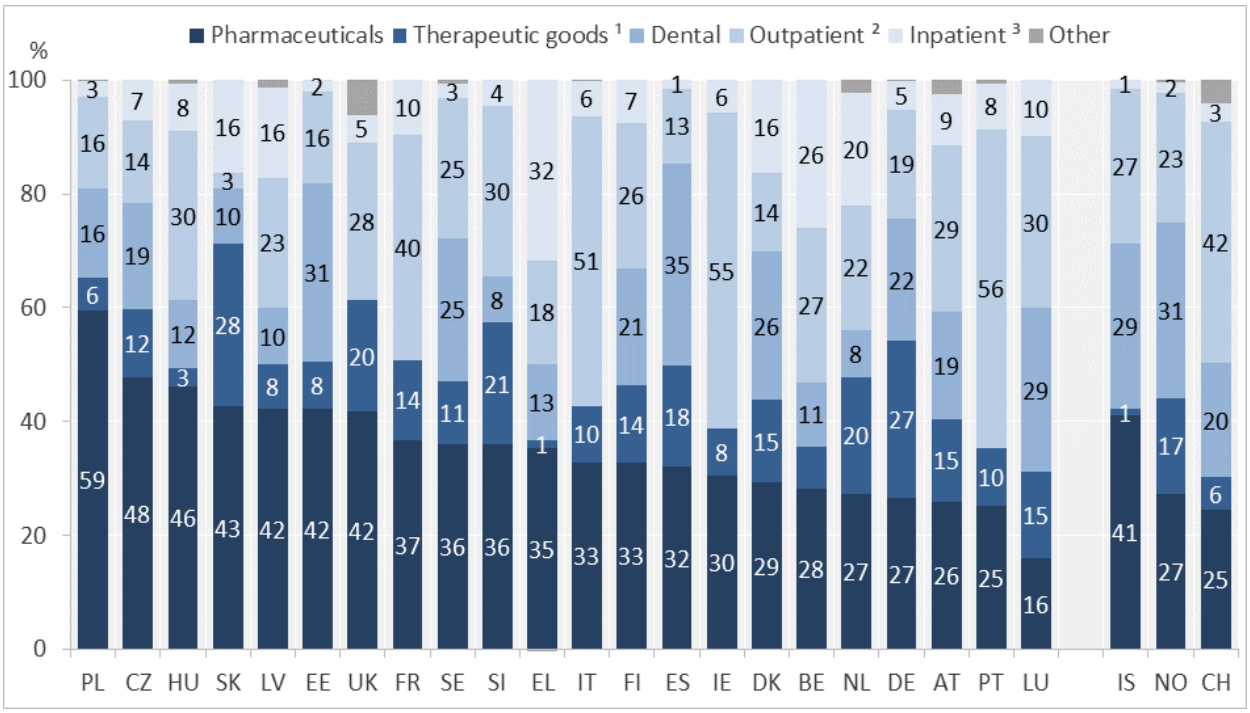


Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices. N/A means data not available.

Source: OECD Health Statistics 2018, (OECD and European Union 2018).

Of the total OOP expenses ([42]), 27% is spent on inpatient care in Belgium (2015) (Figure 16). This is also relatively high compared to other European countries ([43]). Of the countries for which data are available, it is higher only in Greece. This suggests that a large share of the costs of hospitalisation in Belgium not covered by the public system (see also Figure 15) are covered directly by the patient and not by private health insurance.

Figure 16: Out-of-pocket medical spending by services and goods, 2015 (or nearest year)



Note: This indicator relates to current health spending excluding long-term care (health) expenditure.
[1]Including eye care products, hearing aids, wheelchairs, etc. [2]Includes home care and ancillary services (and dental if not shown separately). [3]Including day care.
Source: (OECD 2017).

The share of final household consumption spent on healthcare allows us to assess the importance of OOP expenditure in the household budget. Healthcare goods and services accounted for, on average, 3.3% of final household consumption across the OECD countries in 2017 (OECD 2019a). Belgium, with 3.7% of overall household consumption, is slightly above this average (OECD 2019a). An increase has been observed for Belgium since 2016 (3%) (Devos *et al.* 2019a).

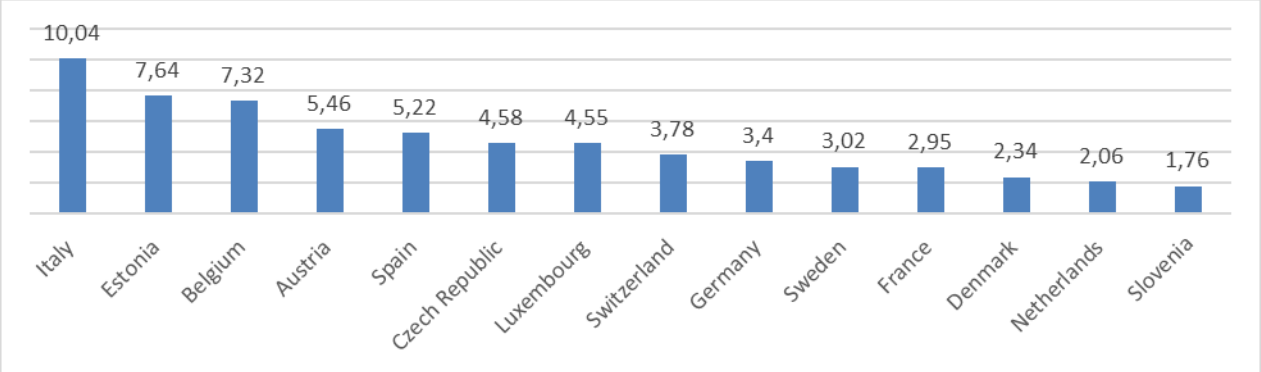
42. *"Out-of-pocket payments are expenditures borne directly by a patient where neither compulsory nor voluntary insurance cover the full cost of the health good or service. They include cost-sharing and other expenditure paid directly by private households and should also include estimations of informal payments to health care providers. Only expenditure for medical spending (i.e. current health spending less expenditure for the health part of long-term care) is presented here, because the capacity of countries to estimate private long-term care expenditure varies widely."* (OECD 2017).
43. Most recent data show that the proportion used to pay for hospitalisation has slightly increased in Belgium, to 28% (OECD 2019a).

3.2.3 Self-reported financial burden of out-of-pocket expenditure

In this section, we present available data on the self-reported financial burden of OOP expenditure. We discuss the results of the following EU surveys: EU-SILC, Survey of Health, Ageing and Retirement in Europe (SHARE) and the European Quality of Life Survey.

A survey among people aged 50 years and older in a selection of EU countries (plus Switzerland) in 2013 (SHARE data, wave 5), provides data on people with unmet needs for healthcare who self-reported that OOPs for healthcare expenditure were a burden ([44]) (Figure 17). The highest proportion of the respondents reporting that healthcare expenditure was a burden for them was found in Italy, with 10% of the respondents. In Belgium, this proportion was 7.3%, which was among the highest of the 14 EU countries (plus Switzerland) (Krůtilová 2016a). The OOP expenditure on medicines was most frequently mentioned in Belgium as the cause of the financial difficulties.

Figure 17: Percentage of persons declaring a burden for out-of-pocket payment of healthcare among European people aged +50 years with unmet needs, 2013

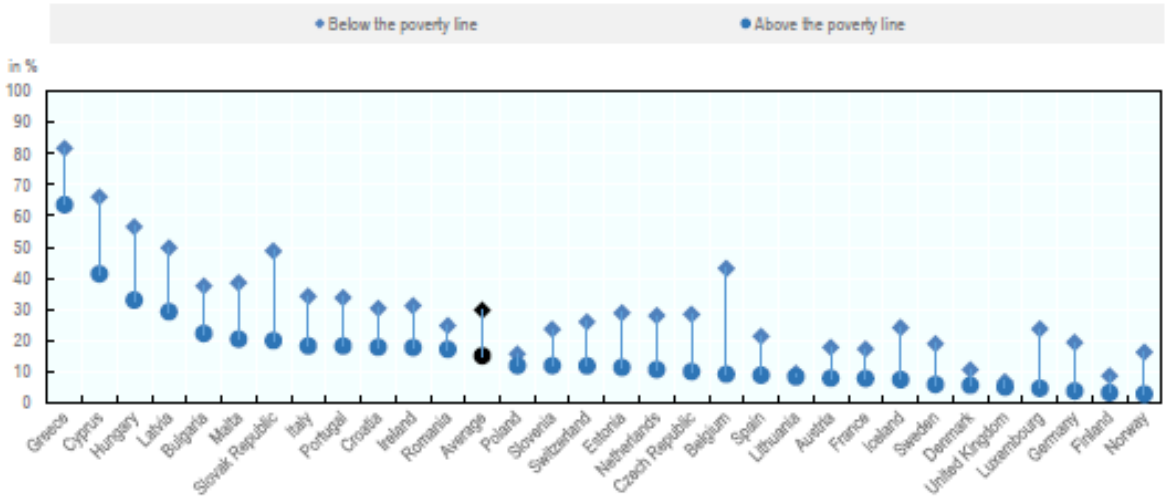


Source: SHARE data in (Krůtilová 2016a).

Figure 18 shows the share of households, in 2016, in which individuals declared that they could only afford healthcare services with moderate or great difficulty. An important gap can be seen in Belgium between households below and above the poverty threshold ([45]): 9.2% of households above the threshold and more than 43.1% of households below the threshold experienced difficulties affording health services, which is the highest score among the Western European countries (OECD 2019b).

44. In this study, *"Out-of-pocket payments include direct payments for health care not covered from any prepaid scheme (health insurance, taxes) and copayments (coinsurance, deductible) for partly prepaid and covered health care services (also known as cost sharing)"* (Krůtilová 2016a).
45. The poverty threshold is set at 60 % of the national median equivalised disposable income (after social transfers).

Figure 18: Percentage of households which find it difficult to afford healthcare services, 2016

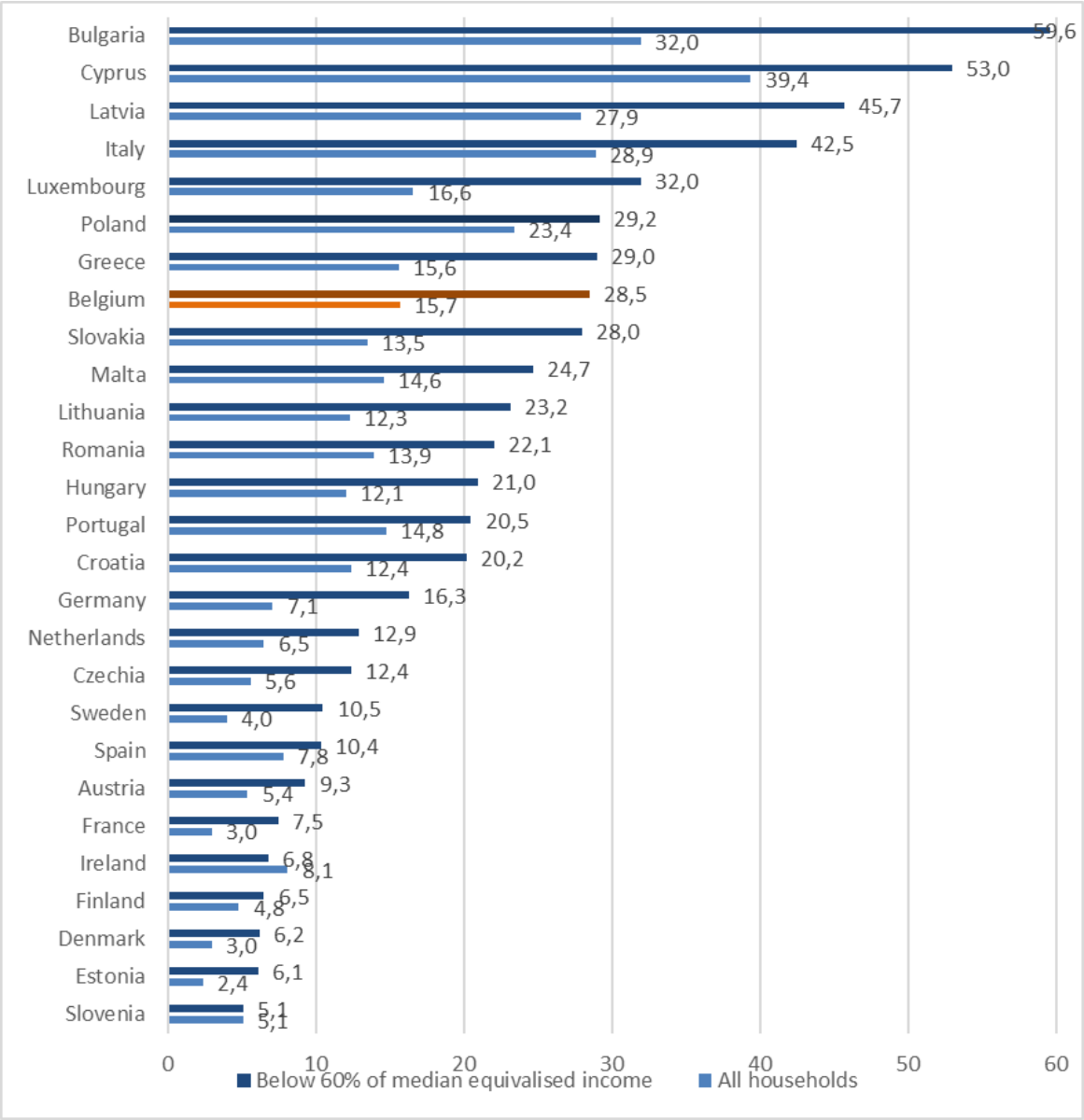


Source: EU-SILC ad-hoc module, ilc_ats12, 2016 in (OECD 2019b).

The percentage of persons declaring that healthcare costs are a serious financial burden ([46]) varies greatly across EU countries (using EU-SILC 2017 data) (see Figure 19). While 15.7% of all persons in Belgium declared in 2017 that medical care was a high financial burden, this share was 28.5% for households with an equivalised income of less than 60% of the median. Of the EU countries, Belgium is 8th in the list of those with the highest percentage of low-income persons experiencing a serious financial burden. Among the neighboring countries, only Luxembourg has a higher percentage and the percentage is significantly lower in Germany, the Netherlands and France.

46. *"Information on financial burden applies at household level and refers to the household as a whole". "The variable concerns only financial burden of out-of-pocket expenditure at the point of use or of payment for medicines. Costs of compulsory or voluntary health insurance contributions should be in general excluded. A burden caused by costs when a household pays the costs up front and then has them reimbursed by health insurance later on can be included."* (2017 Module on Health and Children'sHealth guidelines and questionnaire), https://ec.europa.eu/eurostat/documents/1012329/8706719/2017+Module+on+Health+and+Children%27s+Health/78edbb1e-1756-462d-bf98-cb75df7bde1a (latest consulted on 23/06/2020).

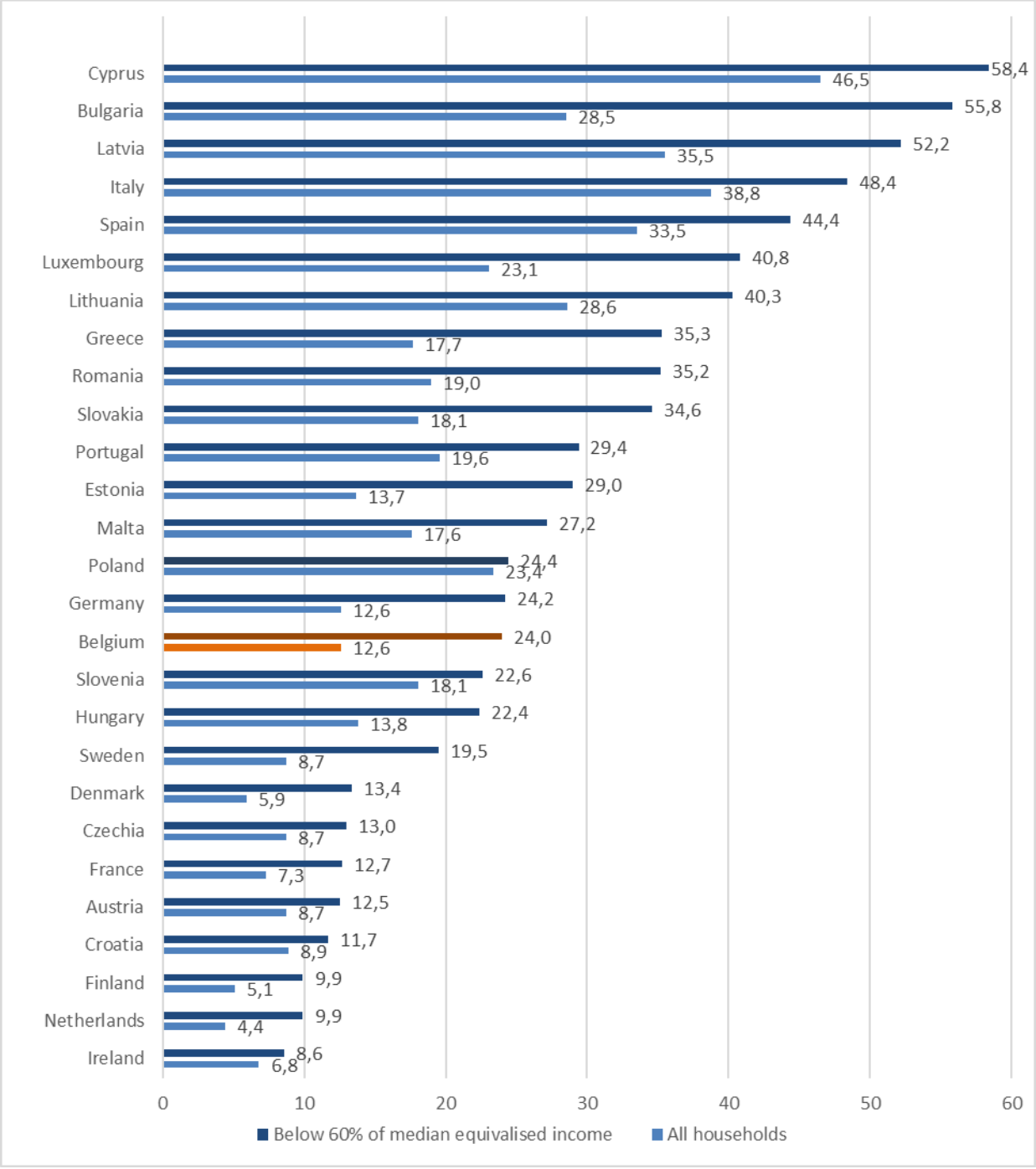
Figure 19: Percentage of persons declaring medical care to be a high financial burden, EU Member States, 2017 (%)



Source: Eurostat, EU-SILC 2017, [ilc_hch01].

Figure 20 shows the percentage of persons declaring dental care to be a high financial burden in Member States in 2017. The proportion in Belgium is 12.6% of persons and 24% for persons at risk of poverty (equivalised disposable income below 60% of the median income).

Figure 20: Percentage of persons declaring dental care to be a high financial burden in EU Member States, 2017

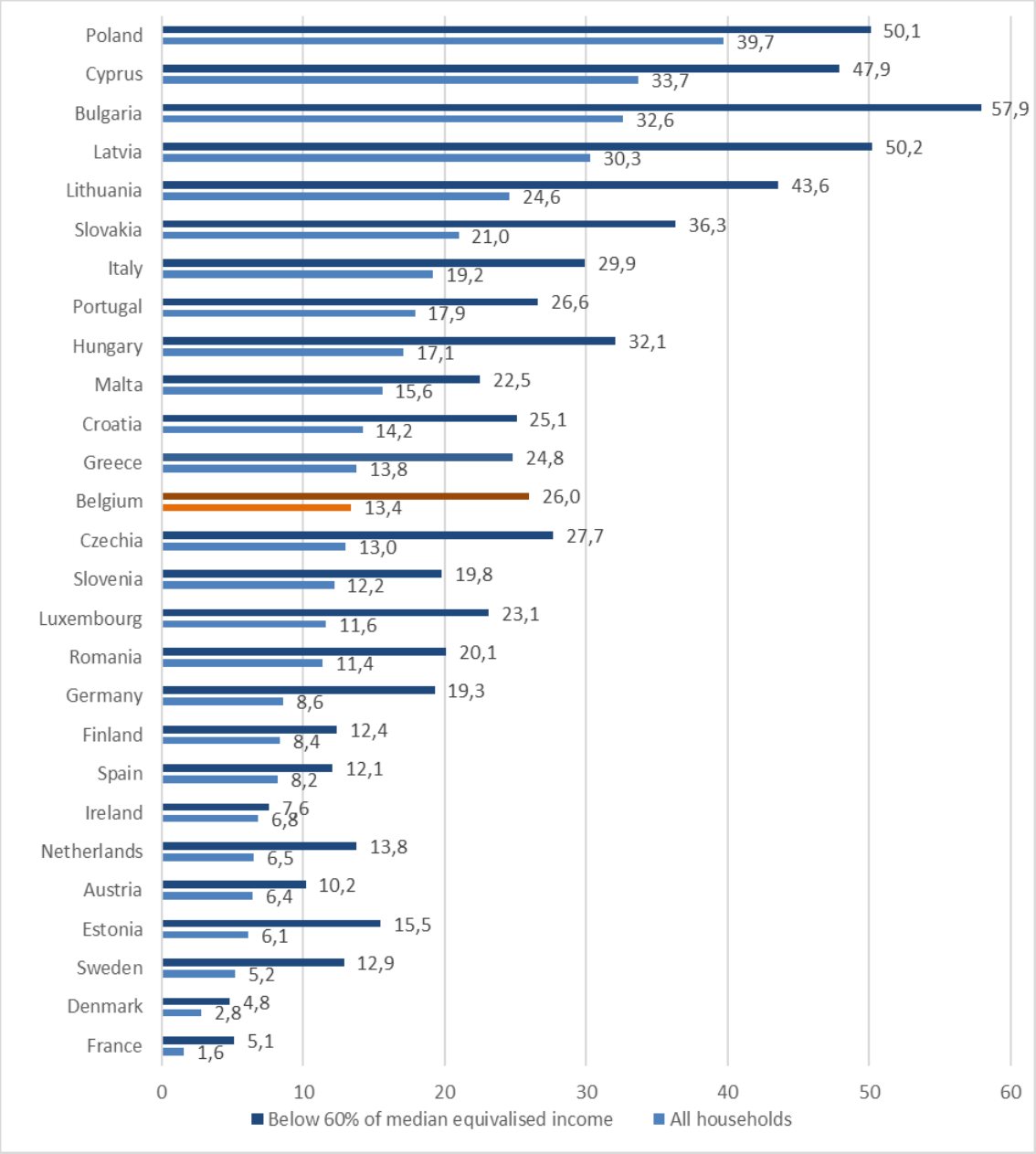


***Source*:** Eurostat, EU-SILC 2017, [ilc_hch01].

The proportion of persons declaring medicines to be a high financial burden in Belgium is similar to that for dental care and medical care: 13.4% for all persons and 26% for persons at risk of

poverty ([47]). Figure 21 shows the percentage of persons declaring the purchase of medicines to be a high financial burden in Member States in 2017.

Figure 21: Percentage of persons declaring the purchase of medicines to be a high financial burden in Member States in 2017

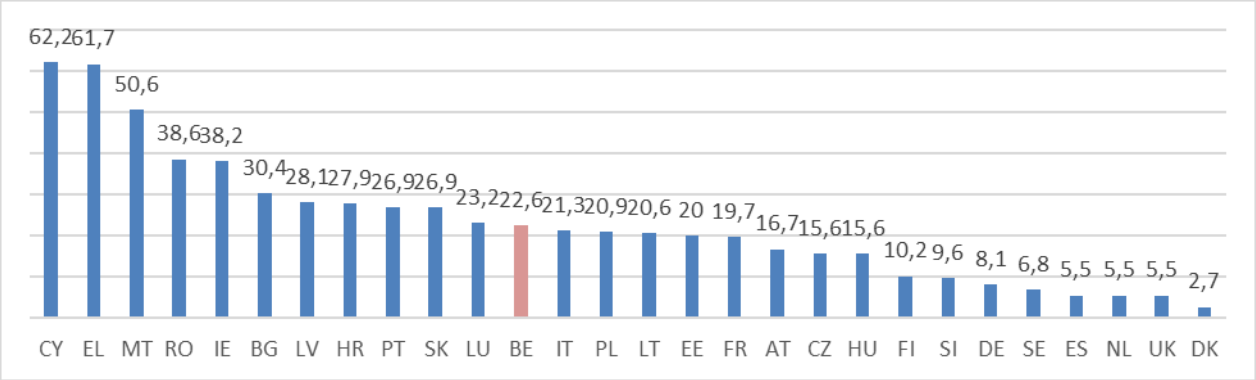


Source: Eurostat, EU-SILC 2017, [ilc_hch01].

47. *"Medicines are products that are used to alleviate symptoms, to prevent illness, or to improve bad health, and which are ordinarily purchased from a pharmacy (including hospital pharmacy)."* (2017 Module on Health and Children'sHealth guidelines and questionnaire). https://ec.europa.eu/eurostat/documents/1012329/8706719/2017+Module+on+Health+and+Children's+Health/78edbb1e-1756-462d-bf98-cb75df7bde1a (latest consulted on 23/06/2020).

In the European Quality of Life Survey, in 2016, the cost of a medical consultation was mentioned as a hurdle by 22.6% of persons in Belgium. Belgium was thus in a middle position among the European countries, ranking 12th in the list of countries with the highest level of difficulties (Figure 22).

Figure 22: Percentage of persons declaring that costs made it somewhat or very difficult to see a medical doctor in 2016



Source: question Q61d ([48]), European Quality of Life Survey, 2016 ([49]).

48. *"Thinking about the last time you needed to see or be treated by a GP, family doctor or health centre, to what extent did any of the following make it difficult or not for you to do so?".*
49. https://www.eurofound.europa.eu/data/european-quality-of-life-survey (latest consulted on 16/06/2020).

Chapter 4. Self-reported unmet needs for medical and dental care in Belgium: an in-depth analysis of the EU-SILC micro data

In this chapter, we provide a description of the characteristics of the persons who are at risk of unmet need for respectively medical (Section 4.1.1) and dental care (Section 4.2.1), and the changes that occurred between 2011 and 2017. Secondly, we identify the main determinants of unmet needs and how these have evolved between 2011 and 2017 (Sections 4.1.2 and 4.2.2).

4.1 Self-reported unmet needs for medical care

4.1.1 Profile of persons with unmet needs in 2011 and 2017

With the aim to identify the characteristics of the persons who encountered unmet needs for medical care (examination or treatment), we estimate the share (with confidence interval (CI) ([50]) of the adult population (+16 years) in Belgium (legally registered) which, in 2011 and 2017, self-reported at least one unmet medical need in the past twelve months for various individual characteristics. These include: 1) demographic characteristics, 2) socio-economic characteristics, 3) characteristics related to two primary needs (housing and eating), 4) social activities, 5) financial difficulties, 6) material deprivation, 7) income and 8) health status proxies. We also assess how the proportion of unmet needs for medical care since 2011 has evolved and, when significant, calculate the odds ratio (OR) ([51]).

In the overall adult population, the proportion of persons who reported unmet needs for medical care for financial reasons was relatively low in 2017 (2%) (Table 5 in Annex III), and had slightly increased since 2011 (1.4%). The risk of unmet needs for medical care was significantly higher in 2017 than in 2011 (OR=1.4*). The other reasons for unmet needs were mentioned much less frequently for the adult population.

50. In this report, we use a 95% confidence interval. This means that the interval estimate is likely to contain the true value of the unknown population proportion. 95% means that we are 95% confident that the interval contains the true percentage of unmet need in the adult population.
51. The odds ratio measures the association between the factor and the probability of unmet needs (ratio of probabilities of unmet needs). If the OR is equal to 1, the probability of unmet needs is the same (for two modalities, e.g. in 2011 and 2017); if OR >1, the probability of unmet is greater (e.g. in 2017 than in 2011); if OR is <1, the probability of unmet need is lower (in 2017 than in 2011). For a categorical factor with more than two modalities, the comparison is made by choosing one modality (identified by the absence of OR value in the table) and comparing it to the other modalities (with OR value in the table). Coefficients (odds ratios) are interpreted as the correlation between the factor and the ratio of probability that an unmet need will be declared.

In Annex IV, we show the detailed figures on unmet medical needs for financial reasons, broken down by various individual and household characteristics, as following:

- broken down by demographic characteristics: gender, age group, number of children under 25 living in the household, marital status, single parent households, country of birth and region (Table 6 in Annex IV);
- by socio-economic characteristics: education level, economic status, working 3 months or less in the past twelve months, household with or without persons working 3 months or less in the past twelve months, and housing tenure status (Table 7 in Annex IV);
- by characteristics related to two primary needs, housing conditions and food: living in overcrowded housing ([52]), deteriorating housing ([53]), ability to keep the home adequately warm, ability to afford a meal with meat, chicken, fish or equivalent, every second day (Table 8 in Annex IV);
- by financial difficulties: ability to face unexpected expenses, ability to make ends meet, and arrears in the past twelve months on utility bills or housing expenses (Table 9 in Annex IV);
- the ability to afford social activities: get-together with friends/family (relatives) for a drink/meal at least once a month, ability to afford one week's annual holiday away from home, ability to afford regular participation in a leisure activity (Table 10 : in Annex IV);
- by material deprivation (having a telephone, a colour TV, a washing machine, a car) (Table 10 in Annex IV);
- by income (equivalised disposable income, at risk of poverty) (Table 11 in Annex IV);
- by health status proxies (self-perceived health, a chronic illness, functional limitations in performing daily activities) (Table 12 in Annex IV).

The unmet needs for medical care are presented according to **demographic characteristics** (gender, age, family composition, region and country of birth) for 2011 and 2017 (Table 6 in Annex IV). Most of the differences in the proportion of unmet needs observed are significant: the probability of unmet needs varies significantly according to these characteristics:

- A significantly higher proportion of unmet needs for medical care can be seen for females than for males (in both 2011 and 2017). There is a significant increase in the probability of unmet needs for females between the two years (OR=1.4*).
- The results for age groups show a slightly higher proportion of persons with unmet needs in the group 25-44 (2.7%) and 45-64 (2.6%) in 2017. Between 2011 and 2017, there is a significant increase for the age group 25-44 years (OR=1.9**).
- In 2017, significant differences in the proportion of unmet needs can be seen between households depending on the number of children under 25: individuals living in a family with one to three children declared unmet needs slightly less often (1.5%) than individuals living

52. A person is considered to be living in overcrowded housing if they do not have a number of rooms available equal to: one room for the household, one room per couple in the household, one room for each person aged 18 or more, one room per pair of single persons of the same gender between 12 and 17 years of age, one room for each single person between 12 and 17 not included in the previous category, and one room per pair of children under 12 years of age.
53. Leaking roof, damp walls/floors/foundation, or rot in window frames or floor.

in a household without children (2%) and in particular than those or with 3 or more children (6.9%). Between 2011 and 2017, there was an increase of the probability of unmet need for persons living in households with 4 or more children under 25 (OR= 12.4**).

- In 2017, significant differences can be seen between people with different marital statuses: the highest percentage is for persons who are separated/divorced (4.6%). Widows and widowers were the group with the lowest figure for declared unmet needs (1.1%).
- Single parents with at least one child under 18 have a much higher percentage of unmet need in 2017 (5.6%) than persons not in this situation (1.8%).
- In 2017, significant differences can also be seen by country of birth: persons born in Belgium declared unmet need less often (1.7%) than persons born in EU countries (2.9%). The highest proportion of unmet need was found in the group of persons who were born in non-EU countries (4.1%).
- In 2017, people living in Wallonia (3.1%) or Brussels (4.3%) had a significantly higher proportion of unmet need than persons living in Flanders. Between 2011 and 2017, there was a significant increase in the probability of unmet needs in Wallonia (OR=1.5*).

Even more important differences (than for demographic characteristics) can be seen if we break the figures down according to **socio-economic characteristics** (Table 7 in Annex IV):

- The proportion of unmet needs, broken down by education level, varies from 0.7% for persons with tertiary education to 3.5% for persons with only primary education in 2017. The risk of unmet needs is significantly higher for persons with primary or secondary education than in the group with tertiary education. Between 2011 and 2017, there was a significant increase of the probability of unmet need for persons with secondary education.
- The proportion of unmet needs varies considerably according to economic status, from 0.5% for the self-employed to 9.8% for disabled persons in 2017. Among unemployed persons, the percentage is also high, at 7.6%. Furthermore, 5.8% of persons with home duties declared unmet needs. The risk of unmet needs is significantly higher for people in these categories than for employees. Between 2011 and 2017, there was a significant increase in unmet needs for people with home duties (OR=2.4**).
- Among households in which all the persons worked for fewer than 3 months during the past year, the percentage of unmet need is much higher (9.9%) in 2017. Between 2011 and 2017, the probability of unmet need has increased for this category (OR=1.7**).
- The proportion of unmet needs also varies significantly according to housing tenure status: the proportion of unmet need among tenants varies between 5.7% and 6.3% (depending on the type of tenant) while for home-owners, it varies only from 0.3% to 0.9% (depending on the type of owner) in 2017. A significant increase can be observed for tenants (all types of tenants grouped together: renting at the prevailing market rate or at a reduced rate) (OR=1.4*), i.e. tenants were significantly more at risk of unmet needs in 2017 than in 2011.

In 2017, important, significant differences can be seen in the proportion of unmet healthcare needs, broken down by **primary needs** (housing conditions and meals), but no significant change can be seen between 2011 and 2017 (Table 8 in Annex IV):

- 8.4% of persons living in an overcrowded household declared unmet needs (versus 2.1% of those not living in overcrowded conditions).
- 4.8% of persons living in deteriorated housing (compared with 1.6% of those not living in such housing).
- A high proportion of people who find it hard keeping their home warm declared unmet needs (15%).
- A very high proportion of persons who cannot afford a meal declared unmet needs (16.5%).

Among the persons who face financial difficulties, the proportion of unmet needs is significantly higher than among persons who did not declare **any financial difficulties** (Table 10 in Annex IV):

- People who were in arrears on their utility bills or housing expenses (rent or mortgage) declared unmet needs substantially more often (22.8%) than those who had not been in arrears in the past twelve months (almost none, 0.2%). Since 2011, a significant increase can be seen (OR=1.4**).
- To a lesser extent, people who said they were unable to deal with unexpected expenses also more frequently have unmet needs (7.7%) than those who were not in this situation (almost none: 0.2%).
- Among people finding it hard to make ends meet, 5.1% declared unmet needs. Since 2011, there has been a significant increase in the likelihood of unmet needs (OR=1.4**).

The risk of unmet needs is significantly higher for persons who have **difficulties affording social activities** (Table 10 : in annex IV) than for those who can afford such activities (between 0.3% and 0.5%):

- 13.7% of the persons who cannot afford a get-together with friends/family report unmet needs (only 0.5% for those who can afford it).
- 7.3% of people who cannot afford a one-week holiday report unmet needs. Since 2011, the probability of unmet needs has increased in this category (OR=1.4**).
- 13.5% of persons who cannot afford a leisure activity report unmet needs.

In 2017, the risk of unmet needs is significantly higher among persons who experience **material deprivation** (table 6 in Annex IV) ([54]):

- 17.8% of people who do not have a telephone report unmet needs
- 6.2 of people who do not have a colour TV report unmet needs
- 19.6% of people who do not have a washing machine report unmet needs
- 12.4% of people who do not have a car report unmet needs. A significant increase in the probability of unmet needs in this category can be observed since 2011 (1.5*).

In 2017, the proportion of unmet needs varies greatly according to **income** quintile (see Table 11 in Annex IV): the highest proportion of unmet needs (6.7%, IC [5.1%-8.7%]) is observed in the group with the lowest income. This proportion is much lower in other income quintiles

54. No odds ratio between 2011 and 2017 has been calculated, since the subsample size is small for persons with a material deprivation. A small proportion of people experience material deprivation (between 0.1% and 1.3%), except for lack of a car (5.6%). The proportions are shown but the confidence intervals are large.

(2.1% in the second, 0.9% in the third, 0.3% in the fourth and 0% in the fifth). Between 2011 and 2017, the probability of unmet need increased significantly for people in the first income quintile (OR=1.6**).

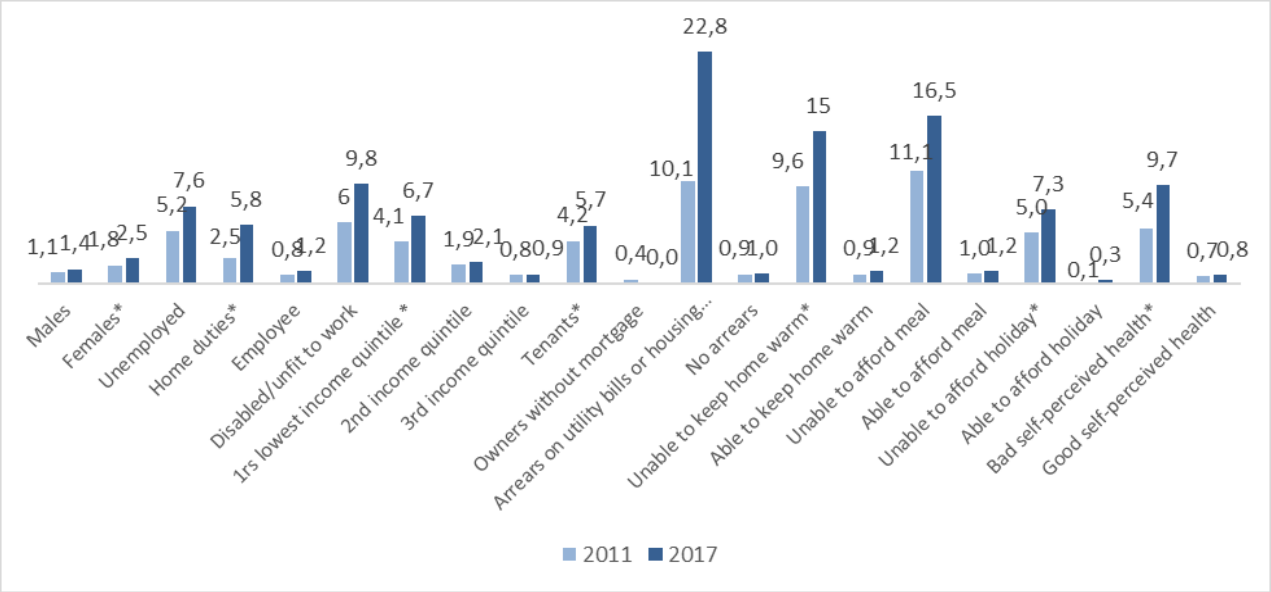
People at risk of poverty (another way of categorising income ([55])) also have a higher proportion of unmet needs (in the sample, this figure was 6.7%, compared to only 1.1% in the group of people who are not at risk of poverty).

Unmet needs are according to **health status** show that (Table 12 in Annex IV). In 2017, people with fair or bad self-perceived health declared unmet needs far more frequently (3.2% of people with fair self-perceived health and 9.7% of people with bad self-perceived health, versus 0.8% of persons with good self-perceived health). There has been a significant increase in people declaring that they have bad health since 2011 (OR=1.9**). We assume that this indictor reflects the overall need for healthcare. Persons with a chronic illness also declared unmet needs significantly more often (4.7% compared to 1.1% without chronic illness) ([56]). Finally, people with functional limitations have a significantly higher proportion of unmet needs. The proportion of unmet need is 4.9%, compared to 1.1% for those without functional limitations.

Figure 23 shows the evolution between 2011 and 2017 of the percentage of people who declared unmet medical needs for financial reasons according to the individual characteristics of the respondents.

55. Persons at risk of poverty: "persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers)".
56. *"The main characteristics of a chronic condition are that it is permanent and may be expected to require a long period of supervision, observation or care. Longstanding illnesses or health problems should have lasted (or recurred) or are expected to last (recur) for 6 months or more; therefore temporary problems are not of interest*" (codebook individual questionnaire 16 years and more 2016, methodological guidelines and description of EU-SILC target variables https://circabc.europa.eu/sd/a/165c80b9-5631-4f5b-b847-29c638715c0e/DOCSILC065%20operation%202016%20VERSION%2022-05-2017.pdf) (latest consulted on 16/06/2020).

Figure 23: Percentage of persons who self-reported unmet medical needs for financial reasons in 2011 and 2017 according to individual characteristics



Source: Eurostat, EU-SILC.

4.1.2 Identifying the determinants of unmet medical needs in 2011 and 2017

In this section, we identify, using a multiple regression analysis, the various factors that influence unmet medical needs (Table 13 in Annex IV) ([57]).

Some predisposing **demographic factors** are associated with unmet needs:

- Gender is associated with unmet needs, and no difference is observed between 2011 and 2017: females are more likely to have unmet needs.
- In 2011, marital status was associated with unmet need: married persons were less likely to have unmet needs than single persons (no differences are observed for other categories of marital status). In 2017, there is no longer a difference between marital statuses.
- Household composition is a factor in unmet need in 2017: households with one to three children under 25 years old are less likely to have unmet needs than households with no children. No difference is observed between households with more than 4 children and households with no children.
- Age is only significantly associated with unmet needs in 2017: older persons (65+) have significantly lower unmet needs than young persons (16-24 years old). For the other age groups, no significant differences are observed.
- In 2017, the region of residence is associated with unmet medical need: the probability of unmet medical need is higher in Wallonia (OR=2.297; IC [1.3 - 4]) or Brussels (OR= 1.9;

57. Multiple logistic regression analysis allows us to estimate the isolated effect of each factor on the probability of unmet need while considering the simultaneous effect of other factors: e.g. females are significantly more at risk of unmet needs than males, irrespective of potential confounding factors such as income level or health status. Such an analysis, however, does not enable us to identify a causal relationship between the factor and the unmet needs.

[1.1 - 3.4]) than in Flanders. In 2011, however, no significant difference between regions was observed. The difference in the level of risk between Flanders and the two other regions has increased between 2011 and 2017.

Various predisposing **socio-economic factors** are significantly associated with unmet need.

Economic status is significantly associated with unmet needs, to a slightly different extent between 2011 and 2017:

- In 2011, no major differences were found between economic statuses, except for retirees, who were significantly less at risk than employees (OR=0.5, IC[0.1 - 3]). In 2017, the self-employed (OR=0.4, IC[0.1 - 1.1]) and students (OR=0.3, IC[0.1 - 1.1]) are less likely to have unmet needs than employees.
- Tenure status is also significantly associated with unmet needs in 2011 and 2017. In 2011, tenants were more at risk of unmet need than homeowners without a mortgage (OR=6.7, IC[3.1 - 14.5]). Homeowners paying a mortgage did not have significantly higher unmet needs than owners without a mortgage. In 2017, the results are similar for tenants (OR=7.8, IC[3.7 - 16.3]), who were still more at risk of unmet needs than owners without a mortgage. However, a new category was more at risk: owners paying a mortgage (OR= 3.3, IC [1.3 - 8.2]). This result is likely to be explained by an increase in the risk of unmet needs for owners who have to pay a mortgage. People living in accommodation rented at a reduced rate are also more likely to have unmet needs than owners without a mortgage (OR=6.6, IC[3 - 14.6]).

For the factors indicating **health needs**, in 2017, self-perceived health status is a significant factor in unmet medical need, and there is a significant difference between 2011 and 2017: the probability of unmet needs for medical care is higher for persons self-perceiving their health as fair (OR=3.2, IC[2 - 5.1]) or bad (OR= 7.3, IC[4.6 - 11.5]) than for those reporting a good health status. In 2011, the probability of people with 'fair' health declaring unmet needs was not significantly higher than for people with self-perceived good health, i.e. this category of health status was not associated with a higher risk of unmet need.

In 2011, chronic illness was associated with unmet needs for medical care (IC=3.7 of OR [2.1 - 6.8]) while this factor is no longer significant in 2017.

Among the **enabling factors,** income is significantly associated with unmet need for both years: people with an income below the first income quintile are significantly more at risk of unmet need than those with higher income levels. In 2011, there is no difference in the probability of unmet needs between the first and the second income quintile groups, while for 2017, a significantly lower probability of unmet needs is observed in the second income quintile than in the first quintile. This result is likely to be due to a worsening of the situation for people in the first income quintile: i.e. more persons with unmet medical needs.

4.2 Self-reported unmet needs for dental care

4.2.1 Profile of persons who declared unmet needs in 2011 and 2017

In 2017, 3.5% of the overall adult population reported unmet needs for dental care for financial reasons, compared to 2.9% in 2011 (Table 16 in annex). There is no significant difference in the risk of unmet needs for dental care for financial reasons between 2011 and 2017. The other reasons are much less frequently mentioned for the adult population (as is the case for medical care): between 0 and 0.8% in 2017.

The unmet needs for dental care broken down by **demographic characteristics** (gender, age, family composition, region and country of birth) in 2011 and 2017 (Table 15 in Annex IV) show that most of the differences in the proportion of unmet needs observed are significant (as for medical care):

- For females, the proportion of unmet needs for dental care is significantly higher than for males (both in 2011 and 2017). Between the two years, for females, the probability of unmet need has increased significantly (OR=1.4**).
- The results for age groups show a much higher proportion of persons with unmet need in two age groups 25-44 (2.7%) and 45-64 years old (2.6%) in 2017 (as for medical care). Between 2011 and 2017, there is a significant increase for the age group 25-44 years old (OR=1.4*).
- In 2017, significant differences can also be seen in the proportion of unmet needs depending on the number of children under 25 in the household: individuals living in a family with one to three children declared unmet needs slightly less often (2.6%) than individuals living in a household without children (3.8%) and in particular less often than those with 3 or more children (10.3%). Between 2011 and 2017, there was an increase in the probability of unmet need among persons living in households with no children under 25 (OR= 1.4*).
- In 2017, significant differences can be observed between marital statuses: the highest percentage is for persons who are separated/divorced (4.6%). Widows and widowers were the group least likely to declare unmet need (1.1%).
- There is a much higher percentage of single parents with at least one child under 18 with unmet needs (7.1%) than of persons not in this situation.
- In 2017, significant differences can also be seen by country of birth: people born in Belgium declared unmet needs (2.8%) less often than people born in other EU countries (6.3%). The highest proportion of unmet needs can be observed in the group of people born in non-EU countries (7.9%).
- In 2017, the proportion of people living in Wallonia (5.1%) or Brussels (7.2%) with unmet needs was significantly higher than for people living in Flanders (2%). Between 2011 and 2017, there was a significant increase in the probability of unmet needs in Wallonia (OR=1.5*) and in Brussels (1.6**).

In 2017, even more important differences can be seen in the levels of unmet needs (more than for demographic characteristics) between groups with different **socio-economic**

characteristics; this was also the case for unmet needs for medical care (Table 16 in Annex IV)):

- The proportion of unmet needs, broken down by education level, varies from 1.3% for persons with tertiary education to 4.7% for persons with only primary education (the proportion is similar for persons with secondary education: 4.6%). The risk of unmet needs is significantly higher for people with primary or secondary education than in the group with tertiary education. Between 2011 and 2017, there was a significant increase in the probability of unmet needs for persons with secondary education (OR=1.5**), as was also observed for medical care.
- The proportion of unmet needs varies considerably according to economic status, from 0.9% (IC [0.3%-2.5%]) for the self-employed to 13.8% (CI [10%-18.7%]) for disabled persons. Among unemployed persons (11.6%) and people with home duties (8.5%) the percentage of people who declared unmet need is also high. Between 2011 and 2017, there was a significant increase in unmet needs for people with home duties (OR=1.8**).
- Among households where the members have each worked less than 3 months during the past year, the percentage of unmet need is much higher (14.1%).
- The proportion of unmet need also varies significantly according to tenure status: the proportion of tenants with unmet needs is between 9.1% and 10.4%, which is much higher than for homeowners (1% - 1.8%).

In 2017, important and significant differences can be seen in the proportion of unmet need for dental care between those with varying degrees of **primary needs** (housing conditions and meals). Significant changes can also be observed between 2011 and 2017 (Table 16 in Annex IV):

- 10.4% of persons living in an overcrowded household declared unmet needs for dental care (versus 3.2% of those not living in such a household).
- 7.1% of persons living in a deteriorated housing declared unmet needs (compared to 2.7% of those not living in such housing). In this group, the risk of unmet needs increased significantly between 2011 and 2017 (OR=1.4*).
- A high proportion of people who find it difficult to keep their home warm declare unmet needs for dental care (21.3%). In this group, the risk of unmet needs increased significantly between 2011 and 2017 (OR=1.5*).
- A high proportion of persons who cannot afford a meal declared unmet needs for dental care (20%).

Among persons facing **financial difficulties**, the proportion of unmet needs is significantly higher than among persons who did not declare any financial difficulties (Table 18 in Annex IV)):

- A much higher proportion of persons in arrears on their utility bills or housing costs (rent or mortgage) declared unmet needs than those who have not been in arrears in the past twelve months (30.5%, IC [25%-36.7%]). The risk of unmet needs has increased significantly between 2011 and 2017 (OR=1.8***).
- To a lesser extent, people who said they could not deal with unexpected expenses also more frequently had unmet needs (12.7%) than those who did not (0.7%).

- Among the persons finding it difficult to make ends meet, 8.4% declared unmet needs. Since 2011, there has been a significant increase of probability of unmet needs (OR=1.4**).

The risk of unmet needs is also significantly higher for people who find it difficult to afford **social activities** (Table 21 in annex) than for those who can afford such activities (between 0.8% and 1.4%):

- 20.5% (IC [16.7%-24.8%]) of people who cannot afford to get together with friends/family report unmet needs (only 1.4% for those who can afford it).
- 11.8% of people who cannot afford a one week holiday report unmet needs. Since 2011, the probability of unmet need has increased in this category (OR=1.4**).
- 20.2% (IC [16.8%-24.2%]) of people who cannot afford leisure activities report unmet needs.

In 2017, the proportion of unmet needs was significantly higher among people experiencing **material deprivation**[54] (see Table 20 in annex):

- 17.8% of people who do not have a telephone report unmet needs
- 13.2% of people who do not have a colour TV report unmet needs
- 26.3% of people who do not have a washing machine report unmet needs
- 17.3% of people who do not have a car report unmet need. A significant increase of the probability of unmet needs can be observed in this group since 2011 (1.4*).

In 2017, the proportion of unmet needs varies greatly between the **income** quintiles (Table 21 in annex): the highest proportion of unmet needs (10.5%, IC [8.4%-13%]) is observed in the group with the lowest income. This proportion is much lower in other income quintiles (4.3% in the second, 2.1% in the third, 0.6% in the fourth and 0.3% in the fifth). Between 2011 and 2017, the risk of unmet needs increased significantly for people in the first income quintile (OR=1.4**).

People at risk of poverty (another way of categorising income[55]) are also more likely to have unmet needs (in the sample, 11.2% compared with only 2.1% in the group of persons who are not at risk of poverty).

Unmet needs are according to **health characteristics** are presented in Table 22 in Annex IV). In 2017, people who perceived their health as fair or bad were significantly more likely to declare unmet needs (3.2% of persons with fair self-perceived health and 13.4% of persons with bad self-perceived health, versus 1.8% of persons with good self-perceived health). Since 2011, there has been a significant increase in unmet needs among people describing their health as bad (OR=2**).

People with chronic diseases also declared unmet needs significantly more often (7.7%) than persons without a chronic illness (2.1%).

Finally, a significantly higher proportion of people with functional limitations declared unmet needs for healthcare. The proportion of unmet needs in the sample is 7.8%, compared with 2.1% for those without unmet needs.

4.2.2 Identifying the determinants of unmet dental care needs in 2011 and 2017

In this section, we identify, using a multiple regression analysis, the different factors[57] that influence unmet dental care needs (Table 23 in Annex IV).

Predisposing demographic factors are associated with unmet needs for dental care in 2017:

- Gender is associated with unmet needs: females are more likely to have unmet needs (OR=1.3, IC[1 - 1.6]) (as for medical care) than men. In 2011, gender was not a factor in unmet needs.
- Marital status is associated with unmet needs: married persons were less likely to have unmet needs than single persons (OR=0.6, IC[0.4 - 1]). In 2011, separated/divorced persons had a higher risk of unmet needs, but this difference can no longer be observed in 2017.
- Household composition is a factor in unmet needs: people living in households with one to three children under 25 years old are less likely to have unmet needs than those living in a household with no children (OR=0.7, IC[0.5 - 1]). The risk of unmet needs is significantly higher for individuals living in a household with four or more children under 25 than in households with no children (OR=1.9, IC [1.1 - 3.4]). Between 2011 and 2017, no change is observed.
- Age category is a factor in unmet needs for dental care: persons aged between 25 and 44 years old are significantly more at risk of unmet need (OR=2.2, IC[1.1 - 4.5]) than young persons (16-24 years old).
- In 2017, the region of residence was a factor in unmet medical needs: the probability of unmet medical needs was higher in Wallonia (OR=1.8; IC [1.2 - 2.7]) and Brussels (OR= 1.8; [1.1 - 3]) than in Flanders, while in 2011, no significant difference between regions was observed. The difference in the level of risk between Flanders and the two other regions has increased between 2011 and 2017, which is likely to be explained by the increased risk of unmet need in Wallonia and Brussels (Table 15).
- Country of birth is associated with unmet needs: people born in other EU countries have a higher risk of unmet (OR=1.5, IC[0.9 - 2.2]) needs than people born in Belgium. In 2011, the country of birth was not a significant factor associated with the probability of unmet needs for dental care.

Various predisposing socio-economic factors are significantly associated with unmet needs. Economic status is significantly associated with unmet needs, but the situation changed between 2011 and 2017:

- In 2011, students were significantly less at risk than employees (OR=0.5, IC[0.2 - 1]), while unemployed persons were at greater risk of unmet needs (OR=1.8, IC[1.1 - 3]) than employees.
- in 2017, self-employed persons (OR=0.4, IC[0.1 - 1]) and students (OR=0.3, IC[0.2 - 1.1]) were less likely to have unmet needs than employees. No difference can be observed for other economic categories.

Housing tenure is also a significant factor in unmet needs in 2017. In 2017, tenants (OR=4.3, IC[2.7 - 7.1]) are more at risk of unmet needs than owners without a mortgage. However, a new category is more at risk: owners paying a mortgage (OR= 2.3, IC [1.3 - 4.1]). The

difference of probability of unmet needs between owners without a mortgage and those paying a mortgage has increased between 2011 (not significant) and 2017. This result is probably due to an increase in the risk of unmet needs for owners paying a mortgage. People living in rented accommodation and paying at a reduced rate of rent are also more likely to have unmet needs (3.9, IC[2.2 - 6.8]) than owners without a mortgage.

With regard to **health need factors,** self-perceived health is a significant factor for unmet dental care needs in 2017 (as was the case for medical care), and there is an important difference between 2011 and 2017: the probability of unmet needs for dental care is higher for persons who perceived their health to be fair (OR=3.1, IC[2.2 - 4.3]) or bad (OR= 4.9, IC[3.4 - 7]) than for those who reported good health. In 2011, however, the probability that persons declaring fair health would declare unmet needs was not significantly higher than for people declaring their health to be good, i.e. this category of health status was not associated with a higher risk of unmet needs. In 2011, chronic illness is associated with unmet needs for dental care (IC=3.2 of OR [2.3 - 4.4]) while this factor is no longer significant in 2017: i.e. no difference in probability of unmet needs for dental care was observed between persons with and without chronic illness.

With regard to **enabling factors,** income quintiles are a significant factor in unmet needs for dental care, in both years: people in the higher income quintile categories are significantly less at risk of unmet need than people in the first income quintile. In 2011, there is no difference between the probability of unmet needs in the first and the second income quintile groups, while for 2017, there is a significant difference between the first income quintile and the second income quintile (at lower risk). The difference in probability between the two lowest income quintiles increased significantly between 2011 and 2017. This result is likely to be due to a deterioration of the situation for people in the first income quintile: i.e. a higher risk of unmet needs for dental care in 2017 than in 2011 (Table 21 in Annex IV).

4.3 Conclusion of the analysis of the EU-SILC micro data on unmet healthcare needs

Overall, 4.1% of the population had unmet needs for medical and/or dental care in 2017. In 2017, we can see an overlap between people with unmet needs for medical and dental care: 72% of people with unmet medical needs also reported unmet needs for dental care. 41% of people with unmet needs for dental care also reported unmet needs for medical care.

As expected, unmet needs for financial reasons are mainly encountered by the least well-off. The results broken down by individual socio-economic characteristics show differences between disadvantaged socio-economic groups: unmet need is much more frequently encountered by persons with no working activity (except for students and retirees). Other results also clearly show the direct link with financial capacity. Indeed, unmet needs for medical care also vary substantially between groups who can and who cannot afford primary needs and social activities.

Among persons with a bad self-perceived health status and among persons with functional limitations, unmet needs for medical care are also more frequent.

A significant deterioration can be seen between 2011 and 2017 for persons who are in the first income quintile group, for both medical care and dental care (while no significant difference is observed in other quintile categories). Unmet needs for financial reasons are also considerably more frequently reported in 2017 than in 2011 among people with low or no working activity and among people with other financial difficulties.

The share of persons who self-report unmet needs is significantly higher in Wallonia and Brussels than in Flanders. The percentage has remained stable in Flanders while a significant increase can be observed in Wallonia (both for medical and dental care).

After adjustment, some predisposing demographic factors are significantly associated with the likelihood of self-reporting unmet needs: gender, age, household composition.

Important differences can be seen in the percentage of unmet needs for various predisposing socio-economic factors. However, after adjustment, only housing tenure status and economic status are significantly associated with unmet needs.

For health need factors, self-perceived health remains a significant factor in unmet needs after adjusting: people who self-perceived their health as bad or fair are at higher risk of unmet needs than those reporting good health.

Finally, the enabling factor, i.e. equivalised disposable income per household (quintiles), also remains associated with the probability of unmet need, even after adjusting for other factors likely to influence unmet need, particularly health need factors. Income inequality is associated with unmet needs.

Chapter 5. Hurdles for access to healthcare reported by interviewees

In this section, we present the hurdles encountered by patients in accessing healthcare, as mentioned during the interviews. The results are presented in six main parts: first, we examine the profile of persons at risk of unmet needs or financial hardship (Section 5.1); second, we describe the access issues per type of healthcare goods and services (Section 5.2); third, we report on hurdles related to availability and acceptability of healthcare (Section 5.3); fourth, we look at issues related to the measures to protect vulnerable groups (Section 5.4); and finally, we discuss findings on what has changed in the health and social care system (Section 5.5).

Unless otherwise indicated, the description of the healthcare system and user charges in each subsection is based on information available on the official websites of the Belgian public authorities (in particular NIHDI) and the sickness funds. The official levels of user charges mentioned are those applicable in 2019, unless otherwise stated.

5.1 Who is most at risk of access problems due to costs?

It goes without saying that people in a precarious socio-economic situation most frequently find it difficult to access healthcare due to financial reasons. For a description of the characteristics of the population groups most at risk, we refer to the quantitative analysis (Section 4.1.1 and 4.2.1). Here, we present some more specific information provided during the interviews. The types of people often cited as frequently facing problems affording access to healthcare are: 1) people without mandatory health insurance, 2) people in a precarious situation, 3) people on sick leave, 4) people with a chronic health disorder and 5) people with frail mental health. Often, people have a combination of various of these characteristics.

5.1.1 People without mandatory health insurance coverage

People without coverage for healthcare are most at risk of not having access to healthcare and of getting into serious financial problems due to health costs (Thomson *et al.* 2019). The rules for coverage applicable in Belgium are explained in Box 4.

The interviewees reported situations of people not covered for healthcare. These include: persons not officially registered in Belgium; people—in particular self-employed people—who did not pay the required social contributions; people who did not take the necessary action to complete the administrative procedures, in particular to join a sickness fund or to provide proof of prior affiliation in another (EU) country. We will discuss each of these situations below.

5.1.1.1 Individuals not (or no longer) officially registered in Belgium

Individuals not officially registered in Belgium are without any doubt among the most vulnerable with regard to access to healthcare. As explained in the methods section, these people have not been included in the scope of our research.

Many interviewees reported substantial problems with regard to coverage of homeless people, but also stressed that the situation has improved, as they can now join a sickness fund by using a reference address.

Major problems have been reported for people who were removed from the population register. Someone may ex officio be removed from the population register by the municipality if, for more than 6 months, he is not living at the address where he is registered and his actual place of residence is not known ([58]). In principle, this happens after a thorough investigation by the municipal services and the local police. People who are removed from the register no longer have an official address in Belgium and no longer exist administratively. This implies a suspicion that the person has left Belgium. This can have far-reaching consequences for his or her access to social rights, including coverage for healthcare.

Many cases were mentioned of people who were deleted from the population register in spite of the fact that they did not leave the country and even in some cases were still living in the dwelling where they had their official address.

Interviewees reported many different circumstances which may lead or led to the deletion of a person from the population register. These include:

- Administrative negligence: persons move without taking further administrative action, for instance young adults who leave the parental home.
- Erroneous deletion: sometimes, the owner of dwelling, wrongly declares to the municipality that the person does not live there anymore. The municipality wrongly records that the person has moved abroad. People may not be aware that they have been deleted.
- Municipal services declare that the dwelling is uninhabitable.

Settling the situation of someone who has been deleted from the population register can take a very long time. A case was mentioned of two persons who lost their rights for more than one year, while they had only moved to another municipality in the Brussels region.

5.1.1.2 Individuals who did not pay their compulsory social contributions: the particular case of the self-employed

Many interviewees mentioned cases of self-employed people without coverage. These have been reported among all socio-professional categories, even among health professionals and the liberal professions. Interviewees from a hospital's social service highlighted that some of these individuals postponed healthcare until their health deteriorated substantially:

> *« C'est toute une catégorie socio-professionnelle, ça va de l'avocat qui est administrateur de bien à médecin, à kiné, à des infirmières à domicile qui ne sont pas en règle de mutuelle, qui eux postposent leurs soins parce qu'ils savent que ça coûte très cher quand on n'a pas de mutuelle, et donc eux parfois, ils arrivent vraiment dans un état catastrophique. »*

Various reasons were mentioned for a self-employed person not to pay social contributions:

- Some have not fulfilled any of the required administrative procedures for a self-employed person.

58. Ambtshalve schrapping/ radiation d'office.

- Some self-employed with a small business intentionally decide not to pay for coverage, because they think they do not need it. As a consequence, their dependants, including children, are not covered either.
- The self-employed person may have had insufficient income. Their income can strongly vary from one month to another and sometimes they may skip the payment due for a quarter.
- A person may be 'bogus self-employed': the employer has not paid social contributions, without informing the employee.
- Some people coming from abroad are 'employed' with the status of 'active partner' ([59]). In principle, an active partner is a co-owner of the business and thus self-employed. However, in practice, the status of 'active partner' may be used to provide someone with a residence permit and he may then be dependent on a boss. According to an interviewee, this practice is often used in family-networks. These people may work for instance in the construction sector, or in small shops. However, in some cases, insufficient social contributions are paid for them. The employee may be aware, or unaware, that no social contributions have been paid. Respondents stressed the highly complex legal situation in which they find themselves.
- Practices were mentioned of EU citizens who declare themselves as self-employed, with the aim of obtaining a residence permit, without however being engaged in real professional activity. Since they are unable to pay their social contributions, they declare the end of their activity a few months later. However, since a new declaration of self-employment means that they can keep their residence permit, the whole cycle is sometimes repeated several times.
- Some people, in particular newcomers, do not know that they have to pay contributions
- People are sometimes not aware of the fact that they are not covered:

  « Il y a des gens qui découvrent qu'ils ne sont pas assurés quand il y a une note d'hôpital qui arrive. Le classique c'est : madame accouche et on se rend compte qu'on n'est pas assuré. On se rend compte qu'on doit 13 000 € de lois sociales. Ce ne sont pas nécessairement des gens qui ont un niveau d'éducation très élevés. »

- People who have performed undeclared work
- People who stayed for a certain period abroad.
- Self-employed people who went bankrupt.
- Some categories of self-employed (such as students, pensioners, those self-employed as a secondary occupation, during illness) may be exempted from paying social contributions or may be entitled to pay reduced contributions (e.g. start-ups). Those who are temporarily in a difficult financial or economic situation may also apply for a full or partial exemption for a given period. Interviewees however mentioned that people do not always ask to be exempted from payment of social contributions.
- People sometimes have difficulties to obtain the right information to set their situation in order. One interviewee highlighted that in some cases people do not take the necessary steps to regularise their situation because they think that they have to pay a very high amount, whereas in reality they may well only have to pay a fraction of the total arrears. The

59. Associé actif/werkende vennoot.

respondent pointed to the social security funds for the self-employed as responsible for this lack of information:

> *« Parfois l'indépendant ne sait pas. Il se dit: 'J'ai 50 000 € de dettes de lois sociales, je ne saurais pas les payer.', alors que peut-être, pour l'année de référence, il n'y en a que 5000 et que 5000, il sait les payer. [...] Hein, les caisses sociales n'aident pas beaucoup. »*

5.1.1.3 Individuals who have not taken the necessary administrative steps

a. To provide proof of employment

Interviewees highlighted how difficult it is to provide the required documentation, proving employment, to the sickness fund, in particular for people with short term and irregular employment contracts ([60]):

> *"Maar dikwijls zijn dat inderdaad mensen die veranderen, die een kleine korte tewerkstelling hebben, en dat wordt blijkbaar toch niet altijd automatisch doorgegeven aan de mutualiteit. Vaak ben je het dan toch zelf die met de papieren of uw inschrijvingsbewijs naar de mutualiteit moet gaan en zeggen van ja maar ik heb in 2018 zoveel maanden daar gewerkt of ik heb dat, dat, dat. En dat blijft heel vaak achterwege."*

b. To join a sickness fund

Self-employed people may have joined a social security fund, may pay their social contributions, but are not aware that they had also to join a sickness fund in order to be covered for healthcare. Such cases were mentioned by several interviewees, in particular about workers from Eastern European countries newly arrived in Belgium. These people are convinced that they are covered. It was mentioned that, in particular when the same organization has both a social security fund and a sickness fund, people are often not aware that they should also join the sickness fund ([61]):

> *« 'Ah mais je suis chez Partena, mais je suis en ordre!' Partena Lois Sociales et Partena Mut, c'est différent. Ah oui, les caisses … Et donc les patients arrivent, sont hospitalisés. En ortho, on en a je ne sais pas combien, je parle pour tous les patients qui travaillent dans le bâtiment, qui arrivent avec pieds cassés, fractures, etc. hospitalisés en urgence. »*

Some young people who leave their parents' home do not take the necessary steps to join a sickness fund.

> *« Il y a de la négligence mais on est dans des gens qui ont parfois des dépendances à la drogue, à l'alcool … l'amour en tête qui quitte tout … Voilà, ça c'est le côté adolescent un peu, … Et donc qui se retrouvent dans toute une série de problèmes. »*

c. To provide proof of coverage in another country

A worker from an EU/EEA country, posted in Belgium on an assignment of less than 2 years, can stay insured in the country from which he has been posted. He needs however to provide proof

60. Although, in principle, this information is to be transferred automatically for persons registered with a sickness fund.
61. However, once these people complete the necessary formalities and join a sickness fund, they are covered retroactively (within certain limits).

of coverage in his home country, to be provided by the healthcare authority in his home country. This will entitle him and his family to healthcare during his stay. A similar procedure may apply to citizens of countries with which Belgium has concluded a convention on social security rights.

Cases were mentioned of posted workers who did not bring the required documents, and of employers (in their home country) who did not pay the premiums for them.

> *« Là, c'est un grand problème parce que certains viennent sans leur document, telle que la carte européenne par exemple. Donc nous devons faire une enquête qui peut prendre 6 mois. Ça dépend le moment où on obtient la réponse de l'autre pays. »*

Several respondents reported problems with people who stayed abroad for more than two years but could not provide proof that they had been covered for healthcare in that other EU country. Social workers reported how difficult it was, administratively, to obtain information on health insurance coverage from the administration of another EU country. It may take more than six months to obtain an answer:

> *« Beaucoup de gens, et beaucoup de jeunes aussi, tentent leur chance quand ça ne va pas, dans un pays en se disant : 'Je vais trouver du boulot.' et c'est la dernière chose auquel ils pensent, bien sûr. Et puis ça ne va pas, et ils reviennent. Ils n'ont pas le document de convention, parce qu'ils ont travaillé mais ils n'ont pas passé leur temps à essayer de mettre en ordre leur sécurité sociale, ça c'est clair. »*

Interviewees also mentioned pensioners who returned to Belgium after having lived for several years abroad and who did not bring the required forms from the country where they were covered.

d. Individuals who did not obtain the correct information on the requirements to be met

Some respondents mentioned that they are regularly confronted with clients who were not given the correct information by their sickness fund on the forms which had to be submitted and the arrears to be paid in order to settle their situation for coverage:

> *« On leur dit tel et tel papiers. Alors, ils vont avec le papier. La 2e fois, on leur dit : 'Non, ce n'est pas ce papier. Il faut revenir avec l'AER ([62]).' Puis, ils reviennent avec l'AER, on leur dit : 'Non, ce n'est pas bon, et tout ....' et donc, voilà. Après les gens sont découragés aussi. Ils se disent : ' Allez vous faire voir avec la mutuelle ! '»*

Social workers in two different hospitals provided an example of a client who urgently needed a medical intervention, but postponed it since he was not covered, and according to his sickness fund had a 6 months trial period before he could be covered. After further inquiries by the social service of the hospital, it turned out that the client could be covered without a trial period:

> *« J'ai un exemple, d'un patient qui devait subir une intervention cardiaque qui n'était plus en ordre de mutuelle. Et une personne me dit : 'Il a un stage de 6 mois'. [...] Puis plus tard, je rappelle la mutuelle, et la personne veut bien aller plus loin dans le dossier. Et quand elle gratte plus loin, elle se rend compte que le patient n'a pas de stage de 6 mois »*

62. AER: avertissement-extrait de role-aanslagbiljet.

e. To cover a child

A social worker mentioned that he regularly came across children who were not affiliated to a sickness fund, because the parents did not take the necessary action, out of negligence. According to him, this sort of negligence has been increasing.

> *« Ou finalement pour les enfants mineurs, les parents qui sont négligents qui ne vont pas faire les démarches pour leurs enfants mineurs, parce qu'il y a aussi, de plus en plus d'enfants mineurs qui ne sont pas couverts alors que les deux parents sont couverts. »*

Once a child is affiliated to a sickness fund, this has retroactive effect. An interviewee stressed that the conditions for coverage of children are very easy to meet:

> *« Donc pour les enfants, c'est vraiment limite de la mauvaise volonté parfois parce que pour les enfants, le système est le plus large. C'est à la date de la naissance d'office. »*

Although children of a person without coverage can in principle be covered as a resident, without having to pay personal contributions ([63]), a professional working in a social service of a hospital reported nevertheless that this is not actually possible when parents do not have any coverage . This leads to a situation where healthcare for children is being postponed or not taking place.

> *« Et autre catégorie, moi j'aimerai insister là-dessus, c'est les enfants. Parce que vous voyez, tous les enfants d'indépendants ou de gens non en règle […]. Et je trouve que parfois, les parents postposent un soin à leurs enfants parce qu'eux-mêmes ne sont pas en règle. »*
>
> *« […] Non, non. Si les parents ne sont pas en règle, l'enfant ne sera jamais en règle. Donc un enfant d'un indépendant qui n'est pas en règle, ne sera jamais lui-même pas en règle. »*

5.1.2 People in a precarious situation

As highlighted in our quantitative analysis (Section 4.1.1 and 4.2.1), people in a precarious socio-economic situation find it most difficult to access healthcare as a result of financial reasons. Here, we provide some more details on the specific mechanisms which may lead to them not having access to healthcare.

Interviewees frequently highlighted that people living in very precarious situations face multiple problems, and taking care of their health may not be their first priority:

- *« parce qu'ils ont plein d'autres soucis et qu'ils ont beaucoup de mal à les régler. Et c'est un ordre de priorité des choses. [...]. Les gens plus précaires sont tellement en stress de pouvoir remplir leur frigo »*
- *« Donc la priorité, c'est payer le loyer et la santé malheureusement, ça passe vraiment dans les derniers postes sauf pour les enfants. »*

Costs may not just be the cost of the healthcare, but also of transport or phone calls to make an appointment:

> *« Il y a des patients qui n'ont pas de téléphone, [...], des patients qui n'ont pas de carte téléphonique, alors en général ils passent pour prendre rendez-vous. Ils n'ont pas de sous pour prendre les moyens de transport, ils se font avoir donc ils paient les amendes. »*

63. Information provided by the NIHDI services, 8 June 2020.

Many interviewees stressed that people can quickly slide into precariousness. A sudden setback can result in a family that was just able to make ends meet being unable to do so, for instance after a divorce or a death:

> *« Elle était secrétaire médicale, elle venait de vivre un divorce. Elle avait dû se reloger en vitesse, elle gagnait tout juste de quoi manger avec son fils et elle ne savait pas payer les lunettes que son fils avait cassées et donc son fils ne voyait rien. Il ne voyait presque plus. Et donc ils viennent aux urgences et la mère était désemparée parce qu'elle ne savait plus quoi faire. »*

Several interviewees mentioned that single parents and families with many children were more likely to postpone healthcare. In particular, parents postpone care for themselves, to allow their children to have such care:

> *« Je dirais, les parents avec une famille, parfois famille nombreuse. Ils vont reporter les soins pour eux-mêmes. Parce qu'ils vont d'abord s'occuper des enfants etc. Ça c'est fréquent. [...] mais parfois ce sont des parents isolés avec beaucoup d'enfants. Ce sont des familles monoparentales. Je dirais que c'est encore pire et que c'est plus marquant. »*

Many respondents pointed to the particular difficulties of people who are socially isolated. They do not have relatives or a social network to support them financially or to take care of them:

- *« La mamie elle a travaillé toute sa vie, elle a une pension de 1150 €, elle a son petit appartement qu'elle doit payer 650 €, elle a ses charges à payer en plus. Il lui reste 300 € pour pouvoir vivre, elle s'est faite hospitalisée 3 fois sur le mois parce qu'elle a fait une chute chez elle. Elle doit rentrer chez elle. Elle doit avoir des soins à domicile, elle doit se payer des médicaments. Elle ne sait pas. Et elle n'a personne autour, pas de famille, rien du tout. Ça c'est terrible. »*
- *"Het zijn vooral alleenstaande ouderen, sociale woning, inkomensgarantie ouderen als inkomen, die toch wel het meest kwetsbaar zijn."*

5.1.3 People on sickness leave

Several interviewees highlighted that people on sickness leave are particularly vulnerable. When falling ill, people may suddenly face both a substantial drop in income and high expenditure for healthcare, while their fixed expenses, such as their rent or loan repayments, remain the same. The rules applying to the payment of sickness allowances are explained in Box 5.

Box 5: Rules on the sickness allowance

Employees and the unemployed receive an allowance of 60% of the capped last salary during the first year of primary incapacity to work. The monthly allowance is paid in two instalments: the first part is paid at the beginning of the month and the second part in the middle of the month. Self-employed persons on sickness leave receive a lump sum allowance, which varies according to their family situation. In most cases this only partially compensates for the financial loss. From the second year of incapacity to work, people receive an invalidity allowance.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

Some interviewees reported that they were frequently and increasingly having to help people with a sickness allowance below the level of the guaranteed minimum Integration Income. These are people whose income, on which the sickness allowance is calculated, is very low, e.g. due to part-time employment, irregular work, low salary or unemployment. These beneficiaries are often not aware that they can apply for a top-up income to the CPAS/OCMW.

Furthermore, people on sickness leave have to comply with a series of administrative requirements, at a time of delicate physical or mental health.

It was stressed by many interviewees that this may result in financial hardship and in people postponing or not seeking the necessary healthcare. It was also mentioned that the combination of the reduction in income, with payment of the allowance in instalments, may lead to a critical financial situation. It may furthermore be a long time before the beneficiary receives the first payment of his sickness allowance.

Interviewees mentioned that one and a half months may go by between the administrative declaration of incapacity to work and the first payment of the replacement income. This may cause temporary financial hardship and difficulties affording healthcare:

> *« Le patient doit re-envoyer encore toute une série de données qu'ils ont déjà, re-envoyer à la mutualité [...] et donc il se passe entre le jour un et le moment où l'invalidité est reconnue, minimum 1 mois à 1 mois et demi. Il faut savoir que pendant ce temps-là, les gens sont hospitalisés, ressortent, ont besoin de payer leurs médicaments, le loyer continue, le propriétaire il ne discute pas. »*

When administrative errors have been committed, for instance by the employer, or for cases that deviate from the standard situation, it can even take longer before the beneficiary receives his allowance. Interviewees testified that some patients become depressed by such setbacks. For some people, the pending period results in them having no access to the necessary healthcare.

An example was given of a socially isolated woman with an invalidity allowance of 1100 € and a rent of 630 €, who was entitled to increased reimbursement for healthcare costs ([64]). She postponed a medical consultation for financial reasons until she got problems with her heart. She feared however the hospital bill.

5.1.4 People with a chronic condition

Accumulated OOP expenses may be problematic for people with a chronic illness and high and recurrent healthcare costs.

A social worker reported that every day she dealt with people with a severe illness or with a handicapped child who had difficulties paying their healthcare expenses:

> *« Des gens qui viennent avec des problématiques de santé entrainant des frais par exemple, une maladie grave, et qui disent : 'J'ai un cancer, je ne m'en sors pas. Peut-on mettre en place des choses plus spécifiques ?', des familles qui viennent avec des enfants qui ont un handicap, qui ont pas mal de frais médicaux. Tous les jours, nous sommes confrontés à ça. »*

64. For an explanation on the status of increased reimbursement, see Section 5.2.

Another interviewed professional gave the example of a diabetes patient, to explain that costs for ambulatory healthcare may be very high:

> *« Les frais médicaux, la pharmacie, voir le spécialiste, vous faire une prise de sang au début pour un dosage tous les 8 jours. La prise de sang, ça coûte. »*

The costs faced by patients with multiple chronic diseases was also mentioned as problematic in some cases:

> *"Voor mensen waarbij [...] er echt sprake is van multimorbiditeit, met verschillende aandoeningen. Chronische aandoeningen en dat ook en dat ook nog. Dat dat totaal plaatje soms zwaar wordt, van medicatie en van kosten en zo. Je bent diabetes en je hebt dat en dat en dat nodig. Labo's, want al die zaken natuurlijk, dat moeten zij zelf betalen."*

5.1.5 People with frail mental health

Several professionals interviewed highlighted that people with fragile mental health (e.g. depression) are particularly vulnerable when it comes to access to healthcare. Often, they do not fit the boxes needed to be granted an allowance: they did not work enough to be entitled to a sickness allowance, they are not disabled, and it may be difficult for them to have their condition recognised. Often they have difficulties in carrying out the required administrative procedures to get their replacement income:

> *« Il est reconnu invalide mais pas beaucoup, ça fait qu'il ne touche pas beaucoup. Pourtant, il devrait être plus reconnu car il a une pathologie psychiatrique mais il refuse d'aller chez le psychiatre. »*

Interviewees from a social service pointed to major issues in paying for unplanned healthcare for some people whose possessions were managed by an administrator. If someone is unable to manage his goods himself, an administrator may be appointed to do this on his behalf. This can be a family member or a trusted person, but can also be, for instance, a lawyer who manages the assets of several individuals. The person who has been put under guardianship regularly receives a fixed amount of money for daily expenses. However, this may be insufficient to cover unplanned healthcare expenses. According to our interviewees, the administrator is often not easy to contact. In case of urgent need, this may cause major problems for the patient:

> *« Il y a des gens qui ont une vingtaine ou une centaine de personnes qu'ils suivent. Mais au final, ils ne suivent personne. Et ils ne sont jamais là. Tu ne peux pas les contacter. »*

It was also mentioned that this administrator may be responsible for applying for increased reimbursement status, on behalf of the individual who is subject to the protection measure.

5.2 The financial hurdles identified per type of healthcare

In this section we describe the affordability issues related to different health goods and services reported by interviewees for ambulatory care, inpatient care and medical products. We address the following domains: primary care (5.2.1), dental care (5.2.2), specialist care (5.2.3), on-call and emergency care (5.2.4), outpatient mental health services (5.2.8), medical examinations (5.2.5), prescribed medicines (5.2.6), medical devices (5.2.7), hospital care and post-treatment

after hospital discharge (5.2.9 and 5.2.10). We start each subsection with a description of the relevant features of the healthcare system determining costs for the patients.

Relevant features of the Belgian healthcare system are described in boxes: the basic features of the Belgian compulsory health insurance system relevant for access in Box 3 ; fee supplements in, the increased reimbursement status in Box 6 and up-front payments and the third-party payment system in Box 7.

Box 6: The increased reimbursement status

People receiving the following (means-tested) social benefits are automatically entitled to Increased Ieimbursement:

- An Integration Income from the OCMW/CPAS, for at least the last 3 months
- An income guarantee for the elderly
- An allowance for persons with disabilities

Furthermore, some categories of minors, such as orphans or some disabled children, also qualify automatically for increased reimbursement.

Other insured persons can apply to their sickness fund for IR status. The granting of the status in these cases is subject to means testing, based on household composition and household (gross taxable) income. In principle, the gross taxable family income for the year preceding the application is taken into account ("reference period"). For beneficiaries with a stable income (e.g. for pensioners), the decision is based on the gross taxable income in the month prior to the application (based on a declaration of honor) (Farfan-Portet *et al.* 2019). In principle, the right is automatically renewed annually on the basis of an audit of income. If the income threshold has been exceeded, on the basis of the information from the tax authorities, the sickness fund will terminate the right or request additional information from the beneficiary. In the event of cessation of entitlement (on 31/12 of the year of the audit), the beneficiary may submit a new IR application ([65]).

The situation is assessed annually before it is decided whether to extend the status by one additional year.

The increased reimbursement status is awarded to the insured person, his/her cohabiting partner, and to their dependents.

Currently about 18% of the population benefits from the IR status ([66]).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

65. Information provided by the NIHDI services, 27 April 2020.
66. On 30 June 2019, out of a total of 11,292,693 insured persons, 920,557 had IR status as recipients of a social benefit, and 1,143,283 after means testing.
(Source: https://www.riziv.fgov.be/nl/toepassingen/Paginas/webtoepassing-statistieken-personen-aangesloten-ziekenfonds.aspx, latest consulted on 02/01/2020).

Box 7: Up-front payments and the third-party payment system

A third-party payment regime, whereby the sickness fund pays the healthcare provider directly and the patient only pays the user charges, applies automatically:

- For hospitalised patients;
- For most reimbursed products provided by the pharmacist;
- For GP consultations and technical acts provided during this consultation to people entitled to the increased reimbursement rate. The third-party payment system, is however not obligatory for GP home visits.

For other outpatient care services, the patient in principle pays the healthcare provider first and obtains reimbursement of the cost of the care from his sickness fund afterwards.

The use of a third-party payment system, is in principle prohibited for home visits and consultations with medical doctors and dentists ([67]). Nevertheless, in specific cases, the healthcare provider may apply the third-party payment system but is not obliged to do so. This applies:

- For medical and dental care (provided by the GP, dentist or specialist) given to specific categories of insured persons, in particular with a low income or high healthcare costs. The healthcare provider can check on a platform whether the patient qualifies for the scheme or, alternatively, the patient has to request the necessary proofs from his sickness fund.
- For dental care for minors and some specific dental care.

Other health providers, such as nurses providing home care and physiotherapists, can apply the third-party payment system, but are not obliged to do so ([68]). This is also the case for medical-technical acts.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

67. And services provided by speech therapists at school.
68. In practice, nearly all home nursing services apply the third-party payer system. Furthermore, these services do not usually claim the applicable user charges, and thus nursing care is often provided free at the point of use.

Box 8: Fee supplements

The fee schedules for healthcare providers are, as are the user charges, set out by the representatives of the healthcare providers and sickness funds in an agreement. The healthcare providers who accede to that agreement (which we will call 'contracted healthcare providers') undertake to comply with the regulatory fees. Individual care providers who did not (or not fully) join the agreement may charge supplements on top of the regulatory fees. These fee supplements are not covered by the compulsory health insurance and are borne by the patient or his private health insurer.

All healthcare providers have to inform patients of their contracting status by clearly and visibly displaying in their waiting rooms whether they are contracted, fully or partially, or not at all. If they are partially contracted, they have to display the days and hours of consultation during which they apply the tariffs of the agreement and those during which it does not apply to them. INAMI and the sickness fund publish an online database in which patients can check the contracting status of any healthcare provider. Furthermore, in principle the hospital has to inform the patient beforehand of the contracting status of the healthcare provider, in case of a consultation at the hospital. If the beneficiary has not been expressly informed by the hospital, the healthcare professional cannot exceed the fees applicable for contracted health professionals (69).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

5.2.1 Primary care

We present in this section information obtained through the interviews on access to independent GP and physiotherapy practices, and the role of community primary care centres in ensuring access to healthcare. We start the section by describing the applicable user charges in primary care (Box 9). For rules on fee supplements we refer to Box 8.

Box 9: User charges applicable in primary care

User charges for general practitioner (GP) care vary according to the setting in which the GP is working and the relationship between the GP and the patient.

Patients can consult an independent GP practice. They can furthermore choose to register with this GP practice, meaning that the practitioner holds their global medical records. User charges for a patient who consults a contracted GP with whom he is registered are set at 4 € for ordinarily insured persons and 1 € for persons entitled to an increased allowance. Patients who did not register with a GP to keep their global medical records pay respectively 6 € and 1.5 €. 67.5% of the population was registered with a GP in 2016 (Devos 2019a).

When consulting a contracted physiotherapist in an independent physiotherapy practice, user charges for a standard physiotherapy session of 30 minutes amount to 6.25 € for ordinarily insured persons and 2.5 € for persons entitled to the IR. The number of reimbursed sessions is limited to 18 per year for common disorders. More sessions may be reimbursed for some pathologies and functional limitations (60 sessions maximum). Beyond the maximum number of sessions there is only a marginal reimbursement of physiotherapy.

69. Information provided by provided by the NIHDI services, 27 April 2020.

Primary care can also be provided in multidisciplinary community primary care centres. These centres are paid with a lump sum per registered patient. They provide at least GP care and nursing care or physiotherapy. They may also provide social care; psychological care, nutritional advice etc. The patient does not pay user charges for the care covered by the lump sum. The federated entities of Wallonia and Brussels furthermore grant subsidies to the centres for coordination, integration, community health and prevention activities, subject to compliance with a series of tasks ([70]).

In June 2019, there were a total of 190 primary care centres of this type covering 450.236 insured people or about 4% of the Belgian population ([71]). The sector experienced a strong growth in the past ten years; the number of centres has almost doubled ([72]).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

5.2.1.1 Independent practices of general practitioners

Some interviewees mentioned that affordability of general practitioner care is not the main issue, particularly not for people with IR status. Many interviewees stressed that automatic application of the third-party payment system for GP consultations for people with IR status was an important step forwards in access to GP care.

A professional reported that some GPs refuse to apply the third-party payment system, since they want to avoid clients in a precarious financial situation ([73]):

> *« Il y a des gens qui ont droit au tiers payant mais qui ne vont pas l'obtenir parce que le médecin refuse, et ne parlons pas des dentistes. Et c'est un moyen d'éviter cette clientèle »*

5.2.1.2 Independent physiotherapy practices

Many interviewed health professionals reported patients who do not follow the sessions of physiotherapy they need due to costs:

> *«Il y a plusieurs personnes qui me disent carrément : 'J'avais 60 séances de kiné. J'ai arrêté, ça coûtait trop cher. '»*

Patients with chronic conditions who we interviewed also mentioned affordability of physiotherapy as one of the main issues. One of them, whose income was just too high for the IR status, mentioned that she was unable to pay for the physiotherapy she needed and that she tried to do some exercises herself and tried to find out herself, in medical books, what she would need.

The lack of third-party payment system for physiotherapy was stressed by many respondents as a major hurdle for access to care. This included for instance older persons with functional limitations. It was mentioned that in some regions, only a few physiotherapists accept third-party payment:

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70. https://www.health.belgium.be/en/health/taking-care-yourself/patient-related-themes/cross-border-health-care/healthcare-facility-5 (latest consulted on 09/03/2020)
71. Information provided by the NIHDI services, 8 June 2020.
72. https://www.mc.be/media/Maisons-M%C3%A9dicales_IMA_r%C3%A9sum%C3%A9_tcm49-43639.pdf (latest consulted on 16/06/2020).
73. Although a sanction applies if the system is not applied (information provided by the NIHDI services, 27 April 2020)

« Déjà pour avoir un rendez-vous ici, c'est déjà difficile, mais pour en avoir un qui accepte le ticket modérateur, c'est encore plus difficile. Donc les tendinites vont trainer par exemple, pendant au moins 2 ou 3 mois. »

Several respondents pointed to the fact that physiotherapists tend to make out an invoice only once every few months. As a result, patients have to pay huge amounts at once. An interviewee provided the example of someone who needed physiotherapy twice a week and only received the invoice every two months or so. The amount due was then around 700 €, which would be partially reimbursed by the sickness fund afterwards. One interviewee suggested that physiotherapists increasingly agree to make out an invoice for every session. She stressed however that the amount due may remain very high, in the order of 50 € per week.

A patient interviewed with a chronic condition stressed that lack of clarity on when the sickness fund will reimburse the bill is a problem for her. She sometimes really needs the money, while it may be between one and three weeks later before she receives the payment:

Another patient interviewed mentioned that she had to pay 300 € up front, and that it was a serious problem for her that she was given no information on the amount that would be reimbursed by the health insurance system:

"Dat was dan 300 € of zo, maar ze zegden ja, we weten niet hoeveel dat bij u terugbetaald gaat zijn. Dan is dat dus een papiertje inleveren en heel spannend wachten van gaat dat veel zijn, op hoeveel gaat dat komen."

The lack of contracted physiotherapists is also an issue in some geographical areas. A chronically ill patient with a chronic condition mentioned that she had been unable to find a contracted physiotherapist in the municipality she moved to. She contacted them all by phone and they told her that all the physiotherapists in the municipality had agreed to apply the same tariff.

5.2.1.3 The community primary care centres

Although the community primary care centres are not specifically intended to provide care to the poor or disadvantaged, it became clear during our interviews that they play a crucial role in ensuring access to healthcare for people in precarious situations.

a. No up-front payments and low user charges, if any, for healthcare

The fact that no advance payments nor user charges are due for the care provided, is a crucial element ensuring access to care in these centres.

A social worker of a CPAS clarified that medical doctors with whom they collaborate are asked to make sure that patients have a GP, preferably in a primary care centre. The main reason for this is that in these centres, no payments are due from the patient.

The primary care centres not only provide GP care, but may also offer physiotherapy, nursing care, psychological care, consultation with a dietician and other paramedical services. In some centres, physiotherapy and psychological care is provided for free, covered by the lump sum, since people would not be able to pay for it:

> *"Dus elke dienst dat wij hier aanbieden, ook de psychologen, wij pakken dat volledig op ons. Daar betalen zij niks voor. [...] Wij betalen dat gewoon zelf, omdat wij weten dat zij anders niet aan den bak komen."*

In other centres, people pay a small fee for services such as psychological care, but if a patient cannot afford it, the centres look for a solution.

b. Prescribing cost-consciously

According to interviewees in primary care centres, they are used to assessing carefully the costs to patients of the tests and treatments they prescribe:

> *"onze artsen gaan dan heel goed zien welke labo ze aanvragen. Voor een gewone dokter is dat misschien tsjak tsjak tsjak, en doet dat er ook nog maar bij, maar dan stijgt uw remgeld. Dus zij gaan heel nauwgezet zien van ik heb dat nodig, dat nodig, en soms echt op voorhand al uitrekenen van voilà dat gaat u zoveel aan remgeld kosten."*

c. Support and social services

The support provided in the primary care centres visited goes far beyond the provision of health treatments or preventive care. They help to plan and organise medical and paramedical care according to the financial situation of the patients. They search for financial solutions depending on the severity and the urgency of health problems. They call providers, to ask whether they agree to apply the third-party payment system, to delay payment for a medical consultation at hospital or to do a home visit when needed; they lend money to the patient to pay the user charges; they lend medical devices/equipment, even cell phones to ensure that the patient is able to receive the necessary treatment; they may have an agreement with a pharmacy. Interviewees stressed that they make major efforts to ensure access to care and to help find solutions for affordability issues (formally but sometimes informally):

- *« Quelqu'un qui me dit : « Je n'ai pas accès, j'ai dû renoncer à … », je lui dis : « Non, il y a moyen. Il faut nous en parler ». Si le patient vient nous dire : « Je ne sais pas payer ça », on trouve une solution. »*
- *« Téléphoner pour les rendez-vous à l'hôpital, je pense qu'on le fait 2 à 3 fois par jour, par personne. »*

They may have a -limited- stock of pharmaceuticals which they provide for free. One primary care centre mentioned that they have a cooperation agreement with a pharmacy. The centre may pay the cost of the medicine for some patients or act as a guarantor:

> *« On a une bonne collaboration avec la pharmacie ici, qui est quand même assez chouette et qui fait beaucoup de crédit pour les patients ou alors comme on le disait, nous avançons l'argent ou on téléphone. »*

They provide help filling in paperwork, for instance before a hospitalisation, and make sure that the patients will not be hospitalised in a single room:

> *"Die pre-operatieve formulieren, die ingevuld moeten worden en waar dat je dan zegt: een éénpersoonskamer of een tweepersoonskamer, daar komen ze mee naar hier. De verpleegkundigen vullen dat in samen met of voor hen, dus die gaan daar niet éénpersoonskamer opzetten."*

or they help people with their entitlement to health insurance:

> *"We hebben ook iemand die fulltime bezig is met die administratie. En mensen die niet in orde zijn… zij neemt sowieso altijd contact op met de mutualiteit en zij gaat bij de mutualiteit bevragen waarom die niet in orde zijn. Vaak zegt de mutualiteit: die persoon moet langskomen, die moet dat en dat bewijs voorleggen; die moet dat meenemen. En dan gaat zij die mensen bellen en attenderen van je moet onmiddellijk nu voor die datum naar de mutualiteit want anders..."*

d. Administrative hurdles to registration

The catchment area of the community primary care centres is circumscribed. This may cause problems, for instance, for people who move. An example has been given of persons who moved from one municipality to another in Brussels and had to deregister from one care centre in order to gain access to the other care centre.

e. Lack of awareness of the provisions for continuity of care

Community primary care centres are organized to provide continuity of care and can point patients to on-call services. A GP working in a primary care centre explained that they ensure continuity of care, together with the other primary care centres, and ensure that the patients are well informed as to what to do when they cannot reach the centre. Despite this, one hospital social worker reported that patients registered in a primary care centre came to consultations in the hospital when the health professional (nurse, physiotherapist) of the centre was absent. In such cases, patients have to pay the costs of care up front, and the interviewee reported that some patients are unable to pay this amount in advance.

5.2.2 Dental care

Box 10: User charges applicable in dental care

Basic dental care, such as a dental examination or filling of cavities, is fully reimbursed for children under the age of 18 and for adults who are entitled to the increased reimbursement rate, if they consulted a dentist during the previous year (if they did not, they pay 1 €). For ordinarily insured persons, user charges range from 5.5 € for a consultation to 14.5 € for fillings (and up to 29 € if they did not consult a dentist during the previous year).

Orthodontic treatment is only reimbursed for children and adolescents. User charges for orthodontics may be substantial. Removable dentures are reimbursed from the age of 50 (with some exceptions for younger people in specific medical circumstances). Fixed dentures are in principle not reimbursed. Dentures can in principle only be reimbursed once every 7 years (with some exceptions in specific circumstances) (74).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

74. For instance, the user charges for the provision of removable dentures (from 1 to 5 teeth), including the dentist's fee, are 18 € for patients with IR status (or 20 € outside the care pathway) and 90.5 € for non-IR patients (or 131 € outside the oral care pathway).

One general practitioner stressed that poor state of teeth is the most serious health problem encountered in their community primary care centre:

> *« Ca, franchement s'il y a un problème ici, ce sont les dents. Parfois on se demande même comment les gens font pour manger. »*

Many interviewees mentioned that people living in poverty do not consult the dentist:

> *"Voor deze groep mensen is elke doorverwijzing naar een andere eerstelijns faciliteit moeilijk en er zijn er een hele hoop bij die dat niet doen en dan denk ik inderdaad aan tandartsen, tandzorg."*

Costs were mentioned as the main reason:

> *« Les soins dentaires coûtent très chers. Donc s'il n'y a pas une aide supplémentaire que la sécurité sociale, les gens n'y vont pas. »*

Interviewees mentioned that many people postpone the replacement of a broken tooth or dentures due to costs, particularly people who are too young to qualify for reimbursement of a denture:

> *« Des dents cassées qui ne sont pas remplacées. Le nombre de gens qui ne savent pas se payer. La dent est cassée, beh elle restera cassée jusqu'à ce que j'aie les sous pour faire l'implant ou la prothèse.*

An interviewee working in social services provided the example of someone who had his denture prosthesis repaired. However, the provider refused to return the denture until the person had paid for the repair:

> *« Ils ne veulent pas rendre la prothèse tant que la personne n'a pas payé. Mais ça je n'ai jamais vu ça, c'est illégal. »*

A social worker pointed to the dramatic health consequences postponement of dental care can have:

> *"Ik heb al verschillende mensen meegemaakt, en dan vooral voor tandzorgen, die dat blijven uitstellen en blijven uitstellen waardoor ze uiteindelijk maagklachten krijgen, ze kunnen niet goed kauwen. Het speeksel werkt niet goed. En de volledige gezondheidskost wordt dramatischer omwille van het uitstellen van die tandzorg."*

One professional interviewed noticed that, at hospital, there are patients with severe Ear, Nose and Throat (ENT) and stomatology complications because their broken dentures have not been replaced:

> *« Les prothèses dentaires, si ça casse, si ça ne convient pas à un moment donné … On a beaucoup de patients qui ont des opérations au niveau ORL et stomato, ils ont eu droit à leur remboursement de dentier l'année passée. [...] Beh c'est fini ! Voilà ! [...] Et donc les gens restent avec leur dentier abîmé, cassé, qui ne convient pas, avec des risques de blessures, des risques de complications, des risques d'infections qui coûtent 4 fois plus chers parce qu'effectivement l'intervention de la mutuelle c'est 1 fois tous les X temps. »*

The up-front payments constitute an important barrier, according to many interviewees.

According to a social worker, dental care is the most difficult type of care to afford, mainly due to the lack of a third-party system. She furthermore clarified that it takes two to three weeks before people have their expenses reimbursed:

"Maar voor mij is het grootste (probleem) die tandzorgen. Dat is iets waar wij eigenlijk vrij regelmatig mee geconfronteerd worden, dat mensen dat niet kunnen betalen.[...] Het is een gebrek aan derde betalers. [...] Als die mensen 2 tot 3 weken moeten wachten op de terugbetaling van een hoge medische kost, dat kunnen die niet aan."

An interviewee stressed that dental care has to be paid up front for children too, which acts as a hurdle for access.

"Ze zeggen dan tandzorgen voor kinderen zijn gratis, maar je betaalt het altijd wel eerst."

The lack of availability of contracted dentists was also raised as an important issue. One interviewee highlighted that many dentists are not contracted, and as a result, dental care for children is often not free:

« Puis il y a aussi beaucoup de dentiste qui ne sont pas conventionnés. Donc même si c'est gratuit, remboursé en fait, finalement on se rend compte qu'il faut quand même payer quelque chose pour les enfants. Ce n'est pas gratuit. »

A patient interviewed told us that she was unable to find a contracted dentist in her neighbourhood:

"Ik ben vorig jaar op zoek moeten gaan naar een nieuwe tandarts na 35 jaar [...] En dan ben ik gaan zoeken op geconventioneerde en dan krijgt ge vier namen door en als ge dan ziet sinds wanneer dat die arts zijn, moeten die eigenlijk ook op pensioen. En dan krijgt ge een hele lange lijst met niet-geconventioneerde, en dan moet die u nog willen aannemen. [...] Dus ik ben in een groepspraktijk binnen gemogen, [...] die zijn niet-geconventioneerd. Maar ge houdt ook rekening met afstand. Ik kan daar te voet naartoe."

5.2.3 Outpatient specialist care

In this subsection we present the difficulties for access to outpatient specialist care raised during the interviews. We start by describing the rules on user charges for specialist care (Box 11).

Box 11: User charges applicable for specialist care

Consultations with a specialist can take place at the hospital or at the doctor's private practice.

For consultations with most specialists, user charges amount to 12 € for ordinarily insured persons and 4€ for persons entitled to an increased reimbursement.

This user fee may be reduced to respectively 7€ and 2€ for one visit a year for specific specialties if the patient has been referred by the GP with whom he is registered and if he sends this referral letter to his sickness fund. However, patients who ask for application of the third-party payment system are not entitled to the reduced user charge for specialist care upon referral of the GP (75).

Patients in principle pay up front and are reimbursed afterward. For some categories of patients, a third-party payment system may apply (see introductory paragraphs 'Description of features of the system which determine the costs for the patients' of Section 5.2). Some hospitals apply different procedures and send the invoice afterwards.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

75. https://www.cm.be/diensten-en-voordelen/ziekte-en-behandeling/terugbetalingen-behandelingen/specialisten/hogere-terugbetaling-na-verwijzing (latest consulted on 12/06/2020).

5.2.3.1 Postponement of specialist care

According to a GP working in a primary care centre, in their centre they rarely have issues with regard to access to specialist care, since the CPAS/OCMW pays for those who need it:

> *« Soit les personnes sont aidées par le CPAS et donc ne paient pas les consultations chez le spécialiste [...] Donc ça c'est une aide vraiment très importante. »*

Nevertheless, several hurdles for access to specialist care were mentioned during the interviews.

Several professionals reported major health consequences for patients who were unable to renew the prescription for an essential medicine due to difficulties affording the medical consultation.

An interviewed social worker provided the example of a chronically ill patient who was hospitalised with heart failure, because he had not taken his medicine. Due to financial problems, he had not consulted his specialist asking him to renew his prescription. To have the pharmaceutical product reimbursed, he also needed the approval of the advisory doctor of his sickness fund. As a result, he did not buy his medicine :

> *« Là, j'ai un homme qui a fait un arrêt cardiaque parce que pour des raisons financières il n'avait pas pu aller chez son médecin traitant, donc il n'avait pas fait sa prolongation de médicaments qui était un anti-agrégant plaquettaire qui est très important dans la prise en charge de sa pathologie cardiaque. ».*

GPs in several community primary care centres provided examples of patients who did not, for financial reasons, consult the specialist they were referred to. An example was provided of a patient who received samples of a medicine for free from his treating specialist. Since he was unable to pay the specialist, he did not return, and thus postponed the use of the necessary medicine, with severe and life-threatening adverse consequences.

5.2.3.2 Restricted access because of arrears in payments to the hospital

One interviewee noted that hospitals have become stricter in verifying the solvency of patients. Hospitals now check that the patient has paid all he owes before admitting him for a medical consultation. One particular hospital service checks the patient's account:

> *« Ils ont des gestionnaires de budget, c'est géré différemment par rapport à avant. Et donc cet aspect-là de l'hôpital qui doit être payé, est primordial maintenant, et donc on a des patients pour lesquels la cellule Checking vérifie le compte des patients avant d'accepter les soins pour les consultations. »*

5.2.3.3 Financial hurdles due to up-front payments

The up-front payment of doctors' fees was perceived as a substantial hurdle for access to care (for the rules on up-front payments, see Box 7).

> *"Mensen die voorschotten moeten betalen bij de zorgverstrekkers, ambulant, dat is zeker een probleem"*

A respondent mentioned important differences between hospitals with regard to up-front payments and the application of the third-party payment system:

"Je hebt veel ziekenhuizen die, als je verzekerd bent, onmiddellijk een derde betalersregeling toepassen. [...] dan krijg je een factuur waarop je alleen nog het remgeld moet betalen. Dan wordt dat onmiddellijk geregeld. Maar er zijn ziekenhuizen die dat niet doen, waar je zelfs een voorschot moet geven."

Interviewees in a public hospital explained that their hospital applies the third-party payment system for patients with financial difficulties:

« Ça, c'est au niveau des consultations. Donc même s'il ne sait pas payer et que la mutuelle est en ordre, il peut quand même avoir sa consultation. On applique le tiers payant et il reçoit la facture à la maison. »

Another interviewee mentioned that patients have to pay 25€ up front in hospital and that, due to this, people may forego healthcare:

"Je betaalt d'office 25 € [...] als voorschot. En dat is voor mensen wel een barrière"

5.2.3.4 Financial hurdles due to fee supplements ([76])

Respondents also raised the issue of the shortage of contracted doctors in some specialties ([77]). As a result, patients have to wait a long time or consult the doctor privately and pay fee supplements. The example of ophthalmology was given. According to interviewees from a community primary care centre, many of their patients are unable to pay the fee supplements. As a result, they may have to wait up to one year:

« Si on regarde en ophtalmo, là c'est typique. Il faut des délais d'un an dans les hôpitaux. Et on sait très bien qu'il y a un endroit où ça va beaucoup plus vite. Mais ils demandent beaucoup plus. »

Another example mentioned was in psychiatry: consultations are postponed due to the high costs of non-contracted practitioners.

The lack of transparency and information on whether or not the doctors are contracted was also raised as an important issue. Patients only find out that they have to pay fee supplements after they receive the bill:

« Ici en consultation, on ne vous dit pas : 'Conventionné, non conventionné', on vous dit : 'Ce sera 50 €, ce sera autant, …' et paf ! Et pour les personnes n'ayant pas cette connaissance ou cette information-là, c'est difficile à distinguer. »

A chronically ill patient interviewed told us that she is unable to find out whether or not the doctor to whom she is referred is contracted:

"Men weet zelden of artsen geconventioneerd zijn of niet. Er ligt in de hal van de kliniek ergens een boek waar je dat in kan gaan opzoeken. Uiteindelijk als je verwezen wordt voor een onderzoek of voor een behandeling, dan hebt je geen keuze. Dan wordt je verwezen. Punt. En dan blijkt achteraf dat die niet-geconventioneerd is. En dat gebeurt meer en meer."

76. For the rules fee supplements, we refer to Box 8.
77. For a discussion on the availability of contracted providers, see section 6.4.4.

5.2.4 On-call services and emergency care

Box 12 describes the user charges applicable for on-call services and emergency care. Interviewees pointed to the high costs of GP home visits at night and the fact that the full amount has to be paid up-front during the visit. It was also mentioned that you need to have at least 20 € phone credit to be able to call the 0800 number of the GP post. Many patients do not have this amount on their mobile. The emergency service only has to be paid afterwards, as the invoice is sent to the patient's home. Hence, patients in need of urgent care may prefer to use the emergency services.

Box 12: User charges applicable for on-call services and emergency care

GPs have to provide on-call services for urgent consultations and home visits. User charges for out-of-hours consultations with a GP are in principle the same as for a normal consultation. User charges for out-of-hours home visits vary according to the age, the pathology and reimbursement status of the patient. They range from 2.58 € for a home visit in the evening (up until 9pm), for a child under the age of 10 with IR status, to 31.02 € at night for an adult without IR status. As a general rule, for this sort of home visit, the patient has to pay the full amount up-front (ranging from 51.69 € to 89.41 €) and will be reimbursed afterwards. For beneficiaries with IR status GPs can apply the third-party payment system, but they are not obliged to do so.

GPs' out-of-hours duties are increasingly organized in centralised GP posts, and these posts are increasingly established close to a hospital emergency service, to enable appropriate triage of patients (see also KCE, 2016) ([78]).

The user charge for 2020 for a consultation in a hospital emergency service is 4.78 € for ordinarily insured persons and 1.77 € for those with IR status. Tariffs are higher if the patient has not been referred to the emergency service by a general practitioner or brought in with an emergency ambulance service. In this case they amount to respectively 21.47 € and 11.93 €. This differentiation has been put in place in order to avoid improper use of the emergency services for non-urgent cases. In principle, the bill is sent afterwards to the patients' home. Hospitals cannot refuse to treat a patient in an emergency situation.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

Invoicing policies may differ between hospitals. In some hospitals, emergency service invoices are sent to the patient's home, after the consultation has taken place. Interviewees from a public hospital suggested that in (some) private hospitals patients have to pay when using the emergency services.

Respondents from several social services reported cases of patients with financial problems or unable to pay their arrears for hospital care, who come to the emergency service when they have serious health problems, since they do not have to pay directly there:

78. Huisartsenwachtposten vestigen zich vaker dicht bij ziekenhuizen, https://www.vrt.be/vrtnws/nl/2019/11/02/huisartsenwachtposten-schurken-vaker-dicht-bij-ziekenhuizen-aan/ (latest consulted on 12/12/2019).

"Dan moeten we de mensen terug door sturen naar het ziekenhuis voor een afbetalingsplan. Dan hebben ze wel die geneeskundige zorg gekregen, maar mensen kunnen het niet in één keer betalen. En dat maakt dat veel spoeddiensten van ziekenhuizen overvraagd worden. Ze ze krijgen dan die onmiddellijke zorg, ze krijgen die onmiddellijke hulpmiddelen en die facturen komen pas later."

« Souvent, j'ai déjà eu des discours comme ça, ils disent : 'Je me suis obligé à venir aux soins parce que c'est devenu urgent. Et je n'ai pas de moyens, je n'ai pas de situation, c'est un peu critique pour moi et beh, je vais aller aux urgences parce que là on va m'envoyer une facture, on ne va pas me demander de payer parce que c'est obligatoire, je ne vais pas bien. Et c'est urgent, j'y vais'. »

To solve the issue of unaffordable healthcare services, some patients may shop around, i.e. they consult different hospital services, sometimes in different cities, consult a GP, then another health service. But they never pay, since they are unable to pay:

« Ce sont des gens qui vont systématiquement aux urgences et donc il n'y a jamais de suivi [...] On a beaucoup été dans la politique des urgences. « J'ai un gros problème, je vais aux urgences et puis je disparais dans la nature car je ne saurais pas payer. »

5.2.5 Medical-technical acts

User charges may be levied for medical-technical services, while patients with IR status are most often exempted. Doctors can apply the third-party payment system and this is common practice. The invoice is most often sent to the patient's home. Laboratories with non-contracted care providers can only charge supplements if they have informed patients about this beforehand, either directly or indirectly through the prescriber.

Referring GPs in a community primary care centre mention that they are frequently confronted with patients who are unable to afford necessary medical examinations. The amounts mentioned were about 8-10 €. The medical examination has to be scheduled for when the patient has just received his social benefit. In case of emergency, the primary care centre may even pay the user charge, to be repaid later:

« Parfois on téléphone pour eux parce qu'ils vous disent : 'Je n'ai pas l'argent pour téléphoner. Pourriez-vous prendre le rendez-vous pour moi ?' 'Pourriez-vous mettre le rendez-vous entre le 1er et le 9 ? Parce qu'après le 9, il n'y a plus d'argent sur mon compte'. […] En même temps, la santé, c'est important. Il y a des problèmes de santé qui ne peuvent attendre le 9 ou le 10. Dans ce cas-là, on avance les 10 € ou tu estimes que ça peut attendre le 8 ou 9 du mois. »

A patient with an ear problem had to visit an Ear, Nose and Throat (ENT) specialist. Since he could not afford this consultation, the GP in a primary care centre reached an agreement with a hospital to spread the payment of the consultation. The patient visited the specialist but refused the medical examinations proposed due to the cost and the need to pay the full fee up front. As a result, there was no diagnosis and the two consultations had thus been useless.

5.2.6 Prescribed medicines

Many interviewees pointed to the high total amounts of out-of-pocket payments for prescribed medicines. Box 13 describes the rules on OOP payments for pharmaceutical products.

Box 13: Rules on out-of-pocket payments for pharmaceutical products

The reimbursement level of prescribed pharmaceuticals in ambulatory care depends on the medical-therapeutic benefits and how "necessary" the medicine is.

- Medicines which are urgently needed, such as medicines for the treatment of diabetes or cancer, are fully reimbursed.
- For other medicines, user charges of up to 15€ per package may apply for ordinarily insured persons and to 9.9€ for IR patients and their dependents.
- For some specific categories of reimbursable pharmaceuticals, such as vaccines, agents used in anti-allergy products and contraceptives, no maximum user charge is set.
- Non-reimbursable pharmaceutical products include basic painkillers, some tranquilizers, contraception for adults (older than 24 years) ([79]) and sleeping pills, and most vitamins. For certain painkillers, chronic pain patients are eligible for a limited reimbursement ([80]).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

5.2.6.1 High total amounts of out-of-pocket payments

Many interviewees provided examples of patients who had difficulties affording medicines, who declined or postponed buying some or all of the prescribed medicines, or for whom the health and social services had to look for creative solutions to ensure that the patient would have access to medicines.

Interviewees stressed that the monthly expenditure on prescribed medicines is very high for some patients. A social worker provided the example of a chronically ill patient who had a monthly bill of 200€ for necessary prescribed medicines:

> *« 200 €, c'est énorme ! Donc ce sont des gens qui sont malades […], ce sont des gens très faibles. Et malgré tout, il y a ça. Et on n'a pas de doute sur la nécessité du traitement. »*

Another interviewee also pointed out that the out-of-pocket payments for pharmaceuticals can represent a substantial share of the household income. Sometimes this is because clients have to take a lot of medicines, but sometimes clients who only have to take a few medicines may still have to pay out a substantial chunk of their available budget:

> *"Er zijn mensen die met een hele zak of met doosjes komen. Ik heb een keer een huisbezoek gedaan, dat was een man, en die had dat heel netjes, die had al zijn pillekes al klaarliggen voor een hele maand, denk ik. En dat waren een stuk of tien dingen. En mensen die niet heel*

79. Since 1st of April 202O this age was increased from 21 to 24.
80. The compulsory health insurance reimburses 20% of painkillers for chronic pain patients. The remainder (the user charge) is eligible for the maximum billing. Palliative patients may receive a palliative lump sum that is intended, among other things, to contribute to the cost of medicines for palliative patients at home. Some other non-reimbursable pharmaceutical products are nevertheless reimbursed for specific indications.

veel medicatie moeten nemen, maar voor wie dat toch een serieuze hap uit hun budget is, naast alle andere medische verzorging die ze ook nodig hebben."

The user charges for some pharmaceuticals may, even for people with an increased allowance, be prohibitive, and not all prescribed pharmaceuticals are reimbursed. An interviewee provided the example of his own grandmother, with IR status, who, every two weeks, had to pay a bill of 80€ to the pharmacy. His grandmother was unable to pay this and thus the interviewee paid it on her behalf:

« Je prends l'exemple de ma grand-mère. Elle est BIM. Tous les 15 jours elle en a pour 80 € de quote-part patient à la pharmacie. C'est moi qui les paie. Elle a une pension de 1117 € je pense, quelque chose comme ça. Comment voulez-vous que… »

Some interviewees mentioned specific categories of medicines that, in their experience, are often difficult to afford. For instance, the high cost of psychiatric medicines was highlighted:

- *« Pas mal de frais pour les gens qui sont en psychiatrie, parce que tout ce qui est neuroleptique, etc, qu'on soit BIM ou pas, il y en a beaucoup qui restent la même chose. »*
- *"Mensen met antidepressiva en dergelijke."*

5.2.6.2 Costs of prescribed non-reimbursed medicines

The issue of high OOPs for prescribed non-reimbursable medicines was also highlighted:

"Tout ce qui est gouttes pour allergies, les larmes artificielles qui sont parfois très indispensables pour les personnes ayant les yeux secs, ça n'est pas remboursé. Des crèmes mêmes antibiotiques pour la peau qui sont parfois vraiment indispensables, ça n'est pas remboursé non plus. Et ça, ça peut vite coûter 10, 13, 15 €."

A social worker mentioned that people often do not buy pain killers due to their cost:

"Er zijn een aantal geneesmiddelen die mensen niet kopen omwille van de kostprijs. [...] Pijnstillers is dikwijls wel een slokop."

During the group interview with chronically ill patients, the affordability of prescribed food supplements was mentioned several times. One of them was a cancer patient who highlighted the costs of calcium tablets:

« Heel mijn oestrogeen wordt onderdrukt. En ik moet op bevel van de dokter, een calciumtablet elke dag gebruiken. Dat is een supplement, dat wordt niet terugbetaald door het ziekenfonds en wordt niet terug betaald door de hospitalisatieverzekering. »

5.2.6.3 Coping strategies of patients with access issues

a. Patients buy only a selection of the prescribed drugs

Several interviewees mentioned that sometimes, patients at the pharmacy choose, from among the products which have been prescribed to them, only those that they consider the most important or affordable:

« Oui bien sûr les gens qui font leur sélection dans leurs médicaments. »

GPs from a primary care centre reported that they sometimes helped the patient to make this choice, to be sure that the most necessary pharmaceuticals would be taken:

Interviewee 1: « Les sirops ne sont pas remboursés. Les sprays ne sont pas remboursés, et donc, à ce moment-là, on voit avec le patient : 'C'est peut-être mieux d'utiliser le serum physiologique. Pour le sirop, c'est peut-être pas important pour vous et prenez un Dafalgan pour baisser la fièvre'. »
Interviewee 2: « On fait le tri avec eux. »

A hospital social worker reported frequent problems with patients arriving with health complications because they had not taken all the prescribed drugs:

« ou ici à l'hôpital, qu'il y a des complications, on leur dit : ' mais vous avez pu prendre votre traitement ?' ' ah beh, non, je n'ai pas tout pris de ce qui avait été prescrit'. »

b. Patients wait for the next payment of their monthly allowance

It was highlighted that patients find it hard to pay for their medicines at the end of the month for chronic illnesses:

« Les patients ont du mal à boucler leurs fins de mois et donc ils ont besoin des médicaments du style pour l'épilepsie, pour le diabète, pour des problèmes cardiaques où ils doivent avoir des médicaments spécifiques. »

A social worker from an emergency service at a hospital reported a peak of patients at the end of the month. She sees some of them returning regularly. They come when they are unable to pay for their medicines and are awaiting the next payment of their social benefit. They consult the emergency service to have their medicine -often for severe chronic diseases such as epilepsy, cardiovascular diseases, or diabetes- dispensed, without immediate payment. The invoice will be sent about one month later to the patient's home:

« Moi aux urgences j'ai des pics en fin de mois de patients que je vois régulièrement parce que fin du mois c'est plus compliqué de pouvoir se payer les médicaments, et donc nous aux urgences, on délivre sur facture, des urgences, les médicaments dont ils ont besoin pour pouvoir terminer la fin du mois en médicaments spécifiques pour leur traitement. »

One interviewee reported that patients postpone the purchasing of prescribed medicines until they have received their pension:

« C'est clair que ceux qui n'ont pas d'aide du CPAS et qui doivent acheter des médicaments, qui ont beaucoup de frais pharmaceutiques, ils reportent et attendent de toucher leur pension, ils attendent le mois suivant pour acheter les médicaments. »

The interviewee stressed that she was talking about patients benefiting from all sorts of special measures, such as the increased reimbursement for healthcare costs or a subsidy from the CPAS-OCMW: some only have to pay 0.5€ or 1€ co-payment for their medicines at the pharmacy, but are unable to do so:

« 0,50 cts ou 1 €, en fonction du type de médicament, même ce genre de médicaments, ils n'arrivent pas à pouvoir se les acheter. Donc on est vraiment dans de l'accès pur à un traitement et on doit, nous, suppléer, trouver des solutions, négocier, sortir 5 € de notre poche, attendre que eux reviennent pour nous rembourser le mois d'après. »

General practitioners from a primary care centre report patients who do not purchase the prescribed medicines, due to a lack of financial resources. The patients tell the doctor during the consultation that they will postpone buying the medicine until they have enough financial

resources. The GPs sometimes provide the medicine required straight away, for free, or call the pharmacy, to buy it at the expense of the community care centre:

> *« Nous parfois, on le leur propose parce qu'on sait déjà que la personne n'ira pas les chercher parce qu'elle nous a déjà fait le coup plusieurs fois, et donc on lui dit : 'On te donnera la moitié du traitement jusqu'à ce tu puisses aller acheter' […] ou alors on a un compte à la pharmacie. On téléphone à la pharmacie afin que la pharmacie mette le médicament sur le compte de la Maison Médicale si c'est vraiment un médicament indispensable. »*

5.2.7 Medical devices

Many examples were given of people finding it hard to afford medical devices. Box 14 presents the rules on OOP payments for medical devices.

Box 14: Rules on out-of-pocket payments for medical devices

Reimbursement levels for medical devices vary greatly according to the device, the patient's condition and social situation. Usually, the compulsory health insurance provides a lump sum, and the frequency of the benefit is set.

In the case of non-implantable medical devices, bandages and incontinence material, reimbursement is limited to specific products and to patients with specific chronic conditions (e.g. for chronic wounds, particular plasters are reimbursed subject to certain conditions). Hearing aids on prescription are reimbursed. For glasses and contact lenses, the reimbursement depends on the eye defect they have to correct and the age of the insured person. Payment for glasses is provided once every two to five years, or when the sight has deteriorated to a pre-defined extent.

Implants and invasive medical devices are reimbursable if they are on a positive and regularly updated list.

For enteral nutrition at home, the health insurance reimburses daily lump sums for the administration of the enteral nutrition; the use of the equipment and the use of the pump. OOPs are estimated at 12 € per day. For parenteral nutrition at home, the co-payment is limited to 0.62 € per day. An additional 3 €-15 €/day is estimated for the equipment (Mistiaen *et al.* 2019a).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

Affordability of the equipment and enteral and parenteral nutrition was mentioned during several interviews:

> *« ce qui coûte très cher c'est la nourriture parentérale. Vous voyez, les trucs de lait là et ça, ce sont des centaines d'euros par mois. Et ça, souvent les patients ont des difficultés de payer ça. »*

The fact that patients had to pay the cost of the equipment for enteral and parenteral nutrition or for nutrition bags in advance was considered a serious issue:

- *« La firme vient déposer du matériel, des sondes, … Donc le patient parfois doit sortir 100, 150 € rien que pour le matériel. Pas pour le gavage en lui-même mais rien que pour le matériel. Et ça, peu de patients savent le faire. »*
- *« j'ai une patiente qui m'explique qu'elle va à la pharmacie chercher ses gavages tous les jours ou tous les 3 jours. […] Et je lui explique que si elle fait ça avec une firme, c'est une livraison*

au mois ou tous les 15 jours. […] Donc j'explique, en lui disant : 'Voilà, vous allez gagner pas des 1000 et des 100 mais si vous commandez et que vous les faites par 15 jours …'. Elle dit : 'Mais je n'ai pas le cash flow' ».

It was furthermore mentioned that clients sometimes re-used stoma material, and suffered infections as a result:

"… of mensen die zo sondevoeding moeten hebben, stomamateriaal en zo, die dat dan hergebruiken en infecties krijgen en ja, …"

Affordability of glasses was also frequently mentioned:

« Oui les lunettes. Ça aussi c'est compliqué. […] Ça les gens attendent et reportent alors que c'est parfois crucial dans la scolarité d'un enfant. C'est très récurrent. »

One of the patients interviewed also told us that she had not worn glasses for years, while in fact she needed them:

"Tja, ik heb al jaren geen bril terwijl ik er eigenlijk een zou moeten hebben."

The prohibitive prices of hearing aids were also mentioned:

"Hoorapparaten dat wordt ook uitgesteld. Dat is ook veel te duur."

The replacement of broken or lost items was considered as an issue for many persons, since the compulsory health insurance does not reimburse costs in such cases:

« Lunettes, prothèses, … c'est vraiment une catastrophe. Il suffit qu'il y ait un mauvais coup, qu'il tombe, qu'il chute, il casse ses lunettes. Et ça c'est la misère. Il y a des gens qui viennent, qui ne voient pas à 1 mètre, et ils n'ont pas l'argent pour se payer les lunettes donc ils attendent. »

Another issue mentioned was when patients use more material than is reimbursed. The example was given of test strips for diabetes patients. A fixed quantity of test strips are reimbursed per month, depending on the type of diabetes. A social worker in a hospital reported cases of patients who used more than the quantity reimbursed or lost part of their stock and are unable to pay the full price. In such cases the CPAS will in principle not pay either.

Some equipment is not reimbursed by the mandatory health insurance. For instance, social workers in hospitals mentioned that crutches were not affordable for some people and that they had to find creative solutions to be able to provide them for free to patients:

« Il y a des gens qui se font mettre un plâtre et qui ne savent pas prendre en charge des béquilles. Et donc nous, on est obligé de leur donner des béquilles parce qu'on récolte des béquilles un petit peu à gauche, à droite. »

The high costs of dressings were also mentioned, although now, the health insurance does provide limited reimbursement.

"Wat ook wel duur is, is verbandmateriaal. Als ze verbandmateriaal moeten hebben, dan begint het soms ook op te lopen, maar ook daar is er van het RIZIV wat tussenkomst in gekomen. Dat was vroeger niet, maar dat is nu wel."

5.2.8 Outpatient mental health services

Several interviewees working in the sector mentioned that in general, access to mental health services is highly problematic:

Interviewee 1: « Ça c'est une catastrophe ! »
Interviewee 2: *« La santé mentale, les logopèdes, les psychologues, la psychanalyse … »*
Interviewee 1: *« Les psychiatres. »*

The rules defining the OOP expenses for outpatient mental healthcare are described in Box 15.

Box 15: Rules on out-of-pocket payments for outpatient mental health services

The mental healthcare system is highly fragmented. A broad range of responsibilities is devolved to the federated entities.

Ambulatory mental healthcare can be provided in community mental healthcare centres - organised and funded by the federated entities - or is provided by individual psychiatrists and individual psychologists, in which case it is reimbursed by the health insurance system. The health insurance reimburses a maximum of 8 consultations with a psychologist per year, and the standard user charge is 11 € per session, or 4 € for those entitled to IR. Some categories of people may be exempted.

For a psychiatric consultation, the above-mentioned user charges for specialist care apply.

There are several other services, such as mobile teams, day care centres, addiction care, suicide prevention services etc., providing ambulatory mental healthcare services, all subject to a specific regulatory framework, funding rules and objectives (Mistiaen *et al.* 2019b).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

A field worker stressed that the recent reform, providing reimbursement of a limited number of sessions for psychological care, is not adequate for people with serious mental health problems, since they need long-term psychological support:

"En wat er nu uitgewerkt is, van dat aantal consultaties voor bepaalde problematieken, dat is niet voor die mensen. Want die mensen die hebben een chronische psychische problematiek, waarvoor niet direct na 4 sessies een oplossing is, maar een hele lange ondersteuning nodig is. Voor die mensen vind ik het echt een heel groot probleem."

Chronically ill patients interviewed postponed mental healthcare due to financial reasons. They mentioned out-of-pocket payments of 60 to 70€ for psychotherapy (from non-contracted providers) and 1,140 € for a multidisciplinary diagnosis for which only the medical act is reimbursed:

"Ik stel geregeld psychotherapie uit, want Maggie de Block denkt dat dat 45 € per keer is, maar dat is eerder 60 tot 70 € per keer, waar dat je niets van terug trekt."

5.2.9 Hospital care

For hospital care, issues have been raised on advance payments, high OOPs and transportation costs for intra-hospital transfers. Important access hurdles to care for patients with payment arrears in the hospital were stressed by many interviewees. Finally, it was highlighted that patients in a vulnerable situation often are not aware of the financial consequences of the choices they make during hospitalisation. Box 16 describes the rules defining the OOPs for hospitalised patients.

Box 16: Applicable rules on out-of-pocket payments for hospital care

For hospitalisation with an overnight stay in a general hospital, different user charges apply per admission and per day, depending on the length of stay, the room and the reimbursement status of the insured person:

Lump sums per admission are: 43.52 € for hospitalisation; 7.44 € for clinical biology; 6.20 € for medical imaging and 16.40 € for medical guards and medical-technical services. IR patients only pay 5.77 € for hospitalisaton and 2 € for medical imaging. Room supplements may be charged for single rooms.

- For most medical acts, user fees apply. For some of these acts patients with IR may be be exempted, for others not ([81]).
- User fees may apply for physiotherapy, implants, prostheses and medical devices. For implants, no distinction is made between patients with IR status and others ([82]).
- From the second day onwards, user charges per day are 16.25 €. People entitled to IR pay 5.77 € per day.
- A daily lump sum of 0.62 € is due for reimbursable medicines.
- Non-reimbursable pharmaceutical products and medical devices used during hospitalisation are fully charged to the patient.
- In psychiatric hospitals, the same daily rates for hospitalisation and a daily lump sum of 0.80 € for reimbursable medicines apply. For a stay of more than 5 years, the daily rate for hospitalisation increases.

For one-day hospitalisation, no user charges per admission or day apply, and no lump sum for reimbursable medicines is charged. Nevertheless, supplements may be charged for single rooms.

The hospital can ask for an advance payment of a maximum of 150 € per week in hospital for people with standard insurance and 50 € for IR patients. For patients who have not paid their contributions to the compulsory health insurance, the hospital may ask for higher advance payments. However, admission to a double or shared room cannot be refused if the patient is unable to afford the advance payment.

Supplements on doctors' fees (Box 8) can only be billed for patients who opted explicitly for a single room, both for a one-day hospitalisation and in the case of hospitalisation with an overnight stay. Upon admission to the hospital, patients have to sign a form declaring that they are aware of the financial consequences of their choice of a single room.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

5.2.9.1 Advance payments and high OOPs

A GP explained that people postpone hospitalisation because they fear the bill. Often, the centre contacts a social worker at the hospital beforehand, asking them to sort out the financial details with the patient before hospitalisation, to reduce the hurdle.

Many interviewees mentioned that OOPs for hospitalisation may be very high for some patients. Cases were reported cases of people who postponed necessary surgical interventions, including for cancer treatment:

81. Information provided by the NIHDI services, 8 June 2020.
82. Information provided by the NIHDI services, 8 June 2020.

"Kankerpatiënte, alleenstaande moeder, die met haar inkomsten wel boven de minimumgrens zat, goed boven de minimumgrens. Maar die moest veel aan haar huis afbetalen. En die heeft toen moeten uitstellen om de lymfeklieren in haar arm te laten opereren zodanig dat ze die zwellingen niet meer had. Die heeft dat heel lang moeten uitstellen [...] om financiële reden"

Examples were also provided of people in debt due to hospitalisation costs:

« Mais ça va très vite, souvent on voit des gens en situation de surendettement à cause de factures d'hôpitaux. Des petits montants, et qui deviennent astronomiques, avec les frais de rappel, les frais d'huissiers. »

OOPs for hospitalisation, in a shared ward, mentioned during the interviews, ranged from 750 € for someone with IR status to 4,500 €. Some examples were provided of high hospital invoices, for patients with long hospital stays, in particular in the intensive care unit:

- *« Ils étaient en chambre commune et là, ils doivent payer 3000-4000 €. [...] Je pense notamment aux trachées et cancers de la gorge, vous voyez, où ils restent longtemps en soins intensifs. Ils restent presqu'un mois parfois à l'hôpital. »*
- *« Madame se souciait fort de la facture d'hospitalisation qu'elle allait avoir. Et là, je me rappelle qu'elle montait à 2300 €. C'était un long séjour en soins intensifs avec deux interventions cardiaques. La dame se disait : 'Comment je vais faire pour cette facture ?' Elle était anéantie. »*

Professionals interviewed mentioned that advance payments are a hurdle for some patients:

"Ingrepen die moeten gebeuren, waar sommige ziekenhuizen voorschotten voor vragen [...] Dat is zeker een drempel voor mensen omdat die dat geld gewoon niet hebben opzij staan"

Highly problematic total advance payments due by patients with long hospital stays were frequently mentioned. The rate is 150 € per week for patients without IR status. One example related to a person who did not accept to undergo a cardiac treatment due to high advance payments. The other one was about a family with newborn twins who needed intensive neo-natal care for several months:

- *« Une opération cardiaque, il y a le passage aux soins intensifs, […] la quote-part patient de la partie hospitalisation, ça coûte de nouveau 150 € par semaine 'Ah beh non, ça ne va pas être possible ! Alors ça fait 600 € par mois ?', 'Oui', 'Ah beh non, beh je vais rentrer chez moi alors.' »*
- *« Et on a des fois, 1 ou 2 petits loulous qui sont en soins intensifs pendant 2-3 mois à 150 €»*

The high burden of prosthesis costs is also often mentioned, even for patients with IR status. Moreover, patients are not always aware of the cost of the device being suggested:

Interviewer: « Donc y compris les personnes avec le statut de bénéficiaire de l'intervention majorée ? »
Interviewee: « Oui, de l'intervention majorée. Parce que quand ce sont de grandes opérations, parfois il y a des implants ou des éléments où la mutuelle n'intervient pas beaucoup pour ça. »

An example was given of an elderly woman on a low income who was hospitalised for heart problems. The doctor proposed a synthetic solution that was new and not yet covered the compulsory health insurance. The out-of-pocket payments amounted to 20,000€. The woman had not properly understood the financial consequences of the option proposed.

According to an interviewee from a CPAS/OCMW, substantial extra costs are billed to patients for one day hospitalisation, above the tariffs set by the NIHDI:

> *« Non, il y a une partie qu'on appelle one-day qui est un montant particulier, qui n'est pas remboursé par l'INAMI. Et généralement qui est quand même assez conséquente. Quelques centaines d'euros. »*

5.2.9.2 Patients with payment arrears from past hospital stays

If patients are unable to pay their hospital bill, the payment can be divided into several instalments. Usually, a payment plan is drawn up. As a consequence, some patients postpone hospitalisation because they still owe money from a past hospital stay:

> *« Et donc on comprend qu'il y ait des gens du coup qui hésitent à se faire hospitaliser parce qu'ils ont parfois encore une dette d'une hospitalisation précédente. [...] Ici, j'ai encore eu une dame, elle sait qu'elle va être ré-hospitalisée, elle va seulement reprendre un 2ème étalement de paiement pour sa 2ème facture et elle était seulement en train de payer la 1ière. »*

Furthermore, it was frequently reported that some hospitals refuse to treat patients with payment arrears:

- « Donc on a beaucoup de patients qui sont dans ce problème-là et donc on dit : 'il faudrait une opération mais ce sera quand vous aurez réglé votre contentieux'. »
- « On ne l'a pas opéré parce qu'elle devait payer 90 €"

Several health professionals interviewed mentioned that patients with financial problems or payment arrears may be transferred to another hospital, for non-urgent care and after the patient's situation is stable. In particular, patients are transferred from private to public hospitals:

> *« Par exemple, on a parfois des gens qui viennent, qui ont dû avoir une broche en urgence. Mais ce n'est pas urgent de la retirer. Et donc ils ne peuvent pas retourner dans cet hôpital privé pour l'enlever, donc ils viennent chez nous parce que chez nous ils peuvent. »*

A physician working in a private hospital told us that children may be transferred to another hospital, because a doctor refuses to operate on a child who does not have private health insurance:

> *« Qu'un médecin, ça existe encore, ne veuille pas l'opérer parce qu'il n'a pas d'assurance privée. Mais si l'enfant doit être opéré, il sera opéré. Pas dans mon hôpital mais … »*

General practitioners explained that they suspect that hospital doctors perform fewer medical examinations on patients with payment arrears or who may find it difficult to afford a hospital stay:

> Interviewee 1: *« Quand il est à l'hôpital, on lui dit que cet examen-là ce n'est pas pour lui car le montant devient trop grand. Donc ils n'ont pas fait d'examen diagnostic. Car on sait que la facture devient trop grande et qu'il ne la paiera pas. […] »*
> Interviewee 2: *« Oui, c'est ce qu'on remarque. »*
> Interviewer: *« Vous voyez ça plus fréquemment ? »*
> Interviewee 2: *« Ouais de plus en plus. »*

5.2.9.3 Transportation costs for intra-hospital transfers

The costs for transfer of a patient between two hospitals are borne by the patient or his voluntary health insurance. However, no transportation costs may be charged to the patient for:

- transport between different sites in the same hospital network;
- a return trip on the same day between two hospitals for an additional examination or treatment that is not available in the first hospital.

Two examples were mentioned of transportation costs which were charged to the patients. The first example was when there was no suitable healthcare professional available in the first hospital to operate on the patient. And the second example was when the hospital could not provide the right treatment to a newborn baby with a rare disease. This baby had been transferred with a medicalised transport many times for the appropriate treatment in another hospital. As the patients were not transferred back to the first hospital within 24 hours, the full transportation cost was charged to the patient. The amounts were high (about 500 and 700 € respectively):

> *« J'en ai encore eu un la semaine passée avec un enfant, on le transportait à X, au départ de chez nous parce qu'il avait une appendicite perforée. [...] je crois que c'était 500 ou 600 € d'ambulance, pour le transporter de chez nous à X et il n'y a pas d'intervention [...] Il n'y avait pas de chirurgien pour l'opérer chez nous donc on l'a transféré à X. »*

It was also mentioned that, if the hospital where the patient has been taken by the emergency ambulance does not have the required specialists, the patient is transferred, after his condition has stabilised, to the right hospital. He has to pay for this transfer:

> *« Le problème c'est qu'on fait des hôpitaux de plus en plus spécialisés. Si vous arrivez en urgence dans l'hôpital où il n'y a pas justement la spécialisation, la facture d'ambulance sera à votre charge. Alors que ce n'est pas vous qui avez demandé à aller là puisque l'ambulance est obligée de vous amener dans l'hôpital le plus proche. »*

5.2.9.4 Incorrect invoice

An example was provided of a patient who received an incorrect invoice and where, after the social services got involved, the hospital agreed to correct the invoice.

An interviewee mentioned the case of a person with an invoice of 3200 €, where tariffs had been applied for a single room, while the client could prove that he had signed a declaration asking to be in a shared ward. After intervention by the social service, the hospital agreed to adapt the invoice.

5.2.9.5 Lack of information on the financial consequences of choosing a single room

Social workers mentioned several clients, with IR status, who were hospitalised in a single room without being informed about the consequences of their choice. As a result, they had very high bills (1000 €):

> *« J'ai des exemples de personnes avec un système majoré, qui sont normalement un peu protégés et qui sont mis en chambre seule, avec un docteur non conventionné. Après cela ils*

reçoivent une facture de 1000 €. Pourtant ils sont au courant que c'est une personne qui bénéficie d'un système majoré. Ils ne lui ont donné aucune information. »

Interviewees mentioned that patients sign the consent form without being properly informed about the consequences, at a time when it is difficult for them to seriously consider the impact of signing the form.

- *« Oui mais monsieur, il a signé le document. Parce qu'il est présent et qu'il est peut-être encore sous l'effet des médicaments. Oui, il a signé quelque chose. »*
- *"Met een opname, ja soms is dat iets heel dringend, 'wil jij op een kamer alleen?' 'Ja', en het is gebeurd. Je kan er niet meer op terugkomen. Je hebt getekend."*

People may also wrongly think that their policy covers the cost of a single room, while in fact they are only covered for the user charges in a shared ward. This may have dramatic financial consequences:

"En het gevolg is ook dat mensen die in een éénpersoonskamer liggen, die mogen geen afbetalingsplan vragen voor die rekening. [...] Ik had eens een mevrouw van Marokkaans origine. Die had ernstige brandwonden en is dan opgenomen in het ziekenhuis. Die mensen dachten: hospitalisatieverzekering, het is in orde. Onze moeder heeft rust nodig en wij moeten met de familie kunnen komen en met ons eigen eten. En die hebben een ongelofelijke hoge rekening gehad, verschrikkelijk."

For one-day hospitalisation, several interviewees pointed to the lack of information on the choice of a single room.

One respondent explained that some patients wrongly assume that in the case of one-day hospitalisation they are automatically hospitalised in a single room. They do not realise that they have actively chosen a single room. They then receive a bill of 1000 € after the event. She reported that the supplements for a single room in one-day hospitalisation have substantially increased in recent years:

"Sommige mensen denken dat dat sowieso een éénpersoonskamer is. Als ze dan zeggen een éénpersoonskamer? Ja, ok. Voor een daghospitalisatie is er een remgeld van 1000 € voor een dag ([83]). Dat vind ik wel enorm verhoogd de laatste jaren. Vroeger had ik, ik werk hier nu 33 jaar, bij daghospitalisatie de indruk dat dat altijd dezelfde prijs was."

Examples were also given of older persons spending one day in hospital who received an invoice for a single room. According to an interviewee, one of these patients declared that he had not even been in a room, he had stayed in the corridor.

5.2.10 Post-treatment after hospital discharge

5.2.10.1 Medicines and wound care

Various types of healthcare (e.g. physiotherapy at home), health material or products may be necessary (e.g. medicines, mobility equipment, plaster and bandage for wounds) after a patient is discharged from hospital.

83. The interviewee refers to the 1000 € bill as a user charge. However, this is not correct; it may be a bill for the total OOPs, including devices used; room supplements and fee supplements.

Social workers mentioned cases of patients who are re-hospitalised because they had been unable to buy essential medicines. An example was given of a child who was having epileptic fits for not taking his medication.

A social worker mentioned several cases of diabetic patients who cannot afford wound care and physiotherapy at home after amputation of a toe, and as a result, have to be re-hospitalised. For some, this ended with the amputation of a leg:

> *« Et donc on se retrouve avec des complications médicales, des gens qui doivent se refaire hospitaliser en urgence parce qu'ils n'ont pas pu faire de la kiné ou des soins infirmiers et ils reviennent avec des plaies monumentales aux urgences. [...] j'ai vu des patients à différents niveaux, on a commencé à amputer un orteil, puis ils sont rentrés à domicile. Mauvais soins, pas de soins de plaies, pas de kiné. Ils ont rien fait, … Hop ! Retour aux urgences ! [...] Gangrène machin ! Hop ! On coupe tous les orteils. Et puis, après qu'est-ce qu'on fait, on coupe une partie du tibia. Il y a des gens qui ont perdu une jambe, juste parce quand ils sont rentrés à domicile, ils n'ont pas pu avoir des soins. »*

An interviewee working in a hospital gave the example of a patient who had to return daily to the hospital for wound care after surgery because he could not afford wound care at home. After three months, he was unable to continue to pay for his wound care at hospital, which costed him between 11 and 16 € per day - mainly the cost of the plasters, which are not included in the benefit package. The social worker arranged for the CPAS to subsidise the costs:

> *« Il (le patient) lui dit : « Ecoutez, aujourd'hui, je ne peux pas payer la consultation. Je ne peux pas payer les soins. » [...]. J'arrive. Je m'aperçois en fait que le patient a eu deux hospitalisations avec les frais d'hospitalisation, enfin les quote-parts, … les acomptes patient et que depuis 3 mois et demi, tous les jours en consultation, il doit payer entre 11 et 16 € pour ses soins. Pour des pansements en fait, pour des plaies. […] Il n'a pas fait appel aux soins à domicile, à l'infirmière à domicile parce que cela lui coûtait. Et donc ce sont des soins où tout le matériel qui est utilisé n'est pas remboursé. C'est le matériel pour faire ces soins qui coûte. »*

5.2.10.2 Fee supplements

A respondent highlighted the consequences for patients who are brought to the nearest hospital by the emergency service. During their hospital stay in a shared ward they do not have to pay fee supplements, but after discharge, the doctor who was responsible for their care, who is not contracted, may charge high fee supplements.

> *« C'est un centre d'urgence, il est proche. On envoie là-bas mais … Quand vous êtes hospitalisé, si vous êtes en chambre commune, ça va, parce que … Mais alors, après si vous avez un suivi, vous devez retourner voir le Dr X, et puis on se rend compte que le Dr X n'est pas conventionné. »*

5.2.10.3 Transportation costs

Non-urgent transport is reimbursed in specific cases. For ambulatory patients who have had chemotherapy or radiation therapy (+ follow-up consultations) and for patients undergoing renal

dialysis in a dialysis centre, transport is reimbursed up to 0.25€ per km (for a maximum number of kilometres). Costs of public transport are fully reimbursed ([84]).

A GP from a primary care centre told us about people who need physiotherapy after hospitalisation, but are unable to afford transport to the physiotherapist:

> *« Il y a parfois des gens qui ne font pas par exemple de kiné alors qu'ils devraient en faire à la sortie de l'hôpital parce qu'ils ne peuvent pas se payer le transport et qu'on n'en trouve pas nécessairement dans leurs campings ou dans leurs coins qui se déplacent aussi. Donc voilà. Ça c'est une réalité qu'on vit sur le terrain. »*

High costs for transportation back to the hospital for post-treatment were often mentioned during the interviews, in particular for severe health issues: chemotherapy, radiotherapy and renal dialysis. Interviewees provided examples of patients in bad health who have to take public transport to the hospital:

- *« J'ai fait une demande pour un patient (en chimiothérapie) qui habitait pas très loin de l'hôpital [...] 9 € l'aller, 9 € le retour. 18 € pour 2 transports [...] pour un vieux couple en ordre de mutuelle mais qui a une pension minimum et qui ne savent pas payer. Et ils viennent tous les jours, tout doucement avec leurs petites cannes en métro. La dame qui tient le monsieur. »*
- *« Dat zijn kosten als mensen dagelijks radiotherapie moeten volgen. En zij hebben geen familie of vrienden die hun tot daar voeren. En dan gaan mensen soms toch tot het uiterste om met het openbaar vervoer tot daar te geraken. Maar soms leidt dat ook wel tot schrijnende toestanden vind ik".*

Outside the big city centres, transportation costs are even higher. One interviewee mentioned OOP for transport costs of up to 135 € a week:

> *« J'ai eu récemment encore un patient, 60 € par trajet aller-retour, trois fois/semaine. 180 € par semaine fois quatre. Alors même s'il y a une petite intervention de l'INAMI qui est compris, et parfois de l'assurance complémentaire de certaines mutuelles et pas toutes, les patients restent quand même à débourser 40-45 € de sa poche. »*

5.3 Other hurdles

5.3.1 Hurdles related to availability

5.3.1.1 Lack of availability of specific healthcare services

Shortage of specific healthcare services was mentioned by several respondents. This includes a lack of contracted providers in some specialties, a lack of community primary care centres, and the shortage of mental healthcare services. In the event of a shortage, waiting times can increase substantially and people who can afford it will turn to the private sector, paying all the care out-of-pocket (for instance in mental healthcare) or paying fee supplements.

84. The health insurance also subsidises transport costs for: rehabilitation for wheelchair patients and minors and for parents of a minor cancer patiënt who is hospitalised.

Many interviewees mentioned the lack of access to mental healthcare services due to long waiting times. In particular, this was true for psychiatrists, psychiatric institutions and centres for mental healthcare:

- *« Les listes d'attente, en psychiatrie surtout, c'est dramatique. Si on doit hospitaliser quelqu'un, c'est quasi impossible. Si on doit trouver une consultation, pour un patient qui n'est pas déjà suivi, c'est quasi impossible. C'est un secteur extrêmement difficile d'accès. »*
- *"Omdat de Centra voor Geestelijke Gezondheid, waar ze wel rekening houden met de inkomens van de mensen, die zijn ook volledig verzadigd."*

Long waiting lists in ophthalmology were also highlighted by many healthcare professionals interviewed, and waiting times in dermatology and gynaecology were also flagged:

> *« Il y a des listes d'attente. Ophtalmo, dermato, psychiatrie, gynéco… Ca ce sont vraiment des spécialités où c'est très dur. »*

Waiting lists -up to two years- to register with a primary care centre were highlighted by several health professionals, as well as the fact that these centres are concentrated in some areas of some cities. Patients who do not have access to a primary care centre have to rely in the meantime on GPs working on a fee-for-service basis:

> *« Et donc si t'es nouveau dans un certain quartier, ils vont te dire d'attendre deux ans et être dans une liste car ils n'ont plus de place. »*

And finally, the lack of availability of physiotherapists willing to provide home care services was mentioned by several social workers:

- *"Parfois, je dois sonner à 10 kiné pour en trouver un qui se déplace à la maison."*
- *"En die kinesisten komen niet meer aan huis, dus de mensen moeten zich nog verplaatsen, wat dan ook al moeilijk is."*

5.3.1.2 Healthcare centres which are difficult to reach

Several examples were provided of healthcare services which were difficult to reach. Most of these have been discussed in Section 5.2.10.3 on transportation costs.

Additional examples were provided of GP out-of-hours duties, organized in a centralised GP post. Our interviewees mentioned that a hospital emergency service was closer than the GP post and, therefore, patients went to the hospital:

> *"Spoedafdeling X is veel dichterbij dan huisartsenwachtpost Y."*

Patients interviewed pointed out how difficult it was to reach the GP post. A patient mentioned that the closest GP post, established in the proximity of the regional hospital, was 20 km from her home and barely reachable by public transport:

> *"Het is allemaal in X [...] het zal ongeveer 20 kilometer zijn. (…)Het is nauwelijks bereikbaar met het openbaar vervoer. Je moet een trein en een bus nemen, wil je daar geraken. Dat is een dagtaak om daar even op visite te komen bij een dokter."*

5.3.1.3 Discrimination and refusal to treat less well-off patients

One interviewee from a social service pointed to a potential perverse effect of the existence of the community primary care centres: GPs working on a fee-for-service basis refused to treat people in a precarious financial situation and thus they all ended up in the primary care centres:

> *« Donc toutes les personnes en séjour illégal, toutes les personnes en situation de précarité, de pauvreté, etc, les gens à la rue se sont retrouvés à un moment donné massivement en maisons médicales parce qu'il y a des médecins qui ont dit qu'ils ne voulaient plus de cette clientèle. »*

A GP working in a primary care centre reported that patients living in poverty are treated differently by health professionals in the hospital: professionals do not listen to them, do not explain and do not examine them properly:

> *« L'accès aux soins des familles en situation de précarité [...], dans les hôpitaux, elles sont prises en charge différemment. Ces familles sont prises en charge différemment par les soignants. Pas par tous, mais c'est quand même générale. Beaucoup de personnes nous disent : « J'ai été mal reçu, il ne m'a pas écouté, il m'a jugé, il a pris mon papier du CPAS et il s'est exclamé : 'Encore du CPAS !' ». Donc le fait d'avoir cette étiquette CPAS est stigmatisant. On ne leur explique pas. On décide pour eux qu'ils ne comprendront rien et donc, on ne les examine pas. Ils ne sont pas pris en charge comme ils devraient l'être. (…) Un spécialiste par exemple ; un orthopédiste, … »*

5.3.2 Hurdles related to acceptability

Many interviewees stressed that, for people in precarious situations, financial hurdles may be intertwined with other barriers, causing them to postpone healthcare.

5.3.2.1 Cultural barriers, health behaviour and health literacy

People living in severe poverty may have a very different attitude to seeking medical help. They may postpone healthcare, waiting until their situation is very serious, may fear pain or the diagnosis, find it hard to plan and keep appointments:

> *« La culture de la santé a quand même une grande part dans la façon de demander des soins. Ce n'est pas que financier. Il y a aussi la peur, le fait de ne pas y penser, le fait d'attendre que cela soit très grave ou d'avoir très mal ou de voir quelque chose avant de demander un accès. »*

People in a precarious socio-economic situation may not contact the healthcare provider to whom they are referred, and if a medical appointment is made, they may not keep it. It was suggested that planning an appointment longer in advance may be a hurdle for people who live from day to day:

> *« Oui si c'est dans 15 jours, ils n'iront pas forcément. Même si c'est gratuit, c'est vrai que soit il oublie, soit … »*

They may downplay their health problems, because they are used to having all sorts of difficulties:

> *« Ce qu'il y a c'est que les personnes quand elles sont fort précarisées comme ça, elles ont l'habitude que ça foire pour le moment et donc elles banalisent ça aussi [...] et puis à un*

moment on voit qu'en fait les gens ont juste baissé les bras d'office et donc que si ça ne va pas, ça ne va pas. »

They may not understand the seriousness of their medical condition and the need for a medical examination:

- *« Si nous, on demande une analyse d'urine pour un enfant, c'est que c'est important. Pourtant c'est difficile de l'obtenir [...] Et ça c'est un des problèmes qu'on a. C'est que nous estimons que c'est important et pas aux patients d'estimer l'importance. Donc parfois, on est vraiment décalés par rapport à ce que nous pensons et ce qu'eux pensent. »*
- *« quand j'insiste : 'Tu exagères. J'ai d'autres choses à faire. J'ai d'autres problèmes.' Ils trouvent des excuses pour justifier pourquoi ils n'ont pas fait un examen demandé depuis 3 mois. »*

Children living in such circumstances do not usually go to the dentist's, in spite of the fact that dental care for children is free. Family habits, culture and fear were mentioned as obstacles: if parents are not used to going to the dentist, and to brushing their teeth, they do not take their children either:

They may feel uncomfortable in the unfamiliar setting of the health service, with doctors speaking to them in a way they are not used to or who treat them disrespectfully. They may not dare to complain or to ask questions:

- *« Quand ça fait un an que t'essaies de te motiver pour aller faire cet examen et tu arrives, la personne ne te dit même pas bonjour. »*
- *« Parce qu'ils n'ont pas osé poser la question ou parce que le docteur était distant. »*

Social workers highlighted that newcomers and non-EU migrants are often not familiar with the concept of family doctors and primary care:

- *« il y a beaucoup de nouveaux arrivants et qui ne connaissent pas le concept qu'est d'avoir de médecin traitant. [...] Tu leur demandes : « Quel est votre docteur de famille ? », « Pas de docteur de famille ». Ça veut peut-être aussi dire qu'ils ne sont jamais traités ou qu'ils vont toujours en urgence pour n'importe quel problème. Ça on voit aussi. »*
- *"Heel vaak mensen van andere culturen… hebben toch wel zoiets van, toch de landen waar zij van komen, is een eerste lijn niet zo gekend. Alleen maar de clinics. De oplossing zit hem ook alleen maar in echt medicatie of echt een operatie, een operatie moet het goed maken"*

5.3.2.2 Digital literacy

Administrative and digital hurdles to accessing healthcare providers were also highlighted. For instance, having to make online appointments was considered as a barrier leading to people postponing healthcare, for instance for GP care.

5.3.2.3 Language issues

It was reported that hurdles were greater when people do not master the language. They may not understand the administrative procedures they have to follow. Also, a medical consultation becomes problematic if they are unable to ask questions or do not understand how to use public transport to reach the hospital, etc.:

- *« C'est la lourdeur administrative pour ceux qui ont droit mais qui ne connaissent pas la langue. »*
- *"En wat we ook merken [...] is waarom die mensen soms moeilijker kunnen doorstromen, zelfs al verwijzen we door, een brief mee, en wordt er een afspraak gemaakt, is de taalproblematiek. Ze kunnen zich absoluut niet uitdrukken of nog een bijkomende vraag stellen of ze geraken er soms niet, de mobiliteit [...], ze weten niet welke bussen."*

5.3.2.4 Mental health problems

Many interviewees mentioned that people with mental health problems are likely to postpone healthcare:

> *« Et puis, il y a des gens qui ont peu d'argent, mais qui ont aussi un contexte de, ce qu'on appelle 'psycharité'. Pour eux, c'est vraiment difficile de se projeter dans l'avenir, ne fut-ce que dans 15 jours. Du coup, ils vivent au jour le jour et souvent ils ne suivent pas. »*

Some professionals highlighted the interplay between financial problems and mental health problems. People may not have the energy to complete the administrative procedures. Administrative problems may lead to delays in payment of social benefits, which may push persons with fragile mental health into depression:

- *« Alors vous avez les gens fragilisées au niveau social et avec des profils plus psychiatriques. Par exemple, des dépressions, on décroche pendant 3 mois et on n'ouvre plus son courrier, schizophrénie. Les gens qui ont des problèmes d'assuétude, l'alcoolisme et autres. Parfois les familles monoparentales, où on fait une dépression et on ne s'en sort plus. Et on ne prend plus rien à bras le corps. [...] c'est souvent une conjoncture d'éléments. Vous avez un problème, vous sombrez. »*
- *« Et puis, il y en a d'autres, parce qu'il y a un accident de parcours, par exemple avec un employeur qui ne vous remplit pas bien vos papiers. […] Et vous avez des gens comme ça, qui tournent pendant un ou deux mois, et puis qui commencent à être tout à fait déprimé, puis qui ne savent pas réellement se soigner parce qu'ils n'ont pas de sous donc … »*

But people with mental health issues also face other problems accessing healthcare. GPs in a primary care centre mentioned that these patients frequently find it hard to keep important medical appointments, lose their papers, did not note down the time of the appointment:

> *« Et alors, quand on a enfin le rendez-vous, justement le patient ne va pas bien du tout ce jour-là et ne va pas à son rendez-vous. [...] ou ils perdent leurs papiers de rendez-vous ou ils n'ont pas d'agenda, ils n'ont pas noté. »*

5.3.2.5 Caring responsibilities for children or partner

Some social workers provided examples of single mothers and elderly persons who postponed hospitalisation because they did not have anybody to take care of their care-dependent partner or children during their absence:

> *« J'en ai eu, des familles monoparentales qui ont reporté leurs soins parce qu'ils n'avaient pas la possibilité de faire garder leurs enfants. »*

5.3.2.6 Lack of suitable housing to properly recover after hospitalisation

We were told of a homeless woman who could not receive the appropriate treatment because of a lack of housing to recover. She needed surgery on her shoulder. The surgeon did not wish to operate because she would have pins after the operation, and therefore needed to be cared for in proper conditions after the operation. She furthermore needed substantial dental care which she cannot afford:

> *« Il faut qu'elle ait un domicile, qu'elle soit dans de bonnes conditions pour que l'opération soit réussie. [...] Et donc cette dame vit avec une fracture. Elle vit avec une fracture et elle est bourrée d'antidouleurs ! Elle [...] est au CPAS, et qui ne peut pas se faire opérer quoi ! Non seulement des dents mais en plus de l'épaule. »*

5.4 Strengths and weaknesses of provisions to improve financial access to healthcare for vulnerable groups

In this section, we discuss the measures to improve financial access to healthcare for vulnerable groups that were discussed during the interviews. These include: the increased reimbursement status; measures for chronically ill patients; the financial support provided by the CPAS/OCMW; the role of other social services and finally, the services provided by sicknes funds and complementary health insurance. We discuss the maximum billing system in Section 6.3.2, and Box 19 provides a description of the scheme. However, we do not discuss it in this section, since it was barely raised during our interviews as an instrument to improve access to healthcare for vulnerable groups.

Several healthcare professionals interviewed pointed out that the measures to ensure access to care for vulnerable groups helped to considerably improve access to healthcare:

> *« Je trouve que les usagers qui sont en ordre de mutuelle, (…) je dirais que depuis qu'il y a eu le maximum des forfaits autorisés et les primes des maladies chroniques, il y a quand même les usagers qui sont bénéficiaires des interventions majorées, ce qu'on appelait l'ancien VIPO, et qui vont en chambres communes, bien sûr, là je trouve que la couverture est … Ce sont des mesures qui ont beaucoup aidé les gens. »*

5.4.1 The increased reimbursement status

As explained in Box 6, some categories of people covered by the compulsory insurance qualify for increased reimbursement levels, and thus pay lower user charges.

Overall, IR status is recognised as an important financial measure which substantially helps low-income patients to access healthcare. However, various issues related to this status were raised during interviews.

5.4.1.1 Affordability of the remaining user charges

Individuals in a very precarious economic situation may sometimes have difficulties affording the relatively small remaining share they have to pay. A GP working in a primary care centre told us that, some years ago, when their centre had not yet received a lump sum to provide care free at the point of use, patients were sometimes unable to pay the user charge of 1€:

« Parfois on leur disait : 'La consultation revient à 1 €' et eux nous répondaient : 'Non, je ne sais pas payer 1 €' Parfois les gens ne pouvaient pas. »

And crucially, in cases of hospitalisation, the status does not provide sufficient protection against high additional costs charged to the patients, as highlighted in section 5.2.9

5.4.1.2 Non take-up

People who would be entitled to IR status, but do not automatically receive it (see Box 6), do not always apply for it.

Social workers interviewed explained that their first job is to check whether their clients are receiving all the benefits to which they are entitled, including IR status:

« Par exemple, quelqu'un en incapacité de travail qui rentre dans les matières du BIM, on doit vérifier s'il n'a pas droit au BIM et on va faire de la proactivité et on va le dépister. »

One interviewee taking part in the group interview of patients with chronic illnesses mentioned that a member of the same patient advocacy group, but who did not attend the interview, missed out on two years of IR status, because she did not know that she had to apply for it herself:

"X heeft twee jaar verhoogde tegemoetkoming gemist, omdat ze niet wist dat ze het zelf moest aanvragen."

A healthcare professional interviewed stressed that some people, in particularly when they are in a difficult social or psychological state, do not submit the forms required as proof of income, even after many reminders. As a result, they lose their rights:

« Vous avez des gens, il faudrait courir derrière eux tout le temps et vous faites un rappel, deux rappels, trois rappels … Vous avez des gens qui sont plus fragilisés socialement, psychologiquement, qui ne perçoivent l'importance de tout ça. »

A social worker reported that some persons had difficulties to provide the required documents:

« Mais si vous voulez le système majoré et vous ne savez plus précisément ce que vous avez fait l'année passée ; avoir travaillé 2 mois puis être resté comme ça, avoir déménagé 2-3 fois … Ce sont des choses que les personnes en situation précaire font. »

An example was also provided of (single parent) families where grown-up children, who are insured as dependents, do not provide their parent with the necessary documents on their income to fill out the application:

« Vous avez aussi, dans les familles monoparentales, un grand adulte qui ne fait rien mais qui ne donne jamais les pièces à sa maman ou à son papa pour remplir les documents, parce que : 'Oooh, je ne sais pas où j'ai mis … ', ça aussi, on a … »

After submitting their application, insured persons have two months to provide formal proof of their income. If they are unable to provide all the documentation within this period, they have to re-submit an application for IR status. Any retroactive rights only apply from the time of the second application, and they lose their rights for the period between the two applications. Interviewees from different social services said that the deadline for submission of the administrative documents is too tight for vulnerable people, and particularly for people in a precarious employment and housing situation. People in precarious housing may lose letters if,

for instance, they have no individual post box. Migrants may also not be used to keeping all the official documents they receive. In such situations, it may take longer to collect all the required documents:

- *« Mais 2 mois pour certaines personnes, c'est peu. Une personne qui a un emploi précaire et qui travaille avec 4 interims différentes, certaines personnes n'ont pas cette notion qu'en Belgique, on conserve certains papiers administratifs pendant 5 ans et d'autres pendants 7 ans. Certains reçoivent les papiers et les jettent et d'autres, vivant dans des logements sociaux ou des logements des Marchands des sommeils, il y a plusieurs boîtes aux lettres, la personne ne reçoit pas toujours son courrier. »*
- *« Vous n'imaginez pas le nombre de personnes qui arrivent trois jours après les deux mois. On doit renvoyer une déclaration sur l'honneur parce qu'en fait c'est lié au registre de la population et que ce n'est valide qu'un laps de temps. »*

The complexity of the administrative procedures for retaining entitlement to IR status was also highlighted ([85]):

> *« C'est la charge administrative qui est parfois très compliquée pour pouvoir rien que, passer du statut de, beh ; on va dire en 2018, j'étais bénéficiaire d'intervention majorée, j'étais BIM. En 2019, ça revient. Ils ont un certain délai pour rentrer de nouveau les papiers. S'ils ne les rentrent pas à temps, ils vont rester assurés obligatoires et plus BIM. Toute l'année 2019, ils vont accumuler, s'ils ont une petite pension, des frais. »*

5.4.1.3 People just above the threshold

There is no progressivity in the financial benefit provided through the IR. People just above the threshold for IR status thus have to pay the full user charges. Many interviewees stressed that these people lose important protection against high healthcare costs.

One respondent explained that the lower middle class who are not eligible for the most important protection measures, including the IR and the social maximum billing, may find it particularly difficult when they have unexpected high healthcare expenditures:

> *« La petite classe moyenne a le plus difficile quand il y a des frais d'hospitalisations et des choses comme ça parce qu'eux ne rentreront dans le MAF que très tard, il faut déjà un plafond de revenus explosé. Ils ne seront pas bénéficiaires de l'intervention majorée, avant d'avoir une prime de maladie chronique. »*

A social worker stressed that a person whose income increases slightly can lose the IR status:

> *« Et pour 7 € de plus, de trop au niveau de leur pension, [...] ils ne peuvent pas bénéficier de ce statut. »*

An example was given of someone whose income was just above the threshold because the transport costs paid by her employer were included in the calculation. Due to this, she was no longer eligible for IR status:

> *« En fait elle touche trop pour obtenir l'IM à cause du remboursement de son abonnement. »*

85. It should be noted that the status is in principle automatically extended annually. The beneficiary only has to take action if he has exceeded the defined income threshold (Box 6).

A chronically ill patient interviewed reported that she had postponed healthcare. She did not qualify for IR status, since her income was just above the threshold:

> *"Ik heb medische verzorging moeten uitstellen in het verleden. Ik val net boven de berekeningsbasis voor de verhoogde tegemoetkoming. 700 € of zo. En ik heb geen toegang."*

5.4.2 Measures for chronically ill patients

Several interviewees stressed that measures to protect people with high healthcare costs (see Box 17), in particular chronically ill patients, significantly improved financial accessibility to healthcare, in particular for some diseases:

> *« Maintenant, plusieurs choses ont été mises en place pour les pathologies chroniques. Des choses qui permettent l'accès aux soins, les trajets de soins qu'ils remboursent justement, qui permettent à ces personnes aux maladies chroniques d'avoir accès aux consultations spécialisées, de manière gratuite ou presque, qui remboursent tous les médicaments importants dans cette pathologie. »*

Box 17: Protection measures for chronically ill patients

Some categories of chronically ill patients with high healthcare costs or high care needs are granted (automatically) the status of chronically ill patient. For these patients, the third-party payment scheme for general practitioners, specialists and dentists can be applied, although the providers are not obliged to apply it. Additionally, the maximum level of user charges before the MAB applies is reduced for these patients (see Section 5.2).

Some categories of chronically ill patients with high healthcare costs furthermore qualify for an annual financial subsidy (lump sum) ranging from 318.23 € to 636.47 € ([86]), depending on the care-dependency of the person.

For persons with chronic renal insufficiency or persons with type 2 diabetes, following a care path ([87]), no user charges apply for consultations with their own GP or with specialists in their illness.

Some other measures to protect specific groups of chronically ill patients from high user charges include, under specific conditions, reimbursement of: an increased number of sessions of physiotherapy (see Box 17), medicines for some chronic diseases (see Box 13), a limited reimbursement of painkillers; reimbursement for some medical devices, bandages and incontinence material (see Box 14).

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

86. Amounts for 2020.
87. The care path is based on an agreement between the patient, his doctor and the medical specialist who is involved in the treatment. The aim is to improve care coordination.

Health professionals interviewed reported that for diabetes patients the situation has improved, but that access to care for other chronic diseases, such as for patients with psoriasis, is more problematic:

> *« Ce qui pose plus problème c'est le psoriasis, des choses comme ça, où il faut aller régulièrement chez le dermato, prendre des médicaments plus particuliers. Penser qu'il faut un remboursement. Ça sera plus difficile. Et c'est tout aussi chronique. Et ça touche peut-être plus. »*

Nevertheless, the accumulated expenses may be problematic for some people, in spite of measures to protect people with high costs for healthcare. The CPAS may subsidise the treatment for the chronic condition, but other unexpected healthcare expenses may be difficult to afford:

> *« C'est s'il vient s'ajouter aux chroniques des hospitalisations, alors là ils ont difficiles. Ça c'est encore des gens que j'ai eu la semaine passée. Ils n'ont pas beaucoup de revenus. Ok, ils savent payer leurs soins parce que ce sont des soins habituels, et qu'il y a quand même pas mal de remboursements. Mais dès qu'à ça vient s'ajouter un autre souci de santé, une hospitalisation et des médicaments complémentaires à ça, parfois ça déséquilibre alors très fort leur budget. Parce que c'est déjà limite. »*

5.4.3 Interventions of the Public Centres for Social Welfare

The Public Centres for Social Welfare (CPAS/OCMW), organised at municipal level, play an important role to ensure access to healthcare. On the one hand they are legally required to sign up persons who qualify for compulsory health insurance with a sickness fund and on the other hand they cover OOP expenses for healthcare for people how are unable to afford necessary OOPs (see Box 18).

Box 18: The role of the CPAS/OCMW in facilitating access to healthcare for vulnerable people

The Public Centres for Social Welfare (CPAS/OCMW) have a legal duty to protect individuals who no longer have sufficient resources to live a life in human dignity. This implies at least the ability to feed, dress, house, take care of oneself and have access to healthcare. The CPAS/OCMWs are organised at municipal level.

The support provided by the CPAS/OCMW can take various forms, depending on the situation of the person. It may involve financial (Integration Income or equivalent), psychosocial, and other medical assistance. The entitlement to the Integration Income and the right to urgent medical assistance for persons illegally residing in Belgium, are regulated and co-financed at national level. Apart from this benefit, the CPAS/OCMW can provide other forms of support and assistance and can freely determine the form and scope thereof, taking into account the specific individual circumstances of the person seeking assistance. Forms of financial support supplementing the Integration Income include, for instance: a subsidy for the costs of less fortunate persons in residential care centres, the provision or advance payment of a rent guarantee. It can also include coverage, full or partial, of medical and/ or pharmaceutical expenses.

Social assistance is a subsidiary measure. This means that the CPAS/OCMW, before granting assistance, ensures that the client is receiving all the social security benefits to which he is entitled. To ensure that they enjoy their rights with regard to sickness, the CPAS/OCMW has to register its clients with a sickness fund. The client can choose the health sickness fund. However, if the CPAS/OCMW does not have the consent of the client, it has to sign the client up to the Auxiliary Fund for Health and Disability Insurance (CAAMI/HZIV).

To allow people residing in Belgium but without an official place of residence, e.g. homeless people, to receive benefits that require an official place of residence (e.g. child benefit, unemployment benefit, health coverage), they can acquire a reference address. At this address, they are administratively accessible for official bodies and will receive their mail and administrative documents. People can use the address of a natural person as a reference address, if the person has consented to this. Homeless people can also request a reference address at the OCMW/CPAS.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities.

5.4.3.1 Covering uninsured persons

The CPAS thus is legally required to sign up persons who qualify for compulsory health insurance with a sickness fund. Where appropriate, the CPAS must regularise the situation by paying the contributions due.

In principle, the client has to be affiliated with the sickness fund of his choice. Since the OCMW/CPAS, however, are not legally obliged to pay the premium due for the complementary services provided by the sickness funds, in practice many of their clients are affiliated with the subsidiary fund for illness and invalidity insurance (HZIV/CAAMI), since they are unable to pay the complementary premium.

Many professional interviewees emphasised that since the beneficiary has to take action himself to choose a sickness fund and that the CPAS cannot automatically affiliate people to the compulsory health insurance, this is an important hurdle to ensuring population coverage:

> *« Le CPAS peut informer les gens mais normalement ce sont les personnes qui doivent prendre contact avec un des organismes assureur. S'il n'y avait pas ça, mais qu'il y avait seulement une organisation qui pouvait mettre tout en ordre, ce serait plus facile. »*

A social worker in a CPAS pointed out that the sickness funds do not recognise the legal competence of the CPAS to sign people up, although this is a legal obligation for the CPAS ([88]):

The CPAS may pay the money due in order to regularise a person's situation, and can ask the client to reimburse part of the arrears, in monthly installments:

> *« On fait des rapports sociaux pour régulariser mais parfois, ce sont des montants très élevés. Alors le conseil demande parfois aux usagers de rembourser, petit à petit, bien sûr. 15 €, 20 € par mois de leur aide parce que si c'est des 3000-4000 €, … c'est un peu pour les responsabiliser. »*

88. In principle, the documents, including the registration form, have to be signed by the insured person. In cases where this proves impossible, the CPAS/OCMW may, with a mandate from the person concerned authorizing him to do so (civil law) or in circumstances where the person concerned was unable to sign (due to illiteracy, for example), sign on behalf of the insured person. In these cases, an explanation of the reason is required (information provided by NIHDI, 27 April 2020).

It was highlighted that the additional expenses for some beneficiaries, if they have to join the CAAMI, and thus do not have voluntary health insurance, may be very high. For instance, for patients who need renal dialysis and have high transport costs, membership of a sickness fund may be much more beneficial:

> *« donc monsieur est affilié à la mutualité X et pour le CPAS, il n'avait qu'à aller à la CAAMI. Et il avait une dette de 400 € auprès de la mutualité X. Et je dis : « Mais ce patient est dialysé ? La CAAMI n'intervient pas dans les transports de dialyse. Tandis que la mutualité X, oui. »*

5.4.3.2 Covering out-of-pocket payments for insured people.

The CPAS/OCMW not only provide coverage, they can also subsidise the financial burden of healthcare costs. The municipalities are free to define their policies in this respect. The way in which this is done and the criteria that apply vary greatly between CPAS/OCMW.

a. Strengths

Some interviewees stressed the importance of the CPAS/OCMW support in ensuring access to healthcare for people in a vulnerable situation. This was mentioned with regard to mental healthcare, and the purchase of pharmaceutical products:

> *« La plupart des médicaments sont soit remboursés par la mutuelle, soit pris en charge par le CPAS. Ainsi, ils ne paieront que maximum 1,50 € par médicament. Donc s'ils ont une carte médicale, qu'ils doivent du Paracétamol, qui coûte quand même presque 10 €, normalement ils paieront 1,50 €. »*

It was stressed that the procedures may be lengthy and cumbersome, but in the end, the client receives the care needed, to pay, for instance, for glasses.

> *« Le CPAS demandera des démarches à n'en plus finir, il faut aller chez trois opticiens différents, obtenir des devis, rentrer tout et attendre encore un mois. Mais finalement, quand même, on obtient les lunettes. »*

b. Weaknesses

Nevertheless, interviewees also mentioned several weaknesses in the system of CPAS intervention to ensure access to healthcare:

Huge differences in policies between municipalities

While some CPAS/OCMW provide a medical card with which all user charges are (fully or partially) covered for the beneficiary, others only subsidise specific healthcare expenses. Non-reimbursed pharmaceuticals or medical devices are usually only covered on a case by case basis. Some only pay ambulatory care, others also pay for hospital care. Some apply a positive list of pharmaceuticals they cover, others assess pharmaceutical prescriptions on a case by case basis or have a contract with specific pharmacies. Income thresholds applicable to financial support may also differ. Some CPAS/OCMW only consider the income of the client or household, which may be set at the level of the Integration Income, others also take into account essential household expenditure and assess the remaining household budget available for daily expenses. Some CPAS/OCMW apply one threshold, others apply several thresholds, and the level of financial intervention may differ according to the threshold. Furthermore, approaches may change substantially over time (see Section 5.5.6). The pool of healthcare providers whose

services are reimbursed may also differ: some CPAS have a positive list of providers who qualify for financial intervention, others require providers to be contracted by the health insurance system and still others have agreements with specific providers. Usually, providers apply the third-party payment system. Some CPAS/OCMW only reimburse care from public hospitals. In some CPAS/OCMW, each application has to be individually assessed by the (elected) Council of the municipality, in others, the social services have important delegated powers, and may decide on the financial support to be provided, based on established criteria and guidelines.

It was mentioned during the interviews that the differences in approach between municipalities may substantially complicate access for the clients, for instance when they move. This is particularly true in Brussels, where policies may differ substantially between municipalities.

Lack of progressivity of the entitlement, in particular for persons with important healthcare costs

The conditions to be entitled to CPAS/OCMW intervention are perceived as too restrictive in some cases. Social workers interviewed mentioned clients with high costs for medicines, who did not qualify for a medical card, since their income is just above the threshold, which, in this particular CPAS, was set at the level of the Integration Income:

> *« Les gens vont à la pharmacie. Ça coûte 30, 40, 50 € de quote-part patient et quand on fait une demande – parce que les gens nous disent que ça c'est tous les 15 jours et nous disent le montant de leur pension – de carte médicale, on nous la refuse car les critères d'octroi sont trop liés au montant des revenus. Et si les revenus sont supérieurs à un revenu d'intégration social, on considère que les personnes sont capables de prendre en charge leurs frais. »*

A GP from a community primary care centre reported the need to help persons just above the income threshold for accessing care:

> *« Oui ils n'y ont pas droit parce qu'ils sont tout juste au-dessus. Oui. Et ça, c'est vrai qu'à ce moment-là on essaie de les aider avec des échantillons, avec ce qu'on a, si c'est urgent, s'il faut dépanner. Sinon ils attendent. »*

A social worker explained that the CPAS/OCMW (where he is working) created a scale to avoid a situation where people just below the threshold would be entitled to full coverage of the costs, while those just above would not qualify for any help. Now they partially cover the costs of those just above the threshold.

The defined threshold of the available income may be inadequate when new, unexpected events mean additional healthcare expenditure. A healthcare professional interviewed highlighted that the CPAS/OCMW may have decided, based on a needs assessment, that a client has sufficient income to cover recurrent healthcare costs. However, if additional healthcare expenditure is needed, due to unexpected events, the client may be unable to pay for the care.

> *« Il leur reste autant à la fin du mois, et ça devrait être suffisant pour manger et peut-être une boite de médicament. Mais si entre-temps l'enfant a une bronchite, le 2e s'est cassé le pied, il y a un plâtre. Il faut payer des béquilles à 25 €, enfin voilà ! A la fin du mois, ça s'accumule. »*

CPAS/OCMW serving only their 'own' clients

Sometimes, other criteria than income are used to define whether people are entitled to financial support. Two interviewees from different services mentioned a OCMW/CPAS that only

covers user charges of people receiving an Integration Income from them ('their clients'). One example was provided of a person who used to receive coverage of his user charges as long as he was receiving an Integration Income. However, since he recently reached pensionable age, he now receives an Income Guarantee for the Elderly (IGO/GRAPA), which is exactly the same amount, but is provided by the Federal Pension Service. Since then, the CPAS no longer covers his user charges:

> *« Un homme pensionné aujourd'hui qui touche le GRAPA. Le GRAPA c'est exactement le même montant que l'intégration sociale. Là le CPAS dit qu'il a suivi cet homme pendant des années et que maintenant, il ne fait aucun soutien parce que l'homme n'est plus chez eux. »*

Organisational hurdles for access to CPAS support

Several organizational issues are also reported by interviewees. A respondent reported that clients of the CPAS are often not aware that the medical card guaranteeing coverage of their healthcare costs is about to expire or do not take the necessary action to extend the validity of their card. As a result, their expenditure is no longer covered:

> *« Et alors le CPAS, oui, ça c'est quand même très fréquent que les patients n'ont pas une carte médicale en ordre parce qu'ils n'ont pas fait les démarches. Les cartes médicales sont envoyées au minimum tous les ans. [...] Ça doit être apporté à l'avance donc s'il n'y pense pas, ils oublient puis ils doivent apporter les preuves de dépenses en pharmacie, ils doivent apporter leurs fiches de revenus, etc., et s'ils ne font pas ça, s'ils ne sont pas présentés au rendez-vous, leur dossier est en suspens. »*

An interviewee explained that, in urgent cases, for instance for a patient leaving the hospital, the CPAS/OCMW has a service providing pharmaceuticals 24/24h:

> *« Quand c'est quelqu'un qui sort vite, l'urgence sociale donne des médicaments. »*

Despite such provisions, the time taken by the CPAS to reach a decision was mentioned by several interviewees as problematic in some situations:

> *Interviewee 1: « Il faut 1 mois de réponse pour une paire de béquilles. »*
> *Interviewee 2: « Voilà, on sait qu'un patient doit être opéré, … je ne sais pas, d'un hallux valgus, il doit avoir des béquilles, une chaussure de barouk à la sortie, les demandes elles sont faites au préalable au CPAS mais si le patient il arrive avec son pied cassé, fracturé et qu'il sort beh, là, ça n'a pas été demandé au CPAS. Donc le CPAS n'a pas eu le temps de nous donner un accord de prise en charge. [...] Pour tout ce qui est remboursé par l'INAMI, oui, on peut avoir des accords très rapides. Mais pas pour du matériel et ce qui n'est pas remboursé, parce que ça, ça doit faire l'objet d'un passage au comité. »*

A health professional claimed that the legal deadline of 30 days to decide on a request is not always respected:

> *« Si tu les appelle de temps en temps, ils te diront au téléphone qu'ils ont le dossier Monsieur X qui est toujours en attente pour des lunettes : 'Ah oui ! Mais la commission c'était hier et Monsieur X n'était pas dedans.' C'est au minimum encore 1 mois d'attente. C'est comme ça. Ça c'est la réalité. »*

Additionally, the patient has to be physically able to go to the CPAS to make a request:

> *« Pour les personnes qui subissent des chimiothérapies, c'est physiquement dur de se déplacer. Ils sont malades, ils ne sont pas bien, ils sont affaiblis et de chaque fois aller au CPAS, c'est dur. »*

Usually, the CPAS only subsidises the cost of healthcare provided by specific providers, for instance those who are contracted by the health insurance system. Some CPAS only subsidise care provided in public hospitals. It was reported that for clients, in particular for newcomers, it is not always clear that they have to consult specific providers. The example was given of a refugee, who had been treated in a private hospital and received a bill for 35,000 €, which the CPAS refused to cover:

> *« J'ai eu une personne syrienne qui se retrouve endettée parce qu'elle n'avait pas compris qu'elle devait aller dans un hôpital particulier [...] Au départ, la dette atteignait un peu plus de 35 000 €. Mais le médecin a finalement offert l'opération. Car il a été touché par l'histoire de la dame, qui est une victime de guerre. »*

Personal hurdles for claiming support from the CPAS/OCMW

Many interviewees mentioned that people find it very difficult to ask for help from the CPAS/OCMW, since they feel stigmatised and are reluctant to depend financially from the CPAS/OCMW :

- *« elle dit : 'Je ne veux pas dépendre du CPAS parce que j'ai travaillé tout ce que j'ai pu travailler'.»*
- *"Ja, ik heb het ook moeilijk dat ik bepaalde raadsleden bij het OCMW ken en dat die ook over mij moeten oordelen. Dat zijn dingen waardoor … dat is een rem."*

5.4.4 Interventions from other social services

a. Strengths

- **Helping people to obtain health insurance coverage or CPAS/OCMW support**

Hospital-based social services make major efforts to cover people who are not covered. Interviewees explained that every week they arrange coverage for several persons. When faced with a patient who is not covered, the first step is to assess the urgency of the medical need. In urgent cases, the patient is always treated. Based on the judgment of the medical doctor, the treatment can be postponed, or the hospital stay can be shortened – these options will be considered. The second step is to take action to have the patient covered by the health insurance system. If health insurance coverage is not possible, they call upon the CPAS/OCMW to cover the expenses.

When they are informed about a patient who may have problems after being discharged from hospital, for instance in affording the necessary medicines, they try to prepare the application to the CPAS/OCMW.

- **Looking for creative solutions to help people access to healthcare**

When confronted with patients who are not eligible for any of the financial support systems and who cannot afford the necessary care, the social services try to find solutions in a creative way.

Interviewees working for the social services, both in sickness funds and hospitals, mentioned that they could call on a private fund for exceptional cases worthy of consideration. They were very discrete on the existence of such fund, which may exist thanks to one or more gifts or an inheritance. One interviewee furthermore gave the example that she called upon solidarity within the muslim community:

- *« Pour ce couple, j'ai fait appel à une fondation, avec qui j'ai précédemment collaboré et qui veut rester d'elle-même anonyme. Cette fondation prend en charge des patients indigents, qui sont dans le besoin. »*
- *« Et j'ai fait appel aux communautés qui sont de confession musulmane, arabe, … et donc j'ai fait appel à une association qui fait appel à la communauté pour venir en aide à cette famille. »*
- *"Tandzorgen dat is iets… nu hebben wij daar een speciaal fonds voor. Mensen die acute tandzorgen moeten hebben en die het niet kunnen betalen, daar hebben wij een hulpfonds voor."*

Many social services also have 'a cupboard or a drawer' with medical devices, to give to people in need. Some reusable devices may be collected from patients who have recovered:

> *« Le service social a eu don de deux chaises roulantes. Donc on peut prêter aux patients en attendant, on prête et on les récupère. [...] Des fois c'est vrai le service social est amené à faire du système D. »*

An interviewee from a hospital social service provided the example of a patient who, after being discharged from the hospital, needed enteral feeding. However, since there was not yet a decision of the CPAS on financial help with the costs of the feeding bags, the patient's wife returned a few days later in panic to the hospital. She was unable to feed her partner that evening. The hospital social service then found an informal solution by providing some nutrition bags for free.

> *« Et donc la semaine passée, la patiente qui est venue avec son époux, c'était fin de mois. Il n'y avait pas encore la décision du CPAS, elle est arrivée complètement alarmée, en me disant qu'elle n'avait plus rien pour le nourrir ce soir (en parlant de son époux) [...] Et donc on a été en salle pour faire les tiroirs. »*

In a similar way, primary care centres mentioned that they have a 'cupboard' with pharmaceutical products, which may be samples provided by pharmaceutical companies:

> *« Ou alors on arrive à trouver dans une armoire sociale les médicaments. Parce [...] les patients ont du mal à boucler leurs fins de mois et donc ils ont besoin des médicaments du style pour l'épilepsie, pour le diabète, pour des problèmes cardiaques où doivent avoir des médicaments spécifiques. »*

b. Weaknesses

- **Difficulties in the communication between social services**

Social workers in hospital social services reported that interaction with the sickness fund is not always straightforward. They may not receive the correct information, or the procedures may be very burdensome, while for hospital services it is important to settle the situation of the patient before he is discharged:

> *« Parfois, on sonne aux mutuelles, on espère avoir la bonne information, on envoie le bon document qui manque, on renvoie un dossier complet. Alors, parfois ça prend du temps parce que par scan, ils n'acceptent pas, il faut par courrier. Donc il leur faut les documents originaux. Quand ils les ont reçus, ils disent : « Tout compte fait, il nous fallait ça aussi. » et alors ça peut durer comme ça des semaines. Puis après, le patient est sorti, on ne le voit plus. »*

An interviewee mentioned that since the General Data Protection Regulation (GDPR) entered into force, sickness funds are more reluctant, or refuse, to provide certain information on a client to a social service. The client thus has to take all the necessary actions to be covered himself. But respondents stressed that some clients are unable to understand the procedures to be followed or are too ill to settle their situation:

> *« Ce qui bloque maintenant, c'est certaines mutuelles à cause des nouvelles réglementations du GDPR sur le secret professionnel, la vie privée. Que certaines institutions, dont certaines mutuelles ne veulent plus nous donner les informations, et donc renvoient ça aux patients. Mais les patients ne sont parfois plus ou pas dans la capacité de comprendre. Et là, nous sommes là pour les aider mais on nous renvoie : 'Le patient doit venir se présenter chez nous et on lui expliquera'. »*

Social workers at hospital underline the importance of having a skilled contact person at the sickness fund. Wrong information on how to get coverage may have serious consequences:

> *« Et il (the patient) était allé à sa mutuelle mais au guichet vous n'avez pas parfois les spécialistes que nous contactons. Donc on ne lui avait pas donné une bonne information, mais du coup. Il ne se soignait pas. Et donc moi après j'ai re-sonné au médecin, j'ai dit : 'Si, il vient de signer le papier. Et demain, il est en règle.' et alors elle (the medical doctor) me dit : 'Ça va, je vais programmer, du coup, les soins pour fin de semaine, parce qu'il a des tâches aux poumons' Vous voyez ? »*

One problem flagged several times was that correspondence from the sickness fund is sent to the patient's home. However, if the patient is hospitalised, he will not receive the document required, for instance for coverage:

> *« Parce que maintenant, le problème qu'on rencontre c'est que, … Je peux comprendre avec le RGPD, les mutuelles refusent de nous envoyer les documents que le patient doit compléter. Ils les envoient aux domiciles, si le patient n'a pas de domicile ou s'il n'est pas en état d'aller chercher son courrier, s'il n'a pas de famille pour relever le courrier, le document il ne l'a pas. [...] Et donc, on ne sait pas le régulariser. »*

It was furthermore mentioned that reductions in the length of stay in hospital made it more difficult for hospital social services to settle the situation of the patients. Once discharged from hospital, it is much more difficult to follow up on the actions the client should take to obtain coverage:

> *« A l'hôpital général, les durées de séjour comme vous l'avez dit, diminuent. Et puis, on est avec un patient qui est alité, qui vient d'être opéré parfois, et donc on ne sait pas faire les démarches à l'extérieur avec lui. Puis le patient sort, est-ce qu'on le reverra ou pas pour continuer à faire les démarches ? »*

- **Differences in approach between social workers**

Interviewees mentioned that there are substantial differences in approach between social workers and solving financial access issues may also depend on how the social worker interprets the situation:

> *« Je trouve aussi qu'il y a beaucoup d'organisations, de fonctions qui pensent avoir le pouvoir pour faire certaines choses et prendre certaines décisions. Avant, je croyais que c'était assez*

strict mais, en réalité, il y a une grande liberté pour plusieurs personnes d'interpréter des choses négatives ou positives. »

5.4.5 Services provided by sickness funds and complementary health insurance

Since 2012, affiliation to a sickness fund automatically implies affiliation to their own complementary health insurance. A compulsory premium is therefore charged to the members. The benefits of the compulsory complementary insurance mainly focus on prevention, care and wellbeing and differ from sickness fund to sickness fund. They may cover a wide array of benefits, such as a sports subscription, sessions at the chiropodist, vaccines or birth premiums. Healthcare related benefits may include financial subsidies for care not (yet) or only partially covered by the compulsory health insurance. They may include a share of the cost of glasses and contact lenses, contraception, long-term care, care material, psychotherapy, dental prostheses, home care devices, patient transport and coverage of user charges during hospitalisation. Members can furthermore voluntarily subscribe to additional complementary insurance policies, such as insurance against hospitalisation and dental care costs.

People who are not willing or unable to pay the sickness fund premium can join the Auxiliary Fund for Health and Disability Insurance (CAAMI/HZIV).

Health professionals interviewed highlighted the importance of the complementary insurance of sickness funds in providing access to home care services:

« Les gens ne sont pas en ordre de complémentaire donc le problème c'est que quand ils sortent et quand ils rentrent à domicile, tout ce qui est soin à domicile, ils n'y ont pas accès. »

A social worker pointed to the differences in coverage of hospitalisation costs between sickness funds, and the impact this may have on the affordability of healthcare expenditure:

« Des fois je reçois des patients, [...], je me dis : « Tiens, s'ils avaient été à l'autre mutuelle, ils auraient juste payé la franchise et tout le reste de leur facture aurait été pris en charge » puisqu'ils étaient en chambre commune et là, ils doivent payer 3000-4000 € parce qu'ils n'ont pas d'assurance hospi. »

The existence of voluntary health insurance schemes linked to the sickness funds may, however, also have perverse effects. A health professional interviewed explained that sickness funds focus on middle class members, since these members are able to purchase the complementary hospitalisation insurance:

"Een ziekenfonds moet financieel draagkracht hebben, dus ze richten zich op de middenklasse die die hospitalisatieverzekeringen extra aankoopt."

5.5 Potential explanations for the deterioration in access to healthcare

Many health professionals interviewed stressed that they now had more clients/patients living in very precarious situations than ten years ago. They mentioned an increasing number of clients facing a combination of difficulties in several fields, including housing, food, social isolation. In particular, many pointed to the increasing costs of housing and utilities. However, an analysis of

these trends is beyond the scope of this report ([89]). Many interviewees also pointed to reforms in the health system that have improved access to care for vulnerable people. We discussed these in various sections above.

In this section we will look at changes in the health and social care system reported by the professionals interviewed, which may help to explain the increases in unmet needs for healthcare for people on a low income, as found in chapter 4.

5.5.1 Shift from inpatient to outpatient care

Several professionals pointed to the reduced length of stays in hospital. While these policies were not questioned in themselves, the interviewees pointed out that they were often not sufficiently linked to policies to support home care and to reimburse the pharmaceuticals and medical devices needed at home:

> *« Moi je pense qu'on a beaucoup mis l'accent maintenant sur les soins en externe, en ambulatoire, rester le moins longtemps possible, mais sans avoir mis de moyens à l'externe, en tout cas pour les patients, de pouvoir se soigner en externe. »*

Some concrete examples, (e.g. nutrition bags) have been described above (see Section 5.2). Transportation costs were also mentioned several times:

> *« Donc c'est vrai qu'on prône beaucoup maintenant les soins à la maison. Repartir le plus vite possible, etc, et de venir en ambulatoire. Quand on habite près de l'hôpital, ça va mais chez nous [...] Et il n'y a rien par-là, donc ils viennent jusque chez nous avec des transports et ça c'est un coût supplémentaire pour eux. »*

5.5.2 Reduction in transportation services provided by non-profit associations

At the same time, it was flagged that there has been a reduction in the number of transportation services offered by NGOs and sickness funds and patient transport is increasingly provided by private businesses, at a higher cost. An interviewee explained that associations who used to offer volunteer-based transportation services have reduced their supply. One sickness fund is now developing a limited service for their members:

> *« Il existe des transports mais c'est de plus en plus privé. Dans le temps, on avait la fondation contre le cancer qui avait des transports de bénévoles. Puis à un moment donné, ils ont décidé d'y mettre fin, il y a 4-5 ans peut-être. Alors, on a retrouvé toute cette population-là, qui avant faisait appel à la fondation, tournée vers d'autres transports. Et donc maintenant les mutuelles ont développé un peu ça. [...] Il y a un nombre limité de trajets, et il y a comme un petit truc non ? »*

5.5.3 Increased cost of pharmaceuticals

According to interviewees from several social services, the OOP payments for prescribed pharmaceuticals have increased substantially over time:

89. Van Dam (FPS 2019) found an increase in the population at risk of poverty since 2011, in particular in the non-elderly population.

- *« Ca a très lourdement augmenté. [...] À chaque réforme quand on a des médicaments qui sautent, qui ne sont plus remboursés, cela alourdit la note. »*
- *« Certaines pommades, certains médicaments, qui ne sont pas pris en charge par l'INAMI. Pour moi, cette tranche-là a augmenté, augmenté en quantité de médicaments prescrits et augmenté au niveau du prix de ces médicaments. »*
- *« Oui, les prix augmentent. Parfois quand on fait des visites à la maison, les gens ont leur table avec les médicaments, ils disent : 'ça coûte de plus en plus cher madame', donc ça j'en ai aussi l'impression. »*

It is not clear from the interviews what the reason is for the stated increases in out-of-pocket payments for pharmaceuticals.

5.5.4 Hospitalisation insurance advertising

It was suggested that the marketing of hospitalisation insurance, including publicity by sickness funds, is aimed at convincing people that healthcare without hospitalisation insurance is unaffordable. According to a social worker, many people have a wrong idea about the costs of hospitalisation and think that they will be unable to pay, while in practice the treatment would be affordable. As a result, people without hospitalisation insurance fear the bill and postpone care:

> *"Omdat je de informatie krijgt van: je moet een hospitalisatieverzekering extra hebben want anders gaat dat veel te veel geld kosten. Maar eigenlijk is dat niet waar. Die desinformatie houdt mensen soms tegen om behandelingen te laten uitvoeren."*

5.5.5 Hospital policies to avoid unpaid bills

It was mentioned that, while hospitals used to send the invoice for ambulatory care to the patient's home afterwards, now patients in some hospitals always have to pay 25 € up front. It was suggested that this changed hospital policy may be a substantial hurdle preventing vulnerable people from consulting a specialist:

> *"Vroeger ging je naar een ziekenhuis, je moest niets betalen op voorhand, de factuur kwam wel achteraf. De ziekenhuizen hebben dat toen in het leven geroepen: ga je naar een spoeddienst of op consultatie in het ziekenhuis, je betaalt d'office 25 € [...] als voorschot. En dat was voor mensen wel een barrière [...] als ze die 25 €, of die 12 € met een verhoogde tegemoetkoming, niet hebben, dan gaan ze niet naar het ziekenhuis."*

As discussed in Section 5.2.9, hospitals have become stricter in checking patients' solvency. Hospitals now check whether the patient is in arrears before admitting him for a medical examination or treatment.

5.5.6 Policies of the CPAS/OCMW

As we highlighted above (see Section 5.4.3), CPAS/OCMW policies on covering user charges may differ greatly between municipalities. Interviewees explained that policies in some municipalities have become stricter and more selective. While they used to cover all healthcare expenditure of people receiving an Integration Income, as well as meeting the costs of affiliation to a sickness fund, they now decide on financial support for specific healthcare costs on a case-

by-case basis, assessing the needs and poverty-level of the client. Furthermore, they only exceptionally fund the costs of joining a sickness fund and generally refer their clients to the CAAMI/HZIV:

- *"Op het papier stond dat het OCMW tussenkwam in de medische kosten, de remgelden. [...] heb ik de evolutie meegemaakt [...] We gaan niet zomaar preventief aan iedereen die waarborgen verlenen. Er moet echt wel een medische nood zijn. En dan is men ook afgestapt van die aanvullende bijdrage sowieso voor iedereen te betalen en is er ook gezegd van we moeten ook kijken naar de behoeftigheid, want niet voor al onze klanten is dat hetzelfde, een deel van onze klanten hebben eigenlijk een vrij lage huurkost, als die bijvoorbeeld huren van een sociale woningmaatschappij. Andere klanten moeten in de privé huren. Er zijn klanten met schuldenlasten, er zijn klanten zonder schuldenlasten. Dus eigenlijk moet dat volledig bekeken worden. De behoeftigheid moet echt wel aangetoond worden voordat wij gaan kunnen tussen komen."*
- *"Medicatie die door het OCMW ten laste wordt genomen, voor mensen met mutualiteit maar met leefloon bv. Deze manier van werken, die vroeger gebruikelijk was, is de laatste 2 jaar bijna volledig afgebouwd. Het OCMW neemt alleen nog in heel uitzonderlijke gevallen medicatie ten laste."*
- *« Et en fonction de certains CPAS aussi, avant, à partir du moment où on avait une carte d'intégration, on avait d'office une carte médicale. Dans certains CPAS, ça a changé. [...] Ils ont un revenu d'intégration mais du coup ils n'ont pas de carte médicale, du coup s'ils ont des frais médicaux à leurs charges beh c'est [...] sur base d'une analyse : 'Ils ont tels revenus, ils ont telles charges' et ils font la différence entre les 2. 'Voilà, ils leur restent autant à la fin du mois, et ça devrait être suffisant pour manger et peut-être une boite de médicament'. »*
- *« Avant, il y a 4 ans, si quelqu'un n'avait pas d'argent et qu'il demande des lunettes qui coûtent cher, le CPAS acceptait de payer la facture. Aujourd'hui, le CPAS dit le contraire : 'On ne paie jamais sauf si notre commission décide que c'est un cas très spécifique'. »*

Some OCMW/CPAS have also become stricter in assessing the income of the patient. An interviewee from a community primary care centre gave the example of a patient for whom their service arranged a so-called "palliative lump sum". This is an additional allowance to cover the costs of medicines, care materials and aids which palliative patients being cared for at home must pay out-of-pocket. The OCMW/CPAS decided to deduct all this lump sum of 686.24 € from the patient's Integration Income (of about 900 €):

> *"Van een patiënt die palliatief is, en waar door onze artsen het palliatief forfait aangevraagd werd, om in de vele kosten wat tegemoet te komen, blijkt nu achteraf dat dit forfait van 600 € integraal afgetrokken werd van het leefloon van ongeveer 900 €. Een maat voor niets dus…"*

Interviewees from the CAAMI mentioned that they had had a substantial increase of members over the last decade (an increase of more than 25%). They put forward two potential explanations for this: first, most of the newcomers are affiliated with them and second, the CPAS refer their clients more systematically to the CAAMI for coverage:

> *« Pas seulement des réfugiés mais aussi des gens qui ont des problèmes et qui sont renvoyés vers des CPAS aussi. »*

5.5.7 Reduced assistance from social services

Several interviewees stressed that support from the social services has been reduced in the last 15 years. The budget, staff and opening hours of the social services have been reduced. As a result, people who are less able to cope with administrative hurdles fall by the wayside:

- *« Ce que j'ai vu en 15 ans, pas seulement dans les CPAS mais toutes les organisations comme les CAW, les points dans lesquels les gens peuvent donner certaines informations, etc, … ils ont diminué. Le personnel, le budget, etc, ont diminué. [...] toutes les communes ont un service d'infos pour certaines choses. Et ça ce sont des choses dans lesquelles ils se sont dit : 'On en a plus besoin, on n'a plus d'argent'*
- *« C'est un peu la même chose ici aussi. On a fait l'erreur de fermer les guichets tous les après-midis et de fermer le vendredi pendant les vacances. [...] Si les gens ne sont pas aidés jeudi à 12h00, c'est directement pour lundi. C'est une queue énorme avec plusieurs questions, etc. Et tous les services font des choses comme ça. »*

Instead, services have been digitalised, which causes problems for people in a vulnerable situation. They may not have a smartphone, their problem may be highly complex and may not fit in the standardised categories of the electronic form, they may not understand, their problem may be very urgent, for instance if their benefit has not been paid and they do not have any means of subsistence:

- *« Et tout le monde pense qu'on peut tout faire avec des flux (electroniques). Tout le monde a un ordinateur [...] Alors ils pensent pouvoir dire aux gens de ne pas venir mais de faire leurs demandes à partir de leur smartphone. Mais il y aura quand même des gens qui devront venir parce qu'ils n'ont, soit pas de smartphone ou un ordinateur, ou ils n'ont pas compris, ou il y a quelque chose … Parce que de temps en temps, ça ne marche pas. Si on n'est pas payé, on n'est pas payé [...] Et ça donne des problèmes. [...] La situation est plus difficile. »*
- *« Maintenant, c'est tout faire via des calls centre, des téléphones, par des emails, … il y a de moins en moins de contact humain. Donc pour les gens c'est difficile parce que quand on a quelqu'un en face de soi, on peut réexpliquer s'il n'a pas compris, quand on reçoit un email, tout ça c'est inaccessible pour notre public ici. »*

5.6 Conclusion on the analysis of the interviews

From the interviews, we identified the following main hurdles to accessing healthcare:

- People who are not covered for healthcare. These include: people who have not paid their social contributions, in particular among the self-employed; people who failed to take the necessary administrative action to be covered, and those who have been deleted from the population register although they still live in Belgium.
- Up-front payments: these are a major hurdle for access to all types of ambulatory healthcare.
- High advance payments and out-of-pocket expenses for patients hospitalised in shared wards, including for those qualifying for increased reimbursement. In particular, long stays and specific costly health material (e.g. prostheses) may result in important affordability issues. Furthermore, hospitals and doctors reduce access to healthcare for patients with payment arrears. Post-treatment can also be difficult to afford. This results in unmet needs with potentially serious health complications due to discontinuity of care.

- User charges for physiotherapy, dental care and medicines.
- Lack of awareness of the differences in status between contracted and non-contracted doctors, and of the consequences, on admission to hospital, of signing the paper asking to be hospitalised in a single room, in particular for vulnerable groups.
- Issues related to the IR status, including: non-take-up of IR status for people not automatically benefiting from the status; persons just above the threshold for IR status; the remaining user charges for some types of healthcare.
- The residual scheme of the Public Centres for Social Welfare (CPAS/OCMW) plays a crucial role in providing financial support for healthcare costs to the least well-off patients. However, there are substantial differences in policies between municipalities.
- The complexity at all levels of the healthcare system, including: the administrative procedures to obtain coverage and the exemptions on paying contributions; entitlement to increased reimbursement, the choice of a contracted healthcare provider, entitlement to the third-party payment system, the care trajectory and referral procedures which must be followed to benefit from reduced user charges, access to support from the CPAS/OCMW.

Chapter 6. Discussion of the findings

In this chapter, we summarise and discuss the findings of both our quantiative analysis and the interviews. We furthermore provide evidence from the literature to put our findings into context. We first discuss our findings with regard to the profile of the people most at risk of unmet needs for healthcare, and most likely to experience healthcare as a financial burden, the determinants of unmet needs for healthcare, and how unmet needs have evolved over the period 2011-2017 (Section 6.1). Next, we discuss the main reasons for unmet needs (Section 6.2). This is followed by the various access hurdles identified: up-front payments (Section 6.2.1); out-of-pocket payments (Section 6.2.2) and the complexity of the system (Section 6.2.3). Then we discuss some of the schemes to protect vulnerable groups, in particular: increased reimbursement status (Section 6.3.1); the Maximum billing system (Section 6.3.2); and the role of the Public Centres for Social Welfare (CPAS/OCMW) (Section 6.3.3). Next, we reflect on some of the consequences of access issues (Section 6.4). We dwell on the strengths and weaknesses of the methods used (Section 6.5).

6.1 Who is most at risk of unmet needs and of experiencing healthcare as a financial burden?

6.1.1 Individual characteristics of people who self-reported unmet needs

6.1.1.1 Situation in 2017

Overall, 4.1% of the population had unmet needs for medical and/or dental care. There is a considerable overlap between people with unmet needs for medical and dental care: 72% of people with unmet medical needs also reported unmet needs for dental care. 41% of people with unmet needs for dental care also reported unmet needs for medical care.

Unmet needs are mainly encountered by the least well-off. They rarely occur in higher income groups, and even not at all in the highest income quintile in 2017. The proportion of the population facing unmet needs for medical care varied in 2017: 6.7% of persons in the first income quintile, 2.1% in the second quintile, and low to zero from the third quintile onwards. For dental care it varied in the same period from 10.5% in the first income quintile, 4.3% in the second quintile, to between 0.3% and 2.1% from the third quintile onwards.

The results broken down by individual socio-economic characteristics also show the differences between disadvantaged socio-economic groups: unmet need is much more frequently encountered by persons with no working activity (except for students and retirees): by the unemployed (7.6% for medical care and 11.6% for dental care), the disabled (9.8% and 13.8%) and persons with home duties (5.8% and 8.5, or in households with a low level of working activity (less than 4 months over one year) (9.9% and 14.1%).

Other results also clearly show the direct link with financial capacity. Indeed, unmet need for medical care also varies substantially between groups who can and who cannot afford primary needs and social activities:

- Among people who cannot afford to go out with friends or family once per month, 13.7% reported unmet needs for medical care and 20.5% for dental care, compared with respectively 0.5% and 1.4% for persons who can afford it. The result is similar for those who cannot afford leisure activities.
- Important variations are also observed according to whether or not people can afford goods related to two primary needs: housing and eating. 8.4% of persons living in an overcrowded household report unmet needs for medical care and 10.4% for dental care (only 1.7% and 3.2% for households which are not overcrowded). More importantly, unmet needs for medical care are strongly related to the ability to meet physiological needs: 15% of persons who find it hard to keep their home warm report unmet needs for medical care (only 1.2% of those who do not encounter this difficulty, and 21.3% for dental care versus 2.5%). Similarly, among people who cannot afford a proper meal every second day, 16.5% report unmet needs for medical care and 20% for dental care. The highest proportion of unmet needs is observed for persons who report they were in arrears on utility or housing bills in the past twelve months: 22.8% for medical care (versus only 1% among those who were not in arrears) and 30.5% for dental care (versus 2.3%). For the persons who were in arrears, a significant increase of the proportion of unmet need can also be observed since 2011 for both medical and dental care.

Unmet needs for medical care are also more frequent among persons with a bad self-perceived health status. In 2017, 9.7% of this group declared unmet needs for medical care and 13.4% for dental care, compared to respectively 3.2% and 6.1% for persons with a fair self-perceived health status, and 0.8% and 1.8% for those whose health is declared as 'good'.

People with functional limitations are also more likely to self-report unmet needs for financial reason (4.9% versus 1% for persons without any functional limitations). Their overall situation is also difficult. Indeed, other figures for 2018 showed, based on EU-SILC data, that in the group of persons partially or severely limited in their daily activities, 30.5% lived in poverty or social exclusion in Belgium, above the EU28 average (28.7%) (FPS 2019). The difference in the share of people living in poverty or social exclusion, between those with functional limitations in performing daily living activities and others, is among the highest in EU countries (14.8%).

Elstad already observed a deterioration of access in Belgium for the least well-off for the period 2008-2013 (using EU-SILC data). The overall finding of his study was that the recession had had a greater negative impact on access to medical care for persons with both low-income and health issues in countries with larger income inequalities (Elstad 2016). He showed a deterioration in the accessibility of healthcare between 2008 and 2013 for the "*Disadvantaged*" group (i.e. those in the lowest income tertile, aged 30–59 and with reported health difficulties). However, although Belgium was placed in the group of "*egalitarian countries*" ([90]), the proportion of individuals with self-reported unmet needs for medical care in the "*Disadvantaged*" group nevertheless drastically increased between 2008 and 2013: from 2.3% in 2008 to 10.7%

90. Elstad grouped countries according to the average ratio of the fifth quintile: first quintile incomes (2007 and 2012).

in 2013, while for the "others" group (not "*Disadvantaged*"), the proportion remained almost stable and low (0.3% in 2008, 1.2% in 2013) ([91]).

6.1.1.2 How unmet needs have evolved over the period 2011-2017

The share of persons who self-reported unmet medical needs in the overall population has significantly increased since 2011, while for dental care, there is no significant increase observed. Per subgroup of the population, the significant increases in unmet needs for medical and dental care are often observed in similar categories.

In different demographic categories, there has been a slight but significant increase of unmet medical and dental care needs: for females (e.g. for medical care 1.8% in 2011 and 2.5% in 2017), in the age group 25-44 years-old (e.g. for medical care, 1.4% in 2011 and 2.7% in 2017), and for households with no children (e.g. 1.4% in 2011 and 2.7% in 2017 for medical care). For tenants, unmet medical needs increased significantly, while no significant difference can be observed for dental care.

Unmet needs for both dental and medical care are considerably more frequently reported in 2017 than in 2011 among people with low or no working activity: for people with home duties (2.5% in 2011 and 5.8% in 2017 for medical care), and for people with a low level of work intensity (4.9% in 2011 and 8.1% in 2017 for medical care). People with financial difficulties also report significantly increased self-reported unmet medical and dental needs (e.g. for those in arrears on utility bills, 10.1% in 2011 and 22.8% in 2017 for medical care).

A significant deterioration in access to medical and dental care for persons in the first income quintile group can be seen between 2011 and 2017, while no significant difference can be observed in other quintile categories.

The finding that there are more persons who self-reported unmet needs in the first income quintile group should be seen in light of the fact that the number of persons at risk of poverty has increased since 2011 (FPS 2019), i.e. there are more people on a low income and thus more persons experiencing financial difficulties accessing healthcare.

Since 2011, a serious deterioration in the accessibility of medical care can also be observed among people declaring their health to be bad (5.4% in 2011 and 9.7% in 2017 for medical care) for both medical and dental care. People who are supposedly most in need of healthcare were more likely to have unmet needs for medical and dental care for financial reasons in 2017 than in 2011.

6.1.2 Determinants of unmet needs for medical and dental care

The following predisposing demographic factors are associated with the risk of unmet needs:

- Gender, females are more likely than males to report unmet needs for medical and dental care, after adjusting for other factors potentially influencing unmet needs (such as income, or

91. A break in the time series occurred in 2011 but this cannot entirely explain the difference between the increases observed between the two population groups ("disadvantaged" and "others").

need factors). In other countries, the gender results are mixed for medical care. In Italy and Ireland ([92]), females were also more likely to report unmet medical need due to cost (Bryant *et al.* 2009; Cavalieri 2013; Connolly and Wren 2017). The results of broader studies in EU countries are also mixed. Chaupain-Guillot showed no differences between males and females after adjustment (Chaupain-Guillot and Guillot 2015) while Israel showed a higher risk of unmet needs for females (Israel 2016)

- Age is also a factor in unmet needs, but the situation differs between medical and dental care. For dental care, the category 25-44 years old is more at risk of unmet needs than the youngest age group (16-24 years old). No difference in risk is observed for the other age categories. For medical care, the results are in line with other studies: elderly persons are less likely to declare unmet medical needs than younger persons (Cavalieri 2013; Chaupain-Guillot and Guillot 2015; Connolly and Wren 2017)
- Household composition is another predisposing demographic factor that remains significantly associated with unmet need after adjustment. Other things being equal, the risk of unmet needs is affected by the total number of children aged under 25. Interviewees also reported that families with many children were more likely to forego healthcare. We suppose that the available financial resources of households with more than 3 children under 25 years (including minors) are more limited than those of other households, and thus its adult members are less able to afford medical care. Marital status and place of birth were significant factors associated with the probability of unmet needs, i.e. married status was a protective factor for dental care compared to single status. Individuals born in other European countries are more at risk of unmet needs for dental care than people born in Belgium.
- Other predisposing demographic factors (persons living in a single parent household) are, after adjustment, not a significant factor in the probability of unmet need. The high proportion of unmet needs observed in these groups is thus more likely to be explained by other factors (such as income level for instance).

Important differences in the percentage of unmet needs are observed between predisposing **socio-economic factors**. However, after adjustment, only housing tenure status and economic status are significantly associated with unmet needs. Other factors are no longer significant, i.e. the risk of unmet needs is more likely to be explained by the other determinants, such as the level of income or health status. With regard to economic status, students and self-employed persons are less likely to have unmet needs than employees. The relatively low unmet needs of the self-employed may seem surprising, when looking at the information provided during the interviews. However, interviewees reported cases of self-employed people with serious problems in access, due to a lack of coverage. While problems in this group may be substantial, a very small share of the total number of self-employed may be affected.

We found a significant increase in unmet needs for tenants between 2011 and 2017. EU-SILC data also show that the risk of poverty or social exclusion for tenants (renting at market price)

92. For Ireland, recent unadjusted results from the last release of EU-SILC show (source Eurostat 2018) a reverse trend in unmet medical need between males and females.

has slightly but continuously increased over the last decade (38.9% in 2007 and 41.9% in 2018) in Belgium (FPS 2019). The 2018 household budget survey, organised by Statbel, the Belgian statistical office, furthermore shows that the share of housing costs in household budgets has increased between 1999 (26%) and 2018 (30.3%) ([93]).

Also, many professionals interviewed stressed that they now had more patients living in very precarious situations than ten years ago. They mentioned an increasing number of clients facing a combination of difficulties in several fields, including housing, food, social isolation. In particular, many pointed to the increasing costs of housing and utilities.

For specific groups in specific regions, the situation is identified as highly problematic. For single persons in Brussels receiving the Integration Income, it was estimated that in 2017 they spent up to 70% of their budget on renting (based on the median rent for a flat for a single person). This leaves only 285 € per month for all other expenses (Englert *et al.* 2018). This result is also in line with the examples given during interviews in Brussels, often on single and isolated persons with a low income and an excessive share of their budget spent on rent.

More recently, another category is also at a higher risk of unmet needs - the gap between homeowners without and with a mortgage has increased. This result may be explained by an increase in the level of mortgages over the last decade, an increase in the number of people in a precarious situation who buy a home on credit rather than renting one, or by an improvement of the situation of owners without mortgages (or both).

With regard to tenure status, the results are in line with the study of Chaupain-Guillot, who found that homeowners in EU countries are significantly less likely to report unmet medical needs than tenants. However, other studies found an association, after adjustment, between education level and unmet needs: in Italy (Cavalieri 2013) and in a broader study of EU countries (Chaupain-Guillot and Guillot 2015) while our results did not show such a link.

The results concerning **health need factors** are mixed. Self-perceived health remains a significant factor in unmet needs after adjusting for other factors (predisposing demographic and socio-economic factors and income). Thus, other things being equal, people who self-perceived their health as bad or fair are at higher risk of unmet needs than those reporting good health. This result is consistent with the fact that the risk of unmet needs primarily depends on the level of health needs. This result is similar to those of other studies: in Ireland (Connolly and Wren 2017), in Italy (Cavalieri 2013), in France (Renahy *et al.* 2011) or in Belgium (Mimilidis and Desmarest 2012) and overall, in EU countries (Chaupain-Guillot and Guillot 2015; Israel 2016). This observation raises the issue of the reduced accessibility of healthcare for those who are the most in need. This inequity in access to health is another dimension of the inverse care law (Hart 1971): "*The availability of good medical care tends to vary inversely with the need for it in the population served*".

By contrast, an important positive change is observed for people with chronic diseases. This factor is no longer associated with unmet medical needs in 2017, while it was in 2011. This may

93. Statbel, Le logement occupe une place toujours plus importante dans le budget des ménages https://statbel.fgov.be/fr/themes/menages/budget-des-menages (latest consulted on 28/05/2020).

come as a surprise, when considering the interviews, in which chronic and disabled patients were clearly considered as at risk of unmet medical needs. The finding could possibly be related to a number of targeted measures applied to improve affordability of care for chronically ill patients in Belgium (see 5.4.2). In other countries, chronic illness is often associated with unmet needs (Cavalieri 2013; Israel 2016; Connolly and Wren 2017).

At last, **the enabling factor**, i.e. equivalised disposable income per household (quintiles), also remains associated with the probability of unmet need, even after adjusting for other factors likely to influence unmet need, particularly health need factors.

6.1.3 Regional differences

Significant regional differences can be observed in 2017. The share of persons who self-report unmet needs is significantly higher in Wallonia (3.1%) and Brussels (4.3%) than in Flanders (1%). Similar regional differences were observed in 2013, at household level, using the Health Interview Survey data[20] : the percentage of households with unmet healthcare needs was lower in Flanders (5%) than in Wallonia (9%) and was much higher (22%) in the Brussels region (Demarest 2015).

After adjusting for other factors -such as predisposing socio-economic and demographic factors, income and health need factors- the difference between regions remains significant. While this result may be explained by regional differences in unobserved individual factors, differences in regional contexts are also likely to influence the risk of unmet needs for vulnerable groups. Since the municipalities (CPAS/OCMW) play a prominent role in supporting vulnerable people, this may be one of the factors potentially leading to geographical disparities.

Even more strikingly, since 2011, the percentage has remained stable in Flanders while a significant increase can be observed in Wallonia (both medical and dental care). For medical care, in Brussels, a slight increase is observed but it remains insignificant. This trend in the Brussels region and Wallonia is also noted in a survey carried out by Solidaris (Solidaris 2019): the percentage of unmet needs increased in 4 years for all types of healthcare, but particularly the need for specialist consultations (the percentage increased from 7.9 points in four years, between 2015 and 2018.

The professionals interviewed who pointed to a deterioration of the financial situation of their clients were all located in Brussels or Wallonia.

6.1.4 Financial hardship leading to unmet healthcare needs

The interviews allow us to distinguish between people finding it difficult to afford healthcare due to a sudden setback, and people in a very precarious overall situation for whom difficulty accessing healthcare is just one of the many difficulties they have faced for a long time.

6.1.4.1 Financial difficulties due to a sudden setback, often a health issue

The first type of factors leading to difficulties affording medical care are abrupt changes in the social (security) or administrative status of the individual at a time when they face substantial

healthcare costs. The main causes are sudden cash flow problems and a substantial drop in income, particularly in case of sickness or maternity leave, which may lead to financial hardship, not only for low-income individuals. Sickness leave may lead to financial hardship, when people suffer an important fall in income combined with incompressible expenses (for housing, food…) at the same time as -sometimes substantial- healthcare expenses. Such an event may also be critical for patients because of their diminished physical ability to undertake the necessary administrative actions.

Additionally, various factors, such as administrative errors made by employers or a disagreement with the sickness fund, can lead to a substantial delay in payment of the allowance. Practical issues, such as problems with exchanges of letters in cases of hospitalisation, have also been reported by others (Van Roy and Willems 2017).

As a consequence, these people are likely to experience financial hardship and to be unable to afford healthcare expenses. Self-employed persons on a low income may be particularly at risk and may reduce the time they spend on sickness leave. For the least well-off, such mechanisms are likely to lead to major financial issues or postponed/forgone healthcare.

6.1.4.2 Precariousness

Precariousness ([94]) is a notion which is not strictly financial. It refers to unstable conditions of life which may lead to major accumulated difficulties in different fields (Geeraert and Rivollier 2014). As precariousness is reflected in several domains of life, it is difficult to quantify through a single indicator. However, both our qualitative and quantitative analyses point to the risk of unmet needs among people who face adverse circumstances.

Among the individuals in households in which people worked three months or less in the past twelve months, 9.4% reported unmet medical needs for financial reasons. There is also a high percentage of persons with unmet needs among those who find it hard to keep their house warm or to eat properly (about 15% reported needs for medical care and 21% for dental care); to pay the utility bills for housing (22.5% for medical and 30% for dental care) or to afford social activities (13% for medical care, 20% for dental care).

Interviewees also reported that permanent financial hardship affects many domains of life, and is likely to impede access to healthcare. One of the major mechanisms leading to unmet needs for healthcare is the existence of other competing basic needs. Since they cannot all be adequately met, priorities are set. In particular, priority is given to other important basic needs such as housing or eating. Beyond the financial barriers and organisational difficulties in accessing healthcare (e.g. transportation), personal and psychosocial characteristics may also form barriers to access. This includes the perception of healthcare professionals (cultural distance, etc.), psychosocial reactions such as the downplaying of health issues, fear, being used to difficulties, being distracted from health problems, etc.

94. « *La précarité est l'absence d'une ou plusieurs des sécurités, notamment celle de l'emploi, permettant aux personnes et familles d'assumer leurs obligations professionnelles, familiales et sociales, et de jouir de leurs droits fondamentaux. L'insécurité qui en résulte peut-être plus ou moins étendue et avoir des conséquences plus ou moins graves et définitives.* » (Wresinski 1987).

We observed a significant increase in the proportion of persons with unmet medical needs who were in arrears on their utility bills or housing costs, i.e. people who face financial hardship for housing have been finding it increasingly difficult to afford medical care since 2011 (OR=2.6***). This finding was reflected by the interviewees, who reported an increase in the number of persons covered for healthcare finding it difficult not only to pay for healthcare, but more generally to pay their bills with their disposable income.

Precariousness leads to unmet healthcare needs, because of the fear of aggravating a difficult financial situation with additional OOP expenses. General practitioners reported how some people prioritize medical care according to its costs and the degree of severity of the health issues. Also, interviewees noted that high OOP payments for healthcare, in particular hospitalisation costs, for people who can just make ends meet can seriously destabilise their overall financial situation for a long time.

Different profiles of people were mentioned, such as persons living on an invalidity allowance, retirees with a low pension, people who are socially isolated, single parent households, the unemployed. Several interviewees also raised the specific problems encountered by persons with mental health issues. As well as having a low level of financial resources, they may be reluctant to consult a doctor. GPs reported that this problem may also aggravate their financial situation, because of the necessity to consult a GP in order to have their condition recognised.

6.1.5 People without mandatory health insurance coverage

Many examples have been provided of people who are not covered for healthcare, including: those who did not pay their social (or personal) contributions, in particular among the self-employed; those who failed to take the necessary administrative action to be covered, and those who have been deleted from the population register while they still live in Belgium.

Gaps in population coverage occur particularly in countries that lack effective mechanisms to enforce collection, and this is more likely to affect relatively vulnerable groups of people (Thomson *et al.* 2016). In EU countries, we can see an increasing trend towards residence-based coverage for the entire population (European Commission 2019b), including some countries with a social health insurance model: France, Croatia and the Czech Republic ([95]).

6.1.5.1 Lack of exhaustive data

We were unable to find data on the number of people who are not covered for healthcare in Belgium, or to estimate the importance of each of the reasons put forward during the interviews.

According to the OECD, 99% of the population in Belgium was covered by the compulsory national health insurance system in 2016 (OECD and European Union 2018). This percentage has remained rather stable over the last decade (Devos *et al.* 2019). The percentage of

95. https://www.oecd-ilibrary.org/sites/3c8385d0-en/1/2/5/index.html?itemId=/content/publication/3c8385d0-en&mimeType=text/html&_csp_=b34e17fcb01ce2b733f2804c894c2118&itemIGO=oecd&itemContentType=book#tablegrp-d1e60396%20table%205.1 (latest consulted on 18/06/2020).

uninsured persons is higher in Brussels, 1.9% and Wallonia, 0.7% and within the age category 25-40 years, where more than 2% are not covered (Devos *et al.* 2019). However, in this indicator, the definition of 'population' (100%) only takes into account people who are affiliated to a sickness fund.

Thus, the 1% of people who are not covered includes:

- People who lost their entitlement for less than two years.
- People who are in a trial period during the process of re-joining a sickness fund

Several categories of persons officially registered in Belgium are, however, not included in these data:

- People covered by another system:
    - Those working for international organisations
    - Those covered in another EU country, for instance posted workers
    - Asylum seekers, in an ongoing procedure, entitled to specific medical assistance schemes
    - People in prisons
- People officially residing in Belgium but not affiliated to a sickness fund:
    - People who lost their entitlement more than two years ago.
    - People performing undeclared work who did not pay personal contributions for healthcare coverage and are not covered as dependent persons;
    - Posted workers not covered in their home country;
    - People qualifying for compulsory health insurance but who did not take the necessary administrative steps to affiliate themselves or their dependents to the sickness fund. This may include people in particularly vulnerable situations, people with mental or addiction problems, etc.
- People in the process of affiliation (going through the administrative process)

Furthermore, the data do not include persons not officially registered in Belgium such as:

- People ex officio removed from the population register (erroneously or not).
- Homeless people without a reference address;
- Undocumented migrants;
- Foreigners who have lived for less than three months in the country.

6.1.5.2 Reasons for lack of coverage

We identified various causes explaining the absence of health insurance coverage.

While the consequences of not being covered are very serious in terms of access to healthcare, there are a whole series of situations in which people are not covered, merely due to a lack of administrative action by them themselves or their parents. This may be due, for instance, to a lack of information, negligence or mental difficulties. The groups affected include non-covered children of a parent who is covered, self-employed workers who paid their social contributions but did not take action to join a sickness fund, or young people leaving their parents' home. It is hard to understand that these realities persist. However, solving these administrative issues is, in most cases, quick, as such cases are less complex than non-coverage for other reasons.

Other problems stem from a lack of enforcement of existing legislation. This is in particular the case of self-employed people who are not paying their compulsory social contributions. Various people can be exempted from paying contributions in specific cases, but these rules make the system so complex that even specialised sickness fund services are sometimes unable to provide clear guidance on the applicable rules. As a result, people do not take action to settle their situation, because they are convinced that they owe a large amount.

Some coverage issues may be caused by loopholes in the legislation, in particular the possibility for EU citizens to obtain a residence permit as self-employed, without deploying real activity, over longer periods.

One of the most serious issues resulting in absence of mandatory health insurance coverage is triggered by the administrative act of deleting people from the population register. This action places the victim in a catastrophic situation in several domains, including loss of all social rights. According to our respondents, some of the people affected by such a measure never left the country, are sometimes still living in the house where they were registered and may even not be aware that they have been deleted. Mistaken deletions have been reported, at the initiative of an owner or because the house is deemed to be uninhabitable. Recent data from the Belgian Institute of Statistics (Statbel) confirm the substantial increase in the number of people deleted from the population register in the Brussels region: from an average of 16,283 persons in the period 2011-2015 to 20,397 in 2016; 20,234 in 2017 and 17,821 in 2018 ([96]). While there may be objective reasons for this increase, the examples provided raise questions on the accountability of services taking such decisions. A closer look at this trend is strongly advisable, given the enormous effects this action has for the citizens.

Finally, some coverage problems result from the inertia of public services in other countries. This applies to EU/EEA migrants or people who have stayed abroad for more than two years and who are unable to provide the required documents concerning their health coverage in the previous country. It sometimes takes a very long time to obtain the required documents. In the meantime, people do not qualify for health insurance coverage, and only have the right to urgent medical care.

6.2 Main reasons for unmet needs identified

6.2.1 Up-front payments

The generalised application of the third-party payment system for GP care for vulnerable groups was generally welcomed by the interviewees as a measure substantially improving access to primary care. Apart from this, up-front payments have been mentioned by most interviewees as a major hurdle for access to all other types of ambulatory healthcare.

Up-front payments are a typical feature of healthcare systems with a fee-for service payment system. In the EU, this applies to ambulatory care in France and Luxembourg, as well as in

96. https://statbel.fgov.be/nl/themas/bevolking/structuur-van-de-bevolking (latest consulted on 29/11/2019).

Belgium. In each of these countries, measures exist to protect vulnerable patients from up-front payments. In Luxembourg, local social security offices can certify, based on a case-by-case assessment, that a person is in financial difficulties. Upon presentation of the certificate, which has to be renewed each year, beneficiaries have access free at the point of use to medical and dental treatment. The costs of the treatment, including user charges, are paid directly by the national health insurance. Across-the-board third-party payment for medical care is under discussion (Swinnen 2018). In France, for beneficiaries with an income below a defined threshold, the total costs of healthcare and medical goods are covered and doctors must apply the third-party payment system (Huteau and Legros 2018).

In the interviews, up-front payments were often cited as an important hurdle to accessing physiotherapy, dental care, specialist care and GP home visits. A peak in the use of emergency services at the end of month was reported, since the invoice for the care provided there is sent to the patients' home afterwards.

For physiotherapy, up-front payments can be very high, since physiotherapists tend to only make an invoice after many sessions. Additionally, patients interviewed stressed that the uncertainty as to how long it would take to receive reimbursement of such large amounts, added extra financial difficulties. For many interviewees this hurdle was more important than the user charges themselves. Even for care that is provided for free for some groups, such as dental care for children, up-front payments remain an important hurdle. Schokkaert *et al.* also found that even fully covered healthcare is, to some extent, postponed or forgone by insured individuals. They suggested that this is due to non-financial factors, such as information or trust in the system. (Schokkaert *et al.* 2017). In our assessment however, up-front payments are an important financial hurdle for this care.

The high costs and prohibitive advance payments for the equipment for enteral and parenteral nutrition were mentioned several times during interviews. Furthermore, this care is only partially reimbursed and only if the advisory doctor of the sickness fund agrees ([97]). As a result, patients who are unable to pay the amount in advance, find themselves unable to receive care and even to be fed, or are forced to take out a debt to care for/ feed themselves.

When the third-party payment system is not automatically applied, the rules are very complex. Patients have to understand to which health services the system may apply and to check whether they may be entitled to apply the system. Then, they must call around to healthcare professionals to ask whether they would be willing to apply the system in their particular case. Social services and community primary care centres spend a lot of time contacting healthcare providers to ask whether they would be willing to apply the third-party payment system for their clients or patients.

The rules on the third-party payment system lack consistency, as illustrated by the following examples:

97. Internal note of the unit of experience experts federal Public Planning Service (PPS) Social Integration, 2019.

- Dentists providing basic dental care are only in exceptional cases allowed to apply the third-party payment scheme for patients older than 18. Nevertheless, some specialist dentists can apply the scheme for consultations.
- Some user fees for particular specialist care are lower for patients who are referred by their GP. However, patients who want to use the third-party payment system for social reasons cannot apply these reduced user charges.

The fact that the application of the rules depends on the willingness of the provider is furthermore not in line with social policies aimed at ensuring a social right.

Interestingly, in the home nursing sector, the third-party payment system is generally applied.

6.2.2 Out-of-pocket payments

6.2.2.1 Out-of-pocket payments and financial access to healthcare

The level of OOP expenses is a crucial element in understanding unmet healthcare needs. In countries where the share of households' out-of-pocket payments in total health expenditure is high, the probability of unmet needs increases (Chaupain-Guillot and Guillot 2015). Rice et al found that perceptions of reduced access to care posed by OOP spending are influenced by three factors: per capita spending, recent changes in OOP requirements, and the existence of effective safety mechanisms (Rice *et al.* 2018).

A distinction should be made between different forms of out-of-pocket payments (OOP) (see Section 1.2). The amount of the direct payment depends on the range of services and products covered (scope coverage). User charges reflect the share of the price of services and products covered (depth coverage), and fee supplements are top-ups of the officially defined tariffs.

Compared to its neighbouring countries, the overall level of OOPs in Belgium is relatively high.

User charges apply in Belgium to most healthcare services, with some, rather limited, exemptions. In most European countries, user charges apply to some health services and products. However, there are substantial differences in the general approach to user charges. In many countries, health services covered by the statutory health system are predominantly available free at the point of use ([98]), while in others, cost-sharing applies for most inpatient and/or outpatient care services ([99]) (Baeten R. *et al.* 2018).

Interviewees explained the different mechanisms resulting in unmet healthcare needs for financial reasons. However, they did not always specify the kind of OOPs they were referring to (direct payments, user charges or fee supplements).

98. Including Austria, Czech Republic, Cyprus, Denmark, Greece, Spain, Hungary, Lithuania, Latvia, Malta, Poland, Romania, Slovakia and also in the United Kingdom.
99. Including Belgium, Bulgaria, Germany, Estonia, Finland, France, Croatia, Ireland, Italy, Luxemburg, Latvia, the Netherlands, Portugal, Slovenia, Sweden and also in Switzerland, Iceland, Macedonia, Norway, Serbia, and Turkey.

Furthermore, patients may, when fully informed, decline healthcare due to costs. They may however also forego healthcare based on partial or wrong information on the costs they will have to bear or to pay up front.

Finally, past unpaid OOP expenses are a further hurdle to accessing healthcare. Arrears on hospital bills were mentioned as a cause of hospitalisation postponements.

6.2.2.2 Out-of-pocket expenses for hospitalisation

Coverage for hospital care is low in Belgium compared to other EU countries. While in the EU as a whole, 93% of the costs of hospital care are covered, only 77% are covered in Belgium (2016). Among EU countries, only in Greece, Ireland and Cyprus compulsory coverage for hospitalisation is lower. As observed by the OECD, in the latter three countries, patients frequently choose treatment in facilities not included in the public benefit package (OECD and European Commission, 2018). The remaining 23% of hospitalisation costs in Belgium are partially covered by voluntary and private health insurance. Nevertheless, more than half of this amount comes from OOPs (OECD, 2019b) ([100]).

High advance payments and OOP expenses were reported for patients hospitalised in double rooms. Interviewees mentioned that the IR status did not sufficiently protect people from prohibitive hospitalisation costs; such costs may represent an important share of the household budget for low-income patients. But also for middle-class people, without IR status, important affordability issues were reported. Various reasons were mentioned, in particular long stays (particularly in intensive care wards) and specific costly health equipment (e.g. prostheses).

Furthermore, healthcare access is likely to be reduced for patients who are in arrears at the hospital. This current situation is highly problematic for both patients and hospitals. Hospitals and doctors reduce access to healthcare when they fear that the patient cannot afford the care. Patients are reluctant to be hospitalised because they are in arrears at hospital. Hospitals are penalised financially if they treat patients who are unable to pay. The policy of many CPAS/OCMW to not financially cover the payment arrears for hospitalisation partially explains this problem of the financial burden being shifted to the patient.

Sickness funds also reported high OOP expenses for hospitalisation costs in a shared ward. The Christian sickness fund estimated average OOPs in wards among their affiliates at 278 € in 2018 (Mutualité Chrétienne 2019). However, they found large varieties between hospitals. Some hospitals charge non-reimbursable fees for some procedures, with the result that the cost charged to the patient for the same procedure can be (almost) as high in a ward as in a single room ([101]). High OOPs for medical devices, regardless of the social status of the patient (IR or not) are reported by the socialist sickness fund. For instance, in 2017, for a knee prosthesis, the cost for the IR patient was estimated at 727 € (548 € for the prosthesis), as no specific preferential tariff exists for IR patients (De Wolf and Laasman 2017). Low-income patients are thus not protected from high OOP expenses for health materials.

100. In Figure (5.2) in the OECD publication, the exact percentage of OOP is not mentioned.
101. https://www.cm.be/actueel/onderzoeken/ziekenhuisbarometer-2018 (latest consulted on 16/06/2020).

The figures for hospitalisation costs for vulnerable people should be considered in light of their healthcare needs and, moreover, the frequency and length of their hospital stay. Indeed, vulnerable people often have a worse health status (Capéau *et al.* 2018; Van Roy *et al.* 2018; OECD/European Observatory on Health Systems and Policies 2019) and thus higher healthcare needs. Overall, people in precarious situations such as low socio-economic status, living in poorer municipalities or with bad housing conditions or socially isolated are more frequently hospitalised, for a longer duration and are less likely to use one-day hospitalisation (even after adjusting with health status) (Closon and Perelman 2003; Hercot *et al.* 2017; Capéau *et al.* 2018; Laasman *et al.* 2018).

As a consequence, individuals in precarious situations may have to pay higher OOP expenses for hospitalisation, that represent a comparatively higher share of their household budget, due to more frequent and longer stays. On the other hand, they may have reduced OOP expenses because of their increased reimbursement status.

Prohibitive costs for transport between hospitals were also mentioned, in particular in regional hospitals with few specialisations, and in cases when the patient has been brought to the hospital by the emergency services. When the hospital system is reformed, with more task division between hospitals, the need for inter-hospital transfers of patients may increase. This issue has also already been raised by other actors ([102]). Charging patients for transportation costs in case of hospital transfers is questionable with regard to equity, as the user charges for treatment vary according to the place of residence: i.e. in an emergency, patients living far from hospital centres are more likely to receive the treatment required at far greater expense than patients living close by. Horizontal equity is achieved (equal treatment for equal need) but at an unequal cost for patients, because some treatments are unavailable in some geographical locations.

6.2.2.3 Out-of-pocket payments for ambulatory care

c. Primary care

Access to GP care is overall considered relatively good, in particular for people with IR status, both in individual practices and in community primary care centres.

Community primary care centres play a crucial role in ensuring access to healthcare for people in precarious socio-economic situations, because of the absence of up-front payments and the low or no user charges. They also play a role which goes far beyond the provision of health treatments or preventive care. They advise patients on affordability issues by informing them about the OOP expenses, they search for financial solutions, contact other health providers to discuss financial matters for patients, lend medical devices/equipment, make agreements with a pharmacy or have their own limited stock of pharmaceuticals to provide for free. However, they

102. https://corporate.devoorzorg-bondmoyson.be/flits/patient-betaalt-tot-2000-euro-voor-vervoer-tussen-ziekenhuizen/?utm_source=2020-01-28%26utm_medium=mailing%26utm_campaign=300%20flits (latest consulted on 16/06/2020).

only cover a small share of the population (less than 4%) and are concentrated in specific (mainly urban) areas.

Financial hurdles for accessing physiotherapy and dental care were frequently mentioned, not only for vulnerable people.

User charges for physiotherapy are difficult to afford for both IR and non-IR patients. As a consequence, physiotherapy is either not taken up, or only for a limited number of sessions. Moreover, interviewees also raised the problem of absence of information on the OOP expenses due after reimbursement.

Prohibitive costs for dental care may be due to high user charges or non-reimbursable care, in particular for orthodontics and dentures (e.g. in case of a broken tooth). Other studies found that non-compliance with the care trajectory is a source of additional user charges, in particular for vulnerable populations. The sickness fund Solidaris found that, in 2017, 30% of their members had not consulted a dentist in the previous year, which led to additional OOP expenses estimated at 27 € per patient on average and more than 35 € for 25% of the patients. Non-compliance rates ranged from 39% for members living in the most deprived areas to 25% for members living in the richest neighbourhoods (Laasman *et al.* 2019). Another study observed that for adults, the probability of having no contacts with a dentist in the three previous years was much higher in the poorest municipalities than in the wealthiest municipalities (47% higher probability) (Avalosse *et al.* 2019).

d. Medicines and medical devices

Medicines are often difficult to afford, and people may decide not to purchase some or all of the prescribed medicines, or to postpone buying some of them, in order to pay for the medicine they need most. Poly-medication is a cause of financial hardship but prescribed non-reimbursed pharmaceuticals such as pain killers or food supplements needed in cases of severe diseases, or skin creams, are also often difficult to afford. The high cost of medicines for psychiatric conditions was also highlighted.

According to many interviewees OOPs for medicines have substantially increased over time. It is however not clear from the interviews what the specific reasons for this increase are. One or more of the following factors could in principle be resulting in higher costs for the patient: 1) an increasing quantity of medicines prescribed; 2) higher prices for non-reimbursable medicines; 3) higher user charges for reimbursable products; 3) delisting of products; 4) a shift towards prescribing pharmaceuticals with higher user charges (e.g. branded products instead of generic medicines) or, 5) a shift towards prescribing more non-reimbursable products (e.g. new and expensive products not included in the benefit package).

Difficulties in affording pharmaceuticals may be aggravated by the higher medication use of disadvantaged social groups. This higher use has been demonstrated for antibiotics, antidepressants and polymedication (Devos *et al.* 2019a).

Glasses, hearing aids and dentures were also often mentioned as difficult to afford. Broken equipment was sometimes not replaced due to its cost, at times with severe adverse health consequences.

e. Post-treatment costs

Unaffordable post-treatment costs are likely to lead to a discontinuity of care after hospital discharge. Affordability issues among low-income patients were highlighted in relation to post-hospital treatment (such as wound care, physiotherapy or medicines), sometimes with major negative health consequences.

f. Transportation costs

For ambulatory care provided at the hospital, interviewees stressed that they regularly meet patients with severe diseases, finding it very hard to afford transportation costs for recurrent trips to get health treatment such as dialysis, chemotherapy or radiotherapy, in spite of the financial support provided by the health insurance system (granted for public transportation or the use of own car).

6.2.2.4 Fee supplements

Fee supplements apply in healthcare systems where healthcare providers who do not agree to adhere to the conditions defined by the publicly funded system, in particular on prices, nevertheless qualify for funding from the public system. Apart from Belgium, this feature exists, in a variety of ways, in several other healthcare systems in the EU. Patients who are entitled to public or contracted outpatient and inpatient care also have access, on a cost-sharing basis, to health services delivered by private or non-contracted providers in Austria, Greece, Finland, France and Portugal. In most of these cases, the providers are free to set their tariffs. In France, since 2016, providers are no longer allowed to charge fee supplements to vulnerable groups (Baeten *et al.* 2018). In many other countries, private providers are not funded by the public system, and patients can access them by paying fully out-of-pocket or through their private health insurance.

Issues raised during the interviews with regard to fee supplements, related to the following problems:

First and foremost, patients living in precarious situations are often not aware of the consequences of the paper they sign on admission to hospital, asking to be hospitalised in a single room. Patients have to sign this form at a time when they are in a stressful situation. They may not have received adequate information on the consequences, or they may not have fully understood. There are indications that in some hospitals, information is not properly provided. This issue was highlighted particularly for day hospitalisation. Patients may also think that the compulsory complementary health insurance provided by their sickness fund covers fee supplements, while it only covers hospitalisation costs in shared wards. Examples were also given of patients who received high bills for excess fees, while they had requested for a shared ward in the form filled at their admission or had not been hospitalised in a single room. The importance of the choice of a single room or a shared ward for affordability of care is shown by figures provided by the Christian sickness fund: 80-90% of the OOPs of patients hospitalised in a single room are fee supplements (Mutualité Chrétienne 2019).

For ambulatory care, the professionals interviewed guided their clients to contracted providers. They mainly raised issues about healthcare providers who charge fee supplements in disciplines where there is a shortage of contracted practitioners. Dental care, ophthalmology and psychiatry have been frequently mentioned.

However, patients who are not supported by a social service or a community primary care centre find it very difficult to understand the system and to find out whether their provider is contracted, partially contracted or not at all. Hospital social services stressed that patients are not aware of the differences in status between contracted and not-contracted doctors, and patients interviewed from a patient advocacy group, who are well aware of the dual system, highlighted that they were unable to find out whether their provider is contracted or not.

The availability of contracted practitioners (applying tariffs agreed between the healthcare providers and sickness funds) can provide an indication of how easy it is to consult a contracted provider in each category of health professionals, and how easy it is to avoid supplements. While the share of contracted GPs is high (86%), important regional differences can be observed ([103]): in Flanders, there are 7.4 contracted GPs for 1,000 insured persons (measured in full time equivalent), in Wallonia 6.81, and only 4.95 in Brussels (Devos *et al.* 2019a). Brussels region thus has a much lower density of contracted GPs than in the two other regions, based on the place of the physician's residence. Important geographical disparities were also observed in the density of contracted dental practitioners in 2016: in Flanders, there were 2.85 FTE for 10 000 population, 3.4 in Wallonia and 4.29 in Brussels (Devos *et al.* 2019a). There are also significant geographical disparities at local level, particularly in dermatology, ophtalmology (De Wolf *et al.* 2019). With regard to specialists, the density of contracted gynaecologists (in FTE) is particularly low in many districts.

It is well known that waiting times are longer if the patient wishes to have an appointment with a contracted specialist. However, patients may get an appointment more quickly in a non-contracted practice whilst paying fee supplements.

If insufficient contracted health professionals are available, this may result in long waiting times to get an appointment with a contracted health professional. In 2013, more than 38% of patients reported they had to wait for two or more weeks to get an appointment with a specialist. About 10% of these patients considered this waiting time as problematic. Waiting times for mental health services can be problematically long (more than one month for 37% of patients in 2013) (Devos *et al.* 2019a).

There is thus an interaction between unmet needs due to cost, on the one hand, and due to waiting lists, on the other. This should be kept in mind when interpreting the data on self-reported unmet needs in the EU-SICL data. Self-reported unmet needs for medical examination and care due to long wating lists, are, based on the EU-SILC data, relatively marginal in Belgium (Sections 4.1.1 and 4.2.1). Respondents may however report that cost is the most important reason for unmet needs, while in reality there is also an issue of waiting times to consult a contracted health provider.

103. Based on the physician's home and not the location of the physician's practice.

6.2.3 Complexity of the system

The complexity of the health system was mentioned by many interviewees as an important hurdle to access to care. This complexity applies at all levels of the system: the administrative procedures to obtain coverage and the exemptions on paying contributions; entitlement to increased reimbursement, the choice of a contracted healthcare provider, the right to the third-party payment system, the care trajectory and referral procedures which must be followed to benefit from reduced user charges, access to support from the CPAS/OCMW, etc. Some interviewees referred to this as 'Kafkaesque'. Several times social workers of hospitals flagged that the social services of sickness funds which they turned to, asking for clarifications for their clients, did not provide them with correct information, and as a consequence they guided their clients to the wrong services, with the wrong information on the amounts due or forms to be filled. Also the professionals interviewed sometimes provided erroneous information on the applicable rules.

An important share of the workload of the staff interviewed involved guiding people through the system: to make sure they are (again) covered for healthcare, to guide them to the contracted health providers, to make sure the providers apply the third-party payment system for their clients, to make sure that their clients/patients are hospitalised in a shared ward, etc. For persons who do not consult the social services, this leads to non-take-up of rights, postponing or refusal of necessary healthcare and important affordability issues.

Reduced availability of and assistance from administrative and social services creates further hurdles for taking up rights. Complex administrative cases in particular require direct interaction with social services. The digitalisation of the administrative process and of access to health-, social and administrative services adds a layer of complexity: people who are not IT literate do not fill the forms.

Some interviewees stressed that a lot of information is available and provided and that they make substantial efforts to reach the target population. However, for those who do not fit specific target groups, for people in the most precarious situations, people who do not speak the language, and people with mental health problems, the information provided is often not adequate. But also well-informed patients, such as the interviewees in the advocacy group of chronically ill patients, stressed that they often did not have the right information on basic issues such as how to find out whether the health provider is contracted, whether they qualify for increased reimbursement status or how much the sickness fund would reimburse of their physiotherapy bill.

6.3 Existing schemes to protect vulnerable groups

6.3.1 Increased reimbursement status

It was in general recognised that IR status is an important measure to help low-income people to afford healthcare. However, various issues related to this status were raised during interviews.

Firstly, **non take-up** of the IR status was reported for people not automatically benefiting from the status.

In order to improve take-up, the NIHDI and the sickness funds, in the period 2015-2017, actively traced and contacted potential beneficiaries of the increased reimbursement, through what was called the "proactive flux" ([104]) (Farfan-Portet *et al.* 2019). It was thought that an estimated 500,000 persons eligible for increased reimbursement were not benefiting from it, in particular among those who do not qualify for automatic granting of the status (Goedemé *et al.* 2017). 539,164 families with an income below the ceiling for increased reimbursement, representing 833,028 insured persons, have been contacted by the sickness funds since November 2015. Out of these, 255,790 persons received IR status on 1 January 2018 ([105]). There were important differences between sickness funds both in the way the potential beneficiaries were contacted and in the success rates in tracking down beneficiaries of IR status and granting them the benefit. Despite the overall success of this initiative, it is thought that there still is still considerable non-take-up, in particular among persons with comparatively lower healthcare costs (Goedemé *et al.* 2017). From 2020 onwards, the pro-active flux has been transformed from a one-off measure into a yearly organised practice (Van Lancker 2020) .On 30 June 2019, IR status was granted automatically to 920,557 persons, while 1,143,283 persons received it after means-testing ([106]) ([107]).

Interviewees reported high non-take-up of the status. This may be the result of a lack of awareness, information or hurdles to undertaking the necessary administrative action or to providing proof of household income (e.g. because of mental health issues, precariousness or lack of action from administrators of goods). The time period within which the administrative steps must be taken is a further barrier. It was highlighted that two months to provide the administrative forms required is too short for people in a precarious situation. Furthermore, the decision to extend the right by an additional year cannot, for some categories of beneficiaries, be taken based on their taxable income. In this case, the status is not renewed automatically, and the beneficiary has to re-apply for a renewal every year. An interviewee from a sickness fund mentioned that they invite their members to renew their application, but that the beneficiaries may not read or understand the letter or not take necessary action. However,

104. This proactive flux was part of a wider reform of the system of IR status in 2014.
105. Van Hellemont (2019) pptx, available at: https://www.riziv.fgov.be/nl/agenda/Paginas/symposium-verhoogde-tegemoetkoming-20190618.aspx (latest consulted on 10/02/2020).
106. Source: https://www.riziv.fgov.be/nl/toepassingen/Paginas/webtoepassing-statistieken-personen-aangesloten-ziekenfonds.aspx (latest consulted on 02/01/2020).
107. From a total of 1,930,202 beneficiaries in total on 31/12/2014 (Farfan-Portet et al, 2019).

others reported that no information is provided to show that IR status can be extended on the basis of an income analysis, in particular when the automatic entitlement ends (NIHDI and POD/SPP 2018).

Secondly, the **lack of progressiveness in the entitlement** was identified as an important issue: persons just above the threshold for the IR status are not entitled to any benefit. They lose important benefits in many domains (including also e.g. social tariffs for the internet, for gas, electricity, public transport, etc.), while their financial resources are not significantly higher. According to some social workers, they even face more hurdles accessing care than people with IR status, in particular when they have to be hospitalised for a longer period.

Thirdly, the **remaining user charges** remain high for some types of healthcare. This mainly applies to hospital care, but also to medical devices and medicines.

It should be noted that in 22 out of 28 EU Member States (including the UK), vulnerable groups are fully exempted from user charges for a broad range of healthcare services. In many EU countries most healthcare services are predominantly free at the point of use ([108]), while some of these countries provide even more exemptions from user charges for vulnerable groups ([109]). In other European countries, specific vulnerable groups are fully exempted from user charges for a broad range of healthcare services and products ([110]) (Baeten *et al.* 2018). Exempting poor people and regular users of care from co-payments was found to be linked to a low incidence of catastrophic spending on health (OECD and European Commission, 2018) ([111]).

6.3.2 Maximum billing

The maximum billing system (see Box 19) was barely raised by the interviewees. This should probably not come as a surprise. The maximum billing (MAB) is a financial protection measure to avoid excessive health spending and to limit annual healthcare costs for all households. It protects economically weaker groups relatively well against the financial consequences of illness (Schokkaert *et al.* 2008). However, an (ex post) financial protection system such as the MAF cannot address unmet needs due to costs (Schokkaert *et al.* 2008). Households have first to be able to pay these costs up-front.

108. Including Austria, Czech Republic, Denmark, Greece, Spain, Hungary, Lithuania, Latvia, Malta, Poland, Romania, Slovakia and also in the United Kingdom.
109. Including Austria, Cyprus, Spain, Hungary, Poland, Romania, and the United Kingdom.
110. Including, Bulgaria, Slovenia, Finland, France, Croatia, Ireland, Italy, Luxemburg, Sweden and also in Norway, Serbia, Iceland.
111. "Catastrophic health spending occurs when the amount a household pays out-of-pocket exceeds a predefined share of its ability to pay. This may mean the household can no longer afford to meet other basic needs like food, housing and heating or cannot afford to meet basic needs without drawing on savings, selling assets or borrowing."(Thomson *et al.* 2019).

Box 19: The maximum billing

To avoid households facing financial hardship due to healthcare costs, the total annual amount of user charges is capped per household. Expenditure exceeding the cap is reimbursed for that year. This system is called maximum billing (MAB). Four types of MAB apply:

- The income MAB is a system for which everyone is eligible. With this type of MAB, the maximum amount is calculated based on the net taxable household income (including income from assets) ([112]). This MAB ranges from 477.5 € for the lowest income category to 1,910 € for the highest.
- The social MAB applies to the members of households that are entitled to IR. The total maximum amount to be paid by households receiving the IR is 477.5 € per year.
- For a child under the age of 19, the maximum amount of user charges due cannot exceed 690 €, regardless of the family income.
- The MAB for the chronically ill: The MAB is reduced by a lump sum of 106 € if: either the total amount of the co-payments of one of the household members during each of the 2 previous calendar years was at least 478€; or, a family member was given the status of "chronically ill" during the current calendar year.

The MAB includes the following user charges: fees of healthcare providers; most reimbursable medicines; technical services such as medical imaging, lab test and admission fees, and daily hospitalisation fees.

Source: own elaboration, based on information available on the official websites of the Belgian public authorities, in particular NIHDI, and of the sickness funds. The text has been reviewed by the NIHDI services.

An annual cap on user charges, above which no further user charges are due, applies in a variety of ways in many European countries. Thresholds can be set per household or per insured person (Baeten R. *et al.* 2018) ([113]). In European countries where such a cap applies, a lower incidence of catastrophic health spending was found (OECD and European Union 2018).

The clients of the interviewees often live from day to day and do not have the financial means to wait until they reach the threshold before being eligible for the maximum billing. They face financial hurdles accessing healthcare before that moment. Furthermore, the social and health workers interviewed are generally not aware of the past co-payments made by the patients. Moreover, the individual cases mentioned with catastrophically high levels of out-of-pocket expenses, in particular relating to hospital care, concerned both user charges and other out-of-pocket expenses, and it was not clear from the interviews which share of the OOPs would qualify for the MAB.

To assess the effectiveness of the maximum billing as a tool to protect households from the risk of impoverishment due to healthcare costs, other quantitative methods may be more appropriate.

112. Since 2019, this is based on the net taxable family income from 2 years earlier. Up to and including MAF 2018, it was based on the net taxable family income from 3 years earlier.
113. Austria, Belgium, Germany, Finland, Croatia, Ireland, Luxembourg, Latvia, Sweden and Slovenia, and also Switzerland, Iceland, Macedonia, Norway, Serbia.

6.3.3 The role of the Public Centres for Social Welfare

The CPAS/OCMW play a crucial role in providing financial support to the least well-off patients in the area of healthcare costs. While our research did not aim to give an exhaustive description of the differences in policies between the municipalities, the interviews allow us to identify a variety of approaches to healthcare cost subsidies for people with health insurance coverage.

There are differences in policies concerning what the financial support is granted for, and subject to what conditions.

In some CPAS/OCMW, coverage of user charges is granted for a broad range or all healthcare services and products in a defined period; in others, it covers only specific and recurrent OOP expenses (based on prescriptions).

Eligibility criteria for CPAS/OCMW financial support also vary considerably. In some municipalities, only income is taken into account (e.g. the Integration Income threshold), in others, expenditure for essential goods and services, such as housing, is also considered. Benefits may be granted only to those with an available household budget below the threshold, while in others there is some progressivity in the calculation of the financial intervention. When no progressivity is applied, persons with incomes just above the threshold are excluded, while they have to pay high and in some cases even catastrophic healthcare costs.

Another difference identified is in the financial support granted to cover OOP expenses for hospitalisation: in some municipalities, there is no financial support for OOP hospital expenses and clients in arrears are offered a payment plan. As was shown during the interviews, this may make patients more reluctant to access healthcare. It may also incentivise hospitals to ask for advance payments or refuse patients.

Since CPAS/OCMW policies vary widely across municipalities, this is likely to result inequities, differentiated treatments for similar situations. Municipalities with a poorer population have less means to invest in social policies and financial support for healthcare costs (Steunpunt tot bestrijding van armoede, bestaansonzekerheid en sociale uitsluiting 2015). While the approaches of the municipalities to coverage of healthcare costs vary hugely, this topic has barely been studied (Service de lutte contre la pauvreté,la précarité et l'exclusion sociale 2014; Steunpunt tot bestrijding van armoede, bestaansonzekerheid en sociale uitsluiting 2015).

The diversity in approaches may be an additional hurdle for patients, in particular in the Brussels region. For instance, moving from one municipality to another may have serious consequences, such as an administrative delay in settling the new situation, different levels of financial support and even a change of healthcare providers.

6.4 Consequences of access issues

6.4.1 Adverse impact of unmet healthcare needs on health

The postponement of necessary healthcare may occur at different stages of the care process: delayed diagnosis, absence of timely health treatment or lack of continuity of care, particularly after discharge from hospital.

The qualitative analysis shows a link between unmet needs for healthcare for financial reasons and the worsening of health status. The impact on health was most clearly reported for patients with chronic health issues. Many examples were provided of chronically ill patients whose health problems could be directly attributed to their difficulty affording usual treatment (e.g. wound complications because of absence of adequate wound treatment after discharge from hospital). Due to a gap in the continuity of care, a rapidly worsening health status was observed, requiring in some cases re-hospitalisation. For other patients, not chronically ill, the causal relationship between postponed or forgone healthcare and health issues is less clear. However, some examples were provided of acute health issues (e.g. postponing medical examinations of lungs because of the absence of health coverage, or dental infections). The link between a worsening health status and unmet needs for medical care for financial reasons was also demonstrated in France, using an econometric model (Dourgnon *et al.* 2012). Renunciation of care was associated with a higher prevalence of a worse health status four years later, regardless of the other individual characteristics likely to influence the evolution of the health status. For particularly vulnerable groups, unmet healthcare needs may lead to a vicious circle with higher morbidity: difficulties in access to healthcare may lead to more severe health issues which require more serious health treatment with higher OOP expenses.

Unmet needs for healthcare, leading to substantial adverse health consequences, play a role in inequalities in health, alongside many other negative upstream determinants (e.g. type of work, nutrition, other stressors, etc.). The overall contribution of healthcare services to the heterogeneity of the self-reported health status is estimated at 10% (WHO 2019). In Belgium, health inequalities can be seen between low-income municipalities (based on the fiscal median income of households) and the well-off municipalities (Avalosse *et al.* 2019). There is excess mortality in the poorest municipalities compared to the wealthiest: people living in poor areas have a risk of death in the current year which is 56% higher than for those living in the richest areas.

6.4.2 The hidden costs of the inaffordability of access to healthcare

6.4.2.1 Costs of the administrative work

From the perspective of the public administration, dealing with individual cases (including also potentially the preliminary administrative work done by the social workers at hospital) may be more costly than the level of expenses themselves for which help is asked.

Additionally, given the complexity of the system, the social services sometimes have to invest considerable time to ensure that people are granted what they are entitled to.

Furthermore, in a municipality without a medical card scheme, the benefit to patients of seeking financial help from CPAS/OCMW for an acute health issue may remain lower than the cost of taking administrative action, particularly when they are in bad health (e.g. tiredness, pain, reduced mobility). This is likely to lead to unmet healthcare needs.

6.4.2.2 Preventable healthcare costs

Adverse health consequences of postponing treatment may not only affect the patient's budget but potentially impact the finances of the other payers. The severe adverse health consequences mentioned by interviewees were likely to generate high health treatment costs: e.g. hospitalisations in intensive care for cardiovascular disease, or infection due to broken dentures, or re-hospitalisations (healthcare cost distribution is specific, i.e. a concentration of an important proportion of the total costs on a small proportion of patients). Such treatment costs can be prevented by better access to healthcare.

6.5 Strengths and weaknesses of the methodologies used

6.5.1 Quantitative analysis

EU-SILC data make it possible to estimate the share of people with unmet needs for medical and dental care in the Belgian population by using a representative sample of the adult population. However, there are several drawbacks in using EU-SILC data.

6.5.1.1 The type of healthcare considered

The survey only measures unmet needs for medical care (examination and treatment): "*medical care refers to individual healthcare services (medical examination or treatment) provided by or under direct supervision of medical doctors*" and draws no distinction between in- and outpatient care. Other types of healthcare need are not included, such as physiotherapy, drugs (prescribed or not) or medical devices (e.g. glasses).

6.5.1.2 Target population

One of the major limitations of EU-SILC data is that certain groups are not surveyed. Some of the most vulnerable groups -those without an official residence and those living in collective facilities- are excluded. This is likely to lead to an underestimation of inequalities, as persons living in such precarious situations are most likely to have higher needs for healthcare and less access to healthcare.

6.5.1.3 Potential bias regarding health needs

People with a similar objective health status, in different social groups, may rate their health status (or morbidity) differently (Devaux *et al.* 2008) and thus estimate their needs for healthcare differently. Age and gender are often identified as factors which cause differences in the self-perception of health status. In the regression model the need for healthcare is adjusted by using three proxies related to the health status:

- a self-rated health measure which is based on a subjective perception of health;
- and two other indicators that may be less subjective: the presence of functional limitations to perform daily living activities and the presence of a chronic illness.

6.5.1.4 Potential bias of self-reported unmet needs for healthcare

Our study provides some insights into the potential declaration bias. GPs interviewed reported that low-income individuals tend to underestimate their needs for healthcare. Hence, for vulnerable groups of population, unmet needs for healthcare may be underdeclared. The risk of distortion between self-perceived and objective needs for healthcare is greater for vulnerable groups in the population than for the more advantaged groups.

Desprès (Desprès 2013) also brought some insights on how individuals interpret the question and may provide biased answers. The perception of relative financial difficulties may distort the identification of one's own unmet needs: if people find themselves in a relatively better situation, they tend to underestimate their own problems, as a way to distinguish themselves from people with an even lower income. She also identified another source of self-censure: when the financial situation of a person has drastically worsened, he may not dare to declare unmet needs to the interviewer as he fears social stigma.

Hence, in disadvantaged groups of the population, underestimation of the share of persons with unmet needs for healthcare may be due to an underestimation of the need for healthcare. Based on objective needs for healthcare, the proportion of people with unmet needs is likely to be higher in these subgroups of population.

6.5.1.5 Question on unmet need in the EU-SILC survey in French and Dutch

The two versions of the question do not actually have the exact same meaning. The wording of the question on unmet need for medical care differs slightly between the French and the Dutch questionnaires: in French, the question is about not having sought medical care; while in the Dutch question, it is more about not having received medical care (see Annex II).This issue should be further investigated, as such a variation in the definition of the problem might result in distortion of answers and thus a bias of the results.

6.5.1.6 Unobserved factors in the statistical analysis

Unobserved factors may also influence unmet needs, particularly those linked to the particularities of local contexts.

6.5.1.7 Disposable equivalised income

The disposable equivalised income is supposed to accurately reflect the level of financial resources, while this indicator does not perfectly capture a household's available resources. However, this may be more of an issue for better-off individuals, since additional sources of income, from assets for instance, may not be declared during the interview.

6.5.2 Limitations of the qualitative analysis

6.5.2.1 Differences in perception of financial access issues

The aim of the qualitative study was to explore the wide variety of problems people face in accessing healthcare in Belgium. The professionals interviewed provided a richness of points of view and experiences. However, they raised the issues from their specific perspective, which is confined by their profession, their roles, the type of institution they work for, the type of clients they work with, the type of catchment area and even sometimes by their own experience. However, the discrepancies actually observed between the professionals interviewed relate more to differences of experience than real inconsistencies in their perception of the situation. For instance, the frequency and seriousness of the difficulties of chronically ill patients in affording healthcare will be perceived very differently by a GP working in a multidisciplinary primary care centre and a social worker working in an emergency service in a public hospital. The latter is more often in contact with chronically ill patients in acute situations and has to find a suitable budgetary solution for patients in a situation of financial hardship.

6.5.2.2 Only visible cases described

What all the interviewees had in common is that they support people with issues in accessing healthcare. This means that they deal with clients and patients who have found their way to the social or health service in question. The interviewees do not have information on those persons who did not call on the health and social services for support. We tried to compensate for this bias during the interviews by also enquiring about the situation of clients who consulted the service for the first time.

GPs interviewed reported that they had patients who openly reported that they found it difficult to afford healthcare. However, they also mentioned cases in which they only posthoc or accidentally found out that patients had not followed a prescription or had postponed a consultation for financial reasons. Social workers also reported that they do not see all the patients who cannot afford healthcare: only a certain share of the individuals in this situation apply for help.

While some specific situations may not have been identified or sufficiently described (e.g. chronically ill patients with a mental health disorder), the qualitative study describes a broad range of individual situations.

6.5.2.3 The profile of interviewees

The variety of profiles of persons interviewed was limited. However, the different profiles of interviewees have allowed us to identify various access issues: the point of view of GPs allows us to identify the frequent access problems faced by patients when they are confronted with minor health events or as a first entry point for more severe health issues. Social workers working at public hospitals deal with a greater variety of patients and are more likely to report a wide range of access and affordability issues. Their experiences are more related to problems

potentially at high risk or directly related to major health events. Social workers in the CPAS/OCMW are in contact with a population in precarious situation.

The profile of interviewees could have been more varied: for instance, for specific affordability issue such as hospitalisation OOP expenses, professionals dealing with hospitalisation invoices could have more in-depth knowledge of the different cost components of hospitalisation charged to patients. Social workers in private hospitals and GPs working in individual practices could have provided different perspectives on the difficulties people face in affording healthcare services. While the qualitative study is not appropriate or sufficient to provide an in-depth analysis of each major hurdle identified, it describes a broad range of issues and also proposes further research for a more in-depth analysis of major and frequent access and affordability issues.

6.5.2.4 The number of interviews

Additional interviews in other rural areas or towns could have brought additional results. However, the most frequent access issues were recurrent after a certain number of interviews.

6.5.2.5 Reliability of the information

As it is difficult to be well-informed about the Belgian healthcare system, some interviewees sometimes provided erroneous information (e.g. overestimation of the costs of dental care).

The study describes the main issues affecting access to healthcare in Belgium. Since the qualitative data collection is limited, both in terms of the number of interviews and of the profiles of interviewees, some specific aspects, or situations (e.g. the particular situation of mental health patients) or underlying psychosocial mechanisms (e.g. the different individual ways to cope with affordability issues) leading to unmet needs for healthcare may remain unknown or are insufficiently described.

6.5.3 Mixed methods study

Some discrepancies are sometimes observed between qualitative and quantitative results (e.g. in relation to the self-employed). However, these mostly reflect differences in the population studied. In the quantitative analysis, unmet needs are analysed in the overall adult population while in the qualitative analysis, only those who have difficulties accessing healthcare are targeted. This means that some results may not appear in the quantitative analysis, as the number of persons in particular categories is relatively small: e.g. the number of self-employed on a low income may be relatively small in this group while qualitative findings mostly relate to self-employed people in the most precarious situation.

Chapter 7. Conclusion and recommendations

7.1 Conclusions: inequalities in access to healthcare in Belgium

While access to healthcare is, for the population as a whole, relatively good in Belgium, inequalities in access to healthcare between the least well-off and wealthier individuals increased substantially over the last decade. This is mainly because people on a low income have found it increasingly difficult to afford out-of-pocket expenses and up-front payments. This issue, combined with the finding of other studies that the number of persons at risk of poverty has increased in Belgium since 2011, should raise political concerns.

Our study did not identify obvious changes in the healthcare system that could help to explain this evolution. On the contrary, several measures were implemented in that same period to improve access to healthcare for vulnerable groups. We therefore hypothesise that one of the factors that could help to explain this trend is a deterioration of the available household budget of some vulnerable groups, after deduction of costs for other essential goods and services. The high proportion and significant increase in unmet needs for medical care among persons in arrears on their utility or housing bills, and the significant increase in unmet needs for tenants, point in this direction.

Our results show that the Belgian health insurance system is not equipped to adequately address the emerging problems and thus to protect vulnerable people from access issues. European comparisons also show the relatively low performance of the Belgian healthcare system for the low-income population. As a consequence, the vulnerable population, most in need of healthcare, are more at risk of foregone or postponed healthcare, with potentially serious negative impacts on health.

Some of the basic features of the health system, such as the fee-for-service remuneration of health providers and the link with up-front payments, make it more difficult to address inequalities in access to healthcare. The measures within the health insurance system to protect vulnerable people from prohibitive healthcare costs have proven to be insufficient. The many reasons for this are discussed in this report. Our study also shows the key role played by the residual scheme, organised by the municipalities, to provide financial support to low-income people to help them access healthcare, based on means-testing. However, the eligibility criteria and conditions for financial support are determined locally. This system is thus likely to lead to inequities in access to healthcare depending on the geographical location.

In light of these results, we invite stakeholders to engage in an in-depth discussion on how to move forward toward universal health coverage. We would urge an open discussion, on the very design of the system for ensuring access to healthcare and on the financial burden on patients, in particular vulnerable patients, in the system. In the context of the current health and economic crisis, the need of such debate becomes even more urgent, considering the high risk of unmet healthcare needs for so many people who incurred a sudden significant drop of their income. Ensuring equal access to healthcare and protecting patients from excessive out-of-

pocket payments should be the main goals of the compulsory health insurance system, not only in principle but also in practice.

7.2 Suggestions for further data collection and research

We identified the following gaps in our knowledge, and suggest further data collection and research on the following topics:

- **An in-depth analysis of the population not covered for healthcare in Belgium**

- **Setting up a monitoring system on the total amount of OOPs paid by the patient, including direct payments,** user charges and fee supplements, in particular:
    - OOPs by type of healthcare, using indicators appropriate for each type of healthcare (hospitalisation, medicines, primary care, laboratory tests, transportation costs, etc.)
    - Comprehensive recording of all fee supplements charged, including for outpatient healthcare
    - the different types of OOPs for medicines; the changes over time in the reimbursement schemes and costs for households;
    - OOP hospital expenses, including for one-day hospitalisation, and OOP expenses after discharge;

- **Monitoring of the availability of health providers,** in particular:
    - analysis of the availability/density of active health professionals (physicians and other professionals), based on their area of practice, agreement status (contracted or not) and linked to the characteristics of the local population;
    - monitoring of waiting times, in particular for contracted providers;
    - study of the number of providers agreeing to apply the third-party payment system for patients not in a scheme co-funded by the CPAS-OCMW;

- **An analysis of the differences between CPAS/OCMW in policies regarding coverage of OOPs, and trends in these policies;**

- **A specific survey/a barometer to regularly monitor access to healthcare, for in-depth study on:**
    - access to healthcare services (with a particular distinction between inpatient and outpatient care) and medicines and how this changes over time
    - the main hurdles for access, including the impact of up-front payments on access to healthcare;
    - the impact on access of schemes to foster access

- assessment of the patients' knowledge about the system, in particular of fee supplements and how easy/difficult it is for insured persons to find a contracted provider.
- the adverse health consequences of postponed/forgone healthcare and the associated costs.

7.3 Policy recommendations

Based on our analysis, we formulate the following policy recommendations:

Reforms of the national health insurance system

Universal population coverage

First of all, we invite stakeholders to engage in an in-depth reflection on population coverage for healthcare. Universal population coverage, based on residence, and enforcing payment of social contributions for those with financial means, may in the end be beneficial for all actors involved.

In the short term, measures should be taken to automatically affiliate, to a default scheme, all people who qualify for coverage but have not taken the necessary administrative action. Social security funds for the self-employed should be made responsible for joining their members up to a sickness fund. The action of deleting people from the population register should be subject to strict conditions, and application of the rules should be closely monitored by the federal authorities. Reversing the deletion of people who can prove they still live in Belgium should be quasi automatic.

Extension of the third-party payment system

The third-party payment system should be extended to all. By priority it should be applied automatically to vulnerable groups, for all types of outpatient care.

Reform of the increased reimbursement scheme

People with increased reimbursement status should be fully exempted from user charges, as is the case for vulnerable people in most EU countries. To make sure that all people who qualify, benefit from this status, it should, as far as possible, be granted automatically, and substantial and repeated efforts should ensure take-up for those who cannot obtain the status automatically.

Beneficiaries with an income slightly above the current threshold for IR status should qualify for reduced user charges, in particular when they face important healthcare costs.

Charging of fee supplements to people with IR status should be prohibited, for both outpatient and inpatient care.

In the short term, the administrative procedures for beneficiaries should be simplified and people should be helped, proactively and intensively, to claim the measures to which they are entitled.

Protect children from user charges

Children should have access to healthcare free of charge, as is the case in most European countries, irrespective of the insurance status of their parents.

Strengthen primary care and expand community primary care centres

Primary care is the entry point to healthcare. No user charges should apply to GP care.

We strongly advocate the expansion of the community primary care centres and a better definition of their roles. They should play a pivotal role in health promotion and disease prevention and in care integration at local level. The provision of social support to their patients should also be included in their core responsibilities.

Improve coverage of hospitalisation

The costs for hospitalisation in a common room should be strictly limited. In particular, costs for long stays and costs for prostheses should be reduced, not only for patients with IR status. The cumulation of advance payments should be limited. The costs of transfers of patients between hospitals should be covered.

A debate is needed on who should cover the payment arrears for hospitalisation of insolvent patients. The current situation is highly problematic for both patients and hospitals.

Improve coverage for specific types of care

Although for people in a vulnerable situation, all types of healthcare cost may form a substantial barrier, there is in particular a need to improve their coverage for some specific types of care, that are currently not or only marginally reimbursed. These include:

- Some categories of non-reimbursable prescribed medicines;
- Medical devices, in particular glasses, dental prostheses and some specific care material and bandages;
- Transportation costs for patients who need to come frequently to the hospital and are physically unable to use public transport or their personal vehicle.

Improve access to mental health services

Access to mental health services should be substantially improved. This implies improvement of both coverage and availability of services.

Increase transparency on out-of-pocket expenses

Overall, patients should be better informed of the cost of treatment. Proactive and transparent communication on any OOP expenses - user charges, fee supplements, non-reimbursed medicines, medical devices - should be mandatory so as to avoid non-agreed/unplanned OOP payments.

More transparency is needed on the contracting status of healthcare providers.

The information provided on the consequences of choosing a single room in hospital should be very clear and the application thereof should closely monitored.

Administrative simplification

Efforts should be made to simplify the administrative processes and to make the procedures automatic, as far as possible, at all levels of the health system.

Reforms of outside the national health insurance system

Harmonisation of the residual financial support provided by the CPAS/OCMW

Policies CPAS/OCMW on covering user charges and out-of-pocket payments should be harmonised, to avoid geographical inequalities in access to healthcare.

Accessible support from social and administrative services

Social services should be easily accessible for vulnerable people. They should provide sufficient possibilities for personal/direct contact, for administrative purposes, as an alternative to online services. Reflection is needed on possible ways to facilitate access to services for people with mental or physical health problems. Proactive actions should be taken at hospital by social services to trace patients at discharge who find it difficult to afford post-treatment costs. Although not a social service strictly speaking, the accessibility to the administrator of goods should be improved. Administrators of goods should be made accountable for ensuring access to care for their clients.

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Annex I Glossary

Table 1: Glossary

English	Dutch	French
Auxiliary Fund for Health and Disability Insurance (CAAMI/HZIV)	Hulpkas voor Ziekte- en Invaliditeitsverzekering (HZIV)	Caisse Auxiliaire d'Assurance Maladie-Invalidité (CAAMI)
Increased reimbursement (IR)	Verhoogde Tegemoetkoming (VT)	Intervention Majorée (IM)
Income Guarantee for the Elderly	inkomensgarantie voor ouderen (IGO)	La Garantie de revenus aux personnes âgées (GRAPA)
Third-party payer system	Derdebetalersregeling	Système de tiers-payant
(Community) primary care centre	Medisch huis	Maison médicale
Integration Income	Leefloon	Revenu d'Intégration (RIS)
Dental care pathway	Mondzorgtraject	Trajet de soins buccaux
Complementary health insurance	Aanvullende ziekteverzekering	Assurance complémentaire
Compulsory health insurance	Verplichte ziekteverzekering	Assurance maladie obligatoire
National Institute for Health and Disability Insurance (NIHDI)	Rijksinstituut voor ziekte- en invaliditeitsverzekering (RIZIV)	Institut National d'Assurance Maladie-Invalidité (INAMI)
Social worker	Maatschappelijk werker	Assistant social
Maximum billing (MAB)	Maximumfactuur (MAF)	Maximum à facturer (MAF)
Fee Supplements	Ereloonsupplementen	Suppléments d'honoraire
Public centre for social welfare (CPAS/OCMW)	Openbaar Centrum voor Maatschappelijk Welzijn (OCMW)	Centre public d'action sociale (CPAS)
Contracted care provider	Geconventioneerde zorgverlener	Prestataire de soins conventionné
User charges (or cost-sharing)	Persoonlijk aandeel (of 'remgeld')	Quote-part personnelle ou ticket modérateur

Annex II Questions on unmet needs for medical and dental care in the EU-SILC survey

An identical question is asked for both medical and dental care (in brackets) :

In French : « *Vous est-il arrivé, au cours des 12 derniers mois, d'avoir réellement eu besoin d'un examen ou traitement medical (dentaire), mais de ne pas l'avoir fait? (1. Oui, c'est arrivé au moins une fois; 2. Non, ce n'est pas arrivé)* »

« Pour quelle raison principale n'avez-vous finalement pas reçu un examen ou traitement médical ? »

« 1. Je n'en avais pas les moyens (trop cher ou pas couvert par la mutuelle ou une assurance)

2. Problème de distance / pas de moyen de transport disponible

3. Il y avait une liste d'attente ou je n'avais pas le document nécessaire pour être référé chez un médecin spécialiste (dentiste)

4. Je n'avais pas de temps, soit à cause de mon travail, soit parce que je devais m'occuper de mes enfants ou d'autres personnes

5. Peur des médecins (dentistes)

6. J'ai préféré attendre pour voir si le problème allait se résoudre par lui-même

7. Je ne connaissais pas de bon médecin ou spécialiste (dentiste)

8. Autre raison »

In Dutch*:* "Is het de afgelopen 12 maanden voorgevallen dat u echt een medisch (een tandheelkundig) onderzoek of behandeling nodig had, maar dit niet gebeurd is? (*1. Ja, dat is minstens één keer voorgevallen; 2. Neen, dat is niet voorgevallen)"*

Wat was de belangrijkste reden dat u toen geen medisch onderzoek of behandeling

hebt gehad?

"*1. Kon het me niet veroorloven (te duur of niet gedekt door de mutualiteit of een verzekering)*

2. Te ver / geen vervoer

3. Wachtlijst / had geen verwijsbrief

4. Geen tijd door het werk of door de zorg voor kinderen of voor anderen

5. Bang voor dokter (tandartsen), ziekenhuis onderzoek, behandeling

6. Wenste te wachten om te kijken of het probleem niet verbeterde uit zichzelf

7. Kende geen goede specialist (tandarts)

8. Andere reden"

Annex III Tables of variables used in the quantitative analysis of EU-SILC data

Table 2: The predisposing factors available in the EU-SILC data

Demographic	Gender	female, male
	Age group	16-24, 25-44, 45-64, 65+
	Country of birth	Belgium (LOC), European country (EU), outside Europe (OTH)
	Citizenship	LOC, EU, OTH
	Region (a)	Flanders (FL), Wallonia (W), Brussels (BX)
Social characteristics	Marital status	single, married, separated/divorced, widowed
	Single parent	yes, no
	Number of children under 18 living in the household (a)	zero, between one to two, three or more
Socio-economic characteristics	Education	primary education, secondary education, tertiary education
	Principal economic status	employee, self-employed, retired, student, unemployed, permanently disabled or/and unfit to work, home duties ([114])
	Tenure status (a)	outright owner
		owner paying mortgage
		tenant/subtenant paying rent at prevailing or market rate
		accommodation is rented at a reduced rate (lower price than the market price)
		accommodation is provided for free
Economic precariousness	Working three months or less in the twelve last months (two indicators are calculated, at individual level and at household level)	yes, no

(a): Variable at household level
Source: authors' own elaboration based on the EU-SILC codebook.

114. Including the category "Other inactive person", "In compulsory military or community service".

Table 3: The enabling and health need factors available in the EU-SILC data

Enabling resources*	Equivalised disposable income** of the household (a)	Quintiles
	At-risk-of-poverty (a)	
Health needs	Self-perceived general health status	very good or good or fair, bad or very bad
	Chronic illness	yes, no
	Functional limitations in activities	yes, no

* Enabling resources are shown at the level of the household and not at the individual level since financial hardship is thought to be mainly determined at the household level. No individual income factors are included.
** after social transfers, each member of the household is weighted: 1 for a person aged 14 or more, 0.5 for each subsequent adult (14 years and older), 0.3 for each child under 14 years old.
(a): Variable at household level
Source: authors' own elaboration based on the EU-SILC codebook.

Other variables with a potential to describe unmet medical needs are analysed at descriptive level but are, however, not included in the multivariate regression analysis. Very few people declared material deprivation. Other questions on financial hardship, such as on arrears or ability to make ends meet, are too closely linked to the problem of unmet healthcare needs for financial reasons. Technical issues related to how many variables to include in the regression analysis also played a role in our decision.

Table 4: Other relevant variables available in the EU-SILC data (not tested in the regression analysis)

Physiological precariousness	Ability to keep home adequately warm (a)	yes, no
	Ability to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day (a)	yes, no
Financial precariousness	Arrears on utility bills or housing cost (mortgage or rent) in the past 12 months (a)	yes, no
	Ability to face unexpected required ([115]) expenses (a)	yes, no
	Ability to make ends meet (a)	easily (including fairly easily and very easily), difficult (including with great difficulty, with difficulty, with some difficulty)
Social precariousness	Get-together with friends/family (relatives) for a drink/meal at least once a month (a)	cannot afford it, yes
	Regularly participate in a leisure activity (a) ([116])	cannot afford it, yes
	Ability to afford one week's annual holiday away from home (a)	cannot afford it, yes
Material deprivation	Having a phone (including a mobile phone) (a)	Yes, no
	Having a colour TV (a)	
	Having a washing machine (a)	
	Having a car (a)	
Housing conditions	Overcrowded household ([117]) (a)	
	Deteriorated housing (leaking roof, damp walls/floors/foundation, or rot in window frames or floor) (a)	

(a): Variable at household level

Source: authors' own elaboration based on the EU-SILC codebook.

115. Required expenses can vary between countries but examples include surgery, a funeral, major repairs to the house, replacement of durables like washing machine, car. DocSILC065 (2017 operation).
116. The activity (ies) considered, such as sport, cinema, concerts, etc should occur outside the home. This (these) would imply some costs for entrance and/or travel (e.g. swimming), for purchases (e.g. riding a bicycle) or for participation in an organised event (e.g. football club fees).
117. A person is considered to be living in an overcrowded household if the household does not have a minimum number of rooms equal to: one room for the household; one room per couple in the household; one room for each single person aged 18 or more; one room per pair of single people of the same gender between 12 and 17 years of age; one room for each single person between 12 and 17 years of age and not included in the previous category; one room per pair of children under 12 years of age.

Annex IV Tables of quantitative results on unmet needs for medical and dental care

Table 5: Reasons for unmet needs for medical care in 2011 and 2017

	2011		2017		Difference between 2011 and 2017
	%	**CI 95**	**%**	**CI 95**	**Unadjusted** ([118]) **OR**
Financial	1.4%	[1.1%-1.9%]	2%	[1.5%-2.6%]	1,4*
Waiting list	0.0%	[0.0%-0.1%]	0.0%	[0.0%-0.1%]	
No time	0.2%	[0.1%-0.4%]	0.0%	[0.0%-0.2%]	
Transportation	0.0%	[0.0%-0.1%]	0.1%	[0.0%-0.2%]	
Wait and see	0.2%	[0.1%-0.3%]	0.2%	[0.1%-0.3%]	
Other ([119])	0.3%	[0.2%-0.5%]	0.1%	[0.1%-0.3%]	

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
Source: own elaboration based on EU-SILC data.

118. Unadjusted OR are calculated by using a univariate regression in order to test the difference between the two years. No variable potentially influencing the variation between 2011 and 2017 is included in the analysis.
119. Fear of doctor/hospitals/examination/ treatment; Didn't know any good doctor or specialist; other.

Table 6: Unmet needs for medical care for financial reasons, by demographic characteristics, in 2011 and 2017

	2011		2017		Difference between 2011 and 2017
Sex	%	CI 95	%	CI 95	***Unadjusted OR***
male	1.1%	[0.8%-1.5%]	1.4%	[1.0%-2.0%]	***NS***
female	1.8%***	[1.3%-2.4%]	2.5%***	[1.9%-3.3%]	***1.4****
Age group					
16-24	0.4%	[0.1%-1.9%]	1%	[0.5%-2.0%]	***NS***
25-44	1.4% NS	[0.9%-2.1%]	2.7%***	[2.0%-3.7%]	***1.9*****
45-64	2% **	[1.4%-2.8%]	2.6%***	[1.9%-3.5%]	***NS***
65+	0.9% NS	[0.6%-1.4%]	0.6% NS	[0.4%-1.1%]	***NS***
Number of children under 25 in HH					
Zero	1.4%	[1.0%-1.9%]	2%	[1.5%-2.7%]	***NS***
One to three	1.5% NS	[1.1%-2.2%]	1.5%	[1.1%-2.2%]	***NS***
4 or more	0.6% NS	[0.1%-2.5%]	6.9%***	[3.5%-13.1%]	***12.4*****
Marital status					
Single	1.8%	[1.2%-2.6%]	2.2%	[1.6%-3.1%]	***NS***
Married	0.7%***	[0.4%-1.2%]	1.2%**	[0.8%-1.9%]	***NS***
Separated/divorced	3.6%***	[2.6%-4.9%]	4.6%***	[3.3%-6.5%]	***NS***
Widowed	1.6% NS	[0.8%-3.1%]	1.1% NS	[0.5%-2.7%]	***NS***
Adult persons living in a single parent household (children aged <=18 years old)					
No	1.3%	[1.0%-1.6%]	1.8%	[1.4%-2.4%]	***1.4****
Yes	5.2%***	[3.3%-7.9%]	5.6%***	[3.9%-8.1%]	***NS***
Country of birth					
LOC	1.3%	[0.9%-1.7%]	1.7%	[1.3%-2.2%]	***NS***
EU	1.6%	[0.9%-2.9%]	2.9%*	[1.5%-5.5%]	***NS***
OTH	3%***	[1.8%-4.8%]	4.1%***	[2.5%-6.5%]	
Region					
FL	1%	[0.6%-1.5%]	1%	[0.6%-1.6%]	***NS***
W	1.8%*	[1.1%-2.7%]	3.1%***	[2.1%-4.4%]	***1.5****
BX	3.1%**	[2.2%-4.4%]	4.3%***	[3.3%-5.5%]	***NS***

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level (based on unadjusted OR).
Reference category is the one without any star
NS: non-significant difference
Source: own elaboration based on EU-SILC data.

Table 7: Unmet needs for medical care for financial reasons, by predisposing socio-economic factors, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Education level					
Tertiary	0.7%	[0.5%-1.2%]	0.7%	[0.5%-1.1%]	NS
Secondary	1.5%***	[1.1%-2.0%]	2.4%***	[1.8%-3.2%]	1.6**
Primary	2.6%***	[1.6%-4.2%]	3.5%***	[2.4%-5.2%]	NS
Economic status					
Employee	0.8%	[0.5%-1.4%]	1.2%	[0.8%-1.7%]	NS
Self-employed	0.6%*	[0.1%-2.8%]	0.5%*	[0.1%-1.4%]	NS
Retired	0.9%	[0.6%-1.5%]	0.8%	[0.5%-1.4%]	NS
Student	0.8%	[0.4%-1.9%]	0.6%	[0.3%-1.3%]	NS
Unemployed	5.2%***	[3.5%-7.8%]	7.6%***	[5.7%-10.2%]	NS
Disabled or/and unfit to work	6%***	[3.7%-9.7%]	9.8%***	[6.8%-14.0%]	NS
Home duties	2.5%***	[1.3%-4.5%]	5.8%***	[3.4%-9.6%]	2.4**
Persons working less 3 months					
Other cases	1%	[0.7%-1.3%]	1%	[0.7%-1.4%]	NS
Working <= 3 months	4.9%***	[3.5%-6.7%]	8.1%***	[6.2%-10.5%]	1.7**
Persons living in households working less than 3 months					
Other cases	1.1%	[0.8%-1.5%]	1.3%	[0.9%-1.8%]	NS
Working <= 3 months	5.9%***	[4.0%-8.7%]	9.9%***	[7.2%-13.4%]	1.7**
Tenure status					
Outright owner	0.4%	[0.2%-0.6%]	0.3%	[0.1%-0.6%]	NS
Owner paying mortgage	0.5% NS	[0.3%-0.8%]	0.9%**	[0.5%-1.6%]	
Tenant/subtenant paying rent at prevailing or market rate	4.2%***	[3.1%-5.8%]	5.7%***	[4.3%-7.6%]	1.4* (for both types of tenant)
Accommodation is rented at a reduced rate (lower than the market rate)	4.1%***	[2.5%-6.7%]	6.3%***	[4.3%-9.1%]	
Accommodation is provided for free	2.1%**	[0.6%-7.0%]	2.8%***	[0.9%-7.9%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference (between categories)
Source: own elaboration based on EU-SILC data.

Table 8: Unmet needs for medical care for financial reasons, by primary needs, in 2011 and 2017

	2011		2017		Difference 2011-2017
Overcrowded household[52]	%	CI 95	%	CI 95	Unadjusted OR
Not overcrowded	1.4%	[1.1%-1.8%]	1.7%	[1.3%-2.2%]	NS
Overcrowded	4.2%**	[1.8%-9.4%]	8.4%***	[4.8%-14.3%]	NS
Deteriorated housing[53]					
No	1.0%	[0.7%-1.3%]	1.4%	[1.0%-1.9%]	NS
Yes	3.4%***	[2.5%-4.6%]	4.8%***	[3.5%-6.6%]	NS
Ability to keep home adequately warm					
Yes	0.9%	[0.6%-1.2%]	1.2%	[0.9%-1.6%]	NS
No	9.6%***	[6.8%-13.4%]	15%***	[10.9%-20.3%]	1.6*
Ability to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day					
Yes	1%	[0.7%-1.4%]	1.2%	[0.9%-1.6%]	
No	11.1%***	[8.0%-15.4%]	16.5%***	[11.7%-22.8%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 9: Unmet needs for medical care for financial reasons, by financial difficulties, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Capacity to deal with unexpected required expenses					
Yes			0.2%	[0.1%-0.4%]	
No	Not included		7.7%***	[6.1%-9.7%]	
Ability to make ends meet					
Yes	0.10%	[0.0%-0.2%]	0.2%	[0.1%-0.4%]	
Difficult	3.50%***	[2.7%-4.5%]	5.1%***	[4.0%-6.5%]	1.4**
Arrears on utility bills or housing cost					
No	0.90%	[0.6%-1.2%]	1%	[0.8%-1.4%]	
Yes	10.10%***	[7.2%-14.0%]	22.8%***	[17.9%-28.6%]	2.6***

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 10 : Unmet needs for medical care for financial reasons, and difficulties affording social activities in 2011 and 2017

	2011		2017		Difference 2011-2017
Get-together with friends/family (relatives) for a drink/meal at least once a month	%	CI 95	%	CI 95	Unadjusted OR
Yes			0.5%	[0.4%-0.8%]	
No, cannot afford it	Not included in 2011		13.7%***	[10.6%-17.4%]	
Ability to afford paying for one week's annual holiday away from home					
Yes	0.1%	[0.0%-0.2%]	0.3%	[0.2%-0.4%]	
No	5%***	[3.9%-6.5%]	7.3%***	[5.8%-9.2%]	1.4**
Ability to afford regular participation in leisure activity					
Yes	Not included in 2011		0.3%	[0.2%-0.6%]	
No			13.5%***	[10.8%-16.8%]	

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 10: Unmet needs for medical care for financial reasons, and specific material deprivation, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Do you have a telephone (including a mobile phone)?					
Yes	1.40%	[1.1%-1.8%]	2.%	[1.5%-2.5%]	
No	7.40%	[1.7%-26.9%]	17.8%	[3.6%-55.2%]	
Do you have a colour TV?					
Yes	1.40%	[1.1%-1.8%]	2%	[1.5%-2.5%]	
No	11.10%	[4.5%-24.9%]	6.2%	[2.2%-16.1%]	
Do you have a washing machine?					
Yes	1.30%	[1%-1.7%]	1.8%	[1.4%-2.3%]	
No	8.50%	[4.7%-14.9%]	19.6%	[11.9%-30.7%]	
Do you have a car?					
Yes	1.00%	[0.7%-1.3%]	1.4%	[1.0%-1.9%]	
No	8.10%	[6%-10.9%]	12%	[8.6%-16.4%]	1.5*

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 11: Percentage of unmet needs for medical care for financial reasons, by income, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Equivalised disposable income					
First quintile	4.1%	[3.0%-5.7%]	6.7%	[5.1%-8.7%]	1.6**
Second quintile	1.9%***	[1.2%-3.1%]	2.1%***	[1.4%-3.1%]	NS
Third quintile	0.8%***	[0.5%-1.6%]	0.9%***	[0.6%-1.6%]	NS
Fourth quintile	0.3%***	[0.1%-0.7%]	0.3%***	[0.1%-0.7%]	NS
Fifth quintile	0.1%***	[0.0%-0.4%]	0%***	NA	NA
At risk of poverty					

>=60% of median Eq. dis. income	0.0%	[0.6%-1.2%]	1.1%	[0.8%-1.6%]	NS
<60% of median Eq. dis. Income	4.8%***	[3.3%-6.8%]	6.7%***	[5.1%-8.9%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level

NS: non-significant difference

NA: not applicable because no unmet needs were declared by the subgroup considered

Source: own elaboration based on EU-SILC data.

Table 12: Unmet needs for medical care for financial reasons, by health need factors, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Self-perceived health					
Good	0.7%	[0.5%-1.0%]	0.8%	[0.6%-1.2%]	NS
Fair	2.4%***	[1.6%-3.5%]	3.2%***	[2.2%-4.5%]	NS
Bad	5.4%***	[3.8%-7.6%]	9.7%***	[7.2%-12.9%]	1.9**
Chronic illness					
Yes	3.8%***	[2.8%-5.1%]	4.7%***	[3.6%-6.1%]	NS
No	0.6%	[0.4%-0.9%]	1.1%	[0.7%-1.6%]	1.7**
Functional limitations					
No	0.8%	[0.6%-1.1%]	1.1%	[0.7%-1.4%]	NS
Yes	3.6%***	[2.6%-4.9%]	4.9%***	[3.8%-6.5%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level

NS: non-significant difference.

Source: own elaboration based on EU-SILC data.

Table 13: Factors associated with unmet needs for medical care, for financial reasons, in 2011 and 2017

Adjusted OR	2011	2017
Gender (ref. male): female	1.509**	1.772***
	(1.027 - 2. 216)	(1.305 - 2.406)
Marital status (ref. single): Married	0.4**	
	(0.199 – 0.805)	
Separated/divorced	0.96	
	(0.543 – 1.696)	
Widowed	0.795	
	(0.307 – 2.054)	
Number of children under 25 in HH (ref. 0): One to three		0.641**
		(0.413 - 0.993)
4 or more		1.843
		(0.871 - 3.899)
Age category (ref. 16-24): 25-44		1.266
		(0.483 - 3.317)
45-64		0.974
		(0.368 - 2.576)
65+		0.179**
		(0.0484 - 0.661)
Region (ref. FL), W		2.297***
		(1.314 - 4.016)
BX		1.960**
		(1.109 - 3.463)
Tenure status (ref. owners without mortgage): owner paying mortgage	1.95	3.302**
	(0.863 - 4.437)	(1.329 - 8.209)
Tenants/subtenants paying rent at prevailing or market rate	6.759***	7.820***
	(3.144 - 14.529)	(3.748 - 16.32)
Accommodation rented at a reduced rate	4.016***	6.614***
	(1.619 - 9.959)	(2.997 - 14.60)
Accommodation provided free	3.564*	7.011***
	(0.885 - 14.344)	(1.945 - 25.27)
Economic status (ref. employee): self-employed	0.51	0.427*
	(0.0875 - 2.981)	(0.159 - 1.143)

Adjusted OR	2011	2017
Retired	0.431*	1.102
	(0.163 - 1.135)	(0.513 - 2.367)
Student	0.478	0.351*
	(0.198 - 1.149)	(0.114 - 1.085)
Unemployed	1.464	1.350
	(0.68 - 3.149)	(0.812 - 2.243)
Disabled	0.842	1.029
	(0.306 - 2.314)	(0.620 - 1.709)
Home duties	0.911	0.946
	(0.343 - 2.417)	(0.470 - 1.905)
Self-perceived health (ref. good): Fair	1.576	3.217***
	(0.81 – 3.066)	(2 – 5.175)
Bad	2.215**	7.303***
	(1.131 – 4.338)	(4.622 – 11.54)
Chronic illness (ref. none)	3.763***	
	(2.08 – 6.807)	
Eq. disp. income quintile (ref. first): Second	0.65	0.526***
	(0.372 – 1.136)	(0.345 – 0.802)
Third	0.412**	0.293***
	(0.199 – 0.851)	(0.161 – 0.534)
Fourth	0.174***	0.124***
	(0.067 – 0.454)	(0.0514 – 0.297)
Fifth	0.095***	
	(0.025– 0.347)	
Ref.: category of reference Confidence interval (95%) in parentheses		

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level

Only OR for variables with at least 10% of significancy are displayed.

Source: own elaboration based on EU-SILC data.

Table 14: Reasons for unmet needs for dental care in 2011 and 2017

	2011		2017		Difference between 2011 and 2017
	%	**CI**	**%**	**CI**	**Unadjusted OR**
Financial	2.9%	[2.4%-3.5%]	3.5%	[2.8%-4.4%]	NS
Waiting list	0.1%	[0.0%-0.2%]	0.0%	[0.0%-0.1%]	
No time	0.9%	[0.7%-1.2%]	0.4%	[0.2%-0.5%]	
Transportation	0.1%	[0.0%-0.2%]	0.1%	[0.1%-0.2%]	
Wait and see	0.2%	[0.2%-0.4%]	0.4%	[0.2%-0.7%]	
Other	1.8%	[1.5%-2.2%]	0.8%	[0.6%-1.1%]	

NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 15: Unmet needs for dental care for financial reasons, and demographic characteristics, in 2011 and 2017

	2011		2017		Difference between 2011 and 2017
Sex	**%**	**CI 95**	**%**	**CI 95**	**Unadjusted OR**
male	2.8%	[2.3%-3.6%]	3%	[2.3%-3.9%]	NS
female	2.9%***	[2.4%-3.6%]	4%***	[3.2%-5.1%]	1.4**
Age group					
16-24	0.7%	[0.2%-2.1%]	1.8%	[1%-3.1%]	NS
25-44	3.4%***	[2.6%-4.3%]	4.7%***	[3.6%-6.1%]	1.4*
45-64	3.6%***	[2.8%-4.7%]	4.2%***	[3.3%-5.3%]	NS
65+	1.8%*	[1.3%-2.4%]	1.8%	[1.2%-2.8%]	NS
Number of children under 25 in HH					
Zero	2.8%	[2.3%-3.4%]	3.8%	[2.9%-4.8%]	1.4*
One to three	2.8%	[2.1%-3.7%]	2.6%**	[1.9%-3.6%]	NS
4 or more	7%***	[3.7%-12.9%]	10.3%***	[6%-17.1%]	NS
Marital status					
Single	3.4%	[2.7%-4.3%]	3.9%	[2.9%-5.2%]	NS
Married	1.7%***	[1.2%-2.3%]	2.2%***	[1.6%-3%]	NS
Separated/divorced	7.2%***	[5.6%-9.2%]	7.9%***	[6.1%-10.1%]	NS
Widowed	2.3%	[1.4%-3.9%]	2.5%	[1.3%-4.7%]	NS
Adult persons living in a single parent household (children aged <=18-year-old)					
No	2.7%	[2.3%-3.3%]	3.3%	[2.6%-4.3%]	NS
Yes	6.1%***	[4.2%-9.%]	7.1%***	[4.9%-10.1%]	NS
Country of birth					
LOC	2.4%	[2.%-3%]	2.8%	[2.2%-3.5%]	NS
EU	3.6%	[2.2%-5.8%]	6.3%***	[4.2%-9.5%]	1.8*
OTH	6.7%**	[4.8%-9.3%]	7.9%***	[5.7%-10.9%]	NS
Region					
FL	2.3%	[1.7%-3.1%]	2.%	[1.5%-2.7%]	NS
W	3.4%*	[2.6%-4.5%]	5.1%***	[3.7%-6.9%]	1.5*
BX	4.5%***	[3.3%-6.2%]	7.2%***	[5.2%-9.7%]	1.6**

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 16: Unmet needs for dental care for financial reasons, and predisposing socio-economic factors, in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Education level					
Tertiary	1.6%	[1.1%-2.2%]	1.3%	[0.8%-1.9%]	NS
Secondary	3.1%***	[2.5%-3.8%]	4.6%***	[3.6%-5.9%]	1.5**
Primary	4.9%***	[3.6%-6.5%]	4.7%***	[3.4%-6.5%]	NS
Economic status					
Employee	2.%	[1.4%-2.7%]	2.5%	[1.8%-3.3%]	NS
Self-employed	1.1%	[0.5%-2.5%]	0.9%**	[0.3%-2.5%]	NS
Retired	1.9%	[1.4%-2.6%]	2.%	[1.4%-2.9%]	NS
Student	1.3%	[0.7%-2.6%]	1.5%	[0.8%-2.8%]	NS
Unemployed	10.4%***	[7.9%-13.5%]	11.6%***	[8.6%-15.5%]	NS
Disabled or/and unfit to work	9.6%***	[6.5%-14.%]	13.8%***	[10%-18.7%]	NS
Home duties	4.8%***	[3.4%-6.9%]	8.5%***	[5.6%-12.6%]	1.8**
Person working less 3 months					
Other cases	2%	[1.6%-2.4%]	2.1%	[1.6%-2.8%]	NS
Working <= 3 months	9.4%***	[7.5%-11.8%]	12.2%***	[9.8%-15.3%]	NS
Household working less 3 months					
Other cases	2.2%	[1.8%-2.8%]	2.6%	[2%-3.3%]	NS
Working <= 3 months	11.4%***	[8.7%-14.8%]	14.1%***	[10.6%-18.6%]	NS
Tenure status					
Outright owner	1.1%	[0.8%-1.5%]	1%	[0.6%-1.5%]	NS
Owner paying mortgage	1.4%	[1.%-1.9%]	1.8%**	[1.2%-2.5%]	NS
Tenant/subtenant paying rent at prevailing or market rate	7.3%***	[5.7%-9.2%]	9.1%***	[7.3%-11.3%]	NS
Accommodation is rented at a reduced rate (lower than the market rate)	8.3%***	[6.1%-11.1%]	10.4%***	[7.7%-14%]	NS
Accommodation provided free	1.7%	[0.4%-7.4%]	3.8%***	[1.6%-8.7%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 17: Unmet needs for dental care for financial reasons and primary needs in 2011 and 2017

	2011		2017		Difference 2011-2017
Overcrowded household	**%**	**CI 95**	**%**	**CI 95**	**Unadjusted OR**
Not overcrowded	2.8%	[2.3%-3.4%]	3.2%	[2.5%-4%]	NS
Overcrowded	8.1%***	[4.4%-14.4%]	10.4%***	[6.6%-16.1%]	NS
Deteriorated housing					
No	2.3%	[1.8%-2.9%]	2.7%	[2.1%-3.6%]	NS
Yes	5.2%***	[4.1%-6.6%]	7.1%***	[5.4%-9.3%]	1.4*
Ability to keep home adequately warm					
Yes	2.%	[1.6%-2.5%]	2.5%	[1.9%-3.1%]	NS
No	15.3%***	[11.9%-19.4%]	21.3%***	[16.4%-27.1%]	1.5*
Ability to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day					
Yes	2.2%	[1.7%-2.7%]	2.6%	[2.%-3.3%]	NS
No	18%***	[13.4%-23.8%]	20%***	[14.6%-26.9%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 18: Unmet needs for dental care for financial reasons and financial difficulties in 2011, 2017

	2011		2017		Difference 2011-2017
	%	**CI 95**	**%**	**CI 95**	**Unadjusted OR**
Capacity to face unexpected required expenses					
Yes	0.6%	[0.4%-0.9%]	0.7%	[0.4%-1%]	NS
No	9.9%***	[8.3%-11.9%]	12.7%***	[10.5%-15.2%]	NS
Ability to make ends meet					
Yes	0.3%	[0.2%-0.5%]	0.7%	[0.4%-1.2%]	2,2**
Difficult	6.8%***	[5.6%-8.1%]	8.4%***	[6.9%-10.3%]	NS
Arrears on utility bills or housing costs					

No	1.8%	[1.4%-2.2%]	2.3%	[1.8%-3.%]	NS
Yes	19.3%***	[15.3%-24.1%]	30.5%***	[25%-36.7%]	1.8***

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 19: Unmet needs for dental care for financial reasons, and difficulties affording social activities in 2011 and 2017

	2011		2017		Difference 2011-2017
Get together with friends/family (relatives) for a drink/meal at least once a month	**%**	**CI 95**	**%**	**CI 95**	**Unadjusted OR**
Yes			1.4%	[1.0%-2.0%]	
No, cannot afford it			20.5%***	[16.7%-24.8%]	
Ability to afford a one week annual holiday away from home					
Yes	0.7%	[0.5%-1%]	0.8%	[0.5%-1.3%]	
No	8.8%***	[7.2%-10.6%]	11.8%***	[9.7%-14.2%]	1.4**
Ability to afford regular participation in leisure activity					
Yes			1.1%	[0.8%-1.6%]	
No			20.2%***	[16.8%-24.2%]	

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 20: Unmet needs for dental care for financial reasons and specific material deprivation in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Do you have a telephone (including a mobile phone)?					
Yes	2.9%	[2.4%-3.4%]	3.5%	[2.8%-4.4%]	
No	14.4%	[5.2%-33.7%]	17.8%	[3.6%-55.2%]	
Do you have a colour TV?					
Yes	2.9%	[2.4%-3.4%]	3.5%	[2.7%-4.4%]	
No	7.3%	[2.6%-18.5%]	13.2%	[5.7%-27.9%]	
Do you have a washing machine?					
Yes	2.6%	[2.2%-3.2%]	3.2%	[2.5%-4.1%]	
No	18.6%	[12.7%-26.4%]	26.3%	[17.3%-38%]	
Do you have a car?[54]					
Yes	2.2%	[1.8%-2.7%]	2.7%	[2.1%-3.4%]	NS
No	12.7%***	[9.7%-16.4%]	17.3%***	[13.3%-22.3%]	1.4*

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 21: Percentage of unmet needs for dental care for financial reasons and income in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Equivalised disposable income					
First quintile	7.6%	[6.1%-9.4%]	10.5%	[8.4%-13%]	1.4**
Second quintile	4.1%***	[2.9%-5.7%]	4.3%***	[3.2%-5.7%]	NS
Third quintile	1.7%***	[1.1%-2.5%]	2.1%***	[1.4%-3.1%]	NS
Fourth quintile	1%***	[0.6%-1.7%]	0.6%***	[0.3%-1.2%]	NS
Fifth quintile	0.3%***	[0.1%-0.7%]	0.3%***	[0.1%-0.7%]	NS
At risk of poverty					
>=60% of median Eq. dis. income	1.9%	[1.5%-2.4%]	2.1%	[1.6%-2.7%]	NS
<60% of median Eq. dis. income	8.6%***	[6.7%-11%]	11.2%***	[8.8%-14.1%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 22: Unmet needs for dental care for financial reasons and health characteristics in 2011 and 2017

	2011		2017		Difference 2011-2017
	%	CI 95	%	CI 95	Unadjusted OR
Self-perceived health					
Good	1.8%	[1.5%-2.3%]	1.8%	[1.3%-2.5%]	NS
Fair	5%***	[3.8%-6.6%]	6.1%***	[4.7%-7.8%]	NS
Bad	7.2%***	[5.5%-9.5%]	13.4%***	[10.4%-17.0%]	2***
Chronic illness					
No	1.7%	[1.4%-2.2%]	2.1%	[1.5%-2.9%]	
Yes	6.1%***	[5.0%-7.5%]	7.7%***	[6.2%-9.5%]	NS
Functional limitations					
No	1.9%	[1.5%-2.4%]	2.1%	[1.5%-2.8%]	
Yes	6.2%***	[4.9%-7.8%]	7.8%***	[6.2%-9.7%]	NS

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level
NS: non-significant difference.
Source: own elaboration based on EU-SILC data.

Table 23: Factors associated with unmet need for dental care for financial reasons

Adjusted OR	2011	2017
Self-perceived health (ref. good): Fair		3.084***
		(2.229 - 4.267)
Bad		4.933***
		(3.459 - 7.034)
Chronic illness (ref. none)	3.155***	
	(2.251 - 4.423)	
Eq. income quintile (ref. first): Second	0.747	0.593***
	(0.514 - 1.086)	(0.444 - 0.792)
Third	0.373***	0.315***
	(0.222 - 0.625)	(0.193 - 0.516)
Fourth	0.256***	0.113***
	(0.140 - 0.470)	(0.0504 - 0.252)
Fifth	0.0827***	0.0503***
	(0.0306 - 0.223)	(0.0171 - 0.148)
Number of children under 25 in HH (ref. 0): One to three	1.066	0.684**
	(0.718 - 1.582)	(0.470 - 0.996)

Adjusted OR	2011	2017
4 or more	2.629***	1.905**
	(1.308 - 5.284)	(1.061 - 3.420)
Marital status (ref. single): Married	0.527**	0.632**
	(0.322 - 0.862)	(0.410 - 0.975)
Marital status = 3, Separated/divorced	1.464*	1.061
	(0.966 - 2.219)	(0.726 - 1.551)
Widowed	0.819	0.573
	(0.422 - 1.587)	(0.288 - 1.139)
Economic status (ref. employee): self-employed	0.514	0.368*
	(0.193 - 1.364)	(0.128 - 1.056)
Retired	1.464	0.807
	(0.771 - 2.780)	(0.482 - 1.351)
Student	0.489*	0.484*
	(0.232 - 1.027)	(0.222 - 1.055)
Unemployed	1.829**	1.173
	(1.122 - 2.981)	(0.758 - 1.814)
Disabled	1.171	0.883
	(0.588 - 2.332)	(0.553 - 1.409)
Home duties	1.371	0.898
	(0.749 - 2.510)	(0.525 - 1.538)
Region (ref. FL), W		1.782***
		(1.162 - 2.733)
BX		1.790**
		(1.055 - 3.036)
Tenure status (ref. owner without mortgage), owner paying mortgage	1.457	2.339***
	(0.872 - 2.436)	(1.315 - 4.159)
Tenant/subtenant paying rent at prevailing or market rate	3.402***	4.343***
	(2.197 - 5.267)	(2.662 - 7.084)
Accommodation rented at a reduced rate	2.696***	3.924***
	(1.683 - 4.319)	(2.251 - 6.840)
Accommodation provided free	0.901	2.653*
	(0.169 - 4.813)	(0.979 - 7.191)
Age category (ref. 16-24): 25-44	3.621*	2.184**
	(0.961 - 13.64)	(1.068 - 4.467)
45-64	3.248*	1.709

Adjusted OR	2011	2017
	(0.829 - 12.73)	(0.788 - 3.707)
65+	1.166	0.765
	(0.283 - 4.799)	(0.305 - 1.920)
Country of birth (ref. local): EU		1.449*
		(0.934 - 2.248)
Other		0.935
		(0.600 - 1.456)
Gender		1.263**
		(1.010 - 1.579)

Confidence interval (95%) in parentheses

*** Significant at 1% level; ** significant at 5% level; * significant at 10% level

Source: own elaboration based on EU-SILC data.