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Executive summary

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Inequalities in access to healthcare in Belgium: executive summary

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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/INAMI/RIZIV), 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

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.

stakeholders. Second, we analysed secondary data (EU-SILC), related to self-reported unmet needs for medical and dental care. Thirdly, we carried out and analysed 13 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. 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 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 was 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]). 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

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

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 and 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. 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. 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.

The report shows 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.