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Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

ASYLUM SEEKERS IN BELGIUM: OPTIONS FOR A MORE EQUITABLE ACCESS TO HEALTH CARE. A STAKEHOLDER CONSULTATION

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ASYLUM SEEKERS IN BELGIUM: OPTIONS FOR A MORE EQUITABLE ACCESS TO HEALTH CARE. A STAKEHOLDER CONSULTATION

MARIE DAUVRIN, JENS DETOLLENAERE, CHRIS DE LAET, DOMINIQUE ROBERFROID, IRM VINCK

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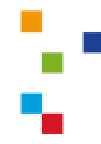

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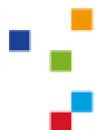

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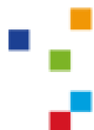

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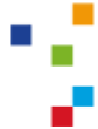

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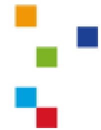

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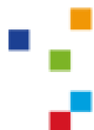

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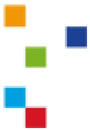

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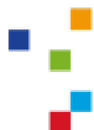

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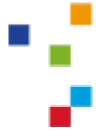
LIST OF ABBREVIATIONS

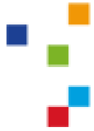
ABBREVIATION	DEFINITION
ADH – HJA	Anonieme Dag Hospitalisatie – Hospitalisation de Jour Anonyme – (Anonymized One Day Hospitalisation)
AMI – ZIV	Assurance Maladie Invalidité – Ziekte- en invaliditeitsverzekering (Belgian Health and Disability Insurance)
AZV – SHA	Anoniem ZiekenhuisVerblijf – Séjour Hospitalier Anonyme (Anonymized Hospitalisations of at least one night)
CAAMI – HZIV	Caisse Auxiliaire d’Assurance Maladie Invalidité – Hulpkas voor Ziekte- en Invaliditeitsverzekering (Belgian Agency for Health and Disability Insurance)
CGRA – CGVS (CGRS)	Commissariat Général aux Réfugiés et Apatrides – Commissariaat Generaal voor de Vluchtelingen en de Staatlozen (Belgian Office of the Commissioner General for Refugees and Stateless Persons)
CPAS – OCMW	Centre Public d’Action Sociale – Openbaar Centrum voor Maatschappelijk Welzijn (Belgian Local Welfare Centre)
EASO	European Asylum Support Office
FARES – VRGT	Fonds des Affections Respiratoires asbl – Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding vzw (Organisations for Tuberculosis and Respiratory Affections) (Belgium)
Fedasil	Agence Fédérale pour l’Accueil des Demandeurs d’Asile – Federaal Agentschap voor de Opvang van de Asielzoekers (Belgian Federal Agency for the Reception of Asylum Seekers)
FGM	Female Genital Mutilation
FOD – SPF (FPS)	Service public fédéral – Federale overheidsdienst (Federal public service, Belgium)
FTE	Full Time Equivalent
GP	Generalist practitioner
HIV – AIDS	Human Immunodeficiency Virus infection – Acquired Immune Deficiency Syndrome
ILA – LOI	Initiative Locale d’Accueil – Lokaal Opvang Initiatief (Belgian Local reception initiative for asylum seekers)



IMA – AIM	InterMutualistisch Agentschap – Agence Intermutualiste (Inter-mutualistic agency)
INAMI – RIZIV (NIHDI)	Institut National d'Assurance Maladies Invalidité – RijksInstituut voor Ziekte en Invaliditeitsverzekering (Belgian National Institute for Health and Disability Insurance)
INSZ – NNSS	Identificatienummer van de Sociale Zekerheid – Numéro National de Sécurité Sociale (Belgian Social Security National Number)
MHPSS	Mental Health & Psychosocial Support Network
MIPEX	Migrant Integration Policy Index (International project on Integration Policies, project sponsored by the European commission)
Myria	Centre fédéral Migration – Federaal Migratiecentrum (Belgian Federal Migration Centre)
NGO	Non-Governmental Organisation
ONE	Office de la Naissance et de l'Enfance (Frenchspeaking Birth & Childhood Office)
OOC	Centre d'Observation et d'Orientation pour mineurs étrangers non-accompagnés – Orientatie en Observatie Centrum voor niet-begeleide minderjarige vreemdelingen (Belgian Orientation and Observation Centre for unaccompanied minors)
PPS Social Integration	SPP Intégration sociale, Lutte contre la Pauvreté et Politique des Grandes Villes – POD Maatschappelijke Integratie, Armoedebestrijding en Grootstedenbeleid (PPS Social Integration, anti-Poverty Policy, Social Economy, Belgium)
RHM – MZG	Résumé Hospitalier Minimal – Minimale Ziekenhuisgegevens (Belgian Minimum Hospital Data)
WHO Europe	Regional Office for Europe of the World Health Organisation

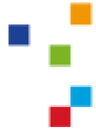
LEXICON

KEY WORDS	DEFINITION
9bis	Refers to the article 9bis of the Law of 15 December 1980 on the access to territory, stay, residence and deportation of foreigners in Belgium stipulating that one may apply for international protection because of humanitarian reasons.[1]
9ter	Refers to the article 9ter of the Law of 15 December 1980 on the access to territory, stay, residence and deportation of foreigners in Belgium stipulating that one may apply for international protection because of a (severe) health condition.[1]
Applicants for international protection	Refers to a third-country national or stateless person who has made an application for international protection for whom a final decision has not yet been taken.
Application for international protection	Refers to a request made by a third-country national or a stateless person for protection from a Member State, who can be understood to seek refugee status or subsidiary protection status, and who does not explicitly request another kind of protection outside the scope of Directive 2011/95/EU, that can be applied for separately.[2]
Asylum seekers	Refers to third-country national or stateless person who has made an application for international protection in respect of which a final decision has not yet been taken. Since 2018, this term is replaced by “applicants for international protection”. In this report, we will therefore use the asylum seekers as this term is still best known in the current language of stakeholders and daily practice. See also applicants for international protection.[2]
Code 207	Refers to the compulsory place of registration of asylum seekers attributed by the Dispatching of Fedasil - see also Code 207 “No show”. This code identifies the authority in charge of the reception of the asylum seekers and the place where the asylum seekers can benefit from the material assistance as defined by the 2007 Reception Law.
Code 207 “No show”	Code attributed to asylum seekers who refuse the compulsory place of residence (e.g. decides to stay with relatives or friends), do not stay in the compulsory place of residence or leave it without informing Fedasil. It is also applied to asylum seekers who do not respect some aspects of the procedures or has introduced a subsequent application. For asylum seekers with a code 207 “No show” medical care is always provided but additional material assistance – i.e. access to housing – will depend on the personal situation of the asylum seekers.



Dublin III Convention	Regulation (EU) Nº 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person.[3]
Governance	Refers to the overall policy, organisation and coordination.
Local reception initiative	Refers to reception places managed by a CPAS – OCMW or an NGO, usually individual housing or familial housing. The number of ILA – LOI places managed by the CPAS – OCMW is determined according to the size and the population of the municipalities.
Person eligible for subsidiary protection	Means a third country national or a stateless person who does not qualify as a refugee but in respect of whom substantial grounds have been shown for believing that the person concerned, if returned to his or her country of origin, or in the case of a stateless person, to his or her country of former habitual residence, would face a real risk of suffering serious harm defined as a) the death penalty or execution; or (b) torture or inhuman or degrading treatment or punishment of an applicant in the country of origin; or (c) serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict; and is unable, or, owing to such risk, unwilling to avail himself or herself of the protection of that country.[2]
Reception network	Refers to the collective centres managed by Fedasil or a partner, specialised centres for unaccompanied minors or victims of human trafficking, and the local reception initiatives. Asylum seekers in detention centres or with a code 207 "No show" are considered as outside the reception network.
Refugee	Refers to a third-country national who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country, or a stateless person, who, being outside of the country of former habitual residence for the same reasons as mentioned above, is unable or, owing to such fear, unwilling to return to it.[4]
Refugee status	Refers to the recognition by a Member State of a third-country national or a stateless person as a refugee.[2]
Subsequent application	Formerly multiple applications – occurs when an individual has previously applied for international protection in another Member State.[5]

Subsidiary protection status	Refers to a third country national or a stateless person who does not qualify as a refugee but in respect of whom substantial grounds have been shown for believing that the person concerned, if returned to his or her country of origin, or in the case of a stateless person, to his or her country of former habitual residence, would face a real risk of suffering serious harm defined as a) the death penalty or execution; or (b) torture or inhuman or degrading treatment or punishment of an applicant in the country of origin; or (c) serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict; and is unable, or, owing to such risk, unwilling to avail himself or herself of the protection of that country.[2]
Unaccompanied minor	Refers to a minor who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person; it includes a minor who is left unaccompanied after he or she has entered the territory of the Member States.[2] In French: *Mineurs Etrangers Non-Accompagnés (MENA)*. In Dutch: *Niet-Begeleide Minderjarige Vreemdelingen (NBMV).*



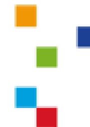
■ SCIENTIFIC REPORT

1 INTRODUCTION

Asylum seekers are persons seeking international protection and whose claim for refugee status has not yet been decided upon. As part of internationally recognised obligations to protect refugees on their territories, countries are responsible for determining whether a particular asylum seeker is a refugee or not. This responsibility is derived from the Convention signed in 1951 related to the Status of Refugees[6] and is often incorporated into national legislation.

In 2014, according to the United Nations Refugee Agency, the 28 European Union Member States registered 570 800 asylum applications, compared to 396 700 in 2013, equalling an increase of 44%.[7] Turkey and Italy were the main recipients of asylum seekers within the European area (87 800 and 63 700 respectively).[7] In the period 2010-2014, 0.35% of the inhabitants of the European Union were asylum seekers. In Europe, the highest number was noted in Sweden in which 2.44% of the inhabitants were asylum seekers.[7] Worldwide, the top five of countries from which asylum seekers originate in industrialised countries were (i) the Syrian Arab Republic, (ii) Iraq, (iii) Afghanistan, (iv) Serbia and Kosovo, and (v) Eritrea.[7] In 2018, according to the European Asylum Support Office (EASO), 634 700 asylum applications were registered in the 28 European Union members, Norway and Switzerland. Syrians were still the main group of applicants, followed by Afghans, Iraqis, Pakistanis and Iranians.[8]

In 2016, the Belgian State, alongside with the other members of the General Assembly of the United Nations, reiterated its willingness to offer asylum for those in need of international protection in the New York Declaration on Refugees, including access to health care.



We commit to combating xenophobia, racism and discrimination in our societies against refugees and migrants. We will take measures to improve their integration and inclusion, as appropriate, and with particular reference to access to education, health care, justice and language training. We recognize that these measures will reduce the risks of marginalization and radicalization. National policies relating to integration and inclusion will be developed, as appropriate, in conjunction with relevant civil society organizations, including faith-based organizations, the private sector, employers' and workers' organizations and other stakeholders. We also note the obligation for refugees and migrants to observe the laws and regulations of their host countries.

We encourage States to address the vulnerabilities to HIV and the specific health-care needs experienced by migrant and mobile populations, as well as by refugees and crisis-affected populations, and to take steps to reduce stigma, discrimination and violence, as well as to review policies related to restrictions on entry based on HIV status, with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, treatment, care and support.

We reaffirm our commitment to protect the human rights of migrant children, given their vulnerability, particularly unaccompanied migrant children, and to provide access to basic health, education and psychosocial services, ensuring that the best interests of the child is a primary consideration in all relevant policies.

We are committed to providing humanitarian assistance to refugees so as to ensure essential support in key life-saving sectors, such as health care, shelter, food, water and sanitation.

We will work to ensure that the basic health needs of refugee communities are met and that women and girls have access to essential health-care services. We commit to providing host countries with support in this regard. We will also develop national strategies for the protection of refugees within the framework of national social protection systems, as appropriate.

New York Declaration on Refugees, 2016

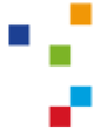
Once a migrant applies for international protection[a]* in Belgium, the Federal State becomes responsible for the provision of health care. Asylum seekers have the right to access health care which is free of charge[b], however they are not integrated in the compulsory national health insurance scheme for Belgian citizens.

Alongside the scientific literature, the Green Book of access to health care (published by the National Institute for Health and Disability Insurance (NIHDI) and *Médecins du Monde Belgique)*, the report of the Audit Court (*Cour des Comptes - Rekenhof*), and the Migrant Integration Policy Index (MIPEX) highlighted the following weaknesses in Belgium.[9-11]

- Variations and inequalities in accessibility, organisation, availability, coverage and quality of care between asylum seekers.[9, 10]
- Lack of continuity of care for asylum seekers in case of transfer between reception facilities, negative decisions, voluntary or forced repatriation or when asylum seekers are granted a refugee status.[9, 10]
- Need for a better implementation of the existing legislation on access to health care for asylum seekers.[11]

[a] Terms marked by a "*" refers the reader to the **Lexicon**.

[b] Asylum seekers could be charged for health care if they do not comply with the procedures regulating access to health care. Detailed explanations can be found in chapter 4.



Overall, the existence of complex, parallel, time- and money consuming administrative procedures for populations who are not part of the Belgian compulsory health insurance is perceived as a crucial bottleneck in equitable access to health care among asylum seekers. In this context, the White book of access to health care suggests a harmonisation of health care access for vulnerable populations, including asylum seekers, through the integration in the compulsory national health insurance scheme.[c]

Equitable access to health care should allow the Belgian state to better cope with national and international obligations regarding human rights, right to health and public health protection.[10-18]

2 SCOPE AND RESEARCH QUESTIONS

Since March 2018, the term "**applicants for international protection***" is preferred to "**asylum seekers**". It includes those applying for a **full refugee status** as defined in the 1951 Geneva Refugee Convention as well as those applying for a **subsidiary protection***.[5] Because this term is currently still most used in daily practice and best known by the stakeholders, the term "**asylum seekers**" will be used throughout the remainder of this report.

This report focuses on equitable access to health care for all asylum seekers, including those applying for protection because of humanitarian reasons (as defined by the article 9bis* of the Immigration Law). In this report, **"equitable"** is defined as *people with the same health needs should have the same access to the health care services (referring to horizontal equity)* and "**access"** as *the legal entitlement to healthcare*.

Individuals applying for regularisation due to medical reasons[d], the so-called 9ter*, are solely included in the scope of the study if they **also** applied for international protection. In addition, asylum seekers residing in detention centres but **still** in the asylum procedure are included within the scope. Last, asylum seekers refusing or leaving the compulsory place of residence[e] – designated hereafter as code 207 "No show"* – or introducing a subsequent application* are also included in the scope of this study.

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c The argument to limit the so-called parallel health insurance systems was also highlighted for prisoners and their (re)integration in the sickness and disability insurance has been suggested. See KCE report 293 *Healthcare in Belgian prisons* https://kce.fgov.be/en/health-care-in-belgian-prisons

d As defined by the article 9ter of the Law of 15 December 1980 concerning the access to the territory, stay, settlement and removal of foreign nationals, *B.S.* 31 December 1980. (Hereafter: Immigration Law)

e This concerns i.e. applicants deciding to stay with relatives or friends.

Rejected asylum seekers in detention centres[f], asylum seekers with a work permit[g], undocumented migrants[h], transit migrants[i], tourists and all the persons in international mobility situations (students, workers, or for family reunification) **are not** within the scope of this study.

It should be noted that equal access to health care for asylum seekers will be assessed primarily by evaluating current administrative procedures and stakeholder consultations. **This report does not intend to evaluate the overall health care system, the quality of care delivered to asylum seekers and the possible differences of treatment on "point of care".** This would require a comprehensive and in-depth analysis of the overall asylum policy in Belgium and Europe (e.g. reallocation policy). In addition, current study only incorporates the opinion and experiences of organisations and (health care) professionals. It does not incorporate the perspectives of asylum seekers themselves. Keeping this limitations in scope in mind, options presented in this report should be considered as a first step to allow equal access to healthcare for all asylum seekers, independent of the place of residence.

Accordingly, the following research questions are formulated:

1. How is health care for asylum seekers currently organised in Belgium?
2. What are the main problems identified by stakeholders in health care organisation for asylum seekers in Belgium?
3. What are the possible options to enhance equitable access to health care for asylum seekers in Belgium according to stakeholders?
4. What are the advantages and inconveniences for each possible option according to stakeholders?

In **Chapter 3** we describe the methods used to address these research questions. In **Chapter 4** we describe current health care delivery for asylum seekers and the context in Belgium. In **Chapter 5**, using interviews and surveys collected from participants, problems in the current health care delivery are identified. In **Chapter 6** different administrative options are proposed with the common aim to enhance equity in access to health care for asylum seekers. Finally, in **Chapter 7**, conclusions are formulated, taking into account the several limitations of this research.

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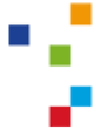
f Rejected asylum seekers – without any pending procedure – are under the direct responsibility of the Immigration Office (*Office des Etrangers - Dienst Vreemdelingenzaken*).

g As they are allowed to work, this category of asylum seekers should be registered to a sickness funds. Their exact number is unknown as they are not identified as "asylum seekers" in the database of the sickness funds. According to stakeholders, they constitute a very limited group.

h Access to health care for undocumented migrants was analysed in the KCE report 257.[19]

i If they did not apply for international protection, transit migrants are assimilated to undocumented migrants.



3 METHODS

For a detailed overview of the Methods, we refer the reader to Appendix 1.

The overall method of this research was a **stakeholder consultation**. By means of a stakeholder mapping (Figure 1), key stakeholders involved with health (care) for asylum seekers in Belgium were identified. Not only the stakeholders were identified who are currently involved in health (care) for asylum seekers, but also those likely to be impacted by a reform of the health care system. This stakeholder mapping was initially conducted by two members of the research team and updated after the desk research and exploratory interviews (see below). Following the framework of Brouwer & Woodhill[20], each stakeholder was categorised according to its degree of (i) interest in the success of the project and (ii) power of influence (formal and informal).

Figure 1 – Stakeholder mapping

Adapted from Brouwer & Woodhill[20]

The research process was performed using a stepwise approach, relying on several data sources, to define options that enhance equity in access to health care among asylum seekers. Figure 2 visualises the overview of the research process. All gathered information during this research process was triangulated and will, therefore, be presented in an integrated manner during the following chapters of this scientific report.

In the **first exploratory phase** (March-December 2017), the **current health care organisation** for asylum seekers was described using (i) Belgian (scientific) literature, (ii) existing Belgian databases; and (iii) semi-structured interviews with key-informants that further in this report will be called 'stakeholders'. The exploratory interviews were held with representatives of the following institutions: Fedasil (n=2), Myria (n=2), *Croix-Rouge de Belgique* (n=1), *Médecins sans Frontières Belgique* (n=2), *Plateforme Mineurs en Exil* (n=1), FPS Justice (n=2), MedImmigrant (n=1), *Agentschap Integratie-Inburgering* (n=1) and *Stad Antwerpen* (n=1). The interviews with stakeholders were conducted between March and June 2017. This resulted in the identification of three key points, which were the reference principles for the proposed options:

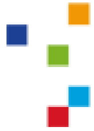
- Responsibilities regarding health care governance* and organisation of health care are divided among different actors.
- The organisation, availability and the covered package of (health) care depends on the reception facility and is not identical for all asylum seekers.
- Health care for asylum seekers is funded by different actors, according to different modalities.

During this phase, the research team drafted a wide variety of components to remediate these problems based on the problems listed during the interviews and literature search.

In the **second phase** (January-May 2018), these three key points and possible options and components for solutions were tested with a large panel of Belgian experts, field workers and policymakers during an **online survey** (April-May 2018). Participants to this survey were selected because of their expertise in the field of migration and/or health care (purposive sampling). Stakeholders included: the **local welfare centres** (*Centre Public d'Action Sociale* CPAS – *Openbaar Centrum voor Maatschappelijk Welzijn* OCMW (n=593), **reception centres** of Fedasil and their partners (n=87), **public institutions involved in asylum and/or health** (n=69), **integration centres and agencies** (n=50),**non-governmental organisations** (NGO) and non-profit organisations (n=43), **specialised health services** for asylum seekers (n=18), **academic experts** (n=14), **professional associations** (n=14),**sickness funds** (n=11), **specialised social services** for asylum seekers (n=10), and **representatives of asylum seekers & refugees** (n=5). This phase served to complete and validate the findings of the first exploratory phase and identify preferences, consensual and non-consensual points. It was, however, possible for stakeholders to freely add relevant components/options or modify the proposed options. The survey was initially developed in French, subsequently translated in Dutch, and pre-tested with a panel of KCE researchers (not part of the research team of this study). The survey was structured around the three themes: (i) governance of health policy, (ii) organisation of health care, and (iii) funding of health care. Each key-point was introduced by a description of the current situation and (dis)agreement on the statements could be rated on a 4-point Likert scale. After each statement, stakeholders could explain their choices in a separate text box (see the full questionnaire in Table 16).

A total of 171 persons participated to the online survey. Among the respondents, 75 reported working in Brussels, 53 in the Walloon region and 43 in Flanders. The average professional experience was 38.25 years. Respondents were working for: CPAS – OCMW (including local reception initiatives* ILA – LOI) (n=71), reception centres (n=27), health services (n=20), sickness funds (n=13), NGO and non-profit associations (12), public institutions (n=10), specialised health services (n=7), representatives of asylum seekers and refugees (n=5), academics (n=3), integration centre (n=1), professional association (n=1), social services (n=1). Concerning the professional activity of the respondents, the final sample included: 71 social workers, 39 health care professionals (medical doctors and nurses), 39 coordinators (either for health or social issues), 38 "advisors" and 5 researchers.

In the **third phase**, the results and non-consensual items of the survey were fine-tuned in a work session (June 2018) with 35 experts, field workers and policymakers using the **nominal group** technique.[21] Stakeholders were affiliated with a wide variety of organisations: Fedasil (n=7), NGO (n=6), *Croix-Rouge de Belgique & Rode Kruis Vlaanderen* (n=4), universities (n=3), health services (n=3), NIHDI (n=3), specialised health services for asylum seekers and migrants (n=3), CAAMI – HZIV (n=2), CPAS – OCMW (n=1),



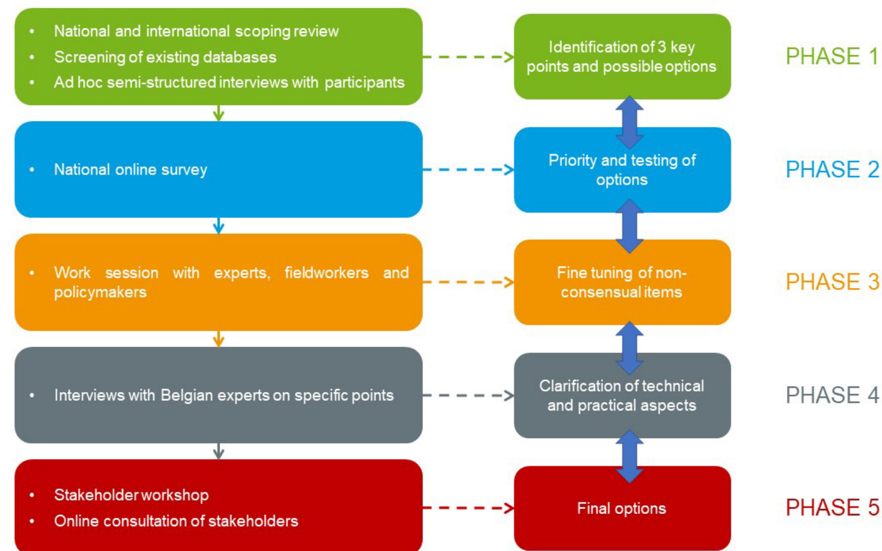
Immigration Office (n=1), PPS Social Integration (n=1), PFS Public Health Intercultural Mediation Cell (n=1) and *Vereniging van Vlaamse Steden en Gemeenten* (n=1). During this phase, additional elements were retrieved to complete the description of the current situation. Stakeholders of the workshop were split into five groups, and asked to reflect on the non-consensual items resulting from the survey (items scoring ≤44% agreement were considered non-consensual). Each group was also asked to discuss about advantages and inconveniences, as well as conditions of implementation. After the separate group discussions, a spokesperson for each group presented the reflections to the rest of the audience and those reflections were further discussed among all stakeholders during a plenary discussion. During this and the following phases, stakeholders could freely add or modify the proposed options.

In the **fourth phase** (July-August 2018), options were refined and further developed during **individual consultations** with stakeholders which would affected by the options. These partners were representatives of the Federal Agency for the Reception of Asylum Seekers (Fedasil), the PPS Social Integration, anti-Poverty Policy, Social Economy (PPS Social Integration), and the National Institute for Health and Disability Insurance (NIHDI).

In the **fifth and final phase**, stakeholders – representing sickness funds, federal and federated entities (see Appendix 1) – were consulted on the feasibility of the resulting options during a **workshop** (September 2018). A total of 25 stakeholders attended the meeting: NIHDI (n=2), cabinet of the Federal Ministry of Public Health and Social Affairs (n=1), cabinet of the Federal Ministry of Social Integration (n=3), cabinet of the State Secretary for Asylum and Migration (n=1), national unions of the sickness funds (*Collège Intermutualiste National*) (n=1), *Landsbond van Liberale Mutualiteiten* (n=2), *Mutualité Chrétiennes* (n=1) and *Mutualités Neutres* (n=1), cabinet of the regional Ministers of Health and Social Affairs (Brussels (n=1) and Wallonia (n=1), representatives of the Federation of CPAS – OCMW (Brussels=2, Flemish=1 and Walloon=1), the Guardianship service of the FPS Justice (n=1), PPS Social Integration (n=2), and Fedasil (n=3).

After this workshop, stakeholders were send a draft report in order to get consent and approval and fine tune the proposed options (**online consultation** of the stakeholders – February 2019).

Figure 2 – Overview of the research process



4 CONTEXT OF INTERNATIONAL PROTECTION AND HEALTH CARE FOR ASYLUM SEEKERS IN BELGIUM

4.1 International protection for asylum seekers

International protection, including the provision of health care and assistance for asylum seekers and refugees, is regulated by several European directives. To date, all these directives have been transposed in Belgian legislation.[22] A detailed overview of the international protection procedure, including the list of European directives concerning organisation of reception and assistance for asylum seekers, can be consulted in Appendix 2.

4.1.1 Procedure for international protection: legal and administrative aspects

Figure 3 visualises the procedure for international protection in Belgium. According to the article 57/6/1§1 of the Foreigner Law, the total procedure should theoretically last 6 months, with a maximum length of 21 months.[23]

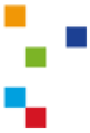
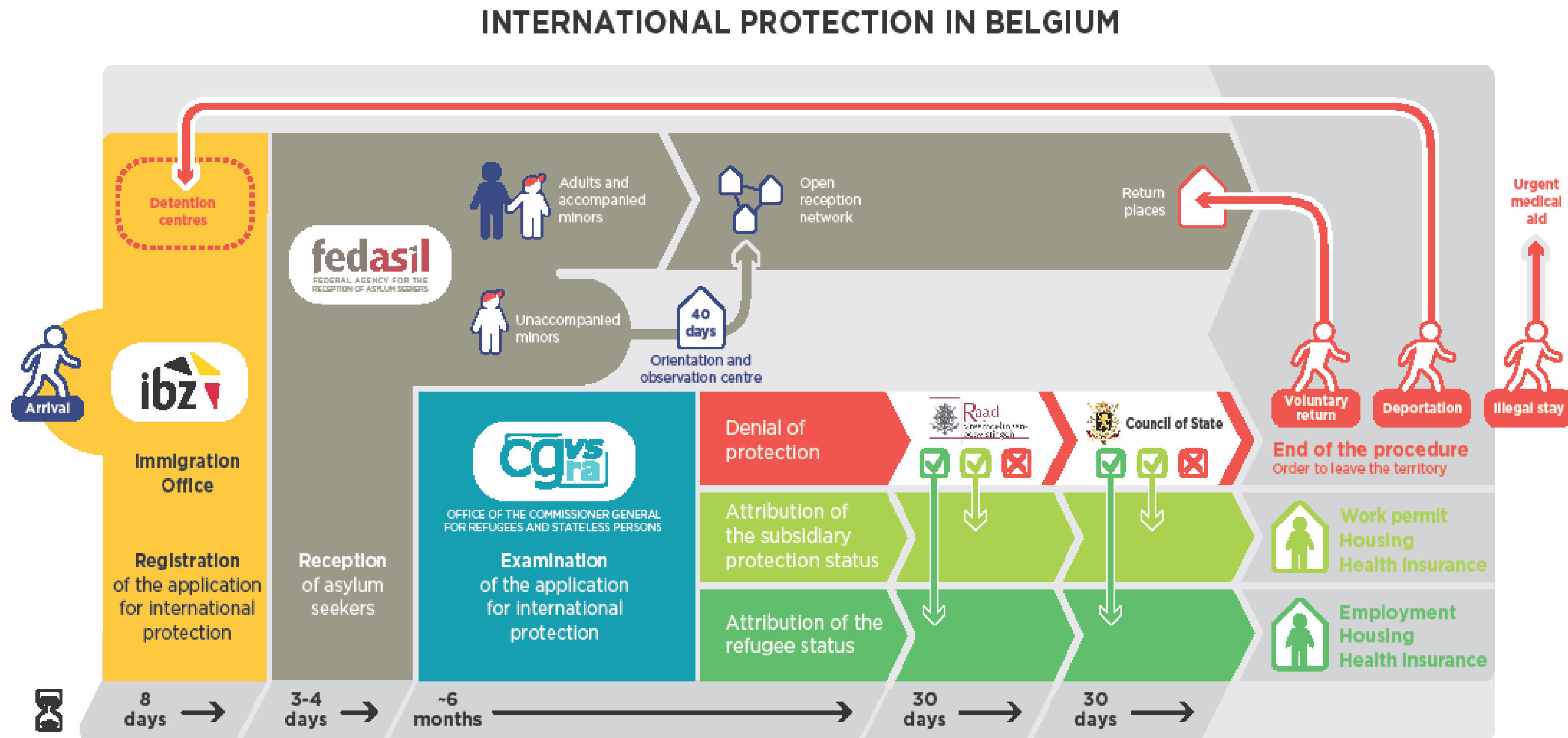
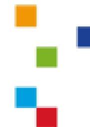


Figure 3 – Simplified overview of the procedure for international protection in Belgium[j]



j Figure 3 includes elements of the figure on asylum procedure developed by Cultures et Santé. See the original graph and the related tool here: https://www.cultures-sante.be/nos-outils/outils-education-permanente/item/431-la-procedure-d-asile-en-belgique.html

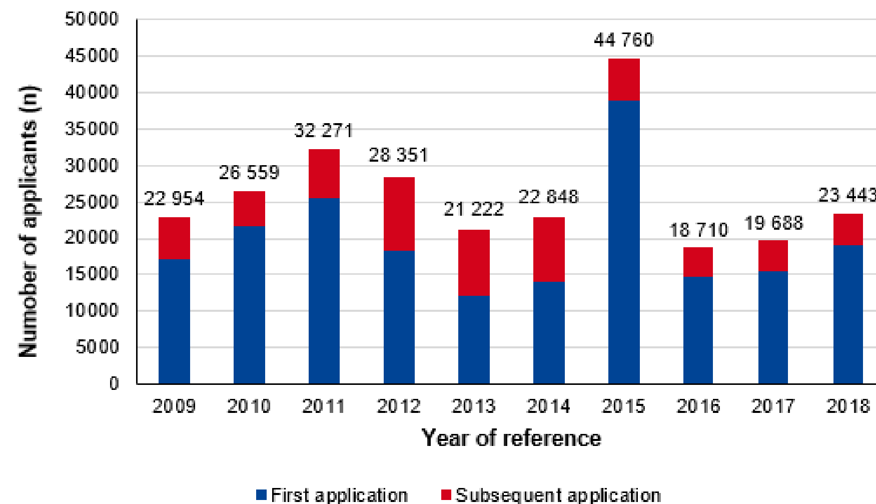


4.1.2 *Number of asylum seekers in Belgium*

Figure 4 shows the yearly evolution of applications for international protection between 2009 and 2018. According to the Office of the Commissioner General for Refugees and Stateless Persons (CGRS), 23 443 persons applied for international protection in Belgium in 2018.[24] Among them, 19 038 persons were first-time applicants while 4 405 applications were subsequent applications.[24] In other words, 1/5 is a subsequent application (18.8% of the applications).

In 2018, 1 239 unaccompanied minors* applied for protection.[k] In addition, 3 434 persons applied for international protection based on the 9bis procedure and 1 450 persons based on the 9ter procedure.[25]

Figure 4 – Evolution of the number of applicants for international protection in Belgium, 2009 - 2018



Source: Adapted from CGRS, 2019

Table 1 presents the number of final decisions taken by the CGRS in 2018. According to the CGRS, the protection rate in 2018 was 49.1% (compared to 50.7% in 2017): refugee status was granted to 8 706 persons while 1 777 persons were granted a subsidiary protection status.[26] Half of the applicants for 9bis and 9ter received a protection status: 1 443 persons in the 9bis procedure and 410 persons in the 9ter procedure.[27]

[k] When an unaccompanied minor is signalled, the Guardianship Service of the FPS Justice may require a verification of the age of the applicant. These numbers included all persons applying for asylum and declaring themselves as minor at the time of the application. For more detailed explanation, see the full report of the Immigration Office.

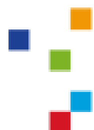


Table 1 – Final decisions of the Office of the Commissioner General for Refugees and Stateless Persons by person and by file for the year 2018

Decisions	Persons (number)	Percentage (%)	Files (number)[l]	Percentage (%)
• Refugee status	8 706	43.3	6 144	39.1
• Subsidiary protection status	1 777	8.8	1 433	9.1
• Refusal because application is judged as inadmissible (*onontvankelijk – irrecevable*)	3 466	17.3	**2 961**	18.9
• Refusal because application is apparently unjustified (*ongegrond – infondée)*	695	3.5	515	3.3
• Refusal after exam of the application	5 156	25.7	4 382	27.9
• Withdrawal of the refugee status and/or subsidiary protection status	280	1.4	265	1.7
Total	**20 080**	**100%**	**15 700**	**100%**

Source: Adapted from CGRS 2019, page 6.

In 2018, Syria, Palestine and Afghanistan were the 3 main countries of origin for first time applicants while Afghanistan, Iraq and Albania were the 3 main countries of origin for the subsequent applicants.[24] It should be noted that Albania is considered a safe country since 2017[28]. By leaving out Albania, Syrians occupied the third rank for subsequent applications.[24] Among unaccompanied minors, 404 came from Afghanistan, 210 from Guinea and 131 from Eritrea.[m] [25, 29]

4.1.3 Material assistance during the procedure for international protection

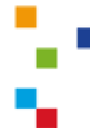
Once registered at the Immigration Office and as long as the procedure is pending, asylum seekers have right to material assistance according to the 2007 Reception Law.[1, 30] Fedasil has the mandate to ensure material assistance - including health care - for asylum seekers in Belgium, except for those residing in local reception initiatives* (ILA – LOI). For those living in ILA – LOI, material assistance is managed by the CPAS – OCMW according to the article 25 of the 2007 Reception Law.

The 2007 Reception Law

The 2007 Reception Law and the related Royal Decree stipulate the conditions for reception of asylum seekers and other categories of foreigners (unaccompanied minors and minors with an illegal permit of stay accompanied by their parents if the parents cannot assume their duties as parents). Asylum seekers are entitled to material assistance (art. 2, 6°, art. 6 and 7 Reception Law) including a.o. housing, health care, legal support, social support, psychological support, pocket money, and professional training (this latter depends on the resources of the reception facilities). Lastly, the 2007 Reception Law also defines the role and mission of Fedasil and the transition process between collective reception centres and local reception initiatives**.**

[l] One file can relate to several persons (e.g. a family).

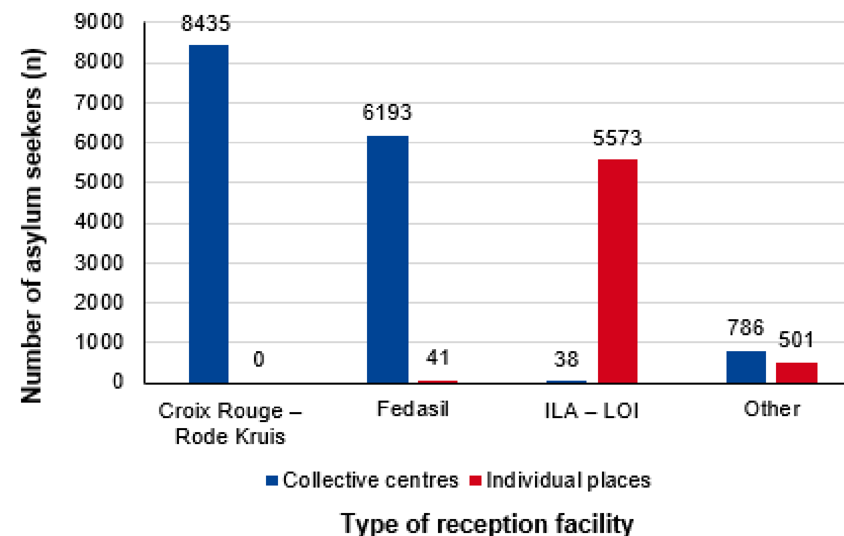
[m] Data included unaccompanied minors aged of 18 and more after the results of the age tests.



Asylum seekers residing in collective reception centres and code 207 “No show” are governed by Fedasil. Material assistance could be delivered by partners such as the *Croix Rouge de Belgique / Rode Kruis Vlaanderen*, based on a convention established by Fedasil (article 62 of the Reception Law) For asylum seekers residing in ILA – LOI, an informal agreement was set in 2002 between Fedasil and the CPAS – OCMW that the latter would be responsible for the management of health care for asylum seekers in ILA – LOI (see article 64 of the Reception Law). Allocation to a collective reception centre or an ILA – LOI depends on family situation, health status, knowledge of local languages, language of application of international protection, and belonging to a vulnerable group such as unaccompanied minors.

In February 2019, 15 452 persons were hosted in a collective reception centre and 6 115 persons in an individual reception facility (Figure 5). Furthermore, 444 persons received a code 207 “No show” at the Fedasil dispatching (among these, 211 received a code 207 “No show” because of a subsequent application). Table 2 presents the details of the different forms of reception, including their target group.

Figure 5 – Repartition of asylum seekers per type of reception facility in February 2019 (n= 21 567) [n]



[n] “Other category” for ILA – LOI includes organisations such as Caritas (n=200), Ciré (n=166), Stad Gent (n=85) and Mentor Escale (n=50). Other partners for the collective reception centres are: Samu Social (n=299), *Agentschap Jongerenwelzijn* – AJW (n=145), *Administration Générale de l’Aide à la Jeunesse* – AGAJ (n=104), *Mutualités Socialistes* (n=47), Synergie 14 (n=10), Sam (n=4) and *Oranje Huis* (n=3). Date of reference : January 2019

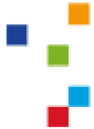


Table 2 – Type of facility, target group, number of centres and capacity of the different forms of reception of asylum seekers in Belgium

	Place of residence of asylum seekers					
	Reception network*					Outside reception network
Type of facility	Arrival centre	Fedasil centres – including Orientation and Observation Centres (OCC) for unaccompanied minors	Partner centres	ILA – LOI by NGO	ILA – LOI by CPAS – OCMW	Private housing Code 207 “No show”
Target groups	All asylum seekers	All asylum seekers OOC: unaccompanied minors Priority to those with medical needs	All asylum seekers	Priority to some vulnerable groups (e.g. “high care” or single women with or without children)	Priority to those with high protection rates	Asylum seekers with friends and/or relatives in Belgium
Number of centres[o]	1	18 Including 4 OOC	Croix-Rouge de Belgique: 20 Rode Kruis Vlaanderen: 15 Others: 9	3	457	n/a
Capacity[p]	813	5380 including 130 places in OOC	Croix-Rouge de Belgique: 5828 Rode Kruis Vlaanderen: 2607 Others: 825	Caritas: 200 CIRÉ: 166 Others: 176	5573[q]	444[r]

o On January 15, 2019.[31]

p On February 2019

q The opening of ILA –LOI in CPAS – OCMW are let at the discretion of the municipalities as the Royal Decree of 17 May 2016 establishing the criteria for a harmonious repartition between municipalities of reception places for asylum seekers in execution of the article 57ter of the organic law of social aid of 8 July 1976 is not yet in execution[32].

r Number of persons having received a code 207 “No show” designation at the Fedasil dispatching in February 2019. Among these 444 persons, 211 persons were subsequent applicants.

Collective reception centres are “open”: asylum seekers are free to leave the centre whenever they want. They are provided with housing, food, sanitary installations and clothing. Families are hosted in a separate room while single persons usually share a dormitory. Asylum seekers have to take care of their own laundry, cleaning of their rooms and participate to community services (maintenance of shared spaces, meal distribution, or support of various activities).

ILA – LOI are mostly private furnished houses, adapted to the household composition. Asylum seekers have the autonomy to organise daily activities and benefit from support of the local CPAS – OCMW.

During the whole asylum procedure, children, including unaccompanied minors, should attend school: “welcome classes” are organised to prepare them for the Belgian educational system by learning French or Dutch. Once finished, they enter the regular educational system, based on their educational level.[s]

Asylum seekers are not allowed to work during the first 4 months of the asylum procedure but may attend training, inside or outside the centres such as language courses or ICT training. After these first 4 months, the asylum seekers are allowed to work and keep their right to reception and material assistance. However, they can be asked to contribute financially if they stay in a centre.[33] Similarly the CPAS – OCMW may adapt support depending on the income. In practice, only a minority of asylum seekers work during the asylum procedure due to various reasons. Sociocultural activities are regularly organised, often with the support of volunteers, with the aim to integrate the reception facilities in their neighbourhoods.

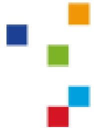
If, during the procedure, asylum seekers want to change their place of stay[t], they need to address this request to the Dispatching of Fedasil. If no transfer is possible, asylum seekers may leave the reception centre and find their own place of residence. They will then be considered as code 207 “No show”.

Key points

- In 2018, 23 443 persons applied for asylum in Belgium, mostly originating from Syria, Afghanistan and Iraq.
- Material assistance is granted to the asylum seekers once they formally applied for international protection.
- Fedasil is legally in charge of the reception for asylum seekers, including health care, during the whole procedure (except for asylum seekers residing in ILA – LOI).
- The majority of asylum seekers is hosted in collective reception centres.

[s] All children on the Belgian territory, whatever their legal status, are submitted to the compulsory school attendance (see the article 24 of the Belgian Constitution).

[t] Asylum seekers may ask to go to another collective centre or to an ILA – LOI: to access an ILA – LOI, the asylum seekers must have stayed at least 4 months in a collective centre (the length could be shorter if the asylum seeker has a high protection rate, that is the highest likelihood of being acknowledged as refugee as it was the case for the Syrians).



4.2 Health problems, health care utilisation and costs among asylum seekers

4.2.1 Health problems

Asylum seekers perceive their own health status as lower compared to the rest of the population but also do have a lower health status than the population of the host country.[34-39] The 2018 report of the regional office for Europe of the World Health Organisation (WHO Europe) identified the following areas of concern regarding health of asylum seekers[40]:

- communicable diseases: vaccine-preventable diseases, tuberculosis, HIV, hepatitis B and C viral infections;
- non-communicable diseases: type 2 diabetes mellitus, cardiovascular diseases (i.e. stroke and ischaemic heart disease), and cancer (especially cervical cancer);
- mental health, including post-traumatic stress disorders, depression, and anxiety;
- maternal health;
- sexual and reproductive health, with attention to previous sexual violence;
- child and adolescent health.

Numerous pre/post migration factors are likely to impact the health status of asylum seekers such as precarious living conditions in the country of origin, torture and violence, refugee trauma, detention, length of the procedures, language and cultural barriers or lack of knowledge about the host country.[40, 41] The conditions of reception could also contribute negatively to asylum seekers' health, but also to the health expenditures.[42] Should a selection bias occur in the country of origin – the so-called *healthy immigrant effect*[u] – the relative health advantage that may pre-exist tends to decrease over time.[43-45] These factors – directly related to the asylum seeker's experience - lead to specific health needs that should be taken into account while providing health care.[40]

Currently, there is no centralised database collecting information on health problems and health care utilisation among asylum seekers in Belgium. Data are collected on a local basis, not all asylum seekers have a digital health record and they are not included in the national or regional health interview surveys. Moreover, not all scientific studies clearly distinguish asylum seekers from other categories of migrants, preventing a full epidemiological profile of asylum seekers in Belgium (see Appendix 3.2).

4.2.2 Health care utilisation and costs

Data related to health care utilisation and costs for asylum seekers cannot be extracted from one centralised database. The database of sickness funds (IMA – AIM); the database containing hospital data (MZG – RHM), and the Finhosta system currently do not have data on health care utilisation and costs for asylum seekers.

Depending upon the place of stay, Fedasil or the PPS Social Integration (or the CPAS – OCMW for health care costs that are not covered by NIHDI nomenclature) are competent for the coverage of health care services for asylum seekers (see Appendix 4). However, the few available data do not allow to give a full overview of health care utilisation and costs among asylum seekers in Belgium.

Key points

- There is currently a lack of accurate data to draw a full overview of the health profiles, health care utilisation, health care costs and consumption of asylum seekers in Belgium.

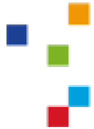
[u] The healthy immigrant effect postulates that immigrants are healthier than comparable populations in host countries: this could be explained by a "positive self-selection" at the departure, the "survival of the fittest", acculturation patterns and immigration policies of the host countries[43-45].

4.3 Current organisation and access to health care for asylum seekers

4.3.1 Legal framework

In Belgium, health care for asylum seekers is regulated by articles 23-25 and 30 of the 2007 Reception Law.[30] The Royal Decree of 19 April 2007 defines a **Plus list** (medical acts not/partially reimbursed by the NIHDI nomenclature, but fully reimbursed to asylum seekers because they are considered necessary) and a **Minus list** (medical acts of the NIHDI nomenclature not allowed for asylum seekers because they are considered not necessary) (Table 3).

Extract of the 2007 Reception Law (French version)	Extract of the 2007 Reception Law (Dutch version)
Art. 23. Le bénéficiaire de l'accueil a droit à l'accompagnement médical nécessaire pour mener une vie conforme à la dignité humaine.	Art. 23. De begunstigde van de opvang heeft recht op de medische begeleiding die noodzakelijk is om een leven te kunnen leiden dat beantwoordt aan de menselijke waardigheid.
Art. 24. Par accompagnement médical, on entend l'aide et les soins médicaux, que ceux-ci soient repris dans la nomenclature telle que prévue à l'article 35 de la loi relative à l'assurance obligatoire soins de santé et indemnités coordonnée le 14 juillet 1994 ou qu'ils relèvent de la vie quotidienne.	Art. 24. Onder medische begeleiding worden de medische hulpverlening en verzorging verstaan, ongeacht of zij opgenomen zijn in de nomenclatuur zoals voorzien in artikel 35 van de gecoördineerde wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen van 14 juli 1994, of tot het dagelijkse leven behoren.
Le Roi détermine, par arrêté délibéré en Conseil des Ministres, d'une part, l'aide et les soins médicaux qui, bien que repris dans la nomenclature précitée, ne sont pas assurés au bénéficiaire de l'accueil en ce qu'ils apparaissent comme manifestement non nécessaires, et d'autre part, l'aide et les soins médicaux relevant de la vie quotidienne et qui bien que non repris dans la nomenclature précitée sont assurés au bénéficiaire de l'accueil.	De Koning bepaalt, bij een besluit vastgesteld na overleg in de Ministerraad, enerzijds de medische hulp en verzorging die in genoemde nomenclatuur opgenomen zijn, maar niet aan de begunstigde van de opvang verzekerd worden omdat zij manifest niet noodzakelijk blijken te zijn, en anderzijds, de medische hulp en verzorging die tot het dagelijkse leven behoren en, hoewel niet opgenomen in genoemde nomenclatuur, wel verzekerd worden aan de begunstigde van de opvang.
Art. 25. § 1er. L'Agence est compétente pour assurer l'accompagnement médical visé à l'article 23 au profit du bénéficiaire de l'accueil, et ce quelle que soit la structure d'accueil dans lequel il est accueilli, à l'exception de celle gérée par le partenaire visé à l'article 64.	Art. 25. § 1. Het Agentschap is bevoegd om de medische begeleiding, zoals bedoeld in artikel 23, te verzekeren ten behoeve van de begunstigde van de opvang en dit ongeacht de opvangstructuur waarin hij wordt opgevangen, met uitzondering van de opvangstructuur beheerd door de partner zoals bedoeld in artikel 64.
§ 2. A cette fin, chaque structure d'accueil garantit au bénéficiaire de l'accueil l'accès effectif à un accompagnement médical.	§ 2. Met het oog hierop waarborgt elke opvangstructuur aan de begunstigde van de opvang de effectieve toegang tot een medische begeleiding.
§ 3. Cet accompagnement est délivré sous la responsabilité d'un médecin qui conserve son indépendance professionnelle envers le directeur ou le responsable de ladite structure.	§ 3. Deze medische begeleiding wordt verleend onder de verantwoordelijkheid van een arts die zijn professionele onafhankelijkheid ten aanzien van de directeur of de verantwoordelijke van de betreffende structuur behoudt.



§ 4. Le demandeur d'asile qui ne réside pas dans la structure d'accueil qui lui a été désignée comme lieu obligatoire d'inscription peut bénéficier d'un accompagnement médical assuré par l'Agence.	§ 4. De asielzoeker die niet verblijft in de opvangstructuur die hem aangewezen werd als verplichte plaats van inschrijving, kan een medische begeleiding krijgen die wordt verzekerd door het Agentschap.
§ 5. Le bénéficiaire de l'accueil peut introduire auprès de l'Agence un recours contre une décision du médecin de la structure d'accueil relative à l'octroi d'un accompagnement médical qui n'est pas considéré comme étant nécessaire pour mener une vie conforme à la dignité humaine, conformément à l'article 47.	§ 5. De begunstigde van de opvang kan bij het Agentschap een beroep indienen overeenkomstig artikel 47 tegen een beslissing van de arts van de opvangstructuur met betrekking tot het verstrekken van medische begeleiding die niet wordt beschouwd als vereist om een leven te kunnen leiden dat beantwoordt aan de menselijke waardigheid.
Art. 30. L'accompagnement psychologique nécessaire est assuré au bénéficiaire de l'accueil.	Art. 30. De noodzakelijke psychologische begeleiding wordt aan de begunstigde van de opvang verzekerd.

Table 6 presents an overview of the current situation of health care organisation for asylum seekers, later described in the following sections. It identifies the different institutions involved in the process of delivering health care to asylum seekers, as well as the different procedures, based on the reception facility. It does not aim to describe all possible collaborations that may exist at the local level.

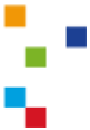


Figure 6 – Current situation of health care organisation for asylum seekers in Belgium

HEALTH CARE ORGANISATION FOR ASYLUM SEEKERS

Federale Overheidsdienst Justitie
Service public fédéral Justice
Guardianship Service
RIZIV INAMI
Health insurance

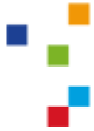
ARRIVAL CENTRE
fedasil
ibz
IMMIGRATION OFFICE
Registration of the application for international protection
1st assessment of the vulnerability
Vaccinations
TBC screening
Hospital
Immediate hospitalization if positive to TBC / if serious and urgent health problem
DISPATCHING OF FEDASIL
Medical and psychological intake
2nd assessment of the vulnerability
Info Point
ATTRIBUTION OF THE CODE 207
Mandatory place of residence

Unaccompagned minors
COLLECTIVE RECEPTION CENTRE
Pharmacy
Care
primary health care
Medical beds
Payment guarantee
Psy
ONE/K&G
Hospital
secondary care
Request for exceptional benefit

CODE 207 NO SHOW
fedasil MEDICAL CELL
Payment guarantee
Care
Hospital
Psy
Pharma

LOCAL RECEPTION INITIATIVE - NGO
Request for exceptional benefit
Medical beds
Payment guarantee
Care
Hospital
Psy
Pharma

LOCAL RECEPTION INITIATIVE - MUNICIPAL
Maatschappelijke Integratie / Intégration Sociale
LOCAL WELFARE CENTRE
Payment guarantee
GP
Payment guarantee
Care
Hospital
Psy
Pharma



4.3.1.1 Organisation of health care for asylum seekers: how does it work?

Since December 2018, asylum seekers should register at Petit-Château – Klein Kasteeltje, the unique and central arrival centre in Brussels, managed by the Immigration Office and Fedasil. After applying for international protection and before being oriented to their reception place, all asylum seekers undergo a medical intake: screening for tuberculosis, check of the immunization status and other medical issues (see Appendix 5 for details). They are also systematically seen by a social worker for administrative and social procedures. The social worker informs asylum seekers about their rights and obligations, including access to health care and/or to legal aid. If necessary, asylum seekers can be assisted by an interpreter.

Once registered, unaccompanied minors are oriented by the Dispatching of Fedasil to an Orientation and Observation Centre (OOC), managed by Fedasil. Each unaccompanied minor is provided with a guardian designated by the Guardianship service of the FPS Justice. During their stay in OOC, unaccompanied minors undergo a first social, psychological, and medical screening to identify potential vulnerabilities. This screening helps the dispatching of Fedasil to orient the unaccompanied minor to the most appropriate reception facility. They also have to await the confirmation of their minority if the Immigration Office has doubts about it: this verification is done by the Guardianship service. If acknowledged as minor, they are oriented to a collective reception centre in which they are hosted in specific departments consisting of a dedicated team of educators.

4.3.1.2 Residents of collective reception centres

The Royal Decree of 2007 determines the health care coverage for asylum seekers – as defined in the article 24 of the 2007 Reception Law.[46] Coverage includes the NIHDI nomenclature, with the exception of acts of the Minus list (such as the aesthetic surgery and some prostheses) and with the inclusion of the acts of the Plus list (such as class D medications and some prostheses).[47]

Table 3 presents the details of the Plus and Minus lists. This applies for all asylum seekers in collective reception centres and those with a code 207 “No show”. Asylum seekers are not required to pay co-payment. Rules for the financial intervention of Fedasil are detailed in a vademecum, including clinical conditions to get access to the acts, products or services.[47] Fedasil develops its own reimbursement rules based on consulting the “Nomensoft” software of the NIHDI. They rely on the Fedasil handbook for the Plus and Minus lists.[47] This also applies for those with a code 207 “No show” (see 4.3.2.3) and those living in an ILA – LOI not managed by a CPAS – OCMW (see 4.3.2.4).

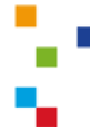


Table 3 – Content of the Minus and Plus lists as defined by the Royal Decree of 2007

Minus list[v]	Plus list
• Orthodontia • Diagnosis and treatment of infertility • Dental prosthesis in absence of mastication problems, whatever the age of the asylum seekers • Purely aesthetic surgeries, except for reconstruction after a surgery or a trauma • Dental care and dental extractions under general anaesthesia	• Class D medications (not A, B, C, Cs, Cx) requiring a medical prescription[w] • Class D medications (not A, B, C, Cs, Cx) on free delivery[x] in the following categories: Antacids, spasmolytic, antiemetic, antidiarrheal, analgesic, antipyretic (paracetamol, salicylic acid, ibuprofen 400 mg, sodium naproxen 220 mg) and medications for oral and pharyngeal affections • Dental extractions • Dental prostheses, only to restore mastication capacities • Glasses for children, prescribed by an ophthalmologist, at the exception of bi or multifocal glasses and tainted glasses, • Glasses for adults, in case of a refraction index of at least 1D at the best eye, prescribed by an ophthalmologist, at the exception of bi or multifocal glasses and tainted glasses, • Powder milk for infants when breastfeeding is impossible

In collective reception centres, primary care provision is organised and coordinated by the medical service of the centre, usually managed by salaried nurses. External generalist practitioners and psychologists consult within the centres during weekdays. Generalist practitioners (GPs) are paid on a fee-for-service basis according to the NIHDI nomenclature.[y] A payment per session is offered for psychologists, with different tariffs depending on the type of session (group therapy or face-to-face therapy).[z] Asylum seekers may access health care outside the centre (i.e. speciality care or surgery) if deemed necessary by the centre medical service (i.e. clinical gatekeeping). In this case, a payment guarantee is issued by the medical or the social service of the reception centre. Fedasil then covers the costs, based on the pricing of the NIHDI nomenclature and the Plus List.

If the asylum seekers wish to consult other health care professionals than those attending the reception centres or bypass the clinical gatekeeping for health care outside the centre, fees have to be covered privately.

4.3.2.2 Asylum seekers with a code 207 "No show"

Asylum seekers with a code 207 "No show" can choose their health care professionals or services. Before accessing care, they should own a payment guarantee from the medical cell of Fedasil, whether it concerns primary or specialty care. Invoices related to health care are directly paid by Fedasil to the health care professionals or services based on the payment guarantee. In case of exceptional costs, the medical cell may request a medical report and/or a cost estimate before authorising, e.g. for an expensive surgery.[48] Asylum seekers with a code 207 "No show" have no

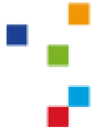
[v] Appendices 1 and 2 of the Royal Decree of April, 9 2007 determining aid and medical care obviously unnecessary which are not guaranteed to the beneficiary of reception and assistance and the medical care in everyday life that are guaranteed to the beneficiary of reception.

[w] Under the following conditions: registered as medications in Belgium, prescribed by a physician with a license to practice in Belgium, with a prescription of the name of matter, taking into account the recommendations for the reimbursement of preference and at the exception of treatments against impotence

[x] Under the following conditions: registered as medications in Belgium and reimbursed on the basis of the price of the cheapest product on the market

[y] Fedasil previously had contracted GPs.

[z] See the *vademecum* of Fedasil for details.



right to health care via the CPAS – OCMW as stated by the article 57ter of the Organic Law of the CPAS – OCMW.[49]

4.3.1.3 Asylum seekers residing in a ILA – LOI not managed by a CPAS – OCMW

Depending on the reception partner, primary health care could be directly provided in the ILA – LOI, i.e. nursing care for those in medical beds. An integrated accompaniment is often provided, with a medical and social record.[50] Asylum seekers could be allowed to choose their GP/specialist or may have to consult with contracted partners. The coverage is similar to those in collective reception centres: NIHDI nomenclature and the Plus list.[51] Invoices are transferred and paid by the medical cell of Fedasil.

In case of emergency or if the asylum seeker has no payment guarantee, the attending physician should add a medical certificate confirming the urgent character of medical encounter to the invoice.[51] If not acknowledged as urgent, asylum seekers have to cover all fees personally.

Control mechanism for collective reception centres, code 207 "No show" and ILA – LOI managed by NGO

A common control mechanism exists for those in collective reception centres, those with a code 207 "No show" and for those in ILA – LOI managed by NGO. Control is managed a priori by the medical cell of Fedasil based on the notion of "necessity" as described in the article 23 of the 2007 Reception Law. Health care professionals in the reception centre should appreciate the necessity and ask for approval by the medical cell of Fedasil.

This a priori and ad hoc control is mostly done for expensive health care costs but, according to the medical cell of Fedasil, this prior approval of the medical cell is necessary but not compulsory. No a posteriori control is done.

4.3.1.4 Asylum seekers residing in a ILA – LOI managed by CPAS – OCMW

The existing rules of the PPS Social Integration are applied to the asylum seekers regarding access to health care: compulsory social inquiry and similar administrative procedures.[52] Based on the results of a social inquiry, the CPAS – OCMW provides asylum seekers with a payment guarantee for health care.[53] Health care professionals or services send their invoices to the CPAS – OCMW together with the payment guarantee. The CPAS – OCMW then reimburses fees, at the same tariff as the sickness funds. Co-payment is not required for asylum seekers. In a second stage, the CPAS – OCWM transfers the invoices to the PPS Social Integration to be reimbursed for the acts included in the NIHDI nomenclature. The PPS Social Integration pay the part that is normally paid by the sickness funds (and the co-payment, if all conditions are fulfilled according to the social inquiry).

Since 2014, the notification of coverage by the CPAS – OCMW is done electronically for hospital care by means of the computerized data transfer system called MediPrima (see Appendix 5.4). MediPrima connects the CPAS – OCMW, hospitals, the Agency for Health and Disability Insurance[aa] (CAAMI – HZIV), and the PPS Social Integration. Within MediPrima[bb] invoices covered by the CPAS – OCMW are paid directly by the CAAMI – HZIV[cc] to the health care providers. The CAAMI – HZIV provides a monthly feedback to PPS Social Integration and gets reimbursed.

Depending on the CPAS – OCMW, asylum seekers have to consult with a specific health care professional or service, may choose from a provided list, or are entirely free in their choice.

Regarding coverage, asylum seekers in ILA – LOI have access to the entire NIHDI nomenclature.[51] The CPAS – OCMW do not apply the concept of a Plus and Minus lists. Each CPAS – OCMW can decide to cover medical care

[aa] The Agency for health and disability insurance acts as a sickness funds for those not willing/not being able to register with a "regular" sickness funds.

[bb] To know more about the MediPrima system: http://www.mi-is.be/be-fr/e-government-et-applications-web/mediprima

[cc] See more here: http://www.caami-hziv.fgov.be/Model4-10-F.htm

or medication which is not regularly reimbursed according to the NIHDI nomenclature (e.g. drugs from the D category, tooth extractions, powdered milk for babies, etc.) through the lump sum allocated by Fedasil[dd] or by using its own funds.

The financial responsibility is borne by the CPAS – OCMW that has granted the payment guarantee. *A posteriori* control visits and random assessments can be organised by the PPS Social Integration.[50] In case of errors, the corresponding costs and potential penalties have to be covered by the CPAS – OCMW. No penalty will be given to the asylum seekers or the health care providers. Within MediPrima, the control of the invoices submitted by the health providers is under the responsibility of the CAAMI – HZIV (electronic billing via MyCareNet if the error rate is ≤ 5%).

4.3.2.3 9ter with a pending application for international protection

As long as the application for international protection is pending and the 9ter application is under scrutiny for the form at the Immigration Office (i.e. admissibility of the application), asylum seekers have the right to material assistance provided by Fedasil, a reception partner or the CPAS – OCMW, depending on their 207 code.

If the application on article 9ter is deemed admissible, asylum seekers receive a temporary permit of stay and have right to social aid (i.e. financial aid) through the CPAS – OCMW. If the medical condition or degree of autonomy allows it, asylum seekers can be asked to leave the reception network: Fedasil supresses their code 207 related to their compulsory place of residence and thereby their right to material assistance.[54] For those needing medical attention and specific services, they will have to find a place in a health care institution (e.g. nursing home) outside the reception network.[55]

If the application on article 9ter is inadmissible and no decision regarding the application for international protection has been taken yet, the right to material assistance persists until the final decision of the asylum application. If international protection is granted, the 9ter application is automatically suspended.

4.3.2 Summary of the key organisational elements

Table 4 presents a comparative overview of the different forms of gatekeeping and access to health care for asylum seekers, depending on their place of residence. Apart from asylum seekers in the arrival centres, all asylum seekers are subjected to a form of administrative gatekeeping (payment guarantee). In collective centres, asylum seekers experience administrative gatekeeping when health care is needed outside the centres. For those in ILA – LOI and Code 207 “No show”, they need a payment guarantee as soon as they need health care.

Similarly a nursing triage is organised in collective receptions centres to access primary and/or specialty care. Asylum seekers in ILA – LOI experience a medical gatekeeping, by a GP, when needing speciality care or psychological care. Asylum seekers with a code 207 “No show” are not limited by a medical gatekeeping. In Fedasil centres, access to psychological care is managed by the psychosocial coordinator while partner centres usually rely on a GP triage for psychological care.

Health care is provided as much as possible inside the collective centres. Some reception centres and ILA – LOI have medical beds for those needing constant attention of health care professionals.

Access to interpreters vary depending the reception facility: in the arrival centre, interpreters are available at the social service. In all reception centres, access to remote intercultural mediation and interpreting is available. Outside the reception centres, asylum seekers can benefit from free interpreting service/intercultural mediation if they are sent to a hospital having in-house interpreters/mediators.

[dd] Fedasil attributes a lump sum to the CPAS – OCMW to cover the expenses of asylum seekers in ILA – LOI (all expenses, not only for medical care).[52]

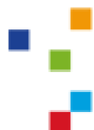


Table 4 – Forms of gatekeeping and access to health care for asylum seekers by place of residence

	Place of residence of asylum seekers					
Type of facility	Arrival centre	Fedasil centres	Partner centres	ILA – LOI by NGO	ILA – LOI by CPAS – OCMW	Code 207 “No show”
Place of delivery of primary care	Inside the centre	Inside the centre	Inside the centre	Inside the ILA – LOI for asylum seekers in medical beds Regular health care system for other asylum seekers	Regular health care system	Regular health care system
Administrative gatekeeping	None	Payment guarantee from the reception centre for health care provided outside the centre	Payment guarantee from the reception centre for health care provided outside the centre	Payment guarantee from the NGO	Payment guarantee from the CPAS – OCMW	Payment guarantee from the Medical Cell of Fedasil
Clinical gatekeeping primary care	Nursing triage	Nursing triage	Nursing triage	Informal triage	Informal triage	none
Clinical gatekeeping specialty care	Nursing triage	Nursing triage	Nursing triage	Informal triage	GP triage	none
Access to mental health care[ee]	Only in case of emergency	Triage by a psychosocial coordinator	GP triage	Informal triage	GP triage	Informal triage
Content of the coverage	Screening for TBC, immunisation and medical intake	NIHDI nomenclature Plus & Minus lists*	NIHDI nomenclature Plus & Minus lists*	NIHDI nomenclature Plus & Minus lists	NIHDI nomenclature No official Plus & Minus : reimbursement let at the discretion of the CPAS – OCMW	NIHDI nomenclature Plus & Minus lists*
Freedom of choice for asylum seekers	None	None	None	None/possible	Possible	Possible
Access to interpreters	No interpreter[ff]	All centres are equipped with the videoconference application, making intercultural mediation available	All centres are equipped with the videoconference application, making intercultural mediation available	Free if asylum seeker is sent to a health care facility with intercultural mediator[gg]	Free if asylum seeker is sent to a health care facility with intercultural mediator	Free if asylum seeker is sent to a health care facility with intercultural mediator

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[ee] The CARDA is a reception centre managed by the *Croix-Rouge de Belgique*, specifically tailored to care for 40 asylum seekers with severe mental health disorders.

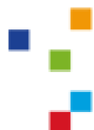
[ff] Interpreters are available for the social service and legal aid.

[gg] Intercultural mediators are available in general and psychiatric hospitals and in some primary care services; either in face-to-face encounters, either through videoconference. All costs are supported by the FPS Public Health. Asylum seekers have access to other services of interpreters but may have to pay for it (Personal communication with I. Coune, Intercultural Mediation Cell and Policy Support Unit, FPS Public Health).

In Table 5, a comparative overview of the distribution of funding, the billing mechanisms and the payment of health care professionals is provided. The distribution of funding for health care is managed for Fedasil in all reception facilities, but the ILA – LOI of the CPAS – OCMW: funding of health care is distributed by the PPS Social Integration and additional budget could be delivered by the CPAS – OCMW on their own budget. For those depending on Fedasil, invoices are either aggregated at an intermediary, either directly sent to the medical cell of Fedasil. Co-payment is not applicable for asylum seekers. Unaccompanied minors are allowed to register to the national health and disability insurance (AMI – ZIV) after 3 months of school attendance or exempted of school attendance by an official body when living in a collective reception centres. They therefore should be registered to the AMI – ZIV before arriving to the ILA – LOI. Fedasil determines fixed fees for psychological care, applicable for all expenses of psychological care at the exception of the ILA – LOI managed by CPAS – OCMW. In this case, the CPAS – OCMW usually follows the existing rules of payment of psychologists.

Table 5 – Summary of the distribution of funding for health care, billing mechanism, payment of health care professionals for asylum seekers by place of residence

	Place of residence of asylum seekers					
Type of facility	Arrival centre	Fedasil centres –	Partner centres	ILA – LOI by NGO	ILA – LOI by CPAS – OCMW	Code 207 “No show”
Distribution of funding for health care	Fedasil	Fedasil	Fedasil	Fedasil	PPS Social Integration Plus lists: CPAS – OCMW on its own budget	Fedasil
Billing mechanism	n/a For health care provided outside the centre : direct billing to the central service of Fedasil	Direct billing to the central service of Fedasil	• Centralisation of invoices by the partner • Sent for reimbursement to Fedasil	*Depends on the NGO* • for health care provided inside the centre : Centralisation of invoices by the NGO • Asylum seeker may have to pay first before being reimbursed by the NGO • Direct billing to the NGO Reimbursement by Fedasil	Invoices sent to the CPAS – OCMW Reimbursement of the CPAS – OCMW by the PPS Social Integration if outside the MediPrima system Direct billing to the Agency for Health and Disability Insurance (CAAMI – HZIV) if the MediPrima system is used	Invoices directly sent to Fedasil



Co-payment	Not applicable	No co-payment	No co-payment	No co-payment	No co-payment	No co-payment
Insurability of unaccompanied minors	Not applicable	Allowed to Health and Disability Insurance (AMI – ZIV) after 3 months of school attendance or exempted of school attendance by an official body	Allowed to AMI – ZIV after 3 months of school attendance or exempted of school attendance by an official body	Should be registered to AMI – ZIV after 3 months of school attendance or exempted of school attendance by an official body	Should be registered to AMI – ZIV after 3 months of school attendance or exempted of school attendance by an official body	Should be registered to AMI – ZIV after 3 months of school attendance or exempted of school attendance by an official body
Payment of primary care professionals	Salaried staff of Fedasil	Nurses: salaried GP: per act	Nurses: salaried GP: per act	Similar as Belgian regular patients	Similar as Belgian regular patients	Similar as Belgian regular patients
Payment of mental health care professionals	n/a	Fixed fees determined by Fedasil for psychologists	Fixed fees determined by Fedasil for psychologists	Fixed fees determined by Fedasil for psychologists	Similar as Belgian regular patients	Fixed fees determined by Fedasil for psychologists
Payment of secondary care professionals	Similar as Belgian regular patients	Similar as Belgian regular patients	Similar as Belgian regular patients	Similar as Belgian regular patients	Similar as Belgian regular patients	Similar as Belgian regular patients

Key points

- Responsibilities regarding health care governance and organisation of health care are shared by different actors. This results in a variance of availability and (health) care coverage among asylum seekers.
- The situation of asylum seekers in local reception initiatives (ILA – LOI) varies per municipality as it depends on the policy of the local CPAS – OCMW which health care provisions from the Plus lists will be covered.
- Health care for asylum seekers is funded by different actors, according to different modalities.

5 DESCRIPTION OF THE PROBLEMS

As reported by stakeholders, current health care system for asylum seekers in Belgium is complex, resulting to inequitable access to health. These problems are situated at several levels: the overarching macro-level (i.e. governance and policy, see 5.1), the meso-level (i.e. organisation of institutions, professionals, and distribution of resources, see 5.2) and the micro-level (i.e. differences in treatment between asylum seekers, see 5.3). It is important to note that most of these problems result from the fragmentation of current (administrative) health care system for asylum seekers. In addition, some of these problems are intertwined and may be embedded in multiple levels, nevertheless, all these problems impact or evoke additional problems at other levels.

5.1 Problems at the macro-level

5.1.1 Lack of coordination

Stakeholders report poor coordination, a lack of communication and collaboration between the different actors in the health care for asylum seekers both at the federal and local levels. At the federal level, the stakeholders point out a lack of collaboration between Fedasil and the network of ILA – LOI. Non-Governmental Organisations (NGO) and non-profit organizations also reported the reluctance of some centres or municipalities to collaborate in health care projects.[hh] Stakeholders also highlighted the need for a better collaboration between health and social care, especially for vulnerable groups such as (unaccompanied) minors, in order to get a comprehensive approach of health care with attention to the non-medical determinants of health. While acknowledging the existence of a strong legal framework regarding access to health care, when compared to some other European countries, the MIPEX assessment confirms this lack of a global health policy for asylum seekers in Belgium and points out the deviations in the implementation of the legislation.[11, 16] Despite having regional immunization programs, Belgium could also better integrate specific attention to asylum seekers, especially children.[57]

5.1.2 Regional differences regarding health care for asylum seekers

Furthermore, stakeholders reported that the federated entities do not have the same philosophy of asylum seekers' health care, resulting in a wide variety in practices between regions or communities. Stakeholders explained that, in Flanders, the *Vlaamse Overheid* covers all the health care activities for asylum seekers under its competency while, in Wallonia, all issues concerning asylum seekers should be managed at federal level. Stakeholders stated this was particularly the case for immunisation and mental health services. These different health care philosophies were also perceived as having a negative impact on the continuity of care when the place of residence of the asylum seeker changes. Stakeholders added that this problem was even more outspoken for disabled persons or those in need of specific medical attention.

5.1.3 Lack of monitoring of health care use and health care costs

Stakeholders reported the lack of centralised data and indicators in Belgium, preventing a proper monitoring of health status and health care needs of asylum seekers, quality monitoring of health care, and costs. This is particularly the case for those with a code 207 "No show" and this contributes to the lack of congruence between the health needs and the current health offer. To date, different data collection systems are used, preventing the aggregation of data to obtain an overall picture and the development of an

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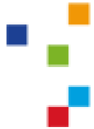
[hh] For example, professionals active in the field of Sexually Transmittable Infections (STI) prevention report difficulties in accessing reception centres: nurses of the centre cancel the appointment or spread inappropriate prevention messages.[56]



efficient control system for adequacy, quality and relevance of delivered health care for asylum seekers. This finding was supported by the Belgian literature.[16-18, 58] The Belgian Green Book of access to health care also stated the need for an in-depth analysis of the health care organisation inside reception centres.[10]

5.1.4 Lack of transparency about health care expenses

Stakeholders regretted that there is no detailed information available on the nature of the costs such as medications or consultations. As Fedasil mainly receives aggregated invoices from partners and lacks human resources to fulfil its different missions, there is no *a posteriori* control possible on the invoices sent by hospitals or health care professionals. Moreover, Fedasil cannot monitor how the partners or ILA – LOI use their budgets. The health care expenses of the CPAS – OCMW are included in the general budget of social aid and, up to now, no detailed data are available.

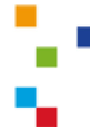
In some cases, stakeholders stated that there is a risk of double billing by health care professionals and, consequently, a double reimbursement of medical care. Several groups of asylum seekers[ii] are already entitled to the Belgian compulsory health insurance (and can, therefore, register with a sickness fund or the CAAMI – HZIV). Since the administrative systems of the sickness funds and reception structures (such as Fedasil and the ILA – LOI) are not linked to each other, double invoicing and reimbursement are possible (only with regard to the part of the invoices that are covered by the NIHDI).

In addition, given the separate health care systems in, for example Fedasil and ILA – LOI, data for the medical acts supplied to asylum seekers are currently not available for the NIHDI. Currently, there is also no identifier to identify asylum seekers in the health insurance. Taking these reasons together, at the moment, medical acts supplied to asylum seekers are not taken into account when drawing up the profiles of the health care professional groups or organisations. This lack of data results in an underestimation of the care provided by those health care organisations where an important part of activity is devoted to asylum seekers.

5.1.5 Lack of administrative support and of qualified personnel to manage administrative tasks

As reported by some stakeholders, Fedasil and the CPAS – OCMW act as parallel sickness funds but cannot rely on equivalent ICT, administrative tools and control mechanisms as the “real” sickness funds. According to stakeholders, both Fedasil and the CPAS – OCMW lack the following competences: control of the adequacy of the acts and fees requested by health care professionals and institutions, application and interpretation of the reimbursement rules and of the delivery of special acts, adaptation of the reimbursement levels based on the index or creation/adaptation of the nomenclature codes to cover the needs of asylum seekers. The medical cell of Fedasil has to take the role of an advisory physician of a sickness fund for the authorisation of delivery of special care (i.e. specific prescriptions, specific surgical interventions) and take decisions on a case-by-case basis. The administrative procedures of the medical cell are perceived as long and complex by health care professionals or social services supporting asylum seekers. The medical cell of Fedasil is currently understaffed to ensure its missions and nurses in reception centres lack administrative support.

[ii] The following groups of asylum seekers are entitled to the Belgian compulsory sickness insurance:
- unaccompanied minors who have completed at least three consecutive months of primary or secondary education;
- asylum seekers who legally work in Belgium, either salaried employment or self-employed;
- asylum seekers with a legal residence permit of more than three months in Belgium; and
- asylum seekers at the expense of a family member who may join a sickness fund.



5.2 Problems at the meso-level

The stakeholder consultations reveal shortcomings in the current practical organisation of health care for asylum seekers on the service level (i.e. meso-level). The current practical organisation of health care for asylum seekers is perceived by some stakeholders as negatively impacting the attractiveness for health care professionals to treat asylum seekers, both in- and outside the reception centres. However, these meso-level problems also have an influence on the health care provided to asylum seekers (i.e. micro-level). These micro-level problems are elaborated in the section 5.3.

5.2.1 *Unclear administrative system for health care professionals*

Stakeholders mentioned the difficulty for health care professionals to understand the current health care system for persons with a temporary residence status and the procedure to be followed to invoice medical acts. Health care professionals that work with different groups of persons with precarious residence status have to comply with different administrative procedures. Stakeholders gave the following example:

"A GP collaborating with different reception facilities will have to send invoices to the local Fedasil centre, the partner centre, the CPAS – OCMW and directly to the ILA – LOI, and thus corresponds with at least 4 different administrative entities to get paid. This GP may also receive unaccompanied minors covered by a sickness fund or asylum seekers with a code 207 "No show". If the GP wishes to send the patient for additional exams to the hospital, he or she will also have to follow different procedures for each reception facility. Moreover, this GP may be working with different CPAS – OCMW, making things even more complex, as these CPAS – OCMW may have different administrative processes."

Quote retrieved from interview with stakeholder

Stakeholders noted that, in some CPAS – OCMW, confusion occurs between asylum seekers covered by the 2007 Reception Law and undocumented migrants who are only entitled to Urgent Medical Aid as defined by the Royal Decree of 1996.[59] This confusion was previously shown in Belgian reports and by the International Organisation for Migrations.[11, 16, 19]

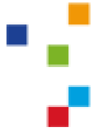
Some stakeholders also reported a lack of transparency on the decisions made by the medical cell of Fedasil for the health care coverage of asylum seekers, especially for those with a code 207 "No show". To benefit from health care inscribed in the Plus List, the asylum seeker may have to send a medical report or an estimate of the costs to the medical cell of Fedasil.[48] Some stakeholders regret that there is no information/explanation about the decisions made by the medical cell (negative or positive) and that there is almost no jurisprudence or official decision on this question.

At CPAS – OCMW level, the decisions of coverage for health care are taken by social workers and not by health care professionals: this is perceived as particularly problematic by some stakeholders as they do not have specific competences on health care.

5.2.2 *Differences in health care system depending on place of stay*

As reported by stakeholders, asylum seekers in reception centres benefit from the NIHDI nomenclature and the Plus list while the application of the Plus and Minus lists is let at the discretion of the social workers of the CPAS – OCMW for those in ILA – LOI. Asylum seekers have direct access to primary care delivered by nurses in reception centres while they first need a payment guarantee to access primary care while living in ILA – LOI (see Table 4).

Stakeholders stated that CPAS – OCMW get subsidies for the reception of asylum seekers (40€ per day/adult + surplus 55% of this amount for children with their parents). These subsidies serve for lodging and pocket money, but can in practice also be used to cover the costs that are not reimbursed by the PPS Social Integration. This sometimes implies that social workers, who decide if psychological care can be covered by the respective CPAS – OCMW, sometimes refuse this kind of care because there is no sufficient budget. Stakeholders also pointed out divergent practices regarding the coverage of health care fees related to inpatient services such as nursing homes, specialised centres for disabled persons or psychiatric centres.



Stakeholders also point out the different practices about the Plus and Minus lists between CPAS – OCMW as contributing to the complexity of the current system for asylum seekers. This complexity was previously reported and was investigated for undocumented migrants in Belgium in a previous KCE study. [11, 16, 19] In summary, there are differences between the collective centres and the ILA – LOI but also within the systems of ILA – LOI related to CPAS – OCMW.

5.2.3 Lack of health care professionals qualified to interact in health care for asylum seekers

Stakeholders identified a lack of mental health care professionals, interpreters and intercultural mediators. Stakeholders pointed out the lack of (child) psychologists or (child) psychiatrists with a specific training to take care of posttraumatic stress disorders or other mental health issues specifically related to asylum seekers. This is confirmed by the SH – CAPAC project, an European project which aims to identify barriers and solutions to access to health care for asylum seekers, including in Belgium[39]. Stakeholders therefore deplored the underuse of psychologists: stigmatisation of mental health issues among some groups of asylum seekers, fear of prejudices, lack of mental health literacy, poor availability of psychologists, etc. are among the reported barriers. Stakeholders also noted that the unequal distribution of asylum seekers on the territory prevents them to access appropriate mental health resources: a stakeholder reported the case of a young asylum seeker having to take the train from Arlon to Brussels to attend a psychologist consultation.

Evidence shows that linguistic and cultural barriers may be reduced thanks to the use of interpreters and intercultural mediators.[17, 18, 60-63] Yet, there are insufficient qualified and trained interpreters and intercultural mediators, especially regarding mental health issues. In practice, non-professional interpreters are often used as confirmed by the stakeholders. Intercultural mediation using videoconferencing is freely offered in the collective reception centres and in some hospitals in Belgium.[63] These resources are underused in private health care practices. Possible causes are the reluctance to involve a third party in the therapeutic relationship – especially in mental health care – or a lack of training to work effectively with interpreters and intercultural mediators.[63]

Related to this lack of qualified health care professionals, stakeholders pointed out the lack of training regarding the specific aspects of health care for asylum seekers: mental health, identification and health care of victims of torture or sexual violence, female genital mutilation and legislation. Ad hoc trainings are organised by NGO and non-profit organisations but could be improved, as stated by some stakeholders. In a recent study, conducted by Fedasil, field workers also reported being unable to correctly interpret some behaviour or to identify complex issues such as psychological problems, familial or sexual violence or human trafficking.[64]

5.2.4 High turnover of health care professionals in reception centres

According to stakeholders, the current system is not very attractive for health care professionals. Symptoms are the high turnover of the workforce in collective reception centres and the reluctance or even refusal to take care of asylum seekers in private practices. The high turn-over of the workforce in reception centres and the fast opening and closing of reception centres prevents the development of an experienced workforce. This shortage of an experienced workforce may lead to the hiring of underqualified professionals.

5.2.5 Reluctance and/or overburdening of (some) health care professionals

Stakeholders also reported that some local health care professionals are reluctant to take over asylum seekers in their private practice and prefer to consult at the reception centre. Within these reception centres, health care professionals can benefit from the administrative and logistic support offered by the centres. Some local health care professionals might also be concerned with the reputation of their private practice. Moreover, as asylum seekers are concentrated in some areas, stakeholders stressed that there is a disproportionate workload on some local health care professionals or hospitals. This can sometimes lead to refusal of providing care. Refusals are

prompted by the perceived administrative and organisational burden, the delays in payment and the lack of support services such as interpreters. Some health care professionals also bluntly refuse to take care of asylum seekers for financial reasons, since the reimbursement currently only covers the nomenclature fees and not the supplements.

Moreover, health services in the centres are often perceived as the reference point for many asylum seekers: some stakeholders reported that fieldworkers often have to deal with demands exceeding their competences and availabilities. Nurses in collective reception centres regularly organise health education sessions but the huge administrative workload prevents them from investing more in this kind of activities. This leads to frustration and discouragement. Stakeholders pointed out the high degree of involvement of health care professionals, especially the nurses, but that may lead to an increased risk of burnout.

5.2.6 Poor and/or unclear collaboration between the different actors involved in health care for asylum seekers

Stakeholders revealed difficulties in establishing collaborations. Poor collaboration was reported between some reception centres and some ILA – LOI, from CPAS – OCMW or NGO: in case of transfer, not all information is shared and that may hinder the social service delivering appropriate support. In some areas, conventions are well established between the reception facility and external associations, supporting a positive collaboration, but, in the absence of such conventions, the respective roles of the actors are not clear and may lead to misunderstandings. Some external services refuse caring for asylum seekers because of the short period of stay in the centres.

5.2.7 Tension regarding patient confidentiality

Stakeholders also reported that the collaboration between the medical staff and the other workers inside the centres is sometimes difficult. Inside the reception centres, tensions arise between the patient confidentiality and the security of all residents. A recent report of Fedasil confirmed the confidentiality – security tensions i.e. in case of communicable diseases.[64]

Literature also raise questions about patient confidentiality when involving volunteers and/or interpreters as support in health care delivery.[60, 61, 64] NGO regret that the asylum seekers are oriented to them when their (health) situation is already unbalanced.[64]

5.2.8 Lack of appropriate health information for asylum seekers

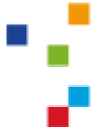
Stakeholders pointed out that health information resources, such as information flyers or health education animations, are not evenly developed and need to be better adapted to the situation of asylum seekers. Stakeholders note that some topics are overlooked while other are not covered at all: some stakeholders note that there are numerous resources for addressing sexually transmitted infections and HIV – AIDS but almost no resources to address chronic diseases. Similar findings were found in the literature.[11, 39]

5.3 Problems at the micro-level

The mentioned macro- and meso-level problems in the health care organisation for asylum seekers cause inequity in health care at the micro-level. According to the literature, to reach equitable health care, care should provide (i) equal access for equal need, (ii) equal treatment for equal need, and (iii) equal outcomes for equal need.[65] We will use this framework to describe the micro-level problems in health care for asylum seekers.

5.3.1 Inequity in access

The literature revealed that asylum seekers lack access to mental health care, interpreters, health promotion and prevention services, access to family planning, sexual and reproductive health and speciality care such as dental care and ophthalmology in Belgium and in other European countries.[36, 39, 66-68] The underlying reasons are individual barriers experienced by asylum seekers as well as barriers related to the organisation of the system of health care. While the characteristics of the population are mainly a given such as pre-existing health problems or the quality of health care received in the country of origin, some of the barriers



might be addressed by adapting the organisation of the delivery of health care.[40, 57, 69]

5.3.1.1 Availability and accessibility of specialised health care services

According to stakeholders, an unequal distribution of asylum seekers over the territory leads to difficulties in accessing specialised services, in terms of availability or physical accessibility. As mentioned by some stakeholders, some regions of Belgium already face difficulties in providing specialised services for the local population (e.g. access to mental health) and this is even more difficult for asylum seekers requiring specific health care and who may have more limited transport facilities. For example, according to some stakeholders, the two reference centres[jj] for the treatment of Female Genital Mutilation (FGM) are in Brussels and Ghent. Similarly, the CARDA, the unique reception centre for asylum seekers with severe mental health problems, is located in Wallonia.

The lack of a complete cartography of the health and social offer for asylum seekers in Belgium has been reported previously.[64] Depending on the centres, additional barriers may prevent asylum seekers from accessing care such as the lack of day care for children or the financial constraints related to the transport.[64]

The relocation policy of Belgium and the unpredictable character of asylum influx also play a role: the relocation policy of asylum seekers does not always take into account the existing resources or does not involve the development of specific local support.[36, 39]

5.3.1.2 Cultural and linguistic barriers

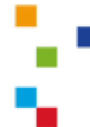
Stakeholders reported that some asylum seekers refuse care because of the gender of the health care professional based on cultural motives or, at the contrary, tend to overuse medical services. This was often reported in the literature: access to health care services is greatly hindered by cultural and linguistic barriers, as it may happen in Belgium.[39, 70-73] Health care is often provided based on poor communication which leads to longer treatment times, provision of minimal medical information, difficulties to explain symptoms and poor understanding of current treatment.[61, 71, 74] Some issues are reported as particularly difficult and are therefore rarely addressed in Belgian reception centres: mental health, sexuality or familial violence.[64]

These barriers are reinforced by the lack of health (care) literacy, in terms of knowledge and information on their right to health care, available services and navigation through the health care system.[39] A Belgian study showed that asylum seekers themselves reported information precarity.[75]

5.3.1.3 Administrative barriers

For stakeholders, asylum seekers in ILA – LOI and those with a code 207 "No show" often face administrative barriers preventing them from accessing health care services. They first need to ask for a payment guarantee before accessing the health care services. Depending on the CPAS – OCMW, the payment guarantee is delivered per act or for a defined period (=medical card). The length of the medical card may also vary from one CPAS – OCMW to another. Some CPAS – OCMW directly conduct a social inquiry for an entire household while, in other CPAS – OCMWs, the social worker has to conduct a distinct social inquiry for each member of the household.

[jj] Created in 2014, these two centres are acknowledged by the NIHDI to provide a multidisciplinary approach to women with FGM, including surgical reconstructions. De facto, these two centres have become over time reference centres for asylum seekers, e.g. to get medical certificates attesting the FGM, the risk of FGM or to take care of complications such as cysts or infibulations. Besides the two reference centres, some medical houses or family planning could take of these women but they are less known. The GAMS is currently preparing a mapping of support services for FGM that should be available by end of 2019.



Stakeholders indicated that the administrative procedures are perceived by asylums seekers as complex and long. This is mostly the case when asylum seekers have to access secondary care. As access to secondary care has to be approved, the procedures may take time and often overcome the necessity of needing care. Some CPAS – OCMW require an estimate of the medical cost before authorising the delivery of health care and the first consultation is not always covered. Hospitals may refuse to receive asylum seekers because of the uncertainty or the delay of payment. If the consultation or the hospitalisation is postponed or cancelled, the asylum seeker may have to renew the application.

5.3.1.4 Heterogeneity in the freedom of choice of health care professionals

As stated by stakeholders, not all asylum seekers have the possibility to choose their health care professionals. Asylum seekers in collective reception centres cannot choose their health care professionals: if they wish to consult with another GP than the GP provided by the centre, the asylum seekers have to cover the fees themselves.

For those in ILA – LOI different situations co-exist: some CPAS – OCMW choose the health care professionals for the patients, others provide a list of health care professionals from whom the asylum seeker can choose and, in some CPAS – OCMW, the asylum seekers may directly choose their health care professionals themselves.

5.3.2 Inequity in treatment

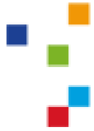
5.3.2.1 Lack of uniformity in the coverage of health care

While in collective reception centres managed by Fedasil or partner organisations, the Plus and Minus lists are automatically applied, stakeholders reported that, in CPAS – OCMW, decisions to cover health care costs outside the NIHDI nomenclature are made on a discretionary basis. Each CPAS – OCMW has the liberty to decide which extra costs will be covered, depending on its internal policy and/or budget. Some CPAS – OCMW use the remainders from their lump sum budget from Fedasil to cover medical care on the plus-list. Also psychological consultations outside the mental health service (long waiting-lists) are paid for with these means. The PPS Social Integration does not apply the Plus list, and does not reimburse the CPAS – OCMW for these costs. This creates inequalities between asylum seekers based on their place of residence. As detailed data on the health expenses are unevenly available, it is impossible, however, to clearly chart the differences in reimbursed care between collective reception centres and ILA – LOI. Furthermore, stakeholders stated that there are also significant differences between the different CPAS – OCMW.

5.3.2.2 Lack of global evaluation of health status upon arrival and departure in the different reception facilities

Fedasil has developed guidelines regarding the global evaluation of asylum seekers adapted for Belgium but, despite their existence, some stakeholders stated that, in their opinion, assessment is limited to tuberculosis screening and an immunisation check. If a broader assessment is organised, not all stakeholders were aware of it.

Stakeholders also regretted the lack of a systematic health assessment at departure when asylum seekers leave the reception centre. This could, however, support the continuity of care. For example, some stakeholders noted that patients needing chronic treatment are not always provided with the necessary medication at departure, or that no arrangements are made to organise general practice care before leaving the reception facility. Concertation with local GPs depends on the CPAS – OCMW. Some stakeholders regretted that the electronic global medical file is not accessible to asylum seekers, although recommended as best practice by the International Organisation for Migrations.[57] Sometimes, according to some stakeholders, the asylum seekers themselves forget to ask for their medical record or treatment when leaving the centre. The absence of a GP in the CPAS – OCMW was pointed as problematic by others in a Fedasil report: without a GP, the CPAS – OCMW cannot consult the patient health record of the asylum seeker and organise health support if needed.[64]



5.3.2.3 Underuse and poor implementation of (existing) guidelines

Stakeholders regretted that there are only a few recommendations or guidelines for clinical practice regarding health care for asylum seekers, tailored to the Belgian context. Despite the existence of supporting documents established by Fedasil, stakeholders seem unevenly aware of it. This was confirmed in a recent Fedasil report: checklists are unevenly used by staff, especially those related to mental health.[64] Difficulties to address the needs of asylum seekers and to apply (intern)national guidelines were previously reported in other countries.[69, 76]

According to stakeholders, there is a concentration of health expertise for asylum seekers in the reception centres but this expertise is unevenly available in the mainstream health care system. For these health care professionals, there is no guidance available, apart for the recommendations of the FARES – VRGT on tuberculosis or some recommendations of the Flemish authority on immunisation.[77, 78] Some stakeholders stated, for example, that health care professionals need guidance on how to work with an interpreter. Additional resources – such as information flyers or websites- are also developed on a local basis but health care professionals are not always aware about how or when to use them.[16]

5.3.2.4 Lack of access to mental health care and lack of alternative treatments

According to some stakeholders, mental health care should be extended to all asylum seekers as part of prevention. Stakeholders regretted that only speech-based therapy is reimbursed in terms of mental health care in the *vademecum*. For some asylum seekers experiencing severe psychological distress, stakeholders expressed the need for alternative forms of mental health therapies, especially for unaccompanied minors. Alternative mental health therapies considered in international literature include animal assisted therapies[79], dance therapies[80] or art therapies.[81, 82] Moreover, it is widely recommended to consider mental health issues in a social determinant perspective.[83] In Belgium, literature revealed a lack of specialised inpatient services able to care for the most severe cases and some professionals have to use involuntary commitment to facilitate access to treatment for them.[64]

5.3.3 Inequity in outcomes

As mentioned above, currently it is not possible to provide a comprehensive overview of the health outcomes of asylum seekers in Belgium due to the lack of data. Moreover, it is difficult to distinguish asylum seekers from other categories of migrants, as illustrated by the recent report of the WHO Europe.[40] Based on their experiences, stakeholders often mentioned the poor mental health of asylum seekers, especially among unaccompanied minors, when compared to other migrants and Belgians.

In this WHO Europe report, mortality rates appear to be lower among all categories of migrants than among the population of the host countries when considering all-cause mortality, neoplasms, injuries and mental, behavioural, endocrine and digestive conditions. Migrants however have higher mortality estimates regarding infections, external causes of death, diseases of the blood and blood-forming organs and cardiovascular troubles.[40] Poorer health outcomes among refugees and asylum seekers compared to host countries populations were also evidenced regarding childbearing and mental health.[36, 66]

5.4 Specific problems for health care with unaccompanied minors

Health care to unaccompanied minors is currently organised in a parallel system (see section 4.3 for current organisation), resulting in specific problems other than those mentioned above.

5.4.1 Lack of coverage through insurance funds for unaccompanied minors

Some stakeholders indicated that, in practice, the coverage of this compulsory health insurance among unaccompanied minors is insufficient. Due to a lack of information, guardians or health care professionals are not always aware that Fedasil or the CPAS – OCMW still intervene to cover the co-payment (*ticket modérateur – remgeld*) and the other medical costs not covered by the AMI – ZIV.

As the registration procedure to the sickness funds is complex, some guardians do not automatically register their pupil, resulting in the fact that Fedasil keeps covering the health care costs. Furthermore, when arriving in an ILA – LOI, unaccompanied minors are supposed to be registered with a sickness fund. Some guardians do not anticipate on this so continuity of reimbursement is not always ensured. Fedasil then continues to cover the health costs for these unaccompanied minors.

5.4.2 Difficulties to comply with the conditions to access the compulsory health insurance

For some unaccompanied minors, stakeholders reported that the condition of school attendance to get access to the sickness funds is difficult to fulfil because of their particular situation, some of them suffering from severe mental illness preventing them from attending school. According to some stakeholders, the large majority of unaccompanied boys from Afghanistan never attended school and are illiterate at 16 or 17 years old. In their country of origin these young boys are considered as adults and have difficulties to cope with the school rules in Belgium. Other stakeholders emphasised the growing number of unaccompanied minors from sub-Saharan Africa who drop out of school to start working for the reimbursement of their journey or to pay for a relative held in custody by human traffickers in the country of origin or in a transit country.

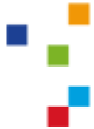
5.4.3 Shortage of guardians

Stakeholders mentioned an acute shortage of guardians to take care of the unaccompanied minors and the incapacity of the guardianship service of the FPS Justice to closely support each guardian. NGO and non-profit associations play a major role but lack support to properly accompany citizen guardians. Citizen guardians are often isolated and their investment in the support of the unaccompanied minors varies, leading to additional inequities. For example, not all guardians accompany their protégés to hospitals while others will cover extra medical support (at their own expense).

5.4 Other issues

During the work session and the interviews, stakeholders further reported some other context-related issues. As these are emerging results, these issues will not be further addressed in this report.

- “Medical tourism”: a rise of “medical tourism” has been mentioned by some stakeholders. According to these stakeholders a number of non-EU citizens come to Belgium to receive expensive medical care but do not necessarily apply for medical visa due to the high refusal-rate. Stakeholders told that, in some cases, arrangements with hospitals are made even before arrival. Once arrived in Belgium, the patient immediately applies for international protection and is directly sent to the hospital for treatment. However, during the writing of this report, no reliable numbers on “medical tourism” were available, so this remark remains annecdotical.
- Unstable funding of NGO and non-profit associations: stakeholders reported that an important part of specialised health care activities for asylum seekers is managed by non-profit organisations (for example activities in HIV-related health promotion or extra-school support for



unaccompanied minors). These organisations experience unstable funding for their activities, risking a loss of continuity of care. Moreover, as they loose their subsidies, non-profit associations have to increase their fees to cover their expenses, and for collective reception centres it becomes increasingly difficult to rely on the expertise of these external partners as they do not have the budget to hire them. Fedasil also highlighted the short existence of some specialised initiatives.[64]

- Lack of self-reliance: some stakeholders warned that, especially in collective reception centres, asylum seekers tend to be infantilized and have few possibilities to make personal choices for daily activities.
- Adverse effect of collective reception centres on health: for some stakeholders, the time spent in collective reception centres should be as limited as possible to prevent additional health problems such as sleep deprivation, anxiety and depression. In addition, the proximity between different ethnic groups can lead to tensions and conflicts, while (health care) professionals feel unable to handle these situations adequately. This was confirmed by a recent study of Fedasil: a stay in a collective reception centre longer than 4 months is deleterious for the well-being of the residents.[64] Moreover, the impersonal aspect of the centres impedes the building of a trust relationship between asylum seekers and staff.[64] Field workers also expect more proactivity from asylum seekers but acknowledge that the reception centres do not always support active involvement of residents.[64]
- Detention centres: currently, the organisation and the payment of health care for those in detention centres is directly managed by the Immigration Office. Although not part of the reception network, stakeholders mentioned that access to health care for rejected asylum seekers in detention centres could be improved, especially for mental health support. Moreover, some residents of the detention centres are still awaiting the final decision regarding the application for international protection and are then still considered as asylum seekers: in theory, these should then be still under the responsibility of Fedasil. However, none of the contacted stakeholders could provide clear information about who is reponsible for paying health care for them[kk]. The negative impact of detention on health and health care was previously reported.[84-87] The WHO Europe also insists on using detention centres as the last alternative possible.[40]
- Autonomy of the CPAS – OCMW: for some stakeholders, the autonomy of the CPAS – OCMW contributes to the inequalities between asylum seekers, as each CPAS – OCMW chooses its own priorities regarding social support and the coverage of additional services. This also raised concerns on patient confidentiality and the access/management of health data by social workers.
- By-passing of the advisory physicians: some stakeholders also reported that asylum seekers sometimes benefit from treatment that should normally be authorised only by an advisory physician of a sickness funds, such as anti-acids.
- Vulnerability of code 207 “No show”: due to the fact that asylum seekers with code 207 “No show” are not within a reception network, however, they are still under the responsibility of Fedasil. Stakeholders fear this could raise additional barriers to access health care.

[kk] Contacts were made with the FPS Justice, Fedasil and the Immigration Office.

Key problems

Problems at the macro-level

- Lack of coordination
- Regional differences regarding health care for asylum seekers
- Lack of monitoring of health care use and health care costs
- Lack of transparency about health care expenses
- Lack of administrative support and of qualified personnel to manage administrative tasks

Problems at the meso-level

- Unclear administrative system for health care professionals
- Differences in health care system depending on place of stay
- Lack of health care professionals qualified to interact in health care for asylum seekers
- High turnover of health care professionals in reception centres
- Reluctance and/or overburdening of(some) health care professionals
- Poor and/or unclear collaboration between the different actors involved in health care for asylum seekers
- Tension regarding patient confidentiality
- Lack of appropriate health information for asylum seekers

Problems at the micro-level

Inequity in access

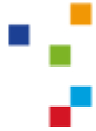
- Availability and accessibility of specialised health care services
- Cultural and linguistic barriers
- Administrative barriers
- Divergent practices in the freedom of choice of health care professionals

Inequity in treatment

- Lack of uniformity in the coverage of health care
- Lack of global evaluation of health status upon arrival and departure
- Underuse and poor implementation of (existing) guidelines
- Lack of access to mental health care and lack of alternative treatments

Specific problems for health care with unaccompanied minors

- Lack of coverage through insurance funds for unaccompanied minors
- Difficulties to comply with the conditions to access the compulsory health insurance
- Shortage of guardians



6 OPTIONS TO IMPROVE EQUITABLE ACCESS TO HEALTH CARE FOR ASYLUM SEEKERS: RESULTS OF THE STAKEHOLDER CONSULTATION

6.1 Fundamental transversal principles to improve equitable access

As discussed in the previous chapter, the current organisation of health care for asylum seekers creates major problems on the macro-, meso-, and micro-level related to equity. Therefore, an in-depth reorganisation and simplification of the system is desirable as a priority. This chapter presents the final alternative options emerging from the different stakeholder consultations, supported – whenever available – by the literature - to reorganise the current health care access (see chapter 3 and Appendix 1 for detailed methodology).

While considering the proposed options, the following three fundamental transversal principles should be remembered:

1. **Asylum seekers have a right to material assistance allowing them to live a life consistent with human dignity.**

As stated by the 2007 Reception Law, material assistance is a form of social aid and should include: housing, food, clothing, medical/social/psychological assistance, daily allowance, legal aid, access to interpreters, training and voluntary return program. The specific needs[ll] of the asylum seekers should also be taken into account, especially for those considered as vulnerable persons[mm]. The 2007 Reception Law provides that medical assistance is always guaranteed to asylum seekers, even when a decision of limitation or withdrawal of material assistance is taken.[30]

2. **Equity in access to health care between all asylum seekers should be ensured.**

Access to health care for asylum seekers should not depend on their status and/or place of residence and should not create inequalities between asylum seekers.

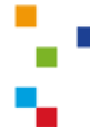
3. **The reform of organisation of health care for asylum seekers should simplify the current system.**

All stakeholders agree that the current situation with different parallel systems for the coverage of health care is not efficient, mainly because it concerns a small number of persons (23 443 persons in 2018 [24]) for a rather limited period of time (in principle less than 6 months [23]). Therefore, parallel systems should be avoided and integration of all types of asylum seekers into one comprehensive system – as a first step to improve health care organisation for asylum seekers should be aimed at. Moreover, current policy intends to integrate different populations as much as possible in the compulsory health insurance system to enhance uniformity. At the moment of writing this report, policy measures aiming at the integration of prisoners in the compulsory health insurance are ongoing.[88]

In the next sections, several options for the improvement of access to health care for asylum seekers are proposed by the stakeholders. This proposed reorganisation will mainly focus on:

ll This study did not aim at describe the specific needs of asylum seekers: there are therefore evidence that being an asylum seekers leads to specific health needs such as particular attention to mental health issues or (sexual) violence. Section 4.2.1 and Appendix 3.2 provide additional details to support the attention to “specific” needs for asylum seekers.

mm Non-exhaustive list of vulnerable profiles: minors, unaccompanied minors, single parents with minor children, pregnant women, persons with a disability, victims of human trafficking, persons with severe diseases, persons with mental health problems, victims of rape or other severe forms of psychological or physical violence, victims of violence or torture, elders.



- distribution of funding,
- governance (i.e. overall policy, organisation and coordination) of the health care delivery.

As distribution of funding impacts the further options for governance, we will discuss these aspects first.

DISCLAIMER	It should be noted that quotes from stakeholders primarily serve to illustrate statements related to the modalities of some options, rather than to confirm or support these statements. Quotes are cited literally. We did not correct wrong wording or misconceptions.

6.2 Distribution of funding of health care for asylum seekers

The majority (64.4%) of the stakeholders of the national online survey supported a change of the actual distribution of funding to a **global envelope** including NIHDI nomenclature (including the current Plus and Minus lists), prevention, screening, health promotion, and support services. Approximately a quarter of the respondents (25.1%) answered that they were not competent to answer this question. Most of the stakeholders favoured the NIHDI as distributor of this global envelope, mainly for practical reasons[nn].

"Sterke administratieve vereenvoudiging (controle artsen zijn het best geplaatst om expertise te hebben en te houden gezien vaak complexe materie; kostenbesparend; alignatie van zorg tussen bewoners van LOI en in collectieve structuren; Op dit ogenblik zijn er grote verschillen waarneembaar tussen OCMW's onderling en tussen OCMW en Fedasil (bv. psycholoog, logopedie, brillen, ...)".

Quote retrieved from national online survey

However, an important proportion of the stakeholders additionally mentioned Fedasil or PPS Social Integration as potential distributor of the global envelop (32.3% and 21.8% respectively)[oo].

Based on the highest percentages, two organisations could take up the role of distributor of funds, either:

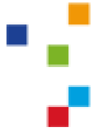
- NIHDI through sickness funds, or
- Fedasil

6.2.1 Option 1: Sickness funds acts as distributor of funding – integration of asylum seekers in compulsory Belgian health care insurance

In the first option, asylum seekers are included in the overall compulsory Belgian health insurance system, including coverage and payment/reimbursement of health care. Sickness funds can act as the distributors of the funding across the health care system for asylum seekers. The Belgian regular health care insurance is based on solidarity and covers almost the entire Belgian population. It obtains its financial resources from social security contributions and subsidies from the Federal Government. Social security contributions are paid by the Belgian citizens and are related to income and are independent of risk. For example, the active population (in terms of working) pays for the non-active population. The compulsory Belgian health insurance is managed by the NIHDI, which provides a

[nn] Respondents were permitted to favour multiple institutions in this question from the national online survey.

[oo] Respondents were permitted to favour multiple institutions in this question from the national online survey.



prospective budget to the sickness funds to finance the health care costs of their members.[89] Therefore, this option is closely related to the current funding system of health care for all Belgian citizens with some exceptions, such as the fact that asylum seekers do not pay any social security contributions (as operationalised in the current system for asylum seekers).

European benchmarking

Among countries with social health insurance system, Luxemburg organises access to health care based on a voucher system during the first three months of stay (similar to the payment guarantees in use in Belgium). After three months, asylum seekers in Luxembourg have to register with the *Caisse Nationale de Santé*. Asylum seekers then benefit from the same coverage than nationals.[11] In Switzerland, access to health care depends on the canton: access, coverage and rules for utilisation vary per canton. There is a negotiation per canton of a collective insurance coverage financed through welfare public assistance. Asylum seekers therefore benefit of reduced health insurance premiums.

A German study demonstrated that this option was more cost-effective compared to a parallel system (in terms of health expenditures).[42] They showed that a parallel health care system for asylum seekers increases costs due to delayed care, treatment of acute health conditions instead of prevention and health promotion, and overhead costs for the parallel system with its own funding, purchasing and reimbursement schemes.

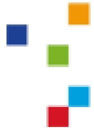
"Wij pleiten voor een verplichting inschrijving in de ziekteverzekering voor alle asielzoekers. Het lijkt ons kostenefficiënt, het is een gekend systeem, het gaat in principe over geen grote groep mensen en voor een vrij korte periode en het kan integratie daarna bevorderen. Nadeel is wel dat het een verkeerd signaal zou kunnen geven, als in 'u mag zich inschrijven dus u mag in België blijven'. Maar dat is eerder perceptie. Dat zou dus gebeuren via het RIZIV, omdat daar de kennis en de methoden al zitten. Het zou ook toelaten om meer cijfers te krijgen over de gezondheidszorg en asielzoekers, controle op de verstrekking van gezondheidszorgen. Het is ook een eenvoudiger systeem en duidelijker, de beschermingsmaatregelen zouden hier kunnen toegepast worden en de medische geschiedenis, e-health, zou ook van toepassing zijn. Wat nu wel, voor velen, voor ongemakkelijkheden, tot zelf misbruiken leidt, zoals bijvoorbeeld iemand die drie keer dezelfde scan krijgt omdat de zorgverstrekker niet weet dat dit al gebeurd is in het verleden."

Quote retrieved from workshop with stakeholders

6.2.1.1 Advantages and inconveniences of the integration of asylum seekers in compulsory Belgian health care insurance

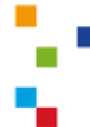
Table 6 – Advantages and inconveniences of integration of asylum seekers in compulsory Belgian health care insurance

Advantages	Inconveniences
Sickness funds and NIHDI are the organisations with the highest **expertise** in the management of medical costs. They have the mandate to make changes to the criteria and tariffs for reimbursement and to control and sanction possible abuses. Moreover, they have the necessary IT systems and **qualified administrative staff**. They are prepared to cope with the most recent evolutions regarding the compulsory electronic medical recipe, digital sending and payment of medical bills, digital control of insurability, eHealth, etc.	An **insurable status** within the health insurance needs **to be created** (with blocking and unblocking some nomenclature numbers/creating new nomenclature numbers for the Plus and Minus list). In addition, asylum seekers have currently **no regular e-ID card** (which is required to receive reimbursement). Asylum seekers will need an identifying document to claim reimbursement (e.g. ISI+ card or electronic badge).
A central government administration is authorized to reimburse/finance medical costs, ensuring administrative **simplification** and supporting **uniformity** and **harmonisation** between asylum seekers residing in reception centres, ILA – LOI, and code 207 "No show". It prevents the development/existence of a costly parallel health care system for only a very limited number of people (approximately 20.000 in 2018).[24] This simplification will be less ambiguous and easier to deal with for all health care professionals.	NIHDI has currently little or **no expertise** in the specific health (care) needs of asylum seekers.
Health care reimbursement policy and its monitoring is already one of the core tasks of NIHDI. Transferring the distribution of funding of health care for asylum seekers to the sickness funds, allows the NIHDI to **analyse and monitor health care costs** for asylum seekers.	NIHDI does not have flexible budgets in case of **future refugee crises**. One additional option could be to transfer the flexible budgets from Fedasil to NIHDI when the applications for asylum increase excessively.
Related to previous advantage, integration of asylum seekers in the compulsory Belgian health care insurance will facilitate **data collection and monitoring** by the NIHDI. This will enable follow-up of the health status and – needs of asylum seekers.	This option has an **unclear political feasibility**.
It is expected that this system will decrease costs, using more performant control mechanisms and less administrative inconveniences (saving time and money).	The length of the international protection **procedure** is in many cases **relatively short**. If international protection is denied (which is the case in around 50% of all applications[25]), it may be not be efficient (e.g. in terms of administrative workload) to include asylum seekers in the compulsory health insurance system.
The rules of NIHDI for a priori (e.g. pharmaceuticals from chapter IV) and a posteriori controls will be applied. This may lead to **rationalisation** and **cost savings**.	
The resources that Fedasil uses to manage the distribution of funding can be devoted to improve the **coordination** of health care and **training** of health care professionals on the particularities of the asylum seekers population, responding to the need of qualified health care professionals and potentially preventing the turnover of health	



care professionals. This could also be used to invest in interpreting services, mediators, or other resources to **reduce cultural and linguistic barriers**.
The integration of asylum seekers in the general Belgian health care insurance is in line with the current philosophy in policy and research to **decrease the parallel systems** for (relatively) small populations (e.g. recommendation to integrate detainees in Belgian prisons in the Belgian health care insurance).[88]
This option leads to an **administrative simplification** that leads to **cost-saving** and **better comprehensibility** of the system for health care professionals and health care organisation outside the reception-centres.
In 50% of cases, asylum seekers receive the status of refugee or subsidiary protection status.[24] Integration in the regular health insurance system (including registration with a sickness fund or CAAMI – HZIV) will facilitate the subsequent integration in society for asylum seekers. **Continuity of insurability** will also be easier when the refugee-status or subsidiary protection status is granted.
There will be **more continuity** if asylum seekers move from one reception modality (e.g. managed by Fedasil) to another (e.g. ILA – LOI managed by CPAS – OCMW).
There will be **more uniformity in the reimbursement rules** (compared to Belgian residents and expect for the Plus and Minus list). This will lead to a clearer and more understandable system for concerned health care professionals.
There is a possibility to cover the **costs of stay in external care facilitie**s (such as rest- and care homes, revalidation centres) in a uniform way. This avoids the current battle between CPAS – OCMW and different administrations on who will be in charge of these costs.
This could improve the coverage of health care for **unaccompanied minors**, as they will be all directly integrated in the national health insurance. Depending on the choices made, this could also lead to the **suppression of the compulsory school attendance** for unaccompanied minors.
There will be an **equal financial access and coverage** for all asylum seekers on the Belgian territory. Depending on the choices made, this could also support the **freedom of choice** of health care professionals by asylum seekers.

Advantages and inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.



6.2.1.2 Conditions for implementation

- **Creation of an insurable status for asylum seekers:** in order to get coverage through the compulsory Belgian health insurance, one needs to fulfil the condition of insurability. This means that asylum seekers need to have an **insurable status** and **contributions** should – theoretically – be paid to the sickness fund and social security.
  - One option is the creation of a **new insurability category** for asylum seekers (currently not included in the compulsory health insurance[pp],) in the health insurance system.

"Wij zijn voorstander van het creëren van een aparte verzekeringscategorie binnen het RIZIV. Het idee zou zijn om een tijdelijk 'totaal verzekerden groep', waar asielzoekers dus onder zouden vallen. Met deze nieuwe categorie zou er dan ook geen probleem meer zijn met de niet-begeleide minderjarige vluchtelingen, want dan vallen ze ook onder deze nieuwe categorie."

Quote retrieved from workshop with stakeholders

  - The new category should be granted to all asylum seekers, irrespective of their (modality of) residence and would thus guarantee a clear and uniform approach. A new insurability category allows to tailor the content of the reimbursed health care and the modalities of the right to health insurance to the particularities of asylum seekers. This corresponds to the idea of the 2016 New York Declaration on Refugees (endorsed by the Belgian State) to *address "the specific health care needs experienced by migrant and mobile populations, as well as by refugees and crisis-affected populations"[90].* In the current system, particularities for asylum seekers are already provided by means of the Plus and Minus lists. These lists could be integrated and/or adapted in the new insurability category.
  - Instead of creating a new insurability category, one could **assimilate asylum seekers to an existing category**, e.g. Belgian citizens (residents). This option would be in line with the idea to treat asylum seekers as much as possible as national citizens. Before the reform of the asylum procedure in 2006[qq], asylum seekers whose request for asylum was declared receivable before 1st of June 2007[rr], were assimilated to Belgian citizens for the period between the declaration of acceptability and the moment of the decision on its merits[ss]. The regular rules of the compulsory national health insurance were fully applied to asylum seekers so that they had the right to free choice of a sickness fund, had a SIS card, needed to pay the (possible) co-payment, had the right to extension of the right to benefit from the health insurance (*prolongation du droit – uitlooprecht* – see further), and the NIHDI payed for health care. After the reform this system ended.
  - If the option of assimilation is chosen, the full application of the "regular" rules for Belgian citizens needs to be questioned. A full application implies that (compared to the current system) asylum seekers would have the "benefits" (no Minus list and extension of the right to health insurance (*prolongation du droit – uitlooprecht*)), as well as the "inconveniences" (i.e. co-payment, contributions to social security and no Plus list) of the system. Yet, it would be

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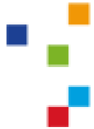
pp Some categories of asylum seekers are already included in the compulsory health insurance: (i) beneficiary through official work, (ii) registered student higher education (at an recognised college or university), (iii) cohabitating spouse of a beneficiary, (iv) a dependent child younger than 25 years, (v) an unaccompanied minor, and (vi) ascendant or cohabitant at the expense of the beneficiary and registered at the same address

qq Law of 15 September 2006 modifying the law of 15 December 1980 related to the access to the territory, the stay, the domiciliation and removal of foreigners, Belgian Official Journal of 6 October 2006

rr This implied that an approval to stay in Belgium for more than 3 months or to stay or reside more than 6 months in Belgium was required.

ss See the article 32, first section, 15° of the law related to the compulsory national health insurance (AMI-ZIV).[91]



possible to adapt specific features for the category of asylum seekers. Today, specific features (i.e. additional advantages in reimbursement for specific categories (i.e. chronically ill patients) already exist within existing categories of the health insurance system.

- The following modalities will need to be considered and may be guiding the choice for a new insurance category of asylum seekers or the assimilation of asylum seekers to Belgian citizens:
  - *Temporary right to coverage from the compulsory health insurance or right to extension (prolongation du droit – uitlooprecht)?*

    The general rule for individuals insured by the compulsory health insurance is that once a right to health care coverage is established (year X), it only expires at the end of the calendar year following the year in which the right was established (year X +1). This right can be extended for one year if several conditions are fulfilled[tt].

    This would imply that individuals could benefit from the regular health insurance even if they do not legally stay in Belgium (e.g. if the request for international protection was denied, but the individual decides to stays illegaly in Belgium). The asylum procedure takes (in principle) maximum 6 months[92]. Since a right that was established in year X only expires at the end of year X +1, an individual, whose request was denied, could, in theory, continue to benefit of the right to health care according to the compulsory health insurance until the end of the next year. This could open the way for bypassing the system of the Urgent Medical Aid for undocumented migrants, since individuals who stay illegally in Belgium without having requested for international protection in Belgium can only benefit form Urgent Medical Aid, whereas those whose request for international protection was refused (and their dependants) could benefit from coverage by the compulsory health insurance.

    An alternative to the application of the right to extension (prolongation du droit – uitlooprecht) is to grant to asylum seekers a **temporary** right (i.e. for the period of the entire asylum procedure) to coverage based on the regular health insurance. This modality could be part of the new insurability category for asylum seekers or could be a inserted as restriction in the option where assylum seekers are assimilated to residents. The latter option would require that the sickness funds are constantly have information on the status of the procedure and may thus imply a considerable administrative charge.
  - *Payment of social security contributions?*

    Since asylum seekers most often do not have sufficient financial means, it is advised that this new category would not depend on the payment of social security **contributions.**[uu]
  - *Definition of the covered package: Plus and Minus lists?*

    Currently the coverage of health care of asylum seekers differs from Belgian citizens in the current health care organisation. Asylum seekers in collective reception centres and code 207 "No show" have the right to the Plus list (even though these services are not included in the NIHDI nomenclature) and cannot benefit

[tt] During the second calendar year preceding the beginning of the period of extension ("refertekalenderjaar"/ "année de référence calendrier"), proof can be supplied that sufficient contributions were paid. For a right in 2017, or "X+2", sufficient contribution needs to be paid in 2015, "year X". The beneficiary should have an insurable status at least at one certain moment during the period starting from the fourth quarter of the period of extension or during the next calendar year. For a right in 2017, or "X+2", one has to have the insurable status in the 4th quarter of 2015 (year X) or in 2016 (year "X+1").

[uu] If asylum seekers are assimilated to residents, this can be solved by including in article 134 of the Royal Decree of 3 July 1996 implementing the Law of 14 July 1994 that the period of international protection is equated with a period in which the required minimum contributions were paid. If a new category is created for asylum seekers a new article needs to be created in the before mentioned Royal Decree.

from some other services that are on the Minus list (even though they are included in the nomenclature for regular citizens). For asylum seekers in ILA – LOI, each CPAS – OCMW can decide case by case to cover health care that asylum seekers are not entitled to, potentially exceeding the lump sum they receive from Fedasil, on their own budget.

If the idea of coverage of additional care and exceptions for asylum seekers is upheld, adaptations will be needed. For the items on the Minus list blocking of specific nomenclature numbers for asylum seekers will be needed. For the items on the Plus list existing nomenclature codes can be applied, but for acts that are currently not covered new nomenclature codes should be created for asylum seekers. For class D pharmaceuticals, however, the creation of a nomenclature code solely for asylum seekers may be problematic since this would imply that pharmacists will have to change their systems. Therefore funding should be organised differently. Either Fedasil could pay it directly, which could be relatively easy in collective centres as nurses usually distribute pharmaceuticals among asylum seeker and can ask for class D pharmaceuticals. However, the problem will persist for those in ILA – LOI, who go to community pharmacies. Another option is that asylum seekers buy it themselves from their pocket money.

Moreover, the specific needs of asylum seekers may justify the covering of supporting services such as interpreters or medical transport. These supporting services, which are currently not covered by the nomenclature, could be paid directly by Fedasil.

In the current system the Insurance Committee (Verzekeringscomité – Comité de l'assurance) of the NIHDI is competent to decide on the content of the covered package. If asylum seekers would be integrated in the compulsory health insurance, Fedasil should at least have an advisory role in the decision-making on the content of the covered package for this category of people.

European benchmarking

According to MIPEX, in European countries with a health insurance system[vv] (exception for Switzerland), the same health care coverage is granted for nationals and asylum seekers. In Switzerland, however, the coverage is determined per canton as part of a negotiation between the insurance funds and the authorities.[11]

- *Free choice of sickness fund or compulsory affilation with the CAAMI – HZIV?*

  Having a valid insurability status can only lead to coverage of health care if the individual is registered with a sickness fund (as sickness funds are the actual distributors of funding in this country). One can opt for a system where asylum seekers freely choose a sickness fund and pay the compulsory complementary health insurance. This compulsory complementary health insurance can either be paid by the asylum seeker or be at the expense of Fedasil. Another possibility is that the asylum seekers (compulsorily) affiliate with the Agency for Health and Disability Insurance (CAAMI – HZIV), where no compulsory complementary health insurance is required. Still another option would be that regular sickness funds waive the additional insurance fee for asylum seekers for the duration of the asylum procedure.

- *Identification of the insurability status via ISI+ card or an alternative mode of identification*

  In order to allow identification of the insurability of asylum seekers by health care professionals, asylum seekers should be provided with an identification document. For instance, as soon as the application for asylum is introduced, the sickness fund to which the patient is affiliated or the CAAMI – HZIV could give the asylum

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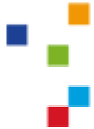
[vv] Austria, Bulgaria, Czech Republic, Hungary, Luxemburg, Poland and Switzerland



seeker an ISI+ card. Currently, an ISI+ card is granted to individuals that benefit from the Belgian compulsory health insurance, but cannot have a Belgian e-ID (e.g. frontier workers that live abroad but work in Belgium). The ISI+ card can contain the identification number of social security (INSZ – NNSS) or the BIS number[ww], which allows the identification of the patient and his/her insurable status in MyCareNet. However, the creation of the ISI+ card can take 3-5 weeks, which means that asylum seekers would need an intermediate solution. The preferable option is to create a new code 'entitled' (*code titulaire – code gerechtigde*) for asylum seekers, reflecting the specificities of the insured status (e.g. right to coverage of elements of the plus list, right to automatic third payer system, etc.). A specific code entitled for asylum seekers would also allow to identify asylum seekers in some of the existing administrative databases and to monitor the provision of health care (cfr. supra).

An alternative option for the ISI+ card is that the sickness fund of the patient provides the asylum seekers with stickers or a paper document on which the 'code entitled' is mentioned.

- *Agreement on who pays what*

There should be an agreement on budget transfers and who is going to bear the costs for health (related) care. It should be clarified which parts of the health care package (e.g. supporting services, co-payment,etc.) remains the (financial) responsability of Fedasil.

6.2.1.3 Organisational changes due to the integration of asylum seekers in the compulsory health insurance

An integration of asylum seekers in the compulsory health insurance also induces several **changes in the current organisation of health care** for asylum seekers:

- **Gatekeeping system:** currently asylum seekers have access to secondary care if they have a payment guarantee. Medical gatekeeping is, depending on the place of residence done by a nurse or a GP at the reception centre, by a Fedasil physician (*service de gestion des processus – dienst procesbeheer*) or by a "regular" GP if health care is managed by the CPAS – OCMW. According to stakeholders, the gatekeeping system helps rationalising health care and should be maintained. Further discussion should elaborate on the need of specific gatekeeping systems for asylum seekers, either by a specific list, either by a (advising) physician.

"… Ambulante zorgen is geen probleem, toch niet op financieel vlak, want het is bijna verwaarloosbaar. Er moet eerder aandacht worden besteed aan dure hospitalisatie en dure geneesmiddelen."

Quote retrieved from workshop with stakeholders

If asylum seekers are integrated in the compulsory national health insurance, one could consider to support gatekeeping through the global medical file (*dossier médical global – globaal medisch dossier*), i.e. all data relating to a patient are managed by a GP selected by the asylum seeker, who ensures that medical shopping is minimized and enhances uniformity in the decisions on access to secondary care. To consult a specialist or for planned hospital care, a certificate of the GP holding the global medical file should be compulsory but sufficient. Submitting the referral to CPAS – OCMW or Fedasil for approval should therefore no longer be required. Gatekeeping to the health care system could help preventing medical shopping of patients.

[ww] See here for more information: https://www.socialsecurity.be/site_nl/civilservant/Applics/ecreabis/index.htm

European benchmarking

Switzerland and Austria have developed a gatekeeping system to prevent medical shopping and to support the appropriate use of health services. In the canton of Bern (Switzerland): asylum seekers have a designated generalist practitioner, endorsing the role of a gatekeeper for some acts. In Austria, gatekeeping takes the form of a compulsory place of residence: asylum seekers should stay there to access the health care services.[11]

« … que évidemment, il y a un risque de medical shopping, mais qui devrait être compensé par un système de coordination des soins, qui devrait être réellement mis en place. »

Quote retrieved from workshop with stakeholders

- **Possible payment systems:** stakeholders of the work-session and the stakeholders have divergent opinions on: (i) the necessity for a reform of the payment system and (ii) the preference for a payment system.

  In the current system, sickness funds distribute the funding through two different payment systems. Mainly a fee-for-service payment but alternatively a lump sum payment (less used). In practice, one could assume that the choice for one of these payment systems will depend on the underlying philosophy to provision of health care.

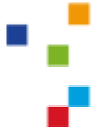
  - **Fee-for-service payment**

    For the provision of health care by individual health care professionals within and/or outside the reception centres, a fee-for-service payment system can be applied. In this payment system, services are unbundled and paid separately. Health care professionals can charge every act they provide (based on the NIHDI nomenclature). When implementing this payment system, it would be preferable to insert an obligatory third-party payment, insuring asylum seekers that they only need to pay the co-payment.

The application of the social third-party payment is compulsory for patients with a preferential reimbursement (*intervention majorée – verhoogde tegemoetkoming*) in primary care since October 2015.[93] In addition, KCE recommended this social third-party payment in its recent report on the organisation of health care for prisoners[88]. Policymakers could exempt asylum seekers from paying the co-payment themselves since often, they lack sufficient means. This co-payment could by paid by Fedasil or the CPAS – OCMW (when the income of the asylum seekers is lower than the living wage (*salaire minimum – leefloon)*).

If a system where the own contribution is paid by the asylum seekers would be upheld, the system of preferential reimbursement could also be a solution (e.g. in 2018, for a regular consultation with a GP adhering to tariff agreements[xx] who holds the patient's global medical file, a patient with preferential reimbursement pays a co-payment of € 1). It could be an option to keep current rules and to only grant the preferential reimbursement for the asylum seekers (and family) if the families' income does not reach a specific level. However, it could also be possible to work under the assumption that asylum seekers do not have sufficient income and therefore should have an automatic right to preferential reimbursement. A careful ponderation between the administrative advantages (avoiding the cost of income assessments) and the deviation of the consistency of the system needs to be made regarding the application of the system of increased reimbursement.

[xx] Fees for physicians are negotiated at the national level in the National Commission of Representatives of Physicians and Sickness Funds of the NIDHI. Physicians can decide individually if they agree with this agreement. Physicians who accept the agreement are obliged to respect the set fees while those refusing to adhere to tariff agreements can set their fees freely.



- **Lump sum payment**

  If decision makers opt for a system where asylum seekers are oriented to community care centres or if care is provided by health care professionals in the reception centres, payment could also be based on a lump sum. Reception centres or caregivers would then receive a fixed amount which can be used to cover all the necessary primary health care services, health promotion and prevention activities as well as medical transport, interpreters, and other supporting activities.

"Wij zouden aanbevelen om te werken via een forfaitair betalingssysteem, zodat er een pool van artsen is die feeling heeft met de doelgroep en expertise. Dat zou een oplossing zijn voor het remgeld. Mocht er toch geen forfaitair systeem gebruikt worden, zou er een derdebetalersregeling kunnen komen: met artsen die ofwel geen remgeld vragen of eventueel Fedasil die dit remgeld kan betalen."

Quote retrieved from workshop with stakeholders

This payment system is closely related to the system currently used in community health centres (*maisons médicales – wijkgezondheidscentra*) in Belgium. Each community health centre receives a fixed amount monthly per registered patient, regardless of whether or not this patient consults the community health centre in that month. The fixed amount is calculated on the basis of a number of patient characteristics of the group of registered patients (i.e. age, gender, social status or disability.) and covers consultations and home visits in primary care (GP, physiotherapy and nursing care).[94]

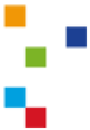
"Wanneer asielzoekers dus zouden verzekerd zijn via de verplichte ziekteverzekering van het RIZIV, kan ook het forfaitaire betalingssysteem bij hen toegepast worden en kunnen ze zich inschrijven bij een wijkgezondheidscentrum, tijdelijk weliswaar. Momenteel kunnen zij dat nog niet. In de praktijk worden asielzoekers momenteel nog meestal gezien door externe artsen in de collectieve centra die betaald worden per prestatie."

"Belangrijk om aan te geven is dat het forfaitaire systeem niet per se samen gezien moet worden met wijkgezondheidscentra maar om een specifiek forfaitair systeem uit te werken voor deze doelgroep bij eerstelijnshulpverleners. Zoals u wel weet bevinden wijkgezondheidscentra zich voornamelijk in de stedelijke context, maar beschikken we bijvoorbeeld nog niet over een wijkgezondheidscentra in West-Vlaanderen dicht bij een collectief opvangcentrum."

Quotes retrieved from workshop with stakeholders

Nevertheless, when considering the system of lump sum payment, it should be taken into account that asylum seekers are often transferred between reception centres and reside only short-term in one centre. The period covered by the lump sum should be short enough to handle these short-term stays or the lump sum should follow the asylum seekers from one reception centre to another. There are currently no (or only partly) validated data on health needs, consumption and costs for health care for asylum seekers available. These data would allow, amongst others, to calculate the amount of the lump sum. The lump sum needs to integrate non-medical activities to cover for all (supporting) services needed. Last, a different organisation of health care provision is needed when choosing for the lump sum payment system. The reimbursement today, both primary care and secondary care, is mainly based on fee-for-service payment which the exception of community health centres. Transforming the actual payment system to lump sum will, however, require important changes.

- **Expertise regarding asylum health:** in order to tailor health care coverage and reimbursement regulations to the specific (health care) needs of asylum seekers, the NIHDI should have an advisory expert in asylum seeker health (care). Stakeholders emphasised the necessity for an advisory role of the medical director of Fedasil to the insurance committee of the NIHDI when it concerns health care for asylum seekers.



- **Coordination of prevention and health promotion activities:** currently prevention and health promotion activities are provided by services of the federated entities and by the reception centres. If prevention and health promotion are included in the global envelope it is necessary to align the policy with the Communities. An option could be to include prevention and health promotion actions that are specifically targeted at asylum seekers in a global envelope (e.g. tuberculosis screening) and to keep preventive actions for the general population (e.g. cancer screening) out of the envelope. In addition, coordination is also required regarding support services (such as interpreters or intercultural mediators) for asylum seekers residing in collective reception centres or ILA – LOI.
- **Long-term monitoring:** health (care) needs, health care consumption and health costs should be monitored.[40] A code for asylum seekers should be created for the minimal hospital summary (RHM – MZG) so that the morbidity profile of asylum seekers can be monitored as is currently done for other patients.

6.2.2 Option 2: Fedasil acts as distributor of funding

As mentioned earlier, an important proportion of the respondents (32.3%) of the online survey also supported Fedasil as a potential distributor of the global envelop[yy].

> *"Fedasil, het orgaan dat instaat voor de opvang van asielzoekers lijkt me een logische keuze. Het is namelijk nu al hun eindverantwoordelijkheid."*

Quote retrieved from national online survey

Therefore, in this alternative option we could imagine that Fedasil manages the distribution of the whole health care budget for asylum seekers, including those in ILA – LOI. The budget is then a global envelope covering all activities related to health care (NIHDI nomenclature, Plus and Minus lists, health promotion, prevention, screening and specific support services). Fedasil could rely on the existing nomenclature for the payment of health care professionals. This option still upheld the principle that asylum seekers, unlike Belgian citizens, are not required to pay co-payments, unless they have a sufficiently high income.

In this scenario two alternative systems of financing could theoretically be considered.

1. **Option 2.1.** Fedasil takes up the role of a sickness fund for *all* asylum seekers, as it does today for asylum seekers in reception centres managed by Fedasil and its partners. In practice, the system would remain "as is", with the difference that Fedasil will also act as a distributor of funding of health care for asylum seekers in ILA – LOI[zz].
2. **Option 2.2.** Fedasil manages a global envelope covering all activities related to health care but administration is done by the CAAMI – HZIV through the MediPrima system. The CAAMI – HZIV will be responsible for the payment of the health care providers and the control of the invoices submitted by health care providers (electronic billing via MyCareNet). Fedasil will have to manage the payment of the supporting services such as interpreters, transport, etc.

Advantages, inconveniences, and conditions for implementation of each system of financing are described below.

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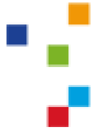
yy Respondents were permitted to favour multiple institutions in this question from the national online survey.

zz Asylum seekers obtaining financial support of the CPAS – OCMW (e.g. an asylum seekers who was not assigned to a centre or ILA – LOI because he wants to live with a family member) will remain under the system of financial support.

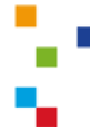


6.2.2.1 Advantages and inconveniences when Fedasil acts as sickness fund for all asylum seekers

Table 7 – Advantages and inconveniences when Fedasil acts as sickness fund for all asylum seekers

Advantages	Inconveniences
Fedasil has high **expertise** in the specific **health (care) needs of asylum seekers.** Fedasil could mobilise this specific expertise to improve the availability and accessibility of specialised health care services and to reduce cultural and linguistic barriers.	Fedasil has **little expertise in the management of medical costs**. They also do not have the required electronic systems for medical cost management (in contrast to NIHDI and the sickness funds). The set-up of the required and up-to-date electronic systems would imply an important financial and continued investment in people and training to acquire the knowledge to ensure the management of medical costs. Since this concerns only 20 000 individuals per year and for a short period, such an **investment would be disproportional**.
There will be **administrative simplification** because there will be a uniform system for all asylum seekers, independent of their place of residence. This could also simplify the access to health care for unaccompanied minors.	**Health care reimbursement, control and monitoring** is not one of the core tasks of Fedasil. Improvement of the monitoring of health care costs and health care uses is uncertain.
Fedasil can rely on **flexible budgets**, which is highly recommended for potential future refugee crises.	Fedasil is **not well placed to negotiate** with health care professionals and health care organisations to conclude conventions and, by doing so, keeping the medical costs under control. It can be expected that Fedasil will use the NIHDI reimbursement rates. This will especially cause problems for the reimbursement of interventions on the Plus list (not reimbursed by the NIHDI for regular Belgian citizens).
There is a relatively **high political feasibility** because it remains close to the situation “as is” with the difference that Fedasil will also act as a distributor of funding of health care for asylum seekers in ILA – LOI.	Asylum seekers granted the residence status (recognition of the status of refugee or recognition of the subsidiary protection status) must **still be registered with a sickness fund or the CAAMI – HZIV**. Switching from one insurance system to another is not simple and partly complicates the integration process in Belgian society and in regular care organisation. Continuity of insurability is, therefore, less guaranteed.
There will be an **equal access and reimbursemen**t for all asylum seekers on Belgian territory. Depending on the choices made, this could also support the **freedom of choice** of health care professionals by asylum seekers.	**Two parallel reimbursement systems** continue to exist, making the system incomprehensible for health care professionals.
	No *a priori* **controls** by the advisory physician of the sickness funds and no *a posteriori* controls by existing control mechanisms of the NIHDI.
	Fedasil is not in favour for this option, because of the high investment in manpower, ICT, etc. They currently lack of administrative support and of qualified personnel to manage administrative tasks

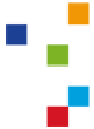
Advantages & inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.



6.2.2.2 Conditions for implementation when Fedasil acts as sickness fund for all asylum seekers

- **Set-up of required up-to-date electronic systems:** in contrast to the NIHDI and sickness funds, Fedasil has no well-developed electronic system for medical cost management. The set-up of this electronic system will require a considerable investment in financial resources and workforce.
- **Revision of the administrative procedure in Fedasil:** several stakeholders reported a delay in the payment of health care professionals by Fedasil. At this moment, the medical cell of Fedasil is only staffed with 3 full-time equivalents (FTE), which explains this delay. An investment in workforce and revision of the administrative procedures might increase efficiency. In addition, currently a payment guarantee is limited for one day. To increase the continuity of care, it should be possible to deliver payment guarantees covering health care for a longer period. This wil also ease the procedure for the medical cell of Fedasil.
- **Increase of the workforce:** human resources will need to be reinforced to allow the timely follow-up and the distribution of payments.
- **Access to information:** Fedasil should have access to the same information as the regular sickness funds to ensure the correctness of the health care reimbursement (i.e. Mycarenet).
- **Extension of competences:** the authority of Fedasil should be extended to health care for asylum seekers in ILA – LOI.
- **Transfer of budgets:** the existing budget of health care in ILA – LOI needs to be transferred to Fedasil, in order to ensure that Fedasil can cover health care costs for all asylum seekers.

This bullet list solely summarizes the high level structural changes that would be necessary to allow the implementation of this option. It is obvious that many problems on the micro level (e.g. the fact that there is no a priori control on chapter IV pharmaceuticals) would need a tailored solution and are not automatically solved by the structural changes.



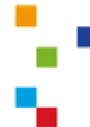
6.2.2.3 Advantages and inconveniences when Fedasil manages the global envelope and administration is done by the CAAMI – HZIV through MediPrima[aaa]

Table 8 – Advantages and inconveniences when Fedasil manages the global envelope and administration is done by the CAAMI – HZIV through MediPrima

Advantages	Inconveniences
This option is **technically easier and financially more feasible** if Fedasil would use the MediPrima-software rather than updating its own system.	Currently MediPrima **solely applies to (in-and outpatient) hospital care**. For primary care pilot projects are ongoing with GP. The application for pharmacies is anticipated. Reimbursement of health care related costs in external rest-, nursing- or care homes is (currently) not possible via MediPrima. The implementation of this system will thus **depend on the evolutions of the applications of MediPrima** that are difficult to predict.
Because the administration will be done by one organisation (i.e. CAAMI – HZIV), it could enhance **monitoring of health care use and cost**s, leading to **higher transparency** in health care expenses.	
This option is probably **technically and politically easier/more feasible** than integration of asylum seekers in the compulsory health insurance. Integration of asylum seekers in compulsory health insurance needs more discussion on the modalities (i.e. new insurance category or assimilation, contributions, co-payment or Plus and Minus lists).	As the CAAMI – HZIV will be responsible for the payment of the health care providers and for the *a posteriori* control of the invoices, this may imply a **substantial increase of the workload** for the CAAMI – HZIV.
The CAAMI – HZIV is already **experienced in health care administration**, which will solve the current lack of administrative support and qualified personnel to manage administrative tasks.	
Health care professionals (in hospitals) are already familiar with the MediPrima system for undocumented migrants. **Administrative system will be clearer** and it could reduce the administrative barriers for both health care professionals and asylum seekers.	
This could lead to a **better uniformity** of the health care coverage, including for unaccompanied minors, depending on the decisions taken by Fedasil.	
This option is **politically more feasible** because it aligns with the system of undocumented migrants who are also integrated in MediPrima database.	

Advantages and inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.

aaa The advantages and inconveniences mentioned in 6.1.2.1 are also applicable for the option where the administration is done by the CAAMI-HZIV through MediPrima. 6.1.2.3 only includes the advantages and inconveniences that are specific for this option.



6.2.2.4 *Conditions for implementation when Fedasil manages the global envelope and administration is done by the CAAMI – HZIV through MediPrima*

- **Improve MediPrima:** several stakeholders mentioned problems with MediPrima. When policymakers choose this option the procedures and utilisation of MediPrima should be evaluated and improved.

« Pour tous ceux qui sont 'de passage', c'est plus compliqué. Il faut de la rigueur et de la volonté pour ces personnes qui doivent se présenter au CPAS pour le dossier administratif. Il y a aussi la barrière de la langue: ils ne parlent pas forcément le français. Il y a moins de souplesse. Le logiciel a rendu les choses plus rigides. »

Quote retrieved from interview with stakeholder

- **Implementation highly depends upon the extension of MediPrima system to primary care:** it is logistically feasible to enrol all asylum seekers in the MediPrima software. However, at the time of writing, MediPrima can solely be used for care provided in hospitals. An extension of the system to primary care is ongoing through pilot projects with GP. A further development of the system for pharmacists and other care providers is planned in pilot projects only. The implementation of this option will thus highly depend on the further evolution of the MediPrima project and the possibility to invoice patients electronically (a condition for MediPrima).
- **New category for asylum seekers in MediPrima:** a new identification category will have to be developed to differentiate asylum seekers from other categories of beneficiaries (such as undocumented migrants) in MediPrima. This is essential to allow a follow-up of health care consumption of asylum seekers and to apply a different tarification (Plus and Minus lists) for this new category.
- **Identification**: in the current system, health care professionals can identify the insurability of the patient via an identification document provided to the patients by the CPAS – OCMW. If the MediPrima system is extended to all asylum seekers, Fedasil will have to provide them with identification documents. Via the INSZ – NNSS number (national number or BIS number) on this document, health care professionals will be able to check the insurance status of the patient in MediPrima.

European benchmarking

In Bulgaria, the identification of asylum seekers is managed by the National Revenue Agency after being informed by the State Agency for Refugees.[11]

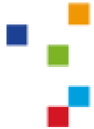
6.2.3 *Option 3: actual actors distribute the funding, administration by MedPrima for all asylum seekers and access to health care covered by health insurance*

In this option, all asylum seekers are entitled to the health care package that is covered by the health insurance to ensure a uniform coverage for all asylum seekers. Costs for health care would be at the expense of the actual funding organisations (i.e. Fedasil and CPAS – OCMW). In this option the existing competences for the respective categories of asylum seekers and the financial responsibilities remain with the same actors as currently. The existing nomenclature codes can be used by the health care professionals and invoicing and control of the bills can be done through Mediprima.

« We pleiten voor een algemene toegang van asielzoekers tot ons gezondheidszorgsysteem, overeenkomstig dezelfde criteria als onze Belgische verzekerden. Inschrijving in een verzekeringsinstelling/ziekenfonds lijkt ons overbodig gezien deze belanghebbenden buiten de scoop van de verzekerbaarheidsregels vallen en geregistreerd worden via andere kanalen. Dit doet geen afbreuk aan hun rechten. »

Quote retrieved from stakeholder consultation

If the idea of 'the same coverage for health care for asylum seekers as for nationals' is upheld, Plus- and Minus lists are, according to some stakeholders, no longer necessary.



"De specifieke lijsten (plus-lijsten) zijn niet meer nodig als al deze asielzoekers/patiënten de reguliere zorg krijgen."

Quote retrieved from stakeholder consultation

This would also imply that asylum seekers benefit from all prevention actions/programs foreseen in the nomenclature by the NIHDI.

"Een vlotte toegang tot preventie en tot de eerste lijn voor asielzoekers betekent dat hun kosten in de tweede lijn zullen dalen."

Quote retrieved from stakeholder consultation

6.2.3.1 Advantages and inconveniences when funding is done by actual actors, administration by MedPrima for all asylum seekers and access to health care covered by health insurance

Table 9 – Advantages and inconveniences when funding is done by actual actors, administration by MedPrima for all asylum seekers and access to health care covered by health insurance

Advantages	Inconveniences
The **existing competences** for the respective categories of asylum seekers and the financial responsibilities remain with the same actors as in the current situation. This **avoids a shift and reorganisation** of the management of costs and competences.	The **inconveniences related to the use of the Mediprima** system as mentioned in 0 also apply here. Fedasil will still need **extra administrative support** and qualified personnel to manage administrative tasks and MediPrima.
Asylum seekers, including unaccompanied minors, receive the **same health care package** as Belgian residents, under the same conditions (e.g. prevention programmes).	If the Plus and Minus lists are no longer applicable, health care may be **less adapted to the specificities of asylum seekers**. This goes against the philosophy of the 2007 Reception Law to grant asylum seekers the necessary care.
There will be **more uniformity** in the general reimbursement rules (compared to the Belgian residents). This will lead to a clearer and more understandable system for concerned health care professionals, **reducing administrative barriers**.	**No *a priori* controls** are done by the advisory physician of the sickness funds. If this role will be taken by the respective services of the OCMW – CPAS and Fedasil, uniformity in decision-making is threatened.
Because the administration will be done through MediPrima, it could enhance **monitoring** of health care use and costs, leading to higher **transparency** in health care expenses.	Even if asylum seekers all have the same coverage, **access to care remains different**, e.g. for asylum seekers in ILA – LOI a social inquiry is done, whereas for asylum seekers in centres managed by Fedasil, this is not the case. Differences will persist depending on place of stay.

Advantages and inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.

6.2.3.2 *Conditions for implementation*

- All conditions related to the implementation of the **MediPrima system** are applicable here (see Table 9).
- **Adaption of the 2007 Reception Law:** Plus and Minus lists in the 2007 Reception Law have to be deleted and necessary care equals all the care covered by the NIHDI nomenclature. In addition, this implies that specific psychological health care is no longer provided for asylum seekers.
- **Set-up of the required up-to-date electronic systems:** in contrast to the NIHDI and sickness funds, Fedasil has no well-developed electronic system for medical cost management. The set-up of this electronic system will require a considerable investment in financial resources and workforce. Instead of working with Nomensoft to manually check the rates of reimbursement rates for medical acts, this electronic system should support automatic update of the nomenclature.
- **Decision whether setting-up a similar control system** (*a priori* by advisory physician of the sickness funds and *a posteriori* control by NIHDI) as in the regular compulsory health insurance system is necessary

6.3 Future governance of health care for asylum seekers

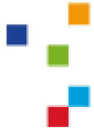
Currently, according to the stakeholders, policy and organisation of health care for asylum seekers is unclear and scattered through different organisations. In line with the integrated vision on the funding of health care for asylum seekers, governance (entailing overall policy, organisation and coordination) of health care for asylum seekers should be centralised and address the problems mentioned previously. The majority of the respondents to the national online survey (85%) agreed with the statement that **health (care) for asylum seekers requires a centralised and coordinated health policy.**

European benchmarking

From MIPEX, it appears that payment and/or coordination are managed by one institution in countries with an insurance-based health system (except for Poland). In Poland, two institutions contribute to the coverage of the health care costs. In Austria and Switzerland, a convention exists between the Federal State and the federated entities to organise funding and coverage, the entitlement being defined at national level.[11]

Therefore, we present two alternative options for the overall governance of health care provision according to the stakeholders:

- Fedasil takes the lead (supported by 39.3 % of the respondents of the online survey), or
- a strategic coordination committee takes the lead (supported by 28.3% of the respondents of the online survey).



6.1.1 Option 1: Fedasil takes the lead in governance

As mentioned above, many of the respondents of the national online survey preferred **Fedasil** to take the lead for the governance in health care for asylum seekers. The key-position of Fedasil is supported by their longstanding expertise regarding reception of asylum seekers.

« Fedasil connait et forme les services qui accueillent les demandeurs d'asile, ils sont le mieux placés pour faire le lien entre les soucis de santé rencontrés par les demandeurs d'asiles. Ils sont les mieux placés pour sensibiliser le monde médical sur la problématique des demandeurs d'asile et cela faciliterait beaucoup le travail des services qui ont souvent du mal à trouver des médecins qui acceptent de prendre des demandeurs d'asile dans leur patientèle. »

Quote retrieved from national online survey

« L'idéal serait de se tourner vers Fedasil car en terme d'avantage, ceux-ci sont réputés pour être spécialisés dans l'accueil, la prise en charge de la santé publique de manière globale. »

Quote retrieved from workshop with stakeholders

When choosing this option, the medical cell of Fedasil should be reinforced in its leadership regarding asylum seekers' health, with an extension of its competences to those in the ILA – LOI networks. Next to their other missions (note that some of the existing missions may disappear depending on if the integration of asylum seekers in the compulsory health insurance is opted for), the medical cell of Fedasil could then:

- develop a **national health strategy** for asylum seekers and support its implementation at local level – including fast responses to unexpected arrivals of migrants;
- **monitor** the health status, health needs, health care consumption, quality of care and costs (in close collaboration with the study service of Fedasil). This would only be the case in the option where Fedasil manages the funding of health care for asylum seekers. If asylum seekers are integrated in the compulsory health insurance, this task should be shifted to the NIHDI;
- develop and/or adapts **guidelines** related to care for asylum seekers for health care professionals (for example in partnership with the EBPracticenet);
- **coordinate** public and private actors involved in asylum seekers health;
- coordinate the actions of **prevention** and **health promotion** of the federated entities with other (local) initiatives
- organise **training** of health care professionals;
- etc.

6.3.1.1 Advantages and inconveniences when Fedasil takes the lead in governance

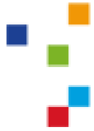
Table 10 – Advantages and inconveniences when Fedasil takes the lead in governance

Advantages	Inconveniences
Fedasil has the **expertise** in the specific health (care) needs of asylum seekers. It is also able to interact adequately with the dynamic aspects of migration influx.	
If Fedasil takes the lead in governance, the problems in **coordination** and **regional differences** towards health (care) for asylum seekers could be solved.	
Depending on the decisions made, differences in health care by place of stay could additionally be **unified** in this option, leading to more **uniformity in health care coverage** and less differences in **freedom of choice o**f health care professionals	
Depending on the decisions made, this could also lead to improvements in **training** of health care professionals, **reducing the turnover and overburdening,**	
Depending on the decisions made, this could lead to a **better access** to (specialised) health services (including mental health) and more **appropriate use** of available services, by, among others, tackling cultural and linguistic barriers. By reinforcing the central role of Fedasil, it could also support **equity in treatment** by harmonising **health care coverage**, by generalising the **global evaluation**, and by developing and implementing (existing) **guidelines**	

Advantages and inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.

6.3.1.2 Conditions for implementation

- **Extension and clarification of Fedasil competencies:** the competency to take up the lead in health care governance for all asylum seekers independent of their place of residence and the specific tasks should be integrated and clearly defined in the 2007 Reception Law. Some topics (such as prevention or health promotion) are subject to federated legislation. This should be taken into account when extending the competencies of Fedasil. Depending on the content and the extent of the tasks that will define Fedasil's governance role, and specifically more specialised human resources may be needed.
- **Collaboration between the NIHDI and Fedasil:** it is obvious that in the option where asylum seekers are integrated in the compulsory health insurance and the distribution of funding is done by the sickness funds, communication between the NIHDI and Fedasil is essential (e.g. for the definition of the covered package). It could be an added value for the Insurance Committee of the NIHDI to rely on the expertise of Fedasil to determine/adapt coverage specifically for asylum seekers.



6.1.2 Option 2: A strategic committee takes the lead in governance

As an alternative for Fedasil taking up the lead in governance of health care for asylum seekers, a **strategic committee** gathering representatives of both public (federal and federated entities) and private institutions involved in asylum seekers health care funding and delivery was proposed to the stakeholders. The strategic committee could take up the responsibility of developing the **national health policy** for asylum seekers, distributing the missions to operational actors and then follow-up on the implementation of their recommendations. Some stakeholders doubted the necessity and the feasibility of such a strategic committee, believing it would be an 'empty box'.

« Est-ce que c'est vraiment nécessaire de créer un comité de migration ? Ça pourrait être bon, parce que ce comité peut définir les besoins. Mais le souci, c'est quelque chose de nouveau qui doit être établi. »

Quote retrieved from workshop with stakeholders

When discussing the option to give the lead to a strategic committee, stakeholders spontaneously redefined the role of the strategic committee as an **advisory board** regarding health care for asylum seekers in Belgium, composed of representatives of both public (federal and federated entities) and private institutions involved in health care funding and delivery for asylum seekers. Hence, experts from different domains in health care for asylum seekers can give input (e.g. organisational models for health care for asylum seekers, covered package, etc.) which may lead to a more integrated policy.

The strategic committee could also be a **platform** where coordination between activities organised by different actors involved (e.g. prevention activities) is facilitated. For public institutions, potential members could be among others: the FPS Public Health (including the Intercultural Mediation Cell), federated entities in charge of health promotion and prevention, Myria, and Fedasil. When it comes to experienced private partners, potential members could be among others the '*Croix-Rouge de Belgique*', the '*Rode Kruis Vlaanderen*', '*Médecins du Monde – Dokters van de wereld*', '*Vluchtelingenwerk Vlaanderen*' or 'CIRÉ'. This interpretation of the committee's role is compatible with the first option where Fedasil takes the lead in governance. The committee could serve as an advisory board whereas Fedasil would be competent for the final decision-making regarding health policy.

"Ook het idee van een 'comité' met verschillende partners lijkt een interessante piste. Ik zie dat dan wel eerder als een soort raadgevend orgaan dat de krijtlijnen uitzet voor een geïntegreerde aanpak, eerder dus als leidraad voor de hulpverleners."

Quote retrieved from workshop with stakeholders

Last, the stakeholders unanimously agreed upon the need for **more collaboration** between the health care actors for asylum seekers[bbb]. However, this does not necessarily requires a new strategic committee. One would hope that increasing the collaboration can be obtained by **enhancing the communication** between the current actors in asylum health care.

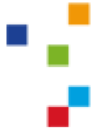
[bbb] The recommendations for intercultural care in Belgium (ETHEALTH) also support the need for more collaboration, not only for asylum seekers care but for all migrants living in Belgium. The FPS Public Health is currently finalising the updated version of the ETHEALTH recommendations (see the Intercultural Mediation Cell and Policy Support Unit)[17, 18, 58]

6.3.1.3 Advantages and inconveniences when a strategic committee takes the lead in governance

Table 11 – Advantages and inconveniences when a strategic committee takes the lead in governance

Advantages	Inconveniences
The creation of the strategic committee allows **interactions** and **exchanges** between experts in health (care) for asylum seekers.	Up to now, a strategic committee is not yet installed. Creating a new committee may lead to **additional fragmentation** of the health care system and undermine the goal of simplifying the system. However, the consulted stakeholder did not quite see the added value of creating a new strategic committee.
The strategic committee will be able to endorse different competences and ensure **coordination between federal and federated entities,** harmonising regional practices regarding health care for asylum seekers, and leading to more uniformity in health care coverage and less differences in freedom of choice of health care professionals.	If the strategic committee does not have a legal framework to decide on essential matters it could become an '**empty-box'**.
A strategic committee allows the **representativeness** of the various actors implicated in health (care) for asylum seekers.	It is possible that the creation of a new strategic committee, together with the 'empty-box' risk will **not be efficient**.
The strategic committee allows for a broader vision and a mix of expertise, by gathering **different competences and coordinating** different actors (i.e. regions, federal, NGO, non-profit associations, ILA – LOI). The strategic committee might **support innovation** and a redefinition of the needs.	Decision-making may take long when many parties are involved. It is more difficult to reach consensus compared to when only one body (Fedasil) has the **final decision-making power** in health care policy for asylum seekers.
This could also lead to improvements in **training** of health care professionals, reducing the turnover and overburdening. This could lead to a **better access** to (specialised) health services (including mental health) and **more appropriate use of available services**, by, among others, tackling cultural and linguistic barriers. By reinforcing the central role of Fedasil, it could also support **equity in treatment** by **harmonising health care coverage**, by generalising the **global evaluation of health status**, and by developing and implementing (existing) **guidelines**	It is not easy to determine **which partners** in the committee will have decision-making power and which partner will have an advisory voice.

Advantages and inconveniences mentioned above originate from interviews with stakeholders, stakeholder consultations, and literature research.



6.3.1.4 Conditions for implementation

- **Creation of the strategic committee:** representatives of both public and private institutions involved in asylum seekers health care funding and delivery should be selected and their mission and specific tasks should be defined and integrated in the legislation.
- **Expertise:** the strategic committee should have relevant expertise in terms of health care for asylum seekers. In order to decrease fragmentation in health care policy for people with a migrant background, one could envision that the strategic committee reflects not only on health care for asylum seekers, but for all migrants in Belgium.
- **Optional decision-making power**: in case the strategic committee gets the power and authority to take decisions, these decisions should be taken independently.
- **Health in all policies approach & intersectoral perspective**: this committee should consider the impact that all policies and other sectors may have an influence on asylum seeker health (such as the reallocation policy, access to labour market or educational system) through social determinants of health approaches.[90, 95, 96]

6.4 Improvements to the current system (quick wins)

Several stakeholders questioned the added value of an extensive reorganisation of the current health care organisation for asylum seekers for reasons of feasibility or undesirability. Therefore, in the following section, several potential improvements of the current organisation (i.e. “quick wins”) are suggested.

Ik ben voorstander van verbeteringen aan het huidige systeem (in eerste instantie quick wins) in plaats van het helemaal om te gooien.

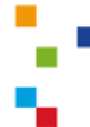
Quote retrieved from final stakeholder consultation

Nous ne partageons pas le point de vue que l’existence de systèmes différents est en soi problématique. Qu’une simplification des différents systèmes est nécessaire, oui.

Quote retrieved from final stakeholder consultation

6.4.1 Quick wins across organisations

- **Revision of the realloctation policy:** transferring asylum seekers from one reception centre to another or between different partner reception organisations complicates continuity of care. When revising the realloctaton policy, continuity of care should be kept in mind. Continuity of care could be increased by developing an electronic health record for all asylum seekers.
- **Analysis and harmonisation of the Plus and Minus lists:** the content of the Plus and Minus lists should be evaluated on the accuracy of the health care need of asylum seekers. This should be based on the content and prevalence of the applications for reimbursement of exceptional costs. This exercise should be done both by Fedasil and the PPS Social Integration (across all CPAS – OCMW). This requires transparancy and motivation of the decision making related to exceptional costs. In a second stage, a common use of the Plus and Minus lists should be envisaged. Hence, if the CPAS – OCMW and Fedasil would use the same Plus and Minus lists the comprehensibility of the current reimbursement regulation in reception centres would be increased, both for asylum seekers and concerned health care professionals.
- **Expanding the current offer of intercultural mediation and raising awareness and information of health care professionals regarding the intercultural mediation:** currently this belongs to the competency of the FPS Public Health and is strongly recommended by the WHO Europe[97].



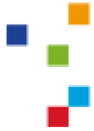
- **Improving access to guidelines and information on migrant health for health care professionals:** In the Netherlands, a website offers centralised information for GPs[ccc]. The Mental Health & Psychosocial Support Network (MHPSS) is another resource that could mobilised by health care professionals regarding mental health issues.[98] Similarly, the European Centre for Disease Prevention and Control published a series of guidelines related to the management of tuberculosis, the screening and vaccination for infectious diseases and the public health guidance on HIV, hepatitis B and C testing.[99-105]
- **Improving training of health care professionals:** There is a vast body of evidence supporting the need for training of health care professionals in terms of communicable diseases, inherited conditions, chronic diseases, nutritional deficiencies, and the effects of displacement, trauma, torture, sexual abuse, and cultural competences, allowing them to care for a diverse patient population.[17, 18, 39, 72, 106-115] Initiatives already exist in Belgium and should be sustained and/or better implemented on the field. For example, Belgian health care professionals and social workers have been involved in European projects aiming at improving their skills and competences when caring for asylum seekers and/or migrants (i.e. MIG-H-Training[ddd] and Train4M&H).[116] To increase the awareness of GPs, Fedasil, in partnership with Domus Medica and the SSMG, has launched an online training for GPs willing to take care of asylum seekers.
- **Coordinating physician within the CPAS – OCMW:** to ensure the reception and continuity of the patients' health record when asylum seekers move from a Fedasil (or partners) reception centre to an ILA – LOI (cfr. the model of coordinating GP in nursing homes).
- **Supporting and expanding the electronic medical file in the reception network:** implementing an electronic medical file that allows communciation between facilities (uniform across Fedasil (or partners) reception centres and ILA – LOI) and health care professionals. Fedasil is currently developing such an electronic medical file. International recommendations stress the need for comprehensive and standardised medical assessment upon arrival in host countries.[40, 117, 118] Since decades, the International Organisation of Migration promotes and supports the implementation of an electronic personal health record for asylum as a tool for a better systematic health assessment and a better continuity of patient care between and within countries.[119, 120]
- **Ensuring the compatibility of the different IT systems:** for example, the systems of the Immigration Office and Fedasil should match, as they both check vulnerabilities of applicants.

6.4.2 Quick wins on the level of the CPAS – OCMW

- **Changes in payment guarantee:** asylum seekers in ILA – LOI and those with a code 207 "No show" often face administrative barriers preventing access; they first need to obtain a payment guarantee before they can access health care services. Depending on the CPAS – OCMW, the payment guarantee is delivered per act or for a defined period. The length of validity of the medical card may also vary from one CPAS – OCMW to another. Some stakeholders stated that many CPAS – OCMW grant the medical card for a period of 1 day. To ensure continuity of care it is recommended to grant a payment guarantee for a longer period. From this point of view, a medical card for a period of one month, similar to the medical card for undocumented migrants, may be considered. This would allow to avoid delays in health care access when a disease episode occurs, and thus reduce the administrative workload for the CPAS – OCMW.

ccc See the website here: https://www.huisarts-migrant.nl/

ddd See more here: https://www.re-health.eea.iom.int/migration-and-health-launch-mig-h-training-project



- **Standardisation of the rules for social inquiry**: some CPAS – OCMW perfom the social enquiry for the entire household while others perform it for each individual. The latter implies that for each member of the household the social worker has to conduct a distinct social inquiry. To avoid repeating the social enquiry, standard rules across the CPAS – OCMW need to be composed and implemented.

6.4.3 *Quick wins on the level of Fedasil*

- **Simplification of the reimbursement procedures:** health care professionals encounter problems with the payment of their interventions. Payments to health care professionals are made by each of the centers separately who in turn are reimbursed by Fedasil. This implies that health care professionals working in several centers have to approach each of these centers to be paid. To enhance efficiency, payment of health care professionals could be centralised at Fedasil. To ensure a timely payment, manpower of Fedasil should then be reinforced.
- **Reinforcing manpower:** as previously mentioned, the human resources of the medical cell of Fedasil should be reinforced. This medical cell is currently staffed by 3 FTE. According to interviews with stakeholders, this number is inadequate to ensure a timely payment of the health care professionals or for follow-up. Second, at this moment there are no standards or rules for the workforce in reception centres (e.g. number of FTE nurses by centre). Based on the audit of the quality cell of Fedasil, a clear definition of the standards with which health care professionals in reception centres should comply could enhance the available expertise. In addition, stakeholders mentioned a high turn-over of workforce in reception centres. Making the working conditions in reception centres more attractive and reinforcing the competences of health care professionals through training could reduce the high turn-over and also lead to better experienced health care professionals.

7 CONCLUSION

Stakeholders reported that the current operationalisation of the health care system for asylum seekers is chaotic, resulting in a high administrative burden for health care professionals, social workers and public services, for a rather limited number of persons (i.e. approximately 20 000 people in 2018 [24]) during a rather limited period of time (in principle less than 6 months). As pointed out by the ‘Green Book of Access’, this complexity contributes to the lack of transparency and an unequal coverage of asylum seekers regarding health care.[10] According to the ‘White Book of Access’ integrating asylum seekers in the MediPrima system could be a solution.[121]

The current report mainly focuses on the options of stakeholders in order to ensure a more equitable access to health care for asylum seekers in Belgium. It does not intend to evaluate the performance of the health care system for asylum seekers nor the quality of care. The proposed options for this reform should, therefore, be interpreted as a first step in a more general reform of the health care system for asylum seekers.

7.1 Prerequisites

Policymakers should keep the following three transversal principles in mind when deciding upon the first steps in the health care reform for asylum seekers (see section 6.1).

1. **Asylum seekers have a right to material assistance allowing them to live a life consistent with human dignity.**
2. **Equity in access to health care between all asylum seekers should be ensured.**
3. **The reform of organisation of health care for asylum seekers should simplify the current system.**

Therefore, this report proposes to abolish parallel systems and integrate all types of asylum seekers (for example unaccompanied minors) into one comprehensive health care delivery system. This is in line with current policy intending to integrate different populations as much as possible in the compulsory health insurance system to enhance uniformity. For example, at

the moment of the writing of this report, policy measures aiming at the integration of prisoners in the compulsory health insurance are ongoing.[122]

7.2 Estimated effect of options on the described problems

Based on an analysis of the current situation in health care for asylum seekers, problems in health care delivery on several levels were identified in Chapter 5: (i) the overarching macro-level (i.e. governance and policy), (ii) the meso-level (i.e. organisations of institutions, professionals, and distribution of resources), and (iii) the micro-level (i.e. differences in treatment between asylum seekers). The majority of these identified problems result from the administrative fragmentation of the current health care system.

Figure 12 provides a detailed overview of the estimated effects related to the problems identified in this chapter, if the conditions of implementation for the proposed options are fulfilled.

Overall, the effect of **the distributor of funding** addresses many problems on the macro level.

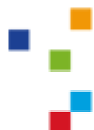
1. The option 1 in which the sickness funds take up the role of distributor of funding responds most to the basic requirements of equitable access to and coverage of health care for all asylum seekers, taking into account the specific needs of asylum seekers (cfr. the aforementioned transversal principles). However, this option would entail the most ‘invasive’ reorganisation.

2. The option 2.1 in which Fedasil distributes the funding for all asylum seekers guarantees equitable access and coverage of health care for all asylum seekers. But, more technical changes and investments in knowledge and human resources will be required to reach the same level of quality and efficiency (in terms of ability to control, and follow up of health care for asylum seekers and to manage payment of care providers) and expertise, compared to the option where the sickness funds (through the NIHDI) take over the distribution of funding. Overall, one can conclude that it would take much effort to make the functioning of Fedasil as a ‘pseudo sickness fund’ for asylum seekers as efficacious as the already existing system of sickness funds.

3. However, and efficient solution for the option 2.2 presented in the second point would be that Fedasil manages the global envelope and the administration is done by the CAAMI – HZIV through the MediPrima software. This option would have a lot of advantages in terms of feasibility, as this option aligns with the current system for undocumented migrants. Nevertheless, this option would also require changes to the MediPrima software to broaden its scope beyond primary care

4. The option 3 closest to the organisation ‘as is’, where the existing competences and funding remain with the respective organisations and where all asylum seekers get access to health care according to the nomenclature of the health care insurance, using MediPrima as administrative tool answers to the requirement of equal coverage of health care for all asylum seekers, but access will remain different since the existing managing organisations (Fedasil and the CPAS – OCMW) keep their competences for the different categories of asylum seekers. This system guarantees an equal treatment between nationals and asylum seekers but may be less attentive for the specificities of asylum seekers regarding health care needs. This option is the least ‘invasive’ one, since the respective competences of the managing organisations do not change.

The costs of these proposed options were not investigated as it was out-of-the scope of this study. One could expect that these options would result in a better coverage which, in itself, might lead to increased short-term costs for health care. However, it can also be anticipated that administrative costs will decrease due to the simplification and harmonisation of the access procedures. This is also likely to decrease the long-term costs for society, giving the fact that 50% of the applicants are likely to obtain a legal permit to stay in Belgium. [42, 123] A previous study with undocumented migrants demonstrated that allowing undocumented migrants to the same health care coverage as nationals decreases the overall costs for the society.[123, 124]



Similar findings were found in Germany after the health care reorganisation for asylum seekers.[42]

In terms of **practical implementation**, all options appear to be feasible. Sickness funds-representatives in the stakeholder meetings did not predict major technical problems for the integration of asylum seekers in the compulsory health care insurance. However, changing Fedasil into a pseudo sickness fund would require an important investment. Stakeholders representing the MediPrima system stated that it is technically feasible to include all asylum seekers in the MediPrima system.

Since it only concerns a relatively small group of individuals, the impact on the workload for the services concerned was also considered to be manageable.

Some stakeholders stated that instead of a major reform, a **stepwise approach** or **intermediate options** ("quick wins") improving the existing system might be more feasible. Yet, although these less 'invasive' alternatives or quick wins may be 'easier' to implement in the short-term, they do not solve long-term problems on the macro level.

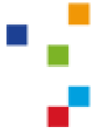
As for **governance**, all stakeholders unanimously agreed that there should be an organisation that coordinates health care for asylum seekers across all reception facilities and categories of asylum seekers. The option where **Fedasil** takes the lead in governance is more preferred by stakeholders than a strategic committee. Although problems related to governance are addressed by both options (see Table 12), the stakeholders fear even more fragmentation if a new decision-making body (i.e. strategic committee) were to be created. Yet, they see an added value in the role of an **advisory committee** composed of the relevant stakeholders in the domain. This seems to be compatible with the option in which Fedasil takes the lead in governance.

Table 12 – Summary of expected effect of options on problems defined in Chapter 5

	Distributor				Governance	
	Option 1	*Option 2.1*	*Option 2.2*	*Option 3*	*Option 1*	*Option 2*
	Sickness funds	**Fedasil**	**Fedasil and CAAMI – HZIV**	**Situation as is – use MediPrima + nomenclature**	**Fedasil**	**Strategic committee**
PROBLEMS AT THE MACRO-LEVEL						
• Lack of coordination	N/A	N/A	N/A	N/A	☺	☺
• Regional differences	N/A	N/A	N/A	N/A	☺	☺
• Lack of monitoring of health care use and health care costs	☺	😐	☺	😐	😐	😐
• Lack of transparency about health care expenses	☺	☺	☺	☺	N/A	N/A
• Lack of administrative support and of qualified personnel to manage administrative tasks	☺	😐	☺	😐	N/A	N/A

PROBLEMS AT THE MESO-LEVEL						
• Unclear administrative system for health care professionals	☺	😐	☺	😐	N/A	N/A
• Differences in health care system depending on place of stay	☺	☺	☺	😐	☺	☺
• Lack of health care professionals qualified to interact in health care for asylum seekers	N/A	N/A	N/A	N/A	😐	😐
• High turnover of health care professionals in reception centres	N/A	N/A	N/A	N/A	😐	😐
• Reluctance and/or overburdening of (some) health care professionals	N/A	N/A	N/A	N/A	😐	😐
• Poor and/or unclear collaboration between the different actors involved in health care for asylum seekers	N/A	N/A	N/A	N/A	😐	😐
• Tension regarding patient confidentiality	N/A	N/A	N/A	N/A	N/A	N/A
• Lack of appropriate health information for asylum seekers	N/A	N/A	N/A	N/A	😐	😐
PROBLEMS AT THE MICRO-LEVEL						
Inequity in access						
• Availability and accessibility of specialised health care services	😐	😐	😐	😐	😐	😐
• Cultural and linguistic barriers	😐	😐	😐	😐	😐	😐
• Administrative barriers	☺	☺	☺	☺	N/A	N/A
• Heterogeneity in the freedom of choice of health care professionals	😐	😐	😐	😐	😐	😐
Inequity in treatment						
• Lack of uniformity of the coverage of health care	☺	☺	☺	☺	☺	☺
• Lack of global evaluation of health status upon arrival and departure	N/A	N/A	N/A	N/A	😐	😐
• Underuse and poor implementation of (existing) guidelines	N/A	N/A	N/A	N/A	😐	😐
• Lack of access to mental health care and lack of alternative treatments	N/A	N/A	N/A	N/A	😐	😐
SPECIFIC PROBLEMS FOR UNACCOMPANIED MINORS						
• Lack of coverage through insurance funds for unaccompanied minors	☺	☺	☺	😐	N/A	N/A
• Difficulties to comply with the conditions to access the compulsory health insurance	☺	N/A	N/A	😐	N/A	N/A
• Shortage of guardians	N/A	N/A	N/A	N/A	N/A	N/A
DEGREE OF REORGANISATION	+++	++	++	+	+	++

☺ Expected effect will be positive, 😐 expected effect will be uncertain (depending on made choices) or mixed, ☹ expected effect will be negative, N/A no expected effect.



7.3 Limitations

When interpreting the results of this study, several limitations should be taking into account.

First, despite the efforts to invite and interview all relevant stakeholders, **it is difficult to estimate whether all stakeholders were equally represented** (see the stakeholder mapping in the method section 3). Some stakeholders themselves indicated that respondents could mainly comprise actors favouring equitable health care for asylum seekers. However, the research team tried to include a wide variety of stakeholders and also invited those of which it could be expected they did not favour equity in health care for asylum seekers. The value of the proposed options, based on "opinions" of the interviewed and included stakeholders, is therefore relative. Moreover, this study only incorporates the opinion and experiences of organisations and (health care) professionals. It does not incorporate the perspectives of asylum seekers themselves. Based on discussions between experts and the research team at the beginning of this study, it was decided not to interview asylum seekers, due to their uncertain situation in Belgium and difficulties to anticipate the potential emotional and mental effects. Relying mostly on opinions of health care professionals and social workers may have oriented the focus of the proposed options, and may partly explain the lack of solutions to directly address the needs of asylum seekers. Accordingly, future research should better include the perspective of all categories of asylum seekers, keeping the potential emotional and mental effects to a minimum.

Second, there is a **lack of Belgian data** to clearly describe health outcomes, quality of provided care, and needs of asylum seekers. Consequently, the proposed options may not be able to impact the health outcomes of asylum seekers directly but rather improve the working conditions of health care professionals and social workers by contributing to an administrative simplification. To avoid this lack of data in future research, the WHO Europe emphasises the need for improved data collection systems to obtain **standardized and disaggregated** data to support adapted health policy.[40] Therefore, future studies should focus on quality of care and health outcomes. The development of an electronic health record for all asylum seekers by Fedasil and the implementation of the personal health record – as recommended by the International Organisation for Migration – could facilitate and validate this data collection.

Because some aspects were out of scope of current study, they are worthwhile to address in future research: efficiency and quality of the health care delivery for asylum seekers, specific (health) needs of asylum seekers, equity issues between Belgian citizens and asylum seekers.

Several issues raised by the stakeholders and identified in the analysis of the situation are not solved by the suggested options. Of particular interest is the **consequences of the reallocation policy on the access and quality of health care**, including the continuity of patient care. Specific problems related to specific categories are also not addressed in this study, such as asylum seekers in detention centres, those with a code 207 "No show" and potential "medical tourists".

APPENDICES

APPENDIX 1. DETAILED DESCRIPTION OF THE METHODOLOGY

This section aims at providing additional details on the methods used during this stakeholder consultation. Stakeholder consultation is an iterative process, aiming at bridging together all actors that may influence or be influenced by a specific issue. All gathered information during this research process was triangulated and will, therefore, be presented in an integrated manner during the following chapters of this scientific report.

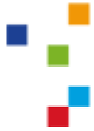
Appendix 1.1. Exploratory phase: literature review and interviews with stakeholders

The exploratory phase aimed at

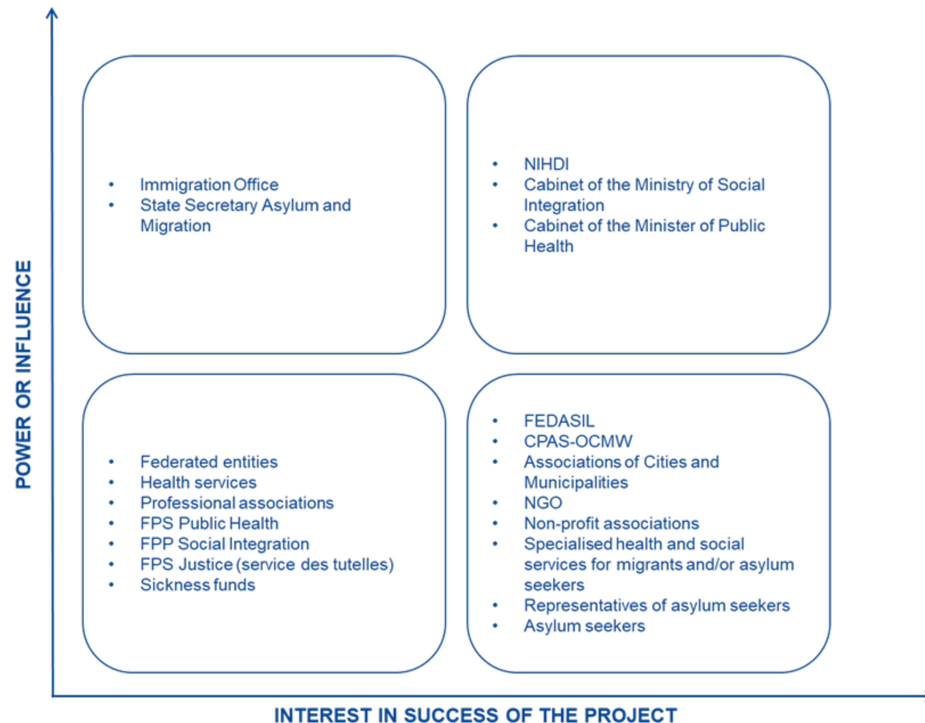
- To make a situation analysis of the current health care system for asylum seekers
- To identify current gaps according to the grey and scientific literature, experts and/or stakeholders
- To identify areas of improvement

Appendix 1.1.1. Stakeholder mapping

The key stakeholders in Belgium related to the issue of asylum seekers' health were first identified by the research team. We considered not only those who are already considering the issue but also those likely to be impact by the reform. To build the first mapping, the previous research experience in the field of migration and health of two team members was mobilised. During the desk search and the exploratory interviews (see below), the mapping was updated.



Each stakeholder was categorised according to its degree of interest and its degree of power – formal and informal – on the issue that is the degree to which the stakeholder could influence the final decisions.



Adapted from Brouwer & Woodhill[20]

Appendix 1.1.2. Desk search

LITERATURE SEARCH

A rapid review of the (Belgian) literature was conducted to map the current situation of health care for asylum seekers using both grey and scientific literature. Two distinct strategies were used to gather data.

The websites of Fedasil, the General Commissariat of Refugees and Stateless, the Immigration Office, the Croix-Rouge de Belgique, Rode Kruis Vlaanderen and Myria were systematically searched. Emails were sent to project leaders and to the stakeholders of the CESSMIR conference of September 2018 to obtain additional reports and/or papers.

The international projects on migrant health were systematically searched: AIDA, MIPEX, SH-CAPAC, EUR-HUMAN, EUGATE and the WHO Evidence series on migrant health (see Table 13). For each project, the following information were retrieved: 1) specific data for Belgium; 2) contact data of experts/potential partners for Belgium; 3) additional projects to be investigated. For and backward strategies were also used. We also searched the following databases: PubMed, CINHAL, the Cochrane Library and Scopus. The original search equation was first developed for PubMed and was then adapted to other databases.

Table 14 presents the inclusion criteria of the scientific literature.

Data from the grey and scientific literature were extracted in an Excel sheet and categorised according the following categories:

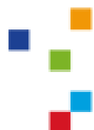
- demographics of asylum seekers in Belgium
- health status and health needs for asylum seekers in Belgium
- organisation of health care in Belgium
- problems for asylum seekers in Belgium
- existing initiatives/solutions for asylum seekers in Belgium

No exclusion criteria were explicitly defined. The selection process was made by the PI, with support of a senior researcher. A total of 321 references

were retrieved, among which 30 legal documents and 17 statistic reports. EndNote version 8.2 was used to store the citations and track the abstracts. The initial search was conducted between March and June 2017. Papers received from colleagues were also added to the databases. No quality assessment was performed on the literature, especially as several sources originated from the grey literature. Results were presented as a narrative synthesis, aiming at drawing a fist comprehension landscape of health status and health care needs of asylum seekers in Belgium and were used to corroborate or complete the information retrieved from the interviews (see below).

Table 13 – Summary description of international projects on migrant health

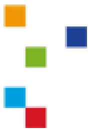
Title project	Description	Website
Asylum Information Database (AIDA)	AIDA is a tool aiming at mapping asylum procedures, reception conditions, detention and content of protection in Europe. This interactive online tool is funded by the European Council for Refugees and Exiles. The tool is updated yearly by a national partner. In Belgium, the national partner is Vluchtelingenwerk Vlaanderen.	http://www.asylumineurope.org
Migrant Integration Policy Index (MIPEX)	MIPEX is a tool which measures policies to integrate migrants in all EU Member States, Australia, Canada, Iceland, Japan, South-Korea, New Zealand, Norway, Switzerland, Turkey and the USA. Dimensions investigated were: access to nationality, anti-discrimination, education, family reunion, health, labour market mobility, permanent residence, and political participation. Last assessment was conducted in 2015. For each dimension, a score on 100 is attributed, the higher the score, the better. MIPEX is funded by the European Union, EQUI-HEALTH and the international organisation for migrations.	http://www.mipex.eu
Supporting Health Coordination, Assessments, Planning, Access to Health Care and Capacity Building in Member States Under Particular Migratory Pressure (SH-CAPAC)	SH-CAPAC aims at supporting European Union Member States under particular migratory pressure in their response to health related challenges. The project activities addresses the double nature of the health response needed: a) responding to acute humanitarian needs and b) responding to structural challenges associated to mainstreaming the response into the national health systems. This project was co-funded by the Health programme of the European Union in 2016.	https://www.sh-capac.org
EUropean Refugees- HUman Movement and Advisory Network (EUR-HUMAN)	EUR-HUMAN aims to enhance the capacity of European Member States who accept migrants and refugees in addressing their health needs, safeguard them from risks, and minimize cross-border health risks. EUR-HUMAN was funded by the European Union's Health Programme (2014-2020) for 12 months.	http://eur-human.uoc.gr
Best Practice in Health Services for Immigrants in Europe (EUGATE)	EUGATE aims at the consolidation of the fragmented knowledge in the field and identify best practice of health care for different immigrant populations.	http://www.eugate.org.uk



	It reviews legislation, policies, and funding arrangements, assess systems of health care services, and compare models of best practice across European countries for the people concerned. EUGATE defines guidelines for best practice and disseminates the findings widely among the relevant stakeholder groups in Europe. EUGATE was funded by the DG SanCo of the European Union (2008-2010).	
WHO Evidence serie on migrant health	Since 2015, the WHO publishes themed synthesis report series summarizing the best available evidence to improve policy-makers' understanding of the specific issues related to migration. Themes include: prevention, diagnosis, treatment and care of tuberculosis among refugees and migrants; equitable delivery, access and utilization of immunization services for migrants and refugees; accessibility and quality of maternal health care delivery for migrants; mental health care for refugees, asylum seekers and irregular migrants; and health status of refugees and asylum seekers.	http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/health-evidence-network-hen-synthesis-reports

Table 14 – Inclusion criteria of papers included in the rapid review

Categories	Keywords
Type of participants	Asylum seekers only Unaccompanied minors
Country of studies	Belgium
Language of documents	Dutch, English, French and German.
Settings	No restriction
Type of studies	No restriction
Design of studies	No restriction
Topic of the studies	Perceived health/subjective health Mental health Sexual and reproductive health Infectious diseases Chronic diseases/non-transmissible diseases Mortality/morbidity health care status, health behaviours, health care needs,



	health promotion, prevention
Time span	2007-2018
Language	Dutch, English, French and German.

- Existing database

To compile evidence about costs and health care utilisation, five databases were systematically searched: 1) MediPrima database of the PPS Social Integration; 2) Fedasil database on costs, 3) the IMA – AIM database of the sickness funds; 4) the MZG – RHM containing hospital data, and 5) Finhosta system containing financial and accounting aggregated data which includes information such as the number of hospital days or the number of hospital stays.

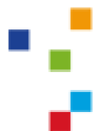
- Interviews with stakeholders

Between March and June 2017, exploratory interviews were held with representatives of the following institutions: Fedasil (n=2), Myria (n=2), *Croix-Rouge de Belgique* (n=1), *Médecins sans Frontières Belgique* (n=2), *Plateforme Mineurs en Exil* (n=1), FPS Justice (n=2), *MedImmigrant* (n=1), *Agentschap Integratie-Inburgering* (n=1) and *Stad Antwerpen* (n=1). Stakeholders were selected because of their expertise in the field of health and migration (purposive sampling). They were identified through reports found in the literature search or through snowball approach. Contacts were made by phone or e-mail: the main objectives of the interview were briefly presented during this first contact. Interviewees did not received a hand-out with the questions before the interview. Each interviewee was invited to name one or more additional experts. On average, each interview lasted one hour. Two members of the research team also attended a workshop organised by *Agentschap Integratie-Inburgering* over access to health care for asylum seekers.

The interviews were supported by a predefined interview guide. Based on the first interview, a thematic coding was elaborated: 1) current problems; 2) priorities; 3) solutions. The final codes were included in the situation description and the problems.

Table 15 – Interview guide of the interviews

Main questions addressed to stakeholders
• Could you present your role and organisation in a few words? ○ What are your daily activities with asylum seekers? ○ Do you care for a specific sub-group of asylum seekers/for specific issues with asylum seekers?
• What are the current major problems regarding health care organisation for asylum seekers according to your experience? ○ Do you have any data, report or information source that support these problems?
• What are the priority problems to be solved? ○ Do you perceived barriers to the resolution of such problems? ○ What are possible solutions for these problems? ○ Do you have any best practices to recommend? ○ Is there any opportunity that may influence the implementation of the solutions?
• Which other key actors should we meet?
• Do you wish to add any comments, remarks?



Appendix 1.2. Priority of options: a national online survey

The online survey, available both in French and Dutch, had two main objectives:

- Validate the key elements of the current organisation of health care for asylum seekers on which are based the different problems as identified in the literature search and the interviews with stakeholders;
- Collect preferences of actors regarding possible options to improve the current organisation of health care for asylum seekers.

Appendix 1.2.1. Instrument for data collection

Data from the literature search and the interviews were gathered to develop basic options regarding three main parts: 1) Governance of health care policy, 2) Organisation of health care, and 3) Funding of the health care.

These options were included in a close-ended questionnaire (see Table 16). Each section of the questionnaire was introduced by a description of the current situation based on the literature and the interviews. In each section, stakeholders had to make choice regarding different options based on a 4-point Likert scale to avoid a neutral opinion. Stakeholders could therefore choose the option “I don’t feel competent to answer”. Other questions investigated preferences of stakeholders regarding possible options.

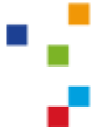
For each statement, stakeholders had the possibility of explaining their choices in a text box. Depending on the answers given on previous questions, some questions were optional.

The questionnaire was initially developed in French and subsequently translated in Dutch and reviewed in both languages by KCE researchers outside the research team of this study. The questionnaire was pre-tested by twelve other KCE researchers (also outside the research team of this study) in April 2018. The KCE researchers testing the questionnaire were selected because they matched the profile of respondents and/or have an experience in the development of similar surveys. After the test, modifications were made to the wording of some questions.

Table 16 – Questionnaire of the online survey regarding health care for asylum seekers

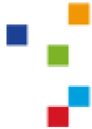
FRENCH VERSION	DUTCH VERSION
Cette enquête repose sur une première phase exploratoire analytique menée par notre équipe de recherche, sur base sur de littérature belge et internationale et d’entretiens avec des parties prenantes. De cette phase sont ressortis 3 constats fondamentaux autour de la situation actuelle des soins de santé pour les demandeurs d’asile en Belgique : • Les responsabilités en matière de gouvernance globale et d’organisation des soins de santé pour les demandeurs d’asile sont réparties entre différents acteurs. • Le contenu de la couverture de soins de santé n’est pas identique pour tous les demandeurs d’asile. • Le financement des soins de santé des demandeurs d’asile est assuré par différents acteurs selon différentes modalités. À partir de chacun de ces constats, nous proposons une série de pistes visant à améliorer l’organisation des soins de santé pour les demandeurs d’asile. L’enquête	Deze enquête is gebaseerd op een eerste verkennende analyse van het huidige gezondheidszorgsysteem, gebaseerd op Belgische en internationale literatuur en interviews met de belangrijkste stakeholders. Deze analyse heeft drie belangrijke bevindingen geïdentificeerd: • De bevoegdheden voor het globale beleid en de organisatie van de gezondheidszorg voor asielzoekers zijn verdeeld over verschillende actoren. • De omvang van de dekking van gezondheidszorg is niet voor alle asielzoekers gelijk. • De financiering van de gezondheidszorg voor asielzoekers gebeurt door verschillende actoren en volgens verschillende modaliteiten. Vanuit elk van deze bevindingen vragen we u om te kiezen tussen een aantal voorstellen ter verbetering van de organisatie van de gezondheidszorg voor

vous permet de vous prononcer sur ces pistes. Sur la base de vos réponses, nous pourrons affiner nos propositions. Chacun des constats est traité dans un module de l'enquête. Un court descriptif de la situation actuelle est accessible en début de chaque module. Les éléments soulignés renvoient vers la définition de l'élément. Vous pouvez à tout moment revenir en arrière ou interrompre le questionnaire. Ce questionnaire sera accessible du 20 avril jusqu'au 15 mai 2018. Il est possible de modifier vos réponses tant que vous ne validez pas l'envoi final. Seule l'équipe de recherche a accès à vos réponses et coordonnées. Si nécessaire, vous pouvez nous contacter par courriel ou par téléphone : Marie Dauvrin (FR) : Marie.Dauvrin@kce.fgov.be - 02 287 33 28 Jens Detollenaere (NL) : Jens.Detollenaere@kce.fgov.be - 02 287 33 67	asielzoekers. U krijgt daarbij ook de kans om uw keuze verder toe te lichten. Op basis van uw antwoorden kunnen wij dan onze voorstellen verder verfijnen. De enquête bestaat uit modules, die zijn telkens opgebouwd rond een bevinding. Elke module begint met een korte beschrijving van de huidige situatie. De gemarkeerde woorden verwijzen naar een definitie van een sleutelbegrip. U kan op elk moment teruggaan naar vorige vragen of de enquête onderbreken. De enquête is beschikbaar van 20 april tot en met 15 mei 2018. Zolang u de enquête niet verstuurt, kan u uw antwoorden nog wijzigen. De enquête is anoniem, en enkel het onderzoeksteam heeft toegang tot uw gegevens (om u uit te nodigen voor de vergadering waarin de resultaten van de enquête worden besproken). Indien u vragen of opmerkingen heeft, kan u contact opnemen met het onderzoeksteam: Jens Detollenaere (NL): Jens.Detollenaere@kce.fgov.be - 02 287 33 67 Marie Dauvrin (FR): Marie.Dauvrin@kce.fgov.be - 02 287 33 28
Partie A: MODULE 1 Les responsabilités en matière de gouvernance globale et d'organisation des soins de santé pour les demandeurs d'asile sont réparties entre différents acteurs. Cliquez ici pour une description de la situation actuelle.	Sectie A: MODULE 1 De bevoegdheid voor het globale beleid en de organisatie van de gezondheidszorg voor asielzoekers is verdeeld over verschillende actoren. Klik hier voor een beschrijving van de huidige situatie.
A1. La santé des demandeurs d'asile devrait faire l'objet d'une politique coordonnée et centralisée. o Pas du tout d'accord o Plutôt pas d'accord o Plutôt d'accord o Tout à fait d'accord o Je ne suis pas compétent(e) pour répondre	A1. De gezondheid van asielzoekers moet het voorwerp uitmaken van een gecoördineerd en centraal beleid. o Helemaal niet akkoord o Eerder niet akkoord o Eerder akkoord o Helemaal akkoord o Ik heb onvoldoende kennis om hier op te antwoorden
A2. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A2. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A3. La politique de santé des demandeurs d'asile pourrait être coordonnée et centralisée par : o Le Service Public Fédéral (SPF) Intérieur via Fedasil o Le SPF Santé Publique	A3. Het gezondheidsbeleid voor asielzoekers kan gecoördineerd en gecentraliseerd worden door: o De Federale Overheidsdienst (FOD) Binnenlandse Zaken, via Fedasil o De FOD Volksgezondheid

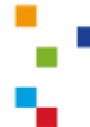


○ Le Service Public Programmation (SPP) Intégration Sociale ○ Le Centre fédéral Migration Myria ○ Un comité stratégique réunissant des représentants des entités fédérales et fédérées ayant des compétences en matière de santé, soins de santé et asile et migration ○ Un comité stratégique réunissant des représentants des entités fédérales et fédérées ayant des compétences en matière de santé et de soins de santé uniquement	○ De Programmatorische Federale Overheidsdienst (POD) Maatschappelijke Integratie ○ Het Federaal Migratiecentrum Myria ○ Een strategisch comité met vertegenwoordigers van federale en gefedereerde entiteiten, dat expertise heeft inzake gezondheid, gezondheidszorg en asiel en migratie ○ Een strategisch comité met vertegenwoordigers van federale en gefedereerde entiteiten, dat enkel expertise heeft inzake gezondheid en gezondheidszorg
A4. Selon vous, quelle serait l'instance la plus appropriée pour coordonner et centraliser la politique de santé des demandeurs d'asile ? ○ Le Service Public Fédéral (SPF) Intérieur via Fedasil ○ Le SPF Santé Publique ○ Le Service Public Programmation (SPP) Intégration Sociale ○ Le Centre fédéral Migration Myria ○ Un comité stratégique réunissant des représentants des entités fédérales et fédérées ayant des compétences en matière de santé, soins de santé et asile et migration ○ Un comité stratégique réunissant des représentants des entités fédérales et fédérées ayant des compétences en matière de santé et de soins de santé uniquement ○ Autre(s):	A4. Wat is volgens u de beste optie voor een gecoördineerd en centraal beleid van de gezondheidszorg voor asielzoekers? ○ De FOD Binnenlandse Zaken, via Fedasil ○ De FOD Volksgezondheid ○ De POD Maatschappelijke Integratie ○ Het Federaal Migratiecentrum Myria ○ Een strategisch comité met vertegenwoordigers van federale en gefedereerde entiteiten, dat expertise heeft inzake gezondheid, gezondheidszorg en asiel en migratie ○ Een strategisch comité met vertegenwoordigers van federale en gefedereerde entiteiten, en dat enkel expertise heeft inzake gezondheid en gezondheidszorg ○ Autre(s):
A5. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A5. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A6. Les modalités d'organisation des soins de santé devraient s'adapter au lieu d'hébergement et/ou au statut des demandeurs d'asile : centres d'accueil collectifs gérés par Fedasil ou ses partenaires ; Initiatives Locales d'Accueil (ILA) ; hébergement choisi par les demandeurs d'asile en cas de «No show» et centres fermés. ○ Pas du tout d'accord ○ Plutôt pas d'accord ○ Plutôt d'accord ○ Tout à fait d'accord ○ Je ne me sens pas compétent(e) pour répondre à cette question	A6. De modaliteiten van de gezondheidszorg moeten worden aangepast in functie van de verblijfplaats en/of het statuut van de asielzoeker (collectieve opvangcentra beheerd door Fedasil of partnerorganisaties/lokale opvanginitiatieven [LOI], "No show", zijnde asielzoekers die zelf een verblijfplaats vinden, en gesloten centra). ○ Helemaal niet akkoord ○ Eerder niet akkoord ○ Eerder akkoord ○ Helemaal akkoord ○ Ik heb onvoldoende kennis om op deze vraag te antwoorden
A7. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A7. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A8. L'organisation des soins de santé pour les demandeurs d'asile devrait :	A8. De organisatie van de gezondheidszorg voor asielzoekers moet:

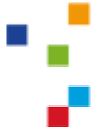
○ Se calquer sur l'organisation actuelle du réseau d'accueil, avec des modalités de soins adaptées aux différentes situations possibles : 1) centres d'accueil collectifs ; 2) Initiatives Locales d'Accueil (ILA) ; 3) hébergement choisi par les demandeurs d'asile en cas de «No show» ; 4) centres fermés. ○ Distinguer entre 1) les demandeurs d'asile dans le réseau d'accueil (centres d'accueil collectifs/Initiatives Locales d'Accueil), 2) les demandeurs d'asile «No show» ayant choisi leur propre hébergement, et 3) les demandeurs d'asile en centres fermés. ○ Distinguer entre 1) les demandeurs d'asile dans le réseau d'accueil (centres d'accueil collectifs/Initiatives Locales d'Accueil/ demandeurs d'asile « No show» ayant choisi leur propre hébergement) et 2) les demandeurs d'asile en centres fermés. ○ Etre la même pour tous les demandeurs d'asile, indépendamment du lieu d'accueil	○ Gebaseerd zijn op de huidige organisatie van het opvangnetwerk, met aangepaste zorgmodaliteiten: (1) collectieve opvangcentra; (2) lokale opvanginitiatieven (LOI); (3) "No show" die zelf een verblijfplaats hebben gevonden; (4) gesloten centra. ○ Een onderscheid maken tussen 1) asielzoekers in het opvangnetwerk (collectieve opvangcentra, lokale opvanginitiatieven (LOI), 2)"No show" die zelf een verblijfplaats hebben gevonden), en 3) asielzoekers in gesloten centra. ○ Een onderscheid maken tussen 1) asielzoekers in het opvangnetwerk (collectieve opvangcentra, lokale opvanginitiatieven (LOI)/"No show" die zelf een verblijfplaats hebben gevonden), en 2) asielzoekers in gesloten centra. ○ Hetzelfde zijn voor alle asielzoekers, onafhankelijk van hun verblijfplaats
A9. Selon vous, quelle serait l'option à privilégier pour l'organisation des soins de santé ? ○ Organisation calquée sur l'organisation actuelle du réseau d'accueil ○ Organisation distinguée entre 1) les demandeurs d'asile dans le réseau d'accueil (centres d'accueil collectifs/Initiatives Locales d'Accueil), 2) les demandeurs d'asile «No show» ayant choisi leur propre hébergement, et 3) les demandeurs d'asile en centres fermés ○ Organisation distinguée entre 1) les demandeurs d'asile dans le réseau d'accueil (centres d'accueil collectifs/Initiatives Locales d'Accueil/demandeurs d'asile « No show» ayant choisi leur propre hébergement) et 2) les demandeurs d'asile en centres fermés ○ Organisation unique pour tous les demandeurs d'asile, indépendamment du lieu d'accueil ○ Autre(s):	A9. Wat is volgens u de beste optie? ○ De organisatie van de gezondheidszorg moet gebaseerd zijn op de huidige organisatie van het opvangnetwerk ○ De organisatie van de gezondheidszorg moet een onderscheid maken tussen 1) asielzoekers in het opvangnetwerk (collectieve opvangcentra, lokale opvanginitiatieven (LOI), 2)"No show" die zelf een verblijfplaats hebben gevonden), en 3) asielzoekers in gesloten centra ○ De organisatie van de gezondheidszorg moet een onderscheid maken tussen 1) asielzoekers in het opvangnetwerk (collectieve opvangcentra, lokale opvanginitiatieven (LOI)/"No show" die zelf een verblijfplaats hebben gevonden), en 2) asielzoekers in gesloten centra ○ De organisatie van de gezondheidszorg is hetzelfde voor alle asielzoekers, onafhankelijk van hun verblijfplaats ○ Autre(s):
A10. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A10. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A11. À l'heure actuelle, le système belge fait une distinction entre les demandeurs d'asile mineurs d'âge non-accompagnés (MENA) et les autres demandeurs d'asile mineurs d'âge. Cette distinction devrait être maintenue. ○ Pas du tout d'accord ○ Plutôt pas d'accord ○ Plutôt d'accord ○ Tout à fait d'accord ○ Je ne me sens pas compétent(e) pour répondre à cette question	A11. Momenteel maakt het Belgische systeem een onderscheid tussen niet begeleide minderjarige (NBMV) en andere minderjarige asielzoekers. Dit onderscheid moet behouden blijven. ○ Helemaal niet akkoord ○ Eerder niet akkoord ○ Eerder akkoord ○ Helemaal akkoord ○ Ik heb onvoldoende kennis om op deze vraag te antwoorden



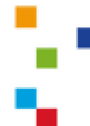
A12. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A12. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A13. L'organisation actuelle de la délivrance des soins de santé pour les demandeurs d'asile devrait être modifiée : les soins de première ligne devraient être dispensés pour l'ensemble des demandeurs d'asile dans le système général de soins, ouvert à toute la population. o Pas du tout d'accord o Plutôt pas d'accord o Plutôt d'accord o Tout à fait d'accord o Je ne me sens pas compétent(e) pour répondre à cette question	A13. De huidige zorgorganisatie voor asielzoekers moet gewijzigd worden: de eerstelijnszorg moet voor alle asielzoekers verleend worden binnen het reguliere systeem dat toegankelijk is voor de volledige bevolking. o Helemaal niet akkoord o Eerder niet akkoord o Eerder akkoord o Helemaal akkoord o Ik heb onvoldoende kennis om op deze vraag te antwoorden
A14. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences):	A14. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A15. L'organisation actuelle de la délivrance des soins de santé pour les demandeurs d'asile devrait être modifiée : les soins qui ne relèvent pas de la première ligne devraient être dispensés pour l'ensemble des demandeurs d'asile dans le système général de soins, ouvert à toute la population. o Pas du tout d'accord o Plutôt pas d'accord o Plutôt d'accord o Tout à fait d'accord o Je ne me sens pas compétent(e) pour répondre à cette question	A15. De huidige zorgorganisatie voor asielzoekers moet gewijzigd worden: de zorg die niet door de eerste lijn wordt gegeven, moet aan alle asielzoekers worden verleend binnen het reguliere systeem dat toegankelijk is voor de volledige bevolking. o Helemaal niet akkoord o Eerder niet akkoord o Eerder akkoord o Helemaal akkoord o Ik heb onvoldoende kennis om op deze vraag te antwoorden
A16. Merci de nous expliquer votre choix (avantages, inconvénients, conséquences) :	A16. Kan u uw keuze toelichten (voordelen, nadelen en/of gevolgen)?
A17. Auriez-vous d'autres suggestions concernant les responsabilités en matière de gouvernance globale et d'organisation des soins de santé pour les demandeurs d'asile ?	A17. Hebt u nog andere suggesties rond de bevoegdheid voor het globale beleid en de organisatie van de gezondheidszorg voor asielzoekers?
Partie B: MODULE 2 Le contenu de la couverture de soins de santé n'est pas identique pour tous les demandeurs d'asile. Cliquez ici pour une description de la situation actuelle.	Sectie B: MODULE 2 De omvang van de dekking van gezondheidszorg is niet voor alle asielzoekers gelijk. Klik hier voor een omschrijving van de huidige situatie.
B1. Tous les demandeurs d'asile devraient avoir accès à la même couverture de soins de santé, indépendamment de leur statut et/ou de leur lieu d'hébergement. o Pas du tout d'accord o Plutôt pas d'accord o Plutôt d'accord o Tout à fait d'accord o Je ne me sens pas compétent(e) pour répondre à cette question	B1. Alle asielzoekers moeten eenzelfde dekking van gezondheidszorg krijgen, ongeacht hun statuut en/of verblijfplaats. o Helemaal niet akkoord o Eerder niet akkoord o Eerder akkoord o Helemaal akkoord o Ik heb onvoldoende kennis om op deze vraag te antwoorden
B2. La couverture de soins de santé pourrait :	B2. De basisdekking van de gezondheidszorg kan:



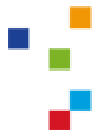
○ Appliquer la nomenclature INAMI, modifiée selon les listes Plus et Moins actuelles ○ Appliquer la nomenclature INAMI, sans les listes Plus et Moins actuelles ○ Étendre la liste Plus ○ Réduire la liste Plus ○ Étendre la liste Moins ○ Réduire la liste Moins ○ Intégrer les activités de promotion de la santé ○ Intégrer les soins préventifs et les dépistages ○ Intégrer des services de soutien à la délivrance des soins comme l'interprétariat et/ou la médiation interculturelle	○ De RIZIV-nomenclatuur toepassen, met inbegrip van de huidige Plus en Min lijst ○ De RIZIV nomenclatuur toepassen, zonder de huidige Plus en Min lijst ○ De Plus lijst uitbreiden ○ De Plus lijst inkorten ○ De Min lijst uitbreiden ○ De Min lijst inkorten ○ Gezondheidspromotie integreren ○ Screening en preventie integreren ○ Ondersteunende diensten (zoals tolken en/of interculturele bemiddeling) integreren
B3. Si vous souhaitez modifier les listes Plus ou Moins, quelles seraient vos suggestions ?	B3. Als u wenst de Plus of Min lijst aan te passen (uitbreiden of inkorten), wat zijn uw suggesties?
B4. Souhaitez-vous inclure d'autres soins, prestations, médicaments, produits pharmaceutiques, produits non-pharmaceutiques ou services dans la couverture de soins de santé ?	B4. Wenst u dat andere types van zorg, prestaties, geneesmiddelen, (non-) farmaceutische producten of diensten deel uitmaken van de basisdekking van de gezondheidszorg?
B5. Merci de nous expliquer votre choix concernant la couverture de soins de santé (avantages, inconvénients, conséquences) :	B5. Kan u uw keuze over de dekking van gezondheidszorg toelichten (voordelen, nadelen en/of gevolgen)?
B6. Avez-vous d'autres suggestions concernant la couverture de soins de santé pour les demandeurs d'asile ?	B6. Hebt u nog andere suggesties voor de basisdekking van gezondheidszorg voor asielzoekers?
Partie C: MODULE 3 Le financement des soins de santé des demandeurs d'asile est assuré par différents acteurs selon différentes modalités. Cliquez ici pour une description de la situation actuelle.	Sectie C: MODULE 3 De financering van de gezondheidszorg voor asielzoekers gebeurt door verschillende actoren en volgens verschillende modaliteiten. Klik hier voor een beschrijving van de huidige situatie.
C1. Le système actuel de financement des soins de santé pour les demandeurs d'asile par différents acteurs devrait être modifié, avec financement d'une enveloppe globale comprenant : la nomenclature INAMI, la liste Plus, la liste Moins, les soins préventifs et les dépistages, les activités de promotion de la santé et les services de soutien (par exemple la médiation interculturelle, l'interprétariat). ○ Pas du tout d'accord ○ Plutôt pas d'accord ○ Plutôt d'accord ○ Tout à fait d'accord ○ Je ne me sens pas compétent(e) pour répondre à cette question	C1. Het huidige financieringssysteem voor de gezondheidszorg voor asielzoekers moet gewijzigd worden, door de financiering van een globale enveloppe die het volgende omvat: de RIZIV-nomenclatuur, de Plus en Min lijst, preventie, screening, gezondheidspromotie en ondersteunende diensten (zoals tolken en interculturele bemiddeling). ○ Helemaal niet akkoord ○ Eerder niet akkoord ○ Eerder akkoord ○ Helemaal akkoord ○ Ik heb onvoldoende kennis om op deze vraag te antwoorden
C2. Qui pourrait financer cette enveloppe globale ? ○ Fedasil	C2. Wie kan deze globale enveloppe financieren? ○ Fedasil



○ INAMI ○ SPP Intégration Sociale ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer cette enveloppe globale. ○ Autre(s) financeur(s) possible(s)	○ RIZIV ○ POD Maatschappelijke Integratie ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet deze globale enveloppe niet betalen. ○ Andere mogelijk financierder(s)
C3. Merci de nous expliquer votre choix en faveur d'une enveloppe globale et de son financement (avantages, inconvénients, conséquences) :	C3. Kan u uw keuze voor een globale enveloppe toelichten (voordelen, nadelen en/of gevolgen)?
C4. Si une enveloppe globale n'est pas souhaitée, qui pourrait financer les soins repris dans la nomenclature INAMI ? ○ Fedasil ○ INAMI ○ SPP Intégration Sociale ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer cette enveloppe globale. ○ Autre(s) financeur(s) possible(s)	C4. Als er geen globale enveloppe moet worden voorzien, wie moet dan de zorg binnen de RIZIV-nomenclatuur financieren? ○ Fedasil ○ RIZIV ○ POD Maatschappelijke Integratie ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet de zorg binnen de RIZIV-nomenclatuur niet financieren. ○ Andere mogelijk financierder(s)
C5. Si une enveloppe globale n'est pas souhaitée, qui pourrait financer les soins repris dans la liste Plus ? ○ Fedasil ○ INAMI ○ SPP Intégration Sociale ○ Entités fédérées en fonction de la répartition actuelle des compétences ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer les soins repris dans la liste Plus. ○ Autre(s) financeur(s) possible(s)	C5. Als er geen globale enveloppe moet worden voorzien, wie moet dan de zorg op de Plus lijst financieren? ○ Fedasil ○ RIZIV ○ POD Maatschappelijke Integratie ○ De federale en gedefedereerde overheden, op basis van hun bevoegdheidsverdeling ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet de Plus lijst niet financieren. ○ Andere mogelijk financierder(s)
C6. Si une enveloppe globale n'est pas souhaitée, qui pourrait financer les activités de promotion de la santé ? ○ Fedasil ○ INAMI ○ SPP Intégration Sociale ○ Entités fédérées en fonction de la répartition actuelle des compétences ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer les activités de promotion de la santé. ○ Autre(s) financeur(s) possible(s)	C6. Als er geen globale enveloppe moet worden voorzien, wie moet dan de gezondheidspromotie financieren? ○ Fedasil ○ RIZIV ○ POD Maatschappelijke Integratie ○ De federale en gedefedereerde overheden, op basis van hun bevoegdheidsverdeling ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet gezondheidspromotie niet financieren. ○ Andere mogelijk financierder(s)



C7. Si une enveloppe globale n'est pas souhaitée, qui pourrait financer les soins repris dans les soins préventifs et les dépistages ? ○ Fedasil ○ INAMI ○ SPP Intégration Sociale ○ Entités fédérées en fonction de la répartition actuelle des compétences ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer les soins préventifs et les dépistages. ○ Autre(s) financeur(s) possible(s)	C7. Als er geen globale enveloppe moet worden voorzien, wie moet dan preventie en screening financieren? ○ Fedasil ○ RIZIV ○ POD Maatschappelijke Integratie ○ De federale en gedefedereerde overheden, op basis van hun bevoegdheidsverdeling ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet preventie en screening niet financieren. ○ Andere mogelijk financierder(s)
C8. Si une enveloppe globale n'est pas souhaitée, qui pourrait financer les services de soutien à la délivrance des soins de santé pour les demandeurs d'asile comme l'interprétariat et/ou la médiation interculturelle ? ○ Fedasil ○ INAMI ○ SPP Intégration Sociale ○ Entités fédérées en fonction de la répartition actuelle des compétences ○ CPAS sur fonds propres ○ L'État belge ne devrait pas financer les services de soutien à la délivrance des soins de santé. ○ Autre(s) financeur(s) possible(s)	C8. Als er geen globale enveloppe moet worden voorzien, wie moet dan de ondersteunende diensten (zoals tolken en/of interculturele bemiddeling) financieren? ○ Fedasil ○ RIZIV ○ POD Maatschappelijke Integratie ○ De federale en gedefedereerde overheden, op basis van hun bevoegdheidsverdeling ○ OCMW's vanuit hun eigen middelen ○ De Belgische staat moet de ondersteunende diensten niet financieren. ○ Andere mogelijk financierder(s)
C9. Merci de nous expliquer vos choix concernant le financement (avantages, inconvénients, conséquences) :	C9. Kan u uw keuze voor de financiering toelichten (voordelen, nadelen en/of gevolgen)?
C10. Auriez-vous d'autres suggestions concernant le financement et le paiement des soins de santé ?	C10. Hebt u nog andere suggesties voor de financiering en de betaling van de gezondheidszorg?
Partie D: COMMENTAIRES	Sectie D: OPMERKINGEN
D1. Pensez-vous à d'autres problèmes relatifs aux soins de santé des demandeurs d'asile qui n'auraient pas été abordés par cette enquête ? ○ Oui ○ Non	D1. Zijn er volgens u nog andere problemen met de gezondheidszorg voor asielzoekers die in deze enquête niet aan bod kwamen? ○ Ja ○ Neen
D2. Si oui, pourriez-vous les exposer brièvement ?	D2. Indien ja, kan u deze kort uiteenzetten?
D3. Quelles seraient vos suggestions pour les résoudre ?	D3. Wat zijn uw suggesties om deze problemen op te lossen?
D4. Avez-vous d'autres remarques ou commentaires ?	D4. Hebt u nog andere opmerkingen?
Partie E: FIN DU QUESTIONNAIRE	Sectie E: EINDE VAN DE ENQUÊTE



E1. Pour quel(s) organisme(s) travaillez-vous ?	E1. Voor welke organisatie(s) werkt u?
○ Organisme 1 ○ Année d'engagement dans l'organisme 1 ○ Fonction principale organisme 1 ○ Code de postal organisme 1 ○ Organisme 2 (si applicable) ○ Année d'engagement dans l'organisme 2 (si applicable) ○ Fonction principale organisme 2 (si applicable) ○ Code de postal organisme 2 (si applicable) ○ Organisme 3 (si applicable) ○ Année d'engagement dans l'organisme 3 (si applicable) ○ Fonction principale organisme 3 (si applicable) ○ Code de postal organisme 3 (si applicable)	○ Organisatie 1 ○ Startjaar organisatie 1 ○ Functie organisatie 1 ○ Postcode organisatie 1 ○ Organisatie 2 (indien van toepassing) ○ Startjaar organisatie 2 (indien van toepassing) ○ Functie organisatie 2 (indien van toepassing) ○ Postcode organisatie 2 (indien van toepassing) ○ Organisatie 3 (indien van toepassing) ○ Startjaar organisatie 3 (indien van toepassing) ○ Functie organisatie 3 (indien van toepassing) ○ Postcode organisatie 3 (indien van toepassing)
E2. Si vous souhaitez être informé(e) des résultats de cette enquête, merci de nous communiquer vos coordonnées. ○ Prénom: ○ Nom de famille: ○ Adresse mail:	E2. Indien u op de hoogte wenst te worden gebracht van de resultaten van deze enquête, gelieve dan uw contactgegevens in te vullen. ○ Voornaam ○ Achternaam ○ Mailadres:
E3. Si vous souhaitez être invité(e) à la rencontre du 26 juin 2018, merci de nous communiquer vos coordonnées. ○ Prénom: ○ Nom de famille: ○ Adresse mail:	E3. Indien u wenst te worden uitgenodigd voor de vergadering van 26 juni 2018, gelieve dan uw contactgegevens in te vullen. ○ Voornaam ○ Achternaam ○ Mailadres:
Merci pour votre participation. Vous êtes d'ores et déjà invité(e) à la rencontre du 26 juin 2018 au Centre Fédéral d'Expertise des Soins de Santé, à Bruxelles. Si vous avez marqué votre intérêt pour cette rencontre, un courriel de rappel vous sera envoyé avec les modalités pratiques. Cette réunion sera l'occasion de mettre en discussion les pistes proposées et de réfléchir aux facilitateurs et aux freins autour des pistes privilégiées.	Hartelijk dank voor uw deelname. Wij nodigen u hierbij reeds uit voor de vergadering van 26 juni 2018 in de kantoren van het Federaal Kenniscentrum voor de Gezondheidszorg in Brussel. Als u hiervoor reeds uw contactgegevens hebt ingevuld, zal u nog een herinneringsmail ontvangen met praktische informatie. Tijdens deze vergadering zullen de voorgestelde opties worden besproken en zal worden gereflecteerd over hun facilitatoren en belemmeringen.

Appendix 1.2.2. Recruitment of stakeholders

Stakeholders were selected because of their expertise in the field of migration and/or health care (purpose sampling). Stakeholders included: the CPAS – OCMW (local welfare centres n=593), reception centres of Fedasil and their partners (n=87), public institutions involved in asylum and/or health (n=69), integration centres and agencies (n=50),non-governmental organisations (NGO) and non-profit organisations (n=46), specialised health services for asylum seekers (n=18), academic experts (n=14), professional associations (n=14),sickness funds (n=11), specialised social services for asylum seekers (n=10), and representatives of asylum seekers & refugees (n=2). They were identified through three different channels: 1) in the literature (i.e. authors of reports); 2) via the interviews; and 3) via the personal network of the researchers.

The questionnaire was sent to 914 stakeholders, either to a personal e-mail address, or to an institutional address on April 20th. Early May, a reminder was sent and the questionnaire was definitively closed on May 21. When possible, the personal address was privileged. Coordinates were obtained through official websites and listings, previous studies, and personal contacts of the research team. Stakeholders were allowed to transfer the link to a colleague (snowball sampling). No incentive was offered to the stakeholders. Respondents completed the questionnaire anonymously, but they were invited to communicate their contact data if they wished to participate to the work session and/or receive the final report. All stakeholders were invited to participate to the work session of June.

Appendix 1.2.3. Data analysis

Descriptive statistics were computed regarding the quantitative questions. An option was considered consensual if 66% of the respondents accepted it. Qualitative data were categorised according to the following predefined themes: advantages and inconveniences of the options, conditions of implementation, examples of situations/problems and solutions.

Appendix 1.2.4. Stakeholders

The online survey was conducted in April-Mai 2018 via the LimeSurvey platform. The questionnaire was started by 631 persons of which 171 completed it fully. Informal feedback from some respondents revealed that the questionnaire was too complex for field workers or that they did perceived themselves as knowledgeable about the topic.

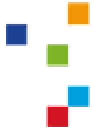
Stakeholders mostly included social workers (n=70) and health care professionals (n=39), followed by coordinators and managers (n=38), advisors (n=18) and researchers (n=5). Among health care professionals, there were 11 nurses and 24 medical doctors (22 generalist practitioners, 1 psychiatrist and 1 internist). The 4 remaining health care professionals were allied health professionals. There were 75 stakeholders from a CPAS – OCMW, 22 from a collective reception centre (Fedasil, *Croix-Rouge de Belgique* & *Rode Kruis Vlaanderen*), 28 from health services (primary care: 17; hospitals: 7; mental health care: 4), 15 from a sickness funds – including CAAMI – HZIV, 15 NGO and non-profit associations, 5 from public federal services and cabinets (public health, justice, social integration), 3 universities, Myria, and the General Delegate to Children Rights.

Despite this variety of profiles among respondents, our results may be positively influenced as most of the respondents were already familiar with the topic of asylum seekers health.

Appendix 1.3. Fine-tuning of options: work session with key actors

The work session aimed at:

- Presenting the preliminary results of the online survey,
- Collecting data on the advantages and inconveniences of options that did not reach a consensus in the online survey,
- Collecting data on the conditions of implementation of possible options,
- Identifying additional data for final recommendations.



Appendix 1.3.1. Stakeholders

Stakeholders were those who expressed their willingness to be invited while filing in the questionnaire. However, as those willing to participate to the work session were mostly “believers”, additional key actors considered as “non-believers” were personally invited by e-mail to the work session to ensure the diversity of the opinions. These additional actors were previously identified in the exploratory phase. A total of 35 stakeholders attended the meeting on June 26, 2018. Simultaneous translation in French and Dutch was provided to ensure the participation. Stakeholders came from: Fedasil (n=7), NGO (n=6), Red Cross (n=4), universities (n=3), health services (n=3), NIHDI (n=3), specialised health services (n=3), CAAMI-HZIV (n=2), CPAS-OCMW (n=1), Immigration Office(n=1), PPS Social Integration (n=1), PFS Public Health Intercultural Mediation Cell (n=1) and Vereniging van Vlaamse Steden en Gemeenten (n=1).

Appendix 1.3.2. Methodology and flow of the work session

The overall methodology of the work session was based on the nominal group technique.

Nominal group technique

“Nominal (meaning in name only) group technique (NGT) is a structured variation of a small-group discussion to reach consensus. NGT gathers information by asking individuals to respond to questions posed by a moderator, and then asking stakeholders to prioritize the ideas or suggestions of all group members. The process prevents the domination of the discussion by a single person, encourages all group members to participate, and results in a set of prioritized solutions or recommendations that represent the group’s preferences”.21

After a short introduction by the KCE research team, stakeholders were split in 5 groups (3 groups of French speaking stakeholders (n=20) and 2 groups of Dutch speaking stakeholders (n=15)). Groups were balanced regarding professional appurtenance of the stakeholders. In each group, stakeholders had to elect a spokesperson and a secretary. Each group was accompanied by a KCE researcher, taking additional notes.

Once the group was installed, the principal investigator of the KCE research team presented each option and pointed out the remaining non-consensual elements resulting from the analysis of the questionnaires. Components of the scenarios that previously reached a consensus threshold of 66% were not discussed. In each group, stakeholders were then invited to discuss the advantages and inconveniences of each elements as well as the conditions for implementation. When all the themes were discussed, each spokesperson was invited to share the reflections with the rest of the audience and individual team members had the possibility to provide additional comments and reflexions. At the end of the work session, the secretaries handed over their notes to the KCE research team. Discussions were also audio-registered.

Appendix 1.3.3. Data analysis

Data were coded and categorised according to the following predefined themes: advantages and inconveniences of the options, conditions of implementation, examples of situations/problems and solutions. Data were then confronted to the consensual options emerging from the online survey during a work meeting of the KCE research team. Four possible scenarios emerged and 16 implementation conditions were identified.

Appendix 1.4. Development of the options

This step aimed at clarifying the conditions of implementation and at identifying further information to support the development of the options. For each condition of implementation, the KCE research team listed elements that needed to be further investigated and identified the relevant data source. Four work meetings were held with representatives of the following institutions in August 2018: Fedasil, the PPS Social Integration and the NIHDI.

Appendix 1.5. Final options: stakeholder meeting

The final options were discussed in September 2018 with the representatives of the sickness funds, the federal and federated entities, involved or likely to be involved in the decision-making process. A total of 21 stakeholder organisations were identified in the previous steps of the project or were identified in the contact database of the KCE: NIHDI, cabinet of the Federal Ministry of Public Health and Social Affairs, cabinet of the Federal Ministry of Social Integration, cabinet of the State Secretary for Asylum and Migration, national unions of the sickness funds, cabinet of the regional Ministers of Health and Social Affairs (Brussels, Flanders and Wallonia), representatives of the Federation of CPAS – OCMW (Brussels, Flanders and Wallonia), the Guardianship service of the FPS Justice, PPS Social Integration, FPS Public Health and Fedasil. Each stakeholder was contacted personally by e-mail. A first reminder was sent by e-mail and a final contact was made by phone to ensure the participation to all stakeholders.

A total of 25 stakeholders attended the meeting: NIHDI (n=2), cabinet of the Federal Ministry of Public Health and Social Affairs (n=1), cabinet of the Federal Ministry of Social Integration (n=3), cabinet of the State Secretary for Asylum and Migration (n=1), national unions of the sickness funds (Collège Intermutualiste National (CIN) (n=1), Landsbond van Liberale Mutualiteiten (n=2), Mutualité Chrétiennes (n=1) and Mutualités Neutres (n=1)), cabinet of the regional Ministers of Health and Social Affairs (Brussels (n=1) and Wallonia (n=1)), representatives of the Federation of CPAS – OCMW (Brussels = 2, Flemish=1 and Walloon=1), the Guardianship service of the FPS Justice (n=1), PPS Social Integration (n=2), and Fedasil (n=3).

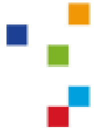
In February 2019, all stakeholders, including those absent during the meeting of September 2018, received a confidential version of the report for final comments. Comments were received from the NIHDI, the PPS Social Integration, the cabinet of the Federal Ministry of Public Health and Social Affairs, Fedasil and the representatives of the Brussels, Flemish and Walloon Federation of CPAS – OCMW. Comments were added to the report to clarify or complete some of the options proposed.

APPENDIX 2. DETAILED PRESENTATION OF THE PROCEDURE FOR INTERNATIONAL PROTECTION IN BELGIUM

Appendix 2.1. European legal framework

The following European directives frame access and organisation of health care for asylum seekers in the European Union.

- Council Directive 2001/55/EC of 20 July 2001. Temporary protection in the event of a mass influx of displaced persons with indications on medical care including emergency care and essential treatment of illness
- Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers.
- Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted.
- Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast)



Appendix 2.2. Procedure for international protection in Belgium

Appendix 2.2.1. General procedure

Since December 2018, all applicants for international protection are welcomed at the central arrival centre of *Petit-Château – Kleine Kasteeltje* in Brussels.[125] [eee] [fff] The arrival centre gathers the registration service of the Immigration Office and the Dispatching of the Federal Agency for the Reception of Asylum Seekers (Fedasil).

In a first step, based on the Dublin III regulation*[ggg], the Immigration Office systematically verifies the responsibility of Belgium for examining the application for international protection or whether another Member State of the European Union[hhh] has this responsibility.[126, 127] The examination of responsibility could lead to three options:

- Belgium has the responsibility for examining the application, the asylum seeker will follow the procedure of international protection as described above and will then benefit of the same rights regarding access to health care.
- Belgium has not the responsibility but decides to pursue the procedure for international protection
- Belgium has not the responsibility and the Immigration Office request the competent EU member state to take over the procedure for international protection. The rejected applicant may appeal at the Council of Alien Law Litigation (Conseil du Contentieux pour les Etrangers – Raad voor *Vreemdelingenbetwistingen*) but still has to travel to the Member State in charge of its application for international protection. The appeal is non-suspensive.

The applicants may be oriented towards a detention centre in Belgium while awaiting the decision of the Immigration Office or their transfer to the EU member state. During the examination of the Dublin regulation, the applicant has the same rights to health care as other asylum seekers, except if he/she resides in a detention centre where health care is organised by the Immigration Office.

If the application is deemed receivable by the Immigration Office, the application is transferred to the Office of the Commissioner General for Refugees and Stateless Persons (CGRS) for the second step of the procedure.

The CGRS manages the applications for international protection and takes the final decision. The decision can be one of the following:

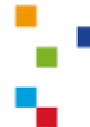
- approval of the refugee status for a 5-years period (unlimited after the 5 years period),
- approval of the subsidiary protection status for a 1-year period (renewable for 2 years by the municipality, unlimited after 5 years),
- denial of protection.

[eee] This arrival centre is a temporary centre while awaiting the new arrival centre in Neder-Over-Heembeek in 2022.

[fff] At the exception of those applying for asylum at the border points of the airports.

[ggg] The regulation nº 604/2013 of the European Parliament and of the Council of 26 June 2013 establishes the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person.[3]

[hhh] With the exception of Denmark (special convention). Although they are not EU members, Norway, Iceland, Switzerland and Lichtenstein are also included in the Dublin III regulation.[126]



In the latter case, the asylum seeker should leave the territory, however:

- may apply again for international protection (there is no limit to the number of applications). Nevertheless, a subsequent application should add new information to the previous application for international protection.
- may apply for a 9ter protection or a 9bis protection: these two procedures are therefore not part of the international protection procedure[1]. The 9bis procedure refers to those applying for international protection due to humanitarian motives – at the exception of medical reasons.
- may be waiting for deportation in a detention centre (under responsibility of the Immigration Office),
- may receive a "*laissez-passer*" to the competent Member State of the European Union (in case of subsequent application),
- may apply for voluntary return (in which Fedasil continues to provide material assistance until their final departure),
- may stay in Belgium, but ends up in illegality,
- may appeal against a negative decision of the CGRS at the Council for Alien Law Litigation
- may appeal against a negative decision of the Council for Alien Law Litigation at the Council of State – *Conseil d'Etat – Raad van Staat* (final appeal).

Appendix 2.2.2. Procedure 9ter – application for the medical regularisation

The 9ter procedure refers to the medical regularisation, applicants are allowed to stay in Belgium when severely ill and if deportation to their country of origin may lead to unacceptable humanitarian consequences.[1] In other words, people can apply for this procedure if the nature of the medical condition could lead to a real life-threatening situation or when the risk of inhuman treatment in the country of origin is plausible (because there is no appropriate treatment).[12] Contrary to asylum procedure (i.e. the application for international protection), the procedure for 9ter is entirely managed by the Immigration Office. In a first step, the application is first examined on its admissibility (*recevabilité – ontvankelijkheid),* i.e. the form of the application. It should, among others, include a recent[iii] medical certificate reporting the disease, its degree of severity and an estimation of the required treatment[jjj]. All relevant medical documents should be attached to the medical certificate and the applicant should have a residence address in Belgium.[128-130]

Once the application is registered, the Immigration Office asks the municipality of residence to control the residence of the applicant. If positive, after authorisation of the Immigration Office, the municipality registers the applicant in the Foreigner register and gives a temporary permit of stay (3 months). This temporary permit could be renewed 3 times for a 3-months period, after that every month. Extension is automatic as long as the Immigration Office does not provide opposite instructions. The registration in the municipality opens the right to the social aid (i.e. financial assistance), including access to health care, managed by the CPAS – OCMW of their place of stay.[129]

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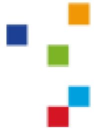
iii Dated of less less than three months at the time of application

jjj See here for a template of the medical certificate for a 9-ter application: https://dofi.ibz.be/sites/dvzoe/fr/documents/certicat%20medical%20type.pdf



The final decision is taken by the Immigration Office based on the content of the application (*fond – gegrondheid*). For those acknowledged under the 9ter procedure, the municipality will then register them to the Foreigner Register (i.e. A card) for one year. After 5 years, the foreigner benefits from an unlimited stay (i.e. B card).[128]

Appendix 2.2.3. Procedure for safe countries of origin

A special procedure exists for applicants for international protection originating from a "safe country". The Secretariat of State for Asylum and Migration determines the list of safe countries, based on the following criteria: legal situation in the country of origin, application of the law, general political circumstances and extent to which protection is provided against persecution and abuse. The Alien Act determines the sources of information necessary for the elaboration of this list[1]. The Royal Decree of December 17, 2017 stipulates the current list of "safe countries of origin": Albania, Bosnia and Herzegovina, Former Yugoslav Republic of Macedonia (recently renamed North Macedonia), Kosovo, Montenegro, Serbia, India and Georgia. The list should be updated yearly but could be updated earlier depending on the evolution of the situation in the countries.[28]

In general, international protection is not necessary for citizens of a country included in the list of safe countries. However, if the applicant can clearly demonstrate he/she can fear persecution or a real risk of suffering serious harm. The burden of proof lies mainly with the applicant.[131] Theoretically, this procedure should not exceed 15 days.[132]

Appendix 2.3. Integration and support for those granted an international protection status

If the full refugee status or the subsidiary protection is granted, status holders have two months to find own housing[kkk], except for vulnerable individuals which have three months (renewable once). Children of refugees and holders of a subsidiary protection status are automatically covered by the status of their parents, when they have arrived together and have applied for international protection at the same time. If the children arrive after the regularisation of their parents, they must apply individually. Family reunification is possible for refugees under some conditions (housing, health insurance and regular incomes) and concerns mainly spouses, children below 18 years, disabled children aged of 18 years and more. Parents of minor refugees could also be reunited through family reunification if they were not accompanying the child when arriving in Belgium.

Refugees and holders of subsidiary protection have access to the labour market similarly than Belgians while holders of a subsidiary protection status need to apply for a work permit. Support is also organised for the integration into the labour market and the recognition of foreign diplomas (although not specific to refugees). In addition, if necessary, they can apply for social aid at the CPAS – OCMW of their new place of residence. They are entitled to the compulsory national health insurance and should register with a sickness fund or with the CAAMI – HZIV.

Once registered to the municipality, refugees and holders of subsidiary protection have to attend integration classes, organised by the regional authorities. Integration classes include: information on the rights and duties of residents in Belgium, individual social intake, language test (that may lead to compulsory language courses), support for administrative procedures, citizenship training and, if necessary, a socio-professional orientation[lll]. These integration classes are not specific to refugees and holders of

[kkk] If the asylum seeker has already a possibility of housing, i.e. with friends, he or she may leave the centre as soon as the status is granted and will receive food vouchers during one month.

[lll] Information retrieved from http://actionsociale.wallonie.be/integration/parcours-integration-primo-arrivants

subsidiary protection but are compulsory to all foreigners living in Belgium for less than three years, with a legal permit of stay of more than 3 months. Are not concerned: European Union and European Economic Area members and Swiss citizens.

After 5 years of residence in Belgium, refugees and holders of subsidiary protection are eligible for local elections and may apply for Belgian nationality (dual nationality is accepted).

APPENDIX 3. SOCIODEMOGRAPHIC PROFILE OF ASYLUM SEEKERS

Appendix 3.1. Gender and country of origin

The majority of asylum seekers are men (63.6% in 2017) and, since 2015, these men mostly originate from Syria, Afghanistan and Iraq. In 2018, the top 3 of countries of origin was Syria, Palestine and Afghanistan for first time applicants while Afghanistan, Iraq and Albania were in the top 3 for the subsequent applicants.[24] It should be noted that Albania is considered a safe country since 2017 [28] and, by leaving out Albania, Syrians occupy the third rank for subsequent applications.[24]

The gender balance for the year 2017 is shown in Figure 7 and depends on the country of origin. A more balanced gender distribution implies a greater proportion of families and/or couples.[26] In 2017, for those applying for 9bis and 9ter, the Democratic republic of Congo, Armenia, Morocco, Russia and Guinea were the five main countries of origin.[27]

Among unaccompanied minors, 404 came from Afghanistan, 210 from Guinea and 131 from Eritrea. Boys represent 86% of the unaccompanied minors (in 2018, 50 boys and 34 girls aged 13 and below applied for international protection)[mmm].[25, 29]

[mmm] Data included unaccompanied minors aged of 18 and more after the results of the age tests.

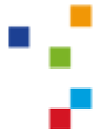
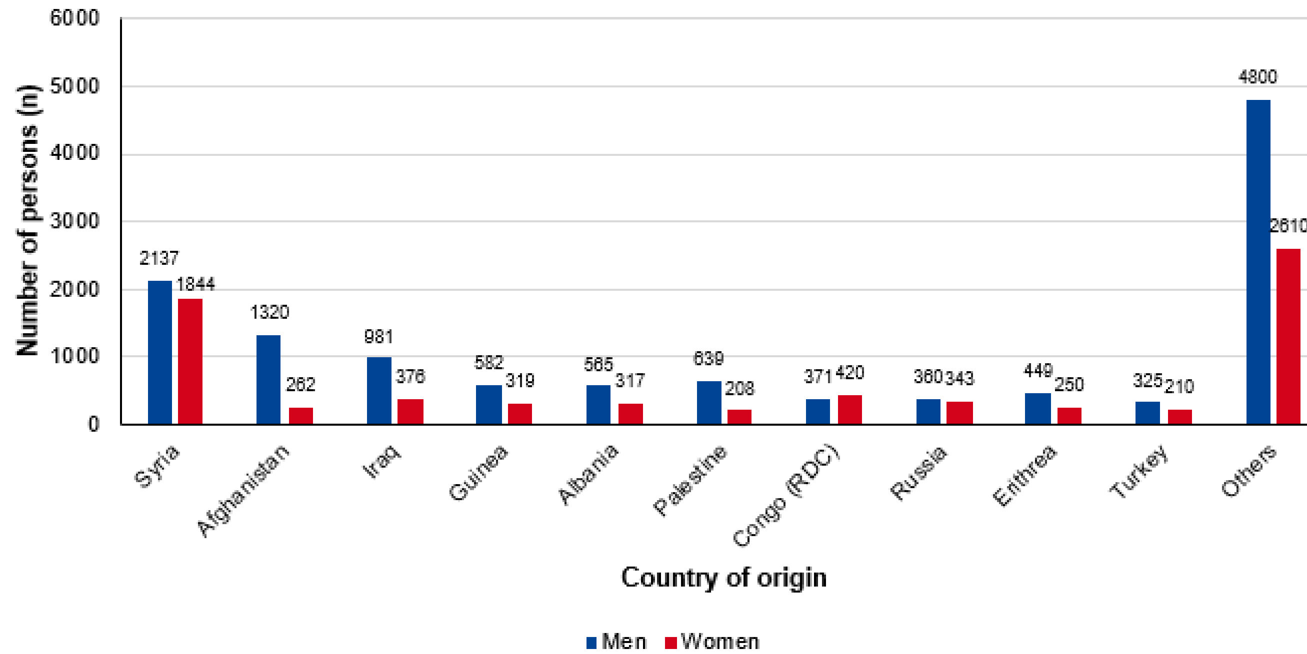


Figure 7 – Gender distribution by country of origin among asylum seekers in Belgium in 2017 (n=19 688)



Source: Adapted from CGRS 2018. It should be noted that Albania is considered a "safe country" (see Appendix 2.2.3).

Appendix 3.2. Epidemiological profiles

There is currently no centralised database collecting information on health problems and health care utilisation among asylum seekers in Belgium. Data are collected on a local basis; not all asylum seekers have a digital health record and they are not included in the national or regional health surveys. Similarly, evidence from the literature could not help us to generalise the findings to the entire population of asylum seekers in Belgium.

Consequently, it was not possible to draw a full epidemiological profile. Despite the lack of contextualised data, we relied on three data sources in this section: (i) grey and the scientific literature, (ii) semi-directive interviews of the exploratory phase, and (iii) the work session[nnn].

Appendix 3.2.1. Mental health

The high prevalence of mental issues was one of the most frequently cited problems by stakeholders of the preliminary interviews and the work session – although they currently lack data to support this finding in the Belgian context. According to stakeholders, asylum seekers often experience a range of traumatic experiences: in the home country, they may have been for a very long period in situations of war, including frequent bombings, other life-threatening events and extremely difficult living circumstances. But also while transiting from home to host country, they often experience traumatizing events, such as abuse by smugglers, life-threatening sea crossings, periods of detention, and hard survival circumstances. Given the difficult experiences many of them have during the flight, stakeholders estimated that the prevalence of mental health problems among asylum seekers is likely to increase.

In Belgium, the 2018 report of *Médecins du Monde* identified the experiences of violence, reported by asylum seekers.[133] These difficult experiences, together with the stress related to being a newcomer in the host country, puts the mental health of asylum seekers under extreme pressure, leading to high levels of mental health problems. This was confirmed by the scientific literature: asylum seekers are at high-risk of mental health distress and by field-data collected by NGOs.[40, 66, 134-141]

Hereby, particular groups, such as unaccompanied minors, asylum seeker children and women, might be even at higher risk.[66] In Belgium, Derluyn found that unaccompanied minors were more at risk of experiencing anxiety, depression, and posttraumatic stress than accompanied minor refugees.[138] Another study evidenced that unaccompanied minors experienced "*more traumatic events than their Belgian peers, and show higher levels of peer problems and avoidance symptoms*".[137, 141]

Appendix 3.2.2. Communicable diseases

Asylum seekers are more at-risk of suffering from tuberculosis and latent tuberculosis infection than the rest of the population.

Figure 8 presents the evolution of the number of cases of tuberculosis in Belgium. According to Fedasil data, the detection rate for TBC screening among asylum seekers at the Fedasil dispatching in 2017 was 130.7/100 000 persons (21/16,071), a decrease compared to the previous 2 years (210.1/100 000 in 2016 and 153.7/100 000 in 2015) but similar to 2014 (125.8/100 000). A total of 16 071 chest X-rays in 2017 detected 21 cases of tuberculosis upon entry.[142]

[nnn] Not all topics were addressed by the stakeholders

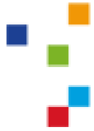
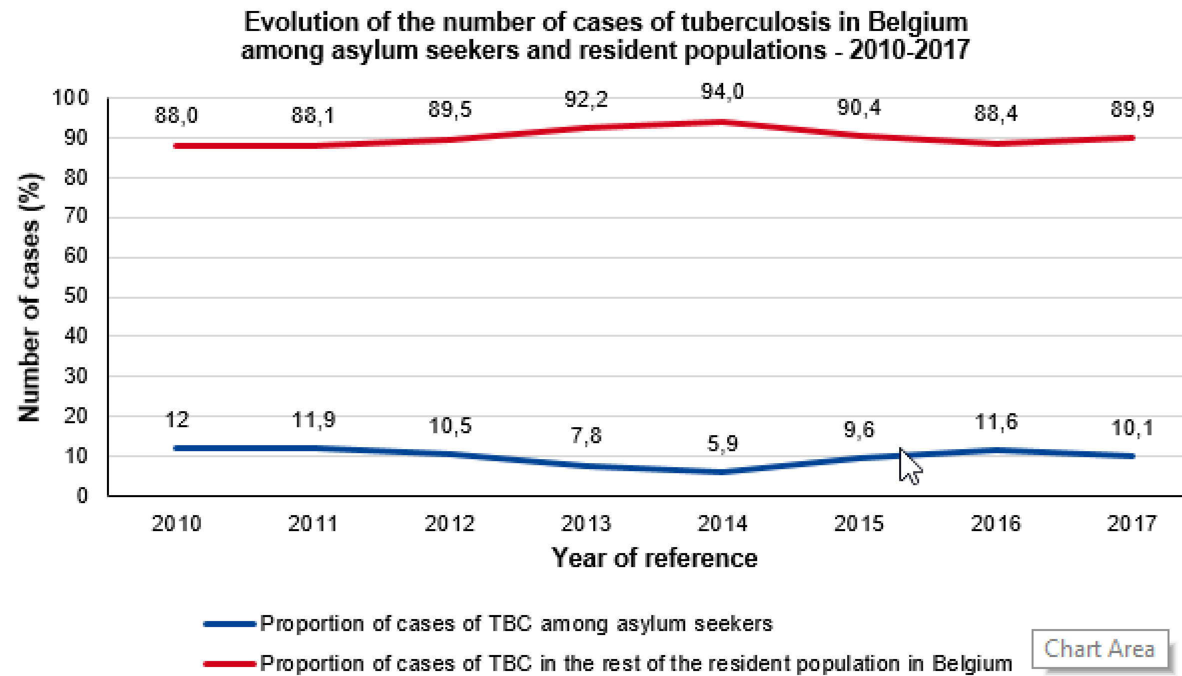


Figure 8 – Evolution of the number of cases of tuberculosis in Belgium among asylum seekers and resident populations - 2010-2017



Source: Fedasil data, personal communication with medical cell of Fedasil, 2019

Additionally, there is currently no data available on the prevalence of HIV – AIDS and hepatitis B among asylum seekers in Belgium, although this was mentioned as an issue of interest by stakeholders.

Appendix 3.2.3. Sexual and reproductive health

In Belgium, Keygnaert found that asylum seekers are more at risk of sexual ill-health.[143, 144] Dubourg et al estimated that, in 2011, 6 260 women residing in Belgium had been victims of FGM.[145] Two countries where the prevalence of FGM is the highest (Guinea and Eritrea) are in the top 10 for asylum applications in Belgium.[24, 146]

Appendix 3.2.4. Disabilities & injuries

Médecins du Monde found that the main health problems for asylum seekers in Belgium are related to respiratory problems (36%), injuries (11%), dental problems (9%), skin problems (9%) and digestive issues (8%). Apart from the symptoms reported by the patients, health care professionals also found that 49% of the asylum seekers had features of infections at the time of the consultation with *Médecins du Monde.*[67] In 2018, they also reported that, in a sample of their patients, 60% of the asylum seekers had experienced violence on the Belgian territory.[133]

APPENDIX 4. HEALTH CARE COSTS FOR ASYLUM SEEKERS

Appendix 4.1. Data related to asylum seekers in the general databases related to health care

First, the reimbursement database of the IMA – AIM, based on the claims data transmitted by the sickness funds, only pertains to the national health insurees[ooo]. This database includes all claims data reimbursed under the national health coverage, in ambulatory as well as in hospital settings[ppp].

Second, the hospital billing data transmitted by the sickness funds to the NIHDI (called ADH – HJA for one day hospitalisations and AZV – SHA for hospitalisations of at least one night) do not include either the data related to asylum seekers.

Third, we explored the possibility of identifying hospitalized AS in the MZG – RHM. This hospital discharge database, hosted by the *SPF Santé Publique – FOD Volksgezondheid*, includes patient diagnoses and procedures performed during every hospitalization in Belgian non psychiatric hospitals, whatever the patient's insurability status. Until registration year 2012, the insurability status recorded in the MZG – RHM could take four different values: (1) non-insured patients, (2) patients affiliated to a sickness fund, (3) patients benefiting from an international convention and finally (4) patients falling under specific agreements (e.g. between French and Belgian hospitals near the border). From registration year 2012, more details must be given about the insurability status in the MZG – RHM. These new categories ensue from the recommendations made by the KCE on the Impact of elective care for foreign patients on the Belgian

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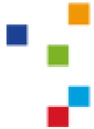
[ooo] Asylum seekers who have a work permit have to register with a sickness funds but they are registered as salaried and not as asylum seekers.

[ppp] Depending on the sickness funds, it is possible to identify unaccompanied minors in the database. For example, at the Mutualités Libres, there is a specific code to identify them. (Personal communication with a representative of the Mutualités Libres, 2018).



healthcare system.[147] The objective was to make the newly created Observatory on Patient Mobility (2011) able to get a better picture of the hospital care received by foreign patients in general. Most probably, asylum seekers are registered in both categories "CPAS – OCMW" and "not insured patients" from 2012.

Unfortunately for the present study, all these categories also include other types of patients such as e.g. Belgian patients with no health insurance. It is therefore not possible to identify hospitalizations of asylum seekers in the MZG – RHM (other data fields such as country of origin and nationality are insufficient to identify asylum seekers).

We also investigated the financial and accounting aggregated data through the Finhosta system hosted by the FOD Volksgezondheid – SPF Santé Publique which includes information such as the number of hospital days or the number of hospital stays. Before registration year 2012, data can be broken down according to the insurance institution (e.g. CPAS – OCMW or Not insured, separately) and the patient type (Belgian and/or paying social contributions versus Foreign patients). But these categories were not refined enough to identify hospitalizations of asylum seekers. From 2012 onwards, the patient type variable disappears and the insurance institution takes the same values as the RHM – MZG insurability status.

Appendix 4.2. Data related to costs for hospital care for asylum seekers in ILA – LOI in the MediPrima database

MediPrima is an IT system that has been installed to manage medical care covered by the CPAS – OCMW for individuals that are not insured and cannot be insured through the national compulsory health insurance: asylum seekers benefitting from financial support from the CPAS – OCMW, asylum seekers in ILA – LOI, undocumented migrants benefitting from urgent medical aid and individuals whose application for regularisation based on article 9ter was judged admissible[qqq]. The MediPrima database covers the entire cycle of decisions to cover medical expenses, from the granting of medical support to the person to the automated reimbursement of health care providers by the CAAMI – HZIV[rrr].[148] At the time of writing of this report, MediPrima only includes information on hospital care or ambulatory care provided in a hospital setting. Currently, pilot projects are ongoing to extend the system to general practitioners and in a second stage to pharmacies[sss].

Based on the database of MediPrima, it is not possible to extract detailed information about the health status or health care utilisation of asylum seekers in ILA – LOI. The data solely allows to make a distinction between individuals receiving urgent medical aid and other categories without any further specification. However, estimations can be made based on data of the categories "asylum seekers in ILA – LOI", "asylum seekers in financial support" and "individuals whose application for regularisation based on

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[qqq] Updates of the MediPrima system are planned to include all beneficiaries of medical aid through a CPAS – OCMW, i.e. Belgian homeless persons.

[rrr] The PPS Social Integration established MediPrima with the following objectives:

1. To computerize the decision of coverage taken by the CPAS – OCMW regarding reimbursement of medical care, and thus to make it accessible to health care providers at the time of the medical consultation

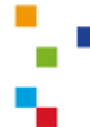
2.To transfer the financial management of the reimbursement of health care to the CAAMI-HZIV, which should allow accelerating the reimbursement of health care and alleviating the administrative burden of CPAS – OCMW

3.To improve controls: the central database makes it impossible for different CPAS – OCMW to submit simultaneous demands of coverage for a same individual; the CAAMI –HZIV can control invoices following the same rules as for the AMI-ZIV

4.To accelerate reimbursements to health care providers

5. To reduce barriers to health care services for undocumented migrants.

[sss] See more on the website of the PPS Social Integration MI: https://www.mi-is.be/fr/outils-cpas/mediprima



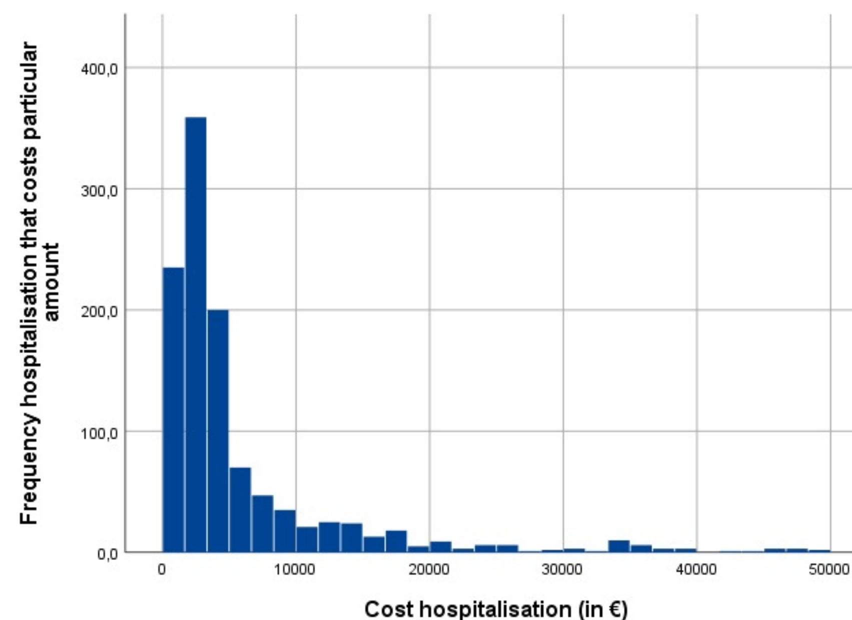
article 9ter was judged admissible”. According to the MediPrima data for 2017, these categories account for 6471 individuals (Table 17). In 2018, only 240 individuals were granted authorisation for temporary stay[ttt] based on a 9ter procedure.[149] This implies that the majority of the billing data relates to asylum seekers in ILA – LOI and those in financial support. The data reveal that the average cost per person per year amounts €2138,35. The distributions of ambulatory and hospital costs are visualised in Figure 9. It should also be noted that there is currently no data available about the number of asylum seekers who do not seek health care during their stay in an ILA – LOI.

Table 17 – Repartition of costs for ambulatory and hospital care for asylum seekers in ILA – LOI, asylum seekers in financial support and recognised 9ter applicants, based on MediPrima data, 2017

	Charged to PPS Social Integration (€)	Charged to CPAS – OCMW (€)	Charged to patients (€)	Total (€)
Type of health care provided in a hospital setting				
• **Hospitalisations**	9 202 683,54	18 077,32	90 850,06	
• **Ambulatory care**	4 410 490,50	14 614,93	100 539,44	
Total	**13 613 174,04**	**32 692,25**	**191 389,50**	**13 837 255,79**

Source: MediPrima data, PPS Social Integration, 2019

Figure 9 – Distribution of hospital consultations per cost category for asylum seekers in ILA – LOI, asylum seekers in financial support and recognised 9ter applicants, based on MediPrima data, 2017 (N=1151)



Source: MediPrima database, PPS Social Integration, 2017

Note: To facilitate readability of the figure, 36 outliers were excluded (costs ranging from €50.404-€152.364).

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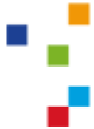
ttt Their 9ter application is considered as admissible and they receive an AI (orange card) for the period of 3 months, prolonged 3-monthly in the first year, and then monthly until a definite decision is made on the subject matter.



Appendix 4.3. Data related to health care costs for asylum seekers in reception centres, code 207 'No show' and Fedasil partners in the database of Fedasil

In 2017, the Fedasil budget for medical costs was of € 15.700.744 in a total budget of € 413.382.024 for the entire Fedasil agency.[150, 151] A budget of € 291.126.538 out of the € 413.382.024 was transferred as subventions[uuu] to the partners in charge of reception of asylum seekers: 61% to the *Croix-Rouge de Belgique*, the *Rode Kruis Vlaanderen* and the other NGO involved in reception centres, 33% to CPAS – OCMW having an ILA – LOI[vvv], 3% to NGO organising voluntary return, 2% to the municipalities hosting a reception centre and 1% to the private operators[www] for reception.[152]

According to the Belgian Court of Audit, for the year 2015, the average cost for medical care for an asylum seeker in a reception centre per day varies from € 6.09 in Fedasil centres to € 3.91 in the reception centres of the *Rode Kruis Vlaanderen*[xxx]. These variations are partly explained by various organisations of health care within the different centres (salaried GPs or external GP), the available services, and the profiles of the residing asylum seekers[yyy]. Communities and regions also cover for prevention and health promotion activities, however, no exact numbers are known on the amount of these resources that are earmarked for asylum seekers.

Table 18 presents the repartition of medical costs among all collective Fedasil centres, the Fedasil dispatching at the Immigration Office and asylum seekers with a code 207 "No show" (reimbursement runs through the medical cell of Fedasil). Hospitalisations, pharmaceutical costs and specialist consultations represent respectively 55.7%, 13.3% and 12.6% of the expenses. Psychological care represent only 2.7% of the expenses.

Table 18 – Medical costs repartition for the Fedasil centres, the Fedasil dispatching and the code 207 "No show" in 2017[zzz]

Medical costs of Fedasil	Amount (€)	Percentage (%)
• Hospitalisations	8 744 278	55.7
• Pharmaceutics	2 093 699	13.3
• Consultations with a specialist	1 983 630	12.6
• Medical imagery	258 843	1.7
• Physiotherapy	357 204	2.3
• Laboratory	491 434	3.1
• Consultations with a GP	483 900	3.08
• Revalidation	424 120	2.7
• Psychologists	415 641	2.7
• Miscellaneous	320 359	2.0
• Orthopaedics	81 394	0.5
• Optician	46 242	0.3
Total	15 700 744	100

Source: Adapted from the financial reporting of Fedasil, page 266[151] – November 2018

uuu These subventions cover all activities related to the reception of asylum seekers and not only medical care.

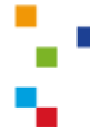
vvv Fix-payment per place in ILA – LOI depending on the occupation rate and the type of resident: the distribution of the subvention is therefore let at the discretion of the CPAS – OCMW. A majored fix-payment is allocated for "medical beds", that is for asylum seekers having specific medical needs.

www In 2019, private operators are no longer involved in the reception of the asylum seekers.

xxx These costs include: GP and specialist consultations, hospitalisations, medical imagery, physiotherapy, laboratories, opticians, orthopaedics, pharmacy, psychologists, and rehabilitation.

yyy For example, the majority of medical beds occupied by asylum seekers with the highest medical needs are located in Fedasil centres.

zzz These costs do not include: the location of medical material, the maintenance and reparation of medical material, the fees for translations and the costs related to medical transportation.[151]



APPENDIX 5. DETAILED PRESENTATION OF THE MEDICAL INTAKE OF ASYLUM SEEKERS

Appendix 5.1. Organisation of health care in the arrival phase

Appendix 5.1.1. Day 0

On day 0, applicants first have to apply for international protection at the Registration Service of the Immigration Office. The officer in charge of the registration of the application asks for existing medical conditions (see Figure 10).

Once registered, all applicants are directed to the medical service of the Fedasil dispatching, which is an orientation and assistance cell. At the medical service, asylum seekers are screened for TBC (only per Rx) and receive a first immunisation shot. A rapid medical assessment is made – see Figure 10– by nurses or a medical doctor.

The specific tuberculosis screening is organised at the arrival centre under the authority of the Fonds des Affections Respiratoires asbl/Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding (FARES – VRGT). All asylum seekers aged 5 years old or older undergo chest X-rays.

The immunization status of asylum seekers is checked during the medical intake and, if necessary, first immunization doses for the Measles-Rubeole-Mumps (*Rougeole Rubéole Oreillons RRO – Mazelen Bof Rubella MBR)* – and the tetanus diphtheria could be administered by a nurse. Vaccinations are made available at the arrival centre by the Flemish authority as part of a generalised vaccination campaign.

Those identified as having high medical needs after the medical check-up are oriented as soon as possible to a medical bed in one of the reception centres or to an external health institution.

Figure 10 – Medical intake of asylum seeker

ACCUEIL DEMANDEURS D'ASIL

INTAKE MEDICAL
Structure d'accueil :

Date :

NOM :	Eventuellement photo
PRENOM : sexe : H / F	
D.N :	
Nationalité :	
Numéro SP :	
Composition familiale : H F E …….	
Langue parlée :	
N° GSM :	

TB SCREENING	
OUI / NON	Date :

PARAMETRES (optionel : à remplir seulement si nécessaire)	
TA :	T° :
Pls :	Pd :

PROFIL MEDICAL			
		Lesquels	Dosage
Documents médicaux	OUI / NON		
Maladies chroniques en traitement	OUI / NON		
Médication actuelle	OUI / NON		
Allergies	OUI / NON		
assuétudes	OUI / NON		
Opérations	OUI / NON		

FEMME			
Gestité :	Parité :	Avortements :	Fausse couche :
Enceinte	OUI / NON	DDR: DPA :	Contrôle gynécologue : Date :
Contraception	OUI / NON	Laquelle :	
Excision (seulement demander aux femmes des pays à risque)	OUI / NON		

PREVENTION		
Polio à vacciner	OUI / NON	
Screening Ebola	OUI / NON	
Prise de sang	OUI / NON	
Rougeole / Oreillons / Rubéole	OUI / NON	
Vaccin DTP	OUI / NON	
Test de vision pour enfants 6 – 18 ans		OD : ….. / 10 OG : ….. / 10

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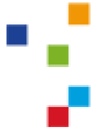

Appendix 5.1.2. Day 1

In the morning of day 1, applicants undergo a psycho-medical intake at the medical service of the arrival centre and their electronic health record is created. If necessary, a medication schema is started. In the afternoon, the applicants undergo the social intake.

Appendix 5.1.3. Day 2

On day 2, the Fedasil dispatching decides whether the asylum seekers are oriented to a collective centre or to an ILA – LOI[aaaa], based on the familial situation, the health status, the languages spoken by the asylum seekers and the language of the asylum procedure.

At this stage, a code 207 "No show" may be attributed if (i) the asylum seeker refuses their right to material assistance to live outside the reception network; or (ii) if the asylum seeker is a subsequent applicant. In this case, asylum seekers with a code 207 "No show" only benefit from medical assistance through Fedasil. All other necessities will have to be obtained privately.[52]

Appendix 5.1.4. Day 3

On day 3, asylum seekers can leave the arrival centre and travel to the reception centre (or their private housing), they are provided with bus- or train tickets and direction. For those with severe health problems, *ad hoc* transportations are organised. Asylum seekers also receive a hard copy of the medical file initiated in the arrival centre if their reception centre has no access to the electronic health record.

Appendix 5.2. Specific aspects for unaccompanied minors

Unaccompanied minors are oriented by the Fedasil dispatching to one of the four Orientation and Observation Centres (OOC), in which they stay 2 to 4 weeks while waiting for the confirmation of their minority (this verification is being done by the Guardianship service). During this period, unaccompanied minors undergo a first social, psychological, and medical screening to identify potential vulnerabilities. This screening helps the Fedasil dispatching to orient the unaccompanied minors to the most appropriate reception facility. If acknowledged as unaccompanied minors, they are oriented to a collective reception centre in which they are hosted in specific departments consisting of a dedicated team of educators[bbbb].

Appendix 5.3. Asylum seekers residing in collective reception centres and code 207 "No show"

ORGANISATION

- Primary care for residents of collective reception centres

Since September 2018, Fedasil centres rely on minimal norms for reception, including minimal norms for medical and psychological support[cccc].

In Fedasil centres, care provision is often organised and centralised within the centre, daily organisation and coordination is mostly managed by nurses, who represent the first contact point for asylum seekers. Nurses are in charge of the follow-up of the medical record, the follow-up of the vaccinations and TBC screening initiated at the Fedasil dispatching, nursing care (including nursing consultations), the administrative follow-up of residents (payment guarantee, appointments or interpreters), referral to the

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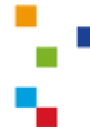
[aaaa] These last years, direct orientation to an ILA – LOI remains exceptional but could exist, depending on the familial situation and the health status of the applicants. Usually, when the collective reception network is saturated, the orientation is first to an ILA – LOI or a centre managed by a NGO and, secondly, to an ILA – LOI in a municipality.

[bbbb] Unaccompanied minors with specific needs or aged of less than 15 years are oriented in specific centres managed by the Communities in partnership with Fedasil. The reception centre of Rixensart has a specific department for the accompaniment of isolated minor mothers, including day care for the babies. The 6 Time-Out initiatives have been developed for unaccompanied minors with behavioural issues. See more info here: https://www.fedasil.be/fr/asile-en-belgique/mineurs/time-out

[cccc] Developed by the Quality Cell of Fedasil, these norms are applicable since September 2018. KCE was not allowed to publish them in this report.



GP, the external specialised services or to psychologists, follow-up of hospitalised patients, health education and psycho-social activities. External generalist practitioners and external psychologists consult within the centres during weekdays.

Each Fedasil centre has a reference person for vulnerable asylum seekers and those with mental health problems and 2 reference persons for FGM. Other centres designated a reference person for Lesbian Gay Bisexual Transgender or Intersex(LGBTI) or victims of human trafficking.[64] In the future, it is expected to have reference persons for gender-based violence and drug addiction.

Additional partnerships exist with *Kind&Gezin* and *ONE (Office de la Naissance et de l'Enfance)* for paediatric primary care. Additionally, pilot projects on psychosocial support are currently conducted in several centres in partnership with *Médecins Sans Frontières*. In the participating centres, a team consisting of an intercultural mediator and psychosocial advisor screen all asylum seekers for mental health problems and organise continuity of mental health care[dddd].

Asylum seekers in collective reception centres are required to consult with the health care professionals present in the centres. If asylum seekers decide to consult other health care professionals, fees have to be covered privately.

- Specialist care for residents of collective centres

When provided with a payment guarantee delivered by the reception centre, asylum seekers may consult specialists or be hospitalised. Payment guarantees are delivered on demand of the GP or nurse of the centre (i.e. clinical gatekeeping). Appointments are directly made by the nurses of reception centres and the asylum seekers cannot choose their health care professionals. In practice, to the extent possible, patient preferences are respected, i.e. organising a consultation with a female gynaecologist when explicitly requested by the patient. Transportation to and from external health care services is organised on ad-hoc basis: transport tickets are paid by the centre or direct transportation could be organised, sometimes with the support of volunteers.

- Primary care for asylum seekers with code 207 "No_show"

Asylum seekers with a code 207 "No show" can choose their primary health care professionals. However, they need a payment guarantee from Fedasil before consulting. In practice, this group of asylum seekers mostly consult in medical houses or with NGO's such as *Médecins du Monde*. Since December 2018, they may also present themselves to the arrival centre of *Petit-Château – Kleine Kasteeltje*.[153]

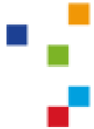
In case of emergency or if the asylum seeker has no payment guarantee, the primary health care professional should add a medical certificate confirming the urgent character of the consultation to the invoice.[51] In theory, if not acknowledged as urgent, asylum seekers have to cover all fees personally. In practice, stakeholders confirmed that Fedasil usually also covers these fees when there is no medical certificate of urgency.

- Specialised and hospital care for asylum seekers with code 207 "No show"

Asylum seekers need to apply for a payment guarantee at the medical cell of Fedasil before consulting with a specialist or hospitalisation. Health care professionals directly send their invoices to Fedasil. Asylum seekers with a code 207 "No show" could choose directly their specialists or hospitals. In practice, health care is mostly provided in public hospitals and with contracted health care professionals.

In absence of payment guarantee, similarly to the primary care, a medical certificate confirming urgency should be added to the invoice.[51] Again, a personal contribution can be asked if this medical certificate of urgency is not available. In practice, this is rarely applied.

[dddd] The final report of the project «Santé Mentale et support psychosocial pour demandeurs d'asile dans les centres d'accueil en Belgique » is currently being edited.



COVERAGE

The Royal Decree of 2007 determines the health care coverage for asylum seekers in execution of the 2007 Reception Law.[46] Coverage includes the NIHDI nomenclature, with the exception of some acts (such as the aesthetic surgery and some prosthesis) (i.e. Minus list) and with the inclusion of some acts (such as class D medications and some prosthesis) (i.e. Plus list).[47]

Table 3 presents the details of the Plus and Minus lists. This applies for all asylum seekers in collective reception centres and those with a code 207 "No show". Asylum seekers are not required to pay co-payment.

PAYMENT OF HEALTH CARE PROFESSIONALS

- Collective centres and partners

Nurses are salaried and directly paid by Fedasil or the partner. GPs are paid fee-for-service, based on the NIHDI nomenclature[eeee]. A payment per session is offered to psychologists, with different tariffs depending on the type of session (group therapy or face-to-face therapy).

Fedasil directly reimburses external health care professionals and hospitals. Partner centres first pay the external health care professionals and send their invoices to Fedasil for further reimbursement. Rules for the financial intervention of Fedasil are detailed in a vademecum, including clinical conditions to get access to the acts, products or services. These rules apply for all collective centres (i.e. Fedasil and partner organisations).

- Code 207 "No show"

Invoices related to health care are directly paid to the health care professionals or services based on the payment guarantee. In case of exceptional costs, the medical cell may request a medical report and/or a cost estimates before authorising it, e.g. for an expensive surgery.[48] Asylum seekers with a code 207 "No show" have no right to health care via the CPAS – OCMW as stated by the article 57ter of the Organic Law of the CPAS – OCMW[49]. If a CPAS – OCMW wrongly opens access to health care for an asylum seeker with a code 207 "No show", Fedasil will correct it, case by case.[52]

CONTROL MECHANISMS

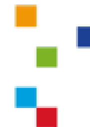
Control is managed a priori by the medical cell of Fedasil based on the notion of "necessity" as described in the article 23 of the 2007 Reception Law. Health care professionals in the reception centre should appreciate the necessity and ask for approval by the medical cell of Fedasil. This *a priori* and *ad hoc* control is mostly done for expensive health care costs: prior approval of the medical cell is necessary but some health care professionals/health care institutions bypass it. No *a posteriori* control is done because of lack of manpower and resources.

Appendix 5.4. Asylum seekers residing in ILA – LOI managed by CPAS – OCMW

After a stay of at least 4 months in a collective reception center, asylum seekers can ask for a transfer to an ILA – LOI. They will then stay in the ILA – LOI as long as the asylum procedure is ongoing. Fedasil attributes a lump sum to the CPAS – OCMW to cover the expenses of asylum seekers in ILA – LOI (all expenses, not only for medical care). This lump sum depends on the occupation rate during a defined period and the costs related to the buildings.[52]

The CPAS – OCMW is in charge of the material assistance of asylum seekers, however, no specific procedural guidelines have been developed by the PPS Social Integration. The existing rules of the PPS Social Integration are then applied to the asylum seekers regarding the reimbursement of the medical costs (compulsory social inquiry and similar paperwork).[52]

[eeee] Fedasil previously had contracted GPs.



ACCESS TO HEALTH CARE (PROFESSIONALS)

Asylum seekers residing in ILA – LOI are entitled to coverage of health care as part of the material assistance provided by the CPAS – OCMW of the municipality of the ILA – LOI. A social inquiry is performed by the social assistant to assess the (medical) needs of the asylum seeker by collecting information on the financial resourse of the asylum seekers (and possible cohabitants).[154] The objective of this social inquire is to assess the financial capacity of the asylum seeker to afford his/her needs (social inquiry is not limited to health care).

Part of the social inquiry concerns the existence of another form of health care insurance or the right to be affiliated with a health care insurance. Some asylum seekers may still have the right of health care through Fedasil. In this case, the CPAS – OCMW will refer the asylum seekers back to their designated reception centre. It is also possible that they have the right to register with a sickness funds (for example, if asylum seekers have a work permit or are unaccompanied minors meeting the conditions of school attendance). This is investigated by means of screening the Crossroads Bank for Social Security (BCSS – KSZ). The CAAMI – HZIV will be contacted by the CPAS – OCMW to check this information.

Based on the results of the social inquiry, the social assistant in charge of the file provides the asylum seeker with a guarantee of payment for the health care provider.[53] Depending on the CPAS – OCMW, the payment guarantee could take the form of a card[ffff] covering primary care for a defined period – i.e. for 3 months – or a document for each single act. Depending on the CPAS – OCMW, the personal situation of the asylum seeker is re-assessed at regular intervals to adapt the material assistance (and not only health care) to its needs.

For hospital care, the notification of coverage by the CPAS – OCMW is done electronically since 2014, thanks to a computerized data transfer system called MediPrima. MediPrima connects the CPAS – OCMW, hospitals, CAAMI – HZIV, and the PPS Social Integration. MediPrima will be extended to GPs and community pharmacies in the near future.

HEALTH CARE PROVISION

When asylum seekers leave a collective reception centre to transfer to an ILA – LOI, they should be provided with a 5-days' supply of medication, a paper copy of their patient health record and other relevant information.

Asylum seekers access primary care through the CPAS – OCMW. Depending on the CPAS – OCMW, asylum seekers have to consult with a specific health care professional, may choose from a provided list or are entirely free in their choice. Asylum seekers may consult as many health care professionals as they wish. In practice, the CPAS – OCMW tend preferentially to pre-establish agreements with medical houses for administrative facility.

Depending on the CPAS – OCMW, asylum seekers may directly choose their specialist or hospital, receive a list of collaborating specialists or hospitals, or are directly oriented to a designated specialist/hospital. Contracted specialists are favoured by CPAS – OCMW for budgetary issues. In practice, the two latter cases are the most frequent situations as it eases the access for asylum seekers and simplifies the administrative aspects.

COVERAGE

For asylum seekers residing in an ILA – LOI, the acts included in the NIHDI nomenclature are eligible for coverage.[51] In theory, CPAS – OCMW do not apply the Plus and Minus lists (as used in Fedasil and partner reception centres). However, each CPAS – OCMW can decide to cover medical care or medication which is not regularly reimbursed according to the NIHDI nomenclature (e.g. drugs from the D category, tooth extractions, powdered milk for babies, etc.) through the lump sum allocated by Fedasil or with its own funds. Attempts for harmonisation exist, since 2018, the 19 CPAS –

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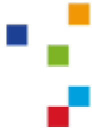
ffff Depending on the health care needs, this card may serve as payment guarantee for GP visits, pharmacy, physiotherapists or nursing care.



OCMWs in Brussels have a common list of class D drugs that will be covered on their own funds or the Fedasil lump sum for both ambulatory and hospital care[gggg].

PAYMENT OF HEALTH CARE PROFESSIONALS

- Health care delivered outside the hospital

Health care professionals/organisations send their invoices to the CPAS – OCMW with the payment guarantee. The CPAS – OCMW then reimburses fees: if the act is included in the NIHDI nomenclature, the CPAS – OCMW covers the same amount than the sickness funds. Co-payment is not required for asylum seekers, which means that all costs are covered by the CPAS – OCMW. However, the CPAS – OCMW does not cover the supplementary honorarium. There is also the possibility of refusing invoices from health care professionals or organisations if asylum seekers do not comply with the legal requirements related to material assistance.[51]

In a second stage, the invoices are transferred to the PPS Social Integration to be reimbursed if the acts are covered by the NIHDI nomenclature. The PPS Social Integration will pay the part that is normally paid by the sickness funds (and the co-payment, if all conditions are fulfilled according to the social inquiry).

If the CPAS – OCMW decides to cover health care which is usually not reimbursed within the NIHDI nomenclature (e.g. drugs from the D category, e.g. certain painkillers, ointments, tooth extractions, powdered milk for babies, etc.), these will be paid with its own funds or with the lump sum allocated to ILA – LOI by Fedasil.[9]

When an asylum seeker is entitled to the compulsory health insurance (e.g. because the asylum seeker is working), the ILA – LOI needs to take care of the affiliation of the asylum seeker to a sickness funds or the CAAMI – HZIV. In that case the PPS Social Integration only reimburses the co-payment, if the income of the asylum seeker is below the minimal income provided by a CPAS – OCMW.[155]

- Health care delivered in hospital

Since 2014, a computerized system, called MediPrima, has been installed to connect the CPAS – OCMW, hospitals, and the CAAMI – HIZV to enhance information flows[hhhh].[148]

The decision of coverage taken the CPAS – OCMW is registered in MediPrima and is directly accessible to health care providers who in case of health problems can immediately know if the consulting person is covered. The patient receives an identification card with his/her name, picture and a NISS – BIS number from the CPAS – OCMW to be presented at the hospital. The health provider notifies through MediPrima that he/she has delivered care. The payment guarantee remains with the health care provider. Within MediPrima[iiii] invoices covered by the CPAS – OCMW are paid directly by the CAAMI – HZIV[jjjj] to the health care providers, reducing the delays for

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[gggg] See the list here: https://www.avcb-vsgb.be/fr/federation-des-cpas-bruxellois/medicamentsd/medicamentsd.html

[hhhh] The PPS Social Integration established MediPrima with the following objectives:

1. To computerize the decision of coverage taken by the CPAS – OCMW regarding reimbursement of medical care, and thus to make it accessible to health care providers at the time of the medical consultation

2. To transfer the financial management of the reimbursement of health care to the CAAMI – HZIV, which should allow accelerating the reimbursement of health care and alleviating the administrative burden of CPAS – OCMW

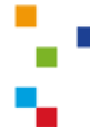
3. To improve controls: the central database makes it impossible for different CPAS – OCMW to submit simultaneous demands of coverage for a same individual; the CAAMI-HZIV can control invoices following the same rules as for the AMI-ZIV

4. To accelerate reimbursements to health care providers

5. To reduce barriers to health care services for undocumented migrants.

[iiii] To know more about the MediPrima system: http://www.mi-is.be/be-fr/e-government-et-applications-web/mediprima

[jjjj] http://www.caami-hziv.fgov.be/Model4-10-F.htm



reimbursement. The CAAMI – HZIV provides a monthly feedback to PPS Social Integration and gets reimbursed. The system will be extended to GPs and community pharmacies in a close future[kkkk].

CONTROL MECHANISMS

The financial responsibility is borne by the CPAS – OCMW that has granted the payment guarantee. *A posteriori* control visits could be organised by the PPS Social Integration. Random assessments are also made on a sample of files to check the correctness of the procedures (i.e. if the substantiating documents have all been collected and are correct).[50] In case of errors, the corresponding costs and potential penalties have to be covered by the CPAS – OCMW. No penalty will be addressed to the asylum seekers or the health care providers.

Within MediPrima, the control of the invoices submitted by the health providers is under the responsibility of the CAAMI – HZIV (electronic billing via MyCareNet if the error rate ≤ 5%). A random sampling of 5% of the files is made by the CAAMI – HZIV for checking the correctness of the administrative documents. As much as possible, the CAAMI – HZIV also attempts to check in 1% of the files what health services were delivered in reality[llll]. The CPAS – OCMW receive feedbacks about the individual expenses covered for asylum seekers and undocumented migrants in their municipality.

Appendix 5.5. Asylum seekers residing in a ILA – LOI not managed by a CPAS – OCMW

- Primary care for residents of ILA – LOI managed by other partners than CPAS – OCMW

Asylum seekers occupying medical beds in the partner ILA – LOI are supported by nursing staff. An integrated accompaniment is often provided, with a medical and social record[64]. Depending on the reception partner, primary health care could be directly provided at the ILA – LOI. Asylum seekers could be allowed to choose their GP or have to consult with a contracted GP.

- Specialised and hospital care for asylum seekers in ILA – LOI managed by other partners than CPAS – OCMW

Asylum seekers could be allowed to choose their specialist or have to consult with contracted partners. In practice, a clinical gatekeeping (by a nurse or a GP) is often organised before referring patients to specialty care.

COVERAGE

Asylum seekers residing in a ILA – LOI managed by a NGO benefit from the acts included in the NIHDI nomenclature and of the Plus list[51].

PAYMENT OF HEALTH CARE PROFESSIONALS

Health care provided inside the ILA – LOI are charged to Fedasil by the NGO. For health care provided outside the ILA – LOI, depending on the NGO organisation, a payment guarantee could be issued to the asylum seeker. In some ILA – LOI, some fees are first paid by the asylum seeker who, in return, are reimbursed by the ILA – LOI. In other ILA – LOI, invoices are first reimbursed to health care professionals. These ILA – LOI are then reimbursed by Fedasil.

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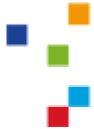
kkkk Extensions are also planned to other population groups such as Belgian homeless persons benefiting from medical aid through the CPAS – OCMW.

llll The check of medical file by the HZIV-CAAMI is in reality not possible as sickness funds have legally no access to diagnosis data.



Appendix 5.6. 9ter with a pending application for international protection

As long as the application for international protection is still pending and the 9ter application is still under scrutiny for the form (i.e. admissibility of the application), the asylum seeker has right to the material assistance provided by Fedasil, a reception partner or the CPAS – OCMW, depending of their 207 code.

If the application on the 9ter grounds is deemed admissible, asylum seekers receive a temporary permit of stay and have right to social aid (i.e. financial aid) through the CPAS – OCMW. If the medical condition or degree of autonomy allows it, asylum seekers can be asked to leave the reception network: Fedasil supresses their code 207 related to their compulsory place of residence and thereby their right to material assistance[54]. For those needing medical attention and specific services, they will have to find a place in a health care institution (e.g. nursing home) outside the reception network.[55]

If the application on the 9ter grounds is not admissible and no decision regarding the asylum application has been taken yet, the right to material assistance persists until the final decision of the asylum application. If asylum is granted, the 9ter application is automatically suspended.

APPENDIX 6. RESULTS OF THE ONLINE SURVEY

A total of 171 persons participated to the online survey. Among the respondents, 75 reported working in Brussels, 53 in Wallonia and 43 in Flanders. The average professional experience was 38.25 years. Respondents were working for: CPAS-OCMW (including ILA-LOI) (n=71), reception centres (n=27), health services (n=20), sickness funds (n=13), NGO and non-profit associations (12), public institutions (n=10), specialised health services (n=7), representatives of asylum seekers and refugees (n=5), academics (n=3), integration centre (n=1), professional association (n=1), social services (n=1). Concerning the professional activity of the respondents, the final sample included: 71 social workers, 39 health care professionals, 39 coordinators (either for health or social issues), 38 “advisors” and 5 researchers.

Appendix 6.1. Governance in health care for asylum seekers

Appendix 6.1.1. Centralised and coordinated health policy

Almost 85% of the respondents agreed with the statement that health of asylum seekers requires a centralised and coordinated health policy (Figure 11) (n=145). Pro arguments were mostly supporting the idea of standardisation and of a better coordination.

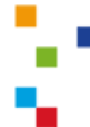
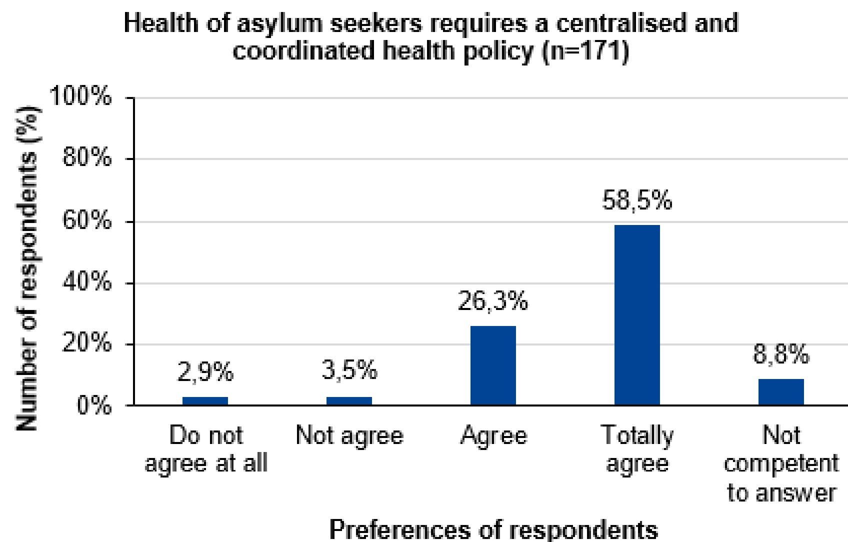


Figure 11 – Preferences for a centralised and coordinated health policy for asylum seekers, according to the respondents to the online survey, Belgium, 2018 (n=171)



Fedasil and the FPS Public Health were the two preferred coordinating and centralising institutions, followed by the creation of a strategic committee health and migration (**Error! Reference source not found.**).

The key position of Fedasil is supported by their existing and longstanding expertise regarding reception of asylum seekers. Fedasil is also perceived as non-independent, with a lack of public health expertise and missing connections with other partners. Some respondents argued that conveying the leadership to the FPS Public Health could be a tool for integration and normalisation, although other respondents pointed out that the FPS Public Health has no competence in asylum seekers health.

The strategic committee was perceived as positive, allowing for more interactions and exchanges across disciplines but also for granting independency. The side-effect is having an “empty shell”, because of the lack of legal power to make decisions.

Instead of a strategic committee, some respondents suggested a coordination committee between public health and Fedasil or giving the operationalisation to Fedasil with a strategic committee for policy aspects.

When stakeholders could choose only one institution, Fedasil was preferred, followed by the strategic committee and the FPS Public Health (**Error! Reference source not found.**).

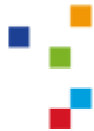
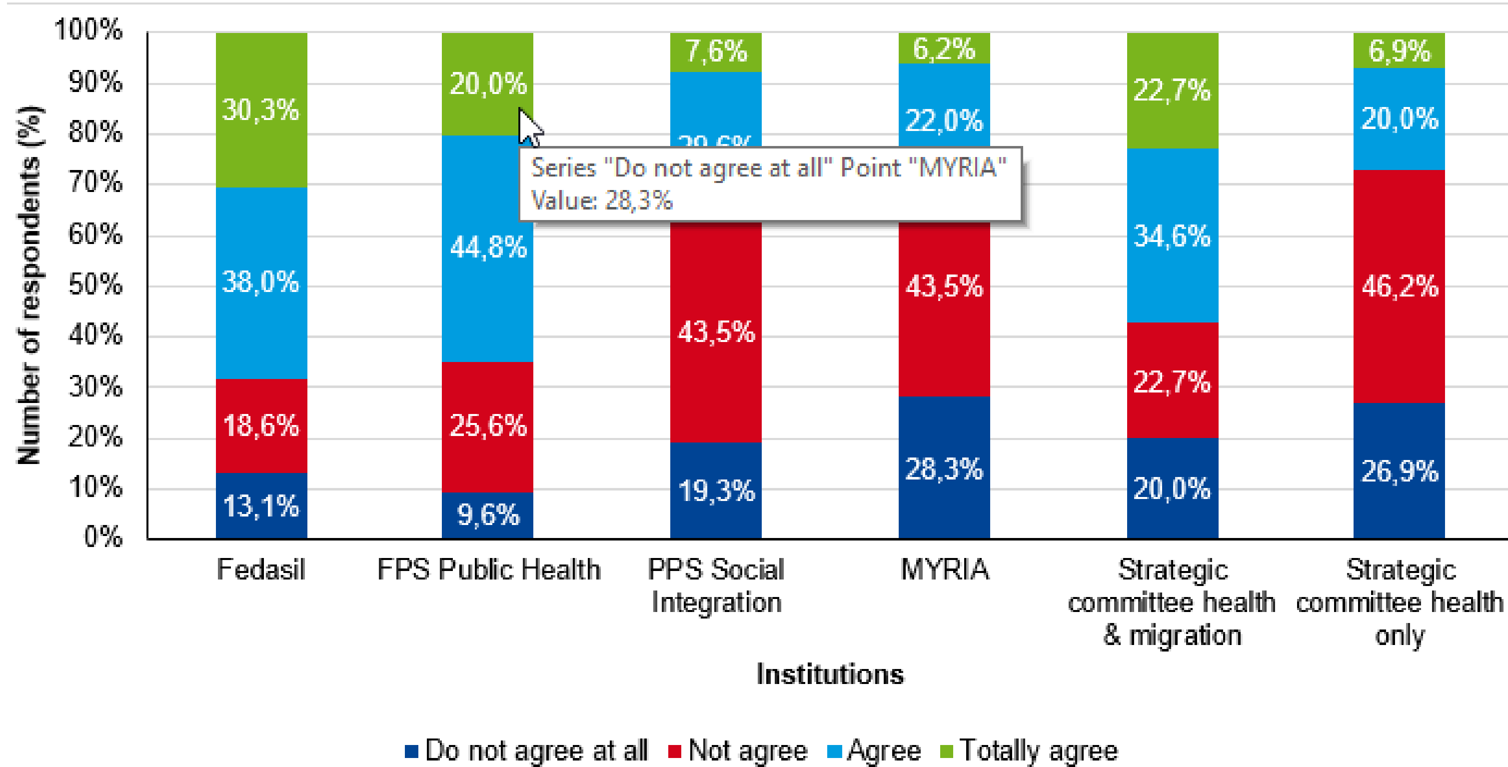


Figure 12 – Preferences for the coordinating institution of the health policy for asylum seekers among the respondents to the online survey on asylum seekers health, Belgium, 2018 (n=145)



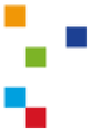
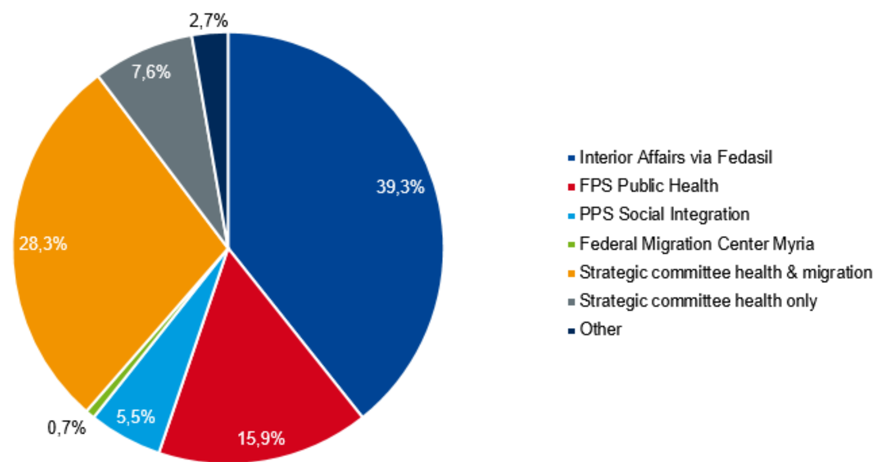


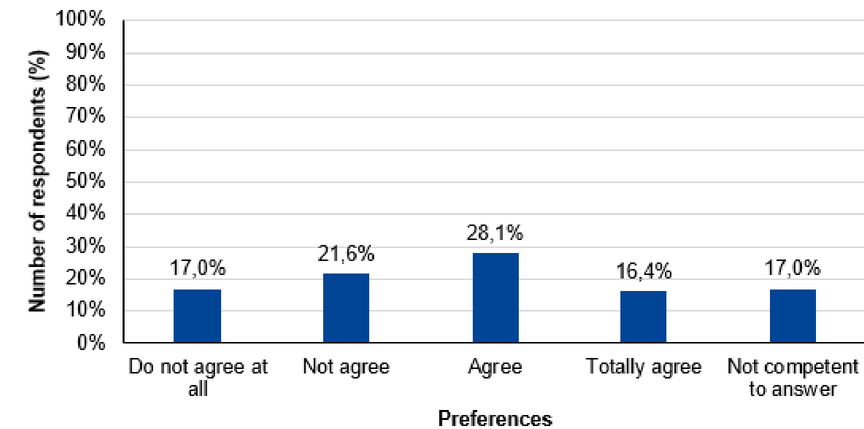
Figure 13 – Preferred leading institution for coordinating a centralised health policy for asylum seekers in Belgium when one choice is allowed, according to the respondents to the online survey, Belgium, 2018 (n=145)



ORGANISATION OF HEALTH CARE FOR ASYLUM SEEKERS

Organising health care according to the place of residence and/or status of asylum seekers was supported by 44.5% of the respondents while 38.6% of the stakeholders did not agree with the health care organisation according to the residence place and/or status (Figure 14).

Figure 14 – Preferences of respondents to the online survey regarding a health care organisation based on the residence place and/or the status of asylum seekers, Belgium, 2018 (n=171)



Among those against a system different according to the place of stay or status (n=76), when allowed to rate several organisational options, the unique organisation of health care was supported by 73% of the respondents (n=56), while 61.9% of the respondents agreed with an organisation of health care based on the current reception network (n=47)(Figure 15).

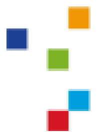
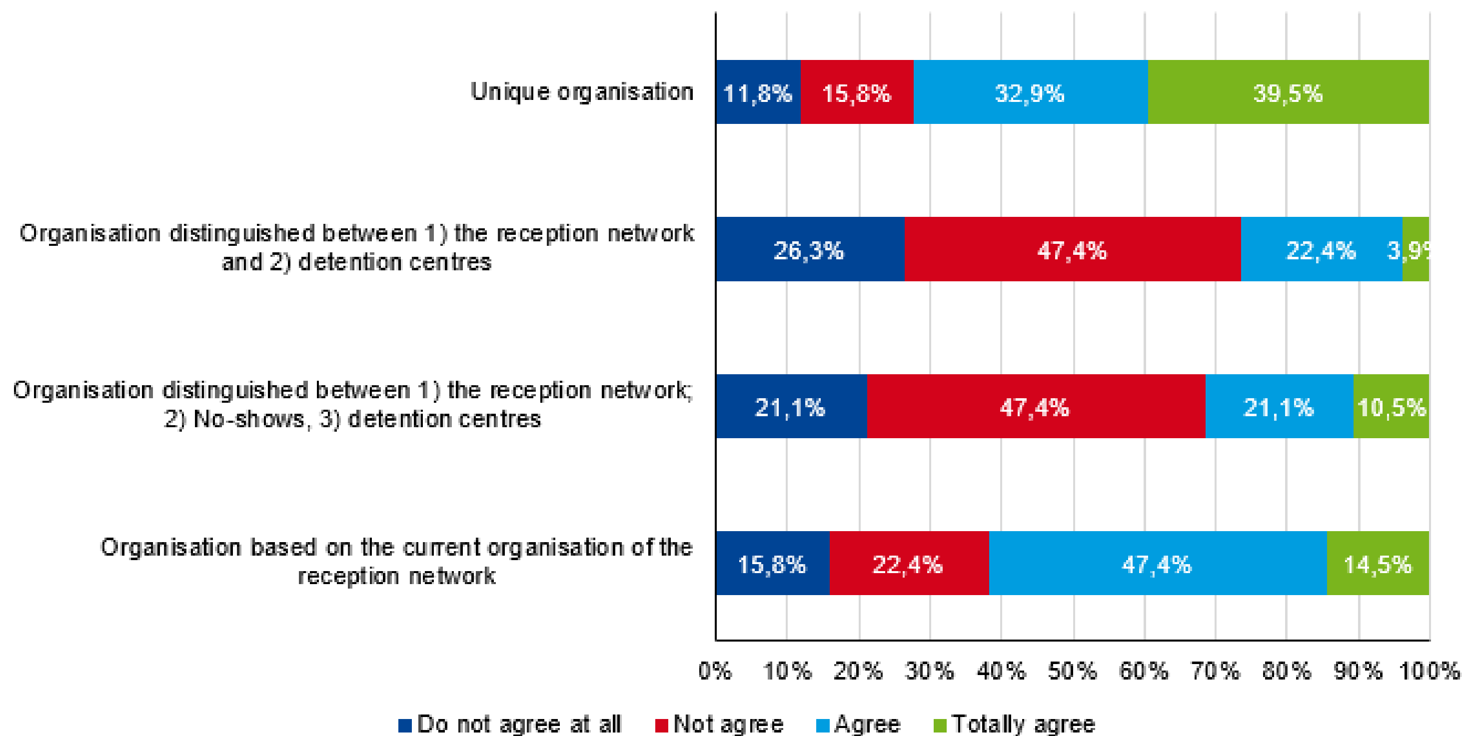


Figure 15 – Preferences for options regarding the health care organisation according to residence place and/or status of asylum seekers according to the respondents to the online survey, Belgium, 2018 (n=76)



Respondents may rate all options the same way

However, when forced to choose one option, 63.2% of the respondents opted for a unique organisation of health care (n=48) (Figure 16). Main argument supporting the unique system concerned the simplification of the procedures as stated by a respondent:

“Il est parfois facile de se perdre dans les différents statuts des demandeurs d'asile, dans l'état de leur procédure, ... Il serait donc plus simple que l'organisation soit la même pour tous. La loi sur les demandeurs d'asile est déjà très complexe, pourquoi ne pas simplifier les choses ? »

Quote retrieved from the online survey

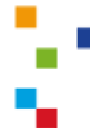
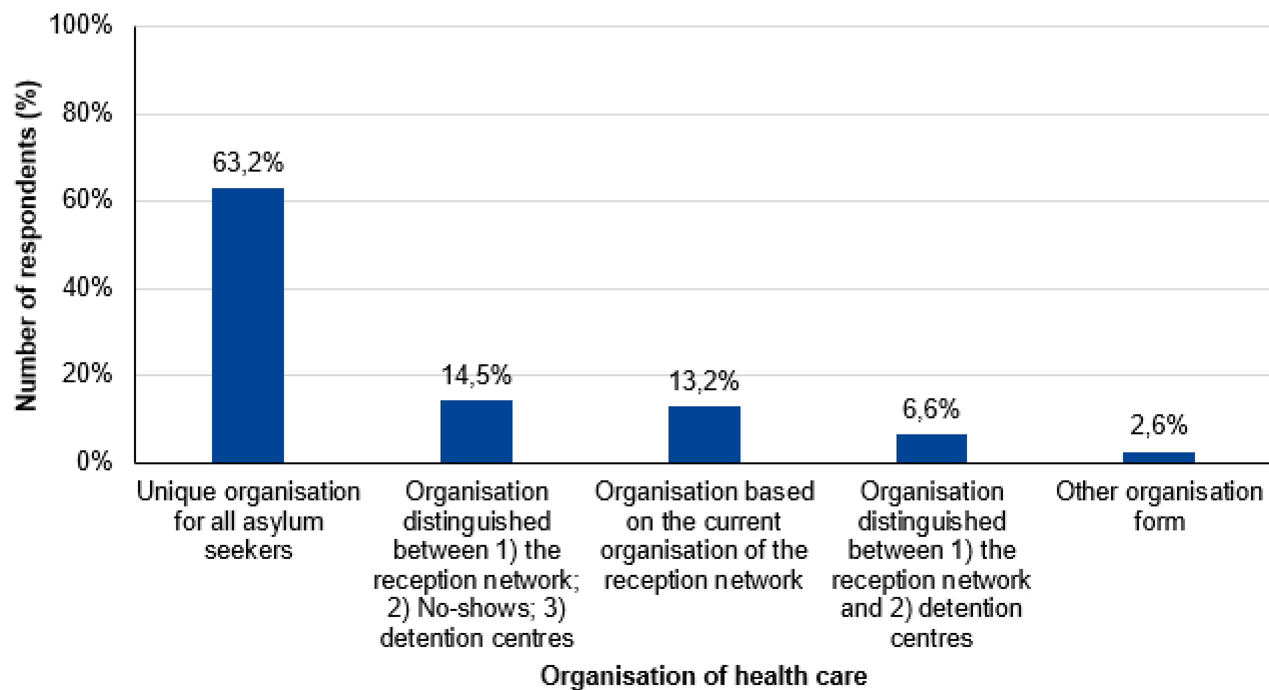


Figure 16 – Preferred organisation of health care for asylum seekers in Belgium – one possible choice, among respondents to the online survey, Belgium, 2018 (n=76)



INTEGRATION OF HEALTH CARE IN THE MAINSTREAM HEALTH CARE SYSTEM

Most of the respondents agreed with the proposal that health care should be provided to asylum seekers in the mainstream health care system (66.7% for the primary care (n=114); 66.1% for health care outside primary care (n=113), see Figure 17).

Integrating health care in the mainstream health care system could favour the simplification of the current procedure and limit a (costly) parallel health care system. Integration could increase the risk of overconsumption of health care. There is also a risk of a lack of specific expertise in the regular health care system.

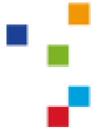
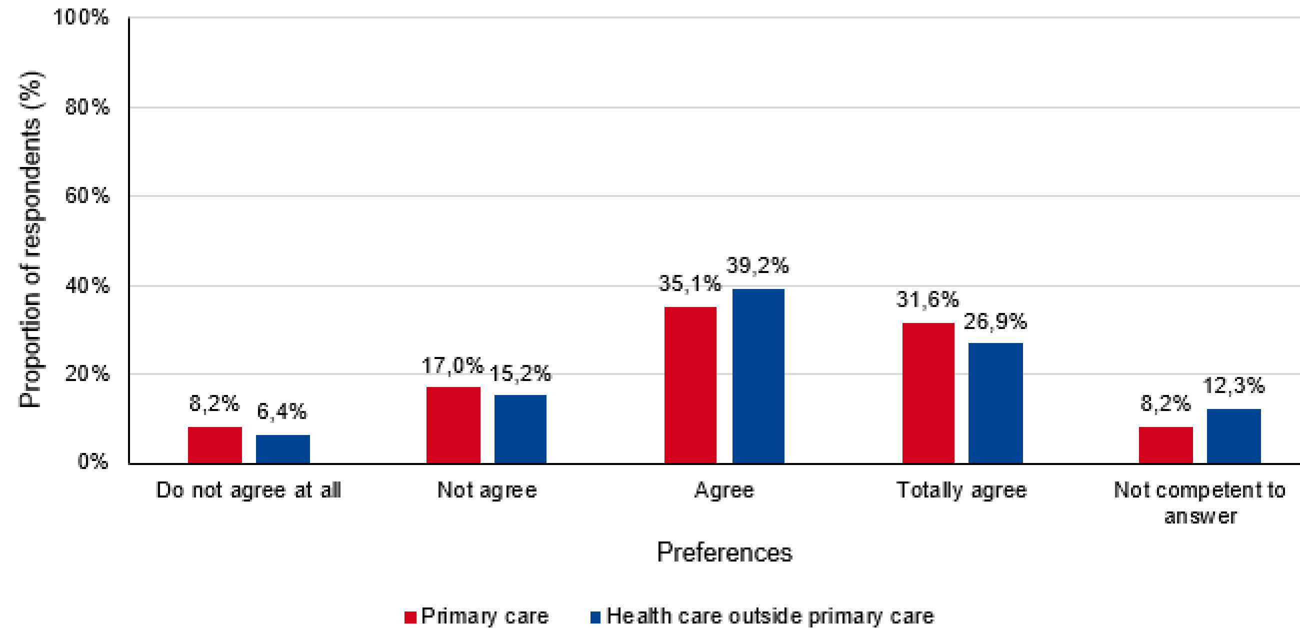


Figure 17 – Preferences for integrating asylum seekers in the mainstream health care system for the primary care and the other lines of care, according to the respondents of the online survey, 2018 (n=171)



HEALTH CARE FOR UNACCOMPANIED MINORS

Almost 20% of the respondents declared themselves unable to answer due to the complexity of the topic (n=32). The majority of respondents therefore agreed with having a different health care organisation for unaccompanied minors (Figure 18). Those supporting a different system argued that the unaccompanied minors require a specific attention because of their loneliness. By contrast, respondents supporting a unique health care organisation stressed the need for equity between all minors applying for asylum.

« Nous estimons qu'il ne faut pas distinguer selon les différents statuts que pourrait avoir un demandeur d'asile. Cela risque en effet de plus accentuer la différence des soins donnés. On veut éviter une médecine à deux vitesses. Chaque être humain est égal. »

Quote retrieved from the online survey

"NBMV zijn een kwetsbare groep en hebben op sommige vlakken extra ondersteuning/begeleiding nodig, ook op medisch vlak."

Quote retrieved from the online survey

Figure 18 – Preferences for the organisation of health care for unaccompanied minors applying for asylum in Belgium, according to the respondents of the online survey, Belgium, 2018 (n=171)

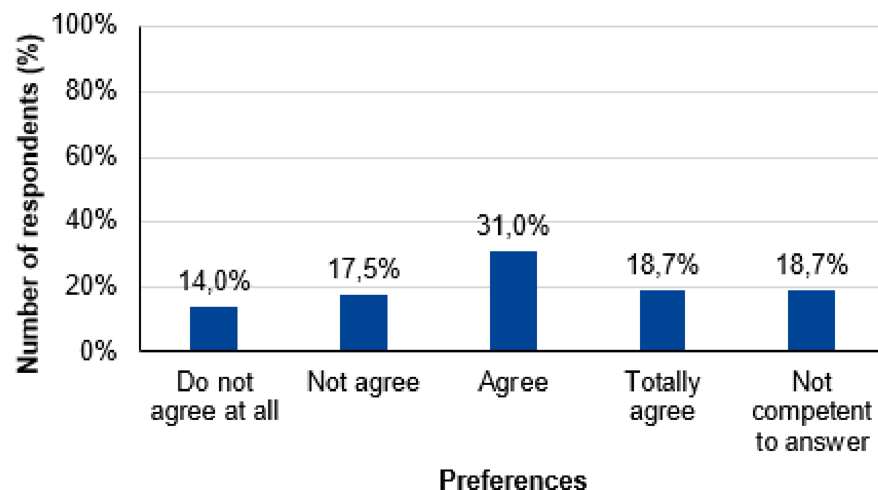
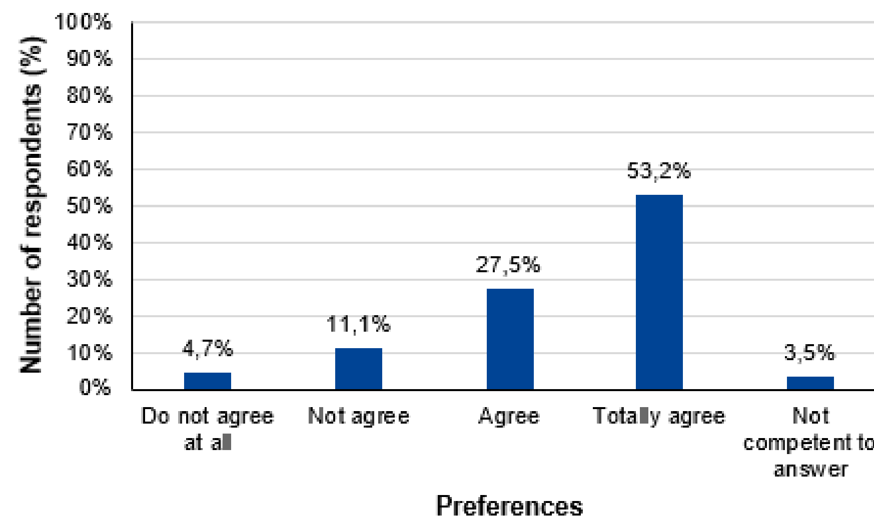


Figure 19 – Preferences for the health care coverage for asylum seekers, according to the respondents of the online survey, Belgium, 2018 (n=171)



COVERAGE OF HEALTH CARE

At least 80% of the respondents agreed with the proposal that all asylum seekers should benefit from the same health care coverage, independently of their status or residence place (n=138) (Figure 19).

The respondents mostly agreed that support services (66.7%, n=92), prevention and screening (56.5%, n=78) and health promotion (50%, n=69) should be part of the health care coverage (Figure 20). The content of the “basic” health care coverage remained therefore unclear.

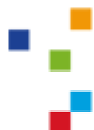


Figure 20 – Preferences for the content of the health care coverage according to the respondents of the online survey, Belgium, 2018 (n=138)

The health care coverage could include (n=138):

Preferences for the content of the coverage (%), by content of the coverage:

Content of the coverage	Do not agree at all	Not agree	Agree	Totally agree	Not competent to answer
Support services	2,2	0,7	24,6	66,7	5,8
Prevention & screening	2,9	2,2	30,4	56,5	8,0
Health promotion	4,3	5,1	29,0	50,0	11,6
A reduced Minus list	12,3	15,9	7,2	8,7	55,8
An extended Minus list	18,1	20,3	4,3	3,6	53,6
A reduced Plus list	21,0	21,0	1,4	1,4	55,1
An extended Plus list	10,1	10,9	10,9	15,2	52,9
The NIHDI nomenclature without the Plus & Minus lists	8,0	23,9	16,7	10,1	41,3
The NIHDI nomenclature and the Plus & Minus lists	7,2	13,8	23,9	20,0	14,5

X-axis: 0, 20, 40, 60, 80, 100 – Preferences for the content of the coverage (%)

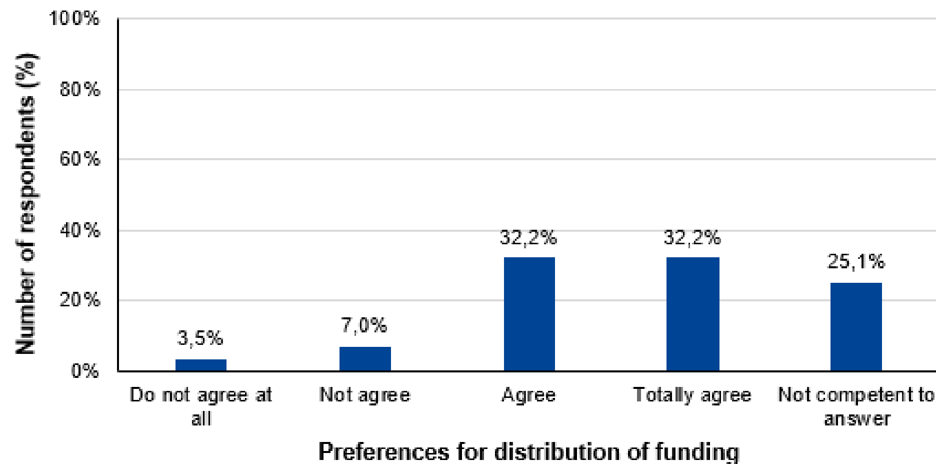
Y-axis: Content of the coverage

Legend: Do not agree at all; Not agree; Agree; Totally agree; Not competent to answer

DISTRIBUTION OF FUNDING OF HEALTH CARE FOR ASYLUM SEEKERS

Twenty-five per cent of the respondents declaring themselves unable to answer (n=43) (Figure 21). The majority of respondents (64.4%, n=110) therefore supported a funding distribution through a global envelope including the NIHDI nomenclature, the Plus list, the Minus list, prevention and screening, health promotion, and support services.

Figure 21 – Preferences regarding a funding scheme based on a global envelop for the health care of asylum seekers, according to the respondents of the online survey, Belgium, 2018 (n=171)



Respondents mostly favoured the NIHDI as funder of the global envelop (36.6%, n=74), mainly for practical issues (Figure 22).

"Sterk administratieve vereenvoudiging (controle artsen bij het RIZIV zijn het best geplaatst om expertise te hebben en te houden gezien vaak complexe materie; kostenbesparend; alignatie van zorg tussen bewoners van LOI en in collectieve structuren; Op dit ogenblik zijn er grote verschillen waarneembaar tussen OCMW onderling en tussen OCMW en Fedasil (vb psycholoog, logopedie, brillen, ...)".

Quote retrieved from the online survey

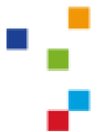
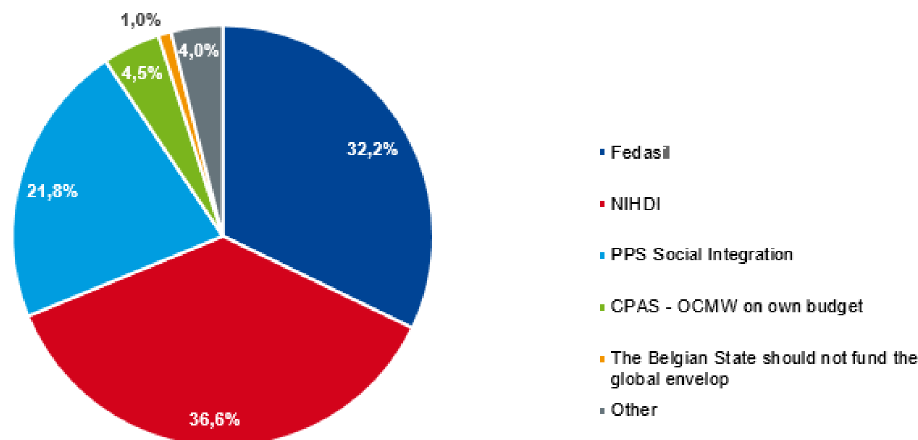
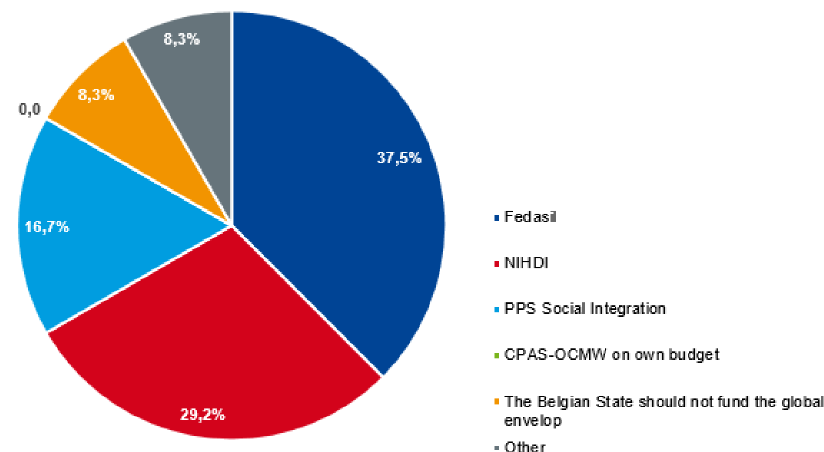


Figure 22 – Preferences of respondents to the online survey for funders of a global envelope for health care for asylum seekers – multiple answers allowed – Belgium, 2018 (n=202)



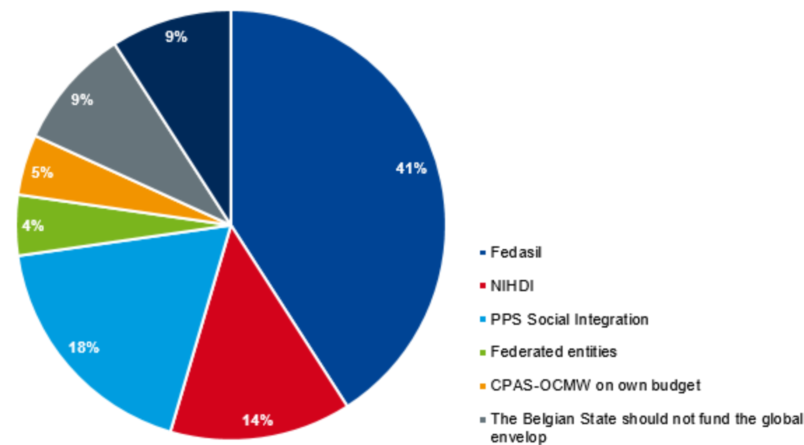
Respondents disagreeing with the global envelop were asked for each part of the coverage which actor should cover for which aspect of health care provision for asylum seekers (n=24) (Figure 23). For the majority of them, the NIHDI nomenclature should be covered either by Fedasil (37.5%, n=9), either by the NIHDI (29.2%, n=7). Other funders suggested were the countries of origin, the United Nations, the federated entities, some banks or the private sector.

Figure 23 – Preference for the funding of the NIHDI nomenclature for asylum seekers if no global envelope is considered, according to the respondents of the online survey, Belgium, 2018 (n=24)



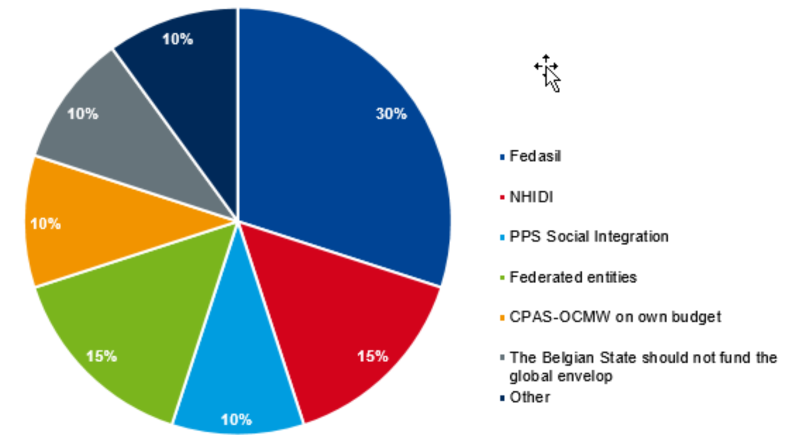
When it came to the Plus list, Fedasil was chosen as preferred funder by 40% of the respondents (n=10). Others included the FPS Interior (Figure 24).

Figure 24 – Preference for the funding of the Plus list for asylum seekers if no global envelope is considered, according to the respondents of the online survey, Belgium, 2018 (n=24)



Only 24 respondents positioned themselves regarding health promotion, by stating that Fedasil should cover for it (30%, n=7), followed by the NIHDI (15%, n=4), or the federated entities according to their competences (15%, n=4) (Figure 25).

Figure 25 – Preference for the funding of health promotion for asylum seekers if no global envelope is considered, according to the respondents of the online survey, Belgium, 2018 (n=24)



Similarly, Fedasil was the preferred financing body for screening and prevention (36%, n=8), followed by the NIHDI (18%, n=4) and, at equal parts, the PPS Social Integration (14%, n=3) and the federated entities (14%, n=3) (Figure 26).

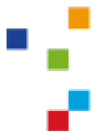


Figure 26 – Preferred funder for screening and prevention for asylum seekers, if no global envelope is considered, according to the respondents of the online survey, Belgium, 2018 (n=22)

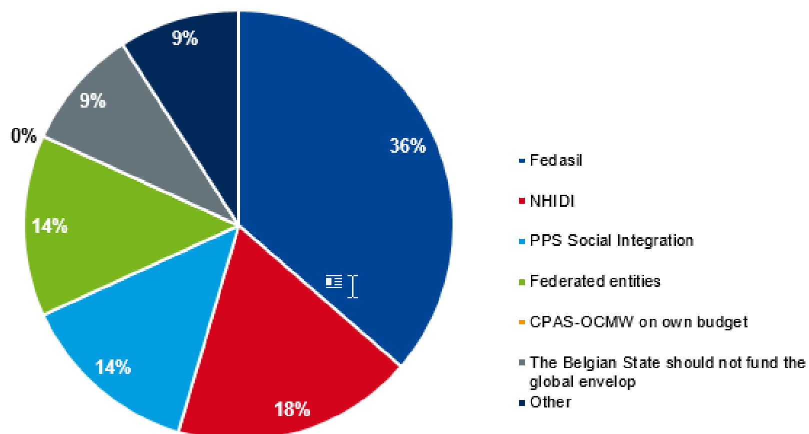
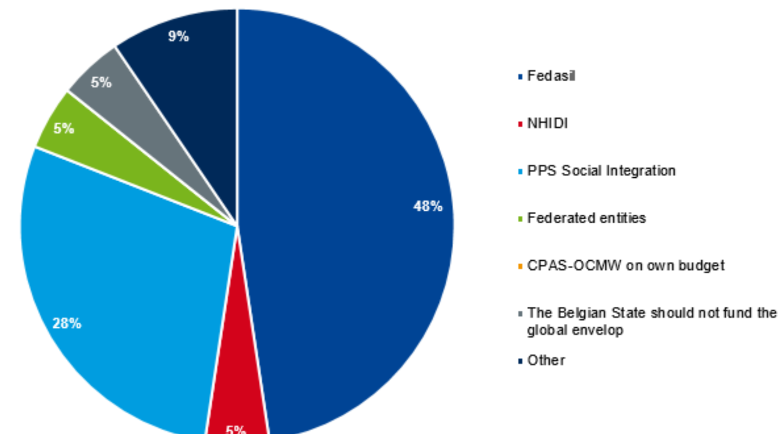
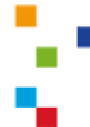


Figure 27 – Preferred funder for support services for asylum seekers if no global envelope is considered, according to the respondents to the online survey, Belgium, 2018 (n=22)



Regarding the support services – such as the intercultural mediators or the interpreters – preferred funder was Fedasil as stated by almost 50% of the 22 respondents (n=11) (Figure 27). Other included the FPS Interior and the NIHDI together.



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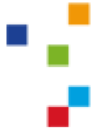

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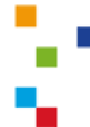

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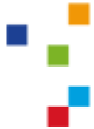

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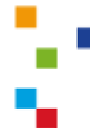

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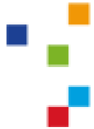

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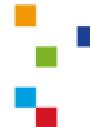

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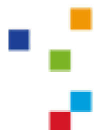

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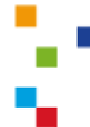

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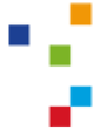

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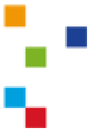

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