

SYNTHESIS

WHAT HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN BELGIUM?



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■ FOREWORD

In 2014, the National Institute for Health and Disability Insurance (INAMI – RIZIV) published, in collaboration with Doctors of the World, a white book arguing for a more inclusive health system. This document was the outcome of a reflection conducted jointly by more than 300 stakeholders in the health and welfare domains of our country. One of their recommendations was to simplify the system of access to health care for different categories of people currently excluded from the national health care insurance system. This is in the wake of this important mobilization of civil society that the present research has been decided. KCE has indeed been instructed to thoroughly analyse access to health care of undocumented migrants in our country. This had never been done.

This is a sensitive subject. Even very sensitive, given the current migration crisis. This makes it all the more necessary scientific study such as this, far from bias and emotional reactions. To do this, the KCE has mobilized mixed research methods, both quantitative and qualitative, and consulted a wide range of actors in the field and beneficiaries. Conclusion: the current procedures have the merit to exist, but they are complex and variable, which leads to a suboptimal access to health care in many situations, and burdensome task of all parties concerned.

Our proposal for an organizational reform, which we describe in this report, aims to find a new balance between access to healthcare for everyone - that is, it must be remembered, a fundamental right for all human being - and just and measured use of our public resources. It should simplify life for everyone, with more legible, simplified and harmonized rules, reduced administrative tasks, reorganization of financial flows and better overall monitoring of the situation.

That said, even if we have taken special care to work without any ideological considerations, we must remain faithful to the demands of the mission of KCE. Reduce or deny access to health care cannot be a legitimate instrument to implement a restrictive asylum policy. Our country is far from being a bad student in human rights and we are rightly proud. We have here an opportunity to continue to care for those in need, but in a way that is both more fluid and better regulated. This should reassure even the most cautious of us.

Christian LÉONARD
Deputy general director

Raf MERTENS
General director



■ KEY MESSAGES

- Undocumented migrants residing in Belgium cannot affiliate with a sickness fund. However, they can contact the Public Centre for Social Action (CPAS) of their municipality to access health care via a procedure called Urgent Medical Aid (UMA), if their state of indigence is demonstrated during the social enquiry. AMU in principle covers all preventive and curative health care, delivered in hospitals or ambulatory
- In 2013, 17,602 individuals benefited from UMA, or between 10% and 20% of the estimated number of undocumented migrants, for an average annual cost per beneficiary of € 2,539 paid by the State. The annual number of UMA beneficiaries has remained stable since 2011. There is to date no evidence of misuse of health services.
- AMU is a strong signal of Belgium's commitment to respect the fundamental right of everyone to access health care. But the complexity of the current procedures is harmful to all stakeholders: uncertain and variable access to health care for illegal residents, cumbersome and costly administrative procedures for CPAS, management difficulties for caregivers, difficult monitoring of care practices and costs for public authorities.
- We propose a reform of UMA reform in 9 points to find a more favorable balance between access to health care for everyone and efficient use of public resources. The reform we propose follows two two main lines: simplify and harmonize administrative procedures; streamline access to health care and the information system.
 - Facilitate application for medical aid
 - Streamline the social survey
 - Standardize medical card
 - Harmonize covered health care
 - Streamline the use of health care
 - Facilitate financing
 - Ensure continuity of care and medical information
 - Improve communication
 - Ensure monitoring of care practices and cost
- The implementation of the proposed reform will require consultation between all the institutions involved: the PPS Social Integration, INAMI, FPS Public Health, CAAMI, and the Union of Cities and Municipalities.



■ SYNTHESIS

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GLOSSARY

ABBREVIATION

BCSS – KSZ
CAAMI – HZIV
CPAS – OCMW
DMG- GMD
EPS
INAMI – RIZIV
RHM – MZG
SPF Public Health
SPP IS-POD MS

DEFINITION

Crossroads Bank for Social Security
Auxiliary Sickness & Invalidity Insurance Fund
Public Social Welfare Centre
Global Medical File
Permanent sample
National Institute for Health and Disability Insurance
Minimal Hospital Summary
Public Federal Service for Public Health
Public Federal Service of Programming for Social Integration



1. WHO ARE THE UNDOCUMENTED MIGRANTS?

- Undocumented migrants^a (UM) are those without a residence permit authorising them to regularly stay in Belgium. They include individuals who have entered the country irregularly, people whose residence authorization (e.g. visa, residence or work permit) has expired or become invalidated, those who have been unsuccessful in obtaining asylum, and those born to undocumented parents^{1, 2}. Asylum-seekers and refugees are not undocumented migrants.
- In 2008 it was estimated that undocumented migrants represent 7% to 13% of all foreign residents in the EU³. In Belgium, the foreign population was 1 214 605 on January 1 2014 (68% of whom are from the EU-28)⁴, suggesting there would be between 85 000 and 160 000 undocumented migrants, including migrants from the EU-28. This represents between 0.8% and 1.4% of the general population. Net regular migration to Belgium has been decreasing in recent years (from 84 997 in 2010 to 46 106 in 2013⁴). However, given the political crises in Syria, Iraq, Eritrea and Afghanistan, the number of documented and undocumented migrants will most likely rise in 2014 and 2015.
- UM have few legal entitlements, for instance they have no right to work. Regarding health care, they cannot be affiliated to a mutual health insurance fund and therefore they are not covered by the legal Belgian health insurance system^b. They are however entitled to receive Urgent Medical Aid (UMA).

^a Other denominations for undocumented migrants are unauthorized migrants, people without papers, irregular migrants. Some authors use the name immigrants to specifically designate the migrants of the 1st generation.

^b The only other rights are: the right for minors to go to school; the right for clandestine workers to be paid a decent salary, to have a safe work and to receive a compensation in case of work accident; the right to start a lawsuit

2. WHAT IS URGENT MEDICAL AID?

- UMA is a procedure by which UM are granted an access to health care in Belgium. Contrary to what its name indicates, UMA is not limited to urgent health care but can, in principle, encompass preventive and curative health care, delivered either in hospital or ambulatory settings, as well as drug prescription⁵. UMA is only intended for UM. A specific medical certificate must be delivered by a medical doctor or a dentist to access UMA^{5, 6}.
- UMA must be distinguished from Emergency Medical Assistance, i.e. health care needed immediately for life-threatening conditions, which is specifically regulated by another law and applies to everyone, including UM.

and to have a legal aid *pro deo* on matters relating to their undocumented situation; the right for indigent families with a minor to live in a welcome centre for 30 days, i.e. for preparing their return to the country of origin; and the right to marry. Moreover, children less than 6 year old have a free access to preventive care (including vaccinations) through the ONE – Kind & Gezin. Unaccompanied minors have the same access to health care than nationals provided they are registered in a school for at least 3 months.



3. WHY DOES UMA MATTER?

The application of UMA is important for three main reasons, the first one being deontological, and the two other ones being consequentialist.

3.1. Human rights

Human rights are inalienable rights which guarantee the fundamental dignity of the human being. Belgium ratified several international treaties specifying that everyone within the jurisdiction of a state, without discrimination, should benefit from health care^{7, 8} (see section 1.3.1 of the scientific report for more details on these treaties). The organic law of Public Centres for Social Welfare (CPAS/OCMW) (art 57 §2 of the law 8 July 1976)⁶ and the Royal Decree of 12 December 1996⁵ translate this commitment in the Belgian law. The non-application of that right impacts directly (delaying or denying access to health care result in diseases being treated at a later, more serious, stage^{9, 10}) as well as indirectly (by a process of marginalisation) on the health of UM¹¹⁻¹⁵.

3.2. Public health

The organization of UMA is also relevant in terms of public health as the incidence of some infectious diseases, such as HIV and tuberculosis, may be higher in some UM populations than in the general population^{10, 16-19}. Incidence data in UM are lacking for Belgium. There is limited evidence about transmission of infectious diseases between migrant and native-born citizens²⁰.

3.3. Costs

Although it is commonly assumed that restricting entitlement of UM to health care results in a wise utilization of public money, evidence is emerging that the opposite is more likely. Treating a condition only when it becomes an emergency not only endangers the health of the patient, but also results in a greater economic burden on health-care systems^{11, 21}.

4. WHY THIS REPORT?

UMA is crucial to grant UM an access to health care. However, field actors often report that the complexity of the procedure is an impediment to an equitable access to health care for this vulnerable population²². Doctors of the World, in collaboration with the National Institute for Health and Disability Insurance (INAMI – RIZIV), has proposed that KCE analyses in depth the current UMA practice in Belgium and proposes, if appropriate, sustainable scenarios for improving access of UM to health care. Legal and administrative procedures to access legal entitlements are out of the scope of this report. This project applies a mixed-method analysis approach. The main steps of the research and data sources are summarized in Table 1

**Table 1 – Main research steps and data sources**

Questions	Data sources
1. Situation analysis (numbers, rules, costs, organization)	<ul style="list-style-type: none">a. Semi-directive interview of 10 managers in the Public Social Welfare Centres (CPAS – OCMW) with the highest numbers of UMA.b. Review of the grey literature on UMA in Belgium, particularly legal documentsc. Analysis of routine data collected by CPAS – OCMW on numbers of UMA applications and acceptance ratesd. Analysis of routine data collected by the Federal Public Service for Social Integration (SPP IS – POD MS)^c, and by the Auxiliary Sickness & Invalidity Insurance Fund (CAAMI – HZIV)^d
2. SWOT analysis (Strengths, Weaknesses, Opportunities, Threats)	<ul style="list-style-type: none">a. Interviews with 33 undocumented migrantsb. Focus groups with 66 health care professionals and hospital managersc. Brainstorming sessions with key informants from governmental and non-governmental organisations with expertise in the field of health care for UM
3. Elaboration of an alternative organizational model	<ul style="list-style-type: none">a. Review of the scientific and grey literature on the access of UMs to health care in a sample of European countries to draw potential lessons for Belgium.b. Elaboration of a new organizational model accounting for the situation and the SWOT analysis.c. Stakeholders and key decision-makers consultation on the UMA reform
4. Scientific validation	<ul style="list-style-type: none">a. Review of this report by 3 independent scientific experts (see colophon).

^c This public organism bears the final responsibility of reimbursing health care delivered under UMA.

^d This sickness fund manages claim data for UMA health care delivered in hospital since mid-2014



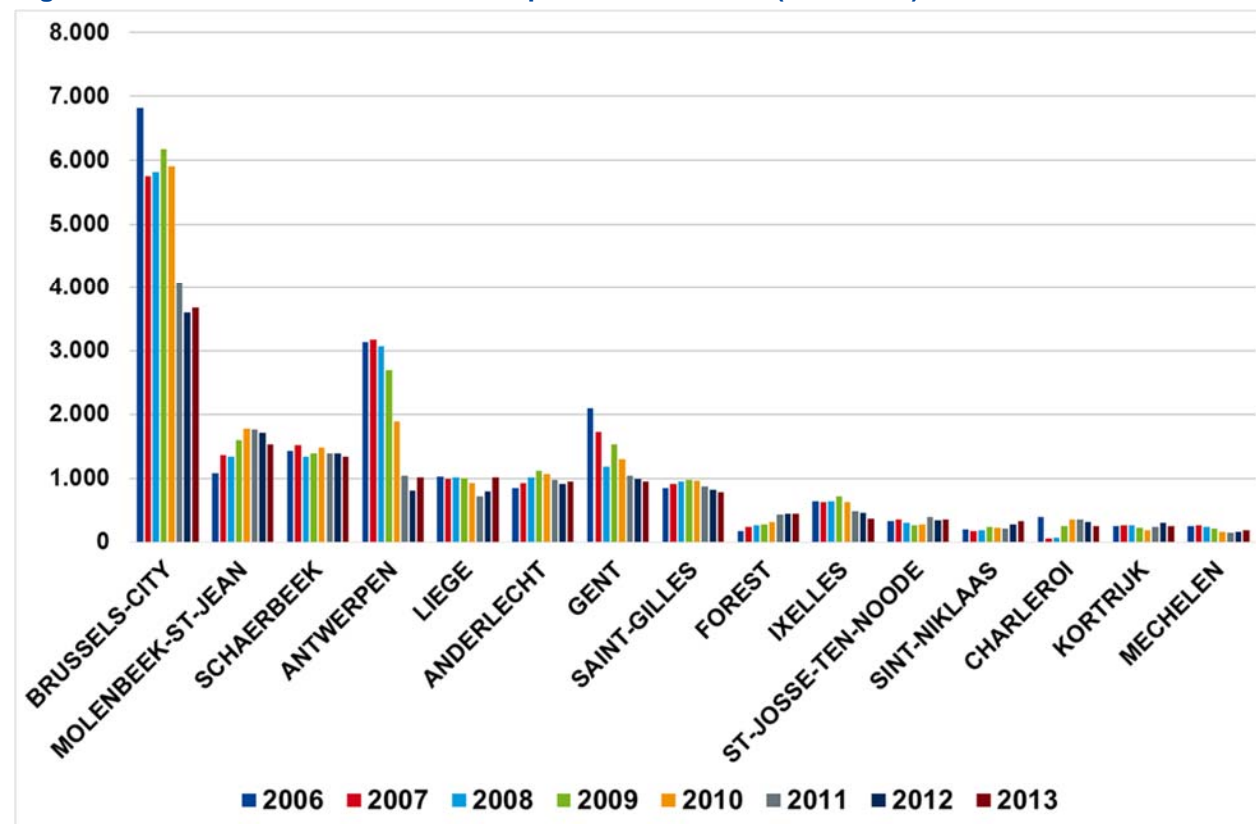
5. HOW MANY INDIVIDUALS ARE CONCERNED?

- In 2013, 17 602 individuals benefited from UMA, 56.4% of whom were males. The overall number has been quite stable since 2011, following a great decrease in previous years. Indeed, the number of individuals who were granted UMA was 22 478 in 2006. The decrease was particularly marked in Brussels City and Antwerp (Figure 1). Its origin is likely multifactorial, one of the main elements being the wave of regularization of UM started in 2009.
- The overall density of AMU beneficiaries was 163 per 100 000 inhabitants in 2013. The geographical distribution of UMA beneficiaries is very uneven, with high concentration in cities, half of the beneficiaries being in the Brussels region. Within the Brussels region, UMA beneficiaries are mainly located in 8 of the 19 municipalities, and particularly in Brussels City (Figure 1).
- We estimated that only between 10% (17 602/85 000) and 20% (17 602/160 000) of the UM population had at least one contact with the medical services during year 2013. As a comparison, this proportion approximates 90% for members of a Belgian mutual health insurance fund, independently of age and sex (source: EPS 2013).
- The proportion of UMA beneficiaries admitted to hospital remained constant at around 20%, a proportion close to what is observed for insurees with a Belgian mutual health insurance of similar age, sex and insurance regimen^e (data standardisation). More detail on pathologies is currently not available.

^e When there is a co-payment, the amount is reduced for UMA beneficiaries as for other vulnerable groups such as widows, orphans, or poor people.



Figure 1 – Number of UMA beneficiaries per CPAS – OCMW (2006-2013)



Source: SPP IS – POD MS



6. HOW DOES IT WORK?

Currently, the Public Social Welfare Centre (CPAS – OCMW) acts as an intermediary institution between the UM and the health care system. Its mission is twofold. First, it checks if the conditions for accessing UMA are fulfilled. Second, it defines on an individual basis the extent of the entitlements to health care. In principle, the UM must first go to the CPAS – OCMW to get the UMA agreement before accessing health care (Figure 2).

6.1. What are the conditions for UMA agreement?

The beneficiary must apply in the CPAS – OCMW either by presenting himself/herself or, in case of hospitalization, through the social service of the hospital who will transmit the signed application to the CPAS – OCMW. The CPAS – OCMW will deliver an UMA agreement, i.e. it will cover the costs incurred by the health care, only if **three conditions** are fulfilled^{23, 24, 25}.

6.1.1. Territoriality

The CPAS – OCMW is competent to examine the UMA application if the UM has his/her effective residence on the territory of the municipality, i.e. if he/she lives there most of the time.

6.1.2. Social enquiry to assess indigence

The CPAS – OCMW will cover the costs incurred by the health care only if the UM or nobody else can do it. Assessing the indigence status of the UM is done through different information checks which constitute the so-called **social inquiry**. There is no formal definition of indigence. It is generally understood as the absence of means to live in a manner compatible with human dignity.

- **No insurability.** The CPAS – OCMW will check if the UM has already a health care insurance. This could be the case if the UMA applicant has been affiliated to a mutual health insurance fund previously (e.g. as a student or because having a work permit) and the affiliation is still valid. This is investigated by screening the Crossroads Bank for Social Security (BCSS – KSZ). The UM may also have a health insurance still valid in his/her country of origin. The CAAMI – HZIV will be contacted by the CPAS – OCMW to check this information. Lastly, the UM might have contracted a private insurance covering health care. Whether the UM comes from a country where a visa is compulsory to enter Belgium, whether he/she comes from a country with a liaison agency or whether he/she must be covered by the European insurance card, are additional information checks.

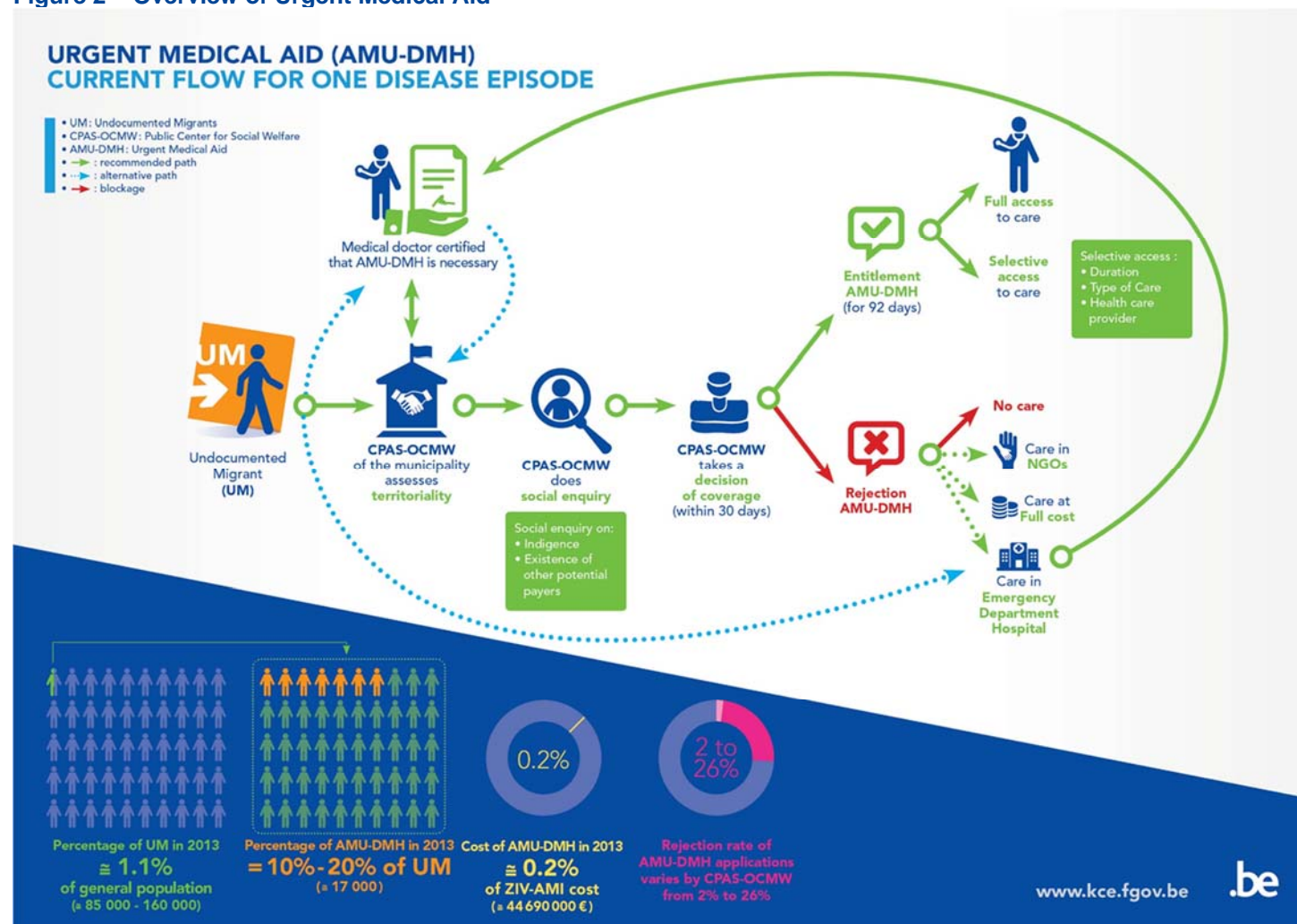
If the UMA applicant resides in Belgium for more than one year, it is not necessary to check his/her insurability, but the applicant must provide documents proving the duration of his/her stay in Belgium.

A last situation is when the UM has indeed an authorization to reside in the country, for instance because a procedure of asylum-seeking is still pending. In such case, health care can be covered by another organism and are not part of UMA.

- **No guarantor.** The CPAS – OCMW will send a request to the Office for Foreigners to check if a resident in Belgium has designed himself/herself as a guarantor of the UM. If this is the case, the CPAS – OCMW may ask the guarantor to ensure the payment of the health care needed by the UM.



Figure 2 – Overview of Urgent Medical Aid





- **Insufficient resources.** The CPAS – OCMW will collect information on the resources of the UMA applicant, and his/her cohabitants if any. The objective is to assess the financial capacity of the UM to pay for his/her health care. Therefore, information will be collected on income and goods, but also on wages, service charges and unpaid invoices. Based on this information, a financial analysis is performed, and the social assistant states if the UM is indigent or not. It is worth mentioning that if the resources of the UM (and his/her household) are below the level of the corresponding minimum welfare payment, the State will not cover the co-payment, except in case of hospitalisation.

The social enquiry will also include identification data of the UMA applicant, as well as the reason for residing in Belgium. If the applicant has no ID number in the national register (NISS), the CPAS – OCMW will deliver one, called the NISS-bis. During the social enquiry, a home visit is organized by a social assistant of the CPAS – OCMW for evaluating housing and living conditions, and confronting UM's declaration and reality²⁵. After one year, the social enquiry must be redone, but it can also be updated in between when it appears that some of the information relating to the UM may have changed. The social inquiry is a legal obligation, the home visit is not^{25, 26}.

When the UM presents directly to the emergency department of a hospital, a preliminary enquiry is started by the social staff at the hospital, but the final responsibility of the social enquiry remains in the hands of the CPAS – OCMW.

6.1.3. Medical certificate for UMA?

The third condition is that the need for UMA must be certified by a general practitioner or a dentist. The UMA certificate describes the health care (GP consultation, specialist consultation, physiotherapy, medical exam) and treatment needed. In principle, a UMA certificate is necessary for every new disease episode or treatment. When the UM presents directly to the emergency department, the UMA certificate is delivered by the hospital doctors.

6.2. What decision can the CPAS – OCMW make?

On the basis of the information collected during the social enquiry, a proposal for decision is submitted to the council of social welfare of the CPAS – OCMW.

6.2.1. UMA agreement or rejection

- The CPAS – OCMW must take a decision to grant UMA or not within 30 days since the submission of the UMA application. This decision is notified to the UM within 8 days by registered mail^f, with explanation for refusal if appropriate. In case of rejection, the UM may file a suit with the Labour court.
- In case of agreement, the CPAS – OCMW provides the UM with a document called a “réquisitoire” which specifies health care and treatments covered and which is a guarantee of payment for the health care provider. However, an increasing number of CPAS – OCMW deliver an individual medical card instead of “réquisitoires”. The medical card specifies the general practitioner to be consulted and the pharmacy where to get the drugs can be obtained. With the medical card, the validity of which can extend to 1 year, the UM does not need to request an UMA agreement at the CPAS – OCMW for each disease episode or for every drug prescription by the GP. For health care delivered at hospital, the notification of coverage by the CPAS – OCMW is done electronically since 2014, thanks to an computerized data transfer system called **MediPrima**. MediPrima connects the CPAS – OCMW, the hospitals and the CAAMI – HZIV, and the SPP IS-POD MS²⁷. MediPrima will be extended to GPs and community pharmacies in a close future.

^f Can also be given directly to the UM against an acknowledgement of receipt



6.2.2. Defining the extent and the duration of the coverage

Each CPAS – OCMW decides what health care will be covered for a specific individual. The UMA agreement can be global (all health care prescribed are covered) or can concern specific care or medication. The criteria used to decide the latter are not transparent. The level of coverage can also vary. The CPAS – OCMW may also decide to cover medical care or medication usually not reimbursed according to the INAMI – RIZIV nomenclature (e.g. drugs from the D category, tooth extractions, powdered milk for babies, etc...).

Usually, the UMA agreement is valid for 92 days. However, this duration can vary from a CPAS – OCMW to another from one day (e.g. for ambulatory care at the hospital) to one year (e.g. for patients with chronic disease).

7. HOW MUCH DOES IT COST?

7.1. Who is the payer?

- The State is the ultimate payer of UMA, via the Federal Public Service for Social Integration (SPP IS – POD MS).
- For primary health care, the health provider transmits the invoice to the CPAS – OCMW, and the CPAS – OCMW gets reimbursed by the SPP IS – POD MS. For hospital care, the health provider transmits the invoice to the Auxiliary Sickness & Invalidity Insurance Fund (CAAMI – HZIV) through MediPrima, and the CAAMI – HZIV gets reimbursed by the SPP IS – POD MS.
- The health care with a code attributed by the National Institute for Health and Disability Insurance (INAMI – RIZIV) and refundable drugs are reimbursed up to the maximum amount stipulated by INAMI – RIZIV²³. Some health care are not reimbursed⁹. Health care outside the INAMI – RIZIV nomenclature is either covered by the CPAS – OCMW, or paid by the UM, or not delivered.

7.2. What is the annual budget?

- The annual global budget paid by SPP IS – POD MS increased from 38 098 081 € in 2006 to 44 688 492 € in 2013, i.e. 17.3% in 7 years (source: SPP IS – POD MS). The relative proportion of the various budget compartments remained constant, with around 70% of the expenses dedicated to hospitalization (Figure 3).
- The mean cost per beneficiary increased from 1 695 € in 2006 to 2 539 € in 2013 (+49.8% in 7 years). The increase was particularly sharp for hospitalization costs (+76.3%). Such an increase for individual hospitalization costs was not observed for the population with a legal health insurance. This difference could be due to increasingly serious pathologies in UMA beneficiaries or changes in hospital billing. Data are currently lacking to address such questions more in depth.

⁹

See the reference document of SPP IS – POD MS²³



- UMA expenses per individual are highly variable among CPAS – OCMW (Figure 4). This may reflect a varying distribution of diseases in different populations. It may also reflect varying patterns of health care utilization, in relation either to different health care seeking behaviours or variations in the accessibility of health care services. Finally, there might be an artefact in Brussels with most complicated cases being transferred to the St-Pierre hospital and eventually getting an UMA in the CPAS – OCMW of Brussels City.
- We evaluated that the average individual cost was 24.5% lower in UMA beneficiaries than in members of a Belgian mutual health insurance fund, after standardization for age, sex and insurance regimen^h.
- The above computations are based on expenses covered by SPP IS – POD MS. It is worth mentioning that costs covered by CPAS – OCMW and costs incurred by the hospitals or NGOs are not included. As these data are not centralized, the amount of UMA expenses not covered by SPP IS – POD MS is unknown. This is a major limitation to estimate the total cost of UMA.

^h In 2012, the UMA expenses amounted to 42 573 035 € for 17 193 beneficiaries, i.e. 2476 € per individual (source: SPP IS – POD MS). This would amount to 3 280 € for members of a Belgian mutual health insurance

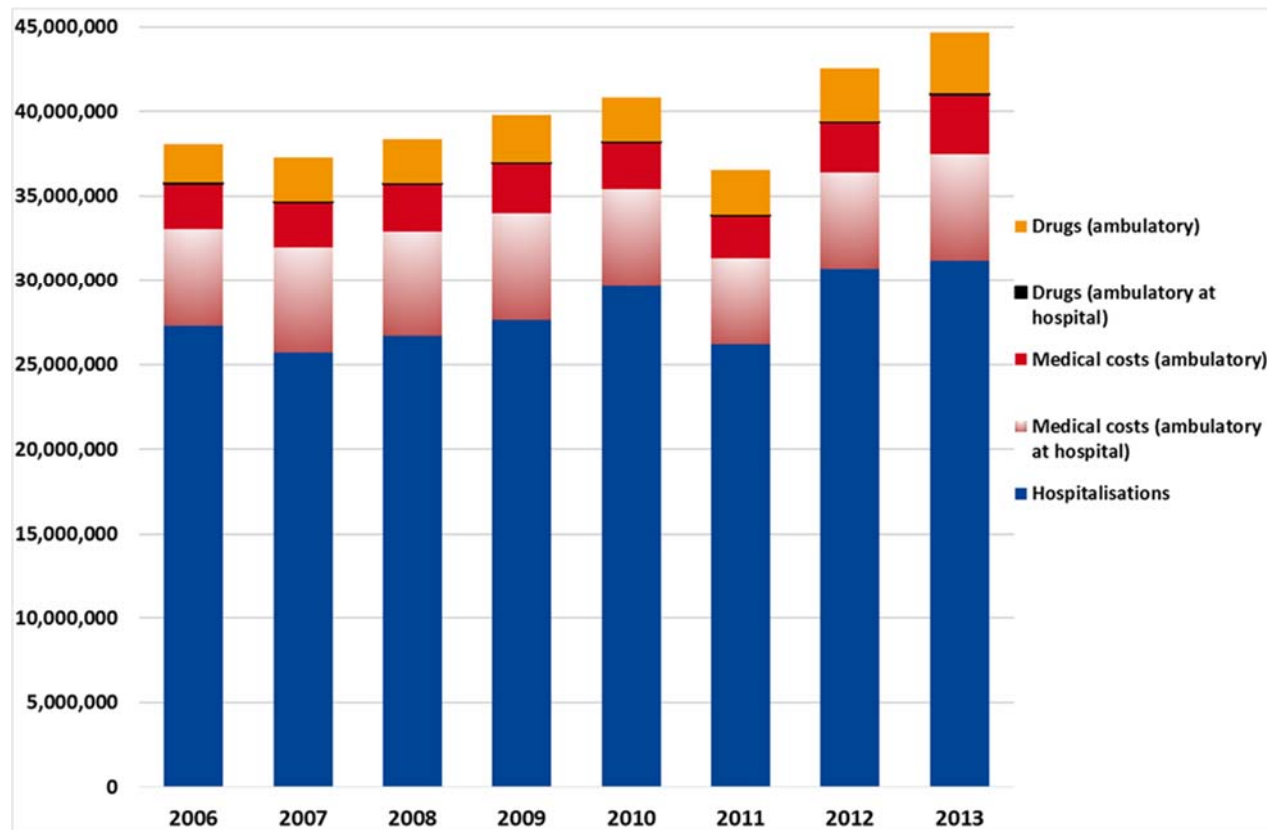
7.3. Is there evidence for medical tourism?

- When someone migrates with the objective of accessing health care in the host country, we talk of migration for health reasons or medical tourism. One of the main obstacles to the implementation of health care for all is the fear that migration for health reasons overwhelm the capacities of our national and local health systems. There is at present no data to confirm or disprove that part of UMA is delivered in that context.
- We know that in year 2014, there were 1 918 visa applications for medical reasons in 2014 in countries where a visa to enter Belgium is compulsory⁴. The rejection rate was 19%. The bulk of applications were from African countries (56%) and the refusal rate of those applications was 28%⁴. It is much more difficult to ascertain the proportion of UM entering the country for medical reasons.
- Data are more difficult to find to ascertain the proportion of individuals migrating to our country for medical reasons. An international survey carried out by Doctors of the World in 2014 in 7 European countries revealed that only 3% of the immigrants (65% of whom were undocumented) presenting at their medical consultation mentioned health problems as one reason for their immigration²⁸. This proportion was similar in 2008, 2012 and 2013. Moreover, the median time between arrival in the host country and the first medical consultation in centres of Doctors of the World was 3 to 8 years. A major limitation of this study is the risk of selection bias, i.e. it is unknown if the respondents were representative of the whole UM population. Such data, although indirect and partial, do not point towards a massive medical tourism. We have not found neither obvious indications of medical tourism in our analysis of data from SPP IS – POD MS and CAAMI – HZIV. This said, the collection of routine data should be improved rapidly to get a more transparent picture of the care practice and costs of UMA. Such data collection is important to establish a fair and viable policy (see section 10.9).

fund (INAMI – RIZIV) with same age, sex and insurance regimen (indirect standardization) (the average expenses for BIM patients in the INAMI/RIZIVINAMI – RIZIV being 4 925 €).



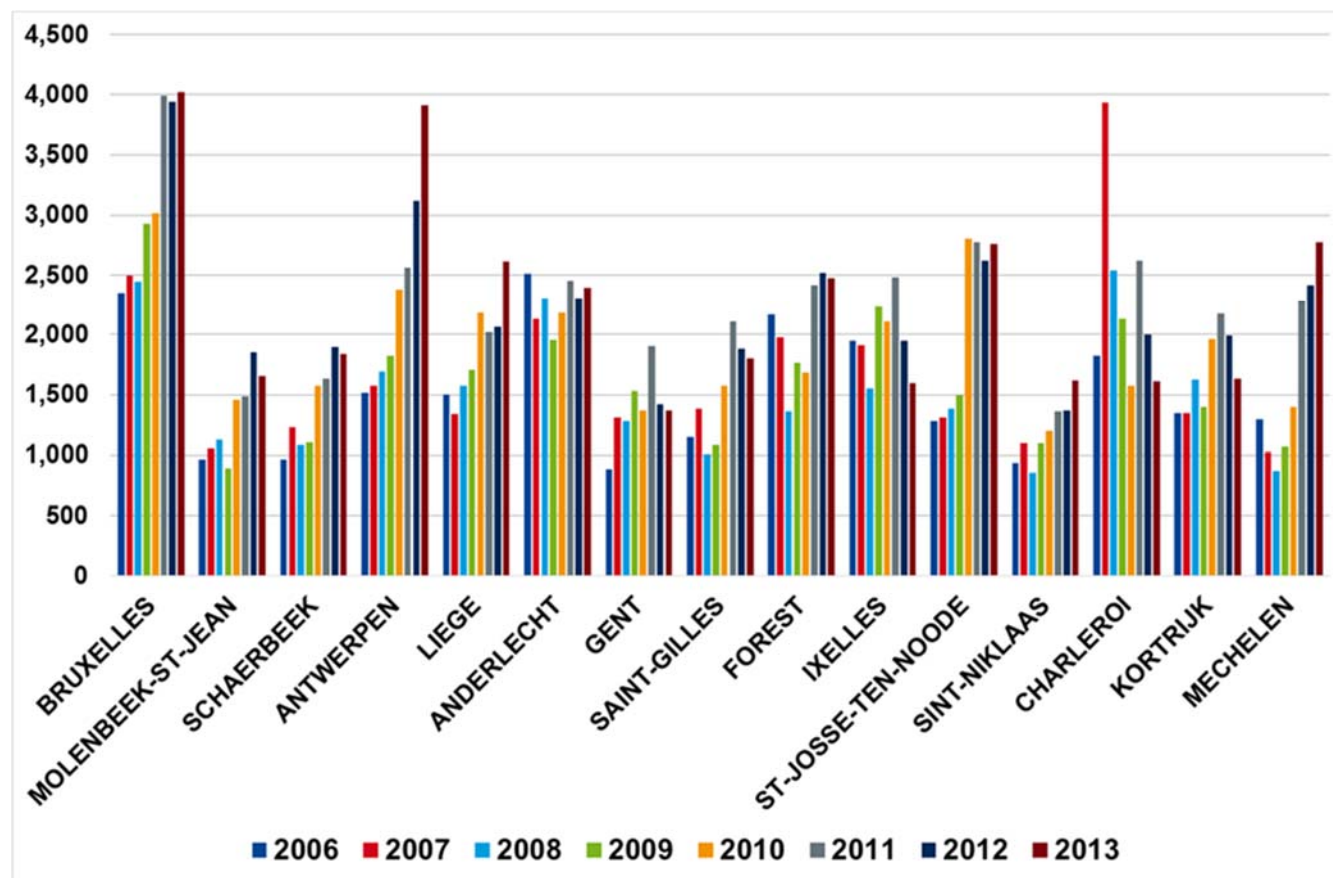
Figure 3 – AMU budget paid by the SPP Social Integration (in €)



Source: SPP IS – POD MS



Figure 4 – Average UMA expenses per UMA beneficiary among the 15 PCSW with the highest provision of UMA beneficiaries (€)



Source: SPP IS – POD MS. CPAS – OCMW are sorted by number of 2013 UMA beneficiaries.



8. WHAT ARE THE STRENGTHS OF THE CURRENT ORGANISATION?

8.1. Health care

- UMA entitles undocumented migrants in Belgium to receive both preventive and curative care and treatment within the regular health care system⁵. This is in favor of equitable health care for all individual whatever his/her legal status, and in favor of continuity in health care.
- Belgium is among European countries where all health care for UM can be covered by the State, as in France, the Netherlands, Portugal and Italy, but not in Germany or Austria for example (for more information on foreign examples, see section 6.1 of the scientific report).
- The free choice of the health care practitioner by the patient is guaranteed to a certain extent. Most of the CPAS – OCMW invite the UM to choose a medical doctor among those having signed a work convention with the CPAS – OCMW. This work convention stipulates the recommendations of the CPAS – OCMW for UMA practice (for example the use of the global medical file or the preferential prescription of generic drugs) and is a guarantee of payment for the medical doctors. The CPAS – OCMW also signs such work conventions with community pharmacies or hospitals.

8.2. Activation of UMA

- The current procedures allow the right to UMA to be activated before the occurrence of a disease episode. If a medical certificate for UMA is not available, it is however possible for the CPAS – OCMW to take a decision in principle on the basis of the social enquiry. The decision of coverage can thus be taken rapidly when a medical certificate for UMA is generated.
- In case of a medical emergency, health care can be provided without having to wait for activation of UMA (i.e. the social enquiry comes afterwards) and without administrative penalties for the beneficiary or the health care provider.

8.3. Connecting role of CPAS – OCMW

- As CPAS – OCMW are located in every municipality and are highly experienced in dealing with vulnerable populations and social problems, the UMA application may be facilitated.
- The managerial autonomy of CPAS – OCMW allows tailoring the support to the local situation and individual needs.
- The privacy of undocumented migrants and confidentiality of information that they disclose is guaranteed. They cannot be disclosed to the police.



9. WHAT ARE THE DIFFICULTIES OF THE CURRENT ORGANIZATION?

9.1. Variations in social enquiry

Partly due to the lack of clear-cut legal description of the organizational aspects of UMA, and partly due to the autonomy of CPAS – OCMW to organize social support, the social enquiry can vary a lot among CPAS – OCMW, even within the CPAS – OCMW of the Brussels region. This is the other side of the capacity of CPAS – OCMW to adapt social support to the individual needs. Such a variability can engender discriminatory decisions and an inequitable access to health care.

9.1.1. Variation in indigence assessment

The threshold under which the resources of the UMA applicants are considered insufficient varies among CPAS – OCMW. It can be equivalent to the minimum welfare payment in some CPAS – OCMW, or higher in others. When the resources of the UM are above the indigence threshold, the subsequent decision of coverage can vary dramatically. In some CPAS – OCMW, it is simply the co-payment of health care by the UM which is not covered. In others, an all-or-nothing rule is applied, i.e. none of the costs incurred will be covered by the CPAS – OCMW, at least in the ambulatory sector. Sometimes, the costs of the health care needed by the UM can also be accounted for in the final decision to grant or refuse the UMA agreement. For example, the CPAS – OCMW may decide to not cover consultations in ambulatory care but to cover the costs incurred by a hospitalization. The conditions to be fulfilled are rarely described on the websites of CPAS – OCMW.

9.1.2. Great variation in rejection rate

We observed that the rejection rate of UMA applications is highly variable, ranging from 2.2% to 26%. The most often reported reasons for refusal were the “lack of collaboration of the UM” which in general means that “the applicant does not respond to invitations by the CPAS – OCMW to show up or does not provide the required supporting documents within a reasonable delay or provides false information”²³ or the “impossibility to prove indigence”, which relates to the refusal or the impossibility to provide supporting documents in relation with income. In contrast, interviewees in

CPAS – OCMW reported that lack of indigence is rarely a reason put forward to refuse UMA. Unfortunately statistics on reasons for refusal were generally not available.

9.2. Variations in entitlement to health care

9.2.1. Global or restricted

The entitlement to health care can be global (i.e. covering all the health care recommended by the health practitioner) or selective (i.e. the CPAS – OCMW has the power to decide what specific care or treatment will be covered). Such variations can be observed between CPAS – OCMW or among UM registered in a given CPAS – OCMW. The grounds for making such a decision are not straightforward. We observed that some CPAS – OCMW may ask for and/or obtain from the prescriber details on the medical file, breaching medical secrecy. A minority of CPAS – OCMW hire a medical doctor to assess the legitimacy of the UMA certificate.

9.2.2. INAMI – RIZIV nomenclature or more

A CPAS – OCMW can decide to cover, with its own fund, health care expenses usually not reimbursed, as defined by INAMI – RIZIV, to patients with a Belgian mutual health care insurance. This can be justified by the high vulnerability of this population. Such practice varies from a CPAS – OCMW to the other, and within a municipality, from an UM to the other. In some cases, this additional entitlement can be automatic. For example, the 19 CPAS – OCMW of the Brussels region refer themselves to a common list of D drugs (e.g. pain killers) which they systematically cover.

9.2.3. Short or long

The duration of the UMA agreement is most commonly 92 days. It can be shorter (1 day) or longer, as some CPAS – OCMW will prolong the UMA agreement up to one year in case of chronic diseases.



9.3. Administrative burden

9.3.1. Social enquiry

The social enquiry must be repeated at least once a year. However, in order to avoid being financially penalized in case of inappropriate UMA decisions, some CPAS – OCMW repeat the home visit every 92 days, even if the UMA is granted for longer, or at every new UMA demand for one given UM. Reassessment of the UM's eligibility to get UMA can be done at any time when there is suspicion of a potential change in the UM's situation. One of the CPAS – OCMW visited redoes the social inquiry monthly. The legal delay of 45 days imposed to CPAS – OCMW to notify the SPP IS of its coverage decision is considered too short by many interviewees.

9.3.2. Territoriality

The condition of territoriality imposed that the social enquiry must be reassessed every time the UM moves to a new municipal territory, i.e. the social enquiry done previously by another CPAS – OCMW is not valid. The condition of territoriality generates a particular burden in the Brussels region where the territory of the 19 municipalities are closely interlinked. Defining geographical competency is even trickier around some magnet structures, such as railway stations (e.g. North station in Brussels), located on more than one municipality.

9.3.3. Health care delivered before an UMA agreement

- A proportion of UM by-pass the administrative procedure and get health care at the hospital when necessary. For example, in the first semester of 2012, the CHU St-Pierre in Brussels reported that the vast majority of UM hospitalized (93.9%; 1,068/1,137) had no UMA agreement from the CPAS – OCMW ("réquisitoire") at their arrival. For ambulatory care, this proportion was 82.0% (4,376/5,334). In the CHU Charleroi during the first 10 months of 2015, 60% of patients whose health care were eventually covered by UMA had no agreement from the CPAS – OCMW at their admission.
- When a UM gets health care directly from the emergency room of a hospital, a social enquiry is started by the staff for social welfare of the hospital. However, the CPAS – OCMW must redo the social enquiry, possibly on the basis of information already collected by the hospital, to avoid financial penalty in case of error. This is duplicated work.

Moreover, it is not always possible to repeat the social enquiry, e.g. the UM cannot be retrieved. In such case, the bill will remain in the hands of the hospital.

- When the CPAS – OCMW of the municipality where the UM has declared residing is unable to ascertain territoriality, the file will be transmitted to the CPAS – OCMW of the municipality where the hospital stands. This clearly increases the burden of CPAS – OCMW having a hospital on their territory. This is also the case for municipality having a magnet structure on their territory.
- There is no guarantee that the CPAS – OCMW will cover the expenses eventually, as this decision will depend upon the social enquiry done by the CPAS – OCMW after the care has been delivered. As a result, the unpaid invoices can be quite substantial. For example, the invoices of the IRIS hospital network (Brussels region) not covered by a CPAS – OCMW amounted to 4 174 200 € in 2012 of which 80% were dedicated to UMA. As an indication, the UMA paid by the SPP IS-POD MS IS for the Brussel region that same year was 28 530 340 €.

9.3.4. MediPrima

Although MediPrima has enhanced the information flows between hospitals, CPAS – OCMW, CAAMI – HZIV and SPP IS-POD MS, it also generates a number of difficulties:

- A specific UM cannot be registered by two different CPAS – OCMW at the same time. As a result, a CPAS – OCMW cannot declare itself competent if another CPAS – OCMW has already done so. This generates additional administrative burden as the CPAS – OCMW which has declared itself competent in the first place must be contacted first to stop its involvement before the UM application can be considered in the second CPAS – OCMW.
- The UMA lasts 3 months and is stopped automatically after that period. The possibility to authorize UMA for longer periods, especially in case of chronic disease, no longer exists.



9.3.5. Human resources

The administrative burden can be measured in terms of person-time necessary to deal with UMA. The data on costs incurred by CPAS was difficult to obtain as in most of the cases social assistants are not allocated only to managing UMA. This is however the case in one the CPAS where a special unit is dedicated to UMA only, showing that the cost in human resources can be quite substantial. This unit employed 12 FTE who managed in 2013 the files of 1 730 UM for whom 4 824 UMA decisions were taken.

9.4. The name UMA generates confusion and exclusion

It sometimes happens that individuals interpret UMA restrictively as “emergency medical care”, whereas it encompasses any health care. Although the law may be purposely vague in defining UMA to minimize cases of exclusion, this ambiguity impacts the health-seeking behavior of UM, as well as the decision-making process of both the health care providers and the CPAS – OCMW, which may result in suboptimal care, refusal of care, or neglect of the severity of certain health problems, particularly mental health problems. This forms a consequence of how narrowly ‘health’ is perceived in the matter of UMA, relating it merely to managing disease and infirmity, rather than being directed at health promotion²⁹.

9.5. Free choice of medical doctor

Most of the CPAS – OCMW pass a work agreement with health care providers (medical doctors, hospitals, pharmacies, etc). The choice of the health care practitioner by the UM is often limited to the list of practitioners with an agreement.

9.6. Difficult communication

Both UM and health care providers lack clear information about what UMA entails and which procedural and administrative steps have to be followed. Both parties stated that they had to ‘learn by doing’, which often resulted in symptoms of stress, in miscomprehension, and overall late provision of care. Limited health literacy on the side of undocumented migrants was sometimes noted, but limited knowledge about global health and intercultural competent care was observed on the side of some health care providers and social assistants.

Moreover, the various circulars and technical documents of the SPP IS about UMA deserve to be clarified on a number of important operational points.

9.7. Difficult monitoring of practices and costs

The routine databases usually at our disposal to identify the type of care delivered (claim data of the sickness funds and minimal hospital summary (RHM – MZG) of the FPS Public Health) are not usable to study care under UMA. MediPrima started in mid-2014 could become a useful database. However, it contains today only claim data (i.e. no diagnoses) from hospitals. Regarding the follow-up of the costs, the FPS IS maintains a transparent accountability of UMA costs. However, costs covered by other institutions (CPAS – OCMW; hospitals; NGOs) are not centralized and not accounted for.



10. RECOMMENDATIONS FOR A REFORM OF UMA

Despite the strengths of UMA (see section 8), our research has demonstrated the existence of barriers and difficulties (see section 9) which complicate its application. The complexity of current procedures is detrimental for all parties: uncertain and variable access to health care for UM, heavy and costly bureaucracy for CPAS – OCMW, management difficulties for the health care providers, difficult monitoring of health care practice and costs for public authorities.

We propose a reform of UMA to alleviate as much as possible these difficulties and to reach a more favorable equilibrium between the right for all to access health care and a rational utilization of public resources. The reform follows two main lines: simplify and harmonize administrative procedures; rationalize access to health care. The various elements of the reform were elaborated to address the difficulties and weaknesses evidenced by our research. These elements are derived from our situation analysis, the experience and the views of interviewees, good practice observed in some CPAS – OCMW, and examples from abroad. They take into account as much as possible the current legal framework. All the elements of the reform were discussed with stakeholders and key decision-makers (see colophon), and their views and suggestions were incorporated in this final version. These elements form a whole and must not be considered in isolation. They are summarized in Table 2. They constitute the basis for reflection and discussion of the main decision-makers in view of improving UMA.

It is quite impossible to accurately forecast today the cost of the proposed reform. On the one hand, the facilitated procedures may hopefully result in a better coverage and increase costs. On the other hand, complex pathologies needing hospitalization because of delayed care should decrease. Costs related to administrative tasks should also decrease. Two recent studies go in that direction^{11, 21} (see section 3.3). Whatsoever, the reform needs to be closely monitored. Any inappropriate use of resources should be detected early and amended.

10.1. Facilitating the demand for medical aid

The UM are encouraged to apply for medical aid to the CPAS – OCMW of his/her municipality of residence outside of any disease episode. A medical certificate of UMA is not required anymore. This will allow avoiding delays in health care when a disease episode occurs, reducing the number of UM going directly to hospital in case of disease, and treating diseases before they become more serious with an impact on treatment costs. This will also allow delivering preventive care, including in mental health, in line with the content of the 1996 Royal Decree⁵. To avoid any confusion about the care package available, the name of UMA must be changed, e.g. it should be called “Health coverage for undocumented migrants” or “Temporary health coverage”

10.2. Streamlining the social enquiry

10.2.1. Health coverage during the social enquiry

As soon as the application for medical aid is introduced, the applicant receives a medical card which initial validity is one month (see section 7.4). The possible health care needed during the social enquiry are covered. During this period, only the primary health care are accessible, except in case of medical emergency.

10.2.2. Streamlined social enquiry

10.2.2.1. *Reevaluate the place of resource assessment*

Today, the information gathered on the applicant resources serves essentially to decide if the SPP IS – POD MI will cover the co-payment for health care delivered outside the hospital setting²⁴. Collecting such information requires efforts of the CPAS – OCMW to spare little money. Indeed 70 of the UMA costs are for hospitalization, and UMA is very rarely denied based on the criterion of (non)indigence, especially in case of hospitalisation. Therefore we propose to re-evaluate the added value of collecting information on the applicant's resources.

Criteria to define indigence should be harmonized among CPAS – OCMW. To have resources beyond the indigence threshold cannot constitute a reason to refuse UMA but only a reason to refuse the coverage of the co-payment. The impossibility to assess accurately the resources of the



applicant (e.g. in case of undeclared work) cannot be a reason to refuse UMA.

10.2.2.2. *The home visit becomes optional*

The SPP IS – POD specifies that “when the demand concerns the coverage of health care, the CPAS – OCMW will evaluate the necessity and the added-value of making a home visit”²⁵. Subsequently, the absence of home visit cannot be a reason for UMA refusal as far as the reasons of this absence are explained transparently (e.g. homeless UM). If the UMA applicant is homeless, the CPAS – OCMW where he/she applies is de facto considered competent to manage that application.

10.2.2.3. *The social enquiry is integrated in MediPrima*

To avoid repeating the social enquiry already done by another CPAS – OCMW or a hospital, the information of the social enquiry will be encoded in MediPrima and will thus be accessible to all CPAS – OCMW. Moreover, MediPrima could serve as a media for information exchange between the various institutions concerned by the social enquiry.

10.3. Standardizing the medical card.

The initial validity of the medical card is one month (see point 7.2.1). The medical card is extended to one year if no obvious elements of fraud are detected during the social enquiry, i.e. elements obviously contradicting the contents of the information previously provided by the applicant. If fraud is suspected, an in-depth social enquiry is started of which the results are presented to Council of Social Action of the CPAS – OCMW to decide on the cancellation of the medical card, without any retroactive effect.

The medical card is standard for all CPAS – OCMW. The medical card is individualized. It is established on the basis of an original identity document, it mentions the name, surname, and number NISS of the bearer, and a photo of the bearer is reliably stapled on it. The name of the applicant's children with age < 18 years are also reported. It also mentions the name and the INAMI – RIZIV number of the general practitioner holding the Global Medical File (GMF) of the UM. Lastly, the medical card also mentions if the copayments are covered and the MediPrima number of the applicant.

If the UM presents at the emergency department of the hospital without a medical card, a medical card with a limited duration (1 week) is created and

care is delivered. The UM must go to the CPAS – OCMW of his/her municipality to get a standard medical card afterwards. If the UM is hospitalized after going through the emergency department, a social assistant (CPAS – OCMW or the hospital) will arrange the medical card during the hospitalization (see point 7.1.2). It is recommended that hospitals managing high numbers of UMA are equipped with a 24 hour-a-day social service to do the social enquiry.

If the UM presents at another level of the health system (GP, dentist, specialized medical doctors) without a medical card and there is no medical emergency, the UM will be sent first to the CPAS – OCMW to arrange a medical card.

Thus the medical card does not pertain to a specific disease episode.

10.4. Harmonizing health care which are covered

The medical card gives the same entitlement to health care to any beneficiary. The CPAS – OCMW is no longer involved in defining the entitlement to health care. The coverage is the same for all UM and the same as for asylum-seekers as defined in the Royal Decree of 09 April 2007³⁰. The list encompasses all the health care of the INAMI – RIZIV nomenclature with 5 notable exceptions: examination for and treatment of infertility; aesthetic surgery except reconstructive surgery after surgery or trauma; orthodontics; false teeth in the absence of mastication problem; dental care and tooth extraction under general anaesthetic.

Generic drugs will be used as much as possible. The rules of INAMI – RIZIV for a priori and a posteriori controls will be applied and overviewed by the CAAMI – HZIV medical consultant.

For UM with insufficient resources, some care usually not reimbursable within the INAMI – RIZIV nomenclature will also be covered, as defined in the Royal Decree for asylum-seekers³⁰: drugs on the D list prescribed by a medical doctor (except treatment for sexual impotence), provided that the generic brand is prescribed and the reference reimbursement price is applied; drugs of the D list not prescribed by a doctor (antacids, spasmolytics, antiemetics, antidiarrheics, analgesics, antipyretics, drugs for affection of the mouth and pharynx), provided that the price of the cheaper product is applied; tooth extraction; false teeth only in case of mastication problem; simple (no bi-focal or multifocal or tinted) glasses prescribed by an



ophthalmologist to children and adults if the latter have a deficiency of at least 1 diopter; milk for infant if breast-feeding is impossible).

For UM not getting UMA, the medical card should still give access to the following minimal package of care: emergency care, screening of sexually transmitted diseases and HIV/AIDS, family planning, vaccinations and screening and treatment of tuberculosis³¹.

Other health care can be covered by CPAS – OCMW on their own fund, by NGO, or by the UM himself/herself.

10.5. Rationalizing the utilization of health care

The UM can freely chooses his/her GP. The utilization of the Global Medical File (GMF) becomes compulsory, i.e. all the data relating to a patient are managed by the GP selected. The name and INAMI –RIZIV number of that GP is reported on the medical card. The medical card covers automatically all the health care delivered in primary care delivered by GP holding the GMF, as well as other primary health care provided that they were prescribed by that GP.

To consult a specialized medical doctor or get planned hospital care, a referral of the GP holding the GMF is compulsory and sufficient. Submitting the referral to CPAS – OCMW for approval is thus no longer required. The INAMI – RIZIV identification number of the GP holding the GMF who requested the specialized care should appear on the claim document.

The cost of the GMF will be covered by SPP IS – POD MI. except in case of medical emergency.

If the UM wishes to select another GP, he/she must contact the CPAS – OCMW to modify his/her medical card.

10.6. Simplifying the financing

The medical card is the guarantee that health care described in section 7.1.4 will be covered by the PPS IS – POD MI. The third-party payment of this health care is systematic. There is patient co-payment only if the UM is not indigent and only for care outside hospital, as this is already the case today. The health care practitioner transmits their invoice with the number of the individual medical card to the CAAMI – HZIV and gets reimbursed. The PPS IS reimburses the CAAMI – HZIV. Health care outside the list can be covered by the PCSW – CPAS – OCMW or the beneficiary.

10.7. Ensuring continuity of care and information

The medical card can be renewed yearly as long as the bearer resides on the national territory. A new social enquiry is made by the CPAS – OCMW of the municipality where the UM resides at the time of the renewal. If this is not the same CPAS – OCMW than the one which delivered the previous medical card, the transfer of competency is facilitated in MediPrima.

If the UM has moved to another municipality than the one where the original medical card was delivered, the medical card remains valid until the end of the year, except if the UM resides permanently in the new municipality, in which case a new medical card is needed. The CPAS – OCMW establishing the new medical card can based itself on the information collected during the first social enquiry (available in MediPrima).

If the UM consults another medical doctor than the holder of the global medical file (e.g. another GP, a doctor at the emergency department), this medical doctor informs the holder of the Global Medical File for updates.

The rapid extension of MediPrima to primary care will be an asset to ensure the continuity of the information.



10.8. Improving communication

To facilitate the communication between the various field actors and administrations, a document describing very precisely the procedures for medical aid and the tasks of every actors is necessary. It will allow harmonizing the practice and reduce the inequities. The present report can serve as a basis for such a document. A short synthesis of this document should be available in many languages on the website of the CPAS – OCMW.

The online translation service developed by the SPF Public Health should be accessible to any health care provider. The intercultural mediators, currently available in hospital setting, should also be available for primary health care via a web-based service.

It is important to organize a training in intercultural communication in health care and to make it accessible to all stakeholders. This training could result in an accreditation for health care providers, and potentially be linked with financial incentives.

10.9. Enhancing monitoring and evaluation

It is crucial to improve the data collection relating to medical aid for UM in order to monitor health care practice and costs.

- The CPAS – OCMW can encode every application for medical aid in MediPrima, as well as the results of the social enquiry.
- A specific code for UMA must be created for minimal hospital summary (RHM) and in the registers of the emergency department (UREG) so that the morbidity profile of UM can be monitored as for any other patients.
- MediPrima must be rapidly extended to primary health care to allow an overview of health care practice and costs. Meanwhile, providers of primary health care will send their certificate for health care provided.

The claim data of the CAAMI – HZIV should be integrated in the INAMI - RIZIV dataset and be analysed in the same way, i.e. feedback to prescribers, identification of potential under-utilization or over-utilization of health care, detection of outliers, field inspections. In the future, it would be possible to draw a picture of the hospital care delivered to UM provided that a separate insurability status code is created, as this was also the case for other foreigners a few years agoⁱ³¹.

ⁱ Following the 2011 KCE recommendations³¹, the registration of the aggregated hospital claims data concerning foreign patients falling under categories 300 (care contracts), 310 (private initiative), 320 (patients attached to an international or European institution) and 330 (non-European patients not falling under international conventions), was made mandatory from MZG – RHM registration year 2013. This simplified registration encompasses the hospital day or admission lump sums, the drugs reimbursements (by product) and the procedures reimbursements (by procedure). It is not clear if non-European undocumented migrants could be considered under code 330 or if

they are not included in this aggregated registration, as falling under code 400 (Not insured).

European undocumented migrants are anyway excluded from this aggregated registration. In the future, it would be possible to draw some picture of the hospital care delivered to undocumented migrants on two conditions:

- create a separate insurability status code for the undocumented migrants, different from code 230 (CPAS-OCMW) and 400 (Not insured);
- extend the aggregated registration of foreigners' claims data to the undocumented migrants recorded under this new code.

**Table 2 – Main elements of the UMA reform**

Reform	
Simplifying social enquiry	<ol style="list-style-type: none">1. The added value of collecting information on the applicant's resources must be re-evaluated2. The home visit becomes optional3. A certificate of UMA is no longer necessary
Harmonizing health care covered	<ol style="list-style-type: none">1. The CPAS – OCMW delivers an individualized medical card valid one month when to the applicant; primary health care are covered during social enquiry2. The medical card is extended to one year if the social enquiry is conclusive, and can be renewed3. The medical card can be delivered in the absence of disease episode4. The entitlement to health care is unique and corresponds to the entitlements for asylum seekers (as defined by RD 2007)
Rationalizing health care	<ol style="list-style-type: none">1. The Global Medical File is compulsory2. The choice of the practitioner is free but access to specialized care is possible only with a request from GP (gate-keeping)3. A priori and a posteriori INAMI –RIZIV rules are applied
Improving communication	<ol style="list-style-type: none">1. UMA is renamed "Health coverage for UM" or "Temporary health coverage"2. Competencies and support to field actors in matter of intercultural communication must be improved3. A common roadmap describing accurately the procedures and the mission of every actors must be elaborated4. In case of conflict, parties can seek advice of an independent mediator
Ensuring monitoring	<ol style="list-style-type: none">1. The results of the social enquiries are available in MediPrima2. A specific code is created in the RHM – MZG and the data registers of emergency department (UREG) to identify beneficiaries of UMA and analyse their morbidity profile3. MediPrima is rapidly extended to the primary care4. CAAMI-HZIV data relating to medical aid to UM must be transmitted to INAMI - RIZIV and analysed in the same way as data from other sickness funds



■ RECOMMENDATIONS^j

To SPP IS – POD MI, SPF Public Health, INAMI - RIZIV, CAAMI - HZIV, and the Union of Cities and Municipalities of the 3 regions, we recommend to form a consultation and technical committee for a 4-phase strategy:

- Establish in the short term a common manual (handbook) describing the procedures of medical aid and missions of each of the service providers. This report, particularly section 10, may be the basis for the development of such handbook. A summary brochure should be available in several languages at all CPAS, including on their website.
- Improve in the short term data collection about medical aid for undocumented migrants, as described in section 10.9, and achieve in the medium term the extension of MediPrima average maturity extension MediPrima achieve.
- Prepare a detailed action plan for the implementation of the reform of medical aid for undocumented migrants.
- Assess the evolving practices of care and costs following the reform and propose, where necessary and on an objective basis, adjustments.

^j The KCE has sole responsibility for the recommendations.



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