



COUNTRY REPORT  
BELGIUM  
MIPEX  
HEALTH STRAND

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# MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

## Country Report Belgium

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## READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at <http://bit.ly/2g0GIRd>. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5 – 8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.



Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News ( <a href="http://news.bbc.co.uk">http://news.bbc.co.uk</a> ), national sources
2. Migration background	Eurostat, Eurobarometer ( <a href="http://bit.ly/2grTjIF">http://bit.ly/2grTjIF</a> )	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database <sup>1</sup> ( <a href="http://bit.ly/1zZWnuN">http://bit.ly/1zZWnuN</a> )	Health in Transition (HiT) country reports ( <a href="http://bit.ly/2ePh3VJ">http://bit.ly/2ePh3VJ</a> ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project ( <a href="http://bit.ly/29IXgf0">http://bit.ly/29IXgf0</a> ), Asylum Information Database ( <a href="http://bit.ly/1EpevVN">http://bit.ly/1EpevVN</a> )

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

<sup>1</sup> For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at <http://bit.ly/2lXd8JS>

# 1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	11.203.992	
GDP per capita (2014) [EU mean = 100]	119	
Accession to the European Union	1957	

**Geography:** Located in Western Europe, Belgium borders the North Sea and the Netherlands to the north, Germany and the Grand Duchy of Luxembourg to the east, and France to the south and west. Belgium is a small country, with an area of 30.528 sq. km. The terrain is flat and plain in the northwest, hilly in the centre, mountainous in the southeast. Approximately 97% of the population live in urban areas, including Brussels (2,045 million inhabitants) and Antwerp (994.000 inhabitants).

**Historical background:** Belgium gained independence from the Netherlands in 1830 and remained neutral for 84 years, but its neutral status was violated by Germany's occupation of the country during World Wars I and II. In 1948, along with the Netherlands and Luxembourg, Belgium became a co-signatory to the Benelux Customs Union. Belgium is a founder member of the EU.

**Government:** Belgium is a federal parliamentary democracy under a constitutional monarchy. It is divided into three regions:<sup>2</sup> the Flemish Region, the Walloon Region, and the Brussels Capital Region. In addition, there are three communities: Flemish (extending to the Flemish Region and Brussels Capital Region), French (Walloon Region and Brussels Capital Region), and German (in a small part of the province of Liège in the Walloon Region bordering Germany). There are also four language areas, which determine the language used in public services but have no further governmental competences: in the Flemish Region Dutch, in the Walloon Region French and (in a small area) German; and in the Brussels Capital Region, French and Dutch. The competences of Regions and Communities differ, making Belgium administratively speaking a highly complex country. Consensus at Federal level is sometimes very hard to reach: after the general election of June 2010, it took 541 days to form a government.

**Economy:** Belgium has a modern, open and private-enterprise-based economy. Since the rundown of the coal mining industry (the last mine closed in 1992), the industrial sector has become highly diversified and is concentrated mainly in the north. The commercial sector is also particularly developed. With few natural resources, Belgium imports substantial quantities of raw materials and exports a large volume of manufactured goods. However, Belgium's open economy and financial sector made it especially vulnerable to the economic downturn.<sup>3</sup> The recovery has been fragile, while long-term growth has been held back by relatively high unemployment rates and eroded cost competitiveness. Public debt remains high. For vulnerable groups, notably immigrants, labour market integration remains difficult and, for many, housing conditions have deteriorated.<sup>4</sup>

<sup>2</sup> [https://en.wikipedia.org/wiki/Communities,\\_regions\\_and\\_language\\_areas\\_of\\_Belgium](https://en.wikipedia.org/wiki/Communities,_regions_and_language_areas_of_Belgium)

<sup>3</sup> EuroChallenge, An overview of Belgium's economy, 2012 <http://www.euro-challenge.org/doc/Belgium.pdf>

<sup>4</sup> OECD, Economic survey Belgium 2015 [http://www.oecd.org/eco/surveys/Overview\\_Belgium\\_2015\\_Eng.pdf](http://www.oecd.org/eco/surveys/Overview_Belgium_2015_Eng.pdf)



## 2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	15,8	●●●●●
Percentage non-EU/EFTA migrants among foreign-born population	53	●●○○○
Foreigners as percentage of total population	11,3	●●●●○
Non-EU/EFTA citizens as percentage of non-national population	34	●●○○○
Inhabitants per asylum applicant (more = lower ranking)	490	●●●●○
Percentage of positive asylum decisions at first instance	39	●●●○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	37	●●○○○
Average MIPEX score for other strands (MIPEX, 2015)	70	●●●●●

To begin with it should be noted that for political and historical reasons, no ethnic census is held in Belgium. Consequently, nationality and country of birth are the preferred indicators of reference when talking about ethnicity and migration. The terms 'migrant' and 'ethnic minority' tend to be used interchangeably in public discussions (Hanquinet et al. 2006). Finally, the political discourse and the recognition of ethnic minorities or migrants vary between regions and communities, with the most significant distinction noted between the Flemish community and the French community (Jacobs & Rea 2012). In Flanders, the terms 'allochtoon' or 'etnische minderheden' are commonly integrated into the political discourse. In Wallonia and the French part of Brussels, the discourse focuses rather on socioeconomic aspects, although the term 'primo-arrivants' begins to pervade the political arena (ibid.) Despite these limitations, several ethnic groups have been identified: Muslims (who are further divided into Moroccans and Turks), Jews, Roma people, and sub-Saharan Africans. Roma people are divided into Travellers ('Voyageurs', Manouches, and Romani), who mostly have Belgian nationality, and the Roma (from Eastern Europe). A national integration strategy exists for Roma, based on the 2012 EU Framework for National Roma Integration Strategies.

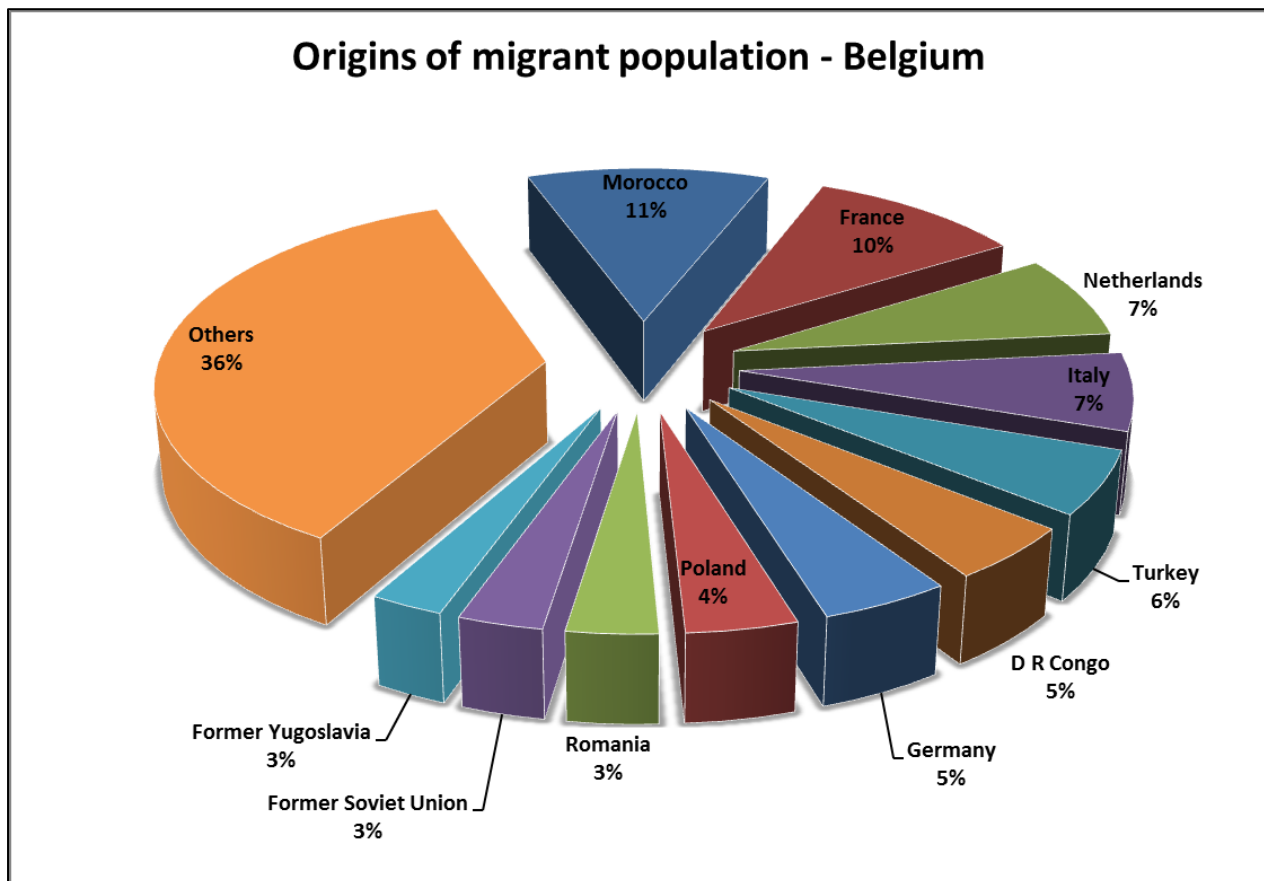
### Migration history

At 15,8% and 11,3% respectively, the percentages of foreign-born and foreign residents of Belgium are among the highest in the EU/EFTA. The difference between the two figures reflect the fact that many migrants have acquired Belgian nationality.

In Belgium, labour migration began in the early twentieth century (Morelli 1992; Hanquinet 2006; Perrin 2006). At that time, foreigners constituted about 3% of the total population and 90% of them came from neighbouring countries. Between the two World Wars, this number rose to 4%, mainly due to migration flows from Italy and Eastern Europe. Belgium's migration policy in the 1930s obliged migrants to work for at least three years in the same industrial sector. This constraint has shaped the current distribution of migrant populations in Belgium, with the main concentrations in industrial areas such as Charleroi,

Liege and Genk. During the 1960s, the extension of migration permits to all industrial sectors and services led to an increased number of foreign workers coming to Belgium's major cities. At first the newcomers were mainly Italians (due to the Coal Accords), Spanish, and Greek migrants, followed by Moroccans and Turks (for the construction of the underground). These workers were later joined by their families. Besides labour migration, study and family reunification are the two main reasons for migrating to Belgium. The next figure shows the country of birth of the main groups of migrants.

**Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)**



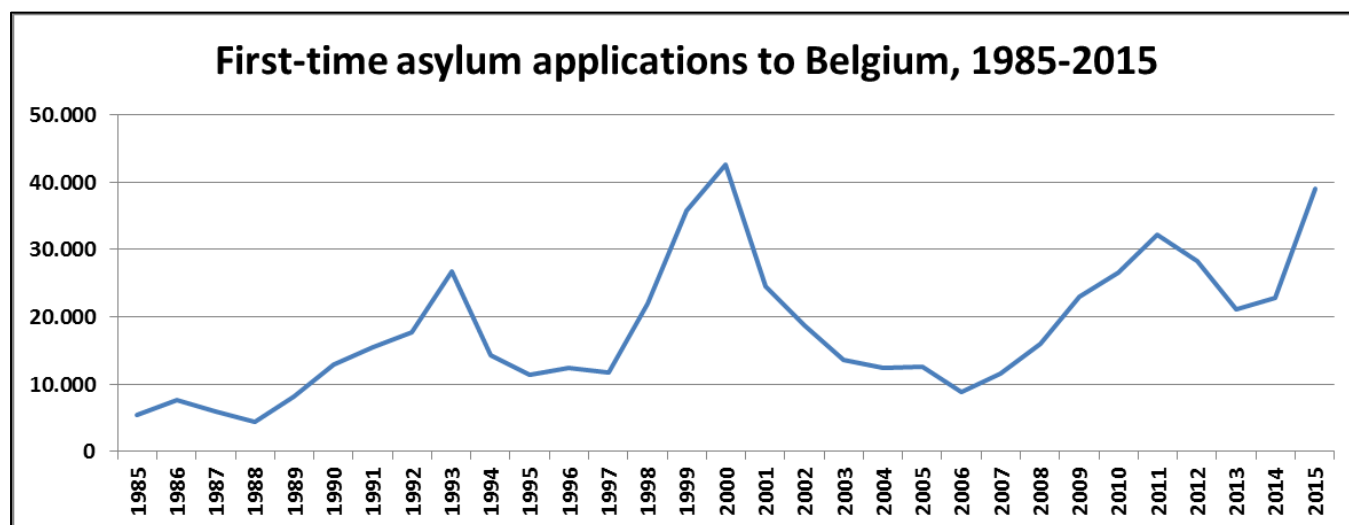
Nowadays, the health sector is particularly concerned with labour migration (Wets & de Bruyn 2011). Some health institutions have developed migration-based recruitment policies in order to combat shortages of health professionals, especially nurses. Migrant health professionals mainly come from adjacent countries such as France or Netherlands, or from traditional immigration countries such as Italy and Morocco. More recently, Poland, Romania, the Philippines, and Lebanon have been identified as the four main countries of origin for foreign nurses. Although data remains sparse, it appears that the provision of health care for the elderly in urban areas such as Brussels has become an economic niche occupied by many nurses with a Congolese background.

#### **Asylum seekers and refugees**

The next figure shows that, as in many countries, the number of applications in Belgium has fluctuated considerably in response to changing global circumstances and national policies. (Data source: Eurostat).



Figure 2. Asylum applications



Depending on their motives for applying for asylum, as well as their entry point in Belgium, asylum seekers are hosted in open detention centres, closed detention centres, or with friends or family.<sup>5</sup> Centres are mostly managed by the Federal Agency for Asylum Seekers (FEDASIL), or by the Red Cross (in agreement with FEDASIL; only open centres). When an asylum application is accepted in the first stage of the procedure, asylum seekers may take advantage of community housing (often provided by local public welfare centres).

Once protected status has been granted, a person can choose their place of residence in Belgium. If needed, they may receive material and financial assistance from the municipal welfare centres.<sup>6</sup> Since 2008, refugees have been included in the National Register.

### Irregular migration

A significant number of rejected asylum seekers remain in Belgium clandestinely and disappear from official registers. Illegal entry and overstaying a visa other pathways into irregularity. Some migrants use Belgium as a transit country en route to the United Kingdom. Consequently, irregular migrants as a group are highly heterogeneous in terms of countries of origin, migration trajectory, socioeconomic profile, as well as health care needs (Dauvrin & Lorant 2012). Between 2005 and 2010, 80,570 irregular migrants were regularised (EMN, 2011).

<sup>5</sup> <http://fedasil.be/en/content/about-reception-centres-0>

<sup>6</sup> *Loi organique des Centres publics d'aide sociale, 1976*

### 3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	3406	●●●●●
Health expenditure as percentage of GDP	10,6	●●●●○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	11	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	18	●●●○○
Score on Euro Health Consumer Index (ECHI, 2014)	820	●●●●●
Overall score on MIPEX Health strand (2015)	53	●●●●○

The following description of the Belgian health system is taken from Gerkens et al. (2010, xxvii – xxx):

“Health policy is both a responsibility of the federal authorities and federated entities (regions and communities). The federal authorities are responsible for the regulation and financing of the compulsory health insurance; the determination of accreditation criteria (i.e. minimum standards for the running of hospital services); the financing of hospital budgets and heavy medical care units; legislation covering different professional qualifications; and the registration of pharmaceuticals and their price control. Federated entities are responsible for health promotion and prevention; maternity and child health care and social services; different aspects of community care; coordination and collaboration in primary health care and palliative care; the implementation of accreditation standards and the determination of additional accreditation criteria; and the financing of hospital investment. To facilitate cooperation between the federal authorities and the federated entities, interministerial conferences are regularly organized. (.....)

Almost the whole population (> 99%) is covered for a very broad benefits package. Since January 2008, there is no longer any difference between health insurance coverage in the general scheme and the scheme for the self-employed, as the latter now includes the coverage of minor risks.

The organization of health services is characterized by the principles of therapeutic freedom for physicians, freedom of choice for patients, and remuneration based on fee-for-service payments.

The compulsory health insurance is managed by the National Institute for Health and Disability Insurance (NIHDI-RIZIV-INAMI), which allocates a prospective budget to the sickness funds to finance the health care costs of their members. All individuals entitled to health insurance must join or register with a sickness fund: either one of the six national associations of sickness funds, including the Health Insurance Fund of the Belgian railway company, or a regional service of the public Auxiliary Fund for Sickness and Disability Insurance. Private profit-making health insurance companies account for only a small part of the non-compulsory health insurance market. In the past, sickness funds received the

budget they needed to reimburse their members but since 1995, they have been held financially accountable for a proportion (25%) of any discrepancy between their actual spending and their budget, for which 30% is determined according to a normative risk-adjusted allocation.

Decision-making in the Belgian health system mainly relies on negotiations between several stakeholders. General policy matters concerning health insurance and its budget are decided by representatives of the government and the sickness funds but also by representatives of employers, salaried employees and self-employed workers. The health insurance system is also regulated by national conventions and agreements between representatives of health care providers and sickness funds (e.g. fees determination).

The Belgian health system is based on the principle of social insurance characterized by horizontal solidarity (between healthy and sick people) and vertical solidarity (based to a large extent on the labour incomes) and without risk selection. Financing is based mostly on proportional social security contributions related to taxable income and, to a lesser extent, on progressive direct taxation, and a growing area of alternative financing related to the consumption of goods and services (mainly value added tax). [...]

Patients in Belgium participate in health care financing through official co-payments and diverse supplements. The main payment mechanism is the fee-for-service payment. There are two systems of payments: (1) a direct payment (mainly for ambulatory care), where the patient pays for the full cost of the service and then obtains a reimbursement from the sickness fund for part of the expense; and (2) a third-party payer system (mainly for ambulatory drugs and hospitals), where the sickness fund pays the provider directly and the patient is only responsible for paying any co-payments, supplements or non-reimbursed services. However, the third-party payer system can be applied under specific conditions for ambulatory care to ameliorate the financial access for vulnerable population groups.

The reimbursement of services depends on the type of service provided, the income and social status of the patient (preferential reimbursement or not), as well as the accumulated amount of co-payments already paid for that year. For more vulnerable population groups, several measures were taken to ensure their access to high-quality care (OMNIO, maximum billing (MAB) system, etc.)

A significant proportion of health care providers are paid on a fee-for-service basis. For salaried employees in the health sector, salaries and career evolution are negotiated through a series of collective agreements. [...]

Overall, the health system was recently assessed as having good accessibility and an appropriate level of safety. However, further improvements in effectiveness of preventive care, appropriateness of care, efficiency and sustainability could further enhance the performance of the overall system. Recent reforms to the health system essentially aim to provide a high quality of care to the whole population and, at the same time, protect the sustainability of the system. The reforms that will be carried out in the coming years will likely continue to promote the objectives of accessibility, quality and sustainability. Further changes will also aim at simplifying the system in order to make it more homogeneous.'

## 4. USE OF DETENTION

Immigration detention in Belgium is regulated by the 1980 Aliens Act,<sup>7</sup> which does not consider detention as a punishment, but as a measure – to be used as a last resort – to ensure removal. Indeed, immigration detention is not a judicial act but an administrative provision, issued by the Immigration Office (Vanderbruggen et al. 2014). The Immigration Office can detain foreigners whose access to the country has been refused; foreigners who applied for asylum at the border; asylum seekers on the territory; migrants with irregular status; and rejected asylum seekers.

Detainees may be held in detention centres for an initial period of two months, which can be prolonged by two extra months with an adjudicated decision for removal, and by an additional month with ministerial authorization. After five months, the detainee should be released but, in exceptional cases related to public order or national security, the detention may be extended to eight months. In total, the maximum length of detention is 18 months, in accordance with the EU Return Directive.

### Detention facilities

Belgium operates five detention centres ('closed centres'): two near Brussels airport (the Caricole Centre and the Repatriation Centre 127bis), as well as three Centres for Illegal Aliens, in Bruges (CIB), Merksplas (CIM), and Vottem (CIV). Total capacity in 2016 was 583 (Vanderbruggen et al. 2014).

In addition, there are five regional smaller INAD (for 'inadmissible passengers') in the airports located at Schengen borders (Bierset, Gosselies, Deurne, Ostende, and Wevelgem). Generally, INAD facilities are not designed for longer term detention, and foreigners can only be held for a maximum of 48 hours prior to their deportation.<sup>8</sup>

The immigration detention centres are very similar to prisons, both in their construction – with bars and fences with barbed wire – and in their security regimes. Indeed, the presence of security personnel within the centres is highly visible, with the exception of the Caricole Centre, where guards do not wear uniforms (Vanderbruggen et al. 2014).

The Immigration Office is responsible for managing and supervising the immigration detention centres, as well as for issuing detention orders (EMN 2014).

### Conditions in detention

The Royal Decree of 2002, renewed in 2009, defines the regime at the centres, indicating the rights, the entitlements and the obligations of detainees. In addition, each detention centre establishes its own 'internal orders' regulating the daily functioning of the facility.

Each centre has its own infirmary, as well as medical staff comprising several nurses, a psychologist, and a physician. Healthcare access and quality may differ greatly between centres. If needed, detainees may be transferred to a specialized medical centre (AIDA, 2017).

<sup>7</sup> *Loi du 15 décembre 1980 sur l'accès au territoire, le séjour, l'établissement et l'éloignement des étrangers*, 15 december 1980, Aliens Act

<sup>8</sup> <http://www.asylumineurope.org/reports/country/belgium/detention-asylum-seekers/general>

### Detention of asylum seekers and other vulnerable groups

In accordance with the Aliens Act, **asylum seekers** arriving without documents are immediately detained at the border. In principle, they may not be detained if they are already on Belgian territory. There are 15 exceptions allowing the use of detention for asylum seekers – for example, if a foreigner is considered to be a threat to public order or national security, if they have served a custodial sentence, or if there are indications that another EU Member State might be responsible for handling their asylum claim so that detention becomes a measure to ensure the transfer (Dublin procedure) (AIDA, 2017).

Detention of **families with minor children** who claim asylum at the border is prohibited. However, for families with minors trying to enter the country illegally, the law foresees the possibility of detention in what are called ‘return houses,’ which are individual houses or apartments created for families awaiting removal. Currently, there are five sites of this type, with a total of 23 housing units where families are held for a very short period on arrival (48h) or just before departure.

Belgian law exempts **unaccompanied children** from detention; they are typically assigned to specific centres called ‘Observation and Orientation Centres’ (OOC), under the authority of the Federal Agency for the Reception of Asylum Seekers (FEDASIL). Children are held in those centres pending recognition of legal status with full rights to access or, in case the asylum claim is rejected, a return decision. Unaccompanied children may be held in OOC for a maximum of 15 days, during which their contacts with the outside world are subjected to special surveillance (AIDA 2017).

## 5. ENTITLEMENT TO HEALTH SERVICES

Score 69    Ranking ●●●●○

### A. Legal migrants

#### Inclusion in health system and services covered

The national 'Insurance for Illness and Disability' (AMI/ZIV) is compulsory for all Belgians and legal migrants registered in the Foreigners Register or the National Register, including recognised refugees. Permission to reside can be granted for several reasons (family reunion, work, study, or temporary work 'au pair'), but AMI/ZIV applies in all cases. Individuals may sign up for supplementary health insurance or private for-profit insurance in order to cover additional treatments or benefits, such as a single room in hospital. For some employees, supplementary health insurance is a benefit offered by the employer.<sup>9</sup>

All patients have to participate in healthcare financing through co-payments and diverse supplements. The complexity of these arrangements represents one of the main problems in the Belgian health system. Payments by patients (which mostly concern ambulatory care) are subsequently reimbursed by the sickness fund, after deducting compulsory out-of-pocket charges (co-payments, supplements or non-reimbursed services). Eligible fees for hospital care and drugs used in ambulatory care are usually paid directly from the sickness fund.

Most health professionals are paid on a fee-for-service basis, but some may also opt for a direct reimbursement agreement with the sickness funds. Physicians (including specialists and general practitioners) can be paid in both ways: they may be in part covered by an agreement (e.g. during 'inconvenient' periods such as weekends or outside working hours), while the patient is charged for all other services. Other health professionals (e.g. nurses) have to choose between working with an agreement or not (Gerken et al. 2010).

Legal migrants living in deprived socioeconomic situations (temporarily or permanently) can apply for social support at the municipal Public Centre of Social Action. This assistance may include medical fees.<sup>10</sup>

In specialist care, specific agreements exist between Belgian hospitals and other countries (covering e.g. cardiac surgery for Algerian children or renal transplantations for Italians). In these circumstances, specific procedures of entitlement and payment are organised. Transnational care is becoming an important issue for some hospitals.

Recognised refugees, as well as persons granted subsidiary protection, are entitled to the same coverage and services as Belgians. Persons who have difficulty supporting themselves can also request financial support.<sup>11</sup>

<sup>9</sup> [http://www.belgium.be/en/health/healthcare\\_costs](http://www.belgium.be/en/health/healthcare_costs)

<sup>10</sup> *Loi du 12 janvier 2007 sur l'accueil des demandeurs d'asile et de certaines autres catégories d'étrangers.*

<sup>11</sup> <http://www.medimmigrant.be/?idbericht=193&idmenu=2&lang=nl>

### Special exemptions

**Pregnant women, mothers and babies:** Legal migrants have the same coverage and entitlement as Belgian women. Childbirth is considered as emergency care.

Concerning perinatal care, three services (*Office de la Naissance et de l'Enfance ONE*,<sup>12</sup> *Kind & Gezin*,<sup>13</sup> and *Kaleido-DG*<sup>14</sup>) provide free perinatal care for all women in Belgium. Post-natal care is free until the age of six. Attendance at these services is left to the discretion of the parents. In certain circumstances these services provide additional support (e.g. home visits of a midwife in the case of multiple births, provision of clothes for women in precarious situations). However, with a few exceptions, no prescriptions for drugs or additional examinations are covered. Federal entities are responsible for perinatal care (including post-natal screening): Communauté française for the *Office de la Naissance et de l'Enfance* in Wallonia, Vlaamse Overheid for *Kind & Gezin* in Flanders and Brussels, and the Deutschsprachige Gemeinschaft Belgien for *Kaleido-DG*.

**Children:** Until six years of age, children, whatever their status, can attend ONE, *Kind & Gezin* or *Kaleido-DG* consultations but there is no provision of medical prescriptions (with some exceptions). Otherwise, they are covered by the health insurance of their parents. Federal entities are responsible for health care for children, including school health services (cf. the previous list for perinatal care).

School attendance is compulsory for all children between 6 and 18. Consequently, all children are seen by school health services (limited to screening for specific health problems such as diabetes or hearing impairment, referrals to specialist care and compulsory vaccinations such as tetanus or rubella). School services may also provide free psychological support for children with specific problems (e.g. mental health, learning difficulties).

Unaccompanied minors benefit from national health insurance without co-payments, but they have to prove they have attended school during the three months prior to the request (except for minors exempted from school attendance).

**Communicable diseases:** Screening for TB on a voluntary basis is free. Special screening campaigns for TB are organised in some places (e.g. night shelters for homeless). In case of an active infection, all medical fees are covered. Reporting of the cases to the Ministry of Public Health is compulsory and non-anonymous for surveillance purposes. Communities are in charge of health promotion, screening, and patient education. Public health surveillance is the domain of the federal authorities.<sup>15</sup>

Screening for HIV is also free and anonymous, but is not systematic. Reporting of cases is compulsory for public health issues, but remains anonymous. After the Ebola outbreak, specific procedures were launched at airports with African flight connections to prevent the spread of the disease in Belgium. Specific services have been designated to care for Ebola patients.<sup>16</sup>

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<sup>12</sup> <http://www.one.be/>

<sup>13</sup> <http://www.kindengezin.be/>

<sup>14</sup> <http://bit.ly/2mrQDtY> (before September 2014 known as *Dienst für Kind und Familie*)

<sup>15</sup> <https://www.wiv-isp.be/matra/CF/connexion.aspx>

<sup>16</sup> <http://bit.ly/2nncpy4>



**Victims of torture or psychological trauma:** For legal migrants, health care is covered by national health insurance. Additional care may be provided free if the person is considered as 'disabled' due to torture or trauma. For example, a person who has suffered mutilations due to torture can receive plastic surgery and psychological aid.

**Victims of human trafficking:** If the trafficker is convicted, the victim will be given a permanent residence card as long as information from them has contributed to securing the conviction.<sup>17</sup>

**Vaccinations:** These are provided for all children by ONE and *Kind & Gezin* (state-funded institutions for the protection and the wellbeing of children), or by school services.

### Barriers to obtaining entitlement

None.

## B. Asylum seekers

### Inclusion in health system and services covered

All asylum seekers, regardless of their country of origin, are screened for TB when applying for asylum (X-ray machines are available at the Foreigners' Office and in some asylum centres). Treatment for TB is free and is often provided in closed hospital units to prevent the spread of the disease. In addition, asylum seekers may receive vaccinations for specific diseases. Some of these expensive vaccinations are not covered by the national health insurance for Belgians: they are considered as non-necessary and are usually only required when travelling abroad. However, they are administered free to asylum seekers.<sup>18</sup>

While asylum seekers are awaiting the outcome of their application, health care may be offered in three different ways, depending on where they are housed.

1. For asylum seekers in **open reception centres**, health care is provided as described in the list of procedures, drugs and therapies covered by national health insurance, with some exceptions. Provision is restricted in some respects, but expanded in others: some services are covered even if not on the national health insurance list. Psychological consultations are also covered by FEDASIL, the federal agency for asylum seekers.

Health care may be provided at the centre or outside it. Usually, family medicine and nursing care are provided at the centre during office hours, while specialist care requires a referral to the mainstream health care system. Difficulties have been reported when arranging referrals or when health care is needed outside office hours. With a few exceptions, there is no on-site health professional. Consequently, emergencies have to be managed by reception staff, with or without first aid training.

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<sup>17</sup> <http://www.medimmigrant.be/?idbericht=171&idmenu=2&lang=nl>

<sup>18</sup> <http://www.vrgt.be/>; <http://www.fedasil.be>

As the asylum seekers are allowed to leave the centre, they may seek help outside it through personal contacts (e.g. local migrant communities). However, NGO reports regularly highlight the overall poor quality of life, the lack of adequate care, and delays in the procedures.

2. For asylum seekers detained in **closed reception centres**, the same rules apply. In practice, however, reports describe the situation as critical because a lack of health professionals and medical supplies exists, as well as delays in procedures. Moreover, these centres are overcrowded and living conditions are reported as extremely poor. All the problems existing in open centres are magnified in closed ones.

A specific problem concerns children inside the closed reception centres (which is in contravention of the Convention on the Rights of the Child). However, this situation arises only rarely.

3. Asylum seekers may choose to live **outside reception centres**. In this case, they enjoy the same healthcare benefits, but there are more administrative procedures. Asylum seekers have to request authorisation for planned consultations, or to provide an attestation of urgent care in case of an unexpected event. In this situation, asylum seekers need to ask for a financial support from FEDASIL.

All costs are covered by the federal state as long as the asylum seeker is in compliance with FEDASIL rules. Specific agreements exist between health professionals or services and FEDASIL regarding health care provided outside reception centres. The reception centre may have its own health care staff, with a status of civil servant, paid for by FEDASIL, or it may have contracts with external health professionals. Asylum seekers who wish to choose their own doctor have to cover all the fees themselves.<sup>19, 20</sup>

It is worth noting that since 2007 direct financial support to asylum seekers has been discontinued. Previously, they could (for example) use this financial support to buy medications not covered by the National Health Insurance Funds, or to consult a psychotherapist.

### Special exemptions

**Pregnant women, mothers and babies:** Childbirth is considered as emergency care. Pregnant women applying for asylum are referred to a hospital. When possible, they will be seen at the hospital for a general check-up before the actual childbirth. Reception centres have agreements with hospitals for the reimbursement of the medical fees. After delivery, the woman and her baby are brought back to the reception centre. If possible, they are given a private room. Perinatal care is provided as for legal migrants (see above).

**Children:** Federal entities are responsible for health care for children, including school health services (cf. the list for perinatal care given above under 'Legal migrants'). In some reception centres for asylum seekers, child consultations are organised on-site by ONE or *Kind & Gezin*.

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<sup>19</sup> <http://www.medimmigrant.be/?idbericht=24&idmenu=2&lang=nl>

<sup>20</sup> *Loi du 12 janvier 2007 sur l'accueil des demandeurs d'asile et de certaines autres catégories d'étrangers.*

School attendance is compulsory for all children between 6 and 18, including asylum seekers in open reception centres or living in the community (but not children detained in closed reception centres). Consequently, virtually all children are seen by school health services (limited to screening for specific health problems such as diabetes or hearing impairment, referrals to specialist care and compulsory vaccinations such as tetanus or rubella). School services may also provide free psychological support for children with specific problems (e.g. mental health, learning difficulties).

Unaccompanied minors benefit from national health insurance without co-payments, but they have to prove they have attended school during the three months prior to the request (except for minors exempted from school attendance). When hosted in a reception centre for asylum seekers, they can benefit from the health services organised within the centre.<sup>21</sup>

**Communicable diseases:** All persons applying for asylum are screened for TB at the border or in the reception centres using a lung X-ray. Other screening for TB on a voluntary basis is free. In case of an active infection, all medical fees are covered. Reporting of cases to the Ministry of Public Health is compulsory and non-anonymous for surveillance purposes. Communities are in charge of health promotion, screening, and patient education. Public health surveillance is the domain of the federal authorities.

Screening for HIV is also free and anonymous, but is not systematic. Reporting of cases is compulsory for public health issues, but remains anonymous. After the Ebola outbreak, specific procedures were launched at airports with African flight connections to prevent the spread of the disease in Belgium. Specific services have been designated to care for Ebola patients.<sup>22</sup>

**Victims of torture or psychological trauma:** Health care is provided in the same way as for other medical problems. Additional care may be provided free if the person is considered as 'disabled' due to torture or trauma. For example, a person who has suffered mutilations due to torture can receive plastic surgery and psychological aid. There are also NGOs that provide free care (e.g. GAMS for Female Genital Mutilation).<sup>23</sup>

**Victims of human trafficking:** If the trafficker is convicted, the victim will be given a permanent residence card as long as information from them has contributed to securing the conviction.

**Vaccinations:** These are provided for all children by ONE and *Kind & Gezin*, or by school services. For asylum seekers, there is reimbursement under certain conditions for some vaccinations outside the national health insurance (mainly for public health reasons).

### Barriers to obtaining entitlement

Unlike Belgians, asylum seekers are subject to a gate-keeping system when they need specialist care. It should be noted that Belgians in poor socioeconomic conditions may also have to deal with additional administrative procedures when accessing health care.

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<sup>21</sup> <http://bit.ly/2mbwR4G>

<sup>22</sup> <http://bit.ly/2nncpy4>

<sup>23</sup> <http://gams.be>

## C. Undocumented migrants

### Inclusion in health system and services covered

The health care entitlements of undocumented migrants are laid down in the 1996 Royal Decree for Urgent Medical Aid (UMA)<sup>24,25</sup> (Dauvrin, 2012). Coverage is conditional on living in poor socioeconomic conditions (e.g. no regular income) and having a fixed address (not a requirement of the Royal Decree but of the Public Centre of Social Action (PCSA) as a condition of starting the UMA procedure). Although the name of the procedure refers to ‘urgent’ medical care, in theory it offers a wide range of services allowing the undocumented migrant to benefit from the same healthcare coverage as Belgian nationals. In practice, however, administrative procedures, lack of awareness on the part of health professionals and patients, implicit selection and other barriers often prevent such migrants from accessing adequate health care services.

UMA covers in theory inpatient or outpatient services, as well as preventive care such as vaccinations. It may involve all procedures, drugs and therapies covered for Belgians. However, delivery and coverage of services are at the discretion of a physician (other professionals are not allowed to initiate an UMA procedure) and of the PCSA. In some circumstances, dental care, ophthalmology and optometry services and plastic surgery are covered by UMA while in others, only basic care is provided, e.g. painkillers and antibiotics. Emergency care is always covered.<sup>26</sup>

During UMA procedures, no direct payment is required from the patient. Health professionals send a reimbursement form to the PCSA, which then rules on the relevance of the rendered services. The Council of Social Aid of the PCSA may refuse the reimbursement request if it decides that the procedures, drugs or therapies were not ‘urgent’ or ‘necessary,’ or that the patients were not in ‘poor’ socioeconomic conditions. Otherwise, the PCSA will then be reimbursed by the Ministry of Social Integration.

UMA is organised at the local level by the PCSA and there are differences between municipalities regarding the coverage granted. Each PCSA has sovereignty in terms of the organisation of UMA. This creates inequities between undocumented migrants living in different places. UMA is a federal law, but as it is part of social aid, its application is left to the discretion of the municipalities, given that social aid administration is a municipal prerogative. Federal authorities may only provide advice or guidance concerning the administrative procedures (Casman & Mazabi 2009; Dauvrin 2012).

Undocumented migrants in the UMA procedure cannot choose their health professionals. The PCSA chooses the health professional or hospital that will be in charge of the patient (except when the patient directly seeks help in a medical emergency). If the migrant nevertheless wishes to be treated by someone else, they will have to cover all fees. In some (non-urgent) cases, additional payment is demanded on admission – although demands for additional payment are illegal in A&E departments. In addition, private health practitioners or services and health professionals without an agreement with

<sup>24</sup> Arrêté royal du 12 décembre 1996 relatif à l'aide médicale urgente octroyée par les centres publics d'aide sociale aux étrangers qui séjournent illégalement dans le Royaume.

<sup>25</sup> Arrêté royal du 13 janvier 2003 modifiant l'arrêté royal du 12 décembre 1996 relatif à l'aide médicale urgente octroyée par les centres publics d'aide sociale aux étrangers qui séjournent illégalement dans le Royaume.

<sup>26</sup> <http://www.medimmigrant.be/?idbericht=25&idmenu=2&lang=nl>

the national health insurance funds (INAMI/RIZIV) may also charge additional fees, which will not be reimbursed by the PCSA. Integrated primary care health services ('medical homes' or 'neighbourhood health centres') are often chosen as the service provider as they have an administrative staff which can assist the health professionals and the patients with the procedures. There is a tendency to refer undocumented patients on to public hospitals, increasing the burden on health professionals there.

### Special exemptions

**Pregnant women, mothers and babies:** Undocumented women need to apply for UMA before the delivery or during their stay at the hospital to ensure that fees are covered.<sup>27</sup> Concerning perinatal care, see under Legal migrants.

**Children:** Federal entities are responsible for health care for children, including school health services (cf. the list for perinatal care given above under 'Legal migrants'). Until six years of age, children, whatever their status, can attend ONE, *Kind & Gezin*, or *Kaleido-DG* consultations but there is no provision of medical prescriptions (with some exceptions).

School attendance is compulsory for all children between 6 and 18, even for undocumented migrants. Consequently, all children are seen by school health services (limited to screening for specific health problems such as diabetes or hearing impairment, referrals to specialist care and compulsory vaccinations such as tetanus or rubella). School services may also provide free psychological support for children with specific problems (e.g. mental health, learning difficulties).

Unaccompanied minors benefit from national health insurance exempt of co-payments, but they have to prove they have attended school during the three months prior to the request (except for minors dispensed from school attendance).

If health care is provided through the UMA procedure, the same procedure applies to children as to adults. Sometimes the PCSA delivers UMA-mandated care directly to the whole family to ensure continuity of care and to simplify administrative procedures.

**Communicable diseases:** Special screening campaigns for TBC are organised in some places (e.g. night shelters for homeless) to reach undocumented migrants. In case of an active infection, all medical fees are covered, but undocumented migrants have to make a request for UMA at the PCSA. Reporting of the cases to the Ministry of Public Health is compulsory and non-anonymous for surveillance purposes. Communities are in charge of health promotion, screening, and patient education. Public health surveillance is the domain of the federal authorities.

Screening for HIV is also free and anonymous, but is not systematic. Reporting of cases is compulsory for public health issues, but remains anonymous. UM have to initiate a procedure of UMA at the PCSA if they need treatment (Sasse et al. 2015). After the Ebola outbreak, specific procedures were launched at airports with African flight connections to prevent the spread of the disease in Belgium. Specific services have been designated to care for Ebola patients.

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<sup>27</sup> <http://www.medimmigrant.be/?idbericht=25&idmenu=2&lang=nl>

**Victims of torture or psychological trauma:** Depending on the legal status of patients, non-profit organisations may provide free care (e.g. GAMS for FMG), but there is no specific assistance from public authorities. For undocumented migrants, health care is provided through UMA. Additional care may be provided free if the person is considered as 'disabled' due to torture or trauma. For example, because of mutilations suffered due to torture, one may receive plastic surgery and psychological aid which is covered by the national health insurance.

**Victims of human trafficking:** If the trafficker is convicted, the victim will be given a permanent residence card as long as information from them has contributed to securing the conviction.

**Vaccinations:** These are provided for all children by ONE, *Kind & Gezin* or *Kaleido-DG* (state-funded institutions for the protection and the wellbeing of children), or by school services. For asylum seekers, there is reimbursement under certain conditions for some vaccinations outside the national health insurance (mainly for public health reasons). For undocumented migrants, all vaccinations covered by the National Insurance must be provided through UMA.

### Barriers to obtaining entitlement

Undocumented migrants have to provide a declaration of legal address in order to obtain urgent medical aid. In some circumstances, the PCSA may provide the address (e.g. for homeless persons, the address of the applicant will be the address of the PCSA). In the mainstream health system, proof of identity (identity card, passport, declaration of the foreign office, etc.) is always required at admission in order to register the patient. 'Borrowing' proof of identity from someone else is quite common, but can be dangerous, especially if they are registered as having a different blood group (Casman & Mezabi 2009; Dauvrin, 2012).

Some procedures involve administrative discretion. Each municipality has sovereignty in organising UMA: a pilot project is under development at the Ministry of Social Integration in order to harmonise and digitalize the UMA procedure. There is also a significant gap between law and practice concerning UMA (see Dauvrin et al. (2012) for details). An investigation has to be conducted by the social assistant of the PCSA to assess whether irregular migrants (or other migrants applying for aid from the PCSA) really live in poor socioeconomic conditions. Social assistants are then the *de facto* gatekeepers.

Being president of the PCSA is a political function at municipal level. Consequently, local politics may influence the number of UMA certificates granted to migrant patients. Traditionally, socialist municipalities are more generous than liberal ones. There is a mismatch between the timeline of PCSA and the medical conditions of the patients: the PCSA council is held once a month, while health professionals get paid three months after the provision of health care. Providing health care for migrants is not under the responsibility of the Ministry of Public Health, but under Social Integration, which may create confusion among health professionals and patients. Respect for patients' rights may not be guaranteed, in particular when patients are in vulnerable situations: migrants benefiting from aid delivered by the state cannot choose their health professionals, they are poorly informed about their rights, the procedures for informed consent may not be respected, and there may be limitations in the available therapeutic options. Moreover, on the health professionals' side, the therapeutic freedom of health professionals is undermined by the PCSA as the PCSA decides whether or not a therapeutic option chosen by the health professional is justified. In some municipalities, there has been a lowering of the threshold of socioeconomic conditions to obtain urgent medical aid - before the economic crisis

<1.000 euros of monthly income, now <800 euros of monthly income (this also applies to Belgian citizens).

There are also complicated procedures demanding high levels of language proficiency and know-how, e.g. when filing an application for UMA at the municipality. Migrants have to understand Belgian political organisation at the local level. Most public employees speak only national languages and no interpreters are provided. Shortcomings of the UMA system were analysed in detail in a report by the Belgian Health Care Knowledge Centre (KCE) (Roberfroid et al. 2015).



## 6. POLICIES TO FACILITATE ACCESS

Score 72    Ranking ●●●●●

### Information for service providers about migrants' entitlements

The Ministry of Social Integration provides regular up-to-date information on migrants' entitlements to health care services through ministerial communication (a practical guide explaining how to apply new legislation), as well as through its newsletter and information sessions. At a local level, municipalities and PCSA are autonomous in delivering information to service provider organisations concerning specific procedures about migrants' entitlements (e.g. opening hours, development of a system of medical cards). However, it is unclear how well organisations pass on this information to their employees. The National Institute for Health and Disability (INAMI/RIZIV) regularly informs health professionals about the updates to reimbursement rules and other procedures.

Some local centres of Intercultural Action organise information sessions for service providers in order to explain procedures. NGOs may provide information which is adapted to the needs of the health professionals, including i.e. examples of medical certificates for UMA.

### Information for migrants concerning entitlements and use of health services

Federal public authorities do not directly provide information specifically for migrants related to health services. However, communities and/or regions fund NGOs and other non-profit organisations in order to provide such information. These NGOs adapt the method of dissemination and the content of the information. For example, the NGO *Cultures & Santé*<sup>28</sup> receives public funding from the Fédération Wallonie-Bruxelles to disseminate information tailored for migrants. The field of action of this NGO encompasses Brussels and Wallonia. Targeted information is provided on an ad hoc basis, e.g. through individual campaigns in certain regions, brochures, and websites updated on a regular basis.

Integration is a competence of the federal entities. In **Flanders**, the Vlaamse Overheid requires that all (legal) migrants over the age of 18 follow an 'inburgeringstraject',<sup>29</sup> especially if they plan to stay for a long period. The civic integration project encompasses a social orientation course (introduction to the Flemish and Belgian society, including use of health services), basic course in Dutch as second language, career orientation and individual programme counselling. The programme is tailored to the needs of the migrant and is compulsory for some target groups: persons who recently immigrated to Belgium and have taken up residence in Flanders, and ministers of religion in a local church or religious community recognised by the Flemish authorities. Other target groups which may benefit from the program are Belgians born abroad who have at least one parent not born in Belgium. The program is delivered in Dutch or in a secondary language. Specific programmes exist for children, delivered in schools. Migrants living in Brussels may attend the Flemish civic integration programme. In **Wallonia** and the French part of Brussels, the regional government introduced in February 2014 a civic integration programme with content similar to the Flemish programme.<sup>30,31</sup>

<sup>28</sup> <http://www.cultures-sante.be>

<sup>29</sup> <http://www.integratie-inburgering.be/landingspagina-inburgering/>

<sup>30</sup> <http://gouvernement.wallonie.be/le-parcours-d-int-gration-des-primos-arrivants-adopt-par-le-gouvernement-wallon>

Besides official structures, federal entities fund NGOs and other non-profit organisations such as MedImmigrant<sup>32</sup> in order to provide such information. Some municipalities organise specific information sessions for newcomers in which they provide information about legal entitlements to healthcare.

There is no distinction between the groups covered by the above targeted information. NGOs provide information without distinction of legal status, or specific information for specific groups (for example, MedImmigrant provides specific fact sheets for undocumented migrants). However, official information is usually tailored for legal migrants.

Targeted information is available in more than two languages of origin, excluding English. Information provided in the 'inburgeringstraject' is available in several languages (see website). Municipalities may decide to provide information in non-official languages. Concerning NGOs, information can be found in Arabian, Turkish, Spanish, Italian, Chinese, Lingala, Swahili, etc.

### Health education and health promotion for migrants

Health education and health promotion is a competence of the linguistic communities: Vlaamse Overheid (Flanders & Brussels), Communauté française/Fédération Wallonie Bruxelles (Wallonia & Brussels) and Deutschsprachige Gemeinschaft Belgien (German community). Prevention programmes, on the other hand, are a competence of the regions: Vlaamse Overheid (Flanders), Région Wallonne (Wallonia) and Région de Bruxelles-Capitale/Brussels Geweest (Brussels). The Federal Ministry of Public Health may develop national plans for reducing health risks (e.g. the National Nutrition Plan), but priorities and the targeting of programmes for migrants are chosen by the relevant community or region.

NGOs and other non-profit organisations may receive funding from the federal or local governments in order to disseminate information. Some associations will then include cultural sensitivity in their health promotion campaigns for migrant populations. Many initiatives are likely to exist at local level, but are poorly documented. Concerning HIV and STI prevention and awareness, special efforts have been made to tailor the method of information dissemination and content in order to better reach and influence migrants, as HIV rates are higher among non-Belgians than Belgians (Sasse et al. 2012).

Health education and health promotion usually target legal migrants, but undocumented migrants may also receive this information, as they generally attend the same services as legal migrants. Data from the national health interview survey and local health services show that non-Belgians have poorer access to health education and health promotion when compared to Belgians (Anson 2001; Bayingana et al. 2006; Derluyn et al. 2011; Lorant et al. 2011). Access to health education and health promotion is more problematic for asylum seekers, because it is often left to the discretion of the health professionals.

Official documents are only available in the national languages of the responsible federal entity. Some NGOs, local health services, or non-profit associations may develop specific tools in other languages, with or without public funding.

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<sup>31</sup> <http://socialsante.wallonie.be/?q=action-sociale/integration-personne-origine-etrangere/dispositifs/parcours-integration-primo-arrivant>

<sup>32</sup> <http://www.medimmigrant.be/?idbericht=1&idmenu=1&state=0&lang=nl>

### Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Such provision exists across the system in major immigrant areas. Intercultural mediators are provided in over 50 general and psychiatric hospitals, funded and supervised by the Ministry of Public Health. To benefit from the services of an intercultural mediator, hospitals have to demonstrate that there is a need for such a service in their practice. An annual report of activities is required in order to maintain the agreement for intercultural mediation<sup>33</sup> (see also Nierkens 2002; Verrept 2008).

Over the last few years, intercultural mediation has also become available through videoconferencing, at no cost to the hospitals and primary care centres that wish to use on this system. This project was extended to the ambulatory sector (outpatient care) in 2015.

Only patients in the mainstream health care system benefit from the services of intercultural mediators. If the patients stay in a hospital where the service exists, there is no difference according to their legal status. There is still no official provision of intercultural mediators in centres for asylum seekers. From November 2014 onwards, intercultural mediation via videoconference was made available at a number of FEDASIL sites. Intercultural mediators are also available at some sites of Médecins du Monde (also through the internet).

Mediators or other similar services, outside the service provided by the Ministry of Public Health, also exist. They are likely to collaborate with hospitals, primary care services, and other outpatient services on a discretionary basis.

### Obligation to report undocumented migrants and sanctions

Reporting undocumented migrants is not explicitly forbidden in the professional codes of conduct of physicians and nurses. However, the Royal Decree on Urgent Medical Aid states that the data collected through the procedure of UMA should only be used to reimburse the medical fees (art. 4). By default, there is no obligation to report undocumented migrants.<sup>34</sup>

### Are there any sanctions against helping undocumented migrants?

Only organisational sanctions exist (organisations discourage care providers from helping migrants who cannot pay). For example, private health services sometimes refer undocumented migrants or patients with a low socioeconomic status to public hospitals. In some hospitals, internal directives require that health professionals first consult the medical board before initiating a treatment for indigent or undocumented migrants. However, the scale of these practices is unknown and may vary over time (Dauvrin 2012; Casman & Mezabi 2009; Roberfroid et al. 2015).

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<sup>33</sup> <http://bit.ly/2msTpPr>

<sup>34</sup> *Arrêté royal du 12 décembre 1996 relatif à l'aide médicale urgente octroyée par les centres publics d'aide sociale aux étrangers qui séjournent illégalement dans le Royaume (1996).*

## 7. RESPONSIVE HEALTH SERVICES

Score 42    Ranking ●●●●○

### Interpretation services

There is no formal requirement to provide interpreters. However, the law on patients' rights states that information should be provided in a clear language to the patient in order to get his/her informed consent. Interpretation of the law is left to the discretion of the health professionals.<sup>35</sup> A recent study in Belgium shows that health professionals, especially physicians, feel responsible for providing interpreters (Dauvrin & Lorant, 2014). Public service interpreters, community interpreters, or other services exist and may collaborate with hospitals on a discretionary basis.

Methods used include face-to-face and telephone interpretation, video links, interpretation by cultural mediators and competent bilingual or multilingual staff, as well as ad hoc interpretation by untrained interpreters. Volunteers (e.g. from the Red Cross) may help with translation, even if they are not credentialed.

### Requirement for 'culturally competent' or 'diversity-sensitive' services

Standards or guidelines exist on 'culturally competent' and 'diversity-sensitive' services, and compliance with these standards or guidelines is monitored by the relevant authorities. The Equity Standards project<sup>36</sup> was launched in Belgium by the public healthcare authorities and seven Belgian hospitals decided to participate in it.

### Training and education of health service staff

There is no policy to support training of staff in providing services responsive to the needs of migrants, despite recommendations from experts (see the conclusions of the ETHEALTH group and EUGATE - Dauvrin et al. 2012; Dauvrin et al. 2010; Dauvrin & Lorant 2010; Derluyn et al. 2011a,b; Lorant et al. 2011). Training and education of health professionals is left to the discretion of the educational institutions or the health services. Initiatives and projects exist, but no overall picture is available. UNIA, the intergovernmental center for equal opportunities, published recommendations for the training of health care professionals but this was not followed by a formal implementation in the curriculum of health care professionals.

### Involvement of migrants

Migrants are involved in service delivery, for example through employment as 'cultural mediators', and are also involved in the development and dissemination of information. Again, initiatives and projects exist at local level but are not systematically documented. Other services may involve patients in community health projects or rely on patients for events such as gym activities for women.

Immigrant organisations are not explicitly consulted on service design and delivery as a matter of policy. They may be consulted on a discretionary basis in some health services.

<sup>35</sup> *Loi du 22 août 2002 relative aux droits du patient*

<sup>36</sup> See [http://www.hphnet.org/attachments/article/291/Equity%20Standards%20SAT%202014\\_Light.pdf](http://www.hphnet.org/attachments/article/291/Equity%20Standards%20SAT%202014_Light.pdf)

### Encouraging diversity in the health service workforce

Some hospitals developed specific hiring strategies (e.g. the GZA-group in Antwerp), but this is not part of a public policy.

### Development of capacity and methods

Adaptation of diagnostic procedures and treatment methods is to a limited extent tolerated, but not encouraged. Policies exist to encourage for the development of treatments for health problems specific to certain migrant communities (e.g. female genital mutilation, effects of torture, rare import diseases, genetic risk factors) and use of complementary and alternative 'non-Western' treatments for physical and mental health problems. Some hospitals have been developing expertise in specific areas – for instance, ICRH at UZ Gent developing expertise in FGM. There have been some attempts, e.g. VAGGA and *De Acht* in Antwerpen, *Solentra*, *D'ici et d'Ailleurs* in Brussels, to work in a more culturally-sensitive way in mental health care. Although there is no specific policy, these projects are often supported through public funding.

## 8. MEASURES TO ACHIEVE CHANGE

Score 29    Ranking ●●○○○

### Data collection

Information about migrant status, country of origin or ethnicity is occasionally included in data regarding health. In the next Health Interview Survey, more data related to migrant health will be included. The possibility of collecting such data exists, but is poorly used by health professionals and the public institutions in charge of collecting data on health, such as the provincial Observatories of Health.

The National Institute of Statistics is explicitly prohibited from collecting data on the father's country of birth. As the Institute of Statistics is partner of the National Health Interview Survey, this interdiction is extended to the rest of the system.

### Support for research

Funding bodies have in the past five years supported research on the following topics: occurrence of health problems among, migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, issues concerning service provision for migrants or ethnic minorities, and evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities.

While some funding bodies call for research projects but do not specify the topics, other funding bodies support specific research projects on migrants. The main funding bodies concerned are *Fonds Wetenschappelijk Onderzoek FWO* (for the Flemish community), *Fonds de la recherche scientifique – FNRS* (for the French community), INNOVIRIS – Brussels Institute for Research and Innovation, King Baudouin Foundation, Houtman Funds and Federal Expertise Centre for Health.

### 'Health in all policies' approach

There is no consideration given to the impact on migrant or ethnic minority health of policies in sectors other than health. If a topic concerns several federal entities (as is the case for health), an inter-ministerial conference could be organised (it was done for the Mental Health Services Reform, after the publication of recommendations for intercultural care and for the Reform of Health Care for Elders).

### Whole organisation approach

No systematic attention is paid to migrant or ethnic minority health in any part of the health system. Measures are left to individual initiatives.

### Leadership by government

No policy measures are introduced on migrant health.

### Involvement of stakeholders

Policy to involve stakeholders is made through ad hoc cooperation (e.g. during consultations on new health strategy or law or through projects). The ETHEALTH project is a one-off project involving stakeholders around migrant health (Derluyn et al. 2011a,b; Lorant et al. 2011; Dauvrin et al. 2012).

*A steering committee was commissioned by one General Director at the Ministry of Public Health. This steering committee was composed of three researchers and two civil servants from the Ministry of Public Health. The steering committee conducted the project, organised the panel meetings, invited the experts, and drafted the report. The steering committee also produced a review of the existing situation in relation to migration and health in Belgium, as well as in other countries, to provide a documentary background for the discussion.*

*The steering committee invited several experts in the field of health and migration in Belgium to take part in the panel. Experts cited by the five members of the steering committee were contacted and asked to join the core group of ETHEALTH. Four experts refused to participate, either due to lack of time or because they did not consider themselves to be experts. They were replaced by other experts on the list. Twenty-one experts finally constituted the panel. The panel was made up of 8 men and 13 women. Four experts were from migrant backgrounds, 13 experts had French as their preferred national language. (Dauvrin et al. 2012)*

### **Migrants' contribution to health policymaking**

Migrant organisations are not explicitly consulted on health policy. All non-Belgian residents, including Third Country Nationals, have the right to vote at local level. To vote at national level, non-EU27 residents need to have a residence permit and have resided legally in Belgium for at least 5 years. They have to sign a declaration in which they agree to respect the Belgian constitution, Belgian laws and the International Convention on Human Rights. After being registered as voters, they may cast their votes just like Belgian citizens; they can also stand for local elections. Although there is no formal consultation, NGOs and CSOs regularly publish position papers before the elections, or when the socio-political circumstances make a reaction necessary.



## CONCLUSIONS

Belgium's ranking on the MIPEX Health strand is somewhat lower than its average rank on other strands: integration of migrants into the health system does not seem to enjoy the priority that is accorded to, say, integration into the educational system or the labour market. Nevertheless, comparing the different subscales of the Health strand, we see that Belgium's policies are among the best in the EQUI-HEALTH sample when it comes to making health services more accessible for migrants, and better than average concerning entitlements and the responsiveness of services to migrants' needs. The widespread deployment of 'cultural mediators', as well as the broad entitlements of undocumented migrants, are particularly strong points.

However, when it comes to the uniformity and stability of policies, the lower than average scores concerning measures to achieve change show that many 'good practices' are not structurally embedded in policy or supported by adequate 'flanking measures' such as data collection and stakeholder consultation. Much of this may be related to the complex and fragmented system of governance in Belgium, which was noted in Section 1 and is particularly problematic in the health sector. (For example, policies for reducing health risks are the competence of the federal government, but health education and promotion is done by linguistic communities and prevention by regional governments.) Responsibilities are spread over many different levels, with the result that no one level regards itself as particularly accountable for shortcomings in migrant health policy. In addition, the rise of a populist, anti-immigration political discourse since the turn of the century accounts for a certain timidity on the part of the government when it comes to promoting the interests of migrants. This phenomenon is also seen in many other countries, especially the Netherlands, Denmark and the UK.

The project ETHEALTH, commissioned by the Federal Ministry of Public Health, convened a panel of experts which in 2011 published no less than 46 recommendations for improvements (Derluyn et al. 2011a; Lorant et al. 2011). Since then, however, little has been done to implement these recommendations. The system for providing undocumented migrants with health care coverage (UMA) was recently subjected to a far-reaching review, which found that arbitrariness and unnecessary bureaucratic complications were undermining the effectiveness of the enlightened legislation introduced nearly 20 years ago (Roberfroid et al. 2015). Again, efforts to remedy these problems are under way, but it is not clear how much success they will have.

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