

# **New vulnerable groups in the Belgian health service**

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The Department of Medical Sociology at the Vrije Universiteit Brussel conducted a study into 'new vulnerable groups in the Belgian healthcare system', commissioned by the Belgian Federal Public Planning Service Science Policy. The main aim of the research was to identify the determining factors that give rise to financial problems in accessing health care among vulnerable sections of society. From the outset, there was a clear intention to provide more than a mere inventory of 'vulnerable categories'; indeed, the focus was on the underlying causes of financial difficulties in accessing the health service that the various 'vulnerable categories' have in common with each other. The result is a comprehensive survey of actual black spots people may encounter in their contacts with the health service. In order to remedy the problems identified, various practicable policy proposals have been put forth, based on the data collected for the study. As a result, the research is highly relevant to government policy. In order to amplify the study to an in-depth sociological analysis, the broader social context of financial problems to access health care was also examined. Which broader social developments played a role in this respect? What are the fundamental changes in the structure of the welfare state and social security (including health insurance) that resulted from these societal changes? Which policy measures in the health service have improved or degraded the financial accessibility of vulnerable groups? These questions will be answered in a macro-sociological analysis.

### ***Micro-level analysis: summary of actual black spots .***

All the black spots that were thrown up by the literature study and the empirical research were arranged across six broad dimensions of 'black spots that hinder the financial accessibility to the health service by socially vulnerable groups'.

1. *Problems related to national health insurance status*
2. *A deprived financial situation*
3. *Problems resulting from the way the institutions work*
4. *A great need for medical care*
5. *The absence of non-professional support*
6. *A lack of knowledge and means of defence*

The presence of one of these factors may be enough to encounter financial accessibility problems, with a (great) need for medical care being an essential condition. However, most vulnerable people combine a number of these black spots, which renders their situation unique. At the same time, the same black spots occur in different problem groups, albeit in different combinations. It is precisely this phenomenon which makes it so hard to divide these people into categories. The following example will make this clear:

*The fact of having a chronic affliction does not mean that there are automatically financial accessibility problems. Some chronically ill patients get through their illness without all too many financial problems, whether it be, for instance, because they have personal means, receive help from family, or have good additional health insurance. A chronically ill person will become vulnerable financially if the income is reduced through incapacity to work, or if the costs of the treatment required are not yet refunded by the national health insurance.*

## **Problems relating to the national health insurance status.**

This dimension refers to the problems related to the fact of being excluded from the health service or of having a precarious status within it. To put it differently, it involves people who are not, or only partly insured under the compulsory national health insurance scheme. People without legal residence status are undoubtedly in the most precarious position of all. It is only in very exceptional situations that they can request a refund of medical expenses under the compulsory national health insurance scheme. Usually, they fall under an exceptional rule, with the refund of their medical expenses being governed by the 'Royal Decree for urgent medical care to people without legal residency'. However, this Royal Decree does not work well in practice. In fact, there is no certainty in law that the medical care provided to people without legal residency will be refunded. This results in huge financial difficulties because of health-care-related expenses, with the people affected often being forced to postpone or cancel payments.

Besides those who do not have any rights within the compulsory social security insurance, there are people who, for a variety of reasons, fall outside the health insurance, despite the fact that, in principle, they are entitled to an insurance against illness. This primarily involves people who have neglected to pay their contributions, or are unable to do so, and who have not complied with the prescribed administrative obligations. Within this group, we find people like the homeless, drug addicts, or travellers.

Finally, there are those people who do not have cover for the entire package of health-care services. The typical example here are self-employed people who have no so-called 'small-risk' optional health insurance. In order to remedy this situation, many observers have suggested integrating self-employed people within the general system.

Increasingly, the lack of a hospital insurance is identified as a black spot. The growing hospitalization-related expenses which are not covered by the compulsory health insurance has resulted in the fact that people who do not have this additional insurance are sometimes lumbered with a huge bill they have to pay out of their own pocket.

## **A deprived financial situation**

This involves black spots resulting from a lack of financial means, or a precarious financial situation. People who have to live on benefits are the most obvious group. A number of people who fall (seriously) ill are faced not only with higher medical bills, but often also with a loss of income because they become unable to work. Several studies have shown that the incapacity and disability benefits are barely sufficient to satisfy basic needs. There is no doubt that they do not enable the people concerned to bear substantial medical costs in addition to providing for their basic needs. The same is true for unemployment benefits, pensions or subsistence payments. Hence, there are calls to reduce the gap between the income-replacing benefits and wages and to ensure they remain welfare-resistant in the future.

In order to restrict the out-of-pocket amounts payable by people faced with high medical bills, a number of specific policy measures have been created: e.g. subsidies for third-party aid, the care deductible, the incontinence deductible, subsidies within the framework of the health insurance. However, the respondents from the study stated that these subsidies are often little more than a drop in the ocean and that, because of the low level of replacement incomes, people are often forced to 'misuse' them as income supplements in order to provide in their basic needs.

It is worth stating, however, that it is not just people on benefits who find themselves in a vulnerable position within the health service. Indeed, even people with an income from labour

which is barely enough to provide in their basic needs are vulnerable. In terms of their budgets, they are teetering on the edge of a cliff in that they have no savings or any kind of personal wealth and can barely survive on what they earn, whereas they often have a lot of debt. If these people are suddenly faced with high medical bills, the additional burden is too much for them, and many find themselves eking out a very precarious existence.

Finally, it was also stated that the financial vulnerability is also caused by a lack of appropriate employment possibilities for vulnerable categories. In this respect, there is an urgent need for additional initiatives, not just for sick and disabled people, but also for other vulnerable categories, such as those with a low educational attainment and some categories of immigrants.

### **Problems resulting from the operation of the institutions.**

This dimension is composed of black spots related to the functioning of the health insurance, the care providers and the social welfare agencies.

Within the health insurance scheme, the complexity of procedures and the administration – i.e. red tape – seems to be a major factor. Even though the facilities for vulnerable categories are present, it is only ‘the fittest’ who know what they are entitled to in terms of benefits, subsidies, special status schemes, etc. A very pragmatic policy proposal in this respect is the creation of a central health-care service desk in each town. This help desk, which has a very low accessibility threshold, would centralize the facilities provided by all policy levels as well as guide people in their dealings with the health service and health insurance.

One obstacle to lowering the threshold for health care is the poor cooperation between providers: for instance, some medical information is not passed on among the various institutions, or even between departments within the same institution. Furthermore, the language used by health-service providers is not always as comprehensible as it should be for socially vulnerable people.

There is also a great deal of criticism of the work of social welfare agencies as an additional factor in the health service (the social welfare services may award financial assistance in order to pay for medical expenses or insurance contributions). For instance, there are problems resulting from the inordinate complexity and lack of uniformity in the social welfare agency regulations when it comes to applying for financial aid in the payment of medical care. Furthermore, the cooperation between social welfare agencies is also beset with problems. According to some respondents from the study, the care provided to patients who receive support from social welfare is of a lower quality. It also seems that a large number of social welfare agencies deny financial assistance to those who have personal assets. As a result, some people (for instance, OAPs who own their own home) are afraid to call on the social welfare agency. Finally, there is the ‘dispersal policy’, under which asylum-seekers who are still in the middle of a recognition procedure are often assigned to a different social welfare agency than the one of the town in which they live. This, in effect, bars them from gaining access to the health service.

### **Increased health-care needs.**

The first major observation is the fact that the medical costs are not limited to those who fall under the compulsory national health insurance package. A great many sick and disabled people are also faced with large bills for non-refundable medical services. In this context, it is possible to distinguish between purely medical and non-medical services. Within the category of non-refundable medical services, the main problems are said to be the cost of category-D medicines, the out-of-pocket hospitalization expenses, and the costs for the treatment of rare

disorders that have been excluded from the national health insurance. In the category of (non-refundable) non-medical costs, the main black spots are reported to be dependency costs (e.g. costs for appropriate transport, home help, personal care), care material (e.g. bandages, incontinence materials, intravenous feeding), and paramedical equipment (e.g. glasses, prostheses, orthopaedic devices). The above-mentioned subsidies are by no means sufficient in order to offset the actual cost of these expenses.

When the refunded medical care is factored in, one observes that two vulnerable situations may give rise to an increased risk in financial accessibility problems. Firstly, there is the sudden appearance of high medical bills - for instance, after a traffic accident or the diagnosis of cancer -, and, secondly, the piling up of medical bills over a long period of time. Families that count several intensive medical care users and the very old are in a particularly vulnerable position.

Many observers view the introduction of the maximum health-care bill (MHB) as a step forward in the financial accessibility to the health service. Nevertheless, this does not mean that one can speak of a system guaranteeing universal access to the health service for everyone – including people who are in a vulnerable position. Indeed, the system only provides aid *after* the costs have been incurred; moreover, in many cases, this aid is paid only after one year, and for people with higher incomes, sometimes after two years. Many respondents from the study stress the fact that measures to increase the accessibility must come into play at the moment the costs are made, not afterwards. A system in which the price of medical services differs according to the financial ability of the patient seems therefore a better guarantee for an accessible health service. In doing so, action is taken at the moment people are faced with the costs. In this respect, valuable proposals have been put forward in order to expand the preference system to a graduated system in which the price of medical services is linked to the income as well as to a number of additional social and illness-related determinants.

### **The absence of non-professional support.**

The extent to which family, friends, neighbours, etc. provide assistance to people in a vulnerable position is very important. This may involve assistance in the shape of help for people who are physically dependent on others (volunteer aid). It is possible to avoid expensive professional help through the assistance of family and friends. Care-dependent sick, disabled, or elderly people, who are devoid of such support were explicitly identified by the respondents from the study as being a category with a higher risk of encountering financial problems to access the health service.

On the other hand, it was shown that the financial compensation for illness or disability in the shape of benefits or subsidies is often insufficient to carry the burden of the increased disbursements. As a result, in addition to using their own reserves, many sick or disabled people are forced to have recourse to 'family solidarity'. When this option is not available, there is an increased risk of financial accessibility problems. It stands to reason that single people and those without any family are in a particularly vulnerable position in this respect, with women and the elderly being at the top of the list.

### **Lack of knowledge and means of defence.**

This black spot is related to the above-mentioned complexity of the health service and the national health-care insurance. As the complexity increases, people with limited intellectual abilities or means of defence will have problems receiving that to which they are entitled, or to obtain appropriate treatment at an appropriate price. There is a link between the complexity

of the health service and health-care insurance, and the 'knowledge' and 'means of defence' of the patient. Furthermore, the 'knowledge' factor also impacts on the budget priorities of an individual or household. People who are insufficiently informed will award less priority to taking out optional insurance policies, and be less inclined to have preventive care, or a rapid intervention in case of medical problems. In the long run, these 'choices' may, in turn, give rise to higher financial thresholds when medical care does become inevitable.

### ***Macro-level analysis: the social context.***

The developments in the accessibility to the health service cannot be divorced from wider structural changes in Western societies. These huge socio-economic changes have also influenced the Belgian social policy and health-care policy. To cut a long story short, the attention of Western governments has shifted towards containing government budgets and safeguarding international competitiveness. In the area of social policy, this has led to austerity measures. There is little doubt that these measures – among them the linear increase in out-of-pocket amounts in 1994, the increased costs of hospital stays or the fact of giving patients more responsibilities – have reduced the general financial accessibility to health care. On the other hand, highly specific, categorical measures were taken in order to spare the most vulnerable groups from suffering the consequences. However, these developments have resulted in a loss of the universal insurance character of the Belgian health service, which has grown towards a less comprehensive insurance, with means-tested corrective measures for socially vulnerable categories. In other words, the part of the cost of medical services that is refunded is less and less the same for everyone, and is increasingly related to 'the category' to which one belongs – or does not belong, as the case may be –, based on a number of well-defined criteria. This marks a slide towards a more 'categorical' system, which, by its very nature, creates more inequalities. Not everyone who is in need of more protection falls within the categories put forward by decision-makers, and a number of vulnerable people are falling by the wayside. This development causes great concern to the respondents from our study.

### **The impact of the markets on the health sector.**

Another major concern voiced by the participants in the study is the increasing impact of the market and commercialization in the health-care sector and health insurance. At the same time, it would be dishonest to try and deny the long-standing presence of the private sector in the health service (the sickness funds, liberal professions, private health-care institutions). Yet, new trends are emerging today. This ever-advancing 'marketization' is inextricably linked with the above-mentioned major socio-economic changes. There are fears that, in the long term, these developments will promote the disappearance of a health service based on the solidarity principle.

On the one hand, there is the 'marketization' of the health care. Partly as a result of the influence of industry, the urge for increasing technical complexity and unstoppable innovation predominates in the present-day health service. This carries major price hikes in its wake. The pharmaceutical and medico-technical industries, in particular, have tuned into this spiral of price increases. The influence of the medico-technical industry is most prominent in the hospital sector, where numerous technical innovations have been introduced, for instance in surgery. The compulsory national health-care insurance is finding it difficult rapidly to include the innovations in the insurance package. As a result, the cost of some of these technical innovations must be borne entirely by the patient. The pharmaceutical sector is

another black spot. The prices of medicines have increased considerably over recent years, with the sales price being often a great deal higher than the actual cost price of a drug. The increased prices are stretching the budget of the compulsory national health-care insurance scheme to the limit. This has resulted in 'gaps' in the insurance package. These gaps constitute 'market niches' in which commercial insurance companies are quick to specialize; they offer additional and optional insurance policies (the second and third pillars). However, the commercial insurance market plays by different rules. In order to keep the activities profitable, there is a selection of the risks. Categories that run a higher risk have to pay higher premiums, or are excluded from the insurance scheme, despite the fact that, because of their vulnerability, it is they who need the insurance the most. The hospital sector is a case in point: the patient out-of-pocket amounts can be very high (a number of additional costs, such as supplements, are not covered by the compulsory health insurance). Additional and optional insurance policies are on offer for these kinds of costs. However, the group that is most at risk of high hospital expenses falls by the wayside since they are often unable to take out a hospital insurance.

### **Black spots in the functioning of the health service and the health insurance.**

In addition to the consequences of fundamental developments in the health sector, there are other causes of problems related to the financial accessibility to the health service. Some of these causes are related to the above-mentioned trends.

In terms of the functioning of the health service, many respondents from the study complain about the complexity of the organization of the health service. Partly due to the state reforms and the politization, health service policy is spread too much across various decision-making levels. Another problem involves the lack of say on the part of patients, who are all too often considered a passive partner and do not participate enough in the decision-making process. In addition, the discrimination towards primary and preventive health care, and the role of fee-for-service medicine in the health service are considered threats to a universally accessible health service. Finally, the medication policy has also come under attack. Recent measures in order to stem the outlay by the health insurance for the refunding of medicines are said to shift the responsibility too much towards the patient, who is at risk of ending up with the bill. Many respondents felt that the health insurance does not have sufficient means to guarantee an accessible health service for all. In addition, wrong choices were made in the organization of the health service and the health insurance. In this context, the research produced a number of valuable policy proposals, which will be discussed later on. Finally, the respondents also pointed towards the gender inequalities within the health service, with providers often being insufficiently aware of the differences between men and women. This has consequences on the diagnosis, treatment and guidance of female patients. It seems there are problems particularly in regard to female immigrants. Moreover, there are obvious cases of discrimination between men and women with the social security which can be ascribed to the gender-blindness on the part of the social security.

### **Some interesting policy alternatives.**

It is difficult to provide a synopsis of the policy proposals that were put forward in this study. Therefore, we should like to confine ourselves to a number of interesting ideas.

The most-often heard plea was that for more financial means for the health service. Many participants in this study feel that it is entirely fanciful to think that the financial accessibility to the health service can be improved without making additional financial efforts. The next question is, of course, where these funds should come from. Although reprioritizing the

government budget will undoubtedly yield a number of possibilities, it pays to remain realistic in this area. The fact of continuing along the beaten path of a health insurance largely financed by contributions from 'labour' does not provide any fundamental solutions. In spite of this, some respondents stated that, by its very nature, a 'reduction in labour costs' limits the financial leeway of the social security. As a result, they felt that this device should be used judiciously. Other respondents said that the solidarity must be deepened; in other words, the highest incomes must make an additional effort. On the funding side, there seems to be mainly unanimity regarding an increased contribution by alternative financial sources, i.e. from general fiscal means, with a higher tax on incomes not derived from labour (capital, speculation, profits, 'green taxes') providing additional room for investment in, among other areas, the health service.

The unilateral increase in financial means for the health service would, however, be very short-sighted. Additional financial efforts must be coupled to a fundamental debate regarding the kind of health service people want for the future. If one wishes to retain and further expand a universally accessible health service – based on solidarity -, it is necessary to introduce fundamental reforms. First and foremost, attention will have to be devoted to the price level of the health care and a reorientation with a focus on preventive and primary care. In terms of the price level of the health care, there is a real need for serious reflection on the current system of fee-for-service medicine. Many respondents consider this to be the cause of the high price of health care. Furthermore, 'fee-for-service' leads to an ineffective use of the health service. Fee-for-service medicine also constitutes an obstacle to necessary policy measures, such as discouragement campaigns, shifts in focus towards primary care, a more preventive health service, etc. These kinds of policy measures indeed always have an immediate impact on the providers' incomes.

The increased attention for primary care and significant reform in primary care may dramatically change the face of the health service: it could simultaneously reduce the financial threshold to the health service for vulnerable groups, and reduce health insurance outlay. This would, however, require a number of measures. Firstly, primary care should become the mainstay of the health service by allowing access to other echelons of the health service – specialist care (secondary care) and intramural care (tertiary care) – only via primary care (spreading). Within this type of concept, the GP, who fully knows the patient's situation, is undoubtedly a key figure, but he must not be alone in an integrated primary care. Paramedical care (e.g. nursing, diet counselling, physiotherapy), preventive etc. assistance must also get a place within an integrated primary care. Furthermore, it is important, particularly for vulnerable categories, that this primary care should not be limited to the medical field; indeed, there should also be room for active social counselling of people with (serious) health problems. In order to make this possible, it is crucial that we depart from the idea of the GP practice and move towards 'primary health care centres', where the above-mentioned types of assistance would be provided in an integrated manner. In this respect, the system of lump-sum medicine and district health centres no doubt offer interesting prospects. Within this kind of system there is no longer any room for fee-for-service medicine, with providers being forced to get at least part of their income from a salary. The question remains, of course, as to the extent to which providers are prepared to do this. In any event, it is clear that this debate will sooner or later appear on the agenda.