ESPN Thematic Report on Inequalities in access to healthcare

Belgium

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Contents

Summary / Highlights

Belgium has compulsory national health insurance through a reimbursement system, characterised by the principles of equal access and freedom of choice. It is organised on two levels – the federal and the regional – with a complex division of responsibilities. All citizens register with sickness funds, which play a central role in the collective negotiation process over fees and insurance coverage. In hospitals, patients have co-payments to pay and – depending on the provider – also supplements. Outpatient care is predominantly based on fees for service, except for primary care centres, which are funded by a fixed capitation payment. Belgium spends a relatively high proportion of its GDP on health (10.4% in 2016) and more than two thirds of the overall health spending is public expenditure (77.2%). Household out-of-pocket payments are relatively high (almost 2% of GDP; 18% of total health spending) and the proportion of complementary private health insurance is 5% (OECD/EU, 2016). Curbing the cost of the system has been a priority in recent years. In 2012, the general healthcare budget was allowed to grow by 4.5%, but this figure was reduced to 1.5% in 2016 and 2017, and to 0.5% for the current budget year.

In terms of public satisfaction, Belgium has among the best-performing systems in Europe (Eurobarometer, 2014). There is nearly universal coverage, and only 2.4% of the population reported some unmet need for medical care. Problems concerning waiting times and geographical availability are also limited. However, Belgium underperforms in terms of equality of access to healthcare and coverage of the most vulnerable groups, such as undocumented immigrants. Unmet need varies substantially by income group, and this income gradient is growing. Several data sources reveal inequalities based on educational level, household composition, employment status and migration background. Low-income households, people with low levels of education, single parents, people who are unemployed or inactive due to sickness, and non-EU migrants show relatively high proportions of unmet need, especially for financial reasons. Inequalities are pronounced in dental care, preventive care, mental healthcare and specialist care. Remarkable regional variation exists in the level of unmet need and inequality of access to care, with the Brussels Region worst on both scores. These levels of unmet need and inequality of access to care, however, are only a rough indication, as underestimation is possible. The most vulnerable groups are either underrepresented in the statistics or are not represented at all, and differences in health literacy and health beliefs may hide higher inequalities in access to healthcare. More objective measures of unmet need based on actual care use and self-reported need for healthcare (i.e. health status) (EC, 2017a) show even larger socio-economic inequalities in access to healthcare (European Health Interview Survey data).

Nevertheless, the Belgian healthcare system does include several mechanisms – such as the ‘increased health insurance reimbursement statute’, the Maximum Billing System, the third-payer measure and chronic illness status – designed to improve financial accessibility, with particular attention on the more vulnerable groups. Recently, these measures were further strengthened, extended and simplified. In addition, to manage the relatively high non-take-up rate, a more proactive approach has been implemented. However, in the context of cost-containment, growing privatisation of healthcare and an eroded growth rate for health spending, these mechanisms are inadequate in the struggle against inequality in access to care. Moreover, access to healthcare is a multidimensional concept that goes beyond financial accessibility. Healthcare has to be culture sensitive, and further sensitisation of people’s right to benefits and entitlements is required. The most problematic areas regarding accessibility are mental healthcare and preventive care, as well as the coverage of the most vulnerable groups, such as asylum seekers and undocumented migrants. Further investment in multidisciplinary primary care centres, which have an important preventive role and which connect with the vulnerable groups of society is therefore recommended, as is increased use of ‘global medical dossiers’. Finally, there is a plea for ‘health in all policies’ by researchers and sickness funds (Callens, 2017; Tellier and Vandenhooft, 2014), as the financial protection mechanisms in healthcare cannot provide a conclusive solution if they do not go hand in hand with providing a healthy home, healthy work, a sufficient income and education.

1 Description of the functioning of the country's healthcare system for access

The Belgian healthcare system is organised on two levels: the **federal level** deals with compulsory healthcare insurance, the financing of hospitals and 'heavy medical care units' (specialised centres with heavy medical equipment, such as radiotherapy) and the registration of pharmaceuticals and their price control. At the **regional level**, the regions and communities are responsible for health promotion, preventive health, different aspects of elderly care, organising healthcare both inside healthcare institutions (hospitals, nursing homes, etc.) and outside (e.g. primary care and home care), and supporting federal bodies in the financing of hospitals (Van Lancker et al., 2017; Segaert, 2014). The overall picture of this division of responsibilities has become complicated after several rounds of state reforms (Segaert, 2014). The most recent reform (the sixth) marks a new move in the transformation to a federal system in which responsibility generally shifts from the federal level to the regional entities.

The principles of equal access and **freedom of choice** characterise the Belgian healthcare system, which has a **Bismarckian-type of compulsory national health insurance** that employs a reimbursement system. The main administrator of the system is the National Institute for Health and Disability Insurance (RIZIV/INAMI). All citizens register with a sickness fund, which in turn receives a budget from the centrally collected contributions to finance the healthcare costs of its members (Van Lancker et al., 2017). Sickness funds are mainly organized according to ideological affiliations. Membership of a sickness fund is compulsory, but each individual can enrol in the fund of his/her choice. Six national associations of sickness funds dominate the market for compulsory health insurance. They also play a central role in the collective negotiation process over fees, insurance coverage and regulation within the RIZIV/INAMI (Schokkaert and Van de Voorde, 2011).[1]

Financing is mostly (two thirds) based on social security contributions from employees and employers (based on income) and to a lesser extent (one third) on taxation (Van Lancker et al., 2017; Segaert, 2014). Curbing the cost of the system has been a priority in recent years. From 2004 to 2012, the general healthcare budget was allowed to grow by 4.5% a year. The figure was reduced to 2% in 2012, 3% in 2013, 2014 and 2015, and 1.5% in 2016 and 2017 (Segaert, 2014; Schepers et al., 2018). For the current budget year, it has been eroded further, to 0.5% above inflation (Schepers et al., 2018). The biggest sacrifices are required from healthcare professionals, sickness funds, the pharmaceutical sector, public pharmacies and the hospital sector, but patients are not immune to these cost-containment measures (Van Cutsem, 2017).

In comparison with the EU average of 9.9% (total spending), Belgium spends a relatively high proportion of its GDP on health (10.4%, with 8% public and 2.4% private spending in 2016) (OECD.stat, 2016). The financing structure is characterised by the prominent role of **social insurance**, as 59.2% (2015) of total health spending is financed from compulsory insurance schemes (compared to an average in 2014 of 43.4% across the EU). The remaining part of public spending is financed by government schemes (18.3%). The total public expenditure makes up 77% of overall health spending, which is close to the EU average (Eurostat, 2015a). Direct **out-of-pocket (OOP) expenditure** is 18% of total spending (in comparison to the EU average of 15%),[2] while (complementary) **private insurance** accounts for only 5%. However, there is a growing occupational and individual

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[1] The fee to join a sickness fund for basic services is nominal and uniform, and the sickness funds are required to offer the same reimbursement packages for basic services, such as visits to the doctor. They also offer supplementary coverage, such as for medical devices and dental or clinical procedures not covered by the basic service. Fees related to supplementary coverage vary between sickness funds.

[2] In 2015, OOP expenditure was 622.94 Purchasing Power Standards per inhabitant, which is higher than in the majority of European countries (Eurostat, 2015a).

insurance segment (e.g. voluntary hospitalisation insurance)[3] to cover the risk of large out-of-pocket expenditure for hospitalisation and dental care (OECD/EU, 2016).

Through compulsory health insurance people have access to a **broad publicly financed benefit package** with **cost-sharing** for most services (Van Lancker et al., 2017). Hospitals are either public or not for profit. Just as it does for drugs, the sickness fund pays the provider directly for hospital care. Patients have to make only co-payments and (depending on the provider) pay supplements. Hospitals and medical specialists can charge supplements over and above their fees to cover the cost of the patient's room or implants and medical devices. Recently, however, the reimbursement level for implants and medical devices has increased and the fees for rooms have been regulated (Cleemput et al., 2015; Van Sloten and Wantier, 2017). In 2010, supplementary charges for two-person hospital rooms were abolished, but supplements for one-person rooms keep on rising (IMA, 2018). Doctors are free to charge a supplement to their fee if the patient is in a one-person room, but these supplements are partly or fully reimbursed, depending on the hospitalisation insurance of the patient and the policy he/she has.

Outpatient care is mostly private, based on independent medical practice and free choice of the healthcare provider. There is no systematic gate-keeping system, and so a patient can see a medical specialist without a doctor's referral. Remuneration is predominantly based on a **fee-for-service payment**. The patient pays for the full cost and then obtains reimbursement from the sickness fund. A list of reimbursable services for each profession – the so-called 'nomenclature' – assigns a specific code to each procedure; this determines the cost and is used as a basis for reimbursement. This list of official scales is derived from an agreement between the government services (via the sickness funds), representatives of healthcare workers and social partners. In 2018, 89.49% of GPs and 81.04% of specialists are fully (or partly)[4] 'conventionalised', which means that they have signed an agreement with the health insurance organisations not to raise their fees above a certain amount. The minority who have not signed any such convention can charge additional supplements, but these are not reimbursed. Although care providers are obliged to inform their patients about their convention status, this dual system remains opaque, particularly for the most vulnerable groups (Cleemput et al., 2015; Henin, 2013).

General medical care can also be funded by a **fixed capitation payment** for patients who have registered with a service provider employed in a primary care centre. The health provider receives a fixed salary and the patients pay nothing, as the fees are settled with the health insurance fund directly. These centres usually house several healthcare providers (GPs, nurses, etc.) under one roof; they form a 'primary care' network and work in a multidisciplinary fashion (Annemans et al., 2008; Boutsen et al., 2017). In the Brussels Region, such centres form a large part of primary healthcare: around 20% of the population is registered with them; in the Walloon and Flemish regions, the figure is only 3% and 1%, respectively (Van der Heyden, 2015a; Boutsen et al., 2017). Patients who are registered with such a centre also automatically have a **global medical dossier** (GMD). A GMD improves the coordination between doctors and specialists and, as a result, provides better individual support for patients (Boutsen et al., 2017). It also provides a reduction in the patient fee for people not registered with a primary care centre. In 2015, 58% of the inhabitants of Belgium (53% in 2013, 20% in 2002) had a GMD, though there are large variations by age (95% of Flemish inhabitants over the age of 74 have one) and by region (67% in Flanders, 47.5% in Wallonia and 40% in Brussels) (RIZIV/INAMI, 2015).

Coverage of the population by health insurance is ensured through the statutory compulsory system, which at 99% is virtually universal (Sagan and Thomson, 2016). One

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[3] The voluntary hospital insurance is also provided by sickness funds; there are different options and so fees vary between and within sickness funds. Note that outpatient procedures performed at a hospital are generally covered by health insurance and not by hospital insurance, which is related to overnight stays. Many employers also offer hospital insurance as part of a salary package.

[4] Partly conventionalised healthcare providers accept the agreement with the sickness funds, but only charge the official rate at certain places or times.

group not covered by the compulsory insurance system are asylum seekers and undocumented migrants (except for unaccompanied minors), because they are not allowed to register with a sickness fund (AGII, 2014). People with compulsory insurance have access to a broad publicly financed package, with cost-sharing for most services. One important development in this respect was the extension of compulsory coverage to the self-employed from 2008. Before that date, only 'major risks' were included in the compulsory health insurance; 'minor risks' (e.g. dental care, GP interventions, prescription medicines) could be covered by an additional voluntary insurance (Segaert, 2014).

Several measures and initiatives aim to limit the total amount of personal contributions that a patient actually has to pay, and to **improve the financial accessibility and affordability** of healthcare for several vulnerable groups (Van Lancker et al., 2017). First, there is a '**right to increased health insurance reimbursement**' (RVV) statute, which provides preferential tariffs for persons of specific social status[5] (8% of the population) or on the basis of their income (10%). Second, in 2002 the **Maximum Billing System** (MBS) was introduced: this sets a ceiling for total OOP payments, determined according to income brackets. Once this amount is reached, healthcare is fully reimbursed. The MBS takes effect per family unit, and the amount one has to pay depends on the type of system used,[6] taking the family composition into account. It is automatically applied. Third, there is a '**third-payer**' mechanism in primary care for certain vulnerable groups (such as persons on a low pension, those benefiting from social assistance or the long-term unemployed). They can visit a GP of their choice and pay a personal contribution of EUR 1 (Segaert, 2014). This arrangement was recently extended (to include more people) and since July 2015 has been obligatory for GPs – a move that has substantially improved the financial accessibility of healthcare. Fourth, patients with a **chronic illness** are eligible for the 'maximum billing system for the chronically ill'[7] and the third-party arrangements (Cleemput et al., 2015).

The healthcare system also has several features designed to enhance the **availability** of services. For example, home visits to patients by GPs are regular practice, and there are normally no waiting lists for GPs. However, patients often have to pay a supplement for home visits, and there may be a wait for specialised services (e.g. mental health specialties). The supply of primary care centres is also insufficient and unevenly distributed, as they are predominantly located in urban areas (Henin, 2013). In addition, there are growing concerns about the shortage of doctors. In 2015, the ratio of practising physicians to the population (302 per 100,000 inhabitants) was below the EU average (Eurostat, 2015b). The average age of doctors continues to rise; not enough older doctors are being replaced by younger colleagues; and the availability of doctors is unevenly distributed among municipalities. These problems are more pronounced in the French-speaking part of the country. This shortage could increase the level of unmet need due to waiting times and/or distance, and there are already some signs of this (Eurostat, EU-SILC, 2008-2016). However, some mechanisms do already exist to ensure an adequate supply of healthcare professionals, including incentives for GPs to take up practices in underserviced areas.

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[5] Originally, the system of preferential treatment was restricted to persons of specific social status (pensioners, widow(er)s, persons with disabilities and orphans). In 1997 and 1998, the benefits of the preferential tariff system were extended to specific groups – the long-term unemployed, aged 50 and over, with at least 1 year of full unemployment (according to the definition of the employment regulations), and persons entitled to one of the following allowances: Integration allowance for handicapped persons, Income replacement allowance for handicapped persons, Allowance for assistance for the elderly, Income guarantee for the elderly, Subsistence level income, Support from the public municipal welfare centres (Segaert, 2014).

[6] The social MBS, the income-based MBS or the MBS based on personal entitlement.

[7] This measure refers to a reduction of the maximum billing ceiling by €100 if a member of the household has annually supported € 450 of out-of-pocket payments during the 2 preceding calendar years (Paulus, Van den Heede, Mertens, 2012)

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Belgium is evaluated positively on the majority of the indicators of the Joint Assessment Framework (JAF) in the area of health data. However, regarding equal access, the country performs at below the EU average (Eurostat, EU-SILC, 2008-2016). The level of **unmet need for medical care is high in the lowest income quintile** and has also been **rising** (since 2010), in contrast to the decreasing trend in the EU since 2013 (Figures A1 and A2 in the Annex). Between 2011 and 2016, the unmet need increased from 4.2% to 7.7% in the lowest income quintile (Eurostat, EU-SILC, 2008-2016). The difference between the 5th and the 1st income quintile (Q1-Q5) in unmet health needs has increased steadily since 2011, reaching 6.8 percentage points in 2015 and 7.4 in 2016 (above the EU average). There is also **large regional variation** (Figure A3): the Brussels Region has the highest level of unmet need and the highest absolute income inequality in unmet need (Q1-Q5), while the Flemish Region has the lowest level of unmet need and absolute inequality.[8] By contrast, the relative income inequality in unmet need (Q1/Q5) is larger in the Flemish Region (based on the data of the Health Interview Survey (HIS)) (Drieskens et al., 1997-2013).

Several sources of data (Eurostat, EU-SILC, 2008-2016; Health Interview Survey (HIS), Drieskens et al., 1997-2013); European Quality of Life Survey (EQLS), 2003-2016; European Social Survey (ESS) 7, 2014) show up important inequalities by educational level, household composition, employment status and migration status. There is an increasing gap between the **lowest educated** (4.3%) and the highest educated (1.3%) in unmet need, which was higher than the EU average (1.3 percentage points) in 2016, but less striking than the income gap (Eurostat, EU-SILC, 2016). There is also large regional variation (Drieskens et al., 2013) (Figures A4 and A5). Forgoing healthcare for financial reasons also occurs more in **single-parent households** (Drieskens et al., 2013) (Figure A6). Moreover, the percentage of people who report being unable to get a medical consultation they need is much higher among the **unemployed** (and especially among women) followed by **the inactive** (due to disability or sickness), while it is lowest among the employed and the self-employed (ESS, 2014) (Figure A7). Furthermore, **migrants from non-EU countries** face more unmet needs and use a GP less often than do natives and migrants from EU countries (Eurostat, EU-SILC, 2008-2016) (Figure A8) (Van der Heyden, 2015a; Hanssens et al., 2017).

Related to the latter, as society becomes more culturally diverse, so problems may arise in accessibility to high-quality healthcare provision. Back in 1999, intercultural mediators/translators were financed in hospitals by federal institutions. In mid-2017, a pilot project started to expand **intercultural mediation** to GPs as well. Through a video conferencing tool, the GP can consult around a hundred cultural mediators/translators, together speaking 20 different languages (FOD Public Health, Food Chain Safety and Environment, 2017). Healthcare and (in particular) mental healthcare are also often not well adjusted to the specific needs of patients with different ethnic origins. More attention needs to be paid to culture-sensitive care, as it is not enough to provide only interpreters (Derluyn et al., 2011).

Despite almost universal insurance coverage, some groups systematically continue to fly under the radar, such as **asylum seekers or undocumented migrants** (AGII, 2014). Although Belgium has a special scheme to ensure some free medical care in case of emergency and essential healthcare, these entitlements often go unrealised because of poor awareness of the rights, fear of being reported to the immigration authorities and

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[8] Absolute inequality refers to the difference between the percentage of unmet need reported by the lowest and the highest income quintile; relative inequality is measured by the ratio of the percentage of unmet need reported by the lowest income quintile to that reported by the highest. Relative inequality measurements tend to be high when the prevalence of the outcome under study is lower (Dudal and Bracke, 2016); therefore it is important to take the prevalence rate of unmet need into account when interpreting relative income inequalities in unmet need.

complex administrative procedures (Derluyn et al., 2011). There is a need for further sensitisation of people with no legal residence permit concerning their entitlement to urgent medical care (Nicaise et al., forthcoming).

Considering the different types of healthcare, the HIS data show that – accounting for age, gender and health status – the better educated are more likely to contact **specialist care** (in particular gynaecologists and paediatricians) (Van der Heyden, 2015b). Among those who contact a specialist, however, the number of consultations does not differ by educational level, suggesting that among the lower-educated there is a constraint on using a specialist, but not necessarily just a financial one. Regarding **emergency services**, only a very small proportion of patients used them because primary care was not available or accessible (Van den Berg et al., 2015). Nevertheless, certain population groups – men, the low-skilled and urban residents – systematically resort to the emergency services, especially in the Brussels Region (Charafeddine, 2015).

Unmet need for **dental care** shows a pattern of increasing socio-economic inequality that is similar to the pattern for medical treatment, but the difference between the lowest and the highest income quintile is larger (Eurostat, EU-SILC, 2008-2016; Drieskens et al., 1997-2013, Van der Heyden, 2015c). In particular in Brussels, there is a large group of young citizens (29%, Drieskens et al., 2013) who have never been to the dentist – i.e. almost twice the proportion in the rest of the country (Van der Heyden, 2015c). Many people do not know how much they will have to pay for dental care, and whether their dentist is (partly) conventionalised or not (Van de Walle, 2017). These factors may also deter people, especially those in low-income categories, who perceive dental care to be (very) unaffordable (EQLS, 2017) (Figure A9). The government has already launched financial incentives to convince people to have an annual check-up (Cleemput et al., 2015). Measures such as free basic dental care for young people under the age of 18 and a reduction in the patient contribution can indeed help overcome financial constraints, but socio-economic differences are clearly also related to socio-psychological and cognitive differences (OECD, 2017). It remains an important challenge in the coming years to get the less-educated to the dentist (Van der Heyden, 2015c).

Despite the high(er) need for **mental healthcare** among the lower-educated and non-EU migrants, these groups have fewer consultations with a psychologist or psychotherapist. Psychologists, psychiatrists and other mental health services are perceived by one fifth of Belgian inhabitants to be rather unaffordable to very unaffordable; among the lowest income group this figure reaches 35% (EQLS, 2016). Possible explanations for this include the fact that mental healthcare generally requires more frequent consultations and the fact that only consultations with a psychiatrist or in a mental healthcare centre are reimbursed for adults (Kohn et al., 2016). However, in the federal budget for 2018, EUR 22.5 million are reserved for the treatment of mild mental health problems, and by the end of 2018 a reimbursement system for psychological care will be implemented (De Standaard, 2018b). The Christian, liberal and socialist health insurance funds have already started reimbursements in order to signal the urgency (Flemish Patient Platform, 2018).

Furthermore, socio-economic inequalities persist in the use of **preventive care**, such as breast cancer screening, vaccinations and preventive dental care (Drieskens et al., 1997-2013). Migrants and ethnic minorities also participate less often in screening and vaccination campaigns (Derluyn et al., 2011). An important challenge for public policy is to find innovative ways to effectively reach out to these disadvantaged groups. Preventive actions at the population level have difficulty reaching this target group. **General practitioners** and **multidisciplinary neighbourhood health centres** can play an important role in tackling socio-economic health differences. Less-educated people and young people are more likely to rely on GPs working in a community health centre. It is therefore desirable to strengthen the preventive role of multidisciplinary healthcare centres and to develop them further (Van der Heyden, 2015a). They also play an important role in the de-institutionalisation of care and contribute to more accessible (first-line) mental healthcare, because of their multidisciplinary approach (including social workers and psychologists) and their focus on integrated care (Boutsen et al., 2017). Following a positive audit of healthcare centres, the temporary suspension of new community health centres has been lifted and the sector can continue to grow (De Morgen, 2018; De Standaard, 2018a).

As mentioned in part 1, **out-of-pocket medical spending** is relatively high in Belgium (18% of total healthcare spending). Households spend 5% of their budget on healthcare and a quarter of households find that healthcare expenditure is difficult to meet within their budgets. The most common reason for unmet need is indeed ‘too expensive’ (Figure A10), but it is unclear how this can explain the increasing inequality in unmet need: non-take-up of benefits and rights, deteriorating income situations, increasing inequality in other life domains (labour market, education, housing) and increasing costs for other basic goods and services could all be possible causes. The Belgian healthcare system already includes several **mechanisms to improve financial accessibility**, with special attention paid to more vulnerable groups. These measures were further strengthened and simplified in the healthcare reforms of 2015. To manage the relatively high non-take-up rate, a more **proactive approach** was implemented to identify beneficiaries and invite them to apply. An exchange of tax register information has been organised, so that the sickness funds can directly contact low-income families (Cleemput et al., 2015; Van Lancker et al., 2017). However, even this proactive approach has not gone far enough, as the barriers may appear earlier in the help-seeking process. Unless people know beforehand that their health provider will proactively rely on the third-payer system, they may avoid a first consultation because they fear additional costs in further treatments. Moreover, the supplements that can be charged by non-conventionalised physicians over and above the reimbursement tariff are a potential threat to the effectiveness of these protection measures, as supplements are not included in the mechanisms, e.g. maximum billing (Cleemput et al., 2015).

As **access to care is a multidimensional issue**, financial accessibility is just one of the determinants (EXPH, 2016). Health literacy and information are also related to access to care and are characterised by the same socio-economic gradient as self-reported affordability of care (OECD, 2017). Furthermore, **geographical proximity** needs to be guaranteed, despite the fundamental reforms of the hospital system and financing, launched in May 2015 (Belgische Kamer van Volksvertegenwoordigers, 2014). One of the strategies to improve quality and rationalisation is the centralisation of expertise in a few hospitals. However, this strategy can also be criticised because people in remote areas and less-mobile patients may be ‘left out’.

In summary, whereas on the one hand attention is paid to the financial accessibility of the healthcare system by vulnerable groups through the implementation and strengthening of several measures, on the other hand **cost-containment** is emphasised, the **privatisation** of healthcare is growing, and in 2017 health insurance was confronted with a substantial package of austerity measures (designed to save EUR 0.9 billion). Concerns have been raised by the sickness funds that these measures may further increase inequality of access to healthcare (Callens, 2017). Based on this analysis, these concerns seem to be justified. In conclusion, the solution to inequality of access to healthcare requires more than just policies limited to the healthcare sector. Inequalities in income, education, housing and the labour market may be further reflected in access to healthcare and vice versa (Callens, 2017). Therefore, a more **holistic approach** is required across several life domains, and intersectional and inter-governmental cooperation has to be encouraged.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Across different sources of data, there is consensus about the growing inequality of access to healthcare, measured as unmet need. The same inequalities and vulnerable groups are detected (apart from the educational gradient, which was found in the HIS, but not in EU-SILC) (EC, 2017a). The level and degree of inequality in unmet need also vary across the datasets. The percentages of people reporting unmet need are systematically higher in the

ESS, EQLS and HIS than in EU-SILC. Moreover, on a European ranking based on more objective indicators[9] representing different aspects of the accessibility of the healthcare system, Belgium was ranked worse, compared to its ranking based on self-reported unmet need scores (EC, 2017a). . **Underestimation of the actual level of unmet need** is possible, because of social desirability or shame felt by respondents. People with no or lower education may also be less capable of evaluating their health needs, and whether a consultation with a health provider is required. In particular, the subjective health assessment by very vulnerable groups (such as the homeless, undocumented migrants and the Traveller community) needs to be interpreted carefully: they appear to underestimate their health issues, as they have lots of other (more acute) problems (Nicaise et al., forthcoming). As well as **differences in health literacy**, differences in **health beliefs** can lead to more underreporting among certain groups. Ethnic minorities and non-EU migrants may have a different perception of health, illness and the related adequate care, which makes it difficult to compare their level of unmet need with that of natives. In sum, self-reported unmet need is a quite **crude parameter**: using it to measure inequality of access to healthcare may lead to underestimation, as more vulnerable groups may underreport their unmet need. Nevertheless, large differences in – and high levels of – unmet need can be considered to be an indication of inequality and problems regarding accessibility and affordability (EC, 2017a).

Another concern is that information in the surveys on racial/ethnic background is limited and problematic, as **ethnic minorities are underrepresented**. Some vulnerable groups are even completely excluded from statistics and surveys based on the national register (Nicaise et al., forthcoming). ‘Satellite surveys’ accompanying EU-SILC (Nicaise et al., forthcoming) show that barely half of the group of homeless, undocumented migrants and Travellers are aware of their right to urgent medical care. Moreover, 10.5% of homeless people and 15.6% of those without a legal residence permit reported in 2010 that they had postponed or forgone necessary care for financial reasons (Nicaise et al., forthcoming). Because of the higher level of unmet need in these groups, their underrepresentation leads to an underestimation of the general level of unmet need and of inequality in access.

Regarding **OOP expenditure**, there is some **overreporting** because items such as cosmetic surgery, non-prescription sunglasses and non-health products sold by pharmacies (which are currently included in the OOP spending aggregate) should actually be excluded from the System of Health Accounts (SHA) (EC, 2017b). It is also important to distinguish between OOP excluding cost-sharing, and cost-sharing with third-party payers. Using aggregate OOP expenditure may give a biased picture of the actual financial burden on households, because a large part of the medical costs is reimbursed by the sickness funds and a smaller part by complementary private insurance (which is not evenly distributed across the social groups). However, no information about OOP excluding cost-sharing is available for Belgium in the SHA.[10] Moreover, concerns have been raised about the reliability of information on private health expenditure. The current official Belgian estimates of private expenditure on health (as published in the OECD Health Data) are not transparent and are overestimated in the healthcare sector, but underestimated in long-term care (Calcoen et al., 2015).

Underestimation of the level of unmet need and of inequalities in access to healthcare, overestimation of out-of-pocket payments and incorrect figures for healthcare expenditure can all lead to wrong conclusions and wrong policies, as these figures may be important for governments in deciding whether to invest in, for example, healthcare, long-term care, culture-sensitive care or special measures for vulnerable groups. In order to get a nuanced and reliable picture, therefore, it is very important to rely on several datasets, healthcare

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[9] Mortality amenable to healthcare, out-of-pocket expenditure, total expenditure on health, share of private expenditure in total expenditure on health, infant mortality, number of doctors, number of nurses, coverage for healthcare, number of consultations per general practitioner, life expectancy at age 65 (EC, 2017a).

[10] Due to the fact that no reliable data are available to split the OOP consumption into the part where cost-sharing has occurred and that part which is entirely supported by the households.

indicators and spending figures (in general, by type, by household, by government and by sector).

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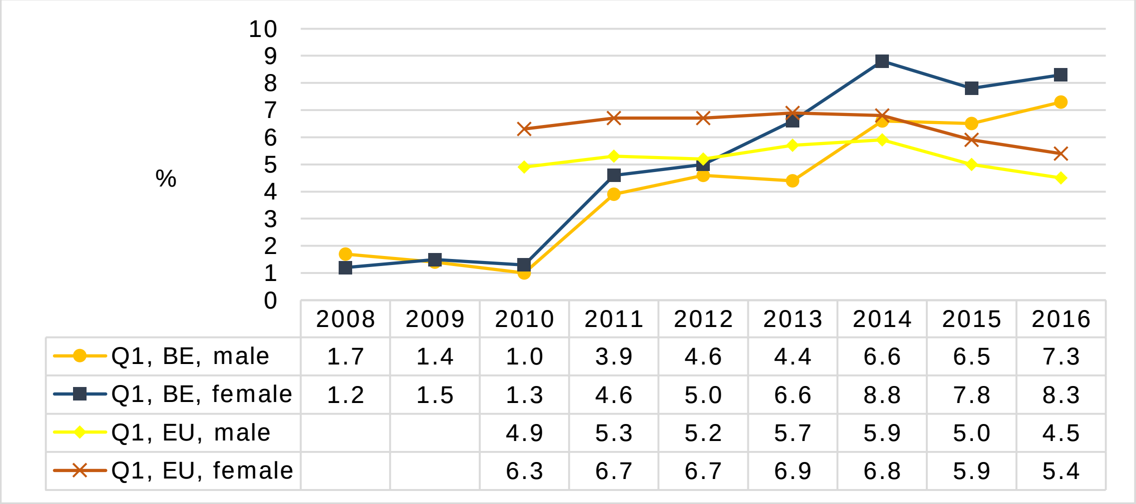
Annex

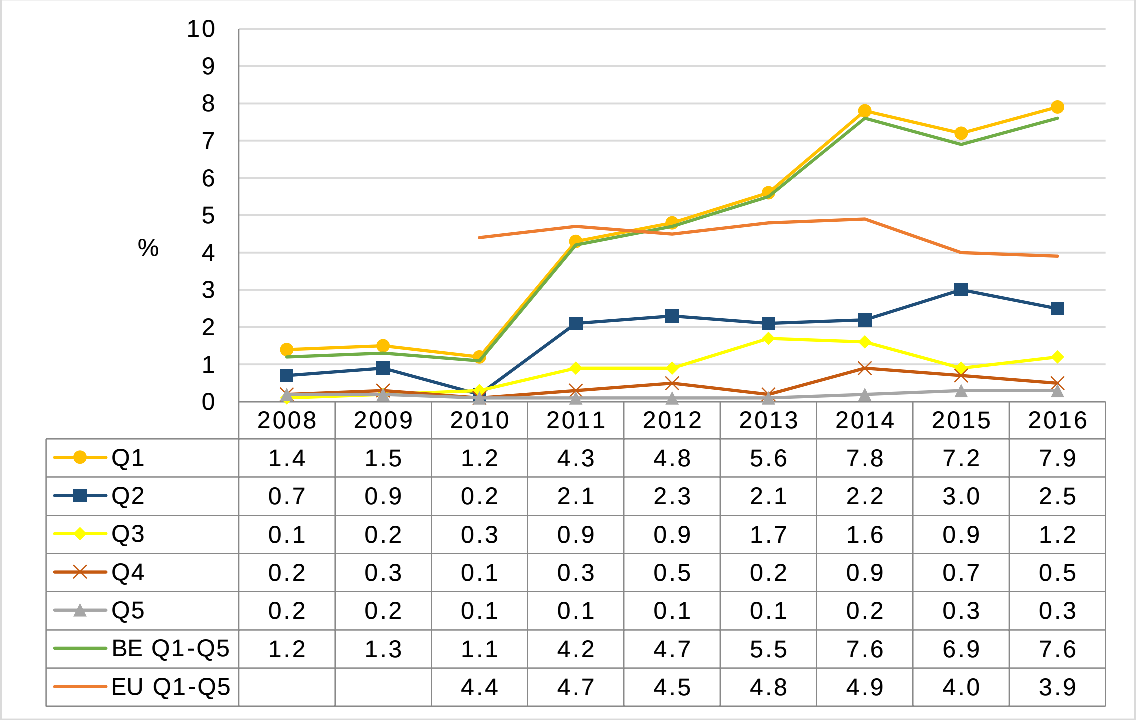
Figure A1: Trends in unmet need among adult men and women of the lowest income quintile, percentages, 2010-2016, Belgium and European Union



	2008	2009	2010	2011	2012	2013	2014	2015	2016
● Q1, BE, male	1.7	1.4	1.0	3.9	4.6	4.4	6.6	6.5	7.3
■ Q1, BE, female	1.2	1.5	1.3	4.6	5.0	6.6	8.8	7.8	8.3
◆ Q1, EU, male			4.9	5.3	5.2	5.7	5.9	5.0	4.5
× Q1, EU, female			6.3	6.7	6.7	6.9	6.8	5.9	5.4

Note: Q1 = First income quintile (lowest income).
European Union Statistics on Income and Living Conditions – Eurostat (EU-SILC) (http://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions), Sample size Belgium, 2016: 5,905; Unmet need measured by: 'Was there any time during the last 12 months when you personally needed a medical examination or treatment for a health problem and did not receive it?' (too expensive, too far to travel or waiting lists).
Source: Eurostat, EU-SILC, 2008-2016.

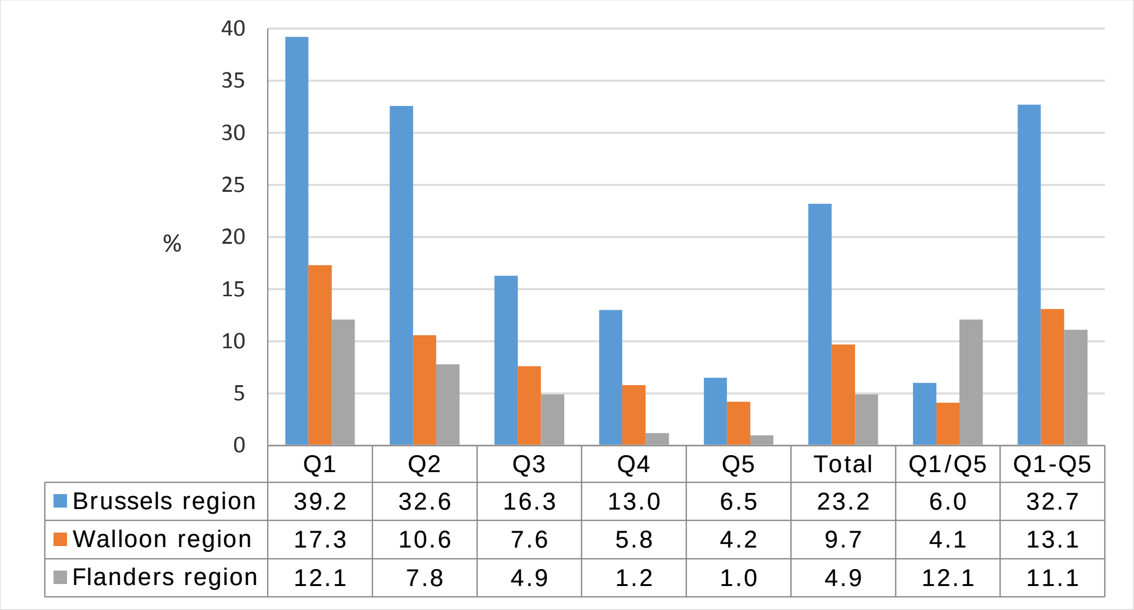
Figure A2: Trends in unmet need among adults by income quintiles, and the absolute inequality, percentages, 2008-2013, Belgium



	2008	2009	2010	2011	2012	2013	2014	2015	2016
● Q1	1.4	1.5	1.2	4.3	4.8	5.6	7.8	7.2	7.9
■ Q2	0.7	0.9	0.2	2.1	2.3	2.1	2.2	3.0	2.5
◆ Q3	0.1	0.2	0.3	0.9	0.9	1.7	1.6	0.9	1.2
× Q4	0.2	0.3	0.1	0.3	0.5	0.2	0.9	0.7	0.5
▲ Q5	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.3	0.3
— BE Q1-Q5	1.2	1.3	1.1	4.2	4.7	5.5	7.6	6.9	7.6
— EU Q1-Q5			4.4	4.7	4.5	4.8	4.9	4.0	3.9

Note: Q1 = first income quintile (lowest income); Q5 = fifth income quintile (highest income); Q1-Q5 = absolute income inequality in unmet need.
Source: Eurostat, EU-SILC, 2008-2016.

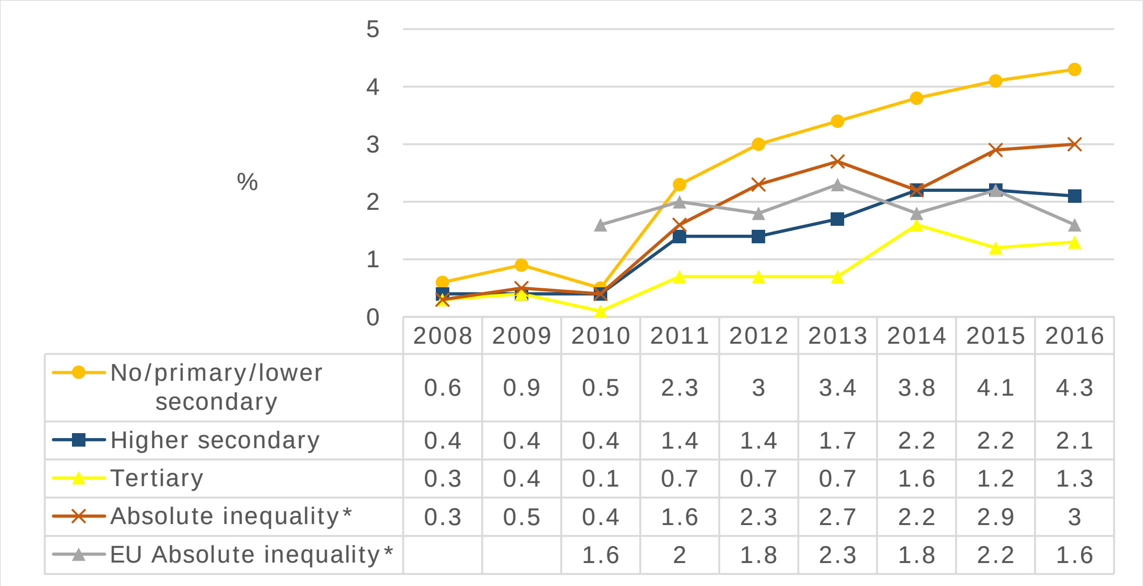
Figure A3: Regional distribution of postponement of medical care for financial reasons by income quintiles, absolute and relative income inequality, percentages, 2013, Belgium



	Q1	Q2	Q3	Q4	Q5	Total	Q1/Q5	Q1-Q5
🟦 Brussels region	39.2	32.6	16.3	13.0	6.5	23.2	6.0	32.7
🟧 Walloon region	17.3	10.6	7.6	5.8	4.2	9.7	4.1	13.1
⬜ Flanders region	12.1	7.8	4.9	1.2	1.0	4.9	12.1	11.1

Note: Q1 = lowest income quintile; Q5 = highest income quintile; Q1/Q5 = Relative inequality; Q1-Q5 = Absolute inequality. For more information about absolute and relative inequality, see Dudal and Bracke (2016).
Health Interview Survey (HIS), Interactive online module (https://hisia.wiv-isp.be/SitePages/Home.aspx), Sample size Belgium, 2013: 10,600; Unmet need measured by 'Was there any time (during the past 12 months) when someone in the family needed the following kinds of care, but could not afford it?'
Source: HIS, 2013 (Drieskens et al., 2013).

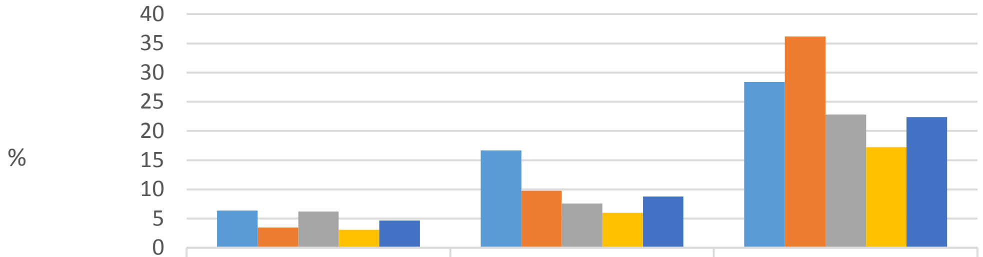
Figure A4: Trends in unmet need by educational level, absolute inequality, percentages, 2008-2016, Belgium and the European Union



	2008	2009	2010	2011	2012	2013	2014	2015	2016
● No/primary/lower secondary	0.6	0.9	0.5	2.3	3	3.4	3.8	4.1	4.3
■ Higher secondary	0.4	0.4	0.4	1.4	1.4	1.7	2.2	2.2	2.1
▲ Tertiary	0.3	0.4	0.1	0.7	0.7	0.7	1.6	1.2	1.3
× Absolute inequality*	0.3	0.5	0.4	1.6	2.3	2.7	2.2	2.9	3
▲ EU Absolute inequality*			1.6	2	1.8	2.3	1.8	2.2	1.6

*Note: * Less than primary, primary and lower secondary education (levels 0-2) – Tertiary education (levels 5-8).*
Source: Eurostat, EU-SILC, 2008-2016.

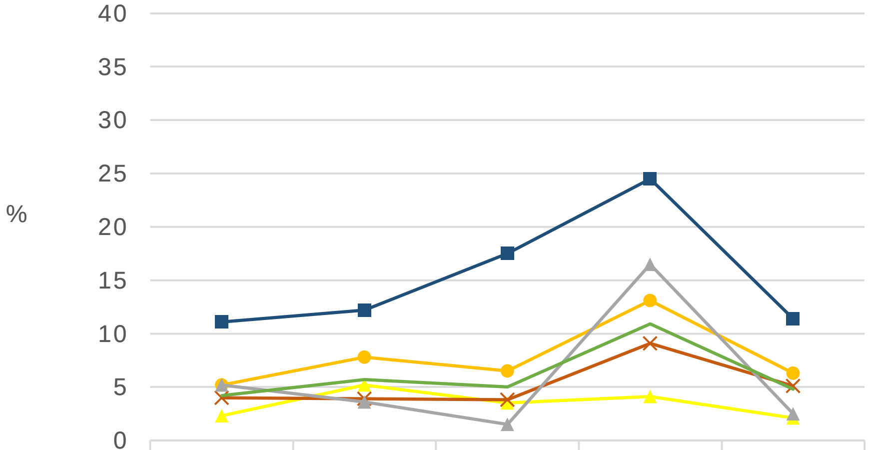
Figure A5: Regional distribution of postponement of medical care for financial reasons by educational level, percentages, 2013, Belgium



	Flemish region	Walloon region	Brussels region
■ Primary or no degree	6.4	16.7	28.4
■ Secondary inferior	3.5	9.8	36.2
■ Secondary superior	6.2	7.6	22.8
■ Superior education	3.1	6.0	17.2
■ Total	4.7	8.8	22.4

Note: Weighted percentage.
Source: HIS, 1997-2013 (Drieskens et al., 2013).

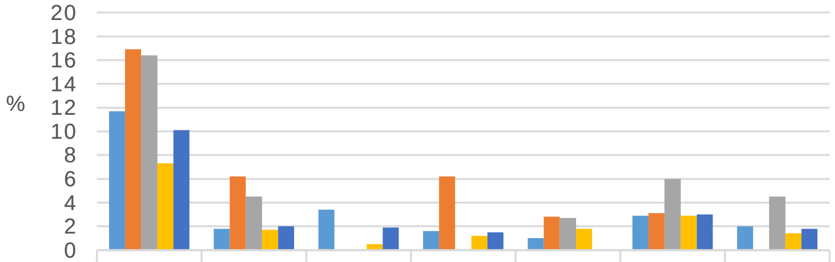
Figure A6: Trends in postponement of medical care for financial reasons by household composition, percentages, 1997-2013, Belgium



	1997	2001	2004	2008	2013
● Single	5.2	7.8	6.5	13.1	6.3
■ One parent household	11.1	12.2	17.5	24.5	11.4
▲ Couple without children	2.3	5.2	3.5	4.1	2.1
× Couple with children	4	3.9	3.8	9.1	5.1
▲ Other/unknown	5.2	3.6	1.5	16.5	2.5
— Total	4.2	5.7	5	10.9	4.8

Note: Weighted percentage.
Source: HIS, 1997-2013 (Drieskens et al., 1997-2013).

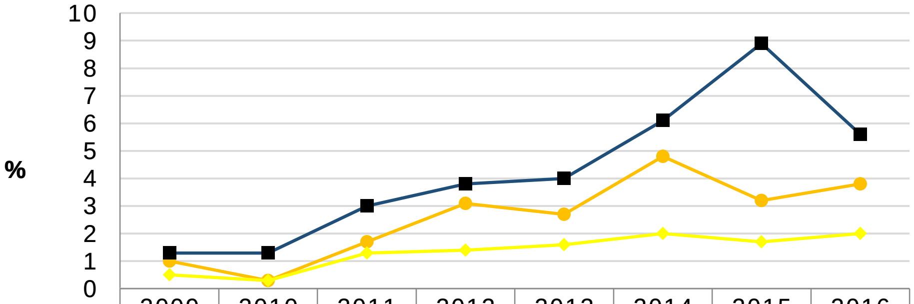
Figure A7: Unmet need by employment status and reason of unmet need, percentages, 2014, Belgium



	All reasons	could not pay	could not take time off work	other commitments	not available where you live	waiting list too long	no appointments available
■ employed	11.7	1.8	3.4	1.6	1.0	2.9	2.0
■ unemployed	16.9	6.2	0.0	6.2	2.8	3.1	0.0
■ inactive (sickness/disability)	16.4	4.5	0.0	0.0	2.7	6.0	4.5
■ non-employed	7.3	1.7	0.5	1.2	1.8	2.9	1.4
■ total	10.1	2.0	1.9	1.5	0.0	3.0	1.8

Note: *European Social Survey (ESS), round 7 (http://www.europeansocialsurvey.org); Sample size Belgium 2014: 1,769; Unmet need measured by 'In the last 12 months were you ever unable to get a medical consultation or the treatment you needed? – Which of the reasons explains why you were unable to get this medical consultation or treatment?'*
Source: ESS, 2014.

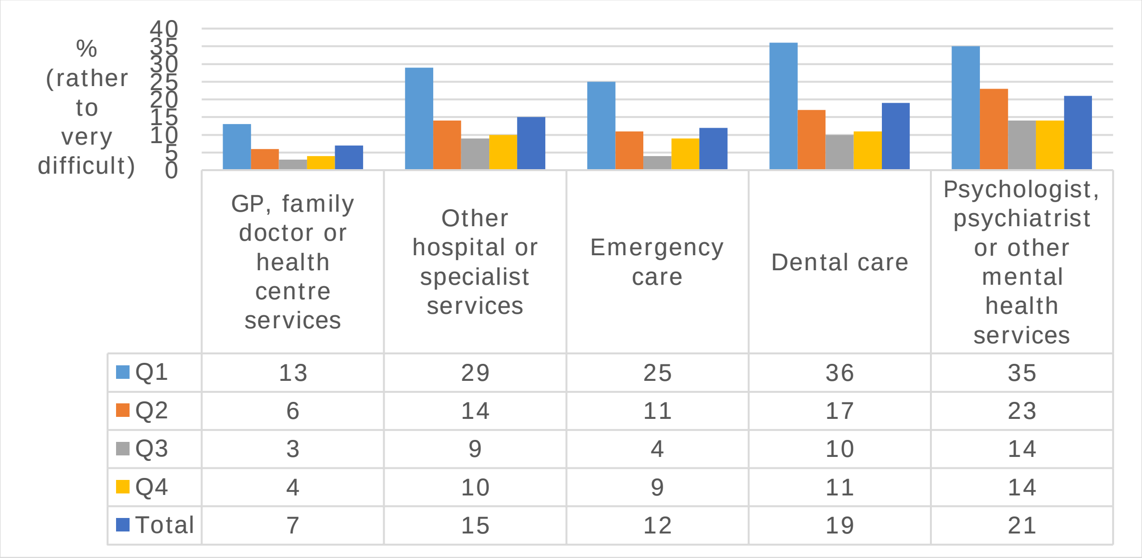
Figure A8: Trends in unmet need by migration status, percentages, 2009-2016, Belgium



	2009	2010	2011	2012	2013	2014	2015	2016
EU migrant	1.0	0.3	1.7	3.1	2.7	4.8	3.2	3.8
non-EU migrant	1.3	1.3	3.0	3.8	4.0	6.1	8.9	5.6
Native	0.5	0.3	1.3	1.4	1.6	2.0	1.7	2.0

Note: migrant = first generation migrant.
Source: Eurostat, EU-SILC, 2009-2016.

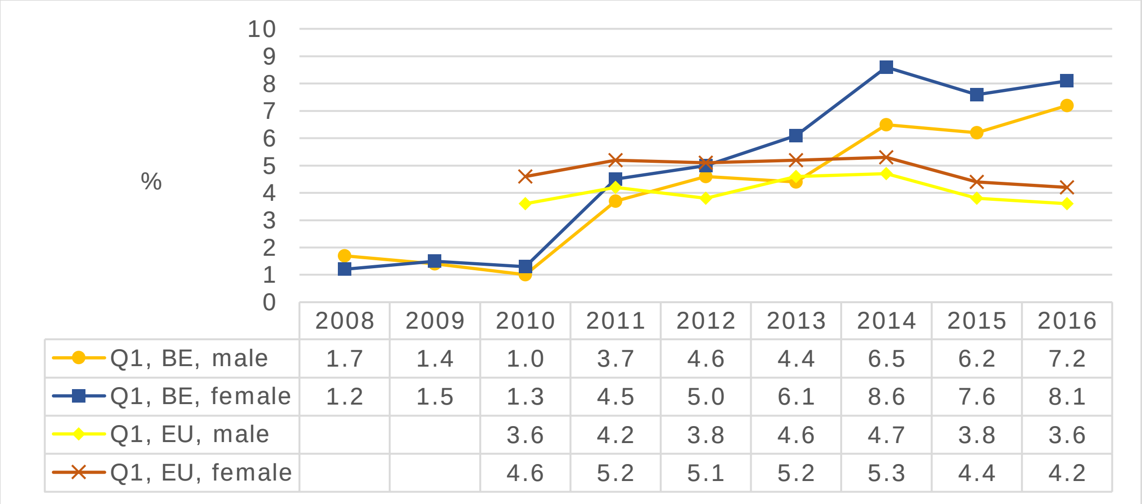
Figure A9: Affordability of different types of healthcare by income quartiles, percentages, 2016, Belgium



	GP, family doctor or health centre services	Other hospital or specialist services	Emergency care	Dental care	Psychologist, psychiatrist or other mental health services
■ Q1	13	29	25	36	35
■ Q2	6	14	11	17	23
■ Q3	3	9	4	10	14
■ Q4	4	10	9	11	14
■ Total	7	15	12	19	21

Note: Percentage of the adult Belgian population that found the types of healthcare rather unaffordable to very unaffordable.
European Quality of Life Survey (EQLS), Interactive online model (https://www.eurofound.europa.eu/data/european-quality-of-life-survey), Sample size Belgium, 2016: 1,017
Source: EQLS, 2016.

Figure A10: Trends in unmet need (reason too expensive) among adult men and women of the lowest income quintile, percentages, 2010-2016, Belgium and European Union



	2008	2009	2010	2011	2012	2013	2014	2015	2016
Q1, BE, male	1.7	1.4	1.0	3.7	4.6	4.4	6.5	6.2	7.2
Q1, BE, female	1.2	1.5	1.3	4.5	5.0	6.1	8.6	7.6	8.1
Q1, EU, male			3.6	4.2	3.8	4.6	4.7	3.8	3.6
Q1, EU, female			4.6	5.2	5.1	5.2	5.3	4.4	4.2

Note: Q1 = First income quintile (lowest income).
This figure is very similar to Figure A1 in Annex 1, which presents the same trend in unmet need but includes also 'too far to travel' and 'waiting lists' as reasons for unmet need. This highlights that unmet need in Belgium is especially because of financial reasons.
European Union Statistics on Income and Living Conditions – Eurostat (EU-SILC) (http://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions), Sample size Belgium, 2016: 5,905; Unmet need measured by: 'Was there any time during the last 12 months when you personally needed a medical examination or treatment for a health problem and did not receive it?' (too expensive).
Source: Eurostat, EU-SILC, 2008-2016.